PLANNING FAMILIAL EN
PLANNED PARENTHOOD IN
FAMILIENPLANUNG IN

EUROPE

Bulletin d'Information Régional
Regional Information Bulletin
Regionale Informationen

Vol 10 No 1 April 1981

In this issue

SEXUALITY AND HANDICAPPED PEOPLE

This periodical is published twice a year by the IPPF Europe Region, 18-20 Lower Regent Street, London SW1 4PW, and is available free-of-charge on request.

S E X U A L I T Y A N D H A N D I C A P P E D P E O P L E

A VIEW FROM NORWAY

Over the last 4-5 years the Norsk Forening for Familieplanlegging (NFF) has arranged courses about life and the handicapped. The initiative for this work stemmed from a seminar organised by the IPPF Europe Region, in March 1976. The courses have been arranged in cooperation with the Norwegian Association for the Disabled, and are financed by the official authorities.

Openness in matters of sexuality has never been an accepted thing in Norway. Even though contraceptives are now readily available, it is not so long ago that one could only buy them by mail order or in vending machines. Nowadays, you can buy contraceptives in supermarkets and at service stations but not in all pharmacies.

School curricula include provisions for sex and family life education, but in practice it is left entirely up to the individual teacher as to whether such education is given. It also depends on the teacher's knowledge in that area and his/her own attitude to sexuality. Very often the school authorities do nothing, in the belief that the parents themselves will deal with aspects of life, whereas the parents hope and trust that the school will give the necessary information. However, recent debates have resulted in a more open attitude towards knowledge of contraception.

While it is now much more easy to talk about sexuality and contraception, it is still usual to think that the handicapped cannot have a sexual life. This is especially true of institutions for the disabled, where sexual feelings are simply not discussed.

Ignorance is strengthened through prejudice which is again reinforced by the modern day ideal of the 'perfect body'. Many people close their eyes to the fact that both physically and mentally handicapped people have the same emotional needs as 'ordinary' people. These attitudes can be found everywhere, both inside and outside the institutions, and also among health personnel.

Some disabled young people, who had lived for many years in an institution outside Oslo, organised themselves into a local group of the Disabled Association and, in cooperation with these people, the first course on Sexuality and the Handicapped was arranged in January 1977. An invitation was sent to all the physically disabled - both those who lived in institutions and those living independently - and to health personnel working in institutions and counselling offices. The meeting was very well attended largely by handicapped people living outside the institutions. The Bureau of Health which covered the costs, also sent two representatives. The course was spread over two days, and dealt with aspects of sexual sociology, biological reproduction and contraception, with special sessions devoted to problems exclusive to the handicapped, for example the emancipation from established standards and established opinions on morality and attitudes to sexuality in the institutions.

It was clear from the concluding discussion that the disabled found this type of course useful, and wished to extend the group of participants to include parents with handicapped children, in addition to the mentally handicapped, and health and social personnel. There was much media interest, including an interview with one of the lecturers and a conversation with one of the participants on the radio.

NFF decided to continue these courses and three of the Board members were designated to work in this area. Since 1978 two of these have been members of a family group consisting of seven people who have the responsibility to plan, organise and evaluate the courses. Every year 7-9 courses are arranged all over the country, and in 1981, we intend to hold 12 courses, of which there will be six one-day courses within institutions. In addition, there will be three followup courses for people who have passed an elementary course and who need to discuss certain problems in smaller groups. Finally, there will be seminars for lecturers and 'key persons' in the different regions in order to hand over the responsibility for the course in different regions.

The programmes themselves have changed since 1977. Partly in response to the local situation as to what extent one should deal with controversial subjects, partly in that the programmes are dependent on the different groups of participants. For example, ethical questions and attitudes towards sexuality have been the subjects of a lot of courses in 1980, as well as technical remedies. Prejudice towards handicapped people and sexuality, the basis of the myth and the purpose of and ideas on a positive change have also been included in the courses. The group is still made of three categories : handicapped people , health/social personnel and parents of handicapped people. Depending on the requirements and regional conditions, the participation of the different categories has varied, but there has been mainly a mixture of all three : some were exclusively for parents and some for health personnel.

Parents have clearly expressed a great interest in taking part in such courses and obviously have a great need to understand their children and to gain concrete knowledge in the field of sexuality. The health personnel have been less forthcoming and have played on the difficulty of attending weekend courses (eg. because of their families).

Our experience show that people who attend our courses have often themselves difficulties in talking about sexuality in public, and therefore feel that it is a difficult subject to take up in the institutions. By the end of the courses, some of them spontaneously acknowledged their value, in changing their own attitudes in particular, and expressed a wish for more numerous and extensive activities in groups. These subjects have been included in the training of medical and health personnel during the last few years, but not systematically and not in every training institute.

The handicapped people themselves have made a great impression on us, especially the young people living independently. They have in many ways pursued the activities of the courses by acting as lecturers, group leaders or 'therapists' during discussion. We believe that the courses have been of great value, both to the individuals and the institutions, as well as in changing general attitudes towards handicapped people and sexuality.

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Sexuality and Disability

Every human being has sexual rights, is a sexual being and can lead a sexual life. Insisting that disabled people should have sexual rights implies that their rights are not as self-evident as those of others. People unable to consider themselves sexual beings are deprived of their rights by their own and society's lack of knowledge, attitudes, myths and values. The only people incapable of sexual life have deficient hormonal development, for which treatment is available.

Sexuality is much more than coitus alone. It includes signals and contacts, caring and consideration. There are several ways (including technical aids) which enable handicapped people to lead a sexual life.

