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The Price of Contraceptives in Europe

In June 1978, the IPPF Europe Regional Council agreed that information on the prices of contraceptives in European countries should be collected. By early 1979, most European member-associations, and a few nonmember-country contacts, had replied to a Regional Office circular enquiring the retail prices of the main contraceptives available in their countries. Insufficient data have arrived from five member-countries; and the sale of contraceptives is illegal in Ireland.

When interpreting the data, it is important to bear in mind the additional service-charges (e.g. consultation, fitting and/or prescription fees) made in some countries. For example in Belgium, each medical consultation (after Social Security refund) costs the sterling equivalent of £1.70; while a private gynecologist charges £17 to insert an IUD. In Czechoslovakia, a gynecological prescription for oral contraception normally amounts to £9.40 p.a.

Assuming 100 contraceptive coitus per annum, the mean annual cost to the consumer of contraceptives bought in Europe approximates 0.5% of the Per Capita Gross National Product (GNP), ranging 0.3–0.7% of GNP between the UK and Spain, respectively: in absolute terms, between about £5 in Portugal and £17 in Austria. The prices of different contraceptives overall range between 0.1% of GNP (for IUDs) and 0.7% of GNP (for condoms, spermicides and oral contraceptives), diaphragm plus spermicide costing around 0.25% of GNP on average. One year's average European supply of condoms, spermicides or oral contraceptives costs around £15–£20, while variations between different brands and countries are considerable.

Assuming a useable lifetime of two years, a diaphragm with spermicidal cream or jelly cost only £1.20 p.a. in Czechoslovakia, but about £11 p.a. in Austria. The most widely available brand, *Ortho* (Ortho Pharmaceutical Corporation, *USA*), costs least in Portugal (£1.30 p.a.), and by far the most in Italy (about £6 p.a.), over double the cost in Austria or the UK (£2.60 p.a.).

Condoms cost £17 p.a. on average in Europe, ranging £8.60–£23 p.a. between Portugal and Austria: between 0.4% of GNP in Sweden and 1.1% of GNP in Greece. For example, the annual cost of *Durex Gossamer* (London Rubber Company, *UK*) ranges from £7 in Portugal to £22 in Austria, the UK price (£10 p.a.) being intermediate.

The cheapest spermicidal vagitory (£6.10 p.a. on average), *Rendells* suppository (Rendell, *UK*), costs least in Italy (£3.30 p.a.), most in Finland (£11.40 p.a.); again, the UK price is intermediate (£6.30 p.a.). The most expensive vagitory (£29 p.a. on average), *Patentex oval* foaming suppository (Patentex GmbH, *FRG*), costs least in Italy (£22 p.a.), most in Austria (£35 p.a.): the FRG price is also intermediate (£26 p.a.). It seems improbable that the cost of manufacturing *Patentex oval* exceeds five times what *Rendells* costs to make; though by all accounts, *Patentex oval* is heavily advertised in several European countries. In Italy, *Patentex oval* costs 1.5% of GNP, whereas *Rendells* costs only 0.2% of GNP.

There is no evidence that foaming suppositories are more effective contraceptives than other spermicides. On somewhat flimsy evidence, aerosols (foams) have long been considered the most effective spermicide. The most widely marketed aerosol in Europe, *Delfen Foam* (Ortho Pharmaceutical Corporation, *USA*), costs £12.60 p.a. on average, ranging twofold between Portugal (£8.20 p.a.) and Denmark and FRG (£18–£19 p.a.).

Oral contraceptives cost £17 p.a. on average in Europe, ranging between £8.70 p.a. in France and Portugal, and £28 p.a. in FRG: between 0.3% of GNP in France, and 1.0% of GNP in Austria, Greece and Portugal. The widest range for a specific brand, *Lyndiol* (Organon International BV, *Netherlands*) lies between £7.90 in Spain and £28 in FRG. Price variation between different oral contraceptives *within* countries is relatively small. The annual cost of three-monthly injectable medroxyprogesterone acetate (Upjohn International Inc, *USA*) also ranges threefold between Portugal (*Depo-Provera*, £6.90 p.a.) and FRG (*Depo-Clinovir*, £21 p.a.). However, GNP varies even more widely (fourfold) between Portugal and FRG.

Assuming that IUDs remain in place for several years, their unit price is relatively low: though mean (annual) prices range fourfold, between £0.75 p.a. in Portugal and about £3 p.a. in the Netherlands. The retail prices of particular brands range even more widely: for the *Copper T 200* (Schering AG, *FRG*), the price ranges from £0.53 p.a. in Portugal to £2.90 p.a. in Italy. The widest intra-country variation is found in the FRG, where the *Lippes Loop* (Cilag-Chemie, *FRG*/Ortho Pharmaceutical Corporation, *USA*) costs £0.67 p.a. (over a lifetime of five years); whereas *Biograviplan* (Grünenthal, *FRG*)/*Progestasert* (Alza Corporation, *USA*) costs £13 p.a. (over two years).

In several European countries (e.g. GDR, Sweden and UK), where both contraceptives and the necessary services are free-of-charge through national health service outlets, nonprescription contraceptives (especially condoms and spermicides), supplied through 'normal' retail outlets, remain unsubsidised. From the consumer's viewpoint, this may represent the main discrimination against using barrier contraception, favouring the use of cost-free, medically prescribed hormonal or intra-uterine contraception; or even self-prescribed withdrawal (coitus interruptus), also free-of-charge!

Philip Kestelman
Medical Secretary

In this issue

Planned Parenthood in Europe: a Personal View

Origins

In 1946, Elise Ottesen-Jensen, the Norwegian-born founder of the Swedish Riksförbund for Sexuell Upplysning (RFSU) invited delegates from other countries whom she had known before the Second World War, as well as others interested in the subject of sex education and planned parenthood, to attend the RFSU annual conference. This was a first step towards the establishment of the IPPF. Among those attending the conference were Conrad Van Emde Boas of the Nederlandse Vereniging voor Sexuele Hervorming (NVSH); Leo Kaprio of the Finnish organisation Vaëstoliitto (who subsequently became Director of the European Region of the World Health Organisation); Chris Brusgaard (Norway); Edward Griffiths (UK); Abraham Stone, Lena Levine and Margaret Sanger (USA). These were some of the people who formed the First International Committee on planned parenthood established at the meeting. Elise Ottesen-Jensen was convenor of the Committee, and Einar Tagen (Sweden) its chairman. The Committee was formed following the adoption by the full conference of the following aim:

'To promote physical and spiritual health, welfare and happiness of the individual, the family and society in a new, free and united world.' In support of this aim, the conference adopted the following resolutions:

'1. Every child has a right to be wanted by both parents, and all parents should have a right to decide upon the number of children they shall bring into the world.

2. It is the right of all people to obtain scientific information on the control of conception and the treatment of infertility, under professional direction.

3. It is the right of all children to receive scientific sex information as part of their general education, and of youth to receive adequate marriage preparation.

4. Colleges and universities should provide facilities for the training of doctors, nurses, midwives and other educators in the field of sex and marriage guidance.

5. Scientific research in the field of sex and human fertility and the development of reliable contraceptive measures, which can be universally applied, is of urgent necessity.'

