

Egypt:

***The Impact of Family Planning on the Lives
of Egyptian Women***

Saneya Saleh and Donald Heisel



**Summary of Preliminary Findings Prepared for
The Women's Studies Project
Family Health International**

October 1998

**This summary highlights findings from a larger scientific report
and includes recommendations from in-country researchers.**

Egypt:

The Impact of Family Planning on the Lives of Egyptian Women

I. Introduction

Among family planning workers, conventional wisdom dictates that there are numerous economic, health and psychological benefits for women who use family planning. Other efforts to improve women's status are believed to be less effective if women do not have the ability to make reproductive choices. Yet, there is little empirical evidence to refute or to support these ideas. Previous research on women and family planning has focused on how various aspects of women's lives, such as education and employment, predict their use of family planning, rather than the reverse – how family planning use may affect work histories or other aspects of women's lives. This study, conducted by the Women's Studies Project (WSP) in six governorates in Egypt, collected data on this reverse relationship, using both quantitative and qualitative methodologies to explore the impact of reproductive choices on women.

II. Study Goals and Objectives

The primary objective of this study was to increase the understanding of the impact of family planning on the lives of women in Egypt, including outcomes such as education, employment, self-esteem, relationship with spouse and community involvement. These outcomes were measured objectively and subjectively through women's self-reports. Because the health benefits of family planning have been fairly well-documented, the study focused on other aspects of women's lives. A second objective was to provide information to policy-makers and program managers to strengthen their capabilities to better meet the needs of women and their families.

III. Study Design

The study was conducted in two phases. The first was formative research focus groups and in-depth interviews to assist in the development of a questionnaire and to determine the feasibility of the logistics planned for the second phase field survey.

In the second phase, women from a representative sample of six of Egypt's 26 governorates were interviewed using a standardized questionnaire. A sub-sample of respondents, originally surveyed in the American University of Cairo's (AUC) Social Research Center (SRC) study on Women and Children's Health and Family Planning in Menoufia governorate in 1990-91, was available for inclusion in the field survey, thus making possible a longitudinal comparison. In-depth interviews were conducted with 10 women from the longitudinal cohort to obtain information that could be used in case studies, which provided greater contextual and detailed information, useful in understanding the impact of family planning on women's lives.

A. *Sample*

The population studied was ever-married Egyptian women of reproductive age, representing urban and rural locations in Upper and Lower Egypt and the greater Cairo area. The governorates selected for the focus group discussions (FGDs) were the same ones chosen for the survey: Beni Suef and Assiut in Upper Egypt, Menoufia and Dakahlia in Lower Egypt, and Cairo/urban Giza.

Phase 1: The qualitative and quantitative phases of this project were designed to be complementary, with findings from the first phase used to inform the questionnaire design in the second phase. Focus groups were conducted with women of childbearing age to learn their perceptions of the impact of family planning on their lives. Participants in these focus groups were identified at each site through community leaders. A total of 96 women participated.

Phase 2: The sampling frame for the household surveys was created in 1995 for another study conducted by the SRC, based on the geographical distribution of data originally derived from Egypt's 1986 census and updated for the 1992 Egyptian Demographic and Health Survey (EDHS). The frame was constructed from a complete list of local areas in Egypt, *shiakas* in urban areas and villages in rural areas. A sample of these areas was randomly selected – approximately four areas in each governorate of Upper and Lower Egypt and 13 areas in the Cairo/urban Giza.

An SRC survey team went to each of the selected primary sampling units to prepare an up-to-date list of every household in the district. The listings were subdivided into segments so that a sample of any desired size could be randomly drawn.

A sample size of 4,500 was necessary to ensure enough statistical power for multivariate analyses for five variables. Researchers determined the most important sub-groups to be contraceptors and non-contraceptors, rural and urban populations, and residents of Upper and Lower Egypt. Within such major sub-groups, researchers examined the relationships between family planning use and the main dependent variables, including self-esteem and economic behavior. The actual size of the cross-sectional component of the study was 4,908 women – more than the original sampling frame.

