Gender, gynaecology and generations

Lindsay Edouard

Summary

The issue of gender is an essential feature of the provision of sexual and reproductive health services and policy formulation should be directed towards the needs of men as well as women. This approach is especially important for youth services, with an emphasis on personal relationships and the provision of condoms for safer sex. The vital role of sexuality education is now recognised for the early promotion of appropriate behaviours, and international guidelines are widely available for adaptation to local circumstances.

Government goals

Twenty-five years ago, in 1985, an editorial in this Journal celebrating its tenth anniversary stressed that family planning was an accepted medical discipline, cutting across boundaries to involve sociologists and psychologists, in the quest for excellence in services "available for and accessible to all women – and men".[1] Family planning is not confined to a narrow segment of medical gynaecology, and in 1985, male involvement was a recurrent theme in numerous articles. The tone and explicit content of articles published during that year demonstrate that the Journal was ahead of its time in its approach to sexual health by being at the cutting edge with respect to gender issues.

The improvement in contraceptive services during the first decade after the reorganisation of the National Health Service may be attributed to its introduction of item-of-service payments: this modality of payment was sometimes deplored but had been widely accepted for other areas of preventive care such as maternity services, immunisation and cervical screening. However, the provision of contraceptive services by general practitioners (GPs) was thought to be blatantly "selective and sexist": for example, they were paid for vasectomy counselling only when this was provided in the presence of the wives of their patients. A decade earlier, they had "wanted to opt out of the prescription of condoms". There was increasing recognition of the value of "a comprehensive family planning service to all patients irrespective of gender".[2]

With the provision of condoms being perceived as not requiring medical input, GPs largely felt that they should not be involved. Perhaps they wanted to avoid giving instructions for their use involving awkward and unsavoury discussions of erect penises.[2] This level of embarrassment may have been the origin of the reference to "the fiddle in the middle" in a symposium report that year.[3] However, blame for poor access to male condoms should not rest only with general practitioners: whereas family planning services were free and male condoms were the second most popular method of contraception, only 7% of condoms were supplied through family planning clinics (FPCs). This poor availability of condoms was in flagrant contradiction of government guidelines, but FPCs had an environment that was not conducive to their utilisation by men, who constituted only 1.2% of attenders.[2]

J Fam Plann Reprod Health Care 2010; **36**(4): 251–252

Algiers, Algeria
Lindsay Edouard, FRCOG, FFSRH, *Member of the Editorial Advisory Board*

Correspondence to: Professor Lindsay Edouard.
E-mail: soranae@gmail.com

Glamour

Contraceptive services also failed to meet the needs of young people, despite the fact that 60% of unwanted pregnancies in Britain occurred in 16–25-year-olds and the recognition of the cost-effectiveness of interventions in that age group.[4] In order to avoid unsafe abortions, there was a recognised need to improve access to integrated contraceptive services as "the 'screw 'em and leave 'em' school of thought" prevailed all too often: young men considered unwanted pregnancy, sexually transmitted disease and "playing fast and loose with her emotions" as being amusing.[5] The media were perceived as being largely responsible for this situation by featuring casual affairs without any reference to adverse implications, as exemplified by the "bed-hopping" activities of James Bond. It was suggested that if the male star of *Minder*, a TV series popular among young people, were to say "Are you on the pill, or shall I use a sheath?", there could be a substantial reduction in unplanned pregnancies. In a footnote to this article, the Editor asked whether GPs could "forget their pride and prescribe sheaths", especially as it would be easier to raise this specific issue as part of a general consultation, rather than waiting for a young man to visit a FPC with its services aimed primarily at women.

A study of the utilisation of contraception among teenagers in South London demonstrated the fundamental role of the nature of the relationship: effective contraception is least likely to be used during casual sexual encounters, especially when "sexual conquest is so important to a young (particularly working class) man's self-esteem, often at a low ebb, especially if he is unskilled and unemployed".[6] As the "so-called permissive society condones, even glamorises, sex without strings", it was felt that more emphasis was needed on emotional aspects of sexual relationships to emphasise responsibility. With the desirability of sharing responsibility for contraception, the lack of a more effective male contraceptive method was a major limitation: as young couples in steady relationships tended to use oral contraception, they would be most unlikely to switch over to condoms as it "would be like a return to black and white television and mascara that runs!" The identification of risk-takers – defined as those in relationships that were unstable, casual or immature – as being at high risk of unplanned pregnancy, was considered to be important in the short term but it was suggested that it would be more appropriate, in the long term, to hold "relationship clinics" where the "dispensing of contraception" would be a subsidiary task.[6]

When first attending a FPC, only 4% of teenage girls were accompanied by their boyfriends, despite having been encouraged to bring them when they phoned for an appointment. In the early phase of their relationships, teenage girls tended to rely on their boyfriends to use condoms but in more stable relationships, partners sought more effective contraception by joint decision. However, young men had anxieties about the risks of oral contraceptives for their female partners.[7]

The *Men Too* campaign had been launched by the Family Planning Association on 2 October 1984, aiming to "persuade younger men to abandon the old, harsh, thoughtless, 'macho' pose towards females"[5] and to increase their responsibility in both personal and sexual relationships. In certain developing countries, male status may be threatened by the promotion of family planning.[8]

With contraceptive practice having more direct implications for another individual than any other clinical discipline, consensual agreement between partners is desirable. Nevertheless, the decision as to whether or not contraception is used is fundamentally a matter of personal choice, the partner having no legal rights, as confirmed by a British court decision that "contraception is a matter in law for one individual, not two". Regarding the utilisation of contraception, parents "do not have full rights of control over the bodies of their children" even if they are minors and similarly, upon marriage, a spouse "does not acquire rights of decision of this nature over the other's body".[9] However, a short report drew attention to a drastic difference in national laws regarding vasectomy: an Italian medical practitioner had been accused of causing bodily harm despite consent from the men for the procedure, with the Florence court ruling that "men do not have the right to be sterilised" and that they "can now be charged with being an accomplice to a crime".[10]

