Natural Family Planning

Diocesan Activity Report

Vol. 3, No. 4, Fall 1992

"Back to School"

Pencils, paper, condoms, book bags, and shiny new crayons are part of the supplies we equip our students with at the start of a new school year.

What was that? Are you perhaps thinking that there's a typo in my last sentence? No, you have read it correctly, "condoms" for some Americans, are part of that back to school list.

Many public health officials today assume that condoms should be among the standard supplies available to our children in our schools— elementary as well as secondary. Consider, for example, the public school system in the District of Columbia. Condom distribution is now a mandatory part of the District's three-part AIDS education program. Parents have no rights to object to their children's participation in it. The first two levels of the program seem to be innocent enough as they mandate teaching basic information on HIV and STDs (sexually transmitted diseases). It is in the third level that specifics regarding condom types and their proper usage are discussed. It is also at this stage that students who are sexually active (or considering initiation of sexual activity) are encouraged to visit the school nurse to receive counseling and condoms.

Supporters of this program are currently engaged in a battle over what they refer to as the "opt out" provision. Some parents wish to have their parental rights and responsibilities honored and want to be able to decide if their children should "opt out" of the mandatory program. The supporters of the program insist that the Commissioner of Public Health made a "wise and sound" decision when he sought to prohibit parents from exercising this right. They insist that there is no proof that such educational programs encourage sexual activity among our youth. They believe they will reduce teen risk behavior. In a September bulletin of the **TeenAIDS Information Network** of D.C., supporters of the program say that an "opt out" provision will only add an "unnecessary administrative burden for the nurses and lead to a less efficient program with students it is designed to reach becoming frustrated due to delays in obtaining condoms." Concerns about the role of parents aside, there are several dire consequences for our children from this type of thinking.

Fact #1: Condoms offer only the *smallest protection* from the deadly HIV virus. To teach our children that a condom will provide them with protection from HIV is akin to feeding them partially poisoned food. Many variables affect the condom's ability to stop HIV. For example, the latex itself will deteriorate if exposed to heat or light, or even after an extended length of time in a package. Prior to the AIDS epidemic, family planning groups considered the condom to be highly ineffective in preventing pregnancy. The scientific literature speaks of effectiveness rates of anywhere from 80% to 85% among heterosexuals. These rates applied to something like flying in an airplane, translate into 15 to 20 crashes every 100 trips. How many of us would step into a plane with that record?

The estimated 80% - 85% effectiveness rate of the condom for heterosexuals changes dramatically for homosexuals. One study of homosexual men reported an effectiveness rate as low as 74%.[1] In a letter to the editor, two doctors commented that "condom failure is "sufficiently high that condom use by risk groups should not be described as 'safe sex'." They urged that high risk

In This Issue . . .

"Back to School" 1

Friendly Collaboration and Fruitful Achievement
Some Experiences and Understanding of the Research Work on the Billings Ovulation Method used in Shanghai, China
Dr. Zhang De-wei 3

Faith, Hope, Goals and Objectives 5

COORDINATORS' CORNER
"The Fish on My Computer,"
Donna Dausman, Diocese of Springfield, IL 6

SCIENCE NOTES
Hanna Klaus, M.D. 8

NEWS BRIEFS 11

groups (i.e., homosexuals and IV drug users) "refrain from penetrative sexual activities" rather than simply use a condom.[2]

Research on heterosexual use of a condom when a partner is infected with HIV is equally frightening. For example, a report presented in 1987 at the Third International Conference on AIDS, revealed that in a three-year study of married couples in which one spouse had HIV, 17% of the partners (or 1 in 6) still caught the virus within a year and a half despite the fact that they had used a condom for every act of intercourse.[3]

In 1987 Dr. C. Everett Koop noted that he regretted his role in creating "condom mania." Speaking in an interview in *USA Today*, he said that condoms should be used only as a "last resort". In fact, when he was the Surgeon General many researchers advised Dr. Koop to promote abstinence and monogamy as the primary instrument to combat the disease, not condoms. As Dr. Theresa Crenshaw, a public health official commented in her address to the National Conference on HIV in 1987, "When a condom fails for pregnancy you gain a life. When it fails for AIDS prevention, you lose a life, usually your own."

Fact #2: Studies of sex education programs which include distribution of contraceptives reveal that they do not lead to effective use of contraceptives. Douglas Kirby (an aggressive proponent of School Based Clinics) in a 1984 report to the Centers for Disease Control, demonstrated the limitations of such programs. He found that an increase in knowledge about human sexuality did not lead students to postpone sexual involvement or to increase use of contraceptives when they become sexually active. In a 1989 report for the Center for Population Options, he again found no impact on effective contraceptive use even when contraceptives were made available. And as recently as 1991, he confirmed his earlier findings that such programs "did not impact on the sexually active teens."[4]

Kirby's findings are confirmed by others. Dr. James Stout, M.D. found that such programs have little or no effect in changing behavior of teens.[5] And in a paper presented before the American Alliance for Health, Physical Education, Recreation and Dance in April 1988, a Dr. Young demonstrated that neither sex education nor knowledge are related to postponement of sexual intercourse or use of contraceptives among teens younger than 17. In other words, there is no difference between the 13-year old who has knowledge of condoms and the one who doesn't.[6]

In light of these facts, the people who support condom distribution within AIDS education programs in our schools are doing a great disservice to our young people. They are asking our children to trust their lives to weak devices rather than strengthening healthy values and behavior. Parents, teachers, and staff in local churches must come together to help young people understand the deeper values of sexual expression. God's gift of human sexuality, fertility, and offering of self to one's spouse must be communicated to our children. Without a commitment to teach these truths, to help our youth develop basic moral values, we have not truly equipped our children with what they need for the current school year, nor for a healthy and holy future.

