What is meant by child sexual abuse?

Child sexual abuse is the abuse of a child for the sexual gratification of an adult or a person who is significantly older. Abuse may range from obscene telephone calls, indecent exposure and voyeurism to taking pornographic pictures, intercourse or attempted intercourse, rape, incest or child prostitution.\(^a\) Legally, the term child refers to the age of consent, which varies in European countries from 14 to 18. Many countries have higher ages of consent for homosexual relationships and relations with dependents.

Offenders come from every class, profession and social and religious background and may be male or female. Male offenders and female victims are most frequent in reported as well as clinical cases. The offender may be a stranger, an acquaintance, a relative or a close family member. If the offender is a parent or someone in the position of a parent (grandparent, step- or foster-parent or older sibling) sexual abuse is then called incest, although the legal definition of incest differs from one country to another.

How frequently does child sexual abuse occur?

Contrary to what is often thought, there is no indication of an increase in the incidence of child sexual abuse in the general population. Earlier and more recent studies in several European countries show that between 10-40% of females and 5-20% of males have experienced at least one incident of sexual abuse during childhood or adolescence.¹

The incidents reported are mostly single incidents of indecent exposure, propositions to do something sexual that are rejected by the child and brief genital touching. Offences involving force or repeated abuse by the same person account for about 1% of the total. In fact, reported sexual offences against small children have decreased in the past 15 to 20 years. The number of offences committed by family members appears not to have declined, however, and 1-2% of female respondents in all studies mention sexual abuse by a close family member. Prolonged and repeated abuse is difficult to assess in general population studies because of the limited number of respondents but is frequently found in special groups such as patients in a psychiatric clinic or hospital.

Serious sexual abuse committed by relatives or friends is underreported. Often the child does not tell, or the adult to whom the child reports the problem will protect the offender. Cases of incest are the most rarely reported; the child is forced or persuaded to keep it a secret. Most cases of incest in courts or clinics are committed by fathers or stepfathers, more rarely by grandfathers or older brothers.

In cases of prolonged abuse, child sexual abuse is only one of the symptoms of a disturbed family, a family that tends to be socially isolated. The

father in such a family is often depressed and possessive and tends to sexualize his problems in his relationship with his children and the mother often appears submissive and unable to protect her children.

The problem of detection

How is child sexual abuse disclosed?

The child may tell somebody or adults close to the child observe a clue that points in the direction of sexual abuse. Often child victims do not tell anybody, even if the abuse has been frightening and unpleasant. Some offenders threaten children to keep them quiet, or they bribe or otherwise persuade them to keep the secret. The latter is common in cases of incest or when the offender is otherwise known to the child. Not infrequently, however, children keep the experience a secret of their own accord, because they instinctively fear the reaction of adults.

In some cases children have visible genital injuries or require medical care because of a pregnancy or of sexually transmitted disease. Usually, however, there are few clinical features, which makes detection not only a difficult but also a delicate matter. Clues or indications of possible sexual abuse may include a sudden change in mood, a change in eating patterns or a lack of trust in a familiar adult.

¹Child sexual abuse; op. cit.
Signs which may indicate sexual abuse has occurred

- Sudden change in school performance, inability to concentrate
- Personality change, becoming insecure, needing constant reassurance
- Lack of trust in a familiar adult or not wanting to be alone with a babysitter or child minder
- Being isolated from friends
- Onset of day or night wetting
- Nightmares or sleep disturbances
- Being affectionate in a sexual way inappropriate to the child’s age
- Aggressive or unusually compliant behaviour
- Regressing to younger behaviour such as thumbsucking, acting like a baby
- Depression, withdrawal, sadness, listlessness, self mutilation, suicide attempts, running away, overdoses
- Not wanting to be alone
- Medical problems such as urinary infections and chronic ailments

Although these symptoms are not necessarily indicative of child sexual assault, if children exhibit extreme or combined symptoms from this list, the possibility of sexual abuse should be considered and investigated.

The indications may be so vague or general that overly eager reports of families about possible child sexual abuse may cause more harm than good.

[Source: Leaflet Child Sexual Abuse: 1 in 10 children are at risk. The Child Assault Prevention Programme, 30 Windsor Court, Moscow Road, London W2 4SN, United Kingdom]

What are the consequences to the child?

They depend on the event, the people involved but also on the situation before and after the event.

