

Natural Family Planning

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In this issue

NFP Related Research	2
Research Briefs	8
Under the Microscope	10
Sperm Survival	
For Your Information	13



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Natural Family Planning

European Study Finds Sympto-Thermal Double Check Method to be Very Effective

The European Natural Family Planning Study Group recently reported a large efficacy study that compared two versions of the Sympto-Thermal method (1). One Sympto-Thermal Method (STM) called the “double check method,” includes use of a calendar day formula and the observation of cervical mucus to determine the beginning of the fertile period. Two biological markers are used to determine the end of the fertile phase (i.e., the peak in cervical mucus and temperature changes). The second STM, called the “single check method,” uses one biological indicator (cervical mucus) to determine the beginning of the fertile period and one indicator (temperature) to determine the end of the fertile period. This efficacy study involved 10 European countries and 15 NFP centers that generated couples for the study during the time period of 1989 through 1995.

The double check method analyzed 16,865 cycles of exposure from 1,046 women. The single check method involved 214 women and 1,495 cycles of exposure. The study was prospective and utilized modern statistical analysis methods (i.e., the Kaplan-Meier method) to determine pregnancy, drop out, and lost-to-follow-up rates. The age range for entry into the study was 19-45.

At the end of 12 cycles of use from the 16,865 cycles analyzed, the double check method had 34 unintended pregnancies for a rate of 2.6%. It also had a drop-out rate of 3.9% and a lost-to-follow-up rate of 3.1%. The single check method (with only 214 cycles analyzed) experienced 13 unintended pregnancies for a rate of 8.5%, a dropout rate of 3.0%, and a lost-to-follow-up rate of 23.4%. Of interest is that there was no pregnancy recorded in women over 40 years of age.

The lower unintended pregnancy rates in the double check group was surprising to the European researchers in that women in the single check group were older, more experienced in the use of NFP, already had on average two children, and were in stable relationships (i.e., 98% were married). The researchers speculated that one of the reasons there were lower pregnancy rates in the double check group was that this method required more pre-ovulatory days of fertility and thus reduced the risk of getting pregnant through long sperm survival. The difference could also have been due to less precise rules and less effective teaching in the single check method.

The researchers concluded that the double check STM is very effective for pregnancy avoidance. They also concluded (based on low discontinuation rates due to dissatisfaction or difficulties) that the chore of charting and the abstinence required are not too difficult to prevent

effective use of these methods.

Comments

The strengths of this efficacy study include the facts that it is prospective, involved multiple sites, was fairly large in number, had well defined participant inclusion criteria and used modern methods of analysis. The comparison of the effectiveness rates between the two STMs could have been stronger if the participants were randomly distributed into each group (i.e., the double check or single check method groups). The researchers also had limited control over the quality of teaching, teaching methodologies and the standardization of instruction.

Although the results are very encouraging and provide further evidence for the effectiveness of NFP methods, the findings can only be applied to women between the ages of 19 and 45 with fairly regular menstrual cycles. The study's exclusion criteria eliminated any women who did not have at least three normal cycles since being either postpartum, breast-feeding, discontinuing the use of the oral contraceptive pill, or post miscarriage. Further studies would be needed to establish efficacy rates for these two ST methods with women in higher or lower age ranges and with women who experience different reproductive categories.

In the words of the authors, the good news is that the findings of this study dispel the long-held belief that natural methods, in general, are ineffective, and, indeed, the pregnancy rate of the double-check method in this study compares favorably with current contraceptive methods, such as IUDs. This pregnancy rate is all the more significant, in that two thirds of the women in the study were spacing and not limiting their family size. Women in Europe aspiring to self-determination and natural methods for fertility control can be confident they are not exposed to an increased risk of unintended pregnancy.

The above quote was directed towards European women and potential family planning users. The results also have implications for NFP providers and health professionals in that they should feel confident in providing and recommending these methods to their patients and clients for their family planning needs.

The European Natural Family Planning Study Groups. **European Multi-center Study of Natural Family Planning (1989-1995): Efficacy and Drop-out.** *Advances in Contraception* 15 (1999): 69-83.

Standard Day Method of NFP: Rhythm Revisited or New Innovation?

