**HIV Infection and Family Planning Work**

The importance of HIV infection can hardly be overstated, but how does the epidemic affect family planning work? We have asked two medical practitioners to present their views on the subject. Dr. J.S. Bingham reviews the epidemiological and preventative aspects of HIV infection for family planning workers, while Dr. Caroline Bradbeer covers some of the problems doctors in family planning clinics will increasingly encounter. The texts complement each other, and we hope the reader will find them informative and useful.

We are pleased to announce the appointment of Dr. Daniel Pierotti to the post of Regional Officer, Sexuality and Family Planning Unit, as from 1 September 1988, succeeding Ms. Wadad Haddad.
EPIDEMIOLOGICAL AND PREVENTIVE ASPECTS OF HIV INFECTION

AIDS, the acquired immune deficiency syndrome, is a new sexually transmitted disease which is now spreading rapidly in much of the world. It is caused by a retrovirus, the human immunodeficiency virus (HIV). Two definite types have now been recognised, HIV 1 and HIV 2, although the latter is rare in Europe. It enters and reproduces within the T-helper lymphocytes of the blood, destroys them and ultimately produces an immunodeficient state. The virus is also neurotropic and may attack other tissues as well.

Most people acquire the infection without symptoms but some have an acute sero-conversion illness, usually a glandular fever-type syndrome. Antigen may be detected in the blood within two weeks of acquisition of the virus and, usually within two months, antibodies to HIV may be detected. There follows a period of latency of variable duration, but eventually asymptomatic carriers may develop HIV-related problems and ultimately the characteristic opportunistic infections and malignancies - AIDS. Prospective studies are suggesting that 6-7% of infected individuals will progress to AIDS each year, but this may change with time.

By 31 December 1987 a total of 10,181 AIDS cases had been reported to the WHO Collaborating Centre in Paris by 28 countries in Europe and the Mediterranean area. In the preceding year the number of cases increased by 124%, with the greatest increase occurring in France (42-43 cases per week). The highest cumulative incidence rates per million were noted in France (55.3), Switzerland (53.8) and Denmark (44.7). By comparison, the rate in the USA was 216 per million population. Of the 10,181 reported cases 81.1% were male and 85.2% were in the 20-49 years age group.

85.9% of the males and 79.5% of the females belonged in this sexually active group, while almost half of all female cases (49.9%) were in the 20-29 years age group. Among the 9,930 adult cases of AIDS, 59% were homosexual or bisexual men, 20% were intravenous drug abusers (IVDAs) and 6% were presumed to have been infected by heterosexual contact. The overall male:female sex ratio was 8.9:1. However, the sex ratio for IVDAs was 2.8:1 and for people infected through heterosexual contact 1.8:1. 51.5% of the female cases were reported among IVDAs.

In the USA, while newly reported cases of AIDS increased by 46% in the year August 1986-August 1987 compared with the equivalent period in the previous year, heterosexual contact cases increased by 85% in the same period. The doubling time of this "heterosexual epidemic" is now shorter than for injecting drug abusers or homosexual men and is largely explained by heterosexual transmission from IVDAs. It is most alarming. There is evidence that homosexual men have modified their lifestyle but it appears that young heterosexuals have not.

The future of the heterosexual epidemic in Europe and the USA will depend on rates of partner change in the heterosexual population. Since the heterosexual population is numerically vastly greater than the male homosexual population, it is conceivable that heterosexually acquired HIV may eventually account for a considerably higher proportion of the epidemic than at present.

Role of family planning workers in prevention

As the disease occurs predominantly in young sexually active people, staff in family planning clinics (FPCs) are well placed to provide information on how to prevent the further spread of HIV infection, provided they keep up to date on HIV and AIDS, so that patients' clients' queries can be answered.

Queries about HIV screening

The issue of screening for HIV will inevitably arise. Many people request an HIV antibody test, often as a means of personal reassurance, but if testing is done, the organization required to deal with the distress caused by a positive result must be available.
Prior to testing the pros and cons of the procedure should be explained and the test should only be performed with the patient's knowledge and consent. There is no evidence, at present, that knowledge of a negative result influences sexual behaviour, but we should try to get the message across about how to prevent HIV infection.

If studies underway to assess the efficacy in asymptomatic carriers of the antiviral drug AZT (azidothymidine), which inhibits replication of the virus, show that it helps in preventing progression of the infection, then there will be an increased demand for testing. For the first time a meaningful intervention will have been identified.

Those identified as having a positive test require expert counselling and medical follow-up, and contact tracing should be instituted where possible. Maintenance of confidentiality regarding the results of HIV tests, especially positive findings, is of paramount importance. Referral of positive patients to a specialized centre is advisable.

Advice on safer sex and methods of contraception

"Safer sex" is sexual activity without exchange of body fluids, as HIV has been found in cervical secretions, in semen and in blood. Anal intercourse (particularly ano-insertive by the infected partner) carries the highest risk, but vaginal intercourse is also dangerous although studies have not shown a significant increase in infectivity during menstruation. Oro-genital intercourse carries a theoretical risk. Mutual masturbation is safe.

Most people desire to continue to have vaginal intercourse and so should be advised how to minimize the risk of spreading HIV. Condoms are the mainstay of prevention provided they are used correctly. Instructions should be given on their use and they should be freely available. Because they can sometimes break, they should be used with spermicides containing nonoxynol-9, which has been shown to kill HIV in vitro.

