PERSONAL VIEW

Celebrating 50 years of our Journal

Sam Rowlands

Visiting Professor, Department of Medical Science & Public Health, Bournemouth University, Bournemouth, UK

srowlands@bournemouth.ac.uk

ORCiD 0000-0001-5940-9079

The Journal has been in existence for 50 years and this semicentennial issue celebrates this special occasion. The evolution and development of the Journal mirrors that of the medical specialty of sexual and reproductive health (SRH) in the UK. Over this half-century, the complexity of SRH became reflected in the content of the Journal, with the richness of qualitative methodology joining the well-established epidemiological studies. Perspectives became wider with input from the social sciences and global health. The Journal has been transformed from a cottage industry to a Journal of international calibre. Looking at the sequence of seven front covers (Figure 1) one can see this transformation. From the first issue, the Greek symbol denoting health care appeared on the front cover; this now looks rather dated. The Rod of Asclepius persisted on the cover (albeit relegated to the bottom of the page in 2011) up until the Faculty of Sexual and Reproductive Healthcare rebrand in 2016. The present cover is altogether more modern.

The first edition of the *Journal of Family Planning Doctors* came out in April 1975 (Figure 1) and the Journal has been published quarterly ever since. From 1977 the Journal became the *British Journal of Family Planning* (Table 1). The Journal began primarily as a means of communication to members of the National Association of Family Planning Doctors (NAFPD) – it was more like a Newsletter and some of the articles were taken from other journals, with permission. This first Journal format (until January 1980) was interesting in that the first article started on the first page. Imagine my surprise and delight when an article I submitted was splashed across the front cover in the January 1979 issue! The Journal was subtitled the 'Journal of the National Association of Family Planning Doctors' until 1993 when the Faculty of Family Planning & Reproductive Health Care (FFPRHC) — as it was then — was founded.

Table 1 shows some selected landmarks in the development of the Journal. Practical advice for clinicians was initially a popular component of the Journal, before the development of structured education in SRH. October 1980 saw the advent of advice to readers from the Clinical and Scientific Advisory Committee, although Questions and Answers from individual experts continued until April 1985. This Committee became the Clinical & Scientific Committee under the auspices of the FFPRHC. In the January 1999 issue, the title of this section changed to advice from the Clinical Effectiveness Committee (CEC). Clinical Guidelines were initially published as inserts in the Journal – this continued until April 2006. Since that time, guidelines (which have become considerably longer) have been published separately. The sixth design for the Journal cover coincided with the commencement of publication by the BMJ Publishing Group (Table 1).

In the early days of the Journal, many distinguished senior colleagues, in a variety of disciplines, gave unstinting encouragement and practical advice to the Editorial team. It was interesting to note that the Journal was never really a parochial publication. Within the first 10 years of its existence, articles had been published from Europe, Scandinavia, Africa and Asia. Since around the time of the millennium, the Journal has become a 'go-to' journal for SRH researchers. Major research groups that have published ground-breaking work in the Journal include: the Oxford-Family Planning Association (Oxford-FPA) cohort study, National Surveys of Sexual Attitudes and Lifestyles (NATSAL) and the Turnaway Study.

Looking through the Obituaries (more latterly called Appreciations), I relived my interactions with some of the great luminaries in our field – David Bromham (whose obituary I sadly

wrote), Dame Josephine Barnes, Nancy Loudon, Fay Hutchinson, Alison Bigrigg, Anne Szarewski and John Newton, to name only a few. It was striking that some from amongst us died well before their time and yet they had already made an enormous contribution to the specialty.

As the Journal became more academic, there has been a debate about the readability of the Journal for those working at the coalface. There is a delicate balance to be struck between practical articles for clinicians and pure science. Anecdotes were removed from the main body of the Journal, as a scientific journal has to be objective. For some years, a correspondent from general practice would take an informal and light-hearted look at the subject, which I know was a popular feature. Nowadays, the Clinical Consult section continues to keep a sense of the real world for readers who are practitioners (still the majority I suspect) and there are also lively posts on the Blog. But the main thrust of the Journal has to be academic.