The effect of brief and accidental sexual abuse depends on the child’s preparedness about sexual matters and contact with strangers, as well as on how people in the child’s surroundings react when the child tells about his or her experience. For example, a child who has received sex education, who is not frightened about sex in general and has knowledge about child abuse, is likely to turn away from undue exposure and reject propositions or attempts at physical contact. If the adult who is told about the offence reassures the child and does not dramatize the matter, no lasting effects are to be expected for the child, even in relatively serious encounters. On the contrary, a child who feels guilty about sex and with whom parents or educators panic, dramatize the event or imply that the child has been defiled may feel much distress and have lasting feelings of anxiety and guilt.

Children who are victims of forcible sex crimes may suffer anxiety, depression, nightmares and insomnia for some time after the event. Many need short term psychotherapy. Children who receive adequate support will experience these symptoms for a shorter period and lasting ill effects will be moderate or nonexistent.

The most serious effects are seen in victims of incest particularly if victimization begins at an early age and continues for several years, when the offender is a father or stepfather, when the offence includes intercourse, when some degree of force is applied, and if the event is kept secret for a long time. Even single events, if the offender is not a parent, but a trusted person who abuses the child’s dependence, may cause prolonged disturbances, especially if the child is unable to tell anybody about it.
Helping children and families

The basic problem of all help is the risk of aggravating harm that has already been done or even creating harm where none exists. This risk is higher in child sexual abuse because such abuse represents not only a serious criminal offence but also breaking a sexual taboo in society.

Child sexual abuse is a serious crime and its reporting to a person in authority will start a complex routine of actions that may create additional problems. The child is questioned, examined and interrogated by social workers, psychologists, doctors and police officers. In cases of incest official action may lead to a complete disruption of the family: the child is referred to an institution, the father jailed, the mother and other family members are left in misery, feeling stigmatized and guilty and often torn between loyalty to the child and to the father.

Child sexual abuse involves also breaking a serious sexual taboo. The victim and, especially, the adults around the victim tend to react hysterically and with strong feelings of anger, fear or guilt.

Deciding how to intervene

When a case of child sexual abuse is reported to the authorities, only one person, trained in handling this problem, should take charge and represent the child. This approach has worked successfully in Israel for many years and is being followed in other countries. Furthermore, reporting a case of child sexual abuse to the authorities should not automatically cause routine criminal investigation, arrest and court proceedings, even if the police are informed. Such action should be taken after careful consideration of the individual case with special concern for the consequences of any action for the child.

As a rule, arrest and court proceedings against the offender should be con-

sidered only in more serious cases, such as when force has been used or the child has been abducted or if deemed necessary in order to prevent continued or repeated abuse.

In recent years crisis intervention offered on a private, voluntary basis to victims, offenders and families involved in child sexual abuse has appeared in some countries as an alternative to intervention by official bodies. In the United Kingdom such programmes include incest crisis lines providing round-the-clock counselling for anyone involved in an incestuous relationship (including male victims and offenders) and family centres that provide support and parental education to families at risk. Although the quality of the help may be difficult to assess, such organizations have the advantage of offering advice on an anonymous or discretionary basis, without involving the authorities. Such programmes are likely to reach cases of child sexual abuse that would otherwise be missed. If the family decides afterwards to report the case to the authorities, they may be better informed of and prepared for the consequences.

What can be done to prevent child sexual abuse?

The most effective form of prevention is to reduce the number of child molesters. Research shows that most child molesters lacked affection and physical contact when they were young. A high percentage were themselves abused as children. Therefore, improving conditions in families at risk would reduce the number of families in which incest and sexual abuse are likely to occur and would also reduce the likelihood that children would later become child molesters themselves. Counselling and therapy for these families at risk are important.

Second, children must be taught how to prevent sexual assault from anyone, including adults known to them. They must also be able, through sex education, to relieve some of the tension and taboos surrounding their bodies and affective and sexual relationships.
Children's lack of information makes them vulnerable. Talking to children will teach them to identify and handle potentially threatening situations, by screaming, kicking, saying no or running, for example. It will also reduce the possible harm resulting from an incident of sexual abuse, because the child will not be excessively shocked or frightened and will tell someone about it.

Parents who can talk with their children in a loving atmosphere and help them learn ways to stay safe are giving their children excellent protection. Furthermore, talking about sexual relationships in the family will help those at risk of becoming child molesters to learn the difference between hugs, kisses and abusive sexual acts.


In Romania and particularly at the Iasi Institute of Medicine and Pharmacy we felt that, although sexology is an autonomous discipline and sexologists do exist, training in sexology should be organized for personnel dealing with public health. As a first step, such training should be for physicians but should eventually be extended to all health workers.

What are the objectives of the training course in sexology for medical personnel?

First, we want physicians and medical students to broaden their ideas beyond purely medical concerns. Second, in Romanian society, a person who has sexual difficulties first seeks advice from a doctor; it is imperative therefore that our doctors are well prepared to deal with such problems in practice. Finally, we want to prepare teachers in sexology who can inform and educate the public about sexuality.

