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Gender, sexuality and communication issues that constitute barriers to the use of natural family planning and other fertility awareness-based methods

M. DIAZ

Centro de Pesquisas e Controle Das Doencas Materno-Infantis de Campinas (CEMICAMP), Brazil

Abstract

Fertility awareness-based methods of family planning are rarely offered through reproductive health services in Latin America, despite evidence that many women use them. Providers state that clients do not want these methods, but provider-bias is evident. Providers overestimate the difficulty of learning and using fertility awareness-based methods, and they underestimate their efficacy. Both providers and clients have difficulty dealing with sexuality (which is central to fertility awareness-based methods). Many providers lack gender sensitivity, 'worsening' the unequal relationship between providers and clients. Experience has shown that when fertility awareness-based methods are well provided, they can have a positive effect on sexuality, self-understanding, and equality in the couple's relationship.

Introduction

Data on contraceptive prevalence in Latin America show that in many countries the prevalence of use of family planning methods based on fertility awareness is higher than those of some of the so-called modern methods. For example, the most recent Demographic and Health Survey (DHS) [1] in Brazil shows that the prevalence of the rhythm method is 2.1% per 100 married or in union women who are fertile and 2.0% are using withdrawal, compared to 0.8% using IUDs, 1.1% using injectables. In the age bracket 25–29, when the fertility is very high, 3.9% of the women use the rhythm method and the prevalence of IUDs is 1.3% (DHS, 1996). Other countries in the region present an even higher prevalence of methods based on fertility awareness.

In addition, studies of contraceptive use by adolescents and young adults who are

beginning sexual activity show that more than half of young people initiate sexual activity without using contraception and more than half of those who use some method rely on rhythm, usually without being educated about its use [2]. On the other hand, the statistics of the reproductive health/family planning services indicate that traditional and fertility awareness-based methods are not being used or are being used at a frequency far lower than that of IUDs or injectables.

Most providers, when asked the reason for the lack of use of these methods in the clinics, answer that these methods are not chosen by women/couples even when they are offered in a context of real free choice among all other options available.

These data raise the question "Are these methods really offered in a context of free option and not accepted by the users, or are they simply not offered adequately in the health services?"

To answer this question, it is helpful to review the experience of groups working with religious institutions to promote the use of fertility awareness-based methods, mainly the Billings method. Most of the institutions have shown that these methods, when offered with adequate information and counseling, are well accepted by a significant proportion of the population and that when they are used correctly have an effectiveness comparable with those of some modern methods [3].

These experiences, which are not unique to Latin America, suggest that the very low acceptance of these methods in services is mainly due to the fact that users do not have the opportunity of choosing them in a context of real free choice because the methods are not adequately offered. Further analysis of this situation is needed.

Analysis

Providers state that fertility awareness-based methods are not accepted by women/couples even when offered in a context of true free choice for the following reasons:

- It is not easy to follow the directions and follow the rules
- Successful use requires the collaboration of partners who usually are not willing to participate in family planning
- It is difficult to accept abstinence (mainly by male partners)
- These methods have very low efficacy

Institutions that promote these methods and give adequate information on how to use them have reported very good results with the use of the rhythm method and the Billings method. On the other hand, in public sector family planning clinics, the time for counseling is very short, so women really do not understand properly the characteristics of the methods and do not learn how to use them. In addition, the lack of previous sexual education of the potential users and the lack of this service in the clinics make it difficult for women to accept methods that require some control of sexual activity.

The lack of participation of men in family planning always has been considered an important barrier to the use of fertility awareness-based methods. Men usually do not participate in the choice of methods, and consequently it is difficult to obtain their collaboration for the use of these methods. However, this lack of participation resides more in the characteristics of services than in men's unwillingness to participate. Most family planning services are part of women's health services, where men do not feel comfortable because a specific space for them is not available and providers are not skilled in working with men. A few experiences in Latin America, i.e. Propater in Brazil and Profamilia in Colombia, have shown that when services encourage men's participation, the response of men is very positive.

Women's concern that their partners will not accept abstinence in the fertile period is strongly influenced by the providers' belief that sex is only sexual intercourse with penetration. Abstinence is presented in a negative way, as a period when sex should be avoided, instead of explaining that abstinence means to only avoid penetration with vaginal ejaculation, but that sexuality can be expressed in other ways such as caressing without intercourse or mutual masturbation during the abstinence period. The open discussion of these alternative practices may increase the acceptance of abstaining from sex with penetration.