These statements are very similar to the aims of the IPPF Europe Region as agreed when it separated from the Middle East and North Africa Region in 1971, and to the policies and objectives of the IPPF Europe Region in its 1979/81 three-year plan:

The policies and objectives of the Region agreed by the Regional Council are:

- to promote recognition of the importance of human relationships, in particular the sexual content of such relationships, and the role of the IPPF in this field and, further, promoting humanitarian considerations including the encouragement of social reform leaving political implications of population to governmental organisations;
- to ensure that IPPF orientation reflects the policies of the different PPAs elaborated in relation to specific economic, social and cultural realities and that information published by the IPPF gives expression to different points of view;
- to emphasise that contraception and abortion are means of fertility regulation and not themselves determinants of family size preferences, or fertility trends;
- to emphasise that to promote or restrict fertility regulation services on anti- or pronatalist grounds is a political act which is not only based on false assumptions, but is also inconsistent with the equal rights of peoples all over the world to regulate their own fertility;
- to encourage a closer cooperation of governments with PPAs, not only in national affairs, through, for example, ministries of health and social welfare, but also internationally, seeking to prevent associations or governments adopting one policy nationally and another internationally;
- to ensure that proper consideration is given to the ethical aspects of activities undertaken by organisations and individuals working in planned parenthood;
- to draw attention to commercial interests in the promotion of fertility regulation.

Edward Griffiths agreed to organise a second conference in England. A committee was set up in Britain led by Helena Wright, to organise an international conference on Sex and Family Life. A number of people in Britain were approached to support the meeting, including those whose main interest was neo-Malthusian. Consequently, the conference, held in Cheltenham in 1948, became a conference on Population and World Resources. Although the topics originally proposed for the conference were also discussed, the 1946 proposals on sex information, freedom of choice on birth spacing, treatment of infertility and marriage guidance, receded into the background.

Sex was not a subject that could easily be discussed in Britain at that time. There was and is a tendency amongst those anxious to overcome their own inhibitions, and those of others, to identify planned parenthood in terms of population as a suitable topic for public discussion, making it almost possible to forget that births are the result of sexual intercourse.

To be fair to some of the early pioneers, who were genuinely involved in offering planned parenthood services in their own countries, they undoubtedly did not realise that by inviting the participation of neo-Malthusian theorists, unconnected with national planned parenthood associations, they would introduce neo-Malthusian politics and change the whole basis of the aims agreed at the 1946 meeting, on which the IPPF might have been established in 1952.

However, an important element in the IPPF constitution adopted in 1952 proposed, I believe, by one of the British, was the establishment of the Regions. This fortunately enabled the Europe, Near East and Africa Region to develop along the 1946 principles.

Europe, Near East and Africa

Elise Ottesen-Jensen was elected first President of the IPPF Europe, Near East and Africa Region. In the first years, the Region had an honorary secretary. During 1955–56 Rotha Peers acted as part-time Regional Secretary, and then became secretary to the Central Medical Committee, which was in the process of being established by Helena Wright, its first chairman. I was appointed at the end of 1956, also on a part-time basis, as the only staff member for the Region.

In 1959 Nina McKenzie joined me to

collect information on activities which were rapidly growing in Africa. Most of her efforts were directed towards contacting physicians, midwives and nurses from Africa working in Britain and putting them in touch with each other in order that they might cooperate on returning to their own country. She made one visit to Africa for the IPPF at her own expense.

The first associations in Africa were in Kenya, Mauritius and South Africa. Africa left the triple Region in 1964 at the time of the third Regional Conference, which was held in London and attended by several delegates from Africa. Although a Regional Office was established in Nairobi, under the direction of James McAllan, and Africans participated in the 1966 Europe and Near East Regional Conference, the African countries south of the Sahara were without a constitutionally established Region within the IPPF from 1964 until 1971. Since 1971, resolutions passed by the Africa Regional Council and its publications have indicated a return to the policies and thinking with which Africa was associated when part of the triple Region. The African delegates had played an active role in the amendment to the IPPF Constitution proposed by the triple Region and agreed by the Governing Body in 1963, to which I shall refer later.

Europe and the Near East

The Region continued as a double Region to be concerned with countries in the Middle East and North Africa until 1971, when the last joint Council meeting of associations in the double Region was held in Beirut. At that time the two newly separated Regional Councils of the Europe Region and the Middle East and North Africa (MENA) Region met independently of each other.

Before 1967, the Region's efforts to assist already established and emerging associations in the Middle East and North Africa were limited, although contacts were made with Algeria, Egypt, Jordan, Lebanon, Morocco and Tunisia. These contacts, particularly in the North African countries, were with governments, members of the medical profession and women's associations. Health personnel from the North African countries participated in training activities organised by the Region in the 1960s.

However, real progress in establishing the MENA Region only began when Isam Nazer, founder of the Jordan association, who had approached the Regional Office when undertaking postgraduate studies in Britain in 1961, left Jerusalem after the 1967 war and joined the Regional Office to be responsible for the MENA countries. It was while visiting North African countries with Isam Nazer, having visited them myself alone before Isam Nazer joined the office, that I became fully convinced of the unsuitability of persons from entirely different cultures endeavouring to promote family planning in countries not their own. Not only as a result of my personal experience but by observing Europeans and North Americans based in, or visiting as foreign 'experts', North African countries, I realised that family planning movements must evolve within the country if they are to prove acceptable, although an exchange of experience and observation of activities in neighbouring countries of similar cultural background can stimulate ideas. Much could be told about developments in the MENA Region after 1967, but this would more appropriately be described by the MENA Region. Suffice it to say that the MENA Region has pursued policies more in line with the 1946 principles than the 1952 IPPF Constitution.

Europe

To dwell at greater length on developments in Europe between 1956 and 1978, while bearing in mind the African participation until 1964 and the MENA participation until 1971, involves description of some general trends, specific references to associations and to individuals who have influenced developments both nationally and regionally.

From the beginning the Europe Region's aim was to seek mutual understanding among all European countries on the right of every individual to freedom of choice in child birth, recognising that within Europe there are many differences in political systems, socio-economic conditions, cultural backgrounds, languages, religions and laws. The emphasis was on demonstrating to governments that people need planned parenthood services, and that such services should form an integral part of health services and should not be prohibited or promoted for pro- or anti-natalist reasons. Governments, of course, should endeavour to be aware of their country's population trends in order to meet effectively people's needs for education, housing, employment; but coercion, compulsion or restriction of planned parenthood information and services for population policy reasons are unacceptable.

In the context of such mutual understanding, each association has, and has always had, its own special characteristics. Other Regions of the world may not be so aware of the individuality of each European country. It has been interesting to observe the differences in national characteristics, the different pace at which the associations have developed, and the way in which many have benefited from the experience of their neighbours' successes and failures.

It has been a major task of the Region to be aware of planned parenthood trends and developments and to identify the main topics of common concern in the majority of countries for discussion in Regional conferences, small seminars and working groups and in Regional Council meetings. It is difficult to judge to what extent these discussions helped to solve problems, to provide insight into attitudes or to change the direction of activities. I believe that there must have been some influence, as changes undoubtedly took place.

To describe how the subject of each conference and seminar was developed, how it was treated and to surmise what their effects may have been, would need a separate article on each. Citation of their titles will have to suffice to demonstrate how the pattern evolved, always on the basis of concern for the individual.

Conferences, seminars, working groups

The first Regional Conference, held in West Berlin in 1957, had as its title *The Healthy Family: Ethical, Sexological and Psychological Aspects.* In an opening address, Hans Harmsen reminded participants that between the two world wars, neo-Malthusian theorists had been mainly 'anglo-saxon'; the International Union for the Scientific Study of Population, established in the 1920s, scientifically studied demographic questions; a reaction to the neo-Malthusian discussions had been the creation in France of an International Committee for Family Life, whose objective was to

resist decreasing birth rates in Europe and to campaign against contraception. (The 1921 law against contraception and abortion in France was introduced in an attempt to raise birth rates.)