Joining the *BMJ* 'family' of journals has been highly successful. The Journal benefits from the solid back-up of this brand with its long-established standards of excellence and the vast machinery of its editorial and production teams. A well-established Journal has become even more impressive in terms of rigorous standards and international reputation. Since its inception, the Journal has had 10 Editors-in-Chief (Table 2). It has currently 16 Associate Editors and an expanded bank of reviewers (those dedicated, anonymous, unpaid and perhaps underappreciated experts whose work all journals rely heavily on).

Anne Szarewski was particularly proud that the Journal Impact Factor (JIF) rose from 1.047 to 1.636 during her ten-year Editorship. Subsequently, in 2014, the JIF broke through the 2 mark and now it has passed 3. Another newer metric, Scopus CiteScore, has increased from 3.7 to 5.1. There were a total of 151,527 online content views in 2023. It is interesting to note that the number of online page views from the USA are not that far behind those from the UK.

The Journal currently functions in a very efficient manner. Initial decisions on whether an article will be considered are taken within 2 days and the time interval for review is 43 days. Impressively, the time from acceptance to publication (online) is a median of only 18 days. This makes submitting an article to *BMJSRH* an attractive proposition, as nothing is worse for authors than inordinate (and often unexplained) editorial and production delays.

How can all this be summed up? Our specialty is probably no different from many others. It has evolved from an embryonic form, become fully-fledged, taken off and subsequently matured over time. The Journal reflects this development but of itself has made its own strides in improvement as an organ of communication. The Journal can definitely be said to have attained and be maintaining a high academic level. It is now well and truly an international journal with a global reputation. Let's hope that a modern Journal can still convey a passion for the subject, be dedicated to focusing on those who use sexual and reproductive health services and continue to appeal to all those with an interest in SRH.

Figure 1 Front covers of the Journal over 50 years

National Association of Family Planning Doctors

THE JOURNAL OF
FAMILY PLANNING DOCTORS

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Use-effectiveness of the condom in a selected family planning clinic population in the United Kingdom

Roger Glass, M.D.* ***Martin Vessey***, M.D.
Peter Wiggins, B.SC.
Department of Social and Community Medicine, University of Oxford, England.

Abstract
A prospective study of the beneficial and adverse effects of different methods of contraception is in progress at 17 clinics run by the British Family Planning Association. The present report is concerned with the findings so far on the efficacy of the condom.

Overall, 62 accidental pregnancies have been observed among 2057 couples using this method of birth control during 1543 woman-years of exposure to risk, representing a use-effectiveness pregnancy rate of 4·0 per 100 woman-years.

It is concluded that there is little reason to encourage couples who are highly motivated towards family planning and who find the condom aesthetically acceptable to change to a more modern method of birth control with its attendant risks unless a very high degree of security is essential.

Introduction
In 1968, a prospective study of the beneficial and adverse effects of different methods of contraception was started at two clinics run by the British Family Planning Association. The study was subsequently extended with the result that 17 clinics are now participating and almost 17,000 women are under observation. We have already described our findings about the efficacy of the diaphragm as a method of birth control (1). A substantial amount of information about the use-effectiveness of the condom has also accumulated, which is summarised in the present report.

Material and methods
For a clinic patient to be eligible for recruitment to the study, she has to be: (a) aged 25-39 years; (b) married; (c) a white British subject; (d) willing to participate; and (e) *either* a current user of oral contraceptives of at least five months standing *or* a current user of the diaphragm or an intrauterine device of at least five months standing, without prior exposure to oral contraceptives.

At the time of recruitment, an admission form is completed for each subject. Among other items, this form includes questions about age, social class, smoking habits, intended family size, and obstetric history. After recruitment, each subject is questioned at return visits to the clinic by a doctor or a nurse and certain items of information are recorded on a special form, including the dates of all pregnancies, both planned and unplanned, and details of all changes in contraceptive practices. Women who default are sent a postal version of the follow-up form and, if this is not returned, are contacted by telephone or visited and interviewed in their homes. Losses to follow-up in the study so far, for all reasons combined, have been less than one per cent of women per annum.