The so-called "female condom" (a sheath that fits into the vagina, held in place by a circular spring as in a cervical cap) is currently being tested. If found acceptable, this is something a woman can use to protect either herself or others if she is infected. Cervical barrier methods, even with spermicides, are probably not reliably protective.

If one of the couple is infected with HIV then sexual intercourse should be advised against but this may not be acceptable to some; then condoms and spermicides must be used. The same advice can be given to those having casual sexual encounters but, if no partner change is taking place, then the precautions need not apply although an increasing number of couples are having HIV antibody tests prior to embarking on a new relationship. The counsel of perfection is: no partner change.

A condom should be used even if other forms of contraception, including the oral contraceptive pill (OC) and the intrauterine device (IUD) are in use. Women with HIV are often IVDAs with irregular lifestyles, so OCs may be impractical. IUDs carry a theoretical risk of trauma to a condom or naked penis and this might enhance the chances of transmitting the virus. Among IVDAs who are still sexually active progesterone implants may be the most satisfactory option.

It is important to discuss with an HIV-positive or AIDS patient the risk of pregnancy and the risk to the newborn infant. Earlier reports that pregnancy accelerates the progression of the disease in the mother do not seem to be borne out, but there is a 30–50% risk of the baby being infected with HIV, usually the result of intrauterine spread of the virus or spread in the intra- or postpartum periods.

Other considerations

Semen donors should all be tested for the presence of HIV antibody at least three months after the most recent partner change, as infection has been spread by this means. Semen should not be used until a second check has been made, three months after donation.
There is some preliminary evidence that women with HIV infection may be predisposed, as are those taking immunosuppressive therapy, to a higher incidence of cervical intraepithelial neoplasia (CIN). Thus, women with HIV should have frequent smears or colposcopic examination of their cervixes, until the matter is clarified.

Many women at risk of HIV infection may also be at risk of hepatitis B and other sexually transmitted diseases (STDs) and appropriate investigations should be carried out.

[From: Dr J.S. Bingham, Consultant in Genito-Urinary Medicine, The Middlesex Hospital, London W1N 8AA, United Kingdom. Note: Specific references provided by author on request.]

**APPROACHES TO PATIENTS WITH HIV-RELATED PROBLEMS**

Doctors in family planning clinics (FPCs) will increasingly encounter problems related to women with human immunodeficiency virus (HIV) infection. By the end of February 1988 thirty-five adult women had been reported as having AIDS in the United Kingdom and an estimated 5 000 were infected with the virus. Although still rare their numbers are increasing.

Patients with HIV-related problems fall broadly into two groups. The largest group are clinic attenders at very low risk of having HIV but who may have been worried by AIDS publicity or may come requesting help to avoid exposure in the future. Among them will be men wanting free condoms. A much smaller group of patients is at high risk of infection or known to be infected and they need specific counselling.

The doctor's first task is to assess to which group the patient belongs.

**Clinic attenders known or very likely to be infected**

Standard tests for HIV are based on the detection of antibodies in the blood. A negative test does not exclude early infection. In cases of recent exposure, repeat testing at three and at six months may be necessary; a high-risk person should be viewed as potentially infectious regardless of a test result.

Testing for HIV in the UK is mainly carried out in STD (sexually transmitted diseases) clinics where trained counsellors are available. It should not, in general, be done in FPCs. HIV-positive patients will usually have received counselling when they were given their test result.

Others at high risk may have elected not to be tested or may be unaware of their risk. They may attend FPCs requesting specific advice on contraception or more general information on safe sexual practices. Whatever the ostensible reason for the consultation, the doctor should take the opportunity to make sure that the patient is aware of all the implications of HIV infection. The counselling should cover the following aspects:

- People at risk of HIV infection in the United Kingdom are: recipients of blood and blood products, intravenous drug abusers (IVDAs) who share needles, male homosexuals, people from sub-Saharan Africa, and sexual partners and offspring of any of these. Currently there is little evidence of infection outside these risk groups, but we cannot tell what will happen in the future.

- Information for doctors concerning the introduction of the HTLV-III antibody test. AIDS Booklet 2, DHSS Communication 1985.

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*Communicable Disease Surveillance Centre (CDSC). AIDS in the UK. Lancet i:661 (1988).*
a) Safer sexual practices: Many high-risk women elect to abstain from intercourse altogether, especially those without a regular partner or who have recently learned their diagnosis. Such women often resume intercourse in time and so still need advice on safe sexual practices.

All high-risk people should be instructed in the proper use of condoms. We recommend them to inform their sexual contacts of the risk. There is a small, theoretical chance of transmitting infection through cunnilingus and a much greater one of transmission through unprotected anal or vaginal intercourse. If both partners understand the situation they can decide what for them is an acceptable degree of exposure.

b) Contraception and pregnancy: Women with HIV infection need a contraceptive method which prevents viral spread as well as conception. Many women opt for condoms to prevent infection and for a hormonal method to prevent conception.

There is good evidence that condoms can stop the spread of HIV so long as they are used correctly; however, they may still break or fall off. The thicker condoms break less often but may not be acceptable to the couple. The new "female condom" may provide the answer for some people. There is no direct evidence that cervical barriers, such as diaphragms, give protection although they may give some since they seem to reduce other sexually transmitted diseases. They should be used with spermicides containing nonoxynol-9.