Kemal Abdel Razzak, Director of Health Education and Social Services in the Ministry of Public Health, and a member of the Egyptian National Commission for Population Problems, was another introductory speaker. He remarked that, whereas it was possible to say that rapid growth in population was in itself an obstacle to economic development and the spread of public services in Egypt, it might be argued, that the situation in Egypt was the result of a lack of proper investment policy in the past, and that the government might now find ways to raise the standard of living through expansion of cultivable areas and agricultural production, after the development of the High Dam of Aswan, and through exploitation of mineral wealth and rapid industrialisation.

The Conference was devoted to such subjects as the psychology of planned parenthood; the acceptance of sexuality in marriage; sex education in schools; education in family relationships; broken homes as a cause of neglected children and of juvenile delinquency; infertility and sterility; abortion; factors disruptive to family life; and a paper was presented by Thorsten Sjövall (Sweden), who later became President of the Region, on the Human Factor in Planned Parenthood.

The 1957 Conference was an important landmark in the development of the Region. It brought together, within the framework of the Region, representatives from all parts of Europe, including representatives of the newly founded organisations in Belgium, France, Italy and Poland; and from Austria, the German Democratic Republic and Yugoslavia where, as yet, no organisations existed. Elise Ottesen-Jensen had, since 1946, visited many of these countries. Conrad Van Emde Boas (Netherlands) had also fostered contacts, and Helena Wright travelled to Poland with the Polish delegates after the Conference.

These contacts were renewed in 1958 when Elise Ottesen-Jensen invited representatives from many European countries to attend the 25th anniversary celebrations of RFSU in Stockholm.

The second Regional Conference, on the *Psychological and Social Aspects of Family Planning* was held in the Social Institute of the Hague in 1960. The Conference had been preceded by an important conference on abortion, organised in Rostock (German Democratic Republic) by Karl-Heinz Mehlan. The Rostock meeting emphasised the promotion of contraceptive facilities in an endeavour to decrease the need for abortion. In Rostock the first regional contacts were made with representatives from Bulgaria, Czechoslovakia and Hungary.

At the third Regional Conference, held in Warsaw in 1962, the demographic situation, *Trends in Family Development in Europe*, were discussed, indicating that the Region did not wish to disregard demographic questions, but rather to place them in their true perspective, emphasising the paramount right of the individual.

The fourth Conference, on *Sex and Human Relations*, held in London in 1964, was attended by a large number of delegates from Africa.

In 1966, the fifth Conference, on *Family Planning and Preventive Medicine*, held in Copenhagen, had a wider representation of the Middle East. The role of health personnel in the provision of planned parenthood services was emphasised.

The sixth, and last, Regional Conference, on *Social Demography and Medical Responsibility*, was held in Budapest in 1969. Some of the background papers were prepared in cooperation with the Regional *Family Planning Trends Committee*, established in June 1965.

The *Committee*, composed of demographers and formed as a result of proposals from Egon Szabady and his colleagues from the Central Statistical Bureau in Budapest, brought together demographers, from among other countries Belgium (Jean Morsa), Denmark (Poul Matthiessen), Greece (Vasilias Valaoras) and Hungary. In January 1967, at a meeting with Halvor Gille, then Director of the UN Social Affairs Division at Geneva, Agnete Braestrup, Regional President, and members of the Regional Executive Committee, it was agreed that the *Committee* be taken over by the Division. At that meeting the term 'social demography' was born. The *Committee* continued to function as a working group on social demography of the UN Social Affairs Division at Geneva, expanding to involve more countries in Europe. The Region continued to be represented at its meetings. The group accepted that planned parenthood services should be available in all demographic circumstances.

After the 1969 Conference, it was agreed that it was no longer necessary to organise large-scale conferences. The topic of planned parenthood as such had been widely aired in Europe, and during the 1970s the Region concentrated on seminars for the Regional Council and seminars and working groups in which not only representatives of associations but others were involved.

The 1971 Regional Council meeting in Beirut, the last joint meeting with the MENA countries, discussed four topics, with a speaker from Europe and a speaker from MENA on each topic; the emancipation of women; youth and parenthood; male and female sterilisation; and the psychological aspects of sterilisation. The theme of psychosocial aspects of planned parenthood was carried through again into the 1972 Council seminar, held in Italy.

In 1973, in Finland, the Council discussed the future role of the IPPF nationally, regionally and centrally, having previously obtained from associations a short statement of their views on their future role. During the discussions, the Council reasserted that the associations must be free to develop as they thought fit within their countries, just as Regions within the IPPF must be free to develop within the framework of the Region and that IPPF centrally should be a means of drawing together the ideas and varying activities of the different Regions, rather than a centrally controlling organisation.

On that occasion in 1973 fourteen government representatives attended a seminar with Council members to discuss the attitudes of European governments to planned parenthood. Attention was drawn to the undesirability of European governments accepting planned parenthood services as part of their domestic health and social welfare policy, while contributing funds through UN organisations and the IPPF for population control in developing countries. This difference in

domestic and foreign population policies was held to be unacceptable.

In 1974, meeting in Belgium, the Council discussed population education and planned parenthood. Norman Rea (Britain) speaking as one who had given many years of his life to the education of the young, expressed the view that the subject of planned parenthood in schools and other youth groups should not be approached from a demographic standpoint, but in the context of sex and family life education.

In 1975, in Portugal, the Council discussed the IPPF and its relation to people, society and government. Before the Council meeting a francophone working group discussed Sexuality and Sex Education in Latin Cultures.

In 1976 in the German Democratic Republic, 1977 in Ireland and 1978 in Turkey, the main topics of Regional Council discussion were respectively: Youth and Sexuality: problems of understanding and cooperation; Transition: the stages of development of the associations – successes and failures; Ethics and planned parenthood.

During the 1970s a number of subregional working groups were organised in English, French and German languages for youth journalists and educators.

Three working groups on different aspects of abortion were held in 1973, 1974 and 1976 respectively on *Induced Abortion and Family Health: a European View; Abortion Counselling: a European View*; and *Ethical Aspects of Abortion: some European Views.* Reports of the three meetings were published and the Council agreed a policy statement on abortion in 1975. A working group held in 1976 on *Sexuality and Handicapped People* aroused awareness in a number of countries of the difficulties encountered by handicapped people in sexuality. Two other subjects dealt with by working groups were *Emotional Problems in Planned Parenthood Services* and *Legislation and Planned Parenthood.*

The Region undertook two surveys: in 1973 on the *legal status of contraception, sterilisation and abortion in European countries* (a volunteer lawyer in each country provided the necessary information at no cost to the Region); in 1975 on the *status of sex education in European member countries*, this too was prepared on a voluntary basis by Mikołaj Kozakiewicz of Poland and Norman Rea of Britain.

Evolution of the associations: Regional activities

There have been three types of associations in Europe. Those, such as the British, which were originally based mainly on advice centres and whose committees were composed of persons working in the centres; those such as the Swedish, based mainly on corporate membership of other bodies; and those which are a national federation of regional groups combining these two structures.

Parallel with the need for the Region to be aware of trends and topics to be discussed in conferences or seminars, was the need for the Region to provide facilities for the associations as they passed through different phases of development. Most readers of the *RIB* will be aware of Jürgen Heinrichs' article (April 1976) in which he sketched in general terms the phases through which an association might pass in the course of its development. When possibilities of planned parenthood services being incorporated in the health service of the country seemed remote, it was understandable that the associations' first concern was the provision of services. At that time the Region encouraged associations to establish advice centres. Later it became increasingly obvious that the main task was educational. There was a period when the activities of some associations seemed to focus too closely on the technicalities of sex, but this trend gradually merged into the broader approach of countries such as Poland, with its emphasis on family life education and understanding of sexual relations in the life of the individual as a whole.

