POPULATION

Sharing in wiser policies
INTRODUCTION

United Nations has declared 1994 the Year of Population. In preparation for UN's International Conference on Population and Development (ICPD) planned to take place in Cairo, Egypt, 5-13 September 1994, new energy has been stirred into the population debate. ICPD preparatory events are being held around the world and 700 non-governmental organizations (NGOs) have expressed their intention to attend.

The World Council of Churches (WCC) is among the major NGOs planning to take part. General Secretary, Konrad Raiser has expressed a renewed and long-term commitment to the issue of population. He has written to member churches asking them for any policy statements they may have on population, and for any information about current activities and future plans. A WCC discussion paper on Population and Development expresses the need for churches to become more involved in the search for a just balance in population issues. It says that a balance must be struck between the need to solve population problems on the one hand, and the need to provide individuals, particularly women, with the opportunity for reproductive rights and health on the other. The paper recommends that the churches make a more positive effort towards providing education on sexuality and towards the promotion of family planning.

Information about family planning methods can provide couples with an opportunity to improve the quality of their lives. It is wrong to deny women and men the knowledge and opportunity to take advantage of family planning. Being able to plan a family and to avoid unwanted pregnancy makes a positive contribution to family life. At the same time, it is wrong to pressurize men and women into using family planning against their wishes even if population growth rates are high. What is needed is wise population policy.

The WCC discussion paper is critical of the way in which the UN conference is linking population to development. It says that because "development" does not have a universally accepted definition, it is most often measured in terms of quantity rather than quality. For example, development is often stated in terms of the economic growth rate. The difficulty is that increases in Gross National Product (GNP) resulting from "development" programmes may not improve the quality of the lives of the poor. For example, a hydroelectric dam project may have added to GNP but it may also have increased poverty and suffering among people living in the surrounding area.

What WCC - including all of us at CMC - Churches' Action for Health - believes is that the priority is for an improvement in the quality of life. This can be achieved through a fairer distribution of wealth and income, the fulfilment of basic needs, both physical and spiritual, and through greater opportunities for the attainment of human rights, including the right to family planning.

A full discussion of the issue of Population should include such topics as mortality, age structures and migration. However, we have chosen to concentrate on the right to family planning, population strategies and policies. This is because both major attention and serious tensions surround this issue at the present time.
Towards Wiser Population Policies

Whether world population finally stabilizes at 10 billion or 20 billion is clearly an important matter. The larger the number of babies born, the greater the number of people among whom the earth’s limited resources have to be shared. But fear of rapid population growth has sometimes led to selfish and misguided policies. The benefits of family planning must be shared if the worldwide trend towards falling fertility and smaller families is to be strengthened.

Even at an early stage, political thinking on population and family planning was confused. Rather than trying to provide all couples with an opportunity for control over their lives and health, the first family planning pioneers were primarily motivated by a desire to control the fertility of the weak in society. US campaigner, Margaret Sanger wrote in Birth Control Review in 1926: “There is only one reply to a request for a higher birthrate among the intelligent and that is to ask the government first to take the burden of the insane and feeble-minded from their backs. Sterilization for these is the solution.”

Ever since, population policies have tended to hit the weak and the poor harder that the rich and powerful. The “population problem” has become equated with population growth in the South. There is a general view that the impending crisis of global resources can only be prevented by reducing population numbers in the South. However, what is equally necessary is a change of lifestyle in the North. The average Northerner consumes 50 times as much as the average person in the South.

Concentrating on “overpopulation” has led to unfair and unworkable policies. During the 1960s, international experts began predicting a global resource crisis as a result of an impending “population explosion”. Those who feared a fall in their living standards called for policies aimed at controlling population growth. Several Asian governments started to convert family planning programmes into tools of population control.
For example, in India, where the family planning programme had begun by providing services on request, was promoting family planning through incentive schemes by 1974. Health service providers were not only offering rewards to those who were sterilized, but were themselves working for incentive payments in return for reaching a target number of family planning "acceptors". Later, when it became clear that the quotas had been set unrealistically high, family planning workers faced penalties if they did not manage to persuade enough couples to accept family planning. They started to put further pressure on people who were not contraceptive users. As a result, the rates of "acceptance" increased but male protest against being forced into having vasectomies brought down the ruling party in India in 1977. It also led to the virtual collapse of the family planning programme in 1977-8.

The coercion involved in China's one-child family planning programme has also had negative consequences. There was widespread resistance to the programme during the early days when it was being strictly enforced. There was also evidence of an increase in female infanticide. Some women became permanently disabled by having attempted to abort themselves of unwanted fetuses.

Blaming others
Another misguided approach in population policies puts the blame for the population problem on a particular group. For example, parents of many children in the South are considered responsible for their own poverty. But would having had fewer children made them better off? Children are a source of great joy and a source of security in old age. Today's debt problems are likely to endure for many years to come. Many children may therefore be the best source of security in old age. Such realities must be addressed in wise population policies.

New directions
During the CMC Health Working Group meeting in Barbados in October 1993, population was taken as one of the main discussion themes. Participants described experiences and concerns in their own countries. They found that their countries shared many of the same problems. For example, high fertility rates, particularly among young women, was leading to overcrowding and family health problems, both mental and physical. Despite falling infant mortality rates, population growth was continuing to present a major problem.

Considerable attention was given to women's and men's reproductive health. There was a reminder that at least 100 million couples who say they want no more children were nevertheless not practising contraception. Abortion should not be considered a family planning method. However, every year, between 40-60 million women seek terminations to unwanted pregnancies. Many of these abortions take place in unhygienic and unsafe conditions. As a result, 200,000 women die from unsafe abortion each year, 98% in the Third World.

It was also recognized that many women would want to plan their pregnancies and have fewer children if they felt that they were given more support for doing so. At present, the obstacles to deciding to adopt family planning may be financial or due to the inadequacy of the services, or they may be due to the lack of support for family planning from governments, religious authorities or family members.
In searching for new directions, participants gained inspiration from the experience of the Caribbean area presented by local participants (see box). Several countries in the Caribbean region had come through a period of high population growth, yet family planning had not been officially promoted as a means of population control. Instead, family planning services had been made available as an integral part of health services.

