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Ireland

The Irish family planning problem began with the Criminal Law Amendment Act, 1935, which first prohibited the import and sale of contraceptives, on penalty of a fine or imprisonment. The Censorship of Publications Act, 1929, prohibited the distribution of printed material advocating "the unnatural prevention of conception", which has generally been interpreted as prohibiting any book even mentioning family planning. One of the many major idiocies produced by that Act was the banning of a book on marriage expressly commissioned by the British Catholic Hierarchy to counter the books on marriage produced by the British Family Planning Association in the 1930s. Among the more sinister side-effects of the censorship laws, however, has been the impossibility of publishing even reasoned arguments or objective information on family planning, a situation prevailing until a few years ago.

But nothing remains the same all the time. In the early 1960s, possibly coinciding with the introduction of oral contraceptives, a few cracks began to appear in the armour of one of the world's most authoritarian Catholic states. A few concerned Catholics, who had come together originally in the cause of education (they were worried, for instance, about corporal punishment in schools), began to worry about very large families. At the same time, some physicians began to worry about women who sought effective contraception but who could not, for medical reasons, take the pill. As a result, a limited non-profitmaking company was established, with the carefully ambivalent title of the Fertility Guidance Company Ltd. The first material manifestation of the new organization was the discreet opening, in February 1969, of a fertility guidance clinic at an elegant and eminently respectable address in a graceful Georgian terrace, near the Irish parliament. Not surprisingly, most people attending the new clinic were from the upper and middle classes, who were prescribed the pill and fitted with diaphragms which, with a tubed spermicide, the client had to acquire by post, either from Northern Ireland, or from the IPPF Regional Despatch Centre in London. Those requiring IUDs were referred to Belfast, where the Northern Ireland FPA cared for them with great kindness and efficiency. The pill was available in most pharmacies, supplied bashfully under the pretence that it was a menstrual cycle regulator.

In 1967, there had been some 12,000 women whose cycles were being regulated. By 1969, there were 20,000 and, by 1973, there were 38,000: about 7% of women aged 15–44 years. In 1971, the Fertility Guidance Company opened its second clinic, in a rather less elegant remnant of Georgian Dublin, but much closer to the poorer families whom the Irish family planners wanted to reach. The Company, renamed the Irish Family Planning Association (IFPA), decided to become more involved in public information and education. By Spring 1973, the two clinics were providing the equivalent of over 10,000 consultations a year.

Meanwhile, a booklet was published, without any reaction from the censorship authorities. In December 1972, a new organization, Family Planning Services Ltd, was established, to provide mail-order contraceptives, since the customs authorities were increasingly confiscating imported contraceptives. Between January and October 1973, the company met about 6,000 requests for condoms, diaphragms and spermicides and, relying solely on voluntary contributions (the sale of contraceptives remaining illegal), built up a substantial bank balance, although still a non-profitmaking organization, like the IFPA.

There was little or no political or legal reaction to all this activity, probably due partly to the horrors in Northern Ireland forcing people in the Republic to question their sectarian state. For the first time in 50 years, the Republic's Catholic politicians began to make conciliatory noises to the northern protestants. The lack of action may also have been partly due to a genuine change in public opinion on the desirability of anticontraceptive legislation. An opinion poll in 1971 showed that, although an overall majority opposed change, a majority of voters under 30 years favoured liberalization. In 1972, a poll of physicians showed 70% in favour of liberalization.

Nonetheless, formal attempts to implement change failed. In the Senate (Ireland's upper house of parliament), an attempt in 1971 by Senators Mary Robinson, John Horgan and Trevor West, to introduce a private member's bill was defeated before the bill could even be published. The Dail (the lower house) refused a first reading to a similar bill, introduced by two medically qualified deputies, Noel Browne and John O'Connell, of the Irish Labour Party, whose official policy is to liberalize the present laws. The Fine Gael Party, currently the senior partner in a coalition government with Labour, also includes change in its official policy. But policy and personal feelings are different things and, if the issue comes to a vote, both parties will suffer considerable defections. Moreover,

since it now seems likely that the opposition Fianna Fail party will oppose change fairly solidly, the prospects of Senator Robinson's new Family Planning Bill, recently permitted a first reading in the Senate, surviving its parliamentary passage seem remote.

It seems that many senators and deputies would rather not be involved at all. Many secretly hoped that Mrs Mary McGee would win her appeal to the Supreme Court. Mrs McGee is a 27-year-old mother of four children, whose action sought to have the current laws declared unconstitutional, on the grounds that they interfered with the authority of the family (an institution specifically protected by the Irish Constitution). Her case was based on the confiscation by customs officers of a tube of spermicide posted to her from London. Her case was lost in the High Court.

Judgment on Mrs McGee's appeal to the Supreme Court was finally delivered on 19 December 1973. By a majority of four to one, the five judges of the Supreme Court ruled it unconstitutional for the law to prohibit the import of contraceptives for personal use. One judge also suggested that, if the remaining prohibition on the sale of contraceptives were tested in the courts, then it too might fall. The Chief Justice, dissenting from the majority verdict, maintained that since it was legal to make and to use contraceptives, the prohibition on their import was perfectly constitutional.

So the problem of legislating for the distribution, sale and advocacy of contraceptives remains. Indeed, there is now some urgency to change the law since, with the sudden legality of importing contraceptives, there is no means of regulating their distribution.

