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ENTRE NOUS



No. 10, July 1987

**WADAD HADDAD retiring
from WHO—service**



"I wish to say goodbye to my colleagues and friends within and outside the European Region of WHO. My sincere thanks to all those who have supported me in my 27 years of service and have helped me to develop the sexuality and family planning programme as it stands today. I am especially grateful for your professional inspiration and critical solidarity.

"I learned to appreciate the challenge and the potential of differences of opinion and culture. I am also touched by the warm friendship I received and the courageous commitment of many working in the field of family planning.

"UNFPA's support went beyond financing this programme. I very much enjoyed my association with the fine group of persons who make up its membership, its richness and liveliness.

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"In fulfilling the expectation entrusted to me by WHO I received strong support from my directors and the staff. Our present work towards the health for all strategy has been a strong challenge to me which gave me strength to move on, to create and to fight, if necessary.

"I am now leaving an institution but not the idea and vision of family planning which I hope, dear colleagues and friends, we will continue to share."

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Dr J.E. Asvall, WHO's Regional Director for Europe highlights an exceptional career

"At the end of May 1987, Wadad Haddad retired from service with the World Health Organization. Few careers in international health work have been more fruitful than hers!

"Her background and experience (in nursing, midwifery, social work and family planning) prior to entering international health work - to which she has devoted almost 27 years - were ideal for tackling the problems of the countries in the European Region of WHO. Her academic qualifications include studies at universities and institutions in the Lebanon (her home country), Belgium, England, France and the United States.

"Her career in WHO started at the country level in Morocco where she served as a nurse educator in general and public health from 1960 to 1972. She then became the officer responsible for public health nursing/midwifery at the Regional Office for Europe of WHO and was given the task of developing, between 1978 and 1984, what became a successful new programme in family planning.

"Concurrent with the adoption of the regional targets for health for all, she had the vision and skill to expand her programme to include the broad area of sexual health, which, as Ms Haddad says herself, 'is a fundamental human right'.

"What makes Wadad Haddad special is the passion and the compassion she brings to her understanding of the conditions of the human being, as all who have had the joy of knowing her will certify. Her marvellous sense of humour and countless stories have made her famous and popular throughout Europe and have helped to make EURO a nicer and more fun place to work.

"What makes her very special, however, is that Wadad Haddad is one of the rare people who manages to do what we should all do: to combine a concern for professional quality and scientific honesty with a personal commitment to help make things really change in countries. To her, scientific advice alone is not enough; we fail in our mission if we do not take personal responsibility for stimulating change in our various Member States. That fundamental attitude has been clearly understood by all her counterparts and friends in the countries of the Region and is the main reason for the tremendous professional respect that she enjoys. That is also why, when she retired, we all felt that an important part of WHO went with her as well. Her wish, I know, is that this spirit of hers will remain and thrive in EURO's work in the years ahead."

Dr Angèle Petros-Barvazian, Director, Division of Family Health at WHO headquarters in Geneva, first met Ms Wadad Haddad in 1968 at a meeting in Geneva where family planning was discussed as part of MCH and as a new area for WHO to support Member States.

Says Dr Petros-Barvazian, "At the meeting I had no doubt that I met a colleague with remarkable human and professional qualities, wide ranging knowledge and a sense of humour within an impressive presence.

"Since that time I have closely collaborated with Ms Haddad and appreciated her keen interest in and sense of commitment to the cause of improved health for women and children through family planning. Her role as the architect of the Sexuality and Family Planning Programme in the European Region and her initiative in launching ENTRE NOUS have been valued by all concerned.

"I have also enjoyed the human qualities and sincere friendship of Wadad and wish her health and happiness in a well-deserved retirement."

Friends and colleagues from the United Nations Fund for Population Activities (UNFPA), the funding agency which supported the Sexuality and Family Planning programme from its beginning remember Wadad Haddad as a dear friend, who through her professionalism, dedication and warmth of personality has made a significant contribution to population programmes.

Says Dr Nafis Sadik, the newly appointed Executive Director of UNFPA: "We have always admired her technical skills and unrelenting dedication to such difficult and challenging issues as human sexuality, adolescent fertility, male responsibility in family planning and women's rights.

"Wadad's personal style, and above all her infectious sense of humour, and keen personal interest in all the people she works with, are undoubtedly important factors in her success. Because of these, and her impressive training skills, she has always been more able than most to address sensitive issues and be listened to by people from all walks of life, ranging from villagers to ministers. ENTRE NOUS is but one of the many examples of the excellence of Wadad's work.

"I have known Wadad personally for many years not only as a colleague but as a close personal friend and sister. I have always treasured her generosity, her deep affection and her unwavering loyalty to principles and people. While we shall miss her in Copenhagen, we hope she will find the time to continue to work in the population and family planning field for the developing countries of the world. We need her."

Wadad Haddad was very keen on helping national counterparts and others to implement the unique and special potential of each country in the Region. We asked a few persons to express what struck them particularly in seeing Wadad Haddad at work.

Professor M.T. Alaoui who has shared many activities with her in Morocco observed that no one could remain indifferent to Wadad Haddad. "She radiates kindness and is always frank and approachable.

"In the very 'intellectual and sophisticated' environment of the World Health Organization and of the Regional Office for Europe, Wadad was intent on maintaining, in each and every one of her activities, a down-to-earth approach based on common sense, as though she had never ceased working in the field.

"This attitude which at first sight may strike one as somewhat simplistic, hides in fact a subtle reasoning. Yet she is self-effacing as would befit a daughter of the Mediterranean soil, of a country rich in history, in culture and in modesty.

"She will always find a place among us."

In the 1970s and early 1980s Wadad Haddad was very much involved in organizing workshops, seminars and international courses, for example in France and Poland. As Professor Krystyna Bozkowa from Poland said:

"It was during these courses that we came to appreciate Wadad as a dedicated teacher and an excellent organizer. She reminded us: '... we teach not so much about what we know but about who we are!' During all the courses Wadad participated actively from the very beginning to the very end, always working to maintain the highest possible standards and at the same time creating an atmosphere of openness and warmth where every participant whatever the language or other limitations, took an active part in the teaching-learning process.

This explains, says Professor Bozkowa, "why mentioning her name in any part of the world brings a warm response from the large population of her pupils, her co-workers, her colleagues and her friends."

