Sexology today
In this issue

This issue of Entre Nous traces the development of a science with less than 2,000 practitioners which, after two periods of dynamic growth earlier this century, today finds itself marginalized and normalized. In a climate where sex is now discussed more openly, people's expectations of sexuality have increased and they are more prepared to look for help if they feel they have a problem. Many different kinds of professionals - not just doctors or psychiatrists - could come to their aid, but as a rule they are not trained in the effective non-medical therapeutic techniques developed since 1960s.

Instead, a pathetically small number of counselling centres struggle not to be overwhelmed by the demand, often finding it hard to keep a toe-hold in the face of official opposition or indifference. Sexology's 'sin' is that it can be used as a weapon by individuals or social groups to break away from the shackles of a repressive authority.

In his guest editorial, Dr Jacques Waynegregretsthe lossof thepioneering spirit in sexology, which he attributes to "taking orders from medicine". Professor John Gagnon (page 7), points out that the media climate in the United States has itself become so sexualized that sex research is unlikely ever again to command the public attention once given to the findings of Kinsey and Masters and Johnson.

On page 5 Dr Patricia Gillan describes sex therapy as a mixture of reassurance, sex education and carefully designed recommendations. Dr Gorm Wagner (page 6) regrets the absence of these skills in the training of priests, nurses, psychologists, lawyers, teachers and others. Many of these professionals, agrees Dr Maurice Humi (page 9), have to deal with requests for sexological services in their daily work, and they may be the very people to whom painful family secrets are revealed.

In his summary of a WHO survey of counselling services in Europe (page 10), Dr John Sketchley points out that voluntary agencies can sometimes tackle matters that statutory agencies cannot, and it may be an advantage to have both. In some countries counselling depends entirely on the work of a few committed individuals, who need to train their successors now to ensure the continuity of their work.

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100 years of modern sexology
by Jacques Waynberg

The human adventure began with an irrepressible need to understand sexuality, to give it meaning and order. Does this make sexology the oldest "human science" in the world? Together with astronomy and metaphysics, it can take credit for having raised mankind up from its cultural "baseline".

Sexuality and love recur as a leitmotif at each stage of our history, not only in the cave paintings of the Magdalenian era, in the hieroglyphic verses to Min, the god of fertility, in the temple at Karnak, in the high religious of the temples at Khajuraho and in pre-Colombian pottery, but also in the works of Plato and Dante (the famous fifth song of Hell in the Divine Comedy), of Sheikh Nefziou (author of the famous Perfumed Garden) and St. Augustine (to whom Christians owe their marriage code), of Hippocrates and Charles Darwin, and many others. In other words, today's Western world has not created its sexual knowledge ex nihilo but has built up a heritage over more than 40,000 years.

Sexology must now be seen in this universal light, since all civilizations are clearly concerned, in their own way, with understanding and sanctioning sexuality — in the same way as they do dietary practices and war. All societies, ranging from those without writing to those governed by books, must ultimately safeguard procreation, develop an erotic art and contain the excesses of sensual enjoyment. In other words, the question is whether the scientific knowledge built up, the religious and social traditions decoded and the variations in sexual function taken into account for "therapeutic" purposes can now form the basis of a new discipline and justify the vanity of a modern age defying its own roots.

It is clear that developments in the so-called "human" sciences at the end of the nineteenth century brought about a radical shift in the existing schools of thought and research on sexual matters. In one century, sexology has moved into the age of reason and become a genuine scientific subject. In fact, a dialogue and methodology that were revolutionary compared with previous sexological traditions became established between 1891 and 1900. To put it briefly, the humanist ideology that had set its stamp on the previous five millennia was transferred, in a single decade, by a "humanitarian" strand of ideology. Knowledge about sex was no longer of use merely to ensure consummated marriages and to offer moral assistance to individuals; it became a pretext for dealing with people's freedom and emancipation. The birth certificate of modern sexology therefore bears the stamp of subversion, of a breach of the contract which had previously bound scientists and religious authorities in a community of demagogic interests.

From then on, sexology would help affirm the validity of a "class war" and participate indirectly in the itinerary of Marxist dogma. Capitalism and bourgeois morality: the same struggle, beginning with the question of homosexuality. Albert Moll in 1891, Havelock Ellis in 1896 and then Magnus Hirschfeld from 1899 set the scene for a militant and non-conformist sexology dedicated for the first time to "happiness", not merely to hygiene. So it is crucially important to note that while the scientific data are much more objective, the experimental models more reliable and the interdisciplinary nature of research more systematic than they were, the metamorphosis of sexology in the twentieth century has been brought about not by these improved instruments but rather by the determination to apply them in conflicts between the individual and the social group.

Modern sexology established itself as a "countervailing power" once the question of the "depsychiatrization" of perversions was raised by Krafft-Ebing and homossexuality became a legitimate issue for discussion.

Under these conditions, it is not difficult to see how the great strides made by the movement in more than 50 years under the impetus of German-speaking authors offended against Nazi ideology and led to its total destruction on 6 May 1933. As we know, this "eclipse" lasted until the postwar period, when English-speaking authors must be credited with the rebirth of contemporary sexology, in particular through the two Herculean labours represented by the works of Alfred Kinsey and of William Masters and Virginia Johnson.

Where are we today? Scientific information circulates throughout the world, but the growing uniformity of "clinical" research topics is reducing the "audience" of this renaissance: there are less than 2,000 "sexologists" in the world today, and about 90% of them concentrate solely on "treating" problems of erection, premature ejaculation, the vicissitudes of the female orgasm or marital conflicts, and so on. No longer are historians, legal experts, sociologists or biologists the "indispensable" partners they once were. The exodus of militants is of even greater concern. Asia's receptiveness to Western sexological theories should not delude us about the real impact those theories have on peoples who are still under close traditional surveillance, or create the illusion that they are universally applicable. In reality, the pioneers' spirit has been lost since the events of 1933 because postwar sexology has sworn allegiance to medical power. There was a time, in the 1960s, when it was possible to believe that the unrest among "sexual minorities" in the United States, the outcry among feminists, the general availability of contraception and the legalization of abortion would lead to the rebirth of a sexology that had been devastated by despotism ... But if we
IPPFW campaign on female genital mutilation

More than 100 million women and girls alive today have been subjected to the pain and horror of female genital mutilation (FGM), reports the International Planned Parenthood Federation (IPPF) in a new leaflet launched recently.

Together Building A Space For Women

has been published in English, French and Arabic, to highlight the incidence and consequences of this long-standing traditional practice.

The leaflet is just one part of IPPF’s campaign to eradicate the practice. In 1989 IPPF sent a questionnaire to all 48 African and Arab World national family planning associations to gauge the extent of FGM and the work being done to overcome it. Many associations are already using traditional village dance and theatre to tackle this traditional practice. Others wanted IPPF’s full support before tackling the cultural and religious forces that lie behind it.

IPPF’s International Medical Advisory Panel have now drawn up a draft statement on FGM, which is being circulated internationally before being finalized. The Panel was shown a film of young girls in Nigeria and Somalia screaming as they were mutilated, sewn up and then forced to walk home with their legs bandaged together. Dr Phillip Corfman of the USA Food and Drug Administration summed up the feelings of the medical experts with the words: “We have victims and we have pain. Something must be done.”

Poland promotes breastfeeding

The National Research Institute of Mother and Child (NRIMO) in Warsaw has recently concluded the first stage of a long-term project to increase the frequency and duration of breastfeeding in Poland.

Surveys showed that although 90% of newborn children could be considered to be breastfed on leaving the maternity ward, by one month later only 66% were still breastfed, three months later only 25%, and six months later only 13%.

Maternal and child health workers were very positive towards breastfeeding. However, 50% of them did not feel that they could promote breastfeeding or support the mother. They lacked up-to-date knowledge of the physiology of lactation and had not received enough training in the management of lactation problems.

As a start, two nurses were employed to visit the NRIMO maternity unit in Warsaw. They helped to solve problems and an in-service training programme was launched. After 18 months the NRMC set up Poland’s first lactation clinic, and later a support group where other mothers demonstrate breastfeeding and answer questions. The Institute has also joined forces with the staff running prenatal courses, so that expectant parents are given two hours of prenatal guidance.

The breastfeeding promotion project was later extended to a small rural region with four maternity units and 8,000 births a year. Teaching materials were developed for staff and for parents, and regional health workers were trained in lactation management.

Monitoring shows that there have already been some positive changes.

A lactation management training programme for regional supervisors is now in preparation so that the project can be extended to the whole of Poland. The target is to increase by four times the number of Polish infants who are still breastfed at six months, by 1995.

This project is being supported by an allocation of funds from UNFPA and executed in collaboration with the Sexuality and Family Planning Unit of the WHO Regional Office for Europe.

IFFLP in Europe

The 23 European member associations of the International Federation for Family Life Promotion (IFFLP) held their congress in Liège-Spa, Belgium in June, with special emphasis on AIDS prevention.