However, the group felt that wise population policy meant much more than offering family planning as part of general health services. Income redistribution and social development were important factors in reducing fertility. Greater sharing was needed at the international, national and individual level.

**International**

At the international level, greater sharing implied a questioning of structural adjustment policies. Such policies made it more difficult for countries in the South to spend on policies which would lead to smaller families. For example, structural adjustment programmes often led to cuts in health and education services. Yet, girls without schooling were more likely to have large families.

There was also a need for a change in thinking about the causes of the population problem. The North needed to face up to the fact of its overconsumption. Widespread production of luxury, unnecessary and junk goods accompanied by vast quantities of waste had to be reduced.

The growing frequency with which development assistance was linked to population programmes was also criticized. Tying aid funding to family planning programmes was paternalistic. It might also be misguided. The decision to choose a small family was based on many and complex factors. It was matter for the couple themselves to decide.

**National**

Programmes of wealth and income redistribution were also needed at the national level. Many group members said that the lack of

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Experience in the Caribbean

WHO nurse adviser, Maria Barker gave an overview of health in the English-speaking Caribbean at CMC Health Working Group meeting in Barbados. She explained population trends in the following way.

"In demographic terms, the region has experienced significant changes in the past two decades. We can be justly proud of some of these changes when we look at the total fertility rate which was as high as six in some countries in the 1960s, and has declined. Today, the total fertility rate for the region is estimated at 2.8. This decrease has been influenced by the lower birth rates. What this means is that instead of five to seven children per woman in the 1950s and 1960s, the average number of children per woman in the 1990s ranges from two to four.

No single reason can be provided to explain the decline of birth and fertility rates. However, some of the factors which must be considered are:

- increased participation of women in the labour market - there has been a 50% increase in the past decade in some countries;
- increased education of women;
- easy access to modern contraceptives;
- relatively strong family planning programme efforts, and
- the social development which has occurred in the region."

Caribbean girls have good educational opportunities.
across to arable land was a major cause of population problems. A small minority owned vast tracts of land while making poor use of its potential. The extent to which nations shared both land, income and other resources among the general population directly affected fertility. Sri Lanka and Taiwan, for example, have low income inequality and dramatically reduced birthrates. In contrast, nations such as South Africa and Mexico with relatively high per capita incomes and relatively great income inequality have higher birthrates.

The Working Group was particularly concerned about the role of community education in wise population policy. They suggested that boys and young men should receive special attention. By guiding adolescent males towards more responsible roles, not only would they themselves benefit but also their families and society as a whole.

More attention needed to be given to women’s status. The fact that women were rarely involved in policy-making meant that they were excluded from making the decisions about population policy and family planning services, an area which touched their lives directly. With the growing strength of the women’s reproductive health and rights movement, there were new opportunities for women to put across their viewpoint at the international level. However, many women continued to face barriers to family planning use at the local and personal level. Some were unable to find convenient or affordable services, others feared the treatment they would receive at family planning clinics. Many young, single women found that information and services were not open to them even when they felt the need for them.

Church involvement
The need for churches to raise the issues which surround population and family planning was a particular concern to the Health Working Group. Population policy, attitudes towards sexuality, family planning and the needs of adolescents were becoming important issues to many both within and outside the Christian community. By highlighting the debate and by creating opportunity for discussion, there would be a recognition that greater sharing and justice is the key to wise population policy.

In the debate regarding family planning and abortion, a primary concern was that the concrete realities of women’s lives should be recognized. By speaking out in favour of safe and effective contraception, church leaders could help prevent many of the 200,000 deaths from unsafe abortion. The Health Working Group felt that the churches should not discriminate against women who feel that they have had no alternative to abortion; on the
contrary, it was felt that they should be prepared to support these women physically, mentally and spiritually.

References
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Power Bratton, S. Six billion and more, see page 16 for details.
Reproductive Health Matters, Number 1, May 1993 on Population and family planning policies: women-centred perspectives.
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HAI's recommendations on family planning services

Family planning programmes will be more effective if reproductive services incorporate the Essential Drug and Primary Health Care concepts. These imply fertility regulating services which are accessible to everyone, irrespective of age, sex or marital status; paying attention to women's overall reproductive health which may lead to safer choices of contraception, and making it possible for women and men to have free choice of methods and balanced information.

For this to happen, it is necessary to meet basic criteria such as those set out in the WEMOS and HAI Guidelines for Distribution and Use of Fertility Regulating Methods:

1. A wide range of contraceptive methods as well as safe abortion and sterilization to choose from;
2. Full, unbiased information about the contraceptive options available; their risks, their benefits, clear instructions about how they should be used, and the possible impact they will have on personal relationships and daily life;
3. An opportunity to decide on which method to use, free from sanctions or incentives;
4. Access to good health care system. Many methods are provider-dependent, and require settings where the user has access to follow-up care, and where removal on demand is assured.

Research efforts should be expanded to improve the availability and convenience of existing user-controlled methods of contraception including barrier and natural methods.

Above all, improving the political, economic and social status of women and involving them more fully in the design and implementation of family planning programmes is liable to have the most long-lasting impact.

Source: Problem Drugs by Andrew Chetley, Health Action International (HAI-Europe), Jacob van Lennepkade 334T, 1053 NJ Amsterdam, The Netherlands.
GHANA: CHRISTIAN FAMILY PLANNING

The Christian Council of Ghana through its Committee on Christian Marriage and Family Life has made family planning an integral part of the health care services that it provides. The approach concentrates on offering quality services to women.

Christians have led the way in family planning in Ghana. The Committee on Christian Marriage and Family Life (CCMFL) was set up even before the international organizations dealing with family planning, such as UNFPA and IPPF, had settled there. Family planning activities are centred on the well-being of the family, and women are treated as subjects, not as objects.

During the early days, the Committee identified two of the greatest problems for married couples in Ghana. Both were family planning related. One was coping with a rapid succession of children. The other, trying to care for too large a family.

