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Relations Between Governments and PPAS

In connection with the IPPF Governing Body Seminar on Government/PPA Relations, to be held in London on 30 October 1975, member associations in the Region were invited to provide some basic information on this subject. A review of the information is given below:

1. Ministry/other government agency with which the PPA cooperates
The principal* ministries involved are:

1.1 *Ministry of Health* – Britain (*Family Planning Association*), Denmark (*Foreningen for Familieplanlaegning*), Finland (*Väestöliitto*), Federal Republic of Germany (*Pro Familia*), German Democratic Republic (*Ehe und Familie*), Poland (*Towarzystwo Planowania Rodziny*), Turkey (*Türkiye Aile Plânlamasi Derneği*) and Yugoslavia (*Federal Council for Family Planning*).

1.2 *Ministry of Social Affairs* – Finland, Netherlands (*Rutgers Stichting*), Portugal (*Associação para o Planeamento da Família*), Sweden (*Riksförbundet för Sexuell Upplysning*) and Turkey.

1.3 *Ministry of the Family* – Austria (*Österreichische Gesellschaft für Familienplanung*), FRG and Luxembourg (*Mouvement Luxembourgeois pour le Planning Familial et l'Education Sexuelle*).

Additionally, in Denmark and Poland the PPAs cooperate with the ministries of Defence and Justice, and in Poland and Turkey with the ministry of Education. In Denmark, the PPA also cooperates with the ministries of Interior, Greenland and Foreign Affairs (DANIDA). In GDR, the PPA cooperates with the ministry of Justice. In Portugal, the APF has good contacts with the Secretary of State and General Director of Health. In Yugoslavia, the PPA is represented on the Federal Bureau for Statistics and the Federal Bureau for Cultural, Educational and Technical International Cooperation.

Belgium – the Belgian Federation (*Fédération Belge pour le Planning Familial et l'Education Sexuelle/ Belgische Federatie voor Gezinsplanning en Seksuele Opvoeding*) contacts with the government are limited to administrative contacts in connection with applications for grants (see 2.1 and 2.2 below).
France – the *Mouvement Français pour le Planning Familial* has informal contacts with the ministry of Health.
Ireland – although there are no formal government contacts the Minister of Health has recognized (1975) *Irish Family Planning Association* seminars for social workers and public health nurses (2.3 below).
Italy – Unione Italiana Centri Educazione Matrimoniale Prematrimoniale has no direct contact with central government, but the recent approval by Parliament of legislation on planned parenthood centres establishes a relationship between UICEMP and regional, provincial and municipal government (2.1 below).
Norway – contact is confined to the financial relationship with the government and its representation on the *Norsk Forening for Familieplanlegging* board (see 2.2, 2.3 and 3.1 below).

2. PPA activities for which the government provides funds
The principal activities funded are:

2.1 *Clinic/Centre* (contraceptive, marriage and family counselling)
Austria – the Staatssekretariat für Familienpolitik supports the costs of five planned parenthood clinics run by the ÖGF; for the first half of 1975–ASch. 410,000 (US$25,000).
Belgium – the ministry of Health subsidizes nonmedical activities of the Federation centres–about 10% of costs.
Denmark – the ministry of the Interior refunds 90% of FF clinic expenditure.
Finland – part of the surplus of the national lottery is allocated to Väestöliitto counselling and planned parenthood clinics.
FRG – the government provides financial support for model clinics established by Pro Familia (see 2.2).
Italy – the Cassa del Mezzogiorno, which depends on the ministry of Mezzogiorno, has allocated LIt 40,000,000 (US$65,000) for the establishment in southern Italy of new centres by UICEMP.
Luxembourg – in 1975 the government allocated to the MLPFES a budget of 1,200,000 francs (US$35,000) which covers most of the running costs of the Centre.

*Cooperation is not restricted to these ministries – several PPAs have contacts with other government bodies/agencies. In several countries Social Affairs and Health are combined in one ministry.

In this issue:

Netherlands – the ministry of Culture, Recreation and Social Welfare subsidizes RS activities which include planned parenthood and psychosocial advisory services (see 2.2).
Sweden – the community of Stockholm provides a grant for the RFSU clinic.