Portuguese honour for Ms Haddad

Ms Wadad Haddad, well known to readers of Entre Nous as the former WHO Regional Officer for Sexuality and Family Planning, has recently been invested in Lisbon with the medal of the National Order of Merit.

This distinction was awarded to Ms Haddad by the Portuguese President for her services to health in Portugal.

Ms Haddad retired from WHO in 1987 and now lives in Paris.

Regretted that sexologists are not involved in the major debates taking place at the end of this century. It is true that research in physiology is moving forward and that treatment protocols are being refined, but the unprecedented ethical issues raised by artificial insemination, world demographic trends, religious fundamentalism and the standardization of behavioural models, for instance, are being discussed in circle

outside sexology’s sphere of influence: 100 years on, H. H. Rygh and his fellow greats would reproach us for that failing!

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- devastated by despotism ...
- but if we look at the situation in objective terms, it is clear that sexologists, by taking orders from medicine, have not been able (or have not wanted) to retain the multiple vocation and multidisciplinary curiosity that the pioneers of the last century so cherished.

People suffering from impotence or vaginismus deserve to be looked after and cared for, of course, but it is greatly to be
A guide to sex therapy

Modern therapeutic techniques based on Masters and Johnson’s work include “sensate focusing”, masturbation and better communication between the partners, writes Dr Patricia Gillan.

In the past thirty years attitudes towards sex therapy have changed rapidly. Pain, illness and reproduction are no longer the focal points of therapy. The sexual freedom of the Sixties paved the way for both men and women to enjoy sex more.

What is sex therapy? Reassurance, sex education and carefully designed recommendations form the basis of successful counseling. Nowadays sex therapy has more in common with education than with medicine, as it is usually considered to be a type of psychotherapy. Many therapists refer to their “patients” as “clients” and it is up to the client to work on recommendations and homework tasks.

The pioneers of modern sex therapy are Masters and Johnson of the USA. They researched “normal” people’s sexual responses in 1966 and the world was astounded by their scientifically based findings. Their sex-therapy book followed in 1970, and “couple therapy” provided by co-therapists became the fashion in Europe. Europeans, however, were more aware of the expense of providing two therapists for couples, and researchers in Britain and Germany established that one therapist could provide therapy just as effectively as two. In the United Kingdom therapy is provided on the National Health Service and of course this has to be cost-effective. Thus co-therapy is more of an indulgence.

Communication is important

Wolpe paved the way for a “desensitization” approach to sex therapy by giving clients carefully graded tasks to carry out, like kissing, but telling them to stop if they became anxious. Masters and Johnson reinforced this approach by asking clients initially to carry out “sensate focusing tasks” in which they begin with touching, stroking, tickling and massaging “non-genital” areas. Communication is a key factor here. In the next stage – called genital sensate focusing – the genitals are stimulated. Finally sexual intercourse is recommended, in the female-superior position.

The most common sexual disorder nowadays is that of low sexual drive or low libido. Usually there is no anxiety present but the person just has no appetite for sex. This is common in both sexes and leads to limited sexual activity. This is all right if both partners have a low sex drive, but if one partner wants sexual activity on a nightly basis and the other partner once a month or less this discrepancy can cause problems.

A better relationship

One way to help low sex drive cases is to use the regular Masters and Johnson tasks along with “stimulation therapy”, in which people are encouraged to fantasize, look at erotica and read recommended sexual fantasy books like My Secret Garden by Nancy Friday. This stimulates the sexual appetite. Couples are encouraged to improve their relationship and carry out non-sexual acts to please one another. They are asked to go on romantic walks together and even to have some “cook-ins” in which they share the fun of using herbs and spices and cook something new and exotic.

Women often remark that if their sex drive is low they do not have an orgasm. Primary orgasmic dysfunction, in which a woman has never experienced an orgasm, is uncommon nowadays and can easily be changed if such a woman follows a masturbation training course, in which she learns to recognize and stimulate her clitoris when alone. Later when she has become more confident she can talk to her partner about this activity and mutual masturbation can ensue.

Many women complain that they cannot achieve an orgasm with their partner, although they can masturbate to orgasm successfully when alone. Often “relationship therapy” needs to be worked on and they need to learn to please each other and improve their communication.

Simple treatment

Premature ejaculation or “coming too quickly” is the most common male sexual disorder. This varies in degree from ejaculating when the penis is touched to insertion for a couple of minutes only. It can be caused by conditioning or anxiety. Obviously a partner can affect this and it does not matter to some women if their partner comes too quickly as they can enjoy foreplay. Nowadays it is recognized that coitus is not the only pleasurable path to satisfaction. Premature ejaculation is easy enough to allow and consists of the man learning to masturbate for 15 minutes without ejaculation, using the “stop and start” technique, discovering the “point of no return”. The man learns to control his stimulation and repeats this homework on several different occasions alone, then with a partner.

Another common male sexual disorder is erectile dysfunction, caused by many factors including anxiety or low libido. The Masters and Johnson approach is effective for this, but recently science has advanced and penile injections can be given to increase blood flow in the penis, causing an erection. Some men prefer to have penile implants so that they can have an erection on demand.

People can be treated individually or as a couple in modern sex therapy. The emphasis is on better communication and greater pleasure.

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Couples often need to work on "relationship therapy", leaning to communicate and to please each other. Photo Viggo Rivad/ billedinset
SEXOLOGY TODAY

Sexology for medical students

Very few professionals whose job is to work with people are given a thorough grounding in sexology. Dr Gorm Wagner describes a course for medical students that is still a relative rarity.

A definition of sexology does not actually exist. In the broadest sense, it contains elements of biology, psychology, sociology, culture and anthropology. The fact that any of these may interact with the others, and can also be influenced at any time by environmental factors, gives some idea of sexology’s complexity. It also explains why every professional who deals with human beings no doubt realizes that some part of a client’s presenting problem, small or large, is often connected with the person’s sexuality.

In principle, a variety of professionals — nurses, psychologists, priests, lawyers, doctors, paramedics and teachers, for example — ought to receive some structured education in “sexology” to enable them to identify problems related to the actual presenting problem: this may be important for helping the individual. But in practice it does not often happen.

Ten years ago, attempts were made in California to make it mandatory to undergo a certain amount of postgraduate training in human sexuality to obtain a licence to work in jobs dealing with people. Unfortunately this was not carried through, although it might have provided a much needed supplement to the range of professional services and might have sparked off similar developments in other countries.

World-wide, the profession which receives the most education in sexology is medicine. However, in most medical schools the formal training in this subject is minimal, due in part to the very small number of chairs in sexology — Germany, the Netherlands, Czechoslovakia and Switzerland being among the few exceptions. Usually professors of sexology are psychiatrists, although in Germany a professor of Sexualwissenschaft or sexual sciences would be more likely to have a psychosocial background.

In the United Kingdom, higher education in sexology exists in a few places. In Scandinavia it ranges from non-existent (Norway) to fully built-out courses in the medical curriculum (Denmark).

In 1972, pilot courses for medical students were tried out at two Danish universities, and the first four courses were evaluated*. They were held immediately before the students started the clinical part of the curriculum, with an average of 120 participants. Each course lasted five days, and on the first four evenings commercial films dealing with sexual problems and topics were shown and discussed. Each day was devoted to one theme approached from various points of view: medical, psychiatric, psychological, social, forensic, educational, criminological and cultural.

The approach used was the inductive problem-setting principle of teaching. In the initial phase of each sequence, the participants were motivated to receive information about a given subject by group discussions, each group consisting of 10-15 participants. Questions were posed which were to be answered later.

Some part of a person’s problem — small or large — is often connected with sexuality. So psychologists, priests, lawyers and others need structured education in sexology. Photo Jørgen Schrøder/Billedhøst

Whenever possible, a videotape related to the subject matter was presented. The group session was followed by an information phase (a 20-minute lecture). The third and last phase was a plenary session during which the participants’ questions from the motivation phase were answered. To obtain a multidisciplinary approach the panel was richly supplemented by guest teachers, mostly from non-medical professional groups.

The topics covered were the following:

Day 1: sexual behaviour (man and sub-human primates), sex differentiation, and sex and gender.

Day 2: sexual physiology, brain mechanisms, intercourse, masturbation, pornography.

Day 3: contraception principles, abortion, counselling, and interview technique. Sexual inadequacy, impotence, and loss of libido.

Day 4: sexual deviants, transsexuals, transvestites and other sexual minority groups. Ethical and legal issues.

Day 5: sexual counselling, case histories, role play, somatic influences on sexual disorders.

The first four courses were evaluated by an external professional teacher, partly by means of a specific questionnaire for the course and partly by applying the SKAT (sex knowledge and attitude) test before and after the course. The latter was difficult to apply as it was originally developed in the late Sixties for American students, who were rather different from Scandinavian students.