A separate additional sample was drawn in Menoufia for the longitudinal component of the field survey. In 1990-91, women from 12 villages were interviewed for an SRC survey. Each household in every village was included, and interviews were conducted with some 9,000 women (approximately 750 women per village). For the Women's Studies Project, two villages from the original 12 were selected, and all the women in those two villages, ages 45 years and younger during the 1990-91 interview, were re-interviewed. The longitudinal sample included 958 women. A purposive sample of 10 women in the longitudinal study was selected for in-depth interviews. These women were selected as exemplars of certain characteristics that investigators considered interesting for more exploratory questioning.

B. Instruments

The questions used for the focus groups were open-ended to give participants wide latitude in exploring the consequences for family planning use. Women were asked to generate their own responses to the proposed dependent variables: self-esteem and autonomy; economic activities; education; family relationships; community standing; and physical and psychological health.

Questions in the survey instrument were constructed to obtain appropriate data for hypothesis testing. Questions included in the in-depth interview were designed to obtain information to augment the household survey.

C. Field Work

A total of 12 focus groups with six to 10 participants each were conducted in 1996. For each group there was a female moderator and note-taker. Focus group moderators were trained by the principal investigator and another investigator with focus group experience.

Questionnaires for the household surveys were pre-tested with 10 women in each study site. In pre-testing questionnaire items, the clarity of questions and the length of time to complete the interview were assessed.

The field research team was comprised of a supervisor and four trained interviewers. All interviewers were female. Coordinators were responsible for the activities of all the field teams and kept local authorities informed of scheduled activities and maintained good working relationships with the local communities in which the survey was conducted. The in-depth interviews were conducted after the field survey was completed.

D. Data Management and Analysis

Analysis of focus group data included the description and analysis of patterns of differences between categories of groups, such as rural and urban residents or women from Upper and Lower Egypt. Statements by focus group members, which clearly articulated specific points made in the analysis of the results, were identified. Suggested topics, questions and response categories were drafted in anticipation of Phase 2 questionnaires.

Survey data were analyzed in two phases for the primary analyses. First, univariate and bivariate analyses of each of the key independent and dependent variables were conducted and presented in the form of descriptive tables and narrative summaries.

Multivariate analyses will be performed as secondary data analyses are completed and are not included in this report. These analyses will use multiple regression techniques, stratified to control for intermediate variables – to test the relationships between the independent variable, contraceptive use and the six dependent variables.

Following the conceptual framework developed by the Women's Studies Project, the key independent variable is the use of family planning. The primary measure of this is categorical: mothers who have never used family planning; mothers who have used in the past, but are not using now; mothers who have not used in the past, but are using now; and mothers who used family planning in the past and are also currently using a method.¹ The questions used to obtain this information were adopted from those used in the Menoufia survey in 1990.

The key dependent variables were self-esteem, personal autonomy, economic activities, education, family relationships, public standing, and physical and psychological health.

Background notes on each of the women included in the in-depth interviews were transcribed, and responses to interview questions summarized separately for each woman.

IV. Research Findings

The results presented here are synthesized from separate final reports on quantitative and qualitative results, prepared by AUC researchers.

A. *Characteristics of Participants*

In FGDs, non-users of any type of contraception tended to be younger married women who had given birth to their first children or who were married only a few months. In the non-user groups, there were 14 less-educated women younger than 26 years old and five more-educated women also younger than 26 years. Among these, only four had ever used a family planning method.

The ages of survey respondents ranged from 15 to 50 years, with a mean of 32.0 years in Beni Suef (at the lower end of the scale) and 35.9 years in urban Giza (upper end). Nearly all (91 to 94 percent) the women in the sample were married; most of those not currently married were widowed. The average age of consummation of marriage varied from 16.3 years in Beni Suef to 19.6 years in urban Giza. The percentage of women in consanguineous unions ranged from 28 percent in urban Giza to 61 percent in Assiut.

