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# Natural Family Planning

Development of National Programs

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*Two roads diverged in a wood, and I—  
I took the one less traveled by,  
And that has made all the difference.*

*ROBERT FROST*

# Preface

During the past 10 years, there has been a broadening interest and excitement in natural family planning (NFP). Much of this interest has resulted from advances in understanding of the methods as well as research in evaluation and accountability. Positive program experiences from all parts of the world combined with the work of investigators using the latest techniques have begun to bring credibility to the NFP movement.

Beginning in the 1930s, Dr. Ogino in Japan and Dr. Knaus in Austria identified the time of ovulation in relation to the menstrual cycle and helped to develop the calendar-rhythm method. Their theory, which was based on the length of previous cycles, was limited in effectiveness by irregularities that occur in many women's cycles. Their work did, however, mark the beginnings of what are now called natural methods of conception control. From this there developed during the 1950s the temperature or thermal method, and, by the end of the decade, the sympto-thermal and cervical mucus methods. The latter two methods, which use either several parameters (sympto-thermal), or a single index (cervical mucus), are a great advance beyond the Ogino-Knaus method, since they depend on scientifically based observations for determining the fertile period.

In 1970 two American groups, the National Institute of Child Health and Human Development and the Human Life Foundation, co-sponsored an international meeting on the status of natural methods of family planning. I was privileged to serve as co-chairman of that meeting (later known as the Airlie House Conference) which provided the opportunity of inter-

acting and working with many of the contributors of the present monograph. The proceedings of the Airlie House Conference were published in a book that may have helped change the terminology from rhythm to natural family planning. The definition that evolved was: "Natural family planning methods are means by which a couple uses the daily observations of signs and symptoms of the fertile and infertile phases of the menstrual cycle to guide the timing of intercourse according to their desire to achieve or avoid a pregnancy."

This definition emphasizes that abstinence is a part of the method, hence the term "periodic abstinence." Natural methods are more than techniques of fertility control. They also involve the challenging task of education in which conjugal love is intimately linked with openness to life.

In November 1983 the Third International Congress of the International Federation for Family Life Promotion (IFFLP) was held in Hong Kong. Since the meeting brought delegates from all over the world, it provided an ideal focal point to examine the developmental aspects of a representative sample of NFP programs as well as the resources, instruments, and major curricula for teachers. Through this exchange, participants were able to enhance their own programs and assist others. This fruitful exchange resulted in this monograph, which provides an update on worldwide advancements and accomplishments of NFP programs.

William A. Uricchio, Ph.D.  
President, IFFLP

# Introduction

This monograph focuses on national natural family planning programs, their development, needs and characteristics. It arises out of the proceedings of a seminar with delegates from NFP programs in 35 to 40 countries. The three-day seminar was held in Hong Kong, in November 1983 during the Third International Congress of the International Federation for Family Life Promotion (IFFLP), which brought together 425 participants from 73 countries.

IFFLP was created in 1974 in Washington, D.C., following an international symposium on NFP convened by the Human Life Foundation. Beginning as an association of delegates from 14 countries, IFFLP has grown in the last 10 years to a thriving international nongovernmental association of over 60 countries with some 120 members, who have a primary interest in the promotion of natural family planning.

The growth of NFP parallels development in natural childbirth and breastfeeding in Western health-care circles. Grass-roots groups sprang up in both developed and developing countries to practice and teach this alternative, non-invasive form of family planning. During the last ten years, the scientific basis of the two major NFP methods, the ovulation (cervical mucus) and sympto-thermal methods, has been well established and reviewed in the scientific literature. The NFP movement now appears ready to offer

its choices to a larger proportion of the population through existing systems of family health care and other educational channels.

The goal of this monograph is both to reflect the reality of developing national NFP programs on a worldwide basis and to analyze the development aspect. Specific characteristics and developmental approaches including various resources and instruments are described as an aid to the establishment of new programs.

The monograph is divided into two sections. The first section presents some 20 or more developing programs. Nine major programs were selected in the four geographical regions or zones of the Federation—Africa, the Americas, Asia-Oceania, and Europe—for detailed analysis by the authors/delegates. Another dozen programs have been presented in a summary form only. The more representative program descriptions were chosen from among 40 IFFLP affiliates.

For the most part, NFP programs and services have been developed in a private network outside the major public family planning programs, and a majority of programs have a religious origin and basis of operation. Dr. François Guy's description of his NFP development consultation work in Africa for the last eight years illustrates how NFP programs have been spreading in French-speaking Africa through Church-based groups.

The second section of the monograph analyzes in greater depth program development, training and service development, and program evaluation. In addition to the presentations of the major theme, comments were invited from several additional speakers. The presentation on program development by Marie-Paule Doyle, former IFFLP president from Canada, introduces a discussion of primary orientations, philosophy, structure, leadership, and funding. Dr. Thomasina Borkman, a social scientist, provides a challenging analysis of the dominant characteristics of existing NFP programs and suggests a mechanism for monitoring the impact of new developments on NFP programs.

The heart of NFP programs is the quality training of its teachers and development of its educational services. There are two presentations on this critical area. Dr. Anna Flynn of Birmingham, England, outlines steps necessary to establish a quality service. Dr. W.D. Clarke brings us the important contribution of the World Health Organization, which developed the Family Fertility Education Resource Package published in 1983, after five to six years of field testing with six IFFLP member organizations.

NFP program evaluation and accountability is one of the primary challenges of the next decade. Dr. John Laing illustrates several years of research analysis in the Philippines on the demographic impact of

rhythm and its potential as an integral part of the national family planning program. Professor Ronald Gray and Robert Kambic from Johns Hopkins University present criteria for evaluation of NFP programs.

The editorial committee, composed of Dr. Claude Lanctôt, who was also the project coordinator, Mary Catherine Martin, an NFP educational and development consultant to IFFLP, and Mary Shivanandan, editorial, research and media specialist in NFP, summarized discussion from the participants and developed the final summary of the total seminar. The committee accepts full responsibility for the selection of the highlights for both the summary and discussion. The respective authors are otherwise responsible for their own contributions, which do not necessarily reflect the opinions of the editorial committee of IFFLP.

In the last section or appendix of this monograph, we have included a comprehensive choice of program addresses and identified major teaching and development instruments as well as an NFP reference bibliography.

The monograph was designed primarily to be a helpful tool and reference for those engaged in NFP program and service development. We hope it may be of value to anyone interested in NFP, whether in government, church, medical or academic circles, as well as the general public.

The Editors

# Africa

Africa was chosen as a priority region by the International Federation for Family Life Promotion in the development of natural family planning soon after the establishment of the organization. In March-April 1977 the African delegates presented an initial request at the first IFFLP zonal meetings held in Yaounde, Cameroon. A second request was presented in the form of a resolution at the First General Assembly of IFFLP members in Cali in June 1977.

A general development plan was prepared in early 1978. As a result, during a period of five years NFP was implanted in several African countries. Dr. Francois Guy's article illustrates this first implantation phase with personal reflections on his own and his wife's involvement in introducing NFP or self-observation methods to French-speaking Africa.

Mauritius has been the pioneer African program of 20 years' standing, serving as a prototype. In November and December 1981 IFFLP organized a trainers' workshop in Mauritius with field visits. This bilingual workshop brought together 65 participants from 20 African countries and governmental observers from 8 countries.

The second phase of the continental NFP development program was initiated in 1983. It combines five to eight years of demonstration/evaluation natural family planning projects in 10 or more African countries.

Zambia illustrates the second generation of NFP programs in Africa. The Ministry of Health in Zambia has adopted a favorable policy towards natural family planning. Special efforts are being made to develop a national NFP training program based on the recently published World Health Organization Family Fertility Education Resource Package. Formal NFP services in both the public and private sectors are also being developed.

Concurrent with NFP development sponsored by IFFLP in Africa, promoters of the ovulation method, Drs. John and Evelyn Billings have invited their collaborators to WOOMB workshops and congresses in Australia and Europe. Programs of a few of these (the Seychelles, Rwanda, South Africa, Tanzania, and Kenya) are described in this monograph briefly. Delegates from 26 African countries attended the Third International Congress of IFFLP in Hong Kong in November 1983.

In August 1983, with support from the United States Agency for International Development, IFFLP initiated a five-year NFP demonstration and evaluation program in Zambia and Liberia, based on the lessons and experience of the Mauritius program. It is hoped that in 1984 a similar NFP technical assistance program will be extended to 10 or 12 French-speaking countries.



Children of Togo, Africa



**Dr. François Guy**

# Family Life Program Development in French-speaking Africa

**FRANCOIS GUY**

*François Guy, M.D., co-founder of CLER; pioneer NFP worker in Africa, France, and Mauritius; founding affiliate member of IFFLP; IFFLP voting member for IREC (Research Institute for Child and Couple), Grenoble, France*

*This paper describes the shared experiences of the author and his wife as consultants to IFFLP in Africa. Over a period of seven years, 54 visits were made to 24 countries to promote natural family planning and family life through public information sessions or training workshops. Dr. François Guy offers a personal*

*commentary on his experiences as a field worker in Africa under seven headings: (1) the child and life, (2) man and woman, (3) family disintegration, (4) a spiritual dimension, (5) time and failure, (6) coming from abroad, and (7) five beliefs for a strategy. The author sees these five objectives as an essential foundation for any*

*action. They are: determination of a precise objective, self-reliance, community participation, choice of concrete objectives, and an appropriate matching of ambition and action. He defines the pedagogical approach he has gradually adopted to attain these ends.*

The first part of this paper presents the shared experiences of the author and his wife as consultants to the International Federation for Family Life Promotion (IFFLP) for Africa from 1976 to 1983. The Federation had undertaken a large five-year plan with consultants visiting both French- and English-speaking countries.

The French consulting team consisted primarily of the author, Dr. François Guy, and his wife Michèle. Mrs. Christiane Ferot of the Coordination Center for Research Teams (CLER) accompanied them on two trips. All in all, 54 visits were made to 24 countries for a total of 384 days over a six-and-a-half-year period. These visits were of different types: 32 were primarily exploratory with public information sessions for groups of various sizes to introduce NFP; 27 were training workshops of at least three days' duration; and four were national or international meetings and conferences (Yaoundé in 1977, Abidjan in 1978, Mauritius in 1981, and Zaïre in 1982). These visits were grouped into 13 separate trips of three to eight weeks' duration.

The map of Africa that accompanies this report identifies the 24 countries visited with the number of visits (one to five) to each. The results of this field consultation between 1976 and 1983 can be summarized as follows:

1. Support to existing family promotion organizations, as in the case of visits to the Congo, Madagascar, Morocco, Mauritius, Réunion and its dependency Rodrigues, Rwanda, Seychelles, and Zaïre.

2. Creation of new organizations now affiliated or in the process of seeking affiliation with IFFLP, as, for example, Burundi, Cameroon, Upper Volta, and Togo.

3. Sustaining contact and information exchanges. Examples are Benin, Central African Republic, the Ivory Coast, Kenya, Niger, Sénégal, Tanzania, Tunisia, and

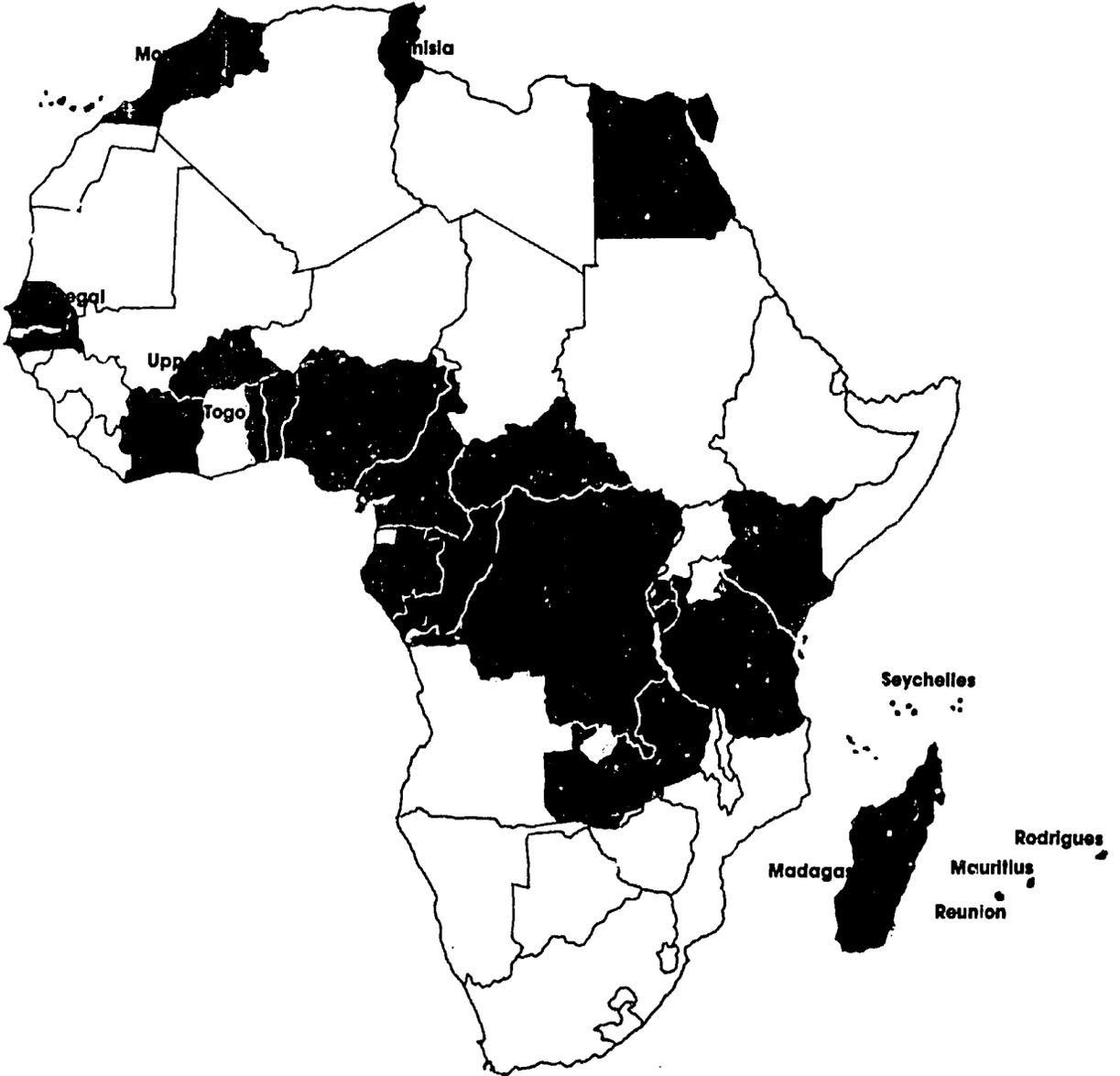
Zambia. In two countries—namely, Egypt and Gabon—contacts were unfortunately lost.

The primary purpose of this paper is to share a few personal comments not from a research or sociological point of view but from that of someone involved in field work. (The authors have already commented on several of these areas in extensive field reports.) We have chosen seven headings to share what these activities have helped us discover and how they have helped us to modify our way of thinking and acting: (1) the child and life, (2) man and woman, (3) family disintegration, (4) a spiritual dimension, (5) time and failure, (6) coming from abroad, and (7) five beliefs for a strategy.

The Child and Life When we came to Africa, we were influenced by such notions as Third World overpopulation and its consequences for the world situation. We had learned to temper our judgment on the question by attributing an equal responsibility to socioeconomic factors and recognizing the extreme diversity of situations. We had heard of the concepts of "vitalism" concerning fertility and the child. This philosophy, which puts man at the service of life in all its forms, is a factor of cosmic unity and a link between individuals and generations. The child is indispensable "pour étendre son nom et sa race" (to spread one's name and one's race), whatever the economic context. According to the proverb: "Beaucoup d'enfants et pas d'argent, ce n'est pas la pauvreté; beaucoup d'argent et pas d'enfants, ce n'est pas la richesse" (Many children and no money is not poverty; much money and no children is not wealth).

We discovered generally that, except in a few countries with small areas, Africa is dramatically underpopulated. We were told this by an African minister of health. The majority of governments, in spite of prompting from international organizations, are quite reluctant to embark on national programs of family planning. At the most they accept the idea of child spacing, and the problem of sterility often concerns them more: "We can find all the money we

# AFRICA



want to limit births," they sometimes say, "but very little to help women have children."

We also learned that, for men and women, the idea of birth regulation is often unacceptable, even scandalous. Some say, "It is improper to speak of this" or "Here, we are in favor of fertility." If we propose to speak of child spacing, they ask us to speak instead of sterility and its treatment. One woman said to us, "I do not want to do anything to prevent pregnancy. The other women will laugh at me if I am not pregnant."

Our African friends have delivered us, at least partly, from the Malthusian outlook that rejects children and have contributed to the evolution of our own outlook. Instead of speaking to African audiences of birth limitation, we now speak of the mastery of fertility. "We do not want to fear or fight fertility," we say. "Rather, we want to understand it better in order to direct it."

Today we propose a double approach: to understand and to serve life. To give life is a blessing, a fundamental need for any being whatever its age or status. We try to bring out this basic attitude from the groups we meet. We propose an exchange or discussion of the advantages (but also the problems) of large families, separating deliberately the knowledge of fertility (fertility awareness), which we invite everyone to admire, from the use of self-observation methods ("Méthodes d'Auto-Observation" or NFP) to space births or explore the problem of sterility.

During a session one day, a man said to me, "We understand that you are not against the child. You speak of children as an African would." Toward the end of one session in Cameroon, a participant explained, "I now understand better that we must modify our way of life; the child is not an accident, but an essential factor in the life of the couple. It is by considering the child in a positive fashion that we must reorient our thinking." Alfred Sauvy, the famous French demographer, said, "It is the love of the child which leads to the planning of the family."

Man and Woman We have heard that the

couple in Africa does not exist, that men and women live side by side, performing their specific tasks without any dialogue. There is a real prohibition of showing feelings and even more of verbal communication. Love does not exist, we were told; marriage is an alliance between two families to ensure the continuation of the blood lines. Sexual life is a taboo subject with strict rules. We discovered, however, that there exists between man and woman an authentic communication, a bond built out of confidence, esteem, attentiveness, and selflessness. "We do not speak of love; we live it," said one man. "The man who says to his wife, 'I love you,' behaves as a little child towards his mother," criticized another man.

We have heard them speak of sexuality and of child spacing and say that for them abstinence is normal and that it is the most widely used of the traditional methods. We have observed their desire to reflect and their capacity to adapt to various discussion techniques and to participate in spirituality movements (such as Teams of Our Lady and Marriage Encounter in Brazzaville, for example).

Our goal is to offer couples knowledge, but also and primarily to help them discover each other, to reveal themselves to each other. We are increasingly convinced that it is impossible to speak of child spacing without becoming interested in the couple's life and problems.

In speaking to African audiences, we have had to evolve our approach. After an initial introduction on dialogue between the partners, I usually propose to the group an exchange on the topic. In this phase, men and women separately ask themselves or each other such questions as: What do you admire in your husband? In your wife? Do you have areas about which you find it difficult to speak and share? What do you do when things are not going well between you? My role is then to gather the contributions from each, to stimulate discussion on areas that have been presented as essential, and to draw some conclusions. For example, I might underline the importance of money questions in the home or the presence of friends. There are as many

possible solutions as there are couples, but mutual trust and respect appear to be necessary preconditions. And in this fashion the audience itself contributes and molds the exchange.

Some women express their appreciation to the men: "They had never told us such things." Others are happy and appreciative "of what they have discovered as good and beautiful in a couple's life." A village chief, who witnessed such a meeting with these themes, observed: "This is the first time that men and women have discussed such topics. We hope to pursue such exchanges in the future."

Family Disintegration We have frequently heard that the joint family system is the structure of the traditional African family. It is described as having tight cohesion between its members, dead or alive. "There are in the village," writes Alex Haley in *Roots*, "three types of people: first, those we see; second, the ancestors; and third, those waiting to be born." Built around the elders, who direct it because they have wisdom, experience, and knowledge, the system maintains itself through solidarity, that is, a sense of hospitality and sharing among all its members. It survives through the fertility of the couples who make it up. To get married is in some way, according to Monsignor Tsinda, "to exercise a ministry of life and of the blood line."

Yet, in the reality of the African situation, our friends have helped us discover the importance of the "destruction" of the African family (the word was coined by one of them) and of the growing polarization and sociocultural distances most pronounced between the city and rural areas and between youth and the elders.

I was struck by a scene that occurred during a meeting organized in Tamberma country in northern Togo, which is away from the major communication centers and well known for the survival of its traditions. We visited one of the well-known tatas, or multilevel huts, where in a separate room a few carefully tended live cinders are kept; they are believed to be indispensable to the survival of the family. Yet only a few hours later and a few hundred yards away, we met in the local

school a group of boys and girls who were from the same neighborhood. They were questioning us on the mechanisms of life, heredity, and sexual maturity. It was impressive to observe side by side the twentieth century and age-old traditions.

Is it surprising to observe that these men, women, and youth have difficulties in absorbing within one generation what most others have taken centuries to assimilate? Such brutal transformations are the cause of much anguish and disorientation. Parents do not understand their children's behavior when they come back from the city. They say, "The children have trodden over their education and our traditions which they should have considered as sacred gifts." Children reject the traditional pattern: "Our customs crush and bore us," they sometimes admit harshly. Cut off from the village and isolated in the city, they are ready to attempt anything in order to survive. In this difficult economic situation, the duty of hospitality becomes an unbearable burden for those in the city who should be ready to receive all the relatives from the village.

As foreigners in Africa, we must not judge its customs. But as well-meaning observers, we could invite reflection on them, asking our listeners, for example, to discover the initial rationale of these traditions that are now criticized. They will then discover their richness and find how, in the current context, the traditions might evolve while still meeting their initial objective. We often refer, as an example, to the case of traditional breast-feeding and that of the initiation rituals. Such traditions address essential values, such as the role of the body in the acquisition of knowledge, of the community in its transmission, of difficulties and the necessary time for maturation.

A Spiritual Dimension The meaning of life, the solidarity between the living and the dead maintains a kind of familiarity with the invisible and explains the "diffuse sense of the sacred" spontaneously present at the heart of the African tradition. It is open to all forms of religious search, whether that of Islam, of Christianity, of Animism, or one of the numerous sects one

encounters today.

A spiritual perspective is present in most activities in the traditional African context. In the People's Republic of the Congo, for example, there is a rather exceptional situation of work undertaken together by government ministries, mass educational organizations, and Foyer Chrétiens. Each respects the others' convictions for a long-term involvement in family life education and promotion.

Africans recognize what has been achieved in the promotion of the family and of women by the different churches, whether they be the Catholic Church or related groups such as the Foyers de Charité (Retreat Centers), parish associations or educational Christian communities. They respect the family life work of other Christian denominations such as the Lutheran-sponsored Family Life Mission movement initiated by Walter and Ingrid Trobisch or the French-Speaking Africa region of the Scripture Union in Abidjan, inspired by Charles and Evelyn Maire in the Ivory Coast, the associate regional secretaries.

Many countries can indeed confirm the basis of the affirmation by John Paul II in Brazzaville on May 5, 1980: "The State can rely on the collaboration of the Church as long as it is a question of serving man and contributing to his integral development."

Without closing our eyes to difficulties and misunderstandings, we appreciate that the sense of hospitality and the natural welcoming disposition of Africa's people permit meetings with groups of completely opposing orientations yet in a climate of trust and appreciation.

Time and Failure We have learned the importance of demographic problems, the principles of planning and evaluating programs, and the criteria of efficiency and method and user-failure rates. We have discovered in the field dropouts, unexplained or unplanned pregnancies. We have met enthusiasm without follow-up, the burnout of teachers, and the departure of those who appeared the most motivated and who had received significant support. We have witnessed the disappearance of groups with which we had worked for

several years. We have without question experienced discouragement, but we have learned the meaning of failure and of time.

During a presentation one day, I was inviting the participants to reflect that in family planning a so-called failure was a new life. A couple in the audience with an infant a few months old asked to speak. "We did not understand the methods very well and my wife became pregnant," said the man. "It was certainly an unplanned pregnancy, but it is not a failure; it is our child." Elsewhere, at the end of a session in a village, a man reminded the audience that one cannot plow a field by throwing the instruments across the field, but that one must accompany the plow along the furrow.

And since then? We dare to speak of the pedagogical value of failures and to admit that what counts is to live with the same rhythm of thought and action of those with whom we hope to work. We readily cite the words of Monsignor Agfe, Bishop of Man: "To work in Africa, one needs three things: initially some patience, then more patience, and finally patience." We remain sensitive to observations from an African collaborator: "You Europeans think that in order to succeed it is enough to have techniques and money. You forget that it must take time and that we are, after all, only people." It is in Africa, in the field, that we have perhaps best understood this pastoral approach of "progressive growth," or the law of graduality that was underlined in 1980 in Rome at the Synod on the Family and in *Familiaris Consortio*. Coming from Abroad What picture do we project of ourselves when we come as experts, consultants, or technical assistants? I had never fully reflected on this question until one day an African called out to me, "You, the expatriates!" I realized the complexity of our situation, we who intervene in such a particular area as family life, in a country with traditions and a culture so different from our own. How are we to define ourselves?

What did we meet in fact? First, we found a lack of trust and a hostility toward our views, even before we presented them. "Here are people who do not have

children themselves and who come to prevent us from having any," one group said to us upon our arrival. The misunderstanding was easy to dispel.

We found rejection of our propositions, which appear to the Africans as incredible. "Settle first the disagreement between various methodologies and come back later to talk," said one African government worker to whom I had explained the different approaches to family planning. But sometimes there was a warm and even enthusiastic reception, no doubt due to the newness of the information as well as to the African traditions of hospitality and tolerance. More often we were met by realism. A Catholic told me, "We do not need foreigners to come to observe and direct us, but don't get any complexes. We have as much difficulty in understanding you as you have in understanding us. This should not prevent us from working together, however." Elsewhere a minister clarified, "It is up to us to receive from abroad what is good for us and to adapt it to our country, just as the foreigner might take from us what is good for him."

We rejoice in observing that family problems constitute one of the best facilitators for international relations. We know that we are at the disposal of our hosts. We must listen to them first and then help them analyze their situation and undertake an inventory of their needs. Then we must share what we know and what we have had experience with so they can choose what might be useful. We must assist them in their own development if they so wish and help them relate their experiences with those of other countries we know and with whom exchanges might be arranged. The objective for us is literally to become "unnecessary servants." In other words, it is our task to work ourselves out of a job.

Five Beliefs for a Strategy In conclusion, I would summarize under five headings the lessons learned from our development experience of the last eight years in Africa. What do we need?

First, we must have a clearly defined objective. Our goal is not the spread of natural family planning, but the discovery of a life style which, through the laws of

fertility, integrates abstinence as a positive value. If we sometimes oppose the two major approaches in family planning, that of techniques and that of awareness, it is because they appear to us fundamentally different in their essence or in their underlying understanding of life and man. Technique by itself cannot solve the problems of man.

Our second need is the belief that each individual holds within himself or herself the necessary elements for self-promotion and development, whatever the sociocultural level. This is the principle of self-reliance, which provides us with the permanent will to encourage, stimulate, and help in the development of these capabilities and not to destroy, replace, or absorb them.

Third, we need to insist that priority be given to community participation in family and conjugal education. The community is the locus of interpersonal relations, and community leaders are known and accepted persons. Moreover, such an approach brings together the most interested men (too often forgotten) and women who in the last resort are the only real agents of change in the concrete reality of their daily lives. It favors autonomy and reduces dependence on professionals and technicians. It facilitates the circulation of information within the group and helps to raise its consciousness. Finally, it can grow beyond a country and spread to an intergroup collaboration as we currently observe with Foyers Chrétiens of Brazzaville (Congo) and l'Action Familiale of Mauritius.

The fourth need is for priority to be given to focusing on realistic expectations in the short term. At the end of a session, I often ask the participants, as an exercise, to predict what they will undertake in the coming month and not in the following year! This is to help them recognize that it is easy to establish grandiose projects but difficult to define a more modest action and to decide on the first steps.

A limited action, carefully undertaken, known and supported by those who initiated it, serves as a sign or anchor on which further steps can be based. All of our

teaching is concerned with concrete realizations. Training is given on practical knowledge, not from books but from problems encountered and possible solutions.

Local sessions are necessary even if their quality is not high, because often they are more effective in motivating the participants, facilitating the identification of future leaders and needs, and developing better teaching aids and instruction. The teaching techniques should be varied so that everyone can participate actively and express himself or herself.

The diversity of language in Africa frequently makes it necessary to work with an interpreter. Our experience shows us that, far from being an obstacle, this technique can in general be beneficial if the speaker and interpreter have taken the time to prepare the session together. The slower delivery pace allows repetition of ideas and can give a margin of freedom or initiative to a competent interpreter, who usually knows better than the speaker which images are most appropriate for the audience. Knowing who the interpreter will be has sometimes made it possible for us to work together to decide on a general plan from which he can work as he sees fit. I can provide him with material, which he then

translates for the audience. In return I ask that he share the remarks and observations of the group!

The final need is for a realistic estimation of our ambitions and work. Michèle and I have had the exceptional privilege even before 1976 (our first visit to Mauritius was in 1963) to be associated with research and field work, especially in Africa. We have had close contacts with couples and with men and women who are quite different from us in their life style, traditions, culture, and religion. They have received us and invited us to share in their problems and joys. We must thank them for all they have taught us and for expanding our outlook, transforming our ways of thinking and action. Because of them and often in spite of ourselves, we have been led to reevaluate ourselves and our actions. We have learned to put into perspective our problems and ambitions and perhaps to be more modest, tolerant, and patient.

As my concluding statement, I would like to share this reflection of Emmanuel Mounier, the French philosopher: "We can only commit ourselves to questionable challenges and imperfect causes. To refuse commitment because of imperfection is to refuse the human condition."

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# L'Action Familiale of Mauritius

**HERVE JUSTE**

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*Mauritius is an island nation in the Indian Ocean located 500 miles east of Madagascar. With a territory of about 2,000 square kilometers, it is slightly smaller than Rhode Island, the smallest U.S. state. The population*

*of Mauritius is about 970,000, and the island's population density is about 530 persons per square kilometer. With a crude birth rate of 27 and a crude death rate of 7.2, the rate of natural increase is 1.9 percent per*

year. These rates imply a doubling time of 37 years and a projected population for the year 2000 of about 1.2 million persons.

About 43 percent of the people live in urban areas. More than a third—36.3 percent—are under the age of 15, and 6.4 percent are sixty or older. A life expectancy of close to 65 years prevails for the population as a whole, with males living to the age of 60.7, and females living an additional six years. The infant mortality rate is about 35 per thousand births.

The population of Mauritius is about 69 percent Indian and 28 percent Creole. The official language is English, but French and Creole are also spoken. Fifty-one percent of the people are Hindu, 30 percent are Christian, and 16 percent are Muslim. The per capita gross national product was estimated at US\$738 in 1981.

The official government population policy is to reduce population growth for demographic reasons. In 1972 the government assumed responsibility for family planning and maternal and child health services, although the Family Planning Association and L'Action Familiale continue their activities.

It was estimated that in 1981 about half of all married women of reproductive age in Mauritius were using some form of contraceptive method, with the public sector providing services for 39.4 percent of all married women and the private and commercial sectors serving 11.2 percent.

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L'Action Familiale of Mauritius was officially established in 1963 on the initiative of Msgr. Jean Margéot to provide Catholic couples with a natural means of family planning and to promote the happiness and welfare of families. It was soon serving other religious and ethnic groups and in 1965 was given financial support by the government. L'Action Familiale is a nongovernmental organization with a board of seven directors, one of whom is a representative of the Ministry of Health and Population Control.

Since 1973 couples have been instructed in the sympto-thermal method of NFP. Services are provided in both urban and rural areas. Training programs are held for teachers almost every year using locally developed teaching materials. Free

referral services are available for couples with physiological or marital problems. Education in "Love and Life" is offered to schools.

L'Action Familiale receives funds from international agencies, local tax-deductible contributions, and grants-in-aid from the government. From 1965 to 1982 about 31,000 couples were taught NFP, about 16.5 percent of all women or couples using a birth control method. Systematic evaluation has not yet been undertaken.

### **Growth and Development**

L'Action Familiale (Family Action) was officially established on April 24, 1963, at the initiative of Msgr. Jean Margéot, then vicar general of the Mauritian diocese. He was advised and assisted in his endeavor by a team of doctors and couples. At that time there was a national demographic problem of exceptional scale and urgency in the country. The total population in 1963 was 713,731. The crude birth rate was 39.9 per thousand, and the annual rate of population growth was just over 3 percent. A density of 384 persons per square kilometer gave Mauritius one of the highest population densities in the world.

Projections published at the time indicated that, if the rate of population growth were maintained, by the end of 1987 there would be 1.6 million persons in Mauritius and even a declining birth rate might yield a population of 1.2 million by that date.

Public opinion was already beginning to show some concern about the consequences of the population explosion, and many couples, especially Catholics, were already practicing traditional birth control methods, such as breast-feeding and the Ogino-Knaus method of calendar rhythm. Msgr. Margéot and his team decided, therefore, to provide, particularly to Catholic couples, a scientific natural method—the thermal method—which had been presented earlier that year by Father Stanislas de Lestapis. Couples were taught the basal body temperature (BBT) method of charting for the determination of the fertile and infertile periods of a woman's

menstrual cycle. They were therefore able to exercise some control over conception and hence their family size. The idea of the regulation of fertility through the use of periodic abstinence was thus officially propagated. Couple-to-couple action rapidly popularized BBT method.

Drs. François and Michèle Guy, two French doctors, who visited the country in August 1963, were invited in December 1964 to impart their experience gained in the field of NFP in Grenoble to the local pioneer team. They devoted two years of their lives to the development of the NFP program, in training of instructors and in the introduction of a youth sex education program in secondary schools and youth clubs. Their invaluable work was essential to the success of l'Action Familiale's program.

Voluntary instructor couples, who numbered more than a hundred at the early stages of the association, set out to work in six urban and rural areas. Their activities were supervised and their training completed through regular meetings. Very soon, through constant sharing on the part of the growing number of couples forming the association, the aims and objectives of the movement emerged clearly, and its methods of action were defined. Legal status was granted to l'Action Familiale in 1964.

### **Objectives, Philosophy, and Principles**

Incorporated under the l'Action Familiale ordinance, No. 38 of 1964, the association has as its objectives "to promote the welfare and happiness of families, to foster the ideas of harmonious married life and responsible parenthood, and to support the propagation of all natural methods of regulating childbirth." According to the philosophy of l'Action Familiale, birth regulation is not just a technical problem; it arises from the choice made by a properly informed couple, aware of the biological, psychological, and socioeconomic aspects of their life. The choice exists only when the couple have clearly understood the values at stake and are not subjected to any moral, intellectual, religious, or political pressures from the outside.

l'Action Familiale stresses the importance of the development of the potential of every human being, and for that reason it was decided at the very beginning of the association to invest in educating couples in human, conjugal, and family life. NFP cannot be taught as a mere birth control device but is presented as a mode of life to foster understanding between husband and wife. The couples are requested to respect life, especially the life of the unborn child; to respect the fecundity of the woman and the couple; and to develop responsibility toward a better and more enlightened conjugal and family life.

In addition to teaching the basic aspects of NFP—that is, the anatomy and physiology of the male and female reproductive organs and the indicators of ovulation—l'Action Familiale also teaches couples how to be responsible parents, how to feed their children, how to maintain a dialogue within the family, and other family values.

l'Action Familiale's outreach program very soon enlisted clients from the other ethnic and religious groups of the population, namely, the Hindus, the Muslims, and the Chinese. The government's decision in June 1965 to give financial support through grants-in-aid to the association gave official recognition to the national character of the program, which was providing free service to the Mauritian community at large.

### **Service and Training**

l'Action Familiale is a nongovernmental organization administered by a board of seven directors elected at a general assembly convened every three years. A representative of the Ministry of Health and Population Control, namely, the principal medical officer of the Maternal and Child Health/Family Planning Division, has sat on the board since 1974.

The board members nominate a number of commissions to advise them. At present there are five commissions—the NFP commission, the youth commission, the medical and psychotherapy commission, the finance commission, and the information and education commission. In 1974 the Mauritius Family Planning Association's

contraceptive clinics were integrated into the Maternal and Child Health Division, and l'Action Familiale was invited to send a representative to the Division's newly formed National Family Planning Committee.

In addition to its national NFP program, l'Action Familiale conducts a human and family life education program in secondary schools and youth clubs and a marriage counseling and psychotherapy service for people with conjugal and marital problems. It also contributes to the marriage preparation program organized at the parish level.

Program evaluation has not been undertaken, but with the inclusion of l'Action Familiale in the program evaluation project designed by the IFFLP and funded by the U.S. Agency for International Development (USAID), alternative organizational frameworks will be explored.

Service Until six years ago, the national NFP service was divided into 12 regions according to the availability of volunteer heads of regions. It has since been realigned into nine districts, which correspond to the standard geographical statistical areas used by the Ministry of Health's evaluation unit. Personnel presently include 1 full-time national NFP coordinator, 3 part-time supervisors, 13 full-time motivators, and 126 part-time educators, as well as a few trainee educators. The educators, who teach at the grass-roots level, at first taught only the BBT method. In 1973 they began instructing couples and women in the sympto-thermal method, emphasizing both BBT and cervical mucus as fertility indicators. Recognition of other signs and symptoms is taught to those who are interested. Initial and follow-up instruction are done either through weekly home visits or at the centers, of which there were 60 in 1983. The centers are located in crucial areas in both rural and urban places. During the first month and perhaps also during the second month, the couple is visited each week at home and is instructed in the fertility indicators on the basis of observations made in the preceding period. During the next three months, educators visit the couples at home every

two weeks. The frequency of the visits is gradually decreased until the couple becomes autonomous.

L'Action Familiale has recently begun introducing and promoting the use of the modified mucus method as it is taught in India by Dr. K. Dorairaj. It is still double-checked by BBT. The introduction of the cervical mucus method has been a blessing for many couples, especially those for whom the woman's cycle was long or irregular. It has also greatly relieved the constant anxiety and tension associated with the previously unpredictable return of fertility before menstruation in the postpartum period and in the premenopausal period.

Training of Personnel A training program for trainee teachers/educators is held practically every year. They meet for about four hours each week for at least 15 weeks. Theoretical topics are presented, discussed, and evaluated. At the same time the trainees are exposed to practical experience with a qualified instructor who is teaching the method to couples and educating them in the related topics of family life promotion. Trainees must be satisfied NFP users who hold at least a primary level school certificate.

Over the years, l'Action Familiale has developed its own training manual and curriculum materials. A guide for educators entitled "Livret de l'Educatrice," as well as a "Cahier de Schémas" have been published. The handbook for users is very popular and is used by many African and European French-speaking NFP organizations.

Support Services A free, part-time medical service is available all over the island for women or couples who are having difficult cycles or gynecological problems that interfere with the observation of fertility indicators. Couples who are having conjugal or familial problems may seek help from our team of marriage counselors whose training was completed early this year by our consultant psychologist, Dr. Robert Fernando.

Another service provided by l'Action Familiale is the human life education program for youth in secondary schools and youth clubs. This program offers not only

sex education but also an education in "Love and Life." The program has three main objectives: to inform youth in a general but clear and objective way about the different aspects of sexuality, love, marriage, and the family; to educate them to adopt responsible attitudes and choices in everyday life; and to reassure them that the problems they are facing during puberty and adolescence are natural and can be handled. This program also enables the youth to express themselves, discuss their fears and worries, and work toward realistic solutions to their problems in a sphere where there is still much inhibition.

Outreach Activities L'Action Familiale educational and motivational programs are supported by monthly television and weekly radio programs. A monthly 10-minute television program and radio programs of about the same length are produced. They are broadcast in two languages, the patois Créole and Bhojpuri.

#### **Financial Support**

During its early years, l'Action Familiale relied on volunteer couples to teach NFP, but with increasing socioeconomic problems, the number of volunteers has decreased.

Grants-in-aid from the government have been received since 1965. For the financial year ending December 31, 1982, the grant was Rs 829,515. In January 1978, however, a governmental decision curtailed aid, thus preventing the establishment of NFP outreach programs in peripheral villages. Other sources of funding include the public, who may take income tax deductions for donations to the association. Some Rs10,000 are also raised by the sale of thermometers, charts, and books. About three-quarters of the 1983 budget of Rs1,072,000 went to pay wages and salaries of personnel.

L'Action Familiale also secures funds from such international agencies as Missio, Misereor, Church World Service, Catholic Relief Services, Family Planning International Assistance (FPIA), and the U.S. Agency for International Development. FPIA funded a two-year comprehensive program of l'Action Familiale in 1974-75 in

the amount of US\$43,818. The local U.S. Embassy and the French Embassy have contributed to self-help projects, and Misereor has donated cars and financed the salary of a youth educator. Missio subsidized travel for a representative from l'Action Familiale to the first IFFLP international congress in Cali in 1977.

L'Action Familiale's contributions to the field of NFP include its participation as a founding member of IFFLP in 1974. Delegates were mandated twice to be representatives for the African zone. The association was invited to participate in NFP experts' meetings directed by the World Health Organization and UNFPA in 1976 and 1980. A program review and evaluation was conducted in 1982 respectively by Geraldine L. Conner, D.S.W., and Nancy W. Veeder, Ph.D., of Boston, Massachusetts. Fairfield University carried out a survey in 1971.

#### **Evaluation**

Table 1 shows the number of new acceptors and users trained during the last four years. There are four categories of users or clients at l'Action Familiale. "Beginners," or "learners," are women and couples who have had instruction and have begun to chart but have not yet completed one cycle. The "nonregistered" category includes those who have charted one complete menstrual cycle and have filled out the association's intake form, providing information on family and reproductive history. "Registered" women and couples are those who have completed three cycles and are recognized as official users by the Ministry of Health, which receives monthly records from l'Action Familiale. "Autonomous" couples are those who have completed and successfully used NFP methods for three to nine cycles and are considered to need no further instruction.

Table 2 shows the number of new recruits registered for each year from the period 1965 to 1982. The total number of couples instructed during this period was 31,682. The total number of recruits is about 16.5 percent of all the women or couples using a birth control method in the country. It represents 8 to 9 percent of the

total number of married women in the reproductive ages.

**Table 1 New acceptors trained annually:**

<u>Mauritius, 1980-83</u>				
<u>Category of user</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>
Beginners/learners	2,394	2,262	2,413	2,567
Nonregistered	2,054	2,107	2,206	2,133
Registered	1,431	1,540	1,710	1,810
Autonomous	557	764	1,071	1,404

**Table 2 Recruits registered annually:**

<u>Mauritius, 1965-82</u>	
<u>Year</u>	<u>Number</u>
1965	1,615
1966	1,953
1967	1,989
1968	1,892
1969	2,266
1970	1,872
1971	2,004
1972	1,739
1973	1,716
1974	1,903
1975	2,001
1976	1,969
1977	1,752
1978	1,252
1979	1,078
1980	1,431
1981	1,540
1982	1,710
<b>Total</b>	<b>31,682</b>

The reasons given for dropping out of the program are shown in Table 3 for the past four years. The category "no longer interested" includes the following reasons: other contraceptive methods, difficulty with abstinence, impatience of husband, difficulty with method, and conjugal or familial problems. "Other causes" includes illness, emigration, menopause, hysterectomy, lost to follow-up, infertility, divorce, in-laws, and death. Very few method failures have been registered, and it seems

**Table 3 Categories of dropouts from NFP program: Mauritius, 1980-83**

<u>Reason for dropout</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>
Planned pregnancy	293	293	248	187
Unplanned pregnancy	105	190	163	144
No longer interested	186	145	91	88
Other causes	231	273	202	182
<b>Total</b>	<b>815</b>	<b>901</b>	<b>704</b>	<b>601</b>

that difficulty with abstinence is the main cause for unplanned pregnancy.

Although the number of recruits has remained steady, there seems to be a gradual downward trend in the number of dropouts, especially in the "unplanned pregnancies" and "no longer interested" categories.

We have not systematically evaluated these and other phenomena, nor have we examined such areas as cost-effectiveness and use-effectiveness of learning and continuing users. We believe, however, that the new supervision aspect of our NFP service has contributed a great deal toward the efficiency of the method, has made it less strenuous to the couple, and has contributed to early autonomy of couples. For the past three years zone supervisors and motivators have undergone special and sustained training in chart review and quality control of instruction and follow-up of clients in order to provide clients with good service.

#### **Accomplishments and Needs**

L'Action Familiale has developed a sound national NFP program. Statistics of the last few years confirm its increasing effectiveness with a lower proportion of dropouts and a higher percentage of autonomous couples.

The program is well rooted in the community and the family, and we believe that the family life education efforts of the last few years are beginning to bear fruit. Our committed staff, especially the NFP teachers, are recruited from and work in their respective communities. They demonstrate a strong client orientation, which has been well documented in the Conner and Veeder study.

We plan over the next few years to continue to emphasize program and service evaluation, and to obtain and feed back service statistics through effective field supervision of teachers. We hope to strengthen the field supervision network and even begin to respond to requests from other African countries to assist them in training their own NFP teacher-supervisor teams.

We expect that the ongoing United States AID/IFFLP evaluation program will

enable us to learn more about our recruitment and outreach efforts in the hope of improving them. Finally, if, as we expect, we are able to document that l'Action Familiale provides an effective and cost-efficient NFP service, we hope to convince

the government that our contribution as a non-governmental organization is worthy of continued and equitable support. Such governmental subsidy would enable l'Action Familiale to expand and meet a growing community demand.



Mathilda Mufwaya of Zambia Nursing Services, and Sr. Mary Gabriel of Family Life Movement of Zambia

# The Family Life Movement of Zambia

**RAYMOND MUCHINDU and RICHARD CREMINS**

*Raymond Muchindu, secretary of Family Life Movement of Zambia, Lusaka, Zambia; Richard Cremins, S.J., director USAID-FLMZ Demonstration Project, Zambia; assistant at St. Ignatius Parish, Lusaka, Zambia*

*ZAMBIA, formerly known as Northern Rhodesia, is a country in southern central Africa with a territory of about 753,000 square kilometers and a population estimated at 6.2 million in 1983. With a crude birth rate of 48 and a crude death rate of 16, Zambia's rate of*

*natural increase is an annual 3.2 percent, and, if present rates continue, the population will double in 22 years and will reach a projected 11 million by the year 2000. Population density in 1982 was 8 persons per square kilometer, and about 40 percent of the popu-*

lation lived in urban areas. Forty-six percent of all Zambians were under the age of 15, and only 3 percent were 65 years old or older in 1980. Life expectancy at birth is estimated at 49.1 years for males and 52.5 years for females. The infant mortality rate is about 105 per thousand live births, down from 159 per thousand in 1970.

About 99 percent of the people of Zambia are Africans, mostly Bantu tribes, and the remaining 1 percent are Europeans and Asians. English is the official language. Religions include a predominance of animists, along with 21 percent Roman Catholics, and Protestant, Hindu, and Muslim minorities. The per capita gross national product in 1981 was US \$586.

Family planning is encouraged by Zambia's government and was specifically mentioned in the 1979-83 Third National Development Plan. The Health Ministry, with funding from WHO and UNFPA, is implementing a three-year maternal and child health and family planning program designed to reach rural areas. The main source of contraceptive supplies is the Family Planning Association of Zambia.

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The Family Life Movement of Zambia (FLMZ) was initiated in 1979 to foster a healthy and happy family life in general and to promote natural family planning in particular. It collaborates with the Ministry of Health and other government bodies as well as private social service organizations and churches. With no religious affiliation, FLMZ serves all interested persons.

The organization trains couples and teachers in NFP; collects and disseminates information on NFP; keeps an inventory of resource materials and makes them available. It has been funded by private donors, fund-raising ventures, and now is participating in a large contract with USAID through IFFLP. In 1982, 22 teachers and 340 users were trained.

NFP programs are now an accepted part of government health programs in Zambia, and FLMZ participates in shaping government policy towards family life education in schools. NFP materials have been published in English, Bemba, and Nyanja. Short-term goals include certification for trainers and tutors and the

establishment of a counseling service.

### **Growth and Development**

The present Family Life Movement of Zambia (FLMZ) came about as a result of contacts with the International Federation for Family Life Promotion (IFFLP), which were initiated by letter from the Council for the Family in 1979. In that same year, a Family Life Promotion Committee was set up by the Christian Council of Zambia, the Zambia Episcopal Conference Development Commission, and the Zambia Council for Social Development to prepare a national meeting on family life and natural child spacing. The meeting was held in September 1979, and it was decided to continue the committee with a mandate to organize a family life movement.

The committee set about to persuade the Ministry of Health to give natural family planning a place in its programs, and its efforts met with success when, in 1980, the permanent secretary of the Ministry of Health decided to include NFP in health programs. The committee continued to meet every month until its family life activities seemed sufficiently developed to establish the proposed movement. A meeting of interested persons was convened on April 25, 1981, at the Natural Resources Development College, Lusaka, and there the movement's constitution was adopted and a national executive committee of 10 was elected. The Ministry of Health reaffirmed its support of the movement's objectives and activities on February 24, 1982, when it selected Dr. M. Tyndall and Sister Juliet Manda to carry out, on a part-time basis, the activities of the movement.

Within a year, several family life groups had been formed at the local level. It is expected that provincial committees will be established after a sufficient number of local groups have been set up in each province.

The movement enjoys more support in urban areas than in rural areas because more promoters and teachers live in towns. It is intended, however, to reach as many rural people as possible when enough teachers are trained. The approach

will be through existing local leadership, hospitals, churches, and other institutions.

The FLMZ has no religious affiliation and therefore serves all interested persons, regardless of their religious beliefs. When the federation of local family life groups is established, its members may, if they wish, be affiliated with churches or other groups.

Representatives of these family life groups will elect the executive committee at an annual general meeting. The executive appoints the director, who is administratively responsible for carrying out its policies and decisions. The committee may also set up subcommittees focusing on different aspects of the work—for example, training and counseling. The movement's basic principles are those of IFFLP, which it has joined as one of its national members. We have no official record of our members' religious backgrounds, but they include a majority of Christians and some Hindus and Muslims.

Most of our clients come from the educated group, but we are gradually extending our efforts to reach less-educated and poorer classes. Every attempt is being made to teach NFP to couples, although husbands typically attend only the first one or two sessions. Another category of clients is couples who are about to marry.

Private-sector NFP teachers are recruited from among users. In the public health service (there are no private hospitals or clinics), nurses assigned by the Ministry of Health are trained. Traditional birth attendants are also recruited.

Aims and Objectives The Family Life Movement of Zambia was founded for the purposes of working for a healthy and happy family life as one of the foundations of human development and for providing leadership, guidance, and education in the fields of family life education in general, and natural child spacing in particular. The FLMZ collaborates with all other bodies interested in these fields, including such governmental departments as the Ministry of Health, Ministry of Labor and Social Services, Ministry of Education, and Ministry of Youth and Sport. It also cooperates with social service organizations and churches. In general, the aims and objectives of the

movement are to promote family life and marriage enrichment programs; to promote respect for human life at every stage of its development from conception to death; to provide motivation and education concerning responsible parenthood and fertility control by natural methods; to coordinate the activities of its members and to offer them the services they need; to represent them to the government and to other national and international bodies; and to promote social action on behalf of the family.

Services Provided So far, the programs and services provided include the following: training of couples in the use of natural methods of fertility control; training of educators in the natural methods; collecting and disseminating information about family life and natural methods of child spacing; keeping an inventory of resource materials and making them available; and combating abortion by remedying the causes that lead people to seek it.

English is our official language, but clients are taught in any of the languages they may understand better. We commonly use Nyanja, Bemba, Tonga, and Lozi; English is used only in teaching more educated clients.

Financial Support The movement at first depended on an annual budget of about US\$20,000 from Misereor in addition to subscriptions from local members and other contributions. Small fund-raising ventures also contributed to its financing. Funds to begin a counseling service were received from a Samaritan group, which later dissolved.

The generous assistance from Misereor will end in December 1983. We now have raised enough money in Zambia to support our activities for at least a year. We are also planning to establish a private company to run a business, whose profits will be given to the movement. This business will probably be a gasoline station in Lusaka. In addition, we have acquired a site for an office building that will provide some rental income as well as accommodation for our own needs.

Relations with Public Health Programs The movement's relationship with the Ministry

of Health is very cordial. In addition to giving NFP methods a place in their policy and releasing staff to work with us, the Ministry has agreed to collaborate in our five-year demonstration program. We are also engaged in dialogue with other governmental ministries mentioned above with regard to family life education in schools. The Catholic Church approached Misereor for funds on our behalf, and the Christian Council of Zambia and the Zambia Council for Social Services collaborated in our foundation.

Our five-year demonstration program, which began in August 1983, will complete its first phase by the end of 1984. The total budget will be about US\$156,715. USAID is providing the funds through IFFLP. In its initial stage, the program will be carried out in three provinces to allow for easy supervision.

The present headquarters of the movement is at Woodlands, a suburban shopping area of Lusaka. Until August 1983 the Catholic Secretariat provided office accommodation and secretarial support. At the provincial level, NFP has reached eight of the nine provinces in the country, and approximately 33 delivery centers have been or are being established.

With regard to affiliation of NFP programs with medical delivery systems, only a few hospitals have a system in which NFP clinics operate side by side with clinics offering artificial methods. A sound base has been laid, however, for almost every clinic to adopt the same system once enough NFP teachers have been trained. This is one of the aims of the five-year demonstration program.

### **NFP Education, Training, and Service Development**

**Teacher Training** Since there was no training program in Zambia when FLMZ was first established, all our first NFP trainers and tutors were trained abroad. They, in turn, have taught teachers when funds permitted and when experts from overseas were available to give guidance. As yet, Zambia has no program for certifying NFP teachers, but it is expected that such a program will emerge during the five-year pro-

gram. Before supplies of thermometers became available toward the end of 1982, the only method taught was the mucus method; since then, however, the temperature and sympto-thermal methods have been taught. This allows clients to have a choice of methods.

Candidates for teacher training must be NFP users if they are not medical personnel. Nurses who are nominated by the Ministry of Health need not be users, but they should at least respect the wishes of the client. We are following a "gradual" approach with respect to selection criteria since we are at present making a first entry into Ministry of Health services.

Training has normally required about five days of lectures, discussions, testing, and demonstration, followed by a supervised practical period of six months. We plan to increase the training period to ten days of classwork with six months of practical work.

The costs of training vary depending on the charges at the institution where the workshop takes place. The minimum has been about US\$15 per day for each trainee's room and board. Additional costs include transport, release time, equipment and supplies, and FLMZ staff time.

There are currently 4 trainers, 16 tutors, and 47 teachers affiliated with the program, none of whom is full-time or paid by the program. All are either volunteers or on release by their employers. Virtually all NFP workers have continued in the program; a very small number have taken temporary leave when they changed jobs. For the past two years, teacher evaluation and continuing education have been conducted by the trainer/tutor team in one- or two-day seminars.

**Service Delivery** The number of users or acceptors trained in the last few years is as follows: before and in 1981, there were 11 teachers and 110 users; in 1982, 22 teachers and 340 users were trained; in 1983, only 14 teachers and 60 users were trained. The drop in 1983 was due to the financial crisis the movement faced in the first half of the year. The figures for 1982, the movement's best year to date, reflect the fact that two training workshops for

teachers were held in that year.

Users are selected from motivated and interested persons who agree to use only NFP methods. We do not have records showing what percentage of users choose each method offered, but nearly all the earlier clients followed the mucus method alone. Since thermometers have become available, more are choosing to use the sympto-thermal method. Cost per user has not been estimated.

Most acceptors are more interested in spacing their pregnancies and in achieving pregnancy than in limiting the size of the family, although the actual percentages of users according to motivation for using NFP have not been calculated. The lack of a record-keeping system in Zambia prevents us from producing statistics on pregnancy rates, percentage of autonomous couples, and continuation rates (one estimate of continuation put the rate at between 70 and 80 percent). Fourteen of the 1981-82 users have become teachers.

#### **Program Evaluation and Accountability**

In the past, the program has been accountable to Misereor for the expenditure of funds. With the new five-year demonstration program, it will be accountable to IFFLP and USAID. As a federation of local groups, the movement is also accountable to formal and informal NFP groups, through which it relates to the community. It is also accountable to government and to public opinion.

#### **Accomplishments and Development Needs**

The greatest accomplishments of the FLMZ to date include establishing the credibility of NFP within the Ministry of Health so that NFP programs are now accepted as part of health programs. Participation in shaping the policy of the government with regard to family life education in the schools has also been an important accomplishment. Some NFP

texts adapted to local conditions have been published, including the booklet "Fruitful Love," in English, Bemba, and Nyanja. The movement involves people from different areas and religious beliefs in a common program. It has gathered together scattered NFP initiatives and turned them into a national movement, and has qualified to be a partner of IFFLP in its five-year NFP demonstration program in Africa. Finally, an important accomplishment has been to encourage NFP in neighboring countries.

The greatest challenges in the long term are to make the whole population aware of NFP and to help in making NFP services available to all who want them. Shorter-term goals include financial self-sufficiency; trainer, tutor, and teacher training and certification; the involvement of doctors, especially male doctors, in the NFP program in Zambia; establishment of a counseling service; and providing support and an alternative to abortion for women with unwanted pregnancies.

Outreach plans for the future call for establishing family life groups in every area, devising a syllabus for family life education, and mounting public relations and motivation campaigns. Our greatest needs at present are for personnel—trained NFP teachers, motivators, trainers, and coordinators at the provincial and district levels. We also need such material resources as office space for national and local centers; transport, which is essential for reaching rural areas; training materials, including films, slides, videotapes, and other visual aids; and office equipment.

In addition to continued scientific research on the underlying basis of NFP methods, Zambia has particular population-related research needs. They include the identification and clarification of Zambia's population problems, the role of birth attendants in NFP and family life education, and a study of traditional attitudes toward child spacing and methods for spacing pregnancies.

# Rwanda

In 1978 a Rwanda delegation attended the WOOMB International Congress in Melbourne. This initiative was jointly sponsored by the bishops of Rwanda in collaboration with the American Catholic Relief Service office in Kigali and the Ministries of Public Health and of Social Affairs and Community Development.

In 1979-80 a first NFP demonstration and service center was set up in the capital of Kigali. In the following years a local network began to extend to the other regions of the country. In 1983 the national NFP program was called Family Action of Rwanda (l'Action Familiale du Rwanda).

NFP activity began in a mixed urban and rural context in the suburbs of Kigali with the NFP service attached to a medico-social center licensed by the government but belonging to the Catholic private health system of the Archdiocese of Kigali. The socioeconomic levels of the clients range from the very poor peasant up to the government employee. The initial NFP teachers were recruited from among the permanent social service staff of the medico-social centers.

The goals and objectives of the services have remained the same from the beginning: first, to offer responsible parenthood as a fundamental duty of the human person in family and social life; and second, a concern for appropriate child spacing within the maternal and child health context. The demographic goal of reducing fertility has always been judged to be secondary and subject to the free, conscious, and responsible decisions of each family.

The NFP service is offered in the two official languages of the country, French and Kinyarwanda. It is usually integrated with other medico-social activities or within human development in general. The existing infrastructure of the center assumed the initial expenses of the NFP service. The

current program is structured around three NFP demonstration centers in Kigali, Butare, and Kabgayi covering the central and southern regions of the country. The primary national center is in Kigali, and the other two are regional centers.

The NFP teacher training program is well established and lasts two weeks. The NFP teacher trainees are selected by the various programs or centers, which then send them to either of the three major centers. The costs of training NFP teachers is borne essentially by the centers that send them for training.

To date, 40 teachers have been trained by the Gikando-Kigali center and 57 teachers by the Butare center. The national program has not yet set up its teacher evaluation program.

From 1980 to 1983 the average number of new NFP users has been about 118 per year. A new user becomes registered as such after submitting at least three charts, coming regularly to follow-up, having visited at least once as a couple, and correctly following the rules of the ovulation method.

The NFP service is currently limited to the teaching of cervical mucus by the ovulation method (Billings). The average cost of teaching a new user couple has not been computed to date. Officially NFP teachers are not recruited from NFP user couples, but a certain number of autonomous user-couples automatically become assistant or extension teacher facilitators (motivators).

The NFP program is largely insufficient with its principal obstacle being the lack of competent and qualified staff. Another need is educational materials adapted to community needs.