Researchers at the Georgetown University Institute for Reproductive Health (GUIRH) have developed a Standard Day formula for determining the fertile period in a woman's menstrual cycle (1). The Standard Day (also called "fixed day") formula is based on a retrospective analysis of the 7,600 menstrual cycles from the World Health Organization Study of the Ovulation method conducted in the late 1970s (2).

In 1996, GUIRH researchers published a study in which they recommended testing the effectiveness of a number of new rhythm type formulas (3). Some of the new formulas required tracking cycle lengths and applying mathematical equations to determine the estimated fertile times - i.e., essentially a reformulation of the old calendar/rhythm method. GUIRH researchers also recommended testing fixed formulas that did not require tracking the length of cycles or using mathematics. They determined the benefits of the fixed formula would include easier client instruction and use. The Standard Day formula does not require charting signs of fertility and can easily be applied to a "necklace" method in which colored beads are used to count the days of the cycle and indicate the fixed days of fertility and infertility.

GUIRH researchers recently reported the results of a study in which they retrospectively applied the Standard Day formula to the same 7,600 cycles from the OM WHO study (1). The Standard Day formula applied was to consider menstrual cycle days 8 through 19 as fertile days (i.e., an 11 day fixed window of fertility). The formula was applied only to 26-32 day menstrual cycles. The researchers also compared the 11 standard days of fixed fertility to a generous 12 days of hypothetical fertility that revolved around the peak day of cervical mucus. GUIRH researchers accepted past research showing that plus or minus three days of the peak day, will include 95-100% of the estimated time of ovulation. They also took into account recent research that indicated the probability of pregnancy only includes a six day period and that fecundity peaks two days before ovulation (4). Therefore, the 11 days of fixed fertility was compared to the 12 days of hypothetical fertility based on 8 days before the peak day of cervical mucus through the third day past peak.

GUIRH researchers found that in the 7,600 cycles analyzed the peak day of cervical mucus and the three days before fell in the 8-19 days of the fixed day formula 96-98% of the time. This percentage of cycles decreased to 80% when the three days after the peak day are included in the calculations and to 34% when all 12 days of the assumed fertile period around the peak day were included.

However, the researchers found that only 25.7% of the WHO study participants experienced menstrual cycles in the range of 26-32 days throughout the length of the study. This percentage of cycles increased to 59.35% when they added plus or minus 2 days to the 26-32 day range. Furthermore, when the Standard Day formula is applied to all 7,600 WHO cycles no

matter the range of length, the probability of pregnancy on a given day was only 0.009. The authors concluded that the standard method could be a very effective method of family planning for most couples who choose it.

Comments

The percentage of the 7,600 WHO cycles (78%) that the Standard Day formula was applied to was similar to the percentage of cycles (76% of 303 cycles) that a similar formula used in a recently published study (5). The study involved 301 Mayan women and used the fixed day formula (day 9-19 = fertile days when cycle lengths = 26-32 days). The Mayan study, however, found that its more liberal formula (by one day) applied to only 129 or 24% of the women participants who had 3 consecutive cycles in the 26-32 day range. The Georgetown study found only 27% of the WHO study women had cycle lengths in the 26-32 day cycle length throughout the period of the study

This writer (RJF) applied the Standard Day formula to 93 NFP charts that have been collected from four previously published research studies. What is unique about these charts is that they all have an estimated day of ovulation documented based on self-detection of urinary LH levels. Using the day after the urinary LH surge as the estimated time of ovulation (ETO), the data from the 93 charts showed that 20 of the 93 cycles (21.5%) had potentially fertile days that fell out of the Standard Day method days of fertility. This number decreased to 10 cycles (10.7%) when the 26-32 day cycle length was applied. In all 20 cycles, the days that fell out of the Standard Day rule were days of high fertility, i.e., the ETO minus 2 days. Therefore, this writer would conclude (similar to what the Mayan study concluded) that the Standard Day rule would apply to about 75-80% of cycles and would theoretically have about an 78-90% effectiveness rate. Researchers at the Georgetown University Institute for Reproductive Health are currently testing the Standard Day method in several countries.

