UPDATE ON ORAL CONTRACEPTIVES AND CANCER

Steroid hormones, both endogenous and exogenous, have long been known to influence the risk of cancer. More recently, a considerable amount of research has been conducted to determine whether using oral contraceptives alters the risk of a woman having cancer and, if so, to what extent. The now widespread use of oral contraceptives, and the importance of cancers of the reproductive system as a cause of morbidity and mortality among women, have made this an issue of considerable public health importance as well as of public concern.

This report reviews major findings related to combined oral contraceptives and cancer of the breast, cervix, ovary and endometrium.

Breast cancer

In many developed countries, breast cancer is the leading cause of cancer mortality among women. Risk factors for breast cancer appear to be related to a woman’s hormonal status — for example, age at menarche, age at first full-term pregnancy, age at menopause — and hence possibly to the use of oral contraceptives. On the whole, findings from more than a dozen studies of breast cancer and oral contraceptives have not shown an overall significant increase in breast cancer risk.

Recently, however, the risk of breast cancer among women who used oral contraceptives for a long time at a young age has received considerable public and professional attention, following a report in October 1983 by Pike et al.a The use of so-called "high progestogen" oral contraceptives for more than two years before the age of 25 was reportedly associated with a significantly increased risk of breast cancer. Pike’s report was subsequently criticized, primarily for the authors’ definition of progestogen "potency", as well as for the study design and method of analysis. In December 1983, McPherson et al. published results from an ongoing study which showed no increased risk of breast cancer with the use of oral contraceptives before the age of 25.b However, the investigators found a threefold higher risk of breast cancer among women who used oral contraceptives for more than four years before their first pregnancy. In November 1985, the Centers for Disease Control published results from the large population-based, multicentre Cancer and Steroid Hormone Study (CASH). This data set showed no


association between breast cancer and oral contraceptive use, either before age 25 or before the first full-term pregnancy.\(^a\)

In summary, the data on breast cancer are generally reassuring and suggest no significant increase in risk with oral contraceptive use. Some concern remains, however, regarding a possibly increased risk among certain women such as very young women, those who used oral contraceptives before their first pregnancy, and those with a past history of benign breast disease or a family history of breast cancer. Additional data are needed to clarify this issue.

Cervical cancer

Cancer of the cervix has been one of the most difficult cancers to study with respect to oral contraceptives, because of potential study bias. For example, women with many sexual partners are known to be at greater risk of having cervical cancer than those with only one partner. If women who use oral contraceptives are more likely to have more sexual partners than women who do not use them, then the apparent association between oral contraceptives and cervical cancer may instead be due to the difference in sexual habits.

Results from seven case-control and three cohort studies that have been published are not entirely consistent. Nevertheless, a pattern has begun to emerge from the results. Five of the case-control studies reported an increased risk of cervical cancer (i.e. a relative risk greater than 1.0) and three of them showed the risk to increase the longer oral contraceptives were used. All three prospective cohort studies have tended to show positive results, and two of them have also found an association with duration of use. Findings from a cohort study reported by Vessey et al. showed an increased risk of dysplasia, carcinoma in situ, and invasive cervical cancer among oral contraceptive users as compared to IUD users.\(^b\)

The most recent report on this issue comes from the WHO Collaborative Study of Neoplasia and Steroid Contraception conducted in eight countries, and shows both an overall relative risk of invasive cervical cancer of 1.19 (of borderline statistical significance) and a significantly increasing risk the longer oral contraceptives are used.\(^b\)

Many of these studies have not controlled for the difference in sexual practices, which is known to be an important confounding variable. The increased risk reported has been generally small - usually less than twice that of the comparison group. Nevertheless, although the positive association seen in most of the studies may be due to biased selection, misclassifications or other confounding variables, a causal relationship between oral contraceptive use and cervical cancer cannot be excluded.

Ovarian cancer

Although the incidence of cancer of the ovary is relatively low, the mortality rate remains high. The risk of ovarian cancer has been shown to be lower among women of high parity, suggesting that pregnancy provides a protective effect. This has led researchers to postulate that oral contraceptives, which like pregnancy, suppress pituitary gonadotropin release and inhibit ovulation, would protect women to some extent against ovarian cancer.