Two research areas would appear to be most useful: biomedical research into the stability and reliability of various fertility and infertility parameters, and psychosocial research, especially research into the psychology of the couple using NFP from various cultural traditions as well as research into the evolution of their relationship and sexual experience.

# Seychelles

The first stage of NFP development began in 1971 with the arrival of a Swiss couple trained by the Doctors Guy. Two Seychellian nurses at the Ministry of Health along with Father Hervé Roduit and Dr. Ferrari took steps to inform several parishes of the role and goals of l'Action Familiale (Family Action). The primary goal was to offer to the Catholic population a natural method of family planning. At the end of 1972, 26 persons had received their NFP teachers' certificates from l'Action Familiale.

The second stage occurred when a second Swiss couple took over the earlier work in NFP, primarily training teachers and conducting in-home follow-up visits of couples using the temperature method of NFP. The teachers would gather users from different parishes for information sessions on NFP and family life education. The preparation of a sex education program for youth was also undertaken. At the permanent center of l'Action Familiale, a room was especially prepared to permit free medical consultation for women having difficulty practicing NFP. Postpartum visits for information and education on NFP were also initiated as an outreach effort in various delivery centers.

The third stage began in 1975 with the departure of the Swiss couple. The movement was now entirely the responsibility of Seychellian staff. In spite of repeated efforts to train teachers, many left l'Action Familiale because of the difficulty of obtaining permanent work within the l'Action Familiale system. To compensate for this loss, Mrs. Glora Greslé, a remarkably talented NFP teacher in southern Mahe, was employed on a half-

time basis.

During 1977 l'Action Familiale received a first international aid grant of US\$3,000 from UNFPA, but the Ministry of Health then withdrew one of its delegated nurses. Fortunately, a teacher from the Ministry of Education obtained a two-year leave of absence to work with l'Action Familiale and visited Mauritius for continued education.

A fourth period began with the government's new five-year health plan. L'Action Familiale succeeded in participating in the discussions and presented its own five-year plan, but its recommendations were not adopted.

Toward the end of 1980 it was decided to concentrate on natural family planning (both the ovulation and sympto-thermal methods) and to promote this work with the Ministry. In 1981 a small pamphlet in Creole on feminine reproductive physiology and fertility parameters was published. The high point of 1981 was the national NFP seminar, conducted over five evenings and arranged by the National l'Action Familiale Committee with the contribution of Drs. Michèle and François Guy.

At the beginning of 1982, a general study day was arranged with all the clergy of the Seychelles. During the year l'Action Familiale, in addition to its specialization in NFP, attempted to integrate itself with the national program on "Family Planning, Family Life Education, and Youth," with some success.

The organization continues to participate in the preparatory meetings for the five-year health plan (1983-88), but its activities have become more and more difficult. Only the permanent center of Mont Fleuri is open for daily visits from new acceptors, follow-up visits from users, or inquiries from those who want to receive information on NFP. We are actively awaiting a brighter and more promising future.

# South Africa

In 1978 five participants were sent from South Africa to attend the WOOMB International Congress and teacher training workshop in Melbourne, Australia. On their return they began teaching in Port Elizabeth, Cape Town, Johannesburg, and Kimberley. In 1980 four women were sent to Birmingham, England, to train in natural family planning. One of these is active in the Eshowe area. Other areas opened in Pretoria in 1979, and from this center Rustenburg in 1981, Orapa-Botswana and Harare-Zimbabwe in 1982. Ga-Rankuwa in Bophuthatswana began as a teacher training center in 1981 and caters mainly for training of nurses. Mariannahill Mission Centre was opened in 1982, and three official teacher training workshops have been conducted so far this year. Courses are mainly in Zulu. The Durban center was started from Johannesburg. Instruction is also available in Newcastle, Pietermaritzburg, Mafikeng, Kimberley, Hlabisa, Nklanda, and Phalaborwa.

Over the years Mary Higgins of Ireland, the Drs. John and Lyn Billings, Kath Smyth and Sue Hall of Australia, Fr. W. Gibbons, M.D., Fr. D. St. Marie of El Salvador, Sr. Francesca Kearns of Guatemala, and Mrs. Mercedes Wilson of Louisiana have conducted talks and teacher training in our country.

Informal national meetings between the center leaders were held at various centers in 1978, 1980, 1981, and 1983. Lesotho also sent representation. A national constitution is under consideration at the moment. This national program is to be under the South African Catholic Bishops' Conference (SACBC), Commission of Christian Services, Department of Health Care and Education. As yet there is no board of directors.

The service is attached mainly to church-related institutions, with teacher training also associated with Ga-Rankuwa Hospital and the Medical University of South Africa.

Clients come from all walks of life, all religions and races. Teachers are recruited from satisfied users or nurses.

Our objectives are to set up programs on fertility awareness and the dignity of womanhood in schools, youth groups, and parent-child meetings and to staff them with competent teachers; to establish centers, train teachers, and conduct continuing education workshops; and to provide introductory seminars for medical personnel, church workers, and those involved in ministry. The ovulation method is the main service provided in English, Afrikaans, Tswana, Pedi, and Zulu.

Informal links have been made with the government family planning clinics. Some have literature on NFP and others refer clients to NFP clinics. There is no affiliation with medical delivery services although some doctors and nurses are involved in training. The present headquarters is in the NFP Department, Sunnyside. All teachers are part-time except for one full-time teacher in Johannesburg Center. The total budget from 1980 to 1984 from records kept in retrospect was provided by sales of books and donations given by bishops or after presentations, amounting to R10,179.24. Expenses were R10,449.70 for the headquarters.

Originally teacher training certificates were issued from Australia and Australian teaching materials used. Since 1981 accreditation certificates have been given out in South Africa, and Tswana/English books, slides, films, and talks are used. Teachers may be taught on a one-to-one basis or in groups of up to 26 women at a time. OM is taught, but other NFP methods and contraception are mentioned. The training of nurses may take a year because of irregular hours. Trainees buy their own books and charts; the premises are provided. The 59 teachers are all part-time volunteers, and only one teacher has dropped out (because of pregnancy). Teacher evaluation is informal. All teachers are users.

No surveys have been undertaken. At the Sunnyside Center there have been 241 new users from 1979 to 1983. The criterion for an acceptor is a client who

returns for at least one follow-up. Fifty-nine percent of acceptors are planning pregnancy, 18 percent want child spacing, and 23 percent are limiting their families.

The program is accountable to the SACBC. Monthly reports are sent to the Archbishops of Pretoria, Johannesburg, and Durban. Outreach is informal with

users telling friends and organizing talks in their homes. Larger groups are organized in halls. It is the responsibility of clients to keep the follow-up appointment. Our greatest needs are in teacher training, organizing a national program, working with the public sector, and involving the medical profession.

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## Tanzania

NFP started in 1976 at the request of the bishops of Tanzania as their active response to *Humanae Vitae*. It was started by the Mother and Child Health (MCH) National Coordinator. In 1977 Missio (Germany) gave funds for one year's salary for an extra teacher.

In 1979 the Family and Youth Apostolate (FYA) Coordinator was employed to work in close cooperation with the MCH and NFP coordinator in giving both family life education and NFP information to couples, priests, religious sisters and seminarians in the diocese. In 1981 the Maryknoll Fathers donated US\$12,000 as a subsidy to NFP for printing the teacher's guide and teaching aid materials.

There is no constitution as such, as NFP and FYA were spread from the national level to diocesan—later parochial—levels. There are 10 dioceses which are members because they have an NFP teacher and another 10 dioceses have a family and youth council. There are 16 NFP teachers who are actively teaching on national and diocesan and/or parish levels on a volun-

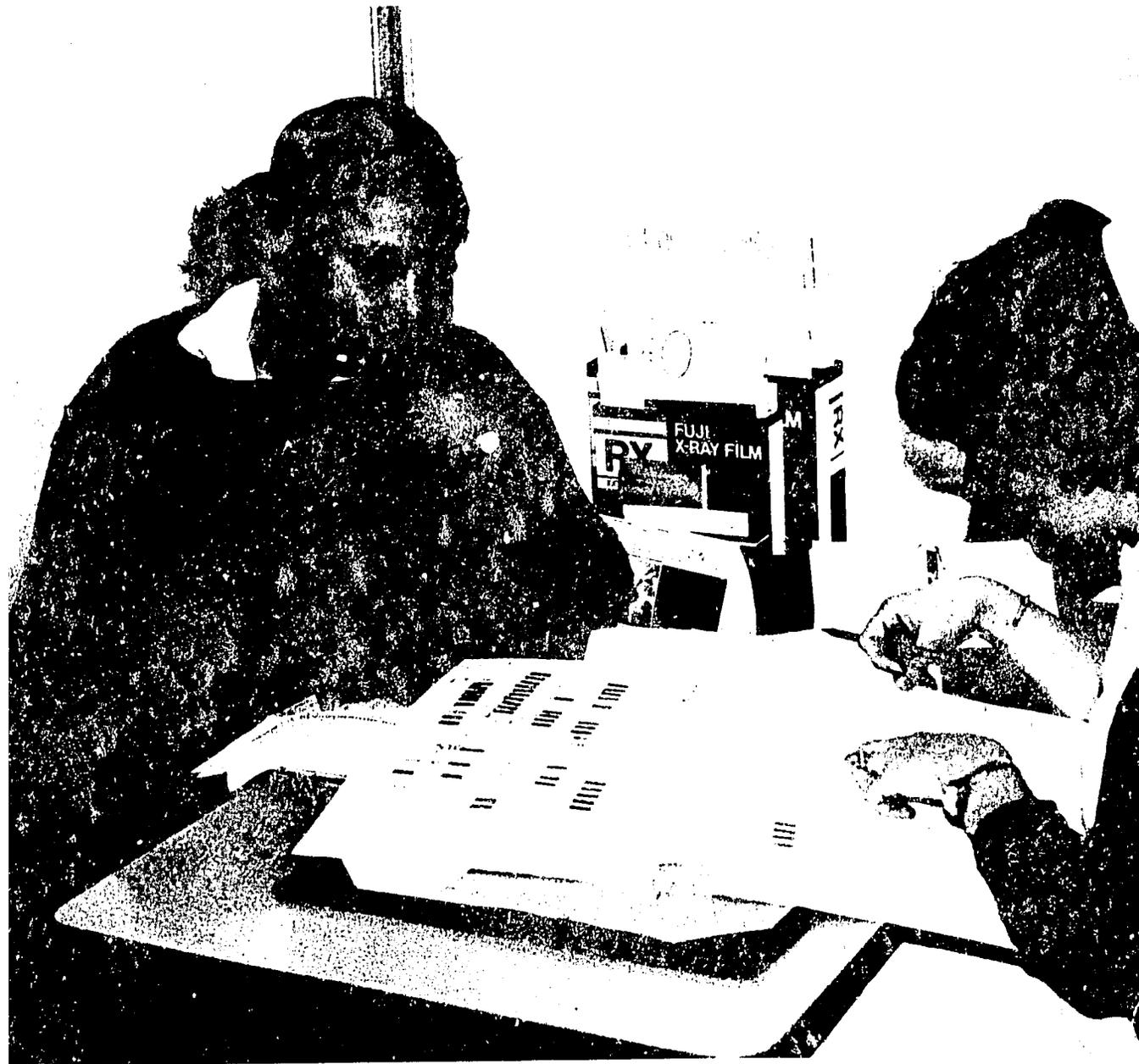
tary basis. There are no organized records of the users' data as such.

The objectives of the group are: (1) to train teachers of NFP on the diocesan and parish levels (religious sisters, medical and nursing personnel, and user couples will be trained to teach other couples); (2) to create family and youth councils at national, diocesan, and parish levels; (3) to integrate NFP services in all Christian, mainly Catholic, mother and child health services; and (4) to make teachers as well as couples aware of the hazards of contraception.

The ovulation method is mostly taught as this is easily understood by people at all levels. Handouts and a booklet have been prepared in Swahili, the national language. We have also developed resource materials for teaching nonliterate. They include analogy with the seasons to explain periods of fertility and infertility, substances from local plants to simulate types of mucus, and symbols rather than colors to show different phases of the menstrual cycle.

Our organization cooperates with the Ministry of Labor and Social Welfare, the Ministry of Information and Culture and Youth, and the Tanzania Parents Association. We have established successful programs in the Dar es Salaam archdiocese and Dodoma diocese.

# Americas



NFP Instructor Suzanne Widmer with client, Diagnostic Center, Hospital Clinic, Universidad Católica de Chile

In the vast region of the Americas, natural family planning programs have gradually been implanted in 12 to 15 countries and are growing progressively. They have developed in different ways according to national character and circumstances.

The oldest NFP program Serena (Service de Régulation de Naissances) in Canada illustrates the experiential or grass-roots strengths of the early pioneers. This program capitalized on the bilingual capabilities (both French and English) of its early leaders and with government subsidies was able to spread to all Canadian provinces.

The Chilean program benefited greatly from strong support from both the Catholic Church and medical institutions. Dynamic professional contributions from medical schools with their research and clinical resources have been especially important in the development of this national program.

Haiti demonstrates how NFP can be implanted in a developing country with limited resources and simple rural teachers. Many of the teachers and a majority of the clientele are illiterate.

In the United States the Diocesan Development Program for Natural Family Planning provides an example of the integration of NFP into the church network of community and diocesan services, especially those related to family life promotion. This is also the case in Venezuela and the Dominican Republic.

Other NFP programs in the Americas illustrate various types or models of development. After a slow initial phase of implantation, NFP programs are now expanding steadily in response to the needs and resources of their respective communities.

# Development of a National NFP Program in Chile

**PATRICIO MENA-GONZALEZ**

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Chile is located on the western coast of southern South America. The Andes Mountains are on its eastern border, and the Pacific Ocean forms its western border. A population of about 11.5 million persons lives in a territory of almost 760,000 square kilometers. A crude birth rate of 22 per thousand is offset by a crude death rate of 7 per thousand, resulting in an annual rate of natural increase of 1.5 percent. If present trends continue, Chile will have nearly 15 million persons by 2000, and the doubling time for today's population is 45 years. Eighty-one percent of Chile's people are urban dwellers, and the overall population density is 15 persons per square kilometer.

About a third of the people are under the age of 15, and about 8 percent are 60 or over. Estimates of life expectancy are 63.8 years for males and 70.4 years for females, with life expectancy for the population as a whole estimated at 66 years. The infant mortality rate is about 35 per thousand births.

The ethnic composition of the population is 66 percent Mestizo, 25 percent Spanish, and 5 percent indigenous Indian. The official language is Spanish, and the population is predominantly Roman Catholic. Per capita gross national product in 1981 was \$2,560; the 1979 income per capita was \$1,950.

Government policy has been pronatalist since 1979 when the government, disturbed by the country's low birth rate, withdrew support for family planning activities. This position is a shift from the strong backing the Chilean

government had previously given to family planning as a health improvement measure. In 1977, the most recent year for which figures are available, about 266,000 acceptors of family planning methods were reported in Chile, a marked increase from the 153,000 acceptors in 1976.

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Development of a national natural family planning program in Chile began in response to an appeal from the Nuncio of His Holiness Paul VI in Chile in 1976. Since then two professors of obstetrics and gynecology have been working together, training their own collaborators and joining forces to organize an NFP teacher training course under the sponsorship of the Comisión Nacional de Pastoral Familiar and accountable to the Chilean Conferencia Episcopal. This course has become a teacher training school. Seeking to serve the Church in the practical application of its doctrine of responsible parenthood, the organizers have succeeded in setting up more than 30 NFP teaching centers throughout the country, two of which are located in the hospitals of the Faculties of Medicine of the Universidades de Chile and Católica de Chile.

The other centers are accountable to various state and private institutions, and in particular to dioceses and parishes. All

*these institutions finance their own NFP activities. In addition, economic aid is at present being received from the United Nations Fund for Population Activities (UNFPA) for a specific project. Between them, the two groups have trained a total of 76 teachers, three of whom work in NFP in other countries. A total of 3,167 users of NFP have been trained to date, most of them using the ovulation method (OM). Various precoded materials have been developed, such as a system of modular teaching adapted to the users' rates of learning and instruments for analysis of acceptability and follow-up of users. These enable research to be conducted on various characteristics of recruitment, teaching-learning, and follow-up of NFP users. An important challenge is the formal incorporation of a national civic institution in the field of NFP to serve as a comprehensive social organ for recruiting acceptors and for obtaining financing to meet the country's NFP needs.*

#### **Development of a National NFP Program in Chile**

In mid-1976 the Papal Nuncio in Chile, the late Msgr. Sotero Sanz Villalba, urged a group of Catholic doctors, in compliance with the wishes of His Holiness Paul VI, to study the application of the ovulation method developed by the Drs. Billings. Two professors of obstetrics and gynecology who attended this meeting and were members of the country's two largest faculties of medicine lost no time in starting on preparations to meet the Pope's request. Both Dr. Alfredo Pérez, a professor in the Universidad Católica de Chile, and Dr. Patricio Mena-Gonzalez, associate professor of obstetrics and gynecology, Universidad de Chile, attended the Congress of the International Federation for Family Life Promotion (IFFLP) held at Cali in 1977. Shortly thereafter, they put independent initiatives into effect.

Dr. Alfredo Pérez went to Australia under the auspices of the World Health Organization (WHO) to acquaint himself with the Billings method at the place where it originated. Professor Pérez continued working on NFP in his private office until

May 1981, when his activities became an official program of the School of Medicine of the Universidad Católica. The program included welfare work, teaching, and research, and it obtained its own premises with regular working hours, files for clinical records, and centralized statistics.

Meanwhile, Dr. Mena-Gonzalez, convinced of the value of NFP after a long and exhaustive examination of development programs based on artificial contraception, responded to the Pope's appeal. He eliminated all contraceptives from his own work and began teaching OM to his private gynecology patients, designing his own teaching instruments and records for users. In April 1978 all teaching of natural methods was transferred from his private office to a parish in Santiago, San Pedro de Las Condes. A group of teachers collaborated in this work under the direction of Professor Mena's wife. The name of the parish was to remain identified with the team that originated there. Its members called themselves the "Equipo San Pedro," although subsequently (in 1982) they were to leave that locality to settle in more suitable premises at the request of the Conferencia Episcopal de Chile.

In March 1979 a Comisión Nacional de Pastoral Familiar was set up as a dependency of the Conferencia Episcopal de Chile. The commission's board of directors invited the two professors and Senora de Mena to participate in its work, and together they formed a Grupo de Trabajo para la Defensa y Promoción de la Vida (Working Group for the Defense and Promotion of Life). By this time the field of action was nationwide. Drs. Pérez and Mena and Sra. de Mena joined forces to implement a national training program for teachers of natural family planning methods, which was launched in March 1980 and inaugurated by the Secretary of the Conferencia Episcopal, Monsignor Bernardino Pinera. This program continued to be the responsibility of the Equipo San Pedro and still is today. Professor Pérez has been training teachers under an independent system as circumstances dictate.

In May 1981 the Faculty of Medicine of

the Universidad de Chile (the national state university) inaugurated a Center for Natural Family Planning Methods, whose mission was to operate as a research, teaching, and welfare center within the framework of university activities. The Equipo San Pedro now has at its disposal—through the informal network of its members—the necessary instruments for taking new and essential steps in the work of spreading knowledge of NFP.

Thus two parallel NFP groups have grown up, one centered in the Universidad Católica and the other in the Equipo San Pedro, both affiliated with the Comisión de Pastoral Familiar. Each has followed its own style and pattern in the performance of a common task, preserving the advantages of the originality and creative impulse of human groups working in different circumstances, but united by common aims, friendship, and the Church. Today both are developing multiprofessional and volunteer groups in preparation for the establishment of a national organization which will enable them to undertake new and more complex tasks.

The activities of both groups are urban in character, an appropriate circumstance in a country whose total population is 80 percent urban. In one case (Universidad Católica), their activities have a markedly university character, whereas in the other (Equipo San Pedro) they reflect a complex organization which today embraces more than 30 teaching centers. Each is administratively independent, but they are linked at the technical and human levels, with a clinic providing advisory assistance in technical, scientific, and welfare fields (Consultorio Universidad de Chile) and a teacher training school accountable to the Comisión Nacional de Pastoral Familiar. The teaching centers are attached to the Church (parishes, dioceses, and so forth), as well as to the municipality (Municipalidad de Providencia), the Ministry of Health, other state health institutions, or private hospitals.

The clientele attracted by the two teams is predominantly middle or upper middle class, with 6 percent and 20 percent from the lower income strata in the Universidad

Católica and the Universidad de Chile programs, respectively. In both universities the clients have extra-religious motivations, unlike those attending the centers under the auspices of parishes or other Church institutions, where the motivation is obedience to teaching. Most of the teachers are midwives or nurse midwives, but some are housewives or professionals specializing in other disciplines. What really matters is that teachers must accept and practice in their own personal lives the lessons taught with respect to the transmission of life and must refrain from all professional activities that imply the use of contraceptives or abortifacients.

The aim has been and is to serve the Church in the practical application of its doctrine by making natural methods accessible to the population. The objectives are to provide services to users; to undertake teaching at all levels in the universities; to train NFP teachers; to conduct research on the various aspects of the problem; and to keep in close contact with the activities of the Comisión Nacional de Pastoral Familiar. It is also a goal to progress from coordination to integration where appropriate; to incorporate formally a national civic institution in the NFP field; and to link up with NFP groups and organizations in other countries as well as with international NFP organizations.

All natural methods are taught, but the ovulation method is particularly stressed. Recently we began experimenting with courses on family life in the hope of improving the recruitment and follow-up of couples at the lower socioeconomic levels.

#### **Finance**

As regards financing, in the case of the Universidad Católica, it has depended successively upon WHO, the Comisión Nacional de Pastoral Familiar, and, since 1981, the School of Medicine of the University itself. The Equipo San Pedro was financed at first by voluntary contributions, during 1980-81 by the Comisión Nacional de Pastoral Familiar, and subsequently, again by voluntary contributions. Wages and other expenditures have been covered by various institutions (Univer-

idad de Chile, municipalities, state, ecclesiastical, or private organizations), to which were added in 1983 UNFPA and the Colegio Médico de Chile (indirect financing).

Budget allocations (amounts given in US\$)

Universidad Católica de Chile		
<u>Year</u>	<u>Source</u>	<u>Amount</u>
1980	Comisión Nacional de Pastoral Familiar	\$16,700
1981	School of Medicine, Universidad Católica	15,000
1982	School of Medicine, Universidad Católica	15,000
1983	School of Medicine, Universidad Católica	15,000
1984	School of Medicine, Universidad Católica	15,000

Equipo San Pedro		
<u>Year</u>	<u>Source</u>	<u>Amount</u>
1980	Comisión Nacional de Pastoral Familiar	\$16,700
1981	Comisión Nacional de Pastoral Familiar	16,700
1982	Private contributions, Universidad de Chile	10,208
1983	Private contributions, Universidad de Chile, Municipalidad de Providencia, Colegio Médico, and UNFPA*	48,784
1984	Same sources as 1983	31,265

\*Equipment funds, Research and Teaching Center, Universidad de Chile

The two working groups have carried out different tasks. For example, the Universidad Católica has collaborated with a ministerial body (Consejo Social de Ministros) in a program for nationwide diffusion of natural methods. The Equipo San Pedro has developed informal links with various Chilean organizations.

As regards the future, we have been authorized to work in various clinics or centers accountable to the Ministry of Health, but as yet we have received no budget. We maintain no link whatever with institutions or clinics concerned with

family planning based on artificial contraception, sterilization, or abortion. The clinic belonging to the Universidad Católica is located in the diagnosis center of the Hospital of the Universidad Católica de Chile. It maintains informal relations with a number of teachers working in 10 supplementary care centers. The Equipo San Pedro is coordinated on the basis of the teacher training school--the Center for Teaching of NFP Methods, accountable to the Comisión Nacional de Pastoral Familiar in Santiago, Chile. Its satellite provincial centers are in Calama, La Serena, San Felipe, Valparaíso, Curicó, Chillán, Concepción, Araucanía, and Punta Arenas. There are 31 centers in all.

In some cases the NFP programs are vertical programs within the context of public or private hospitals or clinics; some are integrated with maternal care programs or are totally independent of the health context, such as those run in dioceses, parishes, and our own teacher training school.

**Teacher Training and Service Development**

Training programs for teachers in both groups have certain requirements for the acceptance of trainees. The programs both present definitions of theoretical and practical objectives relating to fertility detection and techniques for teaching users; ethical and moral principles of the teaching of the Church on sexuality; and development of aptitudes for the diffusion of values implicit in natural methods and necessary for the recruitment and follow-up of users. Both programs offer practical teaching of a tutorial type, with biomedical, pedagogical-administrative, and ethical-moral seminars, periodic appraisals, and a final examination. Teaching material for the programs consists of the OM atlas, technical textbooks, documentation on teaching, and essays on sexuality approached from the Christian standpoint. In addition, audiovisual material and self-teaching tests are used. Teachers are trained in all natural methods. The duration of the course depends in the last analysis upon the qualification of the can-

didate for coping with the practical realities of welfare work.

In the Universidad Católica the training course lasts six months; the Equipo San Pedro requires a minimum of 90 hours of practical work and then authorizes these teachers to return to their teaching sites to take on a small number of users. The Equipo San Pedro has adopted this strategy because it considers that a long maturation period—probably several years—is required to become a thoroughly reliable teacher. It also sees the need for continuing education with periodic refresher courses, as well as supervision in the field. Teachers thus trained have managed to gain a footing in distant provinces despite the lack of specialized medical support and skepticism on the part of local society. They have laid the indispensable groundwork of awareness of church and society—“sowing the seed” for future efforts.

The approximate cost of training each teacher is US\$200, exclusive of study material, per diem, and travel. The Universidad Católica has seven teachers (one full-time, three half-time, and three volunteers) in addition to ten volunteer associate teachers.

The Equipo San Pedro has 47 teachers (9 percent full-time, 91 percent part-time). Eight-three percent are volunteers. Out of the total of 59 teachers trained, 47 are working in Chile, 3 are operating abroad (in Uruguay, Brazil, and Ireland), and 9 (15 percent) have dropped out.

Service delivery statistics are presented below for a number of categories.

#### Number of new users taught per year

	1980	1981	1982	1983*
Universidad Católica	488	512	608	502
Equipo San Pedro	53	324	421	259

#### Methods taught (in percentages)

	OM	ST	BBT
Universidad Católica	71	29	—
Equipo San Pedro	85	5	10

\*Includes January–July 1983.

#### Nature of acceptors (in percentages)

	Planning pregnancy	Spacing	Limiting
Universidad Católica	5.5	88.5	6.0
Equipo San Pedro	6.0	70.0	13.0

#### Follow-up users (in percentages)

	Continuation rate	Pregnancy rate Life Table
Universidad Católica	49.0	13.3
Equipo San Pedro		20.6**
Universidad de Chile	43.4*	17.0

\*Considered as dropouts 28 percent who planned pregnancies.

\*\*Includes errors of method, teaching-learning, and use, Pearl Index.

#### Criterion for defining autonomy of the couples

Universidad Católica User couple not requiring follow-up to interpret their signs and symptoms and to keep a proper record.

Equipo San Pedro User couple not requiring frequent advice, users with approximately three months' use of the method. We define as a spacing/limiting user couple one who resumes intercourse after being trained to detect fertile and infertile periods with reasonable accuracy.

In the Universidad Católica program, practically none of the users wished to become teachers; about three percent of the Equipo San Pedro users did.

#### **Evaluation and Accountability**

In the Universidad Católica the program administration is accountable to the director of the hospital. With respect to achievement of objectives and adherence to goals and philosophical viewpoints, it is accountable to the dean of the Faculty of Medicine. The Equipo San Pedro is accountable in all respects, informally to the boards of directors of each institution and in technical and philosophical matters to the Comisión Nacional de Pastoral Familiar.

We are particularly interested in keeping our medical colleagues informed and seek to do so by communicating results to scientific associations and keeping our doors always open to those who want to get to know us. To the general public information is transmitted through interviews, talks, and lectures, the press, television, and radio. To evaluate teaching effectiveness, precoded modules, comprising the entire teaching content, the time taken, and the name of the teacher responsible are available. All of this information is linked up in the data bank with socioeconomic and cultural, biological, and reproductive

behavior information. In the future it will be easy to calculate teaching costs for each sector and for each teacher by relating total time taken with the number of users.

All the foregoing effort has had no quantitative impact on national family planning programs, but we are well known and the service provided is felt to be trustworthy. I would say that we are progressively more and more sought after, particularly among the better-educated sectors of society.

In order to step up recruitment of clientele at a low socioeconomic level, we have started educational programs on family life for the pregnant women who are cared for in the prenatal clinics, which couples must attend together. These programs emphasize communication, mutual respect, sexuality, and love.

As regards the follow-up of our users, we have statistics on pregnancies, dropouts, and time of use, as well as on the learning process. In all centers the Pearl index is used, and in the university centers life tables as well. As an indicator of acceptability of NFP, the Universidad Católica prefers to label as dropouts those who abandon the program after teaching and after four months' use. In the Equipo San Pedro, specific acceptability surveys are made before teaching and in the course of the follow-up of users.

#### **Accomplishments and Needs**

We consider that the following have been our greatest accomplishments:

1. To have established in two universities in a developing country NFP teaching and research programs, with professional personnel in charge, and subject to all the evaluation criteria of university medical programs.

2. To have established an NFP teacher training school under the aegis of the Comisión Nacional de Pastoral Familiar, on the basis of which a system of NFP centers interconnected by the school has been gradually set up. They are centers with a common methodology but with independent administrations; they are capable of adhering to their stated goals in the face of

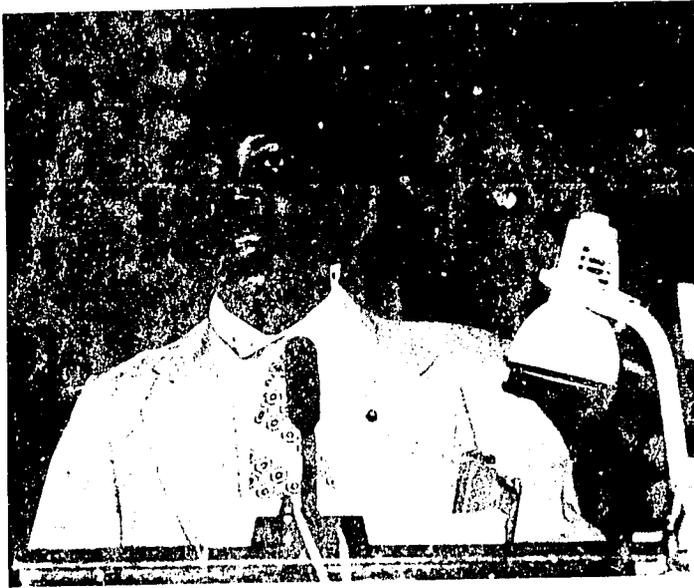
all sorts of difficulties, and in some cases they have generated new NFP centers, all of them embodying the values of the Church in the field of family planning.

We consider that the following are our greatest challenges: (1) to succeed in the establishment and mass diffusion of NFP at the national level; (2) to establish the educational and cultural strategies that will enable us to recruit a large popular clientele; and (3) to incorporate a formal organization capable of meeting the country's present and future NFP needs. This organization would satisfactorily channel current efforts without sacrificing the originality of spirit of enterprise of each working group. It would be a social organ for the recruitment of new adherents in different social, economic, and cultural or religious circles. It would also seek and obtain financing.

We need to train more teachers under steadily improving programs, and we need more gynecologists to act as advisers to the teachers. Concurrently we need to set up a permanent secretariat to maintain coordination of the national system. We also need to obtain financing for congresses, per diem allowance and advanced courses intended for adviser-gynecologists and teachers. Support is also needed for study seminars for members of the clergy and religious orders who are connected with education and pastoral promotion of family life, so that they will have an opportunity to explore NFP in its biological, cultural, psychological, religious, and spiritual dimensions.

We consider it advisable to seek sponsorship for our work from State health, education, planning, information, and research institutions, as well as from churches and sociocultural bodies representative of national activities.

We also regard the administrative and operational aspects as an indispensable component of organic growth. In our view it is scientific research that will lead us to participate in dialogue with the professions and the scientific world.



Fritz François

# L'Action Familiale of Haiti

**FRITZ FRANCOIS**

*Fritz François, national coordinator of  
L'Action Familiale of Haiti*

*Haiti occupies about 28,000 square kilometers of the Island of Hispaniola in the West Indies. It shares the island with its neighbor to the east, the Dominican Republic. Its population of nearly 6 million persons has a crude birth rate of 41 per thousand and a crude death rate of 14 per thousand. The annual rate of natural increase, 2.7 percent, implies a doubling time of only 26 years and a projected population of 8.9 million in the year 2000.*

*Population density is 220 persons per square kilometer, and about a quarter of the population lives in urban areas. The population is quite young, with 41 percent under the age of 15. About 6 percent of the people are 60 years old or over. Life expectancy is 51.2 years for males and 54.4 years for females. Infant mortality is estimated to be between 113 and 130 deaths per thousand births.*

*Ninety-five percent of the people are of*

*African descent. French is the official language, and Creole is spoken by the majority of the people. The predominant religion is Roman Catholicism, practiced by about 80 percent of the population. Protestants constitute 10 percent of the population, and Voodoo is also a popular religion in Haiti.*

*Per capita income in 1980 was about \$260. Per capita gross national product was \$297 in 1981.*

*Haiti's government is committed to the concept of a small family, and family planning is a priority in the national health plan. Abortion is prohibited by law with no exceptions.*

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*L'Action Familiale d'Haiti was founded by a steering committee in Port-au-Prince, the capital in November 1971. In July 1973 it was recognized by the government. L'Action Familiale of Haiti (L'AFH)*

*is a nonprofessional, nonchurch movement. It has several Protestant members among its educators and leaders. Yet, it is a member of the Episcopal Conference of Haiti, which is the responsible legal and financial entity for the program.*

*L'Action Familiale of Haiti is also a nonmedical and nonprofessional movement. The majority of teachers are farmers, and the method of teaching is primarily by the extension method with home visiting. All signs or parameters of the fertile and infertile phases of the menstrual cycle (temperature, cervical mucus and cervical changes) are taught, yet the couple is left the choice and preference of which self-observation methods or combination of indices they prefer according to their motivation and life circumstances. Most opt for the sympto-thermal method to limit births.*

*From 1972-76 l'AFH was administered by a steering committee in Port-au-Prince while different initiatives with the ST method were undertaken across the country. In December 1976 the general assembly of members meeting for the first time requested a national structure more representative of the various regions of the country. Seven persons are working full-time and 190 part-time. A first subsidy from UNFPA was obtained in 1976 for \$13,500. Since 1980 this grant has been replaced by a USAID grant which in 1983 allocated \$30,000 to the program.*

*Since 1976 the program has also received constant financial support from Misereor, Germany, with the objective of establishing and demonstrating the efficacy of the ST method in Haiti. From 1982 to March 1983 at Misereor's request, an in-depth evaluation by a consultant from the Harvard Center for Population Studies was conducted on the work of the program, which concluded that NFP "could become the preferred method of Haiti."*

*The average clientele of users has the following characteristics: one-third Protestant and two-thirds Catholic; one-third married and two-thirds in irregular unions; 77 percent illiterate 11 percent with elementary and 11 percent with some*

*secondary school education. Only one percent has finished secondary school. During the last three years (1980-82) the program registered 7,286 new NFP users with only 286 unplanned pregnancies and 379 dropouts.*

### **Development of the National NFP Program**

L'Action Familiale of Haiti came into existence in 1971 after much pioneering work by a Dutch missionary priest, Father Michel Welters. In 1964 through a mutual friend in the University of Louvain, Father Welters came in contact by correspondence with two beginning national NFP programs: Centre de Liaison des Equipes de Recherches (CLER) in France, and Serena-Canada. Between 1964 and 1969, he reviewed extensively the informal scientific NFP literature and taught himself the sympto-thermal method. In 1967 Father Welters taught the first couples of his parish the strict basal body temperature (BBT) method of NFP.

In 1971 a first medical coordinating committee of physicians in the capital, Port-au-Prince, was formed and approved by the Episcopal Conference. In the following year, the first coordinating committee chose the name "l'Action Familiale d'Haiti" (Family Action-Haiti) to denote its similarity in philosophy and approach to l'Action Familiale of Mauritius. In 1972 the committee also drafted the constitution of the organization, and in July of 1973 l'Action Familiale d'Haiti was officially recognized by the government. From 1972 to 1975 l'Action Familiale d'Haiti (l'AFH) was led essentially by its medical coordinating committee of which Father Welters was the secretary.

When the World Health Organization submitted its preparatory report to the Haitian government, it mentioned that the sympto-thermal method should be integrated into the government plan. By not supporting the proposal, the bishops lost an opportunity. The Haitian offices of the World Health Organization (WHO) and of the United Nations Fund for Population Activities (UNFPA) have always remained

open to—if not very supportive—of NFP but they cannot initiate by themselves any action without the participation of the government of Haiti. The government itself will take no initiative if it does not receive a proposal directly from the Episcopal Conference. In spite of this, l'AFH in 1976 was able to obtain its first subsidy of US\$13,500 from the UNFPA with the possibility of a gradual increase. Since 1979 this subsidy has been replaced by one from the U.S. Agency for International Development (USAID) from whom l'AFH received US\$30,000 in 1983. Up to US\$34,000 is predicted for 1984.

In 1976 Misereor, a German Catholic funding agency, offered a special subsidy to l'AFH with the objective of showing the credibility of the (ST) sympto-thermal method in Haiti, in the hope that it might then be integrated into the governmental plan with international funding. In 1980 Misereor wanted to reduce its assistance. Since the demonstration was not yet completed, supplementary funds were requested for another three years to continue the demonstration and establish the effectiveness of the NFP methods.

From April 1982 until March 1983, Misereor supported a special evaluation of the AFH program which was undertaken by an anthropologist from the Center for Population Studies of Harvard University. The evaluation was generally positive. L'AFH was described as a "highly professional organization with few equals in Haiti. Certainly there is no other local rival organization which could compete with l'AFH's achievements with such a small budget. L'AFH offers its clients a ST-NFP service which is well conceptualized and of the highest possible quality." The evaluator concludes her report: "I personally undertook this evaluation with many questions and doubts concerning the effectiveness of ST in Haiti. Now I am not only convinced that it can work and does work but that with the appropriate recommendations it could be the *method of choice* for Haiti." (Method of choice is underlined by the evaluator.)

The objective in requesting an extension of funds from Misereor has therefore been

accomplished. As an immediate future objective, l'AFH would like to see the government finance its ST-NFP program but leave the structure and work approach of l'AFH independent. For the next few years, as we continue to offer ST to all interested persons, we plan to (1) popularize throughout Haiti basic knowledge of the menstrual cycle so that every woman can learn about her fertile and infertile periods; and (2) popularize the notion of the cervical mucus as the major fertility sign replacing the Ogino (calendar) method.

Haiti is one of the seven countries in which, according to the World Fertility Survey, more than 5 percent of women use periodic abstinence. The World Fertility Survey of 1977 has shown that in Haiti 2 percent of women received IUDs, 7 percent took the pill, and 25 percent used periodic abstinence as a family planning method.

The success of our first objectives is especially related to a change in structure undertaken in 1977. Although the coordinating medical committee played an important role from 1972 to 1976 in developing and building credibility, it was too localized in the capital, and the physicians did not have enough time to expand activities. In December 1976 the general assembly, meeting for the first time, requested that a more representative structure of all the regions of Haiti be established. In fact, between 1970 and 1973 there were many different experiments in NFP-ST conducted by Father Welters in collaboration with a small working group in different areas of the country. In August 1973 the coordinating committee organized a national training workshop with 220 participants from 45 communes.

During the general assembly of 1976, the question of greater participation by the provinces in the direction of the movement was raised. In response in April 1977 the national committee was constituted, composed of a full-time national coordinator and a national administrator with representatives from each region or diocese, each elected for four years. This is the structure that pertains now. There is no more general assembly or coordinating

committee, only this new representative national committee which meets every two months.

The regional director is assisted by a regional facilitator and a regional administrator. The regional director represents the region with full authority. A region consists of several zones with zonal supervisors who oversee the NFP teachers. With the restructuring in 1977, l'AFH became a national movement with its headquarters in Port-au-Prince, a training center in Gonaïves, and three additional centers in Cap-Haitien, Hinche, and Port-Salut.

### Service Delivery

L'AFH is nonsectarian as far as its NFP services and sex education of youth programs are concerned. Not only does it help many user couples who are Protestants, but among its leaders are Protestant teacher couples. A Jehovah's Witness is one of its regional coordinators. Services are offered to everyone without distinction, whether married or not, practicing NFP or not, divorced or remarried. This choice of a nonsectarian approach is not always understood by every bishop, priest, sister, or nurse.

Without this nonsectarian approach it would have been difficult, if not impossible, to coordinate nationally all the various activities such as training, financing, administration, and the selection of teachers and supervisors.

This approach does not exclude relationships with the Church and the bishops. The Episcopal Conference is legally and financially responsible for l'AFH. The legal representative of l'AFH is one of the bishops selected by the Episcopal Conference in agreement with the national committee.

L'Action Familiale is nonmedical and nonprofessional. There is no physician, lay nurse, religious nurse, or midwife. Practically all of the teachers are farmers, and up to 80 percent have not completed their primary education. The approach is couple-to-couple. Our organization reaches everywhere, even the farthest corners of Haiti, whereas contraceptive services are dependent on the country's

inadequate medical structures.

### Clientele

The average clientele has the following characteristics:

Religion:	33% Protestants, 67% Catholics
Marital status:	66% are not married but live in "concubinage"
Family size:	65% have a small family of one to three children 29% have a family of four to six children 6% have a large family of seven to ten children
Age of users:	16% are young (15-24 years of age) 54% are young adults (25-34 years) 30% are older (35-50 years)
Literacy:	77.6% are illiterate or nearly so
Schooling:	10.6% have graduated from primary school 10.6% have attended one to three grades of secondary school 1% have graduated from secondary school

Since 1972 Creole, the language spoken and understood by everyone, has been used. All the teaching brochures and pamphlets have been published in Creole.

In addition to its NFP activities, l'AFH also conducts sex education for young people through audiovisual presentations and the distribution of publications. It also has published a few items on primary health care, intestinal parasites, and venereal diseases, but its primary activity remains NFP.

The Family Hygiene Division of the Ministry of Health is responsible for the national coordination of all family planning activities. L'AFH's relations with this group are quite cordial. It supports l'AFH for three major reasons: (1) the outreach or extension approach of l'AFH (teachers visiting clients) is unique, and the clinical model of the Division of Hygiene cannot easily duplicate it; (2) NFP should be available to the population, and l'AFH is competent to provide this service; (3) the educational approach of l'AFH is basic to human welfare and complementary to the action of the ministry. Relationships with other ministries (Social Affairs, Education, and Health) are also quite cordial, as are those with the Catholic bishops. Relations with physicians, lawyers, and legislators

are very sporadic. There is no movement similar to l'AFH in Haiti.

### **Training of Teachers**

All the dioceses (except one) have their own regional coordinators. Normally the recruitment of teacher trainees is from satisfied NFP users, just as the supervisors are selected from competent teachers and regional coordinators from the supervisors.

At first (1970-76) NFP users were usually trained at the parish level according to demand. The permanent center in Port-au-Prince has served since 1975 as a national meeting center, a library and resource center (thermometers, slides, cassettes), and a continuing education center. Various group sessions for teaching were held in several areas of the capital. It is only since 1981 that the Port-au-Prince center has begun to be used as an actual teaching or reference center for users, on an individual basis. In 1984 it is hoped that this center will also be used for group follow-up of users.

The first permanent intermediate center was established in Gonaïves (1976-80). It was used initially as a training center for teacher trainees selected from among the users from the different dioceses, who were taught between 1970 and 1976 in the parishes. In 1980, with the help of Misereor, a formal training center was built for the continuing education of all l'AFH personnel.

The training of users follows the guidelines of the teachers' booklet, which has been regularly updated every year or two (Editions: 1972-73, 1979-81, and 1983). The teachers' booklet is the essential guide for teaching NFP clients. When a user wants to become a teacher, the same guide is also used, but it is better explained and understood. The various editions of the teachers' booklets follow the same outline, namely, the woman's menstrual cycle; the observation of cervical mucus, taking the temperature, and basic interpretation principles; and special circumstances such as postpartum, premenopause, and postpill. Although l'AFH has an elaborate library with many books, magazines, and slides, it

relies mainly in its training program on a series of 21 drawings.

For the training of the NFP user as a teacher, the instruction is simple and complete, illustrated with examples and testimonials following the plan of the teachers' booklet. (Everything is explained in terms of the woman's cycle.) Comprehension is tested by special questions during the course. The teacher follows the same approach in teaching the client in home visits using as a reference the actual current cycle of the woman. The teacher makes two visits per week in the first month, then two visits per month for the next two months, and occasional visits during the next three months until autonomy is reached. It is a tiring but fruitful schedule.

In isolated areas where there is an absence of nearby NFP teachers, a traveling team (national coordinator, national administrator, and supervisor) undertake a three-step training program for users of three days each, at intervals of one and a half months and three to four months. These teacher-trainee sessions are 5 hours per day or 15 hours per session, for a total of 45 hours for the formal training of an NFP teacher stretched out over a five- or six-month period.

To train a teacher in his or her own parish costs about US\$45.00. If this training is undertaken at the Gonaïves Center, it costs US\$75.00. The continuing education of a teacher is estimated at US\$25.00 per year. The cost of teaching NFP to a new user is estimated at US\$13.00.

To become NFP teachers, trainees must be qualified users for at least six months and have at least four years of elementary schooling. Initially the new teacher follows only three to five new users. There is no specific certification for NFP teachers. Evaluation is usually done orally during training workshops. Such training sessions are usually in small groups of 12 to 20 trainees or individually for 2 or 3 persons. The user must mark the charts with the standard 1-2-3 on each consecutive high temperature day to show that the high temperature phase has stabilized (identifying the temperature shift). This way the teacher can verify the comprehension of



Woman learning NFP under supervision in Gros Morne, Haiti

the user. Temperature charts are sent to the regional supervisor every six months so she or he can verify the work of the teacher. In some areas, regional continuing education sessions are done monthly for one day or every three or four months for three days. Every two or three years, teachers undergo a written multiple-choice test on NFP theory and chart interpretation.

#### **NFP Methods Taught in Haiti**

In the beginning (1976) l'AFH taught only NFP. Gradually we also began to explain all contraceptive methods with their advantages and disadvantages. This was done both to promote NFP and to respect fully the freedom of choice of the couple as stated in article 3 of our constitution. Currently 30 percent of our new users have previously used some form of contraception. From these persons come our most dedicated users. In fact, we hardly need to speak of contraception nowadays, since the people have already had their own experience with it.

At first the strict use of the temperature method of NFP was taught. In the ensuing years, the observations of cervical mucus were integrated into the teaching, and more recently (since 1981) cervical changes have also been taught. The updated constitution (1981 revision) states under article 2, "L'AFH teaches all the signs

of the fertile and infertile periods leaving the couple to choose their preference in self-observation methods or a combination based on their motivation or lifestyle." For l'AFH, this choice belongs essentially to the couple, not to the professional or the NFP teacher. Our principle is to teach and explain everything, enlighten the couple, and let the couple make their own choice.

Experience in Haiti shows that couples prefer the strict ST, meaning they prefer to wait for the stabilized high temperature phase.

#### **Personnel**

Currently l'AFH has 155 part-time NFP teachers and 40 zonal supervisors, of whom four work full time. There are also three national full-time workers.

Our salary scale is as follows:

<u>Position</u>	<u>US\$ per month</u>
national coordinator	\$200 (full-time)
national administrator and supervisor	\$150 (full-time)
zonal/regional coordinator	\$120 (full-time)
regional coordinator	\$60-\$80 (part-time)
zonal supervisors	\$20-40-60 (part-time)
teachers	\$10-\$20 (part-time)

There are no volunteer workers since the teachers receive \$10 per month for 50 hours of work.

In general, the teachers stay in their own

territory. The lack of financial resources is the primary limiting factor. Dozens of potential teachers have presented themselves but have had to be refused. The number of teachers remains stationary at about 150. With adequate funding we could easily increase the number of teachers by 50 per year at \$10 to \$20 per month. We agree, however, with the evaluator (1982-1983) that this level of remuneration is completely inadequate for the work contributed.

### Summary of the Last Three Years

Years	New			
	Registered Users	New Non-Registered	Unplanned Pregnancies	Dropouts
1980	1,576	N/A	123	167
1981	2,170	N/A	76	126
1982	1,871	667	87	86
Total	5,617		286	379

A new user is considered a registered user if the ST is followed for three complete cycles. After six completed charts, users are considered autonomous if they can interpret their own charts and graphs.

We are not using the Pearl formula for effectiveness any more, but from January 1978 until June 1979—over 13,908 months of exposure—resulted in 3.8 pregnancies per 100 woman-years.

The average cost to train a user until autonomy is US\$13.00. The number of clients seeking to become pregnant is very low, about 10 per year. The majority of the users have reached their family size and seek to limit their fertility. Most of our learning users can interpret their records and become autonomous after six complete charts.

### **Evaluation and Accountability**

Financing The national committee oversees all funding and seeks to divide equitably the available funds to satisfy all needs. The committee discusses how best to use the meager resources available. At the end of each year we compare the statistics of each region to assess the best training strategy: at the centralized (regional) or decentralized (local) levels. We evaluate strategies to increase the number of teachers or supervisors and to minimize the cost per user per region. The overall and final report is communicated to the vicar

general to whom the responsible bishop has delegated this function. The funds received from abroad are deposited in the accounts of the bishop of the diocese to be used for the quarterly needs of l'AFH.

Achievement of l'AFH's Goals The objectives to be reached by everyone are spelled out in detail in l'AFH's constitution. Up to now, to verify our objectives we have used a moderately developed yet efficient system of reporting as follows:

- a registration form, to separate the interested from the registered learners;
- a special registration form for breast-feeders and the unmarried;
- an activity log sheet for the teacher to enter the visits made to registered or non-registered users;
- an activity time sheet to identify the teacher's time given to information, teaching, and travel;
- a family registration form for each registered user;
- a dropout record, explaining the reasons for dropout;
- a meeting sheet summary indicating date, place, participants, and topics;
- a monthly activity record for each teacher/coordinator compiled by the zonal supervisor;
- a teachers' activity summary in which supervisors summarize their teachers' work.

In addition to these administrative reports, the zonal coordinators verify the work of each teacher in their area. The national coordinator visits all regions at least once a year. A major problem is that we cannot meet the demand for ST because of insufficient resources, so we have stopped doing any publicity. We do not evaluate our demographic impact because our work is too limited. What is of primary interest to us is the Haitian couple.

### **Accomplishments and Development Needs**

Our most important achievement is to have shown that the ST method can be understood and followed by poor and illiterate people with great success and perseverance. What we consider our greatest challenge is how to raise the

awareness of Haitian Christian leaders (bishops, priests, sisters, and committed laymen). Our greatest needs are (1) public and official recognition of l'AFH by the Episcopal Conference of Haiti before both the Government of Haiti and its Christian community and (2) adequate funding of

our work.

Our program would greatly benefit from applied clinical research on the preovulatory normal infertility in the ordinary menstrual cycle as well as in the special circumstances of postpartum, premenopausal, and postpill women.

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# Diocesan Development Program for NFP

**JAMES T. MCHUGH**

*Msgr. James T. McHugh, director, Diocesan Development Program for NFP (NCCB Pro-Life Committee), Washington, D.C.*

*The United States of America occupies more than 9 million square kilometers, mostly in North America. Forty-eight of its 50 states are contiguous, but the largest state, Alaska, is north and west of the others, and the fiftieth state, Hawaii, is far west of the mainland in the Pacific Ocean. The 1980 census counted 226.5 million inhabitants, and recent estimates put the current population at more than 234 million. A crude birth rate of 16 and a crude death rate of 9 result in a current annual rate of natural increase of 0.7 percent. At present demographic rates, the population would double in 95 years, and the projection for the year 2000 is for a population of 268 million.*

*The population density is about 25 persons per square kilometer; about three-quarters of Americans live in urban areas. About a quarter (23.9 percent) of the people are under the age of 15. The fastest growing segment of the population is the oldest age group; 15.2 percent are currently 60 and over, and that proportion is expected to increase steadily. Life expectancy stands at 74 years (69.3 years for*

*males and 77.5 for females). The infant mortality rate is about 11.4 per thousand.*

*The United States ethnic composition reflects a diverse cultural heritage. The population is predominantly of European origin, but nearly 26.5 million blacks were recorded in the 1980 census. About 14.6 million persons identified themselves as Hispanics. The official language is English. Christianity is the major religion (there are no official religions in the United States), and about 52 million Americans are Roman Catholics. There is a wide variety of Protestant denominations in the country.*

*Per capita gross national product in the United States was \$12,530 in 1981, and per capita income in 1978 was \$8,612.*

*There is no official policy on family planning in the United States. Services are freely available from government or private outlets. Abortion has been legal since 1973.*

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*The Diocesan Development Program for Natural Family Planning was estab-*

lished by the National Conference of Catholic Bishops (USA) in 1982 to help the dioceses of the United States initiate a comprehensive NFP program; coordinate the efforts of existing NFP provider groups; integrate NFP services into all diocesan-sponsored educational, health care, and social services; and expand present NFP programs.

The underlying philosophy of this program is that natural family planning is at the service of the family; that is, it is consistent with a Christian vision of marriage and family life and of human sexuality. Teaching couples to practice NFP successfully involves a commitment to specifically Christian values and is one aspect of the Church's overall pastoral concern for the family.

The national office assists the dioceses in implementing the Diocesan Development Plan for NFP in a variety of ways. Carrying out the program at the local level is the responsibility of the diocesan NFP coordinator and diocesan advisory committee, working with and through diocesan agencies and in collaboration with independent NFP provider groups.

During the past twenty years, impressive gains have been made in developing the various natural family planning techniques and validating their reliability. But as Pope John Paul II notes in his Apostolic Exhortation on the Family, there is need for "a broader, more decisive and more systematic effort to make the natural methods of regulating fertility known, respected and applied."

Accordingly, at the recommendation of Terence Cardinal Cooke, chairman of the Committee for Pro-Life Activities of the National Conference of Catholic Bishops (NCCB), the episcopal conference established the Diocesan Development Plan for Natural Family Planning, effective January 1, 1982, for a period of three years. The primary purpose of the Diocesan Development Plan is to assist the dioceses of the United States in initiating, coordinating, and expanding programs of natural family planning. This project has been funded by the Knights of Columbus, who have provided a grant of \$150,000 per year for each

of the three years.

There are more than 1,000 identifiable NFP programs throughout the United States, many of which are small, isolated, and without sufficient resources. Most of these programs have at least some loose affiliation with the Couple-to-Couple League, WOOMB-USA (now Family of the Americas Foundation), St. John's Human Life Center in Collegeville, Minnesota, or the Creighton University Natural Family Planning Center. Although the work of each of these national groups is helpful, the bishops realized that continued development of natural family planning must take place at the diocesan level. By "development" is meant a determined effort to establish a systematic program involving all the appropriate resources of the dioceses so as to render knowledge of NFP "accessible to all married people and also to young adults before marriage through clear, timely and serious instructions and education given by married couples, doctors and experts" in the words of *Familiaris Consortio*. This effort must be set in the context of the Church's overall teaching on conjugal love and responsible parenthood, which sees NFP as a fundamental approach to human sexuality that places conjugal intimacy in the larger context of marital rights and responsibilities. For the most part, the NFP program is part of the diocesan family life program in each diocese, although in some dioceses it is the responsibility of Catholic Social Services or some other agency.

Extremely important to this development effort is the involvement of priests and religious sisters, many of whom are active participants in the existing programs. Further involvement of parish priests is highly desirable, and the contribution of many nurses, either in hospital-based programs or as part of a husband-wife team, has been a major asset.

Development also involves active participation on the part of Catholic hospitals, social service agencies, and educational institutions. Catholic colleges and universities, particularly those associated with nursing schools, can provide facilities and ongoing programs for the training, supervi-

sion, and accreditation of NFP teachers. Catholic social service agencies are important because very often they have a network of service sites throughout the diocese, and their social workers are in contact with couples seeking assistance in making responsible decisions regarding parenthood.

### **Objectives of the Diocesan Development Program**

The Diocesan Plan for Natural Family Planning Development<sup>1</sup> is directed toward helping each diocese initiate a comprehensive NFP program; coordinate the efforts of existing NFP provider groups; integrate NFP services into all diocesan-sponsored educational, health care, and social services; and expand present NFP programs. A broad-based, multidisciplinary diocesan NFP advisory committee assesses needs and resources, sets goals and priorities, and serves as the advocacy group in promoting the full diocesan NFP program. In addition, a diocesan coordinator of NFP programs is responsible for day-to-day implementation of the program.

The advisory committee and diocesan NFP coordinator are responsible for promoting NFP at all levels of diocesan activity and for developing and implementing a coherent and consistent diocesan NFP program based on diocesan needs, resources, and priorities.

In implementing the diocesan program, the advisory committee and coordinator give primary attention to the following activities:

1. expanding the number of NFP instructional sites in diocesan service agencies and at various central areas throughout the diocese
2. conducting professional updating and training for health care personnel, priests, religious sisters, existing teachers, and key diocesan administrators
3. establishing quality control systems for all NFP instructional services
4. forming a diocesan committee of existing NFP provider groups
5. sponsoring NFP instructor training programs within the diocese.

### **The Role of the National Office**

Unquestionably, the major effort goes on at the diocesan level under the leadership of the diocesan NFP coordinator (appointed by the bishop) and the diocesan NFP advisory committee. Guidance for implementation of the diocesan program is found in the Diocesan Plan for Natural Family Planning Development, authorized by the NCCB Committee for Pro-Life Activities and published by the national office of the Diocesan Development Program located in Washington, D.C. In general terms the responsibilities of the national office include efforts to provide consultation and advice through visits to the dioceses and by phone; provide ongoing communication regarding NFP resources and the activity in dioceses; enlist the support of national and international agencies in fulfilling the goals of the program; develop educational and service models for use by the dioceses and other church agencies and organizations; sponsor or conduct national or regional meetings of the diocesan coordinators or agencies related to them; and sponsor specific research or program development seminars in areas related to implementation of the diocesan program.

The project established by the National Conference of Catholic Bishops is under the direction of the NCCB Committee for Pro-Life Activities. The late Terence Cardinal Cooke of New York was chairman of the committee, which includes 11 other bishops from the designated regions of the country. The national office is staffed by a director, an associate director, and a secretary. Administrative resources of the episcopal conference (United States Catholic Conference) are available to the Diocesan Development Program. A national advisory committee, composed of diocesan directors, is currently being organized.

### **Philosophy of the Diocesan Development Program**

From the foregoing description of the history and structure of the Diocesan Development Program, it is clear that the program is very much an ecclesial entity. It was established by the bishops, is subject

to the bishops, uses the resources of the episcopal conference and dioceses, and is one part of the Church's overall apostolate to the Christian family. There are other private, nonconfessional agencies, as well as governmental and international agencies involved in natural family planning programs, but this specific program is based on the statement of Pope John Paul II in *Familiaris Consortio* that "the ecclesial community at the present time must take on the task of instilling conviction and offering practical help to those who wish to live out their parenthood in a truly responsible way." Pope John Paul states quite clearly that instructing couples in NFP is a responsibility of the "ecclesial community," that is, the Church.

Accordingly, natural family planning is seen as a service to the family that is consistent with a Christian vision of marriage, family life, and human sexuality. Training couples to practice natural family planning successfully also involves a commitment to the following specifically Christian values: the value of conjugal love as a lifelong, faithful interpersonal commitment; the mutual effort of the spouses to decide responsibly on the timing and limiting of births in light of duties to God, to themselves, to the family they already have, and to the society of which they are a part; the realization that in their childbearing and childrearing the couple participates with God in the ongoing work of creation and redemption; the value of the child as a person called into existence by God and redeemed by Jesus Christ; and the normative character of the Church's teaching regarding the moral unacceptability of artificial methods of contraception as well as sterilization and abortion.

In light of these theological understandings, the Diocesan Development Program is in fact a pastoral effort to assist couples in understanding that sexuality, in the words of *Familiaris Consortio* "is by no means something purely biological, but concerns the innermost being of the human person as such. It is realized in a truly human way only if it is an integral part of the love by which a man and a woman commit themselves totally to one another until death."

Furthermore, the choice of natural family planning is not simply the choice of a reliable, aesthetically satisfactory method of birth control, but the affirmation of mutual love and the acceptance of "dialogue, reciprocal respect, shared responsibility and self-control."

