

# 6 Views of third parties

## Contents

	<i>Page</i>
Family Planning Association .....	88
Margaret Pyke Centre .....	89
Consumers' Association .....	90
Mr Philip Kestelman .....	90
National AIDS Trust .....	91
Health Education Authority .....	91
Scottish Office Home and Health Department .....	92
Health Promotion, Wales .....	93
Department of Health and NHS .....	94
National Association of Family Planning Doctors .....	95

## Family Planning Association

6.1. The FPA provided written evidence describing developments in the family planning service since it gave evidence to the 1981/82 inquiry, and furnished a submission of its views-some of which it recognized as being outside the precise remit of our inquiry. It also attended a hearing.

6.2. By way of views, the FPA said that its main concern was that good-quality condoms (ie qualifying for the BSI Kitemark or made to at least an equivalent standard) should be available to the public. Such condoms should be provided free through NHS outlets such as community family planning clinics or GP practices. In addition condoms should be readily available in commercial outlets at a reasonable price. To prevent the introduction (and therefore use by consumers) of poorquality condoms, legislation should be introduced to stop the entry of substandard condoms into the UK. This should include compulsory independent inspection/testing at the port of entry. Any claims made by manufacturers which falsely stated that their condoms conformed to BS 3704 (or any other standard) should be made illegal.

6.3. The FPA said that manufacturers such as LRC should be encouraged to give standardized information on an agreed basis and to provide instructions which should include the use of clear diagrams. In addition they should in all cases provide information about post-coital contraception in the event of misuse of the product. LRC should also be encouraged to offer condoms in different sizes to reflect the need of consumers in the UK. (This need had been recognized by LRC for its export market.) It should also consider the possibility of marketing packs that allowed variety of choice.

6.4. The FPA added that with more condoms (male and female) entering the UK market-place, price flexibility should be allowed to LRC so that it could compete fairly. Any continued price restrictions placed on LRC might reduce its resources for future research and development initiatives in the UK.

6.5. On more factual matters, the FPA told us that there were currently about 1,800 community family planning clinics; the majority of the 12,000 main GP practices also provided family planning services. The number of clinics had declined in recent times partly because of changes in the economics of the NHS, and partly because of the increased role of GPs in family planning. Over the last five years the number of London clinics had fallen by a quarter. The clientele of both the clinics and the GP services were mainly

women. There was a tendency for younger women who had not started their families, or who were spacing their pregnancies, to go to the clinics, whereas mothers who had completed their families tended to use the GP services.

6.6. So far as the problem of high-risk activities was concerned, besides the work of bodies such as the Brook Advisory Centres which specialized in care and service for young people, there had recently been a number of new initiatives specifically aimed at the young, such as clinics outside school time and provision of literature specifically targeted at young people. Initiatives also included work with different ethnic groups, and rural communities.

6.7. The FPA said that the bulk of condoms provided through the NHS were distributed by the clinics-about 17 per cent of the total market. There was very limited condom supply through GPs. In 1975 when GPs entered the family planning scheme they had elected not to provide, promote or prescribe condoms. The advent of HIV/AIDS had caused a number of GPs to modify this attitude in recent years. The decline in the issue of condoms through the family planning clinics had been attributed partly to the mode of distribution in clinics and the conditions under which it took place, the extremely limited choice, and the rationing of supplies.

6.8. Concerning standards, the FPA currently recommended that only condoms carrying the BSI Kitemark be used. This might have to change with the advent of European and international standards. The FPA had been aware of the unfavourable publicity for Mates arising from the 1989 *Which?* report on condoms. It had decided at that time to write to family planners to clarify the anecdotal reporting it had received on the subject and to say that any suggestion that Mates products were less good than other BSI Kitemarked condoms was not justified.

6.9. Concerning the advertising of condoms, the FPA considered that restrictions on television showing times were inappropriate. The advertising produced by LRC and Mates in the 1980s had been of high quality, but in general the UK suffered from a lack of sex education-above all in the wider sense of family planning education. The FPA favoured a more open positive promotion of condom use. Professionals needed to be better equipped to talk about sexual activity, behaviour or practices in a way which allowed discussion of condom usage. Advertising met only part of the problem; the FPA also considered it important that condoms should be available in those parts of retail outlets where women most commonly shopped.

6.10. On sex education in schools, the FPA felt that the Department of Education's circular on sex education took a restrictive approach. It also drew attention to the new Education Act which limited discussion of sexual behaviour or STDs/HIV in the classroom and permitted parents to withdraw children from classes on sex education. In the FPA's view sex education should include full information about contraceptive usage-including instruction in the use of condoms-as part of education in personal relationships.