At least seven studies have reported a decreased risk of ovarian cancer among women who have used oral contraceptives. The most recent and by far the largest study on this topic is the CASH study cited earlier, which found


that women who had used oral contraceptives had half the risk of developing ovarian cancer of women who had never used oral contraceptives.a

The consistency of the results from various studies of ovarian cancer and oral contraceptives is impressive, as is the magnitude of the reported protective effect. Furthermore, it appears that the protective effect may persist after the use of oral contraceptives is stopped.

Endometrial cancer

Many of the known risk factors for cancer of the endometrium are related to a woman's hormonal status, including nulliparity, use of estrogens only, early menarche and late menopause. Thus it is reasonable to investigate the possibility that the use of oral contraceptives affects a woman's risk of developing endometrial cancer.

At least four case-control studies and two prospective studies have shown a decreased risk of endometrial cancer with the use of combined oral contraceptives.b The overall risk in all four case-control studies was reduced by approximately one half. Three of these studies looked at the effect of the duration of oral contraceptive use. Two found a protective effect only after at least one year of oral contraceptive use and one also demonstrated an increasing protective effect the longer oral contraceptives were used. One study showed a protective effect persisting for more than five years following the cessation of oral contraceptive use and another for more than ten years.

A protective effect of combined oral contraceptives is consistent with other evidence concerning the effect of estrogens and progestogens on the development of endometrial cancer.

Women who receive only estrogens after menopause have been shown to have higher risk of endometrial cancer, whereas progestogen used at least six days of each month appears to eliminate this effect. Similarly, sequential oral contraceptives with at least 16 days of unopposed estrogen appear to increase the risk of endometrial cancer.

CONCLUSION

Given the substantial protective effect that combined oral contraceptives appear to provide against ovarian and endometrial cancer, current findings are far from gloomy. Additional information is needed, however, particularly for breast and cervical cancer, in order to describe more definitely the risk of cancers of the reproductive system associated with combined oral contraceptives.

[From: Dr Susan Holck, Medical Officer, Special Programme of Research, Development and Research Training in Human Reproduction, World Health Organization, CH-1211 Geneva 27, Switzerland]

The Product information memo is published by PI ACT six times each year. It features abstracts on contraceptive methods and products, selected from scientific journals and technical magazines. English only.

[For sample copy and further information write: PI ACT, 4 Nickerson Street, Seattle, Washington 98109-1699, USA]
CONCERN FOR THE DEVELOPMENT
OF THE FAMILY IN POLAND

In Poland a specialized organization, the Association for the Development of the Family, stimulates social awareness and plans activities to ensure the development and happiness of the Polish family in socialist society. They include:

- spreading and bolstering full respect for the privileges of all family members and encouraging the fulfilment of family obligations;

- promoting the principles of marital and family relationships, including assistance to parents and teachers in educating children, and in preparing young people for family life;

- assisting families in solving conflicts related to family life;

- diffusing ideas of responsible motherhood and fatherhood and increasing the feeling of responsibility among parents for the successful physical, psychological and moral development of their children;

- promoting contraception and making society aware of the harmful effects of induced abortion.

The Association carries out its activities through lectures, seminars, conferences, the use of the media and publications, premarital counselling sessions, research and cooperation with various national and international organizations and institutions.

The most popular activities are lectures, mainly on problems related to hygiene of adolescence, sexual initiation, the harmfulness of induced abortion, methods of preventing pregnancy, marital conflicts and emotional development. These topics are also subject of various publications from the Association, and of radio and television programmes.

The Association also has a network of premarital and family consultation units specializing in psychological, sexual and legal aspects.

Treatment of gynaecological, endocrinologic and sexual illnesses is the province of specialized medical units providing consultations on gynaecological, andrological and sexual health problems. Contraceptives and drugs used in gynaecology are manufactured by the company Securitas.