A fact not to be ignored from this study is that teaching and applying the Standard Day formula is extremely easy when compared to teaching and applying the methods of NFP. Competent NFP teachers know that teaching the modern methods of NFP can be labor intensive. In an especially fast paced culture such as our own, a simple, reliable, and cost-effective natural method may be appealing to some people. That said, in light of the evidence analyzed from the WHO study which created the Standard Day formula, it should be reassuring to NFP teachers that 93% of the women studied were able to detect an interpretable mucus pattern after only three cycles of charting. NFP advocates might also question the logic of creating a natural method without the flexibility of application to all cycle lengths and reproductive categories. Clearly, further study is needed. It will be interesting to review the results of the next GUIRH research on this topic.

1. Arevalo, M., Sinai, I. and Jennings, V. **A Fixed Formula to Define the Fertile Window of the Menstrual Cycle as the Basis of a Simple Method of Natural Family Planning.** *Contraception* 60 (1999): 357-360.
2. World Health Organization. **A Prospective Multicentre Trial of the Ovulation Method of Family Planning. III. Characteristics of the Menstrual Cycle and of the Fertile Phase.** *Fertility and Sterility* 40 (1983): 773-778.
3. Lamprecht, V. M. and Grummer-Strawn, L. **Development of New Formulas to Identify the Fertile Time of the Menstrual Cycle.** *Contraception* 54 (1996): 339-343.
4. Wilcox, A. J., Weinberg, C. R. and Baird, D. D. **Timing of Sexual Intercourse in Relation to Ovulation; Effects of the Probability of Conception, Survival of the Pregnancy, and Sex of the Baby.** *The New England Journal of Medicine* 333 (1995): 1517-1521.
5. Burkhart, M. C., de Mazariegos, L., Salazar, S. and Hess, T. **Incidence of Irregular Cycles Among Mayan Women Who Reported Having Regular cycles: Implications for Fertility Awareness Methods.** *Contraception* 59 (1999): 271-275.
6. Fehring, R. *Accuracy of the Peak Day of Cervical Mucus to Detect Ovulation.* Presentation at the 20th Annual Meeting of the American Academy of Natural Family Planning. July 29, 2000; St. Paul, Minnesota.

Measuring Urinary LH Found to be the Most Accurate Method of Self-detecting Ovulation

Italian researchers recently evaluated a number of biological markers to determine their accuracy in detecting ovulation (1). They compared the self-detection of urinary LH levels, the peak in cervical mucus, the shift in basal body temperature (BBT), salivary ferning, and salivary Beta-Glucuronidase levels with daily transvaginal ultrasonographic tracking of the developing follicle and corpus luteum. The day before the first day that a corpus luteum could be visualized through ultrasound was considered the estimated time of ovulation (ETO).

The participants in this prospective evaluation study were 48 healthy women between the ages of 21 and 42 who were motivated to learn NFP. Each woman monitored the above 5 biological markers for 6 months before providing data for the study. The urinary LH surge was determined by use of a monoclonal antibodies test stick system (Clearplan, Unipath). Salivary ferning was determined by use of a small optical microscope and peak in cervical mucus was

determined by the last day of an observation of a wet, slippery sensation at the vulva and/or transparent, stretchy mucus. The BBT was measured with a digital thermometer and the salivary Beta-Glucuronidase by laboratory analysis. When data collection began, each women participant also recorded any vaginal bleeding and frequency of intercourse and underwent transvaginal ultrasound from day 7 of their cycle until the day of ovulation was retrospectively identified. Each of the 48 women participants generated 1-4 menstrual cycles of data for a total of 148 menstrual cycles.

The data generated revealed that 100% of the self-determined days of the urinary LH surge coincided with the ETO. The peak in cervical mucus coincided with the ETO 48.3% of the time, salivary ferning 36.8%, BBT 30.4%, and salivary Beta-Glucuronidase only 27.7% of the time. However, the peak in cervical mucus correlated plus or minus 3 days of the ETO 100% of the time and the shift in BBT plus or minus 3 days of the ETO in 94% of the 148 cycles. In 58.7% of the cycles there was no discernable pattern of salivary ferning.