Resource:

The National Catholic Education Association's AIDS Education Task Force has completed an AIDS curriculum. Entitled, **AIDS: A Catholic Educational Approach to HIV** (W.D.C., 1992.) this curriculum is age appropriate, scientifically accurate, promotes chastity, and clearly upholds Catholic belief with regard to human sexuality. It is designed to be used within Catholic schools or religious education programs. Lessons can be taught as a special unit or integrated within a year's program. As the curriculum notes for use within Catholic schools, "one lesson may be taught in religion class, another in science, and a third in health or physical education."

Periodic updates are sent to those who implement the program. Consultation and specialized orientation programs for faculty are available upon request. Information with regard to the Church's teachings is clearly stated, however, the curriculum assumes the teacher's competency in this area. For this reason we recommend that the curriculum is best used by the teacher who has a complete knowledge and acceptance of the Church's teachings on human sexuality. *Further information, contact: NCEA, 1077 30th St., N.W., W.D.C. 20007-3852; 202-337-6232.* ■

---

[1] L. Wigersma & R. Oud, "Safety and Acceptability of Condoms for Use by Homosexual Men as a Prophylactic Against Transmission of HIV During Anogenital Sexual Intercourse." *British Medical Journal* (July 11, 1987), p. 94.

[2] J. Kelly & J. St.Lawrence, *The Lancet* (February 7, 1987), p. 323.

[3] Margaret A. Fischl, et. al., "Heterosexual Transmission of HIV: Relationship of Sexual Practices to Seroconversion." Third International Conference on AIDS (June 1-5, 1987), *Abstracts Volume*, p. 178.

[4] *Family Planning Perspectives* (1991 December).

[5] James Stout, M.D. "Schools and Sex Ed.—Does it Work?" *Pediatrics* (1989 March).

[6] Young. "The Planned Parenthood Poll: A Secondary Analysis of National Data." A paper presented before the American Alliance for Health, Physical Education, Recreation and Dance, Kansas City, MO, (April 1988).

FRIENDLY COLLABORATION AND FRUITFUL ACHIEVEMENT

Some Experiences and Understanding of the Research Work on the Billings Ovulation Method used in Shanghai, China

***Dr. Zhang De-wei**, Advisor-State Family Planning Commission; Vice President-National Advisory Committee of MCH Ministry of Public Health; President-Shanghai Society of Family Planning Science*

China is no stranger to NFP. As early as 1982 Dr. Maria De La Luz Perales made efforts to introduce the Ovulation Method to public health officials. In 1983 staff from the Family Planning Commission attended the International Federation for the Family Life Promotion (IFFLP) Conference on NFP in Hong Kong and established contact with Billings. In 1983 and 1984 Dr. Pat Harrison visited several Chinese cities and left teaching materials. It wasn't however, until 1986 that the Drs. Billings were formally invited to give a teacher training to the State Family Planning Commission in Shanghai and Quangzhou. Later, in 1989 the Billings were also invited to participate in a conference on advances in fertility, sponsored by the Chinese Ministry of Health and the World Health Organization.

*The following article by Dr. Zhang De-wei represents excerpts of a study sponsored, in part by the Family of the Americas Foundation. Dr. Zhang De-wei, an Ob./Gyn. heads the science and technology division of the Shanghai Municipal Family Planning Commission. She presented her study in full, at the Department of Health and Human Services, Washington, D.C. on September 15, 1992. In her study, conducted from June 1988 to May 1990, Dr. Zhang De-wei found that total unplanned pregnancies within OM were 4.3% Pearl rate. A full analysis of this study will appear in a later edition of **Science Notes**. If you would like a complete copy of the study, contact: Family of the Americas, P.O. Box 1170, Dunkirk, MD 20754; 301-627-3346.*

Background

In October 1986, a faculty of experts visited Shanghai China to give lectures on the Ovulation Method (OM) in the city as well as in the county of the Shanghai municipality. Since that time four teacher training courses in the OM were organized in Shanghai (June 1987), Shenghen (June 1988), and Xian (April 1990). Fifty trainees from Shanghai attended the teacher training course and have been retrained in the advanced teacher training course. Another teacher training course held in Shenghen was attended by fifty trainees who came from more than 10 provinces and municipalities. Also, the teacher training course held in Xian, Shaanxi Province, was attended by 200 local students. Most of the trainees were medical doctors (gynecologists), nurses, midwives, and family planning workers. These attendees were recruited from the teaching hospitals of the medical universities, MCH Hospitals and Stations, and different levels of the Family Planning Commission.

Under the support of the Shanghai Science and Technology Committee of the local government we carried out a clinical pilot study. Subsequently, we began to carry out a formal clinical and laboratory study, from June 1988 to May 1990. 688 reproductive aged couples were recruited to use the OM as their only contraceptive method. Most of them used the method for more than 12 months with a total of 10,175 woman months. The effectiveness rate was 93.04% woman year at the end of the 12 months. These clinical results were very satisfactory and encouraging.

There were two laboratory studies of the OM. The topics studied were:

1. A study of the relationship among the cyclic changes of cervical mucus, vaginal smear, and the estrogen and progesterone levels of the women who had used OM. (35 women were involved.)

2. A study of the relationship between the cyclic changes of cervical mucus, the vaginal cytograms and the LH levels. (67 women were involved, 476,100 vaginal epithelian cells were counted.)

In Shanghai, our research project was appraised by the Experts Review Group, in January 1991 and we were awarded in June 1992 the "Prize of Scientific and Technological Progress" of the Shanghai Municipality.

The Study: Long-Term Application of the Ovulation Method

To find out the general situation of the long-term application of OM after the training courses, we made some on-the-spot investigations at several units and held several meetings. The following are our investigation results and conclusions:

1. The Ovulation Method has a wide adaptability and is accepted by reproductive age couples. Once using the method, the majority of couples are unwilling to stop using it and continue using the method for a long time obtaining desired results.