The training course in sexology is organized on an interdisciplinary basis with the participation of specialists in anatomy, physiology, genetics, psychology, sociology, endocrinology, gynecology, law and pharmacy. They contribute to the training and do some teaching, provided the separate subjects fit into an overall philosophy of human sexuality. Some of the subjects covered in the course on sexology are listed below:

- a historical review of sexology as a multidisciplinary science, of the main concerns and the need for training in sexology in Romania and of the state of sexology as a discipline in the world;
- the anatomical and physiological basis of sexual behaviour in men and in women along with sex differences and genetic defects; the endocrine system and sexual behaviour; puberty, physiological maturity and normal sexual behaviour;
- the characteristics of human sexuality, including sexuality and personality, normal and abnormal sexual behaviour and sexual deviations;

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COUNTRY REPORTS

TEACHING A COURSE IN MEDICAL SEXOLOGY

Since the academic year 1977-1978, the Institute of Medicine and Pharmacy in Iasi, Romania, has organized a regular course in sexology for medical students and physicians. This initiative followed discussions among a group of experts who met in Geneva in 1972 to discuss the teaching of human sexuality for health professionals.a

- sexuality and reproduction;
- contraindications for pregnancy;
- natural, hormonal and mechanical contraceptive methods; infertility and its treatment;
- sexual dysfunctions such as impotence, frigidity and vaginismus and their treatment;
- how to deal with sexual insufficiencies as a medical practitioner, and
- ethical and moral concerns about sexuality in a socialist society including sex education.

At first the course on sexology was optional for medical students. Later on it became a specialized postgraduate course in which seven to ten physicians participate each year. The participants greatly appreciate the course.

At the end of the academic year, participants receive a certificate attesting to their training in sexology. Already 46 physicians hold such certificate and have the knowledge required to assist clients with sexual difficulties or to participate in promoting sex education for the public. Most physicians work in the school health service or in the occupational health service, which covers industries employing large numbers of young people.

From Dr E. Zbranca, Head of the Department of Endocrinology, Associate Professor, Medical School of Iasi, 1 Bd. Independentei, Iasi 6600, Romania]

FAMILY PLANNING:
A REPORT FROM "SUISSE ROMANDE"

The first family planning centres were opened in the French-speaking part of Switzerland in the 1960s. At present, 22 are operational. From the outset, a specialized staff was required. Family planning counsellors were appointed and with time their training has become better organized and more extensive. In this article we will describe the main functions of family planning centres in this part of Switzerland and will discuss the role of the family planning counsellor, its development, function, aims and the training required.

Centres for family planning services

Family planning in Switzerland comes under public welfare and is part of preventive and social medicine. Centres for family planning offer information and advice to anyone on the means of regulating fertility and on sexual and emotional relationships. They respect everyone's freedom of choice. Anyone can contact or call the family planning service, irrespective of sex, age, marital status, religion or nationality. Some centres offer information and advice only. These "information centres" employ only counsellors. Other centres provide contraceptives and are called "dispensing centres", with gynaecologists on their staff to prescribe or provide the appropriate contraceptive method. Other centres form part of a hospital.

The following table shows, for each canton of French-speaking Switzerland, the number of inhabitants, the number of active counsellors and the total number of interviews - with individuals or couples - that they conducted in 1985. The number of interviews does not take into account group activities led by a family planning counsellor, nor visits to the gynaecologists in the family planning centres. The number of inhabitants per counsellor is also shown.
Family planning counsellors

At present 35 counsellors work part-time in the family planning centres of French-speaking Switzerland. All the counsellors have had previous training, in the paramedical field (midwife, nurse), in the social field (social worker) or in the psychological field (psychologist, sexologist). Their ages vary between 30 and 55 years. To date, one man only has been trained as a counsellor and is employed in a family planning centre.

How are counsellors trained?

Training to become a family planning counsellor, involves attending a course one day a week for two years, without counting the time spent on written work, study and reading. This training schedule is similar throughout French-speaking Switzerland and Tessin.

The first year consists of a basic course, which is attended not only by potential family planning counsellors but by future teachers of sex education and marriage counsellors as well. The basic course has two components:

- theoretical courses in the fields of medicine, psychology, sexology, sociology and law;
- group work aimed at exchanging views and reevaluating personal norms and values.

The second year involves field work. The trainee learns to conduct interviews with individuals and couples and to lead group discussions. Two examinations are set at the end of the training period.