There is no evidence that hormonal contraceptives have a detrimental effect on HIV infection, and they are probably the best choice for use in conjunction with condoms. But in the UK the majority of infected women are IVDA and may have erratic lifestyles. In these circumstances, the contraceptive pill may not be practical.

Intra-uterine devices (IUDs) carry an increased risk of infection in normal women and this risk may be higher in the presence of HIV. In addition, if an IUD is used with a condom the strings could theoretically cause micro-perforations. In difficult cases long-acting progesterone injections or implants are the treatment of choice.

Pregnancy is not desirable in HIV-positive women. First there is the risk of the baby developing AIDS. Secondly, HIV may be teratogenic: Italian studies have shown that HIV-infected babies often have dysmorphic features, with prominent foreheads and widely separated eyes. Severe dysmorphism correlates well with the early onset of AIDS. However, the results of these studies are not conclusive since most of the mothers were actively abusing drugs and so some of the abnormalities may be drug-related. Thirdly, pregnancy may worsen maternal prognosis. Original studies on pregnant women with HIV suggested that this was an important factor. It now seems that women in the later stages of HIV infection are more likely to transmit their infection to a baby and also have a poor prognosis, unrelated to any pregnancy. Most authorities do believe that pregnancy can be detrimental to maternal health but it is probably not as serious as once thought.

Thus an HIV-positive woman should be advised against pregnancy and offered condoms, spermicide and an additional contraceptive method. If she is already pregnant, she should be counselled about the risks involved and offered testing for HIV antibody and, if she is positive, a termination of pregnancy.

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c) Cervical smears: Studies of women who are taking immuno-suppressive drugs show an increased prevalence of cervical intraepithelial neoplasia (CIN). It seems probable that women with HIV infection have a similarly increased risk, particularly since they are more likely to have been exposed to the genital wart virus.

I have shown this to be the case in a small series, and others have had similar experience*.b. The risk of cervical dysplasia has yet to be quantified but, until it is, frequent smears should be taken regardless of sexual activity, and colposcopy performed at the first suggestion of abnormality. Patients should be informed of this risk.

d) Other tests: Tests for hepatitis B are indicated in all patients at risk of HIV since it is transmitted in a similar way. Hepatitis B is far more infectious than HIV and may be a greater hazard to health workers. A patient who fears she has contracted HIV through sexual intercourse is often more likely to have other STDs and may need appropriate investigations.

Low-risk clinic attenders

If a patient is worried and requests HIV antibody testing or if there is a risk of another STD, she or he should be referred to the local STD clinic. Most of these patients, however, require only advice to avoid future exposure to HIV. At present it is usually sufficient to advise the use of condoms and a spermicide in all casual sexual encounters and with any other partners who are, or may be, from the established risk groups.

Since FPCs are the only widely available source of free condoms in the UK, men should be encouraged to attend.


A supply of condoms can be kept in the reception areas to make it easier for both sexes to obtain them. There are often complaints that too few are given out at any one time.

[Source: 101 Uses of a Condom by Russell Jones, with permission from publisher Grub Street, London 1987]

Clinic staff who normally deal with rather older people in steady relationships should remember that young people with very new or casual relationships may have sexual intercourse very frequently.

Clinic staff

The doctor must consider the impact of the AIDS epidemic on her clinic staff: nurses, domestic and clerical staff are often very frightened of catching HIV from a patient and may need reassurance that the risk is negligible; this reassurance can be coupled with reinforcement of general infection control procedures in the clinic.

While IVDAs acquire the virus from sharing needles and syringes, the situation is different from medical needle-stick injuries since drug users often contaminate syringes by withdrawing blood in order to obtain the last few molecules of opiate. Any subsequent user of the syringe will inevitably inoculate himself with a significant amount of the previous person's blood. Thus spread between IVDAs is frequent, whereas in medical practice it is very rare. To date only 10 health personnel have been reported as acquiring the virus in the course of
their work*. Several hundred have had needle-stick injuries with infected blood and five have become infected, giving a risk of less than 0.04%. Five others were infected through contamination of mucosal surfaces with relatively large quantities of blood.

As with the other modes of HIV transmission (sexual intercourse and mother to baby), ill patients in the later stages of infection may represent the greatest hazard.

Routine clinic infection control measures should be sufficient to destroy HIV. The genital wart virus is far more sturdy than HIV and represents a greater risk of cross-infection. For various reasons clinic staff will not be able to identify every carrier of HIV, so adequate precautions need to be taken for all patients. The virus is destroyed by autoclaving, soap and water and by household bleach. The general principles are therefore to autoclave all instruments or soak them for at least fifteen minutes in activated gluteraldehyde, after thorough cleaning with soap and water. It is this preliminary cleaning which is the most important part of the procedure. Any spilt secretions should be wiped with a 10% solution of household bleach.

All clinic staff should wear gloves when dealing with secretions and any fresh skin abrasions should be covered with water-proof plaster. Sharp instruments should be placed carefully in a sturdy container which should be incinerated with other disposable equipment. It must be stressed that these are general hygiene measures which apply to all patients. Known HIV-positive women need not be, and should not be, treated differently for practical procedures.

The message for all clinic staff is that HIV is hard to catch.  