2.2 *Information and Education*
Belgium – the ministry of Culture subsidizes meetings and courses organized by the Federation–about 20% of costs. Training activities receive a small and variable subsidy.
Britain – the Department of Health and Social Security (DHSS) pays the costs of FPA planned parenthood publications and information services, and finances FPA courses in sex education and personal relationships.
Denmark – the ministry of the Interior pays 50% of the costs of FF information services. DANIDA has financed FF seminars for participants from developing countries.
FRG – the government supports over 90% of the Pro Familia central budget, which in 1975 was DM 800,000 (US$340,000), much of which is spent on information, education and training.
Italy – the allocation from the Cassa del Mezzogiorno (see 2.1) covers UICEMP sex education courses in southern Italy.
Netherlands – RS education activities are subsidized by the ministry of Culture, Recreation and Social Welfare.
Norway – the ministry of Education makes an annual grant of NKr 45,000 (US$9,000) for NFFP sex education courses.
Poland – although the direct government grant constitutes only 1% of the TPR budget, indirect assistance is afforded by the provision of paper and facilities for printing and publishing books and information material. Also, government institutions and meeting places are available to the TPR for counselling centres, lectures, meetings, etc.
Portugal – the government supports training courses for health personnel, and gives some funds for teachers' courses.
Sweden – the Social Welfare Board makes an annual grant of SKr 100,000 (US$25,000) to the RFSU for training courses.

2.3 *Other activities*
Denmark – DANIDA has sponsored an FF consultant working with students from developing countries.
Finland – an annual state subsidy of FM 200,000 (US$55,000) is given for research work undertaken by the Väestöliitto Population Institute.
Netherlands – the ministry of Culture, Recreation and Social Welfare pays the salary of five RS central office staff members.
Norway – an annual grant of NKr 25,000 is made by the government for NFFP general administration.
Sweden – an extra grant of SKr 200,000 was granted to the RFSU in 1975 for special projects in connection with the abortion law.
Turkey grants from the ministry of Health and Social Assistance are spent on seminars, training courses, research and community work.
Yugoslavia – the FCFP receives funds from the Federal Conference of the Social Alliance of Working People of Yugoslavia and Republics and Provinces, and from the government in connection with activities to implement the SFRY Constitution (see 5) and the Federal Assembly Resolution on Family Planning.
France – the MFPF receives no funds from the government.
Ireland – local health authorities have paid the registration fees of those attending IFPA seminars.

3. Government participation in PPA activity

3.1 *Government representatives on PPA policymaking bodies:*
Britain – a DHSS observer is on FPA national council and medical and training committee.
Denmark – representatives of the ministry of Justice and National Health Board are on the FF board.
Finland – the constitution stipulates that two government representatives must be on the Väestöliitto board; municipal representation is also provided for.
Luxembourg – two government observers attend MLPFES board meetings.
Norway – a representative of Health Department is on the NFFP board.

3.2 *Other forms of mutual participation in PPA/government activities:*
Austria – Staatssekretariat representatives attend ÖGF meetings and cooperate in preparing publications and information campaigns, and currently in a film project.
Britain – the FPA was invited 1972/73 by the government to conduct on its behalf a family planning campaign in two towns.
Finland – government representatives attend Väestöliitto meetings, and the Board of Health entrusts Väestöliitto with the provision of information on planned parenthood; information material is officially supplied by Väestöliitto to communal health services.
GDR – the government supports EFA training courses, medical meetings and a range of other activities.
Yugoslavia – government representatives participate in FCFP activities, and it's working groups.

In *Poland* and *Sweden*, officials in the government administration are members of TPR and RFSU policymaking bodies in an individual capacity; the two associations aim to involve government policymakers at a personal level. In *Turkey*, government participation is restricted to joint activities at service level.

There is no government participation in PPA activity in *Belgium*, *France*, *FRG*, *Ireland*, *Italy*, the *Netherlands* or *Portugal*.