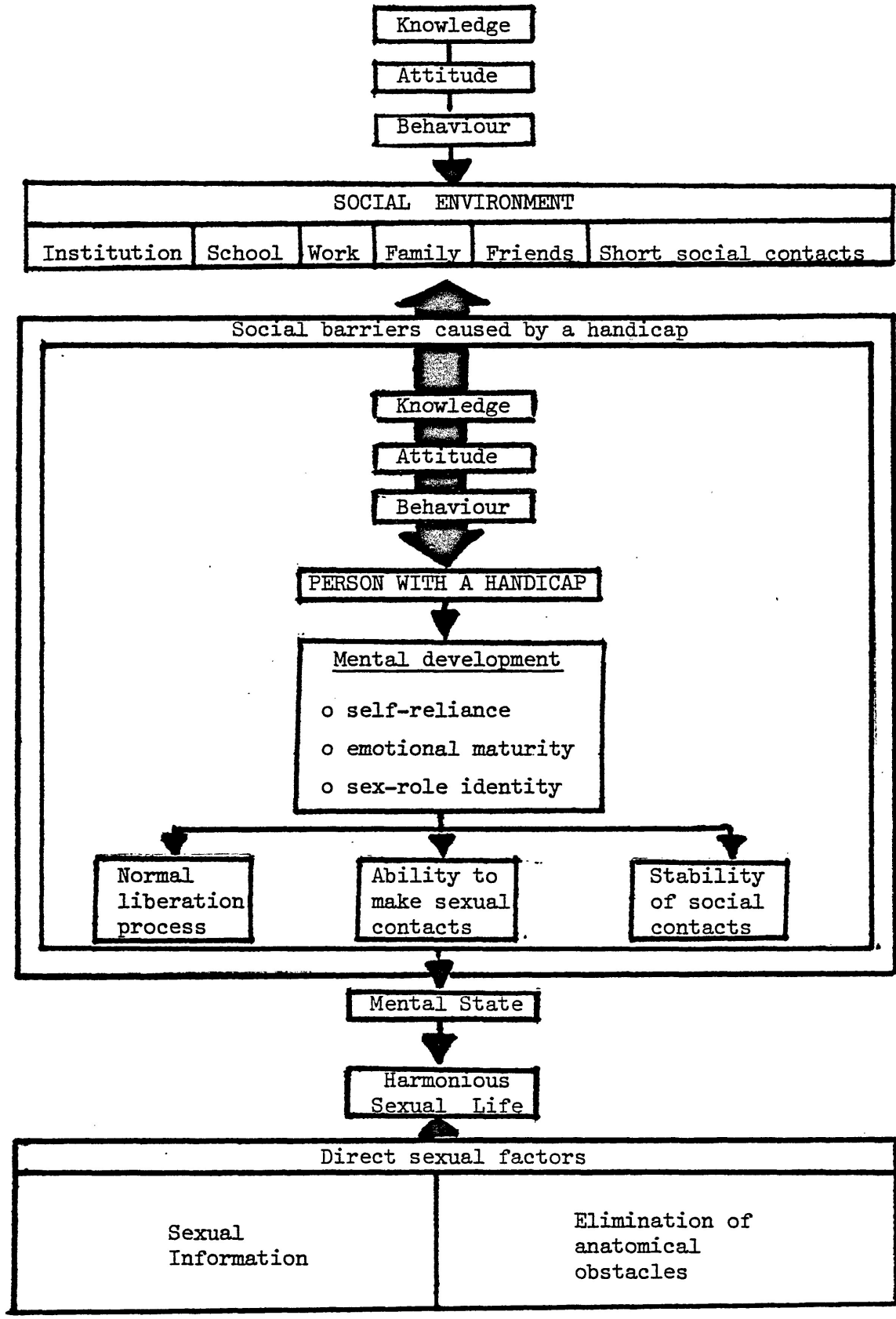
The sexuality of handicapped people has long been neglected. There is a desperate need for knowledge and for changing the attitudes of both society and handicapped people towards this subject.

The diagram overleaf attempts to analyse the factors involved here. What conditions assist the development of harmonious sexuality for handicapped people? The handicapped person is surrounded by social barriers due to attitudes (eg. lack of social contact with the disabled), financial problems (eg. the cost of travelling), poor communications, work and living conditions.

Self-confidence, emotional maturity and sex-role identity are essential for mental development, and are greatly influenced by people's relationships with their environment. Self-confidence stems from one's awareness, as early in life as possible, that one is a valuable human being, loved and trusted, and is counteracted in the disabled parental guilt-feelings and social attitudes. Our tendency to foster aims for the disabled child, based on the non-disabled perspective, rather than offering praise and encouragement, undermines this self-confidence.

Disabled teenagers should be allowed to experience the same puberty crisis as non-disabled adolescents. Psychological help or tranquillisers are frequently requested for congenitally disabled teenagers, accused of rebelling, who are merely behaving just like other teenagers. Indeed, disabled teenagers who resign themselves to their condition need the most help.

To achieve emotional maturity, one must face the difficult task of expressing one's feelings, and interpreting those of others. Confronted with conflicting concepts based on the common belief that the feelings of disabled people should not be offended, it becomes more difficult to reconcile what one is with what one wants to be. The same applies to sex-role identity, though social ideals and the little time that disabled people spend alone with peers must be taken into account. Moreover, parental ignorance of how the disabled can fulfil their sexual desires makes it difficult to foster in the disabled that striving towards sexual and family life which is a common aspiration of other people.


Knowledge
Attitude
Behaviour
SOCIAL ENVIRONMENT
Institution
School
Work
Family
Friends
Short social contacts
Social barriers caused by a handicap
Knowledge
Attitude
Behaviour
PERSON WITH A HANDICAP
Mental development
o self-reliance
o emotional maturity
o sex-role identity
Normal liberation process
Ability to make sexual contacts
Stability of social contacts
Mental State
Harmonious Sexual Life
Direct sexual factors
Sexual Information
Elimination of anatomical obstacles

It is important to recognise that disabled people can become liberated from their parents, and have the mental ability to make and maintain sexual contacts. This liberation process must be viewed in both practical and emotional senses. Parents should aim not to be needed, which is difficult for parents (and institutional staff) to accept. The mental ability to make sexual contacts depends on previous development, and on the stability of social contacts through being treated honestly and straightforwardly. This liberation process and mental development form the basis of harmonious sexual life.

For people whose disability influences their sexuality, it is important to provide the necessary information, and to eliminate any anatomical obstacles. Both partners should be reached, whether or not both are disabled.

Disabled school leavers should be able to:

- assume responsibility for their sexual life;
- obtain information on how to function sexually;
- seek greater opportunities for social contacts, in order to be able to choose a partner;
- have the opportunity to live the sexual life they desire.

What is needed from non-disabled people in order to achieve these goals for the disabled?

- general sexual knowledge;
- the ability to allow the disabled to lead a good sex life;
- the ability to accept noncoital sexuality without imposing common inhibitions on the disabled;
- the ability to communicate properly with anyone in this area;
- the ability to put oneself in a disabled person's situation, and so fight for the right of the disabled to be treated as human beings.

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Sexuality and handicap is one of the growth areas of publications throughout the world. My own file now contains many hundreds of references and is still rapidly expanding. This reflects a genuinely global interest in the topic and is in no way a Western cultural phenomenon. Active interest has been shown in South East Asia, in the Middle East, in the Americas, as well as widely diverse parts of Europe. What is perhaps of particular interest is that this is reflected not simply in professional journals (and there are now professional journals devoted solely to this topic) but the subject has been taken up in books, plays, films and television, bringing the topic to a much broader general public. It may seem strange therefore to suggest that assumptions based on any belief that these two terms are clearly understood by the public at large are falsely based. But it is my belief that this is the case and I believe that there is good evidence and recent evidence to support it. If the International Year of the Disabled does nothing else (and there are those who are dubious about the validity of such one-off, one year campaigns) it might clarify the issue: who is handicapped?