[From: Dr Caroline Bradbeer, Consultant Physician, Department of Genito-Urinary Medicine, St Thomas' Hospital, London SE1 7EH, UK]


ABOUT AIDS LANGUAGE

The language of AIDS is important, because prejudice and discrimination against others are rooted in it. We are exposed to these phrases and labels over and over, and their implicit meanings become a part of our system of beliefs and attitudes towards people with AIDS.

At the risk of sounding sanctimonious here are a few suggestions:

NEVER say 'AIDS victims' or 'AIDS sufferers'. The word 'victim' implies innocence and guilt.

USE 'someone (or people) with HIV infection' or 'someone (or people) with AIDS'.

DON'T call HIV 'the AIDS virus'. It can cause AIDS but doesn't necessarily do so. Some people with HIV infection may never develop AIDS. Call HIV 'the virus which can cause AIDS'.

NEVER use 'AIDS virus carriers' or 'AIDS carriers'. Being HIV antibody positive may not necessarily mean a person is infectious to others.

REMEMBER that there is no 'AIDS test'. The most common test used at the moment is for the antibody developed to HIV by the immune system of someone who has been infected with the virus at some time in the past.

[From: Peter Holmes in: AIDS - Planning local services. Project Paper no 68 (1987). King's Fund Centre, 126 Albert Street, London NW1 7NF]
COUNTRY REPORTS

FRANCE: BEFORE AND AFTER THE 1974 ABORTION LAW

Between the first public discussion about abortion (around 1955) and the passing of a bill (at the end of 1974) which permitted abortion under certain conditions, public opinion in France was divided. On the one hand, people wanted abortion to be legalized in order to uphold the principles of independence and freedom of choice for the women and couples concerned, or simply to prevent the drastic repercussions of 'backstreet' abortion. Yet they refused to make the termination of a pregnancy a 'normal' event. Furthermore, ethical arguments (respect for life and the individual) were not overlooked, and it was only an awareness of the realities of human suffering and tragedy which led a majority of people to support the 1974 abortion law.

Public discussion of the issue had been strongly influenced by estimates of the number of backstreet abortions and rates of maternal mortality. Those in favour of repealing the 1920 abortion law had a vested interest, in order to make the public aware of this problem and to influence the legislature, in putting forward the highest possible figures, whereas their opponents tried to minimize the problem.

Since the 1974 bill was passed, however, the roles have been reversed: its supporters are trying to show that it has reached its goal of bringing all clandestine abortions into the open (no more and no less), which has led them to revise their previous estimates of clandestine abortions. The opponents of the act are doing their utmost to juggle the available statistics covering the recent period and prove that there have been more abortions after 1975 than there were before.

We will never know the full truth. While the number of abortions carried out since 1974 is reflected (albeit inaccurately) in the statistics, there are no figures at all for the period before 1975.

Nevertheless, three arguments favour the view that some continuity exists between the situation before and after 1975 as far as the number of abortions is concerned.

First, estimates of the abortion rates for the two periods are similar in magnitude. Three different evaluation methods of the number of abortions in France have yielded rates of between 14 and 40 abortions per 100 births (or between 120 000 and 350 000 abortions a year) for the period when abortions were illegal. When we study the trend in the number of terminations of pregnancy since 1976, as reflected in the official statistics, we find 130 000 to 183 000 abortions a year (e.g. 134 200 in 1976, 180 700 in 1981 and 168 000 in 1986). These figures may greatly underestimate the actual number of abortions, and the National Institute of Demographic Studies has suggested a figure of approximately 250 000 abortions per year (i.e. 30 to 35 abortions per 100 births), which would be an order of magnitude comparable to the estimated frequency of backstreet abortions before 1975.

Secondly, there are surprising similarities between the characteristics of women who had an abortion during the period 1948–1959, as found in a number of surveys, and those of women now requesting termination of pregnancy.

It is worth looking at the latter group in more detail.

Nearly half of all requests for abortion come from married women. Differences between married and unmarried women are quite pronounced. For example, the majority of unmarried women are quite young (the modal age group is 20–24 years) and 70% of them are primagravidae; there is a high probability that they will request voluntary termination of pregnancy at all ages (never less than 35 abortions per 100 pregnancies), and this is especially marked before the age of 20 or after the age of 40 (over 50%).
Married women are older (the modal age group is 30-34 years) and nearly three quarters of these women have already had at least two previous pregnancies; the ratio of abortions to conceptions is very low before the age of 25 (less than 5 abortions per 100 pregnancies), but it rises steadily with age and from 40 years onwards is the same as in unmarried women.

One final point can be made in support of the view that there has been a certain degree of continuity in the rates of abortion before and after 1975: a number of surveys have all found that abortion is considered as a contraceptive method only by a minority of women (20-25% at most). This shows that abortion has not been 'trivialized' to the point where it is seen as the obvious solution to any unwanted pregnancy.

[Extract from La seconde révolution contraceptive by Leridon, H. et al. Travaux et documents, Cahier no. 117, Institut national d'Etudes démographiques, Presses universitaires de France, 1987 (pp 249-266), prepared for ENTRE NOUS by Henri Leridon, INED, 27, rue du Commandeur, 75675 Paris Cedex 14 (France)]

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THE ZHORDANIA INSTITUTE OF HUMAN REPRODUCTION IN GEORGIA, USSR

The Institute, the only one of its kind in the USSR, was established in 1958 and is named after its founder and first director Dr Zhordania, who died in a plane crash in 1962. It is situated in Tbilisi, capital of the Georgian SSR. This republic has a population of 5.239 million, representing more than 80 nationalities. The largest groups are Georgians, with 68.5% of the population, Armenians, Russians, Azerbaijanis, Ossets, Abkhazians, Ukrainians, Jews and Kurds. There are also three closely related ethnic groups: Khevidisi, Megrelo-Chans and Svans, who have preserved their original traditions and customs.