During the period when associations were establishing their own advice centres and contraceptive supplies were not available within their own countries for legal reasons, the Region provided contraceptives by post, either to individuals or in bulk to the associations. With the help of Margaret Jackson, a leading contributor to the establishment of the IPPF Agreed Test for Total Spermicidal Power (1965), the Region helped associations to manufacture their own spermicides. In 1958, Bohdan Bednarski, Vice-Minister of Health in Poland and Vice-President of the Polish association Towarzystwo Świadomego Macierzyństwa subsequently renamed Towarzystwo Planowania Rodziny (TPR), asked the Region to arrange testing of all so-called spermicidal products in Poland. On their proving totally lacking in spermicidal effectiveness, the TPR began to produce its own spermicide, the manufacture of which has continued to the present day. In France, after the opening of the first centre in Grenoble in 1962, and the subsequent rapid expansion of advice centres throughout the country, the Region was supplying two thousand diaphragms a week, at the peak period, all despatched individually to women in France who had been advised by MFPF centres. A proportion of the profit on sales was returned to the MFPF. The Region helped the French association to set up the manufacture of spermicides in France. Later, the Regional Office bought Lippes loops direct from the original manufacturers in the USA cheaply, selling them to the associations at a profit to the Region. The associations sold them to clients at a profit. However when a multi-national company based in the USA imposed a world-wide patent restriction, the Region could no longer buy direct from the manufacturer. The Region was not even permitted to buy at a wholesale or retail price in bulk, it being explained that this would upset the potential commercial retail market throughout Europe. For a short time thereafter, in cooperation with Ferenc Szontágh of Hungary and Ismail Ragab of Egypt, IUDs were made by hand in the Regional Office.

The Regional Office at one time supplied British forces and their families outside Britain with contraceptives of all types. At that time a regulation of long standing was still in force whereby the only contraceptives provided to the British forces were condoms to unmarried men, as a precaution against sexually transmitted diseases.

As contraceptives became legally available in more and more countries in Europe, the despatch centre decreased its activities. As soon as an association was able to make its own arrangements within the country, or contraceptives became available through ordinary channels, despatch of contraceptives to those countries ceased. Supplies to Ireland continued only until the Irish association found an alternative solution. Now only Italy and Spain

require some help in the provision of diaphragms and spermicides. Italian and Spanish women, having had no access to the diaphragm at a time when its use was common in Northern Europe, are now asking for diaphragms which are not generally available locally.

During the transition period from the provision of services by associations to acceptance by governments of their responsibility, the need to train health personnel at university and health service levels became evident. At this time the Region established training facilities in university hospitals in Belgium, Britain and Yugoslavia. These training activities had a dual purpose: they provided a facility for short-term training for health personnel visiting the three countries; and they stimulated the establishment of training for the host countries' own personnel in the university teaching system which had not, except in Yugoslavia and one UK hospital, previously existed.

Gynecologists, midwives, nurses and social workers from different cities in European countries participated in the training scheme. The visits were never of more than a week or ten days duration. The aim was to ensure the training of sufficient persons who could thereafter establish a training system within the university and other hospitals in their own cities. The facilities established in British university hospitals were also made available to participants from other Regions, mainly to personnel working temporarily in British hospitals. Subsequently, the clinic services in the British hospitals were taken over by the hospitals as part of their routine services.

Throughout this period cooperation was maintained with the WHO Europe Region in Copenhagen, the UN Social Affairs Division at Geneva, and the Council of Europe at whose meetings the Region was continuously represented.

Association influences

Each association has its own history and the annual developments can be observed through the reports to the Regional Council, although as has often been remarked in the Council meetings, there has never been enough discussion of these reports. I can only mention some of the first contacts the Region made and cite a few developments in each country which I believe have been of particular assistance to other countries.

Austria

The first contacts were with Helmut Traun of Vienna who attended the 1957 Regional Conference in West Berlin. Later Horst Leonhardt, a dentist, made some initial moves to establish an association. Eventually the *Österreichiche Gesellschaft für Familienplanung* was established in 1970 by Hugo Husslein, Professor of Obstetrics and Gynecology in Vienna who, in a move unique in Europe, agreed with the other three professors of obstetrics and gynecology in Austria and the heads of the obstetrics and gynecology departments of two other major hospitals to open on the same day, planned parenthood services in the six hospitals. The association exerted pressure on the government to incorporate planned parenthood services in the state health care system. Its main problem has been to ensure that these services were adequate. Recently the association has had to contend with pressure from some sections of the public against planned parenthood services on the grounds that the birth rate is decreasing and has sought Regional support in a working group on planned parenthood in low birth rate countries (see *RIB* January 1979 'Fertility trends and planned parenthood').

Belgium

Belgium was represented at the 1957 Conference. The first centre offering practical services was opened in Ghent in 1961 by Erna Vercautere, who with her co-workers had been in close cooperation with the Dutch NVSH. The French-speaking part of Belgium naturally tended towards cooperation with La Maternité Heureuse in France, and the first centre in Brussels was opened in 1963. Pierre Hubinont, Head of the Department of Obstetrics and Gynecology at the Free University Hospital, Brussels (the Department was involved in the Regional training scheme) cooperated with the Centre and helped to devise a formula whereby the Dutch-speaking and French-speaking groups joined to form a national federation (the *Belgian Federation for Family Planning and Sex Education*) which became the IPPF member incorporating the original Dutch-speaking member association.

Bulgaria

The first contacts with Bulgaria were made on the occasion of the 1960 Rostock conference, attended by Elia Starkalev, Branimir Papasov and Georgy Stoimenov. These links were strengthened when the three professors and Dimiter Vassilev, together with other Bulgarian gynecologists, visited London to observe teaching sessions and practical services in university hospitals as part of the Regional training scheme. On one of those occasions the Bulgarian group brought with them, to demonstrate in the London hospitals, a film on abortion, then a new topic for British university hospitals at a time when the law prohibiting abortion had just been changed.

Denmark

Agnete Braestrup, a pediatrician who had found herself involuntarily drawn into providing sex education in schools where she was responsible for medical services, founded the association in cooperation with the Danish Medical Women's Association. The *Foreningen for Familieplanlaegning* never intended to be responsible for independent clinical services, and acted mainly as a pressure group, although eventually a few clinical services were established in cooperation with local health authorities. A national network of private abortion clinics was already in existence. The association urged that contraceptive services should be more widespread, and that midwives should be involved. A human reproduction flannelgraph, devised by the association, was distributed by the Region in many parts of the world.

Finland

The first links with Finland can be traced back to the membership by Leo Kaprio (now Director of WHO Europe) from *Vaëstoliitto*, of the First International Committee on planned parenthood established in 1946. Vaëstoliitto was primarily established as an association concerned with low birth rates in Finland. The association has always insisted on the rights of the individual to planned parenthood services, while cooperating with governments in family policy measures aimed to increase the birth rate, such as the training of home helpers and housing projects. More recently the association following, to some extent, the pattern of Swedish experience, established a commercial company for sale of contraceptives and other goods. The association is the only one in Europe to have a population research centre. Kauko Sipponen, sociologist, when President of

Vaëstoliitto and a Regional Executive Committee member, contributed significantly to discussions on IPPF policy.

France
La Maternité Heureuse, later the *Mouvement Français pour le Planning Familial*, was founded in Paris following a visit to the Margaret Sanger Bureau in New York of Lagroua Weill Hallé and her husband. The first clinical service was established in Grenoble in 1962 by Henri Fabre and his colleagues, in spite of the still existing laws against contraception. Thereafter centres opened all over France and a system for provision of advice to members was established, following the pattern used for many years in the Netherlands. This system, inevitable in the legal circumstances, was changed following an internal revolution in the association in 1974. The association ceased to be based mainly on medical advice and became a federation of regional groups linked nationally by belief in the same principles of individual rights. The French association is now probably the most 'popular' based in Europe.