Another problem in the acceptance of these methods is that they are perceived by potential users as having a very low effectiveness, a perception that is reinforced by providers. Certainly, effectiveness is one of the characteristics that women take into account in choosing a method, but it is not the most important for all women. Furthermore, when these methods are practised correctly and consistently, they are very effective.

Women should have the right to make a free choice based on a complete knowledge of all the characteristics of the method. Experience in clinics and some users' perspective studies have shown that safety is very important for many women in choosing their family planning method, with the possible side-effects and mode of use being as important as effectiveness.

The insistence on offering only highly effective methods means that very few providers offer fertility awareness-based methods. However, women using methods that are not their first choice or without being adequately counseled may also have a high rate of failures, as is shown by the high failure rates of the pill in routine use in Latin America.

Even LAM, which has proven to be highly effective in the first six months post-partum when correctly used, is not offered because most providers incorrectly think that this method has a very low effectiveness. The following example illustrates the difficulty of convincing providers of the efficacy of LAM.

In a training session which reviewed all family planning methods, all the trainees were surprised to learn that LAM is highly effective during the first six months after delivery. After the discussion, they theoretically accepted that LAM should be included as a valid option in the post-partum period. During a role play exercise, one of the trainees was not able to accept that a woman who had had four children had chosen LAM and tried hard to change her decision to a "more effective method". This situation illustrates how difficult it is to put into practice new knowledge that is

not consistent with previous knowledge and prejudices.

This example illustrates another barrier to adequate service provision: the providers' paternalistic attitude related to choice of methods. Providers have been trained to decide for their "patients". Commonly, a woman comes to a physician with an illness, expecting to be healthy, putting the power of decisions in the physician's hands. Women, who historically have not had power to decide about issues related to their own bodies, have not been able to assume the responsibility of taking care of their own health. Despite intensive training programs undertaken in Latin America, providers still feel that they have the responsibility of choosing the best method for the woman instead of giving the responsibility to women and helping them make their own appropriate choice. Because providers think that effectiveness is the most important characteristic of a method and the responsibility of choice is in their hands, it is easy to understand that providers choose for women methods the providers perceive to be effective

These factors create structural barriers to services. How sexuality is seen by providers also interferes with the use of these methods.

To perform a complete analysis of the process of decision-making in reproductive health, it would be necessary to do a historical review of the construction of sexuality and gender identity in society and how this identity affects women's lives and reproductive decisions. Such a review exceeds the objectives of this paper. A more practical and objective analysis is presented that identifies the main factors influencing the acceptability and use of these methods in family planning services, focusing on issues related to sexuality, gender, and communication.

For a woman to make an adequate informed choice of family planning method, particularly if she is choosing a fertility awareness-based method, she needs to have some knowledge and skills that include, among others:

- Knowledge of her own body and how it functions
- A good relation with her own body, free of fears and shame
- A realization that her body belongs to her and that she has the power over her body
- The power to make decisions about sexuality, (e.g. the woman should be able to accept or refuse sexual intercourse according to her needs, such as when she is fertile and thus at risk of getting pregnant)
- The skills and the power to talk with her partner about her body, her fertility, sexual intercourse, feelings and desires, thus contributing to a more equitable relationship
- The power to discuss with her partner the concept that family planning is a right and a responsibility of both the man and the woman
- Updated, unbiased and prejudice-free information about sexuality, reproduction and family planning methods.

Current situation

What is presently available to women in the region?

In the most qualified services, information is given through lectures where anatomy and physiology of reproduction are explained and contraceptive methods are described. In general, this information is given without taking into account that reproduction is closely linked to sex. The body is presented as a non-sexual entity. Only biological aspects are considered, without taking into account their interrelationship with sexuality and other socio-cultural issues. This is illustrated by the fact that in most clinics, the information about family planning is given without mentioning the word sex.

Even recognizing the enormous technological advances in reproductive health, cultural influences still tend to dissociate reproduction from sexuality, omitting the concept of well-being and pleasure that is inherent in sex.

In provider/client interactions, counseling or consultation, usually the relationship is not balanced. The provider has power conferred by knowledge and professional status and the information received by the woman is limited by this inegalitarian relationship. The provider is authoritarian and the client submits to this authority. This is more evident when the provider is a physician. The relation is still more conflictive when providers impose values that are not necessarily the same as the users' values.

Language is another factor that impairs communication and contributes to the imbalance in the provider/client interaction. Technical language used by the providers may not be understood by the users, contributing to inequality in the relationship and giving the provider power of decisions in matters related to sexuality.

