PLANNING FAMILIAL EN
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FAMILIENPLANUNG IN

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REPORT ON THE 1981 REGIONAL COUNCIL MEETING

The IPPF Europe Regional Council (RC) representing 20 IPPF member associations in Europe, met in Tutzing (Federal Republic of Germany) 1-4 June 1981, chaired by the Regional President, Jürgen Heinrichs (FRG). Observers from Czechoslovakia, Greece, Malta and the IPPF Executive Secretary also attended the meeting.

Formalities were handled on the first evening. With minor amendments the agenda was adopted, the minutes agreed, the 1980 Regional Audited Accounts approved and the associate memberships of the Family Development Council of Bulgaria and the Hungarian Scientific Society for Family and Women's Welfare confirmed.

The Regional Executive Committeé presented its report on major developments since the last RC meeting, and invited discussion.

The past year's activities were discussed. Publications included the *Regional Information Bulletin, Sex Education and Adolescence in Europe* and material on Sexuality and Handicapped People.

Some PPAs had presented a paper : *"Proposals on future initiatives for IPPF Europe Region"* for RC consideration. The REC agreed that comments should be solicited from member association staff and volunteers and studied by a working party to meet in 1981 to discuss proposals and report their recommendations to the 1982 Council meeting. The working party would consist of PPA and Regional Bureau staff and volunteers.

Various Regional and other meetings with regional participation were reported on, including a psychosexual counselling group which had met immediately before the RC.

The discussion topic of the Council was *Consumer Access to Fertility Regulation*. David Nowlan presented the topic, regretting the scant interest hitherto shown in the consumer's view of fertility regulation services. Yet Elise Ottesen-Jensen (an IPPF founder) had urged: *"We can learn from the people. We must listen to them and get our ideas from them"*.

The Consumer Working Group aimed to stimulate greater PPA interest in assessing both the accessibility and quality of services from the client's viewpoint. The discussion had three main purposes : to ask the right questions; to fashion the tools necessary for answering those questions; and to help PPAs use those tools to evaluate services to customers.

After presentation of the topics by the Consumer Working Group, RC members dispersed to five discussion groups and presented their reports to the RC the following day. Then the Consumer Working Group sifted through the various recommendations to establish firm proposals for the Regional Work Programme. (See report on the Consumer Working Group on page 7 of this issue).

Members then reported on significant aspects of their 1980 Annual Reports, summarised below.*

MEMBER COUNTRIES

Austria

There have been some changes since the 1979 general election. Financial aspects of family policy and women's health and planned parenthood are divided between two Staatssekretariats. The closure of one of the major abortion clinics makes the situation more difficult for women in the western part of the country. The ÖGF collaborates with the Government in giving lectures and organising discussion groups during courses for family planning personnel, in writing and editing educational material published by the State, and generally acting as a consultant on activities relating to sex education and contraception.

Belgium

The climate for planned parenthood has in some respects deteriorated further since 1979. Abortion remains illegal, although 10 000 abortions are performed each year, mainly in non-hospital centres. Educational activities are threatened by legislation which would limit the possibilities of teaching institutions to organise extra-mural courses. The Federation continues its training activities and action aimed at liberalising abortion, and plans to research into new contraceptive methods, pregnancy care, migrant and adolescent services.

Bulgaria

Irregular supply of contraceptives (particularly IUDs) remains problematic for the FDC. The number of abortions equals the number of births. Government interest in planned parenthood seems to be increasing, particularly in the field of infertility. The FDC is preparing a large-scale study of infertility, supports liberalisation of the abortion law and seeks to improve contraceptive availability.

Denmark

Public expenditure cuts affect family planning services, although clinic attendance rose by 20%. The FF organised two information meetings for general practitioners and other health personnel, in cooperation with the WHO Regional Office for Europe, and will increase its activities in this field, as a recent survey showed that many women are dissatisfied with the services offered by physicians. The FF has completed a research project on the family planning patterns of pregnant women, and prepared a project on sex education at the request of the National Health Service. The Association has also concentrated on increased distribution of information and education material.

Finland

The birthrate has been below replacement level for the last ten years and has remained stable for four years. The Federation considers that family planning, including the care and counselling of childless couples, is part of family policy, itself a means of influencing population policy. Väestöliitto works closely with the Government and actively attempts to contribute to policy decisions by taking initiatives and participating in the work of state committees. Activities will concentrate on

*Sets of the full 1980 Reports are available from the Europe Regional Bureau

improving the situation of families with children, housing and homehelp policies, genetic counselling, etc, and general information activities. It is hoped that these activities will result in an increase in the birthrate, necessary to achieve a balanced population development.

France

The December 1979 Abortion Law provides for stricter measures in case of non-observance of the law which has resulted in legal actions and sanctions against physicians, and in an increase in the rate of illegal abortions. A survey on abortion has indicated that public services do not respond sufficiently to abortion requests and demonstrated the shortcomings of the law and its inconsistent implementation, as well as the lack of information on contraception. The MFPF will therefore continue to fight for the provision of contraception and abortion, to analyse abuses of family planning rights arising from the Government's pronatalist policy. However, the election of a socialist government gives the MFPF hope for a general improvement in the situation of planned parenthood.

Federal Republic of Germany

Discussion on the implementation of the abortion law continued in 1980, and Pro Familia was again the target of numerous attacks in the press and at the federal and local level, reflected in cuts and reduction in public funding. This experience has led Pro Familia to believe that it must organise and project itself as a professional organisation for family planning. Two pilot-projects, "Sex Education training of educators for out-of-school youth" and "Sex education in the army - family planning for men", were completed. Pro Familia is revising its training programme, paying special attention to sexual therapy. Because of the Government's failure to support a five-year programme of specific target-group counselling, Pro Familia will implement the project on a small scale, through its clinics.