This philosophy was carefully and briefly summarized by Cardinal Cooke two months before his death in his address to the national meeting of diocesan NFP coordinators held in Washington, D.C., July 17-21, 1983:

The family is first of all a community of persons who are called by God to live together in love and mutual respect, and to share their love with one another and with the larger society of which the family is a part. Fundamental to family life is the commitment of the spouses to a lifelong, faithful, exclusive union in which they share with God in the ongoing work of creation. Because of the responsibilities and the risks of childbearing, a negative attitude has developed toward parenthood and often toward the child. God has called them to cooperate with Him in a special way in the work of creation. Others who are unmarried do not share this God-given prerogative, nor do they have the right to take it on themselves. And the child, who stands as a testimony of God's creative love, is also a lasting testimony of the love and mutual commitment of its parents. In your educational efforts you must emphasize this, and not become distracted by the problems of the moment nor preoccupied with the reliability of natural family planning simply as a means to avoid childbearing. Your pedagogy must include a balanced emphasis on conjugal love *and* responsible parenthood, always remembering that parenthood is a privilege and a gift.

#### **Activities**

As indicated above, implementation of the Diocesan Development Program calls for the designation of a diocesan coordinator for NFP and a diocesan advisory

committee that will serve as a leadership group. It also involves systematic development of programs to train teachers and the designation of sites where couples can be instructed and assisted in mastering the techniques.

During the first 18 months of activity, 151 dioceses have appointed a diocesan coordinator, and efforts at implementation have resulted in a series of diocesan consultations and regional and state meetings of coordinators involving 60 dioceses. These meetings indicate that diocesan advisory committees are at various stages of formation, although in some cases the role of the advisory committee is performed by the advisory board of the sponsoring agency. The national office of the Diocesan Development Program has sought to assist the dioceses and provide a national service through various projects or activities.

Consultation has been the primary effort of the national office and staff during this first 18 months in order to stimulate diocesan leadership activity and to help individual dioceses evaluate their efforts and assess their needs. At the outset a survey questionnaire was sent to each diocese to enable the national office to construct a diocesan profile and to pinpoint the most pressing needs. The consultation service is progressive; that is, it is directed first to establishing or expanding diocesan NFP leadership and second to developing those specific services or programs necessary for the growth of a diocesan NFP program. Consequently, although the majority of dioceses have concentrated on establishing leadership and a systematic program, in a small number of dioceses the initial contact has already resulted in the establishment of a teacher training program. Similar efforts are anticipated in many other dioceses by 1984.

Discussions with diocesan coordinators indicated that some Catholic hospitals provided NFP services, but it was difficult to assess the quality and potential of these hospital-based programs. Accordingly, in conjunction with the Catholic Health Association, a survey of natural family planning programs in Catholic hospitals was undertaken.<sup>2</sup> Of the 633 Catholic

hospitals in the United States, 503 responded to the survey. Of these, slightly more than one-third (177) reported that they presently have some type of NFP program. With regard to future development, 56 hospitals with a program and 54 without one showed strong interest in initiating or expanding a program, indicating an opportunity for immediate follow-up. An additional 182 hospitals (66 with and 116 without present efforts) also expressed some interest in expanding or initiating NFP services.

The hospital-based NFP service programs tend to be a cooperative effort on the part of hospital staff and trained NFP couples, and the hospitals expressed interest in recruiting additional teaching couples and establishing criteria to ensure competent teaching and backup services. There are presently some very good training programs, and the Diocesan Development Program has the resources and is ready to assist dioceses in establishing competent training programs.

Most of the hospital programs are small, teaching fewer than 200 couples per year. The majority of clients are seen three or four times, but a substantial number of programs, including the larger ones, see couples six or more times. New clients come from word-of-mouth recommendation by couples using NFP, from pre-Cana conferences, physician referral, and referral from other agencies. The hospitals look forward to closer cooperation with the diocesan NFP coordinator in this area of recruiting.

The survey indicates room for closer cooperation from physicians and clergy and religious sisters. A significant number of hospitals expressed interest in conducting information and education programs for physicians, staff, and chaplains, an activity that could be expanded to include the parish clergy.

On the strength of the information derived from this survey, guidelines for the initiation of a hospital-based NFP program are being developed, and specific consultation to meet the needs of hospitals will be provided. Again, it must be kept in mind that assistance to Catholic hospitals is coor-

minated with the diocesan programs so that each hospital is an integral part of the diocesan effort.

As a consequence of the initial consultation, a number of other issues have come to the fore. The dioceses articulated the need for some program to awaken the interest and enthusiasm of priests and doctors. Neither group is looked upon as a primary teaching resource, but both groups can do a great deal in informing and motivating young couples.

Education of priests and seminarians is seen as a high priority in the Church's commitment to NFP. Priests need to be informed of the scientific reliability of NFP and of the benefits that couples derive from a commitment to NFP. Priests also need to be encouraged to serve as spiritual counselors and motivators for couples. To do this effectively, priests need to see NFP within the total context of Christian family life, and they must appreciate their own unique role in giving couples an enriched understanding of Christian marriage and responsible parenthood.

To reach this audience, a series of meetings was held with theologians interested in and supportive of NFP. This provided both information and bibliographical material. A second step involved circulating outlines to theologians, physicians, and teaching couples and asking for their specific comments and suggestions. Finally, after surveying the literature and heeding the recommendations, the national office published a small book entitled *A Theological Perspective on Natural Family Planning*. The book contains four essays on the theology of marriage, conjugal love, responsible parenthood, and conjugal morality and NFP. Each essay is followed by an outline, a compilation of statements from the Second Vatican Council, and the encyclicals or addresses of recent popes. The book also contains an annotated bibliography. It is directed to priests and teaching couples to assist them in their overall educational and pastoral work with engaged and unmarried couples.

It is generally recognized that a positive attitude toward natural family planning is based on a mature and balanced under-

standing of human sexuality and the process of human reproduction. In effect, this requires an understanding of the fertility cycle in women and the mutual responsibilities of the spouses in practicing periodic abstinence. This basic understanding of human reproduction and of the fertility cycle has come to be known as *fertility awareness*, and among those in the NFP movement, it is generally accepted that instruction in fertility awareness should begin in the adolescent years.<sup>3</sup> Accordingly, many of the diocesan personnel are involved in secondary school instructional programs, and a number of dioceses have established pilot programs for secondary schools. Experience to date indicates that fertility awareness is best taught in the context of education in marriage and family living. The Diocesan Development Program will continue to monitor these pilot projects and provide information to the dioceses.

A national meeting of diocesan NFP coordinators was held at the Catholic University of America, Washington, D.C., July 17-21, 1983. There were 120 participants from 70 dioceses. The Center for Family Studies at Catholic University cosponsored the meeting which focused on (1) the relationship of family commitments and values to NFP; (2) the philosophical and theological assumptions regarding Christian marriage and sexuality that are fundamental to conjugal morality and NFP; and (3) diocesan natural family planning program strategies and instructional techniques. The major focus on family life and marriage as a sacrament served to emphasize the pastoral dimension of the diocesan program. The conference program provided a forum for the interchange of information and experience among diocesan personnel; it also offered substantive presentations on the major themes. The reliability of the various NFP methods was considered to be important, but conference participants also recognized the need for more information about the marriage relationship and the appropriate means of motivating couples to practice NFP successfully.

### Accomplishments and Needs

Experience has shown that a great deal more must be done to communicate the reliability of NFP and the latest educational techniques to physicians and other health care professionals. Many of them still equate NFP with simple calendar rhythm, and many also fail to perceive the difference, both moral and anthropological, between contraception and natural family planning. *Linacre*, the journal of the National Federation of Catholic Physicians' Guilds, is committed to publishing competent articles on NFP, as is *Hospital Progress*, the journal of the Catholic Health Association.

More regular and more structured communication between the national office and the dioceses is called for and is expected to be accomplished by the regular publication of a newsletter. A national advisory committee is being formed to assess the program needs of the dioceses and to assist the national office in establishing priorities and meeting the more general needs.

Some efforts need to be taken to communicate progress in NFP program development to governmental agencies and to assure that access to natural family planning be available to couples. This has been a difficult problem in the United States, where attitudes in the family planning sector toward NFP have been based on a lack of information and/or skepticism. The sector has a history of strong reliance on technological innovations to assure efficiency and effectiveness at the program level. Consequently, the needs and aspirations of married couples with regard to NFP have often been overlooked or disregarded. The government has provided funding in the past for the development of instructional materials, but new ways need to be found for governmental agencies to assist NFP agencies in program development and the delivery of services. This will not be easily achieved, nor does it relieve the Church of its basic pastoral responsibility.

Regional NFP organizations have begun to emerge, independent of Church structures and agencies. For some, these regional organizations are seen as vehicles

for dealing with government; for others, it is anticipated that they will serve the need of regional communication and collaboration. It is too early to assess the impact of these groups or to predict their future activity.

The first 18 months of activity has been encouraging and holds promise for further implementation of the Diocesan Development Program. Many dioceses have evidenced a readiness to expand their present efforts, and there is a clear sense of identity developing among the diocesan leaders. The positive response of the dioceses has tended to validate the basic premise of the Diocesan Development Program, that is, that future NFP development must be a strong diocesan priority, and it must be seen as one part of the Church's pastoral mission to married couples and families. The work of other national and regional NFP agencies and organizations is supportive and helpful, and these groups are expected to have an active and cooperative role in future development efforts. The basic challenges remain to communicate the reliability and personal advantages of NFP to increasing numbers of couples; to create a public atmosphere favorable to the practice of NFP; to give greater credibility to Catholic teaching on Christian marriage, conjugal love, responsible parenthood, and conjugal morality; and to strengthen the Church's pastoral care for married couples and families by integrating NFP instruction into existing marriage and family life programs.

### Notes

1. See *Diocesan Plan for Natural Family Planning Development* (Diocesan Development Program for NFP, 1511 K Street, N.W., Washington, D.C., 20005), 1981. This basic manual explains in detail each of the facets of the Diocesan Plan and provides references to other materials useful for implementing a diocesan program.

2. For more information see Mary Martin and W. Walker, "Survey Discloses NFP Practices, Preferences in U.S. Catholic Hospitals," *Hospital Progress*, February, 1983; and J. McHugh, "NFP Services in Catholic Hospitals," *Linacre*, August, 1983.

3. For some in the family planning field, the term "fertility awareness" means understanding the fertil-

ity cycle so as to limit the use of other contraceptives to the fertile phase. In natural family planning, the term includes a commitment to periodic abstinence

during the fertile phase on the part of both husband and wife and making appropriate efforts to integrate such abstinence into the conjugal relationship.

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# Argentina

Until 1975 the expansion of the natural methods of family planning in Argentina was limited to some small groups without funds. Having developed from a strong religious motivation, these groups in many cases lacked adequate technical experience.

In 1964 the Centro de Asesoramiento Matrimonial (CAM or Marriage Counseling Center) was founded under the sponsorship of the Acción Católica de Profesionales (Catholic Professionals' Movement) but independent of it. Between 1975 and 1979 CAM received institutional support from the Fundación para la Educación, la Ciencia, y la Cultura (Foundation for Education, Science, and Cultural Affairs), and since 1980 it has functioned as a center affiliated to Fundación Acción Familiar (FUNDAFA or Family Life Foundation).

Between 1976 and 1981 CAM received two important subsidies from Misereor (Germany) in the sum of approximately US\$50,000 with a local matching contribution of US\$100,000. This opportune grant facilitated the installation of its first services on marriage counseling in Catholic parishes by well-prepared, paid instructors. This grant enabled delegates from Argentina to participate in the First World Congress for the Family of the Americas and provided funds to publish an account of the first three years of the application of the Billings method in Argentina.

Since 1980 CAM has instituted the Filial Argentina WOOMB (WOOMB-Argentina Affiliate) and begun its program of courses for the training of administrators and instructors on the natural methods of family planning throughout the country. Strong emphasis is placed on the ovulation

method, but other indicators are taught when it is deemed necessary.

In April 1982 the permanent secretary for the family of the Episcopal Conference of Argentina created the so-called Area de Planificación Familiar Natural (Natural Family Planning Office) which, within a year, took the name Area de Servicio a la Vida (Service for Life Office). It offers promotional activities to the 58 dioceses in the country.

Each program has a form of organization appropriate to its own distinct requirements. Some bishops have undertaken the coordination of activities within their own organizational structure; others have entrusted them to lay and family apostolate organizations. In many other locations, institutions similar to CAM have been established in the capital and in the state of Buenos Aires. They include Centro de Orientación Familiar (Family Orientation Center), Centro de Orientación Cristiana Matrimonial (Christian Marriage Orientation Center), and Centro de Asesoramiento Familiar (CAF or Family Life Counseling Center) of San Justo.

As of 1983, 40 courses training approximately 1,000 teachers have been conducted. They work within institutional settings in private facilities or both, and at present provide monthly services of approximately 800 initial consultations nationwide. The instructors, who are persons of homogeneous technical, ethical, and religious backgrounds, have formed a rather unique association called Club de Instructoras Amigas de Lyn Billings (Friends of Lyn Billings' Instructors Club). Its current president is Mrs. Marta Peyret de Zubizarreta. Owing to the relatively high sociocultural level of the urban areas, most of the instructors are high school graduates.

# Canada

In 1955 Gilles and Rita Breault began helping couples in the family planning field. After being joined by several other couples, the Montreal team in 1962 took the name Serena, SÉervice de RÉgulation des NAissances (Service for Birth Regulation:). By 1967 the group had about 30 teams in the province of Quebec. In 1972 expansion to the rest of the country (nine provinces) began, and in 1983 Serena had 500 teacher couples.

The Serena program is based on couple-to-couple meetings in teacher couples' homes. Information is also given to small groups in various locations: parish halls, schools, hospitals, health or social service centers. Services are also available in rural and urban locations. Typical clients are young couples in the first 10 years of marriage, or preparing for marriage. They are lower middle-class, both French- and English-speaking, and Catholic. They reflect the majority of the population. Serena has little access to ethnic minorities, although work with them has begun. Teacher couples are recruited from satisfied clients and have the same characteristics.

Serena's objectives are to: (1) provide information on family planning, (2) teach the sympto-thermal method, and (3) support the couple practicing loving periodic continence as a family planning method. The objectives have not changed since the organization was founded; they have become more defined. Serena teaches the sympto-thermal method in French and English. Other family life development or health services are not offered since there are many other associations and agencies which do so.

Serena Canada has received an annual support grant from the federal government since 1972. Two provincial programs receive funding from their provincial governments. The board of directors of Serena Canada is made up of at least one

couple representing each province. The voting power of this couple is weighted according to the number of teacher couples it represents. The headquarters of Serena Canada is in Ottawa; Quebec, Ontario, Saskatchewan, and Manitoba have offices and paid staff. There are more than 100 delivery centers across the country. There is no formal affiliation of Serena NFP programs with medical delivery systems. However, approximately 10 hospitals have developed NFP centers using Serena teachers or former teachers as their staff.

The initial teacher training consists of 12 to 15 sessions of approximately two hours each. The sessions cover the basics of NFP, special circumstances, how to chart, periodic abstinence, counseling and teaching skills, and the moral aspects of family planning.

Training is done at the local level, but certification and accreditation is the prerogative of the national level after the successful passing of exams and the recommendation of the local team's leaders. The training is usually by lecture, but supplemented by role playing and supervision of the first teaching sessions. Serena specializes in the sympto-thermal method. A good knowledge of the other natural methods is also given. The training is usually spread over a period of six months. The cost is minimal—about \$30 a couple.

Trainees are selected from married couples who are themselves using periodic abstinence as a means of family planning. A few other criteria must also be met. There are approximately 500 teacher couples affiliated with the program. All are volunteers. The dropout rate during the training period is 30 percent. After accreditation the average involvement is four years. Continuing education is assured by team meetings, provincial training sessions, and publication of newsletters and documents. There is no formal evaluation of the teacher's performance.

Serena gives information to approximately 10,000 new couples a year. However, it is not possible to say that all these couples are acceptors as the follow-up is done only at the initiative of the new user. The only criterion for accepting new users

is that both members of the couple attend the class. There are a few exceptions, but in general instruction is given to both partners. Serena teaches mainly the ST method. One of the provincial groups teaches OM and ST to all new users, and offers a third night for follow-up as part of the package.

Serena teacher couples are volunteers; they operate from their own homes so very little expense is involved. If expenses at the provincial and national level are taken into consideration, we may estimate the cost for a new user couple at \$10 each.

Our acceptors are mostly spacers. Couples planning a pregnancy represent approximately five percent of our clientele.

Under normal circumstances couples do not require follow-up for more than three months. Few couples require this follow-up. We cannot say if the reason is that they can manage, or that they have dropped out, nor can we evaluate the continuation rate and the pregnancy rates.

A few couples become teacher couples, but there are enough of them to renew the local groups (five or six couples at a time). We do not actively nor systematically recruit teachers unless members are about to leave.

The program must account for its funds to the members and to the grantors (federal and provincial governments). Objectives are set by the groups for each level, and at each level. From time to time these objectives are brought to the national level and put into a national perspective. Five-year plans are prepared in consultation with every level. Goals and philosophy are set at the national level by representatives of the provincial corporations. There is a constant mechanism of feedback between the national office and the teacher couples.

The evaluation of teaching effectiveness is done in some groups by having the teacher trainer attend the first sessions given by a new trainee. There are some questionnaires prepared to evaluate the

teacher training program in the province of Quebec.

Many research projects have been submitted to funding agencies to evaluate pregnancy and dropout statistics, as well as use-effectiveness of learning and continuing users, but none have been granted. Our program cannot afford to prepare statistics unless funding is provided. In 1982 we participated in a survey prepared by Montreal University which showed that 16 percent of Quebec women using a temporary method of family planning were using a method of natural family planning. However, only one-third of the total population were using a temporary method at the time. This survey was considered representative of the population of Quebec.

Probably our greatest accomplishment is having succeeded in building a very well articulated organization where powers and responsibilities are shared at all levels. Members are committed, active, and responsible. The group is growing steadily in enthusiasm. We have also succeeded in getting substantial public funding with no strings attached.

The greatest challenge is to find nongovernmental funding to replace or supplement what we already have. We would also like to be able to answer, through research, all the questions posed previously in terms of prevalence, acceptors, success rate, continuation rates.

The greatest needs are an executive director and a secretariat for the 10 provincial groups, more material resources and better public relations. We hope public institutions like hospitals, health units, social services, schools, will sponsor their own programs. Research that will benefit our program the most will be in the area of special cases: breast-feeding, premenopause, postpill, adolescence. For the time being, however, the expansion of the program is not impaired by the lack of research.

# Mexico

Natural family planning in Mexico began with the teaching of the ovulation method (OM) in 1970. Development has taken place by degrees, first through information sessions, then through teaching programs and instructor training. Coordination and implementation of these programs at the national level followed together with control and evaluation. There are 280 part-time volunteer instructors certified by the National Billings Center. They work in 116 centers at diocesan and parish levels.

In 1970, after the visit of Drs. John and Evelyn Billings, NFP began to spread in Mexico through promotion of the ovulation method (OM). In 1972 information on the method was spread by persons of different educational, cultural, and occupational levels through various localities in the Mexican Republic. In 1976, under the aegis of Archbishop Antonio López Aviña of Durango Diocese, Father Jesús M. Pérez organized a program for the instruction of teachers of the Billings Method.

In the same year, in Mexico City, the director of the Mexican Center of Gynecology and Obstetrics, a private health, research, and teaching institution, commissioned the laboratory director of the institution, Mrs. María Aurora Guzmán V., to prepare a program to teach the Billings method through four-week courses to patients who showed intolerance to contraceptives or who desired to regulate births by a natural method.

In 1979, the first national ovulation method meeting was convened in Mexico City, which agreed to fund a center for coordination and evaluation of information, teaching, and training in the orthodoxy of the ovulation method in accordance with the lines of the Church's social teachings. The National Billings Center for Family Planning was founded on May 31, 1979. It was staffed by 45 persons, some of whom were professionals in the medical field. The majority came from different educa-

tional and cultural backgrounds. The Center was supported by a bishop and seven priests representing the Church hierarchy.

The laymen and priests who founded the National Billings Center (NBC) have been committed to the teaching of the OM for a number of years. They were responding to calls by the Latin American Episcopal Conference to work in the area of family pastoral care. The bishops, Catholic groups, and parishes were informed of the services that could be provided by the NBC. In order to legalize the newly founded organization with the civil authorities of the country, notarized statutes were registered with the corresponding ministries on June 6, 1980, in the name of the National Billings Center for Natural Family Planning, a nonprofit civil association with educational objectives.

The initial activity of the board of directors of the NBC was to present to the Mexican Bishops Conference a statement of objectives and plan for services. An offer was made to train personnel to establish diocesan and parish centers in each of Mexico's dioceses. The Mexican Bishops Conference gave its recognition on October 5, 1980, through the Episcopal Commission for the Lay Apostolate, signed by its president, His Excellency Bishop Adolfo Suárez. His Excellency Antonio López Aviña, Archbishop of Durango, and members of the Episcopal Commission for the Family were appointed representatives to the NBC. A request was made for incorporation as a member of the World Organization of the Ovulation Method Billings (WOOMB) International. The request was accepted on November 3, 1980, as WOOMB of Mexico.

The structural organization of the NBC is being developed and implemented through departments for coordination of teaching, research, regional centers, program planning, and evaluation.

The coordination of the teaching department selects the learning programs for adults, youth, instructors, and universities. The research department reviews and selects bibliographic material to enrich programs in the moral, scientific, and

teaching areas. The department for regional centers implants and evaluates regional programs undertaken by the Archdiocese of Mexico, the pastoral zones of the Northeast, West, Center, Southeast, Northwest, and South of the Mexican Republic, with their respective responsible persons. The department for program evaluation will begin its functions in 1984 by evaluating promotion, information, training, and the actual implementation of programs.

The cost of teaching each couple in urban areas is US\$20.00 and in rural and suburban areas US\$0.80.

During the period 1980-1983, an evalua-

tion of users was undertaken in Mexico City. Out of a total of 1,320 couples from different educational and socioeconomic levels, more than 90 percent had either avoided pregnancy of spaced births over this three-year period. Of the couples who had learned to use OM in order to become pregnant, 92 percent continued to use OM to date.

After two months of application, 94 percent of the users had become autonomous. Some 16 percent had become trained instructors and opened new centers. Some 78 percent had become promoters of the method through the educational support given them and through their own initiative.

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## Peru

The Centro de Promoción Familiar y Regulación Natural de la Natalidad, (Ceprofarena, Center of Family Promotion and Natural Family Planning) is a nonprofit organization legally recognized under Peruvian laws as a service institution. It is affiliated with WOOMB International and has as its objective the promotion of the spiritual, moral, and material values of the married couple. It also helps couples resolve their fertility problems through natural family planning, especially the Billings ovulation method.

Training in the Billings ovulation method began in Peru in 1974 in Trujillo, a city in the north. It began in a *pueblo joven* (a marginal zone of the city with poor economic resources) called Nueva Esperanza. At the beginning of 1977 dissemination of the method began in Lima in a *pueblo joven* called Ciudad de Dios. Since then various steps have been taken to extend the method. This has been done through conferences, introductory courses, and the media; the teaching and follow-up of couples in permanent consultation centers; the training of competent

teachers; and the preparation of teaching materials.

Forty-five courses on the ovulation method have been given. Both husband and wife attend. Course content includes the biology of reproduction and how to use the OM; communication between the couple and psychological aspects of the method; communication between parents and children; information on artificial contraception; and the witness of couples using OM. More than 5,000 have attended these courses. We have also held four courses especially for instructors; special courses for health workers such as nurses and obstetricians; and outreach meetings in school associations, mothers' centers, nursing schools, parishes, and other appropriate institutions. Training courses have been held in the provinces of Chimbote, Ayachucho, Chíncha, Ica, Puno, Tacna, Arequipa, Aucayacu, Huacho, Cerro Azul, and Nazca.

Teacher training courses include more scientific information on the method, teaching methodology, difficult cases, and the philosophical and moral principles of *Humanæ Vitæ*. The instructors meet periodically to exchange work experience and coordinate future action.

A permanent consultation center was established in Ciudad de Dios more than five years ago. In addition to outreach, presentations to the couple on individual,

couple, and family development, and instruction in the ovulation method, medical consultation is provided. Complete clinical cards are kept on every woman with special attention to gynecological care. The woman's charts are also kept. The office is open once a week on Saturdays from 4 to 6 p.m. The principles of the method are explained every week to assistant instructors, since experience has shown that frequent repetition is necessary to clear up all doubts.

We have the following statistics from this center after five years:

	<u>Number</u>	<u>Percentage</u>
Numbers of couples taught	582	100
Lost to follow-up	62	11
Discontinued OM	53	9
Continuing users	467	80

From the 467 continuing users:

Couples who did not have children	434	93
Couples who planned and achieved pregnancy	5	1
Unplanned pregnancies	28	6

Most of the pregnancies resulted from couples' taking a chance on a day of low fertility.

Results in the *pueblo joven* of Nueva Esperanza after seven years are as follows;

	<u>Number</u>	<u>Percentage</u>
Couples using the method	540	100
Total number of pregnancies	50	9
Couples who did not have children	480	89
No information available	10	2

It is planned to establish permanent consultation centers in different parts of Lima and the country to decentralize the services. Our objective is also to install a network of offices in parishes with instructors trained in the ovulation method and with proper medical facilities. The Ministry of Health has offered to provide the medical equipment. Funds to pay the personnel are now being solicited.

The Catholic Church supports and collaborates in the dissemination of the method through its various facilities.

# Asia/Oceania



A group session during a national NFP seminar in Korea



Asia/Oceania perhaps more than any other region shows how, after an initial implantation phase, various programs are tackling the challenge of program development and evaluation.

The various Australian programs have developed clear central standards in both the selection and training of teachers as well as basic criteria for operating quality services.

The majority of NFP programs in India have been initiated by the Catholic Church with extensive outside funding from a private Catholic funding agency, Misereor of Germany. They illustrate some of the basic characteristics of successful programs serving a large proportion of users of non-Christian background.

The Korean program is a dynamic Catholic Church program integrated into parish and family life services. It is also effectively supported by the professionals from the national Catholic medical school.

In most places the input of public funds remains minimal, if not insignificant. Whereas the programs of New Zealand and Australia with support from their respective governments have grown into quality NFP services catering to an increasing proportion of the general population, other countries, such as Korea and India, still depend primarily on church and religious initiatives.

Many of the national NFP programs have developed national guidelines for the training of NFP teachers and the development of NFP services. The development has been gradual, but there remains much room for improvement.

# Australian Council of Natural Family Planning

JOHN P. GALLAGHER

*John P. Gallagher, M.D., general practitioner; president of the Australian Council of NFP*

*Australia, the island continent, lies in the southwestern Pacific region with the Indian Ocean on its western and southern borders and the Pacific Ocean to its east. With about 7.7 million square kilometers, Australia is about the size of the 48 contiguous states of the United States. About two-fifths of the country lies in the tropical zone north of the Tropic of Capricorn; the rest is in the temperate zone. Most of Australia's 15 million inhabitants live in cities on the coasts, whereas the vast arid interior is nearly unpopulated. This is reflected in the figures for urban population—86 percent—and population density—a low two persons per square kilometer.*

*The vital rates are a crude birth rate of 15.4 per thousand and a crude death rate of 7.4 per thousand, balancing out to a rate of natural increase of 0.8 percent per year. At this rate, the population doubling time is 82 years and the projection to the year 2000 is for 18.1 million persons.*

*The life expectancy of Australians is 73 years, with females' expectation more than six years greater than that of males (76.9 years for females versus 70.5 for males). The infant mortality rate is 11 per thousand. About a quarter of the population is under the age of 15, and about 13 percent of the people are 60 years old or over.*

*Most Australians are of European origin. About 95 percent are of British descent, and 3 percent are of other European heritage. The Australian aborigines make up about .5 percent of the population. The official language is English. Christianity is the major religion in the country; 27.7 percent are Anglican, 25 percent are Roman Catholic, and 25 percent are*

*of other Protestant denominations. The per capita gross national product in 1981 was \$11,190.*

*There is no official government policy on family planning, and services are freely available from government centers and private clinics. It is estimated that 72 percent of women aged 15 to 49 who were in marital or consensual unions in 1980 were using contraception.*

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*The Australian Council of Natural Family Planning, Inc. (ACNFP) was formed in 1975 to coordinate the activities of the 75 Australian NFP centers and the training of teachers. The objects of the Council are to promote Christian marriage and family life and the proper teaching of natural family planning.*

*The NFP services are conducted by volunteers with support from medical and professional consultants. Funds are derived mainly from the government and diocesan sources but are insufficient to maintain and expand the work of the centers.*

*To standardize teacher training and services, the ACNFP has produced a set of guidelines for the selection, training, and accreditation of teachers, compiled a comprehensive teacher training manual, and drawn up a code of ethics for teachers. Members of the Council taught 6,500 new clients in 1982-83 and provided NFP information to another 32,000 individuals*

(by way of schools, lectures, seminars, and so forth).

*The Australian NFP centers are financially accountable to the Australian Catholic Social Welfare Commission, a body responsible to the Australian hierarchy, which disburses the monies received from the Australian government. These grants are given only to centers approved by the bishop of the diocese. The bishops and the Commission can thus control the philosophy, goals, standards, and expansion of diocesan NFP organizations.*

*The Australian Council is at present faced with the problem of maintaining a continuing stream of new teachers and the need to obtain more funds for a paid secretariat.*

### **NFP National Program Development**

Our national NFP program development could be said to have started in the late 1950s with the inclusion of NFP teaching in marriage guidance clinics in Melbourne, Brisbane, and Sydney. Drs. D. Dooley, J. Simpson, J. Billings, R. Galbally, and L. McMahon were the pioneers in this field. By the end of 1970, two years after the promulgation of *Humanae Vitae*, each of the eight archdioceses in Australia had an NFP organization, most as part of their Catholic Family Welfare Service. By 1974 most rural dioceses had an NFP service, thus covering most of the provincial cities of Australia.

As early as 1973 there were moves to set up a national body to serve as a forum and to coordinate the activities of the Australian NFP centers and the training of teachers. The Australian Council of Natural Family Planning was formed in July 1975 and incorporated in 1977. Most of the members affiliated with the Victorian Council of Natural Family Planning eventually resigned from the newly formed Australian Council in mid-1976 to attach themselves to the World Organization of the Ovulation Method-Billings (WOOMB) with headquarters in Melbourne, thereby halving the original membership of the Australian Council. Nevertheless, the Australian Council has flourished and has attained a high status as a voluntary helping

agency in the eyes of the community, the Church hierarchy, and the federal and state governments of Australia.

The objectives of the Australian Council of Natural Family Planning are, in brief, to promote and foster the ideals of Christian marriage and family life; to promote and foster an understanding of human sexuality and the love relationship in marriage; to establish NFP centers throughout Australia which are staffed by competent teachers and backed by good client referral systems should further help be required; and to encourage scientific research into and the evaluation of NFP methods and services.

The services conducted by members of the Council are the following:

1. Individualized NFP instruction and supervision service to couples (Those receiving NFP services in Australia belong mainly to the middle- and upper middle-class strata of Australian society. Non-Catholic clientele now make up almost 40 percent of the total, a different picture from that eight years ago when less than 15 percent were not Catholics. Clientele of first-generation Italian, Maltese, Spanish, and Lebanese migrant parentage are well represented. Services have not yet reached the Vietnamese or Aboriginal sections of society because of lack of resources and language and cultural difficulties.)

2. NFP information lectures to small groups, schools, and members of the social, health, and community welfare agencies

3. Lectures to premarriage instruction classes, nursing mothers' associations, and community health agencies

4. Provision of resource personnel for parent education and human development programs in Catholic and non-Catholic schools.

The services are provided mainly by volunteers. Only six persons receive full-time remuneration; 36 are paid on a part-time basis. Teachers are entitled to, and most claim, small out-of-pocket expenses for such costs as travel and baby-sitting, in order to attend the clinics. The outside funding received by the members of the Australian Council in 1980-84 came from the following sources (figures in Australian dollars):

Australian federal government	\$400,000
State governments	50,000
Archdiocesan and diocesan	100,000
Client fees, donations	90,000
Profit on sale of client materials	<u>10,000</u>
Total	\$650,000

This equals about US\$565,500 (\$121,000 per annum) and is quite inadequate to pay for the cost of training and retraining teachers, the rent of premises, secretarial services, and the maintenance and expansion of services desired by the state NFP organizations.

The membership of the Australian Council for the year 1982-83 includes 75 centers—that is, organized units staffed by trained teachers functioning at a venue recognized by the community as a place for NFP information, instruction, and supervision. Nineteen affiliates are also members. They are individual persons involved in or having an interest in natural family planning promotion and teaching. In addition, 315 teachers (264 trained teachers and 51 trainees), 45 doctors and other professionals (consultants, members of committees, lecturers, and others) and 57 support staff (secretaries, receptionists, priests, and administrators) are members of the Council.

Nine doctors regularly teach and lecture at NFP centers, 25 doctors serve as resource personnel or consultants, and 12 doctors serve on executive committees of NFP organizations.

### **NFP Education, Training, and Service Development**

In Australia, the responsibility for teacher training and service development lies with each state or regional NFP organization. In response to the need for and desirability of uniformity in the standards of teacher training and accreditation throughout Australia, the executive of the Council produced a set of guidelines for teacher training programs, compiled a training manual, produced a set of guidelines for setting up and running NFP centers, and developed a code of ethics for teachers. All these were approved and adopted by the membership in 1979-80. An ultimate aim is to standardize all client

NFP text, handout, and chart material. In addition, the ACNFP produced an information film on NFP ("Caring About Fertility") and a large set of overhead transparencies on human sexuality, NFP, and artificial contraception ("You and Your Fertility").

Candidates for teacher training attend a teacher training course by invitation only. First a center leader or some other person, such as a priest or a doctor, who can vouch for their good character, recommends a woman or couple with the qualities suitable for NFP teaching. A representative of the local teacher training body conducts a preliminary interview to inform them about the training program and to assess their degree of commitment to continue practicing and teaching NFP. If the interview is positive, they are invited to become teachers. Six months of NFP charting is a prerequisite for acceptance. With limited funds, the training of an unsuitable or uncommitted person is a waste of time and money.

### Objectives of Teacher Training Course

The aim of the course is to help trainee teachers acquire a complete knowledge of fertility awareness, its scientific background, and its application in the various methods of natural family planning; to inculcate in them the skills of communication so that they may impart effectively the information to clients; and to develop the sensitivity and understanding required of the teacher-client (helping) relationship.

Trainees are required to attend three live-in weekends for the formal instruction content of the course. This section includes the following: the history and philosophy of natural family planning, morality and the Church's teaching on birth regulation, human sexuality, the teacher-client relationship, anatomy and physiology, the scientific basis for NFP methods, the application of NFP methods in all phases of reproductive life, the evaluation of methods and services, artificial methods of contraception, and, finally, NFP center promotion and administration.

The method of formal instruction is by lecture, audiovisual presentation, films, role plays, reference texts, and so forth.

The time involved is about 40 hours.

In between the periods of formal instruction, the trainee is attached to an NFP center to observe client interviews conducted by experienced teachers. The trainee is required to keep a log of the cases and the lesson learned.

Written assignments have to be completed throughout the period of training. Before accreditation the trainee has to demonstrate his or her ability to give an initial client interview and instruction, to supervise the management of a client, and to conduct a telephone or correspondence service. Most trainees undergo about 12 months of clinic experience before being accredited as teachers.

The total cost of training a teacher is between \$300 and \$400. Most of this cost is subsidized by funds from the government, the parent NFP body, and the local parish or diocese.

The ACNFP, Inc., requires accredited teachers to update their knowledge and skills by regular attendance at teacher training courses, in-service courses, and NFP conferences. Because Australia is a country of vast proportions, some country teachers may have the opportunity to attend only one such course or conference per year. An accredited teacher trained by an NFP teacher training body approved by the ACNFP may teach in any center affiliated with the ACNFP.

For 1982-83, the number of teachers actively involved in teaching according to the latest count was 264. There are 51 trainees, 20 fewer than for 1981-82. There is always a small number who leave the teaching force because of planned pregnancy, family commitments, or moves to areas with no established NFP service. There are no full-time teachers (that is, teachers who work 40 hours per week). There are 23 teachers who are remunerated on a part-time hourly basis or by the session. The rest of the teaching force provides an average of four hours per month over 11 months as unpaid volunteers except for out-of-pocket expenses. Continuing education is provided through teacher training in-service courses and the quarterly newsletter.

As yet, no procedure has been established for evaluating the effectiveness of teachers, especially those who work alone at some country centers. The ACNFP newsletter is teacher-oriented and is a means of updating a teacher's knowledge and skills.

Service Delivery Statistics The services of the ACNFP are available to all who need them irrespective of status or religion. A new client is defined as a couple or person who has had more than one personal interview and received information on NFP methods with the intention of personal practice. The numbers of new clients for the last three years are as follows: 1980-81: 8,000; 1981-82: 6,400; 1982-83: 6,500. In 1982-83 teachers conducted 22,000 interviews. The number of people who received NFP information through lectures, seminars, group discussions, schools, and premarriage talks in the year 1982-83 was 39,600.

A recent retrospective survey by questionnaire of Australian NFP centers conducted in 1982 revealed the following client profile. Though a high percentage of responses fall into the "unknown" category, a general picture is presented below of age, marital status, and motivation of NFP clients.

<u>Age group</u>	<u>Percentage</u>
11-20	4.3
21-30	53.5
31-40	26.6
41-50	3.1
51-60	0.8
Unknown	11.7
<u>Marital status</u>	<u>Percentage</u>
Married	73.0
Engaged	9.5
Single	5.8
De facto (consensual union)	0.6
Unknown	11.1
<u>Motivation to attend NFP clinic</u>	<u>Percentage</u>
To avoid pregnancy	67.2
To achieve pregnancy	17.1
For menopausal counseling	3.8
For other reasons (e.g., breast-feeding, sex selection)	2.9
Reasons unknown (not recorded)	9.0
The symptothermal (ST) method or a	

modified mucus method is chosen by most clients.

In the matter of method and service evaluation, no further studies following that of Johnston, Roberts, and Spencer (1974-76) have been conducted. No recent evaluation has been undertaken on method effectiveness and continuity rates because of lack of finance. Informal evidence points to a minimal method failure rate and an overall pregnancy rate much lower with the use of a multi-marker method than with the use of the temperature or mucus method alone. The introduction of a last early safe day based on a rhythm calculation also appears to have reduced the method failure rate.

No accurate estimate of the time taken to reach autonomy in the use of the methods taught can be given. Autonomy is reached when a couple have decided they can confidently identify the fertile phase and comply with the rules of the method. The impression is that this period varies from 6 to 12 months for women with normal cycles depending upon the type and adequacy of the mucus symptom.

Clients return to centers until they become autonomous. They are taught and supervised individually. Should any medical, marital, or social problem arise, the couple can be referred to the appropriate professionals. The teachers are not trained as marriage or family counselors.

The only estimate we can make of the cost per client to attain autonomy is to calculate a figure from funds received per annum from all sources divided by the number of new clients per annum, a figure which is by no means accurate. Our estimate is \$40 per client compared with \$90 or more for clients who were taught and supervised by professionals. Any fees paid by clients are not recoverable from medical insurance funds as are fees charged by medical practitioners and the Family Planning Association clinics.

The number of clients who may become teachers is estimated to be about 1.0 to 1.5 percent per year.

### **Program Evaluation and Accountability**

The funding of family planning services

(including NFP services) by the Australian government commenced in 1973. The government at the time invited the Catholic bishops of Australia to nominate a national body to be responsible for the distribution and administration of the funds. Since there was no national NFP body at the time, the bishops gave this task to the then National Catholic Welfare Committee, which is now the Australian Catholic Social Welfare Commission (ACSWC). The chairman of this Commission is Bishop Perkins, and its National Director is Sister Agatha Rogers, R.S.M., M.B.E.

According to a formula which has altered little in the last six years, each center is allocated a share of the total grant based on past and estimated clinic workload and expenses. The Commission receives an annual financial statement and budget estimate from each NFP center in Australia, annual statistics in regard to new and continuing clients, total number of interviews, and other community activities (outreach) of the center. From these statistics, the Commission, through Sister Agatha Rogers, presents an annual submission for funding to the Australian government on behalf of the NFP centers. She is the only contact between the NFP centers and the Australian government, and her submission is unaccompanied by any lobbying by individuals involved at the grass-roots levels of the NFP movement. The Commission has no NFP representation, either on the Commission or on its NFP subcommittee, because of the way the Commission is structured. In 1977 the president of the ACNFP met with government officers to explore and discuss the possibility of being funded as an autonomous NFP body. The government preferred to deal with no other body than the ACSWC, a position which still remains today.

The ACSWC will recognize and fund only those NFP centers that are approved by the bishop of the diocese. In this way, the bishops of Australia and the ACSWC have the power to control the philosophy, goals, standard, and expansion of diocesan NFP organizations. This power may never be exercised, we hope, except in some exceptional circumstance which would be

difficult to envisage. The bishops of Australia actively encourage and support the NFP movement but leave its development and expansion to the NFP organizations.

All the state and major regional NFP organizations have a director or board or committee which is appointed or elected to be responsible for the coordination of the activities and administration of their local community NFP program with regard to NFP information and client instruction and supervision.

#### **Accomplishments and Development Needs**

The ACNFP is a large voluntary organization providing a "family ministry," teaching and supporting thousands of couples in the use of natural methods, and giving witness to the ideals of Christian marriage and family life to thousands more each year. Where there is friendship, good will, and unity of purpose among the membership, goals can be achieved. The Council, which is composed of so many autonomous agencies, has made great progress toward standardization of teacher training, clinic services, and client educational material because these tasks were unanimously entrusted to the executive and the standing committees. Goals were set and achieved.

The Council has a teacher training manual, issues a quarterly newsletter, and has produced an NFP information film and a set of overhead transparencies and accompanying texts for community education in human sexuality, natural family planning methods, and artificial contraception.

Our greatest challenge now is to maintain our status by a determined effort to obtain and train a continuing stream of new teachers and resource personnel to meet future demand for information and instruction, and to lobby the government for more funds to provide for a paid secretariat. Neither of these will be easy in the face of the present depression and unemployment.

The efficacy and efficiency of the NFP methods taught and the services provided by members of the Council need to be re-evaluated. A test kit to delineate the fertile phase of the cycle with a high degree of precision would be valuable. The most promising, in our view, are a urinary estrogen-progesterone detection kit and a saliva glucose detection tape. These tests will be most helpful to women with very irregular cycles, to those who are breast-feeding, and to premenopausal women. Such test kits would make NFP more acceptable in our society. Research into the psychosocial aspects of natural family planning is also needed.

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# The NFP Movement in India

**KATHLEEN DORAIRAJ**

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India's population of 730 million is the second largest in the world, exceeded only by the population of China. The country occupies about 3.3 million square kilometers of the Indian subcontinent in South Asia. India is about one third the size of the United States, and the population density—225 persons per square kilometers—is nine times greater than that of the United States. The vital rates include a crude birth rate of 35 per thousand and a crude death rate of 15 per thousand, resulting in an annual rate of natural increase of about two percent. At this rate, the population would double in 33 years, and a projection to the year 2000 shows a population of 966 million persons.

India is predominantly rural, with only about 22 percent of the people living in urban areas. About 40 percent of the population is under the age of 15, whereas 5.3 percent is in the older age groups, 60 years and over. Life expectancy is 50 years for the population as a whole, and India is one of the few places in the world where the life expectancy of men (52.6 years) is greater than that of women (51.6 years). The infant mortality rate is about 122 per thousand.

The Indian population is characterized by great diversity. Indo-Aryan groups constitute 72 percent of the population; Dravidians, 25 percent; and Mongoloids, 3 percent. The official language is Hindi, and English is the associate official language. Many other languages are spoken throughout the country. About 83 percent of the people are Hindus, 11 percent are Muslims, 3 percent are Christians, and 2 percent are Sikhs. Per capita gross national product was \$253 in 1981, according to an estimate made by the World Bank.

Governmental support for family planning activities is a long-established tradition in India. The government was the first in the world—beginning in 1952—to support a national family planning program. The sixth five-year plan, adopted in 1981, has as an objective the increase in acceptors from 22.5 percent of all eligible couples to 36.6 percent by 1985.

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*A national organization was formed in the early 1970s to promote NFP in India. By the end of 1976 a network of 48 NFP*

*service channels had been established primarily through the facilities of the Catholic Church. An emphasis was placed on offering the service to the poor. A simplified ovulation method has gained widest acceptance. NFP services are integrated into family welfare and counseling centers, community health and education centers, and family life education programs. Significant numbers of Hindus and Muslims are served in some programs. At present there are 55 organized, well-staffed NFP programs and a number of small programs. The most progressive are in Kerala. This paper gives details of NFP projects, state by state. To achieve further development, NFP programs need a large influx of trained personnel.*

### **Growth and Development**

Historically, the natural family planning movement in India was initiated by a group of persons with a strongly religious ideology. A national organization was formed to promote natural family planning in the early 1970s, but the work even among Catholics was minimal, mainly because of the conservative view of the Catholic Church leaders. In the mid-1970s, the NFP movement gained momentum and focused on training a large task force of volunteer promoters to offer services mainly to Catholic couples. By the end of 1976, there was a network of 48 autonomous NFP service channels in the country.

As the primary motive was to offer Catholic couples an alternative family planning method, the movement spread mainly through the infrastructure of the Catholic Church in India. Significantly, the movement shifted its focus to reach one segment of Catholics—the poor. This shift was a result of the experience gained in promoting NFP and the realization that NFP was both effective and acceptable to the poor. Voluntary acceptance was found to depend on the communication process and the simplicity of the approach, as well as on a sensitivity to the needs of the poor.

Voluntary developmental agencies that work with poor people now promote natural family planning for nondemographic motives, either through family life

projects and programs or as part of community health, women's development, or other social development programs. Although the motive for NFP is not population control, successful use of NFP will directly affect family fertility behavior and thus contribute to a reduction in fertility.

The voluntary groups have as a powerful guiding force their concern for the poor; they are therefore eager to try any humanistic approach that is acceptable to the large majority of the poor. They are not rigid and closed to alternative approaches, and very often they adapt their approaches to the needs of the people in the local area.

India is a country with a great diversity of ethnic and cultural groups, so the NFP needs of the people may vary considerably from area to area. Among the poor, those who are most motivated to limit their family size and have aspirations for their children may be reluctant to accept the available methods of family planning for physical, psychological, and religious reasons. They may be unaware of methods other than sterilization, or they may have tried other methods and had problems using them.

At present, the NFP method that has gained widest acceptance among the poor has been a modification of the ovulation method developed by Billings. More than 150,000 poor women are using a cervical mucus method effectively either to space or to limit their children. As a rule, this method is promoted in areas with ready acceptors, usually areas with a concentration of Catholic couples, such as Tamil Nadu, Kerala, Karnataka, and Goa. There are also scattered programs in Andhra Pradesh, West Bengal, and Maharashtra.

The only successful experience in promoting the sympto-thermal method among the poor is in the slums of Calcutta, but the effects have to be studied in light of the effort invested and with regard to the replicability of the project.

The acceptance of a method of family planning among the urban and rural poor may depend less on its effectiveness (effectiveness may be more important in other cultural situations) than on its simplicity, low financial and psychological costs,

reversibility, ease of use, and lack of side effects. Moreover, in a country such as India, where there is an urgency to reach out to impoverished groups to help improve the quality of their lives, the focus must be on methods that can be used effectively without close supervision and methods that can be integrated into other developmental programs with minimal input.

Experience in teaching the Billings ovulation method to poor women and couples in the Action Research Project of New Delhi's Indian Social Institute has led to a modification of the method. The specific objective was to improve the acceptability of NFP among the poor with low motivation and to reduce the need for close supervision and follow-up. It was also felt to be important to give the poor the potential to help themselves. The modified method is, in fact, a fertility awareness education program, and it is being used to give women and couples the potential to control fertility for nondemographic reasons. Acceptability has improved considerably, mainly because the modifications reduce the duration of abstinence required. This is possible when identification of the fertile period is more precise. Abstinence for shorter periods is less of a problem despite low motivation among some poor couples.

### **Service Delivery**

Table 1 shows the distribution of services promoting natural family planning in the states of India. These projects are autonomous and have geographical spreads from one to four districts with a large number of centers and subcenters. Some use the infrastructure of other successful programs to reach out to people.

NFP services are also offered through family welfare and family counseling centers or through informal channels by integrating fertility awareness teaching into community health and adult education. They are also offered in marriage preparation or family life education programs.

There is a marked concentration of such integrated programs in South India, especially in Kerala and Tamil Nadu. Inte-

grated family life programs have emerged in South India and in other areas where the priority group is Catholics, but the priority group for NFP services is not necessarily identical to that of family life movements and programs. In the areas where the poor are the priority group and the vast majority are Hindus, Muslims, and tribal people, family life programs designed by the elite for the elite are irrelevant.

Haryana, Punjab, and Himachal Pradesh in the North Zone of India have had no programs or projects at all. In other states throughout India—Jammu and Kashmir, Bihar, Madhya Pradesh, Uttar Pradesh, Rajasthan, Gujarat, Maharashtra, and Orissa—the projects are scarce or limited compared to the size and the needs of the areas. The dearth of programs is due mainly to the lack of personnel to plan, organize, and implement the programs or to the low motivation of the voluntary groups in these areas to promote natural family planning when the obvious need of the area is social development.

Out of the 87 programs (Table 1) initiated between 1976 and 1979, 11 have been discontinued because of the lack of personnel or because of poor results. The latter have been attributed to inappropriate design and communication strategies that do not suit the needs of the people. There is a potential for developing more need-based programs in the areas that have given up projects and in areas where programs have yet to be initiated but where the infrastructure of other successful social development programs is in place.

### **Regional and Local Programs**

Table 2 presents the effects of the programs according to the area characteristics, the approach, the method of NFP promoted, and the number of acceptors and dropouts. There are currently 55 organized, ongoing projects with large teams of personnel. The most progressive are in the state of Kerala, where the programs are well organized and have a large number of acceptors. Family development programs for youth, in the form of premarriage courses and family life education, use an integrated approach to promote respon-

sible parenthood through natural family planning.

Health institutions in the voluntary sector offer NFP services, and some hospitals have an intensive postpartum natural family planning program. In a rural-based hospital in Choondal under the Trichur program, the postpartum program has in four years reached out to 6,054 poor women during the lying-in period. According to Indian custom, a woman returns to her mother's home for her first delivery, so that all the women who are having their first baby and who may be motivated to accept NFP are lost to follow-up when they return to their husbands' home 40 to 90 days after delivery, often without visiting the postnatal clinic. The other postnatal acceptors are local women of parity two or higher, and they are available to follow-up since they return to the postnatal clinic and later to the well-baby clinic. The effectiveness of this kind of postpartum program has not been assessed, but the number of women reached has been remarkably high.

In the Changanacherry, Trichur, Verapoly, Kanjirapally, Kothamangalam, Ernakulam, Quilon, Trivandrum, Palai, Calicut, and Irinjalakuda programs, the approach is through motivational, value-oriented group sessions. Motivated couples are instructed in the use of natural family planning either at the subcenter or in their homes by extension educators. The literacy rate is high in Kerala, so the instructors must be literate and highly motivated men and women. Because of cultural barriers, female extension educators may teach only the wife, and male educators must teach the husband. A higher level of education is one of the characteristics of motivated couples; they are more receptive to change in family and fertility behavior. Houses may be situated at a considerable distance from each other in Kerala, so the extension worker must work long hours and walk from house to house to reach each couple individually. It has been found that the extension approach is more effective than waiting for couples to come to the center for instruction after they have attended an initial motivational group session.

In Ernakulam, the availability of NFP services is publicized through a "mailed coupon system," whereby couples are informed about an NFP center or extension service. The potential acceptor chooses a suitable time and date and mails the coupon back to the project administrative center. Follow-up services ensure that couples are visited by field workers.

In Quilon, the center has no organized backup project, so a dual approach was used. A small priority group of fisher-folk who lived in communities along the coast was selected and visited by field workers. Those who wanted NFP instruction were taught in their huts and were told where they could go for further instruction and motivational sessions if they wanted to become acceptors and users of natural family planning.

In Tellicherry, the infrastructure of the social development programs and the nutritional package program called the Maternal and Child Health Program is used to reach clients. The "Health for a Million" Program in Trivandrum is a project of integrated health and NFP; it reaches out to communities of fisher-folk.

In Palai and Calicut, the NFP program is also integrated with a community health program. Community health workers teach NFP in the homes of women, together with education about health and nutrition.

In the state of Tamil Nadu, the 12 autonomous projects are affiliated with the Tamil Nadu Family Development Center, which was instrumental in helping to organize the programs. NFP is promoted through the infrastructure of the Catholic Church and is only one facet of the family apostolate. In the Tamil Nadu projects, the objective is family development, and NFP is only one of many family programs, including family life education, premarriage courses, and family economy. Services are not limited to Catholics; the poor of all beliefs are reached through the extension approach. During the 1978-82 period, the 12 projects recruited 30,291 NFP acceptors who said they intended to limit or space their children.

In Thanjavur, 455 couples were instructed in 1980-81; of these 58.5 percent

were Hindus, 40.4 percent were Christians, and 1.1 percent were Muslims. About half (52.5 percent) earned less than 200 rupees a month. Out of 1,120 couples recruited in the Vellore project in 1981-82, 35 percent were under 25 years of age and 35 percent were 25 to 29; 90 percent earned less than 300 rupees a month. Of the acceptors, 60 percent were Hindus, and only 35 percent were Christians. In the Tuticorin project, 699 of the 2,973 acceptors are using the method to limit family size, whereas 1,866 are spacers and 418 are using NFP to achieve pregnancy. This project has used the mass media effectively, reaching out to the masses through radio programs.

In Karnataka, the projects have varied motives. The Bangalore project's priority group is the poor in the slums. Although it is part of a family welfare center that offers a number of family services, its target group is the poor. The Mangalore project uses church infrastructure and is part of the family apostolate but also uses the extension approach to reach out to the poor regardless of caste and creed. The project in Mysore is rural-based and the motive is development. It initially used the infrastructure of the maternal and child health (MCH) programs to promote NFP, but the project was redesigned to meet the needs of the people and has shifted to extension educators, who visit women in their homes.

In the Karwar and Bellary projects, NFP is only one aspect of the family apostolate and is promoted as responsible parenthood through the family life program. The Belgaum project is of recent origin, although small NFP centers have existed in the area since 1976. This project is still in the experimental stage; it has a small team of project personnel, but it is using the infrastructure of health and family welfare.

In the state of Andhra Pradesh, where the people are relatively backward compared with those in Kerala, Tamil Nadu, and Karnataka, the projects are of recent origin except for the NFP service center established at Vijaywada in 1974. This project was initiated as a hospital-based service but is now integrated with other family life and social services. The

Hyderabad project is integrated with community health and operates an extension service in the slums. Its work is mainly with poor Muslim women.

The Guntur project is also integrated with health. The Warrangal project began as a hospital-based center integrated with health, but it is now rural-based and integrated with social development, especially women's development and child health. The Malgonda project initiated after 1981, covers very undeveloped remote areas in the state and serves villages with a large majority of scheduled castes (formerly known as untouchables). There are 115 inhabited villages with 342,256 households. One cluster of villages is selected at a time, and NFP education, with a motive to help women space their children, is integrated with women's development and health education. Group sessions and participatory evaluation are the methods used to involve poor women who have very low motivation for family planning. Every village has two local women selected and trained as NFP educators.

The Cuddapah project is also of recent origin and covers the district of Cuddapah, another less developed area with a large percentage of "untouchables." Because family planning is such a sensitive subject, the project is integrated with women's development and the motive is purely health- and development-oriented. The NFP team of 19 field workers and 9 coordinators has covered 15 villages. Although the extension approach is used to motivate and recruit acceptors, subcenters in the villages are used as a backup measure. The Eluru project also serves a very undeveloped region in the state. It, too, is of recent origin and is therefore in the early stages of program development. In Vishakapatnam, NFP is offered only through unofficial channels—community health and a postpartum service in the voluntary health sector.

In Goa, the project uses the infrastructure of the Catholic Church and is therefore integrated as one of the programs of the family life services center catering to Catholics of all classes. The approach is motivational seminars in parish centers,

followed by NFP instruction in parish subcenters. The project, although basically service-oriented, has a research element. In the state of Maharashtra, the two projects in Bombay and Poona cover essentially the poor living in urban slums but are part of the family life services offered by the centers implementing the project. The main reason for shifting focus to the poor in the slums in Bombay with a high concentration of Catholic population was the low acceptability of NFP by Catholics, especially the upper and middle classes who had limited their family size. The youth of upper and middle classes are reached through premarriage courses and value-oriented family life education courses.

There is no formal NFP project in Ahmednagar, but there is a service network through the community development programs. A proposal has been made to integrate NFP formally into the existing health programs, which until recently were closed to NFP and openly promoted sterilization. The need for NFP has come from the masses, who are the beneficiaries of the program.

In Gujarat, the Baroda program, initiated in 1980, is mainly rural-based. In one urban slum in Barod<sup>r</sup>, city couples are approached directly by field workers, but in the rural areas, family planning is a very sensitive issue and therefore has to be introduced through the health infrastructure. The NFP project does not use the local health workers but has its own field workers to implement the project. This ensures that time is given for NFP instruction. The use of community health workers to promote NFP has not been found to be successful because health personnel tend to regard NFP as a marginal program compared with their own health care programs.

In Ahmedabad, the government has shown an interest in NFP, but there is no backup support from voluntary groups to convince the government about the validity of NFP. Moreover, the governmental population policies are themselves antagonistic to the promotion of NFP.

In the state of Madhya Pradesh, the backwardness of the area and the marginality of the masses of people have been the main

incentives for the volunteer groups to concentrate on adult literacy and health, projects that they considered to have higher priority. Enthusiasm has waned because of the poor effects of programs that were not designed on the basis of the needs and perceptions of the people. The Sager project was discontinued mainly because no program director was available; another project also had difficulty in finding persons to carry on the work. There is an obvious need for NFP in these areas, but programs designed on the basis of people's participation will be more successful than programs with a "top-down" model, which has no faith in people.

One district of Madhya Pradesh promotes NFP as part of a feminist movement. These efforts have already spurred a number of women's groups working for the status of women to promote fertility awareness as a means of women's development.

In Uttar Pradesh, there is a microlevel rural program in Allahabad district integrated with the health system. The Allahabad official project, which was initiated in the mid-1970s, has been reduced to a hospital-based center mainly because of a lack of administrative personnel. The Lucknow program has shifted its focus to the rural poor in one district and has been more successful there than in its urban-oriented pilot project. In Jhansi, the effects of a rural-based project are encouraging, and a more widespread program integrated with adult literacy and women's development is needed in the area.

In Rajasthan, the project has focused on Bhil tribals, and more than 8,000 of them have been reached. Follow-up has been difficult in these cases, but of 1,042 women who were followed up, the effectiveness has been high (11 unplanned pregnancies). NFP education is also integrated with the health, maternal and child health, and adult literacy programs of voluntary organizations in some areas of Rajasthan.

In Delhi, the action-research projects have selected as their priority group the urban poor who have migrated from rural areas of neighboring states and who are living in squatter settlements and slums on the fringes of the city. The approach is

purely extension, and the project is not integrated with any other program. The objective is to study the effectiveness of a method suited to the needs of the people. A cluster sample of slums is selected, and women are reached by person-to-person channels of communication. Field workers with similar social and cultural backgrounds and similar family life experiences are chosen for the work. There is a regular pattern of follow-up visits to homes for a period of 12 months.

In Bihar, the Patna and Muzaffarpur projects have reached out to a large number of poor rural and urban women with a team of trained field workers who have similar backgrounds. The acceptability has been very high. Continuation has been disappointing because a lack of personnel prevented follow-up, but the high acceptability is remarkable considering that the clients are not considered "ready acceptors" of family planning or NFP.

In West Bengal, in addition to the Calcutta slum project of the Missionaries of Charity of Mother Teresa, voluntary agencies have projects in the rural areas. The Family Life Commission of Calcutta has a project in the suburban and rural areas on the fringe of this overpopulated city. In the Krishnagar project, natural family planning has been accepted and is used effectively by women and men living in the Indo-Bangladesh border villages. The NFP project has grown into a wide-based community health and development program. In the Baraipur project, the extension approach has been used to reach the rural poor. There are satellite centers in Jalpaiguri and Raiganj in West Bengal, Jamshedpur, and Rourkela in Bihar, and Dibrugarh and Tura in Assam.

