difficult to quantify and study, but they are clinically very significant.

In support of his assertion, "The most prominent disadvantage to current natural family planning techniques is the high failure rate," [p 41] Dr. Woolley quotes total pregnancy rates from a review[3] of use-effectiveness studies of NFP that range from 0.4 to 39.7 for the cervical mucus method of Billings and from 4.9 to 34.4 for the sympto-thermal method (Pearl Index). The same review[3] gives "method failure" rates for the same studies that range from 0 to 5.7 for the cervical mucus method and from 0 to 13.1 for the sympto-thermal method (Pearl index). Even if one sets aside the issue of user intent, these figures compare very favorably with both use and method effectiveness rates for other methods of contraception,[4] including those quoted for spermicides earlier in Woolley's review.[1]

In fact, pregnancies among NFP users are probably better described as (1) "method-related pregnancies," which occur despite correct application of the rules to avoid pregnancy; (2) "teaching-related pregnancies," which occur because of inadequate instruction or inadequate learning of the rules to avoid pregnancy; (3) "informed choice pregnancies," which occur when a couple chooses to have coitus on a day they know to be potentially fertile; and (4) unresolved pregnancies," when there are insufficient data to classify a pregnancy.[5] Klaus[2] has retrospectively reevaluated major use effectiveness studies using these categories, and the major multinational World Health Organization study of the cervical mucus method used similar categories in reporting its results.[6]

The concern of a potential link of "the increased relative fraction of conceptions occurring at the margins of the fertile period" with "higher rates of congenital defects and alterations of the sex ratio at birth" [1 p 42] is not supported by the results of the previously mentioned World Health Organization Study.[7]

Finally, although Dr. Woolley correctly identifies the importance of the skill of the instructor teaching natural family planning, he does not elaborate on his concern for the "intensity of training requirements" as a serious flaw. When taught by professional instructors, NFP does not require inordinate effort to learn.[2] The motivation for use is, of course, prerequisite. There are definite criteria to consider in identifying instructors and programs that are qualified to teach NFP.[8]

In conclusion, I quote from Labbok and Queenan's review[8]:

> The clinical support of a user of periodic abstinence methods demands a clear understanding of the methods. These methods have an efficacy equivalent to or better than many barrier methods, are highly acceptable among certain groups, and, after the teaching phase, are basically cost-free. Such methods should be given due consideration in offering a patient an informed choice of family planning methods.[p 399]

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The above letter was referred to the author of the article in question, who offers the following reply.

To the Editor: I appreciate the opportunity to respond to the criticisms raised in the above letter. Dr. Stanford seems to believe that the published pregnancy rates for NFP methods are artificially large because a significant number of the couples enrolled are actually attempting to achieve, rather than avoid, pregnancy. He cites no evidence for this assertion. It seems unlikely that researchers include couples desiring pregnancy in their studies of contraceptive efficacy. Certainly, there are varying degrees of motivation to avoid pregnancy. But this situation is hardly unique to NFP; in fact, the methods that are *not* significantly motivation-dependent (e.g., IUD, subdermal implants, and surgical sterilization) are the exceptions. If a method requires an unwavering commitment to difficult and restrictive rules, then it should be recommended to only highly selected couples, rather than excused for its poor performance in clinical trials.

The classification scheme of pregnancies advocated by Dr. Stanford (an objection I anticipated and addressed in my article) is useful for research. In clinical practice, however, such distinctions among failures obscure the simple, unarguable fact that users of NFP, as a group, experience many more unwanted pregnancies than users of hormonal, surgical, or barrier methods. In terms of the impact on the couple, a failure is a failure is a failure.

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I believe I was quite clear in stating that the evidence for problems with conception at the margins of the fertile period was "far from conclusive." I am aware of the paper Dr. Stanford cites on this matter, but I do not believe that negative results from one study necessarily disprove the positive results from another.

Current NFP methods are distant finishers behind most modern methods in terms of efficacy, ease of use, user satisfaction and continuation, and overall safety (when accounting for the maternal morbidity and mortality associated with failures). The proper place for NFP methods in clinical contraceptive practice is, for now, limited to the small number of patients who cannot or will not use more effective methods. As should be apparent from my review, I am sensitive to the reasons people select NFP and strongly in favor of any possible improvements in the methods. I fear that the unrealistically rosy picture of current methods painted by many NFP advocates with creative use of statistics and denial of major problems may actually inhibit progress in this area.

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