Assiut had the highest number of children ever born at 7.4 per woman, with 4.9 children surviving. The least mean number of children ever born was 5.5 in Dakahlia, with 4.9 children surviving.

¹ Women who have never had a child are omitted from the independent variable because most of them fall into one of two categories: They are either newly married and have never used because they want to conceive right away or they are infertile. In both of these cases, they have no contraceptive experience to contribute. Between 5 to 9 percent of all women interviewed fell into one of these two categories. Only 42 women out of the 4,908 interviewed said they had used a method prior to having their first child.

B. Knowledge of Family Planning, Attitudes and Practice

Most of the FGD participants knew about family planning methods, particularly injectables and implants. Few knew about condoms, however, and those who knew said their husbands had refused to use them. Some women thought condoms were banned because they had not recently seen them in television ads. Neither sterilization nor abortion were mentioned as family planning methods. Many women mentioned using natural methods, such as breastfeeding, to postpone pregnancy.

Some women made a distinction between family planning and birth control. One literate woman from a semi-urban town in Menoufia said that family planning meant “having a specific number of children for a good, comfortable life.” Another woman said, “Family planning is not birth control. It means spacing births two or three years according to the family’s welfare. In the future, we will feel the value of planning.”

The main source of information about contraceptives for most women was the mass media – television and radio. Other sources of information included health center doctors, neighbors and relatives. In some places in Upper Egypt, women obtained information from “caravans” of doctors who inserted intrauterine devices (IUDs).

Women frequently discontinued methods because of information from neighbors – often based on ill-founded rumors. Some participants said they suffered from side effects caused by oral contraceptives (OCs) and IUDs or had become pregnant while using these methods. The side effects they had most often experienced included headaches, heavy menstrual bleeding, weakness, prolonged bleeding, back pain, or husband’s dissatisfaction with the method. Many participants had tried more than one method and mentioned side effects as the major reasons for switching methods.

Among survey respondents, current contraceptive use ranged from 22 percent in Assiut to 59 percent in Cairo. The majority of current contraceptors used IUDs, although the proportions were higher in Menoufia and lower in the governorates in Upper Egypt, where OC use was greater. Four categories of contraceptive use were defined as the independent variable for subsequent analyses: 1) never use; 2) current use but no past use; 3) past use but no current use; and, 4) past and current use. The longitudinal analysis related contraceptive use in 1991 to variables measured in 1997 using the following categories: ever use, current use (as a subset of current use) and never use. Sixty-three percent of longitudinal study participants had ever used a family planning method, and 52 percent were using a method at the time of the 1991 survey.

Method failure and contraceptive side effects were reported by survey respondents. Seven to 21 percent of women in the six governorates reported a method failure. Of these, about half the women said the failure was due to incorrect use of the method. Thirty-seven percent said the method itself had failed, and the rest did not know the reason for the failure.

Twenty-two to 28 percent of women in the study said they had experienced a health side effect, except in Assiut where the percentage was 41 percent. About half of the women characterized side effects as serious enough to interfere with their ability to take care of their children. The most common side effects were related to menstruation – heavy or irregular bleeding or painful periods. The next most frequently mentioned problem was dizziness. Despite the percentages of women reporting side effects, 85 to 96 percent of women said they were satisfied with their method.

C. Perceptions of the Impact of Family Planning on Women's Lives

Self-esteem

A positive relationship between self-esteem and contraceptive use has been hypothesized, based on the idea that the ability to control one's fertility would improve one's feelings of self-worth. Interestingly in this study, a relationship was found between self-esteem and governorate of residence, with women in the two Upper Egypt governorates having higher self-esteem scores, those in Lower Egypt's Menoufia being in the mid-range, and the lowest scores found among women in Cairo and urban Giza.