When used to avoid pregnancy, we have found OM to be safe and reliable. It does not affect the normal menstrual cycle, or human health, and the sexual life. As it is not limited to cultural levels and/or different occupations, it is easy to learn, convenient to manage, and can be adapted widely. Because it has no contraindications, side-effects, and requires no government investment for manufacturing contraceptives and devices, etc., it is a very good method which benefits the nation and the people. It is especially beneficial to those who:

are unsuited for IUDs (or have experienced IUD failure); have had side-effects from oral contraceptives; are allergic to external contraceptives. Such women worry about having several induced abortions simply because they cannot use contraceptives. On their own initiative, they generally decide to use OM. We have found that they attend the training courses earnestly and follow the OM rules conscientiously. Free from their previous worries, they introduce OM to other women enthusiastically.

2. Clinical doctors of many large factories make full use of video tapes, slide shows, wall instruction charts, booklets, and private records, etc. They have developed many good training methods, such as: concentrated training; individual instruction; and a combination of the two. In addition to the regular follow-up visits, the clinical doctors review menstrual cycle records and exchange experiences. In this way, the information is consolidated, deepened, and improved gradually.

Initially, many doctors and family planning workers had misgivings about OM. They first followed the method themselves and soon their misgivings were dispelled because they received good results. Then using their own experience as an example, they advised other women with confidence. Now they tell me happily:

After the training courses and several years' practice, we are no longer students but we are now teachers. We are making a sustained effort to improve such a task. We have advised many women to avoid or achieve pregnancy according to the OM and achieved the expected results completely. OM is well accepted by reproductive aged women.

3. Recalling the history of carrying out the Ovulation Method, Mrs. Zhou, Director of the Public Health Bureau of Chuansha County, told me conclusively:

At the beginning, we had three problems in carrying out this research item: "Can it be carried out among people of low cultural level?"; "Since rural regions are widespread, is it possible to do training and instruction?"; and "Is it possible to persist in long-term application?"

Our clinic inspections of 242 women in the last four years, enabled us to answer Mrs. Zhou's questions. We found:

a) Among the 242 women, 66.12% were workers and peasants, and 58.68% had an educational level of just junior middle school or lower. This showed that if handled correctly, the workers and peasants, who form the majority of the nation's population, can use OM and use it well.

b) We can carry it out in rural areas by strengthening the managements, which can be done by: training for different levels with specially assigned people; forming networks; and making continuous efforts.

c) Being well accepted by the reproductive aged women, the OM can be used persistently over a long period of time.

In addition, many investigations of those who had already used OM were made. These investigations examined acceptability by the users, reasons and results of discontinuing use, failure when not due to the method itself and evaluations by the users. The result of these investigations showed that most women insisted on continuing use of the method, including those who had failed and had to have an induced abortion. In some units, they tried to persuade their members to accept other contraceptive options other than OM, but they refused. They insisted on using OM, even though for using the IUD they would receive an official vacation day every month.

A leader of Chuansha county considered that family planning also needs to depend on scientific and technological progress. First, they trained and directed women in the county who were not able to have an IUD inserted or to take contraceptives or injectables. These women were, however, able to use OM. **Among these women, the rate of induced abortion has been decreasing every year.** In addition, it surprised me that a woman manager not only used OM herself to get experience but also advised other women to use OM. Through her study of the subject, she has mastered the method.

4. Through learning, practicing, training and instructing, we have summarized several experiences:

a) the 'early day rules' of OM application must be applied in the early part

POPE PAUL VI INSTITUTE FOR THE STUDY OF HUMAN REPRODUCTION

annouunces a national conference celebrating

THE 25th ANNIVERSARY OF *HUMANAE VITAE*

July 25-30, 1993
Omaha, NE

This special celebration will bring together internationally known experts in NFP. Conference topics will emphasize scientific contributions to NFP. In addition, many theological as well as inspirational presentations will be offered.

One of the major goals of the conference is to bring together people who share the same vision and spirit. For this reason we hope all of our readers will plan to support this conference.

Brochures of conference agenda will be forthcoming. *Contact: Pope Paul VI Institute for the Study of Reproduction, 6901 Mercy Road, Omaha, NE 68106-2604; 402-390-6600.*

the dry period a few days before the fertile phase begins;

b) regarding 'peak day rules', abstinence must continue until the morning of the fourth day, not earlier; and

c) the principles of the scientific basis of OM and its 'rules' must be emphasized and trusting to chance must be avoided.

5. Most of the women who joined the clinical research insisted on using OM for the past 4-5 years although the research study had ended. They not only used it themselves, but also taught their colleagues, relatives, and neighbors.

In China, we found that couples with a high education level have greater misgivings about using artificial methods (IUD, OC, etc.). They are eager to understand human reproductive physiology in order to use a natural method. The faculty of Beijing University recently requested that a training course on the Ovulation Method be organized for them.

Expansion of the Ovulation Method in China

In order to accelerate the popular use of OM in China to reach the goal of fertility regulation and to protect the reproductive health of women, the next step of our plan is to:

1. Establish a NFP training Center in An-Hui Province. The trainees will be from each province and municipality in China.

2. Continue to strengthen the existing NFP teaching and training program in Shanghai.

Our preliminary plan for Shanghai is:

1. Visit those who use OM in order to solidify achievements and discover remaining problems.

2. By means of the Society of Family Planning Science, hold OM academic activities for reviewing experiences and extending influences to take further steps to spread OM. At the same time, to plan to set up an OM subdivision under the Society and through activating at regular intervals, strengthening mutual connections and interchanges, consulting, inquiring and discussing will raise the standard of OM to a new level.

3. Attempt to find out the situation of teachers already trained, to gather information, to summarize experiences so as to reach the aim of solidifying, developing, and spreading OM.

4. Gain the support of State Family Planning Commission and Public Health Ministry to form a lecture group and send them to their provinces and municipalities to hold OM training courses. (This will be one of the comprehensive measures for speeding up the nationwide spread.)