In Orissa, one of India's least developed areas, there are three projects in Berhampur, Balasore, and Cuttack-Bhubanashwar. The Berhampur project is a successful wide-ranging program that reaches out to illiterate tribal people through an information adult literacy program. The initial approach, through health workers, was relatively unsuccessful.

In the union territory of Pondicherry in South India, the objective of the project

has been to promote and teach NFP to lay the foundation for a self-supporting people's movement. The focus has been not on quantitative program inputs and outputs but on community involvement.

In the underdeveloped northeast, the population size is small and the tribes there value high fertility. Any attempt to promote fertility control will meet with opposition. NFP education has a low priority compared with other value-oriented family programs, although fertility awareness education is readily accepted by people who place a high value on health.

In the Andaman and Nicobar Islands, NFP is promoted through a widespread community health program.

#### **Accomplishments and Recommendations**

According to a report published by the Indo-German Social Service Society entitled *Natural Family Planning in India, 1981*, a total of 96,641 couples had accepted natural family planning. Of these, 81 percent were poor, earning less than 400 rupees per month, and only 5 percent earned more than 600 rupees per month. Forty-five percent of the couples were using the method to limit family size, 4 percent were using it for spacing, and 14 percent were using it to achieve pregnancy. Of those who were using NFP to control fertility, 61 percent were rural couples and 27 percent lived in urban slums.

Natural family planning is still a marginal program in India in the sense that it has not been accepted by many population experts or by a large number of action groups and development agencies, including some that are related to the Catholic Church. The opposition to NFP comes from, among others, those who feel that population control programs are unnecessary and from

those who doubt that poor women can learn to use NFP effectively.

The success of the present NFP projects in India can be attributed to the efforts of program directors and field workers, the key persons in such a program. The effectiveness of NFP as a method depends on its acceptability to the poor. In a country as large as India, where programs are scarce in areas with low literacy and large populations, there is an obvious need to build on present successful projects and to offer more NFP programs through the voluntary sector, either through social development and health or through women's programs.

The work already accomplished in India highlights the need for manpower development—personnel with the skills to plan, design, and organize need-based people's programs that impart to the poor and disadvantaged the knowledge to help themselves.

A national professional association, the Natural Family Planning Association of India, has organized regional-level training courses to cater to this need, in cooperation with member family life associations and the Indian Social Institute. Other organizations that have contributed to training a large task force of NFP personnel are the state-level Tamil Nadu Family Development Center, the regional-level Natural Family Planning Training Association, Patna, and a private organization, the Center for Research, Education, Service, and Training for Family Life Education (CREST) in Bangalore.

The masses in India view fertility as a natural physiological process that does not require a medical solution. Fertility behavior, even among the poor, is rational, and fertility control methods that are sensitive to the needs of the people will meet with wide acceptability.

Table 1 Distribution of NFP Services in India, by States and Union Territories, by Population Size, Total Fertility Rate and Female Literacy Rate

State or Union Territory	Population, 1981 (in millions)	Total fertility rate		Female literacy rate, 1981		Number of NFP Programs
		Rural	Urban	Rural	Urban	
<u>North Zone</u>						
Delhi	6.20	6.0	3.2	32.07	54.17	1
Rajasthan	34.10	5.7	4.4	5.41	34.24	1
Jammu and Kashmir	5.98	5.2	2.8	N.A.	N.A.	1*
<u>Central Zone</u>						
Madhya Pradesh	52.13	6.3	4.3	8.99	42.30	7+1**
Uttar Pradesh	110.86	6.9	4.8	9.86	35.82	3*
<u>Northeast Zone</u>						
Assam	19.90	4.2	3.1	N.A.	N.A.	1*
Meghalaya	1.33	N.A.	N.A.	23.64	57.40	1*
Manipur	1.43	3.6	2.5	26.61	39.63	1*
Nagaland	.77	N.A.	N.A.	30.13	56.72	1*
<u>Eastern Zone</u>						
Bihar	69.82	N.A.	N.A.	10.16	39.57	2+2+2**
Orissa	26.27	4.7	4.1	18.46	42.55	1+2*
West Bengal	54.49	N.A.	N.A.	22.01	55.26	5+2*
Andaman and Nicobar Islands	N.A.	5.0	3.1	36.70	56.85	1
<u>Western Zone</u>						
Gujarat	33.96	5.5	4.0	24.12	51.03	1
Maharashtra	62.69	4.3	3.7	24.74	54.48	2+1**
Goa, Daman and Diu <sup>a</sup>	1.08	3.3	2.4	42.38	56.40	1
<u>Southern Zone</u>						
Andhra Pradesh	53.40	4.8	3.7	14.10	40.66	7+1*
Karnataka	37.00	4.1	2.8	20.04	47.52	5+2*
Kerala	25.40	3.4	3.1	62.99	70.97	17+2*
Pondicherry <sup>a</sup>	.06	3.6	2.3	34.47	52.46	1
Tamil Nadu	48.30	4.2	3.0	25.07	52.81	12

Notes

a Union Territories.

\* NFP project discontinued.

\*\* NFP services offered through informal channels.

N.A. Not available.

Table 2 Distribution of Program Effects, by Characteristics of Area, Program Approach, Number of Acceptors Dropouts, and Unplanned Pregnancies Reported: India

Area	Area characteristics	Approach	Method promoted	Period of implementation	Number of acceptors/users	Number of dropouts	Number of unplanned pregnancies	Status of project
<u>North Zone</u>								
Delhi	Urban/Rural	Extension	Modified mucus	36 months	5,752	N.A.	9	Action/Research
Ajmer-Jaipur (Rajasthan)	Tribal belt	Extension	Ovulation	24 months	1,042	N.A.	11	Service
Lucknow	Rural hospital-based	Extension integrated with community health	Ovulation + modified mucus	12 months	3,073	N.A.	N.A.	Service

Area	Area characteristics	Approach	Method promoted	Period of implementation	Number of acceptors/users	Number of dropouts	Number of unplanned pregnancies	Status of project
Allahabad*	Urban hospital-based	Center	Ovulation	N.A.	N.A.	N.A.	N.A.	Service
Jhansi*	Rural	Extension	Ovulation + modified mucus	N.A.	1,255	N.A.	N.A.	Service
<u>Central Zone</u>								
Sagar**	Rural*	Extension integrated with health and M.C.H.	Ovulation	12 months	204	N.A.	N.A.	Service
Ujjain**	Rural*	Extension integrated with health	Ovulation	12 months	42	N.A.	N.A.	Service
Khandwa**	Rural*	Extension integrated with health	Ovulation	12 months	N.A.	N.A.	N.A.	Service
Jagdapur*	Rural*	Extension integrated with MCH program	Ovulation	12 months	302	N.A.	22	Service
<u>Eastern Zone</u>								
Patna	Urban slums	Extension development programs	Simplified mucus	36 months	13,641	7,325	517	Service
Muzaffarpur	246 villages	Extension development programs	Simplified mucus	24 months	15,401	4,368	262	Service
Daltanganj*	Rural (Tribal)	Integrated with women's development	Ovulation	12 months	20	N.A.	N.A.	Service
Bhagalpur*	Rural	Integrated with health	Ovulation	N.A.	N.A.	N.A.	N.A.	Service
Krishnagar	Rural	Extension and integrated with health	Ovulation + simplified mucus	36 months	2,869	N.A.	N.A.	Service
Darjeeling*	Rural and Tribal	Family Apostolate	Ovulation	N.A.	N.A.	N.A.	N.A.	Service
Jalpaiguri*	Rural (Tribal)	Extension integrated with M.C.H.	Ovulation	12 months	231	N.A.	N.A.	Service
Calcutta	Rural/Urban	Extension	Symptothermal	7 years	N.A.	N.A.	N.A.	Service/Research
Baraipur	Rural	Extension	Ovulation	36 months	1,140	N.A.	N.A.	Service
Berhampur	Rural and Tribal	Extension integrated with health and adult literacy	Modified mucus	12 months	295	N.A.	4	Service
Balasure	Rural and Tribal	Extension and Development Center	Ovulation	24 months	986	N.A.	N.A.	Service
Cuttack-Bhubaneswar	Rural and Tribal	Center	Ovulation	12 months	115	N.A.	N.A.	Service
Andaman and Nicobar	Rural	Integrated with health and M.C.H.	Modified mucus	N.A.	571	N.A.	N.A.	Service
<u>Western Zone</u>								
Poona	Urban/Hindu Catholic	Extension with Family Apostolate	Ovulation	36 months	517	N.A.	N.A.	Service
Bombay	Urban/Hindu Catholic	Center, extension, Family Apostolate	Modified mucus	12 months	1,170	N.A.	N.A.	Service
Ahmednagar	Rural/Hindu	Extension integrated with health	Modified mucus	12 months	N.A.	N.A.	N.A.	Service
Baroda	Rural/Hindu	Extension integrated with health and M.C.H.	Modified mucus	18 months	578	24	18	Service
<u>South</u>								
Hyderabad	N.A.	Integrated with community health	Ovulation	36 months	639	N.A.	N.A.	Service

Area	Area characteristics	Approach	Method promoted	Period of implementation	Number of acceptors/users	Number of dropouts	Number of unplanned pregnancies	Status of project
Cuddapah	N.A.	Integrated with women's development	Ovulation	12 months	326	N.A.	N.A.	Service
Eluru	N.A.	Integrated with development	Ovulation	6 months	N.A.	N.A.	N.A.	Service
Nalgonda	N.A.	Integrated with women's development	Modified mucus	6 months	500	N.A.	N.A.	Service
Guntur	N.A.	Integrated with health	Ovulation	24 months	366	N.A.	N.A.	Service
Vijayawada	N.A.	Family Apostolate and community development	Ovulation/simplified mucus	36 months	3,650	N.A.	N.A.	N.A.
Vishakapatnam	N.A.	Integrated with health and community development	Ovulation	12 months	N.A.	N.A.	N.A.	N.A.
Warrangal	N.A.	Family Apostolate and health	Ovulation	36 months	1,623	N.A.	N.A.	N.A.
Bally	N.A.	Family Apostolate	Ovulation	36 months	1,623	N.A.	N.A.	Service
Bangalore	N.A.	Family Apostolate	Ovulation	36 months	4,183	N.A.	N.A.	Service
Mysore	N.A.	Development program	Ovulation	36 months	3,849	60	4	Service
Karwar	N.A.	Family Apostolate	Ovulation	24 months	628	N.A.	N.A.	Service
Belgaum	N.A.	Family Apostolate	Ovulation	12 months	N.A.	N.A.	N.A.	Service
Mangalore	N.A.	Family Apostolate	Ovulation	36 months	1,835	N.A.	N.A.	Service
Chickmangalur	N.A.	Family Apostolate	Ovulation	6 months	N.A.	N.A.	N.A.	Service
Vijayapuram	N.A.	Family Apostolate	Ovulation	36 months	9,833	N.A.	N.A.	Service
Calicut	N.A.	Integrated with community health	Modified mucus	30 months	4,102	148	33	Service
Quilon	N.A.	Family Apostolate	Ovulation	36 months	566	N.A.	N.A.	Service
Verapoly	N.A.	Family life services	Ovulation	24 months	820	N.A.	12	Service
Alleppey	N.A.	N.A.	Ovulation	36 months	195	N.A.	N.A.	Service
Tiruvalla	N.A.	Integrated with development	Ovulation	24 months	N.A.	N.A.	N.A.	Service
Trivandrum A.D.	N.A.	Integrated with community health	Ovulation	36 months	4,227	N.A.	N.A.	Service
Ballery	N.A.	Integrated with tribal development	Ovulation	6 months	N.A.	N.A.	N.A.	Service
Trivandrum	N.A.	Integrated with M.C.H. program	Ovulation	6 months	N.A.	N.A.	N.A.	Service
Emakulam	N.A.	Family Apostolate/women's development and health	Ovulation + modified mucus	24 months	1,987	217	Nil	Service
Trichur	N.A.	Family Apostolate and health	Ovulation + modified mucus	36 months	4,102	1,813	73	Service
Changanacherry	N.A.	Family Apostolate	Ovulation	36 months	1,430	N.A.	N.A.	N.A.
Tellicherry*	N.A.	Integrated development and health	Ovulation + modified mucus	12 months	250	N.A.	Nil	N.A.
Palai	N.A.	Integrated with community health	Ovulation + modified mucus	36 months	2,700	N.A.	Nil	N.A.
Kothamangalam	N.A.	Family Apostolate	Ovulation	24 months	725	N.A.	N.A.	N.A.
Palaghat	N.A.	Integrated with development	Ovulation + modified mucus	24 months	2,326	N.A.	N.A.	N.A.
Kanjirapally	N.A.	Family Apostolate	Ovulation	24 months	956	36	5	N.A.
Irinjalakuda	N.A.	Family Apostolate	Ovulation	24 months	2,347	N.A.	N.A.	N.A.

Area	Area characteristics	Approach	Method promoted	Period of implementation	Number of acceptors/users	Number of dropouts	Number of unplanned pregnancies	Status of project
Goa	Urban/Rural	Integrated with family life services	Ovulation	36 months	318	N.A.	N.A.	Service
Madras*	Urban	Integrated with family life services	Ovulation	36 months	630	N.A.	N.A.	Service/Research
Salem*	Urban/Rural	Integrated with family life services + extension	Ovulation	24 months	1,090	N.A.	N.A.	Service
Coimbatore*	Urban/Rural	Integrated with family life services + extension	Ovulation	24 months	1,372	N.A.	N.A.	Service
Tiruchinapalli*	Urban/Rural	Integrated with family life services + extension	Ovulation	24 months	1,727	N.A.	N.A.	Service
Thanjavur*	Urban/Rural	Integrated with family life services + extension	Ovulation	36 months	943 + 455*	20	1	Service
Ootacamund*	Urban/Rural	Integrated with family life services + extension	Ovulation	24 months	953	N.A.	N.A.	Service
Madurai*	Urban/Rural	Integrated with family life services + extension	Ovulation	24 months	1,882	N.A.	N.A.	N.A.
Tuticorin	Urban/Rural	Integrated with family life services + extension	Ovulation	36 months	2,973	N.A.	N.A.	Service
Palyamkottai*	Urban/Rural	Integrated with family life services + extension	Ovulation	24 months	1,097	N.A.	N.A.	Service
Kottar*	Urban/Rural	Integrated with family life services + extension	Ovulation	24 months	3,951	N.A.	N.A.	Service
Kumbakonam	Urban/Rural	Integrated with family life services + extension	Ovulation	24 months	3,255	N.A.	N.A.	Service
Vellore*	Urban/Rural	Integrated with family life services + extension	Ovulation	36 months	953 + 120*	18	N.A.	Service
Pondicherry	Rural	Extension integrated with community development	Ovulation	24 months	240	N.A.	N.A.	Service

Total Number of acceptors—126,941; number of recorded dropouts—14,029

\*Sources: Family Planning Programme in India—IGSSS. Report of the Projects Presented to the Natural Family Planning Association of India.

# Australia

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## WOOMB

The Ovulation Method Research and Reference Centre of Australia operates a Family Life Centre which serves the family through natural family planning, marriage counseling, educational programs on human sexuality in secondary schools, marriage preparation courses, collaborative research in reproductive biology, and the publication of a quarterly bulletin.

Throughout Australia there are 110 affiliated centers which teach natural family planning, staffed by accredited teachers who have received a broad training in natural family planning and who offer the ovulation method as the primary method for routine instruction. Forty-five of the Australian centers are located in the state of Victoria and are grouped as the Natural Family Planning Council of Victoria; twenty-one of the centers are located in the metropolitan area of Melbourne. One subcommittee of the Council is working to provide information for various ethnic groups, and teaching literature is provided in various languages including Chinese, French, Greek, Italian, Polish, Spanish, and Vietnamese. Information about the ovulation method is also available in Braille. A large consultation service is provided by telephone and correspondence.

In the provision of natural family planning, the education of teachers is a matter of primary concern. This involves an annual conference with an intensive teacher-training program, various in-service training seminars, supervised by an educational subcommittee which provides coordinator-supervisors for the various centers. The teachers' educational program comprises not only technical instruction but also a study of the ideals which motivate people to use natural family planning, including respect for the human person, responsible parenthood, and the sense of mutual love with self-commitment. Trainee teachers are usually invited to enter the training

courses from among the couples who are successfully using natural family planning in their own married life, and the training is based upon an apprenticeship within a center for six months to one year, during which the formal seminars and conferences are attended.

A marriage counseling service is conducted from the headquarters center where medical consultation and spiritual advice may also be obtained. The medical consultations include the investigation, by an expert natural family planning teacher, of all pregnancy cycles. A marriage preparation course is provided each month and concentrates on the establishment of emotional harmony in marriage, with emphasis upon the responsibilities accepted by the husband and wife in making their commitment to each other. The sources of some difficulties in making the necessary adjustments to married life are described and become the subjects for consideration in workshops. Information is provided about fertility regulation by natural family planning, as well as the traditional Christian philosophy of conjugal love and family life.

The School Program has been directed to year 11 and year 12 students. The full program includes six sessions, the first being an information night for parents, followed by five sessions each of about one and a half hours duration, usually one session per week in successive weeks. The information night is intended to encourage parents to accept their responsibility to question what their children are being taught in the field of sex education, to educate the parents and give them useful terminology, and in particular to help establish dialogue between the parents and their children which is likely to be initiated by the remainder of the program, if it does not already exist. The School Program has the general title "Christian Sexuality: Creative Love."

In all of the sessions within the schools, time is allowed for discussion within small groups and the answering of questions. Instruction is assisted by various visual aids including films, such as "The First Days of Life." During 1983 the School Program was presented in 21 Melbourne schools

altogether, at some of which the number of students was so large that the program was presented twice. Fifty-nine trained volunteer teachers assisted; the total number of parents who attended was 864, and the total number of students was 2,607. In addition programs of one or two sessions were given by 20 teachers in 13 schools, with an attendance of 152 parents and 362 students.

The teachers involved in the School Program are additional to those who work in the natural family planning centers. They have a separate training course of five sessions which maintains a high standard of teaching and a continuing supply of teachers.

The collaborative research program with Professor J.B. Brown of the Royal Women's Hospital, University of Melbourne, and Professor Henry Burger, Prince Henry's Hospital, Monash University, Melbourne, which began in 1962, is continuing, and has involved the hormonal monitoring of several hundreds of women with various physiological and pathological conditions of the reproductive system. In 1983 the program was expanded when

Professor Erik Odeblad of the Department of Bio-Physics, Umea University, Sweden, visited Melbourne in order to establish correlations between women's observations made after instruction in the ovulation method, the hormonal parameters and the biophysical properties of mucus formed by the cervix during the cycle. It is intended that this project will be continued throughout the next year.

Many of the teachers have been involved in promotional activities, lectures to medical associations, trainee nurses, nursing mothers, and various civic groups. A presentation of the scientific work on which the guidelines of the ovulation method are based was prepared and formed a segment of a very successful television documentary "Breakthroughs." Visits by experienced teachers were made to rural areas and other states in Australia, and during the year eight accredited teachers shared teaching visits to 18 overseas countries altogether, in response to requests for assistance to establish or expand existing natural family planning programs using the ovulation method.

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## Bangladesh

The natural family planning program in Bangladesh was begun by a registered nurse/midwife in the latter part of 1976. She had received her training in the ovulation method from Dr. C. B. Haliburton of Tamil Nadu, India. At present, in addition to the founder/director, the staff includes a program administrator, three field supervisors, two full-time teachers and part-time teachers numbering 13 married couples and 42 individual women or men. Seminars in the ovulation method and teacher training workshops have been held at the program center or at the Caritas Seminar Hall in Dacca, as well as in the various villages where interest has been shown.

Through individual instruction and group workshops, individuals and couples are

taught the signs and symptoms of fertility and the way to time their sexual activities to avoid conception. By means of simple instructions, even illiterate women and men in Bangladesh have already learned to follow this method successfully. If individuals or couples who have used the method themselves desire to teach it to others, they are required to attend teacher training seminars at which the anatomy and physiology of fertility and reproduction are taught in detail. At the end of such seminars, the individual's knowledge and comprehension of the specific details, as well as the application of principles to real life situations, are tested. After basic training, a teacher begins to instruct fellow villagers in the ovulation method and begins to keep records on users. These records are periodically checked by a supervisor to pick up possible errors in interpretation of physical signs, or in the

record keeping itself. Teachers receive on-going education at workshops which are held once or twice a year either in Dacca or at some other central location.

Full-time teachers and supervisors receive monthly salaries, and part-time teachers are paid for their services in proportion to the number of clients they follow (10 Bangladesh Taka per month per active client). Young men and women in high schools, colleges and in premarriage sessions are also instructed in fertility awareness and natural family planning.

Various forms of the communications media are being employed to make the ovulation method better known and accepted as a legitimate and highly effective method of family planning. But our best public relations is done by couples who for years have used the method successfully. In fact, the major part of our promotional work is done through personal contacts and one-to-one teaching and motivation. However, informational and instructional booklets and pamphlets have been written in Bengali and are available from program teachers. A monthly newsletter is sent out from the center to teachers and other interested parties.

The aims and objectives of the program are to cooperate with the government's efforts to control population growth through education in NFP; to provide education in responsible parenthood to premarriage and married couples; to motivate members of all classes and creeds to accept periodic abstinence as a means to avoid pregnancy; to offer natural methods as an alternative to women who discontinue other methods and to disseminate information on NFP through the media; and to promote a respect for life and fertility as a gift.

In addition to the national center in Dacca there are subcenters in the following districts: Jamalpur, Mymensingh, Kushtia, Khulna, Barisal, Noakhali, Pabna, Rajshahi, and Rangpur. The majority of the subcenters date from 1980. They are usually located at dispensaries conducted by other Catholic groups. The NFP teachers are available for consultation and keep their records at these locations. The majority of contacts, however, are made through

home visits in the villages. Three teachers are Muslim and two are Hindu. Additional Muslim and Hindu women are being recruited as teachers for their villages.

At present there are 985 couples (260 of whom are considered autonomous) using the ovulation method to limit or plan their families. It is difficult to claim any substantial impact for the program. It is still a very small undertaking in comparison to the total needs of Bangladesh. Nevertheless we are encouraged by the growing interest in the method among people of all classes and religious groups and the support of workers in other voluntary agencies.

In a country with such a low rate of economic development, few people can afford to volunteer their time and energy to teach NFP. A system of remuneration according to the number of clients has been worked out for part-time teachers. Communication and transportation are particular difficulties. Follow-up often requires hours of visiting house to house, walking from one village to another. Since this makes on-going supervision of clients and new teachers difficult, emphasis will be placed as much as possible on regionalization.

Long-range plans include the establishment of a National Natural Family Planning Association with representation from each of the regional areas which could generally be referred to as Dinajpur, Khulna, Barisal, Mymensingh, and Chittagong, in addition to Dacca. Teachers and supervisors in all these areas will have been trained by the program's founder/director, Sister M. Imelda, so that a standardized system for teaching, data collection, and reporting will be possible.

Because of the need for cooperation between husband and wife, it is preferred that couples learn the ovulation method together. In areas where women and men prefer to come together in separate groups for instruction, that is arranged. In our teacher training courses we ask as far as possible for husbands and wives to receive training and work together in their villages.

In a survey of 448 clients of 16 teachers, it was found that 66 percent were literate and 66 percent Christian. Muslims accounted for 27 percent. Nearly 80 percent

lived in rural areas. Just over 60 percent were in the age group 21 to 30 years. Seven percent wanted to achieve pregnancy, 52 percent to space, and 41 percent to limit their families.

The cost to clients for using the ovulation method is very little. Most village people do not purchase the booklet which costs only Taka 2.00. The charts are provided free of charge. Expenses for two- and

three-day seminars at a parish or village school are covered by the parish or our program.

We feel that a good beginning has been made. We wish both to help Bangladeshis appreciate the need for responsible parenthood and present a program which communicates a value for life and the dignity of the individual.

## Calcutta



Mother Teresa

This summary describes the NFP program of Mother Teresa's Missionaries of Charity in and around Calcutta. The program actually began in 1971, although some base line activities had been initiated as early as 1967. The objective of the NFP program was to impart a sense of human dignity to the couple through the experience of a deep oneness in a free relationship that would radiate love, peace, and joy in the family.

The genesis of the program can be traced back to Mauritius in 1963 with the creation of l'Action Familiale of Mauritius. Sister Paulette joined l'Action Familiale in 1964. She took a keen interest in all aspects of NFP, receiving her training from Drs. François and Michèle Guy and other members of the team. Sister Paulette left Mauritius in 1967 and joined the Missionaries of Charity under Mother Teresa the same year. Thus the nucleus was set for the propagation of the method in the Calcutta slums.

With the approval of Mother Teresa and her active interest and enthusiasm, Sister Paulette organized the program. It took almost a year for her to fully implement her plans. The target population in the program included a total of 120 urban and rural centers in and around Calcutta. Initially, 699 couples were included in the program in 1971, which over the years increased to 43,293 in 1982.

The minimum age of women was 16 years. About 70 percent were between 20 and 29 years of age, whereas 50 percent of the male partners were aged 30-39 years. The population consisted of Hindus, Muslims, and Christians. Their proportions varied from year to year. The final distribution by religious affiliation at the end of 1982 was 26,158 Hindus (60.4 percent), 10,223 Muslims (23.6 percent), and 6,912 Christians (16.0 percent). Seventy percent of the females and 15 percent of the males had no formal schooling; 26 percent of the females and 79 percent of the males had only two years or less of schooling. Twenty-six percent of the couples had two children and 25 percent had three at the

time of enrollment. Eighty percent of the women were housewives by occupation.

Sister Paulette trained the sisters and arranged for their family visits. They initially decided to implement the sympto-thermal method of NFP. The thermometer was used for recording the basal body temperature of the women. The Catholic Marriage Advisory Council (CMAC) in England supplied thermometers and literature and other materials in the English language. In 1973, the Gandhian Institute of studies at Varanasi, India, led by Dr. Anritananda Das did excellent work in the sympto-thermal method of NFP. They highlighted its virtue and appropriate place in the Indian context as a way of life according to Gandhian philosophy. During the three-year period between 1967 and 1970 Sister Paulette, along with her trained sisters and educators, was able to develop a great deal of sympathetic cooperation and involvement with the members of different families. Couples were motivated to adopt the method and followed it conscientiously.

The Sisters of the Missionaries of Charity were trained in the sympto-thermal method and were instructed on techniques of educating couples. The sisters and educators visited the couples once a week and taught them the methods to be followed.

In order to achieve cooperation from the poor couples, some services had to be rendered. These included check-ups and treatment for minor ailments of family members and care for pregnant mothers, newborn infants, and children. NFP has become a work within the framework of the constitution of the Missionaries of Charity, which has proved useful for the success of the program.

Funds for implementation were provided entirely by the Missionaries of Charity. In 1975 the expenses amounted to Rs84,324.00.

The couples (both husband and wife) were trained by the educators in simple terms in the local language. They were also taught to record the basal body temperature by placing the thermometer (supplied to them against a payment of approximately US\$ .30) under the tongue before getting out of bed every morning from the first day

of the period. If necessary the husband or the educators assisted in the proper recording of the temperature on a piece of paper. These were brought to the local centers weekly for check-up and records. The couples were instructed to abstain from sex until three days after the thermal shift. For reasons of simplicity, the sympto-thermal method was abandoned for the modified Billings (OM) method in 1978. The modification used was abstinence in the entire pre-ovulatory phase.

During the initial "unregistered" phase, it was observed whether the couples were able to follow the method properly and differentiate the fertile from the nonfertile phases. Only when they were able to do this were they permitted to enter the "registered" category.

The couples were divided into three categories. The new couples were considered unregistered until they had completed four months of training. After that they were categorized as registered if they were able and willing to follow the method. After the couple had used the method successfully for three years, they were considered autonomous and they did not need to visit the centers in the slum areas for a check-up unless they had problems. They received a certificate recognized by the state government exempting them from the government sterilization program. They were well trained to look after themselves and follow the method in the correct way.

A group of educators was selected from these autonomous couples who in turn trained couples among the neighboring population, checking and reporting any pregnancies among them. While working as educators they received Rs200 per month. About five percent of these educators dropped out mainly because of illness. The educators are supervised by the Missionary of Charity Sisters. In 1982 a total of 110 educators recruited from among the "autonomous" couples were working in the program. Thus a little less than one percent of the autonomous couples became educators. The educational component of the method reportedly worked well.

# Korea

The ovulation method (OM) was first taught in the pastoral care center of St. Columban Hospital in Mokpo, a small town on the south coast. We had limited materials, no experience, and no money. Our teaching was monitored by Drs. John and Lyn Billings by mail from their research center in Australia.

In 1974 Bishop Stewart established NFP centers in all Catholic hospitals, clinics, and parishes in his diocese of Chunchon. Clients were mainly from rural and working-class families. There was a great demand for services. In May 1975 the Catholic Hospitals Association with representatives from all the dioceses met in Seoul to launch the Korea Happy Family Movement (KHFM) as a national organization. Centers were established in all Catholic hospitals and clinics throughout the country. The centers in each diocese had a priest-director and a qualified NFP couple. The coordinating office is situated in the Catholic Medical College in Seoul.

The goal of the KHFM is to make NFP available to every couple in Korea and to teach fertility awareness to young people as a holistic approach to human development. Couples are helped to grow in love and understanding, mutual sharing, and forgiveness. Mother and child care, preventive medicine, and counseling are components of the KHFM, especially in hospital and clinic-based programs. In rural areas the parish-based teacher makes many referrals for diseases detected in the early stages.

The total budget for 1980-82 was as follows:

	Total Budget	Overseas Funding	Diocese Self-Support
1980	₩67,400,000	₩18,080,000	₩49,320,000
1981	₩77,250,000	₩28,570,000	₩48,680,000
1982	₩64,810,000	₩18,000,000	₩46,810,000

Major expenses are salaries, printed materials, and workshops.

In 1978 Korea was one of six countries in the evaluation of the WHO Family Fertility Education Resource Package. The

sympto-thermal method was introduced into four centers at that time.

There are 194 teachers working in 77 centers. Half are salaried, 20 percent receive a part-time salary, and the remainder are volunteers. A national two-day live-in seminar is held every year for teachers. It usually covers the spiritual, psychological, and scientific aspects of family life.

Dioceses conduct their own teacher training workshops with help from the coordinating office in Seoul. The format is usually an afternoon seminar one day a week for six weeks, with consultation and supervision on a follow-up basis for one to two years. The main requirement for teacher training is that the candidate be an experienced user. Normally we require teachers to be Catholic, but we also have Protestant and Buddhist teachers who accept our philosophy. All teachers are first instructed in the OM and then the ST method. Four centers teach ST and the remaining 73 teach OM. We use the like-to-like system: factory workers teach factory workers and so forth. Nurses and school teachers want more sophisticated instruction. Most of the teachers are high school graduates, a few are college graduates, and some are registered nurses.

## Statistics 1980-82

	1980	1981	1982
Number of couples who learned NFP	8,619	9,374	9,619
Surveyed	6,678	5,688	6,725
Not surveyed	1,941	3,686	2,894
Satisfied with practicing NFP	4,816	4,544	4,827
Reverted to other methods and/or gave up NFP	1,535	796	1,553
Husband abroad in a foreign country			150
Pregnancy	227	248	95

The number of pregnancies dropped from 248 to 95 during the nine months of 1982. We found we needed to concentrate on teaching OM during breast-feeding. There is a marked difference in the confidence of women when the couple learn the method together compared with that of young women who learned the method in a female group before marriage. Approximately 50 percent of clients are Catholic;

the rest are of another Christian denomination, Buddhist, or of no religion. They are usually young couples with one child.

We introduce fertility awareness in high schools, colleges, and universities throughout the country on a twice-yearly basis. NFP is part of the curriculum for medical and nursing students of the Catholic Medical College in Seoul. Female students chart their own cycles. Five nursing colleges have our program as part of the curriculum for public health.

Each diocese is accountable for the over-

all administration of its program. Teachers and centers are visited on a regular basis by the national coordinator. An annual survey of the work of each diocese with a progress report is taken every year. A quarterly newsletter is circulated throughout the country. It costs US\$10-15 for a client to become autonomous.

We consider the Church-related structure of the program a big help in promoting KHFM. Our greatest needs are financial and material resources. We would like to see more biomedical and psychosocial research.

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## Pakistan

Following visits of Drs. John and Evelyn Billings to Karachi and Lahore in 1974, Fr. Luke Turon, M.D., acted as a contact for those interested in NFP. Two doctors, one in Faisalabad and one in Sarghoda, began teaching the method in addition to several religious sisters working in rural dispensaries. In 1977 the Bishops' Conference of Pakistan approved a grant from Caritas Pakistan for Rs25,000 to promote NFP.

In 1978 a religious sister and a Muslim working in a government hospital in Lahore attended a workshop on the ovulation method (OM) in Australia. Sr. Elizabeth Ann Yates began teaching couples in north Pakistan and opened an NFP clinic in St. Raphael's Hospital, Faisalabad. Dr. Saad Rana gave lectures to medical and nursing students and published an OM instruction sheet in Urdu.

In 1980 Misereor gave a three-year grant of Rs39,000 per year with which office equipment and audiovisual materials were purchased. In September 1981 Dr. Hanna

Klaus ran a workshop in Karachi and evaluated some of the teachers. An NFP clinic was set up at Holy Family Hospital in Karachi.

The majority of village clients for NFP are from the lower economic group and are Christians; in the cities many clients come from the middle class, and in Faisalabad the majority are Muslim women. Husbands only rarely come for instruction.

The goal of the program is to teach NFP to groups of married couples who can support one another and spread NFP use to society. The ovulation method is taught almost exclusively. Only in Karachi is there regular training and evaluation of teachers. Few statistics have been collected. The centers are all independent in funding and setting objectives. Some help is given by supplying literature, but no reports are required.

Many cultural attitudes in Pakistan militate against any type of family planning. Added to this are the objections that NFP requires periods of abstinence and better communication between husband and wife. More research needs to be done into the psychosocial aspects of the culture, especially the joint family system and its relation to NFP.

# Europe



An English family in Oxford



Europe is the area of the world with the oldest NFP tradition. It was here in the mid-1930s that the temperature method was first introduced as a significant advance over calendar rhythm.

The natural family planning services associated with the Catholic Marriage Advisory Council in England and the Centre de Liaison des Equipes de Recherche in France became significant models for family life promotion NFP programs. In the mid-1960s essential elements of their organization and services were disseminated throughout the French- and English-speaking world. These are also the groups whose experience in NFP teaching has been most extensively analyzed. Together with the experienced younger NFP programs from the developing world, they made a major contribution to the WHO Family Fertility Education and Resource Package of the mid-1970s.

The combination of volunteer NFP teachers with a strong centralized national leadership is best illustrated in both the French and Irish national programs. Both eventually obtained government subsidies, especially for training. The oldest programs of France, England, and Ireland also illustrate the importance of complementary family life services. They provide such services, in addition to NFP, as marriage enrichment, marriage counseling, marriage preparation, family life education, and sex education in the schools. As in the other zones we can foresee significant progress over the next few years as regional collaboration and coordination of training and service standards are improved.



Drs. Jean and Françoise Mutricy

# Centre de Liaison des Equipes de Recherche

## JEAN MUTRICY

*Jean Mutricy, M.D., former president of CLER (1970-80) and current vice-president of CLER responsible for international relations; practicing surgeon; delegate of CLER, Paris, France*

*France, a country in western Europe located between the Atlantic Ocean and the Mediterranean Sea, occupies about 546,000 square kilometers and has a population of 54 million persons. Its crude birth rate is 15 per thousand, and its crude death rate is 10 per thousand. The annual rate of natural increase, 0.5 percent, implies a slow doubling time—it would take 151 years for the population to double at current rates. A projection to the year 2000, also at current rates, shows a population of 56.7 million. The population density of*

*France is just under a hundred persons per square kilometer, and a little more than three-quarters (78 percent) of the people live in urban areas.*

*Twenty-three percent of the population is under the age of 15, and a relatively high proportion (17.5 percent) is 60 or over. The life expectancy of 74 years shows a differential between males and females of about seven and a half years. Males can expect to live 70.6 years, whereas females have a life expectancy at birth of 78.1 years. The infant mortality rate*

is 10 deaths per 1,000 live births.

The population is a mixture of European and Mediterranean groups. The official language of the country is French, although some minorities (Basques and Alsatian Germans, for example) speak their own languages. Most of the French population are Roman Catholics.

Per capita gross national product in 1981 was \$12,130. The per capita income estimate for 1980 was \$8,980.

The French government's position on family planning is officially a pronatalist one, but family planning services are widely available. The World Fertility Survey conducted in France found that 79 percent of married women of reproductive ages (20 to 44) were using contraception in 1978.

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*Centre de Liaison des Equipes de Recherche (CLER) was founded in 1961 to recruit working teams of couples, physicians, and priests dedicated to the cause of natural family planning. At an early stage of development, CLER expanded its activities to marriage counseling and to education on emotional growth and sexuality for youth. Contacts were developed with numerous foreign programs, and couples from CLER participated actively in the International Fairfield Study (USA). CLER also participated in preparatory meetings for the foundation of the IFFLP and sent its delegates to attend the IFFLP congresses in Cali and Dublin.*

*CLER is a recognized public association. Its national secretariat in Paris coordinates the work of its local teams, who work in 76 departments (provinces) in France. CLER edits a magazine and publishes teaching materials designed for instructors and conjugal counselors. Training of personnel consists of an official training program conducted during eight consecutive days. In spite of the difficulties encountered because of the availability of artificial contraception, CLER has continued to believe in the promising future of natural family planning and has organized a session on continuing education for instructors in this field.*

## **Growth and Development**

CLER was created in June 1961 as a result of a national meeting of the Centers for Marriage Preparation on the theme of family planning. Teams of couples, physicians, and priests, independently working on natural family planning, decided to consolidate their efforts and to create a national secretariat, which was called "Centre de Liaison des Equipes de Recherche" (CLER), or Coordination Center for Research Teams. Its founders were Drs. Charles and Elisabeth Rendu, Drs. François and Michele Guy, Father de Lestapis, and Father d'Heilly.

In July 1961 a liaison bulletin began publication. Initially called "Fiches Documentaires du CLER," this bulletin eventually became the magazine *Amour et Famille (Love and Family)*. In April 1962 CLER was officially granted its legal status according to the *Journal Officiel* as an institutional organization under the Law of 1901. The following year, the Catholic Episcopal Conference of France linked CLER to its Family Life Department.

By 1963, 53 of 90 departments had one or several teams of CLER. Their objective was to assist couples who had problems with family planning. This help was provided by trained couple instructors and is known as "couple-to-couple assistance." In the same year, a program of natural family planning was initiated in Mauritius, and Drs. François and Michèle Guy participated in the creation of l'Action Familiale of Mauritius. Even at that early date, groups and individuals from numerous foreign countries had already been in touch with CLER. In 1965, 400 members of CLER responded to a survey from the Pontifical Commission working on artificial contraception issues. In 1966, CLER experienced a crisis as some of its members expressed a desire to have a more flexible movement in a non-Christian setting. They withdrew from CLER and formed another association—"Couple et Famille." CLER then had to train new teams and start again, during the difficult time when the popularity of chemical contraception was growing.

In 1967 Dr. Charles Rendu published a book based on the experience of the

member couples of CLER. The title was *L'Eglise Nous a-t-elle Trompés? (Has the Church Misguided Us?)*. The promulgation of the papal encyclical *Humanae Vitae* clarified the problem posed by the issue of contraception, but it disappointed the great majority of the French people and it was not received as CLER would have wished it to be. Most French couples sided with the ideas of contraception, and the action of CLER, which contradicted this notion, was perceived as outdated. In spite of this opinion, CLER remained active and continues to work in the three areas of natural family planning, marriage and counseling, and education of youth in sexuality and love. In fact, it seemed impossible to separate family planning from education about love.

In 1969 the first eight-day training session was held at the Foyer de Charité de la Part Dieu at Poissy, a retreat center outside Paris. The following year, on the occasion of Dr. Claude Lanctôt's visit to Poissy, the idea was born to create an international federation to unite the various associations in a number of countries who aspired to work on natural family planning and family life education. At this time also, more than 300 couples of CLER participated in the International Fairfield Study (USA) on natural family planning. The idea of creating an international federation was restudied at Cali in 1972, and finally the International Federation for Family Life Promotion (IFFLP) was founded officially in Washington, D.C., two years later.

During this time in France, the pro-abortion campaign was at its peak. Even though CLER and other associations made all possible efforts to enlighten the public, a law permitting abortion was passed in 1975. Public opinion continued to be very favorable toward contraception, and the activities of CLER seemed marginal.

Meanwhile, CLER improved its programs on training, and the sessions at Poissy had more and more influence on participants. Even though natural family planning did not seem to interest the majority of the public, CLER continued to train instructors to be well versed in the methods of self-observation of the female

cycle (NFP). The objectives established by its founders were not abandoned. In 1977 a delegation representing CLER and led by the Rendus participated in IFFLP's First International Congress in Cali. Three years later, CLER participated in the Second International Congress of IFFLP in Dublin and sent a representative delegation to the Bishops' Synod on the Family in Rome.

At this time a certain disenchantment with the use of artificial contraception and a renewed interest in natural family planning began to be felt in France. CLER intensified its instructors' training programs and renewed with real success its public meetings on creating awareness of the use of the methods of self-observation of the female cycle.

Throughout these years, CLER has continued to undertake the training of marriage counselors and of teachers for the education of youth on sexuality and love. This approach toward the young has been very successful since its official introduction. The members of CLER trained in this area have spent many hours in information sessions. They continue to meet with groups of young people (18,500 altogether in 1982). The same year CLER's counselors and instructors met with some 70,000 adults.

The founders of CLER decided that they would create a "coordination center for research teams." The imprecision of this title has been providential, because it has not limited CLER's scope of research activities to family planning. Interest has been extended to many other domains dealing with family life, ensuring thereby a truly comprehensive family life promotion approach.

It is difficult to determine precise figures on natural family planning users because the statistics are prepared for the ministry, which does not require details on this activity. We can estimate a percentage of new natural family planning users at approximately two-thirds of the total. With respect to its administration, CLER is a nonprofit organization, functioning in agreement with the French Law of 1901. It is governed by a board of directors composed of 15 members elected by its general assembly.

This board designates a body consisting of the president, three vice-presidents, the secretary, and the treasurer. CLER's headquarters are in Paris, where the national secretariat of the association is located. France is divided into regions under the responsibility of regional coordinators who supervise the activities of the local teams in collaboration with the national secretariat.

### **Training and Service**

The local teams are the basic work units. Under the direction of team coordinators, their members are assigned to the various activities of CLER. The national working groups (called commissions) meet in Paris. One of them is in charge of the publication of the monthly magazine *Amour et Famille*. This magazine has presently some 3,000 subscribers, and more than 20,000 copies were sold to the public in 1982. Through this publication CLER reaches an audience larger than just its members. Another commission is in charge of research on sexology and on medical ethics. Another coordinates activities on research in natural family planning and takes part in the preparation of technical documents. The Youth Commission is in charge of the training of more specialized teachers for education in sexuality and love. Another commission coordinates all of CLER's trainers to improve its various educational programs.

CLER's trainers must be effective at three levels: (1) that of "know how"—for example, the running of meetings, speaking in public, and training people to listen; (2) that of general knowledge, such as anatomy, physiology of human reproduction, psychology, and sociology; and (3) that of personality development, by participation in studies and discussion groups, group dynamics, and psycho-dramatics.

For the last 10 years, CLER has been officially recognized by the Ministry of Health as a training organization. Its programs conform to the stipulations of the ministry and address specific issues, particularly the teaching of a Christian vision of sexuality.

In agreement with the ministry's regulations, there are two types of training: a

course of 20 hours for instructors charged with giving family planning information to adults and young persons; and a longer course of 400 hours for the training of marriage counselors.

The training sessions usually last eight days at Poissy, with additional weekend sessions on such techniques as how to conduct meetings. Knowledge is tested by written and oral examinations, including NFP (sympto-thermal) chart interpretation. A certificate is granted only after the candidate has passed an assessment on psychological aptitude. The short-term training requires at least a year and often 18 months.

The training program for the other level of marriage counseling offers three sessions at Poissy and weekend sessions on listening techniques. This training is very much oriented toward the psychology of relationships and to helping in personality development. This extensive training program consists of 400 hours of theoretical courses. It is often spread out over a period of three years or more. This is considered indispensable for the psychological development of the candidate marriage counselor. As for the NFP teacher training programs, there are also continuing tests on knowledge and interviews on psychological aptitude. Continuing education sessions for instructors and counselors are provided and organized within the training sessions at Poissy.

### **Evaluation**

The number of marriage counselors at CLER is stable at around 320, which means that the newly trained personnel replace those who depart. As for NFP teachers, their number increased from 291 in 1980 to 350 in 1982. It is not possible, at present, to provide exact figures on the caseloads or clientele characteristics of natural family planning teachers, but we must underline the renewed interest that the French public has manifested toward it.

One of CLER's physician members, Dr. René Ecochard, has proposed to dedicate his complete sabbatical year to the upgrading and continued education of couple instructors in natural family planning. This proposal, presented in September 1983,

has received an immediate and overwhelming response, with more than 250 requests received over a short time. The enrollment costs to finance expenses for this program are practically covered at this date. This program on the further improvement of the NFP teachers will include a small section on theory and a major section on chart interpretation for both the cervical mucus and the sympto-thermal methods. This experience is too recent to have any results available, but its existence is in itself proof of a change in the public opinion.

The area of publicity is left to the initiative of local teams.

Recognized as a public association, a member of the Superior Council for Information and Education on Sexuality, as well as officially recognized by the Ministry of Health as a training institution, CLER receives a subsidy for administrative costs. Its other sources of income are membership dues, contributions, the participation of its members, and, for its training program costs, enrollment fees and a subsidy from the Caisse National d'Allocation Familiale. The budget of the national secretariat of CLER was F1,165,000 in 1980 and reached F1,630,000 in 1982. To this figure one can add the budgets of the local teams. It must be noted that the subsidies of the government continue to represent an important part of the resources of the organization and that it would be most desirable to develop additional sources of financial support.

### **Accomplishments**

As one tries to determine what has been of greatest importance to CLER in the past years, one thinks immediately of the fundamental role played by its training sessions

at Poissy. These eight consecutive days of intensive training twice a year, in July and in September, bring together each time 180 persons at six levels of training. Among these persons we have always had participants from foreign countries. Through these sessions our aims are to provide quality training but with a sense of Man and Christian ethics. The general atmosphere at Poissy is such that many members of CLER come back voluntarily for follow-up sessions on continuing education.

Another very important activity has been the work of the Youth Commission, which has organized training sessions on education on sexuality and love for adolescents and for adults interested in this subject (parents, educators, professors, and others). In addition, an annual session deals especially with the important topic of "Education on the Body and to Relationships" which receives regularly a very favorable response.

The greatest achievement of CLER has been to continue to believe in the importance and promise of natural family planning. After 20 years of relatively unproductive efforts in this field, following the rapid expansion of artificial contraception, an evolution in public opinion especially manifested in the press by feminist movements, proves the justification of our perseverance.

The most important of our needs are certainly to sustain public opinion and to achieve a change of mentality on the part of the medical profession toward a greater acceptance of natural family planning. It seems to us that CLER could benefit from the scientific results contributed by the research done in natural family planning, and from research accomplished in the psychosocial area, from the individual as well as the family perspectives.

# Catholic Marriage Advisory Council of Ireland

**ANDREW KENNEDY**

*Andrew Kennedy, priest; national director of Catholic Marriage Advisory Council of Ireland; delegate for CMAC-Ireland*

*Ireland occupies more than 70,000 square kilometers of an island just west of Great Britain in the Atlantic Ocean. The population of 3.5 million persons is predominantly Irish with an Anglo-Irish minority. Ireland's crude birth rate is 21 per thousand, and its crude death rate is 9, resulting in an annual rate of natural increase of 1.2 percent. The population would double in 60 years at present rates, and the projection for the year 2000 is about 4.1 million persons.*

*Population density is just over 300 persons per square kilometer, and nearly 60 percent of the people live in urban areas. Young people—those under the age of 15—constitute 31 percent of the population, and 15.3 percent are 60 or older. Life expectancy at birth is 73 years. The infant mortality rate is 11.2 deaths per thousand births.*

*The English language predominates in Ireland, although Irish (Gaelic) is spoken by a minority. Ninety-four percent of the people are Roman Catholic, and about 5 percent are Anglican. The per capita gross national product was estimated at \$5,350 in 1981.*

*The trend is toward smaller families in Ireland, although the birth rate is still high. The 1980 total fertility rate was 3.4 children per family. In the last two decades, people's aspirations have moved toward some kind of family limitation.*

*Government policy toward family planning was promulgated in the Health (Family Planning) Act of 1979, which states that: "The Minister for Health shall (a) secure the orderly organisation of family planning services, and (b) provide a comprehensive natural family planning service, i.e., a comprehensive service*

*for the provision of information instruction, advice, and consultation in relation to methods of family planning that do not involve the use of contraceptives."*

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*The Catholic Marriage Advisory Council of Ireland (CMAC) aims to help people initiate, sustain, and enrich their marriage and family relationships. This involves family life education, a marriage counseling service, and a family planning service, which represents about 10-12 percent of the annual workload. The service, mainly Church-inspired, is staffed by trained volunteers and is offered in urban and rural settings at about 100 service delivery points. It is funded by the Church and government and, in the approximately 20 years of its existence, the focus has moved away from a medical model toward a relationship model.*

*The service engages 400 trained teachers, who are supported and supervised by about 40 tutors and two full-time tutor consultants. The board of directors of CMAC is drawn from the membership and is accountable to the Church and government in the allocation of funds (currently IR£50,000 per annum).*

*Teachers, tutors, and tutor consultants are selected and trained. The emphasis in training is to help staff members offer a quality service to enable couples to become autonomous in their fertility management. In-service training is a requirement. Help is needed in developing realistic evaluation procedures for the service.*

## **National NFP Program Development**

The Catholic Marriage Advisory Council's NFP program is part of an integrated service to marriage, which also includes premarriage education and marriage counseling services on a large scale, post-marriage education on a small scale, and education in schools on a medium scale. NFP represents about 10-12 percent of CMAC's annual workload. In this regard, we are similar to the Catholic Marriage Advisory Council in the United Kingdom (U.K.), from which we were founded in 1962. The program is Church-inspired.

The CMAC began in 1962 and was established branch by branch from London. There were 4 branches by 1966, 12 by 1970, 30 by 1975, and 50 by 1982. An independent Council was established in Ireland in 1975, but links with CMAC (U.K.) are still maintained to mutual benefit.

CMAC clients come from a broad spectrum of backgrounds in both urban and rural areas. Teachers are mainly married women, most of them nurses, counselors, or doctors. Our program originally adopted a focus that was primarily medical. After reflecting on our experience and sharing with other groups internationally, we came to see that this approach was inadequate because of its medical, female, and problem focus. Accordingly, we have set about moving the emphasis from medical to human, from female to couple, and from a problem to a normal arena. We are now training all our family planning personnel in counseling skills.

In aiming to help couples integrate NFP into their relationship, we try to enable them to become autonomous in the management of their own shared fertility and, as a corollary, to free them from dependency on technology, medical or otherwise.

The service provided is more than a method; it has a relationship emphasis. We teach the basal body temperature (BBT), sympto-thermal, and ovulation methods. They are taught in the English language.

Our funds come from the government and the Church. We have 50 branches throughout the country and a representative board of directors drawn from the

membership. Our relationship with the government is satisfactory. Funding was very limited before mid-1981, when government funding for NFP began. Since that time, about IR£125,000 has been spent. The grant is negotiated each year.

The central office is in Dublin, and the 50 satellite centers or branches are located throughout the country. Altogether there are about 100 service delivery points.

CMAC has cooperative relationships (but no formal affiliation) with hospitals, health boards, and the body responsible for post-graduate training of doctors. Relationships are also maintained with general practitioners and public health nurses.

### **NFP Education, Training, and Service Development**

There is a selection procedure for all persons joining CMAC. Each candidate must have a warm and open personality; be sensitive, perceptive, credible, and trainable; and have the ability to accept and be concerned for others. Training strives to develop these qualities further and the skills needed to use them effectively.

It is the aim of initial training to give the trainees an understanding of the marriage relationship, especially in the areas of fertility and sexuality, as well as a knowledge of all methods of family planning and especially of natural methods in current use. The training is designed to develop and foster knowledge, skills, and attitudes appropriate to the service and to assist the trainee in becoming an effective helper in fertility management and an effective teacher.

Specifically, the training course includes the following topics: anatomy and physiology, man and woman in relation to fertility, the menstrual cycle, the temperature method of NFP, the cervical mucus method of NFP, the sympto-thermal method, chart interpretation, alternative methods of NFP fertility management, record-keeping, emotional development, human sexuality, marital interaction, self-awareness and self-disclosure, a philosophy of NFP, morality and family planning, teaching and evaluating skills, helping skills, and the place of faith in the life and service of the individual.

The teaching process used is that of in-



Children in County Clare, Ireland

put followed by small group discussion. In the small group there is clarification of the material taught, discussion of feelings and attitudes where appropriate, and application to the work situation of the learning that has taken place. Each small group consists of six to eight trainees led by a tutor.

The first part of the course takes place over two residential weekends and six full days within an eight-month period. This is followed by three to six months of supervised teaching.

Teacher evaluation takes two forms. Throughout the training period there is an

ongoing assessment of the trainee by the tutors in theory and skills learned and feelings and attitudes expressed. At the end of the first part of training, a written examination tests the theory related to NFP. An oral assessment, conducted after three to six months of supervised teaching, focuses on the ability of the trainee to teach NFP effectively and to understand and relate to the dynamics of the couple's relationship. The cost, of initial training is approximately IR£300 per teacher.

All CMAC personnel must have 20 hours of in-service training each year. This is of-

ferred in the form of two-day sessions (about 10 hours) and five to eight evening sessions. In-service training aims to develop further the skills learned during the initial training and to cover other aspects of NFP teaching, such as special circumstances that may be encountered.

A well-trained group of tutors is necessary to implement such a training program. Potential tutors are drawn from the body of teachers. In addition to the qualities needed for selection for the training program, a flair for leadership and an interest in teaching and group work are considered important attitudes for those invited to become tutors. A potential tutor must be a confident and experienced teacher of NFP. Training takes place over three residential weekends, usually at monthly or bimonthly intervals. An ongoing assessment of the tutor trainees is made, and at the end of the period suitable persons are invited to become tutors. Tutors are required to attend two residential weekends of in-service training per year.

Two full-time tutor consultants attached to the NFP department are responsible for tutor training, both initial and in-service. They design and implement the tutor training programs, supervise and assess trainee teachers, and make recommendations to the director regarding the suitability of potential tutors.

CMAC has 400 teachers, none of whom works full-time. All are part-time volunteers. They are encouraged to claim reimbursement for expenses, but most do not. We have no accurate figures of continuation or dropout rates of teachers, but we suspect that the reasons for dropping out of the program include such things as family obligations and moving away.

#### **Service Delivery**

The number of users, both new and continuing, shown in our records from all branches for the last four years is as follows: 7,825 in 1979; 9,164 in 1980; 7,738 in 1981; and 6,145 in 1982. The only criteria for becoming a new user are a willingness and desire to be trained in NFP. All three NFP methods are taught, but we have no figures on the preferences of clients for methods. The sympto-thermal method is

probably the most popular, followed by the ovulation method and BBT. We do not have figures available on the cost per user of training to autonomy.

The vast majority of acceptors use NFP for spacing pregnancies; a sizable minority use it for limiting their families; and a small minority practice NFP for planning a pregnancy. Precise figures are not available. The continuation and pregnancy rates are not known to us. The autonomous couple rate is also not known, and no criteria have yet been devised to identify autonomous couples. No pattern has yet been discerned as to the percentage of users who become teachers.

#### **Program Evaluation and Accountability**

The program is accountable in the administration of funds to the board of directors, the government, and the hierarchy; in achieving target objectives to the board of directors; and in adhering to stated goals and philosophy to the board of directors and the hierarchy. We have outreach activities in each diocese. To recruit clients, we advertise the availability of our service. We offer them the opportunity for follow-up and encourage them, but the initiative is left with them.

We do not yet have a strategy for evaluating teacher effectiveness, cost effectiveness, overall impact on the community or national fertility programs, the relative importance of family life and NFP components, pregnancy and dropout statistics, use-effectiveness of learning and continuing users, or the acceptability of natural methods.

#### **Accomplishments and Development Needs**

We are making a serious effort to offer a professional NFP service to people. Our greatest challenge is to make a greater impact on the community, especially in the matter of attitudes. Many see the debate only at the level of method and have no perception of a philosophy of NFP.

Our greatest needs are more tutors, better tutor training, more full-time personnel; more finance; better literature; and better publicity of a suitable kind.

We see the need for better methods of

administration and operating the program, especially in the area of record keeping. The effective use of better methods would help us considerably and would reduce the number of gaps in our knowledge, which

are evident in this report. We need more information on why people do or do not choose NFP, their motivations, and their experience with abstinence. Demographic research, too, is obviously important.

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## Austria

The Institut für Ehe und Familie (IEF, Institute for Marriage and Family) was founded in 1973 by the Austrian Episcopal Conference. One department was established for natural family planning. The bishops commissioned the first director, Father Alois Jaeger, and Dr. Josef Roetzer to establish and develop NFP in Austria. Some preliminary work had been done earlier beginning with a medical conference in 1965 in Vorarlberg. Because the encyclical, *Humanae Vitae*, met with widespread rejection in German-speaking Europe, progress was difficult.

A special training program for NFP educators was initiated in June 1976 with a meeting in Vorarlberg for the diocese of Feldkirch and bordering areas of Switzerland and Southern Germany. Participants also came from the South Tyrol, Italy. Since then the Vorarlberg center has offered training weekends with Dr. Roetzer for 80 to 120 participants twice a year. A study group called "Natural Conception Regulation" was founded in 1982 within the Family Life Bureau of the diocese, and by May 1983, 46 seminars were given to 1,135 participants. The "Model Vorarlberg" was the first systematic NFP organization in German-speaking Europe.

Independent NFP groups in other Austrian dioceses and bordering areas have developed since 1980, in Kärnten/Carinthia, Steiermark/Styria, the Tyrol, Biberach, Germany, and in Switzerland. From June 1982 to October 1983, classes were held in southern Germany for 1,300 participants.

The basic training model created by IEF and Dr. Roetzer consists of three half-day



Dr. Josef Roetzer and his daughter, Elizabeth Roetzer

classes with six to eight weeks in-between to allow the couples time to gain personal experience; a weekend of further training; and for those couples wishing to teach NFP, additional weekends of intensive training. Individual counseling is offered before and after classes. Leaders of regional organizations and educators remain in contact with Dr. Roetzer for continuing education.

One program of IEF is devoted to scientific research under the auspices of Dr. Roetzer with Dr. Kucera, associate professor at the University Hospital of Obstetrics and Gynecology in Vienna. Spiritual assistance is given by Prof. Karl Hoermann, professor of moral theology, University of Vienna. Regular seminars are held on NFP; a counseling service is provided twice a week free of charge; teacher training is conducted by Dr. Roetzer; and a library on NFP is being built up. Research is planned in conjunction with the university.

Since 1951 Dr. Roetzer has conducted counseling and research through the Mar-

riage Advisory Service Roetzer in Voecklabruck. Services include personal counseling and counseling through correspondence (30 to 50 letters and charts a day). The Service has prepared worksheets and learning aids. Dr. Roetzer's book *Natuerliche Geburtenregelung* (Natural Birth Regulation) has been translated into English, Dutch, Japanese, and Croatian. Slides and transparencies have been designed for both introductory and advanced classes.

Dr. Roetzer has also collaborated with the Family Life Mission of Ingrid and Walter Tröbisch to relate NFP to the general concept of Christian marriage and to bring NFP to the Protestant Church.

Dr. Roetzer has conducted two studies of clients from Austria, Germany, and Switzerland who send in their charts by mail. The 1975-77 study was retrospective,

the 1979-83 preliminary study prospective. The latter survey will be carried on into the indefinite future to discover "the reliability and liveability of NFP under *everyday conditions*." Couples are free to choose any natural method except calendar rhythm and decide either to avoid or achieve pregnancy. Pregnancy is not treated as a "dropout statistic" but as "an interruption in exposure." Only those couples who switch to a contraceptive method or decline further cooperation are considered true dropouts.