The authors concluded that the self-determination of urinary LH levels is the most reliable way to detect ovulation for use with NFP. They felt that although the peak in cervical mucus and the BBT shift have a certain degree of correlation with the ETO, these two markers of ovulation overestimate the fertile period and prolong the period of abstinence when used to avoid pregnancy. Finally, they also concluded that salivary ferning patterns and Beta-Glucuronidase levels are not accurate methods to self-detect the time of ovulation.

Comments

The finding from this study--that the surge in urinary LH is an accurate marker of ovulation-- has been confirmed in previous studies (2). What is unusual in this study is that the day of the urinary LH surge fell on the ETO 100% of the time. Based on physiological events and past research, the day of the urinary LH surge should occur about 24-36 hours before the day of ovulation (3). It is not clear why the Italian study found the urinary LH surge on the day of ovulation.

The research on the peak in cervical mucus and the shift in BBT in the Italian study also coincide with results from previous studies. The peak in cervical mucus is not as precise as the LH surge in detecting ovulation but study after study has shown it to occur + 3 days of the estimated day of ovulation close to 100% of the time (4). That is why most NFP methods have users count three days after peak day before they consider themselves in the infertile part of the menstrual cycle. Previous studies also have shown that the BBT is a less precise but an objective and usable marker of ovulation (5).

Although the self-detection of the urinary LH surge can be considered the most accurate self-detected biological marker of ovulation, it is not necessarily the best biological marker for

use with the methods of NFP. One of the reasons for this is the expense of urinary LH detection kits. These kits (often called ovulation detection kits) costs about \$15 to \$25/monthly cycle. NFP users would need to purchase a kit for each cycle. Furthermore, although the test kits are accurate in detecting ovulation when a LH surge is present, they may miss the LH surge in about 10 to 20 percent of cycles (6). Finally, detection of the urinary LH surge will not be helpful for women who are breast-feeding and not ovulating.

The detection of the urinary LH surge certainly can be a very helpful adjunct with the use of current methods of NFP and in particular with cervical mucus methods. They can be of particular help in confirming the actual peak day and in differentiating the fertile period when women experience continuous mucus.

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4. Moghissi, K. S. **Accuracy of Basal Body Temperature For Ovulation Detection.** *Fertility and Sterility* 27 (1976): 1415-1421.
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Research Briefs

Evidence for Antibacterial Activity of Human Cervical Mucus

German researchers tested 133 samples of cervical mucus obtained at mid-cycle from 122 sexually active women with an age range of 21 to 42 years. They found that all 133 samples showed antimicrobial activity demonstrated by clearly visible zones around cervical mucus filled

holes on colonized agar plates. The antimicrobial activity was not affected by the quality of the cervical mucus (based on a cervical index score) or by the pH of the cervical mucus. The antimicrobial activity, however, was markedly higher in mucus samples that were obtained within hours after intercourse. The researchers concluded that human cervical mucus provides “considerable antibacterial activity.”

Eggert-Kruse, W., Botz, I. and Pohl, S., et al. **Antimicrobial activity of human cervical mucus.** *Human Reproduction* 15 (2000): 778-784.

Is Prolonged Car Driving By Males Related to Male Infertility?

Past studies have shown that men who drive cars for prolonged periods of time (e.g., taxi drivers) have lower sperm counts, sperm motility, and a higher level of sperm morphology than men in other occupational groups. The theory is that the cause of the low sperm quality in male car drivers is due to higher scrotal temperature levels produced while in prolonged sitting positions. To test this theory, Italian researchers recorded the scrotal temperatures of 9 male volunteers every two minutes while walking for 40 minutes and subsequently while driving for 160 minutes. They found that the scrotal temperatures increased significantly (1.7-2.2 degrees C) after 2 hours of driving from the temperatures recorded while walking. The researchers concluded that the link between driving time and scrotal temperatures indicate a potential lifestyle risk for male infertility. (NFP teachers might want to question clients who are having difficulty conceiving about the husband's activities which may cause his body to become hyperthermic. RF)

Bujan, L, Daudin, M. and Charlet, J.P. et al. **Increase in Scrotal Temperature In Car Drivers.** *Human Reproduction* 15 (2000): 1355-1357.