4. PPA influence on government policy
Austria – the ÖGF encouraged the Staatssekretariat to assume financial and administrative responsibility for the planned parenthood clinics (150 throughout Austria).
Belgium – the Federation's protest meeting on abortion was partially instrumental in achieving the

establishment of the Government committee on ethical problems; planned parenthood facilities are now regionally organized–the administration in Brussels and Wallonia take into consideration the advice of the Federation in organizing centres.
Britain – FPA pressure was instrumental in achieving government provision of free family planning services.
Denmark – FF suggestions for changes in legislation 1956–73 (eg. on pregnancy hygiene and sterilization) have been implemented.
Finland – many Väestöliitto proposals relating to family, population and housing policy have been implemented, eg. on child allowances, social housing loans, reduction in family taxation. Recently a proposal, made in 1969, by Väestöliitto for compulsory quality control of contraceptives was approved and implemented.
France – the main influence has been through political activities, notably the former illegal provision of advice on contraception and referrals for abortion, thereby helping to achieve the liberalization of legislation on contraception and abortion.
FRG – Pro Familia has successfully promoted a general awareness of the need for planned parenthood and sexual counselling services, and has assisted in the improvement of information materials and in the design of model projects.
GDR – EFA has had direct and indirect influence on official planned parenthood policy eg. guidelines for the Marriage and Sexual Counselling Centres became instructions from the Ministry of Health. Also EFA influenced the abortion law and regulations on the production of contraceptives.
Ireland – although the IFPA has had no influence on the government, its existence has influenced public opinion.
Italy – UICEMP influence is seen as general, and through personal contact between UICEMP members and government officials.
Luxembourg – the MLPFES has had a decisive influence on government policy. Its programme was taken up by one of the parties in government and its activities are seen by the government as a necessary prelude to changing the abortion law.
Netherlands – the influence of the RS on government policy is perceived as indirect.
Norway – the NFFP perceives its influence in terms of having encouraged government interest in sex education.
Poland – the TPR is considered by the government as an expert adviser on all matters relating to sex education and social policy in marriage and family. The TPR has been instrumental in forestalling changes in legislation which would have restricted access to abortion. The TPR has successfully objected to a project to make premarital counselling compulsory, and to the idea of promoting the arithmetic model of the 3 child family by mass media and other means.
Portugal – APF influence is mainly through personal contact with members of the government, and through public information campaigns.
Sweden – RFSU opinion is sought on government reports in its fields of interest. RFSU influence is primarily via the Social Welfare Board, for which it runs courses and on whose working groups it is represented. RFSU opinion is sought on legislation affecting planned parenthood.
Turkey – the TAPD was instrumental in the passing of the Population Law of 1965.
Yugoslavia – the FCFP has great influence in government policy by eg. formulating the Resolution on Family Planning.

5. Government attitudes to PPA activities

In most member countries, the government attitude is characterized as friendly and showing active interest, particularly in *Luxembourg* where the government depends on the MLPFES for advice and openly encourages its activities, in *Poland* where the government publicly describes the TPR as a necessary and irreplaceable specialized social agency, and in *Yugoslavia* in whose Constitution free decision on childbirth is declared a human right.

In *Belgium*, the government attitude to the Federation is neutral, or hostile to some of its activities eg. campaign for the liberalization of abortion. Regarding planned parenthood in general, the government policy is passive/negative, being viewed solely in a demographic context and motivated by fear of falling birthrates.

In *France*, while not openly hostile, the government attitude to the MFPF is characterized as ambiguous; it favours organizations which are ideologically closer to itself. In *Ireland*, the attitude of the government towards the PPA is simply described as negative, while in *Italy* it is perceived as neutral, but tending to become more friendly. Finally, in *Norway* the attitude of the government is perceived as passive and neutral.

6. Government consultation with PPA on funds given to other bodies (including IPPF) for activities outside the country

In *Denmark*, *Finland*, the *Federal Republic of Germany* and *Sweden* the PPAs have been actively involved in consultations concerning the giving of funds to the IPPF. In the FRG, Pro Familia is also consulted with regard to giving funds to UNFPA, and cooperates with the ministry of Economic Development in supporting a model project in Tunisia.

Differences were perceived between some governments' domestic and foreign policies in the field of planned parenthood. Thus in *Belgium*, whereas the government gives some aid to the IPPF, such aid is given to resolve overpopulation problems in developing countries.

In *Finland*, while Väestöliitto does not receive any state subsidy for family planning one is forthcoming for the IPPF. While the State has not yet any explicit population policy or programme the government supports the activities

of international population organizations with money allocated for development aid.

In *France*, the government does not give financial support to the MFPF and promotes pronatalist propaganda, whereas in French overseas territories, eg. Réunion and Martinique, family planning is encouraged and financially supported. In general the French government is in favour of family planning in Third World countries.

In the *Federal Republic of Germany*, although the government regards planned parenthood as a matter of national autonomy, demographic aspects receive more consideration with regard to other parts of the world than to the Federal Republic itself.