A public statement, issued in November 1973 by the Irish Catholic bishops, was still relevant. In that statement, the bishops had granted legislators the right to make laws as they saw fit (a right not always granted by earlier hierarchies in matters which they saw as falling within the province of morality). However, they warned that changing the laws on contraception might result in increases in illegitimacy, abortion, marital infidelity, venereal disease, promiscuity, and what they termed "the contraceptive mentality". Needless to add, the bishops were challenged publicly to substantiate these assertions, but their statement still carries considerable weight among legislators.

Meanwhile, argument raged in the media: newspapers, radio and television all carried almost clinical details of the contraception debate, much of it vehement in the extreme. IFPA staff and members were accused of procuring abortions, of being profiteers, and agents of foreign capitalism or international communism. But by the end of 1973, it was clear that the government had decided that legislation was necessary. Senator Robinson's bill had not enjoyed universal support, and there were strong rumours that the cabinet was drafting its own legislation.

1974 therefore opened with optimistic prospects of being the year in which access to adequate family planning services might finally be granted to all the people of Ireland. However, around mid-January, it became known that, on 20 December 1973 (the day after the Supreme Court decision), summonses were served on the IFPA, and on Family Planning Services Ltd, to be answered in a Dublin District Court on 19 February 1974.

The IFPA summonses alleged that, in mid-1973, they had advertised and offered for sale "contraceptives, namely intra-uterine devices, contrary to Section 17 of the Criminal Law Amendment Act, 1935"; and had distributed, without a written ministerial permit, their booklet, 'Family Planning, a guide for parents and prospective parents', which "advocates appliances to be used for the purpose of the unnatural prevention of contraception (sic!) contrary to Section 16 of the Censorship of Publications Act, 1929".

The Family Planning Services Ltd summonses alleged that, in mid-1973, they had sold the IFPA booklet, without a written ministerial permit; and had sold contraceptives: a named brand of condom, and a named brand of spermicidal aerosol.

Evidently, where contraception in Ireland is concerned, the law is still the law!

David Nowlan
Irish Times Medical Correspondent.

Note. In October 1973 the Irish Family Planning Association became an associate member of the IPPF.

Legal Survey Revised

The Regional *Survey of the legal status of contraception, sterilisation and abortion in European countries* has been up-dated (1 January 1974) to include revisions made in legislation since 1 January 1973. The new entries (collectively) are available price £0·25 *plus* postage. The complete survey, incorporating the revisions, is available price £0·50 *plus* postage from 64 Sloane Street, London SW1X 9SJ.

Sexuality and the Handicapped

One of the consequences of social and economic development is that as its beneficial effects are felt by more and more members of a society so, too, are the problems of a minority in a society revealed more clearly than perhaps they were previously, and attention is turned to the solution of these problems. This essentially simplistic notion is of such generality that it can be argued in a variety of particular circumstances. Certainly if one turns to planned parenthood as part of social development, it is clear that minority interests come to the fore when the majority appear to be responding to the message of planned parenthood. In a way, this was one of the conclusions of the Regional Council seminar in Turku, Finland, 1973, which turned its attention to the difficulties encountered by minority groups of various kinds in the area of planned parenthood activities – not least in education – one of these groups being the handicapped.

Interest in the sexual problem of the handicapped has developed and increased over the last few years in several countries in Europe. In 1973 RFSU, the Swedish Society for Sex Education, devoted one issue of its *Bulletin* to the problems of the handicapped; in the Netherlands, long concerned in this field, a book on sex education and the handicapped has been published; in Britain a film has been produced on sexuality and the physically handicapped, and work has been published on sex education and the mentally handicapped. These examples could be proliferated if one cared to search the experience of other countries in the Region. It seems to me that concern for the handicapped (as for other minority groups) is a right and proper concern of the IPPF if it is to function as a sensitive instrument in both social and individual relationships. My purpose is to consider the nature of handicapping conditions, our attitudes towards them and the effect that both of these may have in considering the sexuality of the handicapped.

It would be wise, I think to explain what I mean by "handicapped". Under this heading I would include all those who are physically, intellectually, emotionally or socially handicapped in any way. These four categories are not mutually exclusive – on the contrary one of the cruellest features of handicapping conditions is the tendency for one or more of these conditions to overlap with another. This is one of the reasons why it is possible to make generalisations about the nature of handicapping conditions. By virtue of their handicap these people are impeded in the necessary activities of ordinary daily living. They are often restricted in the range of the activities that they can undertake, and even in these activities they have to expend more effort than

people who are not handicapped to achieve the same results. For this reason – and this is our first consideration as a 'caring' institution – the stress and strain of ordinary living is greatly increased. Our second consideration, which we must face squarely, is that to be handicapped is to be different from other people, and because of this relationships with other people are affected. It is not easy to establish stable relationships when awareness of the "difference" tends to lead to isolation. By this I simply mean that in the continuum total integration in society – to total isolation from society, the tendency is towards the latter rather than the former. Being unable to do what other people do tends to isolate, and this undermines self-confidence and increases self-consciousness, particularly the fear of exposing inadequacies relating to the handicapping conditions. The third accompanying consideration is that a handicapped person will be affected by the way people feel about him/her. The more obvious the deformity or handicap, the more obvious is the distaste or revulsion (if that is not too strong a word) that other people feel, however well meaning they may be. We must, I think, recognise in all honesty that very few of us can face all kinds of handicap with equanimity. After twenty years working with a variety of differently handicapped people, there are still times when I feel very uneasy when faced with certain kinds of handicap. A handicap may also lead to educational problems and to difficulties of employment.