Tasks and activities

When the first family planning centres were set up, giving information on contraceptive methods was the main task of the counsellor. She was there to assist the doctor. Gradually, two facts emerged. First, it was observed that information is not enough to overcome resistance to the use of contraceptive methods or to prevent contraceptive failure. In addition, contraceptive practice affects the individual through his body, his sex life and his family life. Contraception cannot therefore be dealt with in isolation. At the same time, the demands of clients were changing. A large number sought the counsellor’s advice on personal or relational problems, either overtly or by using the excuse of a consultation for birth control.

Consequently, family planning counsellors’ tasks in individual and couple counselling as well as in group work have widened. They currently involve three levels of activity:

- Information and education on contraception, sterilization, the anatomy and physiology of reproduction, and problems related to sex life.

* The centre for family planning in Fribourg opened in 1986.
Information is not limited to passing on facts but is tailored to each client and to her/his personal experience. It takes into account the sociocultural environment of the client as well as the level of psycho-sexual development.

- **Listening - counselling - providing assistance.** By listening, the counsellor has an opportunity to clarify the needs of the client, bring out implicit queries, and deal more effectively with the problem (for example, sexual problems, couple conflict, conflict between teenagers and parents). Thus, the counselling session becomes a rare opportunity to explore certain aspects of the individual and sexual life of the client, and make her/him aware of them. Counselling sessions sometimes may bring out buried problems and conflicts.

- **Referrals to specialists.** When clients have problems that are beyond the skill of the counsellor, she refers them to an appropriate specialist: doctor, psychiatrist, marriage counsellor, sexologist, social worker. To avoid unnecessary and frustrating steps for the client, the counsellor's skill in appraising the problem and selecting a specialist is quite important.

In addition, the counsellor promotes family planning in the community and is a focal point for spreading knowledge about family planning, its uses and aims, particularly in the face of public indifference. The counsellor also gives family planning training to medical and paramedical personnel and to social workers, as well as to community leaders (teachers, politicians, religious leaders, union leaders). Their role is constantly changing and is adapting to the growing complexity of demand. In this way, counsellors contribute to the health and welfare of the population.

[From: Mrs N. Belhadjali, Association suisse des conseillères en planning familial, 43 rue de Bourg, CH-1003 Lausanne, Switzerland]

"**CONSULTORIO TEENAGER**: AN ITALIAN EXPERIENCE OF A CONTRACEPTIVE SERVICE FOR YOUNG PEOPLE"

Teenage sexuality is still controversial for Italian adults and, by and large, they prefer to ignore it. Unfortunately, few data exist about the sexual activity of teenagers.

In 1983, the Unione Italiana Centri Educazione Matrimoniale Prematrimoniale (UICEMP, a voluntary nongovernmental organization in family planning with 12 branches providing contraceptive and post-coital services, referral for sterilization, pregnancy testing and counselling) conducted a survey among teenagers that showed that 80% of young girls were sexually active before the age of 18; 1.5% were sexually active at 13, 10% at 14, 17% at 15, 28% at 16, 23.5% at 17.\(^a\) The same survey found that 74% used no effective method of birth control and that 45% of young girls wait at least 18 months to go to a family planning clinic after their first sexual contact, while only 10% use a family planning service before they are sexually active.

In Italy, teenagers account for 2.6% of all abortions, and this proportion is smaller than in other countries.\(^b\) The official figures, however, tend to underestimate the real situation and do not account for back-street abortions, which are still widespread throughout the country.

Professionals dealing with family planning and sexual problems in the 1200 state family planning clinics throughout the country have not encouraged teenagers to use the clinics.

\(^a\) One year experience of the adolescent project of UICEMP. Bollettino UICEMP, January 1985, pp 13-16.

A study made by a group of doctors in 1979 showed that only 3% of clients at the state family planning clinics in Milan were under 20. On the preventive side, sex education courses are given in few schools and are almost absent in upper secondary schools when pupils most need information and advice.

In view of these facts, UICEMP established a pilot project to provide family planning services called "Consultorio Teenager" for young people, to demonstrate that the need is great but can be met.

The project started in March 1983 in five UICEMP clinics located in large towns: Milan, Turin, Genoa, Rome and Palermo. For one afternoon a week the clinics are open to people under 20 years of age. They can come for family planning advice and prescriptions, pregnancy testing, post-coital contraception, abortion referral, sexual information, and counselling about their sexual lives and relationships. Other problems, such as those with drugs or mental health, are referred to other specialized services.

Features of the service that help youngsters overcome their fears and use the family planning services include:

- giving more attention to a counselling than to a directive medical approach;
- a woman gynaecologist on the staff of each clinic;
- staff and volunteers with high motivation and a positive attitude towards adolescent problems;
- a flexible appointment system, so that young people without appointments are also seen;
- guaranteed emergency services such as pregnancy testing and post-coital contraception; and
- the option of counselling by telephone only.