In *Ireland*, the government, in spite of its negative attitude to planned parenthood domestically, was nevertheless a signatory of the UN Teheran and other declarations which have identified family planning as a basic human right.

In *Italy*, government attitudes distinguishing between family planning policy domestically and abroad could be discerned in the statements of some government representatives to the Bucharest WP conference and at other international conferences.

In *Luxembourg*, political attitudes are not openly expressed, but the tendency in government thinking is in favour of reducing population growth in developing countries while encouraging births at home. In spite of this the MLPFES is nowadays more associated with human rights and freedom than with demography, as formerly.

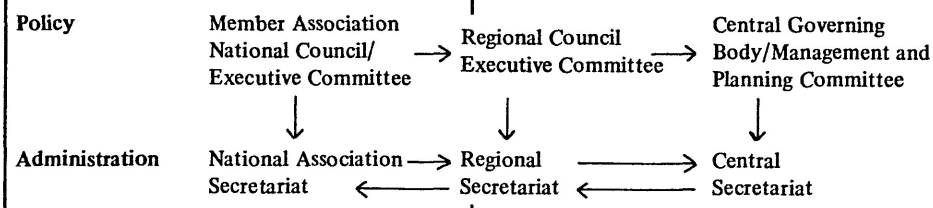
In *Norway*, the government raises large funds for foreign family planning, including the IPPF, but appears to be less interested in family planning in Norway.

In *Sweden*, the government has been rather concerned about the way international funds in this field, mainly through the IPPF, are used. Whereas in Sweden planned parenthood activities are primarily based on information, international activities are more centred on contraception.

Communications in the Europe Region

Regional activities are undertaken on the basis of policy decisions arrived at by national association representatives in the Regional Council and Standing Committees, and by Council and Committee representatives on the executive committees of those bodies.

Regional Office activities are undertaken to implement Regional activities. Policymaking and administrative structures are interdependent. Within the Region, policymaking comes from below, i.e. the administration exists to execute Regional policy. Outside the Regional structure, initiatives emanate from the IPPF centrally, and thus the Regional Office fulfils an intermediary role between the IPPF centrally and member associations in the Region.



Adherence to the above principles, and adaptation to central requirements (the two are not always compatible), have shaped the system of communications in the Region.

Correspondence/telephone are the media for day-to-day communication on administrative matters between the Regional Office and Regional committees, PPAs and other organizations/individuals, and between the Regional and the Central Offices. The administration is directly or indirectly concerned with obtaining or conveying information, much of which is subsequently refined into Regional documents for communicating Regional policy and activities to the committees and, when published, to the public.

Committee meetings are the main forum for policy discussion and decision on IPPF Regional and Central matters.

Communications in the Region usually relate to policy decisions, eg. the Regional Information and Education Committee recommends to the Regional Council that a Regional survey on sex education in Europe be undertaken; the Regional Office circulates the questionnaire to appropriate committee members and PPAs, and compiles the results, which may then be published and used for future policymaking at national and/or Regional levels.

Working group meetings on topics agreed by the Regional Council as part of the Regional Work Programme, and publications of the reports of the meetings, are an important Regional activity. The meetings, which aim to facilitate and promote ideas and activities, and to exchange information between different member-associations, are organized by the Regional Office. In 1973, sub-regional English, French and German language working groups were held with the aim of disseminating information on matters of Regional interest to a wider audience. This exercise was repeated in 1975 with a series of sub-regional seminars on different aspects of sex education.

Through its publications, the Region aims to report within the IPPF family developments in the Region at Regional and national levels. The Regional Information and Education Committee, at its meeting in June 1975, recommended that steps be taken to promote Regional publications, and to ensure a wider distribution of publications. The decision to publish the *Regional Information Bulletin* in French will facilitate communication of Regional policy and activities to a wider audience. The publication of a simple leaflet, *Information on Contraception*, in nine European languages, was

intended to assist migrants in Europe. The allocation of ISBN numbers to Regional publications will facilitate their inclusion in library catalogues.

By attending international meetings, representatives of the Europe Region aim to make known its policies and activities.

However, personal contacts at non-IPPF meetings, and with individual visitors to the Regional Office, have greatly decreased in recent years, since most PPAs are now sufficiently well established to be able to deal with enquiries, requests for information etc. from within their countries.