Research related to the aims of the Association is conducted by the Centre for the Study of the Contemporary Family which also collects and disseminates information about the family.

The Association for the Development of the Family consists of a basic unit, the local circle, located within one voivodship and forming the voivodship division. (A voivodship is a unit, corresponding to a province. At the moment there are 49 voivodships in Poland.) The Voivodship Congress, its Board and Revisory Commission exercise authority over a voivodship division. At the national level, authority rests with the National Congress, the Executive Board and the Main Revisory Commission.

The Association has ordinary members, sponsors and honorary members. All citizens of Poland can be members of the Association if they are accepted by the Board on the basis of a written declaration. Sponsors can be any physical and legal person interested in the activities of the Association who declares financial support for its activities. Finally, Polish citizens with special merits may become honorary members of the Association.

[From: Mr Jerzy Witezak, Secretary General, The Association for the Development of the Family, Żarzad Główny, ul. Karowa 31, 00–324 Warsaw, Poland]
ADOLESCENT GIRLS TALK ABOUT SEX, CONTRACEPTION, PREGNANCY AND ABORTION

Seventy-two girls under 18 were interviewed by social workers in Roubaix, France.

Their answers confirm the main findings of various surveys and national studies: girls with a lower socio-cultural and economic background have less knowledge about contraception and a greater risk of an early pregnancy. They use some method of contraception but contraceptive information as well as sex education, is incomplete. Young people criticize the way they are informed about sex and contraception but have no specific idea about how to remedy this state of affairs.

We have extracted some individual reactions from girls in the survey.

N. and V. talk about sex and contraception

N. is 16 and in high school. V is 17. She has a boyfriend and had sex with him on several occasions.

— Both: "Sex education is often given when there is no need. It does not touch us, especially when we feel how uncomfortable the teacher is about this matter. Abortion is a complete failure. To have a child so young brings all kinds of problems. Delivering a child is also frightening. We could give birth to an abnormal child."

— V.: "The pill is OK but I would not like to take it all the time. Contraception is complicated. I don't trust it too much. After all, sex is not as great as we have been told. It is difficult to explain. First time I did not really want but my boy friend insisted. I was afraid he would leave me if I refused. Often it is done in a hurry at his home. We are scared his parents might arrive."

— N.: "I prefer to wait till it feels good. If the bloke drops me because I refuse to give in, he is not any good anyway."

I. was interviewed in a maternity ward

I. is 16. Her first first baby was born two days ago. She was thrown out of the house by her parents when she was 13. They did the same thing to their seven elder daughters. I. lived with girl-friends. She met her boyfriend 18 months ago and since her pregnancy has shared a little house with him. He is 21, has completed his military service and is a clerk.

— I.: "Of course, 16 is very young to have a child. However I want only one. I don't think you can love all your children equally when there are many."

— Interviewer: "Did you want a child right away?"

— I.: My boyfriend wanted me to take the pill but I didn't really care. I rather liked being pregnant. I have discovered lots of things. From now on I will have to take the pill or maybe use an IUD since we don't trust the condom. All the social workers whom I have met since I left home wanted to place me in a foster home but I hid. What I would have liked was a small studio and once in a while a talk with a social worker or an educator. They could have helped me find a job."
M. had just had an abortion

M. is 17. Her parents are divorced and she lives with her aunt. She goes to school and is in her last year of study for the "brevet d'enseignement professionnel". She is engaged to a 19 year old baker who just left for military service. That is why they requested an abortion. She had her first intercourse at 15.

- M.: "I had little information on sex and contraception outside school. At school the teacher rushed through the programme. He was obviously ill at ease. I read some books and knew I could become pregnant. This has always been a major point of discussion with my lover. He wanted me to take the pill but he did not want to use a condom. I feel a woman should not bear the whole responsibility for contraception."

"There has never been any real talk with my parents. Perhaps that's also why I decided to have an abortion. On the other hand to have a child at my age is too early. I know that my aunt and my grandmother would have helped me raise the child but I want to raise my child myself, with the father. Otherwise it is sad. It doesn't make any sense. I feel that apart from the financial problem, I would be unable to do it. I am not an adult yet. What I have been through makes you think. Now I am going to take the pill because I don't want to be pregnant again. Maybe in the future. I have understood that one cannot just make a child like this. I took a risk and I am paying the price. Too bad!"