Counselling is usually given on an individual basis. But young people rarely come alone to our clinics; they are accompanied by a friend, or a small group of friends, so that the questions and problems of the client are mixed with those of the friends. This means that the counsellor must be able to manage group counselling without forgetting the initial client.

Because of fears of an internal examination among girls, women gynaecologists were chosen for the staff. The examination is never imposed until the girl feels ready to have it. Contraceptives are also given without an internal examination. When an examination is performed, it is done in such a way as to help the girl both to know her body and to overcome fears and taboos about it.

Each clinic has a receptionist or another member of the staff acting in this capacity. One or two social workers are involved in the counselling session that is proposed to all youngsters when they contact the clinic for the first time and later if requested by them or deemed necessary by the gynaecologist. One member of the team gives telephone counselling to youngsters who live far from the clinics or who are too frightened or shy to come to one.

Staff are recruited for their motivation and skills in dealing with adolescents' problems. It is essential that counselling be given in a friendly, relaxed and non-judgemental atmosphere, although this does not mean that counselling is given in a non-professional way.

The rooms at the UICEMP centres used for the service have been re-arranged and have a more congenial ambiance. All young persons coming to the centres receive a small card illustrating the service and its location.

In the first months of the project, most adolescents came to the clinics because they had read about the service in young people's magazines. Three years later, most youngsters new to the service have learned about it by word of mouth.

Contrary to expectation, the service has been popular from the beginning. From March 1983 to June 1984, the numbers of visits to the five UICEMP centres were:

- 944 in Milan
- 796 in Turin
- 596 in Genoa
- 417 in Rome
- 126 in Palermo

The clinics have actually been somewhat overcrowded. In Milan and Rome two clinic sessions a week were held instead of one.

At present the clinics remain popular and the urgency of organizing something especially for young people is now more widespread among staff working in family planning clinics. Some regional and municipal authorities are organizing conferences and training courses for their staff with the help of UICEMP. In Milan and Rome, the state family planning clinics are beginning to organize services for teenagers as part of the family planning service.

Despite the success of the "Consultorio Teenager" project, some problems remain.

First, boys are a minority among our young clients; their attendance at clinics should be promoted.

Second, more educational activities for teenagers should be organized. One or more counselling sessions are not sufficient to help young people to develop a sexual identity, to clarify the meaning of boy-girl relationships and to acquire correct information on sexual matters.

Third, parents should be encouraged to accept their children's sexuality and should communicate with them about sex. A large majority of our teenage clients come to the clinic while keeping their parents ignorant about their sexual life.

Finally, teachers should acknowledge the sexuality of their students so they become at least a referral point for teenage needs in this sensitive area.

We hope that in a short time the "Consultorio Teenager" will be just one, although certainly the oldest and maybe the most experienced, of many services offered to the young in Italy.

[Antonietta Corradini, National Secretary, UICEMP, Via E. Chiesa 1, 20122 Milan, Italy]

FAMILY PLANNING INVOLVES DEALING WITH WOMEN'S ISSUES

From its beginning in 1966, the Mouvement luxembourgeois pour le planning familial et l'éducation sexuelle has been involved with several women's issues.

In the first instance women had to be freed from undesired pregnancies through contraception. Then we were active in the fight to legalize abortion, which resulted in an abortion law passed in November 1978 by the Liberal-Socialist majority. The law permits abortions to be carried out in the first 12 weeks of pregnancy for medical, eugenic or ethical reasons. At the same time, family planning centres were granted official status and the Family Planning Association passed a convention with the government to provide information, education, prevention and counselling services in case of unwanted pregnancy.
We offer couples or women who come to see us the widest possible choice of contraceptive methods. We are convinced that personal choice ensures the proper use of any method of contraception. By no means do we try to impose a specific type of contraceptive method, even though some methods may seem more effective than others. The client should make his or her own choice of contraceptive method: the pill, the temperature method, an IUD, spermicides, the cervical cap or sponge, condoms or sterilization. The last remains illegal in our country, but many physicians propose it for women as well as men.

Our main goal as a family planning association is to inform the public, to respect individual choices and to help all women avoid unwanted pregnancies, for which we feel there is no ideal solution.

The Family Planning Association participates each year in Women's Day and with women's organizations in the country we have protested against procuring, which is prohibited but widespread in the country, against pornography and against the sexual exploitation of women and children.