6.11. The FPA welcomed the launch of Femidom as a form of barrier contraception for women. The Association would favour the introduction of more products of this kind and was aware that a number of American companies were working on other varieties of female condom. It expected this type of condom to obtain a niche in the market. It had not been possible so far to develop a standard for the product. But CEN was looking into the question, and Femidom had passed the US Food & Drugs Administration scrutiny procedures. The FPA had no reason to believe that female condoms were any less effective, when used properly, than male condoms.

## **Margaret Pyke Centre**

6.12. The Margaret Pyke Centre for study and training in family planning also functions as a family planning clinic as well as conducting research into new contraceptive methods, including Femidom. It is located in Soho, and is the largest training centre in the UK for doctors who wish to qualify in family planning. In written and oral evidence the Centre expressed concerns similar to those put forward by the FPA and the National Association of Family Planning Doctors about the desirability of a compulsory standard for both domestically-manufactured and imported condoms.

6.13. In describing its own activities, the Centre told us that its research and its work as a clinic were separately funded. Condom distribution was more liberal than that of other clinics, partly because patients who attended the family planning clinics were automatically offered condoms in addition to their usual family planning method if they perceived themselves to be at risk from sexually-transmitted infection. The clinic also operated a walk-in service for young men, and endeavoured to be as unbureaucratic as possible. Patients were given a month's supply of condoms at a time. The Centre was restricted to three products-two LRC, one Mates-plus Femidom. The Centre had been aware of the complaints about Mates in 1989 partly because of its role as a main centre for emergency contraception-the so-called 'morning after' pill. The risk of rupture in condoms was increased by the fact that they were frequently used by inexperienced young people who did not know how to apply them properly. The recent CA condom survey had revealed a high level of mishandling among condom users. One of the very positive aspects of the Femidom tests was the very low level of rupture-only 0.01 per cent.

6.14. Like the FPA, the Centre did not think that advertising was as important as a complete change in public attitudes and the training of doctors in family planning. In the Netherlands, where family planning was reputedly freely discussed within the family, children were given effective sex education, and the medical professions were trained from the outset in contraceptive techniques and issues. The Centre understood that over 90 per cent of teenagers in the Netherlands obtained their family planning advice from their GPs.

6.15. The Centre considered that advertising needed to be more appealing to adolescents. The kind of humorous advertisements put out in Scandinavia would be attractive to them.

6.16. The Centre said that it would favour more research into developments of new types of male condoms, particularly with new materials-such as polyurethane-which were less likely to rupture.

## **Consumers' Association**

6.17. In August 1993 CA published a report on contraceptive sheaths, its third since 1987. Its second report, in 1989, had been critical of a Mates condom, and this was believed to have had an adverse effect on Ansell's progress in the UK market. In oral evidence CA representatives described the current survey and report as a follow-up to the 1989 report covering availability of brands, performance, safety, and the provision of appropriate information and advice on use. CA had been advised by an independent consultant. Samples for testing had been obtained from a variety of retail, vending or mail order outlets in a number of locations. The NHS was not covered and in no cases were supplies obtained direct from manufacturers.

6.18. The testing had been carried out by an overseas laboratory, and included the airburst test, which CA considered to be wholly appropriate, since it was part of the requirements in the draft European Standard, although it was not part of the current British Standard. In CA's view the tests which were expected to be included in the European and international standards would raise levels of protection compared with the Kitemark. The electronic test, favoured by manufacturers, had not been used. Nine of the 34 brands examined had failed the airburst test, including one each from LRC and Ansell. In accordance with normal practice CA had informed suppliers of failed products in advance of the publication of the report.

6.19. CA expressed its support for the establishment of a single European Standard, and its hope that a joint testing organization could be established. CA's principal concern, however, was over the enforcement by member states of the provisions of EC directives. If a common market in condoms were established, it would argue very strongly for a rigorous enforcement and test programme. On condom development, CA considered that the quality both of the products and of the information supplied with them had improved over the last 11 years.

## **Mr Philip Kestelman**

6.20. Mr Kestelman, an independent consultant formerly employed by the International Planned Parenthood Federation, gave oral evidence and provided us with a number of submissions on aspects of condoms.

## **National AIDS Trust**

6.21. The National AIDS Trust (NAT) is a national body supporting local and specialist voluntary organizations concerned with helping people with AIDS and with preventing the spread of the disease. We invited it to convene a number of colleagues active in this field to brief us on their activities and the resources available to them, and in particular to give us information and views on the distribution of condoms and the role of advertising.