German Democratic Republic

The Association continued to inform the public through radio and television programmes, newspaper articles and reports in schools and youth clubs. EFA set out ideas for a training programme for social workers, in order to integrate family planning aspects in their curricula. The Association organised a meeting on "Medical and educational problems of sexuality", which included education and training for psychosexual counsellors, and is preparing a one-week symposium on "Childless Couples", to be held in September 1981. The EFA annual meeting will be devoted to "Sexuality and Handicapped People". The Association plans to meet with other medical associations and the Ministry of Health, to identify areas of future activities, such as the provision of services for new, small target groups.

Hungary

The HSSFWW concentrated on activities which promote a scientific comprehension of the family function. The Society continued its educational activity relating to preparation for family life, and took part in the training of teachers and health personnel on the subject. It participated in a study on the side-effects and complications of contraceptives, as well as in clinical trials of new contraceptives. Studies on the sexual life and the contraceptive and abortion behaviour of young people are in progress. A roundtable conference will be held

in October 1981 on "Preparation for Family Life". The next Congress of the Society, in 1982, will have the theme of "Development of fertility trends, family planning and birth control".

Ireland

Under the new Family Planning Act (1979), the IFPA has been granted a licence to provide contraceptive information and services, but cannot sell contraceptives. Consequently, the Association had to set up a separate organisation for contraceptive sales. The IPPF Members' Assembly passed a resolution aimed at informing the United Nations that Ireland's new law contravenes the UN Declaration on Human Rights. The IFPA has improved its contacts with trade unions, the teaching profession and disabled persons, and has generally increased its activities.

Italy

An abortion referendum was held with overwhelmingly positive response in favour of the present law, and was followed by a UICEMP congress on the implementation of the abortion law in May 1981. Generally, the law on family planning is implemented in very few regions, and whole areas remain without any family planning clinics. UICEMP is concentrating on education and counselling activities, but is still impeded by a critical financial situation. The Association has requested further IPPF assistance.

Luxembourg

The Government has not improved its attitude towards the law on sexual education and abortion, and has refused to increase its subsidies. Meanwhile, the Association has increased its clientele and opened a new centre which will be funded by the local authorities. The MLPFES enlarged its information activities through radio broadcasting and articles in the daily press, and started many new activities.

Netherlands

The Association is fighting against the new abortion act, by which abortion remains restricted. However, in practice, abortion is widely available. The RS activities encompass contraception services, psychosexual therapy, education and training programmes. A telephone information service has been set up and it is hoped to help young people especially. The RS produced a booklet for young people on contraception and sexuality, which has been a great success.

Norway

The NFF continued its cooperation with the Bureau of Health and arranged courses for public health personnel throughout the country, and for handicapped people, and produced leaflets on sexually transmitted diseases and contraception for distribution to schools. The NFF intends to concentrate on information for young people still at school and will receive government grants for special projects.

Poland

Due to recent political events, TRR finds itself confronted with a strong movement fighting against contraception, abortion and sex education. Contraceptive supplies are becoming increasingly scarce and the liberal abortion law is threatened. In spite of this critical situation, TRR have continued with their counselling and sex education programmes and publications, and hosted the Second Seminar of Socialist Countries on Family Planning and Sex Education. Nevertheless, the Association is forced to fight for survival to such an extent that they have regressed to the position of the 1950s, when their battle first began for the freedom of family planning in Poland.

Portugal

In the face of increasing governmental statements favouring 'natural' methods of contraception, APF continued to cooperate with the Health Department and Comissão da Condição Feminina, and had project and training contact with the UNFPA. Conferences were organised on psychosexual counselling and demographic problems, and activities were extended in providing information for young people. The Association intends to increase volunteer participation and reduce its general expenditure. IPPF grant assistance remains APF's main source of income and APF has requested further help for 1982.

Sweden

RFSU continued its work in the information and education field through holding courses on a diversity of subjects, and producing publications. Summer camp activities increased and have been very successful in giving people of different ages and backgrounds the opportunity to meet and exchange thoughts and experiences. The Association also concentrated on youth and sexuality, and has expanded its research and activities with rape and sexual assault victims. Following the formulation of an ideological standpoint, within the next few years RFSU will work towards a deeper examination of issues concerning sexuality, and disseminating its activities to the public.

Turkey

During 1980, TAPD continued to concentrate on propaganda and education, particularly aimed at workers and soldiers. The Association intends to extends its programmes in the areas of youth education, sexuality and the physically handicapped and training for parents. The new government in Turkey is aware of its responsibilities in connection with family planning and is considering legalisation of abortion and female sterilisation.

United Kingdom

The ready availability of family planning services in the UK has led to a re-examination of the FPA's role. However, the abortion rate was still rising, indicative of a gap in education and information work, and the FPA intend to concentrate in this field. Acting as a pressure-group, the Association has played a significant part in persuading Area Health Authorities not to reduce expenditure on clinic services, and the FPA itself still runs clinics in certain regions. In spite of a favourable statement by the Minister of Health on the provision of contraception to persons under 16, the FPA's work was hampered by an economic recession and a Conservative Government committed to public spending cuts, hence the very real problems facing the health service and family planning facilities.