[Source: Excerpts from a study; Grossesse précoce et service social sur Roubaix, Lille, June 1984, conducted by Mme Lucie Delbaere, social worker, 180 Rue Jean Moulin, 59100 Roubaix, France]

A REPORT ON LEGAL ABORTION IN ITALY

Since 1980, a system of monitoring legal abortion has been implemented by the Istituto Superiore di Sanità in collaboration with the Ministry of Health and Regional Health Services, based on three-monthly questionnaires compiled from individual forms by the regional health departments. The data are used by the Minister of Health to present an official report to Parliament each year. The surveillance system was organized and sustained by Dr Simonetta Tosi, who dedicated her intelligence and scientific competence to the cause of women's health in Italy. She unfortunately passed away last year and this report on legal abortion in Italy in 1983 is dedicated to her memory.

Abortion on request during the first 90 days of pregnancy was legalized in Italy in May 1978. Under this legislation, abortions can be performed only in public hospitals or in approved private hospitals or outpatient clinics. The procedure is free of charge. To obtain an abortion a woman must get a doctor's certificate and wait at least seven days. A minor (under the age of 18) cannot obtain an abortion without written permission from her parents, guardian or from a judge acting in loco parentis. Second trimester abortions can be authorized only if the pregnancy constitutes a grave threat to the mother's life or when fetal abnormality is expected.

The reported waiting time before abortion in seven regions in Italy shows that 70% of women wait less than 14 days. Written permission to minors was given by parents in most cases (58.6%). The vast majority of abortions (79%) in 1983 were performed in public hospitals, usually by vacuum aspiration and under general anaesthesia. Under current Italian abortion legislation, health professionals may refuse to perform an abortion or to participate in the procedure on moral grounds. These conscientious objectors must inform the local health authority of their decision.
In 1983, 59.1% of obstetricians/gynaecologists refused to perform an abortion, 50% of anaesthesiologists and a similar percentage of paramedical workers. These percentages, however, vary greatly (between 30% and 80%) among regions of the country.

A total of 233,976 legal abortions were performed in 1983. The abortion rates from 1980 to 1983 were: 16.1, 16.2, 17.2 and 16.9, respectively, per 1000 women aged 15–49 years. However, there are wide regional differences, with rates under 10 per 1000 to rates over 20 per 1000. Abortion ratios for 1980 through 1983 are, respectively, 345.3, 363.2, 380.2 and 381.7 per 100 live births and show the same geographical variation (higher in northern and central Italy, lower in southern Italy and the islands).

What are the sociodemographic characteristics of women requesting legal abortions? With respect to age, abortion rates are highest for women aged 25–34 and lowest for those under 18. The proportion of minors having an abortion (2.6%) is smaller in Italy than in other countries. This may be related to the difficulties in obtaining consent from parents, guardians or judges. Further, 70.5% of women undergoing abortion are married, compared to lower figures for Norway (44%), the United Kingdom (34%), Canada (25%) and the United States (22%). Over 90% of all legal abortions in 1983 were obtained within the area of residence of the applicant.

The proportion of repeat abortions increased; 18% had one prior abortion and 6.9% two or more. The figures for 1982 were 12.5% and 5.1%, respectively. Repeat abortions are not indications of moral decline or of a decrease in contraceptive practice but are trends to be expected for a number of years after abortion has been legalized.

Slightly more than half of Italian women (53%) undergoing abortion have two or more surviving children. This sets Italy apart from other countries, where abortions are more frequently observed in nulliparous women.

Most abortions (83.5%) are performed within 10 weeks of gestation and only 0.9% as emergencies outside the legal limit of 90 days. There is a marked relationship between the age of women and the gestational period in which abortion is obtained: abortions late in pregnancy are more common among women under the age of 20 and above the age of 35.