When the relationship between contraceptive use and self-esteem was further analyzed, in Upper Egypt, self-esteem scores were lowest among never users, highest among current and past users, and somewhere in between among those who had used contraception in the past but were not current users or those who were current users but not past users. In the governorates of Dakahlia and urban Giza, women who had never used family planning methods had lower self-esteem. In the longitudinal sample, ever use of contraception in 1991 was negatively related to negative feelings about oneself; that is, women who had used a method were less likely to experience negative feelings about themselves. No relationship was found between contraceptive use and positive feelings. Further multivariate analyses may provide additional interpretations for these findings with the identification of possible mediating variables for these relationships.

Personal autonomy

“Personal autonomy depends on the level of closeness between the couple. If from the beginning they are used to taking each other's opinion, then this is the way they will live their whole life. ... If the husband treats the woman like a pig in the house ... she can never take any decisions.”

– Illiterate woman living with garbage collectors in squatter area

Most women felt the need to seek their husband's opinion and approval on every matter or decision culturally appropriate in Egypt. There is, however, some gap between real and ideal culture. Explicitly, men have the final say on many matters, but implicitly women make decisions on their own or through negotiation with their husbands. Women said, however, that they like to make their husbands feel they have the final say.

Among the FGD participants, less-educated women, who were not employed and who earned no money, always asked their husband's permission before going out to visit family or friends or before purchasing household items. "She has to take her husband's permission because he is the one who is going to pay," one study participant said. However, if children are sick and need to be taken to the doctor, a woman will take them immediately and tell the husband when he comes home, said study participants. If the woman has no cash, she will borrow from a friend to pay the doctor.

When asked if a woman can make decisions without asking her husband, one woman living in a squatter area said, "She can take the decision and ignore whatever her husband tells her. ... It really depends on her and how she wants her husband to appear in front of the people. ... She may want him to appear good, so in front of people, she is the obedient wife, or she does not care how she makes people view him, so she disobeys him making him feel small."

An educated woman working in Beni Suef said, "I can take some decisions without consulting with my husband in cases of emergency, such as giving condolences if there is a death for any of my colleagues or family. It is an obligation that I have to fulfill immediately. ... I will tell him when he comes home."

All women said they must consult their husbands and ask permission because husbands are important to them. "Marriage is sharing," one study participant said.

With regard to the education of children, both spouses make decisions together, hoping that their children would be better off than they were. Most women expressed great aspirations for their daughters, hoping they will obtain a good education and then a good job. Only then would they [daughters] have a high level of personal autonomy, study participants said.

Some of the literate focus group participants said that because they were able to control their fertility, they were now able to manage other aspects of their lives. "A woman's life becomes organized. She can have plans and goals and a peaceful mind," said one woman.

Among survey respondents, there was limited evidence of a relationship between family planning and autonomy. Women in Menoufia and Cairo who were current and past contraceptive users were more likely to report that their husbands had refused them permission to visit their families.

Economic activities

In FGDs, less-educated women who worked said they believed that when a woman works for pay she has the right to keep some of the salary to herself, but she should share in the family expenses with her husband. More-educated women believed that work was very important for women's psychological and social well-being and for asserting their own identities.

Women in the focus groups felt that education and employment were very important for women's independence, autonomy and self-esteem. Women had a stronger voice in decisions most relevant to them and believed decisions should be made jointly by husbands and wives through discussions and negotiations. Work, however, brings "double" responsibility and role strain to married women, and it does not necessarily contribute to dignity and self-actualization. "The woman now plays the role of the worker, the teacher and the housewife ... the responsibility is shouldered by the woman ... children's school, work, health ... the husband is just a consultant. The burden that a woman carries is heavy."

In focus group discussions, some women indicated that childbearing had a negative effect on women's participation in the labor force and on earnings. Said one: "The path of my career changed because I got married and got a child immediately, so I resigned from my teaching job at the university because I was scared of being a bad wife. I did not continue my Ph.D. degree. I worked as a pharmacist. However successful my work is now, this was not my main goal. I wanted to complete my Ph.D. I had never thought of opening a pharmacy, and I used to consider this as something for my retirement only. The pharmacy is a successful business, and I feel that it is important once I began working in it and it requires a certain expertise."