Yugoslavia

The Association's major work programme has been directed towards the realisation of planned parenthood as a constitutional human right. Other activities have included youth education, seminars and courses on social and health care, training for social workers and a project to provide family planning information and access to Yugoslavs temporarily working abroad. The FPCY continued to liaise with the UNFPA on various scientific based research projects, and has received good coverage through the mass-media.

NON-MEMBER COUNTRIES

Czechoslovakia

The Czechoslovak demographic situation has always been of great interest to the government; although a pronatalist population policy encouraged a rise in fertility levels in the 1970s, 1980 has seen a decline. Hence parenthood education and family planning are closely integrated into government policy. Contraception is readily available, a liberal abortion law operates and sex education is compulsorily taught. In 1980 attention focused mainly on the improvement of the existing system of parenthood education, through surveys and research to be carried out over some years.

Greece

Legislation on the establishment of family planning clinics was finally passed in 1980 and as a result the Family Planning Advisory Committee was set up to look into ways of implementing this law. Facilities are still very limited and uncoordinated and, although most contraceptive methods are available, these are little used. Despite the restrictive law, illegal abortion is widespread.

Malta

Following extensive groundwork throughout 1980, including research showing evidence that sexual activities were increasing among Maltese youth, and that a high proportion of medical officers working with the Government were prepared to provide family planning services for their patients, in May 1981, the Department of Health and Environment introduced Family Welfare Clinics as part of its plan to develop community services. So far three family planning clinics have been established with the aim of providing relationship counselling, child health care and gynecological services as well as family planning facilities.

The Council then considered the Regional Work Programme and Budget 1982. The Consumer Working Group proposals were agreed. The migrant project would continue with three small working group meetings in 1981 and a full meeting in 1982 to complete the project. The Yugoslav representatives reported on the progress of the Regional project on Planned Parenthood as a Human Right which the Family Planning Council of Yugoslavia is largely executing on behalf of the Region. A preliminary report of a working group on Psychosexual Counselling was circulated, recommending that the discussion topic for the 1982 RC meeting be 'Living and working with sexual aspects of life', which would include aspects of group counselling. This was agreed by the Council. Denmark proposed to organise a seminar on adolescent sexuality and unwanted pregnancy and Finland expressed its intention to continue with a project on involuntary infertility, welcoming participation from other PPAs.

IPPF Central matters were the subject of two Council Resolutions, respectively urging practical implementation of Action Area 2 of the IPPF 1982/84 Plan (Increasing Commitment to Population as a Crucial Factor in Development) regarding material published centrally, including *People*, and urging full implementation at all levels of the 1980 Central Council Resolution on reorganisation of the IPPF secretariat, including monitoring its implementation.

Sten Heckscher was re-elected Regional Treasurer and Sten Heckscher, Jürgen Heinrichs, David Nowlan and Nevenka Petrić were elected Regional representatives to the Central Council.

Finally, it was agreed that the Regional Council should meet next in May 1982 in the Netherlands.

LEARNING FROM PEOPLE
Consumer Access to Fertility Regulation

The 1981 IPPF Europe Regional Council meeting's Discussion topic was 'Consumer access to fertility regulation', based on Regional consumer activity commenced explicitly in 1980. The discussion was introduced by the Consumer Working Group (Dilys Cossey, Elisabeth Jandl-Jager and David Nowlan). Dilys Cossey (UK) spoke on the regulations affecting contraceptive advertising in her own country, where television is prohibited from advertising branded contraceptives (unlike the Netherlands or Sweden).

Elisabeth Jandl-Jager (Austria) observed the variation between countries in contraceptive availability, based on the revised IPPF *Directory of Contraceptives* (1981). David Nowlan (Ireland) presented the results of a questionnaire enquiry among Irish FPA clinic visitors. Finally, the Regional Consumer Officer (Philip Kestelman) urged good quality printed information for consumers.

Following group discussion and reporting, the plenary session agreed that the Consumer Working Group (CWG) should evolve concrete proposals, based on group recommendations, for the Regional Work Programme/Budget 1982. The results emphasised the primary role of member-associations in implementing Regional consumer activities at the national level. As amended by the Regional Council, these proposals are summarised below.

IPPF member-associations should contact national consumer-bodies, in order to enquire systematically the price, quality and availability of contraceptives and fertility regulation services. The CWG clinic questionnaire should be circulated to PPAs for local use as appropriate. Existing services aimed at specific target-groups should be evaluated.

Advertising should be monitored, and the influence of national regulations assessed. PPAs experienced at influencing the gap between individual wishes and social needs should share their knowledge regionally. Client record cards should also be evaluated.

Member-associations lacking knowledge of contraceptive methods suitable for different target-groups should inform the Regional Bureau, and summarise national consumer research for Regional publication as appropriate. Finally, PPAs should examine the roles of medical and nonmedical personnel in providing fertility-related services.

The Regional Bureau is pursuing these matters vigorously, and will summarise Regional experience of consumers, for consideration at the 1982 Regional Council meeting. The broad aim of Regional consumer activity is to raise consciousness of the consumer predicament in fertility regulation. As one IPPF founder (Elise Ottesen-Jensen) once put it: *"We can learn from the people. We must listen to them and get our ideas from them. We do not know everything".*

PLANNED PARENTHOOD AND TRADE UNIONS

France

In 1971, MFPF (Mouvement Français pour le Planning Familial) militants decided to reach all population sectors more or less equally, by increasing and diversifying their activities. They felt very anxious to reach the most underprivileged people in the field of sexual information, increasingly convinced that everyone should find the approaches most suitable to her/his social group.