Induced abortion was legalized in Italy to eliminate the human, health and economic cost of illegal abortion. Have legal abortions replaced illegal ones? It is difficult to answer the question with certainty, although interregional differences may permit some tentative conclusions. Neighbouring regions with similar socioeconomic levels, fertility rates and availability of maternal and child health services have vastly different legal abortion rates. It is assumed that in regions with available and efficient health services, illegal abortion has been largely replaced by legal abortion and the population's demand for induced abortion has been met. In applying these regional rates to the other regions we can estimate the number of "expected" abortions; these are around 100,000 and most numerous in the southern regions (about 71,000 cases). Different models to calculate illegal abortions have been applied to the Italian data and produce estimates of a similar order of magnitude.
The prevention of abortion rests largely on the existing network of 2091 national maternal and child health services (Consultori Familiari) and of 176 private Consultori Familiari. At these facilities women can obtain information and practical help for contraception, pregnancy care, and care after the birth, as well as a doctor's certificate for abortion.

Previous studies have suggested a number of explanatory factors. One-child households are on the increase in Europe as well as the number of childless families. This trend does not imply a rise in the number of voluntarily childless couples. It is presumed that a majority of childless couples are involuntarily childless or – and this is a recent trend – that more women tend to postpone childbearing into their thirties and are then unable to conceive.

Some studies have investigated whether childlessness by choice is a sign of mental immaturity, but this conclusion has not been borne out by the facts. Do couples decide not to have children because of changes in the values ascribed to family life and to having children? In countries where divorce rates are high (in Denmark 1 out of 3 children experience the divorce of their parents before the age of 10) and in Scandinavian countries, where many children and adults live in serial families (the family in which one is born is not the same as the family in which one grows up), having children and parenthood may not provide an emotional and practical cushion any longer. The increasing number of women joining the labor force and the secularization of society also contribute to smaller families. Whether these changes in values and family structure contribute to a conscious decision not to have children has not been shown conclusively.

A number of studies focus on voluntary childlessness as a choice of lifestyle. Childlessness is then related to continuing a career, keeping one’s freedom in the sense of a flexible and spontaneous way of life, enjoying togetherness as a couple and being socially active.

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**Voluntary Childlessness:**

**An Exploratory Study of 17 Danish Couples**

In western and northern Europe and especially in the Scandinavian countries, a growing number of young couples get married or set up life together (cohabit) with a conscious decision not to have children or to postpone childbearing. The trend appears in countries whose cultures do not strongly disapprove of choosing to have no children. There are no reliable data, however, on how many couples are voluntarily childless.

This limited study of Danish couples does not estimate the prevalence of voluntary childlessness but explores some of the reasons why couples decide not to have children.

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*a* Voluntary childlessness should be distinguished from involuntary childlessness or infertility. There is a normal base rate of infertility, estimated at 10% but widely varying between different countries (from 2% to 50%), because of chromosomal, congenital and endocrinologic abnormalities in some people, as well as acquired infertility related to various infectious conditions, especially sexually transmitted diseases.

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*a* Demographic Trends in the European Region, WHO Regional Office for Europe, 1984 (WHO Regional Publications, European Series no. 17), page 73.

Do we find these factors in our study of 17 self-selected Danish couples? Most of them (9 out of 17) had lived for more than 6 years in a stable relationship; 8 of the 17 were married, 7 lived together and 2 had separate residences. None considered themselves religious. Only 2 lived in a rural area; 4 women were under 30 years of age, 6 between 30 and 34 and 5 were 35 years old and over. Four women and two men were not Danish nationals.

The couples were not childless because of any strong opinion against having children. They accepted that it is natural to have children, and that people experience themselves through children. However, they did not feel that children are the meaning of life, nor were they afraid of being lonely in old age. The couples said they identified perfectly well with their genders and felt children bring so many practical and emotional obligations that the relationship between husband and wife becomes less intense. The dominant attitude throughout the interviews was the individual's right to choose a life freely.