These factors have a direct bearing on our work in IPPF in relation to handicapped people. For example, if we take the first consideration – restricted activity – it means that the kind of contraceptive advice that we can offer to some physically handicapped people is restricted because certain physical incapacities or limitations make certain contraceptive methods inappropriate. We also have to recognise that an increasing isolation from other people can make the developing sexuality of the adolescent and post-adolescent phase a more difficult and sensitive phase than it need be, e.g. there may be an increased need for auto-erotic satisfaction. Since we learn to cope with our developing "self" and come to terms with our sexuality not only by responding to our own development but also by our reaction to the way that other people respond to us, it may be that any hint of distaste expressed by others, towards the handicapping condition will hinder that development. It is also possible that impediments to education and employment will play a part in our traditional attitudes towards marriage and the handicapped, which have not been characterised by wholehearted endorsement in the past. An educational impediment, or an intellectual handicap may further restrict sex education activities from the point of view of the level of material, language used etc., which have to be individually considered.

Implicit in what I have said about the nature of handicapping conditions are the attitudes that we have towards handicapped people. More explicitly there is tendency firstly to regard them as not fully human ("thank goodness I'm not like that" is a phrase commonly heard in this connection) and secondly, to regard them, even when of mature age, as somehow not adult. These attitudes seem to me to lie at the base of our treatment of handicapped people, especially in terms of sexuality and sex education. It is very important to understand that we are dealing with human beings who, like other human beings, grow into adults whose feelings should be treated with the same individual care and concern as those of others. The importance is based on my belief that sexuality and sex education are vital elements in the process of developing satisfactory human relationships and growth to an adult self.

We cannot as an organization shrug this problem off and say that it is a concern primarily for the parents of the handicapped. It is difficult for the parents of handicapped people to stand back and view the situation objectively, difficult because they themselves may not have the necessary materials, language or training. Parents of normal children often find this task difficult enough. Nor can we always rely on those with responsibilities for the health and welfare of the handicapped to undertake the work because they, too, often lack these same elements. As planned parenthood organisations, we should join with parents, parents' organizations, health and social organizations, teachers and others working with the handicapped, and join our experience with theirs to the benefit of handicapped people. Some organizations are already active in this field – we need to know more about their experiences. Others need encouragement to begin – we should provide it. It means embarking on a collaborative exercise which will add a dimension to our work which is both worthy and worthwhile. I am aware that this will be difficult, but then the best enterprises often are. I am aware, also, that it will probably always be a very small part of the work in which we are generally engaged, but I am concerned that we should not overlook it, for I believe that the way that we treat our handicapped minorities is a measure of our standards as a civilised community.

Norman Rea
Vice Chairman
Regional Information and
Education Committee

Francophone Journalists Seminar

The third and final sub-regional journalists seminar planned for 1973, held at the Riemers Stiftung Centre in Bad Homburg/Frankfurt, 27–29 November, brought together press and radio journalists from Belgium, France, Luxembourg and Portugal to discuss the *rôle of the media in communicating information on planned parenthood.*

Introducing the seminar, Jørgen Hornemann of Radio Denmark and Chairman of the Regional Information and Education Committee, explained that the seminar was experimental and that the Region sought an exchange of ideas rather than specific results. "The seminar is not intended to arrive at a consensus on how better to sell contraception, but to critically review developments up until now with a view to arriving at a tighter formulation of ideas on how to communicate information enabling the achievement of planned parenthood".

Karl Plümer, Chairman of the Sex Education Committee of the IPPF member association in the German Federal Republic, traced recent ideological and practical developments in the field of sex education in the GFR. Background information included the startling figure of 170,000 pregnant brides (the majority under the age of 20 years) among 440,000 couples married in 1972. Mr Plümer concluded by insisting that planned parenthood should be viewed primarily as an extension of individual liberty, not in a demographic context.

Speaking on the 'Role of the Mass Media', Kina Fayot, from the IPPF member association in Luxembourg, traced the historical role of the media in promoting planned parenthood, and concluded that serious treatment of the subject was comparatively recent. It was essential, said Mme. Fayot, that the media relate planned parenthood to other fields of social development e.g. housing and employment – the opportunities for making these relationships were numerous. Too frequently news items, features etc. provided distorting images which tended to perpetuate ignorance and misunderstandings which isolate people. Mme. Fayot believed that the media should focus more than hitherto on communicating with minority groups in society.

Discussion following the presentations ranged widely and included the following points:– one of the fundamental problems faced by the

media and planned parenthood associations (PPAs) was a certain state of political immobility in areas which influence and are influenced by planned parenthood. More attention needs to be paid to causes rather than symptoms e.g. sensational reports on abortion cases are common, while in-depth articles on underlying causes and implications are comparatively rare. In this context, it was considered that press conferences and other information activities of PPAs ought to treat aspects of planned parenthood in a broader perspective, and not be undertaken only as a reaction to immediate situations.

