

THE TEACHING  
OF HUMAN SEXUALITY  
IN SCHOOLS  
FOR HEALTH PROFESSIONALS

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## PREFACE

*Of all forms of health education, the provision of advice and instruction in matters relating to sexual behaviour demands the greatest tact, integrity, tolerance and understanding of human behaviour and personal relationships. Members of the health professions, although frequently asked for help by people with difficulties in their sex lives, are often ill-equipped with the knowledge and skills needed for counselling in human sexuality, sexual behaviour, family planning, etc., and may be reticent about giving such advice or unwilling to do so.*

*An important function of medical schools, nursing schools and schools of public health is therefore to provide instruction that will help students, when they enter practice, to counsel patients who come to them with sexual problems. It is hoped that this short review of the subject will not only be useful to schools wishing to introduce such subject matter into the curriculum, but will also enable those institutions already providing courses in human sexuality to evaluate what they are accomplishing and improve the quality of their training programmes.*

*The book is based on contributions by a number of specialists from different parts of the world, one of the aims being to identify ways in which sociocultural and psychosexual differences with regard to sexual behaviour and human sexuality interact with health and modify medical and nursing roles and functions in the provision of health care. Besides setting out the knowledge, skills and attitudes that are needed for successful counselling and teaching, the book also makes suggestions for curriculum planning and examines a few programmes in different countries.*

*The contributors met in Geneva in September 1972 for an interchange of views and in assembling and editing the contributions account was also taken of these discussions. Thus, the book represents the consensus of an international group of experts.*



## CHAPTER 1

### DEFINITIONS AND SCOPE OF INQUIRY

For the purposes of this book, the term 'human sexuality' refers to the whole range of behaviour associated with the psychobiological phenomena of sex. Sex and reproduction and the powerful drives which sustain them have moulded the culture of all human societies and the lives of individuals. The pervasive influence can be found in the religious, artistic, social, and economic expressions of man, and has resulted in a great variety of legal and moral rules designed to accommodate the instinctual drives to the requirements of society.

These 'requirements of society' are different for each human group, and what was accepted in one place and one time may be totally irrelevant to another place and another time. Social and technological changes which have been taking place with increasing speed during the last hundred years, such as the emancipation of women, the decline of the importance of inherited wealth, the technology of birth control, and the general increase in education about sexual matters, have eroded the foundations on which sexual behaviour was based and presented most societies with a situation in which the material facts are in conflict with social custom and philosophy.

The emergence of sex education in its various forms is a social recognition of the problems that rapid change is creating. Since the social situation and the assumptions about sexual behaviour vary from one country to another and even among subgroups within a community, the educational process cannot follow any prescribed course but must be flexible and adapt itself within a wide framework of the known facts.

The purpose of sex education is to assist people to conduct their sexual lives successfully. It may be individual or collective and cover the

prevention or treatment of sexual difficulties. All doctors and nurses will encounter people seeking information, advice, or therapy about sexual problems and should be in a position to diagnose and treat not only the physical condition but also educational deficiencies in their patients. They will also be consulted on educational programmes for schools and the community at large.

The concept of sexual health includes three basic elements:

- (1) a capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic,
- (2) freedom from fear, shame, guilt, false beliefs, and other psychological factors inhibiting sexual response and impairing sexual relationship,
- (3) freedom from organic disorders, diseases, and deficiencies that interfere with sexual and reproductive functions.

A good educational programme will include all three elements, emphasizing what is required in a given situation. It will take account of specific problems encountered within each area. Building a programme should be preceded by the careful identification of educational needs, which can differ widely from one society to another. In cultures, for instance, where traditional controls on sexual and reproductive behaviour are losing their effectiveness but have not been fully replaced by new attitudes and behaviour, the conflict between sexual drives and social demands may be the central theme of sex education. This cannot receive proper emphasis if curricula are borrowed from contexts where the focus is on the individual and the primary mode of assistance is clinical.

Sexual questions are always partly social questions, and in a period of rapid social change sex education becomes an important preoccupation of social learning. It goes beyond the doctor-patient relationship and becomes a component of family and community health, including school health, relating itself to such issues as family and marital relations, the improvement of maternal and child care, family life education for school-age children and youths, the treatment of sexually transmitted diseases, the promotion of mental health, and even the desegregation of the sexes in education, employment, and social life. What a sex educator teaches in such contexts must flow from the nature of the adjustments that individuals and groups are prepared to make.

The content of a programme must be based also on identification of the roles that health practitioners of various categories are expected to play in sex education. Wide differences may exist between various communities and societies in what is seen as problematic. Fact-finding about the kind of assistance expected, and the sources from which it is to come, is particularly important for curriculum planning.

## A DILEMMA FOR HEALTH PRACTITIONERS

In relation to human sexuality as a health entity, the role of medicine has been far from clear. To a large extent the health professions have avoided involvement by the simple expedient of providing no sex education at the professional level in medical and nursing schools. Consequently, the physician and the nurse often lack essential knowledge and, naturally enough, prefer not to become involved in a branch of medicine in which they find themselves personally embarrassed and professionally incompetent.

Patients do not accept this attitude, however. More and more aware of the sexual nature of their problems, they turn with reason and confidence to their health practitioners, but often encounter a reluctance to tackle the problem or are given a superficial reply.

The cumulative effect of these opposing forces has been to precipitate a crisis of confidence. The public is beginning to suspect that health professionals in general have neither the skill, the time, nor the inclination to deal with sexual problems; and the practice of going to them for sexual information or treatment is being questioned. In some places, physicians are themselves automatically referring patients with sexual problems to nonmedical sex counsellors.

This trend is unfortunate. Human sexuality is a proper concern of health practitioners, and the treatment of sex problems is an integral part of preventive and therapeutic health care. This is well illustrated by the way in which those physicians who have developed family planning programmes in recent years have invariably become involved in questions related to human sexuality.

Another aspect of the problem relates to cultural change. Even where programmes have been developed to deal with sexuality, they have not always been designed with a full and clear understanding of the cultural concepts and attitudes surrounding the subject.

## NEW ROLES FOR HEALTH PRACTITIONERS

Sex education for the preservation of both physical and mental health, the social implications of sexual conduct, and the understanding of sexuality for responsible parenthood call for new roles for the health practitioner. These fall into three major categories—educational, therapeutic, and community.

### EDUCATIONAL ROLES

Health practitioners have an essential role to play in the following areas.

