Fertility Plateau in Egypt
A Qualitative Study

November-2011
Social Research Center
The American University in Cairo

---

1 This study was done under the project “Policies to address fertility plateau in Egypt” coordinated by the Social Research Center (SRC) of the American University in Cairo (AUC) and supported by the United Nations Population Fund (UNFPA), Cairo Office.
List of Acronyms and Abbreviations

List of tables and figures

acknowledgement

Chapter one: Background information

1.1 Factors Contributing to Fertility Plateau in Egypt

1.2 Egypt Current Family planning initiatives

1.3 Main Family Planning Service Providers in Egypt

1.4 Religious Perceptions OF Family Planning

1.4.1 Islamic Perceptions

1.4.2 Christian Perceptions

1.5 Obstacles and barriers

Chapter two: Objectives and Methodology

2.1 Objectives

2.2 Study Instruments and Methodology

2.3 Sample description

2.4 Study limitaions

Chapter three: Attitudes Towards Two Child Norm

3.1 Optimal number of children and the sense of numbers

3.2 Sex preference and optimal composition

3.3 Decision making regarding childbearing and contraception

3.4 advantages and disadvantages of Birth Spanning

3.4.1 Advantages of Birth Spanning

3.4.2 Disadvantages of Birth Spanning

3.5 Cultural factors and their impact on childbearing and FP

Chapter Four: Contraceptives

4.1 Contraception: knowledge and attitudes

4.2 Sources of Information

4.3 Preferance

4.4 Influence on Decisions

4.5 Cost

4.5.1 Cost of FP

4.5.2 Cost of giving birth

4.6 Accessibility

4.7 Usage of contraceptives

4.7.1 Who uses contraceptives

4.7.2 Obstacles to Contraceptive use
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>IDI</td>
<td>In-depth Interview</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>MARP</td>
<td>Most at Risk Population</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>SBC</td>
<td>Strategic Behavior Communication</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>SMS</td>
<td>Short Message Service</td>
</tr>
<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TV</td>
<td>Television</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
</tbody>
</table>
# LIST OF TABLES AND FIGURES

<table>
<thead>
<tr>
<th>No</th>
<th>Name of figures</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table (2.1)</td>
<td>List of the FGDs Conducted</td>
<td>20</td>
</tr>
<tr>
<td>Table (2.3.1)</td>
<td>% Distribution of the FGD Participants’ Sample by No. of Children They Have and Educational Level</td>
<td>26</td>
</tr>
<tr>
<td>Table (2.3.2)</td>
<td>% Distribution of the FGD Participants’ Sample by No of Children They Have and Age</td>
<td>26</td>
</tr>
<tr>
<td>Figure (1)</td>
<td>Factors Contributing to Fertility Plateau</td>
<td>8</td>
</tr>
<tr>
<td>Figure (2.3.1)</td>
<td>% Distribution of the FGD Participants’ Sample by Gender</td>
<td>22</td>
</tr>
<tr>
<td>Figure (2.3.2)</td>
<td>% Distribution of the FGD Participants’ Sample by Age Categories and Gender</td>
<td>22</td>
</tr>
<tr>
<td>Figure (2.3.3)</td>
<td>% Distribution of the FGD Participants’ Sample by Educational Status and Gender</td>
<td>23</td>
</tr>
<tr>
<td>Figure (2.3.4)</td>
<td>% Distribution of the FGD Participants’ Sample by Work Status and Gender</td>
<td>24</td>
</tr>
<tr>
<td>Figure (2.3.5)</td>
<td>% Distribution of the FGD Participants’ Sample by Expenditure per Month and Gender</td>
<td>25</td>
</tr>
<tr>
<td>Figure (2.3.6)</td>
<td>% Distribution of the FGD Participants’ Sample by No. of Children They Have</td>
<td>25</td>
</tr>
<tr>
<td>Figure (5.3)</td>
<td>Actions to be taken after Discontinuation</td>
<td>53</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENT

Study team is thankful for the interviewees who participated in conducting the study along with the males and females who participated in the focus group discussions and the in-depth interviews. Without them, this work could not have been conducted.
During the latter half of the twentieth century, most developing countries experienced a rapid decline in fertility. Many countries attained the replacement fertility level of 2.1 births per woman by 2000. Although many countries are expected to continue their fertility decline until their total fertility rate is below the desired replacement level of 2.1 births per woman, a number find themselves facing the problem of a fertility plateau, experiencing stalled fertility while in mid-transition.