As a family planning association, we maintain close links with homes for battered women and with services for women in distress. Prostitutes regularly come to us for diagnosis and treatment of sexually transmitted diseases. The police refer prostitutes who have been abused to our services, so we can establish proof for the judge when a prostitute decides to sue her pimp. We then try to find shelter for her till she can safely go home or be repatriated without having to fear reprisals from the underworld. Collaboration on this matter with services from other countries, however, remains difficult.

We inform the public on questions about sex and love and about problems of women and of youth. We openly denounce the stereotypes of women and men that we find in our society, according to which women should be passive and easy to influence and to exploit, whereas men are supposed to be aggressive and lacking in feelings and sensitivity.

Fighting for women does not imply waging war against men. We fight for a better understanding between the sexes, for respect for their differences, and we are very much opposed to preconceived ideas, particularly exaggerated notions of sexual prowess. To us a movement to liberate women should also aim at liberating men from the roles that society traditionally imposes on them. This is not a simple matter for men or women.

[From: Dr M.P. Molitor-Peffer, President of the Mouvement luxembourgeois pour le planning familial et l'éducation sexuelle, 18-20 Rue Glesener, L-1630 Luxembourg]

**INTERCOUNTRY NEWS**

**ENTRE NOUS NOW IN PORTUGUESE**

In addition to the English/French and Spanish versions, ENTRE NOUS is now translated and printed in Portuguese, beginning with issue No. 6. Like the other language versions, ENTRE NOUS in Portuguese will appear twice a year.

Congratulations to the Directorate-General for Primary Health Care of the Ministry of Health of Portugal for this fine job of promoting family health and family planning. ENTRE NOUS in Portuguese is not only being distributed in Portugal, but is also being sent to other Portuguese-speaking countries of the world.

[Inquiries to Dr Maria da Purificação Araújo, national focal point for ENTRE NOUS, Directorate-General for Primary Health Care, Ministry of Health, Alameda Afonso Henriques 45, 1056 Lisbon Codex, Portugal or Ms Wadad Haddad, Regional Officer for Sexuality and Family Planning, WHO Regional Office for Europe, Scherfigsvej 8, 2100 Copenhagen Ø, Denmark]
CONTAINMENT OF AIDS IN EUROPE: SHOULD FAMILY PLANNING WORKERS BE INVOLVED?

By 30 June 1986, 3041 cases of AIDS had been reported to the WHO Collaborating Centre on AIDS, Paris. The high case death rate and the increase in the number of reported cases make AIDS an important disease for public health in Europe. In 1985 the WHO Regional Director for Europe constituted a task force in the Regional Office for Europe (EURO) with the Communicable Diseases unit as focal point, to help Member States monitor events, formulate policies and take appropriate measures.

No specific and effective means for the primary or secondary prevention of AIDS are yet available and current measures are essentially based on health education efforts aimed at encouraging healthy lifestyles, personal hygiene and safe sexual practices. Such efforts require a large number of trained health personnel who can provide condoms, are informed about safe sex, and have the approaches and skills to talk about sex effectively.

This is the view expressed by Ms Waddad Haddad, Regional Officer for Sexuality and Family Planning in a background paper for a WHO/EURO meeting on the containment of AIDS held in Graz, Austria, 7-9 April 1986.

According to Ms Haddad, the role of family planning in AIDS containment is:

- to facilitate the extension of family planning services to offer supplies, education, information and counselling to people at risk of AIDS;

- to promote the training in sexuality of all health professionals working with AIDS or potential AIDS victims; and

- to promote the training of counsellors working with people at risk of developing AIDS.

An important source of information on sex and AIDS is personnel working in family planning services.

This implies that the concept of family planning as a service providing contraceptive supplies is widened to mean a service that also offers advice, information and counselling on fertility, sexuality and relationships. This change has indeed taken place over the years. Family planning personnel should also accept homosexuals as well as heterosexuals among potential clients if they want to take their place in the fight against AIDS and they should give safe sex in terms of sexually transmitted diseases (including AIDS) as high a priority as safe sex in terms of contraception.

Greater priority to sexual behaviour and sexually transmitted disease would have far-reaching beneficial effects. For example, health workers could encourage the young to use condoms and spermicides, instead of routinely recommending the pill. The condom reduces the risk of cervical cancer, as well as infections with sexually transmitted diseases. It also presents an alternative to enjoy safe sex.

[Source: Le BICMIQ, No. 2, 1986 Hôpital Saint-Luc, Centre hospitalier affilié à l'Université de Montreal, Canada]

Family planning services should also train people working with AIDS patients in sexuality. In fact, anyone involved in working directly with AIDS patients or potential patients needs to have had training in sexuality, as the discussion of sexual relations is an essential part of the prevention and counselling of AIDS patients, their friends and groups at risk.
Training in sexuality differs from most other forms of training proposed for health personnel. The exploration of attitudes and feelings and the acquisition of counselling and communication skills are as important as the acquisition of knowledge. Health workers also need to be aware of their own attitudes and how these affect their response to patients. They need to be able to convey acceptance of their clients’ lifestyles and preferred sexual practices and suggest ways in which to make these practices safer.