#### *Sex education as preventive medicine*

Health practitioners are today being requested to contribute to sex education in terms of the individual education of patients, aiding parents in the understanding of their roles, helping teachers in their work with children, and helping children and adolescents to understand their developing sexuality. It has become increasingly difficult to measure up to these responsibilities because of changing sex attitudes and the vast amount of new knowledge that is being accumulated in this field as a result of recent research.

#### *Marriage preparation*

Enlightened young people today are recognizing the wisdom of going to a physician before marriage to seek help about such matters as sex adjustment and contraception.

### *Community enlightenment*

Society tends to look to its health practitioners to guide it in dealing with the many sex-related problems that arise in community life. Perceptive health practitioners can see in this a great opportunity to stress the preventive value of sex education, but it demands from them a good understanding of the cultures and subcultures in which they practise and considerable competence in educational planning and practice.

#### THERAPEUTIC ROLES

Health practitioners are increasingly being confronted by individuals and families with problems such as unwanted pregnancy, premarital and extramarital sex relationships, infertility, sexually transmitted diseases, marital disharmony, and so-called abnormal sexual behaviour.

The training of health practitioners enables them to some extent to deal with the clinical aspects of these problems, but they are often unable to go beyond these limits, either from lack of knowledge or because of a reluctance to discuss such matters and their own ambivalent attitudes to sexuality.

#### COMMUNITY ROLES

If human sexuality is recognized as a health component, services to people with sex-related problems should become an integral part of the total programme of community health care. However, there is evidence that popular literature, widely read by ill-informed people, can produce anxiety and distress and can lead to demands for unrealistic levels of sexual performance. This calls for an attempt to bring about responsible attitudes in the use of the mass media for public sex education.

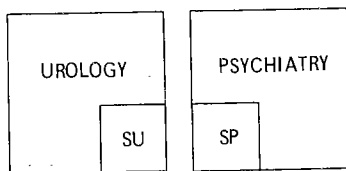
It is also desirable to alert community leaders to the fact that some forms of behaviour now labelled 'sexual misdemeanours' are rooted in emotional disturbance and yield more readily to psychotherapy than to punitive measures.

#### SEXOLOGY AS A MEDICAL SPECIALTY

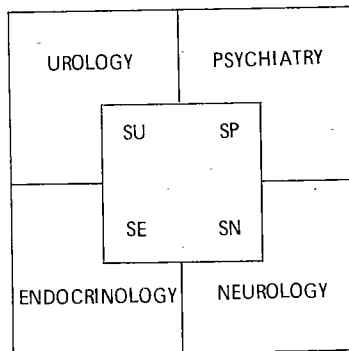
The possibility that endorsing sexology as a medical specialty might bring this whole new field of training for health practitioners into better perspective has been examined.

The treatment of sexual pathology has been shared by a number of medical specialties—urology, psychiatry, endocrinology, neurology, gynaecology, etc. As new knowledge about sexual functioning has

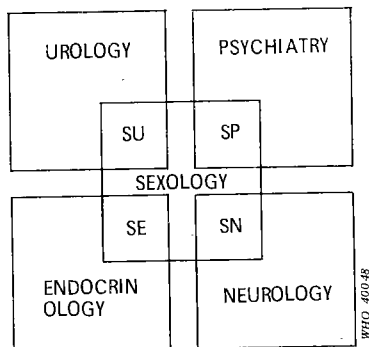
### THREE CONCEPTS IN SEXOLOGY<sup>1</sup>



1. Sexology as aspects of other specialties (uncoordinated)



2. Sexology as aspects of other specialties (coordinated)



3. Sexology as independent specialty incorporating sexual aspects of other specialties

<sup>1</sup> SU, SP, SE, SN: sexual aspects of urology, psychiatry, endocrinology, and neurology. These four medical specialties are only illustrative; other specialties, such as dermatovenereology and obstetrics/gynaecology, would be equally relevant.

accumulated, this fragmented approach has proved to be more and more inadequate. The developing science of sexology has come to include a much larger body of knowledge than could be contained within what were merely limited aspects of the older specialties. In time, professionally trained sexologists have emerged, and the scope of their knowledge and skills has proved to be far greater than that formerly contained within the framework of existing specialties. Only the sexologist can fully understand, and effectively treat, the entire pathology of sexual disorders.

An investigation of this situation led, in some countries, to the establishment of sexology as a special branch of medicine and to the setting up of a network of sexological services, the ultimate object being to exclude the non-sexologist from dealing with sexually disturbed patients.

The training of medical sexologists, developed first in the Prague Institute of Sexology (founded in 1921), has now led to the establishment of an autonomous and independent specialty with its own methods of investigation, enabling all relevant symptoms to be studied and coordinated into a final diagnosis and an appropriate treatment plan. Those aspects of sexology, which had formerly been fragmented by their inclusion as limited aspects of several other specialties, are now incorporated into the specialty of sexology. This gives the sexologist complete competence in his own field.

The accompanying diagrams illustrate three concepts of medical sexology. In the first, it is almost entirely fragmented, being regarded as aspects of several specialties, with little or no coordination of the separate investigations. In the second, concept coordination is attempted, but the field is seen as being no greater than the sum of those aspects of sexuality treated by the specialties concerned. The third diagram shows these aspects in their true perspective as limited portions of a much greater field, whose main area is not covered by any other branch of medical knowledge.

Some people believe that making sexology a specialty might hinder the giving of this training to all health practitioners, especially to auxiliary health personnel. There seems to be no reason, however, why this should necessarily be the case.

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## CHAPTER 4

# TRAINING NEEDS OF HEALTH PRACTITIONERS

### PERSONAL QUALITIES

Attempts have been made to enumerate any special qualities, such as sensibility, understanding, empathy, and tolerance, that training should seek to develop, but those that have been listed differ only slightly from the qualities that should be cultivated during the training of any doctor, nurse, or educator. In dealing with sexual matters many personality qualities are put to the test, and students who finally cannot tolerate the situation should reconsider their suitability for the task.

In some cultures students will have to overcome their embarrassment before they can become competent in dealing with sexual problems. All practitioners must learn to accept their own sexuality, to be aware of biases, and to accept the patient with understanding and tolerance.

*The physician* should cultivate an ability to establish rapport with the patient, frankness in taking a sex history, and tact in making a diagnosis. He must also be able to guide and supervise other professional colleagues.

*The nurse/midwife* should set her goals in terms of supportive relationships with patients who have sexual problems; helping patients in such matters as feminine hygiene, pregnancy, labour, and family planning; helping parents to deal constructively with the sexual manifestations and questions of their children; and assisting teachers with sex education in schools.

*Social workers* are primarily concerned with people's total life situation, and as counsellors will be confronted by problems that have an important sexual content or sexual overtones, which may seem to them shocking. It will be necessary for them to develop ease in conversation with men and women both singly and together on sexual matters, and to know to whom to refer when in difficulty.