Characteristics of CrM Fertility Care System Users

A key to effective use of NFP is good instruction. The Creighton Model Fertility Care System (CrMS) involves an introductory session and (at a minimum) eight individual follow-up sessions over a one year period. Joseph Stanford, M.D., and Ken R. Smith, PhD at the University of Utah evaluated the number of follow-up visits completed by new CrMS users (i.e., 1,458 women/couples) from 8 centers in the United States. They found that 75.7% of the study participants completed 4 follow-up sessions, 64.7% completed 5 sessions and only 29.6% completed at least 8 follow-up sessions. The characteristics of the participants who were most

likely to continue instruction included those who were Catholic, white, college educated, had higher incomes, and intended to temporarily avoid pregnancy. Stanford and Smith pointed out that CrMS centers should pay special attention to the needs of women who are not white, Catholic, and who have less education and income.

Stanford, J. B. and Smith, K. R. **Characteristics of Women Associated With Continuing Instruction in the Creighton Model Fertility Care System.** *Contraception* 61 (February, 2000): 121-129.

Risk of Ischemic Stroke is Increased With Current Use of Oral Contraception

The increased risk of stroke with oral contraceptive (OC) use has been known since the pill was introduced over 40 years ago. What is still unclear is whether the newer formulations of the pill with much lower doses of estrogen are also risk factors for stroke. Researchers from the University of California – San Francisco conducted a meta-analysis of studies published from January 1960 through November 1999 that investigated the risk of ischemic stroke with OC use. Although 73 studies were published on that topic during the designated time period, only 16 studies met their inclusion criteria of sample size, control group comparison and adequate data for analysis. The researchers meta-analysis indicated that when hypertension and smoking were controlled the relative risk of stroke with the low dose (estrogen) formulations was almost twice that of non-users. The relative risk of the higher dose pills was almost threefold. However, since the incidence of stroke is relatively rare in a young age group, the increased risk of stroke with the low dose is only 1 additional stroke over a year per 24,000 women. For the high dose the relative risk of stroke translates into one additional stroke per 12,000 women.

Gillum, L. A., Mamidipudi, S. K. and Johnston, S. C. **Ischemic Stroke Risk With Oral Contraceptives.** *Journal of the American Medical Association* 284 (2000): 72-78.

Under the Microscope

Sperm Survival

A common physiological assumption foundational to the use of natural methods of family planning is that sperm live (in vivo) only a short time (several hours) in the environment of the vagina. This is because the vagina is a hostile acidic environment for sperm. Sperm, however, can live about 3 days and sometimes up to 5 days in women's cervical crypts when “good” cervical mucus is present. Cervical mucus protects and nourishes sperm.

Although most NFP methods and teacher training programs provide information on the life span of sperm, they do not go into much depth as to the evidence for sperm survival times. Most NFP teachers and users take sperm survival information on faith. However, on occasions NFP couples or teachers are confronted by the question “how do we know how long sperm can survive in a woman's reproductive track?” Lengthy sperm survival also has been the blame or explanation for unexplained pregnancies, i.e., pregnancies that occur outside the normal length of the fertile period.

Speculation has long existed about the length of the life span of sperm once deposited in the vagina. Dr. Herman Knaus, one of the developers of the calendar/rhythm method, speculated that sperm lost the capacity to fertilize by 48 hours after intercourse (1). Researchers were also aware early on (by the early 1930s) that there was a difference between the fertilizing capacity of the sperm and their motility and that sperm lost their fertilizing capacity before their motility (2).

There are three basic ways in which researchers provide evidence for sperm survival. One is by measuring the time from a single act of intercourse to the estimated day of ovulation and subsequent fertilization and pregnancy. The other method is by recovering sperm deposited in the female reproductive track at different time periods and then observing the sperm's ability to move and fertilize. Another way is by assessing the capacity of sperm to fertilize human ovum in vitro after the sperm has been collected and stored in an environment other than the female reproductive tract.