- participants felt they were often out of touch with their audiences and not reaching those they would like to. It was agreed that too often journalists, 'experts', advice givers etc. tended to concentrate on their conception of people's needs, rather than needs expressed by the individual. Telephone radio programmes were often revealing in this respect. It was agreed that 'democratisation' of information is a two-way process.
- the so-called *feminine press,* while deplored in the sense that its existence reflects what were considered to be largely artificial distinctions between men and women, cannot be ignored. In those countries where this press is powerful it should be utilised more in the dissemination of information on and discussion of planned parenthood.
- on the question of utilising semi-'pornographic' publications as channels of information on aspects of sex, opinion varied (as indeed it had in the two previous seminars). It was agreed that while pornography was a matter of personal taste, information in such publications is often unbalanced. Fantasy should not be confused with reality – the ability to distinguish between the two presupposes a quite sophisticated sex education.

The seminar ended with a number of informal recommendations from participants. The report and recommendations, together with those of the other seminars, will be reviewed by the Regional Information and Education Committee at its meeting in Belgium in June.

Julian Heddy
Secretary to Regional Information and Education Committee

Condom Testing: Part 2

(Part 1 was published in the June 1973 *Regional Information Bulletin*).

Correction
In Part 1, it was incorrectly stated that "About half of all holes detected are between 14 cm from the closed end and 2·5 cm from the rim". This should have read: "About half of all holes detected are beyond 14 cm from the closed end".

Bursting

Condoms satisfying electronic testing, but containing holes only detectable by rolling the water-filled condom over absorbent paper, seem unlikely to fail as contraceptives (or prophylactics). Far more serious are condoms which burst during coitus.

Regrettably, no laboratory test has been devised to predict the chance of a condom bursting in practice. Neither the causes nor the incidence of such catastrophes are known with any precision. Burst condoms have been plausibly attributed to faulty handling or lubrication. Nonetheless, a conviction remains that certain condom brands are more prone to burst than others, irrespective of their incidence of holes, which may or may not present foci for the initiation of tears in the rubber.

Tearing sufficient to burst a condom comprises at least three factors: local stretching producing a tensile stress exceeding the rubber's tensile strength; tear initiation; and tear propagation. Neither tear initiation nor tear propagation can be measured satisfactorily on thin rubber articles.

Tensile Properties

However, the rubber's *tensile strength,* the breaking force applied perpendicular to unit unstretched cross-sectional area, can be measured in various ways. So can its *elongation at break,* the extension produced by the breaking force, expressed as a proportion (%) of the unstretched length. A rectangular, dumb-bell-shaped, or cylindrical test-piece is cut from a condom, and its unstretched dimensions (including mean single-wall thickness) measured. The test-piece is then automatically stretched to breaking point, when the load and length are measured, and the tensile strength and elongation at break calculated.

The 1972 British Standard requires test-pieces cut from 5 condoms to be tested. The lowest and highest test-results are excluded before averaging the remaining three values. The requirements are applied to the resulting mean tensile strength and elongation at break. The British, Hungarian and Japanese standards prescribe a minimum tensile strength of 200 kg/sq cm; and a minimum elongation at break ranging from 600 to 700%. (Lower requirements are applied after artificial ageing under various conditions).

Air-Inflation

Not all condom standards prescribe tensile properties. The Swedish and USA General Services Administration (both governmental) standards, and the standard applied by the Danish Pharmacyowners' Association, prescribe bursting volume requirements.

The Swedish Standard requires 100 condoms from each batch to be inflated with air, at a rate of 25–30 litres/min, and their bursting volumes to be measured. The mean bursting volume must be at least 25 litres, and the relative standard deviation not more than 25%. The USA Standard requires 8 condoms per batch, inflated with air, to burst without exception above 28.3 litres (1 cu ft); and another 8 condoms, after artificially accelerated ageing at 70°C for 7 days, also to burst without exception above 28·3 litres. The Danish Pharmacyowners' Association Standard requires 115 condoms per batch, inflated with air, to manifest a mean bursting volume ($\bar{V}$) such that $(\bar{V} - 20)/\bar{R}$ exceeds 0·70, where $\bar{R}$ = mean range (difference between largest and smallest) of 23 sets of 5 consecutive bursting volumes.

Although these bursting volume requirements may seem diverse and complicated, they have the common aim of limiting the *dispersion* of individual bursting volumes about minimum means, and hence of limiting the proportion of condoms bursting below a certain volume. For example, assuming that bursting volumes are normally distributed, the Danish requirement allows less than 5% of condoms to burst below 20 litres. On the Swedish Standard, if the mean bursting volume were the minimum, 25 litres, the proportion of condoms bursting below 20 litres could be as high as 21%, but the proportion below 10 litres could not exceed 1%. In practice, the USA Standard, tolerating none out of 16 condoms bursting below 28·3 litres, is totally unrealistic.

If condom bursting volumes were normally distributed, requiring $(\bar{V} - 10)/s_v$ (where s_v = standard deviation) to exceed 2·6 would constrain the proportion bursting below 10 litres to less than 0·5%. However, departure from a normal distribution means that $(\bar{V} - 10)/s_v$ must exceed about 4·2 to achieve this objective. Since manufacturers will seek to exceed any

limit comfortably, it is suggested that requiring $(V - 10)/s_v$ to exceed 3·00 constitutes a minimum acceptable standard, the sample size being 100 condoms.

Relationship between Tensile and Bursting Properties

Evidently, high elongation at break is a necessary condition of high bursting volume: thus condom bursting volume is roughly proportional to the cube of elongation at break. The relationship between tensile strength and bursting pressure is a little more complex.