Today, family planning services are offered at eight of the church Committee’s clinics. The services are offered by nurses who are supervised by medical doctors. Before a birth control method is recommended, the woman receives a thorough examination. She is informed about the various methods of contraception available, and asked about what she knows and believes might offer the best option for her circumstances. The client’s life situation and her wishes are always taken into account when the advice about which method to use is given.

The contraceptive pill is the most commonly chosen method. Many women are afraid to use the IUD because of strange stories circulating about it. Rumour has it that the IUD will go into your heart and cause heart failure, or that it will cause massive blood loss.

Until 1978, the Committee included Depo-Provera, the hormonal injectable, in its range of available methods. However, this was stopped when it became known that the international health and women’s organizations were warning against it. In fact, there had already been problems. Some women had experienced heavy bleeding which had sometimes lasted for several months.

Norplant is not used. This hormonal contraceptive preparation comprises six small sticks
which are implanted under the skin. The hormone seeps slowly into the body causing infertility for a period of up to five years. The decision not to offer Norplant was taken on the basis of possible harmful side-effects.

Clients at the clinics are kept under continuous supervision. Should a woman not return for a check-up within four months of a previous visit, a fieldworker will visit her at home.

**Infertility**

In the clinic in Accra, close to Christian Council of Ghana offices, one of the doctors pays special attention to the problem of infertility. He investigates possible causes in both the male and the female partner. Where possible, he treats the couples involved, and is sometimes successful. However, a great deal of attention is given to discussing human reproduction with the couple. For example, at present, there is still a widespread belief that infertility is always the fault of the woman.

**Theological motivation**

According to Charles Konadu, a pastor who has been Committee Secretary since 1981, "human beings are responsible for that with which God entrusts them." Thus, he reasons, people are responsible for the children that they have received. But he also says that it is important that a child grows up knowing that there is a "life worth living" for him or her. As a pastor, Konadu feels called to point out this responsibility to the members of his congregation. "We are stewards," he says, "and we cannot sit back and let more people come into the system than the community can handle. It is a challenge for us to let the church members know that family planning methods are a gift of God."

Konadu says that women's equality is still a long way off. "Our men need to have it pointed out to them that women are equal and have a right to respect." He also believes that the Committee has a responsibility towards helping the women to recognize their rights.

**Future challenge for young and old**

Teenage pregnancies in Ghana now make up 30% of all pregnancies, according to UNFPA reports. The problem has taken on such proportions that everyone is now talking about it.

When asked the reason why early pregnancy is such a big problem, women tend to blame poverty. For example, there is evidence that many young girls turn to prostitution or accept money and gifts from wealthy, older men ("Sugar Daddies") in order to survive. Men, on
the nuclear family, young men face serious financial responsibilities by marrying at an early age. In order to avoid supporting a young wife who wants to finish her education, the youth may even deny that he has fathered the child.

The Committee shows its commitment to young people through its training courses and income-generation projects. However, unmarried people are not offered family planning. Nevertheless, Christian counsellors have begun to recommend that the church involve itself in this education process. They argue that a change in attitudes is needed if teenage pregnancies are to be prevented.

The necessary changes in thinking will not come about if new opportunities for discussion are offered only to youth. Education about sexuality and social responsibility should be made available to both young and old. Older men need to recognise that when they take advantage of young girls, it can have traumatic and long-term consequences. There needs to be some questioning of the laws on rape in Ghana and of the link between rape and teenage pregnancy. The Church needs to be involved in a theological reflection on women as created in God’s image. Christian Council of Ghana could play an important role in stimulating this debate.

Although many people said that teenage pregnancy was something new, professor of theology and director of the Akrofi Christaller Memorial Centre for Missiology and Applied Theology, Kwame Bediako disagreed. “Teenage pregnancies were also very common in earlier days,” he said. “The difference being that at that time these pregnancies were desired. Children were welcome. There was always room for them in the ‘extended families’.” He said that the birth of a child gave validity to the marriage of the child’s parents. Without children, a relationship would simply fall apart.

Reluctant fathers
Bediako says that the “enormous stir” that teenage pregnancies causes today is the result of a change in society. With the shift towards
USA: WOMEN OF COLOUR SPEAK OUT

Ana Teresa Ortiz of Boston Women of Color for Reproductive Freedom spoke on "International solidarity and population policies" at 7th International Women and Health Meeting held in Uganda in September 1993. This article is based on her paper.

I am a Puerto Rican health activist living in the US, and a member of Boston Women of Color for Reproductive Freedom. Our group comprises women of African, Latin American, Asian and indigenous descent. We mobilize around the health needs of Boston's women of colour, including a campaign to keep our local hospital open.

Despite the fact that we live in the North, we have much in common with the women in the South. When it comes to health care and population policy, we face similar problems. We, too, have to struggle for the right to determine our own fertility.

Consider, for example, the way in which contraceptive technologies such as Depo-Provera and Norplant have been pushed upon our communities. These are being promoted even in areas in which women do not have access to the health care needed as back-up for these family planning technologies. There are also problems relating to the monitoring of side-effects and method failures. This is not done because the resources are simply not available.

The original safety testing of Norplant also troubles us. We are concerned that the women included in the clinical trials may have a different health status from that of women in general. There is a wide range and diversity in women's health. Consider for example, the serious concerns raised by the Native American Women's Health Resource Centre of Lake Andes in South Dakota. They point out the high rates of diabetes, hypertension and smoking among women in their communities. These conditions are contraindications for Norplant.

Another concern shared by many of us is that some of the marketing of Norplant is being directed at adolescents. This is despite the fact that there is no data on the health conse-
quences of use in this age group. According to a report by concerned teen-health advocates, young women implanted with Norplant at a clinic in one of Boston’s public housing projects had not been questioned about health conditions that were contraindications for Norplant. Equally worrying was the fact that the report revealed that some of the young women believed that Norplant would protect them from HIV infection.

Population control
But nothing gives us greater concern than the potential for abuse of contraceptive methods, such as Depo-Provera and Norplant, in pursuit of population control. Unfortunately, population control is alive and well in the USA. There have even been cases in which women, having been convicted of child abuse or substance abuse during pregnancy, have been sentenced by the courts to Norplant implantation. Instead of being provided with support to care for their children or being given voluntary treatment for their addiction, women are subjected to abusive population control measures.