Wadad Haddad was known as a teacher but also as an exemplary representative of her Organization. For example she visited Turkey many times and is remembered by Professor Eren Kum, an old schoolfriend from 1957 when both were doing graduate work at Teachers' College, Columbia University, New York, as "a sincere and devoted representative of the WHO European Region during her assignments in Turkey. Her contacts with her counterparts were very fruitful and her lectures were perfect and always inspired the listeners. She is the kind of person who is willing and ready to share her knowledge and experience in the fields of nursing and midwifery, as well as family planning. She is a person who can make a good, clear judgment of the people she comes across either professionally or socially."

The preceding tributes to Wadad Haddad amply testify to her professional competence and achievements. Yet all suggest that there is something more to her competence and drive to achieve results, which Dr Maria da Purificação C. Araújo from Portugal encapsulates in the following comment:

"But if besides all this you search for a human understanding, a spontaneous and contagious gaiety, a contentment with being alive, a love for story telling, a true and dedicated friendship, a sensitivity to the needs and suffering of people and a capability of sincere emotion before a thing of beauty - you will find Wadad Haddad."

EDITORIAL

A SAFE AND REVERSIBLE MALE PILL BY THE YEAR 2000?

At present, the male partner has only a narrow choice if he wishes to participate in family planning i.e. the choice between the condom, a vasectomy or withdrawal.

Condoms have stood the test of time and are the principal method of birth control in countries such as Japan. They are also an important factor in reducing the incidence of sexually transmitted disease, including the spread of AIDS virus.

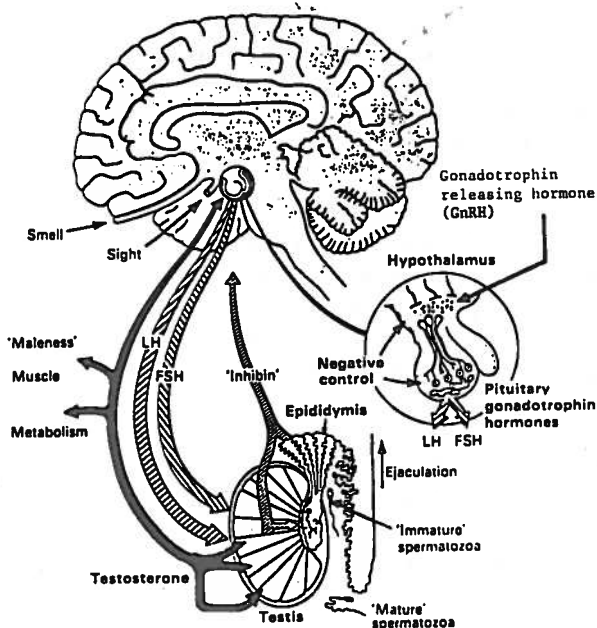
Surgical vasectomy is now well accepted as a safe and effective method of sterilization by more than 50 million men in the world. While relatively few men request reversal after vasectomy, the knowledge that it is available would make the procedure of vas occlusion more acceptable. Recently, Chinese surgeons have described their experience since the early 1970s, based on about 500 000 men, of the safety and efficacy of blocking the lumen of the vas deferens by injection through the skin of occluding materials. The ease with which the plug may be removed suggests that this procedure may offer a simple method of reversal.

No acceptable antifertility drug has yet been produced despite more than a decade of intense research effort. The problems encountered relate to individual responsiveness to the drugs tested. The complex process of sperm production by the testis (spermatogenesis) is not yet fully understood and the number of sperm produced by normal men - hundreds of millions per day - presents a formidable problem for drug regulatory control. No drug regime has yet been found to completely suppress sperm in the ejaculate (azoospermia); also some individuals who are totally suppressed may spontaneously 'escape' with the reappearance of sperm in the ejaculate.

For men to have the same choice as women, a safe antifertility pill is needed. It should be capable of reversibly suppressing sperm production or sperm function without interfering with libido or any other short or long-term features of the health status of men. Such drugs must achieve complete azoospermia in all men over a long period with certain recovery of full sperm production after they stop taking the drug. The requirement for azoospermia may be relaxed only if it can be shown that those residual sperm produced by men whose sperm production is only partially suppressed (oligospermia) are incapable of fertilizing ova.

The hormonal approach to antifertility

As in women, the major control over reproduction in men is through the secretion of two protein hormones (gonadotrophins) by the pituitary gland. These are called follicle stimulating hormone (FSH) and luteinizing hormone (LH). Their names relate to their function in women. Their secretion by the pituitary gland is provoked by the release from the hypothalamus region of the brain of a so-called "releasing hormone" (called Gonadotrophin releasing hormone (GnRH)) which is transferred in small blood vessels to the pituitary gland.



There is "feedback" control of GnRH release and of the pituitary gland based on the secretion of testosterone and possibly of a protein hormone (inhibin) by the testis, by which the level of gonadotrophins being secreted into the blood stream is continually adjusted. This delicate interplay can be unbalanced in several ways to achieve suppression of sperm production.

The prevailing view is that both of the gonadotrophin hormones must be suppressed. Because LH secretion controls the production of androgens (mainly testosterone) by the testis, this means that the general principle of hormonal fertility regulation for men involves the combination of an antigonadotrophic drug with an androgen drug for replacement.

The antigonadotrophic component can be a steroid and several, called progestins because of their similarity to the female hormone progesterone, have been used (e.g. depot-medroxyprogesterone acetate, DMPA). They are usually combined with a testosterone preparation e.g. testosterone enanthate. Some 100 studies have been done in which approximately 1200 volunteers have participated. The most effective so far have achieved azoospermia in about half of the volunteers; the remainder were reduced to oligospermia, most with sperm counts below 5 million per ml of semen (normal sperm concentration would be approximately 75 million/ml).

In recent years, hormones with a closely similar structure to that of the GnRH, have been synthesised either as GnRH agonists or as GnRH antagonists. The GnRH agonists, which have been used to suppress gonadotrophin secretion and thereby the secretion of androgens in men with cancer of the prostate, have also been tested in normal men and found to suppress sperm production. However, the same problem has arisen as with the steroid combinations. Intramuscular injections of testosterone preparations are needed to retain libido and potency and all currently available preparations appear to restimulate sperm production.

