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International Perspective on NFP

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In January of 1983 when I joined USAID there was considerable political pressure from Congress (at the request of NFP advocates) to increase funding for NFP; the pressure was coming mostly from Congressmen Henry Hyde and Bob Livingston.

USAID responded by:

1. Supporting the IFFP (1983 - 1985) under a cooperative agreement
2. Supporting the Family of the Americas Foundation (FAF) for Ovulation Method teaching and training materials, including a video on the Billings Method, and for US-based training of 250 NFP teachers/trainers from developing countries.
3. In 1985, in order to consolidate this work, I prepared a new program description and USAID issued a Request for Applications to select an organization to implement and manage all centrally-funded NFP related activities. Georgetown University's Department of Obstetrics and Gynecology won the competition and the Institute for

International Studies in Natural Family Planning was established and from that time onwards almost all NFP-related proposals had to be funded through GU. The cooperative agreement was renewed several times and the IISNFP changed its name to IRH. Most recently, in 2008, the IRH won another competitive procurement to implement USAID FAM Project.

A major influence on what USAID could and still can fund (including under sub-grants through GU) was governed by a set of policy and legislative requirements, including:

1. 1986 - USAID/USG Policy Determination 3 (what is called PD3) Informed Consent legislation is reauthorized to safeguard against potential abuse of sterilization and ensure that there are no incentive payments made to accept, provide or refer clients for voluntary sterilization, AND to ensure informed consent in the selection of a contraceptive method.

2. 1985, 1987, 1989 - DeConcini legislative amendment under Title II of the Foreign Operations, Export Financing, and Related Appropriations Act, 1989 (becomes Public Law 100-461) which states, in part, under the heading of Population, Development Assistance:

"Provided further, that none of the funds made available under this heading may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions; and that in order to reduce reliance on abortion in developing nations, funds shall be available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods. Further, that in awarding

grants for natural family planning under section 104 of the Foreign Assistance Act no applicant shall be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning; **and, additionally, all such applicants shall comply with the requirements of the previous proviso...**" meaning, at least, to provide information about where a client could get information about other methods of family planning.

Because of the unwillingness of some NFP providers to comply minimally with this legislation, USAID had to defund some organizations and developing country programs.

Related to international NFP, I would first begin with on key event. 1976, the WHO Task Force that I managed initiated a prospective multicentre clinical trial of the Ovulation Method in Auckland New Zealand, Bangalore, India, Dublin, Republic of Ireland, Manila, Philippines and San Miguel, El Salvador. Task Force also initiated the comparative evaluation of the Billings and STM in Colombia. The Billings trial resulted in a set of landmark publications in the journal Fertility and Sterility in 1981, 1983, 1984, 1987: 1. The Teaching Phase, 2. The Effectiveness Phase, 3. The Characteristics of the menstrual cycle and of the fertile phase, 4. The outcome of pregnancy and 5. The Psychosexual Aspects of Billing Method use. **This research provided the independent evidence that the Billings Method was highly effective when used correctly to prevent unplanned pregnancy.**

Next I want to share with you some Demographic Trends related to the use of modern and traditional methods of family planning:

SHOW SLIDES BEGINNING WITH DEFINITIONS

Current use of, and other data on, contraceptive methods from the Demographic and Health Surveys (DHS) by country tabulated by CPR for all methods, can be obtained from the website for Measure DHS (www.measuredhs.com) and you too can use the Stat Compiler function to do your own tabulations.

Finally, I will close with some Reflections:

It is often said that history is prologue. 22 years ago I presented the Keynote address on "NFP: Recent Developments, Future Prospects and Challenges" at the IVth International IFFLP Congress in Ottawa. Some of my remarks then are still valid today:

1. We are still obsessed with "failure" rates or "effectiveness" rates and there is dispute about the relative importance of perfect use rates versus typical use rates. Methodological issues and absence of high quality RCTs limit the reliable evidence on the effectiveness of NFP methods.

[In this regard, who among us would have any faith in the data from a clinical trial of the Ovulation Method in Shanghai in which 688 MWRA accrued 11,075 months of use with a method effectiveness rate of 98.12%, a use-effectiveness rate of 95.64% and a continuation rate of 93.04%?]

2. Some continue to dispute the role of breastfeeding as defined by the Lactational Amenorrhea Method (LAM) as a natural method of family planning.

3. Questions still abound about NFP such as

- How acceptable are the methods?
- Who can use the methods?
- How long is the required period of abstinence?
[Incredulously, on July 19, 2006 a leader in the Billings Method stated the "NFP allows a woman to identify the approximate 100 hours [4days!] . . ."]
- How well can couples comply with the periodic abstinence requirements? For whom are there such requirements? Most clients do not report religious reasons as the primary reason for choosing NFP.

[In Ottawa, I showed data from 130 couples interviewed randomly who were taught the STM at a Catholic Hospital in Ontario between '78-'81 and the definition of "abstinence" was "avoiding all physical contact," 2.3%; "physical touching except the genitals," 20%; "touch genitals but no orgasm," 16.9%; and "may involve orgasm," 60.8%. Since I believe in full disclosure, during the discussion of my presentation, I was informed that the NFP program at that Catholic Hospital did not promote abstinence only during the fertile period.]

- What effect does the practice of NFP have on the marriage relationship? There is an absence of data to support the view that the practice of NFP improves the marriage relationship.
- What is the cost-effectiveness of NFP?

[Can we do any better than cost per woman taught or cost per autonomous user and a CYP of 2 CYPs per trained, confirmed adopter?]

- Need to escape from the destructive polarization of attitudes between NFP and other methods [**and** between the different NFP methods]
- Unless NFP is mainstreamed within public and NGO sector FP/RH programs, it will remain a boutique method for the very few
- Generally speaking, there is a negative bias about NFP, perhaps because there is controversy about the demand, use, use-effectiveness and cost-effectiveness of NFP. Hence, family planning professionals, family planning program managers and policymakers have been hesitant to include NFP in national programs despite their main advantages on terms of:
 - lack of side-effects,
 - highly effective if used correctly - just like all other user-controlled methods! -,
 - non-medical delivery and educational value. "It is up to the NFP community to provide data from their programs demonstrating that these are myths."

Objectively speaking, the IRH with their research and program work on the SDM have demonstrated that the method can be mainstreamed and the demand and number countries requesting technical assistance to introduce the method is impressive, as I showed you earlier

The relatively new issue for all FP methods, including NFP, is the imperative to reduce risk of the acquisition of HIV/AIDS and other STIs. No currently available methods other than male and female condoms, and mutually monogamy among uninfected partners practicing an effective method of contraception, can prevent unplanned pregnancy and the

acquisition of HIV and other STIs. Offering NFP to some couples who will practice unprotected sex outside the fertile period may be a dis-service since if there is a risk of HIV acquisition there will be no protection afforded, which is critical to women who cannot trust their partners about being faithful. NFP providers need to be counseling about HIV risk reduction, including the ABC approach. For the most part, I think the A and B messages will appeal to couples who chose NFP, but this may not be the case when NFP is mainstreamed.