*The health education specialist* deals with the general public and performs an organizational function, which should be shared by *all* members of the professional team. In this work he may encounter hostility and rejection, which he must be emotionally prepared for and which he must be able to cope with. In particular, ability is needed to work with parents in the home, teachers in the school, and community leaders. In areas where the services of a health education specialist are available, such a person could assist in reinforcing or strengthening (or both) the educational components of the services of other members of the professional team and help to plan an organized and sustained educational programme that could be extended to the home, the school, and the community.

In addition to fulfilling their respective roles, health practitioners and auxiliary workers should have a common understanding, and when necessary they should cooperate closely as a team.

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## CHAPTER 5

# SUGGESTIONS ON THE EDUCATIONAL PROGRAMME AND THE CURRICULUM

In the context of professional education, training should be focused on the needs of the student in terms of attitudes, skills, and knowledge. In each of these interdependent areas the syllabus should state clearly the aims of, and justification for, the study, and what new abilities the student is expected to acquire by following the course. Although these educational objectives will vary with the kind of student and the cultural setting in which the students will be working, many elements common to all situations will emerge. The important thing is that in the development of the course the objectives should be clearly stated in behavioural terms.

As an example, the general aim of the student and his teachers may be defined as the acquisition of attitudes, skills and, knowledge, the application of which will help individuals and social groups to manage their sexual and reproductive lives successfully. This implies the acquisition of diagnostic, therapeutic, and educational skills suitable for individual patients, and epidemiological, managerial, and public relations skills suitable for the organization of educational programmes on a community scale.

### ATTITUDES

All investigators have reached the conclusion that the skill of the health practitioner in communicating with the patient about sexual matters is at least as important as his knowledge of the subject. Experience in the USA shows that the major obstacle to the physician's effectiveness is his own embarrassment and discomfort. Although the

health practitioner may have been exposed to the same general cultural environment as his patient, he often comes from a different social and educational milieu and rarely shares the same inhibitions and methods of expression.

Many students may need help in coming to terms with their own sexuality, and much experimentation has been carried out to discover how this can best be done. Three methods have been found useful. One is to provide the student with an opportunity to have his own sex history taken and its implications discussed in private interviews. Another is through small group discussions with other students, usually with a senior leader, at which cases or social problems are considered. A third method, now under trial in the USA, involves the use of films portraying sexual behaviour with unusual candour. These films show men and women engaged in such sexual activities as masturbation, heterosexual intercourse, and homosexual activities. A number of these films are shown, one after the other, to a group of medical students. Immediately afterwards, the students are involved in group discussion in which they share their emotional reactions to the films. These usually include some degree of sexual arousal, shock, and sometimes embarrassment, disgust, or hostility. By talking over these reactions together, the group soon becomes relaxed and discovers that apprehension and discomfort have vanished. Sometimes the students are given a second opportunity to see the films and to discover how much their anxiety levels have been lowered. This lowering of response has been explained psychologically by John Money in his theory of the rapidly diminishing effects of pornography.

It is assumed that what happens during this process is desensitization followed later by re sensitization. Students in many parts of the world grow up in cultures that evade direct confrontation with sexuality; sex acts are private and secret, and are only referred to by indirect suggestion or by joking. They have no language which suits the subject and no practice in serious communication about it. The result is that they may come to fear the reality of sex because they feel shy and believe it will plunge them into a tumult of uncontrollable emotions. Unless the doctor has overcome this anxiety, he will be ill at ease whenever a patient brings up the subject. This may lead the health practitioner into defensive attitudes, blaming the patient for inadequacies or over emphasizing organ dysfunction and avoiding any reference to feelings.

#### SKILLS

It is obvious that knowledge alone will not equip the health practitioner to handle his work effectively. He will need to learn a number of clinical

skills. Dr Mace, working with a group of medical students over a 5-year period in the USA, has concluded from interviews and group discussions that they wish to learn:

*1. How to recognize a possible sexual difficulty in a patient who has not reported such a problem in specific terms*

They wish to know what signs to look for in an emotionally stressed patient, with or without psychosomatic symptoms.

*2. How to ask appropriate questions in order to explore the sex life of the patient*

The aim is to take a comprehensive sex history when necessary, and to do this without embarrassing or discomfoting either the student or the patient.

*3. How to accept the patient as a person, and to be objective about his sexual behaviour*

It is important to avoid over-reacting either positively, by being unduly aroused or fascinated, or negatively, by feeling disgust or making moral judgements.

*4. How to diagnose a sexual problem with reasonable accuracy*

The student wishes to know exactly what difficulty he has to deal with; Dr Mace's experience, during many years of taking referrals from doctors, has been that the doctor's judgement as to the nature of the sexual difficulty is often inaccurate, sometimes wildly so.

*5. How to offer real help to the patient, even if the problem is a very complex one that has to be referred*

As one of Dr Mace's students put it, 'I don't want to send any patient away having done absolutely nothing to help him'. Most students would hope to be able to treat simple sexual difficulties themselves; and all would want to be able to render effective 'first aid', even if this amounted to no more than showing understanding and offering reassurance.

*6. How to make an effective referral, when necessary, to a reliable source of help*

The students were emphatic in saying that they wanted to understand the kinds of therapy that are available to deal with the various types of sexual problems, and to make a good choice among the specialists dealing with the various aspects of the problem.

These skills can be learned only to a limited extent by reading books and hearing lectures. Observation of, and participation in, clinical experiences must also be made possible. Case discussions are useful,

particularly when they are preceded by actual demonstration interviews with patients. Role-playing experiences, in which the student can participate both as interviewer and as patient in the investigation of simulated sexual difficulties, are valuable in providing a 'safe' and controlled setting for the early stages of learning. The value is enhanced when the interview can be observed by fellow students through a one-way mirror and is also heard and seen by the student by means of sound recording or closed-circuit television. Many variants of these procedures are possible, e.g., the student may use a telephone for advising a patient confronted with a sexual crisis situation, the conversation being listened to, and afterwards discussed, by the whole class.

#### KNOWLEDGE

At one time it was thought that sex education meant individual or mass dissemination of information about the 'facts of life'. Now we recognize that the subject of human sexuality is vast, sensitive, and complex—especially for students whose goal is not merely to learn, but also to prepare to teach others.