GnRH antagonists tested in non-human primates appear to be more effective than GnRH agonists in suppressing sperm production. However, the problems arising from testosterone supplementation remain. In addition, toxicity problems involving histamine-induced peripheral oedema have so far prevented the testing of GnRH antagonists in humans.

Recent advances in research relate to immunization against FSH alone and to the suppression of FSH by inhibins which are hormones produced by the testis.^a These approaches may eventually lead to a complete and reversible antifertility effect and would eliminate the need for androgen replacement.

Androgen replacement

All male antifertility drugs based on pituitary suppression require appropriate long-term androgen replacement therapy. Current formulations and modes of administration have failed to mimic the natural secretion rates of testosterone. Intermittent injections have yielded high levels in blood which have served to restimulate sperm production. Currently, very promising modes of testosterone substitution are being developed. These include a new long-acting testosterone ester; the release of testosterone incorporated into biodegradable microspheres; and finally, transcutaneous release from patches applied to the scrotal skin.

Acceptability of male antifertility drugs

To date, clinical studies have aimed to define the efficacy of antifertility drugs regardless of the acceptability of the mode of drug administration. Thus, steroids have been given by intramuscular injection and the GnRH agonists either by injection or by pump infusion. Ultimately, formulations of drugs will need to be developed that allow oral administration or much less frequent injections than now.

^a Findlay, J.K. The nature of inhibin and its use in the regulation of fertility and diagnosis of infertility. Fertility and sterility, 46: 770-783 (1986).

A five-country acceptability study conducted in 1976 by the WHO Special Programme of Research, Development and Research Training in Human Reproduction showed that most men preferred a pill to injection, although widely spaced injections were not unacceptable. In order to develop a regimen for men that could be self administered, French clinicians have administered progestin pills that are taken orally plus testosterone cream applied to the general body skin. In the most successful trials, sperm counts were reduced to azoospermia or severe oligospermia. Unfortunately, some of the women partners developed some masculine features, e.g. hair growth, from the testosterone cream transferred from their partners. Clearly, better orally-administered drugs are needed.

One other factor in the acceptability of hormonal drugs acting on the testis is the relatively long period before azoospermia is reached (usually 3-6 months) and before recovery following cessation of treatment (6-12 months).

Drugs acting on sperm stored in the epididymis: a new avenue?

Sperm from the testis are washed into a storage organ called the epididymis, through which the sperm spend 1-2 weeks slowly moving and maturing. A drug that interfered at this post-testicular stage would have several advantages: it would not disturb spermatogenesis, libido, or any other hormonally-related event; its effect would be rapid in onset (within 1-2 weeks), and, on withdrawal of the drug, the return of normal sperm into the ejaculate would also be rapid.^a

No non-toxic antifertility drugs with this action are available to date although several chemicals have demonstrated the feasibility of this approach in animals. Moreover, certain drugs in accepted medical practice have

^a Waites, G.M.H. Post-testicular antifertility methods. In: Diczfalusy, E. & Bygdeman, M., ed. Fertility regulation today and tomorrow. New York, Raven Press, 1987.

a reversible antifertility action in men, at least partly through interference with normal sperm maturation in the epididymis: for example, salazosulfapyridine, a drug used in the treatment of ulcerative colitis, and root extracts of *Tripterigium wilfordii*, in use in Chinese traditional medicine for the treatment of rheumatoid arthritis and various skin complaints. The latter agents encourage the conviction that drugs with a rapid and reversible effect on sperm in the epididymal duct would work in man. They also present a challenge to pharmaceutical chemists to join the search for more active, non-toxic substances of similar composition.

Conclusion

Men throughout the world are ready to accept vasectomy and to volunteer for clinical studies for the testing of male antifertility drugs. In addition, an increasing number of biomedical scientists, especially in the developing world, are taking an interest in this important field of family planning and the WHO Task Force on Methods for the Regulation of Male Fertility is promoting research and clinical studies in the following main areas: hormonal means of reducing sperm production to azoospermia; evaluation of the functional capacity of residual sperm from men reduced to severe oligospermia; efficacy of new drugs acting on sperm stored in the epididymis.

This encourages our belief that the prospects for the development of a safe and reversible male pill by the year 2000 are surely very promising ■

[From: Dr G.M.H. Waites, Scientist, Task Force on Methods for the Regulation of Male Fertility, Special Programme of Research, Development and Research Training in Human Reproduction, World Health Organization, CH-1211 Geneva 27, Switzerland]

COUNTRY REPORTS

THE RURAL MIDWIFE AND SEX EDUCATION IN TURKEY

Sexuality is part of people's lives and is linked to the health of their family, their plans in raising a family and their general wellbeing. Sex education prevents the undesirable effects of sexuality and the distress caused by sexual problems. However, its application remains a critical issue in Turkey.

In our educational system the child has contact with the school teacher from the age of 6 to 11, which is the extent of compulsory education. But parents' and teachers' efficiency in sex education is questionable. This leaves the rural midwife, acting as a community nurse, who is the only person to provide sex education as a component of her health education work, not only for children but for the entire community, including school teachers.

Have rural midwives been prepared to provide sex education?

There were reported to be around 12 470 midwives in the country in 1983, although the actual figure is probably higher. They come from different areas and carry with them the taboos, prejudices, misconceptions and ill-feelings about sex prevalent in their own communities.

Three or five years of professional education in midwifery,^a after primary

^a The three-year midwifery course after primary schooling was increased to five years in 1976. At present most midwives have followed the five-year course.

school education, does not make the midwife much older than 15-18 years when she finds herself carrying all kinds of responsibilities and facing various health problems in the community. With the handicap of her background plus the fact that she is an adolescent herself, how can she be expected to influence the attitudes, values and beliefs about sexuality of her community? How can she manage to provide sex education to meet the needs of a community that varies in size between 2000 and 2500 people? How can she persuade people to accept sex education?

In our new system of education for midwifery, the entrance requirement for the midwifery course has increased to eight years of education (five years primary and the first three years of secondary education). Still, the midwife is relatively young when she graduates. The body of knowledge she acquires during training is also insufficient.

The rural midwife needs to come to terms with her own sexuality to be able to take full responsibility for community sex education. She needs appropriate guidance, supported by a sound education in history, geography, sociology, anthropology and psychology. Such information is also necessary to determine the needs of the community.