On 1 January, to herald International Year of the Disabled, the journal *New Society* published the results of a survey of attitudes to the disabled: "Our image of the disabled, and how ready we are to help" by Stuart Weir. The first table in this survey shows the results of an open-ended question: What do the words 'handicapped' and 'disabled' mean to you? 54% thought that disabled meant loss of motion, paralysis, amputation, as opposed to 37% who thought these terms referred to the handicapped. 12% thought that 'handicapped' referred to the mentally retarded whilst 3% thought that this referred to the disabled. As Stuart Weir points out "people see 'handicap' more as a mental or congenital condition and 'disability' as something ... which has been caused by an accident or disease". Detailed analysis of a sample of the questionnaire forms showed that many people made the distinction explicit: "If you're handicapped, you haven't got full use of your faculties. If you're disabled, you haven't got full use of your limbs."
"Handicap is something mental, such as a mongol or retarded person, disabled is physical."
"The main difference is that you're disabled because you become that way, not born that way."
"'Handicapped' is born with a disability; disabled means it's more likely to be caused by an accident or crippling disease."
"The image which dominates people's perception of disability and, to a lesser degree, handicap" says Weir, "is the wheelchair". One can only be glad that the survey did not include the word impairment to confuse the issue further.

In order to clarify this issue I should perhaps refer to the definitions used in a survey carried out by the British Office of Population Censuses and Surveys some years ago:

Impairment: lacking part or all of a limb, or having a defective limb organ or mechanism of the body.

Disablement: loss or reduction of functional ability.

Handicap: the disadvantage or restriction of activity caused by disability.

One might well ask whether such distinctions matter. My reply can only be that my case studies in sexuality and handicap in certain member countries of IPPF Europe suggest that they are important distinctions. Those who are impaired are not always handicapped, and the degree of disability is not always related to the degree of handicap :

Very severe handicap : needing special care

Severe handicap : needing considerable support

Appreciable handicap : needing some support

Little or no appreciable handicap : impaired but needing little or no support for daily activity

It is only when one includes sexuality in daily activity that the reason for these distinctions becomes clear. Consider a problem such as psoriasis: a non-contagious skin disease marked by red scaly patches. Reflect on the plight of a young man or woman with severe manifestations of this disease. By any normal definition they would not be impaired : they do not lack part or all of a limb, nor do they have a defective limb organ or mechanism of the body. Nor can they be regarded as disabled because strictly speaking there is no loss or reduction of functional ability. And yet these young people may well be handicapped because of a disadvantage or restriction of activity. In terms of wanting acceptance, wanting contact with a partner, wanting closeness, wanting the warmth of relationship, their sexuality may well be disabled because they feel they must withdraw, cover the skin, refrain from any contact. So far as the intimacy of sex is concerned they are truly handicapped, and handicapped in a way that can be psychologically destructive. One woman I met suffering from this complaint had become so obsessed with it that she had withdrawn from all physical contact, wearing gloves all the time and even going to the extreme of disinfecting all her belongings lest they be touched by some other person. Not surprisingly she kept any kind of social contact to an absolute minimum and had no relationship of any but the most formal and professional kind with any other person. By contract it is also clear that some who are seriously impaired by physical handicap and have a severe loss of functional ability may yet achieve warm close loving and lasting sexual relationship where partners have come to terms with their sexuality and their impairment in relation to each other. Those who doubt this possibility would be well advised to study carefully '*Sexual options for Paraplegics and Quadruplegics*' by T O Mooney, Theodore Cole and Richard Chilgren, published by Little and Brown, Boston. This book is a source of explicit sexual information with many photographs where the paraplegic and quadraplegic can find practical methods for developing sexual competence and finding sexual expression. It is to be highly recommended to all those with a genuine concern for the sexual function of the handicapped.

The *New Society* Survey also very interestingly touched on attitudes to marriage and the disabled : if your son, daughter or close friend said they were going to marry a disabled person, would it be a good or a bad idea if the person were :

	good idea	bad idea
physically handicapped by loss of a limb	46%	19%
mentally ill	8%	68%
blind	49%	20%
deaf	54%	15%
mentally handicapped	8%	64%

ABORTION IN BELGIUM

Abortion remains illegal in Belgium. A 1923 law prohibits abortion under penalty of two to five years' imprisonment. Even informing a woman where to go for abortion is subject to six months' imprisonment.

Despite the law, the Roman Catholic Church and other conservative forces, some hospitals and non-hospital centres, set up by the women's and family planning movements, perform abortions. This article considers the background.

The first step : to dare

Initially, women seeking abortion were discreetly given clinic-addresses in the Netherlands, Switzerland or the United Kingdom.

In 1973, Dr Willy Peers was accused of performing 300 abortions in a Namur maternity hospital. Dr Peers was arrested but, following widespread public outrage, was released while awaiting trial. Much public debate ensued.

Other hospitals began to perform abortions. In July 1973, the government legalised information on contraception and established a commission to consider fertility regulation as a whole. In 1975, a student family planning centre in the *Université Libre* of Brussels included abortion among its services.

In March 1976, a group of women decided to defy the law. The Brussels Contraception Collective openly began to perform skilled abortion in a private house. They aimed to provoke a reaction from the authorities, medical profession and public opinion, and so reform the law; and to help solve the problem of unskilled abortion. They also sought to encourage health care which allows people to understand and take responsibility for their own bodies.

The various non-hospital centres operated from a feminist viewpoint : the woman's request was sovereign. On the other hand in hospitals, the decision to provide abortion rested with health personnel.

In October 1976, aware of the risks, the Information and Guidance for Couples (IOC) and the Brussels Contraception Collective held a press-conference to clarify their position, joined by three hospital centres (Baudour, Brussels and Namur). The Public Prosecutor merely charged those women who had spoken on television, and the centres continued their activities unhindered.

The growth of non-hospital centres

Demand rapidly overtook the capacity of the existing centres. Women were referred by hospitals, physicians or word of mouth. Most centres of the Fédération Belge pour le Planning Familial et l'Education Sexuelle (FBPFES) usually referred women to private clinics in the Netherlands or the UK.

The first wave of repression, and the press-releases which followed, helped to advertise these centres. Further Contraception Collectives were opened in Charleroi, Liège and Verviers; and more recently in Ghent (the first in Dutch-speaking Belgium).

In 1977, two new family planning centres in working class districts of Brussels included abortion among their services.

Also in 1977, to signify their commitment, and to help women to get abortion in Belgium rather than abroad, the FBPFES decided to establish its own abortion clinic. Today it functions as an autonomous centre affiliated to the FBPFES. (FBPFES now has 39 centres, of which 12 perform abortions.)

Two types of centres have been established : like university centres, some family planning centres provide abortion, but are mainly concerned with education and contraception; while others concentrate on abortion and contraception.

By 1973, the Netherlands clinics were performing several thousand abortions every year on Belgian women. The number is now under 10 000, mainly from the Dutch-speaking part of Belgium. There are eight non-hospital abortion centres in Brussels, four in Wallonia and one in the Dutch-speaking part, but none in Flanders.