We were meeting trade unionists in our centres when they came for advice on contraception, abortion and sexuality. Some of them soon noticed the relationship between these problems and their living and working conditions, sharing our views.

Trade unionists began formulating these questions in terms of basic claims, and requested MFPF to come and explain this analysis and to establish information offices for all workers in work-places.

Little by little, union executive structures have been questioned by these activities and have contacted us.

Why work with trade unions?

This work with trade unions results from two key-ideas which have gradually prevailed among MFPF militants.

The first concept is linked to our wish to re-integrate sexuality at all levels of daily life. Our judeo-christian and patriarchal societies have long repressed and denied sexuality and, when it became impossible to ignore the modern trends of liberation, they capitulated, while seeking to reduce sexuality to the medical and psychological levels, restricting it to an individual approach in the narrow context of the family.

In the face of this prevailing attitude, and confronted daily by real personal difficulties on the one hand, and by the public authorities' resistance to promoting legislation and means of self-determination on the other, MFPF was able to establish the following principle as a basis for action : sexuality is closely linked to living and working conditions; it is not a medical issue but depends on social, economic and cultural conditions.

The second key-idea for the MFPF results from the awareness of social inequalities. The shortcomings of the French laws on contraception and abortion, and their slow implementation and evolution, have yielded a concrete understanding of the unequal access to basic sexual freedoms, by sex and social background.

Naturally, these two concepts generated our willingness to work with those sharing the wish to combat social inequalities, and to bring the sexual debate to places where it is most stifled but most immediate : work-places where the organisation, the pace, the noise ... deny the body, but also where relations between men and women, differences in salaries, promotion chances and the hierarchy continually remind us that men and women are not born equal.

How ? The 'Relay Policy'

In the first place, these concepts led us to seek to share our views with trade union leaders and militants, so that they not only incorporated in their claims the struggles to legalise contraception and abortion, and against sex discrimination, but above all that they themselves participated in changing people's minds on these matters.

Trade unions and works councils accepted relatively easily the establishment of MFPF offices in work-places, but that was not our main object. We wanted trade unionists themselves to take responsibility for sexual issues in the context of union activities, thus proving that sexuality is everyone's business, not only for specialists, sexologists or physicians but, linked to living and working conditions, it may be discussed collectively everywhere, including the work-place.

From this evolved the 'relay policy' with trade unions. Trade unionists come to the MFPF for a reflexion course as part of laws providing for continuous training during working hours. Then they hold sessions at work (in relaxed circumstances, eg. during the lunch-hour), when many subjects are discussed : sex education for children, contraception, abortion, puberty, the menopause, alcoholism, drugs, free-love, homosexuality, day-nurseries, sexism in school-books, prostitution, motherhood, childbirth, painless nonviolent childbirth, wanting children, responsible parenthood, part-time work, sexology, etc.

This collaboration and these common views also created strong opposition to government policy, reticent and sometimes opposed to the basic principles of sexual liberation, ie :

- recognising people's freedom of self-determination and providing the necessary means;
- reducing State interference in private life, and
- combating sexist discrimination.

Agreed bases for these ideas were established with the Force Ouvrière, a trade union which essentially fights for improved working conditions, without questioning the capitalist society. But no definite action followed.

However, the big trade union powers, the Confédération Générale des Travailleurs (CGT) and the Confédération Française Démocratique des Travailleurs (CFDT) which link workers' demands to changing society, requested from us the following :

1) either to participate directly in their national union training schemes by disseminating our ideas, so that sexual matters were integrated into union demands;

2) or to organise 'relay policy' training for trade unionists wishing to open offices at their work-place;

3) or a joint activity between MFPF and union militants, in order to integrate our action into demands on the same level as salaries, unemployment, working conditions, women's conditions, communal facilities, day-nurseries, etc.

Our response was varied :

- offices in work-places,
- libraries,
- debates on the various aspects mentioned above,
- exhibitions,
- book-displays,
- film-shows,
- pamphlets,
- contacts with Parliamentarians,
- participation in MFPF activities, and
- continuous reflection with the MFPF.

Moreover, at the federal level, the trade unions CGT, CFDT and the Fédération de l'Education Nationale, and the MFPF have acted as a pressure-group on the previous government on several occasions, such as voting on contraception and abortion laws and their implementation by the following activities :

o mass distribution of joint literature

o joint representation to different parliamentary groups, and

o demonstrations.

When the Left coalition was dissolved in 1978, trade unions decided that common action was no longer possible, even on specific issues, and we had to continue working with each union separately.

Another difficulty is that union leaders are mostly men, who give priority to other demands, and accept with difficulty the challenge to relationships between men and women presented by considerations of sexuality, contraception and abortion. But the main obstacle to information in work-places came from company executives.

Indeed, the 'bosses' found dangerous these discussion places. To discuss collectively all life's problems in the office or factory brings an awareness and demands opposed to management interests, and it is easy for them to prevent the establishment of these offices.

We hope that the recent political change will allow us to intensify our activities in this respect.

Andrée Jaubert
Simone Iff
Paris

Yugoslavia

Organised social action in fertility regulation began in the 1930s, when progressive women's, workers' and other social forces gave it increasing attention in view of the rising women's employment. Initial activities were scattered in industrialised areas, spreading elsewhere later, particularly through lectures on preventing unwanted births, risks of abortion, etc. This pioneer action resulted from the Marxist viewpoint that man must be liberated in all aspects of life, so that his social emancipation includes control over human reproduction. The Yugoslav Communist Party (then clandestine) at its Fifth National Conference in Zagreb in October 1940, recommended that abortion should be available on request, until conditions for having children improved.