The areas of knowledge considered necessary for a basic understanding of the subject are:<sup>1</sup>

- (1) Sexual development—biological and psychological
- (2) The reproductive process
- (3) The variety of sexual expression
- (4) Sexual dysfunction and disease
- (5) Cultural aspects of sex
- (6) Marriage and the family

The breadth of the field is explained by the pervasive influence of sex on human behaviour. The act of coitus is the vortex of powerful drives and its biophysical and psychological implications are vast. They include the physical health of the reproductive system; satisfaction and frustration; pregnancy and the parental responsibilities that follow; cultural controls that decide what is sexually right and wrong, permitted and forbidden; and the responses of the partners, which affect, and are affected by, their individual emotional health.

The sources of knowledge for both laymen and health workers are also diverse. Sex has always been a theme for literature and morality, and

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<sup>1</sup> Two examples of curriculum content are reproduced in Annex 1.

many of the views expressed by poets, playwrights, and theologians are firmly embedded in the public conscience, conditioning individual expectation and response. A considerable popular literature, ranging from school textbooks to pornography, has been circulating more or less freely for many years. A vast scientific literature of very uneven quality has grown up, and more recent interest by behavioural scientists is also helping to enlarge the range of beliefs of which the health worker must be aware.

#### VALUES

Since sex relationships are perhaps the most sensitive of all human relationships, it is not possible to ignore questions of human values as they affect behaviour. Health practitioners cannot be effective if they do not develop an understanding of the moral, aesthetic, and religious sensibilities of the people with whom they will have to deal.

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## CHAPTER 6

# CURRICULUM PLANNING

### WHEN SHOULD EDUCATION IN HUMAN SEXUALITY BE CARRIED OUT?

As far as timing is concerned, teaching programmes in human sexuality require careful phasing. Some degree of repetition of the material is appropriate as the student moves through the years of preparation for his professional responsibilities. Havighurst's concept of the 'teachable moment' is particularly applicable. Evidence suggests that, in the early years of study, the focus of student interest is his own developmental adjustment with reference to sexual behaviour. At a later stage, when he has accepted his own sexuality and established his values, he is ready to concentrate on the assimilation of knowledge, especially of those aspects of sexuality that seem most relevant to his special areas of interest. Later still, when he is involved with patients in clinical practice, his major interest will be in diagnosis and treatment. There is no stage in the training of the health professional at which teaching in this area would not be appropriate. It can begin in the first year, and it can be usefully included in refresher courses for health workers fully engaged in the practice of their profession.

### HOW SHOULD THE EDUCATION BE CONDUCTED?

In the course of experimentation, the value of a team approach, using teachers from various fields, including the behavioural sciences, has been demonstrated on many occasions. However, there are two distinct patterns which employ this approach. One arranges for specific areas of sexual knowledge to be covered by particular departments—*anatomy, physiology, urology, gynaecology, endocrinology, psychology, psychiatry, etc.*—in the context of their general curricula, leaving the student to

integrate this material for himself. This has obvious advantages in that it leaves existing curricula undisturbed; but it also has disadvantages, and has been found inadequate in countries where both approaches have been tested. The representatives of different medical disciplines can provide only separated aspects of sexology, and these may be taught at widely different times. This fragmentation of knowledge was found to lead to confusion and to foster controversy. Consequently, in the countries referred to it has now been abandoned.

The other pattern coordinates the corpus of teaching in human sexuality in one unified course offered at a given time, or, better, in units spaced out over the entire training period. The material is, as already indicated, best provided by a number of teachers representing all the relevant disciplines, but working together as a team. By this means, the material, drawn from many sources, can be presented within the context of a broad philosophy of human sexuality that gives it coherence and gathers the many pieces, as in a jig-saw puzzle, into an intelligible whole.

No dogmatic statements can, however, be made. This is a new field of training for health practitioners, and much experimentation will be needed. The variety of needs indeed demands a degree of flexibility, and, apart from accepting a few basic principles on which general agreement has been reached, curriculum planners would probably be wise to adopt a flexible approach and avoid stereotypes.

#### BY WHOM SHOULD THE EDUCATION BE CONDUCTED?

Teaching should be the responsibility of both men and women. Apart from their experience and knowledge of the subject, teachers will require training in educational methodology. Since much of what is taught is emotionally charged and must be taken on trust by the student, whoever deals with the subject should be a person who inspires confidence in the students and is able to deal with all the types of question which human sexuality provokes.

#### EVALUATION

In view of the relatively new and experimental nature of this teaching, it is particularly important that every programme should have evaluative procedures built into it. Evaluation will be based on the stated objectives of the course and cover attitudinal, behavioural, and cognitive changes. Procedures already employed have included anonymous questionnaires to test students' reactions; objective tests of various kinds to measure attitudinal and behavioural changes; and interviews with participating

students, either individually or in small groups, intended to identify their needs and to determine how far these are being met. On the basis of information gained from these sources, the curriculum will require continuing modification or restructuring.

#### RESOURCE MATERIALS

In all training programmes an adequate library of selected materials should be available to the students. A sample bibliography is provided in Annex 2.

In this field of teaching the use of audiovisual aids is of special importance. Such aids should be selected for their appropriateness to the course and their relevance to the cultural background of the students, and should be properly timed and adequately interpreted to support the broad goals of the programme. Teaching aids should be tested on samples of students before being used generally. Teachers will also appreciate that the comprehension of new visual and auditory materials may require just as much practice as their dextrous use.

Aids in general use consist of models, films, videotapes, film strips, wall charts, sound recordings, and exhibits of various kinds. Evidence suggests that cultural differences in customs, dress, language, and behaviour become so important that materials judged to be entirely suitable in one region or culture may well be totally unacceptable in another. For this reason it seems best to recommend that each cultural group, as it develops training programmes, should evolve its own appropriate teaching aids.

## CHAPTER 7

### WHAT TRAINING IS ALREADY BEING GIVEN?

It is very difficult to collect accurate information on current training programmes. A few studies have been made, but nearly always their object has been to investigate what schools for health practitioners are teaching in the areas of human reproduction and family planning. Although it is hardly possible to teach these subjects without reference to human sexuality, it must be stated very emphatically that a knowledge of reproduction and contraception does not of itself provide the training needed to deal with sexual problems.

#### SELECTED SPECIFIC PROGRAMMES

The four programmes described below are ones in which four of the contributors have participated extensively.

##### *Colombia*<sup>1</sup>

In a group of medical schools in Colombia the first step was to prepare a careful plan, which was then submitted to the medical faculties. Since the plan necessitated changing the curriculum, it proved difficult to get it accepted. A less orthodox approach was then adopted. Interest in the idea of sex education was developed in the university as a whole, and this created a favourable climate. Seminars were then held for medical school teachers, and a basic library of books on human sexuality was provided. Several of the teachers then expressed their willingness to

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<sup>1</sup> Contributed by Dr Cecilia C. de Martin.

introduce more specific sexual material into their courses, and this met with a favourable response from the students. The opening up of communication in this area between teacher and student soon made it clear that the medical student is simply a late adolescent who has assimilated the attitudes and inhibitions common to his culture, and that without special training he is poorly equipped to deal with the sexual difficulties of patients.