Communication in the administration of Regional policy

The system of communications has evolved pragmatically over the years, and is basically conducted along the orthodox lines of communication between the committees and the secretaries of those committees. Thus the Regional Secretary supervises the day-to-day activities of the office, referring whenever appropriate to members of the Regional Executive Committee for advice. The Regional Secretary is responsible for implementing decisions taken by the Regional Executive Committee at its quarterly meetings, and communicating decisions, requesting information/ opinion etc. from Regional Council members. The Secretaries to the Regional Information and Education Committee and the Regional Medical Committee have the same function in relation to their respective committees. Two years ago, it was decided that all communications to the Regional Council and standing committees should be copied to the national association secretariats for information.

The secretaries to the Regional Information and Education Committee and Regional Medical Committee are responsible for organizing meetings of working groups and drafting the reports of those meetings. The meetings are prepared in cooperation with the appropriate committee members and PPAs which nominate participants for meetings.

The general framework for all these activities is the annual work programme agreed by the Regional Council at its annual meeting.

In addition to administration within the framework of the Regional Work Programme, the Regional Office also assists the Central Office in handling requests for information to PPAs eg. work programmes and budgets and financial report forms from grant receiving associations, work plans from all associations, questionnaires, etc. and forwarding replies to the Central Office.

Among the problems encountered in communications in the Europe Region, the most troublesome is the disorganized way in which contacts are made by the IPPF Central Office in the Region, eg. circulars are frequently dispatched from the Central Office to unnamed people or to people without specifying in which capacity they have been sent material.

The initiation of correspondence by the Central Office with individuals or organizations within the Region has led to confusion on the part of the correspondent and the Regional Office. A system for communication between the Central Office and Regional representatives on Central committees, national associations and individuals in the Region is desirable.

In order to avoid repeated requests to PPAs for reports, and to simplify its own work, the Regional Office uses the annual reports to the Regional Council, and work plans, as part of the annual Regional report to the Governing Body. Only for financial reporting can the five grant receiving associations in the Region be said to belong to the IPPF Central Office reporting system. All other information forwarded to the IPPF Central Office is gained in the course of specific requests by the Regional Office for information for Regional purposes. (The exceptions are Central Office questionnaires, eg. the Unmet Needs Survey 1973).

Theoretically the communication system in the Region is straightforward, ie. there is a clearly established administrative pattern for dealing with committees and national associations. Obviously communication is a two-way process, and quality and quantity of information depends on the care which is taken in formulating requests and in formulating replies. It is also necessary to keep a critical eye on the usefulness of information requests. Certainly one of the main purposes of communication within the Region is to obtain information, usually for rather specific purposes, and effective channels of communication to this end are important to the work of the Region.

Communication between member associations in the Region

PPA activities within the Region are linked with Regional activities. The specific activities of the autonomous member associations give rise, through suggestions for the Regional Work Programme made by PPA representatives on Regional policy making bodies, to more general Regional activities. On the other hand it is a continuing task for the Regional Office to enable and promote contact between PPAs in the Region so that they may benefit from each others experiences in fields of mutual interest, and be made aware of initiatives undertaken in fresh fields. The development of bilateral contacts between PPAs in recent years is an indication of increased self-sufficiency.

Thus the national policy and activities of the individual member associations are independently formulated, *and* these policies and activities collectively form the basis for Regional policy and activities.

In this context good communications between PPAs benefit everyone. Exchanges of publications, of information through invitations to meetings, of information on research activities undertaken by the PPAs

themselves or by other national institutions are to be stimulated by all means. There are language difficulties which, however, can to some extent be overcome by sub-regional groupings of interests. It is nonetheless felt that means should be explored for cross-cultural exchanges. PPAs sometimes fail to grasp the significance and relevance of activities undertaken by PPAs in other countries to their own activities. Often the problem is simple ignorance of activities undertaken in other countries. It should be admitted too, that there is scope for improvement in direct Regional/PPA exchange of information. The *Regional Information Bulletin* maintains the important function of making known the different experiences of PPAs in fields of mutual interest.

Finally, but importantly, technical difficulties in the speedy communication of information are increasing. There are other bureaucracies and the telecommunications system in Europe is overburdened and subject to periodical breakdowns.

Conclusion

From the overall Regional point-of-view, most communication is directly or indirectly linked with the administration of Regional policy, and does not relate to technical assistance. The existing pattern of communication is geared to seeking information from PPAs—information which will form the basis for discussion and decision by the appropriate Regional committees. These decisions, and activities consequently undertaken, are reported on to the PPAs.