These topics of instruction are offered in the second part of secondary education. I therefore propose that students should receive primary education as well as both the first and second parts of secondary education before entering midwifery school. By the time the student has completed her secondary education, she is 17-18 years old, a far more acceptable age for entrance to the midwifery school and she will be better prepared to learn about sexuality and the principles of sex education. ■

[From: Gulden Uyer, Associate Professor and Assistant Director, School of Nursing, Hacettepe University, Ankara, Turkey]

DANISH PHARMACIES GIVE "STRAIGHT FACTS ABOUT CONTRACEPTION"

In Denmark every fourth pregnancy ends in induced abortion, which means 20 000 abortions every year in a population of 5 million people. Of these, about 4 000 are performed on women under 20 years of age. This is in spite of the fact that Denmark is a developed country with a high level of education, compulsory sex education in state schools, easy access to effective contraception, and free advice from general practitioners and contraception clinics.

It is therefore necessary to look for new ways to reduce the number of unwanted pregnancies and abortions. What about involving pharmacies?

Danish pharmacies are part of the primary health care sector. It is quite natural to involve the pharmacy in closer cooperation with general practitioners, clinics, district nurses, and school teachers - all of whom provide information and teach about family planning and contraception. In 1984 the Family Planning Association and the Association of Danish Proprietor Pharmacists began discussing how pharmacies could be more active in giving information and guidance about family planning and contraception. This led to the two associations planning a campaign called "Klar besked om praevention" (or in English "Straight facts about contraception"). The objective of the campaign was:

- to increase the amount of information given by pharmacies about family planning and contraception to their customers and the public;
- to make the public aware that the pharmacy is a natural place to seek information and advice on these subjects.

The campaign took place in April 1986, and included several activities.



(a) Motivation and education of pharmacy staff

Pharmacies have always sold contraceptive products, but have not, traditionally, participated in information campaigns. Condoms and diaphragms are often kept in pharmacy drawers and cupboards, well out of sight of the customer.

To motivate pharmacy personnel to participate in informing the public about contraception, one-day "theme" days were arranged all over the country where the campaign was introduced to pharmacy staff, and discussions were held on how the pharmacy can provide information about various methods of contraception.

In addition to these theme days, 3-to 4-day "postgraduate courses" were offered to pharmacy staff since no instruction is given on contraception in their basic education. By the time the campaign for the public began, about 60% of the pharmacies' staff had participated in theme days or postgraduate courses.

Pharmacy staff also received a handbook to help them inform customers and answer questions about contraception. The handbook, together with a textbook on contraception, was sent to all pharmacies in Denmark.

(b) Public awareness through posters and pamphlets

A brightly coloured poster with the slogan "Straight facts about contraception - Get the pamphlets in your pharmacy" was produced to inform the public about the campaign.

Nine pamphlets were prepared. A general pamphlet describes all contraceptive methods to permit users to compare individual methods. Eight other pamphlets describe individual methods in detail: the diaphragm, condom, IUDs, birth control pills, mini-pills, suppositories and foam, sterilization and natural family planning.

Bright colours and graffiti were used for all the campaign materials to capture the interest of young people who were the primary target group of the campaign.

(c) Provision of new products

The pharmacies' assortment of condoms was expanded and modernized to include a profiled type with a granulated, rough surface and one of extra thin quality.

(d) Public relations activities

To reach young people who are not regular customers of pharmacies, the pharmacies sent letters to local schools along with the campaign poster and pamphlets and invited schools to come to the pharmacy as part of their sex education programme. Students could then look at the information materials and hear the pharmacist explain the various methods of contraception. The campaign was also advertised in magazines for young people.

The pharmacies received publicity materials they could use to send to local practitioners, district nurses, clinics and local newspapers. The campaign was introduced to the public

at a press conference with coverage by newspapers, radio and television. Many articles were published discussing the sex habits of young people, the high abortion figures, sex education in state schools, and other subjects.

Campaign results

The campaign was conducted over a one-month period. A week after the campaign ended, a questionnaire was sent to all pharmacies to find out (a) how motivated the pharmacies were to take an active part in the information campaign and (b) whether pharmacies had received any reactions from the public to the campaign. Altogether, 72% of the questionnaires were returned.

Some of the activities initiated by pharmacies during the campaign period were:

99% of pharmacies displayed campaign materials in pharmacies; 79% had regular internal staff meetings about the contraception campaign; 39% sent letters to state schools; 30% sent publicity materials to doctors; 9% to other institutions; and 19% of pharmacies provided information about the campaign to local newspapers.

What are the reactions of the public registered by pharmacies during the campaign period?

77% of pharmacies said that customers showed interest in the campaign; 22% reported an increase in the number of questions about contraception at the counter and 53% an increase in the sale of condoms; 38% said they had received requests for sex education from state schools; and 70% received requests from other institutions.

The results of the questionnaire indicate that:

- pharmacists and pharmacy technicians can be motivated to take a more active part in supplying information about contraception;

- pharmacies, schools and health personnel in the primary health sector can cooperate more closely in providing information on contraception;

- the population can be encouraged to use the pharmacy to ask questions about contraception. Condoms and diaphragms have come out of drawers and cupboards and are now on public display in Danish pharmacies.

In March 1987 the campaign was followed up by a countrywide poster competition for schoolchildren in 7th to 10th class (aged 14 to 17 years). The theme of the competition was "take care of your love". The youngsters were asked to illustrate the subject of contraception in words and drawings.

Pharmacies were centrally placed in the campaign, as the youngsters had to collect the rules for the competition at their local pharmacy and deliver their poster back there.

The purpose of the campaign was to continue to remind the public that the pharmacy is a natural place for obtaining advice and guidance on contraception. At the same time the goal was to influence sexually active young people to use contraceptives and to encourage them to go and buy them from a pharmacy ■

[From: Assistant Professor Lillian Møller, Danish Pharmacy Seminar College, Milnersvej 42, DK-3400 Hillerød]



[SIGLO CERO, Bulletin of the Federación Española de Asociaciones Protectoras de Subnormales, No. 97, 1985, p. 61.]

A COMPARATIVE STUDY OF THE ATTITUDES OF PARENTS AND TEACHERS TOWARD THE SEXUALITY OF THE MENTALLY RETARDED^a

The attitudes of parents and teachers toward the sexuality of mentally retarded have been studied extensively. However, no comparison of the attitudes of both groups has been made and we therefore carried out a comparative study in Guipuzcoa, a province in the Basque area of Spain.