On the demographic front, Egypt has passed the peak of the demographic bulge due to the decline in fertility of two decades ago. However, more needs to be done to further reduce the pace of fertility decline which has leveled at about 3.1 for almost a decade. The fertility rate cited in the 2008 Egyptian Demographic and Health Survey (EDHS) was 3.0 births per woman, only slightly lower than the rate observed in the 2005 EDHS (3.1 births per woman). In rural areas, the fertility rate is 3.2 births, around 20 percent higher than the rate in urban areas (2.7 births). Fertility levels are highest in Upper Egypt (3.4 births) and in the Frontier Governorates (3.3 births) and lowest in the Urban Governorates (2.6 births). Education is strongly associated with lower fertility, as is wealth. The fertility rate decreased from a level of 3.4 births among women in the lowest wealth quintile to 2.7 births among women in the highest quintile.

In Egypt, rapid repeat birth (RRB) has been identified as a risk factor for adverse prenatal outcomes. RRB is defined as a birth occurring within 24 months after a previous birth, or for an adolescent mother, a repeat birth while still a teen, regardless of the interval between the two births.

Understanding the motives and factors that form the attitudes, behaviors and actions taken to control birth among the community is necessary to reach the fertility rate goals. It is worth mentioning that many studies have been developed in different Egyptian governorates to investigate the obstacles facing fertility reduction. The government is involved in providing

---

2 Egypt Human Development Report, 2010
public family planning services, literacy programs and employment opportunities for women. The remedies for a fertility plateau lie in the subtle manipulation of these factors, encouraging a decline in fertility trends and allowing countries to complete their fertility transitions.

1.2 EGYPT CURRENT FAMILY PLANNING INITIATIVES

The Egyptian state adopted many initiatives to reduce the fertility rate, mainly carried out through the Ministry of Health (MoH), NGOs and funding agencies. They were as follow:

- **First** - Ministry of Health initiatives
  The MoH developed some policies and programs included in the five year plan for Egypt. The aforementioned strategy integrates different ministries that might play a role in enhancing the understanding of the reproductive health needs and family planning (Ministry of Mass Media, Education, Endowment and Youth). A primary goal of those initiatives is trying to reduce the fertility rate to 2 instead of 3.

  Another purpose of these policies and strategies is to provide the needed care for women during childhood, adolescence, premarital, pregnancy and birth, and in older age. Those programs and initiatives do not focus only on family planning issues but also women’s overall reproductive health. Thus, treatment of the pregnant women and the provision of medical support during childbirth is essential to (MOH) policies.

- **Second** - Initiatives conducted through the Non Governmental Organizations (i.e. Takamol, Egyptian Association for Family Planning and many other organizations)

  In March 2006, Pathfinder was awarded a contract from USAID to conduct a new five-year project in Egypt known as Takamol. Named after the Arabic word for "integration," Takamol promotes an integrated model for strengthening maternal and child health, family planning, and reproductive health services. As the culmination of nearly three decades of USAID assistance to Egypt in these areas, Takamol is working to prepare the Egyptian Ministry of Health and Population (MOHP) to fully support and sustain these services as USAID phases out its assistance. Specifically, the project:
• Supports the Ministry of Health in training and building the capacity of its health system managers, service providers and staff;
• Scales up global and Egyptian best practices to ensure that high quality integrated services are available at the community level; and
• Encourages the committed involvement of male and female religious leaders, corporations, local businesses, and civil society in taking ownership of community health.