This attitude appeared in discussions of partner relationships and careers. A good relationship was defined as one that supports the partner's right to freedom of movement, opportunity to choose and to offer solid friendship. A child was seen as an impairment of freedom and likely to reduce the intensity of the couple's relationship.

Restrictions of freedom following the birth of a child had been observed by all interviewees among their close friends with children. Also, 10 women had worked for some time with children (as teachers in nursery schools, paediatric nurses or youth counsellors) and indicated a positive interest in children and young people. Two had cared for their younger siblings at home. Three of the seventeen expressed doubts about whether they would be able to fulfill the requirements of motherhood.

Most of those interviewed made the decision not to have children in their early twenties, and it was a decision they made alone or with their partner. Had they ever desired to have children? Eleven women and five men had not actively considered not having children. They just had not made any decision about it. The desire to be pregnant was present among 4 of the 17 women.

Did agreement on childlessness exist among the two partners? Four couples disagreed about not having children at all and had agreed to postpone having children. The women in these four couples felt that having children would mean the end of their relationship and they did not want such a confrontation. Each of the men and women agreed that a strong desire in the partner for children would be a great problem.

The 17 couples were not aware of any inability to have children. Condoms were used by 7 out of 17 couples, along with an IUD or the pill. Six women had had an induced abortion and two of them were sterilised later on.

To conclude, the attitude of the Danish couples could be interpreted as selfish. They do not want to sacrifice themselves to a child. The public may easily associate them with the rich who have a dog, furs, a car and a glamorous life. Although public attitudes towards motherhood are changing, voluntarily childless couples tend to occupy a deviant position in society.

The 17 couples interviewed exercised an option available to them: choosing a particular lifestyle without children. Are they pioneers? Do they have stronger inner resources to choose a child-free lifestyle? These are questions the present study cannot answer. The study may, however, stimulate debate and research to better understand this phenomenon and its implications for society and for the health and social services.

[Excerpts from a Study on couples without children: voluntary childless couples carried out by Mrs E. Christensen, Women's Research Centre in Social Science, Aalborg 49, DK-1304 Copenhagen K, at the request of and financially supported by the Sexuality and Family Planning Unit of the WHO Regional Office for Europe]
SEXUAL HEALTH
ACKNOWLEDGED IN STUDY ON HEALTH

The WHO Global Programme for Appropriate Health Care Technology has for several years been responsible for a multinational study, conducted in 10 countries, on different methods of administering insulin to diabetics: the injection of insulin or continuous insulin infusion by pumps. In addition to evaluations of which form of therapy is easier to carry out and of the costs associated with each, effects on the daily life of the patient are also considered. In fact, divorces have been occurring among female diabetic patients who choose to wear a pump in spite of the husband not feeling at ease with a pump-wearing wife. In particular, the quality of life has been recognized as an important consideration. One aspect of quality of life is how individuals relate to their own sexuality. Since diabetes is known to have effects on the peripheral nerves, some sexual adjustments may be necessary for a gratifying sexual life. Hence, in this study, the participants were asked to evaluate their love and sex lives in a questionnaire. An analysis of the replies will be available in 1987.

The acknowledgement that health also encompasses sexual health and the resultant consideration of this component of an individual's wellbeing are encouraging. A growing number of studies in the future will hopefully include the consideration of the patient/client's sexual wellbeing when evaluating health.

[From: Dr Kirsten Staehr Johansen, Manager, WHO Global Programme for Appropriate Health Care Technology, Danish Hospital Institute, Nyropsgade 18, DK-1602 Copenhagen V]

MEETINGS REVIEWED

UPDATE ON SEXUALLY TRANSMITTED DISEASES

From 28 to 30 October 1985 three days were devoted to sexually transmitted diseases in Rabat. Senior medical officers from the provinces, dermatologists, specialists in midwifery and gynaecology and national representatives from the three Maghreb countries (Algeria, Morocco and Tunisia) attended as well as national and international teachers. The meeting was organized by the National Centre for Human Reproduction and Family Planning in Rabat, together with the Family Planning unit of the WHO Regional Office for Europe. Its objective was to discuss the epidemiology, prevention, diagnosis and treatment of sexually transmitted diseases to develop a strategy for the management of these diseases in these countries.