France, Graham, and Grosling et al., prospectively monitored the time of intercourse with the estimated day of ovulation and subsequent pregnancy in 91 natural conception cycles (3). They estimated the day of ovulation both by hormonal measures (LH) and by the peak in cervical mucus. They found in the 55 pregnancies that resulted from a single act of intercourse, that 20 – 21% of them arose from sperm that survived 4 days or more. Three of the pregnancies indicated a 6-day sperm survival time, 7 days if you consider the day after the LH as the ETO. France et al., however, experienced a lot of variability in the LH surge and cervical mucus as indicators of ovulation. Wilcox, Weinberg and Baird conducted a similar study with 221 health women but unlike France et al, they only used hormonal measures to estimate the day of ovulation (4). They found that there are only five fertile days before the day of ovulation. This indicated to them that sperm retain their capacity to fertilize up to five days in the female reproductive track.

Rubenstein, Straus, and Lazarus, et al. in a early study recovered sperm from the cervix, uterine fundus and Fallopian tubes of 51 women who had hysterectomies and found that the longest time period that sperm retained their motility post insemination was 50 hours (5). On the other hand Peroff and Steinberger found motile sperm in cervical mucus up to seven days after they were recovered from female reproductive tracts (6). In a more modern study by Gould, Overstreet and Hanson, spermatozoa were recovered from human cervical mucus at various intervals after artificial insemination (7). They found that sperm were able to penetrate the zona

pellucida of the human ovum from 1 to 80 hours after insemination. They also recovered sperm up to 180 hours after insemination that maintained swimming speeds comparable to freshly capacitated sperm. They concluded that the human sperm fertilizing capacity in the female reproductive tract (i.e., in vivo) might last for 80 hours or longer. Their findings were similar to those by Cohen, Fehilly and Walters who found that sperm that were stored at room temperature or refrigerated were able to fertilize human ovum in vitro after five days (8).

Therefore, the evidence the above cited literature provides is that sperm have the ability to fertilize human ovum (when they are in a good environment) for up to five days but that the optimum fertilizing life span is from 1 - 3 days. Five days seems to be the limit of spermatozoa fertilizing capacity in vivo. Wilcox et al., only recorded 12 conceptions that could be attributed to sperm that were more than 2 days old. What this evidence means to NFP teachers is that the instruction that sperm live from 3 to 5 days in good cervical mucus is still relevant and up to date. The likelihood that sperm can fertilize human ovum up to seven days is remote but further evidence is welcomed.

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4. Wilcox, A. J., Weinberg, C. R. and Baird, D.D. **Timing of Sexual Intercourse In Relation to Ovulation**. *The New England Journal of Medicine* 333 (December, 1995): 1517- 1521.
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6. Perloff, W. H. and Steinberger, E. **In Vivo Survival of Spermatozoa In Cervical Mucus**. *American Journal of Obstetrics and Gynecology* 88 (1964): 439-442.
7. Gould, J. E., Overstreet, J. W. and Hanson, F.W. **Assessment of Human Sperm Function after Recovery from the Female Reproductive Tract**. *Biology of Reproduction* 31 (1984): 888-894.

8. Cohen, J., Fehilly, C. B. and Walters, D. E. Prolonged **Storage of Human Spermatozoa at Room Temperature or In a Refrigerator**. *Fertility and Sterility* 44 (1985): 254-62.

For Your Information

New Mercury Free Based Thermometer

R. G. Enterprises, Inc. has available a new mercury-free basal thermometer. The company was established in 1996 to introduce safe, mercury-free fever thermometers to families in the U.S. and Canada.

The Geratherm Basal Thermometer functions like the standard mercury basal thermometer. A special metal alloy called galinstan is used instead of mercury. Galinstan is non-toxic and safe for both the user and the environment. The thermometer is slightly larger than the standard mercury basal thermometer and comes complete with instructions for use. Contact: R. G. Enterprises, Inc. 2000 Town Center, Ste. 1900, Southfield, MI 48075; 248-351-6237; FAX 248-351-2645; E-mail: rgenterprises@msn.com. Website: www.1thermometer.com.

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NFP Teacher Training Programs, Annotated Directory

Basic information on national, regional, and local NFP teacher training program is listed. Information includes methods provided, fees, length of instruction, languages training offered in, and options for on-site or home-study.

Copies can be purchased for \$5.00 plus \$3.50 shipping and handling. The directory can also be accessed from the NFP website.