Final results of this study are expected to provide information on fertility and infertility, unplanned pregnancy, pregnancies while experimenting in the margins of the fertile period, pregnancies due to the use of barrier methods, and planned pregnancies as well as continuation rates after pregnancy.

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## Italy

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### CISF

The promotion of NFP, with some exceptions, was limited to Catholic couples until a few years ago. Very little attention was given to family planning in the university medical curricula. Hardly any mention was made of NFP. Doctors have extremely negative judgments on NFP.

In 1974 the Italian government introduced legislation to establish Consultori Familiari, centers for "social and psychological counseling" as well as for distribution of contraceptives. They became primarily family planning centers distributing the pill and IUD to women. The Church then set up its own Consultori Familiari to provide counseling and also NFP.

One of the agencies that was active at the outset is the Centro Internazionale Studi Famiglia (CISF), a foundation of the

Periodical Group of the Society of St. Paul and the Associazione Don Giuseppe Zilli (former director of *Famiglia Cristiana*). The center avails itself of a scientific board, which includes sociologists, psychologists, theologians, philosophers, journalists, and physicians.

The aim of CISF is the study, research, and promotion of family life on an international and national level. Its activities include the training of marriage counselors, training of teams to prepare couples for marriage, organization of seminars, and the publication of materials including the magazine *La Famiglia Oggi* (*The Family Today*).

A major contribution of CISF has been the training of 1,500 counselors, social workers, psychologists, priests, religious sisters, and physicians in marriage counseling. About 21 courses were held in 12 different regions in northern, central, and southern Italy. Many who underwent training are now working in private and public Consultori Familiari. Some of these courses were sponsored by the Bishops' Conference or the Consultori Familiari in the region. In these courses NFP was amply

covered. The first objective was to train the counselors in the "client-centered" (Carl Rogers) approach and then to equip them with the knowledge of NFP. The subject was approached from medical, psychological, and moral perspectives. All methods were presented and then natural methods (mucus method, basal body temperature method, and sympto-thermal method) were explained in detail, with instruction on charting and educating couples in NFP.

This initial training often stimulated the participants to undergo further specific NFP training. This is why CISF is now planning courses in NFP for teachers and couples. Short courses on NFP were given to social workers, student teachers, and engaged and married couples in various parts of Lombardy (the Milan area).

There has been in Italy a need for aids for the training of couples in NFP. The parent group of CISF, *Famiglia Cristiana*, was the first to promote and publish in Italy books

by the Drs. Billings. CISF has now published a "kit" for NFP education entitled *Educazione ai Metodi Naturali*. It was written by two gynecologists and includes a section on moral aspects written by a priest.

The kit consists of a guide book with 40 colored illustrations, 86 colored slides, and a cassette. The kit is being promoted all over Italy and is available for translations in other languages.

CISF is also interested in research in NFP, which the Ministry of Health does not support. An example is the recent policy of the local health authorities in Milan, which had allocated funds for a university department to carry out some research in the field of NFP. Unfortunately, because of the economic cuts in public funds, so far the funds have not been made available.

After this extensive work CISF feels ready to organize specialized courses for training NFP teachers. CISF hopes also to finance both biomedical and psychosocial research in NFP.

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## Italy

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### NFPSRC

The Natural Family Planning Study and Research Center (NFPSRC) is part of the Catholic University of the Sacred Heart. Work began in the field of NFP in 1975 with the establishment of a Marriage Counseling Center. In 1980 a distinct Natural Family Planning Study and Research Center emerged working exclusively in NFP. Both the Marriage Counseling Center and the NFPSRC helped to set up 15 regional centers throughout Italy with subsidiary centers. They now teach NFP, primarily the Billings ovulation method, in hospitals, family counseling centers, parishes, and private homes, both in urban and rural areas. The clients belong to various socioeconomic classes; the

majority are Catholic.

In addition to providing teaching of the Billings ovulation method to clients, the Center conducts training courses. Teachers are taught all natural methods, but particular emphasis is on the ovulation method. The Center maintains an up-to-date bibliography on NFP and on contraception as well and provides translations of books, manuals, and articles into Italian for clients and teachers. The Center has undertaken research on cervical mucus and hormonal correlations, and it coordinates work on the ovulation method in Italy through periodic meetings of regional supervisors, the promotion of in-service courses and congresses, and correspondence with satellite centers.

The Center also provides a medical consultant clinic for difficult cases and offers a two-year integrated course on "The Regulation of Human Fertility" at the university level. Candidates for the teacher training program are selected by personal

interview from among volunteers attending lectures on NFP, in particular the ovulation method, and from clients who are confident of NFP efficacy in solving problems of fertility regulation and who have the right moral qualities and communication abilities. The teacher training program comprises technical instruction in NFP, a practicum of two years, and study of the ideals that motivate the NFP user. Ongoing education is a condition of accreditation. Regional seminars are held two to three times a year, national seminars once a year.

Currently 350 teachers are affiliated with the program, mainly part-time and volunteer. The continuation rate is as high as 99 percent. The goal of the program is to bring the individual person and the couple to a total vision of man and a deeper comprehension of the dignity of human life and the true nature of conjugal love, the transmission of life, and responsible procreation. The Center tries to promote dialogue, reciprocal respect, self-discipline, and love for the child. Teaching is considered thorough when it couples respect for human life with accurate information and proper understanding.

Organizational support is provided by the Catholic University of the Sacred Heart, which has set an annual budget of about Italian L130 million. Affiliated centers are supported by local volunteers. Some have refused public monies to "preserve the spirit of NFP." Financial support is sometimes supplied by dioceses for couples to attend teacher training courses. More personnel and material resources are needed, but funds would not be accepted if tied to conditions. The program would greatly benefit from scientific, biomedical, and psychosocial research.

The Center has also assisted in organizing NFP centers in Belgium, Spain, and France. Orientation courses are also given to nursing and medical students, midwives, doctors, and missionaries.

Following a preliminary survey, the Center designed and distributed data collection forms to all regional ovulation method centers, and results are expected to be computerized in 1984. This will give details on number and characteristics of users, satisfaction with NFP, pregnancy and dropout statistics, and previous family planning use.

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## Malta

For many years the only agency in Malta for the teaching and promotion of family planning was the Cana Movement, founded in 1956. It is a church-based family organization whose aims are to educate young people and engaged and married couples in Christian values of family life and to offer premarriage and marriage counseling services.

The NFP program was started in 1956 and consisted mainly of lectures by doctors in premarriage courses on calendar-rhythm and the temperature method. The Floriana Center has remained the national center, but as a result of demand the first district center was opened in 1961 at St.

Julian's, a private Catholic hospital serving mainly a middle- and upper middle-class clientele. The second center opened in 1963 in Paola, a blue-collar district. Other centers were opened at Quormi (1965), Gozo (1965), B'Kara (1966), Rabat (1970), and Zejtun (1977).

NFP was always presented in conjunction with premarriage courses. NFP was explained to audiences through the Cana Movement; then individual counseling was given to couples in the NFP centers. At first NFP was taught by a team of doctors who volunteered their time. By 1977 there were 25 of these volunteers, but after a doctors' strike against governmental health policies, several left the island, leaving only one gynecologist, six general practitioners, and one psychiatrist.

In 1961 the Cana Movement began em-

ploying trained marriage counselors who were also trained as family planning teachers. At present 16 marriage counselors also instruct in NFP. In 1975 the Billings ovulation method was introduced. It was combined with the temperature and to a lesser degree the calendar method. Hence, we adopted the ST method.

After 1976 the Cana Movement started training NFP teachers and introduced NFP courses both on a national level and on a district and parochial basis. NFP teachers are recruited from women, preferably those in the 25-35 age group who are married and have children. They should have a secondary level of education and be users themselves. Our goal is to have one teacher attached to each of our 60 parishes.

The NFP course consists of six sessions, one every two weeks. Courses are held in small groups of about 10 couples. Referral is available for moral, psychological, psychiatric, and gynecological cases. Clients for the most part are Maltese and come from all socioeconomic classes. Most come from the lower classes. The middle class is the next most frequently represented group. Almost all are Catholic.

The Cana Movement has no fixed source of income, and services and courses are free of charge. Our main support comes from fund-raising activities. Until 1980 the Cana Movement received an annual grant of M£600 from the Ministry for Social Service but then it was discontinued. In 1981 the government opened the state family clinic which provides all forms of family planning except abortion, which is illegal in Malta.

Our budget for 1980-84 is as follows:

<u>Projected Income</u>	
Fund raising	M£21,000
Sale of books	M£ 5,900
Sale of thermometers	M£ 4,000
Donations	<u>M£ 3,600</u>
TOTAL	M£34,500
<u>Projected Expenditures</u>	
Salaries (office staff)	M£19,100
Office equipment and supplies	<u>M£18,700</u>
TOTAL	M£37,800

The main administrative body is the Cana Council, which is made up of the director, president, secretary, and

representatives from each commission of the movement. The NFP program is the responsibility of the NFP coordinator.

The training program for NFP teachers consists of a six-session course conducted by one of our doctors and the NFP coordinator. Each newly certified teacher is attached to a tutor (a doctor or experienced teacher) for several months. Once every month all teachers attend a meeting in which specific cases and difficult charts are discussed. Currently 6 teachers are affiliated with the NFP program, along with 16 marriage counselors and 6 doctors. The NFP coordinator is salaried and works part-time. All others are part-time volunteers. Only one teacher has temporarily dropped out for pregnancy. Tutors informally evaluate the teachers' work whenever the need is felt.

The numbers of user couples trained during the past four years are as follows: 483 in 1980, 564 in 1981, 521 in 1982, and 483 up to August 1983. New users are mostly engaged couples; a small percentage are married couples who are dissatisfied with other methods. We have no reliable statistics on the method selected by the users or continuation rates but are in the process of making a scientific survey. It is estimated that the cost of materials for each user is M£2.82. We estimate that 5 percent of our acceptors are planning a pregnancy, 85 percent are spacing births, and 10 percent are limiting their families.

The NFP program is accountable primarily to the Cana Movement's administration. This includes accountability for administration of funds. Ultimately it is accountable to the diocese and archbishop with regard to stated goals and philosophy. Outreach and recruitment of clients is carried out mainly through the parishes and the local newspapers. Our monthly magazine, *Familja Kana*, has a wide circulation, and the Cana booklet on NFP has been reprinted four times since 1976.

We are still in the process of developing strategies for evaluation. Our experience has shown that once NFP has become a way of life for the couple, they find that their interpersonal relationship, both sexual and otherwise, greatly improves. Our

greatest challenge is lack of factual data and statistics. We need to train more teachers and to open at least four new centers. We

need more material resources and personnel capable of conducting scientific, biomedical, and psychosocial research.

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## Portugal

In 1965 following a visit by the French national marriage preparation chaplain and a physician couple from Grenoble, the Serviço de Entajuda e Documentação Conjugal (SEDC, or Conjugal Interhelp and Documentation Service) began with a group of six couples and a priest from Lisbon who agreed to study NFP together and to learn as they maintained contacts with the French groups. From this beginning gradually knowledge and experience grew. Both rural and city groups asked to learn about NFP, and their experience was shared especially in parishes and schools.

The service eventually became linked with the Catholic Physicians Association through its medical members and had its proceedings and activities published in the association's magazine, *Medical Action*. Similarly, the Catholic Nursing Association also became progressively involved.

The work is carried out essentially through church channels with the invitations for courses usually made by a priest, a bishop, a sister, or a couple. Courses are offered in nearly all 19 dioceses in the country. There are seven active service centers in both urban and rural settings, and all are linked with the national office in Lisbon. In the rural parishes all couples practice NFP. All services are offered free of charge at the national and regional levels, but voluntary contributions are accepted.

The initial central team in Lisbon conducted its own training through reading and discussion and by attending the formal training sessions held by CLER in Poissy, France, from the very first session in 1969.

The formation of regional centers came about through a series of weekend training sessions, at the end of which the most motivated couples were recruited for a continuing education program in liaison with the Lisbon National Center. The Catholic Nursing Association created its own complementary service with a special training program for nurses and other interested persons. A former woman member of the service was asked to be its coordinator.

National training courses have been held for the last five years. An initial general information and education certificate is given, which can then be supplemented with a specialized NFP teacher's certificate. The NFP teacher's certifying exam is coordinated nationally with the NFP training program of the Catholic Nursing Association. A woman physician has created an NFP service at the National Miserecordia Hospital of Lisbon with well-structured NFP teacher training courses for health assistants. This NFP program is within the context of a general family planning program (excluding abortion) which must be offered to the whole population. SEDC collaborates in the NFP service only.

The service does not maintain strict records. It is estimated that currently about 50 NFP teachers taught approximately 400 women users during the past year.

# United Kingdom

## CMAC

The Catholic Marriage Advisory Council (CMAC) was founded in 1946 as a marriage counseling organization. An NFP service has been offered since its foundation. Beginning in London, the service has spread to 79 centers throughout the United Kingdom. Centers are mostly in the larger towns and have close ties with the local Catholic church.

Most NFP clients are in the professional and middle classes and the majority are Catholics. Instruction was given first in the calendar method and then in basal body temperature by doctors and nurses. In 1976 it was decided that NFP instruction should be given mainly by nonmedical teachers, and in the following year the first group was taught the mucothermic method of Professor John Marshall.

Instructors ideally are recruited from users of NFP. They must have been married for at least three years and be under the age of 50. They can be members of any religious creed or none. Wherever possible, husband and wife teams are recruited. To meet the need to orient health service personnel, family planning nurses have been accepted for NFP training courses so they can offer NFP to clients in family planning clinics, even though they themselves are not users.

Instruction by mail is also provided by Professor Marshall for clients living a long way from a center. Eight hundred new clients per year are taught this way. In a survey of 108 couples in 2109 cycles using the ST method and recording both pre- and postovulatory acts of intercourse, an overall failure rate of 7 percent was achieved with a method failure rate of 3.9 percent.

The headquarters service of instruction,

in-service training, administration, and support is paid for, in the main, by a government grant amounting in the last financial year to £25,000 and by a grant of about £1,000 from the National Catholic Fund.

The initial course for NFP instructors provides 18 hours of instruction and practical work. Training takes place over three entire days with an interval of one to two weeks between each training day. Instruction is given in the anatomy and physiology of reproduction, the mucothermic method, and charting. Role playing is used to develop teaching ability. Psychological difficulties and their management are discussed in group sessions. Trainees complete a test paper and are subject to ongoing assessment during practical sessions. Plans are under way for a probationary period of instructor service followed by further testing before a final certificate of qualification is issued. The cost of the initial training of instructors is about £25 each (inclusive of course materials). There are just over 100 active teachers, all of whom are unpaid, part-time volunteers. About half the total number trained have dropped out, but a decision has been made to screen trainees more carefully during recruitment to reduce this unsatisfactory figure.

The program is accountable to the CMAC National Executive Committee and, for the expenditure of government funds, to the Department of Health and Social Security.

The NFP service of CMAC has an honorary medical consultant, Dr. Elizabeth Clubb, and a national tutor, Mrs. Jean Johnson. In addition, an administrator of the CMAC medical services has recently been appointed. All are responsible, through the chief executive, to the CMAC national executive committee. The NFP service is represented on the medical advisory committee by the medical consultant, the national tutor, and the administrator. The national tutor sets up training courses for instructors. Training of tutors has recently been instituted as well. Tutors will offer regional support and in-service training to instructors.

Evaluation techniques have yet to be

devised. Lack of staff and funds have prevented the collection of adequate statistics. The greatest accomplishment is that NFP doctors and tutors have been invited in both London and the region to offer introductory sessions on NFP to health service personnel and family planning nurses undertaking training and in-service updating. A recent CMAC working party paper on the relationship of the NFP service to the remedial counseling service has provided guidelines for the furthering of

liaison and communication between the two groups. A major contribution to NFP has been the development of slide-tape programs by Dr. Clubb. They illustrate the basic ST method, the return of fertility during breast-feeding, and NFP for the premenopausal woman.

Needs include more instructors and tutors with the necessary administrative backup, including publicity. Scientific, method-related research would be most beneficial.

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## United Kingdom

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### NEFTA

In 1946 the Catholic Marriage Advisory Council (CMAC) was founded in London and undertook, as part of the work of marriage counseling, the teaching of natural family planning. The very nature of its origin and name indicates that most of CMAC's clientele are Catholic, but the time arrived when it was generally accepted that natural family planning was no longer exclusively Catholic. It was, therefore, in response to increasing demand from patients, doctors, and nurses for a service in natural family planning, that the NFP center was set up in the department of obstetrics and gynecology in Birmingham Maternity Hospital in 1975. This was in accordance with the policy of the Department of Health and Social Security to provide free family planning services. The center has three functions: training, research, and service to patients.

After much discussion, the teachers expressed the opinion that current organizations did not fulfill their aspirations completely, so they requested establishment of a national association of natural

family planning teachers. It was not until 1982 that this need was met. The National Association of Natural Family Planning Teachers was founded in October 1982 and is open to any certificated natural family planning teacher and any other person who is in sympathy with the objectives of the association. The principal aims of the association, which is a registered charity, are to promote the availability of NFP education and service to all persons and to maintain standards of competence in NFP in line with international standards.

The first annual general assembly meeting in October 1983 elected a committee consisting of a president, chairman, vice chairman, secretary, treasurer, and four general members. The headquarters of the association is NFP Centre, Birmingham Maternity Hospital, Queen Elizabeth Medical Centre, Birmingham. There are eight regional centers, each with its own coordinator. They are Bristol, Cardiff, Coventry, Glasgow, Nottingham, Liverpool, Newcastle, and Sheffield. Birmingham, Bristol, Nottingham, Liverpool, and Sheffield are also teaching centers. There are six additional teaching centers at universities or hospitals and a total of eight central service delivery centers with three or four subsidiary centers each.

Financial aid is received from the Birmingham Health Authority, which pays lecturer and tutor fees and expenses and donates an annual grant of £500. A good relationship exists between district health

authorities and NFP clinics. The former provide lecture theaters and equipment and pay students' course fees.

NFP clients are referred from the public health system and family planning clinics. NFP orientation is given to all government family planning personnel. Clients are also recruited through church-related activities in parishes and marriage preparation courses. The association provides all methods of NFP, teaching mainly in English but also in some Asian languages. There is participation in well woman clinics, infertility clinics, and preconception clinics. A home visiting service is available in many areas, and user and support groups function in most places.

Centers for teaching natural family planning by members of the National Association of NFP Teachers are spread throughout the United Kingdom. At the present time it is not possible to give the number of new users trained for the period 1980-83 nor to estimate cost.

The criterion for new users is simply a wish to learn about fertility awareness with a view to using this knowledge to plan their families in a natural way. Clients are taught all methods and then, with the help of the teachers, select the method that is best for them. Seventy-five percent choose the multiple index (sympto-thermal with cervical mucus); 10 percent choose the ovulation method only, and 15 percent choose BBT only. Approximately 50 percent of clients are spacing their families, 25 percent are limiting, and 25 percent are planning pregnancies. Teachers are often

recruited from satisfied users.

The standard of the teaching program is stringently monitored by the committee of the National Association. They in turn are accountable to the members of the Central Midwives Board for the standard of teaching for nurses and midwives and to the Dean of Postgraduate Medical Education of the universities for doctors.

Funds are administered by the treasurer of the association with the approval of the committee. Course programs are continually reviewed, changed, and updated in the light of constructive evaluation from students and according to new developments. Full accountability for course programs is the direct responsibility of the committee. A system for evaluating teacher effectiveness has been developed through chart analysis and monitoring of clients behavioral adaptation.

Our greatest accomplishments have been the establishment of the chair in natural family planning within the Queen Elizabeth Medical Centre, University of Birmingham, and establishment of teacher training courses first at the center and later in university hospitals outside the Birmingham area. Facilities for research projects and trials at the center have also been acquired.

Our greatest challenge is to ensure that natural methods are offered by trained certified teachers in every family planning clinic as an equal alternative. Our needs include more doctors, greater material resources, publicity through the media, and a permanent administrative staff.

# Program Issues



Women in Mauritius learning NFP

Since the first part of the book provides specific examples of national NFP programs, this second part of the monograph focuses on the concepts, processes, and main issues of NFP program development.

The various subsections or chapters were specifically structured around the three major themes of:

1. Program development
2. Education, training, and services
3. Evaluation and accountability.

Papers were commissioned from NFP experts on key issues such as the sociology of NFP programs, the production of the major training and resource package of the World Health Organization, and the demographic analysis and impact of NFP programs.

Perhaps most significant are the major commentaries from the participants and the summary of program issues which attempt to draw a picture of the development challenge of the next 20 years.

The major issues appear to be how to upgrade and expand NFP services ensuring accountability without losing some of the cultural rootedness which the pioneer volunteer programs maintained.

The challenge for many programs will, no doubt, be how to combine a creative mix of volunteer teachers with the professional support of a full-time staff of coordinators and administrators. Solutions are likely to vary from country to country as NFP services expand into the wider government, church, and medical spheres.

Since the major development issue is how to introduce quality natural family planning information and services into existing community systems, the editors hope that this book will serve as a practical guide.

# Development of National Natural Family Planning Programs



Sr. Solange Ménéard of Cameroon with an African participant at NFP workshop

## MARIE-PAULE DOYLE

*Marie-Paule Doyle, M.S.W., executive director of Serena Canada; founding president of IFFLP (1974), Ottawa, Canada*

*This paper outlines some key issues on the development of national NFP programs. The first step is to define the objectives of the program. The second stage is to choose a model. The NFP movement presents two contrasting modes: (1) from the bottom up, and (2) from the top down. Choosing a leader is also critical, as are sharing power and responsibility. Communication needs to be developed with grass-roots, church, and government constituencies. A discussion of funding for NFP programs concludes the paper.*

Ten years ago, there were few national natural family planning programs. We now have many more national programs, and several are scheduled for implementation in the next few years. This congress should be the ideal time to reflect on the more or less conscious decisions that are giving shape to the newcomers. In this paper I was asked to address three sets of questions: (1) purpose and functions of a national NFP organization; (2) funding and national program accountability; and (3) national program growth and redefinition of goals.

### **Purpose and Functions of a National NFP Organization**

The first stage, and certainly the most important, is choosing objectives. Progress cannot be made without a clear idea of what is to be accomplished. Time should be taken to plan and to clarify objectives. In my experience, there is often considerable difference between the plan on paper as presented to others, and the inner, personal plan that one accepts and finds motivating.

Do all family planning program directors here really want to establish national programs? I doubt it. Some may think it's too much work; that they will never find the funds; that communication with other parts of their countries is too difficult; that

the people who will be meeting are too difficult to please. Others feel more comfortable in a small program although they may revise their objectives once the work is under way. Some may feel they are being pressured by the International Federation for Family Life Promotion (IFFLP), which takes a broad view and communicates a feeling of urgency not yet perceived at the local level.

If these feelings or other similar ones exist, they will more than likely have an impact on the choice of objectives. There will be a great deal of difference between official objectives and those which the local group considers realistic and which they agree to implement.

When the time comes to assess program performance, I wonder which objectives will be used as a point of departure. Since this question will become crucial sooner or later, I would encourage groups to ensure that their stand is known before becoming enmeshed in an ambitious program and large-scale financing if a large program is not what they wish.

After choosing objectives, the next stage is choosing a model. There are two main development models for a national natural family planning program. One works from bottom to top, the other from top to bottom.

The model that lays a base before setting higher level structures in place is dependent on the existence of local centers already operating in parallel fashion without too much communication between them. They gradually feel the need to unify and coordinate their activities. The national structure caps an existing grouping, which agrees to exchange a little autonomy for greater coordination and improved possibilities of widening the scope of their activities.

Development of this model is a tour de force on the part of its organizers; nothing

is more difficult than convincing a group of pioneers to work harmoniously. Personalities are strong, precedents have already been established, and negotiation is seen as a waste of time. It often takes a second generation or the advent of a "common enemy" to achieve unification.

The second model works from the top down, from an individual or group in authority attempting to serve an entire country. The challenge of this model is twofold: to find in each area local, involved, and tenacious workers who will successfully implement the stages of the master plan; and to decentralize power sufficiently so that the entire weight of the program does not rest on the shoulders of one person or on too small a group of people.

The next stage is choosing a leader. Development of a national natural family planning program is very often the responsibility of one individual. The knowledge, abilities, dynamism, scope, involvement, and perseverance of that person will make the difference between a dynamic program and one that will never take wing. You already know a great deal about the characteristics of a program if you know the person in charge. A program closely tied to church structures will frequently be directed by a priest or nun. Physicians will establish clinics, and researchers will set up research centers before thinking about service units. Couples will appreciate the couple-to-couple approach and presentations in the home, or they will use community facilities. All these decisions, crucial in the establishment of a national program, will probably never be discussed since the director will think that the *modus operandi* he has chosen is the only suitable one. At a congress such as this, it is possible to compare the experience in one's own country with what happens in other countries and to question what is taken for granted.

Another challenge in establishing national programs is sharing power and responsibilities. Again there are two basic options: an influential board of directors composed of responsible lay people or clergy in schools and dispensaries, and representatives of the regions to be

represented, or representatives of programs with whom one feels most comfortable and who are familiar with the field. There is no easy answer. Both choices entail problems, but it seems to me there are more problems when leaders have no co-workers and do not share power and responsibilities. Their programs are very vulnerable because they are dependent on the presence of one person and are frequently restricted to that person's viewpoint.

A dynamic program finds ways for dealing with important issues as they arise. These may be issues such as philosophy, recruiting and training standards, service standards, relations with church or state, or financial autonomy. Some groups have national commissions on particular subjects, others submit these issues to administrators who in turn consult educators. The more communication and interaction there is in decision-making between the national team and local groups, the more dynamic and well-integrated is the organization.

Natural family planning programs are frequently relatively unknown or misunderstood locally. No one among us should feel uneasy or think he or she is the only one leading an unsung program. We are all in the same boat, from the least experienced to the veterans. We still have a long way to go. Our priests and seminarians do not understand much of our work and think they have discharged their duty to inform themselves and support us by saying to the faithful: "In family planning, follow your conscience." Our moralists have fallen on hard times lately. Our universities have been dazzled by the promise of contraception; our health and welfare professionals are ignorant of recent natural method developments; our journalists are prejudiced and erect barriers between us and the public.

There is a lot to be done in encouraging local cooperation. Many national programs are working in the dark without being aware of, or enjoying, their success. The encouraging thing at the international level is that progress accomplished in one place is useful elsewhere. Furthermore, since prophets are not honored in their own countries, the message is often better

accepted elsewhere.

A national natural family planning program is expected to develop lines of communication with government authorities in its own country and with other church organizations working with families. Although it is quite easy to envisage dialogue with ecclesiastical authorities when a national program is Catholic in origin, it is frequently much more difficult to find a place in the sun among state programs. But should the attempt be abandoned before it is begun?

Program experiences range from most positive to most negative, and this matter of the interrelation between programs and state authorities is one of the most controversial we can broach here. It is crucial for many of us, however, since on our response depends access to public funds for our programs, our influence on documentation produced by the state, and establishment of public services offering natural methods to a population larger than we can ever reach. Is cooperation with the state possible or desirable? At what cost?

Promoting research is another function of a national organization working with natural methods. It is a function beyond the means of most of us. We have neither the funds nor the personnel to do "big-time research," and as we are service-oriented, research is not one of our priorities. Our inability to provide data on our work, however, means that we are not being taken seriously. In the absence of "big-time research," perhaps we should consider "small-time research."

That is the option chosen by programs that decide to accumulate information and to analyze it without waiting for things to be done on a large scale or for big-name specialists to tell them how to do it. And we have in our groups some who are well informed on returning fertility during breast-feeding, others who are familiar with the practical effectiveness of the method they teach, still others who are interested in psychological or pedagogical matters, and many more.

#### **Funding and National Program Accountability**

A national program needs money. Noting this does not advance science, but denying it does not advance the program.

A national program needs money, but not just any money, not from just anyone, not at just any old time, and not just any amount. Money can build or destroy an organization, depending on the administrator's ability. Ideally and ultimately, a national program should derive its core funding from more than one source. It should fund itself in part, and it should regard projects only as a supplement.

What is core funding? It involves expenditures essential for the maintenance of a national secretariat: salaries and benefits, rent, office expenses, travel, and conference expenses. These expenditures are essential for the survival of the organization, but ironically they are the most difficult to have covered by a funding agency. All funding agencies are justifiably afraid that eternal dependency may be established. The basic requirements of a national program will not disappear in time, so the program needs a stable funding source. Core operating funds should be sought from multiple sources. To depend only on one source is the big mistake that leads to catastrophe when, for one reason or another, the well runs dry.

A degree of financial autonomy is essential for any national organization. Most of the time this autonomy is a result of members' financial participation and sales to the public. It is utopian to think that any national organization can survive on its own funds alone, but relative autonomy averts many crises. Project funding should only complement revenues. These projects are often supplementary work done in addition to a rigorous timetable. Sometimes they do not even fit into organizations' priorities. They cannot ensure financial stability; they do not last long enough, and their renewal is too risky. The administrator of a national program must balance his funding sources (core, internal, and project) so as to not imperil his organization's financial future.

Natural method programs have only very recently had access to major family planning funding sources. The sums available are minimal in comparison with funding agency total expenditures. Natural family planning methods are valid and viable and meet the needs of a sizable por-

tion of the population. Natural methods are educative and help to develop individuals' personal resources. Why are they not then a natural choice for international development agencies? All of us from developed countries should press our national and international authorities to grant a fair share to NFP programs.

Some of you may think money is not to be refused whenever it is offered. In my opinion, it is very dangerous for an organization to accept a great deal of money before it is ready to carry out a large-scale project. Collective wisdom must be developed so that we can determine when a national program has sufficient infrastructure to receive a substantial sum.

When Service de Regulation des Naissances (Serena) expanded from one province to nine others in Canada, our annual budget increased by 300 percent. We had 15 years' experience and more than 200 trained teacher couples. Our administrative structure was in place, and yet we found it very difficult to absorb so much money overnight. New programs, however, are being asked to accomplish this quasi-impossible exercise. This is a concern. Is it really impossible to respect programs' development rhythm by putting reasonable sums of money at their disposal instead of chunks on which they may choke?

Financial stability is the dream of all of us but an impossible dream for most. Because the programs are not self-sufficient, we never know what the future will be. In our planning we need to develop three scenarios: what to do if we receive less funds, if we succeed in getting more funds, and third, what to do if funds remain stable. This kind of exercise is especially important when we have staff or are planning to add staff.

#### **National Program Growth and Redefinition of Goals**

A responsive organization must intermittently reassess its goals and objectives. Reassessment of goals and objectives seems to be the obvious thing to do when a program is not developing as hoped. But that is not the only time when this reorientation exercise is useful!

At the end of each activity period, it is

important to review results obtained and to reassess whether needs have changed. Programs with good annual statistics are in a better position to follow the evolution of their program regarding client numbers and origin, and teacher numbers and characteristics. Ongoing programs can always benefit from adjustment.

The most obvious adjustments, however, are needed when program conditions alter. These adjustments may be occasioned by legislative change, by establishment of a family planning grant program, or by the fact that for the first time, natural methods are being offered to couples in state-financed clinics. These major changes require considerable adjustment of program objectives and strategies.

Many programs hesitate to abandon their orientation as a movement to develop as a service. When they examine the impact of such a shift, they find multiple possible disadvantages, including: a less firm philosophic orientation arising from the service reaching a larger clientele, which may have more diverse basic options; a more professional than apostolic orientation, since often the establishment of more service points will almost inevitably entail hiring full-time professionals who may supplant part-time volunteers; loss of administrative control, since as a result of an appreciable financial injection, the program requires people with different abilities who will replace program pioneers on more or less short notice; and uncertainty as to future results, since the jury is still out on whether natural method teaching is as valid in a service (public) context as in an apostolic (private) one.

We are really at the crossroads with the development of our programs. Some will want to forge ahead and accelerate development of a national program by covering their country with service points, ensuring co-workers in every sphere of authority, and using large sums of money. Others will prefer to mark time and observe the efforts and results of others before proceeding. Who is right? It is very difficult to say since the first group may break their backs by assuming too heavy a load, while the second may wait a long time in vain for an opportunity that will not come again.

# Experiential Learning and the Professional in NFP

THOMASINA SMITH BORKMAN

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*NFP services are growing beyond their original part-time volunteer-based beginnings. The expansion of high-quality NFP services to more people and countries is the challenge now. This paper invites you to consider some directions NFP services can take and their implications.*

*Certain assumptions which, in fact, are value judgments, underlie this sociological analysis. These are: NFP should be made available at low cost to many interested people in many countries within a reasonable time period; the services should be of high quality, accountable and respectful of the diverse values of the people involved; and finally, the methods should be grounded in biomedical science.*

*In sociological terms, NFP is a social innovation and like any innovation needs to become known and respected. As part of this process of expansion, NFP leaders need to promote the acceptance and credibility of NFP among established leaders and institutions. Three orientations have provided the primary leadership in developing NFP services up to now: (1) NFP teachers and users with experiential knowledge of NFP, (2) the medical profession, and (3) religious groups, especially Catholics. NFP services currently combine these orientations in a variety of mixtures in different programs and countries. Each of these orientations offers both advantages and disadvantages to service delivery. The experiential is not presently given legitimacy while the religious and medical are.*

*The paradox of NFP is that services can-*

*not expand to a large number of places without existing institutional networks, but if essential features of the experiential component are lost, only a few people in any locality will be reached. Furthermore, if these NFP programs are designed according to the conventional professional or medical model, the services would be so expensive and ineffective that the advantage of the network would be lost.*

*New kinds of programs and nonprofessional occupations need to be designed that enable experiential experts to play their irreplaceable role in the institutional context.*

*This paper raises this challenge for NFP and institutional leaders.*

Natural Family Planning services are a relatively new social innovation having been created during the past 25-30 years. During this time, several kinds of groups—with medical, religious, and experienced-user orientations—have evolved their own approaches to teaching NFP to women or couples. Many of these efforts have been ad hoc, part-time, and volunteer-based. Many have been too informal and irregular to be entitled service programs. Some groups are free-standing and independent, whereas others operate inside such institutionalized delivery systems as medical care systems or Catholic marriage and family programs.

Dr. Claude Lanctôt (1982) recently summarized the status of these NFP services.

It appears clear that NFP has achieved

a new status of respectability and credibility. Yet it is still very close to its grass-roots origins being still in many places method specific, women oriented, and mostly by peer instructors. The challenge of the next decade will be to expand the movement into offering quality services to a much larger number of potential clients.

The challenge of expanding high-quality NFP services to more people and places is accepted here as the issue of interest. This congress is an important occasion, and I invite you to consider some major directions that the development of NFP services is likely to take based on the history of these services and the apparently available options. The implications of following these directions will be spelled out. This sociological analysis suggests that there are major pitfalls to expansion if NFP services are simply modeled after existing medical, educational, or religious delivery systems. Some suggestions are offered to avoid these pitfalls.

Certain assumptions have been made that were used as criteria in conducting this sociological analysis. These assumptions are also in fact, several value judgments. Current sociology recognizes that certain value judgments are necessarily involved in sociology and any scientific work (Gouldner 1962, 1968; Foss 1977). Often these value judgments are implicit, not explicit. Certain explicit value judgments underlie this analysis, and they represent the criteria or parameters in terms of which the analysis was conducted.

There are three basic assumptions:

First, NFP should be made available to many interested people in many countries within a reasonable period of time. This assumption focuses on the idea that the capacity for wide diffusion of services should guide the direction of their development.

Second, the NFP services that are developed should be low-cost, high-quality, accountable to their constituencies, and respectful of the values of the people involved. Once NFP services come into the public domain, whether they are mandated by church, medical, or government policy, the services can no longer be solely a part-

time, volunteer activity. Moreover, publicly authorized services have to be accountable and have external means to measure quality. Also, publicly authorized services cannot usually be restricted and available to persons of certain religious or ethical value positions while excluding persons with other values.

Third, the methods should continue to be grounded both in biomedical science and in the experiential knowledge (Borkman 1976, 1979, 1980) of successful users. This assumption refers to the knowledge base of NFP services and to what kind of expertise is needed to direct NFP programs. Two kinds of knowledge are distinguished here. Both seem essential for effective NFP services: (1) the *application* of biomedical research findings on human reproduction and fertility, and (2) experiential knowledge gained by practicing NFP or teaching NFP to users.

1. The essential biomedical scientific knowledge is *applied* information taken from research findings. It is important to encourage biomedical research on reproduction and refinement of the methods, but as a separate activity from NFP service programs. Medical professionals per se are not necessary to provide NFP services. The applied research material is neither highly technical nor extremely complex. It has been well demonstrated that nonliterate and educated people alike from many cultural backgrounds can be taught the applied biomedical knowledge and can use it effectively in practicing NFP. Therefore, neither the teaching of NFP nor the directing of programs needs to be controlled by physicians or other health professionals on the basis of technical or specialized knowledge. The physician or other medical professional is needed on a consultant basis, however, for problematic medical conditions and to review the applied biomedical knowledge base of NFP services.

2. The essential kind of knowledge for an effective NFP program is experiential knowledge of NFP. This refers to trusted information gained by personal, lived experience (Borkman 1976, 1979, 1980) that many teacher users and long-term NFP users obtain through their practice of NFP. The experiential knowledge of NFP ir-

cludes the practical application of the biomedical information to everyday life plus the emotional and relational aspects of the abstinence, sexuality, and communication between the partners. The necessity of experiential knowledge is recognized by many NFP service programs that require teachers to be users.

#### **Elements in a Publicly Accountable NFP Program**

From a sociological perspective, NFP is a social innovation, and, like any innovation, it needs to become known and respected. Social innovation refers to ideas or practices that are new to the involved individuals or organizations; it does not mean new in the sense of never previously occurring throughout human history (Borkman 1979). What is needed to translate this social innovation into respected and effective program services that can be diffused to many people and countries? The services need to become regular programs, have quality control and accountability standards, develop new NFP occupations, and become accepted by relevant leaders and institutions. Some people call this professionalizing an NFP program.

As can be seen, the term "professional" is problematic because it has many meanings and is used in different ways by people. Some of what people discuss under the term "professional" I will discuss under the headings of: regular program, quality control, and accountability standards and NFP occupations. There is another meaning to the term "professionalize" that is a danger for NFP programs. I will discuss it later.

Since NFP is changing from a local option to a service mandated by public policy in some countries, NFP services will need to be *regular programs* that are publicly accountable and have some means of showing the quality of their services. Regular programs are defined here as legally and financially responsible services that are regularly available and have a continuous, identifiable presence in the community. A regular program is contrasted with a part-time, ad hoc "fold-up" group that may rely only on volunteer effort. A program administrator who is publicly responsible

and accountable is another ingredient of a regular program; the administrator function represents the program to the relevant communities. A regular program may rely on part-time, unpaid volunteer effort for most of its service provision, but the identifiable, continuous presence is provided by the administrator.

A second necessary element is the *conceptualization* of the NFP program in terms of its nature (an educational approach, a religious or a medical one); the values attached to it; what groups (medical, experienced user, or religious) will control it; how it is viewed in relation to other family planning methods; and how the program articulates with other local health, family planning, marriage and family, and educational services.

Third, the functions of NFP teacher, supervisor of teachers, and program administrator need to develop into identifiable occupations. Occupations are job positions that define responsibilities, duties, and privileges, and that have selection criteria, standards for training, experience, performance, and ideologies. Ideology refers to the set of ideas that occupational members develop about the nature of their work, its linkages with other occupations, ethical standards, what the occupation contributes to its clients and to society, and so forth (Freidson 1973).

These issues pertain to the fact that in many places the spread of NFP services is hindered by the lack of trained, committed NFP instructors. These instructors would be trained to work regularly in NFP programs and have the "occupational qualities" of confidence, commitment to follow program guidelines and procedures, willingness to submit to administrative control for the good of providing regular services, and familiarity with paper work, terminology, and organizational practices of agencies so that they could operate as "professional" as contrasted with "amateur." I am deliberately using descriptive terms about what is needed for occupational performance rather than using the terminology of professionals. Some of what is meant by "professionalizing" NFP is to call for the above qualities in contrast with the qualities found among many cur-

rent instructors, who are not systematically or uniformly trained or tested in any way to identify the level of their knowledge and skills; who are unpaid volunteers whose commitment to NFP lies in their zeal about its values (and are thus effective teachers); who may not be occupationally committed to providing services in an NFP program by submitting to its administrative procedures; who may not be familiar with the practices and "culture" of agencies.

Fourth, external quality control and accountability standards for NFP programs need to be developed and agreed upon. These standards are mainly for outsiders—the relevant local communities who give the legitimacy to a program that is vital for its diffusion. These program elements include such aspects as standards of follow-up, confidentiality requirements, record-keeping requirements, guidelines for supervising teachers, and so forth. There are major dangers in defining and implementing quality and accountability standards. The most frequent error in developed countries with high educational levels is to equate standardization, the written form, or activities done by a professional group as *prima facie* evidence of quality and accountability.

Fifth, obtaining acceptance from the relevant leaders and institutions is critical for obtaining funds, for attracting clients, and for becoming a regular program. All of the preceding four elements contribute to the legitimating of NFP programs.

### **Three Orientations Found in Current NFP Services**

Three orientations have provided primary leadership in developing NFP services up to now: (1) NFP teachers and users with experiential knowledge of NFP; (2) the medical profession; and (3) religious groups, especially Catholics. NFP services currently combine these orientations in a variety of mixtures in different programs and countries. There are experientialists with strong religious orientations leading voluntary associations like John Kippley's Couple to Couple League. There are other experientially controlled voluntary associations that are moderate in medical and in

religious orientation, such as Serena Canada. Physicians who often have religious values have led some groups, either voluntary associations of primarily experiential users like the World Organization of the Ovulation Method Billings (WOOMB) or more medically based clinics with some emphasis on research, like Dr. Roetzer in Austria. Religiously oriented programs are often within the context of Catholic marriage and family programs like Ireland's, but these programs have strong input from health professionals and experiential users who teach NFP.

The three orientations are important because each seems to contribute something vital to the philosophy and knowledge of NFP as it is currently constituted. It seems that effective NFP services combine some aspects of all three orientations. As discussed earlier, the biomedical, scientific grounding of NFP methods is absolutely critical, and their appropriate application ensures that NFP is reliable and effective as a family planning method. Similarly, the experiential knowledge for teaching NFP to newcomers and for informing issues of NFP service delivery seems critical from past history. The extreme case would be using males without personal experience of NFP who learned it from books and lectures as teachers; one would expect many dropouts and unsuccessful users. The religious dimension as world view is seen here as key in providing a value framework within which NFP is interpreted. Values are often articulated in NFP by religious groups, but this need not be the case. In this paper, religion is being defined in two senses: first, as the world view in which human values guide choices and behavior; and second, as an institutional entity which encompasses a network of organizations, occupations, and administration. Many secular or nonsectarian value-oriented groups, however, also could and do provide a value framework within which NFP can be interpreted. For example, the feminist health movement and alternative living groups like Summertown (Shivanandan 1979) are examples of value-oriented groups.

Each of the three orientations also

represents a direction that NFP can develop as service programs. What are the major strengths and weaknesses of each orientation as a form of service delivery for NFP? Strengths and weaknesses were identified relative to the value judgments that were the criteria for analysis.

The strength of the religious orientation lies in its clear and continuous articulation of the human and religious values of NFP. Religious institutions could also facilitate the expansion of NFP services by designing programs linked with their existing institutional networks (as is being done by the U.S. Catholic Diocesan Development Plan). The weaknesses of the religious orientation are that: (1) some religious groups are intolerant of value systems other than their own; (2) some religious groups would not offer services to persons with value systems different from theirs; (3) some religious services impose their marriage or family services as a condition of participation in NFP; (4) some religious power structures and organizations do not legitimize experiential user knowledge and may not be respectful of it or incorporate it appropriately into their service program; and (5) religiously based services would be unacceptable to some persons in some localities.

The strengths of the experiential learning include the following: (1) experiential users as the teachers of NFP can be very effective and suitable in many cultural contexts; (2) experiential knowledge as a major basis for a new *occupation* of NFP teacher and teacher-supervisor would be effective; (3) the experiential approach incorporates human and religious values and is sensitive to local cultural contexts; (4) an experiential approach stimulates users to become volunteers to teach or help with NFP services, thus lowering the cost; and (5) NFP would be viewed as an educational approach compatible with a variety of functional areas. The weaknesses of the experiential approach are these: (1) in some contexts experiential users are intolerant of other value systems and do not respect diverse value systems; (2) there is a lack of models of experientially based human service occupations; (3) there is a lack of models of

experientially based publicly accountable regular programs; (4) it would be difficult to develop external quality and accountability standards for local programs that were suitable for application in a variety of places; and (5) experiential knowledge is not socially legitimated in the modern world, and it may be difficult to incorporate it faithfully into institutionalized medical or Western religious service programs. Overall, the experiential orientation results in great value diversity of NFP programs, but serious conflict can arise in the struggle to develop regular programs with new occupations, quality, and accountability standards and to obtain legitimacy for NFP programs. The resulting NFP services, however, would likely be low-cost, contain many volunteer users, and be widely available to many people.

The strengths of the medical orientation are also several. They include the following: (1) updating NFP methods would be facilitated by the relatively close links of biomedical researchers and clinicians providing services; (2) existing models of quality and accountability can be relatively easily applied to NFP; (3) existing models of how to develop regular programs and their elements are easily applied to a new area like NFP; (4) the prestige and power of the medical profession would increase the credibility and respectability of NFP; and (5) the rapid expansion of NFP services would be facilitated by incorporating NFP programs into existing medical care delivery systems.

The weaknesses of the medical orientation lie especially in the related dangers of *professionalization* and of *medicalization*. These processes would be likely to make NFP services expensive, to limit severely their availability to a few people, and to threaten value diversity and the human and religious values attached to NFP.

Medicalization refers to the social-political process of defining a phenomenon as a disease or within the medical pathology system under the jurisdiction of the medical system to be controlled by physicians (Conrad and Schneider 1980, Zola 1977). An often-quoted example of medicalization is the recent change in the

United States from defining alcoholism as a crime under the criminal justice system to the current concept of alcoholism as a disease that is treatable within the medical treatment system. I selected this illustration of medicalization because there are important parallels to which I will return, between the treatment of alcoholism and the provision of NFP services.

Contraceptives are already medicalized, and fertility is regarded within a pathology orientation by the medical profession. This approach is antithetical to the values of NFP, where fertility is viewed as a natural life process not to be artificially suppressed. There is already an example of the medicalization of NFP—those health personnel who redefine NFP and label it from within their medical orientation “fertility awareness with a barrier method.”

Sociological analyses of cases of medicalization point out that when the medical profession takes over a condition, they conceptualize it to fit their world view (Conrad and Schneider 1980). The world view of scientific medicine contains the tendency to strip conditions of their human and religious value connotations and to replace these with technical connotations. Eric Cassell, himself an M.D., is one of many who argue that medicine is inherently moral but knowledge of this fact is denied with the belief that

the physician does not make ethical decisions, he only makes technical decisions. Such concern for morality is not a generalization of expertise but an accepted part of the physician's role, and is so recognized by the society, though largely in a covert manner. But he and the patient protect themselves from the awesome implications of that responsibility by hiding behind the belief that doctors only make technical decisions. (Cassell 1973: 57).

If NFP were to become the territory of the regular medical establishment—with the exception of those physicians who support NFP for its value orientation, such as Roetzer, Billings, and Hilgers—it is quite predictable that many of the human and religious values attached to NFP would be

stripped away in favor of redefining it in technical terms. Concurrently, the value diversity of NFP among different cultural and religious groups could be diminished. The medicalization of NFP would likely be accompanied by its professionalization, since the two seem to occur together.

Sociologists define the term “to professionalize” as the process through which occupational groups attempt upward social mobility, that is, to increase their prestige, remuneration, autonomy from clients, and control over their work territory (Wilemsky 1964). In the professionalizing process, occupations usually emulate prestigious, autonomous professions like the medical profession (Freidson 1970; Starr 1982). Although the ideologies of professionalizing occupations often center around altruistic ethics of service, objectivity and impartiality, and a client service orientation, sociological analyses of these occupational groups reveal that their behaviors are often contradictory to their ideologies (Gerstl and Jacobs 1976). Occupational groups often restrict recruitment by imposing standards of formal education and training that serve to limit the number in the occupation. Restrictive recruitment or standards of training also lead to exclusivity in who is allowed into the occupation. Part-time or volunteer workers may be discouraged from obtaining training in attempts to uphold uniform and high salary levels. Many standards supposedly instituted to establish and maintain quality control lead to expensive training and certification mechanisms that are never demonstrated to accomplish their objective. Thus, in a variety of ways, the occupational groups are self-serving at the expense of service to clients and client interests.

The professionalization of NFP has pitfalls that could lead to serious problems. Two particular dangers are (1) diminishing the experiential-user knowledge since it is not easily codified in written form and is not respected in professional models of occupations; and (2) discouraging the training and utilization of part-time and volunteer experiential users as NFP teachers or participants in programs. Maximizing the use

of volunteers in NFP programs can keep costs down and enthusiasm high, which is important to motivating couples, whereas the professionalizing of NFP occupations would drive costs up and dampen zeal.

Having considered some strengths and weaknesses of the three orientations as service delivery systems, what can we conclude? The paradox of NFP is that services cannot expand to a large number of places without using existing institutional networks (medical or religious), but if these networks lose the experiential component of NFP, then only a few people in each locality will be reached. Furthermore, if these NFP programs and occupations are designed according to the conventional professional or medical models, the services could be so expensive and ineffective that the advantage of the network would be lost. The temptation would be to professionalize NFP occupations if conventional models are followed. Similarly, the current model of the medical profession, if applied to NFP programs, could medicalize NFP and distort its integrity. New kinds of programs and nonprofessional occupations need to be designed that enable experiential experts to play their irreplaceable role in NFP and that preserve the values attached to NFP.

#### **Suggested Recommendations**

I have considered some of the potential advantages and disadvantages of following the extremes of each of the three orientations (religious, medical, or experiential) as a model of NFP programs and services. The approach will need to be novel in order to retain the combination of needed ingredients from all three orientations: the religious respect for human values, the applied biomedical knowledge of fertility awareness and reproduction, and the experiential learning of translating the biomedical knowledge to everyday life within the value framework of the involved individuals. Exactly how to accomplish this in any pragmatic situation is impossible to say; indeed, the important message is probably to maintain the spirit of the strengths from the three orientations, not to rigidly or systematically apply some formula in a

standardized manner.

The following recommendations suggest how NFP services can make a successful transition from part-time, "fold-up," volunteer services to regular programs staffed with trained instructors, whether paid or unpaid.

1. Invite persons who have a commitment in each of the orientations to help in planning and development. It is important to have adequate representation of the three orientations, not just tokenism. Careful attention should be paid to choosing an experiential expert who will not be intimidated by the authority of health personnel or religious representatives.

2. Prepare a straightforward and explicit outline of values and criteria regarding NFP programs similar to mine at the beginning of this presentation (or in even more detail). The first step to awareness is to become cognizant of the values and criteria for a program within which one wishes to operate.

3. Invite a sympathetic but independent outside observer to help assess whether the approach is consistent with its own values if a group is in doubt about its direction or process. There are probably many experienced persons who would provide free consultation in exchange for helping to develop a novel value-oriented service program for NFP.

4. Try developing two solutions to any problem you face rather than one. As appropriate, select contrasting types of solutions: for example, if appropriate, an inexpensive rickshaw solution and a more expensive limousine solution if you have funds; or a solution depending totally on volunteer staff along with a solution depending on paid staff and minimum volunteer help. This approach may reduce attachment to a single solution, and it may open up more possibilities.

5. Look for other areas of human services that face similar problems and examine the ways they conceptualized issues and the solutions at which they arrived. For example, the alcoholism treatment field has agencies termed "social model" or "social-experiential model" (Borkman 1982) programs that faced similar dilem-

mas. The experiential knowledge of the recovering alcoholic from Alcoholics Anonymous was not legitimized in professionally based programs; the mutual self-help form of service giving had limitations since it was a "fold-up service" and a regular program was needed; the recovering alcoholic—an experiential expert—was not necessarily trained "occupationally" or in how to submit to an administrative program; and linkages with medical care and other social services had to be made.

The social experiential model alcoholism programs have developed an administrative and organizational structure that satisfies local legal, financial, and public accountability requirements (not without some controversy), but not at the expense of the experiential orientation. Experiential expertise informs basic policy-making and is paramount in staff services to program participants. Scrutiny is made of any proposed practice for its implications for the values of the agency. There are many other parallels that could be useful to persons developing NFP programs.

6. Adapt a model based on apprenticeship and service in developing NFP occupations such as instructor, trainer of instructors, and administrator, not a professional occupation based on formal education. The latter can quickly lead to concern about status, prestige, and other areas of self-interest. Training that emphasizes on-the-job apprenticeship and minimizes special training facilities or formal schooling is much more in keeping with the experiential learning that is the strength of current NFP instructors and is in keeping with fostering many volunteer instructors.

Consider new technologies that could be exploited for didactic training in the applied biomedical aspects. An example is the use of video cassettes for training sessions. Training could be designed to be as low-cost as possible and to make it widely available in many places.

7. Adopt an "NFP Impact Statement." I am suggesting a new kind of systematic analysis of selected consequences of any proposed procedure, policy, or practice on the client, the program, or values. The idea

for this came from "Environmental Impact Statements" (EIS) that are required by U.S. law in certain physical development situations (Finsterbusch, Llewellyn, and Wolf 1983). The EIS is a formal analysis of the probable physical and social consequences of developing a new project such as a dam, highway, or nuclear power plant. The EIS can be used by policy-makers as a rational basis for weighing the positive and negative consequences of proposed projects. The requirement to think out potential consequences seems to be a valuable exercise.

A few ideas of the kinds of guidelines that could be used for the NFP Impact Statement will be mentioned for illustration; many others could be added depending on the values and objectives of the persons developing the program. Will the change (a) limit or increase access to training or services? (b) treat volunteer and paid staff alike or differently? (c) increase, decrease, or maintain the same level of costs to the NFP clientele or program? (d) increase, decrease, or have no impact on client involvement and participation in the learning process and receiving services? (e) decrease or increase client autonomy in the use of the method? (f) increase, decrease, or maintain the amount and quality of client volunteering in the program or in instruction? (g) increase, decrease, or maintain current levels of social distance between the NFP occupation and clientele?

In conclusion, it seems likely that it will be especially difficult to incorporate and legitimize the experiential-user role in new occupations and programs since the experiential user is not accepted as a vital part of service giving in current medical care or religious delivery systems. The task before you now in the expansion of NFP is the challenge of developing new NFP occupations and programs that fit within existing medical care or religious delivery systems without compromising the integrity of NFP.

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## Comments

### STEPHEN BURKE

*Stephen Burke, A.C.S.W., assistant director of Catholic Social Services, Diocese of Providence, R.I., USA; director of NFP of Rhode Island*

Before reacting to several points in Mrs. Doyle's excellent paper, I would like to say a little about my own work. My wife Sheila and I direct Natural Family Planning of Rhode Island, a program of Catholic social services in Rhode Island. The program,

begun in November 1977, is sponsored by the Catholic Church, and we are directly accountable to it. It is funded through Catholic Social Services, and we also receive Title X monies from the United States government for the education and training of NFP teachers in the public sector. I am also secretary of the committee for standards for New England Natural Family Planning, Inc., an organization representing the NFP interest of the six northeastern states. Nine of the 11 dioceses in the New England region are members of our regional association.

Mrs. Doyle has given us several models of natural family planning national development, from top down to bottom up. I personally favor development from

the bottom up for several reasons. First, there is far less likelihood of losing the real-life perspective of day-to-day married life that comes from instruction and follow-up of natural family planning services with couples. For example, it seems to me that in some cases priests have lost a sense of real married life by the way they characterize spontaneity and its value in a conjugal relationship. I have often felt that if they lived with a woman, their views on sexual spontaneity would change.

Second, developing a program from the bottom up—namely, beginning to teach people and gradually building from there—offers more of an opportunity to grow incrementally in thoughtful steps. Third, development of NFP from a grass-roots level seems to me to be less intrinsically authoritarian. It allows more opportunity for participation by NFP consumers and instructors.

As Mrs. Doyle points out, the affiliation that can exist between church-sponsored NFP groups and governmental authorities is both interesting and controversial. Since government can be an advocate for artificial contraception and, in some countries, for legalized sterilization and abortion, our position can indeed be delicate. Some years ago two dioceses pulled out of New England Natural Family Planning, Inc., because they did not want to deal with governmental bureaucracy and its controls, and they disagreed with the rest of the membership on issues of belief and ethical practice for NFP programs.

Specifically, one of the most divisive issues among members of the New England region was the feeling on the part of the two diocesan programs that the rest of the membership was involved with "material cooperation in the sin" of some of its clientele. Currently, three of the nine member dioceses are receiving federal funds for various aspects of NFP development. Monies are being used for service to NFP adult consumers, for education and training in NFP for government family planning staff, and for adolescent fertility awareness in family life education programs.

I think that we have difficulty dealing with governmental authorities in NFP

because of the size and power of government. Often we feel we cannot cope with the strong advocacy position they take for artificial contraception and other practices we cannot condone. This can make us feel very ambivalent toward their money, as Mrs. Doyle has suggested.

In order to deal with this unique relationship with government, I suggest several positions that church-sponsored NFP programs can take. First, we have to be able to deal from a position of strength. This means that we must, as private programs, have a secure sense of ourselves. We must take the time and sometimes endure the pain to develop a program philosophy and put it in writing. We should know where our own ethical boundaries are. Every program should have its own statement of philosophy and purpose. This means that we should also be able to deal with the controversial questions that arise in NFP. Whether we teach unmarried people, whether we refer for artificial contraception, and how we handle questions related to oral-genital sexual expression are several examples of hard questions that come up.

Second, we must have a readiness to diversify NFP service delivery systems. We should be able to deliver NFP in clinics, homes, hospitals, and social service agencies. We should be able to offer group as well as individual instruction and we should be able to employ various types of teachers depending on the demands of our local situations and the populations we wish to reach. Finally, we should be able to teach all methods of NFP. This diversification is very appealing to governmental authorities, and it also reaches a great many more people than we can reach in our own private programs. NFP has been marketed to a much wider consuming public in Rhode Island because we were able to train traditional family planning providers to teach NFP. I am convinced that there are many people who simply would never walk through the doors of a Catholic agency to learn NFP.

Third, we should have an understanding that government funding is probably not a stable source of money for ongoing NFP

teaching programs. Political administrations change, and they are particularly sensitive to political forces that surround them. Further, it is probably best that we keep our main funding base in the organization that shares our values. In other words, always own at least 51 percent of our own NFP company's stock.

Lastly, I think we need to have a basic openness of mind. NFP will flower when we love people and accept them where they are. We can also accept programs and agencies where they are as well. Several years ago, when we trained 19 women from government family planning agencies to teach NFP, we had no idea of the impact this training would have. Because we didn't know their own life circumstances, we asked them, as a follow-up measure, to chart their own cycles or the cycles of a friend. All of them freely chose to chart their own cycles. We found out later that three of them were trying to become pregnant. Their new awareness of themselves

and their fertile signs did more to "sell" NFP than any indoctrination we could have done.

In ancient Greece, there was a mythical character called Procrustes. It seemed that Procrustes had a house by the side of the road, and he grabbed everyone passing by the house and put his victims on his bed. If they were too short for the bed, they were stretched to fit, and if they were too long for the bed, their feet were cut off. Procrustes has a lesson for us. Perhaps what we can do is to get rid of the bed on which we try to make people fit our point of view and bring in a banquet table around which we can share our gifts and strengths in sharing the message of NFP with our brothers and sisters.

I will be happy to provide copies of our standards for programs in the New England region as well as my own program of statement of philosophy and purpose to any country representative who requests them.

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#### **KATHLEEN DORAIRAJ**

*Kathleen Dorairaj, M.D. director of the Family Life Center of the Indian Social Institute; president of the National Family Planning Association of India, New Delhi, India*

It is important to consider fertility behavior and family planning programs within the broader socioeconomic context of a country. In the case of India, where the level of socioeconomic development is low, programs must be designed that are sensitive to the needs and concerns of the poor, whose motivations and rationality in the area of childbearing must be considered. If such concerns are neglected, fertility reduction programs will not be successful. Family planning and the reduction of fertility are not ends in themselves but only one means of enhancing human welfare. Fertility behavior cannot be isolated from other aspects of social and economic development.