Project interventions target 200 primary health care units in 12 Upper and Lower Egypt governorates, selected urban poor areas in Cairo, Giza, and Alexandria, and 25 district/general hospitals in Lower Egypt.

The Takamol integrated model strengthens the capacities of these facilities to better serve the needs of their communities through renovations and the provision of equipment, training, outreach, and community participation. Two cross-cutting themes, gender and social responsibility, have also been woven into all of the project’s activities so that communities and corporations contribute to the improvement of health care and facilitate women’s empowerment.

  o Egyptian Association for Family Planning
    • Projects funded by the IPPF:
      1- Meeting Adolescents Reproductive Health Needs.
      2- Access
      3- Advocacy
      4- Gender and Reproductive Health
      5- HIV/AIDS
      6- Post abortion services project.
    • Projects funded by The United Population Fund:
      Meeting Adolescents Reproductive Health Needs
    • Projects funded by The US Agency for International Development:
      Clinical Service Improvement Projects (CSI)

Third - Funding Agencies

After the United Nations Development Assistance Framework (UNDAF) Agreement was signed to initiate population activities, the country office was established in 1972 and United Nations Population Fund (UNFPA) has supported Egypt through eight five-year country programs ever since. The current country program is based on the Common
Country Assessment (CCA) and aligned with the United Nations Development Assistance Framework (UNDAF) outcomes. Emphasizing fertility and family planning, the overall focus has shifted from the traditional service delivery model to one aimed at population policies and strategies, advocacy for population issues, and strengthening partnerships. Emphasis has been on capacity development of systems rather than of individuals. Human rights have been an overarching framework for promoting reproductive rights and for addressing the needs of vulnerable segments of the population, including young people. Culturally sensitive approaches have been employed in terms of the selection of partners as well as the strategies selected to address key population challenges through the various projects. With regards to population and development, the program focuses on ensuring the access of decision makers to evidence-based population information and in-depth knowledge of the population dynamics to guide the decision-making process. The program is also focused on strengthening the monitoring and reporting of local gender plans that are derived from the National Five-Year Plan (2007–2011). In terms of reproductive health, the program is focused on ensuring that relevant measures are taken to uphold the quality of reproductive health services within the health sector reform, and that the capacity of the Ministry of Health for commodity security is maintained. The program is also increasing the access to and improving the quality of the VCT services for STIs and HIV and AIDS, including for the vulnerable segments of the population, and contributing to the introduction of youth friendly reproductive health services.

**Fourth** - Other developmental agencies (i.e. the Social Fund for Development (SFD))

Though the Social Fund for Development was not initially heavily involved with family planning services, they included family planning initiatives as part of overall developmental activities in order to eliminate poverty and enhance living conditions. The SFD currently leads an initiative that funds 118 NGO among which 50% are working on reproductive health and family planning in three governorates. They provide maternal care, nutrition for newly born babies and health care during pregnancy.
In conclusion, many initiatives, programs, and organizations work to enhance reproductive health in Egypt by trying to reduce fertility rates. It is helpful and thus recommended to highlight all factors that reduce the fertility rate.

1.3 MAIN FAMILY PLANNING SERVICE PROVIDERS IN EGYPT

Four main groups of family planning service providers for Egyptian women were identified. They were as follows:

1- Places affiliated with the Ministry of Health: They provide the service of low cost as they are subsidized by the state:
   a. Public hospital
   b. Public clinics
   c. Health unit
   d. Health centers
   e. Mobile units
   f. Medical caravans
   g. Motherhood and childhood care centers
   h. Family planning centers

2- Places affiliated with NGOs and churches: They provide service at a modest cost that is affordable for target beneficiaries:
   a. Centers
   b. Medical caravans
   c. Mestawsaf (small health clinic)

3- Private service providers: They provide service at high prices as they are profit-seeking projects:
   a. Private hospitals
   b. Private clinics
   c. Private health units

4- Traditional service providers:
   Midwives

---

3 Midwives sometimes perform a simple operation to block the female Fallopian tubes (female sterilization).
Based on different evaluation and assessment surveys that were conducted, community members favor the private service providers, as they care for people, are clean and treat people nicely. The different surveys conducted revealed that the community people are in favor of the governmental service providers due to their low cost and accessibility. It is foreseen that the community people appreciate the low cost but they trust more in private service providers. In rural areas, midwives are preferred due to low cost and psychologically comforting their female clients.