It can be shown that condom bursting pressure is directly proportional to the thickness and to the tensile strength of the rubber, and inversely proportional to the square of its elongation at break, roughly speaking. Hence if a condom standard already prescribes low thickness and high bursting volume (and so elongation at break), it may be seen that high tensile strength is a necessary condition of high bursting pressure.

Curiously enough, no condom standard prescribes bursting pressure requirements. It transpires that requiring $(\bar{P} - 10)/s_p$, where $\bar{P}$ = mean bursting pressure (in cm water), and s_p = standard deviation, to exceed 3·00 is a realistic standard, and constrains the incidence of bursting pressures below 10 cm water to less than about 0·5%. A typical excess pressure, between the inside and outside of a bursting condom, of 15–20 cm water (one fiftieth of atmospheric pressure) may seem rather small. However, that pressure is applied over a large area of rubber, so that the total bursting force typically exceeds 100 kg, well over the weight of an average adult!

Although high tensile strength and elongation at break are necessary conditions of thin condoms with high bursting pressure and volume, they are not sufficient conditions. Condoms may burst at low values as a result of other defects. To ensure that these are not due to holes, condoms already *known* to be free from holes, after filling with water and rolling on absorbent paper, may subsequently be subjected to air inflation.

The consumer's interest clearly lies in minimising the incidence of condoms with very low bursting volume and/or pressure, whether due to very low tensile strength and/or elongation at break, or to other defects, including holes. Measuring bursting properties involves inspecting a large proportion of the whole condom surface, and prescribing not only mean values, but also dispersions (and hence the incidence of very low values). On the other hand, measuring tensile properties involves inspecting only a small portion of the whole condom, and prescribing mean values only, since any very low values may be presumed to be due to other causes. In sum, tensile properties reflect the 'strength' of the rubber; while bursting properties reflect the 'strength' of the condom.

Thickness

Tensile properties should be independent of condom dimensions. Bursting properties depend on tensile properties *and* dimensions, which mainly vary in respect of *thickness.* (The unrolled length and width laid flat of a wide variety of condom brands are substantially similar, since they must fit the presumably fixed dimensions of the erect penis). The 'strength' of a condom increases with its thickness: for this reason, washable sheaths (now to be found only rarely) are 2–3 times thicker than disposable condoms, effectively defined by an upper limit to their single-wall thickness.

The consumer's interest lies in both strong *and* thin condoms. Hence a compromise must be made. Having determined minimum acceptable condom bursting requirements, it only remains to determine a maximum reasonable thickness, and how to articulate such a requirement. Given requirements on freedom from holes and bursting properties, it is unnecessary to stipulate the *minimum* thickness of condoms.

Generally speaking, condoms increase in thickness from the rim to the closed end, where measurement is difficult. Standards prescribe either mean thickness, or thickness in the midbody portion of the condom. For example, the USA Standard requires the single-wall thickness of 5 condoms per batch to be measured 1 cm from the rim, 3 cm from the closed end (excluding any teat), and midway between: no reading may exceed 0·009 cm, and the mean thickness must lie between 0·004 cm and 0·007 cm. The British Standard requires the double-wall thickness of one condom per quantum, measured about 8 cm from the rim, not to exceed 0·016 cm.

The Swedish Standard has no thickness requirement, but requires the mean weight of 10 condoms per batch (after removing any dressing) not to exceed 1·70 grams. The USA Standard requires the weight of *each* of 20 condoms per batch, and the British Standard that of one condom per quantum, not to exceed 1·70 grams.

Limiting the maximum overall weight of a condom is a rather crude means of limiting its thickness, although the principle is sound enough. Different condom brands are of relatively uniform width laid flat, although the cumulative weight of the overall length, including the rim and the teat (if any), may vary somewhat. The consumer presumably perceives the *average* condom thickness up to a certain distance from the closed end. What distance?

At their April 1972 meeting held in London, an IPPF Working Group on Condoms agreed upon a minimum condom *length* (excluding any teat) of 16 cm, and noted the impracticability of detecting holes within 2 cm of the rim. Accordingly, they agreed that holes should only be evaluated up to 14 cm from the closed end, the measurement (but not the evaluation) excluding any teat.

It is therefore suggested that the mean thickness of condoms, up to 14 cm from the closed end, be circumscribed as follows. Each of 10 condoms per batch should be unrolled onto a cylindrical former of appropriate diameter (about 3·5 cm), and its length (excluding any teat) recorded. Any teat, and the portion of the condom beyond 14 cm from the closed end, is then cut away, and the 14 cm portion washed in water or propan-2-ol (to remove any dressing), before drying to constant weight, which is recorded. Requiring the weight of each of these 14 cm portions not to exceed 1·000 gram implies a maximum mean single-wall thickness in this region of about 0·007 cm, and minimises any variation between condoms, and hence the chance of tolerating relatively thick condoms, despite a satisfactory average.

Thicknesses calculated on this basis range between condom brands between about 0.005 cm and 0.008 cm. The thinnest condoms are made in Japan, the thickest ones in Eastern Europe and the USA. An interesting finding is that teat-ended condoms tend to be significantly (about 10%) thicker than comparable plain-ended condoms.