German Democratic Republic
The 1960 Rostock conference, mentioned earlier, proved to be the starting point for the establishment of *Ehe und Familie.* The association succeeded in convincing the government that the provision of contraceptive services and legalisation of abortion would not in itself lower birth rates but would improve MCH and family welfare. The subsequent twenty years have proved the correctness of the association's views. Karl-Heinz Mehlan's ceaseless energy and enthusiasm gathered round him supporters from many professions, including Lykke Aresin, a psychiatrist and present member of the Regional Executive Committee.

German Federal Republic
Anne-Marie Durand-Wever, one of the early pioneers in Europe, who had continued to endeavour to give planned parenthood advice during the years when to provide such help was a punishable offence, was one of those whose practical efforts were invaluable in the organisation of the first Regional Conference in 1957. *Pro Familia* has a history of continuous and expanding cooperation with other welfare groups in the establishment of services. The association is a federation of autonomous Land associations, and has recently undertaken a major review of its overall aims and policies (see *RIB* January 1979).

Hungary
The first contact with Hungary was made at the 1960 Rostock conference, to which gynecologists had brought a film on abortion which was subsequently used by the Region. Later, Egon Szabady of the Central Statistical Bureau and his colleagues András Klinger and Karoli Miltenyi approached the Region proposing cooperation in socio-demographic studies. This led to the establishment of the Regional *Family Planning Trends Committee*, referred to earlier. The 1969 final Regional Conference was held in Budapest at the invitation of Egon Szabady and his colleagues. It was not until later that the *Hungarian Scientific Society for Women's and Family Welfare* was eventually established as a scientifically-oriented group, comprised mainly of demographers and gynecologists, but with the Hungarian Women's Council as a corporate member of the association.

Ireland
The first contact was with Michael Solomons, a gynecologist who agreed that the Region could refer to him, at the Dublin hospital in which he worked, women who wrote desperately seeking help at a time when no contraceptives were available. James Loughran, a general practitioner from Dublin, with Michael Solomons and others decided, in spite of legal problems, to establish an association (the *Irish Family Planning Association*) with clinical services. The Region was able to help with provision of contraceptives. Gradually the association established a flourishing clinical service. Now, in cooperation with other groups, it is endeavouring to prevent the introduction of retrograde legislation on contraception.

Italy
Vittoria Olivetti, who attended the 1957 conference, in cooperation with others, including Giulia Gentili Filippetti, established an association in the mid-1950s. The association changed its course some years later and ceased to be an IPPF member. Giulia Filippetti later drew together in a federation several independent groups in the different regions of the country which became the IPPF member (the *Unione Italiana per l'Educazione Matrioniale e Prematrimoniale*). Now that the law prohibiting contraception and abortion has been changed, and that it has become a regional health authority responsibility to establish planned parenthood services, UICEMP is reviewing its task and directing its energies towards ensuring that the government services are adequate. Diplomacy, courage and an early recognition of the importance of midwives and social workers have helped to promote UICEMP which a more aggressive approach might have delayed.

Luxembourg
In Luxembourg the first contact was made with Henri Clees, a gynecologist in the capital city, where the *Mouvement Luxembourgeois pour le Planning Familial et l'Education Sexuelle* was founded. It later became a broader based organisation including teachers, social workers and others. Apart from the one centre in the capital city, energies were directed towards encouraging the inclusion of sex education in schools. Kina Fayot, a leading member of the association, was Regional Vice-President, contributing both to Regional and central IPPF meetings.

Netherlands
The Netherlands was the first country in the world in which a planned parenthood centre was established, at the end of the nineteenth century, due to the efforts of Aletta Jacobs, the first women physician in the Netherlands. When an association (NVSH) was reformed after 1945, it was based on sex education and provision of contraceptive services to members. The association moved increasingly towards a policy of sex education and sexual freedom which lead to a split with the clinic-based foundation, *Dr. J. Rutgers Stichting* which became the IPPF member. The two associations are linked by NVSH representation on the board of the Rutgers Stichting. The contribution of the Dutch experience to other associations which emulated their strategies when contraception and abortion were illegal, was significant.

Norway
It was not until comparatively recently,

although Norway was represented at the 1957 conference, that the *Norsk Forening for Familieplanlegging* was founded. It was always maintained that adequate services were provided in the national health service. This was ultimately recognised not to be so and the association played an important role as a pressure group in this area. It has been active in a number of unusual ways such as the use of medical students to provide sex education in schools, and has been in the forefront of discussion on sexuality and handicapped people.

Poland
Poland has played an active part in the Region, Jadwiga Beaupré of Krakow and Tadeusz Bulski of Warsaw participated in the 1958 meeting in Stockholm. Beaupré had before that made contact with the Region while visiting London on a WHO scholarship. Jan Lesinski, then Director of the Warsaw Maternal and Child Health Institute, attended the 1957 conference. Bohdan Bednarski, Vice-Minister of Health and Eugenia Pomerska, Head of the Department of Maternal and Child Health in the Ministry of Health, were looked upon, as a result of their unfailing support and initiative, as the father and mother of the *Towarzystwo Planowania Rodziny* although Marcin Kacprzak as the association's President guided the association for many years. Kacprzak, Małgorzarta Bulska and Mikołaj Kozakiewicz, successive members of the Regional Executive Committee, continued the Polish connection. The lively and varied nature of the TPR and its active members continue to be an example of an association's independence, vitality and essential function in a country where planned parenthood has been accepted as a part of the national health service for 25 years.

Portugal
The *Associacão para o Planeamento da Família* was founded before the 1974 revolution largely by the efforts of Manuel Neves e Castro, and managed to survive in difficult circumstances. After the revolution progress was quicker and particularly facilitated at a time when Albino Aroso, now President of the association and a Regional Executive Committee member, was Minister of Health and when the decision to incorporate planned parenthood in the health service was taken. The main task now is to implement that decision.

Sweden
Elise Ottesen-Jensen was the founder of the Swedish RFSU (1933) as well as founder of the IPPF. The association began as a popular movement based on sex education. It was the leading association involved in commercial sales and experienced in recent years a loss of control over its subsidiary company, which caused problems both in its image amongst its members and in its public image. The association has experienced changes but emerged with basic principles unchanged, and renewed vigour from the regional branches has recently become apparent.

Turkey
Developments in Turkey differed from those in the rest of Europe, as Turkey has been subject to outside pressures of a kind not applied in other European countries. Attempts were made by a foreign funding organisation in 1962 to introduce population planning/control into Turkey by a system involving the creation of a department in the Ministry of Health separate from the Maternal and Child Health department; special salaries to staff throughout the country, higher than current salaries, and crash IUD insertion programmes. Such plans, superimposed on a country with memories of decimation of the population through war and now placed between the influence of two major powers were unlikely to succeed and did not. The *Türkiye Aile Plânlamasi Derneği* was formed with close links to the government but, over the years, has managed to adapt its tactics based on an approach more closely related to planned parenthood in the European context.

United Kingdom
Although there had never been a law against contraception in Britain, services were not available. The *Family Planning Association* established service centres and understandably perhaps failed to recognise when the time was ripe to encourage the inclusion of services in the National Health Service (NHS). This led to the treatment of planned parenthood services as a separate NHS item. However, the FPA eventually underwent a major change in 1974/75 when the number of clinics was reduced from a thousand to nine. It is now mainly concerned with education, in cooperation with the Health Education Council. One of the major FPA achievements was its training activities for over 25 years, which formed the basis of training activities incorporated into the NHS and from which health personnel from all over the world have benefited.