In Ghent, it has proved more difficult to recruit Dutch-speaking physicians prepared to risk their careers, since repression is felt more strongly in Flanders, with its stronger Catholic traditions. (On the other hand, the first contraception centres were established in the Dutch-speaking part of the country : in 1960 in Ghent and 1961 in Antwerp.)

In July 1978, the Prosecutor's Office raided two centres, and seized the clinic records of women who had had abortions there and been informed against. Some health personnel were convicted. These early raids took the centres by surprise, but they managed to organise, hid any documents proving abortion, and publicly declared that they would not hand them over.

Between July 1977 and June 1978, ten legal reforms had been proposed in Parliament. Only complete decriminalisation of abortion was acceptable to the non-hospital centres. However, a very restrictive proposition was under discussion when the government fell.

In order to advance their cause, pool ideas on practice and coordinate their attitude towards repression, eight centres (existing or in the process of being established) combined in the 'Action Group for non-hospital Centres performing Abortion' (GACEHPA). They drew up the following charter :

The aims of the non-hospital centres are :

- to give women practical information on contraception and sexual problems.
- to combat unskilled abortion by performing abortions under good medical and psychological conditions.
- to achieve complete decriminalisation of abortion.

The following principles apply to all GACEHPA centres :

- The women's free choice : the decision to terminate pregnancy is taken by the women.
- Nondirective and guilt-free reception : individual and/or collective reception allows the woman to decide without moral pressure, after discussion. Contraceptive failure and future contraception are discussed.
- Good medical and psychological conditions : abortions are performed by trained physicians. To the woman who wants it, the team offers psychological support before, during and after abortion.
- Continuity of care : medical follow-up is required after abortion. In-depth information and discussion on contraception are essential.
- Functioning of the centres : each centre is collectively managed by the workers. The cost of abortion is the minimum necessary to cover running costs. The centres use a standard clinic record to collect nationwide statistics.
- The existing centres seek to promote the establishment of new centres pursuing the aims of women's health and complete decriminalisation of abortion.

Practice

In the centres, work and administration are shared collectively. Health personnel choose to work there for a token salary, because they feel ideologically involved.

Abortions are performed up to 10 weeks since LMP by aspiration. Each woman is welcomed individually and cared for until after the operation. The abortion is not performed on the day of first visit, to allow women to absorb the information, and to change their minds.

Follow-up is always done three weeks after the abortion. All centres emphasize contraception. Layworkers are trained to listen, in contraception, and in assisting during the abortion. Physicians are trained in hospitals and centres.

Conclusion

For six years, all centres have offered *practical* help to many individual women. They have combated abortion's clandestine nature, and placed it alongside other medical procedures. By their collective structures, guilt-free reception and relaxed atmosphere, they seek to break the solitude of women in difficulty, and to encourage contact between them.

As time passes, it becomes increasingly difficult to deny their role, which hospital gynecologists have publicly acknowledged, and which a substantial number of the public are aware of :

- either because they have had an abortion;

- or they are informed by GACEHPA demonstrations, by committees for liberalising abortion (created in 1973), or by the FBPFES.

But what has also brought the centres to public attention is the printed word sympathetic to those charged with having abortions, or helping women to get abortions. 20 people from non-hospital centres have been charged, though no date has been fixed for trial. This presumption of guilt has prevailed since 1973.

The French-speaking television programme *à suivre* ('to be continued') has also contributed to the awareness of GACEHPA centres. The film was followed by a debate, creating a considerable stir, but was seized by the authorities the day after its screening.

GACEHPA now has 13 centres, which continue the daily struggle to help women, demonstrate publicly and try to multiply, so creating an irreversible situation in Belgium.

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FERTILITY REGULATION IN ICELAND

The health services in Iceland have been planned along similar lines as in the other Nordic countries, in the last decades. A few facts in connexion with family planning are however different.

The birth rate was very high in the years 1947-1964 (27-28 per 1000). As the death rate was low (6.8 - 7 per 1000) the annual population growth was 2%. Since 1964 there has been a steady decrease in the annual birth rate presently 16 - 17, with the death rate remaining stable.

The decrease in the birth rate after 1964 coincided with the introduction of oral contraceptives and IUDs in 1961-63. The use of oral contraception increased markedly from 1964, and within a few years this method was used by over 40% of women in Iceland. In recent years a slight decline in use of this method has been noted, mainly among women aged over 35 years.

Insertion of IUDs started on a small scale in 1963, in close cooperation with IPPF and the Population Council.

After the first five years, during which this method was tried, there was a rapid increase in the use of IUDs. At present, over 30% of women use different types.

Diaphragms, spermicides and condoms have been available for decades and are still in common use throughout the country. Information about contraception has been easily available, as has been their procurement. It can be assumed that this explains the rather low abortion rate in Iceland.

Parliament passed new legislation on abortion and sterilisation in 1975. The incidence of induced abortion was at that time approximately 5% of total deliveries. In spite of certain differences from the legislation in other Nordic countries and in the United Kingdom, the law can be considered liberal.

The five-year period since 1976 shows a steady increase in the number of abortions to approximately 10% of total deliveries, a figure far lower than expected when the law was enacted.

The number of women aged over 30, and especially over 35 years, seeking sterilisation (mainly through laparoscopy) has increased every year since 1975.

These data support the view that the number of abortion has peaked and will eventually decline.

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'OH, WHAT A TANGLED WEB WE WEAVE WHEN FIRST WE PRACTISE TO CONCEIVE'

The first family planning legislation to be introduced in Ireland has been law for three months now. Under the Health (Family Planning) Act 1979, contraceptives of all types may be sold only by pharmacists on presentation of a physician's authorisation, which can be supplied only to those who desire contraceptives for *bona fide* family planning purposes.

During the week before 1 November 1980, when the Act became law, the people of Ireland displayed their lack of confidence in the legislation by flocking to the family planning clinics. As the queues for supplies lengthened, the panic-buying indicated the fear and confusion that the Act was causing.

At this time, the Catholic hierarchy issued a statement on family planning drawing attention to the 'weight of scientific evidence' on the abortifacient action of IUDs. Reports appeared in all papers stating that the Department of Health was to ban all IUD imports. The Minister of Health immediately refuted this statement. This kind of confusion was typical given the vagueness of the legislation.

The reaction to the legislation was immediate. Loud condemnation of the restrictiveness and discriminatory nature of the Act came from many and varied groups and individuals. Hundreds turned up to a one-day event in Dublin organised by the campaign *Contraception Access for All*. Students, physicians, family planning personnel, political parties, women's groups, individuals and even a senator attended. On the same day successful protest rallies/activities were held in Cork, Limerick and Dundalk.