6.22. In their evidence the witnesses drew attention to the particular problems for their 'outreach' groups working with young homeless people of both sexes who supported themselves by prostitution. This was probably the group most at risk, but also the most difficult to educate or organize. A particular difficulty in supplying such people was that their requirements could not always be met by the standard NHS condoms, so non-Kitemarked products had to be separately obtained. There were special problems in persuading people in African and Asian communities to acquire the habit of obtaining and using condoms. The limited availability of Kitemarked black condoms, the clinical packaging of NHS products and the problem of allergies all militated against the acceptability of condoms among the young people who were in greatest need of them.

6.23. The need for male condoms strong enough for anal use, but also acceptable for oral use, was emphasized. This applied in heterosexual as well as homosexual contexts: outreach workers had learned that some female prostitutes were under the mistaken impression that anal intercourse carried less HIV transmission risk than vaginal intercourse, because literature promoting condoms said that they were for vaginal use only. But condoms for anal intercourse cost four times the price of a normal condom. The British Standard for condoms applied, in the view of the condom manufacturers, only to condoms sold for vaginal use. It seemed possible that the European Standard might enable them to overcome their fears about liability if they were to market their products for anal use.

6.24. So far as funding was concerned there was general agreement that free distribution was essential—particularly among people on social security benefits—but that NHS resources were constrained. Because of the way in which HIV prevention resources were organized, GPs found difficulty in obtaining funds for distribution of free condoms. Family planning clinics apparently considered that they would be able to distribute more condoms than their present budgets permitted. The question of accessibility was also very important, particularly among the young. Assistance from manufacturers was patchy and seemed to be largely directed to the better-known institutions. The witnesses favoured the promotion of safer sex as a package involving the avoidance of both STDs and unwanted pregnancies. They took a similar view to the FPA about the unhelpful nature of recent Parliamentary developments concerning the restrictions on sex education in the new Education Act, and about the need for a more open approach to discussion of family planning and sexual health issues (see paragraph 6.10). While fully alive to the need to target high-risk groups, the witnesses considered that to make the message about safer sex acceptable, it should be directed to the population as a whole. Switzerland had conducted a major programme of condom promotion over a number of years and its results were understood to have been encouraging as regards raising the level of condom awareness and usage in the young population.

## **Health Education Authority, Scottish Office Home and Health Department and Health Promotion, Wales**

6.25. All three bodies furnished evidence and views on their implementation of the Government's policies concerning reduction of unwanted pregnancies and avoidance of STDs.

### **Health Education Authority**

6.26. The HEA, apart from activities in England, has responsibility for the Government-sponsored UK-wide mass media publicity aimed at increasing the acceptability of the condom. This accounts for a major proportion of funds allocated for AIDS-related activities, which take up about a third of the HEA's total annual budget (which amounted to £35 million in 1993/94). Both film and television publicity were extremely expensive—the total cost of the film *Mrs Dawson*, for the production of which LRC had made its

staff and factory freely available to the HEA, had amounted to over £2.5 million, mostly on screening (ie the cost of advertising slots). The film *Mr Brewster*, which had been running for a shorter period, had so far cost £1.5 million; again this had largely been screening cost. Radio, and particularly local ethnic radio, was particularly useful for targeting minority groups and young people generally. It was also much cheaper.

6.27. The HEA told us that it was represented, along with its Scottish and Welsh colleagues, on the coordinating body for Public Education (CAPE), which included members from relevant Government departments such as Health, Education and the Home Office. The Central Office of Information, which had responsibility for the Government campaign against HIV/AIDS until 1987, when it was taken over by the HEA, advised on the effectiveness of different media approaches, and undertook appropriate commissions.

6.28. The media approaches were mainly conducted by advertising agencies employed by the HEA. The Authority emphasized the importance of experience in this subject area in which there was considerable project overlap and a background knowledge of earlier work was very important.

6.29. One particular project had at ministerial direction been selected for 'market testing' and put out to tender. The HEA bid had not been successful and a public relations company had won the contract. The cost (£250,000) had been debited against the HEA AIDS budget.

6.30. In its public relations work the HEA had worked with manufacturers, principally LRC. It was quite open to co-operation with other suppliers, but obviously could not 'tout' for business.

6.31. The HEA stressed that it could not duplicate the approach of commercial advertising, which had a specific contribution to make to the normalization process and was well placed to develop and exploit the scope for novelty and fashion appeal which were extremely important factors in winning over young people to regular condom use.