The FPA has, as in so many other fields in Britain, adopted a somewhat different attitude from that of other European countries towards the IPPF and planned parenthood. The association was the only one of the European associations to adopt an openly neo-Malthusian attitude, perhaps largely as a result of minimal contact with other PPAs in Europe. Some Britons played an influential role on the IPPF internationally, some of whom had never been directly connected with the FPA. Among those actively connected with the FPA who have played and continued to play an active Regional role are Helena Wright, Margaret Pyke, Margaret Jackson and Denys Fairweather, as already mentioned, and Betty Tewson who, as Regional Treasurer, not only supported Regional interests but also endeavoured to clarify regional policy within the FPA itself and to bring the FPA into closer contact with other European countries – a policy continued by Alastair Service.

Yugoslavia
The first contacts with Yugoslavia were made by Abraham Stone, a Russian-born US citizen, who travelled round Europe making contacts in a number of countries in the mid-1950s which resulted in the attendance at the 1957 conference of several representatives from Yugoslavia. The *Family Planning Council of Yugoslavia* functions as a federation of organisations in the six republics and two autonomous provinces of the SFR of Yugoslavia, and it is largely through FPCY efforts that the right of the individual to freedom of choice in the size of family has become an integral part of the constitution of Yugoslavia. Franc Novak and Lidija Andolšek of Ljubljana played an active role in Regional activities, including cooperation in the Regional training scheme. The FPCY, through its former President Vida Tomsić and present President Nevenka Petrić and other Regional Council representatives, has always kept a watchful eye on developments in the IPPF, and had adopted a responsible attitude towards its commitments as a member of the Region.

Non-member countries
Relations have been established with

groups in most of the nine non-member countries, with the exception of *Albania.*

Contacts with *Czechoslovakia* are long standing, but only recently has a family planning committee been established with Jiri Srácek and Vladimir Wynnyczuk, friends of the Region since the 1960s, taking an active part. Czechoslovakia has proved that the availability of planned parenthood services can continue alongside family policy measures which have encouraged an increased birthrate.

The first Regional contacts in *Greece* were with Maro Kanavarioti and John Danezis in 1963 at which time it was hoped that an association would be founded. However, at that time various influential persons feared that contraception would lead to a further decrease in the birthrate. Now there are two associations, which have declared their intention to cooperate. A committee established by the government to advise on population matters has recommended that planned parenthood services be established while recognising the country's low birthrate.

At one time the Region supplied the Social Institute in *Iceland* with contraceptives, and there has been some contact with the Ministry of Health and successive professors of obstetrics and gynecology in Reykjavik, although there is no association.

Visits to, correspondence with and attendance at Regional Council meetings by representatives from *Malta* seemed to be leading to the establishment of an association, but unfortunately these plans have been halted.

It was hoped that visits to *Romania*, participation in the Regional training scheme and contacts with the Polish association might lead to closer cooperation with Romania, but the government's attitude, unlike that of any other European country today, has restricted the use of contraception and abortion in an attempt to increase the birthrate.

The Region has had many contacts in *Spain* since the mid-1960s, initially with health personnel participating in the Regional training scheme. Since the end of the Franco regime all those who had been working in spite of restrictions have now been joined by other groups all over the country. These groups have organised meetings to further cooperation with the aim of creating a federation of regional associations which might join the IPPF.

The health service of the Canton de Vaud, *Switzerland*, was for a time an affiliate IPPF member as a result of cooperation with René Burnet, head of the health service in the Canton de Vaud. Subsequently it was hoped that a national federation of groups in different cantons might become a member. However, agreement was not reached between the groups and thereafter Switzerland in keeping with its traditions regarding international organisations, has not become a member. Although the Canton de Vaud was the first to establish such services in the Lausanne University hospital and elsewhere in the Canton, services are now available in other university hospitals, and more generally throughout the country.

Delegates from the *USSR* attended the 1962 conference in Warsaw. More recently contacts with the GDR, Polish and Yugoslav associations have induced a more favourable view of the benefits of planned parenthood and there have been occasional contacts throughout the years at, for example, WHO Europe meetings.

Individual influences

In IPPF Europe it has always been constitutionally laid down that representatives of associations on the Regional Council must be elected from Council or Board members of the association. Thus the leading personalities in the Regional Council and on the Regional Executive Committee have been able to bring to the Region their professional experience, and a knowledge of planned parenthood problems and ideas from their association. This has benefited other countries in the Region. I found myself that working as a volunteer for some years in an FPA centre was an invaluable practical experience.

Each Regional President has played his or her personal role in the evolution of the Region. Elise Ottesen-Jensen was President of the Region from its inception in 1952 until 1957, but she attended meetings and influenced people for many years thereafter. Her ideas and principles have been maintained within the Region and are best reflected in the aims agreed at the 1946 conference.

Conrad Van Emde Boas (Netherlands), a psychiatrist concerned with sexual reform and human relations, succeeded as Regional President 1957–64. His experience with the NVSH helped the establishment of the associations in Belgium and France. He urged the elimination of neo-Malthusianism from the IPPF, particularly when the changes in the IPPF constitution were proposed in 1963. In the early stages of the establishment of the French association he spoke to groups of physicians who had shown interest in the movement, suggesting that by working together as a group they could influence the rest of the medical profession towards a more open attitude to sexual questions. He described a study in the Netherlands of couples who were prepared to use the infertile period in combination with a diaphragm or condom during fertile days – an experiment which could well be revived today.

Agnete Braestrup (Denmark) Regional President 1964–69, brought her experience of sex education as a pediatrician and school physician to other countries. She took part in a first Regional visit to the Lebanon in 1969 and spoke to a group of school children organised by Tewfik Osseiran, one of the founders of the Lebanese association. She also took part in the first Regional visit to Turkey in 1963, meeting several of those who were to become founders of the Turkish association. She was active in developing relations with Austria, the Federal Republic of Germany and Norway. While adopting a liberal view of abortion, she was nevertheless always insistent that adequate contraceptive services should be provided to lessen the need for abortion. Agnete Braestrup urged a more equitable geographical distribution of the senior honorary officers in the IPPF centrally and endeavoured to resist the diminution of volunteer influence.

Thorsten Sjövall (Sweden) a psychiatrist and a friend for many years of Elise Ottesen-Jensen, was Regional President 1969–74. His emphasis was always on the right of the individual to freedom of choice and on the psychological aspects of planned parenthood – on what people, not governments, wanted. Thorsten Sjövall brought these ideas to the Regional Council and to the IPPF centrally, and in travels throughout Europe. He urged the autonomy of

associations and regions, repeatedly pressing for consideration of European opinions in the IPPF centrally and more open discussion.

Denys Fairweather (Britain), Regional President since 1974, as a professor of Obstetrics and Gynecology is in a unique position to emphasise that health personnel should work as a team to incorporate planned parenthood in their activities. He has emphasised that the 'medical' committees should not be narrowly limited to members of the medical profession only. He has sought both regionally and at a global level to reassert the influence of the volunteer in the IPPF. He endeavoured when Chairman of the central Management and Planning Committee to demonstrate that the availability of more and more funds is not necessarily beneficial to the Federation as a whole, nor to the member associations. Self-reliance, he has emphasised, is more likely to encourage initiative.