If “liberalisation” of sexual attitude is defined as increased attention to — and openness about — sexual problems, the evaluation suggested the following:

● the students had increased their basic factual knowledge
● they showed a more liberal attitude to heterosexual relations, although the increase was small and not statistically significant
● they showed a significantly more liberal attitude towards “sexual myths”
● women became more liberal towards abortion, while the opposite was significantly true for men
● both groups became significantly more liberal towards masturbation.

During the Seventies the course was held twice a year at the University of Copenhagen, and a substantial amount of teaching material was developed.

By 1980, the course had been split into two courses, one on basic sexology, still held at an early stage in the medical training, and the other on clinical sexology, held at the very end of the clinical part. Since 1985, both courses have been integrated officially in the medical curriculum.


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Sex and science

Although legitimized now as a bona fide science, sex research is still the target of criticism from both right and left. Professor John H. Gagnon explains why.

In the United States the great blockbuster moments in sex research are associated with the names Freud, Kinsey, and Masters and Johnson. In very different ways these figures brought sexuality into the domain of science through the application, however flawed in each particular instance, of the conventional methods associated with the social, behavioural and biological sciences. While there has been great public attention to particular findings or methods or explanations, what has been least understood is the role that these researchers played in making the study of sexuality a part of "normal science".

In the United States the work of Masters and Johnson was the last research programme to create a media "storm". In their work they had breached the last methodological barriers by engaging in observational and laboratory studies, and they had attended to what appeared to be the final secret of desire: the orgasm. Furthermore, they opened the gates to programmes of sex therapy that could be applied to conventional couples in an increasingly assembly-line fashion.

It is important to point out that no single piece of research or research project in the future is likely to attract the media attention that these earlier researchers did. The media climate of the United States is now so sexualized that scientific studies, no matter how dramatic, will not stand out for many days against the background of sex as presented in film, television, magazines and press. The "sex stream" is so dense that sex research findings no longer count as media events of any great significance.

Even though sexuality can now be the subject of scientific research, it remains a disputed terrain because of its central role in important individual and collective struggles in all cultures. As a consequence the conduct of research on sexuality plays a role in the larger conflict in western and world societies about the proper role of sexuality in the life of the individual, couples, families and larger social collectivities. This means, quite properly in many instances, that the findings and methods of research are subject to the interpretations (and sometimes the limitations) of those outside the scientific and scholarly community.

This normalization of science means that most of the recent developments in sex research have been increasingly in either specific research-topic areas as provoked by recent social problems, or developments in specific disciplines. Three major applied research programmes have developed since 1970, provoked by:

- the social problem of unwanted fertility among the young: beginning in the early 1970s and continuing to date there have been a number of national surveys and a very large number of micro-studies on the fertility of young women containing a very small number of questions on sex limited to coital behaviour; these have chronicled the increasing proportions of young people having intercourse during their teen years; some surveys have asked similar questions of older women, both married and single;
- the AIDS epidemic: a large number of studies of sexual behaviour and behaviour change among "risk groups" have been undertaken; they focus narrowly on particular sexual practices and numbers of partners as measures of risk potential and risk reduction; such highly medicalized and decontextualized studies might, if reinterpreted, have some relevance to the study of sexuality in general;
- the problem of sexual abuse of women and children: a large number of studies of varying quality have been conducted, in an attempt to determine both the prevalence of sexual abuse and its sequelae.

There have also been major developments in research on sexual therapy and on patterns of sexual arousal which have their origins in the work of Masters and Johnson (reviews of this work can be found in Patterns of Sexual Arousal by Rosen and Beck and Sexual Desire Disorders by Leiblum and Rosen). Finally, there have been three other major lines of work on sexuality: feminist studies which have focused on the relationship between sexuality and gender; the history of sexuality and sexual minorities; and the contemporary and historical study of gay men and lesbians. There is considerable intellectual and subject-matter overlap in these three areas, and it is primarily in them that the larger questions of the nature of sexuality and its relationship to social life have been sustained, in contrast to studies provoked by particular social problems, where more narrow questions have been asked.

It is also important to note that there has arisen in the United States a tradition of pseudo-sex research designed primarily for media consumption. Such "reports" are based on such inadequate methods that they are not even wrong. They are part of the sexual "fake-lore" of society, with which quality research must compete.

Criticism of sex research now comes from both the right and the left. There is considerable contemporary evidence of resistance by traditional religious groups and their representatives in political life to the practice or sex research, as well as to what they consider manifestations of sexual permissiveness (e.g. erotic art, sex before and outside marriage, marriage among persons of the same gender, gay clergy, and so on). From the left, sex research has been criticized for being sexist, homophbic and elitist. All such complaints, by both groups, have merit.

The conduct of sex research in accordance with the relevant rules of evidence is not easy, particularly in this culturally conflictual climate. It is, however, the only way that a body of knowledge of sexuality about which it is worth while to quarrel can be created.

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Sex research plays a role in the larger conflict about sexuality's proper place in people's lives. This is why it is scrutinized - and criticized - by non-scientists and non-academics. Photo Pie Johansen®/Billedluset

ENTRE NOUS 18, August 1991
Spotlight

A survivor's story

I was born in Amsterdam in 1915 and grew up in an orthodox Jewish family. During puberty and adolescence, however, I dissociated myself from every form of orthodoxy, though without rejecting the good with the bad.

In 1940 I became a general practitioner in Amsterdam but in 1942 my wife and I were obliged to disappear to avoid deportation. We were hidden in a small town near Amsterdam until the Liberation of Holland on May 5th 1945.

After the Liberation I was confronted with the catastrophe of the Jewish community. My family and hundreds of relatives and friends were murdered in the concentration camp. A classic psychoanalysis lasting many years helped me to work through my deep feelings of mourning.

In the meantime I was trained in psychiatry at the University of Amsterdam and obtained my PhD with a thesis on depression (1948). In 1946 my friend Gé Nabrink founded a new organization for sexual reform (NVSH), and I and the psychiatrist Coen van Emde Boas helped him to organize the medical section.

Van Emde Boas was a sexologist, a pupil of Bernard Prementa (1890-1944), who directed a contraceptive clinic in Amsterdam from 1938 to 1940. Prementa wrote the first textbook of medical sexology in Dutch; he was murdered by the Germans in Auschwitz. Van Emde Boas assisted Prementa before the war at the clinic. I had the privilege in succeeding him from 1955 to 1962.

I have published several papers and books on medical sexology. In particular I presented several papers at international congresses on my clinical research in primary functional vaginismus.

In 1953 I became, as a psychiatrist, a staff member in the dermatological department of the University of Amsterdam. I founded the first department of psychodermatology in Europe and studied psychogenic itching states and the psychology of skin contact.

In 1975 I was appointed chief of the department of medical sexology at the University Hospital, Utrecht. My cooperation with the professor of gynaecology, Ary Haspels, the inventor of the morning-after pill, was very fruitful. In 1977 I became the first professor of medical sexology at the State University of Utrecht. Together with Dr Haspels I published a series of papers, and taught medical students, GPs, gynaecologists and psychiatrists.

In 1984 I took the initiative of founding a Society of Sexology in the Netherlands and Flemish Belgium, together with Walter Evenard and Walter Vanderreycken. Today the Society is flourishing and has recently organized in Amsterdam the 10th congress of the World Association of Sexology.

In 1973 I was asked to produce an International Handbook of Sexology. I asked Dr John Money from Baltimore, USA, to help me as co-series editor. The first volume was published in 1977 (Elsevier, Amsterdam, New York) and the eighth will appear in 1992. The Handbook has already been translated into Italian and Japanese.

In 1990 I was honoured with the Magnus Hirschfeld Medal in Berlin. Today I am emeritus professor, with a private practice in Amsterdam.

In the Netherlands there is hardly any animosity between medical and non-medical sexologists. The Faculty for Homosexual Studies and NISSO (Netherlands Institute for Social Sexological Research), both in

Utrecht, cooperate with the medical institutes. There are sex researchers in every university.

Holland is, generally speaking, a prosperous, affluent and tolerant society, but with many relics of the restrictive patriarchal sexual morality. Contraception is totally accepted, despite the views of the church authorities. Homosexuality in adults is legal, as is abortion. But, as in other European countries, there is a tendency to return to more restrictive attitudes. A strong progressive movement for sexual reform, supported by scientists working in the field of sexology, is still necessary.

The east-west divide

Ideological barriers may be falling in eastern Europe, but the information and technology gap remains the same. Dr Petko Velichkov reports from Sofia

Bulgaria's first medical sexology service, staffed by a psychiatrist, opened in 1963 at the Institute of Neurology and Psychiatry, and in the following year physicians from various specialities formed themselves into a sexology section of the Union of Medico-Scientific Societies.

But in the early 1970s, when private practice was prohibited by law, no thought was given to the need for medical sexology in health care. It was a time of grandiose and often unrealistic projects. A few enthusiasts did plan a department of human reproduction, to be staffed by 11 highly specialized physicians, but nothing came of it because of poor leadership, the unsympathetic attitude of the health authorities and practically no financial support.