Many women in our communities find themselves with little choice but to accept the contraceptive method on offer to them. Their right to choose is denied them because they do not have information on the full range of existing alternatives. Having accepted Norplant, some women have been refused their request to have the implants removed.

Incentive schemes to encourage use of these methods are becoming increasingly common. We consider their introduction to be indefensible. In poverty-stricken communities, cash-bonus incentives may effectively function as coercion, and certainly have the result of

"Reaganomics(*) and privatization fever has widened the resource gap. The income of the richest 1% doubled between 1977 and 1992, while the average income of the poorest fifth of families fell by 14%.

(*) Economic policies of former US President, Ronald Reagan."
sanctioning a negativity towards women who refuse to accept the offer.

In 17 US states, cash-bonus incentive programmes have been proposed which specifically target women of colour and poor women who are willing to accept Norplant implants. The Philadelphia Inquirer even went as far as to suggest that Norplant might be the solution to poverty among African-American families.

Since the introduction of Norplant, some states have introduced regulations to restrict government benefits for women who do not control their fertility. Women who have additional children while drawing public assistance may find that their payments have been reduced or withdrawn.

**Women’s participation**

What is needed is for women to participate in defining their own health care and family planning needs. When they are left out of this, they are automatically left out of the development of the health technology which they are to be offered. The end result is that, instead of women’s needs determining technology, the technology determines the health care programmes.

In both the North and the South, public health planners ignore community development at their peril. By treating health care and family planning as somehow independent of political and economic power, their best plans yield mediocre or poor results. Worse still, they may lead to even greater oppression."

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**Life and health in USA**

Reaganomics(*) and privatization fever has widened the resource gap. The income of the richest 1% doubled between 1977 and 1992, while the average income of the poorest fifth of families fell by 14%.

- During these difficult years, the number of people without health care services grew. African Americans and Latinos (people of Latin American descent) made up 50% of the increase in uninsured people.
- 14 million women of child-bearing age have no health insurance.
- In New York City, the poverty rate for female-headed households increased from 41% in 1969 to 63% in 1987.
- Women of colour are less likely to receive health education, early diagnosis and treatment for life-threatening illnesses.
- Women of colour face serious health risks. The rate of hypertension is 82% higher among women of colour than white women. (Hypertension is implicated in 30% of all maternal deaths.) Puerto Rican women have the highest recorded rate of cervical cancer in the world. Native American women are eight times more likely than white women to develop diabetes. Relatively low cancer rates are attributed to their short life expectancy.
  - Infant mortality for African-American infants (17.6 deaths per 1,000 live births) is more than double that for white infants, according to figures from the National Center for Health Statistics. On the poorest Native American reservations, the infant mortality rate exceeds 22 per 1,000 live births.
  - AIDS has hit communities and women of colour particularly hard. At least 53% of women with AIDS in the USA are African-American and 21% are Latinas (female Latinos). In New York City, African-Americans and Latinos make up only 23% of the population but Latinas and women of African descent make up 82% of cases of AIDS among women in the City.
  - USA has the dubious record of “leadership” in narcotic addictions, handgun homicides and rate of imprisoned persons per head of the adult population.

Source: Ana Teresa Ortiz
INDIA: FAILED BY THE FAMILY PLANNING SERVICE

If more women are to use contraception, family planning services must address the realities of women’s lives. In India, even women who want to use family planning often face serious obstacles. Although the services are free, the main contraceptive option is sterilization. Having this operation involves the woman in a considerable investment of time and effort. As the following case study shows, women who are without the support of family and friends may not be able to offer the necessary investment of time. What the woman in this story, and many other women, want and need is a choice of temporary methods, such as the pill, diaphragm or condoms. Later, they may want to return to the hospital for sterilization. Clearly, to be effective, family planning services must provide women with information, a choice of methods, counselling and follow-up.

Twenty-five year-old “M” is the second wife of a wealthy fisherman who owns a mechanized boat. The families of both she and her husband were opposed to the marriage because her husband’s first wife was still alive and well.

“M” lives in the thatched house her husband built for her, where he visits her from time to time. Since her family lives more than 50 kilometres away, she has no social support. When her first three children were daughters, she was ridiculed by the first wife who accused her of being incapable of bearing sons. To prove the first wife wrong, “M” chose to become pregnant again soon after the birth of her third daughter. If the fourth child were a son, she had decided that she would have a tubectomy.

The delivery turned out to be a complicated one and she was rushed to hospital. She haemorrhaged heavily and was given a blood transfusion. The child was a son. The doctors advised her to stay on in hospital, have the sterilization a few weeks later and then go home soon afterwards. In the meantime, however, her one year-old daughter was taken ill with malaria. Having no-one to help her look after the child, she left hospital against medical advice. Sadly, despite her efforts, the daughter died.

Now, three months later, “M” is in a dilemma. She wants to return to the hospital for sterilization. But what would she do with the newborn? What if he fell ill and died like the third child? All the same, she did not want another child and was afraid she might end up getting pregnant again.

From a presentation by Dr T K Sundari Ravindran in “Creating Common Ground in Asia”, a report of an Asian regional meeting on women’s perspectives on the research and introduction of fertility regulation technologies, organised by WHO’s Special Programme of Research, Development and Research Training in Human Reproduction, Manila, Philippines, October 1992.
NATURAL FAMILY PLANNING

Couples vary in their family planning needs and preferences. Therefore, it is important for family planning providers to offer as many different methods of fertility regulation as possible. Natural Family Planning can be an effective option, particularly for people who do not wish to use other methods for medical, religious or personal reasons.

According to the World Health Organization, Natural Family Planning (NFP) refers to "methods for planning and preventing pregnancies by observation of the naturally occurring signs and symptoms of the fertile and infertile phases of the menstrual cycle, with the avoidance of intercourse during the fertile phase if pregnancy is to be avoided".