The evolution towards free decision-making in fertility regulation paralleled the rise in women's employment. In postwar Yugoslavia, the trade union confederation naturally handled these problems.

Around 1950, the Women's Commission of the Central Council of the Confederation of Trade Unions of Yugoslavia introduced concrete measures to help working women protect themselves against unwanted pregnancy, without resorting to abortion, then the most widespread method of fertility regulation, not only for women's social emancipation, but also for general social emancipation. The idea was to provide abortion in health institutions, to avoid both its consequences and its causes. With the help of trade unions and other social organisations, the Federal Assembly regulated on preventing unwanted pregnancy in 1951.

As women's industrial employment rose steadily during the 1950s, abortions also increased and became a significant issue with socio-economic repercussions on women, on working organisations employing many women, on health insurance, etc. motivating the trade unions. Rapid postwar industrialisation increased the standard of living, weakened traditional customs and raised the proportion of women in the workforce to 25% by 1954.

After 1960, the focus of planned parenthood activities was the Conference for Social Activities of Women in Yugoslavia. Trade Unions maintained their cooperation, were represented in the Federal Coordinating Board for Planned Parenthood (established in 1963) and subsequently in planned parenthood bodies at all levels, but have not expanded their activities in this field.

1981 represents a turning-point of trade union interest in planned parenthood. On 20 May 1981, a meeting on 'Humanisation of Relations between the Sexes and Reponsible Parenthood : an integral part of youth education at all levels' was organised in Belgrade by the Central Board of the educational, scientific and cultural trade unions and the Family Planning Council of Yugoslavia, the Permanent Conference of the Institution for Promoting Education and the Presidency of the Conference of Socialist Youth. The meeting concluded that social action in this field had achieved positive results, albeit unevenly; that scientific research had permitted introducing this topic into teacher training institutions and that action is needed to overcome obstacles in the path of the Federal Constitution, Constitutions of republics and provinces and other social documents.

Participants at the meeting agreed the following bases for future activities :

- the need for schools to develop social selfmanagement and free personality, based on scientific socialism;
- the need to consider the harmful effect on personality development of conservative and patriarchal influences and a petit bourgeois concept of sexual relationships;
- the need to develop and promote human relations among people at work, in society and the family, and between the sexes;
- the need to promote cooperation between family and school, to which trade unions can specifically contribute;
- the need to educate young people in human sexual relationships and responsible parenthood;
- the urgent need to train future teachers in this field, where trade unions can again play an important role; and
- the need for additional training in this area for practising teachers. Since the Confederation of Trade Unions includes teachers, it can contribute significantly here.

In educational, scientific and cultural activities, the Central Board of the Confederation of Trade Unions and the Family Planning Council of Yugoslavia will hold joint discussions on implementing the above conclusions. Moreover, all trade union newspapers will publish these conclusions, so interesting a wider audience in the humanisation of sexual relationships and responsible parenthood.

Nevenka Petrić
Belgrade

FAMILY PLANNING SERVICE PROVISION FOR IMMIGRANTS AND ETHNIC MINORITIES IN BRITAIN : THEORY AND PRACTICE

Introduction

This article discusses some of the general theoretical issues surrounding the provision of family planning services to immigrants and ethnic minorities; and examines what provision has been made to date in Britain and what still needs to be made to cater for some of the remaining areas of unmet needs.

It makes special reference to Asians, for the reason that of all the ethnic minorities in Britain their family planning needs have received the greatest special attention from both researchers and health authorities. This is because they have been perceived to have the greatest cultural, religious and linguistic difficulties in making use of existing family planning services. Because of what research is available much of the article concerns the health services as a whole rather than the family planning services in particular.

The political context of family planning for immigrants

'People say to me : "What's the use of putting an end to immigration when you can't put an end to immigration through the uterus" '. This was the remark of a Norwegian doctor, describing the pressures she faced, working in an immigrant health clinic in Oslo, to insert IUDs into immigrant women. But the sentiment it embodies is just as widespread in Britain.

The point it highlights is that to raise the subject of family planning provision for immigrants is to step onto politically sensitive ground. Many people will be immediately suspicious about the motive : whether it is a genuine, caring concern to improve family planning provision for the individual immigrant or rather, a demographic concern to regulate the fertility of the immigrant population.

The dangers of misinterpretation and mistrust are particularly great at a time of economic depression and a corresponding increase in racial hostility and deterioration in race relations. Moreover, now that immigration into Britain on the scale which took place in the prosperous years of the fifties, sixties and early seventies has ended, racialist feeling which previously focussed on the number of immigrants entering the country now increasingly concerns itself with the fertility and population growth rates of immigrant groups already resident. And just as the popular press and politicians once so exaggerated the numbers of immigrants 'flooding' into the country, so do they now exaggerate the fertility of those living here. The mythology is just as potent. The 'brown peril' looms as large as ever - it's just that it now looms over a horizon tinged with questions related to family planning.

This political sensitivity of the subject has almost undoubtedly been an important factor in the general neglect of the special family planning needs of ethnic minority groups.

But a second important political, or at least ideological, consideration has also contributed to this neglect. This has been the guiding belief in a policy of equal treatment and a commitment to integration (if not necessarily assimilation) of minority groups into the host society. Special services, the argument has run, should be allocated on the basis of need not colour. Clients should be categorised according to their common disadvantage not their race. Policies of positive discrimination and special services, it has been believed, run the risk of amounting on the one hand to racial privilege and favouritism, or on the other, to racial ghettoisation and an abandonment of the objective of integrating minorities into making use of existing services.