Methods

Data were collected through a questionnaire sent to 185 members of the teaching staff of various centres for the mentally retarded in Guipuzcoa province. The response rate was 61.5% (N = 114). A random sample of 180 parents (92 mothers and 88 fathers) of 180 mentally retarded people were interviewed in person, using the same questionnaire.

^a Aizpurua, I. Sexualidad y subnormalidad. Actitudes de los padres y de los educadores. Bilbao, Universidad del País Vasco, 1985.

The 33-item questionnaire measured attitudes toward seven areas of sexuality: living together, sex education, masturbation, homosexuality, heterosexuality, premarital intercourse and family planning and the responses to the statements contained in the questionnaire were rated on a Likert scale with 1, 2 or 3 points per item according to lower, average or higher agreement.

Results

The mean scores of the teaching staff are significantly higher than those obtained by the parents for each of the seven categories.

Category	Mean score for	
	Teachers	Parents
- Living together (6 items: max. score 18, min. score 6)	15.23	11.98
- Sex education (6 items: max. score 18, min. score 6)	16.04	12.52
- Masturbation (6 items: max. score 18, min. score 6)	16.05	12.34
- Homosexuality (3 items: max. score 9, min. score 3)	7.51	5.35
- Heterosexuality (8 items: max. score 24, min. score 8)	20.26	15.68
- Premarital intercourse (1 item: max. score 3, min. score 1)	2.77	1.59
- Family planning (3 items: max. score 9, min. score 3)	7.60	5.80

The total score based on all 33 items is also significantly higher for the teaching staff (84.60 points) than for the parents (64.81 points).

Discussion

The parents are less tolerant in general because of their older age, greater devoutness and lower educational level, and in particular when their children are severely retarded and/or female. More than half the parents think they are as tolerant as most of the teachers, in spite of the large real difference.

The teaching staff shows a significantly more tolerant attitude overall than the parents towards the sexuality of the mentally retarded and for each of the categories. The differences between the two groups increase in this order: sex education, family planning, homosexuality, living together, heterosexuality, masturbation and premarital intercourse.

The attitude towards premarital intercourse appears to be, for both groups, the best indicator of tolerance towards the sexuality of mentally retarded.

The promotion of closer interaction between parents and teachers, to achieve better mutual understanding and a gradual convergence of attitudes, would benefit the sexual and general development of the mentally retarded ■

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[From: Iñaki Aizpurua,
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 Spain]

EVALUATION OF THE EFFECTS OF A VIDEO PROGRAMME ON SEX EDUCATION AND PERSONAL RELATIONSHIPS OF 11- TO 12-YEAR-OLDS^a

In the French community in Belgium, sex education and personal relationships are not systematically taught in elementary school. Activities in this field remain individual and scattered: some teachers dedicate one hour to it, some associations will draw up a brochure, a comic strip or a video tape.

The Centre de Documentation et d'Information de la Fédération belge pour le Planning Familial et l'Education Sexuelle (CEDIF) has therefore prepared a video tape for children from 8 to 12 years of age. "Un amour de Cupidon" is a fiction film lasting for about 20 minutes. Its main objective is to dedramatize the subject of sex and help children to feel comfortable about it. A certain amount of information is presented and it is up to the youth leader to elaborate on it or ignore it according to the children's previous experience, age and education. This film therefore aims at quite definitely something more than the mere transmission of knowledge.



^a Summary of a report entitled: Evaluation des modes d'utilisation et des effets d'un vidéogramme d'éducation sexuelle et affective auprès d'enfants de 11-12 ans. University of Liège, Laboratoire de Pédagogie expérimentale, Liège, 1986.

We shall now briefly report on the survey of the impact of this programme on the children's perception, shyness and embarrassment, on the basis of semi-structured interviews, both before and after the film was shown.

Methods

The survey involved a sample of 91 children (50 girls and 41 boys) whose average age was 11 and a half years, enrolled in 12 schools and nearing the completion of their elementary schooling.

Some 10 children from each form were interviewed individually before the film was shown, in order to ascertain their understanding of sexual matters.

The verbal and non-verbal reactions of all the children were observed during the film and the discussion afterwards.

About one week after the showing, the same children were interviewed again in order to determine the development of their understanding after some time. At this stage, the sample covered only 74 children as two schools refused to allow the interviewers back mainly on account of the reactions of some parents.

Results

1. How babies are made

Before the film projection, only 12% of the children do not know anything or are unable to explain what they have heard. All the others have some knowledge and a certain idea of what happens. The innocence of children is indeed a myth. But what do they know?

Some (15%) have some information but they are ill at ease, embarrassed to speak about it and are really incapable of expressing anything at all and we respected their behaviour. Others (13%) have a mixture of correct knowledge and unreliable information. The following can be quoted as an example.

Jean-Yves: When a woman sleeps with a man, the baby is made.

Q.: Is it enough to sleep together?
No, you must make love.

Q.: What does that mean?
You have to show that you like each other a lot.

Q.: What happens?

A seed is made and it grows and grows and in the end it becomes a baby and after nine months, the baby comes out.

Q.: Who has the seed?

The mother.

Q.: What is it called?

I do not know.

Q.: And does the father have a seed also?

Yes, he gives it to the mother.

Q.: Do you know what it is called?

No.

Others still (8%) give vague, imprecise and poorly structured replies. Another example is David.

David: It is a contact of a male person with a female person. So the woman has her period, there should be a contact and the baby develops if she does not take the pill.

Many children (44%) have fragmentary yet correct knowledge. And only 6% of the children have complete and correct information. Laurence is one of them.

Laurence: You've got to wait for the woman to have her period

Q.: The man does not have to wait?

He has nothing?

(She hesitates). He must wait to have some sperm. The woman has some sort of liquid in her body. The man's "willy" will harden. He then puts his willy into the vagina of the girl, then he ejaculates sperm which will travel in the body of the woman. Then it fertilizes.

Few children (10%) place the act of reproduction in an emotional context; it is mostly centered around desire, pleasure, and this is more true even for boys than for girls.