329 scientific workers and physicians of different specialities work at the Institute which has wide-ranging activities relating to (a) birth control (contraception and the prevention of abortion); (b) medical and sociological aspects of demography in Georgia; (c) clinical and experimental andrology; (d) diagnosis and treatment of female infertility of endocrine and inflammatory origin; and (e) the creation of comprehensive human reproduction services in the Republic.

The clinical sector of the Institute is composed of departments of andrology, reproductive endocrinology, reproductive pathology, pathology of puberty and contraception. They have laboratories for hormonal diagnosis, biochemistry, genetics, morphology, pathophysiology, bacteriology and immunology, and carry out procedures for diagnosis or treatment such as laparoscopy, hysteroscopy, echoscropy, metrosalpingography, microsurgery of reproductive organs, and vacuum aspiration. The Institute is the regional centre for endocrine surgery.

The Institute has so far opened 17 consulting rooms all over the Republic of Georgia, and plans to open an additional 13 by the end of 1990.
With these additional facilities, it will be able to provide a comprehensive human reproduction service for the Republic.

A survey conducted by the Institute among 3 000 married Georgian women of reproductive age showed an ideal number of children of 3.67, a desired number of 3.09, an expected number of 2.7 and an actual number of 2.2. It was found that 76.1% of the women had the number of children they wanted. Among those who had not reached the desired number, 45.6% gave poor health as the reason, and others economic or social considerations. Social and psychological motives emerged as the main factors related to child-bearing, with economic conditions being of minor importance. The birth of a third child is mostly related to the desire to have a child of the opposite sex, particularly a male child. The survey also revealed that couples seldom discuss sexuality and contraception amongst themselves.

Infertility and contraceptive use

The proportion of infertile couples in the population is 10%. However, if we add to this figure women who can give birth but who have genetic contraindications, and also women who can become pregnant but in whom pregnancy and labour would be fatal, the percentage rises to 15%. Inflammatory and endocrine factors are the main reasons for infertility.

Only 18% of women living in the Republic use modern methods of family planning. The others have recourse to abortion. The high abortion rate led in 1986 to the establishment of a department of contraception at the Institute to deal with this problem and promote the use of contraception.

The most popular means of contraception used by women are the rhythm method, mechanical contraceptives, coitus interruptus, oral pills and chemical means. The use of contraceptive means (mainly condoms) by males is low.

The challenge is to convince medical personnel and patients of the effectiveness and safety of modern contraception, and to have physicians explain and prescribe appropriate methods to couples. The problem of adequate contraceptive supplies should also be looked into.

The Institute has launched public information campaigns about the health hazards of abortion, and a leaflet is distributed to all women attending the clinics for an abortion. This effort needs to be evaluated in terms of changes in fertility regulating behaviour.

[From: Dr A.G. Khomassuridze, Director, Zhordania Institute of Human Reproduction, 43 Lenin St, Tbilisi, 380009, Georgian SSR, USSR]

CAN MIDWIVES BE TRAINED TO INSERT IUDS? RESULTS FROM TURKEY

Since the early 1960s the Turkish Government has given priority to family planning as a measure to improve maternal and child health (MCH) services, and the IUD has been the most frequently recommended contraceptive means.

The IUD is quite acceptable to women in Turkey if provided properly. However, the major obstacle in the implementation of an IUD programme was the resistance of male physicians to the method. Since there are few female physicians in the country, one solution was to train female non-doctors in IUD insertion.
A three-phase service and research project was carried out by the staff of the Department of Public Health of Hacettepe University in Ankara, with the collaboration of WHO.

First, a study was conducted in 1976 in two centres, one in Manila (Philippines) and the other in Ankara-Cubuk (Turkey), to find out whether an assistant-nurse-midwife (ANM) could learn to perform a pelvic examination, an IUD insertion and a follow-up examination.

The study showed that 14 ANMs in Ankara-Cubuk and 13 in Manila were successfully trained to provide IUD services. Among 341 cases of IUD insertion checked in Turkey, only 21 minor and 9 major misdiagnoses were found to have taken place.

A training method was developed, and a manual for IUD insertion published by WHO for general use.

In the second phase of the research project (1977-78), the competence of trained ANMs in IUD insertion was compared with that of physicians. Clients were randomly assigned to physicians or ANMs. Clients who had pathological findings were sent to the gynaecologist. One month after insertion, all clients were examined by an independent physician. No difference in performance was found between the two groups. Follow-up of clients showed that the performance of the ANMs was similar to that of physicians. The percentage of correct insertions was 92.7% for physicians, and 94.4% for ANMs. IUD expulsions, removals, pregnancies and complications were similar in both groups.

The third phase of the research project (1979-82) was carried out by the Ministry of Health in collaboration with WHO, to study the use of trained non-physicians to provide IUD services in the country: How successfully can ANMs provide IUD services in Turkey? What effect has the teacher on the training of non-physicians? and how important is supervision in the field?