1.4 RELIGIOUS PERCEPTIONS OF FAMILY PLANNING

Religion plays a central role in shaping the social norms of many Egyptians. It was crucial to investigate the religions perceptions in Egypt towards the family planning issue.

1.4.1 ISLAMIC PERCEPTIONS

Around 90% of Egyptian society identify as Muslim (CAPMAS website 2010), it was crucial to highlight the perceptions and advice of various Muslim community leaders of and about family planning by reviewing statements published in the newspaper and media programs. It proved quite difficult to gather a coherent understanding of advice given regarding FP issues in Islam due to the limitation of discussions in Interrogation books (Tafaseer) but our findings suggests that the main source of FP recommendations is religious figures from El Azhar who are widely listened to in the Egyptian and Arab communities. Muslims rely upon the advice of religious figures generally according to a three-level of institutes.

1- The first main level is the Egyptian Consultation Department ("Dar El Eftaa El Masria") which is responsible for giving clear and reliable religious recommendations. They developed a hotline that is responsible for providing advice.

2- The second level is the religious people in different mosques who are responsible for leading prayer and providing some information during the Friday sermon. It was notable that they have some influence on the community, especially in the rural areas.

---

4 El Azhar is one of the oldest universities in the world, having been established a thousand years ago. The scientists of El Azhar are respected and popular among the Egyptian community and the Arab World. Religious sciences are more dominant in El Azhar as it teaches many religious classes, engages in religious debate, Trains many religious leaders, in addition to some other sciences.
3- The third level is the TV and radio programs that invite different types of religious people to provide religious information and recommendations. These programs are widely listened to especially among unemployed housewives.

In addition to the types of figures mentioned above, NGOs have begun to pay more attention to the influence of religious leaders, inviting them to give lectures in the villages through big conferences.

The current perceptions of Islamic figures toward family planning is clear. It was notable that we have two main perceptions:

- The first, which is not widely observed among the community, is the fundamentalist perspective which is totally against family planning activities. They site some statements (“Hadeith”) from prophet Muhammad (PBUH) who encourages married people to have children. However, the same Hadeith was explained by religious moderates in a different way thus allowing for a non-literal interpretation of this Hadeith.

- Both moderates and fundamentalists were fully against abortion and tubal ligation and vasectomies (sterilization) as they are religiously forbidden and it is considered unacceptable to kill infants or to stop the ability to give birth. The Holy Quran said

151. Say (O Muhammad صلى الله عليه وسلم): “Come, I will recite what your Lord has prohibited you from: Join not anything in worship with Him; be good and dutiful to your parents; kill not your children because of poverty — We provide sustenance for you and for them; come not near to Al-Fawâkhish (shameful sins, illegal sexual intercourse) whether committed openly or secretly; and kill not anyone whom Allâh has forbidden, except for a just cause (according to Islâmic law). This He has commanded you that you may understand.

Sourh,6 El Ana’am part 8, Ayah 151

Religious figures considered any fetus inside the uterus a child that should not be killed.
Both groups of religious leaders were also against the law being proposed by the Ministry of Health and Population that mandates married people should only have two children. However, moderates did support the idea of family planning in which families have a plan that would rely upon their economic and health status.

The moderate figures suggested that a woman’s poor health was the main reason to stall pregnancy and that otherwise there was no necessity to plan the family. They also recommended abortion only under the condition that giving birth would endanger the mother's life. Moreover, they supported the idea of having fewer children if the family was not able to provide good and secure living conditions for the children.