Until the mid-1970s Bulgarian sexologists paid tribute to the concept of the primary psychogenic origin of sexual problems, but for ideological reasons the in-depth analytical approach could not develop. Contacts with professionals from western countries were restricted.

A real breakthrough came when one person had a chance to attend the annual meeting of the International Academy of Sex Research in Prague in 1979. That gave an impetus to the idea of a possible somatic participation in sexual disorders, and for a while Bulgarian sexologists too contributed to the mind-body dichotomy, looking for complete differentiation between psychogenic and somatic sexual problems. Today, however, six full-time sexologists are working in Bulgaria and their diagnostic and therapeutic efforts are directed towards a happy marriage between mind and body.

Nearly everything high-tech that is needed for a proper evaluation of the client's problem is lacking in Bulgaria, but worst of all is the limited access to up-to-date professional information. At the country's biggest medical library there is not one journal of sexology - there are 80-odd books on the subject, but only 12 published after 1980. For comparison, the same library holds more than 300 monographs on ideological and political issues.

Since 1963 there have been some 77,000 sexological consultations, but only 15% of the clients are women. The proportion is reversed in patients seeking a change of gender - 34 female to only 2 male - although in the developed countries this proportion would be 50/50. Obviously Bulgarians are still too macho in their socially stereotyped attitudes and behaviour, so that it seems easier to be a man than a woman. Over

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The Netherlands
Sexology in the throes of change

Swiss counselling centres are in a precarious position, writes Dr Maurice Hurni, but the public are demanding an ever wider range of services.

Switzerland can pride itself on having produced some renowned and first-rate sexologists. Unfortunately, the name of Dr Tissot of Lausanne is still associated with his book on masturbation and the terrible repression of that practice to which he lent medical justification. On the other hand Dr Auguste Forel (1848-1931), born in Morges, is now regarded as one of the main founders of modern sexology. His many papers (and in particular his book La question sexuelle) bear witness to his exceptional open-mindedness and show the extensive contribution he made to giving sexology scientific legitimacy.

As in its European neighbours, sexology in Switzerland "took off" in the 1960s, thanks largely to the work of Masters and Johnson. Before then, treatment of sexual problems had been mainly the responsibility of psychiatrists. Around that time, family planning centres (often with related sex counselling units) were opened in Basle, Zurich, Lausanne and Geneva. Interest in sexology was being expressed mainly by gynaecologists and psychiatrists, who often had to stand up to a repressive medical or political environment. In the past ten years or so this environment has tended to become a little more favourable; however the main counselling centres are still in a very precarious situation, often in painful contrast to the public's increasingly urgent requests and interest.

In addition, sexology has recently benefited from many inputs from other disciplines: urologists, vascular surgeons and endocrinologists have come to the assistance of gynaecologists with some spectacular techniques such as self-injection of erection-generating substances at the base of the penis, vascular surgery (ligatures, flaps) or fitting of very sophisticated penile prostheses. Sexology must therefore now take up the new challenge of initiating a genuine and respectful dialogue between the various specialists involved; if it does not do so, it runs the risk of becoming "atomized", with attendant compartmentalization of the various categories of actors and, above all, of their patients.

Sexology centres

The four main sex counselling centres (Basle, Geneva, Lausanne and Zurich) have each developed their own specific features; however, they are in broad agreement with each other on the theoretical bases for their activities, such as the work of H. Kaplan. Basle has a long tradition of cooperation with gynaecologists; Geneva also offers consultant services in various hospital units and has developed a number of physical approaches; Lausanne has pursued topics related to the couple (dynamics of the consulting couple and co-therapy), while Zurich relies on family approaches and makes use of its famous concept of collusion.

Sexual disorders

As to the nature of the disorders which lead patients to consult, there seem to be fewer "simple" difficulties which can be ascribed mainly to a lack of information or treated by a short course of interventions; conversely, there appears to be an increase in the number of sexual disorders originating in profound pathology in the individual or the relationship. We are accordingly seeing an increased incidence of lack of orgasm or lack of desire. In addition to dealing with known disorders such as premature or delayed ejaculation, impotence, lack of orgasm and vaginismus, consultations must increasingly respond to other new demands such as the assessment of requests for gender change in transsexuals, sexual difficulties related to attempts at assisted reproduction, interventions to deal with problems caused by unnatural sexual practices, and problems related to rape, incest or HIV seropositivity.

Training

It is generally agreed that delivery of this category of care calls for appropriate training, in addition to a highly developed feeling for relationships and a delicate clinical approach. Such training is offered to medical students either in the early stages of their studies (Lausanne) or at the end (Zurich), as well as to physicians in various specialties (mainly psychiatrists) at the end of their training. Balint groups (Zurich) enable established physicians to learn how to tackle sexual problems in their patients.

In addition to physicians, members of other professions also benefit from courses in sexology: nurses, psychologists, specialists in psychomotor disorders, marriage counsellors, family planning counsellors and all those who have to deal with requests for sexological services as part of their daily work. These are very often the people to whom painful family secrets (such as incestuous relationships) are revealed, increasingly frequently as a result of encouragement in the media; such approaches require very delicate handling.

It is clear that sexology in Switzerland is in the throes of change. The extent of the demand for services in this field and the high degree of motivation of sexologists are positive elements; they will be of great value in the future, if we wish to pursue this promising development.

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WHO surveys psychosexual services

Against a background of rapid changes in attitudes, reports Dr John Sketchley, dedicated people are struggling to help the psychosexually troubled.

In many parts of Europe there has been a change in the traditional sex roles of men and women. Various countries have experienced the women's liberation movement, the emergency of sexual minority groups, and an increasingly liberal attitude towards recreational sex as opposed to reproductive sex. Further changes have been produced by the advent of HIV and AIDS.

Over the years these changes have created new expectations. People look upon a full sexual life not just as a hope, but as a right, and even as an essential part of healthy human development. The consequence of this has been twofold. People now talk about sexuality more openly and this opens up the changes to an even larger part of the community. The second change is that more people look for solutions when they perceive they have a sexual problem.

Slowly, health services have begun to respond to the expressed need for solutions to sexual problems, often in the face of great opposition and with a great deal of caution. In many countries there is a growth of voluntary agencies and self-help groups which deal with the issues, often in a non-medical setting. Just as there has been a move by women to counter the perceived medicalization of pregnancy and birth and to return to a more 'natural' view of things, so also there is an effort, particularly on the part of minority groups, to act against the medicalization of sexuality.

The WHO Regional Office for Europe has recently undertaken a survey of psychosexual counselling services in Europe. The purpose was to find out what services were available and to give publicity to good practice in this field.Psychosexual services were defined as a service that a large net would bring in more information. The definition embraced counselling, befriending, self-help groups, psychotherapy, clinical psychology and psychiatry, as well as the giving of advice and information in relation to sexual problems.

The survey was conducted in three stages: first, pre-testing of a questionnaire; second, administration of the questionnaire; and third, visits to selected countries: Ireland, Israel, Poland and the United Kingdom. The test run of the questionnaire took place in six European countries. After the amended questionnaire was sent to all Member States in the WHO European Region.

The aim of the questionnaire was to gather factual information. However, despite follow-up letters, only a few countries replied, sometimes simply to say that psychosexual issues were dealt with by the medical profession. The conclusion to be drawn from this appears to be that either ministries of health did not know what was being offered to people, or they did not wish to know, or, for reasons that can only be guessed at, did not wish to say what they knew.

The visits were fortunately much more revealing. It is clear that a lot is happening, both in the statutory and the voluntary sectors. It was possible to speak to highly dedicated people, often struggling against lack of resources, ignorance and mistrust to bring help to the psychosexually troubled. Since in many countries this work is still in its pioneering stage, it inevitably depends on the commitment of a few individuals, with a consequent threat to continuity.

One very interesting matter to emerge is that the origin of psychosexual services may be different in different countries. For example in Israel the services developed from gynaecology, in Poland from psychiatry, and in the United Kingdom from clinical psychology – a thesis ready-made for the writing!

Often voluntary groups are able to tackle matters that the statutory agencies cannot. The reason may be constitutional. For example in Ireland, existing laws on the family make it difficult for government agencies to deal with health education related to HIV, but the voluntary groups have greater freedom. The advent of HIV has in fact produced in all countries some remarkable community developments, at the grass roots, with excellent health education in the form of posters, booklets and films. These developments show that it is an advantage to the community to have voluntary and statutory bodies working together.

All the countries visited are undergoing rapid changes in attitudes to sexuality. In part this is because of greater communication between countries, and in part because of the rethinking demanded by the presence of HIV. The changes range from a return to the "older values", with a strong condemnation of homosexuality and recreational sex, to a greater ability to talk about sexual issues openly and admission of a wider range of acceptable forms of sexual behaviour.