The Ministry of Health and Social Assistance selected 201 ANMs from 14 provinces. Six training centres were established, and the staff of these centres were taught the training method developed during the first phase of the study. The same training materials were used.

The 201 ANMs were randomly allocated to the six training centres and were evaluated through written tests before and after the training. Once in post, each trainee was helped by her supervisor to start providing IUD services.

To test the role of supervision, different types of supervision were scheduled and, at the end of at least one year of field practice, each trainee was re-evaluated in Ankara by the principal investigator.

It was found that all 201 ANMs were equally and satisfactorily trained in the six training centres, using the same training materials and methods. In actual field situations, the trained ANMs performed 29 000 activities related to IUD insertion, under supervision, in the year after the training.

A final evaluation was made of the trained ANMs after at least one year of field practice, giving the following results:

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a The project was supported by the Special Programme of Research Development and Research Training in Human Reproduction, WHO, Geneva.


### Final evaluation of ANM performance

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*Of the 201 non-physicians, 27 were excluded because they were not able to attend for final evaluation*

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The number of IUD insertions done, the time elapsed after initial training, and supervision were factors with a significant effect on ANM performance. They point to the need for retraining of non-physicians and the importance of support by the local physician in the field. One third of ANMs and nurse-midwives needed a refresher course two years after the initial training.

The positive results of this research project convinced the Ministry of Health and Social Assistance to approve, in May 1983, a new population planning law authorizing the use of trained midwives for the provision of IUD services in Turkey, and it is now in effect. The Ministry has also established regional centres for the training of ANMs, and over 30 are now functioning. The training programme continues.

Finally, an attempt has been made by the Ministry to include the teaching method developed by the project in the undergraduate curricula of nursing-midwifery schools.

By using trained midwives for IUD services, the FP programme in Turkey can expand into more rural parts of the country where these health professionals are available and already provide accessible and acceptable services. In this way family planning practices generally, including IUD insertion, will improve and spread throughout the country.

[From: Professor Ayse Akin Dervisoglu, Department of Public Health, Hacettepe University, Ankara, Turkey]
A NEW HELMSSMAN FOR THE ORGANIZATION

Dr Mahler, Director-General of the World Health Organization, officially informed the Executive Board of his wish not to be considered for a fourth term of office after July 1988.

The Board recommended that the Forty-first World Health Assembly declare Dr Mahler Director-General Emeritus, in appreciation of the dedicated services rendered by Dr Mahler to health and development the world over throughout his long career in WHO, and in particular as its Director-General from 1973 to 1988. The title was conferred at the Assembly's meeting in Geneva in May 1988. The Board and the Assembly felt that under his inspired leadership WHO has fulfilled more strongly than ever its constitutional role as the directing and coordinating authority on international health work.

Dr Mahler will be succeeded by Dr Hiroshi Nakajima.

Regional Director of WHO's Regional Office for the Western Pacific since 1978, Dr Nakajima has promoted new forms of collaboration between the Regional Office and Member States as well as with other UN agencies. Several innovative programmes have been started under his leadership. For example, the Western Pacific Region was the first to start an integrated AIDS control programme on a regional basis.

In his acceptance speech, Dr Nakajima stressed the importance of maintaining world peace as a pathway to social development and ultimately to Health for All. He indicated his awareness of the need to forge new partnerships, not only with North-South but also with East-West participants, and the need for concerted and timely action. Talk alone, he said, is no longer enough.

Having lived for half his life outside Japan, his country of birth, especially in Manila, Geneva and Paris, our new Director-General has broad international experience. He speaks, reads and writes excellent English, French and Japanese and reads Chinese and German well.

ENTRE NOUS pays a respectful tribute to Dr Mahler, pioneer of the Health for All movement and warmly welcomes Dr Nakajima, his successor.
EURO’S REGIONAL PROGRAMME ON AIDS

To strengthen the worldwide efforts of WHO’s Global Programme in combatting AIDS, the Organization’s Regional Offices have established sub-units on AIDS. In September 1987, the Regional Committee of WHO’s Regional Office for Europe adopted its programme on AIDS.

The regional programme is currently headed by Dr Alexander Gromyko, a graduate from Moscow Medical Institute with more than 20 years’ experience in his country and with WHO in eradication programmes and research on viruses. He will be joined shortly by social scientist Mrs B. Gredler, AIDS coordinator from Austria.

The programme’s priorities include making available worldwide the specific skills of European countries, such as surveillance systems for AIDS cases, pilot HIV serosurveillance systems, and computerized data collection and exchange of information between countries. These systems will be further developed in Europe and made available for wider distribution via the Global Programme on AIDS.

Other activities of the programme include helping WHO’s Member States to develop national programmes on AIDS prevention and control and assessing the concurrence of these programmes with policies and strategies recommended by WHO. The latter will be done by establishing pilot countries/regions. To prevent the further spread of HIV infection, model programmes promoting safer sexual practices among homosexuals and intravenous drug abusers will be tested as well ways of ensuring proper counselling of HIV-infected persons, AIDS patients and parents of infected children.

Of specific concern is the development of guidelines for the care of AIDS patients in their terminal stage. Prevention will be enhanced by promoting comprehensive health education and information for various population groups, and particularly for schoolchildren and adolescents.