A report on the seminar is available in French from the Sexuality and Family Planning Unit of the WHO Regional Office for Europe. It includes an update of present knowledge on various problems pertaining to traditional as well as non-traditional sexually transmitted diseases, including AIDS, and a set of recommendations to guide the process of implementing a programme for prevention and treatment geared to the Maghreb countries


A DRAFT REPORT ON ARTIFICIAL REPRODUCTION

In March 1985 the Sexuality and Family Planning Unit of the WHO Regional Office for Europe organized an informal consultation in Copenhagen to discuss the medical, ethical, legal, psycho-social and demographic aspects of artificial reproduction, in particular artificial insemination by donor (AID) and in-vitro fertilization (IVF).

Artificial reproduction challenges workers in family planning and sexual counselling to consider the implication of recent advances for their work. It also raises new questions of public expectations, ethics and legality that cannot be evaded. For example, is artificial reproduction an alternative method of procreation that individuals can use freely or is it a medical act intended to overcome infertility in women or men? Should techniques of artificial reproduction be used only for married couples or should single women (infertile or fertile) or widows be allowed to benefit from these new methods? What are the rights of the child born through the application of one of the methods of artificial reproduction, especially when a third party is involved? How should these rights be protected? There are questions concerning the consent and the anonymity of people involved in procedures of artificial reproduction, as well as questions concerning the requirements people should meet before having access to methods of artificial reproduction.

These questions are of growing concern to Member States and to the WHO Regional Office for Europe. Your comments are welcome on this matter and on the draft report, which can be obtained by writing to the WHO Regional Office for Europe, Sexuality and Family Planning Unit, Scherfigsvej 8, 2100 Copenhagen Ø, Denmark (13 pages, in English only).

EDUCATIONAL AIDS

THE PROFILE OF A CAMPAIGN: "MEN TOO"

In 1981, Whitacker, a young male medical student approached 12 family planning clinics and described his reception in the following terms:

"On entering the clinics I was always the only man in the room and I felt self-conscious. If I was met with surprise, or even worse, giggling, I became embarrassed and uncomfortable. If I was met with suspicion, and even accused of trying to obtain condoms for resale, my self-conscious feelings were turned to those of guilt."

Some of the blame for lack of male involvement, estimated at 1.2% of the 1.5 million clinic users in England and Wales, can be pinned on the agents of contraceptive provision, but services exist within a social climate. Social attitudes towards men and contraception reveal two separate views of male sexuality: the image of man as a superstud and the man who equates fertility with his virility. In addition, women, who fought long and hard for means to control their own fertility, may be reluctant to hand over control.

Currently the most popular methods of family planning are also female methods; there are 3.5 million users of the pill in the United Kingdom, compared to 2.8 million condom users in 1980, although this is a recent phenomenon. Earlier methods used to achieve fertility decline in Europe were mainly directed at males (withdrawal and the condom). Finally, there is generally little media interest in contraception and, when it

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comes to features and advice on contraceptive methods, female methods predominate. Male coverage is scanty and reflects stereotyped social attitudes, especially in the popular press, reinforcing the male macho or heroic superstud image among readers and viewers.\(^a\)

Why involve men more?

It would help prevent more unplanned pregnancies, but there are other reasons. The preoccupation with women as users of contraception is a reflection of our gender arrangement; men sire children and women bear and rear them. This is not in the interest of a shared responsibility between men and women for parenthood and living together sexually. Greater involvement for men in deciding about contraception is likely to influence favourably sex roles and allow relationships between men and women in which each can be tender or tough, working or weeping without anyone objecting.\(^b\)

In 1984 the Family Planning Association (FPA) of the United Kingdom decided to develop a campaign involving more men in family planning. The Men Too campaign was launched in October 1984. To succeed it was essential to look at new ways of communicating and of reaching men, not only women who are the traditional base of support of the family planning association. This was done by inviting well known men, sports personalities, pop groups, disk jockeys, actors, comedians and writers at the press conference, to launch the campaign. Television was also used to reach teenage boys. Since the FPA has no advertising fund, it applied for free public service announcements to all independent television stations and by spring 1985 ran short 30-second spots on all of them, using well known personalities. In addition, courses were started for receptionists at family planning clinics to help them make men feel more welcome, and a special poster was provided for waiting rooms.