Width

The IPPF Working Group on Condoms declined to recommend any range of acceptable condom *width,* conventionally measured across the condom laid flat. National standards prescribe minimum widths ranging from 4·4 cm to 4·9 cm, and maximum widths ranging from 5·4 cm to 5·6 cm. The Japanese Standard prescribes no width: indeed, there exists a satisfactory Japanese condom tapering uniformly from a width of about 5·0 cm at the closed end to 4·2 cm at the rim. Moreover, shaped condoms vary in width between about 3·4 and 7·0 cm.

Consequently, circumscribing condom width comprehensively is a cumbrous

process. The USA Standard is singularly complicated in this respect, effectively excluding shaped condoms specifically countenanced (up to 7·0 cm wide near the closed end) in the British Standard. The British and Swedish standards apply width limits of 4·9 – 5·6 cm up to 8·5 cm from the rim of the condom. Ultimately, condom width may be expected to be consumer-regulated.

Marking

All condom standards prescribe the marking of a *date* (usually month and year) of manufacture and/or recommended expiry. The relationship between the dates of manufacture and expiry, even under normal conditions of storage, is largely arbitrary. From the consumer's point-of-view, a date of expiry is preferable, and implies that the manufacturer can guarantee the quality of the condom, in the sense of conforming to a standard, up to that date.

In an attempt to simulate the process of natural ageing, certain standards prescribe tensile or bursting requirements after *artificially accelerated ageing*. However, the conditions prescribed vary widely, the only common feature being a temperature of 70°C. The Indian and USA standards require test condoms to be suspended in an air oven for 7 days; the Hungarian and Japanese standards, for 3 days. The British Standard requires samples, packaged as intended for supply to the consumer (i.e. rolled, lubricated if appropriate, and hermetically sealed), to be aged for 12 hours at 70°C.

Since there is little evidence that such artificial ageing actually simulates natural ageing, the IPPF Working Group on Condoms agreed that a condom standard need not prescribe ageing requirements, provided that its other requirements may be applied at any time up to the date of expiry claimed by the manufacturer.

Instructions

Only the British Standard requires condom packets to include *instructions* for use, although none is specified. Various authorities warn against genital contact before placing the condom, on the basis that pre-ejaculatory fluid may contain spermatozoa, although this has been controverted. The advantage of a teat-ended over a plain-ended condom, and of ensuring a free space between the penis and the closed end of a plain-ended condom, to accommodate the ejaculate, have likewise been controverted. Finally, there seems little warrant for the conventional emphasis on withdrawing *soon* after ejaculation, let alone immediately.

Condoms are customarily used at a time of sexual arousal, when only the most rudimentary instruction is likely to be recalled. Putting on a condom rarely poses problems; but taking it off, or rather, forgetting about it altogether, may well do so. Accordingly, the one simple instruction, important above all others, is that, whenever the penis is withdrawn from the vagina, *the rim of the condom should be held to the man's body.*

Supplementary Spermicide

Evidently, the additional use of a vaginal spermicide will reduce the risk of conception in the event of a burst condom, or of a significant escape of semen through a large hole near the closed end, after ejaculation. Using a condom without spermicide at every coitus will result in pregnancy once in somewhere between 1 000 and 10 000 instances, depending on the quality of the condom, and on the couple. Using a condom with a spermicide at every coitus might reduce this risk between 10-fold and 100-fold.

However, insisting on supplementing the condom with a spermicide may inhibit the consistent use of a condom alone. In other words, although the *theoretical* effectiveness of combining a condom with a spermicide is obviously higher than that of either contraceptive used alone, the *use-effectiveness* of the combination may well be lower than that of the condom used alone.

It would seem more promising to incorporate a spermicide into the lubricant commonly applied to condoms. However, certain spermicidal lubricants may damage the rubber during storage. Moreover the lubricant, applied to the rolled condom just before hermetic sealing, migrates away from the closed end during storage, so that any incorporated spermicide may not be placed in sufficient quantity near the cervix during coitus. Any advantage gained from supplementing a 'good quality' condom with a spermicide thus appears slight.

Contraceptive Testing Manual

For some time, it has been planned to publish an IPPF *Contraceptive Testing Manual,* intended to discuss condom testing in more detail than in these two articles, as well as the testing of other contraceptives. 1974 is now expected to be the year of publication.

Philip Kestelman
Secretary to the
Regional Medical Committee

IPPF Anniversary Conference – Summary and Comment

The IPPF 21st Anniversary Conference held in Brighton on 22–27 October 1973, with the theme *Planning for the Future*, brought together for the first time representatives of all member-associations and of governments, UN agencies and nongovernmental organizations – some 500 delegates in all. The meeting opened in London, and continued for five days in Brighton.

Welcoming the delegates on behalf of the IPPF, the President, Dr Fernando Tamayo, offered a partnership in family planning activities to all governments of the world. He urged national family planning associations to deal with governments carefully and with respect, pointing out that "most government programmes want, and have asked for, the kind of help that the private association can continue to provide, whether this be in training, in motivational efforts, in applied research or in demonstration clinics that provide a model of what services should be." Dr Tamayo felt that the wide representation at the conference indicated the global character of the population problem, and emphasized that the "quality of life" was "everybody's business", while still remembering that, in all our efforts, "human dignity" must be respected.

In his keynote speech, Mr Rafael Salas, UNFPA Executive Director, referred to the growing sense of the complexity of the relationships involved, to the importance of the context in which individual decisions on family size are made, and to the need for a comprehensive approach to the problem of rapid population growth, going beyond the traditional confines of demography and family planning. Hopefully, we now recognize that there is more to economic development than an increase in the gross national product, and we can see an increasing emphasis on the "quality of life" and on the "primacy of social goals". The target should be the realization of the motto of World Population Year, 1974 – "One world for all".