Did you know?

“The Pill is 40”

Forty years ago May 9 (1960), the U.S. Food and Drug Administration gave G.D. Searle and Co. its approval to market Enovid-10, the drug that overnight became known as “The Pill.” Sadly, since its approval, nearly 80 percent of all American women born since 1945 have taken the pill sometime during their life. In all of the coverage we perused from women's magazines to

newspapers, only the “benefits” of the pill were applauded. Nothing was said regarding its abortifacient actions or of its role in promoting sexual promiscuity. A telling statement made in 1960 by the FDA Associate Commissioner John L. Harvey, may shed light on today's glaring omission: “We had no choice as to the morality that might be involved. When the data convinced our experts that the drug meets the new drug provisions, our own ideas of morality had nothing to do with the case.”

“No More Cycles for Women”

A new birth control pill is being studied that will only give a woman four menstrual-like bleeds a year. Dubbed “Seasonale,” the pill is the work of Gary Hodgen, director of the Jones Foundation Institute, an infertility center at Eastern Virginia Medical School in Norfolk. The premise of the pill is that the menstrual cycle does not need to occur in women as frequently as nature has designed. According to Hodgen, until the twentieth century, the history of women's reproductive patterns reveal that a great proportion of the pre-menopausal years were typically spent in pregnancy or breast-feeding. This means that “infrequent” menstruation was the norm. Taking a great leap from this bit of history, Hodgen believes that women's health can be enhanced by less menstruation. No longer will women have to suffer “bloating, headaches, mood swings or cravings” not to mention the cyclical “bleeding.” Leon Speroff, a professor of Obstetrics and Gynecology at Oregon Health Sciences University School of Medicine was quoted by the Washington Post as saying that “in truth, no one knows how many periods a woman should have.” Without scientific evidence to support or disprove this approach to menstruation, Speroff thinks that “women can decide for themselves whether to menstruate.” He dismisses opposition to this “idea of choice” as “really a social reaction” not based on medical fact. The American College of Obstetricians and Gynecologists have not yet taken a position on the issue.

“Allergies linked to Menarche”

A study published in the British medical journal *Thorax* (July 2000), found that the development of allergies in children may be related to the age at which their mothers started having menstrual periods. The study found that the younger the age of the woman's menarche, the more likely her children were to have allergies as adults. Dr. Xu, research author, said his preliminary findings support the idea that estrogen may play a role in allergies. He noted that previous studies have suggested that “women with high estrogen concentrations may be more likely to suffer allergies and that conditions in the womb might influence the development of allergies later in life.”

In the Mail

We received two letters questioning some information in the Focus sheet “Action, Effectiveness and Medical Side Effects of Common Methods of Family Planning” by Hanna Klaus, MD. One letter from Dr. John Billings raised concerns regarding the name “Ovulation Method,” effectiveness rates for the Ovulation Method, and definitions concerning “Method Related” and “User Related” pregnancies. A second correspondent questioned how Dr. Klaus estimated the effectiveness rates per each family planning method listed on the Focus sheet. Both letters prompted interesting conversation in our office. The following editorial is the result of one conversation, while a brief response by Dr. Klaus addresses some specific issues raised in both letters. Due to the length of each letter, only their questions are referred to in the text below.

“What's in a Name?”

Correspondence on our Focus sheet “Action, Effectiveness and Medical Side Effects of Common Methods of Family Planning” by Hanna Klaus, MD, has caused me to ask “what constitutes a valid generic NFP term which represents the multitude of NFP systems?” Knowing the NFP community as I do, the titles “STM” and “OM” do not indicate the great variety of NFP systems lined up under each. Yet, when developing generic NFP resources it is especially important to keep things simple. For example, in our National Directory of Diocesan NFP Coordinators, methods represented in each diocese are indicated as “OM” and/or “STM.” We have found that diocesan NFP teachers are so transient that if we listed the methods represented by the training schools per each diocese, we would spend most of our time mailing out corrections!