The government of India not only sup-

ports family planning but has had a full-fledged national family planning program integrated with the health infrastructure since 1950. And yet, after 33 years of family planning programs and substantial investments of human and financial resources, the program effects have been poor. Fewer than 25 percent of the married couples in the reproductive ages have accepted the family planning methods promoted. In the 10 years between the 1971 and 1981 censuses, the population increased by 136 million persons, and the annual growth rate increased slightly, from 2.20 percent in the 1960s to 2.23 percent during the decade of the 1970s. The government has mounted a "multi-pronged attack," involving governmental agencies, the private sector, mass media communication campaigns, and monetary incentives, together with a focus on the promotion of theoretically more effective family planning methods.

The Indian experience points up the relationship between development and population. The upper classes and upper-

middle classes, who have benefited most from socioeconomic development since independence, now have only two or three children and accept a method of family limitation when the desired family size is reached. They have high aspirations for themselves and their children, and they place a high priority on education as a tool for social mobility. Thus, they are motivated to accept family planning and to invest their personal resources in fewer children. The poor, however, have not shared in the fruits of India's socioeconomic development. Poverty and malnutrition continue to contribute to infant deaths, and parents need to have enough children to ensure that some will survive to care for them in their old age. They are therefore "below the threshold level" for acceptance of official methods of fertility control. They are especially not receptive to the primary method promoted by the Indian government program, that is, sterilization.

It is in this context that natural methods of family planning become an important alternative. NFP is acceptable to poor couples because it is not permanent and because it permits them to space their children and thus focus on the health and

nutritional requirements of each child. If more children survive, fewer pregnancies and births are required. Women need not spend their reproductive years in compulsory, repetitive motherhood, and so NFP contributes to the health and welfare of women as well as children. NFP can also improve the quality of family life because it improves communication between spouses. Women, especially poor women, who learn to use NFP acquire knowledge about their own bodies that gives them the means to control fertility.

Natural family planning involves identification of the fertile and infertile phases of a woman's menstrual cycle and requires sexual abstinence during the fertile period to avoid pregnancy. Family planning proponents in India are often antagonistic toward NFP because many of them believe that NFP is synonymous with the outdated calendar-rhythm method. A large number of them are not even receptive to learning about the more modern approaches to NFP. Most family planning experts are men who perceive that women, especially poor women, will not be able to identify the fertile period. They believe that the poor are prolific because they are irrational and unable to abstain from sexual intercourse.

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#### **EDGAR PAZ-GONZALES**

*Edgar Paz-Gonzales, M.D., obstetrician and gynecologist; founder and chairman of AVEMO-Billings (Asociación Venezolana para Aplicación del Método de Ovulación Billings), Caracas, Venezuela*

Many priests, educators, and physicians particularly, have worked in favor of natural family planning in Venezuela for a long time (in my case for over 21 years). Many publications and works on NFP have been presented before the Venezuelan Society of Obstetrics and Gynecology.

We distributed Dr. Billing's book, *Método de la Ovulación* (Ovulation Method). The Christian Family Movement

in Latin America put us in contact with Mrs. M. Wilson of WOOMB-USA, who invited us to the first Congress for the Family of the Americas which took place in Guatemala in July 1980.

The 14 Venezuelans who attended the congress agreed to initiate a national NFP program to implement exclusively the Billings method. Its main attraction to the majority of Venezuelan physicians, including gynecologists, was its novelty. Upon our return it became necessary to create an organization that would direct and support the NFP program. A nonprofit community association was founded October 12, 1980, named Asociación Venezolana del Método de la Ovulación Billings (AVEMO BILLINGS). It was legally constituted and registered with a constitution and published bylaws.

The members of our board of directors were selected from the founding group with His Excellency Archbishop of Valencia, Msgr. Luis Eduardo Henriques, designated as national counselor. Valencia is the third most important city in the country and is the site of major industrial development. Thereafter the board of AVEMO Billings created the Centro Nacional and a working team to undertake the promotion of the Billings method through presentation of talks, conferences, and publications and to inform administrators and educators through seminars, workshops, and other activities.

The Ministry of Health and Social Assistance in our country, the official body responsible for the national health and well-being of Venezuelans, conducts a program entitled "Family Planning," which recommends only artificial methods of contraception and disregards the natural methods. Almost the entire medical profession accepts and approves of this program. We decided that it would be more productive to solicit the support and assistance of the Catholic Church for AVEMO.

The bishops received our presentation well and invited us to present it to the conferences of clergy in different dioceses. Later with the assistance of clergy, religious orders, and secular apostolic movements, we proceeded with seminars of three days' duration for the training of instructors of the Billings method.

We then founded Centros Diocesanos Billings (Billings Diocesan Centers) to undertake the expansion of the movement to their respective dioceses and, with the assistance of the national center, we proceeded with the creation of centers to provide services in the parishes and other locations within easy reach of the public. Services to the public were then initiated. With a minimum of personnel in each

center, we offer instruction and follow-up and aim to keep proper records and statistics.

In July 1982 the first national meeting of instructors of the Billings method took place. Delegates from almost the entire country participated.

Our program has expanded from Caracas, the capital, to other important cities and dioceses such as Valencia, Acarigua, Porlamar, Ciudad Guayana, Puerto Ayacucho, Los Taques, La Guaira, Maturín, San Carlos, San Cristóbal, and Barquisimeto. We will soon establish centers in the remaining dioceses. The program functions in urban, suburban, and rural areas, in private residences, parishes, and church facilities. The services provide assistance to all classes of clientele coming to the different centers without regard to race, creed, or social status. To date the instructors have been recruited from couples engaged in apostolic movements and religious members of various orders throughout the country.

Our primary objectives are promotion and expansion of services to the entire country, securing funds, and improving the training of instructors. We have concentrated on teaching the Billings Method in Spanish but have some experience teaching in the indigenous language in missionary zones.

We have not obtained any official financial assistance to this date, although we have contacted various public administration staff and overseas institutions. We depend entirely on the collaboration of a few private individuals and organizations and on volunteer staff. Because of the newness of our program and lack of accumulated data, we have difficulty in providing valid statistics on couples using NFP, percentage of dropouts, cost effectiveness, and pregnancy rates.

# Discussion

The need to make natural family planning available to all was discussed under three main topics: expansion of service, leadership, and funding.

Expansion of Service Two issues were highlighted in the discussion: the relationship between private NFP organizations with an explicit value system and the more pluralistic public sector programs; and the difference between NFP as a social movement and NFP as merely one kind of family planning service.

Some organizations do not aim to make NFP available to all potential clients or to try to staff all delivery points. Rather, they see themselves as a reference source for the best teaching, training, and literature in the NFP field. They also try to train couples to be models of successful integration of periodic abstinence into their relationship. Many NFP leaders question whether it is possible to reach the whole country and at the same time pass on NFP values.

A key question for many conference participants, who wish to make NFP available to all, is what attitudes they should take towards clients' values and behavior. What policy should NFP programs have toward single people (not sexually active), engaged couples, and cohabitators? It was suggested that NFP values be presented as an essential ingredient for the successful practice of NFP. For example, teachers should point out that NFP works best in a stable, committed relationship and depends on the love and responsibility between partners. One program director has found that a couple expresses the values of NFP more by successful practice of periodic abstinence than by spelling out the values in words.

A participant from the public sector observed that many potential clients want NFP only as a contraceptive, and these people are automatically turned off by marriage enrichment courses. Some people—for example, singles—come to an NFP pro-

gram and cannot get NFP training because the program is limited to married couples. How do you set up a non-Catholic service in a developing country that has only a Catholic program?

Some private sector providers solve the problem of values by having no selection criteria for clients but insisting on strong selection criteria for teachers. Religious affiliation may be less important than the acceptance of periodic abstinence in the teacher's own life and the motivation to share knowledge of the practice with others. It is not uncommon for all teachers in a private program to be Catholic while 50 percent or more users are non-Catholic. In the experience of some providers, non-Catholics can be more strict in their value orientations than Catholics.

Many clients come to NFP for health reasons. Several participants believe that all have the right to learn about their bodies and to use the knowledge to limit their fertility. You do not refuse to teach physics because a student might make a bomb. An Asian participant noted that information about artificial methods of family planning is readily available to young people, so it makes good sense to teach unmarrieds about NFP as well.

The distinction between NFP as a movement and a service was defined in several ways. Some NFP providers call themselves a movement and have a clear philosophy and ideals, but they have no problem providing services to individuals who lack such a commitment. The core group of committed volunteers is the guiding force behind the service. Others see the movement as broader, incorporating the whole aspect of family life education, in which an NFP service is provided.

Leadership An important issue in development of NFP programs is leadership. Priests and sisters start many programs, especially in remote areas. They are willing to work in places where others cannot or will not go. The challenge is both good leadership and how to pass on leadership.

Participants generally felt that the role of priests and religious (defined as both men and women celibates who have dedicated themselves to the Catholic Church), like

that of doctors, should be as facilitators. Once a program has been initiated, they should have the humility to step down. This does not mean there is no place for religious. One medical provider has found that some clients may still prefer to talk to nuns for reasons of confidentiality.

There are great contrasts between programs in various countries. In one developed country, medical and church groups are not being reached at all. In an African nation, leadership is based on a hierarchy with the initiator a bishop, the president a doctor, and service provided by the couples.

Funding Funding is important in the expansion of service and raises many questions with regard to program philosophy and accountability. An African participant stressed that developing countries are caught between two conflicting sets of expectations: NFP motivators come from religious groups, and funders have their own ideas. Many religious NFP providers do not accept the referral clause that some international funding agencies may require. This clause mandates referral of dissatisfied clients who request methods of contraception not provided by the NFP service to other family planning services or health personnel. On the other hand, governments are reluctant to fund single-method programs. Both groups, it was suggested, would accept referral of clients to a family doctor.

One participant from a developed country urged that NFP personnel should press for accountability of the funds their country gives to the United Nations Fund for Population Activities. How much goes for natural family planning?

Contrasting yet similar views on funding were presented by a private European funding agency director and a United States government representative. Some agencies see nothing wrong in incorporating a philosophy of family life promotion into an NFP program, but this value system should not be mandatory. Some international organizations have been reluctant to fund NFP because they perceive NFP as the ineffective calendar rhythm method. Further, they consider NFP to be neither cost-

effective nor very acceptable. Information on start-up costs, number of autonomous users, number of unplanned pregnancies, and continuation rates is needed. There is little hard data on acceptability of NFP. It is important to know if a couple with an unplanned pregnancy comes back to NFP later on.

One private Catholic funding agency funds NFP not just for demographic or economic development goals but for achievement of family and self-fulfillment goals. At the same time funding agencies need hard facts and technical know-how for funding.

There is the problem of meeting the challenge imposed by the sudden infusion or withdrawal of funds. Each program should answer the question: Is the project culturally appropriate? Do we have the staff? Assistance can be provided in kind.

A program director from Africa does not think NFP providers should always think of someone else to provide the funding. He described his own organization's income-generating projects, which included real estate rental and for-profit business. Volunteer services are a form of funding coming from inside the organization. One participant stressed the importance of taking account of the whole picture. The problem of funding can be mitigated by inserting NFP into existing church, government, or medical delivery systems or into a literacy program.

The problems of funding vary from country to country. In one poor Latin American country, some couples cannot afford to pay for the service. But paying for NFP adds to the motivation to use it successfully. Therefore, couples are expected to pay, but if they cannot afford it, the program subsidizes the couple. In a European country the service has to be free because other family planning services are provided free.

Funds, it was pointed out, are needed not just to run NFP programs but to unify the NFP movement nationally or regionally (which one participant recommended as the second level of development). It is expensive to bring people together. Who pays those expenses?

# NFP Education, Training, and Service Development



Sr. Paulette, Missionary of Charity, counseling woman on NFP in Calcutta

## ANNA FLYNN

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*This paper attempts to look at the problems facing NFP programs in the 1980s and outlines a suggested plan of action at both a local and a national level to meet this challenge.*

*The most critical factor in any NFP delivery service is the quality and competence of the NFP teachers. Therefore, to achieve a high-quality NFP service, a program must ensure that adequate training courses are available. This requires standards for curriculum content for use not only in local or area programs but also nationally and internationally. Outlines for such courses based on the WHO/BLAT Family Fertility Education Resource Package and that of the U.S. curriculum outlines are offered as a help for programs desirous of initiating or updating training programs. Continued NFP education is also important because of rapid developments in science and education. This paper offers suggestions for the implementation of continued education.*

Historically, the cyclical fertility of the female has been recognized, but it has been traditionally associated with menstruation. The twentieth century saw the development of scientific methods to identify the fertile time in the cycle. Scientifically based methods of natural family planning by planned sexual intercourse or abstinence during the fertile phase allowed couples to plan their families.

The same scientific discoveries that produced the development of natural methods also made it possible to eliminate completely the fertility phase in the cycle. I refer, of course, to the introduction of the oral contraceptive pill, which seemed the answer to family planning problems. Contraceptive clinics quickly sprang up to "deliver" the pill and other contraceptives,

and contraceptive technology began its flourishing developments.

In contrast to the highly technical nature of the artificial contraceptives, natural methods depend principally on educating people to detect their own fertility. They entail a delivery system different from that of artificial contraception. The development of NFP services started when private pioneering groups began to be established to help couples in the use of the natural methods. These groups often received financial and moral support from the Church at the local or diocesan level and were closely associated with other socio-moral programs within the Church framework, such as marriage counseling and family life education. In general, with a few notable exceptions, the NFP services were delivered by lay volunteers who received local training only. Accountability was to the local church group. Thus, a myriad of NFP movements, each with its own training and delivery system, sprang up in different countries. There was very little rapport even between neighboring countries, and no effort was made at international expansion.

While NFP remained very much a movement at the grass-roots level, the contraceptive services had developed rapidly in the intervening years from being private clinics to becoming fully integrated into the general medical services of each country. They were staffed by well-remunerated professionals, and they operated at national and international levels.

These developments served to isolate the NFP programs, which came to be seen as quasi-religious rather than health-oriented and which were generally discredited by the medical profession, by the official family planning (contraceptive) services, and often by government health services. All of this led to a lack of con-

fidence in NFP by the public.

In the latter half of the 1970s, however, NFP evolution moved more rapidly, with expansion not only within the NFP network but also in the relationship between NFP and the official contraceptive services. Concern with the possible side effects of artificial techniques caused the public to take a second look at natural methods of family planning. The last decade, therefore, has seen a steady expansion of NFP programs and services in both the developed and the developing world.

In some parts of the developed world, NFP has expanded out of the church centers into existing medical services. In England, the original NFP movement (Catholic Marriage Advisory Council) offered NFP services in the 1950s and 1960s as a church-based organization. The NFP center in Birmingham, founded in 1975, is based in the Obstetrical and Gynaecological Department of the University Hospital. There it offers training courses in NFP leading to an official certificate recognized by the medical services, with lecturers and course tutor fees remunerated by the Area Health Authority. It also has a service clinic in the hospital running parallel to the contraceptive clinics. Although it maintains a very close liaison with the diocese and its parishes and Catholic schools, its accountability is to the University and area health services.

A further development from the center over the last two years was the establishment of regional centers, similar to that in Birmingham, at Liverpool, Bristol, Newcastle-on-Tyne, Sheffield, and Nottingham. These centers have developed within the medical networks but as yet are often partly financed by the diocese and maintain a close liaison with each other and Birmingham through the National Association for NFP Teachers. Other countries in Europe are also developing along similar lines.

The founding of the international NFP organizations, World Organization of the Ovulation Method Billings (WOOMB) and International Federation for Family Life Promotion (IFFLP) in the 1970s served to coordinate and stimulate further the small NFP programs at diocesan or national level

by developing an international NFP forum. In addition, these organizations were the driving force for the unplantation and expansion of NFP in developing countries. Since 1977 they have sowed the seed of NFP in African and Latin American countries. Through the general assemblies of these international organizations and through other international seminars and workshops, experts from the medical, social, behavioral, psychological, and educational disciplines, scientific bodies such as the World Health Organization, the British Life Assurance Trust (BLAT), the U.S. Department of Health and Human Services, to name but a few, have been attracted to offer their expertise.

All of this has led to a better understanding of the scientific basis of the different NFP methodologies, their acceptability, their efficiency, and the importance of an appropriate educational technology for the more effective delivery of NFP. Thus, out of the small individual grass-roots movements that constituted NFP programs 30 years ago, a professional, multidisciplinary, international service has developed, recognized by official governmental bodies and health services as having something positive to contribute to the health of the community, quite independent of the moral and ethical values it also offers to some.

This growth poses a serious challenge to NFP movements and programs worldwide. The important question for each one of us in the NFP field is whether we are prepared to meet this challenge. I believe that the future of NFP over the next two decades will be determined by the response we give.

#### **The Challenge of NFP Developments in the 1980s**

In order to meet the challenge, we should proceed in an orderly fashion to take stock, plan action, and take action.

All good business people take stock not once in a lifetime, but yearly or more often. If they do not, they are left with out-of-date items that constitute a liability. In our NFP programs we should also take stock of the demand for our services and of our resource potential. Our first question should be: Who are the people likely to look for NFP services? To put it another

way: What do we know about our user population? What are their characteristics? Their expectations? Their problems? Where are they found? How can they find us? These are fundamental questions to be answered before we begin to plan our service program.

Let me give an example. Historically, NFP services were very much church-associated, and many programs still have their clinics, personnel, offices, and instructors on the property of the church to which they are attached. Changing attitudes to contraception and a return to nature have made increasing numbers of people interested in natural family planning, not because of any moral reasons but for medical and/or cultural reasons. Will they be prepared to seek out a church-associated clinic? Or will they mistrust the clinic as a means of religious indoctrination? Are these people better served through the medical network? Such clients usually come from contraceptive clinics and feel more at ease in the health-clinic situation. Referral is easier, the location and booking system are already well known, and only a minimum of adjustment is required on the part of the client.

NFP offers opportunities other than just avoiding pregnancy. It can be used to achieve a pregnancy and therefore is suitable for infertility and preconceptional clinics. These are normally situated in a hospital outpatient or other specialized clinic. Breast-feeding mothers are naturally attracted to NFP, but the best place to contact them is in the maternity unit of the hospital or La Leche League. Premenopausal clinics are fashionable nowadays, and they too can be fruitful soil for the implantation of NFP. Thus, the public and private health-care delivery systems may be necessary to help the NFP services maximize the potential user population.

Well-women clinics and women's educational centers and certain feminist groups are developing in Europe and America. They are often interested in the fertility awareness component or in NFP itself and are another group of potential users. Inputs into medical schools, nursing schools, teacher training colleges, schools, and colleges, mainly through the fertility

awareness component of NFP, are an important orientation service, since they are likely referral sources to NFP services later. Finally, home visits and teaching may be necessary to reach certain families who are either unable or unwilling to attend a clinic.

We now ask ourselves the next question: Having identified the user population, what resources do we have to meet their needs in regard to NFP? There are various types of resources, including personnel, finance, clinics and training centers, and backup support services for referral of clients and related activities.

### **Personnel**

Probably the most effective part of an NFP service is its personnel. Many different persons will be involved in an NFP program, but they fall into three main categories: administration and organization, instructors or teachers, and public relations and fund raising.

With regard to administration and organization, each program should have an organizing committee to coordinate all those involved in offering NFP services. This committee is also responsible for the standards of service, training programs, and the fertility acceptance philosophy of NFP. For this reason, several disciplines should be represented to evaluate standards and monitor progress. A salaried administrator/coordinator is desirable, although this is not always a reality for many programs. A salaried secretary, either part-time or full-time, is essential.

The well-trained, competent NFP teacher is the linchpin of any NFP service. The importance of the NFP teacher was emphasized by Dr. W. D. Clarke, Director of BLAT, when, at the International Seminar on Natural Family Planning held in Dublin in 1980, he stated, "Teachers are the crucial factor (to NFP) because, in my experience, a good one can make even a bad method work, but a bad one can ruin the best methods and plans."

Teachers should be able to offer all NFP methodologies to clients. For several reasons clients may prefer to use a single indicator of fertility or to select and combine several indicators in a multiple-index approach. The teacher should be able to

help them select but should not attempt to influence them to use a particular method because she (the teacher) has found it useful personally.

In larger programs and as more teachers are trained, it becomes possible to "specialize" in teaching NFP to particular groups—e.g., postpartum, infertility, premenopausal, and postpill—thus offering a more efficient service to these particular groups of clients.

The programs should have at least one public relations officer who coordinates the relationship of the center to the public. Very often this is combined with the work of the administrator or the secretary or other members of the central program. Public relations efforts require training on the different methods of reaching the public. The mass media are the best advertisement, and people need to be trained in public speaking and other media skills in order to use mass media efficiently. A very important public relations task is orientation talks for those likely to be referral sources for NFP clients—hospitals, clinics, medical schools, church groups, priests, seminaries, religious congregations, and school governors.

#### **Finance**

As the program becomes better known, sources of funding begin to emerge. In general in today's world, in order to attract funds, donors must be convinced that the program has the necessary trained personnel and that it is responsible and accountable for the funds given. Professionalism is the key word—nobody has either the cash or the inclination to give hard-earned money to what seems to be an amateurish program without definite goals and without trained personnel.

Assistance is not limited to financial support. Help may be obtained for training—for example, a hospital or university may provide lecture space, equipment, photostating facilities, or lecturers' and tutors' fees. Occasionally a teacher who works in NFP delivery within the family planning clinic will be remunerated as a professional.

Funding demands the accountability of a quality service. It is often difficult to sustain high quality with an all-volunteer staff.

Time is one of the most important commodities for NFP delivery service, and volunteer workers cannot always contribute the necessary time. Moreover, the program cannot impose standards that are too rigorous since there is not remuneration for services. Programs with volunteer staff may be reluctant to seek and accept funding from public bodies because they are not able to offer the services expected. This is a pity, and, in my opinion, it is better to accept the challenge and improve the services to meet the demand.

On the other hand, a good mix of professionals and paraprofessionals with the volunteers may achieve the best for the program. The professionals, to justify their salaries, will have to give excellent service, whereas often the apostolic zeal of the volunteers is an even greater incentive to make the program work. It is most important that all NFP workers—whether involved in the day-to-day running of the center, in orientation of the public to NFP, or in NFP delivery at the client level—are kept abreast of the latest developments in NFP, both in basic scientific work and in better methods for delivering NFP.

#### **Clinics and Training Centers**

NFP has a rich and varied clientele. Consequently, one should aim to have the clinics as widely dispersed as possible to cater to those looking for NFP for moral reasons (church clinics) as well as those with health reasons. It is important that the clinic sites be accessible in both location and hours of service, attractive for clients, and well staffed. There is a great advantage in being located in an official health or hospital clinic, since all the above requisites are practically ensured.

Although many NFP teachers may staff the clinic, one person should be responsible for its efficient running and accountable for this to the center. To avoid overloading the clinic, a booking system is advisable, and at least 30 minutes should be allowed for each new client.

A network of domiciliary NFP teachers is very useful for the follow-up of the clients in or near their homes. A close liaison should be maintained between the clinic and these teachers, with the clinic having

the overall responsibility for the client. This helps to ensure quality control of the teachers in the network and is important in ascertaining when a couple have become autonomous users.

Any NFP program must offer some training, both orientation courses for public relations and basic NFP teacher training. This necessitates a site for training courses, and much will depend on how the program is set up, its goals or end points, and its personnel and financial resources. Where there are several small NFP programs, a central training center, well equipped and in almost continuous use, may be a more economical solution than several small, poorly equipped training centers. The central training center could then have a training team recruited from the smaller programs. This ensures quality control for the training program.

Having looked at the demand for services and at our resource potential, we can now begin to plan. There are many kinds of planning objectives—short-term, medium-range, and long-term—and a program requires all three kinds. Each objective should be clearly defined. Usually one plans more than one can realistically achieve, and for this reason, it is important to identify priorities in the planning and to set time limits for achievement.

Accountability and budgeting are essential so that plans can be developed in an orderly fashion, always aiming for the overall long-term plan. Budget items include staff, training, finance, and locations, among others. Ideally one should budget for a three- to five-year expansion goal. Although a program may have very few current resources, a well-planned future program is probably the best way to attract funding. Therefore, a clear exposition of the potential demand and a plan that seeks to remedy the lack of resources suggest a program that is accountable and responsible. "Think Big" is a good slogan for NFP programs.

Finally, one arrives at the action stage, as defined by the demand, the potential resources, and the plans, both long- and short-term. In the course of taking action, one must take into account any additional information being discovered and any

necessity to modify the plans. NFP service development can occur and be responsive to the requirements of the users only if the program continually takes stock, plans action, and takes action in an ever-recurring cycle.

#### **Education and Training for NFP Instructors**

To develop training programs of a high caliber, two types of training are necessary: (1) basic NFP teacher training courses, and (2) tutor training courses. Teacher training courses are essential to any program and are usually developed locally by the program. The tutor is the person who trains the teachers. Normally each small program does not have a well-defined tutors' course (although most have in-service days to help develop tutors). There should be one, however, at least at a national level, in which all satellite programs participate and to which they have access. A national tutors' training course helps to ensure quality control for all basic courses in the region.

#### **Basic NFP Teachers' Training Courses**

Historically, NFP was taught in a woman-to-woman or couple-to-couple system, where very often the instructing woman or couple had a large personal input and drew heavily on personal experience. Sometimes a fanatical zeal in promoting NFP for either moral or cultural reasons was expressed. There was no assessment of the standards or quality of instruction given, but it certainly varied considerably.

The development of a more professional approach to family planning in general, usually within the health services, and the growing realization that the critical variable for successful NFP is the trained, competent teacher prompted the initiation in the mid-1970s of more formal training for NFP delivery.

Curriculum objectives for training NFP teachers were formulated in the United States in 1974 by Mary Martin for the Human Life and Natural Family Planning Foundation under contract with the U.S. government. These were shared in 1975 with the World Health Organization

(WHO) for the further development of a standardized curriculum for NFP worldwide. WHO worked with BLAT to develop the Family Fertility Education Resource Package which contains four modules: (1) fertility awareness, (2) ovulation method, (3) sympto-thermal method, and (4) living with NFP (sexuality and responsibility). In addition, it includes an educational handbook.

The important common factors in the two programs are described below:

1. Fertility awareness includes a discussion of basic anatomy and physiology, making this module particularly well suited to schools or for persons who wish to know more about their bodies but who may not necessarily plan to use NFP.

2. All current NFP methodologies are included, thus emphasizing the importance of training NFP teachers to impart all methods so that the client may have a choice.

3. The importance of modern teaching techniques in the curriculum is stressed in the training objectives module (Martin) and the educational handbook (WHO/BLAT). The teacher not only must have the necessary background knowledge but must be able to communicate it to the client.

4. Living with NFP is an important module that is missing from the American curriculum, although without doubt it is implied in the training objectives.

A somewhat later development in NFP than that of methodologies was the realization that the successful use of natural methods required that the couple be able not only to define the woman's fertile period but also to handle their sexual behavior during the fertile phase according to their desire to avoid or achieve pregnancy during that cycle. It is most fortuitous that the resource package managed to incorporate this realization. It guides the trainee-teachers toward their major role of helping clients to become autonomous and suggests ways of approaching this "delicate" subject.

The WHO/BLAT project highlighted certain basic aspects of what constitutes a good training program for NFP teachers. In summary, it points out that a teacher needs

more knowledge than a user in order to give her confidence and ability; she requires an opportunity during the course of her training to talk about sexuality and its control; she must have supervised teaching practice, using materials with which she is familiar; she needs an adequate support system for consultation about problems; and she needs training in educational methods. Because of these requirements, self-instructional methods for training are inadequate, and a group system including both men and women is the ideal.

#### **Selection of Candidates for NFP Training**

What are the characteristics of a good NFP teacher? All training agencies must ask this question in the interest of being economical in their efforts. We all know certain attributes or qualities that certainly seem to make for success, such as motivation, commitment, empathy, or the ability to learn. It is not always possible, however, to identify all of these attributes in a person, even when we know what the desired qualities are. How often is it our experience that the ideal candidate eventually turns out to be a poor teacher? The opposite can also occur.

Ideally, the NFP teacher should have some personal experience in monitoring her own fertility and a fertility acceptance attitude. Some training programs offer a pretest to all their candidates. Even then one still has the problem of differential learning rates: the slow learners feel inadequate, while the quick learners get bored or frustrated. There are several pedagogical techniques to overcome these problems, and tutors for these courses should be trained specifically to deal with such situations.

When NFP demand and interest were low, the small number of candidates who wished to become teachers allowed for little or no selection. Increasing demand is now forcing teaching programs to get some return for their outlay in training. Nevertheless, there will always be some dropouts, and if they are a high percentage of trainees, the training program should reexamine itself.

From my short experience, I find that the quality of the training offered is prob-

ably the most critical variable in determining the continuation of the NFP teacher. Another very important element is follow-up and support from the center, including in-service training through chart analysis, assessment of pregnancy charts, special physiological situations, data collection, and involvement in research projects.

#### **Assessment of the NFP Teacher**

Ideally, the successful teacher is one who can teach the clients to chart correctly and understand the indicators of fertility; to determine correctly the fertile days in the cycle; to adjust sexual behavior according to their family planning intentions (avoid, space, or limit pregnancy); and to recognize any departure from the normal in the cycle and to seek expert help if it is required. The teacher should also have the latest information with regard to research and NFP delivery.

Before the teacher is given responsibility for clients, however, it is wise to have a qualifying examination. This may take various forms, but it should include a test of comprehension of the basic knowledge necessary to teach clients NFP, including all the current indicators of fertility. After a practicum of teaching NFP under supervision, the trainee should demonstrate the ability and sensitivity to understand difficulties, either physiologically or psychologically and sexually, that couples may have in the practice of natural methods and the ability to maintain confidentiality. The ability to teach the basic methodologies to clients should also be demonstrated. A final certificate should be issued to those who pass the basic qualifying examination. This is important for three reasons: it gives the teacher the confidence she needs to know that she is qualified and capable of teaching; it is a safeguard for clients and gives them confidence in their teacher's competence; and official health services may demand a diploma before employing an NFP teacher.

In the Birmingham Training Program Assessment, the diploma is recognized by the Central Midwives Board for nurses, health visitors, midwives, and lay people and by our postgraduate dean at the University for postgraduate training for doctors. All the regional training courses sponsored by Birmingham (there have been five over the past two years) also enjoy the same facilities for the diploma, provided they are organized, directed, and examined by the Birmingham training team.

The fact that the NFP training courses are recognized by official bodies like the Central Midwives Board and the University gives them increased standing and credibility with both professionals and the general public. It also helps to ensure high quality in the training courses and in the assessments.

#### **Continued Education for NFP Teachers**

Several activities ensure continued education for NFP teachers. First, in-service days are held at the center several times a year, and attendance at one of these each year is obligatory to continue on the Register of Certificated Teachers. Regional meetings are also held at each of Birmingham's six satellite centers at least once a month. Chart analysis and various difficulties are discussed. The Association of Natural Family Planning Teachers, a national organization for England, Wales, and Scotland, serves as a coordinating body for NFP teachers for all areas. It also serves as a link between the teachers and the health and family planning services and other NFP groups. Finally, a newsletter is produced that is the official communication of the association. It keeps teachers informed about newer techniques, research, and other items of interest.

These are the critical areas in which an NFP program needs to take stock, plan, and take action to ensure quality education, training, and service.

# Family Fertility Education Resource Package

W. DONALD CLARKE

*W. Donald Clarke, Ph.D., director of BLAT (British Life Assurance Trust); producer for WHO of the Family Fertility Education Resource Package, London, England*

*Dr. Clarke affirms that the quality of NFP services depends on the quality of the teacher. NFP requires a teacher who actively involves the client in the learning process, especially as most NFP learners are adult. This approach is also appropriate for those who train NFP teachers. Continuing education, practice teaching, gradual progression in handling difficult cases among NFP clients are recommended strategies. The WHO/BLAT Family Fertility Education Resource Package as an important aid to NFP teaching is described in the rest of the paper*

Dr. Flynn's analysis of the situation regarding teacher training and NFP is extremely perceptive and accurate. She has identified correctly that the quality of any service is first and foremost dependent upon the quality of the teachers. Good teachers need three things: a sound knowledge of the subject that they are teaching; the type of personality that makes them acceptable as a person to their students; and the availability of sound, reliable support services that can provide them not only with technical and logistic services but also with access to continuing education for themselves.

It is an illusion to think that there is just one model of a good teacher. On the contrary, good teachers come in all shapes and sizes with different personalities and teaching styles. Learning takes place most effectively and efficiently when there is a match between the personalities of teacher

and student and when the teacher has taken the trouble to understand what sort of person the student is and how he or she can be motivated to learn. It is possible for a teacher who relies upon a didactic, authoritarian style to be successful in some situations, such as where the learners expect, and want to be told, what to do and how to behave without having to think for themselves.

It is much more likely, however, that the successful teacher will be the one who requires her learners to be active participants in the learning process and who spends more time listening to them than they do to her. (Not for nothing has it been said that man has two ears and one mouth so that he can listen twice as much as he speaks!) Unfortunately, the majority of NFP teachers seem to be of the authoritarian, didactic type and lacking in any professional training. Consequently, they tend to teach in the manner or style that they themselves were taught either at school or in college or in church. Their attitude clearly announces, "I know I am right. I have the knowledge. It is my task to give you this knowledge. It is your task as the learner to listen to me, to recognize me as the authority, and to do what I say."

It often seems to the outside observer that the major concern of such teachers is to get another notch on their guns or another medal by getting a learner to pass the test and thus prove what good teachers they are. Such an approach is almost exact-

ly opposite of what is required in NFP teaching. NFP teaching is about human behavior and human attitudes just as much as it is about knowledge and skills. To change behavior or attitudes requires a far less dominating approach and a much greater willingness to see the task from the point of view of the learner.

Most NFP learners are adult learners. They are not school children or high school, college, or university students. NFP teachers will get nowhere until they recognize and come to terms with this basic fact. The characteristics of adult learners are the following: they have to be highly motivated to want to learn; they will learn only what they feel they need to learn; they want to be guided, not judged; they learn best in an informal setting; and they need to be given the chance to absorb what they have been taught.

The strange, unrecognized thing about this description is that it also applies to NFP teachers when they themselves are learning to teach. So it is a lesson that has to be learned by those who train NFP teachers! Dr. Flynn's call for a continuing education provision for NFP teachers should be listened to by those who have the power to establish it. Teachers need the chance to practice their art in informal settings where they, too, can make mistakes and learn from them. Let them learn first how to teach the easy cases among the women, for example, with regular cycles, a fair amount of intelligence, and a reasonably high level of motivation. Then let the teachers come back and learn how to deal with the more difficult instances, such as those presented by the nonliterate or premenopausal. What is needed is a planned system of teacher training and continuing education.

It is to be hoped that the WHO/BLAT Family Fertility Education Resource Package will provide one vital component of a planned systematic education. It has taken years of careful work to develop, with meetings of experts, field tests in six countries, further meetings of international experts, and a large financial investment in publication. It offers suggestions, guidance, and practical help in the form of visual aids to all NFP teachers who deal with the topics of fertility awareness, living

with NFP, the cervical mucus method, or the sympto-thermal method. Unlike some other publications, the resource package makes no claim to be the right or only way of doing something. On the contrary, it encourages teachers to adopt those parts they feel are appropriate to their situation, to adapt those parts that they feel need modifying to fit their situation, and to reject everything else. The only aspect of the package that has any semblance of a claim to authority is the education handbook because if professional educators are asked how NFP should be taught, then this is their answer.

The resource package represents a major advance in the teaching of natural family planning. Based on a five-year study conducted in six countries by the World Health Organization, it contains only those resources that have proved helpful for teachers. It is as scientifically accurate and rigorous as it is possible to be, but at the same time it is presented in such an interesting and artistic manner as to make it easy for both teachers and learners to grasp the necessary concepts.

The primary target audience is all those people involved in teaching and learning NFP, but so great is the clarity of the explanation that it is also likely to appeal to nurse trainers and teachers of school children, who will be able to select those items, such as the physiological and anatomical ones, that are highly relevant to their work.

The kit contains the following items:  
Anne and Graham This 11-page booklet showing a short story in the form of a cartoon strip is designed to stimulate discussion with learners on the importance of communication within a relationship. Also included are three sets of questions related to the cartoon story, each set being for learners of different ability, and two short cartoon strips on attitudes to abstinence from sexual intercourse. This booklet forms part of the "Living with Natural Family Planning" module.

Living with Natural Family Planning This module examines different aspects of the individual and joint responsibilities of the man and the woman that are necessary for the successful use of natural family plan-

ning methods. With the help of cartoons and diagrams, it deals with periodic abstinence, the expression of sexuality, and communication. As with the other modules, all the visual aids are to be found together in a compendium.

Fertility Awareness This module uses labeled anatomical drawings to provide some basic information about the male and female reproductive anatomy and physiology that are related to fertility. It covers both male and female reproductive systems, the pituitary gland and the brain, and the menstrual cycle, which is shown by a segmented wheel with a color scheme that runs throughout the package.

Cervical Mucus Method The cervical mucus (CM) method in this package is a variation of the Billings ovulation method in which the days of relative fertility are identified by self-observation of cervical mucus throughout the menstrual cycle. Subjects covered are the mucus symptoms and observation, charting and interpretation, the peak day rule, and use of the CM method to avoid or achieve pregnancy. The fertile and infertile types of mucus are clearly shown by photographs.

Sympto-Thermal Method The sympto-thermal (ST) method identifies the days of fertility and infertility by changes in basal body temperature in combination with other signs, symptoms, and/or calculations. Step-by-step diagrams show how to observe and record the temperature readings on an ST chart.

Handouts and Charts Both the CM method and the ST method modules have handouts that explain in concise textual and visual form how to fill in the charts after making the relevant observations. Handout sheets are suitable for photocopying. Alternative ways of charting by direct use of thermometer and lined paper are also shown. The ST module covers the uses of the method, the relative fertility during the menstrual cycle, diagnosing probable pregnancy, changes in the cervix, the recording of intercourse, temperature, mucus, and other signs and symptoms. Practice ST charts show specimen results of body temperature, cervical mucus, and other signs and symptoms that can be used

to determine the fertility of the woman. Common anomalies in the results are shown and explained. The CM module also has fully explained practice charts.

Throughout the package, abstract concepts and complex charting are made easier to follow by using step-by-step diagrams which include manipulation of charts, pencils, and menstrual cycle wheels. The various components of ST and CM charts and instructions on how to fill one in are systematically presented and fully explained on the text side of the card. Particular Stages of a Woman's Reproductive Life This section explains what is happening in a woman's body at particular stages of her reproductive life and how it may alter her body temperature and cervical mucus. The stages are: immediately after the menarche, postpartum, discontinuing hormonal contraceptive, and premenopause. The effect long cycles have on interpreting fertility is also shown.

Education Handbook This 63-page handbook explaining in detail the Resource Package contains sections on the choice of family planning methods, design and contents of the package, and how to use it. It has a full compendium of objectives, key concepts, and visual aids and a glossary of terms used in the package. The handbook also gives directions for planning a course using the package, teaching techniques, the role of the teacher, and how teachers themselves can be trained.

NFP teaching is at a crossroads, a point at which decisions have to be made. There are a number of inspired teachers about, and they have been successful; in fact, rather like the statement in Dr. Flynn's paper, they have even managed to make difficult methods work. But at the moment there are no signs that this inspired few can generate enough teachers to match the need. In other words, current teaching methods are not really independent of their inventors; so the choice has to be either to have a small cadre of inadequate teachers almost immediately or to try to develop, at first more slowly, a large number of teachers independently of the inventor of a method who rely more on a compromise between teaching methods.

# Comments

## MAUREEN BALL

*Maureen Ball, national coordinator of the New Zealand Association of NFP*

The New Zealand Association of Natural Family Planning has 125 active trained teachers who are partially remunerated. A basic training course takes approximately 12 months. Candidates must be users who are able to function efficiently in a clinic, and they must subscribe to the aims and objectives of the Association. Each candidate is selected by the national coordinator before a training course.

Trainees attend a three-day residential seminar with expenses paid. For best results no more than 20 and no fewer than 10 are trained as a group. Lectures, group discussion, and role-playing are used to present the following topics: anatomy and physiology; hormonal influence during a menstrual cycle (acted out as a drama); the concept of "combined fertility"; teaching and interviewing; special circumstances (for example, breast-feeding or premenopause); and motivation. Self-administered tests are used for comprehension exercises.

After six weeks trainees complete a written exam. They then commence role-play work under supervision in mock clinics to gain teaching and interviewing skills. Pregnancy investigation is included in this part of training as a role-play exercise. When the supervisor is convinced that the trainee has gained enough role-play experience, he or she starts teaching under supervision. The supervisor is present at all interviews at this stage and will try to arrange for the trainee to see a wide range of clients.

A second three-day residential seminar (usually approximately 10 months after the first) consolidates the basic training. Trainees then complete their final exam paper, which includes a comprehensive case history of a real client-couple and a

research project. This research involves the trainee in a public relations exercise, seeking out the people in other service agencies who can be helpful if clients need referral. Successful trainees are then accredited.

Both men and women are trained as teachers. They are selected from those who are pleased with natural family planning and would like to help others. Men work with a female teacher when they are teaching couples. They are available for consultation when a male client would prefer to talk to a man alone. Men do not teach female clients by themselves. A few doctors, who are interested in providing a medical back-up service to their local NFP teachers, attend sessions in our training courses. We have no trainees from our Polynesian or Maori communities.

In the national coordinator's office in Auckland, we have up-to-date records of the workload and status of every NFP teacher in the country. To maintain accreditation teachers must attend four study days per year and complete a residential postgraduate course every three years. A government grant covers their expenses. Teachers who take leaves of absence for family or other reasons are given refresher courses on their return.

We maintain a friendly relationship with the Family Planning Association. We do not have the money or resources to promote our service aggressively but supply local newspapers with news items.

The annual NFP conference provides an opportunity to invite members of other agencies, doctors, and health workers to join us and share both our education and our fellowship. This conference brings together about 120 NFP teachers from all over the country. Before the conference the 14 area leaders meet and report on developments and events in their own areas. These area leaders are elected each year by their local teachers. They are

responsible for the four local study days per year, and they keep the national coordinator informed of developments in the area.

Good communication among teachers throughout the country is essential to maintain morale. Some teachers in country centers would be very isolated and cut off if it were not for our communication network. Our quarterly newsletter, sent to all accredited teachers, provides an opportunity for continuing education as well as a forum for sharing news and views. Information is also channeled through area leaders.

Our NFP teachers, both men and women, work in clinics by appointment. We teach "symptoms" only to a couple who have a fully breast-fed baby during the time that the mother has no signs of returning fertility or is not cycling. As soon as the breast-feeding situation changes and/or signs of fertility appear, we teach the sympto-thermal method (i.e., symptoms and temperature), with cervical palpation for those who are interested.

Our approach to teaching stresses the "combined fertility" of the couple. When a male and female teacher work together, the male explains the male partner's role and the techniques of temperature taking and recording. The female teaches the female client about mucus symptoms as a sign of days of possible sperm survival in the preovulatory phase. Emphasis is placed on the "waiting time," which starts with the onset of mucus symptoms due to the

man's fertility, to his sperm survival. The "waiting time" finishes when the male partner is able to show the female partner that those symptoms led to ovulation. The temperature chart confirms that ovulation has taken place.

Over 50 percent of our clients are not Catholics, and most come from a mainly middle-class, educated socioeconomic group. Our biggest group of clients are breast-feeding women. The next largest are those discontinuing the pill or injectable Depo-Provera. Many of them are planning to have another baby but want time for the effects of the chemicals to wear off. We have not yet worked out a satisfactory data collection system on continuation rates. Our third largest group, many referred by doctors, are trying to achieve pregnancy.

We teach fertility awareness in secondary, mainly Catholic, schools. We have just introduced further training for our NFP clinic workers to become educators. Some accredited NFP teachers receive intensive training in public speaking, group leadership, and classroom techniques. In the future, only NFP teachers with an educator's certificate will work in this area on behalf of our Association.

Our greatest needs are to expand our services to all cultures and socioeconomic groups; to promote our services better; and to improve data collection processes. We also need more research on reliable fertility indicators and development of such products as a urine test kit to detect the approach of ovulation.

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## THOMAS HILGERS

*Thomas Hilgers, M.D., obstetrician and gynecologist; associate professor of Department of Ob/Gyn, Creighton University; director of NFP Education and Research Center, Omaha, Nebraska, USA*

The Creighton University Model is unique because it allows not only for the development of a program of excellence in the delivery of natural family planning ser-

vices but also for the continuation of education through the development of independent natural family planning education programs. The philosophy of the program promotes the development of strong education programs for new natural family planning teachers throughout the country.

The Creighton Model is built upon six different certificate programs. The basic programs involve the training of new natural family planning teachers (natural family planning practitioners and natural family planning instructors). The advanced

programs involve the further training of NFP practitioners so that they may either establish or participate in natural family planning education (natural family planning educators and natural family planning supervisors). The NFP educator is specifically trained in the natural family planning core curriculum that has been developed at Creighton University School of Medicine.

In addition to these programs, two specialized certificate programs are also available. One involves the training of physicians (natural family planning medical consultants) to enable them to participate in the future training of natural family planning teachers. The final program is the most recent; it allows for a sound theoretical base to be given to priests and non-Catholic clergy, so that they may be more knowledgeably involved in the natural family planning movement.

The Creighton Model has been devel-

oped through the research efforts of the Creighton University Natural Family Planning Education and Research Center. The program began in 1978 and has already exhibited a major impact on the development of natural family planning services in the United States. Several NFP practitioner and instructor training programs have been conducted in the United States, and many more are in the planning stages. The Creighton program offers a new and unique opportunity to build a solid foundation for the future development of natural family planning services.

The program at Creighton University, under the auspices of the Creighton University Natural Family Planning Education and Research Center, is accredited by the American Academy of Natural Family Planning. In addition, its certificants are eligible to pursue certification by the American Academy of Natural Family Planning.

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## ANDREW KIURA

*Andrew Kiura, M.D., surgeon; founding member and current president of Family Life Counselling Association of Kenya, and its voting delegate to IFFLP; currently associated with the Kenya Medical Research Institute; elected member of IFFLP African Zonal Council; with his wife, Jane, member of the Pontifical Council for the Family*

The Family Life Counseling Association of Kenya (FLCAK) conducts training programs for teachers and tutors and imposes strict criteria for the selection of trainees. Teacher trainees must be married women, married couples, or religious sisters. The ideal choice is considered to be the married couple. The woman must be between 24 and 45 years of age, and she must have been charting her menstrual cycles before training for at least six cycles, two of which must have been ovulatory. She should have a good knowledge of the rules of the NFP method she intends to train in, and she must be confident of the efficacy and advantages of NFP. She must use only an NFP

method in her own life, and she must continue charting and forwarding her charts to FLCAK at least every three months.

The candidate for training must not have any other volunteer activity in the community because of the time required for NFP training and teaching. The candidate must be committed to continuing education and must attend follow-up courses to stay up to date in NFP knowledge. She must also have a commitment to continue promoting and teaching NFP. Married women must have the consent and support of their husbands. Ten years of schooling is the absolute minimum for acceptance as an NFP teacher trainee. Finally, each candidate must have a local sponsor, which may be a hospital, parish, or community organization. This is important because it ensures that the teacher is acceptable to the community and will return to the community and make use of the training received.

To make sure that the criteria are met, candidates undergo a selection process, which consists of a written paper to test knowledge of NFP and an interview, in which the trainee's chart is also discussed. The interview seeks to assess the trainee's

attitudes toward NFP.

Although Dr. Flynn recommends that the teachers be able to teach all methods of NFP, we have found that our program must be flexible. Teachers who will work in rural settings usually offer only the ovulation method, which is easier to use and more acceptable for rural populations. In urban areas, teachers are trained to offer all methods of NFP. It is important that all teachers in one country use a common methodology of teaching, charting (symbols), and record keeping. Clients who move from one area of the country to another become confused if their new teacher emphasizes a different methodology. A national association of NFP teachers, such as the one in England, would help to standardize teaching methods, and this is a development that other countries should emulate.

The tutor is even more important than the teacher in the overall program, because this is the person responsible for the proper training of teachers. Well-trained tutors make it possible for the program to offer high-quality service and to spread much faster throughout the country. FLCAK is placing a great deal of emphasis on tutor training. Although teachers are trained at the regional or diocesan level by the tutors, the training of tutors is done at the national level.

Criteria for acceptance into the tutors' program include at least three years' experience teaching NFP; ability to communicate in English or Swahili; sound knowledge of and belief in NFP; organizing and counseling skills; commitment to real improvement of marriage; availability to conduct NFP workshops; and sponsorship by some organization. Couples are preferred as tutors, but if only one partner is a candidate, there must be evidence of full support of the spouse.

Selection is made through both oral and written testing during the interview for the

tutor's course. In addition to further knowledge of NFP, the tutors' program includes, among other topics, counseling, ethics, leadership, making visual aids, program design, and program management. Both the teacher trainee and the tutor trainee courses contain supervised practical work, both real and simulated.

Two types of teacher training programs are offered. The first, an intensive training course, is offered to nurses and doctors who intend to start NFP programs in the various hospitals. The course lasts four to six weeks, depending on the level of education and experience in NFP, and is given in all-day sessions. The certificate awarded to those who complete the course will exempt them from the compulsory eight-week family planning course at the national hospital.

The other type of training program is primarily for nonmedical personnel who meet the teacher selection criteria. They must attend three one-week residential workshops, which are held during the school holidays in April, August, and December. The timing of the workshops allows the participation of school teachers, who constitute the majority of the trainees in this course. The workshops are carried out at the diocesan level by a team of tutors.

The training materials used in the courses are primarily the WHO Family Fertility Education Resource Package. FLCAK participated in the research and trials that led to the development of this package. We have some complaints with it: we believe that it does not emphasize the prolife aspect of NFP adequately and it tends to evade the philosophical and moral issues inherent in sexuality. We also think that the presentation of the ovulation method is not detailed enough, but we have been able to modify certain portions to accommodate our own needs. We also have adapted Dr. Mary Martin's NFP instructors' training modules (the American curriculum outline) for use in our training programs.

## NOTKER KLANN

*Notker Klann, director of section on counseling and coordinator of the National NFP Program for German Bishops Family Life Program (Zentralstelle Pastoral), West Germany*

The Working Group for Natural Family Planning at the Central Agency for Pastoral Questions of the German Bishops' Conference (Arbeitsgruppe Natürliche Familienplanung bei der Zentralstelle Pastoral der Deutschen Bischofskonferenz) was the first NFP organization in the Federal Republic of Germany. Working closely with Dr. Anna Flynn of Birmingham, the Group organized and carried out a training course for persons who wished to become NFP teachers and for resource persons in the areas of preparation for marriage, family and adult education, and youth services. The course was financed by donations and by support from the Catholic Church.

The course was designed to include both informational and practical components. Informational units focus on knowledge of fertility awareness, methods of family planning, and living with NFP. The fertility awareness unit teaches basic anatomy and physiology as it relates to fertility, since understanding the biology of reproduction enables the trainee to comprehend the basis for natural family planning. Topics include male and female reproductive organs; hormonal control systems; the effects of estrogen and progesterone and their significance for NFP; indicators of different phases of the menstrual cycle (main symptoms, less major symptoms, combining different symptoms); and "double check" as a procedure.

The unit on methods of family planning offers general information on artificial contraceptives and their relationship to the natural methods of birth control. In this way, the instructor is able to help couples make responsible decisions about the choice of methods, taking into account their particular situations and motivations and their family planning intentions.

The unit that focuses on living with NFP

stresses that the successful use of NFP methods depends essentially on the joint decision made by both the man and the woman. Different aspects of this decision are discussed, and the possible difficulties that may result are addressed. The aim is to show future instructors that NFP methods depend on both the awareness of fertility and the corresponding understanding of the sexual behavior of both partners. It is pointed out clearly that abstinence may require a fundamental change in a couple's sexual behavior, which may lead to positive as well as negative reactions and behaviors.

A couple's motivations for learning NFP must be clarified with the instructor. The expression of sexuality must be explored in a wide context with regard to its physical, psychological, and cultural aspects. This requires an exchange of views and emotions and an understanding of roles within society and of moral, religious, and ethical values.

The teaching methods used in training NFP instructors include both demonstration and teaching by experience. This may be done in small groups or with one-to-one counseling. The trainee must be prepared to take the experience and level of knowledge of his or her clients as a starting point for NFP instruction. In this context, the art of listening is of special importance.

At the conclusion of the theoretically oriented course units, the trainee must pass a written examination. Trainees are tested on hormonal control systems, symptoms of fertility, application of periodic abstinence, and sexuality. Those who intend to work as educational experts in adult education, youth work, and preparation for marriage complete only the theoretical part of the course, which takes a total of 21 hours of class instruction in addition to the considerable time expended on personal study of the course materials.

Those who are training to become NFP instructors proceed to the practical part of the course. Each future instructor must introduce three couples to NFP, an activity that helps to develop teaching abilities. The trainee is required to write a report on each couple that contains all the important information necessary to assess the

teaching process. This information forms the basis for an oral examination that is conducted after at least three couples have been instructed. A teacher trainee must attend at least three regional meetings, participate in two supervisory meetings, spend at least 27 hours working as a teacher, and complete a final 12-hour colloquium. The theoretical and practical components combined require 72 hours of instruction and practice.

Following successful completion of all requirements, the candidate receives a certificate of qualification as an NFP instructor. There is not yet an autonomous organization of those who have finished the training course. The Working Group forms the informational network for all these teachers.

Continuing education is an important requirement for all instructors, and each one must declare a willingness to participate in continuing education activities. A written statement to this effect is completed.

The Working Group on Natural Family Planning has been asked by its commissioning institution to present a report on experiences in the training course. For this purpose, the registered cycles of the participants in the course as well as those of the couples who have been introduced to NFP will be used. This analysis has not yet been undertaken, but about 2,400 cycles are available for investigation, and a computer program has been developed espe-

cially for the purpose of analyzing the data.

At the same time, medical research relating to subjectively measured ovulation and its comparison with objectively measured ovulation was completed in 1983 by Dr. Freundl of Dusseldorf. In addition, results from a psychological examination administered to those who took part in the training course will be analyzed. The findings are expected to supply information about the personality traits of NFP users and about the effects of NFP practice on the relationship of the couple.

The results of scientific investigations pertaining to NFP are very rarely published in medical journals in the Federal Republic of Germany, so the average level of knowledge among physicians about NFP is very low. The training course has succeeded in stimulating interest among practicing gynecologists and scientists. Three dissertations on various aspects of NFP have been completed, and they will be published in the near future. Medicine and the medical profession are held in high esteem in the Federal Republic of Germany, so it is particularly important to promote medical research in the field of NFP and to focus on postgraduate education for physicians. Moreover, research in psychology and sociology is necessary to learn more about couples who practice this method and perhaps to contribute to the development of materials to publicize NFP.

## **CLARA LOCKHART**

*Clara Lockhart, Ph.D., national coordinator for family life (including NFP) in Dominican Republic; academic dean at the University Dominicana*

The Church is the only institution dedicated to natural family planning in the Dominican Republic. Services are offered to 8,921 couples or 0.7 percent of fertile women. In 1978 the Departamento de Pastoral Familiar (Department for Family Life) was created by the Dominican Republic's Episcopal Conference to assist and coordinate at a national level the services to the

family with emphasis on natural family planning. This was later elevated to an episcopal commission with a national coordinator, a diocesan or couple coordinator (for eight dioceses in all), couples representing marriage and family movements, coordinators for responsible parenthood, and a young person.

The Equipo Nacional de Pastoral Familiar (National Team for Family Life) was established by this commission to bring about uniformity in the expansion of the work. Composed of committed professionals such as physicians, nurses, psychologists, counselors, sociologists, and educators, the national team's principal objectives are:

(1) to plan, elaborate, and evaluate activities and programs at the national level; (2) to standardize the work undertaken in each diocese; (3) to represent the commission; and (4) to develop and supervise the national program on family planning by the Billings ovulation method, dispersing the latest scientific knowledge through appropriate media.

Each diocese created its own family life pastoral team with a similar structure and a local diocesan coordinator to represent them at the national team.

The Commission for Fertility Regulation within the national team has the following aims: to provide couples with knowledge of natural family planning and to help them establish a new style of life centered on conjugal love, mutual knowledge, and communication so they may create an awareness of co-responsibility in the procreation of children.

The first NFP centers arose from the need to have an office site for counseling couples. At present there are only 14 centers, since the core of the work consists of going to where the users live to instruct them through local meetings, workshops, and home visits according to needs. This is especially true in farming areas and in the hills where transportation is difficult.

Caritas and other private institutions offer medical consultation facilities for the teaching and follow-up of the couples. They either provide gynecological consultation or refer clients to an appropriate center. The diocesan teams for fertility regulation are composed of professionals, priests, and couple instructors trained in the ovulation method. The first centers were created in 1975, and the headquarters was established in 1978 in the capital of Santo Domingo.

The service is geared toward the poor, of whom there are several categories: the poor farmer, the urban migrant, the hill farmer, and those in need of total assistance.

Couples are motivated through radio and television programs and publicity brochures to attend workshops on the ovulation method. An instructor is assigned to them for teaching and follow-up.

NFP acceptors are practicing Catholics, Protestants, and Jehovah's Witnesses. At present there are 8,921 users in the program of whom 1 percent wish to achieve pregnancy, 5 percent wish to limit births, and the remaining 94 percent wish to space births. In most cases when the user can identify with clarity the fertile phase and the couple achieve a level of satisfaction with periodic abstinence in harmony with their family planning intention, the woman leaves the program. She comes back only when she experiences changes in her cycle or when her circumstances change. The user may feel confident after five or six cycles, but she is still given long-term follow-up until her autonomy is proven.

Most dropouts take place in the first or second cycle. The most frequent cause is disagreement between husband and wife on periodic abstinence. For this reason records are set up only after the second or third cycle, thus giving the couple the status of "registered" in the program.

In general 4.7 percent of the users become instructors. They must be fertile couples and users of the ovulation method. During their follow-up term they are given special training as instructors. If the training takes place in rural areas, it will be followed by a second and third phase after the first course. In the city one intensive training workshop is given to instructors of the ovulation method. The objectives and context vary according to the socioeconomic level of the participants. The general objectives are: (1) to master the scientific aspects of the ovulation method; (2) to learn educational techniques; and (3) to gain group skills for working with people.

The content is, first, theological and ecclesial based on the documents of the Church on the family and, second, biological and psychosocial. The latter topics include anatomy and physiology, the interpretation of the ovulation method, human sexuality, psychological differences between men and women, the psychological advantages of the ovulation method, the Dominican family and the contribution of the ovulation method to the integration of the couple, and supervisory practice.

The continuing training classes are basic

for both learning and evaluation. Evaluation is both written and oral. The trainee is evaluated on examinations and also on the supervised practicum in teaching couples. Enthusiasm for the ovulation method, confidence in its effectiveness, and experience as a couple are also required. Once these conditions have been met, a certificate is issued by the Episcopal Commission for Family Life, which accredits the trainee as an instructor of the ovulation method.

### MARY CATHERINE MARTIN

*Mary Catherine Martin, Ph.D., M.S.N.,  
NFP education and development consultant to IFFLP*

The concept of fertility acceptance must be emphasized as a learning principle when offering NFP services to couples. NFP provides the means for a couple to avoid or achieve pregnancy. The couple's decision is based upon knowledge of the woman's cycle and their procreative intention. They use periodic abstinence to avoid pregnancy or engage in intercourse to achieve pregnancy.

The growth of the couple in their relationship through the development of intimate and loving dialogue has been identified as a long-term motivator in the successful practice of NFP. In addition the couple experience confidence in identifying the fertile and infertile phases of the cycle and learn to discuss their family planning intentions.

In the Western world, modern contraception has been widely practiced for the past 20 years. The underlying philosophy of most methods of contraception is based upon some form of fertility suppression by temporary or permanent means.

As NFP services expand, it is important to emphasize that the fundamental pedagogical philosophy of learning to live within the procreative potential of the couple is one of fertility acceptance. Fertility acceptance reflects the couple's ability to live positively with the knowledge of fertility. To suggest that NFP is simply fertility

To ensure quality control in teaching, we demand: (1) highly qualified personnel in the teams for fertility regulation—doctors, nurses, psychologists, priests, and teachers of the ovulation method; (2) development of a program of 32 to 40 hours; (3) reevaluation of informational materials; (4) periodic evaluation of the program by the national team; and (5) teaching supervision through instructor meetings with the head of the department of fertility regulation.

awareness or knowledge that a couple may use in combination with other methods of family planning is not accurate and should not be identified as NFP. Fertility awareness is, in fact, knowledge; fertility acceptance—that is, living with knowledge of fertility potential and integrating sexual behavior in harmony with procreative intention—is natural family planning.