Abstaining from sexual intercourse to avoid pregnancy is a practice common to many cultures around the world. However, abstaining during the fertile phase of the woman's cycle, often called "periodic abstinence", is a relatively new concept. It is based on the woman's observation of one or more of her naturally occurring signs and symptoms of fertility, usually her cervical mucus (vaginal secretion), basal body temperature, and cervix, which change during her menstrual cycle as a result of hormonal changes, particularly oestrogen and progesterone.

As a woman observes these signs and symptoms, she records her observations on a chart and interprets her findings to determine whether she is fertile or infertile. When a couple has this information, they can decide whether or not to abstain from sexual intercourse during the fertile phase of the woman's cycle, depending on their family planning intention.

NFP includes several methods of determining the fertile and infertile phases of a woman's menstrual cycle. The best known are the cervical mucus, basal body temperature, and sympto-thermal methods.

An additional NFP method is often referred to as the "rhythm" or "safe period" method. If used correctly, it involves calculations based on the length of previous menstrual cycles and application of this information to predict the infertile and fertile phases of the current cycle. However, surveys on family planning knowledge and practices indicate that most people who state that they are using this method are simply avoiding intercourse on the days they believe (based on a variety of assumptions and often erroneous information) the woman is most likely to become pregnant. Because of the variety of practices related to the rhythm method and the lack of scientific research on this topic, it is not the focus of this article.

Effectiveness
The effectiveness of a family planning method is described in terms of how many women, out of 100 women using the method, will become pregnant during 12 months of method use.
A family planning method many be very effective in theory (i.e. when it is used exactly as intended). But it may be less effective in actual practice because it may be used incorrectly.

WHO has studied the effectiveness of cervical mucus method in five countries: El Salvador, India, Ireland, New Zealand and the Philippines. Ninety-four per cent of the women in the study were able to observe and record their cervical mucus symptoms correctly and to determine their fertile phase during the first cycle in which they were using the method. For couples who used the method correctly, it was 97% effective. This means that for every 100 couples using the method correctly, for 12 cycles, or one year, only three women became pregnant.

However, as is the case with any family planning method that relies on the user to understand the method and use it correctly, there were a number of couples in the WHO study who were not able to use NFP successfully. Thus, in the study, 86% of the women who used NFP incorrectly became pregnant during the 12 month period. Overall, the effectiveness rate for all couples in the study was 78%. This means that for all couples, including those who used NFP correctly and those who did not, 22% became pregnant during one year. Numerous other studies of NFP effectiveness have shown similar results: depending on the knowledge and motivation of couples using the method, effectiveness rates of NFP range between 80% and 90%.

**Advantages and disadvantages**

Effective use of NFP requires couples to adapt their sexual behaviour. While this may be considered by some people to be an advantage of NFP, other people may consider it a disadvantage. The following advantages and disadvantages should be reviewed carefully in this light.

Frequently cited advantages are lack of physical side effects, increased self-awareness and knowledge, self-reliance (rather than reliance on a family planning programme or other source to provide contraceptives), minimal financial cost once the couple has learned to use the method, increased male involvement in family planning, and the fact that while NFP services must be provided by trained NFP teachers, it is not necessary for NFP providers to be highly skilled medical personnel.

There are several disadvantages as well. Most couples require at least three cycles to be able to use NFP correctly. During this time, frequent contact with the NFP teacher is needed. The commitment, motivation and cooperation of both partners are essential. The woman must keep daily records of her fertility signs and symptoms, at least during the first few cycles. Some couples experience emotional stress as a result of not being able to have intercourse for between eight and 16 days of the woman’s menstrual cycle. NFP is not as effective in actual use as some other methods of family planning.

**Associated risks**

Because NFP does not involve any drugs, devices, chemicals or surgery, it does not have the health risks of possible side effects associated with most other family planning methods. However, if couples do not use it correctly - that is, if they do not observe, record, and interpret the woman’s fertility phase - there is a risk of pregnancy. Under these circumstances, the risks to the woman’s health are the same as with any other pregnancy.

This article is adapted from Natural family planning: an important option for child spacing by Victoria Jennings and John T. Queenan, Institute for International Studies in Natural Family Planning, Georgetown University School of Medicine. It appeared *NU Nytt om Ulandshalsövarden* 2, 91.

For more information, including a Guide for Natural Family Planning Trainers, write to: Institute for International Studies in Natural Family Planning, Georgetown University School of Medicine, Department of Ob/Gyn, 3600 Reservoir Road, NW, Washington, DC 20007, USA. Tel: 202 687 1392. Fax: 202 687 6846.

WHO has published recent information about natural family planning, see page 15.

For information about the full range of family planning methods, please write to one or more of the relevant agencies (such as International Planned Parenthood Federation) listed on opposite page.
USEFUL CONTACTS

**Boston Women’s Health Book Collective**
This group is renowned for the pioneering work *Our Bodies, Ourselves*, which has been translated into many languages. The New *Our Bodies, Ourselves* is an updated and expanded edition of the classic. Both publications include discussion of the different family planning methods from women’s perspective. One of the Collective’s 1993 International women and health information packet addresses Population policy, population control, sterilization and sterilization abuse. The group is part of International Women’s Health Documentation Network referenced in Contact 134.

For more information, contact: International Program, Boston Women’s Health Book Collective, PO Box 152, Somerville, MA 02144, USA. Tel: 617 625 0277. Fax: 617 625 0294. Email: bwhbc@igc.apc.org.

**Evangelische Kirche in Deutschland (EKD)**
The Advisory Commission of the Evangelical Church in Germany (EKD) for Development Affairs has produced a study entitled *World Population Growth: A Challenge for the Churches* (German title: Weltbevölkerungswachstum als Herausforderung an die Kirchen) in 1984. The report can be ordered (free of charge in small quantities) from Churches’ Development Service (AG KED), see address below.

More recently, *Geschäftsstelle der AG KED (Association of Churches’ Development Service)* has produced a report entitled *The churches’ perspectives on population policies and family planning*. The report follows two workshops at Tübingen on the theme. Team member Eva von Hertberg is also involved in preparation of a study to be presented at the UN Conference in Cairo.