The countries visited, almost without exception, manifested a difference between the urban and rural citizen. People in cities, open to "modern" influences, have more tolerant attitudes, while rural dwellers tend to be more traditional in their views. Psychosexual services, as distinct from family planning services, are based mainly in towns, and rural people may not know about them and find it difficult to go to them. However, in Israel and Ireland there were anecdotes of country people travelling long distances to obtain the help they need.

All the countries studied distinguish sexual problems from relationship problems and see a close connection between the two, declaring that a relationship problem can often lead to a sexual problem. However, it is fascinating to note that in some countries, for example the United Kingdom, the presenting problem tends to be sexual, while in others, for example Israel, it is the relationship problem that presents.

The people involved in psychosexual work impress by their commitment, their desire to improve, and their ability to withstand pressures such as suspicion and lack of official support. The worry that arises in this situation concerns the future, with few resources, little official back-up and sometimes hostility; in other words how can the continuity of the work be assured? The answer must lie in part in getting together a small group of like-minded people who in due course will be the heirs. Innovators traditionally often find it difficult to delegate to their disciples, but a lack of delegation and teamwork can be very dangerous. Fortunately, the pioneers mentioned in the survey are trying in the main to prepare their successors.

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The birthplace of sexology

Berlin's close connections with sexology, deliberately destroyed by Hitler and the Nazis in the 1930s, are at last being revived. Professor Erwin J. Haebeler reports.

The concept of a special science of sex (Sexualwissenschaft or sexology) was first proposed by the Berlin dermatologist Iwan Bloch in 1906. Only two years later, in 1908, his medical colleague Magnus Hirschfeld, also in Berlin, published the first Journal of Sexology. In 1912 Bloch, Hirschfeld and others organized the first Sexology Society, and shortly after the First World War, in 1919, Hirschfeld founded the first Institute of Sexology in one of Berlin's most beautiful villas.

Hirschfeld also convened the first International Conference on Sexology in Berlin in 1921. This in turn led to the founding in 1928 of the World League for Sexual Reform in Copenhagen, under Hirschfeld's leadership. Co-presidents were August Forel, the Swiss psychiatrist, and Havelock Ellis, the English sex researcher. The League demanded, among other things, the legal equality of women and men, access to contraception, the reform of obsolete sex laws and general systematic sex education.

The sex reformers held several more international congresses in London (1929), Vienna (1930) and Brno, Czechoslovakia (1932). Another congress was planned for Moscow, but in January 1933 Hitler came to power in Germany, and in less than four months Nazi vandals had ransacked Hirschfeld's institute. The collection and all scientific papers were destroyed, the library publicly burned a few days later. Hirschfeld, who had left Germany in 1930 for a lecture tour around the world, saw the destruction of his life's work in a newsreel at a Paris cinema. He died in 1933 in Nice.

His death marked the end not only of German but of European sexology because the social and political climate became hostile to reform in all European countries. In any case, most of these countries soon afterwards came under Nazi domination.

Because of the Nazi menace, the German and Austrian sex researchers fled into exile: Max Marcuse, Felix Theilhaber and Ernst Klimowsky to Palestine, Ludwig Levy-Lenz to Egypt, Max Hodan to Sweden, Eugen Steinach to Switzerland, Hans Leffeldt, Ernst Gräfenberg and Wilhelm Reich to the USA. This short list does not include the many psychoanalysts, sociologists, literary and art historians and writers such as Ernst Toller who had made significant contributions to sexology. A great many of them were Jews for whom escape from the Third Reich had become a matter of survival. Indeed, Hirschfeld's great rival, the physician Albert Moll, was saved from the death camps only because he died of natural causes in Berlin just in time in 1939 (on the same day that Sigmund Freud died in London).

Moll had also organized an International Society for Sex Research, which held congresses in the Berlin Reichstag (1926) and London (1930). Moll, Hirschfeld, Bloch and Max Marcuse wrote or edited important sexological handbooks summarizing the knowledge of their time. Many early sexologists were also involved in the production of documentary and dramatic films promoting sexual knowledge and sexual reform. Their most important activity, however, was undoubtedly their tireless campaigning and public speaking in lecture halls all over Europe. Here again, Hirschfeld was the undisputed champion, who on his world journey gave many lectures in the USA, Japan, China, Hong Kong, Indonesia, India, Egypt, Palestine, Greece, Austria, Switzerland, Italy and France. He thus introduced his new science everywhere, encouraged and supported by many prominent local newspapers, scientists and politicians.

Unfortunately, to this day sexology has not yet returned to its birthplace, Berlin. However, soon after the opening of the Berlin Wall and before the formal reunification of Germany, the Third International Conference on Sexology was organized, in July 1990, in both the Eastern and Western parts of Berlin. To honour the memory of the great pioneers, the newly created Hirschfeld Medal was also awarded, for the first time, to two Jewish sexologists: 75 year-old Ernest Borneman of Austria and 70 year-old Herman Musaph of the Netherlands (see page 8).

The fourth Berlin congress, devoted to "Sex and the Law" was scheduled for June 1992, the year of the European Free Trade Zone. Again, the organizers are hoping for a positive response and another strong push towards reestablishing sexology where it truly belongs.

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World Congress

The Xth World Congress of Sexology took place in Amsterdam on 18-22 June 1991, with the logo: SEX MATTERS. Some 800 participants attended from 51 countries. The topics were very diverse: from women's issues to sexual torture, from the diagnosis and treatment of impotence to adolescent sexual behaviour and its problems, from sexuality and disability to transsexualism, from HIV to family planning.

A congress of this kind gives sexologists a unique chance to exchange ideas and experiences. They come from very different professions - some are therapists but also researchers, others are educators or work in the field of prevention. The dialogue between these different professions is very important. It heightens the perception of every individual professional, and "ordinary people" - the clients and target groups - certain benefits more from sexology if the professionals have a broader scope. The congress proceedings will be published before the end of 1991. The title will be Sex matters. Because sex matters!

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Promoting sexual health

Dr Hanne Wielandt suggests that knowledge of the causes of sexual problems can be turned round and used to create a positive sexual identity.

Sexuality is an integral part of the human character that develops as part of the maturation process. It is influenced by all sorts of individual experiences, so the impressions gained in childhood and adolescence are very important for sexual well-being.

A trauma is often identified as the cause of a sexual dysfunction. For example, sexual abuse is in western societies commonly associated with incest or rape during the abuser’s childhood. Under other cultural circumstances, circumcision might be perceived as the main form of sexual abuse. Whatever the case, it seems that sexual abuse is felt to be an increasing problem. Its effect on the victim is usually a feeling of oppression and low self-esteem, which often leads to vigorous personal development.

Some sexual problems are obviously a consequence of earlier events. Male circumcision can cause erection problems if there is scarring and contraction of tissue on the penis. In the case of female circumcision, sterility and obstetrical problems are clearly not the only risks. However, it must be considered in the light of sexual norms in the communities where circumcisions are performed. The culturally determined perception of self is an important factor in the relationship between physical development of the genitals and the experience of sexual problems. This is why reports on sexual problems encompassed by a culture with a non-western cultural background and not experienced by those with a western background are not always comparable.

In traditional western thinking, sexual problems have been causally linked to past events. In this frame of reference it is easy, for instance, to interpret sexual dysfunction as a result of incest in childhood. However, the sexual abuse is only one aspect of the emotional disintegration and neglect in the incestuous family. The sexual symptoms relate not only to the incest experiences but also to the more fundamental emotional conditions. Thus, the sexual dysfunction must be seen as a symptom of distortion in the personality of the victim.

Instead of focusing on the consequences of sexual abuse and their possible treatment, it might be more productive to attempt to reduce sexual problems. The conclusions reached from an analysis of the causes for sexual dysfunction can also be used to reverse the process, to “relate forwards”, as it were. Perhaps it is worth creating settings which facilitate the positive development of sexual identity, as in the following examples.

Sexuality in children and young people is characterized by an absence of language. In western cultures, verbal communication plays an important role in upbringing and education. Consequently, the lack of a sufficient sexual vocabulary frustrates young people.

To overcome this, adults and children need a sexual language. The adults must communicate freely about sexual subjects both between themselves and with their children. Small children understand explanations given in a very concrete way. Hence, the grown-up person must address the child in direct and honest language, not enveloping sexual subjects in euphemisms – no “birds and bees”. The adult must be prepared to repeat the explanations, gradually increasing their complexity as the child matures.

A young girl needs to be given an appreciation of her female sexuality. One way of doing this is to talk to her about her sexual organs and their function. Preparation for the onset of menstruation reduces a girl’s anxiety in relation to her first period. Girls need information about sexual maturation, therefore, prior to puberty. A well established female contact (the mother, a female relative, one of the girl’s female friends) can play an important part in this, supported by sex education, for example in school.

The myths that circulate about first sexual intercourse need to be exposed. Brutal stories about wedding nights have caused many girls to have a fearful attitude to sex. Any attempt to provide unbiased information about female sexuality will obviously improve a young woman’s love life. It is often overlooked that a gynaecological examination in adolescence can have an educational aspect. Usually teenage girls are healthy and only come into contact with the medical establishment for contraceptive counselling. Nevertheless, this first gynaecological examination is an excellent opportunity to give a girl an understanding of her sexual organs and their function.