Data from the survey did not provide strong support for a relationship between contraceptive use and employment, controlling for educational level. Among more-educated women in Beni Suef, those who were current users were more likely to have a paid job, but this is the only group in any governorate for which this was true. More-educated women in urban Giza, who currently use or are past users, were more likely to say that they were pleased to have their jobs. Multi-variate analyses will provide more information related to mediating variables.

Education

Participants believed that education was important for their daughters. One woman said that she plans to send her daughters to school and insist they get a good education even if she has to sell her own clothes to finance this.

Both parents want their daughters and sons to get a good education. Parents discuss education for children, and most agree on the issue. Almost all women said that parents considered the opinions of sons and daughters when making decisions about schooling. Only in Upper Egypt was one of the mothers against her daughter going to school because she needed the daughter to help at home. Another mother said that her father and mother-in-law did not agree on sending her daughters to school.

The illiteracy rates among survey respondents ranged from 36 percent in Giza to 80 percent in Beni Suef. As expected, completion of secondary school by respondents varied by governorate with only 6 percent in Beni Suef and 11 percent in Assiut completing secondary school compared to 22 percent to 27 percent of women in urban and Lower Egypt.

Analyses designed to examine the relationship between contraceptive use and education focused on women's desire for further training. For most women, education is terminated prior to

marriage and, therefore, contraceptive use is unlikely to have any impact on educational attainment. In Assiut, where 12 percent of women overall expressed an interest in further training, older women (over 30 years) who were currently using a method and who had used a method in the past were more likely to be interested in further training. The same was true for women who had used a method in the past but were not currently using a method. In Cairo, older and younger women and those who were less well-educated were more likely to desire more training if they were past and current contraceptive users.

Family relationships

Egyptian women tended to see themselves in relationship to others, as members of group or in the context of their structural roles as wives and mothers. They rarely thought of themselves as individuals with their own potential or needs. For most female study participants, the welfare of the family was more important than their individual welfare. Individualism was often equated with negative outcomes.

Women were subordinate to men in the home and had the primary responsibility for childrearing and housework. With regard to a man's responsibility at home, some women said that a husband helps only if the wife is sick or has just delivered a baby. When a child is sick, all women take the child to the doctor, whether the husband is home or not. If the husband is home, they ask his permission to do so.

Mothers-in-law influenced women's decisions about family size. A woman in a village near Assiut said that her mother-in-law threatened her if she did not have more children. She told her she would find another bride for her son. Some women, however, seek their mother-in-law's advice and help if they have problems with their husbands. Often the mother-in-law solves the problem.

Women's subordinate position played a role in family size. Fears of divorce and polygamy led women to have more children, even if they did not want to. Many women felt pressured throughout their marriage to produce more children in order to prevent divorce. One of the respondents said that her husband did marry another woman, but continued to pay for care of her and their children and the upkeep of the house. She felt financially dependent on him and did not ask for a divorce. She did not believe she had the resources to raise their children on her own. Survey respondents varied in their belief in the need to have husband or other male kinsman for protection, from 48 percent in Cairo to 84 percent in Upper Egypt. More than 85 percent of the married women said they were happily married.

All women believed that children were very important. Children perpetuate the family name and give parents prestige and happiness, study participants said. When asked if they will advise their daughters to plan their families, one of the less-educated women near Assiut said, "after the first child to know if she is fertile or not." Another said, "after the first male child." In the survey, 76 to 87 percent of the women in each governorate agreed that children were necessary for a happy life. The percentages were lowest in the urban governorates.

Public standing

Two behaviors were used as indicators of public standing: participation in nongovernmental organizations (NGOs) and political behaviors, such as voting or participation in political events. The majority of focus group participants were not members of political parties; 3 to 14 percent of survey respondents in each governorate were registered to vote. Only a few of the educated women were members of sports clubs or syndicates or an NGO. Most of the more-educated women worked in government offices, such as social units or health units, as social workers, researchers, secretaries and nurses.