The first major difficulty for the family planning clinics was that they had to apply for ministerial approval even to continue giving information, advice and consultation on family planning; consent to offer this service was given for a year, after which a further application had to be made. Under the legislation no family planning clinics could sell contraceptives. All clinics rely heavily on this source of income as no state subsidy is provided. To overcome this problem some clinics succeeded in operating a franchise with a pharmacist, which involved extra finance. The clinics also had to overcome the attitude of the Irish Pharmaceutical Union who gave strict instructions to members that it was "totally contrary to their policy for members to take up employment in family planning clinics". Other clinics are still trying to organise such an arrangement. Clinics which refused to apply for consent were taking legal advice on the possibility of a successful challenge to the Act on Constitutional grounds.

On the question of supplies, again confusion reigned during the first couple of months. Companies who wished to import contraceptives had to apply to the Minister for an import licence. Licences were only considered after 1 November. For a couple of months, even those pharmacists who wished to stock contraceptives had great difficulty in obtaining stocks. "The demand for extra quantities by importers proved that people had access to contraception and that the law was working satisfactorily" was the view expressed by the Minister of Health, Dr Woods. Licences to import in excess of seven million condoms had been granted to four Dublin-based firms since November and in just three months, orders worth more than £1 million had been placed in Britain. The Minister did not mention that importers had stated publicly that they were ordering grossly exaggerated amounts to avoid having to keep paying £100 fee for the Ministerial Licence they needed for each order imported.

Importers also agreed that only one in ten of the country's pharmacists have opted to dispense contraceptives. Surveys carried out by the media indicated that of 85% of pharmacists in rural counties contacted, only 11% on average were dispensing or stocking condoms, even on medical prescription. In one of the major cities of Ireland, three months after the Act, only two out of forty-one pharmacists were stocking or dispensing condoms. Three of the largest maternity hospitals' outpatients' departments stated that only natural methods were available. 200 physicians (20% of all general practitioners in the Republic) stated at the end of January 1981 that they would supply contraceptives directly because they considered the vast majority of pharmacists were not cooperating with the Act. One physician considered that only about 20% of the population had access to contraceptives. The physicians felt duty bound as a result to supply the contraceptives to patients themselves and to liberally interpret the clause *bona fide* family planning purposes so that single persons would not be excluded. The Irish Medical Asssociation stated that many of their members regarded the Act as a disaster. 60% of IMA members indicated they would work within the law, 39% would abstain for reasons of conscience and 10% because they felt it was such a "daft" law. However, as only about 200 Irish physicians have been trained in family planning methods, it seems that the will of the 60% will not be matched by the skill that the wide availability of methods requires.

In February the *Contraception Access for All* Campaign conducted a nation-wide survey into the workings of the Act, the findings of which will be the subject of a public tribunal in April. Already they are having problems. Of 160 physicians circulated with a questionnaire, less than half responded. Pharmacists have also been angry or fearful of answering questions such as 'Are you stocking contraceptives?'

Health Boards

The Act envisaged that the Health Boards would complement the role of physicians and pharmacists under the new Act. A letter from the Minister dictated that Health Boards would onlu provide advice and information and would definitely not sell contraceptives. Most of the country's Health Boards did not have sufficient information to do anything but debate their attitude to IUDs, and whether or not lower-income groups who received medication free from the State would be reimbursed their contraceptive costs. Dr Woods made it clear that the taxpayer would not subsidise contraceptive costs for lower-income people.

The Irish Medical Union and the Department of Health have agreed that physicians under the State medical scheme would receive the usual fee from the Department for consultation on family planning given to lower-income patients. In the event of one physician refusing, the patient can go to another who would receive double the fee. However, as none of the family planning clinics' physicians come under this scheme they receive no reimbursement for the large number of lower-income patients they deal with. In fact, instead of providing some State subsidy to the clinics who have the expertise and are already providing services for thousands of patients, the new Act has made it more difficult for the clinics to survice financially. Not only does the Act aim to deprive them of income from contraceptives, but contraceptives are now subject to Value Added Tax and thus to a 25% increase.

In contrast, as a direct result of the Act, the Minister has given initial grants totalling £70 000 to help promote 'Natural Family Planning Methods' in Ireland. £35 000 have been given to a voluntary organisation 'The National Association for the Ovulation Method in Ireland'. The new law does not require or indeed provide for any testing standards or for outlets.

In answer to questions in the Irish Parliament, the Minister of Industry, Commerce and Tourism stated in December that the Government did not intend to control contraceptive prices. This does not affect the family planning clinics, which are non-profit-making limited companies.

There is no provision for education or training in the new law. The position on IUDs is still unclear.

It appears that only after the law has been tested in the Courts, will the tangled web of our "Irish solution to an Irish problem" be unravelled.

Christine Donaghy
IFPA,
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1881 - 1981 : A CENTURY OF ORGANISED FAMILY PLANNING IN THE NETHERLANDS

The organisation of a conscious family planning network in the Netherlands came from the influence of the British Malthusian League, founded in 1878. The Dutch Nieuw-Malthusiaanse Bond (Neo-Malthusian League - NMB) was established in 1881 by C V Gerritsen, a grain merchant from Amersfoort, B H Heldt, an Amsterdam cabinet maker, and J M Smit, a teacher from Apeldoorn. By 1882 there were 125 applications for membership.

Both the British and the Dutch organisations were rightly named after Thomas Robert Malthus. While they differed from his approach in that they considered prolonged sexual abstinence (which Malthus wanted to impose on the lower classes) to be harmful, on the whole they supported Malthus's theory; in brief that an excess of 'relatively inferior' people over the available means of subsistence, especially natural resources, would lead to mass poverty, backwardness, disease and war.

In their basic programme of 1881, Smit wrote, under Item 6 : "Over-population is the chief cause of poverty, ignorance, crime and disease". Article 2 of the NMB constitution affirmed that : "The object of the League is to disseminate knowledge of the population law, its consequences and effects on the manners and customs of people".

The Neo-Malthusians felt that, in the interest of 'our present day society' too rapid a population growth should be halted. But, unlike Malthus, they advocated contraception and sought to improve it. Right from the start they tried to combine sexual guidance with practical aid in the form of providing contraceptives. Yet it was not the NMB which originally established clinics for this purpose, but rather people who were either members or sympathisers of the NMB. The first was the physician Aletta Henriëtte Jacobs who, it is claimed, was the first person in the world to give free instruction in her Amsterdam clinic to women of no or limited means on how to use contraceptives. She opened her clinic on January 17, 1882.

As a rule, NMB members and sympathisers felt personally concerned about the fate of the oppressed and underprivileged and for instance, campaigned for female emancipation and general suffrage. Leading pioneers in the first days of the NMB included the preacher-physician Johannes Rutgers and his wife, Maria W H Hoitsema.

Within the NMB, as well as outside it, socialists (especially Marxists) began to dispute Malthus's politico-economic views and consequently the League's foundation. Gé Nabrink (*Seksuele Hervorming in Nederland* / Sexual Reform in the Netherlands/ 1881-1971) observes that it was clear to the theoreticians of the workers' movement "that the cause of social misery should not be looked for in population growth, but in the capitalist system of production which does not function for the benefit of the people's needs, but is maintained exclusively to make profits for a small group of possessors". However, it was not until well into the twentieth century that the NMB successor (the Nederlandse Vereniging voor Seksuele Hervorming - NVSH) came to dissociate itself emphatically and systematically from Malthusian economic and political views.