Finally, a 25-minute video was produced for teenage boys, called "Danny's big night" (Producer: Paul Morrison, Director: John White, scriptwriter: Trix Worrell), to raise boys' awareness of their sexuality and personal relationships. The video, which is set in a multi-racial inner-city area, tells the story of Danny and his girlfriend Lorraine and raises many questions.

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\(^b\) Wellings, K. Defining the problem. Ibid., pp 5-15.
How does it feel to be a young man? How do young men want to be seen by their peers? How do they feel about girls? What is a caring relationship? The video is designed to be used in small groups with a leader. Notes for group leaders are provided to help bring out relevant points.

The climax of the campaign was a one-day National Conference called Men, Sex and Relationships, held at the end of March 1985 in London. Four hundred professional and lay people attended, one third of them men. The Men Too campaign has generated considerable interest in other countries in Europe. Following the conference media coverage, in the press, on radio and television, in pop music and in magazines read by young men, has been extensive.

Have men become more involved in family planning? Data for 1985 are not yet available. The 1984 figures that reflect the onset of the campaign indicate a 13% overall increase of men using family planning clinics, compared to 1983, and a 40% increase of 18- and 19-year-old men over the same period. In addition, special one night a week sessions, for men only, have been introduced in five National Health Service family planning clinics.

[From: Romie Goodchild, Press Officer, Family Planning Association, 27-35 Mortimer Street, London W1N 7RJ, United Kingdom]

"Somehow, some way, we must get it across to our males that birth control, self-control, is something a man can be proud to have achieved."

[Helen Brook, President and Founder of Brook Advisory Centres]

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**What To Write For**

**BARRIERS TO CHANGE:**

**THE CASE OF IRELAND AND TURKEY**

In the last few decades ideas about family planning have spread with remarkable speed throughout the countries of Europe. Educational programmes have been established and services created. However, sharp contrasts exist between countries in the rate of change and in the acceptability of family planning programmes. Why?

The differences do not arise accidentally and indicate the presence of forces that promote or prohibit change. Identifying and understanding these forces would be useful, so the Sexuality and Family Planning Unit of the WHO Regional Office for Europe commissioned a study on this issue in two countries, Ireland and Turkey. Both countries have been slow to accept family planning practice but for quite different reasons. In Turkey administrative and logistic problems related to the level of development of the country predominate, while in Ireland administrative problems are secondary to religious and cultural factors of great strength and pervasiveness.

The lesson learned from the analyses of the two countries is that a cost-effective as well as an ethical approach to family planning must be based on an analysis of each country's history, social institutions, value systems and methods of government.

ENTRE NOUS IN SPANISH

Beginning with No. 5, ENTRE NOUS is translated and printed in Spanish by the Instituto de la Mujer, Ministerio de la Cultura, Almagro 36, 28010 Madrid. One thousand copies are distributed in Spain. Another thousand are sent via the WHO Regional Office for the Americas to Spanish-speaking Latin American countries.

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THREE COUNTRIES EVALUATE THEIR FAMILY PLANNING PROGRAMMES

Following a set of guidelines on the evaluation of the managerial process for national health development issued by WHO, the Regional Office for Europe undertook to apply these guidelines to the area of family planning in three countries of the Region: Hungary, Portugal and Spain. None of these countries had evaluated their family planning programmes before.

For a copy of the report, Evaluation of family planning programmes, Copenhagen, WHO Regional Office for Europe, 1983 (unpublished document ICP/MCH 501/S01, UNFPA-RMI/79/PO5), 77 pages (English only), write: Sexuality and Family Planning Unit, WHO Regional Office for Europe, Scherfigsvej 8, 2100 Copenhagen Ø, Denmark.

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