In addition to the Regional Presidents, other members of the Regional Executive Committee and Regional Council have offered their time and knowledge to the Region, and indeed to the IPPF centrally. Helena Wright (Britain) through her teaching of health personnel made an invaluable contribution to the Region and to many countries outside the Region. Jürgen Heinrichs (Federal Republic of Germany), now Regional Vice-President, endeavoured in spite of bureaucratic obstacles to exercise his responsibility in the Central Finance Committee, encouraging fellow committee members to do likewise, to question apparently accepted theories and to withstand pressures from donor governments. He finally succeeded in bringing forward for discussion a proposal that the IPPF should have a Members' Assembly, and a Central Council meeting annually, although his original proposals were amended before acceptance. This proposal for a Members' Assembly had been suggested on earlier occasions, particularly by Thorsten Sjövall.

Mikołaj Kozakiewicz, sociologist at the Academy of Sciences in Warsaw, has also played a prominent part in the Region in creating a broader understanding of sex education in terms of family life education. Through his Chairmanship of the IPPF Social Sciences Working Party he has sought to emphasise that planned parenthood should be approached within the socio-cultural context of each country.

Jørgen Hornemann of Denmark, a pastor and journalist, contributed much to the expansion of information within Europe and to the *Regional Information Bulletin.* He endeavoured to bring some order into the IPPF central communications and publications system seeking to abolish bureaucracy and propaganda and replace it with information on a broader basis, as well as to reassert the role of the volunteer in that sphere of IPPF activities.

Others have played their part, and some are mentioned in other parts of this article.

Regional staff

The Regional Office staff consisted initially of one part-timer, increasing to a peak of some 25 persons, of whom 6 were employed in the despatch of contraceptives, and 2 involved in the administration of the Regional training scheme. As these Regional activities became redundant, the staff gradually reduced to the present 8 people, of whom 4 work part-time.

In the first 10 years contact was mainly with individuals in the different countries by correspondence, visits to countries and many visitors to the Regional Office. As the associations became more established contacts were rationalised to focus on correspondence with the national office of each association and to expand the relationship with the Regional Executive Committee and the Regional Council (compared with the earlier emphasis on the Regional President only). This latter development was not just natural evolution, but the result of a deliberate attempt by the Regional staff to involve more volunteers in Regional responsibility.

The future?

I began by describing the changes that took place between 1946 and 1952, when the IPPF was officially founded. The present position of Europe in the IPPF can only be assessed in the light of a brief summary of IPPF developments after 1952.

In 1957, the IPPF Governing Body met in West Berlin at the time of the first Regional Conference. On that occasion, Abraham Stone read to the IPPF Governing Body a letter from Vida Tomsić explaining that the socialist countries of Europe could not join the IPPF while the IPPF Constitution was based on neo-Malthusian theory. The Governing Body did not respond to that letter.

In 1962, when I visited Ljubljana for the first time, Vida Tomsić gave me a copy of the 1957 letter, which I drew to the attention of the Europe Near East and Africa Regional Executive Committee. Subsequently, the ENEA Regional representatives at the 1963 Governing Body meeting proposed an amendment to the IPPF Constitution. Changes were agreed by the Governing Body placing planned parenthood as a human right in first, instead of third, place, deleting the neo-Malthusian statement, and amending a statement on a balance between world resources and population. However, the change agreed by the Governing Body was not subsequently reflected in IPPF central activities or publications. Many misunderstandings about the meaning of planned parenthood might otherwise have been avoided.

Thus in 1966, in Geneva, at the World Health Assembly, a resolution to include planned parenthood in WHO activities, proposed by Norway and Sweden and supported, among others, by the UK delegation, had a population control basis. Frances Dennis (Director of the Information Department of the IPPF Central Office) and I spoke with Karl Evang, Norwegian delegate, and Malcolm Tottie, Swedish delegate as well as the UK delegates. We pointed out that to remove from their resolution the phraseology urging population control on the 'developing' countries through family planning, and to base the proposal on maternal and child health and the need for contraception to reduce the incidence of illegal abortion, would satisfy the opposition evident among delegates from 'developing' countries and elsewhere and would more appropriately fit the WHO aims. The resolution was amended to emphasise maternal and child health, and was accepted by the Assembly.

Why did the IPPF centrally continue and intensify its population control propaganda? The reason must be that this was the way to raise money, whether from individuals and large companies or from governments, and that those who were influential in the IPPF believed that large sums of money given to associations in 'developing'

countries would reduce birthrates. Like those who had influenced developments between 1946 and 1952, several had not become involved in the IPPF through their national associations.

Money and contraceptives given to the IPPF by governments, from Europe, North America and elsewhere are provided by the foreign ministries of those governments, and are naturally an expression of the foreign policies of the donor governments. Politicians decide foreign policies, with the aim of benefiting their own country. The governments of recipient countries are not so naive as not to realise this. They may therefore be suspicious of the donors' motives, and thus of planned parenthood, or they may allow the money to be accepted, as foreign currency is needed, while not necessarily facilitating planned parenthood. These facts were made clear at the 1974 World Population Conference, and I believe resulted in some donor governments deciding to adopt a 'low profile' in this field.

Some individuals and associations in 'developing' countries believe that the European associations are selfish and demonstrate a lack of concern for other countries' problems by criticising the development of the IPPF into a fund-distributing agency. This is a misunderstanding. The European associations are, I am sure, anxious that everything possible should be done to improve the standard of living in 'developing' countries, but it is doubtful whether pressure through the IPPF to promote population control will have that effect. Population questions arouse political reactions both nationally and internationally which may override individual freedoms.

I believe that for the IPPF to be a federation of regionally grouped autonomous national associations, concerned with the individual right to sex information, education for human relationships and planned parenthood and to be at the same time a fund-distributing agency on behalf of donor governments in the richer countries concerned with population control in the 'developing' countries is contradictory. Concern for individual rights must mean the grouping of persons and welfare groups within an association determined to safeguard and promote the interests of the people, with control in the hands of elected persons.

Joan Rettie, London

IPPF testing ends

The IPPF Agreed Test for Total Spermicidal Power (1965) evaluates the *spermicidal* effectiveness of spermicidal products under laboratory conditions: not their *contraceptive* effectiveness in practice. The IPPF Agreed Test essentially prescribes that 1 gram of the product, diluted 12 times in physiological saline (0.9% NaCl) about body temperature (35–37°C), shall kill all the spermatozoa in 2½ ml of fecund human semen (a typical volume of ejaculate) within 40 seconds. (Leaving a spermicidally-covered diaphragm in the vagina for six hours after the last ejaculation thus represents over a 500-fold safety-margin!).

The IPPF Agreed Test superseded the Baker Test, originally described in the classic textbook by John Baker (1935): *The Chemical Control of Conception*; and the Sander-Cramer Method, preferred in the USA. In the *Journal of Reproduction and Fertility* (1962), W. N. Harris described what he termed "the new IPPF test", which evolved into the IPPF Agreed Test for Total Spermicidal Power (1965). This followed lengthy discussion among the IPPF Medical Committee's Evaluation Subcommittee (and later its Chemical Spermicides Subcommittee).

Despite the title, the IPPF Agreed Test was never formally endorsed by the IPPF Medical Committee (which subsequently became the Central Medical Committee), nor by any other regionally representative IPPF body. The IPPF Test has not been reprinted since 1967, when it was published in the IPPF *Medical Handbook.*

Since about 1960, the IPPF has maintained a spermicidal testing unit, which has submitted products to the IPPF Agreed Test, at the request of manufacturers (mostly European). The annual number of testing reports rose to a peak of 117 in 1972, and has greatly declined since then. In January 1975, the Europe Regional Office assumed full administrative responsibility for IPPF spermicidal testing. It was made clear that IPPF spermicidal testing reports were *not* certificates of approval, and were *not* to be used to promote commercial products.