1.4.2 CHRISTIAN PERCEPTIONS

About 10% of the Egyptian population identifies as Christian. In terms of family planning advice, Christians do not have the same hierarchy of figures as Muslims in Egypt. They rely upon priests in the church or the Highest Priest to provide recommendations and suggestions on these issues.

Religious Christian leaders did not share many of the ideas adopted by the Islamic fundamentalists. Yet, the perception towards abortion was exactly the same as the Islamic interpretation. Given the understanding that human life begins at conception, taking the life of an unborn child is considered no different than infanticide. As far back as the second century, both practices have been condemned by the Church. Abortion makes the womb a place of death instead of life. The ability to give life should be celebrated as a gift, never to be taken for granted. It is the very thing that separates women from men. Christians believe it is also the gift God gave women to save humanity. Most importantly, all were given the opportunity for salvation through the birth of Christ which represented Mary's choice to give life in the face of adversity.

In the Bible, the first command ever given to woman and man was to "And God blessed them, and God said unto them, Be fruitful, and multiply, and replenish the Earth, and subdue it: and have dominion over the fish of the sea, and over the fowl of the air, and over every living thing that move the upon the Earth"
Holly bible (Genesis 1:27-28)." A nation that grew, as did the Hebrews in the Old Testament, was termed blessed, while one that shrank was considered cursed. Christ's last command, as recorded in the book of Matthew, parallels the Lord's first command. Jesus says, "Go and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, and teaching them to obey in everything I have commanded you."

While Christian and Muslim figures were against abortion and sterilization, both groups were receptive to family planning that is based on the socioeconomic conditions of the families. Temporary contraceptives, as opposed to permanent methods, were considered acceptable.

1.5 OBSTACLES AND BARRIERS

Many researchers have investigated the different factors that can be categorized as barriers and constrains to reducing the fertility rate. They can be clustered as follows:

1- Norms and traditions that support families having more children in order to be responsible for supporting the family and "support " them.

2- Norms that discriminate between males and females, especially in rural, poorer areas. These norms suggest that having male children is more desirable and encourage some families to continue having children until a son is born.

3- Poor socioeconomic conditions that might make people willing to have more children to support the family financially, especially in rural areas where most work is related to agriculture.

4- Religious fanatics who still believe that family planning goes against the will of God.

5- Inappropriate and unsatisfactory family planning services.

6- Inaccessible services as some communities, especially nomads and those living in remote areas, cannot afford to traverse the long distances required to receive service.

7- The influence of parents and community members who advise that married people have at least three or four children who will provide them with companionship and support in the future.
CHAPTER TWO: OBJECTIVES AND METHODOLOGY

This study was conducted in order to assess and investigate the current attitudes and perceptions toward the two child norm in Egypt. However, due to the limitations of qualitative sample as it is not acceptable to generalize the results, it was crucial to investigate the aforementioned topics on different levels and socioeconomic groups in the community.

2.1 OBJECTIVES

The overall goal of this study is to address the fertility plateau in Egypt by investigating different elements that might play a major role in defining the attitudes, motives, behaviors, obstacles to family planning. The following topics were covered:

1. Define the characteristics of the beneficiaries and provide a description of their attitudes towards two child norm in order to identify the dominant preferences.
2. Assess perceptions of and preferences for different types of contraceptives.
3. Outline the influence of women's empowerment on the attitudes towards the two child norm.
4. Investigate the reasons for the high level of unmet family planning needs among the married women who currently do not use FP services and how these needs can be met.
5. Identify the features of family planning programs that could be improved so as to reduce the rate of discontinuation of contraceptives, increase use effectiveness of the method and highlight any gaps in family planning services.

2.2 STUDY INSTRUMENTS AND METHODOLOGY

The qualitative study was undertaken between the end of December 2010 and the middle of January 2011 in three main governorates: Cairo the capital of Egypt, El Gharbeyia Governorate in Lower Egypt and Assuit Governorate in Upper Egypt.