From the above account, it will be clear that all the information that has been obtained about the use-effectiveness of the condom relates to couples who changed to this method of birth control *after* recruitment to the investigation. Some couples have, of course, used the condom for more than one period of time since the date of

Continued on page 4

*Present address: Mount Sinai Hospital, New York City, U.S.A.

Contrasting views of use and provision of family planning services

R. Snowden and C. J. Grossmith*

Introduction
The purpose of this paper is to provoke some discussion concerning the delivery of family planning services in clinics and in general medical practice.

Most studies concerned with the examination of contraceptive methods have either tended to concentrate on those characteristics directly linked with the method itself, namely its mode of action, its effectiveness in preventing pregnancy and the side effects associated with its use; or on those characteristics associated with the user of the method, such as age, parity and social class. It is only in recent years that serious attention has been given to factors associated with the provision of contraceptive methods. (1, 2).

The interaction of the method, user and provider variables should be borne in mind when considering family planning services, especially if such a service is taking place in institutional settings such as family planning clinics or in general medical practice. The users view of specific contraceptive methods may be very different from the view of those providing the method. The provider's view often contains implicit and sometimes explicit biases which include an

Continued on page 6

*Family Planning Research Unit, The University of Exeter.

The British Journal of Family Planning

The Journal of the National Association of Family Planning Doctors

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Oral Contraceptives and the Liver

Sheila Sherlock, M.D., F.R.C.P.
Department of Medicine,
Royal Free Hospital School of Medicine,
London

Oestrogens, particularly those contained in oral contraceptives, may have untoward effects on the liver. Serum transaminase levels in women starting the pill, in the majority, show an increase during the first week or two. These transaminase values reduce as the medication continues. The significance of this change is unknown. It is presumably not very serious as serious hepatic disease is extremely rare following oral contraceptives.

Cholestasis

The first topic I want to deal with is the effect of oestrogen-containing pills on the flow of bile. Most of the constituents of oral contraceptives, whether they be progestogens or oestrogens, are C17 substituted testosterones and as such, tend to reduce the flow of bile; that is, they have a cholestatic effect. Bile flow into the duodenum is controlled by two main processes. Firstly, it depends on the amount of bile salts that are excreted into the bile, and secondly by a mechanism that is independent of bile salts. Cholestatic steroids such as oestrogens presumably act on the membrane of the bile canaliculus and so interfere with the bile salt independent flow. Every woman who takes the pill would have a tendency towards the retention of bile; that is, a tendency towards cholestasis. It is, however, very rare to encounter true cholestatic jaundice in women taking oral contraceptives, and the likelihood has diminished as the pills have become more and more 'mini'. However, in Chile pill jaundice is the commonest type in the community, so that a series of 50 patients could be collected very easily. These women developed pruritus and mild elevations in serum bilirubin and alkaline phosphatase values when they took the pill. This complication was usually found during the first four cycles, and was very rare later. This then is an immediate effect of oestrogens. This cholestasis is quite benign; if the treatment is withdrawn the patient recovers. The liver biopsy shows only changes in the canalicular membrane —there is no question of hepatocellular necrosis or dysfunction and recovery is complete. The geographic distribution is most peculiar because pill cholestasis is commonest in Scandinavia and North Germany and Chile, but very rare in other parts, including this country. The genetic predisposition is shown by the family histories; mothers and sisters of patients who experienced this pill cholestasis will also show the tendency. There is also a link with pruritus and jaundice in the last trimester of pregnancy. Of 58 patients with cholestatic reaction to the pill, 42 had had a previous pregnancy and 27 of these had shown pruritus or jaundice during the last trimester. In general, those that itch on the pill will do so during the last trimester of pregnancy, and this complication of pregnancy is believed to be equally benign. However, some of these patients do show an increased tendency towards gall stone formation and there is some evidence from Sweden that foetal wastage is greater. These women therefore react abnormally to steroids. It is interesting that the oestrogens produced in pregnancy are not in fact C17 substituted testosterones, so that this chemical configuration cannot be essential for the production of cholestasis. The taking of oestrogen-containing contraceptives and pregnancy are essentially cholestatic phenomena, although you don't often think of them as such. Consequently if a patient has an underlying tendency towards cholestasis this will be made overt or enhanced either by pregnancy or by contraceptives. This explains how patients who, with primary biliary cirrhosis and who are still in the presymptomatic stage, develop overt cholestasis with itching either during pregnancy or when oestrogens are given.