Whereas socialist critics did not oppose birth control or contraception as such, the NMB did run into fierce resistance from some churches and Dutch authorities precisely because it promoted birth control through contraception. One Dutch government after another continued to refuse recognition of the NMB as a legal institution for any debts incurred by the League. Nevertheless the NMB grew in size and importance, publishing periodicals and brochures, and succeeded in setting up guidance and information centres. In so doing it gave medically unqualified persons a role to play in practical aid under medical supervision.

Particularly after the first World War, a number of NMB members sought to change guidance and aid activities in the sense that they would no longer be aimed primarily at instructing people in a proper use of contraceptives, but rather at a wider sexual reform, including a fight against the prejudices applied to certain phenomena, such as homosexuality and ways of cohabitation that were not socially acceptable. This development suffered an abrupt interruption in 1940 when the German Fascists occupied the Netherlands and banned institutions such as the NMB.

The NMB emerged from the débris of the occupation, after the Dutch Government had lifted the prohibitions imposed by the Germans. However, since the NVSH was not recognised as a legal body until 1958, a foundation remained necessary upon which to operate the various practical aid centres.

For as long as the sale and advertisement of contraceptives continued to be banned in the Netherlands, the NVSH grew into an organisation with a membership of over 200 000, 5% of whom played an active role. Today's membership stands at 35 000, but the Union has lost none of its drive.

In the NVSH, more clearly than in the NMB, a difference arose between advocates of alternative forms of sex life - found mainly among the relatively well-to-do - and those champions for the interests of the masses of hard-pressed wage-earners. The former won the day when the NVSH had to decide on whether to separate sexual reform from practical aid : in 1969 the NVSH congress shed its guidance and information centres under the slogan *Sexual Revolution*. Since then, these centres have been organised under the Dr J. Rutgers Stichting. Later, however, the NVSH became convinced that the divorce between sexual reform and practical aid was harmful to both activities, whereupon it again set up practical aid centres of its own, this time aimed primarily at the provision of abortions and counselling by telephone, whereas the NVSH clinics, in addition to performing abortions, provide services such as artificial insemination and sterilisation.

The NVSH, a co-founder of the IPPF in 1953, considers one of its tasks to be to combat the neo-Malthusian trends that repeatedly appear in family planning and sexual reform, both in the Netherlands and abroad.

The Dr J Rutgers Stichting and NVSH are among the chief family planning organisations in the Netherlands, but they are not the only ones. Others include an 'Independent Organisation for Birth Control and Sexuality' (Medewerkersraad '70), the 'Stichting voor Medisch verantwoorde Zwangerschapsonderbreking' (Medically Warranted Abortion Foundation - Stimezo) which operates a number of clinics, the J A Schorer Stichting for counselling homosexuals, the Protestant Foundation for Promoting Responsible Family Formation (PSVG) and a number of Roman Catholic marriage counselling agencies.

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POLAND : A STEP BACKWARDS

A long-established tradition of non-governmental, organised family planning activity and a powerful Catholic Church have always existed side by side in Poland, but it is only in the last few months that Church antagonism has come strongly to the fore. With the growing political and economic unrest and the emergence of the free trade union Solidarity Catholic groups have seized the opportunity to campaign actively and openly against family planning services, which consequently appear to be seriously threatened.

Formerly Catholic opposition to family planning, especially the 1956 Abortion Law, was always manifested in semi-clandestine ways. Their activity was largely centred on the publication of critical articles, Church sermons, and the organisation of Catholic groups working with youth, such as 'Oazy' and Gaudium Vitae'. These groups had the financial backing to develop an extensive network of premarital and marital counselling centres, rivalling the Towarzystwo Rozwoju Rodziny (TRR) not only in number - having over 12 000 centres compared to the TRR's 64 - but in the level and scope of their activity.

In spite of pressure from the Catholic deputies in the Sejm, the government steadfastly refused to allow any discussion in Parliament on the Abortion Law until the mid 1970s, when the situation changed. Two things were largely responsible for this; the pronatalism of Edward Gierek, First Secretary of the Party, who wanted a demographically strong and united nation; and the growing dissatisfaction of the people, stemming from the government's clumsy handling of the 1970 Gdansk crisis and their ensuing economic mistakes. As the public mood became increasingly restless and antagonistic, Gierek found he needed the influential Church's support.

In 1975-6, following growing difficulties with imports and investments, the State took the opportunity to save money - and thereby please the Church - by curtailing the contraceptive supply. Moreover up to 1980 there were frequent attempts in Parliament to restrict the Law on Abortion. However, thanks to the expert advice, especially medical, requested by the government decisions on the law were continually postponed.

In 1980 working class upheavals and economic crises intensified governmental need for Church support. Solidarity became a well-known public and legal institution and, partly due to their demands, the State made several important concessions to the Catholics. These included media coverage of mass and recognition of, and more time for, the activities of groups such as Oazy.

Using this new freedom, certain right-wing Catholic groups, supported by the popular Cardinal Wyszinski, Primate of Poland, are now able to work openly. They are organised regionally, as autonomous groups under different names, but all have the same meaning - Movement for the Protection of the Unborn Child. They publish literature, organise seminars on the 'natural' methods of fertility regulation and distribute photographs of foetuses and information of anti-abortion groups, as well as visiting state and TRR clinics to try and influence clients waiting for contraceptive and abortion counselling.

In November 1980 TRR published their 'Standpoint of the TRR Praesidium on Contraception in Poland'. While primarily intended as a weapon against Catholic agitation, TRR reiterated their position with regard to family planning services, producing clear and persuasive arguments as to why these services should remain accessible.

TRR note that the crude birth rate remains one of the highest in Europe at 19.5 per 1000 in 1979. Poland is therefore in an excellent demographic position and the danger to this positive trend lies, not in continuing the prevailing conditions for contraception and abortion, but in a drastic deterioration of material and social conditions for families. The State should only be concerned with encouraging wanted births, and fertility regulation should be used to determine the potential number and spacing of births. Abortion should be treated as an emergency resort to be used in cases of contraceptive failure or when there are serious medical or social contraindications; abortion is not tantamount to contraception. Most of the Western European countries followed the example of the socialist bloc in legalising abortion and abortion rates remain essentially stable. However, the undesirable effects of illegal abortion can be seen in Roumania. Clearly the only effective measurement against abortion is good information on, and quality and quantity of, contraception.

However, availability of contraception in Poland remains alarmingly bad. The total lack of contraceptives in 1975-76 means that even now there are still very big shortages in quantity and variety. There are no low oestrogen pills available, and Polish condoms are of a very low standard. Only 61% of fertile urban women and 50% of fertile rural women use any contraception. The latest research (Jaczewski and Roadmoski, 1979) shows that only 7% of women and 17% of men use reliable (eg. non 'natural') methods. It is not surprising that one out of three urban women have had at least one abortion.