For example, instead of just advising a client to avoid penetration and ejaculation within the body, the adviser should be able to say: “Yes you can enjoy masturbation or ejaculation anywhere on the body you like”. Advisers must be able, when asked, to discuss practices such as oral/anal contact in a positive way, by explaining why they may not be safe.

Safe sex also entails the restriction of the number of sexual partners. Such a restriction is much more likely to be acceptable if it is done freely, as a matter of practical safety, rather than in an atmosphere of moral judgement. Judgements on “promiscuity” or “casual sex” have no place in the fight against AIDS.

Finally, family planning has a part in an AIDS containment strategy through training counsellors, professionals and lay volunteers to deal with people who are serologically positive and with their families. For them, advice on healthy lifestyles and on how to avoid transmitting the AIDS virus is not enough and not the main issue. Such people are likely to feel they are sitting on a timebomb and workers will need all their counselling skills to help them cope with their anger, fear, and dilemmas.

[From: Ms Wadad Haddad, Regional Officer for Sexuality and Family Planning and Ms Mary Porter, family planning consultant, WHO Regional Office for Europe, Scherfigavej 8, 2100 Copenhagen Ø, Denmark]

SEXUAL COUNSELLING FOR DISABLED PEOPLE: A PERSONAL VIEW (PART 2)\(^a\)

We can do much for disabled children early in childhood. Congenitally disabled children experience confusing body signals. Parents and staff do not want to hurt them and are tolerant about their behaviour. Parents and staff should, however, support the self-confidence of children from the start and give them the confidence to interpret these signals. Parents can build up their self-esteem by letting them know deep inside that someone loves them just as they are.

Disabled people may raise questions such as: Can I have intercourse? What positions can we use? How can we prolong the intercourse? What other activities can we choose? Can you help me to buy a vibrator? What can I do to release the tension? How can I please my partner? Can I have children?

How should these questions be answered?

In my experience with various groups I’ve seen that most people are willing to talk for hours if they are not forced into an unfamiliar way of thinking but can discuss their feelings about different ways of being sexually active.

For example, we have discussed positions in intercourse that can be favourable in certain conditions; for example, reflex erection can be sustained if the partner of a man with a spinal cord injury is sufficiently active. We have discussed where to go to check on the possibility of having children. We have discovered that there are no technical aids developed for the disabled to better enjoy sex but that handles originally made for cups and pens on ordinary vibrators can be used for this purpose and that people can train their erogenous zones and discuss the effect with their partners. We have also discussed personal vulnerability in intimate relations; sometimes it is useful just to sit down and make up one’s mind about what one really feels about different areas of sexuality.

We have discussed findings from a Swedish study on how people with different disabilities handle sex and life with a partner. The study found that such factors as the severity of the disability, the age at which one becomes disabled, or the age at which one first has sexual intercourse do not create problems in sexual life. Instead, one's self-image as a human being and ways of communicating with a partner to find new ways to reach mutual satisfaction determine one's opinion of one's sex life. For example, a married man of 60 with multiple sclerosis who has not had an erection for 10 years, can consider his sex life satisfactory because he still has close physical contact and the urge to satisfy his wife's needs. Thus the physical facts of disability do not determine the experience of the condition!

In my view a person caring for disabled people should:

- have good or general knowledge about sexuality;
- give disabled people the opportunity to lead a sexual life;
- accept other kinds of sexual activity than intercourse, seek knowledge about them and not impose personal sexual hang-ups on disabled people;
- discover personal shortcomings in communicating with people;
- exercise imagination to understand a disabled person's situation; and
- fight for disabled people's right to be regarded as whole human beings.[

[From: Ms Inger Nordqvist, Coordinator and project Leader in Sexuality and Disability, Handikappinstitutet, Department of Information and Education, Box 303, S-161 26 Brome, Sweden]

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**Meetings Reviewed**

**PROSTITUTION: NOTES ON A MEETING**

An International meeting of experts on the social causes of prostitution and strategies against procuring and sexual exploitation of women took place in Madrid, Spain on 18-21 March 1986. It was organized by the Department of Human Rights and of Peace of UNESCO, Paris, and supported by the Spanish Government's Instituto de la Mujer. It was chaired by Miss W. Tamzali from UNESCO.