Children mostly perceive the conception of the baby in terms of a little seed. For one third of the children, mainly the girls, the man deposits the little seed in the body of the woman; for another third, especially boys, the mechanics remain very vague and only 20% know clearly that it is the encounter of the seed of the man and the seed of the

woman that results in the conception of the child. This image of the small seed should therefore be very thoroughly reconsidered as it leads to so many misrepresentations without really helping the understanding.

After the projection of the film and the question-answer period, nearly half the children (43%) have information that can be rated complete and correct, a fair number (35%) have correct though fragmentary information and at the same time the number of wrong, vague or imprecise replies decreases. The impact of the video programme and of the presentation is therefore considerable.

Half the children (51%) have understood correctly the process of reproduction, though 31% remain certain that it is the man who deposits the seed inside the woman. Furthermore, the children are much more at ease, less shy in speaking about it; their vocabulary is more precise and correct, there are fewer silences and less embarrassed laughter, they get more directly to the point and talk more.

2. With whom the child discusses these matters

Some children (20%), mainly boys, do not discuss sex with anyone. However, 65% state that they have talked about it at least once with their parents, mostly (two thirds of the cases) only with their mother. The other children talk about it with an elder brother or sister, or with an adult member of their family (aunt, uncle, godmother).

It seems that about 35% of children feel relaxed and open and nearly half are embarrassed. Parents' embarrassment takes on varied forms: some refuse flatly to discuss it "now", some are embarrassed and ill-at-ease, or hesitate, others reply to certain questions and not to others, or reply strictly to questions asked.

Pierre's example (11 years) is typical in that respect.

Pierre: I do not always talk about it. With my brother, I don't know when I have sexual reactions, I feel embarrassed when he sees me and he explains.

Q.: What about your parents?

I do not dare, it doesn't happen so often ... I don't know ... I do not dare admit it, I always think about admitting it, but I do not dare, I would like them to talk to me about it. My brother told me that all children have sexual reactions. Is it true?

Girls seem to be in a better position than boys in talking about sex: their mothers try at least to inform them of the existence of periods. Once the subject has been brought up, the girls might find it easier to raise other questions that are on their minds. Boys, on the other hand, do not regard their father as the best person to approach, so they turn to an elder brother or to a friend or what is worse still, they do not talk about it at all.

This last result confirms the pressing need for children to approach their parents: 63% of children feel that this sort of information is primarily their parents' responsibility as their parents know them best.

Of course, conversations among friends are another source of information. Nearly 70% of the children interviewed discuss it among themselves: for boys it is mainly to laugh about it, whereas for girls, it is to exchange information.

Let us conclude this overview of results by mentioning that more than half the children have read books on the subject, either educational books (37%) or pornographic books (31%) and nearly 60% of children have watched educational films or popular documentaries on television, or fiction films with love scenes.

General conclusions

It would appear, at the end of our survey, that "Un amour de Cupidon" could be a very good pedagogic tool for the youth leader or teacher who wants to deal with sex education and personal relationships in school. This film which is simple, full of innocence and tenderness, helps to dispel the awkwardness felt by children and parents alike when faced with these questions. In addition, it makes it possible to go

beyond simply transmitting knowledge, and places sex education and personal relationships on the plane of attitudes and self-image.

Our survey has also given us a chance to look at the more general problem of teaching personal relationships and sex education to children towards the end of their elementary schooling which we can summarize as follows:

1. The many interviews we have carried out with children does away with the myth of their innocence. In our society, which is widely dependent on the media, most children have some knowledge whether they have acquired it from a film or a broadcast, or a conversation among chums. The idea that children know nothing about sexual matters is wrong and out of date.
2. Parents and teachers are not always aware of these bits of knowledge that children have acquired. Children feel vaguely that it is something they should hide and this only increases both the lack of communication and probably, in the end, the feeling of guilt in children who think they know things that they should not.
3. One of the ways of resolving problems is the cooperation between families, schools and family planning institutions. Families and schools are involved because their role is to socialize and educate children, while family planning institutions are experienced in the field of sex education and personal relationships and can help families and schools to deepen their knowledge and, as a result, to ask the right questions.
4. It appears that one session is not enough to modify radically the knowledge and attitudes of children about sexual matters. No subject can entirely be mastered in a single session. Schools should not therefore arrange a single session of sex education and personal relationships and feel that their job has been done. Instead, a programme should be drawn up based on a progression of questions and thought on the subject.

Our survey was exploratory. The results, although not representative are indicative and raise some real questions that still require appropriate answers:

- At what age should personal relationships and sex education start at school?
- What educational strategy should be developed to carry it out?
- How should it be evaluated, bearing in mind that knowledge and attitudes learned in youth affect the behaviour of tomorrow's adults? ■

[From: M.-C. Miermans and M.-T. Casman, Laboratoire de Pédagogie expérimentale, Université de Liège, Sart Tilman - B32, 4000 Liège 1, Belgium]

LEGISLATION ABOUT SEXUAL OFFENCES IN SWEDEN

The Swedish Association for Sex Education (RFSU) opened the first rape crisis centre in the country in 1977, following a debate about rape with various women's organizations. The centre offers help to rape victims and has also started research on the impact of sexual assault on women, on methods to support and assist rape victims and on the social and emotional profile of convicted rapists at the time of the rape. The resulting reports^a have helped to clarify the issue of rape and its reported increase by 40% over the last 10 years.

^a (1) Hedlund, E. et al. Valdtäktskliniken. Stockholm, Prisma, 1979. (2) Hedlund, E. Valdtäktskrisen. Stockholm, Liber, 1983. (3) Hedlund, E. & Lundmark, G. Valdtäkt - vanmakt. 60 män berättar. Stockholm, Delegationen för social forskning, 1983 (DSF Report, No. 1). (4) Rape. A drama from two perspectives. London, FRUS/IPPF, 1985.

In July 1984, Sweden passed a new law on sexual offences. The law defines rape as an act whereby one person is forced by another into coitus or comparable sexual intercourse such as anal or oral penetration through violence or serious threat. The sex of the victim or the offender is not specified. Homosexual assault can therefore be punished as rape. According to the law, sexual intercourse between children/young people under 18 and their parents, guardians or other persons who are responsible for their upbringing, care and supervision, is prohibited as is sexual intercourse between adult brothers and sisters and between adult children and their parents.