5. To conduct, at the request of faculties of Beijing and Shanghai universities and Middle School, extensive courses that will enable the influential teachers to learn for themselves this valuable knowledge and to teach it to their students. ■

Faith, Hope, Goals, and Objectives

Diocesan NFP coordinators represent many areas of education and expertise. Some come from the medical or health care professions, while others come from the field of education. One may have training in theology, while another has none. One may keep organized files, while another works best with paper arranged around them. Someone may prefer sole leadership, and another prefer a team approach to administration. Regardless of one's education or expertise, all diocesan NFP coordinators would insist that deep faith, boundless hope, along with solidly trained teachers, and support from the diocese comprise the essential elements which form the life of their programs. Despite these good elements, there is a missing link. Often, many diocesan NFP coordinators are not clear as to how to identify goals and strategize objectives as they direct their programs.

Coordinators should know that there are program management skills which are essential to the growth of diocesan NFP services. Learning how to write better goals and objectives is not all that difficult. Two simple definitions should be kept in mind when attempting to articulate one's program goals and objectives:

Goals are the points of destination to which you want your program, teachers, and clients to reach.

Objectives are the means by which you will get there.

The diocesan NFP coordinator must keep in mind that the program's philosophy permeates all services of the program. The program's philosophy is the reason why the services exist. But it is the articulation of clear goals and objectives which will enable the program to live that philosophy, to grow and prosper. For example, if an NFP coordinator wishes to work toward progress in attracting more clients, then a plan of action is needed. Likewise, if an NFP coordinator wishes to know if the clients moving through his/her program have reached autonomy and are attaining their family planning intention, then a way to evaluate client follow-up is needed. In other words, **the desired outcome must be articulated, and the steps to take to get there must likewise be spelled out.**

Coordinators should know that there are different types of goals. Some goals are easily attained and measured. Other goals fall into the realm of "the Kingdom of God." Both types of goals must be attended to because NFP services as offered under the auspices of the Church address two levels of life; i.e., family planning education and marriage enrichment through spiritual growth. Coordinators must be able to distinguish which goals can be achieved in this life time and which goals can only be achieved in the distant future.

Let's take a look at some of the goals

which fall under family planning education. There are goals which seek to:

- **impart information;** *e.g., "The client will know the physiology of human reproduction.";*
- **achieve a skill;** *e.g., "The client will chart according to the NFP method's rules.";*
- **change a person's behavior;** *e.g., "The client will practice periodic abstinence when trying to postpone a pregnancy.";*
- **achieve a level of quality;** *e.g., "The NFP program will have a user effectiveness rate of 90%.";*
- **add on different responsibilities;** *e.g., "The NFP program will offer adolescent fertility appreciation and chastity education.";*
- **change attitudes;** *e.g., "Medical professionals will accept NFP as a viable method of family planning."*

It should be clear as to which of the above goals are easily achieved and those which are not. When writing goals, remember that the goal should state simply the desired outcome. Goals should be written as positive statements, usually in one sentence. In order to arrive at your statement, ask yourself questions such as, "What do I want for the program?"; "Which group of people do I wish to reach?"; "What do I want the clients to walk away with?"; "What message needs to be brought to our clergy?"; "How can my program become a resource for others in the diocese?"; "How can classroom instruction foster growth in conjugal spirituality?"; etc. Words to be used in a statement of a goal should be pro-active, future oriented, and as realistic as possible. Instead of saying, *"The clergy should know what NFP method effectiveness rates are,"* say, *"Clergy will know standard NFP method effectivness rates."*

Objectives should be equally clear, systematic, noting time lines, and above all practical (even if the goal is a long term one.) For example, if your goal is to become "a resource for others in the diocese," then your objectives may look like this:

1) *The diocesan NFP coordinator and an assistant will collect:*

a) *Serious and popular articles on: NFP methodology, fertility/ infertility, contraceptives, marriage and family life studies;*

b) *Pertinent books; and*

c) *Appropriate audio/visual materials.*

* *Collecting resources is an ongoing activity.*

2) *As the diocesan NFP program's resources grow, mailings will notify appropriate diocesan personnel to make use of the lending library. This will be done quarterly.*

3) *In a six month period, NFP teachers will be prepared to give talks on NFP and related issues for: marriage preparation sessions; RCIA; parish adult religious education programs; seminarians; and Catholic secondary and college level audiences.*

4) *Every six months appropriate Catholic agencies and/or departments within the chancery will receive a mailing on diocesan NFP activities and services.*

5) *Once a year the NFP coordinator will visit appropriate Catholic agencies and departments within the chancery in order to update them on resources and invite them to participate in any special projects or activities.*

Spelling out the objectives, the steps to take in order to achieve this goal, can provide an important opportunity for coordinator and NFP teachers to work together for the common good of the program. Such brain-storming sessions can create a better sense of belonging, yield stronger strategies, and foster a sense of greater responsibility among each member of the diocesan team.

Often, human beings move through life in intuitive or even automatic ways. For some activities in life that may be the best way to operate; however, there are some things in life which need to be addressed consciously and methodically. Sometimes we must do all that we can to bring a dream into reality. NFP promoters know how difficult their work is, and yes, faith remains to be the cornerstone of our activity. Yet, clear goals and objectives can serve as powerful instruments through which the diocesan NFP coordinator can take the necessary steps to build stronger programs and services! ■

COORDINATORS' CORNER

"The Fish on My Computer," How the Standards Helped Our Diocesan NFP Program.

Donna Dausman, Diocese of Springfield, IL

The fish on my computer. Are you confused by the title? Let me assure you that it is very appropriate. For the past 17 years I have served as the volunteer NFP coordinator for the diocese of Springfield in Illinois. Our diocese cuts a large swath across central Illinois. It has a few "big" cities, ranging in size from 10,000 to 100,000, and lots of little towns and farmland.