This equal treatment approach rests on a worthy ideal, but often seems unrealistic in practice. It fails to recognise that by treating everyone equally a service may fail to cater for unequal needs. It fails to see that there may in practice be such a close identity between a particular category of need and the needs of a particular ethnic minority that it may be practical or even vital to provide for both together. It fails to acknowledge that an overall policy of integration need not be incompatible with the provision of specific separate services to meet specific minority needs.

A report by the Wandsworth Council for Community Relations (WCCR) on *Asians and the Health Service*(published in 1978 but based on research in the early seventies) put these points clearly when it argued that : 'If cultural background, language problems, feelings of alienation or particular health problems create special needs or even isolate the Asian population from the health service, thereby placing them at risk, it is imperative that services be adapted to take account of these factors. This may necessitate the creation of separate facilities for part of the Asian community or special provisions directed largely if not exclusively at Asians'. The report concludes by suggesting that : ' Providing the same service to all in the face of differing needs is *not* an equitable service'.

This seems to me the right approach. But attitudes on the provision of special services still differ; and fashions change over time. One person's - or one year's - special service is another person's unfair favouritism which, in turn, is another person's ghetto.

Separate provision in practice

However, it does seem that an approach of selective special provision has gained increasingly wide support in recent years. From the laissez-faire, equal treatment philosophy of the sixties, the seventies saw an emerging realisation that some minority groups did have pressing and separate needs which were not being catered for by the existing services.

It is not possible to speak more precisely than this because the Department of Health and Social Security, the Government ministry responsible for health service provision, has never laid down clear guidelines to health authorities at a local level, on the provision of services in multiethnic areas. No doubt this is in large part because of the political considerations we have been discussing.

The result has been that the response of health authorities to the needs of ethnic minority populations has varied considerably. Furthermore, the special services provided by different authorities have tended to be more related to individual judgements than to any systematic assessment of needs. An investigation by the Commission for Racial Equality and the Association of Directors of Social Services (CRE/ADSS) found that those authorities who had taken action had done so in very different ways which could not be justified in terms of differences in need. The WCCR survey found that most action often appeared to be taken in the areas with relatively small Asian populations, and vice-versa.

The CRE/ADSS report concluded that : 'The response of social service departments to the existence of multi-racial communities has been patchy, piecemeal and lacking in strategy'. The conclusion would seem to apply equally to health, and specifically family planning, provision.

Family planning services for immigrants and ethnic minorities : existing and needed

Let us now examine in more detail the special family planning needs of immigrant communities in Britain, mention some of the services that are currently provided to meet these needs, and try to identify some of the main areas of remaining unmet need. Again, the emphasis will be heavily on the needs of and services provided for Asians.

Language and communication

In time non-English speaking immigrants will learn English. Until they do however, some, and particularly the elderly and, to a lesser but considerable degree, women, may have inadequate language skills to make best use of family planning services.

An obvious way of overcoming the language barrier is by using interpreters. Use of interpreters has a number of drawbacks, including the interpreter's possible own unfamiliarity with terminology and resulting dangers of misinterpretation, loss of interpersonal control by the doctor or nurse, reluctance of patients to discuss sensitive subjects in front of a third party, actual or perceived dangers to confidentiality, the range of languages spoken within a given area, and, not least, cost. However, none of these problems are insurmontable, and a great deal more interpreters are needed than are employed at present. The WCCR survey found that only 13 out of 46 health authorities with high ethnic minority populations had employed interpreters. The report recommended that more health authorities 'consider the appointment of interpreters as the most effective solution to interpersonal communication problems'. It further suggested that more health authorities employ interpreters on an on-call basis, to be available outside working hours for emergency cases.

Only six of the authorities in the WCCR survey mentioned the use of language cards or phrase books and these were used mainly in hospitals. These are inevitably limited in scope - limited even further to the extent that many Asians are illiterate in their own language - but they are cheap and relatively simple, and must be better than nothing.

Health authorities can also help overcome language problems by holding language classes at clinics for patients or by seeing that staff are taught or undertake to learn the predominant Asian language or at least some words of it. Language classes at clinics can in addition serve as a useful introduction to the service, attracting clients to a clinic who might not otherwise attend. Some health authorities may consider the job of language tuition as outside their brief. But a number have successfully initiated them and there seems good reason why others should try to follow their example.

IEC material in immigrant languages is produced by a range of different agencies. The Family Planning Association itself produces leaflets in the four main Asian languages. Asian leaflets are also produced by the large contraceptive manufacturing drug companies and by a number of different health authorities at a local level. In addition, the Health Education Council and the Commission for Racial Equality both produce material, including posters, on related maternal and antenatal matters.

The problem here is less one of adequate production of IEC material than of effective publicity and distribution of what is produced. The WCCR report found that many health authorities were not aware of the full range of material available. Another aspect of the problem of distribution may be that, to the extent that Asians do not use the family planning services in the first place, material which is distributed through these services will fail to reach them. Alternative approaches to disseminating material therefore, such as through appropriate community organisations, might enable it to reach a wider audience.

One other problem with the IEC material currently produced is its emphasis on the printed and written word. While a number of the health authorities in the WCCR survey acknowledged that many of the Asians unable to speak English were also illiterate in their own language, few 'had implemented any alternative means of communication other than the written word'. Those who had, had found diagrammatic and photographic material and other audio-visual aids to be very useful. There is a need for more of this kind of material to be made available for use by illiterate patients around the country.