In early 1980, the sexual exploitation of children was much debated in Swedish society. Consequent research focused on the effects of the crime on the victim and on treatment methods for children and families. Models for cooperation between police, social agencies/child guidance clinics, and the judicial system were also studied.

Official statistics report an increase in the number of sexual assaults on children (under 15 years) by 50% since 1982. The increase may be related to the more frequent coverage of these crimes in the mass media, which tends to encourage families to report the crime to the police. An unpublished investigation at a hospital in Stockholm showed that 30% of all inpatient teenage girls in 1984, had been sexually assaulted during their lifetime.

In the last few years there has been a new approach to family violence. More attention is being paid to the vulnerability of the victims, especially of women and children. For example, the Swedish Government has ordered the distribution of a special manual to staff of the judiciary and the medical and social services. The manual advises on how to make the situation easier for the victims of sexual crimes. In addition, police, lawyers, nurses, doctors and social workers are trained to be more sensitive to the needs of the victims and to give crisis support.

In Sweden, sexual crimes are regarded as a violation of a person's human integrity. Victims of sexual crimes get more support than victims of other crimes. For example, during legal proceedings, the victim is entitled to have a contact person, who can be a social worker, a nurse or a private person. A new law being proposed provides access to a lawyer without any personal cost to the victim. Most perpetrators are sentenced to compensate the victim for personal suffering. If they do not have the money, the victim is compensated by the state.

Sex crimes appear to be relapse crimes. At present there are discussions in Sweden about starting a treatment programme for sex offenders and small scale projects are in operation. Again this is evidence of an increased awareness in Swedish society of the seriousness of sexual crimes ■

[From: Ms Eva Hedlund, Swedish Association for Sex Education, P.O. Box 17006, S-104 62 Stockholm 17, Sweden]

INTERCOUNTRY NEWS

Rafael M. Salas, Executive Director of the United Nations Fund for Population Activities (UNFPA) died suddenly on 3 March 1987. He was 58 and is survived by his wife and two sons.

Mr Salas was appointed head of UNFPA when it became operational in 1969. He guided its growth from a small organization to the largest source of international population assistance worldwide. At the time of his death, UNFPA had a worldwide staff of more than 270, a projected income of \$145 million in 1987 and a global operation which has assisted close to 4800 population projects in 149 developing countries and territories and in five regions throughout the world.

In 1974, he served as the United Nations' co-ordinator for the World Population Year. Highlight of the year was the World Population Conference in Bucharest, Romania, at which the international community arrived for

the first time at a consensus on population. In 1984, he was named Secretary-General of the International Conference on Population in Mexico City, at which the global consensus was reaffirmed and extended.

The Sexuality and Family Planning Unit of the WHO Regional Office for Europe expresses its sympathy and condolences to all colleagues in UNFPA - for the loss of a great leader and a fine human being.



[Dr Nafis Sadik]

On 20 April 1987 the Secretary General of the United Nations announced the appointment of Dr Nafis Sadik as the Executive Director of UNFPA, a position with the rank of Under Secretary General. Her appointment follows the death of Mr Salas on 3 March 1987.

A native of Pakistan, Dr Sadik has been active in the population field for more than 25 years. She joined UNFPA in 1971 and rose quickly to the position of Chief, Programme Division and was appointed Assistant Executive Director in 1977 and given the rank of Assistant Secretary General in 1982.

As Assistant Executive Director, she managed a professional staff of more than 100 at UNFPA headquarters in New York and in the field, and was responsible for the planning and programming of population assistance with a budget allocation of some US\$116 million in 1986 to 134 countries and territories around the world.

Dr Sadik was the first female recipient of the Hugh Moore Award in 1976, named after a pioneer in the United States credited with calling attention to the World Population Crisis, and was cited for her leadership in the family planning field as well as for her leadership in encouraging other women to find careers in the population field. She has written numerous articles for leading publications in the family planning and health field, and edited a book, Population: the UNFPA Experience (New York University Press, 1984).

Dr Sadik is a member of numerous councils, scientific bodies and advisory committees.

Born in Jaunpur, India, 18 August 1929, Dr Sadik was educated at Loreto College (Calcutta) and received her Doctor of Medicine degree from Dow Medical College (Karachi). She served her internship in gynaecology and obstetrics at City Hospital in Baltimore and completed further studies at the Johns Hopkins University and at Queens University, Kingston, Ontario.

Warmest congratulations and best wishes from ENTRE NOUS ■

MEETINGS REVIEWED

WORKSHOP ON NATURAL METHODS OF FAMILY PLANNING IN A NON-RELIGIOUS CONTEXT

An Intercountry Teachers' Training Workshop was organized in Jablonna, Poland, from 26 to 29 August 1986 by the Sexuality and Family Planning Unit of the WHO Regional Office for Europe, in collaboration with the National Research Institute of Mother and Child, Warsaw.

The Workshop was intended to exchange information and discuss natural family planning methods as an appropriate technique for identifying the fertile period of the menstrual cycle and thus helping couples to achieve or avoid pregnancy.

Discussing the subject in a non-religious context was not meant as a "back to nature" movement or as a denigration of the excellent work of many church-related natural family planning organizations. It was felt by the Workshop organizers that every health professional working in family planning should be knowledgeable about the so-called natural methods and provide or suggest them when relevant. In fact, they should be able to offer the whole range of available family planning methods.

Terminology

It was felt that the term "natural family planning", which appeared in the literature around 1971, as well as the term "period abstinence" should be replaced by the term "fertility awareness methods".

The word "natural" implies that other methods are unnatural and, therefore, bad. In fact, breastfeeding is the only true natural method of family planning. There is nothing natural about abstinence which is a culture-bound practice. The term "period abstinence methods" has a generally negative connotation. The participants recommended the use of synonyms for "awareness" (such as knowledge or understanding) if it is difficult to translate the concept into other languages.

Fertility awareness methods comprise the basal body temperature method, the cervical mucus (Billings) method, the sympto-thermal method and the calendar or rhythm method (Ogino-Knaus). They all have in common the planning or preventing of pregnancies by observing the naturally occurring signs and symptoms of the fertile and infertile phases of the menstrual cycle. Intercourse during the fertile phase will maximize the probability of pregnancy. To prevent a pregnancy couples should abstain from intercourse on potentially fertile days in the woman's cycle.