This concept is important to emphasize at this time precisely because of the interest being shown in NFP by ministries of health and governments for whom contraception or fertility suppression has been widely accepted and common practice. Erik Erikson, a noted anthropological psychologist, in a 1980 article in the *International Journal of Psycho-Analysis* has suggested that, because of the precision in contraceptive technology, a new form of psychological repression may be developing among couples who use family planning systematically. Erikson states that some couples who consciously choose to use family planning methods may not realize that they are choosing not to be parents. If this happens, says Erikson, repression of the procreative drive and need may occur and the individual or couple may require professional counseling to deal effectively with this state.

Fertility acceptance is the preferred pedagogical and attitudinal concept to promote when teaching couples NFP because it properly reflects the philosophy of learning to live with and to integrate periodic abstinence into the couple's sexual behavior within the framework of their procreative potential.

# Discussion

All agreed that the competent, trained teacher is the key to a good natural family planning program. The discussion centered on the selection process for teacher trainees, the methods of training, the nature and content of teaching materials, and the context in which the teaching takes place.

Selection of Teacher Trainees There was little disagreement on the importance of the selection process for new teachers and on the necessity of designing programs to meet both urban and rural needs. In both the developed and developing world, birth attendants and midwives should be considered as potential trainees.

There was less agreement on whether teachers should be current NFP users. Some programs consider this essential. Others are willing to waive this requirement in the public sector provided the prospective NFP teacher knows the fertility indicators and can chart her own or a friend's cycle. There was also some divergence of views on the degree of commitment to a prolife attitude that should be expected on the part of teachers and clients. Representatives from some national NFP programs said they would refuse to teach NFP to anyone who indicated they might terminate an unplanned pregnancy; others would accept such users in the hope that NFP practice might persuade them to change their position.

Teacher Training Should the trainee be trained locally or sent away to a regional, national, or international teacher training center? Participants disagreed on the practice of sending teachers away for training. Some Latin American teacher trainees are being trained in the United States, for example, because high standards of training are not available locally. After a core of teachers has been developed, then local teacher training programs in Latin America will be started.

Even if a teacher receives basic training away from the home site, it was felt that

supervised teaching and clinical practice at the local level are essential. Another view was that regional training is good for training tutors (those who train teachers) but not for field teachers. Many consider it a good idea to select a few teachers and make them tutors. Concern was also expressed that trainee teachers be equipped with counseling skills as well as interview techniques.

Many programs face difficulties in sending teachers to a new location. Several suggestions were made to ease this situation. Identification of the teacher with an organization and local sponsorship both can be helpful. Preferably a trainee should come from the community that has indicated a need. It is a mistake to send someone to a place where there is no community support and no possibility of follow-up for a new teacher.

In a well-developed program in Africa, teachers work in teams for support and evaluation. In the experience of another program director from Latin America, it sometimes happens that there is a request for NFP, a person is trained and sent back to the community, but the teacher does not receive local support.

Going to a community and establishing a center is another approach. It is possible to go to a community and pick two or three pioneers. Some will continue while others may drop out. Some NFP teachers will never make a team. A well-established North American program has found that second-generation leadership tends to be more stable. This national program works with teams of at least two couples. Another program has developed guidelines for providing support for an isolated teacher. Medical and educational NFP backup programs for the isolated teacher are important.

Because of distance or other factors, face-to-face teaching is not always possible. In such cases self-teaching materials can be used. Dr. John Marshall in England has had some success with self-teaching materials in his correspondence courses. Some people prefer to learn that way even when they have access to a teaching center. In Australia there are correspondence courses in every state, and all teachers are

trained to be correspondence course teachers.

Discussion participants wanted to know how many hours of teacher training are essential. According to the World Health Organization, which developed and tested the Family Fertility Education Resource Package, the amount of time required to train teachers using these materials varied greatly, ranging from about 11 hours in the Philippines to 49 hours in Colombia. A program in Europe finds that 27 hours is the minimum for basic teacher training; this does not include instruction in special circumstances. Another European program provides 50 hours of training but includes "special circumstances" and family counseling in the course.

The supervised practicum is usually spread out over several months before certification. The question was raised if any programs are training teachers without supervised practicum. In one country trainees teach clients on their own and then bring the clients' charts to the supervisor.

Teaching Content With regard to teaching content, some programs teach all fertility indicators but leave the decision up to the client as to which ones are used. Others teach primarily the ovulation method and believe that all fertility indicators should be taught but not all NFP methods. The New Zealand program concentrates less on the cyclic fertility of the woman than on the combined fertility of both the man and the woman.

In response to a question on uniform teacher training standards and materials, a U.S. participant noted that there are many different types of teacher-training programs in the United States. Another participant with experience in many countries said there was no standard across the board but that NFP teacher training materials were becoming fairly uniform.

An African from a country with a multi-ethnic society maintained that uniform materials may be inappropriate for different cultural groups within the same country. Modification will always be necessary. He asked why uniformity was being so strongly recommended.

A distinction was then made between a core model with the essential factors and a curriculum. (A curriculum can be defined as all of those teaching/learning activities that constitute the teaching program.) The core for NFP teacher training programs should be the same, but modification of the curricula will always be needed to suit the needs of the individual learner. Different curricula may even be needed for the same city, one for church-based programs, one for family planning programs, and another for university programs.

As NFP programs expand into the public sector, one participant considers it very important to define NFP within the context of periodic abstinence. Such a definition determines how the instruction and counseling services are designed. It does not take much time to teach physiology, but it requires a great deal of time to help couples incorporate periodic abstinence into their relationship.

There was some discussion about definition of terms. Fertility awareness was defined as knowledge. It is up to the client to decide what to do with this knowledge. Natural family planning, however, includes periodic abstinence. Knowledge of fertility combined with use of barrier methods is not NFP. There were conflicting opinions on how to approach this issue: "The NFP issue is one of normal sexuality with abstinence. It's difficult to go from no abstinence to a great deal of abstinence." "To refuse to accept or address use of the condom and withdrawal within the context of NFP is to deny reality." "You have to [allow leeway] for a couple to move gradually to NFP." "Yes, learning takes time to occur. If your goal is to get to NFP (periodic abstinence), then toleration but not endorsement of the use of other methods may be within the NFP framework."

The Teaching Context Many participants favored the couple-to-couple approach in teaching NFP. One program director said such training works very well with a special group of engaged couples planning a wedding together. You can see some extraordinary reactions in couples, which really inspire the teacher.

Several program directors find the small-

group learning situation the best. Couples speak out more in a group. Many teachers come out of such groups. The World Health organization found that small-group teaching was effective. Some programs use a combination of small-group teaching and individual instruction. Some confine the instruction of general physiology to groups of couples but reserve other matters for a private session. Another approach is to have a group session first. Then, after charting a cycle, the couples return for individual instruction.

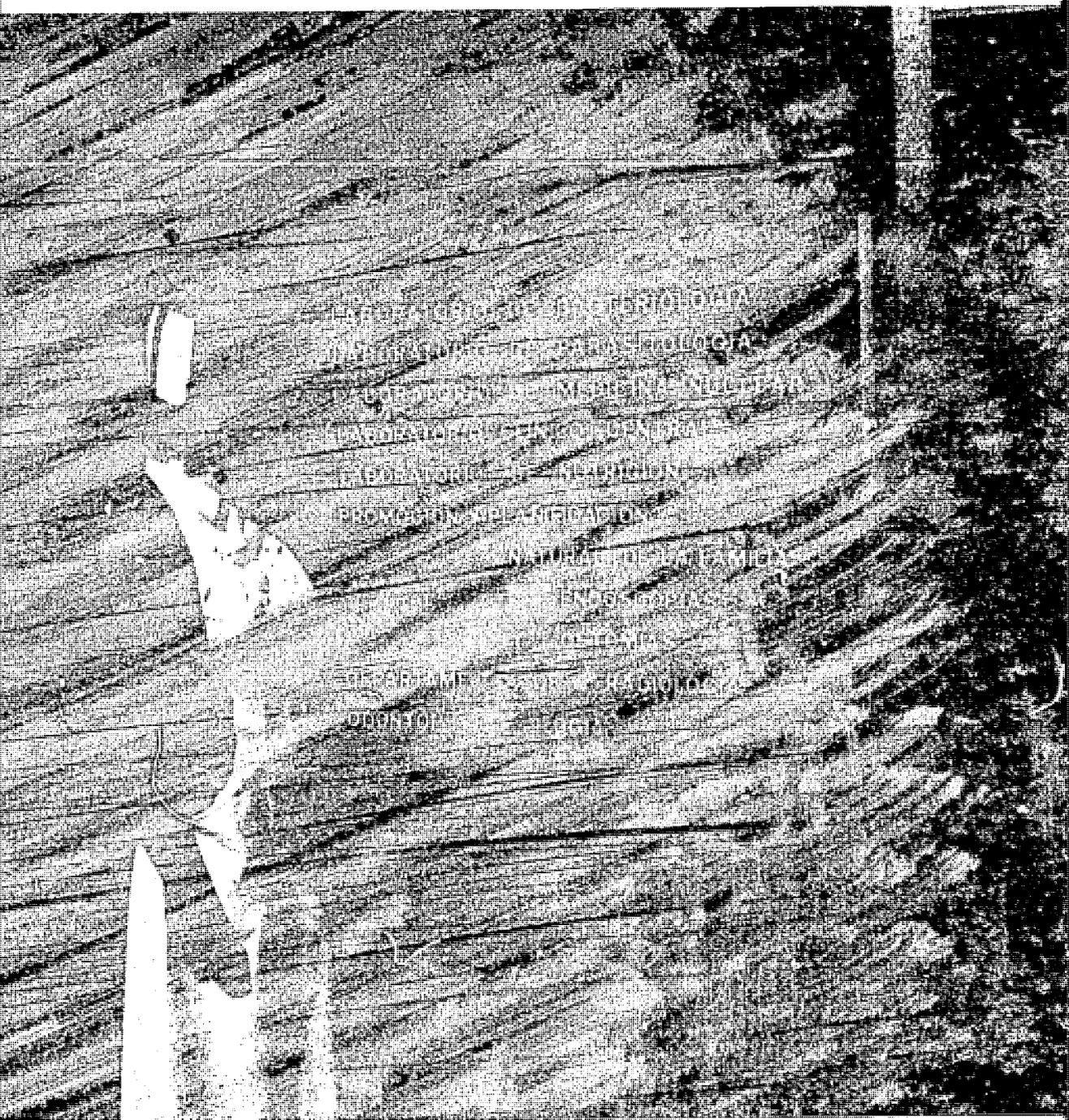
An African national program found that when government funding was accepted, the couple-to-couple approach was no longer possible. Instead, the program developed special courses for husbands in the evening.

Some feel that the couple approach is not suitable for all cultures, especially a Muslim country or where the extended family system prevails. In the Muslim context many cultural attitudes prevent any type of family planning. Added to this are the objections that NFP requires periods of abstinence and depends on better communication between husband and wife. Such communication is seen as a threat to the existing type of relationship, in which

the status of women prevents the wife from participating in decision making.

Couples in some cultures will have to practice NFP in the context of an extended family system. Not only do the couples have to be motivated to use NFP, but their relatives also have to be motivated to give proper freedom to the couples so that they can make more decisions as a couple and develop a style of life that will promote the development of both partners. Changing social patterns often bring new opportunities. It might be that training in NFP increases the couple's ability to choose wisely and to persevere in making the most of these new opportunities.

A number of NFP programs encourage participation in Marriage Encounter, a marriage enrichment program. Couples who have experienced this type of marriage enrichment appear to be more receptive to NFP. Autonomous NFP couples are surprised that they can learn more about marital communication through such programs. Many NFP programs find that the couple successfully practicing NFP is the best advertisement for the method. Such couples become a resource and have a multiplier effect in attracting new users.



NFP Instructor Suzanne Widmer at the entrance to the Diagnostic Center, Hospital Clinic, Universidad Católica de Chile

# NFP Program Evaluation and Accountability

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*The first part of this paper describes the four major types of program evaluation in any family planning program. These are process, outcome, impact, and cost-effectiveness evaluation. Adequate records are essential data for evaluation. Besides user characteristics, statistical measures include volume, coverage, quality, and effectiveness indicators. The second half of the paper examines factors that are critical in evaluation of NFP programs. NFP is an educational rather than a biomedical technology. Since education occurs over time, definitions need to be made when a learning user becomes a registered client, discontinues, or becomes autonomous. Classification of planned and unplanned pregnancies also need to be clearly defined. Sample forms for registration, follow-up, and discontinuation are presented.*

The objective of an NFP program is to provide services for couples wishing to use NFP in order to plan or prevent pregnancy. Thus, the "client" is rightly the focus of interest. The extent to which the program provides such services efficiently, however, is also a matter of legitimate concern since it affects the quality of client care. The evaluation of NFP programs is ultimately an important means of improving services to clients. In this paper we will

consider the types of program evaluation, the data required, and the statistical measures to be used. We appreciate that this does not address the humanistic aspects of NFP, but it is, nevertheless, of importance to consider the broader programmatic issues.

## **Types of Program Evaluation**

There are four major types of program evaluation (Gorosh 1982 and Fisher 1983): Process Evaluation is a management-oriented assessment directed toward improvement of *program operations*. It might be an output measure of the extent to which a program is meeting predetermined objectives such as the number of couples registered, or it might be used to monitor major areas of the program by in-depth analysis of a particular process such as training.

Outcome Evaluation is an achievement-oriented measure of the effectiveness of the program *among users of services*. In family planning, outcome is usually measured by the number of new users, the continuity of use, and discontinuations for pregnancies or other reasons. The most common procedure is the estimation of use-effectiveness by life-table procedures, which provide continuation and discontinuation rates expressed per 100 woman-

years. Another outcome measure is the couple-years of protection against pregnancy provided by the program. This is the number of years an average couple will be protected from pregnancy by family planning use.

Impact Evaluation is an achievement-oriented measure of the effect of the program on the overall population. In family planning this is usually an estimate of the demographic impact of a program as measured by the number of births averted or declines in birth rates. It is difficult to measure demographic impact because the information needed is complex and hard to obtain, because one cannot predict what fertility might have been in the absence of the program, and because women using the program may be merely substituting NFP for other methods of family planning. Cost-Effectiveness Evaluation is a measure of the relationship between program costs and achievement. In this regard, cost-effectiveness is largely a managerial tool "for determining how to deliver family planning services less expensively" (Sirageldin 1983). It is an assessment of the economic efficiency of the program derived from estimation of the costs of categories of program input. Such inputs are the training of teachers, couple recruitment and teaching, which are broken down into expenditure components such as personnel, facilities, supplies, and service activities such as administration, couple services, and travel. In order to allocate costs to these activities, it is necessary to have some measure of time spent on each activity, such as time spent in teaching or on travel. Then these costs must be expressed in relation to such outputs as new acceptors or such outcomes as couple-years of protection.

Cost-effectiveness studies are an aspect of Operations Research. They are complex and require a special evaluation effort beyond the scope of normal programmatic evaluation.

#### **Data Required for Evaluation**

Both qualitative and quantitative data are needed, but the focus here will be on quantitative measures. The basis for any data

system is the *individual records* for each couple. These are primarily designed for client management, local decision making or administration, and monitoring. The record forms must be simple, brief, and appropriate to the skills and the concerns or responsibilities of the personnel using them day-to-day. The additional demands for special research or evaluation must be kept to a minimum. If records are too lengthy or complex or if they appear to be irrelevant, they will not be properly maintained. Records are needed for entry of a couple into a program and for monitoring client progress (Figures 1 and 2). There is, additionally, a need for discontinuation records, which will be considered in the next section.

The individual records are used to produce *aggregate* statistics to evaluate larger components of the program, such as monthly activity reports. Aggregate statistics, also called service statistics, can be abstracted from the individual records and entered onto simple, clearly labeled, and logical summary forms. These statistics provide the program directors with information such as how many clients are entering NFP instruction each month, how many are under the supervision of the instructor, how many have discontinued, and how many have become autonomous. Special additional records are needed for cost-effectiveness analysis, particularly in the assessment of time expenditures. A simple log of time spent by personnel on different program activities can be constructed for this purpose.

#### **Statistical Measures**

Numerous statistical indicators can be developed for program evaluation:

User characteristics by age, parity, marital status, and so forth can be used as descriptive statistics of couples entering the program.

Volume indicators, such as the numbers of new clients registered, in training or autonomous, and the number of discontinuations by category, summarize the overall program activity.

Coverage indicators, such as the percentage of the population covered by services

or percentage of target reached, measure the degree of program achievement

Quality indicators, such as client satisfaction and knowledge or duration of training, are important to assess the effectiveness of the educational and other processes.

Outcome or effectiveness indicators Use-effectiveness is one of the most important measures of both program and method performance. It is known that the use-effectiveness of contraceptives varies over time, in part because less effective users tend to discontinue early, leaving a selected population of more effective or motivated users as the predominant group over time. To overcome these problems, life-table techniques have been developed to estimate continuation or discontinuation rates over time, and such life-tables are considered to be the most valid procedure to evaluate use-effectiveness of family planning (Tietze and Lewit 1973).

To construct a life-table, one needs to know the number of subjects commencing NFP charting and their date of entry, the date of discontinuation, the date of last observation for losses to follow-up, and the number of subjects continuing use at the end of the observation period. The data for estimating use-effectiveness may be derived from individual client records which should be constructed so as to make information retrieval as easy as possible. To facilitate this, it is best to use a special discontinuation form such as shown in Figure 3. Information on reasons for discontinuation is complex and requires careful definitions of different reasons for stopping the method. These definitions must be clear, unambiguous, and mutually exclusive. If, for example, a woman discontinues for multiple reasons, rules must be established for deciding which should be classified as the primary reason. The definitions of discontinuation relevant to NFP are given later in this paper.

The definition of the circumstances of pregnancy is of particular relevance to NFP. Pregnancies should be categorized into user-related pregnancies due to breaking of rules; pregnancy due to misunderstanding of instructions, or teaching errors; and method-related pregnancies due to

conceptions outside the apparent "fertile period." These are difficult to define unless charts are available for the conception cycle, acts of intercourse are recorded, and conception can be attributed to a specific act of intercourse. In many cases the categorization of a pregnancy will be ambiguous. There is also a problem of "competing biases." The client may be reticent to admit that rules were broken, and the NFP teacher may be reluctant to attribute a pregnancy to a method failure. Moreover, clients may retrospectively classify a pregnancy as "planned" to avoid embarrassment over an unplanned conception.

Nevertheless, from the programmatic point of view, the final evaluation depends on the total number of pregnancies regardless of their origin. If the method is theoretically perfect, but the couple can use it only imperfectly, then programmatically the method may be of limited value. For example, if one had a theoretically perfect method of contraception but large numbers of users failed to use the method properly, it would have relatively limited programmatic value, as compared to another method which might have lower theoretical efficacy but be used more consistently.

Routine client records can be easily maintained during the teaching/learning phase, but it is difficult to obtain such information on autonomous users who are self-sufficient and not under supervision. Since autonomous clients may be the majority of NFP users, and autonomous use is one of the main programmatic advantages of NFP, special studies are needed for this group. Probably the most efficient study approach is to identify autonomous users from teachers' records and to conduct special follow-up surveys to identify continuing and discontinuing couples. These surveys, however, are an added evaluation effort beyond the routine program statistics and entail significant costs and organizational problems.

It is difficult to measure the demographic impact of a family planning program, but as an intermediate step, one can estimate the couple-years of protection (CYP), which is simply the contraceptive

protection time afforded by method use. For NFP, the couple-years of protection can be calculated from the number of new users and the discontinuation rates over time (Gorosh and Wolfers 1979). Although of limited scope, CYP is a useful measure with which to estimate the "effectiveness" component in a cost-effectiveness analysis.

**Cost-effectiveness measures** Cost-effectiveness estimation is complex and the methodology is beyond the scope of this presentation. Cost-effectiveness is, however, an important aspect of evaluation, particularly in the case of NFP where the high start-up costs of teaching are offset by the longer-term economics of autonomous users who practice the method without ongoing supply or service costs.

NFP is becoming more widely accepted by national and international agencies such as USAID and WHO (Sirageldin 1981). To maintain existing support and to expand NFP, it is important to examine objectively its cost-effectiveness in relation to the costs and effectiveness of other methods. It is probable that NFP will prove to be cost-effective when one properly determines the long-term low costs of autonomous users. To establish this, however, there must first be rigorous evaluation of costs and use-effectiveness both during training and autonomous use.

#### **Basic Definitions for NFP Program Evaluation**

The definition of what is being measured is basic to any science. So as not to compare apples and oranges, NFP programs should have a clear idea of what they want when they ask for statistics. One program's "acceptors" may be another's "registered clients" and still another's "users." Programs should provide their definitions in any written reports and papers.

Because NFP service is an educational rather than a biomedical technology, the acceptance and use of NFP by clients is a gradual process that happens over time. This is different from methods of family planning in which a single event, such as an IUD insertion, will change a client from nonuser to user status. NFP also requires

two persons' cooperation rather than the consent of just one party. Our definitions attempt to take these considerations into account.

There is a point in a program at which clients will be given the opportunity to make an informed decision as to whether or not they want to use NFP. At about the same time, the client will provide personal history information to the program (Figure 1). Once the personal information has been provided and the client has made an informed decision to use NFP, the client crosses a boundary from nonregistered to registered status, and is defined as registered or admitted to the program. Programs should keep as a basic service statistic a count of all clients who register for NFP use (Lanctôt 1981 and Kambic 1981).

A second key point in NFP service comes when the registered client first begins to chart. Another threshold has been crossed. For some clients this may occur on or even before their day of registration. For other clients, who are presently pregnant or undecided about NFP use, it may be several months before they begin to chart their first cycle. Once the client starts to chart, she should be in relatively frequent contact with her NFP instructor until she reaches autonomy or discontinues.

The number of clients first starting to chart added to the number of clients presently charting under the supervision of an instructor is another service statistic to be kept. We call this total the number of "learning users" in the program.

Those users who do not discontinue the NFP methods will eventually reach a point where they are able to use a method without follow-up instruction. We call this type of user autonomous. In order to classify a user as autonomous, the following conditions should be met (Lanctôt and Martin 1981):

1. The learning user will correctly chart her daily fertile indicators.
2. The learning user will consistently identify the fertile and infertile days of her cycle.
3. The learning user will adjust with at least relative satisfaction to the periodic abstinence required by NFP.

**FIGURE 1  
REGISTRATION FORM**

**Identification**

Client's Name \_\_\_\_\_

Client's Address \_\_\_\_\_

Office Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

**Registration Date**

Day

Month

Year

**Identification Number**

Project

District

Teacher

Client

1. How old were you at your last birthday? (in years)

2. Are you:

- |                          |                       |
|--------------------------|-----------------------|
| 1. Married               | 3. Single             |
| 2. Engaged               | 4. Divorced/separated |
| 5. Other - specify _____ |                       |

3. If married, how many years have you been married?  
(Code 0, if less than 1 year)

4. If married, how old was your spouse at his last birthday?  
(in years)

5. How many living children do you have?  
(If more than 9, Code 9)

a. Boys	<input type="text"/>
b. Girls	<input type="text"/>

6. When did your last pregnancy end?  
(Code 0 if never pregnant)  
(Code 1 if pregnant now)

<input type="text"/> <input type="text"/> Month	<input type="text"/> <input type="text"/> Year
----------------------------------------------------	---------------------------------------------------

7. What is your religion?

1. None	4. Protestant/other Christian
2. Traditional	5. Muslim
3. Catholic	6. Hindu
7. Other - specify _____	

8. How many school years have you completed?

0. 0	5. 9-10
1. 1-2	6. 11-12
2. 3-4	7. 13-14
3. 5-6	8. 15+
4. 7-8	

9. Why do you want to chart your fertility signs?

- 1. To have a child
- 2. To space
- 3. To limit
- 4. For self-knowledge
- 5. Have a child of other sex
- 6. Other – specify \_\_\_\_\_
- 7. N/A

**Cycle and Breast-feeding Information**

10. Are you breast-feeding now?

- 1. No
- 2. Partial (Baby gets food and breast-feeding)
- 3. Total (Baby gets only breast milk)
- 4. N/A

11. When did your last period/menses begin?  
(Code 0 if no menstruation since last birth)

   
Day   
Month   
Year

**Family Planning Practice**

12. a. Among the following methods, which method are you using now?

b. If you are not using any method, name which was the most recent method you used.

- 0. None
- 1. Pill
- 2. IUD
- 3. Injection
- 4. Barrier
- 5. Breast-feeding
- 6. NFP
- 7. Withdrawal
- 8. Abstinence
- 9. Other – specify \_\_\_\_\_

13. When did you stop using the most recent method?

   
Month   
Year

14. Where did you hear about the NFP program?

- 1. Doctor
- 2. Other health worker
- 3. Motivator/field worker
- 4. User
- 5. Clergy
- 6. Media – specify \_\_\_\_\_
- 7. Friend/relatives – specify \_\_\_\_\_
- 8. Other – specify \_\_\_\_\_

**Family Planning Intention**

15. When do you want your next pregnancy to begin?

- 0. No more pregnancies desired
- 1. Trying to become pregnant now
- 2. Within a year from now
- 3. After one year but before two years
- 4. After two years but before three years
- 5. After three years
- 6. It doesn't matter
- 7. Don't know

16. Does your spouse share this intention?

- 1. No
- 2. Yes
- 3. Don't know
- 4. N/A

17. If you are trying to become pregnant now, how many months have you been trying?

**FIGURE 2  
FOLLOW-UP FORM**

**Identification**

Woman's Name \_\_\_\_\_

**Today's Date**

<input type="text"/>					
Day		Month		Year	

**Identification Number**

<input type="text"/>						
Project	District		Teacher		Client	

**Charting**

1. Follow-up form number?

2. This follow-up visit is at:

1. Client's home
2. NFP clinic/center
3. Elsewhere/specify \_\_\_\_\_

3. When did you begin charting?

(Fill in 99, 99, 99 if client did not start charting)

Day Month Year

4. How many months has it been since you began charting?

5. How many complete cycles have you charted?

6. Who is mainly responsible for keeping your chart?

1. Self (client)	5. Client memory
2. Spouse	6. No record kept
3. Instructor	7. N/A
4. Other/friend	

7. Client record shows she is charting: (Mark all that apply)

1. Mucus	4. Calendar	<input type="text"/>	<input type="text"/>
2. Temperature	5. Other minor signs (breast tenderness, etc.)	<input type="text"/>	<input type="text"/>
3. Cervix	6. No record	<input type="text"/>	<input type="text"/>

8. The chart shows:

1. Not every day charted—not enough information to interpret
2. Every day charted—not enough information to interpret
3. Every day charted—enough information to interpret
4. Days necessary to interpret the fertile time are charted

9. Is there any difficulty in identifying the relatively preovulatory infertile, the fertile, and the completely postovulatory infertile time?

1. No difficulty
2. Client has difficulty (specify)
3. Teacher has difficulty (specify)
4. Both have difficulty (specify)

10. Intercourse is recorded:

- 1. At least the last intercourse in the preovulatory, "safe days"
- 2. At least the first intercourse in the postovulatory, "safe days"
- 3. Both 1 and 2 above
- 4. All (including fertile period)
- 5. Incomplete record
- 6. No record

11. a. Do you or your spouse have any difficulties with abstinence?

- 1. No
- 2. Occasional difficulty
- 3. Always difficulty
- 4. Uncertain

b. Who has the difficulty?

- 1. Woman
- 2. Spouse
- 3. Both
- 4. Uncertain

12. During the fertile phase do you?

- 1. Abstain
- 2. Have intercourse without contraceptives
- 3. Have intercourse with a barrier
- 4. Have intercourse with withdrawal or have other genital contact
- 5. No comment from client

13. Do you intend to avoid pregnancy for the next three (3) months?

- 1. No
- 2. Yes
- 3. Don't know

14. Has your spouse received any instruction in NFP either alone or with you?

- 0. None
- 1. One
- 2. Two
- 3. Three or more
- 4. N/A

15. If the couple wants to avoid pregnancy, are they following the rules?

- 1. No, they don't understand the method
- 2. No, they are taking risks
- 3. No, they are using barrier methods
- 4. Yes
- 5. Don't know

\*If no, specify how the rules are being broken and why \_\_\_\_\_

\_\_\_\_\_

**Autonomous**

16. a. Is the client autonomous?

- 1. No.
- 2. Yes

b. If yes, give month and year classified autonomous

   
 Month

   
 Year

**Discontinuation**

17. Has the client discontinued NFP use?

- 1. No.
- 2. Yes

\*If yes, fill out a discontinuation form

**FIGURE 3  
DISCONTINUATION FORM**

**Identification**

Women's Name \_\_\_\_\_

**Today's Date**

               
 Day                      Month                      Year

**Identification Number**

                       
 Project                      District                      Teacher                      Client

**Discontinuation**

1. Date of discontinuation 
                 
 Day                      Month                      Year

2. Kind of discontinuation

- 1. Lost to follow-up
- 2. Health related
- 3. Personal
- 4. Pregnant

3. Complete a follow-up form for the pregnancy cycle or for the last cycle prior to discontinuation.

4. Lost to follow-up

- 1. Whereabouts unknown
- 2. Left area

5. Health/medical

- 1. Menopause
- 2. Medical condition/medicine or drugs that prevent charting – specify \_\_\_\_\_
- 3. Hysterectomy
- 4. Deceased
- 5. Other – specify \_\_\_\_\_

6. Personal

- 1. Privacy — does not want to be followed
- 2. Social/family pressure
- 3. Lack of confidence in NFP
- 4. Method too complicated
- 5. Excessive abstinence
- 6. Prefers other method
- 7. No need
- 8. Other – specify \_\_\_\_\_

**Pregnancy Analysis – Client**

7. Date of last menstrual period 
                 
 Day                      Month                      Year

8. Client became pregnant and this was confirmed by:

1. Test (immunological)
2. NFP chart
3. Physical exam
4. Other - specify \_\_\_\_\_

9. Is a photocopy of the original pregnancy chart attached?

1. Not available (If not available, attach comments on pregnancy from the user and teacher)
2. Yes

10. Client states pregnancy is due to:

1. Both client and spouse decided to try to conceive
2. Client and/or spouse took risks
3. Client did not think she was fertile

11. Will the client ever use NFP in future?

1. Definitely not
2. Probably not
3. Probably yes
4. Definitely yes

**Pregnancy Analysis - Instructor**

12. In the judgment of the instructor the pregnancy is due to:

1. Misunderstanding by the client
2. Incorrect or insufficient information given by the instructor
3. Conscious departure from rules—no barrier use
4. Conscious departure from the rules—barrier use
5. Method related (must have a chart)
6. Unresolved
7. Planned pregnancy (User had no intention to avoid this cycle)

13. a. Conception is a result of intercourse on cycle day  
(Code 0 don't know)

b. In the apparent

1. Preovulatory infertile time
2. Fertile time
3. Postovulatory infertile time
4. Unknown

**Review by Supervisor**

14. Reviewed by supervisor on

   
Day   
Month   
Year

15. Supervisor's comments

1. Agree with discontinuation analysis
2. Disagree with discontinuation analysis - specify \_\_\_\_\_

NOTE: THESE THREE FORMS ARE ABBREVIATED

4. The learning user will demonstrate an ability to recognize any change in the basic cycle pattern which should alert her to seek additional instruction (for example, postpartum amenorrhea, breast-feeding, premenopause, cycle disruption).

The program should determine the number of clients becoming autonomous each month.

Once a client couple is registered, they either become autonomous or discontinue. The first category of discontinuation is "never started charting." Those are the clients who register but never take the next step of starting to chart NFP. Such couples are important indicators of program acceptance. If the rate of noncharters is high, we want to know why and examine such things as teaching technique, informed consent procedures, and profiles of those who do not chart. It is important to mention that those who do not chart will not be included in effectiveness and continuation life-table statistics because they never begin NFP use.

Once a client begins to chart, there are a number of reasons for discontinuing use of NFP: pregnancy, loss to follow-up, personal reasons, and medical reasons. Let us first examine pregnancies and natural family planning use.

When looking at NFP programs and methods, both professionals and family planning users want to know the answer to this question: "When NFP is used to avoid pregnancy, how well does it work for the average user?"

Unplanned pregnancies are defined as "conceptions by a woman who is on record as intending to use NFP to avoid or delay a pregnancy." The client who wants no more pregnancies is called a "limiter." If the client wants only to delay pregnancy for a period of time, she is called a "spacer." The important element in this definition is that although the client has gone on record as wanting to space or delay pregnancy for a certain time interval, she nevertheless becomes pregnant before the end of this time interval (Brennan and Klaus 1982, Lanctôt and Parenteau-Carreau 1973).

The client's intention to space or to

avoid pregnancy should be asked at registration and can be categorized as follows: no more pregnancies desired; before becoming pregnant wants to wait at least one year, two years, or three years; wants to become pregnant in the next year; is trying to become pregnant now.

The intention should be checked from time to time by the teacher, especially if the client's chart shows intercourse during the fertile period. The teacher should make a note in the record if the intention of the client changes.

If a client does become pregnant while trying to avoid pregnancy, or before the end of the desired spacing interval, the teacher should interview the client, review the pregnancy chart and NFP record, and complete a discontinuation form.

The teacher may find that the client states that the pregnancy occurred because: both the man and the woman decided to try to conceive; the man did not cooperate; the client ignored her fertility signs; or the client did not think she was fertile.

With the above information the teachers can classify the unplanned pregnancy as one of the following:

1. Client education-related: the client could not correctly apply the NFP rules because she was either poorly taught or incorrectly learned the method.

2. Client use related: the client correctly understood the method and rules but did not follow them because of choice (decided to conceive), or pressure by the spouse or partner, or because the couple ignored the rules or "took a chance."

3. Method-related: the client understood the method and applied the correct rules but became pregnant.

4. Unresolved: no category can be applied to the unplanned pregnancy.

Pregnancies that are not unplanned can be classified as client-planned, clients were trying to conceive; and client-open, clients were open to pregnancy but not actively trying.

In addition to pregnancy, there are other types of discontinuations:

1. Lost to follow-up: a client will be lost to follow-up if she can no longer be contacted by the program.

2. Medical discontinuation: the client stops charting because of a medical condition that makes it impossible to chart.

3. No further need: the client no longer needs family planning services because, for example, of hysterectomy or menopause.

4. Personal discontinuation: any reason for stopping the use of NFP that is not accounted for in the above reasons.

NFP has become more widely accepted but in order to establish and promote NFP, programs must be evaluated in a manner comparable to that for other methods of family planning. This implies a greater degree of rigor and accountability for NFP so that the method may be made more widely available and accessible. Of particular importance is the need to assess the acceptability of NFP programs in terms of registrants and learning users, the use-effectiveness of NFP methods during both learning and autonomy, and the cost-effectiveness of NFP programs.

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# Research on Natural Family Planning in the Philippines

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*The Philippines has one of the highest NFP prevalence rates in the developing world. The calendar-rhythm method of NFP has been promoted by the Philippine Family Planning Program since its inception, and over the years a substantial body of research data has been accumulated. This paper presents major findings from past research, describes current research, and discusses future research needs.*

*Among the findings presented are the following: (1) most NFP users have relied on and continue to rely on some form of calendar rhythm rather than the more modern forms of NFP; (2) there has been an upward trend in rhythm practice, despite the family planning program's relative emphasis on promoting other methods; (3) most rhythm users are self-taught or taught by friends rather than by specially trained family planning professionals; (4) rhythm users' continuation rates are similar to those of pill users, lower than those of IUD users, and higher than those of condom users; (5) rhythm users' failure rates are considerably higher than pill or IUD users' failure rates, but similar to those of condom users; and (6) overall pregnancy rates following acceptance of rhythm are remarkably similar to those of pill acceptors, in spite of the greater effectiveness of pills while in use. Data on the use-effectiveness of basal body temperature (BBT) and the mucus method indicate that these methods tend to have been practiced somewhat more effectively than rhythm.*

*Rhythm practice varies widely, and its underlying principles do not appear to be well understood by users. Religious reasons appear to play only a limited role in the decision to use NFP.*

## **Introduction**

Among the world's developing countries, the Philippines has one of the highest natural family planning (NFP) prevalence rates. World Fertility Survey data on 19 developing countries reveal that, among the countries studied, the Philippines was second only to Peru in current and past use of the calendar-rhythm method. Among exposed (i.e., fecund, nonpregnant) married women in the Philippines, 11.3 percent were found by the 1978 Republic of the Philippines Fertility Survey (RPFS) to be current users of rhythm, compared with 14.3 percent in Peru and 10.4 percent in third-ranking Sri Lanka.

The Philippine family planning program, coordinated by the Commission on Population (POPCOM), has offered rhythm as an official program method since family planning promotion became official government policy in 1971. The inclusion of this method among family planning services is attributable to the fact that the Philippine population is predominantly (about 85 percent) Roman Catholic. Promotion of rhythm, however, has generally been less enthusiastic than that of other methods (Special Committee...1978). In the early 1970s, pills were the most strongly promoted method. In the mid-1970s, emphasis shifted to condoms to in-

crease services to rural couples far from clinics. Sterilization replaced pills and condoms during the late 1970s as the method most favored by program officials and workers. In recent years, however, official interest in NFP has increased sharply, spurred by survey findings of the late 1970s indicating widespread popularity of calendar rhythm and by increasing awareness of more reliable techniques for identifying the safe and unsafe periods.

Over the years, a considerable body of family planning program-related research in the Philippines has shed light on the practice of NFP, primarily calendar rhythm. This paper provides an overview of the currently available data related to NFP practice and effectiveness in the Philippines and discusses the needs and prospects for additional research.

#### **Trends in Rhythm Prevalence**

The first nationwide survey to provide data on contraceptive practice was the 1968 National Demographic Survey (NDS), conducted two years before the national program got under way. It indicated that 5.5 percent of married women aged 15-44 were practicing rhythm (Laing et al. 1973). By the time of the next national survey in 1972 (Barretto 1974), the proportion using rhythm had risen to 7 percent despite more vigorous promotion of pills and the IUD by program clinics. Six years later, in 1978, the RPFIS indicated that the proportion using rhythm had risen still further, to 8.9 percent.

Table 1 shows the trend in prevalence for each of the most widely used methods according to the three national surveys. In 1968 and 1978 rhythm prevalence was exceeded only by withdrawal prevalence. In 1972 rhythm and pills were tied as the most widely used methods. During the 1968-78 period, the proportion of married women 15-44 who said that they had ever tried the rhythm method rose from 9 to 23 percent.

Rhythm users have relied more on non-program sources than on program personnel for instruction in the rhythm method. For instance, in a survey in 1980 of wives living in areas covered by the National Family Planning Outreach Program (Laing

1981), 36 percent of the rhythm users cited doctors, nurses, or midwives as their sources of instruction. A majority of rhythm users (58 percent), however, said they had been instructed by friends and relatives. Only 6 percent cited Outreach workers, whose training in contraceptive methods is not sufficiently detailed to qualify them as reliable rhythm instructors.

Even among rhythm acceptors at clinics, many received their instruction from non-medical workers who were, in most cases, insufficiently trained. In the 1974 National Acceptor Survey (Laing et al. 1977), for instance, only 67.5 percent of the interviewed rhythm acceptors said that they had received rhythm instruction from a doctor, nurse, or midwife. Almost all the rest had been instructed by part-time "lay" motivators whose training was intended only to develop skills in motivating couples to try contraception, not to qualify them as rhythm instructors.

#### **Use-Effectiveness among Rhythm Acceptors at Clinics**

During the 1970s, three nationwide surveys, the 1972, 1974, and 1976 National Acceptor Surveys (NAS), were conducted. With each successive round, the time period of observation and the sample size increased. As a result, the most reliable rates available come from the 1976 round.

Some key continuation rates are shown in Table 2. First-method continuation rates are the percentages of acceptors of the specified method who are still using *that method* at the end of the specified time period (12 or 36 months). All-method continuation rates include as "continuing" those cases who have changed methods and still use *any* method at the end of the specified time period. It can be seen that the highest continuation rates were consistently found for IUD acceptors and the lowest for condom acceptors. The rates for pill and rhythm users were very similar. Though relatively short-term rates were slightly higher for pill acceptors than for rhythm acceptors, longer-term rates were about equal.

Accidental pregnancy (failure) rates, both life-table and Pearl pregnancy rates, are presented in Table 3. The life-table

rates indicate the percentage of acceptors who became pregnant while using the specified method within the indicated time period. They show that rhythm users had the highest cumulative rates at both 12 and 36 months, followed by condoms, pills, and the IUD, in that order. The rhythm-condom comparison may be misleading, however, since more condom than rhythm users drop out early and therefore cease to be counted when they become pregnant accidentally. The Pearl rates are more appropriate, since they include in the denominator only woman-months of use. The Pearl rates indicate that the probability of failure among rhythm users (20.2 pregnancies per 100 woman-years of use) is no greater than the probability of failure among condom users (21.3).

In life-table analysis of pregnancy rates, the joint effects of continuation and failure rates may be seen in measures of "extended use-effectiveness." One such measure is the "over-all" pregnancy rate (Table 4)—that is, the percentage of acceptors who became pregnant within a specified period of time following acceptance, regardless of whether they were using any method at the time of conception or whether the pregnancy was desired. Condom acceptors had the highest pregnancy rates and IUD acceptors by far the lowest. Pill rates were lower than rhythm rates in the short term, but by the end of the third year after acceptance, the cumulative pill rate was equal to the cumulative rhythm rate. This is a startling finding since it indicates that fertility is so much higher among pill users after discontinuation that the advantage of the pill's low failure rate *while in use* is completely canceled out within three years after acceptance. It should be borne in mind, however, that pill acceptors tend to be younger than rhythm acceptors and are therefore more likely to become pregnant.

Trends over time are shown in Table 5, which presents continuation and pregnancy rates of acceptors in 1970-72 and acceptors in 1975. Continuation rates declined and overall pregnancy rates increased for all methods except rhythm. These findings suggest that, while the pro-

gram was increasingly recruiting less-motivated couples to try the methods it was promoting most heavily, the rhythm acceptors, continuing to be largely self-selected, maintained earlier levels of motivation.

#### **Use-Effectiveness among Rhythm Users in General**

In 1977 the Philippine Family Planning Program shifted its emphasis from providing services through clinics to a village-based Outreach Project. With this program shift, the research focus on clinic acceptors shifted to a focus on "eligible couples" in Outreach areas. As a result, the National Acceptor Surveys were supplanted, in 1978 and 1980, by Community Outreach Surveys (COS). Because of the nature of the sample, a new procedure was developed for collecting and analyzing data on use-effectiveness.

Each respondent was asked about her contraceptive practice during each of the 30 months preceding the interview. Those who reported pregnancies during this period were asked whether they had been using a method at the time of conception. Method-specific monthly continuation and failure rates were computed from the responses and converted into annual continuation rates and Pearl pregnancy rates. Since the continuation rates were not duration-specific, they are not comparable to the 12-month life-table rates, which refer specifically to the first 12 months after acceptance.

The 12-month continuation rates and Pearl pregnancy rates for each of the reversible methods with at least 50 woman-years of observation are shown in Table 6. Among the four methods, the rank order of rhythm appears to have improved despite the fact that nearly two-thirds of the rhythm users in the COS said that they had learned the method from nonmedical sources. The rhythm continuation rate was well below that of the IUD but somewhat higher than the pill rate. The rhythm failure rate was higher than the pill failure rate but not nearly as high as the condom failure rate.

The 1980 COS also showed that 5 per-

cent tried combinations of methods—3.4 percent used rhythm plus withdrawal, 1.2 percent rhythm plus condoms, and 0.7 percent condoms plus withdrawal. The use-effectiveness data for the first two categories of combined use are shown in Table 6 (there were not enough cases in the third category for inclusion), together with data on withdrawal alone, which was the most prevalent method among the COS respondents. The estimated continuation and failure rates of rhythm plus condoms were almost identical to the corresponding rates of rhythm alone, but rhythm plus withdrawal appears to have been a strikingly more effective combination. It was as likely to be continued as the IUD and as use-effective in preventing accidental pregnancy as the pill. Withdrawal alone, in contrast, was somewhat less likely than rhythm alone to be continued for a year and somewhat more likely to result in accidental pregnancy, but it was clearly superior to condoms in both regards.

#### **Use-Effectiveness of BBT**

During the late 1960s and early 1970s, the Asian Social Institute (ASI) operated 24 clinics in urban areas of the Philippines that offered both calendar rhythm and the basal body temperature (BBT) method. In 1971 a follow-up survey of acceptors at the Manila clinic was conducted for the purpose of obtaining data on use-effectiveness (Laing 1971). Of the 142 respondents, 72 said they had used BBT, 60 said they had used calendar rhythm, and 10 said they had used both. The 10 respondents who had used both were combined with those who said they had used BBT only, yielding a sample of 82 BBT users. The 12-month continuation and pregnancy rates of the two groups are summarized in Table 7. The continuation rates for BBT were considerably lower than those for calendar rhythm, but the failure rates and overall pregnancy rates were about equal. Thus, despite the theoretical advantage of BBT over calendar rhythm, there was no evidence of a practical difference in this instance.

In 1971 another organization, the Responsible Parenthood Council (RPC),

began operations in four pilot provinces, using a nonclinical approach to promote the use of BBT. Parishes were used as training and administrative centers. Volunteer couples from rural areas were recruited and trained as BBT instructors. They were then provided with supplies and sent back to instruct other couples in their villages. This project subsequently expanded to cover nine provinces but lost the momentum and enthusiasm of its first year or two and ceased operations about 1976. Late in 1971 a survey was conducted in the four pilot provinces to evaluate the RPC performance (Laing 1972). Analysis of these surveys revealed a six-month all-method continuation rate of 66 and a six-month overall pregnancy rate of 19. Corresponding rates from the 1972 NAS (Laing 1973a) for rhythm acceptors at clinics were 71 and 26 respectively and from the 1974 NAS (Laing 1978) were 77 and 18 percent respectively. Thus, the RPC program appeared to be less successful than the clinical program in terms of continuation but about the same in terms of pregnancy. The differences are not great, however, and may be attributable as much to differences in the characteristics of the populations studied as to differences in the methods provided. Furthermore, since the rates refer to such a short time period following acceptance, they can be taken as only suggestive of longer-term effects.

#### **Nature of NFP Practice**

As noted above, the most widely practiced form of NFP in the Philippines is calendar rhythm. In a recent survey of 308 rhythm users in the Bicol Region of the Philippines (Bicol University 1983), all but one of the respondents said that she was using calendar rhythm. The one exception claimed to be using the mucus method. Only five percent said they had heard of BBT, and seven percent said they had heard of the mucus method. Comparable data at the national level are not available, but it is known that there are so few agencies offering instruction in more advanced NFP methods that only a negligible proportion of NFP users could have been exposed to them.

There is, of course, considerable variation in the practice of calendar rhythm. A variety of evidence points to the widespread use of crude formulas that do not take into account variations in cycle length. The very fact that most rhythm users claim to have received instruction from friends and relatives suggests that many do not take variation of cycle length into account. Furthermore, the Bicol study cited above notes that none of the respondents took such variation into account in spite of the fact that 21 percent reported irregular cycles. Focus-group discussions involving rhythm users living in rural areas near Manila also revealed a general lack of awareness of the need to tailor formulas to the individual couple (Verzosa et al. 1980).

The formulas reported call for abstinence periods ranging from about eight days to more than three weeks. In the focus-group discussions, for instance, most formulas identified the "safe" days as five to ten days before and after the start of menstruation (Verzosa et al. 1980). It is not clear from the research report how the date of the next period was estimated, but in most cases it was probably a simple matter of assuming that it would be either on the same date of the succeeding calendar month or exactly four weeks following the beginning of the last period. It is widely believed that cycles are "regular" if they fall on the same calendar date each month, a belief that disregards the variations in length of calendar months.

Some couples count only the days after menstruation as safe, especially if they know the woman has irregular cycles. Some others do just the opposite, abstaining on all but the estimated last five days of the cycle. This practice is reinforced by the widespread taboo on sexual intercourse during the days of menstrual bleeding. By the time bleeding has stopped, couples who follow the conservative "five days before, five days after" formula assume that there is already a risk of pregnancy and therefore try to restrict sex to the last five days—that is, about Day 23 to 25 onwards.

In the Bicol survey (Bicol University 1983) the reported formulas tended to be less conservative, the most common ones

being "10-10-10" (ten safe days, ten unsafe days, ten safe days) or variations like "8-10-9" or "9-9-9," which are appropriate for couples with at least fairly regular 27-to-30-day cycles. Thirty-six percent of the respondents, however, reported more conservative formulas, like Days 1-20 or Days 1-15. (The latter may not be as inaccurate as it might at first appear, since some couples start counting from the first day *after* menstrual bleeding, in which case it would be equivalent to the former.)

The findings from the Bicol survey and the focus-group discussions can be viewed as merely exploratory. Much more information is needed on the variations in rhythm practice. Relevant data from larger-scale studies, such as the 1976 National Acceptor Survey and the Community Outreach Surveys, are limited to responses to questions about the time during the menstrual cycle when the woman is most likely to conceive. Even in the 1976 NAS, where most of the rhythm acceptors had been instructed by clinic personnel, only 21 percent of all respondents and 39 percent of rhythm users said they thought it was between 7 and 21 days before or after the beginning of the period (Laing and Alcantara 1980).

In the 1980 COS, the question was changed to make it more directly relevant to the respondents' own experience: "When do you think is the best time for a couple to avoid sex in order to prevent pregnancy: during the wife's menstrual period, right after the period, midway between periods, or immediately before the next period? Among current rhythm users, 34 percent gave the correct answer (midway between periods), 38 percent said right after the period, 24 percent said immediately before the next period, and 2.5 percent said during the period. Such responses indicate widespread ignorance of ovulation and its timing.

#### **Reasons for Preferring Rhythm**

In the 1974 National Acceptor Survey (Laing et al. 1977), respondents were asked to compare the four program methods. Rhythm was preferred to condoms by 68 percent and to the IUD by 69 percent. Pills

were preferred to rhythm by 58 percent, but when the respondents were limited to those who had tried both methods, rhythm was preferred by 53 percent. (Among those who had tried both rhythm and the IUD, however, the IUD was preferred by 54 percent.) Clearly, the rhythm method was a very popular method in spite of the fact that the program had been placing much heavier emphasis on the promotion of pills. When asked why they preferred rhythm over the other methods, respondents were most likely to cite medical safety (absence of side effects, pain, or health dangers) and convenience (no need to get supplies, have insertion, or interrupt the sex act). Some also cited effectiveness and husband's support, especially in contrast to condoms. Interestingly, almost none mentioned religious or moral reasons.

The focus-group discussions (Verzosa et al. 1980) revealed a similar pattern of responses—lack of side effects and lack of interference with the sex act were the most common responses. A few respondents in this study also mentioned compatibility with religious teachings. It is doubtful, however, that this finding reflects growing awareness or concern with Church teaching. The 1980 Community Outreach Survey included the following question: "Do you think your religion approves or disapproves of modern family planning methods like the pill, IUDs, condoms, or sterilization?" Of the Catholic respondents, 8 percent said they didn't know the Church's stand; 74 percent said they thought the Church *approved* of such methods; and only 15 percent said they thought the Church *disapproved*. Eight years before, respondents in the 1972 National Acceptor Survey had given similar responses to a similar question: 25 percent had indicated that they did not know the Church position; 61 percent had thought it approved; and 14 percent had thought it disapproved (Laing 1973b).

The 1980 COS questionnaire asked respondents what they liked most about their current method. The response mentioned most often by far by rhythm users was that it was not harmful or painful (71 percent). Convenience (15 percent) and ef-

fectiveness (9 percent) were mentioned much less frequently. Effectiveness was usually cited in a defensive manner—"It's effective enough"—rather than as a categorical assertion that rhythm is highly effective. Only 1.6 percent said their main reason for practicing rhythm was that it was not immoral or sinful.

#### **Problems with the Calendar-Rhythm Method**

Owing to its high failure rate, the calendar-rhythm method of NFP is inappropriate as a method for most couples seriously interested in limiting family size. The main difficulty, especially for the husband, appears to be abstaining throughout the entire "unsafe" period. This difficulty of abstaining is exacerbated by the conservative formulas often adopted, which result in excessively prolonged periods of abstinence, with only a few days each month available for sexual intercourse. Such an onerous schedule invites chance-taking. In the 1978 COS (Laing 1979a), 36 percent of rhythm users admitted to taking chances at least occasionally.

The burden of prolonged abstinence would be reduced for some couples by better instruction in the calculation of the safe and unsafe days—especially the monitoring of cycle length and the tailoring of the formula to individual circumstances. Even for women with perfectly regular cycles, however, the minimum abstinence period of eight days would be excessive for some. A frequently cited problem (Verzosa et al. 1980) is that husbands are especially likely to lose control after drinking. This problem would continue even if the abstinence period could be reduced. Furthermore, the required abstinence period would continue to be relatively long for wives with irregular cycles.

There is little reason to doubt that improved education and instruction would lead to improved calendar-rhythm use. In the 1980 COS, for instance, women who knew that the time to avoid sex in order to prevent pregnancy is midway between periods reported proportionally fewer accidental pregnancies than did other

women. Their Pearl pregnancy rate while using rhythm was 24.3; in contrast, among those who said they thought sex should be avoided right after the period, the Pearl pregnancy rate was 30.6; and among those who said they thought sex should be avoided immediately before the next period, it was 50.4.

The main problem with trying to improve understanding and practice of the rhythm method appears to lie in finding a cost-effective way of doing so. Findings from the 1980 CGS (Laing 1981) indicated that neither full-time, paid family planning field workers nor village-based volunteer workers were adequately knowledgeable to provide instruction in calendar rhythm; moreover, such workers would not have the large amount of time necessary for providing such instruction without seriously impairing their ability to do the other tasks expected of them.

These conclusions were borne out by a recent project in southern Mindanao (Valera 1982), where 25 paid workers and 94 village-based volunteer workers underwent special training to qualify them better as calendar-rhythm instructors. Their knowledge about the method was tested before and after training. In addition, a sample of 336 rhythm users in the workers' areas of jurisdiction were interviewed six months later. The training was found to be effective in increasing the workers' knowledge, but the interviews of the rhythm users revealed that only four percent of them had received rhythm instruction during the six months that had elapsed since the workers had been trained. Furthermore, another test of the workers' knowledge at this time indicated that they had lost most of the knowledge they had gained during training.

#### **Prospects for Future Program Efforts**

In recent years, the attention of family planning program managers has been increasingly directed toward the need to improve NFP instruction and practice in the Philippines. This concern has grown out of an increasing awareness of the high prevalence of this method, the low degree of knowledge about how it should be used,

and the development of improved techniques for estimating the safe and unsafe days. As a result of these considerations, together with the difficulty noted above of asking existing program workers to take on NFP instruction in addition to all their other tasks, POPCOM is presently committed to a policy of upgrading NFP practice "though the training of volunteer workers of community-based organizations, particularly religious lay leaders" (Commission on Population, 1983). Since POPCOM is only a coordinating agency, the implementation of such projects will be contracted out.

Three large-scale, three-year projects have been approved. The first (Philippine Business for Social Progress 1983) will integrate NFP instruction into the work of 124 existing community-based organizations in 244 communities, whose main function is to promote socioeconomic development. The second (Archbishop Gabriel M. Reyes Memorial Foundation and Philippine Cultural Communication Service Corporation 1983) will be focused on one province and will integrate NFP training into the family life component of a community development program. The program, which has been pilot-tested in one village, will be extended to cover the entire province. The third project (Philippine Federation for Natural Family Planning 1983) will train selected couples in four or five parishes who will, in turn, instruct other couples in NFP.

Findings from past and ongoing research suggest that these projects will encounter serious difficulty in their efforts to promote NFP. In the evaluation of the BBT project of the Responsible Parenthood Council, it was found that many clients instructed by community-based volunteer couples (who were themselves BBT users) complained that they had difficulty understanding instructions and that they were not visited frequently enough. Clients felt that the volunteer couples seemed more interested in recruiting acceptors than in taking time to instruct and guide them. In addition, there were shortages of thermometers and charts, and many of the clients had difficulty using and storing them safely. Ani-

mosity rapidly developed between the RPC workers on the one hand and the other family planning field workers and clinic personnel on the other, each side accusing the other of "client grabbing." The principles of calendar rhythm were ignored, even though the project managers were aware that the BBT method was not well suited to estimating the first unsafe day. One-third of the persons listed as acceptors did not in fact try BBT. Primary reasons for nonacceptance included pregnancy (33 percent), perceived difficulty with the method (22 percent), lack of cooperation from spouse (13 percent), no thermometer (9 percent) and postpartum amenorrhea (8 percent).

More recently, there have been small-scale efforts to instruct couples in the mucus method. The best-known of these efforts is the WHO multicenter trial, in which the University of Santo Tomas (UST) in Manila was a participating center (World Health Organization 1981). The data on use-effectiveness indicated that the UST sample had the lowest accidental pregnancy rate among the five centers. The Pearl rate was 13.8 pregnancies per 100 woman-years of use for the effectiveness phase (excluding the three-month initial teaching phase). Including the teaching phase, the Pearl rate was 17.9. Both of these rates are well below the Pearl rate of 22.9 found for rhythm users in the 1976 NAS during the first year after acceptance (Laing and Alcantara 1980), indicating that the mucus method was used somewhat more effectively than the calendar-rhythm method. The difference is not very great, however, considering the presumed superiority of the method and the greater care taken in instruction in the UST study (the calendar-rhythm acceptors had not undergone a "teaching phase" of three to six months) and in follow-up (each subject was seen monthly in the UST study). In contrast, most of the calendar-rhythm acceptors were not followed up at all, and many did not visit the clinic even once after acceptance.

Of 23 failures in the UST study, 20 (87 percent) were a result of conscious departure from the rules. Only one accidental

pregnancy was attributable to method failure, one to inadequate teaching, and one to inaccurate application of instructions. Comparable figures are not available for calendar rhythm, but it is certain that more failures among calendar-rhythm users are due to both inadequate instruction and method failure. With such a high pregnancy rate due to conscious departure from instructions, however, the UST findings suggest an absolute limit to the effectiveness of the mucus method in the Philippines, no matter how low its "method failure" rate.

In 1982 and 1983 the Program for the Introduction and Adaptation of Contraceptive Technology (Program...1983) conducted focus-group discussions with groups of mucus method users, dropouts, and instructors in and near Manila and in Central Mindanao. The findings revealed that the method, as understood and practiced, was a simplification of the correct procedure. For instance, several clients were unaware of the peak day and its importance, and many of the rest had difficulty identifying it. Some users recognized only wet and dry days, without differentiating among variations in consistency during wet days. They simply viewed all dry days as safe and all wet days as unsafe, without regard to the pattern over time. The instructors appeared to understand the importance of patterns over time, the peak day, and variations in types of mucus; it appears, however, that this information was not being communicated adequately despite frequent home visits (at least weekly for several months). Though clients were instructed to abstain for the duration of the first teaching month so that seminal fluid would not become confused with cervical mucus, most did not comply. Charting had been practiced by most clients in the early months, but most stopped keeping charts within the first year. Almost all failures were attributed to the husband's desire for sex during the unsafe period.

Difficulties with abstinence and lack of cooperation from the husband are counterbalanced for some couples by advantages. In her analysis of data from a study of suc-

cessful, long-term NFP users in Iligan City, Esperanza Aranas-Dowling (1979) reported that the respondents cited several advantages of abstinence, including heightened pleasure from love-making, greater sensitivity of spouses to each other's needs, increased understanding about sexuality, and increased self-confidence resulting from their ability to control their urges. It must be borne in mind, however, that these advantages were reported by couples who had been able to learn and use the method successfully for at least a year.