For further details: AG KED, Kniebisstrasse 29, D-70188 Stuttgart, Germany.

**Isis International**
A report of a meeting in Mexico, July 1993, entitled *Women and Population Policies* by the Latin American and Caribbean Women’s Health Network is available from Isis International in Chile. The report looks at the issue and in preparation for the UN International Conference on Population and Development to be held in Cairo in 1994.

For more information - about the Network and the publication, contact: Isis International, Casilla 2067 - Correo Central, Santiago, Chile. Tel: 562 633 45 82. Fax: 562 638 31 42. E-mail: isis@ax.apc.org.

**Isis-Wicce** has moved
Isis Women’s International Cross-Cultural Exchange has moved from Geneva to Kampala. Address: Isis-Wicce, Box 4934, Kampala, Uganda.

**International Planned Parenthood Federation**
IPPF produces a number of publications and wall charts on family planning and reproductive health, many in several languages. A list is available on request. *Family Planning Handbook for Doctors*, in English, French and Spanish, and *Family Planning Handbook for Nurses and Midwives*, in English, French, Spanish and Arabic, are available at £9.00 and £2.50 respectively.

For further information, including a publications list, write to: IPPF Distribution Unit, International Planned Parenthood Federation, Regent’s College, Regent’s Park, London NW1 4NS, UK.

**UNFPA (United Nations Population Fund)**
Organizers of the UN’s International Conference on Population and Development (ICPD), UNFPA plays host to the Conference Secretariat. If you want to take part in the Cairo meeting, 5-13 September 1994, along with at least 700 other NGOs, write for details and accreditation to: Linda Librant, NGO Advisor, ICPD Secretariat, c/o UNFPA, see address below.
UNFPA produces *Populi* magazine, 10 times a year, in English, French and Spanish, available free of charge from UNFPA country offices, UN Information Centres or direct from head office in New York. UNFPA also produces State of World Population report, taking a different theme each year.

Address: UNFPA, 220 East 42nd Street, New York, NY 10017, USA.

**Secretariat for Women’s Declaration on Population Policies**

Women’s organizations have a Secretariat for a declaration that they have prepared for the 1994 ICPD.

For a copy of the Declaration, and to endorse it, contact the International Women’s Health Coalition at: 24 East 21st Street, New York, NY 10010, USA. Tel: 212 979 8500. Fax 212 979 9009.

**Women’s Health Action Foundation**

This organization provides a wide range of information, particularly about women and pharmaceuticals. Recently, it has produced Guidelines for the distribution and use of fertility regulation methods. These are available in English and Spanish, free of charge.

Details: Women’s Health Action Foundation, Postbus 4263, 1009 AG Amsterdam, The Netherlands.

**World Health Organization**

A booklet listing *Publications 1987-1992* is available from WHO’s Programme of Research, Development and Research Training in Human Reproduction. *Natural family planning, What health workers need to know* has been published recently. For materials relating to the health of women as mothers, a publication list is available from WHO’s Maternal Health and Safe Motherhood programme.

Details: WHO, 1211 Geneva 27, Switzerland.

**USEFUL PUBLICATIONS**

*Searching for the new heavens and the new earth, An ecumenical response to UNCED*  
This brochure produced by the WCC is available in English, French, German, Spanish, Portuguese and Russian.

Contact: World Council of Churches’ Unced Group, 150 route de Ferney, PO Box 2100, 1211 Geneva 2, Switzerland.

*Six billion and more: Human population regulation and Christian ethics*  
This book lays down the theological groundwork for developing a Christian contraceptive ethos. With a background in environmental issues and Christian religion studies, author Susan Power Bratton has provided a new way of looking at the Bible and church history in terms of population issues.


**List of free materials in family planning/ Maternal and child health**  
This substantial publication is available free of charge to training and service organizations in developing countries and to international agencies. A 1993 supplement has recently been produced in English and French.

Details: Program for International Training in Health (INTRAH), The University of North Carolina at Chapel Hill School of Medicine, 208 North Columbia Street, CB#8100, Chapel Hill, North Carolina 27514, USA.

**Reproductive Health Matters**  
This excellent new journal offers in-depth analysis of reproductive health matters from a women-centred perspective. It aims to promote laws, policies, research and services that meet women’s reproductive health needs and support women’s right to decide whether, when and how to have children.

Details: Reproductive Health Matters, 1 London Bridge Street, London SE1 9SG, UK. Tel: 44 71 357 0136. Fax: 44 71 357 0137.
# INDEX OF PAST CONTACT ISSUES