6.32. The HEA had found LRC very helpful: its range of outlets and contacts were a useful asset in developing ways of encouraging condom use. A particular problem in the past had been the lack of accessibility to condom sales, particularly in rural areas where the local chemist might be the only possible source. The spread to garages, self-selection in supermarkets, vending machines etc were all helpful in this regard as was the enlightened attitude of some GPs.

6.33. Besides resource constraints, the major problem for the HEA was that of being able to put across its message without running the risk of adverse social or legal reaction. Issues relating to pornography and the law relevant to under-age sexual relations were not well documented in recent case law and officials were bound to be cautious in how courts and judges might react-even in present day circumstances. This problem was encountered by all official bodies dealing with public health issues in this field and in the absence of a political initiative, for example in the 'age of consent' area, Government departments were naturally cautious in addressing the question of targeting young (under-21) homosexual communities.

## **Scottish Office Home and Health Department**

6.34. The Scottish Office told us that in addition to participating in the national activity mentioned in paragraphs 6.26 and 6.27, its Home and Health Department (SOHHD) and Health Education Board for Scotland (HEBS) provided a number of complementary initiatives relating to Scotland's special circumstances. HEBS had developed various 'condom awareness' initiatives, focusing on the avoidance of unwanted pregnancies and spread of STDs, including HIV. HEBS had conducted market research to identify the most appropriate and effective means of getting its safer sex/condom promotion messages across both to the general public and to particular groups likely to indulge in risky behaviour. For example, young people were targeted in specific messages about unwanted pregnancies and STDs; such messages were distributed as enclosures in publications for young people.

6.35. The SOHHD said that the National Health Service in Scotland was committed to a completely free family planning service at clinics, hospitals and in primary care. The policy was accordingly that condoms should be freely available and accessible to all who wished to use them. The SOHHD was shortly to issue a *Guide to Good Practice in Family Planning and Reproductive Health Care* to assist purchasers and

providers of services. This would emphasize the provision of services for the young, along with well-planned sex education programmes in schools and an honest and open approach to sexuality. Health boards would be asked to consider the provision of condoms outside the medical setting, eg in discotheques.

6.36. The SOHHD stressed that the availability of condoms and their proper use were important elements of STD/HIV prevention strategies in Scotland. Health boards and voluntary organizations played crucial promotional roles. The Scottish Ministerial Task Force on HIV and AIDS, in its report *Prevention The Key*, published in March 1992, recognized that the availability of condoms and their proper use were important elements of HIV prevention strategies. The Task Force report highlighted some of the work in this area including the Lothian Health Board 'C card' service, enabling individuals to obtain free condoms from various outlets by using a 'credit' card system; the Greater Glasgow Health Board 'drop-in' centre for street prostitutes, maintaining contact with the prostitutes, issuing them with free condoms and providing advice on social, drug and general health care matters; and other Health Board initiatives such as condom availability schemes and novel means of distribution, eg key fobs containing condoms and the installation of condom machines in licensed premises and other public places.

6.37. The Task Force report made a number of specific recommendations concerning condoms. As a follow-up to some of them discussions were held between Health Departments and manufacturers on the various issues raised. Manufacturers including LRC subsequently made presentations to the HIV/AIDS Co-ordinators of the Scottish Health Boards which had assisted the Boards in developing their HIV/AIDS prevention work.

6.38. The SOHHD told us that the voluntary sector in Scotland had played a very important part in terms both of public education/prevention of HIV infection and of treatment and care of those infected or affected by HIV/AIDS. Its function was considered to be complementary to that of the statutory sector because voluntary bodies were often better placed than statutory bodies to reach populations most at risk. Their special expertise and knowledge and their ability quickly to identify and meet local needs efficiently and imaginatively had been extremely important and valuable in the fight against HIV/AIDS.

6.39. We were also informed that the Scottish AIDS Monitor (SAM) 'outreach' activity, sponsored by Health Boards, sought to promote safer sex and condom use by instigating and encouraging 'peer group' education (including provision of free condoms) within the bars and clubs frequented by homosexual/bisexual men. The sensitive use of humour had also been shown to be an advantage in this area.

6.40. The Scottish Office considered that condom manufacturers and suppliers had a positive role to play in the promotion of safer sex by making their products more attractive, especially to the young. This, combined with persistent health promotion messages advocating their use and a more open approach to their supply, would make a significant contribution in the area of safer sex.

## **Health Promotion, Wales**

6.41. In its evidence Health Promotion Wales (HPW) furnished details of a number of initiatives and gave a brief account of its objectives and concerns about condoms.