If lack of criticism of the system can be taken as an indication, the system functions adequately. Group and plenary discussions at the Region Council seminar in Portugal, June 1975 (see Vol 4 No 3 July 1975 *Bulletin*), brought out several points related to IPPF administration and communications. A closer look at certain tensions in the existing system may be called for.

Abortion-Pastoral Care

A consultation on "Pastoral Care of those Confronted with Abortion" was organized by the *World Council of Churches* (Geneva), and held in Monbachtal in the Federal Republic of Germany, 6–11 October, 1974.* Thirty three people, over half of whom were women, from eleven European countries participated in the discussions, which were held in English, French and German speaking groups. An Indian physician, a New Zealand Methodist minister (Secretary, Office of Family Ministries, WCC), and an American Vatican observer also attended. The IPPF Europe Region was represented by a delegate from *Pro Familia.* The Consultation was jointly chaired by a married couple, both counsellors.

The object of the Consultation was not to discuss abortion from an ethical point-of-view, but to explore a concrete pastoral problem ecumenically. The attempt was made on the understanding that "nearly every woman, alone or along with her partner, her family, or her parents, at some time has been or will be faced existentially with the question of abortion". In a letter to the Churches, formulated at the end of the meeting, the term pastoral care was explained thus: "We defined Pastoral Care not only as interpersonal counselling, or as an exclusive function of the clergy, but in wider terms which include the struggle for social justice, participation in political decision making, education in responsible living, etc. We included in the term 'counsellor' doctors, nurses, social workers, therapists, midwives, educators, teachers and all similarly engaged in a caring ministry. We recognized that the Church has no monopoly here and that indeed in many countries most of this work lies outside church structures".

This definition already shows that the conference avoided distinguishing between "church" and "society" as opposing factors in discussing abortion. Crucial differences of opinion on the subject were evident both inside the churches and between the participants. Different opinions were stated with frankness. The official report describes these differences vividly when outlining the participants' attempt to identify abortion as "failure": "At one end of the theological and ecclesiastical spectrum it was felt that abortion in every case and in every situation represented sin, since the obligation of every pregnant woman was to have a child. At the other end of the spectrum it was felt that abortion represented a failure of sexual education of family planning—and if the term 'sin' was used in this context, it was appropriate only for the collective sin of mankind. In part our common adoption of the term 'failure' rather than the specifically theological term 'sin' was forced upon us by our evident theological differences".

Thus theological differences accounted for one kind of tension among participants at the meeting. Another tension arose from the different approach between delegates with a theological training and those with a training in the humane sciences and in non-directive therapy. And, last but not least, there was a tension due to the different churches living in their socio-political and legal context. In countries where legislation concerning sex education, family planning and abortion is rather prohibitive, churches may work for liberalization. In countries with liberal legislation, churches may develop conservative programmes in favour of the defence of life.

In view of the great differences of opinion among the participants, one might ask: what was the result of this consultation? It may be seen as twofold:

1. Without doubt, there was an astonishing process of learning among participants. A deliberate attempt was made to live through the tensions rather than try to evade them. This attempt was successful. The consultation was remarkably free from hypocrisy. The official report of the Consultation states: "We recognized frankly that the churches themselves are at least partially responsible for the current situation (ie. the abortion problem). For centuries they have attempted to shape people's attitudes towards sexuality and family relationships, and as a result they must acknowledge their own role in shaping current social attitudes—even if the latter are now in contradiction to the Gospel". The atmosphere of frankness during the consultation was, of course, to a large extent influenced by the organization of the conference which facilitated dynamic interaction between individuals, the group and the theme; it was also due to the well-balanced mixture of professions among participants (counsellors, social workers,

**Pastoral Care of those Confronted with Abortion*, published by the World Council of Churches, 150 route de Ferney, 1211 Geneva 20, Switzerland.

theologians and physicians).

2. A second result was a Letter to the Churches, in which points of agreement were expressed in two key paragraphs:

"We realize that abortion is a symptom of a much deeper malaise in society, and we had to confess that we as the Church are caught up in the collective guilt. We surely bear some of the responsibility for the situation we now face" (Paragraph 5).