Psychological considerations are now being increasingly introduced into the teaching of such objects as human reproduction, family planning, and venereal disease. The progressive acceptance of human sexuality as an appropriate, and indeed necessary, part of medical education has now provided a foundation upon which more ambitious teaching programmes can be developed.

#### *Philippines*<sup>1</sup>

In 1964, a course on 'Perspectives in Medicine' was introduced in the Medical School of the University of the Philippines in order to relate medical practice to cultural and social phenomena. A unit was included to teach human sexuality as a part of family planning and related health care. At the Philippine Women's University a course exclusively on human sexuality is given to nursing students. Research on community attitudes to human sexuality is now integrated with the teaching of health professionals so that their training in this field may be based on an understanding of the indigenous attitudes of their future patients.

#### *Switzerland*<sup>2</sup>

In 1969, a course in sexology was inaugurated in the Medical School at the University of Geneva, beginning in the Department of Gynaecology and later enlarged to include psychiatry and forensic medicine. The course now covers 20-25 hours of teaching on normal sexuality and sexual pathology.

In 1970, a series of seminars on clinical sexology was inaugurated for hospital residents and practising physicians in the community. They are held on two evenings a month, and begin with a case presented on closed-circuit television, and this is followed by a discussion. Summaries of some of the material presented in these seminars appear each year in a special issue of the journal *Médecine et Hygiène*.

A Foundation for Research in Sexology has been established and is closely associated with these teaching programmes. It has carried out

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<sup>1</sup> Contributed by Dr F. Landa Jocaró.

<sup>2</sup> Contributed by Dr W. Pasini.

studies in such subjects as psychiatric aspects of homosexuality, abortion, and sex during pregnancy.

A programme has been developed in which a number of physicians are appointed and paid by the Government to give sex education in the public schools. The Medical School provides monthly supervisory sessions for these physicians.

#### USA<sup>1</sup>

The programme at the Bowman Gray School of Medicine in Winston-Salem, North Carolina, USA, is now 10 years old. At first, lectures on aspects of human sexuality were introduced into the courses of various departments by staff members of the Behavioral Sciences Center. They were well received, and a new 36-hour course on 'Preparation for Patient Interviewing' was inaugurated in 1969 for all first-year students, in which demonstration interviews, role-playing, and small group discussions were included. In 1970, a further 36 hours were made available, providing a 2-hour period each week throughout the whole of the first year; and later that year a further 36 hours were added in the second year. It was then possible to place the teaching of human sexuality within the larger context of communication and interaction between doctor and patient.

In their third year all students, in small groups of four or five, have a series of intensive seminars on the clinical management of sexual difficulties. Altogether, about 40–50 hours are devoted to *required* teaching in human sexuality. In addition, it is possible for a fourth-year student to take a 3-month elective course (also available to residents) in sexual and marital counselling, if he wishes to specialize in this field.

#### REGIONAL PROFILES

From the available information the following facts were elicited:

#### USA

A number of medical schools in North America have been developing programmes in human sexuality for about 10 years. In 1963, only a few schools had formal programmes of teaching in the fields of sex and marriage. The number has now increased dramatically, and at the last count about 94 out of 110 medical schools had introduced them. The whole development is being coordinated by the Center for the Study of Sex Education in Medicine in Philadelphia, which has already issued several publications. The Center has also produced a Sex Knowledge

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<sup>1</sup> Contributed by Dr D. R. Mace.

and Attitude Test (SKAT), which has now been given to some 4000 medical students.

Although nursing schools in North America are far behind medical schools in offering programmes of teaching in human sexuality, a start has been made. A few articles have now appeared in the nursing journals, and in the spring of 1970 a national conference of nursing educators and sex educators was held in New York. A study of sex education in schools of nursing in the USA has been completed by the Sex Information and Educational Council of the USA (SIECUS). Replies have been received from 148 out of 375 nursing schools approached. All schools that completed the questionnaire offer *some* formal study in human sexuality in their curricula. Generally, this is integrated into existing course structures. In seven schools (4.7%), however, a course principally or solely on human sexuality is offered; and in the schools not yet offering such a course, one in four of the administrators favoured doing so.

### *Europe*

It has been particularly difficult to secure a clear picture of the European scene. A study made in 1968–69 by Professor Pierre Hubinont, based on a questionnaire sent to all European medical schools, seemed to promise some clues. However, apart from replies by medical schools in north-western Europe, the responses were disappointing. The main topic on which information was sought was the teaching of human reproduction and contraceptive techniques, and apart from this, nothing was obtained except fragments of information from various countries.

*Great Britain.* In 1968, a questionnaire was sent to the final-year students in a number of British medical schools. The main emphasis was on teaching human reproduction and family planning; some questions were also included in the field of human sexuality. The responses showed that only 57% of the students had received any teaching in normal psychosexual development, but only 37% considered their knowledge 'professionally adequate'. In the area of sexual difficulties unrelated to marriage, the corresponding figures were 37% and 26%. In the area of marital adjustment, only 19% had had any teaching. Among the students who had received no teaching at all in any of these three areas, an average of 86% wished it had been available to them.

Students' comments were sometimes caustic: 'Teaching about VD is compulsory, but the study of normal sex relations is ignored.'

*Czechoslovakia.* It was reported that, at the Charles University in Prague, a one-semester elective course in medical sexology (lekarská sexuologie) has been made available to senior medical students.

*Switzerland.* Since 1969, at the medical school of the University of Geneva, a course on sexology has been offered to students during their

eighth and ninth semesters; and since 1970, a clinical seminar in sexology has been available.

#### *Asia*

A co-ordinated programme entitled 'Perspectives in Medicine' has been offered in the College of Medicine of the University of the Philippines. This includes teaching of human sexuality as part of family planning and related health care training.

#### *South America*

A promising beginning has been made by the Colombian Association of Medical Schools. Under joint pressure from the community and some professors and medical students, several schools 'became officially interested'.

#### CONCLUSION

It is clear that the information available on current curricula is fragmentary and that a thorough study of existing practice would be valuable. It is to be hoped that, as a result of this report, interest in teaching human sexuality will be stimulated and more information be assembled.