TRR tactfully refrains from distinguishing between specific types of contraceptives but emphasizes that public health personnel should be well informed on all methods and guarantee women access to any of these, 'natural' or otherwise. All doctors, not only gynecologists, should receive family planning training, and condom vending machines should be placed in easily accessible places such as railways, restaurants and toilets.

The document finally ends by asserting that contraception is very closely linked with the health of women and the family, and should thus be treated exactly as any other area of preventive medicine. If abortion is to be discouraged, especially among very young women, the government should not restrict the law on abortion but rather should make facilities for abortion and contraception more readily available.

TRR's main reason for producing this standpoint is contained in Clause 3; the fear that pressure from the conservative milieu would increase to try and blackmail the authorities into revising the liberal laws on family planning. This prophecy was realised in February 1981 when the Minister of Health was forced to publish a list of proposals to restrict the law : only gynecologists will be permitted to perform abortions; special counselling will be required for termination of the first pregnancy, making an abortion harder to obtain; abortions will only be performed in hospitals; and physicians can refuse to perform abortions on moral grounds.

It is impossible to say that the anti-abortion movement is a Solidarity movement for, although they claim Solidarity approval, there is no official statement of support on behalf of the trade union. However, Solidarity has strong Catholic support, and Catholic groups - whether Solidarity members or not - are prepared to push forward much more extreme demands. It is evident that if the political unrest continues these groups will gain a stronger hold. For it is becoming increasingly easy to envisage a situation whereby the state, forced to make concessions, will make changes in the most obvious field open to them - restricting access to abortion and contraception, and thereby damaging TRR's work of the last few decades.

FAMILY PLANNING INFORMATION SEMINAR

The British Family Planning Association held a two-day seminar on its Family Planning Information Service for 15 European FPA staff at its central office in London, on 8 and 9 October 1980, as part of the IPPF Europe Regional 1980 Work Programme.

The British FPA provides its information services on a yearly government grant of £160,000 (1980), with a mandate to ensure that people 'know about and use the family planning services which are available through the National Health Service'. The service provides a wide range of information materials and services. This includes the production of leaflets on all methods of contraception and related subjects such as sexually transmitted diseases, breast self-examination, cystitis, and facts about sex for teenagers, and of a quarterly journal which is mailed to 29,000 general practitioners throughout the country. 'Fact Sheets' and 'Informs' are also produced for use by journalists, professionals and students. A Library and Walk-In Information Centre is open to the public five days a week, from 09.00 to 17.00, and a walk-in advice bureau from 11.00 to 15.00 for anyone wanting to discuss personal problems in confidence with a sympathetic and trained advisor. A telephone information service operates five days a week, from 09.00 to 17.00 providing information on clinic locations and opening times, on contraceptive methods and a wide range of related subjects, and referring to other organisations which can help. Last year the service, including the FPA Regional offices, answered over 100,000 inquiries by letter, telephone and personal visit.

The seminar aimed to demonstrate to other FPA information/administrative staff how the service is run, to promote exchange of information and experience and to generate new ideas for this kind of work. Completed evaluation forms collected at the end of this seminar indicated that these goals were largely fulfilled.*

The seminar was conducted in groups of four who worked with FPIS staff in their offices and saw the finer detail of the service at work, and larger discussion sessions which dealt with press and 'pressure group' activities. This mix proved a good way both of getting to know one another, of stimulating specific questions and of enabling the general sharing of

ideas and experience. Participants consequently felt better placed regarding whom they should contact for information in their sister organisation and how to share particular ideas they might have.

The discussions were wide-ranging and stimulating and it was fascinating to discuss the problems almost all European FPAs are facing in terms of eg. financial stringency, political trends to the right, and problems with contraceptive methods. Widespread misconceptions about the work of other FPAs were also clarified. Dilys Cossey's lively talk on campaigning for various legal changes and influencing the media and politicians was stimulating, especially for those who are seeking change in abortion legislation in their own countries, and there was wide discussion on several areas of press work, such as how to deal with the Depo-Provera controversy, and the continuing battle for balanced reporting on such issues as sex education.

The seminar ended with a visit to the FPA youth project *Grapevine* in Islington. This resulted in a fascinating exchange in which many misconceptions about the project were aired and discussed, of benefit to both those who had attempted similar projects and the *Grapevine* project itself. In addition, FPA staff were asked to fill in a 'country profile' giving details about their FPA and the family planning situation in their country, which will be compiled by FPIS staff and produced as an 'Inform' on European FPAs in the early part of 1981.

Maggie Jones
London

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* Of 13 evaluation forms completed at the end of the seminar :

13 felt the course was worthwhile; 10 felt they were able to adequately share their own experience of information work; 13 felt the seminar had clarified their own needs in information work; and 12 felt that attending the seminar would help them to improve their own FPA information activities.

The comments were warm and lively and included :*"The seminar was well organised"... "It was sincere and friendly"... "It was practical"... "It has given important impulses"... "I got practical ideas that would be useful for our organisation".*

COOPERATION BETWEEN THE YUGOSLAV PPA AND THE UNFPA IN SCIENTIFIC RESEARCH

In the Socialist Federal Republic of Yugoslavia, the Federal Conference Council of the Socialist Alliance of the Working People of Yugoslavia for Family Planning presents requests to the UN Fund for Population Activities (UNFPA) for projects related to the humanisation of relations between the sexes and responsible parenthood. This role of the Council has been agreed with the appropriate federal, republican and provincial authorities so that the Council coordinates the execution of the projects, which are actually conducted by different university faculties.

The Yugoslav PPA not only helps to carry out these projects, but also cooperates with other coordinators in formulating the project proposals.

In March 1977, the UNFPA agreed to sponsor, using its own resources, the following projects : 'Programme for the professional training of family planning health personnel' through the Family Planning Institute of Ljubljana and the Institute for Social Politics in Belgrade, and an 'Evaluation of previous family planning activity in Yugoslavia', through the Centre for Demographic Research at the Institute of Social Sciences in Belgrade.

By the end of 1979, work on these projects had been successfully concluded, and the UNFPA praised the results achieved.

In March 1979, the Institute of Pedagogy at the Faculty of Philosophy in Zagreb started work on a 'Programme for the professional training and advanced studies of teachers working in family planning'. This project ended in 1980.