We offer NFP in 6 of the larger cities, covering the diocese reasonably well. For many years this program has been primarily hospital based and funded, with a minimal diocesan budget and verbal support. Our teachers are well trained and represent more than one methodology. Illinois is blessed because we have the Illinois Family Planning Association, which through its annual conferences, provides high quality continuing education which would be difficult to provide at a diocesan level.

A few years back (sometimes it seems like a lifetime) I was asked to serve on the DDP's committee that wrote the **National Standards**. Because of being

involved in that project I was also asked to have our diocese be part of the demonstration which would test the then newly written implementation process. Although it was a great deal of work, I enjoyed being a member of that early committee. It was an important experience in which I had learned so much. Despite these good feelings, when asked to be part of the demonstration dioceses, I wasn't sure I was going to like it. How could our diocesan program with its minuscule budget and volunteer staff possible meet the **Standards**? How on earth would I possibly find the time to complete the paperwork?

Well, I must admit it was much easier than I had anticipated. Of course, I must also admit that because I was in on the creation of the document I had some advance knowledge of what I would need to develop and do in order to meet the standards. Nevertheless, when I sat down to begin I felt overwhelmed. That feeling quickly changed to one of happiness and pride—pride at what our small band of dedicated volunteers had created and managed to maintain. What wonderful dedicated people there are in NFP ministry!

Preparing the documentation for the Endorsement process took less time than I had anticipated. The preparation did require meeting with the teachers, doing some program development, and yes, a fair amount of paperwork. But the process was very valuable for evaluating and professionalizing our program.

As each of our teachers looked at the forms for self assessment and teacher observation they too had mixed feelings. Each had positive feelings about the opportunity to receive DDP certification, but at the same time were concerned about how to fit the paperwork into their busy schedules of family, Church, work, etc. Today, those who have completed the process decided that in spite of the work, it was worthwhile because, as one of the forms says, *"it gives the experienced teacher the opportunity to assess his/her capabilities, discover strengths, and acknowledge areas that need development."* In other words, our teachers were delighted at how much they knew and had accomplished. The self assessment affirmed their abilities and revitalized their commitment to NFP.

The Endorsement process provided some excellent opportunities for integrating NFP into the diocesan structure. Having the Bishop's signature on the application for Endorsement opened the door for communication with the bishop. Also, in preparation for the site visit I met with both the bishop and the vicar general to completely explain the Endorsement process and how our diocesan program complied with it. The DDP representative also met with the bishop. These actions, along with some strong support from diocesan personnel, brought about a greater committment from the diocese.

"it gives the experienced teacher the opportunity to assess his/her capabilities, discover strengths, and acknowledge areas that need development."

Which brings us to the fish on my computer. Because of my long term involvement in NFP: at the diocesan, state, and national levels; the diocesan lay ministry formation program; and the demonstration site visit which required the interaction between diocesan personnel and DDP representatives; the diocesan NFP program is now an integral part of the newly reopened Marriage and Family Life Office. I now have the unique opportunity to integrate all that I have learned over the years with regard to the Church's teaching on marriage and family, chastity and NFP, into the activities of the office. I no longer "do" NFP paperwork at my dining room table in between other tasks, but in an office, complete with a new computer and an aquarium-like screensaver. People who never called before, including other diocesan offices, are suddenly calling for consultation and assistance. NFP teachers are becoming more well known as resources for chastity education and family issues, as well as NFP. It's easier to publicize NFP classes and Mother/Daughter programs because we are "part of the system."

Was it worth the effort to apply for DDP endorsement? Definitely! Why? Because the implementation process allowed the diocesan structure to become more aware of the totality of the NFP program. The process was one of the reasons for NFP becoming a real part of the structure. So if you are a volunteer coordinator of a fledgling diocesan NFP program, I strongly urge you to apply for DDP Endorsement and Teacher Certification. It is invaluable for assisting in program evaluation and development. It definitely provides opportunities to integrate NFP more fully into the diocesan structure. And when you become weary, the kids crying, the laundry's piling up, and the DDP paperwork seems impossible, just remember the fish on my computer. With the help of the Spirit all things are possible, and you too, may find yourself with desk, computer, and an invitation to bring the good news of NFP and the Church's teaching on marriage and family to every facet of Church life—from within the diocesan structure! ■

SCIENCE NOTES

Hanna Klaus, M.D.

Maternal Serum Screening for Fetal Down Syndrome in Women Less Than 35 Years of Age Using Alpha Fetoprotein, hCG, and Unconjugated Estriol: A Prospective 2 Year Study. O.P. Phillips et al. *Obstetrics & Gynecology* 80:353-358, September 1992.

If a woman is 35 years of age or more at delivery, her risk of having a fetus with Down syndrome detected in the second trimester of pregnancy is 1 in 274. It is routine to offer prenatal diagnosis to women who would be more than 35 years of age at delivery; hence the present study prospectively used 3 screening techniques: maternal serum alpha-fetoprotein, human chorionic gonadotropin (hCG) and unconjugated estriol (uE3). When these three analytes were elevated beyond the range of normal and calculated for gestational age, amniocentesis or chorionic villus of sampling was offered.

In a lower socio-economic population which also served as the consultation center for the surrounding area of Tennessee and bordering states, 9,530 women were screened for fetal Down syndrome. Two-thirds from the central institution were from a lower SES group, the referrals who represented a middle socio-economic population. The mothers' mean age was 24.5 years. Three hundred and seven (3.2%) of the women fit the profile and were offered genetic counseling and prenatal diagnostic tests. Of these, 214 underwent prenatal testing, predominantly amniocentesis. Four cases of fetal Down syndrome were detected while three were undectected. The four women who were found to have fetal trisomy-21 elected to abort their babies.