"We saw a great need for the churches to be more life-affirming. There is a war to be waged against all the powers of death, and a need to demonstrate attractively the Christian meaning of life and human destiny. In fidelity to the Gospel we felt we ought not only to speak of hope for mankind, but to stretch every nerve to make hope into a reality. In the abortion issue we saw much that revealed hopelessness, despair and life-negating attitudes. Abortion is a sign of failure—both of our European society and man-woman relationships, a sign of solitude, a lack of community spirit and solidarity" (Paragraph 13).

In the same Letter to the Churches, two appeals are intended to stimulate realistic alternatives to abortion. It was the conviction of a majority of the delegates that the churches are wasting their time and energy largely in order to influence legislation. That a crusade against abortion should be fought at the legal level was very much doubted. Delegates felt that, in every case, the struggle would "take place on the issue of free human decision". These considerations were the background for the following appeal to the churches:

"We believe the churches should promote positive alternatives to abortion by working for change in the socio-economic field, and where possible, to take a responsible part in legal decisionmaking, in civic affairs, and in education (eg. social services, social security, housing, education for responsible parenthood, sexual education, etc.)" (Paragraph 11).

"We want the church to make word and deed one, eg. by offering real alternatives to abortion. We recognize that this is a call to invest far more money, time and energy to make this a reality. Discipleship here, as elsewhere, is costly. Condemnation is cheaper than compassion" (Paragraph 15).

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Physicians and Fertility Regulation

In France, opinion on contraception and abortion is divided. Arguments are based on ideological, social or demographic considerations, yet when confronted with a personal decision on reproductive or sexual life, attitudes may be quite different.

The same is true of the physician. The attitude of the medical profession to contraception and abortion is mixed. Physicians' attitudes vary with ideology, medical practice, relationships with patients, and personal view on contraception and abortion.

Unfortunately, the physician's opinion affects not only himself. Frequently he has to implement the law in relation to those approaching him for abortion or contraception. Although physicians now increasingly include contraception if not abortion in their medical practice, their ideas have nevertheless not changed radically. One can distinguish different types of medical attitude:

1. Some physicians remain resolutely opposed to all progress. They espouse the most traditional and conservative ideas, and are often close to the Catholic hierarchy. They constitute an important pressure-group, as they are often at the top of the university hospital hierarchy, or leaders of professional organizations such as the *Conseil National de l'Ordre des Médecins.* Their opinion is well expressed in the following extracts from their statements:

"The physician has no role in contraception" (May 1962);

"The Conseil National de l'Ordre des Médecins rejects any role by the medical profession in abortion for personal convenience. . . . If the law requires the physician to participate in such abortions, the legislators must designate special places for this purpose (avortoirs), and special staff" (April 1973).

On sterilization (April 1973): "Undertaken for nonmedical reasons, these operations are governed by Article 309 of the Penal Code, which punishes with 5–10 years imprisonment the instigator of injuries due to mutilation, and by Article 316 of the same Code, punishing by life imprisonment a person guilty of the crime of castration".

The Council states that "prophylactic sterilization, solely for contraceptive purposes, is strictly forbidden".

This attitude has the merit of being clear and consistent. It is particularly dangerous, since it completely ignores reality and harks back to out-of-date legislation (the last prosecution for vasectomy was over 40 years ago). In fact, the attitude sows confusion, blurs distinctions, and confuses the complications of illegal with those of legal abortion, sterilization with castration, etc.

Lastly, this attitude gives rise to pressures to prevent or distort the implementation of the law, particularly in public hospitals, with departmental heads forbidding physicians in their departments to perform abortions. Thus in May 1975, the Directeur de l'Assistance Publique, in a letter to the heads of all Paris hospital departments, reminded them: "The regulations of the law of 17 January 1975 oblige public hospitals to perform abortions on request, provided that the requisite conditions have been fulfilled . . . it is clearly the responsibility of physicians, particularly those who work in public hospitals, to implement the law".

Even today, rather few abortions are performed in Paris hospitals. Contraception and abortion are considered low priorities for hospital physicians, who prefer "interesting cases", especially complicated ones which will allow them to exercise their "art". Thus there is no place in the public wards for abortion cases, and a gynaecologist favouring abortion will only perform D & C under general anaesthesia, since aspiration without anaesthesia is insufficiently rewarding for the surgeon.