GUM guidelines

Vaginal discharge was described as being "the 'bread and butter' of many modern departments of genito-urinary medicine" and its optimal clinical management included microscopy of a specimen "on the spot" by the clinician thereby avoiding the overburdening of referral clinics.[11] With vaginal discharge often having more than one cause, there was "the necessity of the second look or follow-up approach". Whilst remembering that "normal vaginal secretions merely starch or stiffen underclothing, drying on white material with a pale 'honey' colour not unlike that of a pale manila envelope", sexual activity and contraceptive practice were important aspects to be elicited in the sexual history. With "experimental sexual activity and the availability of sex shops", devices were becoming increasingly important in clinical practice as they could go missing and present as vaginal foreign bodies. Trichomonas infection was considered "for practical purposes always sexually transmitted and its presence, therefore, should be regarded as a marker of sexual promiscuity on the part of the patient or her partner". If she had symptoms, the female was certainly infected whereas the male sexual partner could be infected but asymptomatic: this situation was even more reason for male involvement in the clinical management of vaginal discharge.

A review of the acquired immunodeficiency syndrome stated that, in developed countries, it was associated with homosexual men, heroin abusers, Haitian emigrants and haemophiliacs, but pointed out the preponderance of heterosexual cases in Zaire, Rwanda and Haiti, whilst acknowledging that Haitians have "difficulties in admitting to homosexual practice".[12] Spread was already known to be mainly through semen and blood, with no "evidence for transmission by casual personal contact or by aerosol exposure". Whereas screening of sexual contacts of affected individuals was strongly recommended, major ethical and social problems were anticipated if population screening, including screening of blood donors, were carried out in the absence of reliable tests of individual infectivity.

Glory

Attitudes to gender issues have changed in many parts of the world over the past 25 years. Sexual and reproductive health now occupies a prominent place in health policy, and the delivery of services should go far beyond clinical considerations, to encompass outreach strategies for targeting disadvantaged groups. The dual issues of gender and youth are especially relevant in view of the power imbalances that still permeate societies.

Youth is well recognised as a valuable resource for health[13] and an integrated approach to sexuality education incorporates safer sex into the context of relationships so that that young people can make informed decisions. Resources are now readily available for school curricula, starting at an early age, when appropriate behaviours are best learned and adopted.[14] Differences in norms between cultures and generations should be acknowledged and adjustments in the use of those international resources should be made according to local circumstances. The International Year of Youth commenced on 12 August 2010, World Youth Day: activities will promote youth participation and dialogue across generations and are testimony of the recognition of youth in the international development agenda.

The changing concept of masculinity in many countries challenges entrenched perceptions of gender by promoting partnerships that go beyond the traditional roles of men and women, both for family planning and for the promotion of maternal health. Men are now increasingly involved as agents of change to modify gender roles by altering attitudes. The United Nations Entity for Gender Equality and the Empowerment of Women and headed by Ms Michelle Bachelet, the former President of Chile, a new agency that will be simply known as UN Women, is currently being created by the United Nations.[15] With two such major initiatives commencing this year, there are great hopes for the intensification of international efforts to address issues relating to sexual and reproductive health.

Statements on funding and competing interests

Funding None identified.
Competing interests None identified.

References

1 Editorial. The next five years. *Br J Fam Plann* 1985; **11**: 79–80.
2 Rowlands S. Contraception for men: where do general practitioners stand? *Br J Fam Plann* 1985; **11**: 109–110.
3 Pearcy P. Report of the XIIth Current Fertility Control Symposium, October 4/5, 1984. *Br J Fam Plann* 1985; **10**: 131–133.
4 Leathard A. Family planning: facilities surveyed. *Br J Fam Plann* 1985; **11:** 62–63.
5 Delvin D. Men and contraception. *Br J Fam Plann* 1985; **10**: 101.
6 Skinner C. More male responsibility or more equal responsibility? Teenagers and their use of contraception. *Br J Fam Plann* 1985; **11**: 60–62.
7 Tobin JM. How promiscuous are our teenagers? A study of teenage girls attending a family planning clinic. *Br J Fam Plann* 1985; **10**: 107–112.
8 Annandale VE. Traditional control of fertility in Western Samoa. *Br J Fam Plann* 1985; **11**: 63–66.
9 Norrie KM. Family planning and the law: other people's rights. *Br J Fam Plann* 1985; **10**: 102–107.
10 Anonymous. Vasectomy in Italy. *Br J Fam Plann* 1985; **11**: 69.
11 Oates JK. The management of vaginal discharge. *Br J Fam Plann* 1985; **11**: 80–86.
12 Bird AG. The acquired immunodeficiency syndrome. *Br J Fam Plann* 1985; **11**: 49–55.
13 World Health Organization. *Young People's Health – A Challenge for Society.* Report of a WHO Study Group on Young People and "Health for All by the Year 2000". WHO Technical Report Series Number 731. Geneva, Switzerland: World Health Organization, 1986; 56–67.
14 Division for the Coordination of UN Priorities in Education. *International Technical Guidance on Sexuality Education: An Evidence-informed Approach for Schools, Teachers and Health Educators.* Document ED-2009/WS/36 Rev3. December 2009. Paris, France: United Nations Educational, Scientific and Cultural Organization, 2009.
15 Burki T. UN Women to spearhead new drive for gender equality. *Lancet* 2010; **376**: 405–406.