6.42. HPW said that the issue of condom use was important in Wales because, firstly, rates of pregnancy were high among women under 20 in Wales, and many of these pregnancies were unintended. HPW was concerned to ensure that young people who were sexually active had access to safe and effective contraception. The condom as a method of contraception for teenagers was more easily available than medical methods, had no side effects and was particularly suited to the infrequent, unplanned sexual intercourse which was characteristic of many younger teenagers.

6.43. HPW was also concerned at the constant or increasing rates in Wales of a number of sexually-transmitted diseases including chlamydia, herpes, genital warts and HIV infection. Effective use of condoms provided protection against transmission of these infections and was therefore promoted by HPW in safer sex campaigns targeted at groups within the population who were sexually active and/or were identified by

epidemiological data as being particularly at risk of contracting an infection (eg young people, particularly students; homosexual men; prostitutes and their clients).

6.44. In promoting condom use in the context of safer sex campaigns, HPW had four concerns which it considered to be particularly relevant to the scope of the MMC inquiry. These were:

- (a) *Quality*: If condoms were to be effective in preventing unwanted pregnancy and sexually-transmitted infections, issues of quality were extremely important. Condoms available to the public should ideally be equal to or exceed the BSI Kitemark standard. HPW would support moves to prevent the introduction and, therefore, use by consumers in Britain of poor-quality condoms. Pricing policies should be designed so that manufacturers which met BSI standards were not penalized at the expense of firms which produced lower-quality products.
- (b) *Acceptability to consumers*: Experience from HPW projects had highlighted the fact that consumers appreciated the choice of a range of condoms. Limitations on choice could discourage use and therefore undermine safer sex campaigns. Within the framework of quality set out above, British consumers should ideally have access to a range of sizes, thicknesses and designs.
- (c) *Effective use by consumers*: Research suggested that many cases of condom failure related to incorrect use. Condom manufacturers should be encouraged to provide standardized, agreed information and to provide instructions in clear language which should include the use of clear diagrams. It would also be desirable to provide information about post-coital ('emergency') contraception, in the event of misuse of the product.
- (d) *Accessibility*: In addition to free provision through family planning clinics, HPW would also support initiatives to provide condoms through general practice. In addition, condoms should be available for sale at a wide range of retail outlets, including vending machines sited in social venues, to ensure that it was possible for potential users to obtain them with a maximum of ease and a minimum of embarrassment.

## **Department of Health and NHS**

### ***Condom purchasing policy***

6.45. DoH and NHS representatives attended a joint hearing. The NHSSA told us that one of its objectives was to combine the NHS's purchasing strength wherever it was dealing with a dominant supplier. NHSSA would actively promote products that were competitively priced. But a new entrant whose product was accepted by the NHS would still need to advertise and promote it, since the final buying decision rested with the doctor and user, rather than the central NHS purchaser. To some extent this weakened the effectiveness of the NHS as a purchaser since these decisions were taken by individuals who could be affected by brand loyalty.

### ***Quality standards***

6.46. The DoH said that it recommended only Kitemarked products and the NHS main contracts were awarded for Kitemarked condoms. There was nevertheless some purchasing of non-Kitemarked products for special uses. The NHS would purchase CE-marked condoms if these were introduced. The adoption of a European Standard backed up by the CE mark would widen the NHS supply base and remove the perception of the Kitemark as a barrier to competition.

### ***Decline in condom distribution through family planning clinics***

6.47. The NHS representatives said they did not consider that the declining trend in condom supplies through family planning clinics could be ascribed to any deliberate restriction, introduced for financial reasons, on the provision of contraceptive services. It was DoH policy that there should be no prescription charges for family planning services, including condoms. It seemed possible that the more widespread availability of condoms through commercial outlets might have contributed to the decline in distribution through the family planning clinics.

### **National Association of Family Planning Doctors**

6.48. In a letter to the MMC, the Association, which had submitted views to the previous inquiry, expressed its support for measures that would predictably lead to a reduction in the cost per item to the consumer of contraceptives while maintaining their quality. The Association noted that an increased variety of colours, shapes and even flavours of condoms had appeared over the last few years, now that there was at least one other major manufacturer involved in the field. The Association reported that little attention seemed to have been given to a choice of size, even though the World Health Organization data suggested that this might be a problem for one-third of condom users in the UK. It also suggested that condom manufacturers, including LRC, should do more to warn about the possible need for post-coital contraception, in the event of condom leakage or slippage.