2. The second and much larger group consists of physicians who are not opposed to the law. They are often general practitioners, faced with straightforward requests from people, to which they would like to respond, but who have often not been properly trained. They send a woman requesting abortion to a more or less specialized clinic. In the case of contraceptive advice, they prescribe a pill without being particularly interested in the

problem. Particularly in the case of young women, they will refuse to prescribe, or will judge her sex life. In any slightly out-of-the ordinary case, they will probably send the women to a specialist.

3. The third group consists of so-called modernists, who have realized that modern techniques of contraception and abortion are interesting; here is a new field in which to make a name and money. For years now, physicians have declared their interest in planned parenthood, keeping abreast of scientific research, and attending international conferences. They know much, and have their own solution to all problems.

4. Finally, a minority of physicians try to cultivate a different attitude. In general, they have attempted to understand people's struggle for the liberalization of contraception and abortion, and have themselves engaged in this fight. Often dissatisfied by traditional medical practice, they have found in this area a concrete possibility for practising a different kind of medicine. They have been able to do so because there was a clearly articulated demand from healthy people who were therefore not dependent on them, because this field had not yet become dominated by traditional medical rules, and because they felt solidarity with their clients.

Such physicians, who are not always militant, listen to people's requests, try to understand their meaning, and so help them to decide in full awareness of the situation. These physicians should not impose their own point-of-view, but provide all the information to enable the woman and man to choose what is appropriate to their real situation.

It is difficult for a physician to apply these principles consistently in both traditional health structures and in militant organizations, while eschewing his traditional power.

Thus we see that the attitude and behaviour of physicians can be very different. This classification may seem a caricature. The limits are not always so clearly defined, and the groups overlap. However, one general characteristic of the physician emerges. His attitude to contraception and abortion does not usually differ from his attitude in other areas of medical practice.

A physician's social position gives him numerous privileges, and it is difficult to expect a physician to re-examine his attitude or position. Nevertheless, one might hope that he would not exploit his position, imposing his decisions on those who consult him, that he would combat ignorance, inform himself and others, and have as straightforward and objective an attitude as possible. All too often when a woman comes for advice, the physician emphasizes the complications of contraception and abortion. Does he have the same attitude when a woman comes with a pregnancy that she wants to carry to full-term? Does he speak to her of all the hazards of delivery?

Much progress would have been made if physicians had consciously understood that decisions on fertility and its regulation finally rest with the woman and the man, and that it is not for him to decide what is best for them.

Guardians of tradition have well understood that in all this there is a threat to their own concept of medical practice. When, for example, considering abortion on request, they say: "Anything tending to transform the physician into a technician acting solely at the consumer's request, or even worse, on the instruction of authority, is totally contrary to the interests of the individual" (Executive Committee of the Conseil National de l'Ordre des Médecins, 7 March 1974).

In fact, it is contrary to the traditional interests of the physician!

If human beings should choose to have children when they want them, and to lead a sexually liberated existence, the physician should reflect on the role he is given by the law. He ought to be wondering whether the health structures and their limitations, and his university training, should be abandoned, and so respond to the real needs of his clients.

Pierre Jouannet
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Emotional Problems in Planned Parenthood Services

A Regional Working Group on Emotional Problems in Planned Parenthood Services met in the Regional Office, London, on 16–18 September 1975, under the chairmanship of Dr Thorsten Sjövall (Sweden). Participants came from Britain, German Democratic Republic, Ireland, Italy, Luxembourg, Poland, Portugal and Turkey.

Introducing the psychosexual background to the discussion, the Chairman noted that fertility limitation tended to be presented as unquestionably beneficial, although emotional conflicts were evident among a significant minority of clients seeking advice on fertility regulation.

A distinction was drawn between clients requiring relationship counselling, and those requiring sexual counselling. The importance of discussing the situation with both partners, separately and together, was emphasized. The problems of young people received particular attention.

Regarding the role of health personnel, it was agreed that trained social workers, with their general experience of personal problemsolving, were probably in the best position to advise couples, although problems were typically presented in a clinical context initially, implying that physicians also required training in the field. The Working Group did not consider itself competent to make detailed recommendations on the training of health personnel.

Psychosexual counselling should not be divorced from other aspects of family health services, despite its specialist nature. Very often, emotional problemsolving lay in the political realm. For example, overcrowded housing meant lack of privacy and opportunity for sexual expression.

The Regional Secretariat is currently preparing a draft report on the meeting, for circulation to participants. The final report will be circulated to the Regional Council for consideration at its annual meeting in June 1976.

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