Traditional expectations about male sexual performance may produce a feeling of personal inadequacy in young men during their first sexual relationship. This can have a profoundly negative influence on how they experience the situation and thus on their expectations of sexual relationships later in life. It is possible that all the information now being put out on AIDS prevention through the use of condoms will make attitudes to male sexuality more realistic.

Public debate about condoms implies the discussion of sexual behaviour, and it may enable young men to ask for guidance at the beginning of their sexual life without losing their self-esteem.

It must be remembered that sexual offenders are usually male. Providing teenage boys with an adequate level of self-esteem, therefore, can have a doubly beneficial effect. Firstly, it may prevent the appearance earlier in life of the feeling of inadequacy which is often found in male sexual offenders. And secondly, it will make them less likely to be the victims of a sexual offence.

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Adulthood should talk freely between themselves and to their children about sex. Explanations can become more complex as the child matures. Photo Sven Oredson/Billedhuset
The threat to love and joy

The HIV/AIDS pandemic has renewed interest in the universal right to sexual health and a fulfilling sexual life, and in the promotion of safe sexual practices for everyone regardless of sexual orientation or lifestyle. However, the positive and attractive aspects of sex all too often fall under the shadow of preoccupation with the problematic aspects of sexuality and sexual health.

Worldwide it is estimated that sexual intercourse accounts for some 80% of the global spread of HIV transmission so far. In Europe about 40% of the cumulative total of AIDS cases have been infected by HIV through anal and vaginal sexual intercourse, and the indications are that sexual transmission is increasing at a relatively much faster rate than other forms of transmission.

In Europe at present:

- heterosexual transmission is increasing particularly sharply and transmission is mainly from men to women. The reservoir of infection rests at present with men (infected by sex with other men, by sexual encounters in highly endemic countries outside Europe, or by unsafe injecting of drugs), and transmission from woman to man in the absence of concomitant sexually transmitted diseases (STDs) is much less effective than in the other direction. Women, therefore, are the vulnerable group; relatively speaking very little heterosexual transmission is taking place at the moment from women to men.
- there are indications that sexual transmission between men is increasing again in some groups and in some countries, as complacency sets in or as sexual activity—which for a time was held in abeyance by fear alone—gradually increases again;
- injecting drug users are at a group still very much at risk of HIV infection. It is important to remind ourselves that the sexual behaviour of drug users and their partners is likely to determine the future growth of the HIV pandemic in Europe.

Time-lag in the east

Developments in Eastern Europe are so far five years behind the rest of the continent, which means that there is an opportunity not to be missed to take energetic preventive measures. However, the situation in the east is of particular concern for two reasons:

- the present social and economic unrest could be accompanied by great shifts in sexual behaviour, and may pave the way for an increase in injecting drug use; and
- generally speaking these countries lack the human, technical and financial resources needed for HIV/AIDS prevention and control, particularly in the field of health promotion. The assistance and support of other European States with greater experience of this particular problem and more funds are vital, therefore, to the eastern countries’ prevention and control programmes.

In the words of the Director General of WHO: "...no country can combat the disease in isolation. Preventing the spread of HIV, caring for those affected, and minimizing the social and economic repercussions of the AIDS pandemic require the strength that comes from partnership".

Sex as recreation

HIV is transmitted through sexual and other forms of behaviour that are intimate, taboo or even denied. But to promote sexual health, it is necessary to recognize officially and explicitly that sexuality is mainly a recreational activity, not just a matter of procreation. There is no need to reduce sexuality to reproduction; sexual health must be seen in its broadest sense, with reproductive health an important but not the only focus of interest, and with STDs and HIV (however serious they are as threats to enjoyment, health and life) representing the small, negative side of the equation. In this sense their importance lies in the threat they pose to joy, love, the expression of feelings and the need for bodily contact.

The importance of STDs and HIV infection for the individual concerned or for society should not be minimized, on the contrary. However, problems of sexual health must not overshadow the pleasures of enjoying sexual health. Herein lies the very reason for promoting sexual health in a positive sense. Religion or other ideologies must not be allowed to ensure us into looking at sexuality as a problem. In all their expressions, life and health will meet obstacles to their enjoyment. STDs and HIV infections are obstacles to sexual health and to expressions of sexual life. However, solutions to the problems of HIV infection and other STDs must be founded on a basic belief in sexuality as a positive force, and on the right to sexual health as a basic human right, along the lines of the right to health in general.

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STDs and HIV, serious though they are, should not overshadow joy, love, the expression of feelings and the need for bodily contact. Photo Heine Pedersen©Billedhuset
Sex in old age

It is quite natural that there should have been an increase of interest recently in the sexuality of elderly people. The proportion of elderly people in the population is of course increasing, due among other things to better living conditions and more efficient health care, both preventive and curative. And sexuality is one of the human rights, irrespective of age.

A number of studies in recent years have indicated that people do engage in a certain amount of sexual activity at an advanced age. The study described here was carried out with the help of a questionnaire mailed to a random selection of men and women aged 60-80 living in the greater Stockholm area of Sweden. The respondents were assured of complete anonymity. Of the 1,574 questionnaires sent out, 509 were returned, a reply rate of 32.3%.

The questionnaire comprised 29 questions, each giving up to six alternative answers. Some concerned background data, such as sex, age, civil status, school education and further education, profession or occupation. Other questions related to physical and mental health, religiosity and loneliness, and several asked about sexual interest and behaviour.

What sort of elderly people responded? They were not a group with a particularly high education (only 11% had matriculated). Their physical and mental health was good, they had many social contacts, and few felt lonely. Twenty per cent of them were religious, but most had a liberal attitude to sex.

Interest declined with age

In both sexes, sexual interest and sexual activity (intercourse and masturbation) were found to decrease with increasing age, which corresponded closely to the results of earlier studies. Men were found to be more sexual than women in every respect. Regarding women's sexuality the study established, to the researchers' regret, women's low interest in sexuality as well as their great lack of sexual satisfaction and low frequency of orgasm (the latter, of course, also affected many men).

It was not possible from the material obtained to answer the question whether the women's low sexual interest and lack of sexual satisfaction was primarily a sign of sexual frustration, i.e. did the elderly women still feel a sexual need which was unsatisfied due to unfortunate circumstances and/or an uninteresting or uninterested partner? Or had their innate sexual desire received no nourishment during the course of their lives, due to an upbringing in a sexually hostile environment and society's neglect of female sexuality, which prevented its development over the years? When these women were of reproductive age, in the 1940s, the dread of an unplanned and unwanted pregnancy was very great and the possibility of a legal abortion very small. Moreover, in many people's opinion, when women reach the menopause their sexuality is presumed to be finished. The researchers assume that all these factors played a role in making the women's sexual commitment low compared to that of the men.

Religion not a factor

When these people grew up, religion had a fairly firm grip on the Swedish population. The State Church (which is Lutheran) and also the nonconformist churches played a normative role regarding sexuality, condemning premarital intercourse, masturbation and especially homosexuality.

As already mentioned, 20% of the group stated that they were deeply or fairly religious. There was nothing to support, however, the belief that the religious are less sexual regarding either interest, activity or the experience of attraction to their own sex. If the study had been done among elderly people living in rural areas, however, differences might have appeared.

Undoubtedly, younger generations, especially women, are more liberal sexually and more sexually conscious than older generations. But there are still people — men as well as women, and of all ages — living under a certain sexual oppression. Fortunately, recent studies, this one included, show that elderly people can have a sexual interest and be sexually active. It is to be hoped that this knowledge will contribute to an increasing tolerance towards elderly people's sexuality, and a better understanding of it.


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Crisis in Albania

Maternal and child deaths in Albania are among the highest in Europe.
Dr Katerina Tabillo makes an urgent plea for help

Albania is passing through a historic period, a time of reforms and attempts to improve political, economic and social life. But along with these developments have come economic crises causing new threats to maternal and child health.

The population of Albania is 3.14 million; about 33% are under 15 and 2.5% are infants under one year old. The birth rate is 26.5%, and the average number of children per family is 3.7.

Annual income per capita is US$ 922, which is very low compared to western countries and even to eastern countries. The food situation is very bad, and there is a great shortage of food for children, including milk and other protein-based foods. This is especially serious for the under-14s. Some 30% of children under three show varying degrees of wasting, and in some areas, especially in the south-east, the figures are as high as 40%.

As a result of the increasing lack of food, bad hygienic conditions and transport difficulties, the incidence of disease and infant mortality is increasing. In children the main diseases are respiratory and gastrointestinal infections. The viral hepatitis rate is 353 per 100,000 inhabitants. Infant mortality is now over 30 per 1,000, the worst rate in Europe. Infant deaths at home have been increasing and now account for over 50% of child mortality. This figure is higher if one adds the 11% who are brought in too late and die during their first 24 hours in hospital. It is not always possible to get elementary medical assistance for these children.