At the first plenary session in Brighton, Dr Corbett McDonald, Director of the IPPF Office of Evaluation and Statistics, presented his interpretation of data collected from a study of demographic trends, fertility regulation practice, and the availability of services in 209 countries. This *Survey of Unmet Needs in Family Planning* formed the basic background document for the conference. It appeared to show that one third of the world's adult population has sufficient knowledge of contraception to plan their families,

though only half the adult population, and far fewer younger people, have adequate access to information and education on family planning. Less than one third of all fertile couples are practising family planning regularly, half of them by methods of doubtful reliability. It seemed from the figure given that roughly one third of the world's pregnancies are deliberately terminated legally or illegally, and that abortion is a prevalent method of fertility regulation, though of course there are enormous regional differences in the figures. It was noted that 60% of governments make no contribution to family planning, and that less than one third of all services are supported by governments, the rest by national or international funds.

Dr Thorsten Sjövall, IPPF Europe Region President, offered a provocative view in his paper on *Human Rights and Welfare Aspects*, tracing the development of IPPF policy and aims, and noting the dichotomy between population and human rights aspects – facts that can be more or less measured, and values that cannot. As a result of present IPPF central policies, he suggested that, in the eyes of innumerable people today, "we are something between nothing at all and an organization with the starkly dominating aims of curbing population increase in the world, particularly the poor world". He cautioned against the establishment of large staffs of employees, many of whom were professionals outside the field of administration, and emphasized the need to keep a balance between employees and volunteers. In conclusion, he asked: "Why not take the less controversial, more unifying and probably more stable concepts of human rights, public health and individual welfare as our leading issues in presenting what we stand for at the global level?"

Dr Bernard Berelson, President of the Population Council, in considering the *Contribution of Family Planning to Demographic, Economic and Social Goals*, referred to the fact that lowered birth rates accompany economic and social development. He concluded that, while development speeded fertility decline, family planning must be part of the process that speeds development. Family planning makes a direct contribution to economic and social goals, by giving the poor the same opportunities as the rich for personal control over childbearing. He felt that so fundamental are our concerns that the effort is properly justified on medical, philosophical *and* demographic grounds, for all are closely involved.

In a comprehensive though rather technical presentation, Professor Rodney Shearman (Australia) discussed *New Possibilities for Fertility Control*, describing contraceptive delivery systems, implants, intracervical devices, vaginal rings and medicated intra-uterine devices. He tended to dismiss present efforts in postcoital contraception, and suggested that attempts to devise a single tablet (once a week, once a month) approach had been relatively unrewarding. The immunological approaches, too, had been fairly unsuccessful, and he saw no immediate prospect of new contraceptive methods for men. He saw no sign, even on the distant horizon, of a method of administering prostaglandins suitable for self-medication. Even the ability to detect ovulation reliably still evaded us. Present work on pheromones suggested the prospect of developing an olfactory method of fertility regulation, but this was still many years away. Professor Shearman felt that, given enough financial support, each of the approaches discussed in his paper, excluding pheromones, could be resolved in less than five years. He emphasized, however, that this would be of little avail if concurrent efforts were not made to influence the acceptability of contraception in different societies.

Inadequacies in the provision of information, education and methods were cited by Dr Alexander Kessler (WHO) as *Barriers between Contraceptive Services and the Consumer.* Too little attention was paid to men in these respects. More importance should be placed on the diffusion of information by the satisfied customer. The main conclusion drawn was the necessity for a much greater orientation towards the needs of the consumer.

Social and Economic Change and Planned Parenthood was the theme for a series of papers, the opening one given by Mr Wajihuddin Ahmed (Pakistan). He contended that "a social system that promises nothing to the individual cannot lay down breeding rules for him" – social action must come first. Planned parenthood will find social acceptance only as a rearguard action against poverty. Referring to the uneven distribution of resources between societies, and the tendency for the rich to aggravate pressure on resources by multiplying their wants and consumption, he said: "The concern expressed in Washington over growing numbers is not shared in Accra or New Delhi, for the simple reason that Washington is not prepared to accept its own responsibility in relation to what man has for his subsistence and progress". Admitting that we did not know enough about the full demographic impact of the Chinese experiment, he concluded that we could learn at least two lessons from Chinese experience: (1) the demand to limit fertility must come from a caring and disciplining social whole, not from a wellwishing outsider; and (2) if we show no interest in poverty, people will think that population control is a fraud.

Mrs Nani Soewondo (Indonesia) spoke on the influence of legislation and policy in improving the status of women. *Social and Cultural Values Affecting Fertility and the Adoption of Family Planning in Africa* were discussed by Professor Francis Okediji (Nigeria) who showed that recent fertility declines have been correlated with widespread access to superior social services, rising female education, and withdrawal of children from the labour force for schooling. Ultimately, however, factors affecting fertility and the adoption of family planning were strongly rooted in an even distribution of social and economic benefits within a nation.