The Population Center Foundation is presently sponsoring a study designed to test the relative effectiveness of calendar rhythm and the mucus method as taught by parish-based volunteer workers in two provinces in the southern Philippines. Informal progress reports from the project areas indicate considerable difficulty in finding potential acceptors of either method who are willing to undergo instruction and able to complete the teaching phase successfully (de Guzman, 1983). In one area covering about 5,000 couples, only 59 couples, 30 for the mucus method and 29 for calendar rhythm, out of a target of 100 had been enrolled after completing the teaching phase during the first 18 months of project operations. In the other area, which got a later start, 42 had been enrolled in the first six months out of a target of 200. Major reasons for nonenrollment among those who have undergone initial instruction have been pregnancy, amenorrhea, inability to understand or follow instructions (especially charting), and lack of cooperation from the spouse. Instructors report that participants in training sessions, which are held in the evening, often become sleepy; about half of the couples are represented by only one spouse (usually the wife); many bring children with them and are distracted; and many have difficulty detecting mucus patterns, are embarrassed about recording information on sexual contact, or openly admit to being too lazy to maintain their records.

#### **Needs and Prospects for Future Research**

Although a good deal of useful informa-

tion on NFP practice has already been gathered in past research efforts, there are still many gaps. Several research projects already under way or expected to start before the end of 1983 are intended to help fill these gaps. In addition to the three large-scale NFP action projects described above, two other projects, designed primarily for research purposes, are presently under way.

The above-mentioned study, testing the use of parish-based volunteer workers to instruct couples in calendar-rhythm or the mucus method, is expected to provide qualitative data on the operational problems of implementing such a program as well as comparative quantitative data on the use-effectiveness of the two types of NFP. It will attempt to improve on past studies of NFP use-effectiveness by distinguishing between different types of failure (method failure, inadequate instructions, incorrect application of instructions, and conscious departure from instructions).

A second ongoing study is the 1983 National Demographic Survey (NDS), which is expected to update the information on national prevalence of NFP last obtained in the 1978 RFFS. It will also deal with such concerns not studied in previous national-level studies as awareness of different types of NFP, questions on the timing of use of the current method (for use-effectiveness analysis and comparison among methods), reason for termination of use, source of instruction, things liked and disliked about the current method, and the perceived duration and timing of the abstinence period for a woman with a regular 28-day cycle.

Three new studies are just now getting under way. The most ambitious is an in-depth survey of a representative sample of about 700 NFP users in 8 of the country's 13 regions (Demographic Research and Development Foundation 1983). The sample will consist of all respondents in the 8 regions interviewed in the 1983 NDS who said that they were currently using NFP. They will be followed up after about eight months and interviewed at length about their awareness, knowledge, perceptions, attitudes, communications, and practices

concerning the different types of NFP. The questionnaire will be largely unstructured so as to encourage the collection of detailed qualitative data. In addition, data will be obtained for analysis of short-term use-effectiveness between the NDS and follow-up survey data. The findings from the follow-up survey will be combined with the NDS data on NFP for a single major report on NFP in the Philippines.

The other two studies are tests of program strategies. One will test the establishment and operation of NFP centers in hospitals in Metro Manila that have not previously offered family planning, usually for religious reasons. The major objectives will be to determine the extent of demand for such services and to document the effectiveness of NFP use by the clients of the centers. The other study, to be conducted in central Mindanao, will test the active promotion of calendar-rhythm use in combination with either withdrawal or condoms (Silva 1983). It will attempt to minimize confusion by presenting a single formula for calculating safe and unsafe days (7 safe days, 14 unsafe days, the rest safe). It will recommend minimizing the frequency of sexual activity during the unsafe days and always using a backup method on those days. The effects of this intervention on actual practice and use-effectiveness will be assessed after a 12-month intervention period.

These studies should greatly increase our understanding of how the various forms of NFP are practiced and how they might be disseminated more effectively. Some major research needs still remain to be filled, however. One is the need for prospectively collected data. Another important research need is a better understanding of the role of the husband, both in the initial decision to practice NFP and in the duration and effectiveness of NFP use. The main source of research data related to NFP practice has been from wives. There is a need to learn more about the point of view of husbands, particularly those husbands who have tried NFP and given up or those who have not even tried. What little information is available directly from husbands has been drawn almost entirely

from interviews and focus-group discussions of men currently using NFP.

Several operational issues also need study. Given the heavy reliance of NFP on clear instruction, there is a special need to collect more information on the content and quality of instruction. A corollary is the need to assess the training of instructors and the quality and utilization of informational support materials (e.g., leaflets, radio broadcasts) that may be employed to augment instruction. Similarly, charts, calendars, record-keeping forms, and other such aids need to be evaluated with regard to ease of use and appropriateness for the couples for whom they are intended. The popularity of NFP among Philippine couples and the increasing commitment of program resources to upgrading its practice clearly justify increased commitment of research efforts.

NOTE: The unabridged paper by Dr. Laing, "Natural Family Planning in the Philippines" appears in *Studies in Family Planning*, Vol. 15, #2, Mar/April 1984.

Table 1 Survey Estimates of Contraceptive Prevalence among Married Women 15-44, by Method: Philippines 1968-78 (In percentages)

Method	Survey date		
	1968	1972	1978
Rhythm	5.5	7	8.9
Pills	1.3	7	4.8
IUD	.9	2	2.4
Condoms	a	1	3.8
Sterilization	b	b	5.3
Withdrawal	6.2	4	9.5
Others	1.6	2	2.3
Total	15.5	23	37.1

Sources: Laing, et al. 1973 (for 1968); Barreto 1974 (for 1972); NSCO, et al. 1979 (for 1978).

a Included under "other."

b Less than 1 percent.

Table 2 Cumulative Life-Table Continuation Rates of Clinic Acceptors, by Method: Philippines 1976 National Acceptor Survey (In percentages)

Method accepted	First-method		All-method	
	12 months	36 months	12 months	36 months
Rhythm	42	19	57	30
Pills	48	17	61	30
IUD	68	39	81	54
Condoms	23	6	51	26

Source: Laing 1979b.

**Table 3** Cumulative Life-Table Rates and Pearl Pregnancy Rates: Philippines, 1976 NAS

Method	Life-table pregnancy rates		Pearl pregnancy rates
	12 months	36 months	60 months
Rhythm	13.8	22.9	20.2
Pills	5.1	9.5	7.8
IUD	2.4	5.1	2.6
Condoms	10.4	12.9	21.3

**Table 4** Cumulative "Overall" Pregnancy Rates: Philippines, 1976 NAS (In percentages)

Method	Overall pregnancy rate	
	12 months	36 months
Rhythm	36	61
Pills	28	60
IUD	13	59
Condoms	40	66

**Table 5** Cumulative 12-Month Continuation Rates and Overall Pregnancy Rates of Clinic Acceptors by Method and Acceptor Cohort: Philippines, 1976 NAS

Method accepted	First-method continuation rate		All-method continuation rate		Overall pregnancy rate	
	1970-72		1975		1970-72	
	1970-72	1975	1970-72	1975	1970-72	1975
Rhythm	43	42	58	60	36	30
Pills	54	37	66	54	23	40
IUD	68	61	82	74	10	20
Condoms	23	18	50	47	32	40

**Table 6** Annual Continuation Rates and Pearl Pregnancy Rates Estimated from 1980 COS Data

Method	Number of woman-years of observation	Annual continuation rate	Pearl pregnancy rate
Rhythm	710	51	33
Pills	423	42	19
IUD	165	70	4
Condoms	114	10	60
Rhythm + withdrawal	246	73	17
Rhythm + condoms	71	51	31
Withdrawal alone	767	43	44

Source: Laing 1981.

**Table 7** Twelve-Month Use-Effectiveness Rates of Calendar and BBT Acceptors at ASI Clinics in Manila, 1971

Type of rate	BBT	Calendar
First-method continuation	32	47
All-method continuation	41	52
First-method failure	24	27
Overall pregnancy	40	38

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## Comments

### MARIE MIGNON MASCARENHAS

*Marie Mignon Mascarenhas, M.D., director of CREST; pioneer in NFP in India; member with her husband of the Pontifical Council for the Family*

Two studies of NFP in India cannot be ignored by any family planning worker because they established the credibility of NFP in this country. They are the Karnataka State Study (KSS), which was carried out from 1977 to 1981, and the World

Health Organization (WHO) study of the ovulation method in five countries, of which India was one. The WHO study was the first to compile data from India. Bangalore was selected from 20 centers in India to conduct this research, with the consent of the Indian Council of Medical Research and the Ministry of Health and Family Planning. Certain highlights from the study should be mentioned for the benefit of NFP workers.

An important finding was that 94 percent of the women, many of them illiterate and from different cultures and religious backgrounds, learned to distinguish the fertile period in the very first cycle. The continuation rates were higher than those for any other method of spacing used in India (see Table 1).

The method effectiveness was on the order of 98 percent, and the use-effectiveness of the method in India was 85 percent. The study involved 278 couples in India alone and was done over a period of about two years. A simultaneous monitoring program of progesterone assays was done for every woman seven days after she had claimed to have reached her peak day, as detected by the sensation of wetness or observation of mucus changes. The study was the most diligent NFP study ever undertaken and studied 1,000 parameters in five countries. It proved that NFP was scientifically valid and that it was an applicable and a practical method for spacing or limiting pregnancies in developing countries regardless of educational level.

The other study, KSS, was conducted throughout the state of Karnataka; 3,500 couples were registered, and a systematic follow-up, similar to that used in the WHO study, was observed. The KSS found that women's libido was significantly higher in the pre- and postmenstrual phases (i.e., corresponding to the infertile period) than at other times during the cycle. Difficulties caused by abstinence were reported by only 1.7 to 4.6 percent of the husbands in the Karnataka Study. Detailed records on this aspect of the method were maintained throughout the study. It was found that 97 percent of the husbands were cooperative. The majority of these couples were not

Christian (51.5 percent were Hindus and 8 percent were Muslims).

One of the most important by-products of NFP is the enhancement of the woman's dignity that results from using the method. The woman finds that fertility knowledge is fertility control. Moreover, an educational method that integrates the teaching of health, hygiene, and nutrition is particularly appealing to both women and men.

The method also encourages breast-feeding and stresses its importance. It should be noted that the contraceptive effect of breast-feeding is a physiological phenomenon of major importance; in developing countries it prevents more pregnancies than all the other methods of contraception.

Promotion of NFP in India appeals to groups that value the health and welfare of women and children. These include social, educational, and religious women's organizations. Governmental agencies are also being reached, and one of the most effective voices for NFP is often a successful user. It must be remembered that NFP does not have any companies with drugs or devices to sell, and sales must be in users.

Outreach efforts are being made to bring the medical profession into closer cooperation with NFP workers. To nurses and medical students, the NFP message emphasizes the safety, effectiveness, and acceptability of the method, criteria that are met only with an NFP method. It is stressed that NFP can reduce infant morbidity and mortality because it helps women to space their children and contributes to the health of each child.

There is no need to criticize or decry other types of contraceptives. NFP has an intrinsic worth, and its medical advantages

Table 1 Continuation Rates for the Ovulation Method in India

	WHO Study	Karnataka State Study
Number of couples entering	278	2,790
Continuation rate		
After six months	84%	93.0%
After one year	78%	75.0%
After two years	71%	70.8%

are sufficient for its promotion.

Community health workers are presented with the advantages of NFP that couples gain by not being dependent on doctors, hospitals, or drugstores. The child health and welfare services are ideally

suited to promote NFP as integrated with health education for nutrition and hygiene.

Women's groups respond to the very powerful argument that women who use NFP are not called upon to face any risk or hazard to health.

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## KWANG-HO MENG

*Kwang-ho Meng, M.D., associate professor of Department of Preventive Medicine and Bio-statistics, Catholic College, Seoul, Korea; delegate of the Korean Happy Family Movement-NFP*

In a broad sense, evaluation of a public program is undertaken to determine if the program is "worthwhile." But program evaluation is often frustrated by confusion over what is meant by "worthwhile" and how it can be measured. In fact, the word "evaluation" has been defined in the past in different ways, depending upon the context in which it was used and the programs that were under consideration.

In the field of public health, the American Public Health Association has defined evaluation as "the process of determining the value or amount of success in achieving predetermined objectives." In the field of social science, evaluation consists of the application of social science techniques in the appraisal of social action programs. Interest centers around the assessment of behavioral changes, of related attitudes and motivations, and of the factors influencing them.

On the other hand, economists often define evaluation in terms of a cost-benefit analysis. The cost of all inputs into the program, such as personnel employed and materials utilized, is estimated and compared with the benefits accruing from it. The object of evaluation is to maximize the benefit per unit cost at every stage of operation of the program.

It is thus apparent that evaluation approaches vary in complexity and demand different degrees of knowledge and skill.

Evaluation of family planning programs has usually been based largely on the more pragmatic public health approach. In this type of evaluation, the program objectives and the way of measuring the program effects to meet the objectives are considered.

The goals and objectives of government family planning programs are concerned primarily with increasing availability of services and reduction of the birth rate to predetermined levels. Selection of program evaluation topics and measuring the effects of the program may not be so difficult in these cases.

Evaluation of NFP programs, however, should be different from that of other family planning programs because the goals and objectives are somewhat different. As Dr. Borkman conceptualized some years ago in the *International Review of Natural Family Planning*, NFP is a "value-oriented interpersonal behavioral innovation." That is why NFP has been perceived as either a movement or a social service program in many countries. In those countries, the most important goal of the NFP program is still enriching marriage, improving the couple's relationship, or sanctifying the family, not regulating fertility. Because of this goal, a more sociological approach toward evaluation—namely, evaluating behavioral changes between partners or even toward God—is needed in NFP program evaluation.

In general, I agree with Dr. Gray's description of evaluation, but I would like to add my personal experiences. First, evaluation of the performance of the people in managerial positions, including teachers, is very important. This is because the success of an NFP program depends largely on who is running the program.

Many NFP programs are headed by religious leaders, such as priests and sisters. Their eagerness to improve the program and the amount of time they devote to it are reflected in the performance level of teachers, and thus in program outcome. The time they give to the program should be recorded and included in the evaluation.

The effectiveness of teachers and the learning activity of users can be evaluated by observation of teaching sessions. Special forms need to be prepared to record observations of the evaluators.

Second, I am glad that Dr. Gray did not mention the Pearl index in measuring use-effectiveness of NFP methods. This index disregards motivations and the variability of couples with regard to their monthly risk of conception. In my opinion, those who have not completed charting at least three cycles should not be counted as NFP users, but many studies still include those couples in the evaluation. This results in a relatively high Pearl index for NFP as a method of family planning.

Dr. Gray recommended using life-table techniques to determine use-effectiveness, but we must be cautious in applying this technique to NFP. As we all know, life-table rates can be calculated only up to the cutoff date; for example, if the interval between start of a program and the cutoff date is 12 months, life-table rates are obtainable only up to 12 months at the most.

For life-table analysis, we must assume that the pattern of NFP practice is constant over time, but this is not the case. In NFP the continuation rate is much more dependent on the degree of motivation than in any other family planning method, and the longer the observation period, the more couples who are successfully using NFP. Studies show that a couple who becomes autonomous in NFP use have a higher probability of continuing NFP practice. The estimated "life expectancy" of NFP may, therefore, vary with the duration of observation.

Couple years of protection (CYP), on the other hand, is a good measure of NFP use-effectiveness. Since the life expectancy of NFP is longer than that of other contraceptive methods, we even get relatively higher

CYPs in NFP if the number of subjects we observe is the same.

Behavioral changes before and after the acceptance of NFP should be evaluated as a program outcome. As I indicated earlier, NFP is a part of family life promotion, and therefore, changes in the relationship between the husband and wife, the couple's commitment to their children, and even a couple's loyalty to the Church should be indicators of program success. Percentage increase in church attendance and in those receiving the Eucharist have been used as indexes of program success in one diocese of Korea.

Third, the aim of cost-effectiveness analysis is, as Dr. Gray pointed out, to measure the relationship between program costs and achievements that cannot be measured properly in monetary terms; examples are the work of volunteers and the improvement of family life resulting from the program.

Finally, I would like to mention briefly the necessity for research in the field of NFP evaluation. Since the principle of NFP is the responsible regulation of birth attained through an educated awareness of and acceptance of the natural cycle of fertility and infertility, the attainment of the goal is affected by many factors, especially psychological factors. Studies on factors affecting NFP practice can be very useful for planning and revising programs.

In the field of NFP, evaluation efforts have concentrated primarily on the biomedical evaluation of NFP as a family planning method in terms of use-effectiveness. This, of course, is an important evaluation measure of NFP, particularly for outside funding supporters, such as governmental agencies, who see NFP as another fertility regulation method. What we NFP workers, especially Church-related NFP workers, really need, however, is to see the NFP program as different from other family planning programs. Its ultimate goal is different, so we need to discuss how to evaluate it properly for improving the program performance with respect to the promotion of family life.

We, of course, have to clarify our goals and objectives before we can evaluate our

program. The problem of identifying specific program objectives is a major problem associated with the evaluation of a public program. A second problem is measuring the effects of the action program. In the first regard, the Diocesan Development Program for Natural Family Planning in the United States is one good example of what

the NFP program goals and objectives should be.

In conclusion, evaluation of effectiveness in preventing pregnancy is just one aspect of NFP program evaluation. Two other important aspects of evaluation of program accomplishment are performance analysis and public (client) response.

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## SHEILAGH O'ROURKE

*Sheilagh O'Rourke, Ph.D., anthropologist; coordinator of evaluation project l'Action Familiale-Haiti (1982-83), Haiti*

First, I would like to express my admiration for the astute presentations of Dr. Gray and Mr. Kamboic. As an anthropologist who has spent a year evaluating an NFP program in Haiti, however, and as one who has benefited from discussions with many who represent programs elsewhere in the developing world, I would like to add a few suggestions.

For many of the NFP programs in developing nations, much of what has been said here is presently impractical. Many NFP educators—i.e., those who would be expected to perform most of the proposed data collection—are persons with limited literacy. They have little experience in filling out forms and keeping written records. In Haiti, for example, as part of the evaluation, a sample of educators was asked to complete the organization's couple registration form, which asked for basic socioeconomic, fertility, and family planning data. In most cases, they were unable to do this, or could do so only with assistance. We should note that these educators are persons who are otherwise competent in their work. Their clients—mostly nonliterate couples—are well trained in NFP principles and practice.

Obviously, such educators cannot be expected to collect extensive, accurate data on their client couples. The ability to fill out forms is a *learned* skill that takes practice and training, a skill acquired early in industrialized nations but not in most

developing countries. This lack of experience must be taken into account in any program of data collection in the developing world.

How, then, does one meet the demands for service statistics and for program evaluation and accountability? First I would suggest that donor agencies be reasonable in their demand for data collection and accountability. Since most NFP program personnel have limited formal education, the onus of gathering and tabulating such data falls on the organization's highly educated few. These educated few already have many other diverse demands on their time (e.g., training educators, writing promotional materials). Thus too many demands for too much data place tremendous physical and psychological strains on some of the organization's most valuable people.

In the developing world, the educator who wants to keep his job quickly learns that even the small income of an NFP educator depends on reporting "good numbers" (i.e., many training sessions held, high numbers of acceptors). Motivation for fabricating results is not confined to developing countries or to NFP organizations. In the developing world, this problem is just more accentuated. Moreover, my experience in Haiti has led me to believe that its NFP organization produces the most reliable family planning service statistics in the country. At this particular stage of the development of NFP internationally, it is critical to have really accurate data on each program. How many couples are truly being reached with the NFP message? How many of those couples reached are accepting NFP? Problems in

outreach and in attracting new acceptors can be corrected only if the existence and parameters of those problems are known, and they cannot be known if data are fabricated.

To collect this essential data on new acceptors, one need ask only five questions: name(s), address, age(s), parity, and date of inscription. One short simple form asking only these questions could also have space for the client's NFP history. Educators could note on the form: the date of each training session that the client attends; the fact that the client has become autonomous in NFP and the date on which this occurs; or the date the client withdraws from instruction for any reason, including pregnancy. As long as a client continues NFP instruction, subsequent months' data would be entered on the same form.

Such a simplified form would retain all the most important data and would also be suitable for those with limited formal education. Service statistics could easily be extracted from such simplified forms by more educated personnel. For example, the number of new acceptors, each educator's monthly client caseload, continuation and discontinuation rates, reasons for discontinuation, and pregnancy rates could all be tabulated from one such form.

My third suggestion is that data for any and all of these needs—service statistics, program evaluation, and accountability—

be obtained by scientific sampling procedures. It is not absolutely necessary for each program to collect aggregate data on each and every one of its functions. Some programs may find it impossible to collect data on every new acceptor, each new acceptor's demographic characteristics, every educator's workload, total discontinuation rates, total pregnancy rates, and other items. In this instance, it is preferable to collect quality data on a randomly selected number of cases (e.g., pregnancy rates, total workload of educators, costs per client), than to assemble a large quantity of poor data. Again, better educated personnel or personnel hired specifically for this purpose would be expected to do the bulk of this work.

I am aware that many will object to these suggestions because the NFP movement is presently an "outsider" striving to gain acceptance, and its statistics, therefore, must be of the highest possible quality. But I believe that by limiting the data needs, tailoring them to the ability levels of the personnel involved, and by using specially trained personnel in some instances to collect randomly sampled rather than aggregate data, quality statistics can be obtained. What I have attempted with these suggestions is to reconcile the tensions between the needs for good data and the abilities of some organizations to provide these data. Quantity is sacrificed for quality.

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## Discussion

In this discussion the major concerns of participants were the need and feasibility of evaluation, the process of evaluation, including the nature and detail of evaluation forms, and the role of the outside consultant.

The process of evaluation itself may alter the program being evaluated. There is sometimes a fear that evaluation records

will be used for staff evaluation. Many administrators are afraid of accountability because they fear that their mistakes will be found out. Evaluation should not be presented as a form of judgment. It is critical not to use records to penalize staff; such a practice may motivate educators to falsify records. The use of in-service training for staff evaluation was recommended.

Much attention was given to the content of an admission form. A list was made of both essential and desirable information to be obtained. It was agreed that both the woman and the man should provide the following information: age, marital status,

number of births and number of living children, time since last pregnancy, intention to space or limit, breast-feeding status, previous family planning use, name and address (urban/rural), education, occupation, and ethnic or religious group.

The first eight items were considered essential, the rest optional.

It was noted that the complexity of the form is related to the type of analysis to be undertaken. The use of computers may not always be appropriate. It is necessary to move gradually from limited to extensive data collection. From the beginning of a program there is a need to build in the possibility of expansion. The evaluation process should be planned together with the establishment of the program. Too many forms, however, may cause an obsession with pieces of paper and the consequent neglect of acceptor couples.

A participant from Africa noted that there can be resistance to filling out forms and questioned if there were a place in African development programs for outside evaluators. It was recognized that forms used in Western countries may be inappropriate and that developing countries need simplified record-keeping. The simplification, however, should not be so great as to render the forms useless. Another African program director has found that forms, even simple ones, take three or four sessions to complete. If too much information is asked in one interview, the clients become suspicious. There is also the question of where to keep forms. The World Health Organization has provided funds to its collaborators for security filing cabinets.

A program director remarked that if the educator/teacher is to collect statistics, then he or she should receive appropriate training. People need to have an explanation of the purpose of evaluation forms.

The representative of an international funding agency said it was important to distinguish two kinds of data collection: (1) data for service programs and (2) data for research projects. Many participants recognized that it is necessary to have statistics to provide to potential funding agencies. The representatives of the donor

agencies underscored this. It is difficult to obtain funds without minimal statistics, which are also important for credibility. Good management also requires some degree of evaluation.

NFP programs have not had input into the development of such survey questionnaires as the World Fertility Survey. Statistics are also needed to convince the medical profession of the value of NFP. Pregnancy statistics are especially critical in the view of one participant.

To satisfy potential donors' need for evaluation, one African participant suggested that the donor agency provide an evaluator. This was not considered a good idea by other participants.

An Asian participant raised the question of the basic differences in motivation between funding agencies and their influence on the forms chosen for evaluation. International Catholic donors do not have the same motivation as international population agencies. This difference was not seen as necessarily crucial. Every kind of funding agency needs basic statistics on program performance. Moreover, basic evaluation is a way to educate the trainers to ask: "What am I doing? Is it worthwhile?" There is a need to develop different levels of forms. It is primarily a question of degree.

Bringing in an outside evaluator raises the issue of the role of the consultant. Not everyone in NFP understands the role of the consultant. The funding agency and NFP personnel need to work out an agreement about what the consultant will do. A potential problem is that local consultants may be affiliated to the local multi-method family planning programs, which are often hostile to NFP. There is a need to build bridges in the local community. An African remarked that people in developing countries are accustomed to the idea of evaluation but are not trained in proper NFP evaluation.

How do you transfer the skills of the consultant to the program so that the program becomes autonomous? Most agreed that that is the ideal. The United Nations has changed the emphasis from technical assistance to technical cooperation. So the

role of the consultant is first to provide technical skills, then to transfer technical expertise to the local program, and then to act as a broker. But too much must not be promised.

In NFP there is the particular dimension of accounting for the autonomous user. Then there are also "secondary users," those not taught by a program but who learned it from a trained NFP user. They are not always included in current surveys. Couples do make a transition to autonomy from NFP programs. It is essential to follow autonomous users and obtain data on extended effectiveness.

The question of when to begin using months of couple experience for life-table analysis received attention. It was suggested that couples be included when they commence charting. In some countries couples are not registered until they have charted three cycles. Even if they are not counted in official statistics, the relative proportion of early dropouts is a good indicator of acceptability. The important factor is that published statistics should include information about when couples' experience was counted.

A question was asked about including the postpartum amenorrhea period in use-effectiveness statistics. This is, obviously, a

problem. Postpartum amenorrhea can contribute to NFP success rates. It is possible to calculate life-table rates with or without women with postpartum amenorrhea, but it is necessary to state what was done in compiling the statistics. The longer the observation period, many believe, the better NFP rates look. Once a couple becomes autonomous they may contribute many years of pregnancy-free experience to life-table analysis.

One participant expressed uneasiness with excluding early cycles (the learning phase) in evaluation procedures. He believes also that all cycles without any possibility whatever of pregnancy should be left out of the exposure period. He also suggested that rates of intercourse per cycle should be included.

The issue of quality versus quantity measures was also addressed. Questions can be asked about client satisfaction and client knowledge. Couple communication factors and religion have also been found to be important.

Finally, there was the question of the budget for evaluation. When too much of the funding goes for evaluation, the service provided to the community can suffer. It is important to clarify the percentage of the budget for services versus evaluation.

# Summary of Program Issues

*As NFP programs begin to expand and to integrate into larger systems of services for couples and families, many issues surface. The key issue is how to increase the number and quality of NFP programs that are well funded and staffed with competent and confident NFP teachers and a growing staff of administrators. Organizations also need to consider the types of program evolving, the effectiveness of the programs, and the long-term impact of NFP services on the local community and the country as a whole. To achieve cost-effective programs a major challenge is to design delivery systems combining paid and volunteer staff. The following recommendations apply to those programs which want to expand. It is recognized that some programs will choose to remain small and intensive.*

## **Program Development**

The salient issue for many NFP programs is the need to expand services and include NFP as an integral part of larger service systems to couples and families.

To meet the challenge of expanding programs, change is required. Systematic planning and redefinition of goals must be undertaken to achieve an orderly transition into the larger systems of services such as the pastoral services of the Church, family life education, and health care delivery systems, including family planning programs.

Critical to NFP programs in this process of expansion is the setting of priorities. NFP, as it has grown, has become identified in national programs with family life, youth and parent education, health care systems, and the area of human values related to sexuality, marriage, and family. Attention should be given to the following needs:

- To identify and maintain development priorities specific to NFP in the process of integration with larger systems.
- To develop precise definitions of previously undefined and intuitively understood NFP program standards, training procedures for teachers, evaluation and quality control measures for both teacher training and NFP services.
- To identify and define specific agency relationships among the various organizations and the national NFP program, so that larger systems within a country can be properly utilized and monitored.
- To establish regional and national NFP resource centers so that human and technical resources, related to the improvement and development of better NFP services in both the public and private sector, can be available.
- To develop leaders who are both open and receptive to the philosophy of the grass-roots, experiential, user-oriented NFP programs, and the needs of the larger systems involved.
- To secure funding from more than one source in order to establish a firm base of financial support. Along with this need is the recommendation to prepare a variety of budgets and project activities.
- To develop program administration manuals, personnel policies, and job descriptions to insure upward and lateral job mobility in NFP services.
- To develop a mechanism for continuing education for NFP teachers, program administrators, trainers/tutors and support staff within larger systems of delivery. The NFP person-

nel will require a full orientation to the larger system of care in order to utilize more fully the resources of the system and realize better accessibility and quality of NFP services.

Governments and other funding agencies can provide valuable assistance in the form of resources to improve quality NFP program development in both public and private programs. This could include funding for specialized resource personnel who could be helpful to all groups involved in the delivery of NFP within the national program structure(s) in the country. Assistance in the development of advertising, informational films, program brochures, literature reviews and instructional materials would be a valuable contribution to the standardization and quality of NFP services as programs expand. NFP expertise would be required in the design and approval of films, teaching materials and other specialized NFP materials. At the same time, existing resources for training in leadership and program administration could be utilized. National and regional workshops and seminars for both public and private NFP experts on issues related to the delivery of NFP could facilitate the process of integration.

The expansion of NFP programs will require flexibility on the part of both the NFP program and the larger organization into which NFP will be integrated. Specific program plans, objectives and goals must be stated in measurable terms, so that the accomplishment can be assessed. As the goals and objectives are met and redefined, new needs will surface. It is important that the identity of NFP remain visible and not become lost in the many other priorities already established in the larger, existing system of pastoral, family or health care.

NFP programs have typically started with motivated, experienced, volunteer teacher couples, who are concerned with the delivery of NFP within a volunteer network. As NFP programs integrate with larger systems of delivery, the spirit and experience of the teacher and service groups must be maintained. Experienced NFP teachers and program administrators should have active roles in the decision-

making body at the national level. Included in this recommendation are requirements for additional training in program administration, planning and budgeting.

When the larger system assumes leadership in the national organization, experienced NFP personnel must help to identify priorities of NFP. Perhaps, in the initial phases of integration, the priorities of NFP service delivery need to be overemphasized to achieve an acceptable level of attention in a new national structure. In instances where the NFP program has achieved national status, it must begin to work closely with other NFP programs within the country sponsored by family life organizations, health care systems including family planning, and national programs concerned with education for youth and families.

The national NFP program should establish resource centers for other national organizations to learn about and receive training in NFP. The private NFP programs have a role in refining and improving the delivery techniques of NFP as well as studying the related areas of family life, conjugal life, and education for youth and parents. The resource center could become a focus for other agencies and disciplines interested in the study and development of NFP.

#### **NFP Service Department**

The major issues related to the development of NFP service programs are how to design accessible programs to meet client needs and to provide competent NFP teaching staff and sufficient follow-up instruction to enable the learning couple to apply the appropriate natural method and begin to integrate periodic abstinence into their relationship.

Design of Service Programs NFP programs which meet the requirements of learning couples and provide accessibility to both initial method instruction and sufficient follow-up instruction need to contain the following:

- The capability to offer instruction in both the cervical mucus and symptothermal methods of natural family

planning.

- Linkages to education for youth and parents, premarriage instruction and family life programs.
- Regularly scheduled and accessible instruction with teachers available for follow-up.
- Accessibility by walking or by public transportation, to enable learning couples to attend the classes.
- Continued recruitment and information sessions for potential clients to build the volume of new clients necessary to maintain a regularly scheduled NFP service.
- Flexible and varied time schedules to meet the needs of working women, women with families and children, and learning couples. It may be necessary in some countries and cultures to plan programs that can be directed to the men and women separately.
- Sufficient record systems for clients so that the instructor and program director can contact clients if they have not returned for follow-up, and can assess program results.

The expansion of NFP services will require a greater number of competent trained NFP instructors, so that increasing numbers of learning couples can be given programs that are expanding with a mix of paid and volunteer teachers and support staff it will be necessary to increase the number of staff to insure proper teaching of a larger number of couples.

The experience of many NFP programs indicates that teaching the fertility awareness component, that is, the signs and symptoms of fertility, takes a relatively short period of time, i.e., one or two sessions. However, to teach the natural methods to avoid pregnancy, it is necessary to help couples develop confidence in identifying the fertile days of the cycle, apply the appropriate method rules, and use only the infertile times for intercourse. Couples usually begin to become comfortable with periodic abstinence within six to eight cycles. Some programs will review charts for at least a year or more to

establish use-effectiveness rates for program evaluation.

Ongoing evaluation of the NFP service program is important to determine if the program is meeting its goals. It is also important that the program review these goals and objectives, at least annually, to delete obsolete objectives and set new ones. This idea of setting goals implies written or intuitively understood program standards.

Staffing of Service Programs Several criteria need to be considered in staffing an NFP service program with competent teachers. These include the following:

- The use of NFP teachers only for teaching.
- A distinct NFP service staffed by competent NFP teachers who can provide an educational service.
- Training of volunteer, motivated, user couples to become information and education staff, so that a trained teacher does not have to do all NFP-related tasks in a service.
- Training of motivated educators, preferably parents, who use natural methods and work as teachers in the school system, to provide fertility awareness information at appropriate grade levels in the schools. These information specialists would be a valuable aid in recruiting new clients for NFP, as young men and women enter premarriage programs.
- Provision of either volunteer or paid staff to assist the NFP teacher in registration, record keeping, and other administrative duties.
- Establishment of financial and community awards or incentives, such as social and family events, trophies, acknowledgment, and community recognition for volunteer workers within a program.

The expansion of NFP into public agency organizations, such as ministries of health, raises the issue of design of the NFP service, since sometimes it would be situated in a service offering all family planning methods. The staffing and design of

such a service needs to be carefully considered in relationship to the duties to be performed. It is suggested that the staff of the NFP program develop this service as a distinct and different service from other family planning methods.

NFP requires an educational service directed primarily to couples. It demands initial instructional sessions, with small group or individual follow-up instruction available at varying times during the day and evening. It may be preferable for professional staff to specialize in certain areas. Teaching NFP requires a positive attitude towards recognition of the fertile and infertile days of the cycle, as well as support of the client or couple's decision to use NFP. The staff could become easily distracted from developing an innovative educational service if they had to switch from NFP to provide other methods of family planning. Rather the focus needs to be on building a strong educational program based on knowledge of the fertile and infertile times of the cycle and helping couples become confident in their ability to use NFP and integrate abstinence into their lives.

#### **Funding of Service Programs**

Expansion of NFP services requires increased funding. There is a need to combine both full-time paid personnel and volunteer personnel, as the NFP program grows towards offering a regularly scheduled service to larger numbers of clients. The majority of existing national NFP programs have evolved within the Catholic family life environment and/or secular organizations with a strong Catholic frame of reference. Many of the existing NFP programs in the developing countries have received funding from Catholic international and national organizations.

As these existing programs become more secularized and/or integrated within broader systems of services to families, the issue of equity of funding from international agencies becomes paramount. Equity in funding implies the following:

- The need for the agency which offers NFP only, to receive funding for pro-

viding NFP services to a target population.

- The need for other organizations, just beginning NFP services within a multi-method organization, to receive funding for NFP services offered to those in the community that they serve. It must be noted that the family planning agencies already receiving international and government funding might receive priority for additional funding for NFP. This type of inequity must be avoided to respect the appropriate and fair distribution of NFP services to all.
- The need to state core NFP program standards so that funding for NFP services can be distributed to those programs providing high quality. All agencies should recognize the same core NFP program standards. However, there may be differences in presentation, depending on the overall orientation of the agency or program offering the service.
- The need to respect cultural and religious preferences of people and communities served when funding appropriations are made.
- The need for periodic program evaluation before continued funding occurs. Each program offering NFP services should have stated goals and objectives, as well as specific plans of action. Periodic evaluation determining the effectiveness of the action plans is required. Continued funding should be based on the ability of the NFP service program to meet its goals.

#### **The Clientele Served in the Community**

Various types of organizations may offer NFP within a related family life service, rather than a health care or family planning facility. NFP service programs should identify and define the target population within the community. This is very important in the total orientation and design of the NFP service program. Educational services are defined by the combination of the task to be learned and the orientation and needs of the learner. In defining the target popula-

tion of a NFP program, questions raised include:

- Do the couples come from a variety of socioeconomic and educational levels?
- Are couples attending the program primarily because of a religious value system or a concern for their health?
- Are the couples young and still interested in having a family, or are they older couples who do not want additional children at this time?
- Are the couples unable to read or write?
- Do the couples and women live in urban areas with relatively easy access to the instructional service, or do the couples live in rural areas where they have to travel long distances for instruction and chart reviews?
- Are the couples seeking to achieve pregnancy or to avoid pregnancy?

It is important to realize that, even within the same program or organization, NFP instruction may require different types of approach because of the characteristics of those who come to the service. When many programs of NFP instruction coexist in a community, it is important to understand that there will be variations in the teaching approach based upon the needs of the clientele served and the types of methods taught.

Designing an NFP instructional service is different in nature from setting up a clinic service in which the client is seen once or twice for a medical evaluation. It is essential that the staff of the NFP instructional service be competent and confident in their abilities to teach and follow client couples in the use of NFP. This implies both a central and extension approach of service accessibility, a distinct effort to utilize motivated, competent NFP instructors, who do not have other conflicting job assignments, as well as an effort to mix both paid professional and paraprofessional persons in the delivery of the NFP service. As NFP educational services become part of a larger system of delivery, it is essential to focus on their proper

development from the beginning of the integration process.

### **NFP Trainer and Teacher Programs**

There are two central issues related to the development of core national NFP teacher training program standards. First, consensus needs to be developed by the national NFP organizations and national agencies in which the NFP instruction is to be integrated, concerning the overall aims and specific objectives of the content for NFP teacher training. The Family Fertility Education Resource Package, prepared by the World Health Organization, offers a comprehensive training kit for preparing NFP teachers and users. Teaching suggestions, content and visual aids are included for teaching fertility awareness, sexuality and responsibility, the cervical mucus method, and the sympto-thermal method. In addition, there are suggestions for teaching/learning activities. This kit is recommended as a resource to the existing national training program. Some countries that do not have a national training program may want to use it after adapting it to the culture and local language.

The NFP teacher training program includes formal instruction and supervised teacher experience. It is usually necessary to have teacher training programs with formal content of about 7 to 10 days, to present the essential factors of NFP, some teaching techniques and discussion of attitudes and counseling techniques used in support of couples who use the methods.

The supervised practicum varies from four to six months and depends upon the number of available NFP clients in the service. It is recommended that a new NFP teacher trainee teach and provide follow-up to at least 10 couples preferably in a variety of categories. For example, it is important that NFP teachers learn how to teach women in special circumstances such as breast-feeding and couples wishing to achieve pregnancy.

In some countries, providing couples with information on breast-feeding, nutrition, and oral re-hydration for child care can be important areas for NFP teacher training. This information can be given to

couples interested in learning NFP methods.

NFP teachers need to attend continuing education workshops in order to maintain current teaching skills. Often NFP teachers have been trained, but then either do not practice their teaching skills or do not keep up with current developments. The location for the NFP teacher training program becomes a key point for recruitment, follow-up, and supervision of the teacher trainees for extended lengths of time. Some of the issues to be considered in selecting the place include:

- Convenience for NFP teacher trainees.
- Ability of the NFP trainees to obtain clinical teaching opportunities with supervision by an experienced teacher.
- Convenience of frequent (at least monthly) meetings with the training faculty for the new trainees to discuss problems and teaching approaches and to profit from group discussion and additional chart review of clients.
- Convenience for national, multi-disciplinary faculty to be formed and to provide the NFP instructors with training that addresses the varied fields related to NFP and family life. Examples of such faculty include physicians, maternal and infant-care nursing specialists, psychologists, educators, priests and family life counselors. National experts in these respective fields can be recruited and encouraged to become active in the NFP faculty team. Experienced NFP teachers within the country should be utilized as NFP faculty as well as trained to be clinical supervisors during the follow-up instruction for the teacher trainees.

### **NFP Teacher Training**

The needs of the learning couple direct the service orientation of the agency offering natural family planning. This requirement determines the design of programs for teacher training. NFP teachers need to be trained to provide all NFP methods. The

training must be explicit about those signs of fertility that are reliable for certain phases of the gynecological and reproductive situation of the woman. NFP teachers need to complete a course in the formal content of NFP with a supervised practicum by an experienced NFP teacher during which they teach a certain number of couples and follow them. It is recommended that an isolated teacher without recourse to supervision is not desirable, and that most teachers prepared in this fashion do not function later as NFP teachers, because of a lack of confidence in the ability to teach.

Objective evaluation is needed of both the formal course content and the supervised teaching experience. This includes (a) competency tests related to the objective knowledge of the formal instruction, and (b) personal evaluation by the clinic supervisor of the new teacher's ability to provide initial and follow-up instruction and to work within the agency offering the NFP service.

It is important that the NFP teacher have confidence in NFP. It is preferred that NFP teachers use one of the methods themselves. The issue of competence to teach NFP correctly and confidently is important. It is less costly to recruit NFP teacher candidates from a group of persons already using one of the NFP methods. NFP teachers should be enthusiastic, confident, and knowledgeable about NFP in the larger system of service in which NFP is being introduced.

Commitment on the part of the trainee and the hiring agency are desirable. The new trainee should be committed for a period of time (two years) to provide a teaching service in the agency. If the trainee works in a national ministry of health and is subject to transfer, their NFP teaching skills should be transferable to a new job assignment, whenever possible. Commitment on the part of the agency employing the NFP teacher implies that the trainee has attitudes and personality characteristics that are supportive to the agency in which he/she will be employed. It also implies a commitment on the part of the employer to utilize the skills of the new

NFP teacher.

The attitude of the NFP teacher trainees should be conducive to a teaching/learning situation. This means they are open to new situations and accept couples and clients with a nonjudgmental attitude. It is difficult to assess this latter quality, but it is desirable that the agency recruit individuals with open attitudes. To be a teacher implies being open to learning more about the field(s) in which one is teaching and an ability to transmit this information to others.

International NFP experts are a primary resource for the national program. They should be utilized as consultants to the existing faculty and leadership, especially in those countries that do not have faculty for training NFP teachers. Arrangements with international NFP training consultants should be made so that eventually the country will be relatively autonomous in its ability to train NFP teachers.

Preparation of national faculty, tutors, or trainers (these terms are used synonymously) becomes a third key issue in the consideration of developing national NFP teacher training programs. Some of the following points are relevant for consideration of national faculty for NFP teacher training programs:

- The faculty include expertise in a variety of topic areas, including reproductive biology and physiology, the current natural methods, specific teaching experience in the cervical mucus and symptothermal methods, instructional experience and small group discussion techniques. In addition, experts in family life educational programs and health services are useful in providing enrichment to the basic training program for NFP teachers.
- The core faculty be chosen for their skill in teaching or training teachers in NFP.
- The faculty be trained on a continuing education basis on how to use the Family Fertility Education Resource Package. Expertise should also be sought in management and evaluation.

- The faculty agree on materials, goals and objectives they wish to use to add to the core NFP teacher training program. For example, additional materials related to infant care, nutrition, and re-hydration may be vital for some national programs. Still others may be interested in furthering particular programs related to family life and education for youth which support the values of the family in that country and culture.
- The faculty initially include some of the site supervisors who will be supervising the new NFP teachers in their initial teaching experience. The site supervisors should be skilled in teaching techniques particularly related to teaching NFP and helping couples become autonomous in the practice of NFP.

Regional NFP teacher training workshops have to be carefully planned to include sufficient national representation so that appropriate follow-up of new NFP teachers could occur within the country at supervised locations. The issue of defining tutor or trainer preparation workshops to facilitate NFP teacher training needs further definition at this time.

### **Evaluation**

Program evaluation for NFP programs involves several dimensions which include both local and national evaluation program standards. The primary issue in program evaluation is to establish a monitoring system that gives timely data to the program administrator and staff to check routine operation of the service system and progress toward the goals of the program. Based on the data, the program operations can be adjusted or the goals amended. Additionally the evaluation data can be used to set new goals and contribute to knowledge about how to deliver NFP services more effectively.

National evaluation looks at the entire program while local evaluation examines a small part of it. However, the same data collection system can be used for both. This monitoring system should be design-

ed with care. Standardized definitions and systems invite interprogram comparisons and exchanges which may lead to improvements.

The following are some of the data needs for NFP program evaluation:

- Number of couples or individuals served.
- Regions or districts of the community served.
- Number of couples still using NFP after a specified time period.
- Number of clients who discontinue NFP.
- Reasons for discontinuation.
- Characteristics of clients, e.g., age, parity, education, religion, urban/rural, ethnic group.
- Number of unplanned pregnancies.
- Information on cost effectiveness.
- Number of planned pregnancies that result when couples come to the service to learn how to achieve pregnancy.
- Time it takes to assist couples to reach a stage of autonomy in correctly using NFP.
- Number of information sessions given to related agencies or groups who may serve as a source for recruitment of NFP clients.
- Amount of time spent on preparation of news releases or radio and television scripts and the approximate numbers of persons reached through such media campaigns.
- Number of information sessions given to potential clients, and the actual number of new couples that enter the program.
- Amount of time and content for supervised instruction or for on-the-job training that a supervisor provides for the NFP teachers.
- Amount of time it takes to train NFP information specialist/promoters.

To evaluate national programs these data are necessary but may not be sufficient. National program evaluation implies the same kind of effort, but is more complex and usually also involves the following:

- A network of program directors using the same reporting forms and

monitoring processes for describing the information collected and used at the local program level at similar intervals.

- An external person who can assist in analyzing the overall information regarding the problem areas related to national NFP program expansion.
- Persons trained specifically in data recording systems, (including the use of computers) to analyze the data and prepare regular reports.

Analysis of national and individual programs should begin with formally stated and implemented NFP program standards. The evaluation should be able to measure the accomplishments attained by those programs. When the goals have been achieved, NFP program development then focuses on other areas that need to be addressed by both local and national programs.

Process and Outcome Evaluation should be conducted together for the process may have to be modified if the service output is deficient. Process evaluation is directed towards improvement of program operations. Outcome evaluation measures the effectiveness of the program among users of services. Each program should be conducting these kinds of evaluations on a continuing basis in order to serve their clients and their communities more efficiently.

Impact Evaluation refers to the long-term results of an NFP program. Some of the criteria used to determine the overall impact of an NFP program would include the following:

- An increase in the number of organizations showing interest and cooperation in the development or expansion of NFP efforts.
- Improved attitudes and knowledge of NFP methods both on the part of the clientele, health professionals, government, the press, and other community service groups.
- A levelling or a reduction in the number of unplanned pregnancies or in the birth rate, if this is the desire of the program and country providing

the service.

This type of impact evaluation is more difficult to obtain in an educational service. Many other kinds of impact can also be measured, for example, the number of mothers or satisfied users who later instruct their children or friends in NFP and fertility awareness. Some programs feel that although NFP does not have as high a use-effectiveness rate as some of the "artificial" methods, over time it may be a better method of family planning because it meets the cultural needs of the people served and thereby can have an effective long-term impact. More research is needed on this issue.

The strategies used to achieve a program's goals will also determine to some extent the nature of a program's impact. Periodic program evaluation should examine the impact of these strategies on the communities served and, if necessary, change the strategies for achieving program goals.

Cost-Effectiveness Evaluation refers to the ratio of the actual cost of providing a family planning service to the number of clients served or the number of continuing users. Most NFP programs have high start-up costs which often diminish as increasing numbers of clients are served over time. The longer a couple uses NFP successfully, the less the cost to both program and client.

In family planning cost-effectiveness studies, one approach is to relate program costs to the number of couple-years of protection (CYP). CYP is the number of years that a couple uses the method and does not have an unplanned pregnancy. These types of studies are just beginning to be undertaken in NFP programs and few results are available. A more cost-effective service

may be realized with groups of clients attending one instruction rather than individual instruction.

Program administrators should survey the autonomous clients periodically with a simple questionnaire or interview schedule to determine if they are still using the method. Once a couple becomes autonomous in the use of NFP, they may contribute many years of pregnancy-free experience to the life-table analysis.

Couples may decide to have another baby while using NFP methods. At this point they would not be using the method to avoid pregnancy. After the child is born and the couple returns to the use of NFP, they would again be entered into the long-term statistical analysis process and would again contribute to continuing use-effectiveness information.

### **Conclusion**

This monograph clearly demonstrates the progress in the NFP field in the last 20 years. In many countries, with the assistance of NFP consultants and special development projects, successful NFP programs have been developed. An increasing number of NFP teachers, generally operating in a volunteer capacity, have resulted in a national leadership in NFP. Governments, international funding agencies, and private organizations have shown greater interest in including natural family planning among the family planning choices offered. Both public and private organizations concerned with health care and family life have become involved in the serious delivery of NFP information and education services. We hope this book will be a catalyst in the process of expanding NFP services and integrating them into the larger network of services to couples and families.

# Appendix

# Appendix

In developing the list of NFP centers and resource materials for this Appendix, we were guided by the existing network of IFFLP members and their activities; therefore, we recognize that the lists presented are not comprehensive or complete.

## LIST OF NFP CENTERS

### AFRICA

Burundi Action Familiale du Burundi C.E.D.-Caritas. French-speaking and Kirundi. Founded 1979. Address: F.P. 2110 Bujumbura, Burundi. Tel. 4055.

Central African Republic Service d'Education à la Maîtrise de la Fécondité. French speaking. Founded 1982. Address: Dispensaire du Foyer de Charité, B.P. 335, BANQUI, RCA. Tel. 61-11-05.

Congo Foyers Chrétiens. French speaking. Founded 1966 (First General Assembly, 1970). Address: P.O. Box 200, Brazzaville, Republic of Congo. Tel. 81-2285.

Kenya Family Life Counseling Association. English speaking and tribal languages. Founded 1977. Address: Mater Misericordiae Hospital, P.O. Box 30325, Nairobi, Kenya. Tel. 5566.

Madagascar Fivondrovan'ny Tokantrano Kristiania (FTK) Family Life Promotion Movement. French speaking and Malagasy. Founded 1974. Address: Immeuble Falda, Antanimena, B.P. 1382, 101-Antanarivo, Madagascar. Tel. 26084.

Mauritius L'Action Familiale. French and English ★† speaking. Founded 1963. Address: Route Royale, Rose Hill, Mauritius. Tel. 43512.

Morocco L'Heure Joyeuse. French speaking (Arabic). Founded 1955. Address: 5 Rue El Jiraoui, Casablanca, Morocco. Tel. 24-40-37.

Nigeria Catholic Secretariat of Nigeria. English speaking. Address: Force Road, P.O. Box 951, Lagos, Nigeria. Tel. 25339.

Rwanda Action Familiale du Rwanda (Centro Medico-Social Gikondo). French speaking (local language). Founded 1978. Address: Boite Postale 442, Kigali, Rwanda. Tel. 4535.

Seychelles Action Familiale Seychelles. French and English speaking. Founded 1970. Address: P.O. Box 289, Mont Fleuri, Seychelles. Tel. 227819.

Sierra Leone Family Life Education Programme. English speaking. Founded 1979. Address: 29 Howe Street, P.O. Box 129, Freetown, Sierra Leone. Tel. 22371.

South Africa (Republic of) National Natural Family Planning Association. English speaking. Founded 1979. Address: Khanya House, P.O. Box 941, Pretoria 0001, South Africa. Tel. 3-6-458/9.

Tanzania Family Life Education and NFP. Service of the Tanzanian Episcopal Conference. English speaking (and Swahili). Founded 1976. Address: P.O. Box 2133, Dar-es-Salaam, Tanzania. Tel. 30071/2.

Tunisia Action Familiale. French and Arabic speaking. Founded 1981. Address: 27 Rue des Mimosas, 2070 La Marsa, Tunis, Tunisia.

Upper Volta Entr'Aide Familiale. French speaking. Founded 1977. Address: B.P. 481, Bobo Doulasso, Upper Volta.

Zambia Family Life Movement. English speaking. Founded 1977. Address: P.O. Box 31965, Lusaka, Zambia. Tel. 212070.

### THE AMERICAS

Argentina Secretariado para la Familia. Spanish ★† speaking. Founded 1981. Address: Paseo Colón 221 (PB), 1399 Capital Federal Buenos Aires, Argentina. Tel. (01)-33-3701.

Bolivia Centro de Vida Familiar Arquidiocesano. Spanish speaking. Founded 1978. Address: Avenida Armentia 512, Casilla 8596, La Paz, Bolivia. Tel. 36-40-57.

Brazil Centro de Pastoral Familiar (CENPAFAM). ★ Portuguese and Spanish speaking. Founded 1974. Address: Alameda Franca 889, 01422, Sao Paulo, S.P., Brazil. Tel. 28-28-015.

Canada Serena. English and French speaking. ★† Founded 1955. Address: 55 Parkdale, Ottawa, Ontario K1Y1E5, Canada. Tel. (603) 728-6536.

Chile Comisión Nacional de Pastoral Familiar. ★ Spanish speaking. Founded 1981. Address: Ch. Hamilton 11051, Santiago, Chile. Tel. 80280. Universidad Católica (Medical School). Spanish speaking. Founded 1979. Address: Casilla 144-D, Santiago (Attn: Alfredo Pérez), Chile. Tel. 99-58-71/48-76-42.

Colombia Carvajal Foundation. Spanish speaking. † Founded 1962. Address: Apartado Aereo 46, Cali, Colombia. Tel. 52-11-29.

★ Centro de Pastoral Familiar para America Latina. Spanish speaking. Founded 1974. Address: Calle 65 No. 13-50, Mezzanine, Bogota, Colombia. Tel. 211-3217.

Dominican Republic Comisión Episcopal de Pastoral Familiar. Spanish speaking. Founded (no date available). Address: Apartado Postal 186,

Santo Domingo, Dominican Republic. Tel. 685-9741.

Ecuador Instituto Ecuatoriano de Accion Familiar  
★ (IEDAF). Spanish speaking. Founded 1976.  
Address: Esmeraldas 2811 y Calicuchima,  
Guayaquil, Ecuador.

Haiti Action Familiale d'Haiti. French speaking (and  
★ Creole). Founded 1971. Address: Rue des  
Casernes No. 65, B.P. 528 (Archevêché), Port-  
au-Prince, Haiti. Tel. 2-3459/2-5181.

Mexico Centro Nacional Billings de Planificación  
★† Natural de la Familia (WOOMB/Mexico).  
Spanish speaking. Founded 1979. Address:  
Ave. Paseo Palmas 745-12, Col. Lomas de  
Chapultepec, 11000 Mexico City DF, Mexico.  
Tel. (5) 540-2470.

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† Founded 1973. Address: Saint John's Univer-  
sity, Collegeville, Minn. 56321 U.S.A. Tel.  
(612) 363-3313.

★† The Couple to Couple League International,  
Inc. English speaking. Founded 1971.  
Address: 3614 Glenmore Avenue, Cincinnati,  
Ohio 45211 U.S.A. Tel. (513) 661-7612.

New England Natural Family Planning Inc.  
English speaking. Founded 1981. Address: 90  
Cushing Ave., Boston, MA 02125 U.S.A. Tel.  
(617) 436-8600 (ext. 311).

Natural Family Planning of Rhode Island,  
Catholic Social Services. English speaking.  
Founded (no date available). Address: 433  
Elmwood Ave., Providence, RI 02907 U.S.A.  
Tel. (401) 467-7200.

★ Diocesan Development Program for NFP.  
English speaking. Founded 1980. Address:  
Suite 334, 1511 K St. N.W., Washington, D.C.  
20005 U.S.A. Tel. (202) 737-1339.

★ Los Angeles Regional Family Planning Coun-  
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able). Address: 3250 Wilshire Blvd., Suite  
320, Los Angeles, CA 90010 U.S.A. Tel.  
(213) 386-5614.

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English speaking. Founded 1977 (formerly  
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308 South Tyler Street, Covington, LA 70433  
U.S.A. Tel. (504) 892-4046.

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11th Ave. South, Minneapolis, MN 55415  
U.S.A.

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speaking. Founded 1978. Address: 601 North  
30th Street, Omaha, Nebraska 68131 U.S.A.  
Tel. (402) 449-4715.

Venezuela Avemo Billings. Spanish speaking.  
Founded 1980. Address: Apartado 70505,  
Prados del Este, Caracas, Venezuela. Tel.  
34-73-76.

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Australia Australian Council of NFP, Inc. Founded  
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Address: 1 Robert Street, Willoughby NSW  
2068, Australia. Tel. 028-417-55.

★ Ovulation Method Research and Reference  
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Founded 1976. Address: 27 Alexandra Parade,  
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Tel. 03-481-1722.

Hong Kong Catholic Marriage Advisory Council.  
★† English speaking (and Chinese). Founded  
1965. Address: 502 Caritas House, 2-8, Caine  
Road, Hong Kong. Tel. 5-242-071  
(ext. 259-260).

India Center for Research, Education, Service and  
★ Training for Family Life Promotion (CREST).  
English speaking. Founded 1975. Address: 24  
High Street, Bangalore, 560005, India.

Natural Family Planning Association of India.  
English speaking. Founded 1974. Address: 43  
Lodi Estate, New Delhi, 110003, India.  
Tel. 622-379.

★ Tamil Nadu Family Development Centre.  
English speaking (and Hindi). Founded 1976.  
Address: 37 Allithusai Road, Aruna Nagar,  
Post Box 702, Puthur, Tutuchirapalli, India.  
Tel. 25635.

Indonesia National Bureau of NFP Services. English  
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Ciding Timur 71, Jakarta Pusat, Indonesia.  
Tel. (021) 46710.

Japan The Family Life Association. English speaking  
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Building, Shiba 3-4-16 Minato-ku, Tokyo 105,  
Japan. Tel. (03) 454-7040/452-5734.

Korea (South) Korea Happy Family Movement. Eng-  
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Tel. 593-5141-9.

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Malay). Founded 1983 (previous activities  
from 1973). Address: 23-F, Mk. 13, Ayen Itam,  
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New Zealand. Tel. 689-919.

Pakistan Natural Family Life Office. English speak-  
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dress: P.O. Box 592, Goroka, E.H.P., Papua  
New Guinea.

Taiwan Catholic Happy Family Service Association.  
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Thailand National Commission for Family Life Promotion. English speaking. Founded 1977. Address: 2 Soi Soensuk, Prachasongkroh Rd., Bangkok 10310 Thailand. Tel. 277-3354.

## EUROPE

Austria Marriage Advisory Service. English speaking.  
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England Catholic Marriage Advisory Council. English speaking. Founded 1946. Address: 15 Lansdowne Rd., London W113AJ, U.K. Tel. 01-727-0141.

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★ Institute Recherche sur l'Enfant et la Couple (IREC). French speaking. Founded 1973. Address: 16 Place Notre Dame, 38000 Grenoble, France. Tel. (76) 44-04-14.

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Ireland Catholic Marriage Advisory Council of Ireland. English speaking. Founded 1946 (1975 Ireland). Address: All Hallows College, Dublin 9, Ireland. Tel. 575649/371151.

Italy Centro Internazionale Studi Famiglia (CISF). Italian speaking (and English). Founded 1973. Address: Via Monte Rosa 21, 20149 Milano, Italy. Tel. 49.82.941.

Centro Ambrosiano Metodi Naturali. Italian speaking. Founded 1982. Address: Via Bice Cremagnani 15, Vimercate, Milano, Italy. Tel. 02/8599556.

★ Center of Study and Research on NFP, Università Cattolica del 5, Cuore, Facoltà de Medicina Chirurgia. English speaking. Address: Roma Policlinico "A. Gemelli," Largo Agostino Gemelli 8, 00168, Rome, Italy. Tel. (06) 33051.

Poland Klub Inteligencji Katolickiej. English and Polish speaking. Founded 1956. Address: ul Kopernika 34, 00-336 Warszaws, Poland. Tel. 27-39-29.

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Scotland Scottish Association for Natural Family Planning. English speaking. Founded 1979. Address: Cnester House, Beardsden, Glasgow, Scotland.

Spain Delegación Espanola de la FIDAD. Spanish speaking. Founded 1978. Address: Apartado de Correo 24, 071 Barcelona, Spain.

Sweden Familjeframjandet. English and Swedish speaking. Founded 1976. Address: Post Office Box 3076 S-161 03 Bromma, Sweden. Tel. 08-373395.

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† Denotes centers which may provide lists of materials and price lists upon request.

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For additional publication titles, contact those NFP organizations starred (★) on the NFP center list above.

## NEWSLETTERS AND PERIODICALS

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*CMAAC-Bulletin*, Catholic Marriage Advisory Council, 15 Lansdowne Road, London W113AJ, England. (quarterly)

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## AUDIOVISUAL MATERIALS

Lists of audiovisual materials used by national NFP programs may be obtained by writing to the NFP organizations that are starred (★) in the list of NFP centers in the Appendix.