Screening with fewer than the three techniques ("analytes") would have yielded a lower number of detected cases. Two of the three undetected cases occurred in women aged 19 and 22. The calculation from the 3 analytes comparison with gestational and maternal age is rather complex and yields at best 60% positives and a 5% false negative rate. *[The paper fails to speak of any cases which are aborted with the expectation of Down syndrome when in fact none was found. HK.]* It does speak however of the cost impact analysis of such a screening program: the gross cost estimate for each case of fetal Down syndrome detected in the study is about $100,000, but the authors balance this against an estimated cost for the health, education, and residential care of an individual with Down syndrome of $196,000. This figure did not include costs such as "loss of productivity of parents, counseling and social work services, increased divorce rates, and problems with siblings." The authors suggest a formal cost-benefit analysis in 1990 dollars is needed. *[They should also consider a long-term follow-up of women who were persuaded to abort their children. HK]*

Local Luteolytic Effect of Prostaglandin F_{2a} in the Human Corpus Luteum. B. Bennegard et al. *Fertility and Sterility* 56:1070-1083 December 1991.

Regularly cyling women scheduled for sterilization volunteered to receive a single injection of Prostaglandin F_{2a} directly into the corpus luteum. Twenty healthy women and sixteen control women were studied. After the injection, serum progesterone fell 30% immediately and the luteal phase was shortened by 2-5 days. Luteinizing hormone levels were not affected by the changes in serum progesterone.

Intravenous Immune Globulin for the Prevention of Nosocomial Infection in Low-Birth-Weight Neonates. C.J. Baker et al. *The New England Journal of Medicine* 327:213-219, July 23, 1992.

Premature infants with very low birthweights are at great risk for hospital based (nosocomial) infections. Immune bodies (IgG) seldom are transferred from the mother to the baby before 32 weeks. A multicenter double-blind study of neonates weighing 500-1750 grams at birth was conducted on 588 neonates who received either intravenous immune globulin or placebo. The infusions were well tolerated. There was significant reduction in the risk of hospital infection among immune globulin recipients. Eighty-five percent of the infections were due to Staphylococcus aureus. The babies who received immune globulin had fewer days in the hospital (62 vs 68), while those babies who were infected had shorter hospital stays (80 vs 101 days). The number of patients was not large enough to permit adequate assessment of reduction of mortality, but the study was clearly effective in terms of shorter hospital stays and cost saving.

Understanding the Current Status of Oocyte Donation in the United States: What's Really Going on out There? M.V. Sauer and R.J. Paulson. *Fertility & Sterility* 58:16-18, July 1992.

A registry of the outcomes of oocyte donations has been maintained since 1985. Sixty-seven clinics have reported 547 transfers of ova to other women during 1990. Centers varied in offering anonymous and nonanonymous methods of donor participation. Only 29% provided exclusively anonymous services; 18% provided only nonanonymous matches. The American Fertility Society Ethics Committee had recommended ano-

nymity. Of interest is that the mean age of recipients was 44 years with a range of 45-55 years. The authors recommend a reasonable age limit set at 50 years for a potential recipient. Beyond this age, there is little obstetric experience. Altogether, 900 embryos had been transferred as a result of oocyte donation which resulted in 275 clinical pregnancies. There are no data on live births. *[While recipients' health may be favorable to gestating a pregnancy at age 55, the wisdom and practicality of a 70 year old mother of a teenager was not even alluded to. HK]*

Prospects for Human Gene Therapy. E.M. Karson et al. *The Journal of Reproductive Medicine* 37:508-514, June 1992.

The National Institutes of Health have conducted extensive tests with gene markers using retroviruses as carriers. After extensive sheep testing, work has begun using cells of human fetal cord blood obtained at the time of term or premature deliveries as early as 19 weeks. These have been able to express transduced genes in vitro. Cord blood from fetal sheep was sampled and transduced outside of the body then transfused back in utero into the fetal sheep. The markers were present up to two years after birth.

Much work remains to be done on gene transfer, but the potential exists for treating some genetic diseases after prenatal diagnosis either in utero or shortly after birth. Some work has already been done in humans such as the combined immunodeficiency disease resulting from adenosine deaminase deficiency (ADA). Other possible candidates could be various disorders of metabolism, such as argininosuccinic aciduria, citrullinemia, Gaucher's disease type I, phenylketonuria, and purine nucleotide phosphorylase deficiency. However, structural proteins for most tissues such as muscle, visceral organs, and neurons, cannot be supplied via bone marrow transfer. Nevertheless, this therapy will undoubtedly be developed in many directions and bears watching.

Expectant Management of Ectopic Pregnancy. P. Ylostalo et al. *Obstetrics & Gynecology* 80:345-348, September 1992.

The treatment of ectopic pregnancy has undergone a number of changes. The clinical picture has also changed in the last few years. While the numbers of ectopic pregnancies have increased, the frequency of ruptured tube and other severe complications has decreased. With serum hCG (human chorionic gonadotropin) studies and vaginal sonography, the detection and viability status can be assessed readily.

Instead of open surgery, laparoscopy has been used increasingly, aspirating the pregnancy instead of surgically opening or removing the tube. Non-surgical methods include puncture and aspiration of the ectopic pregnancy, local injection of potassium chloride or prostaglandin, or general or local use of methotrexate, or hyperosmolar glucose. *[Methotrexate causes absorption of the trophoblast while prostaglandin would cause contraction of the tube, presumably with expulsion of contents; the other agents destroy the tissue locally. HK]*

Spontaneous resolution can occur in ectopic pregnancies. It was documented in 57% of 119 patients, but required lengthy hospitalizations. In later studies, expectant management was offered when the ectopic pregnancy was less than 5 cm in diameter and showed no signs of rupture or of acute bleeding. In these selected studies, the success rate was between 64-100% and tubal patency was retained in 70-100% of cases. In the present study, 318 patients with ectopic pregnancy were studied in Helsinki University Central Hospital. Eighty-three were selected for expectant management after a vaginal ultrasound and determination of serum hCG, if: 1) serum hCG decreased more than 2% in two estimations over two days; 2) there was no sign of intrauterine pregnancy; 3) the abnormal tubal mass was visible but did not measure more than 4 cm; 4) there was no fetal heartbeat; and 5) there were no signs of tubal rupture or bleeding. The women were discharged and seen as outpatients at daily or longer intervals until the hCG level decreased below 10 IU/L. Among the 83 patients who were treated expectantly, 69% had spontaneous resolution (18% of all ectopic pregnancies). The remainder required laparoscopic salpingoltomy because of clinical symptoms. The symptoms which indicated the need for laparoscopy were pain, constant or increasing hCG level after an initial decrease, increase of fluid on the culdesac (on vaginal ultrasound) or an increase in the diameter of the ectopic mass. More women were treated by surgery in the first year than in the second year. As more experience was gained, the need for interference decreased. When women present with an ectopic pregnancy in which the embryo has apparently died, expectant treatment may be sufficient.