I do hope that readers do not follow the stupid rule that women who had hepatitis donkey's years ago must not receive oestrogen-containing contraceptives. I still get patients sent up from family planning clinics with this sort of referral. It is really rubbish, because two-thirds of the population have antibodies to hepatitis A in the blood and so must have had the disease in the past, although not usually recognising it. Because a woman has had hepatitis, she should not be denied this form of birth control. The next question is how soon after a known genuine attack of hepatitis should the pill be allowed. The answer is that it may be prescribed at all times as regards the liver because the only likely reaction is some mild benign cholestasis. However, serum biochemical tests may change and so produce a confusing clinical picture. For instance, if a patient is recovering from hepatitis, after a couple of months transaminases and phosphatases are returning towards normal but administration of the pill may lead to a deterioration in these tests. In general, it is wise if possible to wait about three months after recovery from viral hepatitis before resuming the pill.

Gall stones

I now want to consider the relation of

continued on page 6

Contents

Leading articles

Oral Contraceptives and the Liver 1
Sheila Sherlock, M.D., F.R.C.P.

The Place of Ultrasound in the Location of the Lost IUD 7
Mary Pollock, M.D., F.R.C.O.G.

Other articles

Sexual attitudes in the People's Republic of China 9
P. E. Brown, M.B., B.S., M.R.C.G.P.

A course in Human Sexuality for Medical Students at St. George's Hospital 16
Elizabeth Stanley, M.R.C.S., L.R.C.P.

Editorial 2
Letters 3
Questions and Answers 4
Reviews 10
From the Journals 11
New Contraceptives 13
The Chester Conference 14
Meetings 17
News and Views 18
Index to Volume 2 19

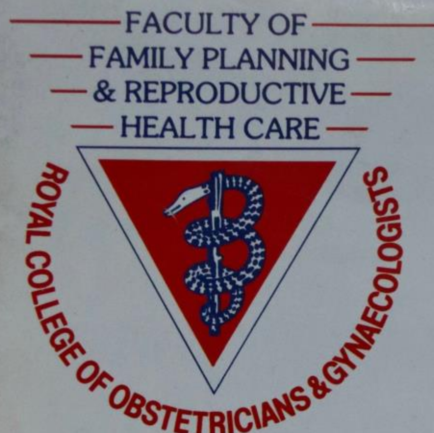
The British Journal of Family Planning

The Journal of the National Association of Family Planning Doctors

Contents

Editorial	**1**
From the Chairman	**2**
Domiciliary family planning—A service described and assessed Elphis Christopher, M.B., B.S., D.C.H., D.OBST., R.C.O.G.	**3**
Natural methods of family planning Anna Flynn, M.R.C.O.G.	**9**
Use of prostaglandins in obstetrics and gynaecology N. Siddle, M.B., CH.B., M.R.C.O.G. and M. Elstein, M.D., M.B., CH.B., M.R.C.O.G.	**14**
Medico-legal implications of family planning John Barker, M.B., B.S., D.OBST., R.C.O.G., D.M.J.	**18**
Letters	**22**
Obituary	**24**
From the journals	**24**
Question and answers	**26**
Reports	**27**
Training	**29**
The Institute of Psychosexual Medicine	**29**
News and views	**30**
Anniversary	**32**
Review	**32**