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## CHAPTER 8

### HOW TO START NEW PROGRAMMES

The ultimate aim is to provide universal training in human sexuality for all health practitioners. Although we are at present far from attaining this goal, there is evidence that some useful starts have been made. It may be helpful to assess some of the difficulties likely to be involved in initiating new programmes, and some of the criteria for success.

#### DIFFICULTIES ENCOUNTERED WHEN INTRODUCING COURSES IN HUMAN SEXUALITY

##### *Administrative opposition*

Although the introduction of any new subject to the medical curriculum may excite opposition, the teaching of human sexuality has experienced more than ordinary neglect. Quite apart from the emotional reactions of some senior faculty members, there is little awareness of the need and little experience of what needs to be done, or what can be done, in providing training. There is also a lack of specialized teaching staff capable of assuming responsibility for organizing the curriculum and the teaching.

In the battle for students' time, the introduction of a new subject encounters considerable and unreasonable opposition. The justification for introducing sexology depends on the concept of a doctor's job and the time he can spend on an essentially time-consuming type of consultation. Thus, some administrations conclude that justification is marginal or completely lacking, others that the problem has been exaggerated or that it is an offshoot of psychiatry rather than general medicine. The

growing chorus of complaint from patients, medical students, and general practitioners at the neglect of a subject so central to human health and disease is bringing about a grudging recognition of its importance in medical and nursing education.

#### *Departmental rivalries*

Even when general agreement is reached that sex education is necessary, it may be delayed because no department will accept responsibility. The prime mover may be a teacher in a department not directly concerned with sexual matters, and the departments more directly involved may be uncooperative.

#### *Curriculum difficulties*

Unless a curriculum revision is taking place, heads of departments generally resist attempts to introduce new subjects into professional education. The argument is that they do not have enough time to teach what they ought to be teaching, so how can something extraneous be introduced? Some sex education courses have been started informally out of class time, enthusiastically attended by the students, and then later incorporated into the curriculum.

#### *'We are not qualified'*

This reaction concedes the case for education in human sexuality, but insists that there is no one on the staff who can do it properly, so it is better to leave it alone. There is truth in the suggestion that this kind of teaching should be done well, and that it is not easy in some countries to find opportunities for special training. The preparation of teachers, either in special national courses or through fellowships for study abroad, should be encouraged.

#### CRITERIA FOR SUCCESS

The following are some of the criteria which have been met by programmes already established and successful:

*(a) There must be at least one teacher, respected by his colleagues and students, who is qualified to teach human sexuality and dedicated to the task of getting a programme established*

All effective and lasting programmes have been built up by the determined and patient efforts of individuals who were deeply convinced of the importance of providing this training for health practitioners. Many

of these pioneers were people who had had opportunities to attend conferences and seminars at which they came to see both the need for, and the possibilities of providing, this extension of medical education.

*(b) The support of the administration and of senior staff can make a tremendous difference*

A sustained effort to convince those in authority is generally required. Even if the first reactions are discouraging, personal discussion, the presentation of convincing studies, and pressure from the student body should overcome this resistance. It is sometimes more effective if an outside specialist in sexology, who can put the case persuasively, can be invited to visit the school and meet the faculty members for informal discussions.

*(c) The support of students should be enlisted*

This is never difficult. They are interested not only in view of their future practice, but also in order to meet their personal need for a better understanding of their own sexuality. If a course cannot be included in the curriculum, a series of evening discussions or a weekend seminar can be arranged. Once the students realize what is possible, they may put their case directly to the administration.

*(d) An informal, experimental course is often the best beginning*

It should be undertaken on a modest scale, but carefully planned to avoid the sensational and the needlessly controversial. Even if the school will not sanction the teaching of human sexuality formally, it is difficult, without appearing unreasonable, to refuse to allow the idea to be put to the test on a tentative basis. Given a teacher who knows his subject, and can communicate freely and objectively about sex, such an experimental course can hardly fail. Once it is established, faculty chiefs can be invited to attend sessions as observers and see for themselves what is happening.

## CHAPTER 9

### SUGGESTED FUTURE ACTIVITIES

It seems certain that a new field of medical education is now developing to meet an urgent and widespread need. Although sexual attitudes and behaviour patterns vary widely in different cultures, sexuality is part of physical, social, and mental wellbeing the world over. At present, there is a serious lack of opportunity for health practitioners to study the subject and an even more serious lack of teachers to plan, carry out, and evaluate educational programmes. It is suggested that the following short-term and long-term activities might be undertaken to help countries develop such programmes and to coordinate their development on a worldwide scale.

#### SHORT-TERM ACTIVITIES

(1) An investigative survey of present programmes, activities, and services in the area of human sexuality: this survey would not necessarily have to be made in depth. Just enough facts would be collected to provide a reliable picture of what is actually happening—information which we now lack.

(2) The convening of a series of scientific meetings for thorough exploration of the field: these would include, for example, the sharing of experiences by health practitioners who have established successful training programmes; study of the sociocultural factors to be taken into account in a given region before launching new programmes; pooling of research findings and agreement concerning the implications for health of a wide range of sexual phenomena; and discussions of policy by representatives of national and international health organizations.

(3) The provision of immediately needed resources, such as a centre for the exchange of information; a comprehensive bibliography; a directory of agencies; and some assistance and guidance for new programmes, especially in the developing countries. No more than a beginning could be made in the provision of resources at this stage—further expansion would come later.

#### LONG-TERM ACTIVITIES

##### *Preparation of specialists*

The preparation of a cadre of specialists who could provide leadership at regional and national levels is a necessary first step to developing programmes. They should be selected on the basis of wide geographical distribution from among health practitioners already possessing a wide knowledge of one or more aspects of sexology. Their preparation would be completed by attending to the gaps in their experience and strengthening their abilities in curriculum planning and educational methodology. Their training could be arranged through such means as fellowships, seminars, and meetings for in-depth study.

##### *Programme development*

Programme development should move through three stages. First, there should be meetings on a national level of deans and administrators from schools for the health sciences; these should be followed by assistance to schools in curriculum development and to training courses for teachers in these schools; finally, there should be continuing support and evaluation of the new teaching programmes.

##### *Provision of resources*

Provision of resources should include the establishment of a central clearing-house for information, with the later development of regional branches and advisory services; maintenance of an up-to-date directory of agencies and organizations in the field; provision of library facilities and audiovisual aids; and continuing assistance in curriculum development.

##### *Research and evaluation*

Initiation and support of new research, both intracultural and cross-cultural, in the field of human sexuality; coordination of existing medically oriented researches in human sexuality; and ongoing studies of developing training programmes are required.