Fifty-seven to 63 percent of the women surveyed said that they thought women could always find time to help their communities. In the Upper Egypt governorates, these percentages were higher among women who had any contraceptive experience compared to those who had none.

Psychological health

In the survey, depression was measured as an indicator of psychological health. Interestingly, depression scores varied among governorates, from the lowest levels in Dakhalia to the highest in Cairo. Holding governorates constant, however, differences were found between current contraceptors and past or non-contraceptors. The lowest scores were found among current users and the highest among never users. Findings for the longitudinal analysis were consistent: Women who reported never use of contraception in 1991 had higher depression scores in 1997 than did ever users.

Psychological well-being was discussed at length among focus group participants. When they were asked, “What makes you happy?,” many women voiced a wish for recognition by significant others, namely husbands and superiors at work. The health and success of the children and the happiness of the husband and his well-being were mentioned by the majority of the women. Some women mentioned their wish for security – that is, having enough to eat, to finance children’s needs and to educate them.

Because family ties are important, researchers were not surprised to find that what makes women unhappy is their children’s failure in school, their husbands’ failure at work, or a loved one’s illness. “The whole world smiles when the husband is happy and in a good mood,” said one study participant. “A kind word of recognition for the work of the woman at home makes her extremely happy and vice versa.”

Less-educated women voiced concerns about financial needs and fear of divorce. They said they often gave in to their husbands’ wishes to satisfy the men’s egos and make them happy. Many women had been socialized to play a subordinate role in their family, in relationship to their fathers and brothers, and this continued in their marriages. Many believed a husband has the right to beat a wife if she does not obey, if she answers rudely, or if she refuses to sleep with him. If they quarrel all the time or do not keep themselves well-groomed and clean, women said husbands have the right to remarry. Some defended their answers by quoting the Koran, “The man has the

right to marry two, three or four.” However, this view showed a misunderstanding of the intent of Koran text, researchers said.

Focus group participants provided many examples of how, through fertility control, family planning increased their psychological well-being. A literate woman from Menoufia said, “It gave me a chance to sleep in a clean nightgown at night. I do not get out of my bed at night to find which child is crying. I also change the beds every few days and they stay clean. It also gave me more time to tutor the children as well, and when they come back from school they find they can have a nice warm meal. My children have become very successful and each one has a room of his own instead of sharing the room with three other children. I also have time to enjoy my youth and health, and I have extra time to devote to social work. I am raising children who are beneficial to their country and have a sense of belonging. They are not frustrated.”

Another woman said, “Using family planning affects a woman’s personality. A working woman needs planning more. It also differs from an educated to a illiterate woman.” And another woman said, “Using family planning allows the woman to feel secure and not worried all the time that she might get pregnant.”

V. Conclusions and Recommendations

Egyptian women live in a culture where their status is considered subordinate to men in terms of their freedom of movement and their rights within marriage and the family. Within cultural expectations, however, women are able to determine many aspects of their lives. Women in the focus group discussions were able to articulate benefits they received from use of family planning. Fewer children meant greater control over other aspects of their lives, which enhanced their general well-being, whether defined in terms of their role of mother, wife or individual. To the extent that the use of family planning actually accomplishes the goal of fertility reduction, it can improve the lives of women and their families.

Survey findings generally supported FGD findings. Some geographic differences were found among respondents, generally reflecting expected urban/rural and Upper Egypt/Lower Egypt differences. The most robust results were related to psychological aspects of women’s lives – self-esteem and depression – suggesting greater psychological health among women who were able to control their fertility.

VI. Study Details

This research was conducted by the Social Research Center at the American University of Cairo. Dr. Saneya Saleh and Dr. Donald Heisel were the principal investigators. Dr. Laila Kafafi and the staff of the Family Health International (FHI) office in Cairo provided technical assistance and support. Dr. Cynthia Waszak of FHI was the technical monitor. Financial support for this study and others in the Women’s Studies Project was provided through a cooperative agreement from the U.S. Agency for International Development.