However, certain manufacturers mentioned satisfactory testing results in their packets and/or advertising implying IPPF approval. By March 1976, the Regional Medical Executive Committee realised that the IPPF must either prohibit any commercial use of its name altogether, or establish standard wording, e.g. 'satisfies the IPPF test for spermicidal effectiveness'.

In June 1976, the Europe Regional Medical Committee agreed to recommend this standard wording, in order to clarify that such spermicides were *not* IPPF-approved, and that the IPPF tested only *spermicidal* effectiveness. (Also in June 1976, the newly revised *Directory of Contraceptives* published a list of IPPF spermicidal testing results, 1971–75).

In March 1977, the Central Medical Committee noted that the alternative to standard wording was to prohibit any mention of the IPPF in a commercial context, and referred the matter to the Management and Planning Committee (since replaced by the Central Executive Committee). The Management and Planning Committee *resolved* "that the opinion of UK counsel be sought as to whether the use of the words 'This product satisfies the IPPF test for spermicidal effectiveness' by manufacturers would have legal implications for IPPF".

Following advice from an IPPF solicitor, the Management and Planning Committee (November 1977) *resolved* "that IPPF shall not permit its name to be used in any way as a recommendation or endorsement for any contraceptive product or in any advertisement for contraceptive products and shall withdraw its name from the so-called 'IPPF Agreed Test for Total Spermicidal Power (1965)' "; *and* "that the Central Medical Committee should consider and report to the Executive Committee whether IPPF should continue testing of spermicidal products".

In February 1978, the Regional Medical Executive Committee proposed that the Central Medical Committee should *endorse* the prohibition on using the IPPF name to promote any contraceptive, *reconsider* withdrawing the IPPF name from the IPPF Agreed Test, and *recommend* continued IPPF spermicidal testing, subject to manufacturers undertaking not to mention the IPPF in promoting their spermicides. Since November 1977, the Regional Office had already prescribed, as a condition of IPPF spermicidal testing, that manufacturers submit a written undertaking not to use the results, in their packets and/or advertising, to promote their products; and not even to mention the IPPF in either context.

In April 1978, the Central Medical Committee agreed that IPPF spermicidal testing should continue, and that it probably posed no major risk of litigation, but that the IPPF Panel on Law and Planned Parenthood should discuss the legal implications world-wide. It also recommended improving the IPPF Agreed Test, and asking the International Organisation for Standardisation to establish an international standard on spermicides. (The IPPF Test has been criticised for addressing a fixed weight, 1 gram of spermicide, whereas one vaginal dose may vary in weight from 0.2 to 2

gram.) The Law and Planned Parenthood Panel and Central Medical Committee jointly recommended seeking an English legal opinion on IPPF liability.

The legal opinion suggested that IPPF spermicidal testing entailed no legal risk. However, as minuted after the Central Executive Committee meeting in November 1978, "claims for mistaken reliance by either manufacturer or consumer, on a spermicide satisfying the IPPF test, cannot be avoided"; and "such testing can be misinterpreted by the consumer as a seal of approval given by IPPF". So the Central Executive Committee recommended, and the Central Council decided "that testing using the 'IPPF Agreed Test for Total Spermicidal Power (1965)' conducted by the Europe Region in the name of IPPF be discontinued".

Accordingly, in December 1978, the IPPF Spermicidal Testing Unit submitted its final product to the IPPF Agreed Test for Total Spermicidal Power (1965), and issued its final spermicidal testing report (numbered S 78/32). Subsequently, no spermicidal product has been, or will be accepted for IPPF testing.

Comment

In considering the arguments presented for terminating IPPF spermicidal testing, it may be noted that, while legal claims arising from mistaken reliance on a spermicide, satisfying the IPPF Agreed Test for Total Spermicidal Power (1965), are alleged to be unavoidable, it seems remarkable that, after nearly 15 years of IPPF spermicidal testing, and over 1200 testing reports, no such claim has ever arisen! Moreover, the written undertaking not to mention the IPPF promotionally, as a condition of IPPF spermicidal testing, has only been extracted from manufacturers over the last year or so.

Termination of IPPF spermicidal testing does not of course prevent a spermicide from satisfying – whether actually or potentially – the IPPF Agreed Test for Total Spermicidal Power (1965), a procedure and title established (though not copyrighted) for over 15 years. Any laboratory can perform the IPPF Agreed Test. Indeed, since the IPPF no longer tests spermicides, it may no longer be able to insist upon a written undertaking not to mention the IPPF name in a commercial context. The testing protocol was devised under IPPF auspices, and has no other name. So perhaps all that is now possible is to call it the *former* IPPF Agreed Test for Total Spermicidal Power (1965).

Philip Kestelman
Medical Secretary

Obstacles to Contraception

In the Regional Office on 6–7 March 1979, Lykke Aresin (GDR) convened an English-speaking, subregional working group meeting to discuss 'Obstacles to contraception'. (In Lisbon on 20–22 April 1979, Albino Aroso is convening a French-speaking, subregional working group meeting to discuss 'Obstacles to PPA activities'). Contemplating the vastness of the field under consideration, the English-speaking working group experienced some difficulty in focusing on a particular aspect.

Ultimately, it was agreed to discuss approaches to adolescents, with specific reference to the recently published IPPF booklet, *Adolescent Sex: its Difficulties and Dangers.* Adolescents do not form a homogeneous group, even within each age-range into which sex education in schools is inevitably stratified. Parental attitudes, emotional maturity and sexual experience differ widely between individuals of the same age.

The working group noted that imparting sex education to children through their parents was universally acceptable. Moreover, parents form a more homogeneous group than their adolescent children. It was suggested that relatively undifferentiated information could therefore be given to parents, who could transfer it to their children in an individualised manner, with due regard to differential sensitivities. Not all parents may be approached in this way: but their children may absorb reliable information from relatively few, well-informed members of their own peer-group.

One fundamental problem is the adult assumption that adolescents should either be deterred from coitus altogether, or should be well-protected against pregnancy if they proceed. There is an underlying attitude that the only worthwhile, really 'mature' sexuality inevitably involves coitus, whereas techniques of noncoital sexual gratification (e.g. 'heavy petting') are satisfactorily available, once the question (e.g. the taboo on masturbation) is raised. One purely semantic problem is the colloquial use of the term 'sex' to mean, not sexuality in general, but coitus in particular; as if other modes of sexual expression were of merely secondary importance.

The working group were cautioned against opposing all obstacles to contraception indiscriminately. There are rational obstacles (e.g. medical contra-indications to, and serious side-effects of particular methods); and contraception may be promoted uncritically for ulterior (e.g. neo-Malthusian) motives. *Objectionable* (e.g. misleading) obstacles to *voluntary* contraception should be resisted uncompromisingly.

Profiteering industrial attitudes should be exposed, in the interests of consumers, whether in the field of contraceptive pricing or quality, or of unwarranted claims for effectiveness or innocuity. On the other hand, the symbiotic relationship between profit-making agencies (e.g. manufacturers and their shareholders) and nonprofit-making concerns (e.g. the IPPF and its member-associations) occasionally inhibits mutual criticism. Health personnel are particularly vulnerable to the blandishments of commercial enterprises.

Finally, attention was drawn to the World Health Organisation Special Programme of Research, Development and Research Training in Human Reproduction, and in particular to its Task Force on Psychosocial Research in Family Planning, which had originally focused on the acceptability of specific methods of fertility regulation. It is expected that the subregional working group's full report will be tabled at the May 1979 Regional Council meeting, to be held in Cavtat/Dubrovnik (Yugoslavia).

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