Cost, as always, is a problem. IEC resources can be expensive to produce. Economies in the amount of IEC material produced, and rationalisation of what is produced and distributed, could be achieved by greater centralisation of the responsibility for development and production of material. If so many different agencies were not producing so many different publications, the quality of what is produced - without losing too much sensitivity to differing local needs - could be improved and considerable confusion and money saved in the process.

Staff training

An understanding of the background, culture, special needs and problems of ethnic minority clients should be an essential starting point of an effective and relevant service. The WCCR report suggests that in-service training on the social, economic and cultural characteristics of the Asian community should be given to health service staff - both medical and nursing staff and staff responsible for administration and planning of service provision.

A recent report by the Community Health Council in the London Borough of Brent entitled *Black People and the Health Service* (1981) spoke of widespread prejudice, ignorance and misunderstanding of black people on the part of white health service staff. To give one example, the report said that : 'Asian women prefer to have female relatives with them during childbirth. But in Central Middlesex Hospital female relatives.... have been asked to leave'.

Research into the antenatal care of Asian women in Coventry between 1976-9 by researcher Hilary Homans, found that too many general practitioners and hospital doctors were failing to prepare or warn women of internal examinations. Some women were 'extremely upset' by their internal examinations, simply because they were unprepared for them.

These are the kind of difficulties which appropriate training could do much to overcome. Research has shown however, that really very little training of this kind is provided to health or social service staff. Only 14 authorities in the WCCR survey mentioned training at all, while courses or seminars appeared often to be sporadic, organised on the initiative of one particular member of staff, limited in the topics covered and not necessarily compulsary even for staff coming into close contact with Asians. The Family Planning Association has in the past also run training courses for those working with ethnic minorities. But these have also been sporadic and have reached relatively few people.

Domiciliary services and 'satellite' clinics

There is considerable evidence from a wide range of sources that Asian women are reluctant to attend conventional family planning clinics. For example, a survey earlier this year at one of Manchester's busiest clinics showed that attendance by Asian women was abnormally low for an area with a sizeable Asian community. Only two of the more than 140 women visiting the clinic during the course of the survey were Asian.

As Alix Henley puts it in her book *Asian Patients in Hospital and at Home* (1979) : 'None but the bravest of Asian women will attend a family planning clinic of their own accord'. She concludes that : 'Home visits therefore are likely to be the only way of reaching them'. Elphis Christopher, a doctor with wide experience of providing domiciliary family planning to immigrant women of different nationalities in the London Borough of Haringey, suggests in her book on *Sexuality and Birth Control in Social and Community Work* (1980) that in her experience 'this is an acceptable agency for family planning advice where women are too embarrassed and modest to attend a clinic or to go to a general practitioner'.

Another alternative service might be special clinics for Asian women, perhaps operating on a mobile, 'satellite' basis, visiting Asian community centres at appropriate intervals. Separate health clinics for immigrants have proved successful abroad. for example Norway, and might be a very constructive medium-term solution for family planning provision in Britain.

Women doctors

One of the main reasons why Asian women do not use conventional clinics, as the recent Manchester survey and much other research have shown, is a fear of being examined by a male doctor. Greater staffing of family planning and antenatal services by female doctors therefore would undoubtedly make the services far more attractive to Asian women.

An interesting finding of Hilary Homans' research into antenatal services in Coventry, which is relevant here, is that when a woman doctor was not available, Asian women preferred to see a white male doctor than an Asian male doctor, even if there were difficulties with communication. To be examined by a man familiar with their own culture might be forbidden in some cases, whereas it might be less unacceptable to be seen by a man who was culturally removed from the customs and beliefs they held.

Conclusion

The limited and uneven response of the health service to the family planning needs of immigrants and ethnic minorities reflects both ideology and expediency. The lack of central guidance in a politically sensitive area of service provision has led to uncertainty at a local level and a widely different response, often not corresponding directly to differences in need. As increasing numbers of health authorities have become convinced of the need to take action and adapt their services so the main obstacles to action have become financial rather than ideological. We live in a real not ideal world and financial constraints inevitably play a part. Conflicting priorities compete for limited resources . But perhaps cost should only be allowed to be an excuse up to a point. If the needs are great enough, and the evidence, however subjectively assessed, suggests that they are, then the resources ought to be made available.

Peter Freedman
London

UKFPA COURSES ON SEX EDUCATION AND PERSONAL RELATIONSHIPS FOR WORKERS WITH THE MENTALLY HANDICAPPED

In recent years, there has been a growing awareness of the needs of the mentally handicapped in the fields of sex education and personal relationships. This has produced an increasing demand for help and information from those working with the mentally handicapped, who are often assigned the task of giving sex education to those in care.

The UKFPA has been working in the field of sex education since the 1940s, when the FPA began courses in contraceptive technique for health personnel. When the National Health Service took over responsibility for contraception services in Britain in 1974, it also assumed responsibility for training health personnel. Meanwhile, the FPA has decided that its long training experience should be used to provide family planning courses for other professionals. Courses for health visitors, nurses and social workers were organised, aiming to provide information on family planning methods and services, to examine the needs of those seeking family planning advice and to discuss how to meet these needs.

It was soon recognised that there was also a need for courses in sexuality and personal relationships. The establishment of the FPA Education Unit in 1972 led to the development of such courses for teachers, youth and community leaders, social workers and health visitors. Some participants in the early courses were teachers and carers for the mentally handicapped, who needed a specially designed course. Over the last few years, the FPA has run many courses for these staff, some funded by the Department of Health and Social Security, others by local health authorities or social service departments. With increasing awareness of the needs of the mentally handicapped and new policies to integrate the mentally handicapped into the community, this has become the most rapidly expanding area of FPA work.