Fertility awareness methods (FAM) in Europe

An ad hoc survey conducted in May 1986 among 20 representatives of Family Planning Associations (FPAs) in Europe revealed that most (85%) offered fertility awareness methods on demand and a few as a specialized service. In 9 of the 20 countries, Catholic Church-related organizations offer the methods, in general, alongside family planning associations, family doctors or gynaecologists and in some cases feminist and ecologist groups. The services co-exist but seldom cooperate. In about half of the countries represented, counsellors are specially trained in FAM.

Controversy exists as to whether FAM should be provided as a single method programme or as part of a comprehensive family planning programme.

Participants at the meeting felt that part of the controversy would be resolved by viewing FAM in a non-religious context, which does not mean devoid of moral value but presenting FAM in the context of the total wellbeing of the client.

Applicability of fertility awareness methods for special groups

There are conflicting claims as to the applicability of FAM for postpartum women, breastfeeding women, women who have just discontinued using hormonal contraceptives or the IUD, premenopausal women or adolescents.

How reliable is the recognition of fertility signs in these "special circumstances"? In fact, little is known about the actual effectiveness of FAM when used by women in these special circumstances, even if method rules are modified to suit the special condition of irregular ovulation and menstrual cycle. Data from clinical trials or field studies are lacking to back up the claim that FAM are applicable to all stages in a woman's reproductive life.

Sexuality, lifestyle and FAM

Views differ as to the sexual conduct men and women should adopt during the fertile period. To some only abstinence from sexual intercourse and non-genital love-making are appropriate. Others who view sexuality in a non-religious context consider other options for sexual conduct, such as mutual masturbation, oral sex and the use of condom, diaphragm, sponge, spermicidal creams and jellies and withdrawal.

Participants at the meeting recommended that teaching and counselling of FAM should explicitly address alternative forms of sexual activity on fertile days.

Lifestyles are changing in European countries, as exemplified by declining marriage and birth rates, and by increasing divorce rates, one parent-families, consensual unions and the number of women working outside the home. FAM should be provided as an option, in a non-religious way, and not be restricted to couples with more traditional values and lifestyles. The FAM have an important potential for increasing body awareness.

Training requirements

Who should teach or counsel FAM? What type of preparation is needed? And how long does it take the user to know the method and successfully apply it?

From reported training experiences, it appears that the users of FAM are the best teachers and that effectiveness in terms of preventing unplanned pregnancies is related to the teacher's experience in teaching the methods. It was strongly suggested at the Workshop that lectures on FAM should be included in the training programmes of medical and allied health professions, to change the health profession's generally negative attitudes towards FAM.

Participants agreed that both theoretical information and practice in explaining FAM is needed, but future teachers of FAM should also be able to deal with the medical, mental and

psychological problems of potential users or be aware of their limitations in those areas and make appropriate referrals to local medical and social service agencies.

Experience has shown that it takes the user on average three cycles to understand the method and monitor, record and interpret the fertile phase correctly. Independent practice, without a supervisor, is achieved after 4-12 months.

The time required to teach the knowledge and practice of FAM varies greatly. Some programmes spend 30 minutes to one hour introducing the method and then followup users for 15 minutes every two weeks for a few cycles and once a month for the next 12 months. Other programmes spend less or more time. The minimum time required to teach women or couples and obtain successful user practice is not known.

Research

In practice, FAM are about 80% effective. Current interest and research activity are high in the development of inexpensive and easy-to-use biochemical kits to predict ovulation, such as marking urinary metabolites of estrogen and progesterone. These technical means would help in more precisely determining the fertile period but not necessarily in preventing pregnancy.

A number of research questions relate to: whether FAM should be provided alone or as part of a multi-method family planning programme and what the cost-effectiveness is of each approach; assessing the correct use of and demand for such methods; and the applicability of FAM to women in "special circumstances" as defined earlier ■

[A summary report (English, French, German and Russian) of the Workshop is available from the Sexuality and Family Planning Unit of the WHO Regional Office for Europe, 8 Scherfigsvej, DK-2100 Copenhagen Ø. A full report is being prepared in English]

WHAT TO WRITE FOR

THE NATURAL WAY. THE BILLINGS METHOD

Dr Anna Cappella of the Catholic University of the Sacred Heart in Rome, Italy, has produced a simple and attractive booklet on the Billings method. The process of fertilization is explained in simple words and images. The non-fertile period is compared to arid land, fertile days to lush country with heat and moisture. The illustrations of how to assess cervical mucus with two fingers are excellent and both text and graphics are well suited for the average lay reader ■

[Cappella, A. The natural way. The Billings method. BBE, Torino, 1985. 48 pages. Price 6000 lire or corresponding amount in US dollars. Available in English, French, Italian and Spanish. Write to Dr Anna Cappella, Center for Study and Research on Natural Regulation of Fertility, Catholic University of the Sacred Heart, Largo Agostino Gemelli 8, 00168 Rome RM, Italy]

WHO documents

- ARTIFICIAL REPRODUCTION

In March 1985 the Sexuality and Family Planning Unit of the WHO Regional Office for Europe organized an informal Consultation on the above subject. A summary of the meeting appeared in ENTRE NOUS no. 8, 1986. The 11 page

report is now available, in English only, and can be obtained free of charge by writing to the Unit ■

- HEALTH PROMOTION: CONCEPT AND PRINCIPLES IN ACTION A POLICY FRAMEWORK

A 27-page booklet from the health promotion programme of the WHO Regional Office for Europe is intended as a discussion document for the development of policy and programmes in health promotion including family planning and sexual health. The document was written following a meeting held on the subject in July 1984. Available in English only. Inquiries to Health Promotion Unit, WHO Regional Office for Europe, 8 Scherfigsvej, DK-2100 Copenhagen Ø ■

FAMILY PLANNING HANDBOOK FOR MIDWIVES AND NURSES. INTERNATIONAL PLANNED PARENTHOOD FEDERATION, 1986 (79 PP)

This widely used handbook is now in its third edition. There is a new chapter on motivation and counselling. All contraceptive methods are covered concisely with their advantages and disadvantages. There is also a chapter on how midwives and nurses can help infertile couples. A very useful resource ■

[Order from IPPF, P.O. Box 759, Inner Circle, Regent's Park, London NW1 4LQ, United Kingdom. Price: US\$ 6.- including postage. Also available in French and Spanish]

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