Treatment of Premenstrual Syndrome With Fluoxetine: A Double-Blind, Placebo-Controlled, Crossover Study. S.H. Wood et al. *Obstetrics & Gynecology* 80:339-344, September 1992.

A dysfunction of serotoninergic transmission has been considered to be involved in the development of severe emotional disorders, particularly depression and anxiety. The serotoninergic systems (those which produce serotonin in the brain) are important for regulation of several

functions including appetite. In view of the prominence of changes in mood, behavior, and appetite in premenstrual syndrome (PMS), it was suggested that abnormalities in central serotoninergic activity could be involved in the production of PMS.

PMS is defined as a cyclic appearance (only) during the luteal phase of distressing physical and behavioral symptoms which interfere significantly with socioeconomic functioning. Animal experiments have linked fluctuations of ovarian steroids and serotoninergic function: estrogen and progesterone influence this activity. In the hypothalamus, estrogen induces a day/night pattern of serotonin rhythm while progesterone increases the rate of serotonin turnover. A decreased serotoninergic activity in women with PMS during the luteal phase has been suggested by indirect observations such as reduced platelet uptake of serotonin and by lower serotonin levels in peripheral blood.

When serotonin agonists are given, they may induce mood elevation, while agents which diminish serotonin activity have been associated with behavioral changes including irritability and social withdrawal. Since other drugs with serotinergic activity have shown good results in women with PMS, a double-blind placebo controlled crossover study was undertaken with fluoxetine, is a highly selective serotonin uptake inhibitor.

To be recruited, subjects needed to have regular cycles of 26-32 days length, evidence of ovulation by urine pregnandiol or serum progesterone, premenstrual symptoms confined to the second half of the cycle which resolved within 4 days of the onset of menses, observed for at least 2 cycles. The women had medical and psychiatric evaluation, recorded PMS symptoms with a calendar of premenstrual experiences which were rated on a Likert scale. Daily scores were summed across two 7-day periods for the follicular phase and the luteal phase. The Beck Depression Inventory, State-Trait Anxiety, MMPI, and Profile of Mood States were administered during follicular and luteal phases. Any subject who had demonstrated abnormality in the follicular phase was disqualified. A struc-tured clinical interview was also administered. A family history of depression in a first degree relative was an exclusionary criterion. Less than 10% of women presenting for evaluation for PMS met the research criteria. Eight women who met the criteria, as well as those for late luteal phase disphoric disorder, were recruited for participation in the study. They agreed to use barrier contraception during the study and were randomized into a double-blind placebo-controlled crossover design.

In the 6-month treatment phase, the women received fluoxetine 20mg or a placebo daily for three cycles. Treatment with fluoxetine reduced the luteal phase scores of physical and emotional symptoms to those of the follicular phase levels, while placebo made no difference in either case. Fluoxetine was well tolerated. The commonly seen side effects: headache, insomnia, anxiety, nausea, and dizziness were not encountered in these subjects. Fluoxetine appears to be a highly effective treatment of both the central and the somatic symptoms which accompany PMS in women who have no other history of psychiatric disorder. Larger studies are needed to determine the efficacy of this drug comparing it with other treatment modalities, and to assess long term effectiveness and safety.

Endometrial Ablation: Improvement in PMS Related to the Decrease in Bleeding. H.T. & C.F. Lefler. *Journal of Reproductive Medicine* 37:596-598.

Half of the women evaluated before and after ablation of the endometrium for menorrhagia also had symptoms of premenstrual syndrome (PMS). An additional 35 women had symptoms associated with their menstrual period which were not adequate for a diagnosis of PMS. Following removal of the endometrium the women either had no menses at all or were only spotting. At the same time, there was a remarkable reduction in the severity of their symptoms.

While the connection between heavy menstrual bleeding and PMS symptoms has not been explained, heavy menstrual bleeding is obviously dependent on the amount of functioning endometrium. Evidently destroying much of the endometrium also relieves premenstrual syndrome. *[The feedback loop between the endometrium and the ovary has long been recognized. For instance, removal of the uterus causes involution of ovarian endometriomas even when the ovaries are not removed. The nature of the feedback loop has not yet been understood. HK]*

Fertility in Italy and Spain: The Lowest in the World. M. Perez and M. Livi-Bacci. *Family Planning Perspectives* 24:162-171, July/August 1992.

Fertility rates in Italy, Spain, and Portugal are among the lowest of any large population in the world. The decline had been established in Italy and Spain by the end of World War I, and has generally continued to decline. The age of marriage has increased. The total fertility rate (TFR) declined from 1975-1990 from 2.18 to 1.39 in Italy and from 2.78 to 1.39 in Spain. After legalization, abortion increased 25%, then leveled off.

The World Fertility Survey studies of contraceptive use 1977-1979 and 1985-1986 found that barrier methods were most popular in both countries, while withdrawal was used by 11% Italian and 6% Spanish couples, rhythm by 9% Italian and 4% Spanish. IUDs were at the same level as withdrawal and the pill even lower. The article laments the lack of the use of "modern methods," while acknowledging that 40% of couples use either withdrawal or rhythm, yet can regulate family size to their satisfaction.