Due to the nature of the study, it was crucial to gather information and opinions from more than one source. Therefore, the following groups were investigated:

1. Beneficiaries were consulted through focus group discussions. Three types of FGDs were conducted. The first type addressed the perceptions and attitudes towards the
two child norm, the second discussed the reasons for discontinuation of family planning and the third concentrated on the unmet needs among those who do not use family planning.

2- Various decision and policy makers were consulted through in-depth interviews
3- Community figures who work to raise awareness or might have an influence on beneficiaries such as religious leaders, NGOs, promoters, etc.

Two instruments were utilized to collect information on similar items and topics, in order to ensure the reliability of data. Following is a detailed review of the adopted methodology.

**Focus Group Discussions:**

Three types of FGDs were conducted as follows:

**a. FGD conducted to discuss the attitudes towards two child norm**

Issues covered:

1- Optimal number of children and the sense of numbers, meaning what is the most acceptable number.
2- Sex preference and optimal family composition.
3- Decision making concerning childbearing and contraception.
4- Advantages and disadvantages of postponing and spacing childbearing.
5- Knowledge and attitudes toward contraception.
6- Costs and benefits of having children.
7- Culture forces and their impact on childbearing and contraception.

The aforementioned FGD was conducted with currently married women and men in El Gharbeyia Governorate in Lower Egypt.

**b. FGD conducted to investigate the reasons of higher discontinuation rates of FP in rural Upper Egypt**

Issues covered:

1- Information about FP and sources of information (i.e. specific information, rumors, etc.)
2- Decision to use FP (i.e. role of husband, mother in-law, doctors, others)
3- Reasons for discontinuation of FP (i.e. method, health, fertility).
4- Behavior after discontinuation of FP (i.e. intention to use, switching method).
Three FGDs were conducted in Upper Egypt with married women of different socioeconomic characteristics in order to define the reasons for discontinuing use of contraceptives.

c. FGD conducted to understand the reasons behind unmet FP needs

Issues covered:
1. Knowledge and attitudes towards contraception
2. Reasons for non use
3. Decision making
4. Accessibility to services (geographic, economic, administrative, information, psychological).

Four FGDs with currently married women who had never used family planning services and had unmet family planning needs in rural Upper Egypt were conducted. The following table contains details about the FGDs that were conducted.

<table>
<thead>
<tr>
<th>Area</th>
<th>Type of FGD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gharbeyia Governorate</td>
<td>Two FGDs with currently married women (less than 30 years old) and two FGDs with currently married men (less than 35 years).</td>
</tr>
<tr>
<td>(4 FGDs with male and females)</td>
<td>The urban FGDs participants were highly educated, employed and had a high standard of living, while the rural participants were uneducated, nonworking and poor.</td>
</tr>
<tr>
<td>Assuit Governorate</td>
<td>Three FGDs with currently married women discontinuing use of FP (IUD, pills and injections) in rural Upper Egypt.</td>
</tr>
<tr>
<td>(7 FGDs with females)</td>
<td>Four FGDs with currently married women who have never used FP with unmet need for family planning in rural Upper Egypt (two are willing to use- two with those are unwilling to use)</td>
</tr>
</tbody>
</table>

**In-depth Interviews**

More than six types of interview guidelines were developed and conducted with the following stakeholders:
1- Policy makers (ministerial level and governorate level)
2- Religious leaders (in Cairo Governorate- in Assuit Governorate)
3- NGOs
4- Health promoters
5- Developmental organizations
6- Service providers

The in-depth interviews were the main tools to fill the information gaps. Therefore, they contained the following topics:

1- Strategies and methods to achieve family planning objectives
2- Projects and initiatives
3- Obstacles and barriers
4- Evaluation and monitoring
5- Most of the topics covered in the FGDs in order to check the reliability of the information gathered

2.3 SAMPLE DESCRIPTION

The study team tried to be committed to the sample required for each type of the FGDs, meaning the educated high social status and the non users of contraceptives… etc resulting in responses from community members with different socioeconomic backgrounds. This section will discuss the main characteristics of the FGD samples. 78 respondents were interviewed in 11 FGDs (13 men, 65 women). Each FGD was conducted with an average of six to eight people.