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<table>
<thead>
<tr>
<th>No</th>
<th>Date</th>
<th>TITLe/AUTHOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>4/78</td>
<td>Realization of an Integrated Health Services Programme in Rural India - E.R. Ram</td>
</tr>
<tr>
<td>45</td>
<td>6/78</td>
<td>Appropriate Technologies for Tackling Malnourishment - J. McDowell</td>
</tr>
<tr>
<td>46</td>
<td>8/78</td>
<td>The Churches take a new look at the contributions of people with disabilities... in the search for their liberation from isolation - WCC</td>
</tr>
<tr>
<td>51</td>
<td>6/79</td>
<td>In Search of Wholeness... Reaching Out to One Another in Caring and Healing - CMC</td>
</tr>
<tr>
<td>52</td>
<td>8/79</td>
<td>Safe Water: Essential to Health - E. Ram</td>
</tr>
<tr>
<td>53</td>
<td>10/79</td>
<td>Community Building Starts with People: A report of the work of an ecumenical health and development agency in Nicaragua - G. Parajon</td>
</tr>
<tr>
<td>57</td>
<td>8/80</td>
<td>The Village Health Care Programme: Community-Supportive or Community-Oppressive? An examination of rural health programmes in Latin America - D. Werner</td>
</tr>
<tr>
<td>59</td>
<td>12/80</td>
<td>Nursing: The Art, Science and Vocation in Evolution - R. N. Barrow</td>
</tr>
<tr>
<td>60</td>
<td>2/81</td>
<td>International Year of Disabled Persons 1981 - S. Kingma, N. Acton, J. Steensma</td>
</tr>
<tr>
<td>64</td>
<td>11/81</td>
<td>Aging Today: A Question of Values - J.A. Murdock, M. S. Adesola, F. Poletto, M. Skeet</td>
</tr>
<tr>
<td>67</td>
<td>12/81</td>
<td>Stories Behind the Facts in the Health Sector - J.A. Monahlo</td>
</tr>
<tr>
<td>68</td>
<td>6/82</td>
<td>Understanding the Causes of World Hunger - F.M. Lappe and J. Collins</td>
</tr>
<tr>
<td>69</td>
<td>8/82</td>
<td>Tackling Child Malnutrition in the Community - J.E. Brown and R.C. Brown</td>
</tr>
<tr>
<td>71</td>
<td>12/82</td>
<td>Healing and Sharing Life in Community - WCC, S.J. Kingma</td>
</tr>
<tr>
<td>77</td>
<td>2/84</td>
<td>Rediscovering Traditional Community Health Resources: The Experience of Black Churches in the USA - J.W. Hatch, F.C. Robinson</td>
</tr>
<tr>
<td>78</td>
<td>4/84</td>
<td>Training Health Workers - L.A. Voight</td>
</tr>
<tr>
<td>79</td>
<td>6/84</td>
<td>The Ceara Experience: Traditional Birth Attendants and Spiritual Healers as Partners in Primary Health Care - J.G. Araujo</td>
</tr>
<tr>
<td>80</td>
<td>8/84</td>
<td>Women and Health: Women's Health is More than a Medical Issue - C. Lyons</td>
</tr>
<tr>
<td>81</td>
<td>10/84</td>
<td>The Church and Health: Reflections and Possibilities - J. McGilvary</td>
</tr>
<tr>
<td>82</td>
<td>12/84</td>
<td>Experience of a Community-Based Programme in Sudan - H. P.C. John</td>
</tr>
<tr>
<td>83</td>
<td>2/85</td>
<td>Today's Youth: What are their Health Needs? - D. Bennett, N. Kodaga, S. Denise</td>
</tr>
<tr>
<td>84</td>
<td>4/85</td>
<td>Answering &quot;Why&quot;: The Ghanaian Concept of Disease - P.A. Sarpong</td>
</tr>
<tr>
<td>85</td>
<td>6/85</td>
<td>Setting our Priorities for Health - 1985 Meeting of CMC</td>
</tr>
<tr>
<td>86</td>
<td>8/85</td>
<td>The Child's Name is Today - D. Morley</td>
</tr>
<tr>
<td>87</td>
<td>10/85</td>
<td>Nurses: A Resource to the Community - R. Harnar</td>
</tr>
<tr>
<td>88</td>
<td>2/86</td>
<td>&quot;I've Made It; You can Make It, Too&quot;: Adolescent Fertility: Looking for Solutions to a World-wide Problem - E. Coit</td>
</tr>
<tr>
<td>89</td>
<td>4/86</td>
<td>From Indonesia: Practising Wholistic Healing - B.A. Supit</td>
</tr>
<tr>
<td>90</td>
<td>6/86</td>
<td>Infant Feeding Today: What's Best for the Babies? IBFAN and CMC</td>
</tr>
<tr>
<td>92</td>
<td>2/87</td>
<td>Update on: Malaria, AIDS, Guinea-Worm - D. Hilton, D. R. Hopkins</td>
</tr>
<tr>
<td>94</td>
<td>6/87</td>
<td>Listening and Caring, Towards Healing of Nations - J. Njemc</td>
</tr>
<tr>
<td>95</td>
<td>8/87</td>
<td>National Black Women's Health Project: Empowerment Through Wellness - E. Avery, F. Ward</td>
</tr>
<tr>
<td>96</td>
<td>10/87</td>
<td>Financing Primary Health Care Programmes: Can they be self-sufficient? - V.H. Vaca, S. and M.S. Kreider</td>
</tr>
<tr>
<td>97</td>
<td>12/87</td>
<td>Health Story-Telling - D. Hilton</td>
</tr>
<tr>
<td>101</td>
<td>2/88</td>
<td>Health For One Million: Just Another Slogan? - L.M. Ephraim and Sister Eyvind</td>
</tr>
<tr>
<td>102</td>
<td>4/88</td>
<td>Doing Our Best, All Out Us - Progress with Mental Disabilities - B. Webb-Mitchell</td>
</tr>
<tr>
<td>103</td>
<td>6/88</td>
<td>Health Teaching Made Easier - How to Create a Manual - B. Rubenson</td>
</tr>
<tr>
<td>104</td>
<td>8/88</td>
<td>Community-Based or Oriented: The Vital Difference - D. Hilton, A. Hope, E. S. Thomas, S. Osih</td>
</tr>
<tr>
<td>105</td>
<td>10/88</td>
<td>Essential Drugs: A Convincing Concept - C. Albert</td>
</tr>
<tr>
<td>106</td>
<td>12/88</td>
<td>Justice and Health: Latin American Reality - G. Meyer</td>
</tr>
<tr>
<td>107</td>
<td>2/89</td>
<td>Health Healing and Wholeness in a Wounded World - K. Cranberg-Michaelson</td>
</tr>
<tr>
<td>108</td>
<td>4/89</td>
<td>Base Christian Communities and Health: Nangina Project - G. Dedrichs</td>
</tr>
<tr>
<td>110</td>
<td>8/89</td>
<td>Our Village is Our Life... and Our Health - VAHS, P. Swan</td>
</tr>
<tr>
<td>111</td>
<td>10/89</td>
<td>The Whole Person Health Ministry: The Bethel Baptist experience, Kingston, Jamaica - A. Allen</td>
</tr>
<tr>
<td>112</td>
<td>12/89</td>
<td>Tobacco and Health: behind the smoke screen - Candace Corey, Judith Mackay, P. Pradervand</td>
</tr>
<tr>
<td>113</td>
<td>1/90</td>
<td>Kaapio: The people of New Caledonia struggle to hold on to their culture... and their healing tradition - E. Senturias</td>
</tr>
<tr>
<td>114</td>
<td>3/90</td>
<td>&quot;We have done it ourselves&quot;: A community-based health care programme in the Machakos District of Kenya - J. Crowley</td>
</tr>
<tr>
<td>117</td>
<td>9/90</td>
<td>Health in a Search for Wholeness: The journey of the Medical Mission Sisters - M. Pawath, S. Summers</td>
</tr>
<tr>
<td>118</td>
<td>11/90</td>
<td>Health in Workplace: It's everybody business - J. Booker-Festeri, L. Wise, P. Marin, IOHSA; CMC</td>
</tr>
<tr>
<td>119</td>
<td>1/91</td>
<td>Children: Agents of change in the restoration of their own rights, including health - A. Swift (UNICEF); R. da Souza Filho; P. Weltz-Whelan; M. Lemos; S. El work; Z. de Lima Soares; Child to Child Trust; CMC; OREARQ Foundation</td>
</tr>
<tr>
<td>120</td>
<td>3/91</td>
<td>The Hospice Movement: Providing compassionate and competent care for the dying - C. Saunders; T. Kashwagi; T. Banks; A. Mannam</td>
</tr>
<tr>
<td>121</td>
<td>5/91</td>
<td>Saying No to the Debt - Candace Jagel</td>
</tr>
<tr>
<td>122</td>
<td>7/91</td>
<td>and</td>
</tr>
<tr>
<td>124</td>
<td>4/92</td>
<td>Health Development among the Nomadic Peoples of East Africa - G. Kimirei, E.M. Nangawe, Mark L. Jacobson, Mrs A. Wahlenberg; Sr F. Oguijawa; CMC</td>
</tr>
<tr>
<td>125</td>
<td>6/92</td>
<td>(r)training Doctors for Community Medicine to meet the Health Needs of the Majority - E. Senturias; C. Andrew Pearson, CMC</td>
</tr>
<tr>
<td>126</td>
<td>8/92</td>
<td>AIDS: A Community Commitment - E. Senturias; B. Shenk; CMC</td>
</tr>
<tr>
<td>127</td>
<td>10/92</td>
<td>Leadership and Community Participation for Health, Part I - C. Jagel; M. Skold; D. Kasie</td>
</tr>
<tr>
<td>128</td>
<td>12/92</td>
<td>Community-Determined Health Development: A vision of the future from Zaire - P. Nickson</td>
</tr>
<tr>
<td>129</td>
<td>2/93</td>
<td>Leadership and Community Participation for Health, Part II - C. Jagel</td>
</tr>
<tr>
<td>130</td>
<td>4/93</td>
<td>Popular communication for health: Letting people speak for themselves - INCUPO, EPES</td>
</tr>
<tr>
<td>131</td>
<td>6/93</td>
<td>Supporting women: Fighting discrimination to improve health</td>
</tr>
<tr>
<td>132</td>
<td>8/93</td>
<td>Participatory evaluation: The Peña experience - M.T. Feuerstein</td>
</tr>
<tr>
<td>133</td>
<td>10/93</td>
<td>Campaigning for breastfeeding: Church and community action</td>
</tr>
<tr>
<td>134</td>
<td>12/93</td>
<td>Resource centres. Building living libraries - ARHTAG</td>
</tr>
</tbody>
</table>