At the beginning of 1979, the UNFPA agreed to sponsor five new 3-year projects encompassing different aspects of family planning :

- Humanisation of relations between the sexes, and responsible parenthood (Department for Pedagogy and Psychology at the Faculty of Philosophy in Sarajevo)

- Integration of the contents on the humanisation of relations between the sexes within education at all levels, and the training of young people in responsible parenthood (Teachers' College at Nikšić, Montenegro)

- Evaluation of previous family planning investigations to discover people's attitudes towards family planning, and a programme for the professional training and education of family planning workers (Kosovo Province) (Institute for Social Medicine and Regional Institute for Health Care, Priština)

- Family planning in the underdeveloped regions of Serbia (Institute for Mother and Child Care, Belgrade)

- Some aspects of people's demographic behaviour in times of crisis (eg. the earthquake in Montenegro) (Medical Institute of Titograd)

Working relations between the PPA and UNFPA are good. Since 1971 representatives from the Fund have visited Yugoslavia several times to discuss the format and implementation of projects, and members of the UNFPA European Field Staff have visited the institutions which conduct the projects.

These activities have broadened the scope of several Yugoslav universities as experts from diverse disciplines have come together because of the interdisciplinary character of the approach to project implementation.

There are three educational, four medical and two demographic projects. Four of these are of national importance, and the rest relate more to Republics and Provinces. However, the project undertaken at the Sarajevo university has not only grown into a project of national importance, but has become international since personnel from various other countries will be attending the courses. Two-month courses and one-year postgraduate studies for foreign students will begin in 1982.

On the basis of the results achieved so far, cooperation with the UNFPA can be said to be very successful and stimulating. As well as publications, two of which are in English, several successful symposia have been held. The biggest contribution to these projects stems from the university milieu, where the impetus has been given, particularly in the education field, to promote activities on the humanisation of relations between the sexes and responsible parenthood.

The educational value of the scientific research attached to these projects has had a permanent impact on the humanisation topic, promoting its integration within the curriculum at all educational levels. More than 200 applications were received for 60 places for postgraduate work on the Sarajevo project, thus showing the depth of interest in this area of human life.

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Family Planning Council of Yugoslavia,
Belgrade

MIGRANTS AND PLANNED PARENTHOOD NEEDS : A NEW FIELD IN REGIONAL ACTIVITY

Ideas for an activity concerning the family planning needs of migrants in Europe are by no means new, but it was only in 1980 that concrete proposals were formulated and presented to the Regional Council. These were approved, and consequently the 'Migrants and Planned Parenthood' Project became an integral part of the 1981 Regional work programme.

The initiative for the Project came largely from the German association *Pro Familia* who, faced with an increasing number of migrant clients - principally from Turkey, Greece, Italy, Spain, Portugal and Yugoslavia - formulated a pilot study on the migrant clientele, which was intended not

only to determine the socio-economic and cultural background of these clients, but to look more closely at why the clients came to seek help, and which methods of counselling were most successful. From this basis, the Regional Project has developed.

In essence, the Project is to be viewed first and foremost as a piece of research which will fill the currently existing gaps in information in this area. In its preliminary stages, project work broadly consists of data collection through questionnaires; these will provide a basic framework on the migrant situation throughout Europe - who goes to what country, their socio-economic and cultural backgrounds and what influence, if any, this would appear to have on demographic behaviour within nationalities - and a more detailed study of family planning services and migrants. For example, how much are family planning services used by migrants? Do any clinics provide special migrant services (eg. interpreters, printed information in the appropriate language and/or specially trained counsellors familiar with the different ethnic backgrounds)? Are migrants a 'special' group in that they might have needs which differ from natives' needs, and are not being met? And if this is so, what can or should be done to meet such needs?

The duration of this Project, and any further action in the form of working groups on specific areas, more detailed studies on certain aspects of migrant and planned parenthood needs, and recommendations to relevant bodies working with migrants (eg. EEC, ILO, WHO, ICEM and the Council of Europe), depend of course on the level of PPA involvement, and the quantity and quality of material received in response to the two questionnaires. 12 PPAs expressed an active interest by nominating a contact person to work on the Project. Given that the Project is at the moment in the difficult and painstaking stage of data collection and statistical analysis, the level of participation remains encouragingly high.

Clearly, therefore, many PPAs have shown that this topic interests them, and would welcome more information on migrant groups. The completed questionnaires, while demonstrating this curiosity, nonetheless highlight the present lack of information on migrant groups themselves, let alone their planned parenthood needs (if any). Few clinics provide any break-down of migrant client statistics, even if such statistics are requested in the first place.

Although the Project is still in its early stages, certain features have become apparent, viz. the lack of existing information and the essential need to find a definition of 'migrant' that is understood by, and acceptable to, everybody. In the context of the project, 'migrant' is used mainly to mean 'immigrant', eg. anyone born outside, but resident inside, a particular country. This term is subject to various interpretations within different countries. For example, in the FRG the concept of 'migrant' implies 'guest workers' from Greece, Spain, Italy, Yugoslavia, Portugal and Turkey : intra-European (including EEC), short-term immigrants, usually employed as cheap labour. In the United Kindgom, however, there are large migrant populations from Asia and the West Indies: extra-European, and usually permanent, immigrants. To the average British person, any coloured resident is called an 'immigrant', regardless of whether or not they were actually born in the UK. Moreover, any definition is further complicated by the need to find a word that will cover movements between, for example, the FRG and the GDR, or the Irish Republic and Northern Ireland.

The problem of defining 'who is an immigrant?' will be one of the topics discussed by Project participants in a working group meeting in May. The group will also look at the results of the questionnaire evaluation, problems in migrant data availability, the family planning work with migrants within the individual countries and communities and, finally, assess the viability of conducting specific migrant-orientated activities.

Whether or not this meeting gives rise to new initiatives in future areas of action with migrants, it is anticipated that the Project will have achieved a new and comprehensive basis of information on migrants and family planning services in Europe.

Handicapped People and Sexual Relationships

This 109 page publication* reports on two seminars on Handicapped People and Sexual Relationships, organised by Pro Familia because it was felt that there was a lack of communications with, and of knowledge on how to behave towards, handicapped people.

This publication is not intended as a complete work on this subject, but aims to stimulate readers to further discussion and ideas. It examines the background of the project, the changes in sexual attitudes of the handicapped and counsellors, sexuality in relationships with handicapped people, and the legal aspects of handicapped-oriented activities. This publication also includes a bibliography.

* Pro Familia (1980) : *Sexualität in der Partnerschaft mit Körperbehinderten.* Pro Familia Arbeits-Materialien Nr.25

For further details, contact Pro Familia, Cronstettenstrasse 30, 6000 Frankfurt am Main 1, Federal Republic of Germany.

Childlessness

In December 1979, a Regional working group met in London to discuss *Psychosocial aspects of voluntary and involuntary childlessness.* In May 1980, the Regional Council considered the working group's report. In January 1981, the Regional Executive Committee decided that, with minor amendments reflecting comments received, the report should now be published.

Accordingly, Regional Council members and PPA secretariats will receive the report with this *Bulletin.* Otherwise, this typewritten report (in English only) is available, *price £1.00 + postage,* from the IPPF Europe Regional Office, 18-20 Lower Regent Street, London SW1Y 4PW.