Maternal mortality is increasing, and now stands at 30-40 per 100,000 pregnancies. Over 50% of these deaths are the result of complications following illegal abortions.

(Abortions have been legalized and is available at the couple’s request.) Medical assistance to pregnant mothers is becoming more problematic. There is an increase in pregnancy-related diseases such as eclampsia and anaemia, but a severe shortage of drugs to treat these diseases.

To preserve the lives and health of pregnant mothers and children, Albania needs urgent and intensive help.

Within the framework of the general democratization, the government has adopted a new family planning policy which is in accordance with the methods and practices of UNFPA.

In view of the economic difficulties, the still high birth rate and the shortage of drugs and medical supplies, Albania would very much appreciate support and concrete assistance for the new family planning policy in the form of a range of contraceptives for both women and men and medicines for the treatment of pregnancy-related conditions.

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Deaths of women from pregnancy-related causes are increasing. The food situation is very bad and clinics cannot get drugs or supplies. Albania urgently needs help. Photo Michel Setboun/UNFPA

UNFPA programme to begin in 1992

Until this year Albanian couples had to rely on traditional methods of family planning to regulate their fertility. Both modern contraception and legal abortion were available only on medical grounds.

In April 1990, UNFPA approved its first country programme for Albania for the period 1992-95, at a cost of US$ 3 million. Half of this amount will be spent on maternal and child health and family planning.

The strategy will be to strengthen gynaecological and obstetric care and to create a national family planning programme. Family planning services will be provided at all maternity clinics and women’s health centres, and contraceptives will be supplied to pharmacies.

The immediate objectives for the three years will be to reduce maternal deaths by 50%, perinatal mortality by 30% and premature births by 20%, and to protect from unwanted pregnancy at least 10% of the Albanian women of reproductive age who are at risk.

A new family planning unit in the government Department of Maternal and Child Health will manage the programme. Some 240 gynaecologists and 400 midwives will be specially trained and a new national reference centre is being created, the Maternity Institute.

The programme will be coordinated with an information, education and communication project run by the Health Education Unit and the Albanian Women’s Union. The Women’s Union has already begun a survey of 2,000 women to investigate how they use maternal and child care.

(UNFPA’s Report on Albania can be obtained from: UNFPA, 220 East 42nd Street, New York, NY 10017, USA. ISBN 0 89714 1369)

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Ten years after the start of the national programme, pregnancy in the 15-19 age group is still a problem

Northern dwellers think of the Seychelles as a land of daydreams, of fine sandy beaches, of warm sunshine and original, delicately flavoured dishes of bat or octopus in coconut milk, a land where the children trailing home from school all carry a fish fresh from the market for the family supper.

The friendly, smiling people of the Seychelles live mostly on only three of the 102 islands that make up their country. Almost all year round they are invaded by tourists attracted by the summer temperatures, the miraculous supply of fish and the absence of the cyclones which so cruelly plague their sister islands, Mauritius and Reunion.

In 1990 the population was 67,378, with 1,617 births, a birth rate of 24 per 1,000, a death rate of 8.1, and a population increase rate of 1.8%. Like everyone else, the Seychellians have their problems of everyday life and have learned to control their fertility.

Health care is free, provided by 49 doctors and 300 nurses. The islands’ health indicators are excellent and gradually approaching those in Europe: infant mortality is 17.9 per 1,000 and maternal mortality negligible. Very few women die of pregnancy-related causes, for reasons which include the presence of qualified personnel and the availability close at hand of health centres staffed by doctors.

Abortion is permitted on medical grounds up to 12 weeks, provided that a panel of three doctors give their unanimous approval. Women who have illegal abortions, however, are not punished, so in the event of complications they go immediately to hospital and most problems are caught in time.

In 1979, UNFPA helped set up the Seychelles’ national family planning programme, which by 1986 had been extended to all 18 health clinics. Modern contraceptive methods are widely available, including pills, IUDs, condoms, injectables and female sterilization. The staff have all been trained, either abroad, in nursing school, or at refresher courses. Contraceptive supplies are always in stock, and leaflets are available in the local language.

Yet after a splendid start and a record number of 7,650 users in 1985 (roughly double the 1979 figure), by 1990 only 4,640 people were still contracepting and the number of new acceptors (684) was less than half as great as the number who actually left the programme.

There are several possible explanations for this disapppointing downturn in the popularity of family planning. First, there is no alternative to the national programme except for pharmacies, which serve 10% of current users, most of them young people. Another explanation may be the almost total absence of doctors from the programme in rural areas — where prevention is almost entirely the domain of the midwife — and from secondary-level hospitals. Also, male users of the service are almost non-existent, perhaps because of the fact that the providers of the service are exclusively women.

Finally, the number of abortions is not negligible in the Seychelles. In 1990 therapeutic abortions stood at 8.7% of live births, which compares favourably with percentages of 20% to 35% in western Europe. However, when the known number of illegal abortions with complications (and therefore treated in hospital) is added, the figure in 1989 was almost 21%.

But the most worrying aspect of the situation is the number of pregnancies in girls aged 15-19. Between 1979 and 1989 the figure for pregnancies in this group dropped by half, but was still as high as 314, and girls aged 15-19 accounted for 28% of all legal abortions.

Only 10% of family planning users belong to this age group, and all of them have already been pregnant: girls who have not yet been pregnant, thus passing into the category of “mother”, dare not come to the clinics for fear of meeting someone they know in this very small country. Moreover some of the staff with teenage daughters have been known to lecture young clients on their morals, or even — in rare cases — demand parental permission before providing contraceptives.

The drop in 15-19 year-old pregnancies between 1979 and 1989 was apparently due to the introduction by the Ministry of Youth of camps where the entire juvenile population are sent for two years, going to school in the mornings and in the afternoons attending workshops run by youth leaders. Only five girls become pregnant each year at these centres, and only 20 at the polytechnics. But in that case, where do all the other pregnancies come from? It seems that they occur among girls who have graduated from the youth centre but are not bright enough to be admitted to the polytechnics for further education. They find themselves in a vacuum between the supervised centres and the professional world and perhaps — using the only means they have — are asserting themselves through their sexuality. In more than 50% of such cases the father of the child does not admit paternity. As for the girl, her personal and professional future, as well as her family situation, are bleak.

Aware of these problems, the Health Ministry plans a special centre for young people in Victoria (the capital), where contraceptive advice will be only one of a range of opportunities for discussion and information. There will be a telephone hotline and the family planning counsellors will be young nurses of both sexes, recently qualified, with whom the clients have more in common. Young people will also have a say in the running and design of the centres. With these improvements, the Ministry hopes, when young people in future are ready to begin their sexual life, they will do so under the best possible conditions and be safely protected from unwanted pregnancy.

Dr D. Pierroti
WHO Regional Adviser for Europe for Sexuality and Family Planning

Health indicators in the Seychelles are almost as good as in Europe. But why is family planning not as popular as it was? Photo D. Pierroti®
Reports

Human reproduction

Sex therapy
Dr Patricia Gillan’s practical Sex Therapy Manual discusses different types of sex problems and sets out the ways in which they can be managed and treated. It provides real case histories with actual therapy dialogues, deals extensively with group, individual and couple therapy, and covers both heterosexual and homosexual couples. Available from: Blackwell Scientific Publications, Osnay Mead, Oxford OX2 OEL, United Kingdom (order no 0632 016666). Price £17.70 excluding postage.

AIDS in the community
Talking AIDS: A Guide for Community Work has been produced by the International Planned Parenthood Federation to promote understanding of the disease and to support people infected with HIV. Published by Macmillan. ISBN 0 333 49781 3

Books

Latest on abortion
Induced Abortion: A World Review, 1990 Supplement, by Stanley K. Henshaw and Evelyn Morrow, is the latest instalment of an international abortion factbook begun by the late Christopher Tietze. Published by: The Alan Guttmacher Institute, 11, Fifth Avenue, New York, NY 10003, USA. Price $25 plus $2.50 postage and handling, prepaid. More recent political information appears in Dr Henshaw’s article in International Family Planning Perspectives, Vol. 16, No. 2, June 1990 ($8 plus $0.80, prepaid), from the same address.