Finally, the regional programme on AIDS will develop scenarios to estimate the social and economic impact of AIDS on societies and nations, and study the legislative instruments needed for AIDS prevention and control.

[Further enquiries to: Dr A. Gromyko, Regional Programme on AIDS, WHO Regional Office for Europe, Scherfigsvej 8, 2900 Copenhagen 0.]

New publication dates for ENTRE NOUS

We apologize for the delay in your receiving issues 11 and 12 of ENTRE NOUS. For technical reasons we have changed the publication dates. From now on the July issue will appear in October and the December issue in March of next year, so issue no 13 is due out March 1989.

The need to save on paper and postage has led us to abandon the simultaneous production of ENTRE NOUS in English and French. The current issue is produced and mailed separately in English and French, and you will have received either the English or the French version. However, the content of both the English and French version is the same.

Please do tell us if you prefer to receive ENTRE NOUS in the other language version. For our Spanish- and Portuguese-speaking readers, the Spanish and Portuguese language edition will continue as before. We are sorry for any inconvenience these changes may cause and hope you continue to enjoy ENTRE NOUS.

[Dr L. Van Parijs, consulting editor]
CONCEPTS OF SEXUAL HEALTH

A working group on concepts of sexual health was convened by the WHO Regional Office for Europe from 5 to 7 May 1987, to look at the relationship between sexuality and health, variations in people's sexual needs, factors affecting their sexual wellbeing and requirements to achieve sexual health.

The group indicated that sexual health has been used as a normative and restrictive concept throughout history and in different countries and cultures. For example, what sexual activities are healthy or unhealthy and for whom? Was the sexual abstinence advocated by nineteenth century physicians healthy or does it have damaging effects, as stated by subsequent sexual reformers? While acknowledging the relationship of sexuality and sexual health with prevailing human values in society, the working group proposed two criteria which should be implicit in all definitions of sexual health: first, individual sexual needs and experiences are unique. They vary by culture, age, physical and mental ability and personal preferences. Secondly, each individual has the right to protect him/herself or to be protected from sexual exploitation and abuse.

The group then turned to a discussion of variations in sexual needs and experiences: differences in male/female roles in cultures and societies; different attitudes in Europe towards the sexuality and preparation for sexual life of adolescents; the relative neglect of sexual realities in middle and old age; the misconceptions and myths surrounding sexual needs and possibilities for satisfaction of chronically sick and disabled people, and the stigmatization of homosexuality in most cultures of Europe.

Among conditions affecting people's sexual wellbeing are privacy, independent housing, availability of reliable family planning methods, and laws concerning contraception, family planning, abortion, sex education and divorce. Relevant areas for change in these conditions were discussed by the working group.

Finally, what measures can countries take to promote their people's sexual wellbeing? The group first identified a series of preventive measures: education and information about sexual relationships and practice for all ages, training of professionals to be more sensitive and adequate in dealing with sexual issues, and work at community and policy-making levels to tackle the socioeconomic and legal barriers which prevent people from living a satisfying sexual life. At a second level, the group found that countries should be able to provide professional help and therapy for individuals or couples with sexual problems, for victims of sexual abuse and for sexual offenders.

EDUCATIONAL AIDS/ TRAINING MATERIALS

TRAINING MATERIALS ON SEXUALITY AND FAMILY PLANNING

Sexual problems are quite common and often cause unnecessary distress. People with such problems may seek help from health or social workers who are often unable to give it, partly because they lack the necessary information and skills and partly they themselves are affected, like their clients, by taboos and constraints surrounding this subject.

The Sexuality and Family Planning unit of WHO's Regional Office for Europe has therefore encouraged the development of training materials for health and social workers on various aspects of sexuality and family planning. These materials are based on the "modular" approach and have been prepared by experts. They have been tested in the field and are aimed at increasing the knowledge and skills of health and social workers in the areas of sexuality and family planning, but they also encourage health professionals to take a closer look at their personal attitudes towards sexuality.

The development and production of the training materials is financially supported by the United Nations Population Fund (UNFPA).

The four training manuals listed below are currently available*. The last three can be ordered from the Sexuality and Family Planning unit, WHO Regional Office for Europe, Scherfigsvej 8, 2100 Copenhagen, Denmark, while the first should be obtained from the Département des Enseignements, Centre International de l'Enfance, Château de Longchamp, 75016 Paris, France.


* Other manuals are in preparation: Guidelines on STDs and AIDS for family planning programmes; Guidelines on certain aspects of homosexuality; HIV and AIDS: counselling skills for health professionals.
The book is easy to understand and is intended for nursing teachers, student nurses, teachers and students at other schools that have contact with disabled people, staff at care institutions, and people with disabilities, their families and loved ones. It is designed for use in staff training courses and adult study groups and seminars, and for other educational settings.

[Write to: Mrs Inger Nordqvist, The Swedish Institute for the Handicapped, Box 303, S-161 26 Bromma, Sweden. Book orders to the same address. Price: 35 Swedish Kroner]

Options for change. A staff training handbook on personal relationships and sexuality for people with a mental handicap

Written by Hilary Dixon, this handbook is a joint publishing venture by the British Institute of Mental Handicap (BIMH) and the Education Unit of the Family Planning Association (FPA). It is based on a series of BIMH-FPA workshops that have been held annually since 1983. The book gives examples of learning-by-doing for staff working with mentally disabled people, showing for instance how to prepare for discussion on sexuality, how to explore feelings and attitudes, and how to acquire skills in communicating about sexuality.