1. Gender

The majority of the sample was female (83.3%). As literature about the usage of contraceptives is places the responsibility of contraceptive use on women, more women than men were consulted specifically for the FGDs.
2. **Age**

The data collected revealed that the majority were between 20 and 40 years old (this is the period of fertility among Egyptian women). About 57.0% of the women in the sample were between 20 and 30 years old. For most women, this age represents the peak of fertility. Male groups were older than female groups, as 70.0% of male respondents were above 30 years.
3. Educational Level

It was notable that the male sample had a higher rate of literacy than females. Only 7.7% of male respondents were illiterate versus 36.9% of female respondents. However, the focus on a small and very specific sample of men may be the reason for such a discrepancy in literacy. The data revealed that only 10.8% of the female sample received higher education Compared to 23.1% of the male sample.

![Figure (2.3.3) : % Distribution of the FGD Participants’ Sample by Educational Status and Gender]

4. Work Status

While the majority of female sample were unemployed housewives, 12.3% of female respondents have jobs as administrative workers. The majority of the male sample was employed as administrative workers and unskilled laborers. This result was primarily due to the selection of two sample groups: One educated and of higher socioeconomic status and the second uneducated and of lower socioeconomic status.
Figure (2.3.4): % Distribution of the FGD Participants’ Sample by Work Status and Gender

5. **Monthly Expenditure**

In order to ensure reliable information about sample income and expenditure, it was recommended that data be gathered on expenditure only. There are three reasons behind this approach: 1) community members are often unwilling to give information about their income 2) male respondents are often unwilling to disclose all information about their income in front of their wives 3) earning daily and possibly variable wages might make it very difficult to calculate income. It was notable that the majority of the male sample spent less than 500 EGP per month. However, 36.9% of the female sample spent between 1000-1500 EGP per month.
6. **Number of Children**

The total number of children varies between zero and five children per respondent. 26.9% of the sample has three children and 24.3% of the sample has more than three children. This finding suggests that whatever perceptions or attitudes respondents adopt, they do not necessarily have a large number of children. The three children is consistent with the national fertility rate reported in the EDHS 2010.
The data revealed that the educational level had no foreseen influence on the number of children as illiterate respondents were more committed to having between two to three children. However, the intermediate graduates were more likely having more than three children. About 70.0% of the university graduates have more than two children.

Table (2.3.1) : % Distribution of the FGD Participants’ Sample by No of Children They Have and Educational Level

<table>
<thead>
<tr>
<th>Education</th>
<th>No of Children</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illiterate</td>
<td>20.0% 40.0% 24.0% 12.0% 4.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Read and write</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>50.0% 16.7% 33.3%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Preparatory</td>
<td>20.0% 30.0% 30.0% 10.0% 10.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>7.7% 26.9% 30.8% 26.9% 7.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>University</td>
<td>30.0% 50.0% 20.0%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2.6% 12.8% 33.3% 26.9% 17.9% 6.4%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Regarding the age influence, it seems that older groups have more children than the younger ones. About 70.0% of the older groups have more than two children. While among the younger groups, only about 40.0% have more than two children.

Table (2.3.2) : % Distribution of the FGD Participants’ Sample by No of Children They Have and Age

<table>
<thead>
<tr>
<th>Age Categories</th>
<th>No of Children</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 20</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>20-&lt; 30</td>
<td>2.4% 22.0% 36.6% 24.4% 14.6%</td>
<td>100.0%</td>
</tr>
<tr>
<td>30-&lt;40</td>
<td>2.8% 2.8% 27.8% 30.6% 22.2% 13.9%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Total</td>
<td>2.6% 2.6% 12.8% 33.3% 26.9% 17.9% 6.4%</td>
<td></td>
</tr>
</tbody>
</table>

2.4 STUDY LIMITATIONS
It is crucial for any study to understand its limitations in order to be able to understand the context of data collected and the reliability of such information. The following are the main limitations of this study:

1. 11 FGDs were conducted including those who stopped the using of three main contraceptive methods (IUDs, pills and injections). Sample diversity in terms of age, education and social status was difficult to attain as the same group contained educated and non-educated, middle class and poorer respondents. This structure may have resulted in certain respondents dominating the space during the FGDs and not allowing as much room for respondents of a different education level or social status to share their views openly. In order to overcome this problem, the moderator tried to encourage everyone in the group to speak up regardless of education level or social class and tried to prevent any one person from dominating the conversation.