The final discussion paper was given by Mrs Wendy Marson. Under the title *A View for the Future*, she ranged widely, suggesting future roles for associations, questioning the regional structure of IPPF, and commenting on volunteer-staff relationships. She considered that the Governing Body was physician-dominated (41%), lacking in youthful representation (less than one third under 50 years of age), and only one third women. The same pattern emerged from her analysis of the Management and Planning Committee. She was heartened by the infusion of youth into the Conference as one-third of delegates. "We must pledge ourselves to the reduction of the worst forms of poverty and to raising the minimal standard of living for all; there must be an expansion of human freedom." In conclusion, she urged the IPPF to balance service activities with innovative roles; to give attention to strategies to influence reproductive motivation; to respond to a diversity of problems and programmes; and to nourish, strengthen and diversify its roots in the countries. We must be prepared "to fold our tents and turn our energies to endeavours of the times".

These papers provided the main substance for discussion in 12 groups for four days. In the programme preamble, it was stated: "No attempt will be made to arrive at a consensus or a compromise, but a system of reporting has been devised which will encourage

the main trends of feeling and the broad areas of agreement to emerge, as influences on the formulation of future policy". These trends were presented in a masterly summary by Professor Brian Abel-Smith at the final session of the conference. The main points which emerged in his summary were:

1. Unplanned infertility is as much the concern of the IPPF as unplanned fertility.
2. We are concerned about the balance between world population and world resources, not because we want to curb any nation's population for its own sake, but because we are concerned about people – about those alive today, and those who will be alive tomorrow and the day after.
3. In the light of the prevalence of abortion, there appears to be considerable support for the Federation's new non-promotive but humanitarian policy on abortion.
4. We must be concerned not only about, but with, world poverty, in terms of economics and human rights.
5. The will to integrate planned parenthood work more closely with other work for economic and social development emerged clearly.
6. The IPPF must never diffuse its role as the world spokesman for planned parenthood.
7. We need to build on and extend the range of traditional contraceptive practices, and involve indigenous practitioners, for whom suitable training needs to be provided.
8. The earlier in life we get our message across, the longer the impact within the woman's limited period of fertility, and the greater the impact on the period of the man's greatest potency.
9. In many societies, family planning cannot progress until the status of women is raised.
10. The message must, wherever possible, be taught early in the schools as part of sex education, population education, and education for family and community living.
11. In our plans for the future, we must involve youth in a more positive way at all stages.
12. In relation to the future, it is regrettable if a national association suffers a sense of deprivation, rather than the elation of triumph, when it hands over its clinics to the government. There are still many roles for the association, including:
    - 12.1 monitoring government services;
    - 12.2 filling gaps in government services and experimenting with new types of service;
    - 12.3 promoting new training programmes;
    - 12.4 sponsoring research and evaluation programmes;
    - 12.5 pressing government and international agencies to include a family planning element in all development programmes;
    - 12.6 pressing for better coordination of family planning activities;
    - 12.7 pressing national governments to support at the international level all initiatives to improve the status of women.

It is clear that there is an experimental and pioneering role for national associations in developing new methods of communication, and pioneering more culture-challenging messages, than any government programme would dare to use. While a government gains short-term respect by being respectable, a voluntary body may gain long-term respect by being responsibly disreputable!

Personally, I emerged from the conference with a definite feeling that something had been achieved. The free exchange of views internationally at a person-to-person level is bound to generate some energy. The challenge now is for the IPPF, through its Governing Body and Management and Planning Committee, to harness the energy, and drive it forward in its "adult" years. Above all, we must maintain a major degree of flexibility in outlook and action. While the IPPF may develop policies, it is for each national association to take or leave or go beyond, any policies developed or suggested at the centre. This is the understanding which can hold together diverse countries or groups in what is inevitably one of the most emotive areas of human activity.

As Professor Abel-Smith concluded: "We have our marching orders – our work will not be finished until no child is unplanned, unsought or unwanted, and until there is a safe and prosperous future for every child born on this planet".

Denys Fairweather
Regional Vice President

"More than 90% of most current family planning programme costs are for personnel and not for supplies", according to Dr Malcolm Potts (see first issue of *People* circulated at the Brighton Conference). How amazing then to see the luxury with which the convention was organized of delegates from the more privileged socio-economic classes representing IPPF member associations. Can one really have heard the voice of the people as exhorted by Elise Ottesen-Jensen? Can one really have had the opportunity of defining under such conditions the *real* "unmet needs of family planning".

"Brighton talks will strengthen voluntary role" read the headline of the October 1973 IPP *News*. Can one speak of "consultation between family planning associations" when the only plenary meeting supposed to have been devoted to an exchange of views between associations (three hours during the six day conference) was in fact nearly wholly occupied by the presentation of two reports?

Perspectives for the future was the subtitle of this Conference. Was it possible to speak of a future when the only possibility for expression offered to the younger delegates (who were clearly in the minority) was an informal meeting held outside the scope of the general conference for one evening? If a Youth Committee were to be created within the IPPF, as certain of the Central Office staff seem to want, would not this risk perpetuating discrimination against young people?

"Population policies and programmes are not alternatives to, or substitutes for, economic and social development, and population planning is not an end in itself", says Rafael Salas, Director of the United Nations Fund for Population Activities (*People*, October 1973) and yet, only the excellent paper by Wajihuddin Ahmed, entitled *Social Economic Change and Family Planning* which constituted 10 out of thousands of pages of material circulated during the Conference emphasized the need for such changes. His paper concluded: "If a society is too inert or too timid to make these changes, its attempts to control population may not go beyond the ineffectual zeal of officials and the philanthropy of the simple minded".

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to the Conference.

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