"Options for change" consists of two parts. Part 1, on "Methods", explains to the trainer how to organize a workshop, a course or a series of study days for staff. Part 2, on "Materials", contains practical exercises, case studies, quizzes and other materials that can be used in the training activities proposed in Part 1.

The handbook is practical, detailed and should be easy to use by trainers familiar with working with groups.

[Available from: FPA Education Unit, 27/35 Mortimer Street, London W1N 7RJ, United Kingdom. 87 pages, English only. Price: 6.60 pounds]
Bodies. Participatory teaching materials

While working in the Mental Handicap Services of Winchester Health Authority in the United Kingdom, Mary Dicks and Alan Levin developed a particular approach to talking with mentally disabled adults about sexuality.

The approach takes the form of a jigsaw-like game based on four figures (a man, a woman, a boy and a girl) which can be played by up to eight players. There are four base boards (man, woman, boy, girl), a pack of 23 playing cards each showing a body part, and 28 body parts to fit the inset boards.

The materials should be used in a small group and are designed to overcome the initial embarrassment experienced by many people when teaching and learning about the human body. They also provide visual information about male and female, child and adult bodies, encourage discussion on body similarities and differences, and help develop suitable vocabularies among the disabled for talking about the human body.

To the authors, sex education includes the presentation of facts and the development of social skills, but it is also an emotionally, socially and culturally relevant context for sharing experiences and feelings. Such a context depends on conditions such as:

- A "stress-free learning environment". People are more likely to discuss topics openly if they are relaxed and find the session enjoyable.

- "Active participation". People who lack the confidence to make a verbal contribution to the discussion should be encouraged to participate non-verbally, which may lead to the necessary confidence to speak up.

"Bodies" is designed to meet these conditions, while introducing one basic topic in sex education: talking about one's own body and those of other people. The materials provide an opportunity for individuals to learn from their peers and enable the group leader/teacher to identify areas of misunderstanding and concern. They also encourage discussion, so that teaching can be related to each individual's experience and attitudes.

Designed primarily for adults who have a mental handicap, they have been successfully used with children who have learning difficulties. The authors have found the materials useful for any group which wishes to explore this learning approach towards sexuality.

[For a copy of "Bodies" write to: FPA Education Unit, 27/35 Mortimer Street, London W1N 7BJ, United Kingdom, English only. Price: 6.60 pounds]
Feminist groups, dissatisfied with male-dominated medical services, have also established family planning services linked to other areas of women's health.

The authors conclude that to develop truly alternative services, some of the assumptions underlying family planning provision need to be changed. Conventional family planning clinics must begin to establish a range of different services or to support and extend existing alternative services. Family planning associations and other nongovernmental organizations may have a role to play as mediators between established and alternative services. They could help alternative projects by giving premises, back-up information and financial assistance.

Other WHO documents


A WHO scientific group was convened in December 1986 to assess current knowledge about the action, safety and efficacy of IUDs. There have been notable advances in the types of device now available (copper and hormone-releasing devices). On the other hand much concern has been expressed by governments, family planning bodies, the media and individuals about the increased risk of pelvic inflammatory disease and subsequent tubal infertility associated with IUD use. These and other questions were examined by the group, which concluded that the IUD-associated risk of pelvic inflammatory disease is much lower than previously thought and IUDs are now probably the second most commonly used (60 million women) reliable reversible method of contraception world-wide.

Their use in both developed and developing countries should continue to be supported. IUD stocks that are exhausted should be replaced by the more effective copper-releasing IUDs.
A refreshinglly written WHO publication for family planning counsellors and programme administrators on barrier contraceptives and spermicides which have the great advantage that they can be distributed through a variety of outlets, both commercial and non-commercial. The content will meet the pragmatic needs of family planning staff. The chapter on methods and specific user groups can be readily applied by the counsellor in discussing family planning needs and possible solutions with the individual client or the couple.

Programme managers will find the section on the logistics of barrier methods and spermicides (covering manufacturing, supplies, stocks, shelf-life and quality control) of particular interest. The book features a special section on AIDS and the use of condoms in preventing HIV transmission.

This publication, which has been financially supported by UNFPA, is one of a series of technical guidelines for the provision of contraceptive services. Other guidelines already published by WHO have been concerned with female sterilization, induced abortion, oral contraceptives, injectable contraceptives and intrauterine devices.

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ENTRE NOUS may be freely translated into your national language and reprinted in national journals, magazines and newspapers provided that acknowledge- ment is given to ENTRE NOUS and the WHO Regional Office for Europe.

Inquiries should be addressed to the authors of signed articles. For information on WHO-supported activities and WHO documents, contact the Unit of Sexuality and Family Planning, WHO Regional Office for Europe, Scherfigsvej 8, 2100 Copenhagen 0, Denmark.

WHO publications should be ordered direct from the WHO sales agent in your country or from WHO, Distribution and Sales Service, 1211 Geneva 27, Switzerland.

ENTRE NOUS was created in 1983 by Ms Wadad Haddad, Regional Officer for Sexuality and Family Planning. ENTRE NOUS is produced by the Sexuality and Family Planning Unit, with the assistance of Dr L. Van Parijs, consulting editor, in collaboration with national correspondents in WHO's European Region and contributors from international agencies.