## OUTLINE OF CURRICULUM CONTENT FOR THE TRAINING OF SEX EDUCATORS<sup>1</sup>

1. *The process of reproduction*: Reproductive biology—heredity—sex determination — menstruation — conception — pregnancy — embryology — childbirth — multiple births — infertility and sterility — contraception — abortion — population control.

2. *Sexual development*: Sexual components of physical, mental, and emotional growth during infancy, the prepuberty period, puberty, early adolescence, and late adolescence to adulthood—fixation and arrested development—sexual responsiveness in early adulthood, middle age, and old age—menopause and climacteric.

3. *Sexual functioning*: Male and female anatomy and physiology—masturbation in infancy, childhood, adolescence and maturity—nocturnal emissions—sex dreams and fantasies—coitus and the art of love—male and female homosexuality—sexual deviations (sadism, masochism, fetishism, exhibitionism, etc.)—male and female coital response—coital inadequacy (premature ejaculation, impotence, vaginismus, dyspareunia, orgasmic dysfunction)—myths and fallacies relating to sexual functioning.

4. *Sexual behaviour*: Cultural values relating to sex—views of various religious groups—sexual restraint—chastity—fidelity—celibacy—sex ethics—sexual guilt—laws relating to sexual behaviour—premarital petting—premarital coitus (fornication)—extramarital coitus (adultery)—out-of-wedlock pregnancy—prostitution—cultural attitudes to sexual varietism.

5. *Sex and gender*: Male and female sexual characteristics (primary and secondary)—hermaphroditism and transsexualism—masculinity and femininity—gender roles and stereotypes—male dominance—women's liberation.

6. *Marriage, family and interpersonal relationships*: Courtship and mate selection—sex adjustment in marriage—sexual communication in the family—oedipus and electra conflicts—incest—sexual inhibition—sex education in the home—parents as gender models—psychology of family relations—sex in changing marriage patterns—group sex.

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<sup>1</sup> This material is taken from the booklet *The Professional Training and Preparation of Sex Educators*, 1972, American Association of Sex Educators and Counselors, Washington, D.C. It is described as 'illustrative rather than exhaustive'.

7. *Sex and health*: Sex-related biological anomalies and anatomical malformations—sex and hormones—venereal disease—sex and mental health—sexual anxiety and conflict—sex and neurosis.

8. *The study of sex*: History of sex beliefs and attitudes in Western culture—sex in other cultures—sex in subhuman species—the scientific study of sex (Havelock Ellis, Freud, Kinsey, Masters & Johnson)—findings of major sex studies—ongoing sex research.

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**KNOWLEDGE, SKILLS, AND ATTITUDES REQUIRED BY HEALTH PROFESSIONALS  
FOR DEALING WITH PROBLEMS OF HUMAN SEXUALITY\***

Problem area	Knowledge	Stage <sup>1</sup>	Field <sup>2</sup>	Skills	Stage <sup>1</sup>	Field <sup>2</sup>	Attitudes	Stage <sup>1</sup>	Field <sup>2</sup>
I. Unplanned pregnancy	1. Why family planning? (social, family, and individual points of view)	UG,PG,IS	M,N,S	1. Individual interviewing and counselling	UG,PG,IS	M,N,S	1. Personal acceptance of importance of a small family norm	UG,PG,IS	M,N,S
	2. Methods of family planning	UG,PG,IS	M,N,S	2. Group counselling	PG,IS	M,N,S	2. Each case to be regarded as a person and not a number	UG,PG,IS	M,N,S
	3. Acceptability, effectiveness and harmlessness of methods for family planning—socio-cultural factors	UG,PG,IS	M,N,S	3. Clinical techniques: diaphragm and jelly IUD insertion oral contraceptive (examination) sterilization, male and female	UG,PG,IS	M,N	3. Sexuality an important and wholesome aspect of life	UG,PG,IS	M,N,S
	4. Barriers in communication for family planning—socio-cultural factors	UG,PG,IS	M,N,S	4. Follow up of cases	PG,IS	M	4. Unambiguous personal attitudes to sex, use of contraception, and abortion	UG,PG,IS	M,N,S
	5. Interpersonal relationships and personal problems related to the use of contraceptives	PG,IS	M,N,S	5. Record keeping	PG,IS	M			
	6. Medical termination of pregnancy—indications and legal aspects	UG,PG,IS	M,N,S	6. Ability to discuss sexual matters in a frank and unembarrassed manner	UG,PG,IS	N,S			
II. Premarital relationships	1. Social mores and customs	UG,PG,IS	M,S	1. Individual interviewing and counselling	UG,PG,IS	M,N,S	1. Non-judgemental attitudes	UG,PG,IS	M,N,S
	2. Family life and sex education for the young	UG,PG,IS	M,N,S	2. Conducting programmes in family life and sex education for schoolchildren, college students and out-of-school groups	PG,IS	M,N,S	2. Acceptance of sex as good, clean, healthy, and necessary	UG,PG,IS	M,N,S
	3. Contraceptive advice for the unmarried	PG,IS	M,N,S	3. Contraceptive advice to the unmarried	PG,IS	(special)			
	4. Services for unmarried mothers	UG,PG,IS	M,N,S	4. Premarital counselling	PG,IS	M			
				5. Premarital examination	PG,IS	M,N,S			
				6. Ability to discuss sexual matters in a frank and unembarrassed manner	UG,PG,IS	M,N,S			
				7. Record keeping	UG,PG,IS	M,N,S			