Despite the transformations and profound changes in life styles and values that have occurred in the last few decades, many people still have a great deal of difficulty dealing with matters related to sex. The prevailing socio-cultural model greatly influences the construction of sexual and gender roles and how sexuality is lived and perceived. In general, health services work with a concept of reproductive health that gives priority to biological aspects, omitting or devaluing socio-cultural aspects.

Returning to the list of conditions necessary for women to choose and use fertility awareness-based family planning methods properly, it is easy to see that services are far from offering clients an orientation that takes into account issues of sexuality and gender and that communication skills also are not adequate. This probably is due to the fact that providers have great difficulty dealing with these issues also, just as their clients do, and did not receive adequate training to deal with these issues. In addition, they are part of the same culture that, on one side encourages people to think erotically about the body but, on the other side, is repressive and controlling, emphasizing norms and reinforcing taboos. In other words, health professionals may help to maintain the situation, but they also are victims of the system that impedes their becoming agents of change.

The principal impact of taboos is that they are greatly responsible for the maintenance of a state of lack of information, contributing to continued feelings of

anxiety and blame that sexual issues evoke. Negative feelings – blame, shame, anxiety, fear – are the consequences of the meaning of sexuality that has been transmitted from generation to generation, where sex is seen only as the instrument of reproduction and accepted only in heterosexual relations within marriage. This concept of sexuality has a very negative influence in the way sexuality is perceived and lived.

A study in Mexico [4] on the meaning of sexuality through three generations of women showed that changes, when they occur, include advances and recessions, showing that the process of change is neither sequential nor continuous. In the first generation (grandmothers), the family, school and church give the support for the transmission of knowledge of sexuality to the next generation, strongly maintaining the beliefs and practices prevailing in that time, having mostly a religious orientation.

From the second to the third generation (mothers to daughters), information is influenced by other factors because a lot of new sources of information are now available, such as radio, television, cinema, and written information on family planning. Women began to participate more in remunerated work and to be more affected by external influences through travel and other interactions. All these influences, including the wider dissemination of pornography, made possible the construction of other meanings for sexuality. Daughters perceived sexuality as an experience not exclusively related to reproduction and accepted desire and pleasure as components of sexuality. Still, the central attitude that went through the three generations was the religious position that accepts sexuality only when legitimized by marriage [4]. Despite all the changes in the way sexuality is currently understood, moral and religious censure greatly affects the way sexuality is lived.

Discussion

It is important to consider the role of family planning services in overcoming the barriers to providing fertility awareness-based methods.

The current concept of family planning including reproductive health and rights demands the inclusion of sex education among its activities. The main objective of sex education is to open a space for thinking about, and discussion of attitudes, roles, beliefs, values, behaviors, practices, and taboos about sexuality taking into account the person's physiologic, sociologic, psychologic and spiritual dimensions.

Within this context, family planning can open possibilities not only to control the number of children a couple has but also to reconstruct the meaning of sexuality, from a repressive and blameful one to a healthier sexuality perceived and lived with pleasure. In addition, a healthy sexuality may contribute to reconstructing gender roles and decreasing the power imbalance between men and women.

It can also encourage individuals, mainly women, to have a better knowledge of their bodies and a better perception and consciousness of their own sexuality, allowing them to enjoy intimacy without fear, blame or shame. It can also help people to reevaluate their emotional world, including the expression of tenderness and love, sharing the responsibility with their partners.

Better and healthier sexuality may also help to make more effective the learning process of how to avoid an unwanted pregnancy through a better understanding of all family planning methods and their interaction with sexuality, allowing a real free informed choice of the best option. Women living a healthy sexual life have greater possibilities of using fertility awareness-based methods successfully.

It is clear that fertility awareness-based methods are fundamental for promoting a better knowledge of the person's own body and of the physiology of sex and reproduction, and it can contribute to women's empowerment and family well-being.

Experiences with community groups have shown that it is possible to improve women's knowledge about sexuality, that women/couples can use successfully the fertility awareness-based methods, and that better knowledge of sexuality brings important benefits for the woman and the couple. However, most of these experiences are with religious groups linked to the Catholic Church. As a result, the participation of people who are not religiously-motivated to use these methods is limited. The link with the church creates suspicion that they are only a way of religious proselytism and that they are not real methods.

The greatest challenge is to incorporate and add these methods to the available options in reproductive health services. The addition of these methods may bring important benefits to women, not only as a family planning method but also in their sexual and general well-being.

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