Vol. 6 No 1
April 1980



The British Journal of Family Planning

The Journal for all interested in reproductive health care

CONTENTS

EDITORIAL
The service needs of training 215

ORIGINAL ARTICLES
Oral contraceptive use in relation to chest and limb symptoms 216
M P Vessey, R Painter
Mishaps occurring during condom use and the subsequent use of postcoital contraception 218
UK Family Planning Research Network

REVIEW ARTICLE
The levonorgestrel-releasing IUD 221
Tapani Luukkainen

FAMILY PLANNING PRACTICE
Inserting intrauterine devices without clamping the cervix 225
Arthur P K John
Is the fitting of an intrauterine contraceptive device a painful experience? 227
Clare Seamark
IUD problem clinic, Bristol 1988–1992 229
Gill Cardy

FAMILY PLANNING AND PUBLIC HEALTH
Quality contraception or sexual health care? A survey of family planning clinic managers in one health region 232
Elinor Thompson, Jean Chapple

FAMILY PLANNING AND SOCIETY
Contraceptive provision to prostitutes in two Birmingham saunas 236
Susan E Mushin

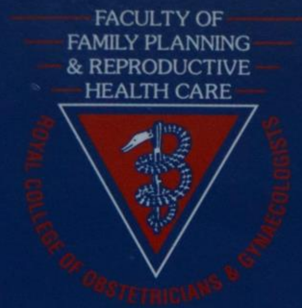
FAMILY PLANNING IN OTHER COUNTRIES
Family planning in a rural population of Crete, Greece—results of a health interview survey 239
Christos Zilidis, Anastas E Philalithin, Ioannis Vlachonikolis
Male sterilisation in China 243
Bing Xu
A review of family planning in Ireland 246
Walter Prendiville, Mary Short

FAMILY PLANNING AND AUDIT
Monitoring structures, processes and outcomes by a prospective study of intrauterine contraceptive devices (IUDs) fitted in community clinics 248
Sarah Wilson

CASE REPORT
Extensive calcification of an IUD 252
M Katesmark, B J Auld

From the Clinical and Scientific Advisory Committee 253
From the Journals 254
Reviews 254
Letters 256
News and Views 257
Meetings and Courses 257
Notes for Contributors 215

Vol 19 No 3
October 1993



The British Journal of **Family Planning**

An international journal for health professionals interested in reproductive health

25th ANNIVERSARY EDITION Vol 26 • No 2 • April 2000

CONTENTS

EDITORIAL

Emergency contraception with levonorgestrel: one hormone better than two 67

ORIGINAL ARTICLES

Women's knowledge of, and attitudes to, contraceptive effectiveness and adverse health affects *Jayne Edwards, et al* 73

A survey of GP views on intra-uterine contraception *Sunanda Gupta, John Miller* 81

Immediate post-abortal insertion of the frameless GyneFix IUD: initial experience in China *Xiaoming Cao, et al* 85

Sexual health and the practice nurse: a survey of reported practice and attitudes *Tim Stokes, Judith Mears* 89

The demand and supply of nutritional advice and guidance in Scottish family planning services *Sophie Tessier, et al* 97

REVIEW ARTICLE

Are computers of any use in a family planning clinic? *Alison Bigrigg* 100

CASE REPORTS

Medroxyprogesterone acetate [Depo Provera] injections. Development of striae *Mamta Gupta* 104

Amenorrhoea despite displaced levonorgestrel intra-uterine system *Catherine Bobrow, et al* 105

BRIEF REPORT

Multidisciplinary learning in family planning clinics *Paula Baraitser, et al* 107