III. Infertility	<ol style="list-style-type: none"> <li>1. Etiology of infertility</li> <li>2. Social factors in infertility</li> <li>3. Sexual factors in infertility</li> <li>4. Medical, ethical, psychological, and legal aspects of AID and ovum transplants</li> </ol>	UG,PG,IS M,N UG,PG,IS N,S PG,IS M PG,IS M,N,S	<ol style="list-style-type: none"> <li>1. Investigation and treatment of infertility (special techniques)</li> <li>2. Individual interviewing and counselling</li> <li>3. Follow up of cases</li> <li>4. Record keeping</li> <li>5. Ability to discuss sexual matters in a frank and unembarrassed manner</li> </ol>	UG,PG,IS M UG,PG,IS M,N,S UG,PG,IS N,S UG,PG,IS M,N,S UG,PG,IS M,N,S	<ol style="list-style-type: none"> <li>1. Sex as wholesome and necessary for success in marriage</li> <li>2. Unambiguous personal attitudes to AID and ovum transplants</li> </ol>	UG,PG,IS M,N,S PG,IS M
IV. Marital disharmony	<ol style="list-style-type: none"> <li>1. Sexual anatomy and physiology and sexual response</li> <li>2. Preparation for marriage</li> <li>3. Adjustment in marriage</li> <li>4. Causes of marital breakdown (a) interpersonal, (b) sexual, (c) external</li> <li>5. Marriage guidance</li> </ol>	UG,PG,IS M UG,PG,IS M,N,S UG,PG,IS M,N,S UG,PG,IS M,N,S PG,IS M,N,S (special)	<ol style="list-style-type: none"> <li>1. Premarital counselling</li> <li>2. Prenatal examination</li> <li>3. Techniques of marriage guidance</li> <li>4. Individual interviewing and counselling</li> <li>5. Group counselling</li> <li>6. Record keeping</li> </ol>	PG,IS M,N,S PG,IS M,N,S PG,IS M,N,S (special) UG,PG,IS M,N,S PG,IS M,N,S UG,PG,IS M,N,S	<ol style="list-style-type: none"> <li>1. Non-judgemental attitudes</li> <li>2. Positive personal attitudes to marriage</li> </ol>	UG,PG,IS M,N,S UG,PG,IS M,N,S
V. Venereal diseases	<ol style="list-style-type: none"> <li>1. Incidence and types of VD</li> <li>2. Diagnosis and treatment of VD</li> <li>3. Social aspects of VD—care of contacts, rehabilitation</li> <li>4. VD as a public health problem—health education</li> </ol>	UG,PG,IS M,N UG,PG,IS M,N UG,PG,IS M,N,S UG,PG,IS M,N,S	<ol style="list-style-type: none"> <li>1. Methods of investigation, diagnosis and treatment of VD</li> <li>2. Individual interviewing and counselling</li> <li>3. Methods of health education for VD</li> <li>4. Rehabilitation of victims</li> <li>5. Follow up of cases</li> <li>6. Dealing with the innocent spouse</li> <li>7. Record keeping</li> </ol>	UG,PG,IS M,N UG,PG,IS M,N,S UG,PG,IS N,S UG,PG,IS N,S UG,PG,IS N,S UG,PG,IS M,N,S UG,PG,IS M,N,S	<ol style="list-style-type: none"> <li>1. Non-judgemental attitudes</li> <li>2. VD case not only needs medical care but social rehabilitation</li> </ol>	UG,PG,IS M,N,S UG,PG,IS M,N,S
VI. Sexual behaviour	<ol style="list-style-type: none"> <li>1. Types of sexual behaviour</li> <li>2. Range of normality in sexual behaviour</li> <li>3. Psychological aspects of abnormal sexual behaviour</li> </ol>	UG,PG,IS M,N,S UG,PG,IS M,N,S PG,IS M,N,S (special)	<ol style="list-style-type: none"> <li>1. Individual interviewing and counselling</li> <li>2. Techniques of psycho-analysis</li> <li>3. Techniques of psychiatric treatment</li> <li>4. Record keeping</li> </ol>	UG,PG,IS M,N,S UG,PG,IS M,N,S PG,IS M,S PG,IS M,S PG,IS M,S (special) UG,PG,IS M,S	<ol style="list-style-type: none"> <li>1. Non-judgemental attitudes</li> <li>2. Acceptance of sexual deviants as mentally ill persons rather than as criminals</li> </ol>	UG,PG,IS M,N,S UG,PG,IS M,N,S

\*Chart prepared by Dr Sarah Israel.  
 1 UG = undergraduate training ; PG = postgraduate training ; IS = in-service training.  
 2 M = medical ; N = nursing ; S = social work.

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*Annex 4*

**SOME AGENCIES ACTIVE IN THE FIELD  
OF HUMAN SEXUALITY**

A number of agencies throughout the world are already working at a high professional level in the field of human sexuality in areas such as education, clinical services, or research. The list below is not claimed to be complete, but is intended merely to serve as preliminary information. Other similar agencies are invited to inform WHO of their activities.

*Belgium*

Centre international de Documentation et de Recherches sexologiques,  
Université catholique de Louvain,  
Mgr. Ladeuzeplein 20,  
Louvain

*Czechoslovakia*

Institute of Medical Sexology,  
Charles University,  
Prague 2

*Federal Republic of Germany*

Institut für Sexualforschung,  
Universitätskliniken Eppendorf,  
Martinstrasse 52,  
2 Hamburg 20

*Italy*

Centro Educazione Matrimoniale e Prematrimoniale (C.E.M.P.),  
Via Pantano 17,  
20122 Milan  
Centro Italiano Sessuologia,  
Città Università,  
00100 Rome

*Netherlands*

Dr Conrad van Emde Boas,  
Stationweg 80,  
Amsterdam-Z

*Sweden*

Dr Maj Jultén,  
Genetiska Institutionen,  
Karolinska Sjukhuset,  
Stockholm 60  
RFSU (Swedish Family Planning Association),  
Rosenlundsgatan 13,  
10462 Stockholm

*Switzerland*

Fonds de Recherche sexologique,  
28 Bd de la Cluse,  
1205 Geneva

*USA*

American Association of Sex Educators and Counselors,  
815 15th Street, N.W.,  
Washington, D.C. 20005  
Center for the Study of Sex Education in Medicine,  
Department of Psychiatry,  
University of Pennsylvania School of Medicine,  
4025 Chestnut Street,  
Philadelphia, Penn. 19104  
Institute for Sex Research, Inc.,  
Morrison Hall 416,  
Bloomington, Indiana 47401  
Sex Information and Education Council of the United States (SIECUS),  
1855 Broadway,  
New York, N.Y. 10023  
The Society for the Scientific Study of Sex,  
Suite 1104,  
12 East 41st Street,  
New York, N. Y. 10017

*USSR*

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- Dr D. R. Mace, Professor of Family Sociology, Behavioral Sciences Center, Bowman Gray School of Medicine, Wake Forest University, Winston-Salem, N.C., USA
- Dr Cecilia C. de Martin, Director, Sex and Family Life Education and Population Education Programs, Colombian Association of Medical Schools, Bogotá, Colombia
- Dr C. de Medeiros, Technical Adviser, Ministry of Public Health, Lomé, Togo
- Dr W. Pasini, Assistant Professor and Director, Unit of Psychosomatic Gynaecology and Sexology, Faculty of Medicine, University of Geneva (representing the International Federation of Gynaecology and Obstetrics, Geneva, Switzerland)
- Dr Samira I. Salama, Lecturer in Psychiatric Nursing, High Institute of Nursing, Faculty of Medicine, Cairo University, Cairo, Egypt
- Dr G. S. Vasilchenko, Senior Scientific Researcher, Ministry of Health of the USSR Moscow, USSR
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