The participants, from many parts of the world and with a varied background of disciplines and experience, concluded that prostitution is yet another form of sex discrimination, constitutes sexual violence and is a grave violation of human dignity. It should moreover be noted that research carried out in the United States has shown that a high percentage (60-85%) of women involved in prostitution have been victims of incest, assault or rape. This has been found to be the first step in the breakdown of a woman's identity, which is necessary to turn the human body into a sexual commodity for economic exchange. Prostitution, in close connection with the pornography industry, is becoming more erotic and sophisticated, in order to attract more clients. Thus, in Europe, it is no longer a case of "white slavery" but rather of "black or oriental slavery". Women, very often practically children, are literally imported from Africa or from Eastern countries, and are shut up in the brothels of Europe where, in a situation of total slavery and under the complacent look of the police authorities, they become "vaginas in which men masturbate themselves".

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*Report from Mrs Ana Vicente, observer of the meeting, Comissão da Condição Feminina, Av. da Republica, 32-2, 1093 Lisbon Codex, Portugal.*
The participants also rejected the idea that freedom of speech validates pornography, that the need for leisure from work validates sex tourism, that the need for rest and relaxation for man validates prostitution by soldiers, or that the need for a passive wife validates the traffic in women through international marriage agencies. These sex industries have produced a massive, multibillion dollar, transnational and national traffic in women, which is promoted by organized criminal gangs of procurers, marriage agencies, sex tour agencies, organizers of massage parlours and brothels, and producers and distributors of pornography. This means that laws or interventions made locally or nationally must also be imposed internationally. It also means that laws should not penalize the prostitute but rather the clients, the pimps and the procurers.

[The report of the meeting can be obtained by writing to Miss W. Tamzali, Department of Human Rights and of Peace, UNESCO, 7 Place de Fontenoy, 75007 Paris, France]

**Educational Aids**

A "GOOD SENSE DEFENCE" CAMPAIGN FOR PREVENTION OF SEXUAL ASSAULT ON CHILDREN

In 1986, KIDSCAPE launched a campaign in the United Kingdom to teach children between 5 and 11 years old "good sense defence" practices against sexual assault. With Thames Television, a free pack of information material for parents and guardians has been provided and can be obtained free of charge from KIDSCAPE.

The material contains a booklet, a poster and a leaflet. The booklet is to be read by parents or guardians. Then they can go on to read with the child the "keep safe" code on one side of the poster. The other side of the poster is for the child to fill in on its own. When the child has finished, it is best for parents or guardians to go through the poster with the child and chat with them about some of the ideas they have put down. The idea of the code is to give parents a way to broach the subject with the child of keeping safe from sexual assault. Finally, the leaflet contains facts about the sexual abuse of children, and information about books and teaching materials and where they can be obtained.

The campaign is based on the belief that parents and guardians can help their children by teaching them how to recognize dangerous situations and inappropriate touching, to say no and get away, and to refuse to keep bad secrets. Children who know what to do are not only less at risk because they are informed, but they are also more confident.

[From: KIDSCAPE, 82 Brook Street, London W1Y 1YG, United Kingdom]
HAYING A BABY IN EUROPE

The WHO Perinatal Study Group was set up in 1979 to study and report on the issues surrounding birth and birth care in Europe. This is their final report. It describes and reviews official and alternative services and information and evaluation systems. A key finding of the study is the variation in the rates for many procedures from country to country, without any resultant variation in mortality or morbidity rates. It shows that the use of many of them could be usefully reviewed.

This report is intended to be read by those who actually use the birth services, and not just by those involved professionally in providing them. It has therefore been written as far as possible in a simple style, without jargon.

[Having a baby in Europe. Copenhagen, WHO Regional Office for Europe, 1985 (Public Health in Europe No. 26), 157 pages, Sw. fr. 13.-]

TWO REPORTS FROM THE UNIT OF SEXUALITY AND FAMILY PLANNING

- Improving Family Planning Services for Migrant Populations

From 11 to 14 December 1984 a WHO/ICC Working Group met in Paris to discuss the above subject. A summary of the meeting appeared in ENTRE NOUS, No. 6 1985. The complete 218-page report, issued by the International Children's Centre is now available and may be obtained free of charge from the Unit. In French only.

[L'amélioration des services de planification familiale pour la population migrante, Paris, 1986]

- Sexuality and family planning

Following a Consultation on Sexuality held in November 1983, the Unit of Sexuality and Family Planning has now published a 62-page report on the meeting, updated with recent research findings on the subject. A review of the main findings of the meeting was reported in ENTRE NOUS, No. 5, 1984. The publication is available in English only, with a summary in French, German and Russian.