RECOMMENDATIONS FOR CLINICAL PRACTICE

Emergency contraception 93

FACT REVIEW

Interactions with hormonal contraception *Alyson Elliman* 109

NEWS

Faces behind *The British Journal of Family Planning* 71

25 Years of *The British Journal of Family Planning* 72

New faculty contact details 72

FPA launches *Bodyworks* booklet 99

Greater understanding for Depo Provera 108

New RCOG guidelines 108

25th Anniversary NWSSMFP 113

Chlamydia – the facts 122

Clem and Lydia promote new campaign 122

Notes for contributors 70

Book reviews 112

Obituary – Dame Josephine Barnes 1912-1999 115

From the journals 116

Letters 116

Meetings and courses 118

PMH

January 2011 Vol 37 Issue 1

JOURNAL OF
Family Planning and Reproductive Health Care

AN INTERNATIONAL JOURNAL

Commentaries
The White Paper: opportunity or poisoned chalice?
S Wilkes, A Oxby

Testing for *Chlamydia trachomatis*: is more choice a good thing?
J Smith, A Cook, C Packer, H Stokes-Lampard

Articles
Risk factors for chlamydial infection in chlamydia contacts: a questionnaire-based study
G Schembri, P Schober

Chlamydia screening by community pharmacists: a qualitative study
G Dabrera, D Pinson, S Whiteman

Attitudes towards human papillomavirus vaccination: a qualitative study of vaccinated and unvaccinated girls aged 17–18 years
K Williams, A Forster, L Marlow, J Waller

Women in Cairo, Egypt and their risk factors for unmet contraceptive need: a community-based study
M M Kotb, I Bakr, N A Ismail, N Arafa, M El-Gewaily

Review
Premature ovarian failure
K Maclaran, N Panay

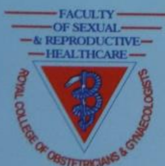
Personal view
In family planning service programmes 'coordination' is greatly overrated
P D Harvey

From our consumer correspondent
Sex in the commercial break: how bouncing speech bubbles informed the nation
S Quilliam

A better way of working
An innovative GP training post in sexual and reproductive health care
D P Edgcumbe, C Cooper, L Gilbert, R Al-Shaikh, G Dawe, P Brimblecombe

View from primary care
Taxing times
R Steele

History of contraception
The Kahun Gynaecological Papyrus: ancient Egyptian medicine
L Smith



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BMJ | Journals

January 2018 Volume 44 Issue 1

BMJ Sexual & Reproductive Health

IN THIS ISSUE

Conscientious objection in sexual and reproductive healthcare

Contraception for adolescents with disabilities: more than just preventing pregnancy

Tailored use of combined oral contraceptives: informing women of their options

Where do British women and men obtain contraception? Analysis of a major survey

Getting information on intrauterine devices from YouTube

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Table 1 Selected landmarks in the evolution of the Journal

Journal issue	*Landmark*
April 1975	*Journal of Family Planning Doctors* launched
April 1977	Journal renamed *British Journal of Family Planning (BJFP)*
July 1982	First article on doing Audit of family planning services
October 1982	First article on conducting research in family planning clinics
January 1984	First output from CSAC labelled a guideline
January 2000	Special Millennium edition with guideline as an insert
January 2001	Journal renamed *Journal of Family Planning & Reproductive Health Care (JFPRHC)*
January 2002	Journal available in electronic format
April 2006	Online submission and peer review started
April 2010	Community SRH specialty established in UK
January 2011	Journal published by BMJ Journals
January 2017	Social Media Editor in post
April 2017	Patient involvement statement required
January 2018	Journal renamed *BMJ Sexual & Reproductive Health (BMJSRH)*

CSAC = Clinical and Scientific Advisory Committee; SRH = sexual and reproductive health

Table 2 Editors-in-Chief of the Journal

Editor-in-Chief	*Years of tenure*
Michael Smith	1975-1977
Ruth Skrine	1977-1983
Bridget Friedmann	1983-1985
Elizabeth Forsythe	1985-1991
Jeanette Cayley	1991-1999
Fran Reader	1999-2003
Anne Szarewski	2003-2013
David Horwell	2013-2015
Sandy Goldbeck-Wood	2015-2019
Sharon Cameron	2019-present