A resource design which is inclusive of all NFP methods is the challenge which we face every time we develop materials for the diocesan NFP programs. That said, we also have to tailor each resource to a specific audience. The above Focus sheet was written for a lay audience. It was intended to be used as a simple resource in marriage preparation programs and NFP class instruction. It offers an “at a glance” summary of the action, effectiveness, and medical side effects of the variety of family planning methods. It makes clear that the natural methods are the only ones which are compatible with Catholic Church teachings. That said, it also offers basic definitions of the two most popular methods of NFP--OM and STM on the back page as well as common definitions of family planning terms for effectiveness. In defining OM and STM for the lay person, who we presume, knows nothing of NFP, we said the following

STM utilizes the woman's observation of her primary (cervical mucus, Basal Body Temperature, cervical changes) and secondary signs of fertility (breast tenderness, mid-cycle pain, etc.). Differences surface among the schools of STM in how the temperature is recorded as well as with regard to the definition of the basic STM rule.

OM utilizes the woman's observation of one sign of fertility (cervical mucus). Differences surface among the schools of OM with regard to emphasis. Some schools emphasize “sensation,” others “observation” of the cervical mucus.

Although the above statements are true, we know that they can raise questions in the minds of NFP promoters. For example, at this point in time, any “mucus only” (or mostly) method is popularly referred to as the “Ovulation Method.” NFP promoters know that technically that is not correct. The Ovulation Method is the term which Dr. John Billings first coined in 1964 to speak about his system of Natural Family Planning. In fact the “World Health Organization in the 1970s conveyed . . . that the title Billings Method should be introduced and accepted as an alternative to the name Ovulation Method . . .” (personal correspondence from John Billings, 31 May 2000). Indeed, Dr. Thomas Hilgers has been clear that his approach to the mucus sign is a completely different system from that of the Billings Method and should be referred to as the Creighton Model FertilityCare™ System. So what is correct? Can we continue to popularly refer to any “mucus only” or “mucus mostly” method as “Ovulation Method?”

I think the answer, especially for NFP promoters, is to keep it simple! We must remember our audience. A general resource, such as the Focus Sheet above, only makes sense if the concepts are simple, clear, and accurate. “OM” and “STM” as NFP terms have undergone their own growth. They are popular references to single-indexed (OM) and multi-indexed (STM) natural methods. If a popular NFP term is used as above--including its definition--they should not confuse or mislead the novice. But the jury may be out on this topic. Should NFP promoters continue to refer to all multi-indexed NFP methods as “STM” and all mucus methods as “OM?” Or, should we in the NFP community try to change the language? We could call all multi-indexed methods just that--”MIM.” Likewise, we could refer to single-indexed methods as “SIM.” What do you think?

Until I hear from you, and until all NFP teacher training programs are in agreement--my guess is that we will continue to rely on “STM” and “OM” to indicate those methods which we so ardently provide in the dioceses.

T. Notare, Managing Editor

“Dr. Klaus Clarifies”

In response to correspondence, clarification on the effectiveness rates cited for the natural methods are in order: the figures for method related pregnancies were taken from James Trussell's computation provided for the Food and Drug Administration's authoritative package inserts for all contraceptive medications. As such, I accepted the “worst case scenario” so that we would not be in conflict with the information available to most of the medical profession in this

country. The user related category was likewise taken from Trussell but modified in light of studies published in peer-reviewed journals. At the time the Focus sheet was written additional NFP studies, some unpublished, were not available. If this information is taken into consideration the rate for method related pregnancies with the Ovulation Method is “0-3%,” and “0.51-14.9%” for user-related pregnancies.

Another correspondent had questions concerning projected use-effectiveness figures for all methods listed for a five-year period. His projections were highly theoretical, but based on the correct supposition that couples expect to be sexually active not only for one year but during most of their marriage. He observes that with prolonged use of any method, unplanned pregnancies generally arise.

With regard to the definitions of words associated with effectiveness studies, while Trussell and Kost use the terms “perfect use” and “imperfect use,” the FDA package insert states “perfect use” and “typical use in the first 12 months of use.” The Focus sheet did not include the words “in the first 12 months of use” because of space constraints and therefore may have confused some readers. That will be corrected in a reprinting of the resource. Meanwhile, for a fuller discussion of this issue see my article “Terminology in Natural Family Planning Revisited” in *Linacre Quarterly* (February 2000).

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