AIDS prevention

Contraception and sexuality
Dr Esther Sapiro’s Contraception and Sexuality in Health and Disease has been completely revised and adapted for a UK edition by Toni Belfield and John Guillebaud. Published by McGraw Hill. ISBN 0 07 70 7097 6

by Bedford Square Press, 26 Bedford Square, London WC1B 3HU, UK. ISBN 0 7199 1275 X

BOYS
WILL BE...?
SEX EDUCATION AND YOUNG MEN

A-Z of methods in Russian
New from Dr Andrei Popov, the medical demographer (Entre Nous 16): How we can effectively, safely and without harm to our health prevent pregnancy. With cartoons, it explains the comparative working, effectiveness and reliability of condoms, rhythm methods, withdrawal, IUD and pill. Published by: National Centre for Biotechnology “Biopolis”, Korp. 3, 4 ul. Aviamotornaya, 111116 Moscow. Price: 2 rubles.
The future of contraception

Gamete Interaction: Prospects for Immunocontraception (1990), edited by Nancy J. Alexander et al., presents the latest data in the field, proposes directions for future research and outlines the steps necessary for the ultimate development of a contraceptive vaccine. Published by Wiley-Liss Inc., 41 East 11th Street, New York NY 10003, USA. ISBN 0 471 56847 3

UN on population

New Romanian contraception manual
Contraceptii (1990) by Professor Basenil Zbranca is a comprehensive guide to contraceptive and contraceptive methods and their efficacy. For the general public in Romania and Soviet Moldavia, as well as for doctors. In Romanian, with French summary. Published by: Junimea, Str. Cuza Voda Nr 29, Iasi, Romania. ISBN 97337 0108 4

Laws out of date and out of touch
La loi et l'avortement dans les pays francophones by B.M. Knoppers and J. Bruili is a first step into a largely unexplored subject area: abortion laws in 27 francophone countries, 19 of them in sub-Saharan Africa. The authors conclude that the law is inadapted to reality and the suffering of women, of their children, of the family. In French with an English preface. Published by: Les Editions Themis, Faculty of Law, University of Montreal, P.O. Box 6128, Succ. A, Montreal, Quebec H3C 3J7, Canada. English summary also available (reprint).

Ready reference

Contraception for providers
The British Department of Health's Handbook of Contraceptive Practice (1990) is intended for family planning nurses, doctors and other health professionals. Includes the needs of mentally and physically disabled people, and the importance of STDs. Available from: Department of Health, Alexander Fleming House, Elephant and Castle, GB-London SE1 6BY, UK.

Magazines/newsletters

Outlook is published quarterly by PATH in English, French and Spanish and is available in Chinese and Portuguese. It carries news on reproductive health products and drug regulatory decisions of interest to developing countries. Vol. 9 No. 1 (April 1991) features Interactions between Oral Contraceptives and Therapeutic Drugs. From: PATH, 4 Nickerson Street, Seattle, Washington 98109-1699, USA. Fax (206) 285-6619. Free in developing countries.

People, the quarterly journal of the International Planned Parenthood Federation can be obtained from: Distribution Unit, IPPF, PO Box 559, Inner Circle, Regent’s Park, London NW1 4LQ, United Kingdom.

Planeamento familiar is the quarterly newsletter of the Portuguese Family Planning Association (APF), Rua Artilharia Um 38, 20 Dio, P-1200 Lisbon, Portugal.

Studies in Family Planning is a twice-monthly international journal on family planning, health and development in developing and developed countries. Free in some cases. Enquire to publishers: Population Council, One Dag Hammarskjold Plaza, New York, NY 10017, USA.

Africa Link is an illustrated family planning magazine published twice yearly in April and October, in English and French, by the Africa Regional Secretariat of IPPF, Madison Insurance House, Upper Hill, POB 30234, Nairobi, Kenya. Fax 726596.

Abortion Research Notes is a regular publication of the Transnational Family Research Institute, 8307 Whitman Drive, Bethesda, MD 20817, USA. Fax (301) 469-0461. Price $25 per volume.

Population Today, a news monthly on population and demography, is published 11 times a year by the Population Reference Bureau, 187 Connecticut Avenue NW, Suite 502, Washington DC 20009, USA.

Population Reports with an international flavour are produced five times a year by the Population Information Program, The Johns Hopkins University, 5227 St Paul Place, Baltimore MD 21202, USA.

DHS Newsletter reports on progress in the Demographic and Health Surveys Program, a nine-year project to help developing countries. Twice-yearly from: IRD/Macro, 8850 Stanford Boulevard, Suite 4000, Columbia MD 21045, USA. Fax (301) 290-2999.

Population Headliners is issued monthly by the Population Division, Economic and Social Commission for Asia and the Pacific, UN Building, Bangkok 10200, Thailand.


Research in Reproduction, quarterly, summarizes advances in reproductive physiology, and related current events. Free from: IPPF, POB 759, Inner Circle, Regent’s Park, London, NW1 4LQ, UK. Priced wallcharts on reproductive physiology are also available.

Videos

Natural method

Fertility, a Guide to Natural Family Planning is a six-part VHS/PAL teaching video on the sympto-thermal method produced by the Department of Medical Illustration, University of Oxford, John Radcliffe Hospital, Oxford OX3 9DU, UK. Price £60 plus VAT.

General

USAID abortion restrictions

Many NGOs in developing countries receiving USAID population funds believe that any involvement at all with abortion will disqualify them from USAID support. This is not accurate. The US Government’s clarifications on its Mexico City Policy are explained in a leaflet from the Population Crisis Committee, 1120 19th Street NW, Washington DC 20036, USA. They cover: research, training and equipment, abortions to save the mother’s life and in cases of rape and incest, and post-abortion counselling and services.

Safe motherhood

The Safe Motherhood in Action Kit from Family Care International focuses on prenatal care, obstetric care and family planning, with examples of successful activities and technologies, references and contacts for more information. From: Family Care International, 588 Broadway, Suite 510, New York NY 10012, USA.

Training opportunities

Information systems, USA

The International Statistical Programs Center of the US Census Bureau, in cooperation with Tulane University’s School of Public Health and Tropical
Medicine, offers a training programme in Population and Health Management Information Systems for professionals from public and private sector agencies in developing countries responsible for the design and maintenance of health and management information systems. The eight-month diploma course focuses on goals, options and strategies, basic data collection, processing and analytical skills. Cost: US$14,375 plus travel and subsistence. Shorter options and a master's degree are also available. Contact: Dr Leslie Solomon, chief, training Branch, International Statistical Programs Center, Bureau of the Census, Washington DC 20233, USA. Tel: (301) 763 2860. Fax: (301) 763 7589.

Maternal and child health, France
The International Children's Centre in Paris is offering a French-language course on Maternal and Child Health: Planning and Organization of Integrated Community Programmes, from 14 January to 16 April 1992. Intended for health professionals, the course emphasizes situation analysis, problem-solving, decentralized and integrated planning of health activities, and community participation. Details from: Dr Michel Pécévis, International Children's Centre, Château de Longchamps, Bois de Boulogne, F-75016 Paris, France. Tel: 16 1 45 20 79 92. Fax: 16 1 45 25 73 67.

13th World Congress of Gynaecology and Obstetrics (FIGO) and Symposium on Professional Training for Safe Motherhood. Details from: Congress Secretariat, Obstetrics and Gynaecology Society of Singapore, c/o Dept. of Obstetrics and Gynaecology, National University Hospital, Lower Kent Ridge Road, Singapore 0511. (Singapore, 15-20 September 1990)

Mental Health and Multicultural Societies in the Europe of the Nineties. Organized by the WHO Regional Office for Europe and the advisory council for mental health care in Rotterdam, this international conference will focus on international mental health policy and planning, intercultural mental health care, and comprehensive mental health care services for migrant groups. Details from: Mrs A. Boin, SOGG, P.O. Box 23115, 3001 KC Rotterdam, The Netherlands. Tel: (010) 4367577, Fax: (010) 4367273. (Rotterdam, 15-18 September 1991)


Antiprogestin Drugs: Ethical, Legal and Medical Issues. Details from: Antiprogestin Drugs Conference Registrar, American Society of Law and Medicine, 765 Commonwealth Avenue, 16th floor, Boston MA 02215, USA. Tel: (617) 262-4990. Fax: (617) 437-7396. (Arlington VA, USA, 6-7 December 1991)

Second Congress of the European Society of Contraception. Main theme: the benefits and risks of contraception. Details from: Professor George Creatas, 9 Kanari Street, GR-0671 Athens, Greece. Tel: (301) 7770850. Fax: (301) 3620848. (Athens, 6-9 May 1992)

Fertility and Isolation. The main themes of this symposium will be the history of fertility in islands, economic systems, sociology, and family and political demography. Details from: Ms Catherine Orly, Service Etudes et Recherches, Rue Hippolyte-Fouque, Sainte Clotilde, F-97488 Saint-Denis Cedex, Reunion, France. (Reunion, 18-23 May 1992)

What's on the menu today?

Nutrition policies are a relatively new phenomenon in Europe. To develop them effectively, policy-makers need to know not only what people ought to be eating, but also what they actually are eating. Food balance sheets, household budget surveys and individual-level studies all provide data on the dietary patterns of populations. This book makes a critical assessment of these data sources, examining what each can (and cannot) tell us and how they should be used.

Nutrition policies require an intersectoral approach. This book will be a vital guide to all those who could and should contribute to people's nutritional well-being: food producers and manufacturers, officials in ministries of agriculture, industry, trade and health, and individuals in positions that entail decision-making on food, such as caterers, hospital administrators, and food importers and retailers.

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