Early courses run by the Education Unit were organised conventionally, using lectures and some group work, requiring only minimal involvement by course members. However since the mid-1970s the Unit has designed and developed course methods seeking to involve participants much more in their own training process. All courses are run by a small team of FPA-trained tutors using participatory methods, such as role-play, group discussion, quizzes and communication exercises. The courses are designed to be relevant both to course members themselves and to them in their work.

Objects, content and methods vary somewhat between courses, but the general aim is to accumulate knowledge and to create a sensitive awareness and understanding by participants of their own and other people's attitudes in such a way that they can increase their competence and confidence in handling sex education and personal relationships issues with their client groups.

The objectives of courses for carers for the mentally handicapped are as follows :

- to increase the awareness and sensitivity of course members to the sexuality of the mentally handicapped

- to explore attitudes and feelings about human sexuality
- to provide some relevant factual information
- to identify the needs of the mentally handicapped in sex education
- to consider how some of these needs can be met.

The FPA has run courses for the staff of adult training centres, residential homes and hospitals for the mentally handicapped. Most courses last three days and are intended for professional staff. (Others have sometimes attended : on a recent course, a centre's minibus driver and one cleaner attended - due to the nature of their work, they have frequent contact with the mentally handicapped.) There is also a demand for courses from parents.

All participants complete an evaluation form after the course. It is clear from their remarks that there is a great need for information, help and support in this area of their work.

Below are some typical remarks of course members :

"It has given me an opportunity to share my own and others' attitudes towards sexuality in general, which can only improve my work with sexual and personal relationships with the mentally handicapped".

"By role-playing a parent I now find that this has given me a greater understanding of their problems and worries".

"I gained a good deal of information on how to inform parents who ask for help or who demand changes".

"The course has been worthwhile because it has brought together other professional people so that you don't feel that you are sticking your neck out without support".

The FPA Education Unit will be glad to supply more information about these courses to others working in the field.

Enquiries to: The Education Unit, Family Planning Association, Margaret Pyke House, 27-35 Mortimer Street, LONDON W1N 7RJ.

Joyce Rosser
London

THE IFPA AND THE INTERNATIONAL YEAR OF THE DISABLED (1981)

The Irish Family Planning Association (IFPA) has long been involved in sexuality and the disabled. We are naturally eager to intensify our work in this field, capitalising on the International Year of the Disabled.

In October 1980, the IFPA and the Disabled Persons Action Group held a successful seminar in Dublin, entitled 'Sexuality and the Disabled'; speakers included the specialists Norman Rea and Colm O'Doherty. Disabled people and representatives of relevant organisations attended the seminar. On the basis of discussions at this seminar and consultations with relevant groups since then, the IFPA has drawn up a future work programme.

The IFPA are currently investigating the possibility of starting a special psychosexual counselling service for the disabled.

The IFPA feel that the distribution of information on family planning to disabled people needs improvement, particularly in institutions. The Disabled Persons Action Group will work with the IFPA in a special information drive.

The Disabled Persons Action Group urges attention to the education and training of the caring professions in sexuality and the disabled. To this end, the IFPA will compile a series of such programmes, hopefully providing information and creating among professionals working with the disabled a greater awareness and sensitivity towards their sexual needs.

The IFPA will of course develop and improve other ideas over the months to come, and will particularly watch closely the projects of other PPAs.

SWITZERLAND - a Correction

Professor Marianne Mall-Haefeli, of the Social Medicine Department in the Basel University Gynecological Clinic, has recently pointed out an error in the article on fertility regulation in Switzerland, published in the October 1980 issue of the *Regional Information Bulletin* (Vol 9, No 2, pages 13-14). There it was incorrectly stated that abortion remains illegal under federal Swiss law.

In fact, according to Paragraph 120 of the Penal Code of 1937 (effective in 1942), a qualified physician (with the concurrence of another medical specialist, designated by the competent cantonal authority) may perform an abortion necessary to prevent an otherwise inevitable danger to the pregnant woman's life, or a serious and permanent threat to her health.

Moreover, no law governs medically skilled male or female sterilisation. As with other methods of fertility regulation, the availability of sterilisation varies between cantons.

YOUTH AND SEXUALITY

Adolescent sexuality and sex education are topics which attract a vast amount of comment, much of it based not on hard facts but merely on supposition. Now, for the Europeans at least, there exists a ready and reliable source of factual information in these areas.

Sex Education and Adolescence in Europe sets out to inform the reader about the reality of educational attitudes and sexual behaviour of young people in Europe, the ways sexuality is investigated and the variety of educational approaches to the topic. The first part of the study consists of a survey of recent investigations into sex education and brief descriptions of the various models of sex education. The second part reports the results of a cross-cultural study carried out in 19 European countries to examine the situation of young people in the fields of sexuality, marriage and the family, eg. rate of development, sexuality, contraception and abortion, marriage, parenthood, family, sexual norms and deviance.

Although intended primarily for sex educators, family planning practitioners and social scientists involved in sex research, *Sex Education and Adolescence in Europe* will prove a valuable handbook for anyone with more than just a passing interest in this important subject area.

Sex Education and Adolescence in Europe is published by International Planned Parenthood Federation (Europe Region), 18-20 Lower Regent Street, London SW1Y 4PW, UK at £4.50 plus postage.

ISBN 0 904983 07 2 118pp May 1981

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