February 1994
ANNOUNCEMENTS

A seminar for those working in health entitled Ethical challenges of health and healing today will take place at Ecumenical Institute, Bossey, 14-24 September 1994. The workshop will focus on population and AIDS. The course will be given in English, with simultaneous translation into French and German.

For further details write to: Ecumenical Institute, Château de Bossey (Vaud), CH-1298 Céligny, Switzerland.

Rexford Asante joins CMC
We are delighted to welcome Rexford Kofi Oduro Asante to the CMC - Churches’ Action for Health team. He joins us as Executive Secretary for Health and Healing, with a special responsibility for further strengthening our relations with the church-related coordinating agencies around the world.

Kofi, as he prefers to be known, is a medical doctor from Ghana. After studies in the former Yugoslavia, Ireland and USA, Kofi worked in Ghana’s Ministry of Health and in the University of Ghana Medical School before joining African Medical and Research Foundation (AMREF) in 1980.

With his wide experience, particularly with hard-to-reach populations and in poverty alleviation, we know that he will be an asset to the team. We extend to him and his family all good wishes for their future happiness in Geneva.

Handbook on computer and health
This brief health and safety guide is designed for non-governmental organizations (NGOs) who use computers in their work. However, it would be useful to anyone using a personal computer. It deals with the various physical hazards and with stress, and it has a section on workplace design for health safety. It outlines European safety requirements and provides up-to-date safety guidelines.

It is currently available in English and Chinese from Asia Monitor Resource Center, 444 Nathan Road 8-B, Kowloon, Hong Kong, (It was compiled and typeset in Hong Kong). For other languages, please write to co-publisher, Evangelisches Missionswerk in Deutschland eV, Communications Desk, Mittelweg 143, D-2000 Hamburg, Germany. Language versions currently available (other than English and Chinese) include Arabic, French, Indonesia, Korean and Spanish. All are free of charge.

CONTACT is the periodical publication of “CMC - Churches’ Action for Health” of the World Council of Churches (WCC). It is published six times a year in English, French, Spanish and Portuguese. Selected issues are also published in Kiswahili in Kenya, and Arabic in Cyprus. Present production exceeds 32,000 copies.

CONTACT deals with varied aspects of the community’s involvement in health and seeks to report topical, innovative and courageous approaches to the promotion of health and integrated development. A complete list of back issues is published in the first annual issue of each language version. Articles may be freely reproduced, providing that acknowledgement is made to CONTACT, the bi-monthly publication of CMC - Churches’ Action for Health, WCC.

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The average cost of producing and mailing each copy of CONTACT is Swiss francs 4 (US$2.50), which totals Sfr 24 (US$15) per year for six issues. Readers who can afford it are strongly encouraged to subscribe to CONTACT to cover these costs. Please note that orders of back issues of CONTACT are charged at the above rate. The CCP account number, for payments made in Switzerland in Swiss francs, is CMC/WCC, 1211 Geneva, CCP 12-572-3.