NEWS BRIEFS

DDP ANNOUNCEMENTS

1993—25th Anniversary of Humanae Vitae. As you know 1993 is an important year for us. If your diocese or NFP organization is planning special events during 1993 to celebrate the anniversary of the encyclical, please notify the DDP. We will publicize all special events in the newsletter.

Directory of Videos on NFP—*Correction:* Please change the phone number for Hallel Communications on p. 1, #3. The correct number is 914-365-2277.

UPCOMING EVENTS

National Prayer Vigil for Life, co-sponsored by the NCCB's Secretariat for Pro-Life Activities, the Basilica of the National Shrine of Immaculate Conception, and the Archdiocese of Washington, D.C., will be held on January 21-22, 1993 at the Basilica. The Vigil will begin with a Solemn Eucharistic Celebration at 8:00 pm on the 21st, followed by holy hours which will conclude with 7:30 am Mass. All are invited to take part either in person or spiritually in your homes. *Contact: Secretariat for Pro-Life Activities, 202-541-3070.*

Billings Ovulation Method Association will hold an update and recertification meeting March 5-7, 1993 in San Francisco, CA. Drs. Lyn and John Billings will be among the speakers. Teacher training workshop for new teachers will follow on March 8-11. *Contact: BOMA, c/o NFP Center of Washington, D.C.; 301-897-9323.*

American Academy of NFP invites all promoters of NFP to mark their calendars for the day/week of March 25th, 1993 to celebrate National NFP Day. Initiated in 1991, the event received wide spread media attention and proved to be an excellent vehicle for the promotion of NFP programs at the local level. Brochures on the event will be forth coming. *Contact: Kathy Rivet, Chairperson, Public Relations, AANFP, 4 Winter Circle, RFD #3, Manchester, NH, 03013; 603-424-5191.*

Illinois NFP Association will hold its statewide celebration of the 25th Anniversary of ***Humanae Vitae.*** Georgetown, IL, March 26,27, and 28, 1993. *Contact: INFPA, Mary Therese Egizio, 402 S. Independence Blvd., Romeoville, IL 60441, 815-838-1002*

ANNOUNCEMENTS

We sadly announce the passing of Rev. Marc Calegari, S.J. Fr. Marc so loved the truths expressed in **Humanae Vitae** that he made it his life's work to pass this teaching on to others.

We ask you to pray for Fr. Marc's soul and for his family and friends who will miss him greatly.

Diocese of Metuchen's (N.J.), NFP Coordinators, Rosemary and Stephen Kern, were interviewed by Linda Ellerbee for a film entitled **"Contraception: The Stalled Revolution."** A production of Maryland Public Television and Better World Society in association with Lucky Duck Productions, this film was written and hosted by Ms. Ellerbee. Although this film is "pro-contraception," according to the Kerns, they were surprised by the fair treatment of them and NFP by Ms. Ellerbee. Airing dates were set for late September and early October. Check your local Public Broadcasting stations for viewing. *Contact: Rosemary and Stephen Kern, 10 Covered Bridge Rd., Flemington, N.J. 08822; 908-782-4447.*

Diocese of St. Cloud, MN held a Fall Enrichment Conference on October 3, 1992. Entitled, "Intimacy, the Loving Connection," the event featured well known family therapist, Clayton C. Barbeau. The one day conference was sponsored by the Marriage Encounter Communities, and the diocesan programs of the Family Life Bureau: Marriage Preparation, Parenting Workshops, and Natural Family Planning. *Contact: Kay Ek, 305 North 7th Ave., Suite 102, St. Cloud, MN 56303; 612-252-2100.*

Diocese of Santa Rosa, CA in conjuction with **What Every Woman Should Know Outreach Program,** will offer: client classes; teacher training; and continuing education for nurses at Redwood Memorial Hospital, Fortuna, CA.

Contact: Regina Corley, NFP Coordinator, Office of Catholic Charities, P.O. Box 4900, Santa Rosa, CA 95402; 707-528-8712.

What Every Woman Should Know Outreach Program—USA announces a **Billings Ovulation Method Home Study Course.** This course is for training teachers and also for teaching clients. Continuing education credits are available for nurses. What Every Woman Should Know Outreach Program is approved by the DDP as a Comprehensive NFP Teacher Training Program and is a Licensee of WOOMB International, Inc. *Contact: June E. Frakes, R.N., P.O. Box 41, Wofford Heights, CA 93285-0041; 707-725-2189.*

Worldwide Marriage Encounter, Inc. announces February 14, 1993 as "World Marriage Day." This day is a special day to honor married couples for their love, faithfulness, and commitment to one another and the Church. *Contact: National WMD Team Coord., Nick & Diane Barbaccio, 27307 Cloudrest Way, Hemet, CA 92544; 714-658-34791.*

MATERIALS

Family of the Americas has completed their video "If You Love Me . . . Show Me!" An animated, 37 min., color video which explores the reasons why teenagers should reserve sexual relations for marriage. *Contact: Family of the Americas, 1-800-935-2222.*

NATURAL FAMILY PLANNING
Diocesan Activity Report

Vol. 3/No.4

Fall 1992

Diocesan Development Program for Natural Family Planning
A program of the NCCB Committee for Pro-Life Activities

3211 4th St., N.E.
Washington, D.C. 20017-3240
202-541-3240
Fax 202-541-3203

Most Rev. James T. McHugh, Director
Theresa Notare, Special Assistant, Editor
Silvia U. Juárez, Administrative Aide

Contributors
Donna Dausman
Hanna Klaus, M.D.

The Natural Family Planning Diocesan Activity Report is published quarterly. Its purpose is to serve the Roman Catholic diocesan NFP programs of the United States through offering: national and international news of NFP activity; articles on significant Church teachings, NFP methodology and related topics; and by providing a forum for sharing strategies in program development. Contributions are welcomed. All articles may be reproduced unless otherwise noted. For more information contact the editor.

The activities of the DDP for NFP are generously funded by a grant from the Knights of Columbus