2. Some topics were still taboo, especially concerning the usage of condoms as a contraceptive method. It was the task of the moderator to encourage people to talk freely by using some slang words and communal expressions to discuss the taboos.

3. The majority of respondents repeated that two children was the ideal number of children, regardless of their decisions to have more children and their beliefs that having three or more is best. The moderator strongly encouraged discussants to speak freely.

4. The first place selected to conduct the FGDs was inside an NGO that provides FP services. Therefore the study team selected another NGO that provided other health services rather than FP services in order not to influence FGDs participants’ opinion due to having the FGDs inside a family planning unit. Other FGDs were conducted in houses as the setting was more familiar and comfortable for the groups.

5. Two main governorates were selected to conduct the FGDs in urban and rural areas in order to cover the diversity of the attitudes. However, it is crucial to point out that the data collected can give us an idea about the situation in these two governorates only.

6. The in-depth interviews covered Assuit and Cairo governorates in order to address policies at the central level and within other governorates.
CHAPTER THREE: ATTITUDES TOWARDS TWO CHILD NORM

One of the main objectives of this study is to investigate the attitudes and behaviors towards the two child norm. Therefore, fertility preference should be investigated in order to focus on the main elements that formalize these attitudes. Generally speaking, this issue was covered on two levels. The attitudes of community people and the attitudes of FGDs participants were investigated in order to get accurate information. It was noted that people in the FGDs might be willing to express ideal attitudes only though questions concerning community members were used to encourage participants to speak openly.

3.1 OPTIMAL NUMBER OF CHILDREN AND THE SENSE OF NUMBERS

Generally speaking the EDHS 2008 reported that ever-married women 15-49 years of age, on average desire almost three children regardless of education, work status, wealth quintile, and place of residence.

Through the discussion of the optimal number of children in the FGDs, it was notable that the all participants in the FGDs and in-depth interviews were against the idea of having only one child for the following reasons:

1. Having one child may have a bad psychological effect on the child. "The child will be spoiled if he is only one. He becomes a headache for his parents, as he wants to fulfill his needs...he becomes selfish and self centered," reported one of women in El Gharbeyia Governorate. "One child under these living conditions is not sufficient...He feels lonely...His relation with younger or older sibling contribute to the formation of his character...Lonely child might suffer from depression," reported a man in El Gharbeyia.

2. Parents were concerned that if an only child dies, then the parents will be left with no children. "Three children are better as if one die then you will have additional two. These two children might support each other," reported a woman in El Gharbeyia.
3. Two or more children can support each other after parents pass away. "Two children will live and support each other, at schools, home, etc.,” reported a woman in El Gharbeyia.

4. The child wants a sibling. "He might feel alienate...so he needs a brother who might be supportive for him," reported a female in El Gharbeyia.

Having one child might be acceptable under some conditions (i.e. the mother is unable to have another children due to health problems). Moreover, in case of limited income, having one child might be acceptable.

However, the majority of respondents reported that the optimal number of children desired is three children. "Three children is the best as they are exactly as two children and they might support each other;", reported a woman in El Gharbeyia. The men had another point of view, suggesting that the maximum number should be only two children due to the expenses for each child. "If they are two and I get 100 EGP per month so the money will be divided by two but if they are 3 children they portion would be less," reported a man in El Gharbeyia. Parents felt responsible for the provision of furnished apartments for their children to get married and males were much in favor of only having two children. "In the future, I should secure a house for my child to get married and assist him with the expenses of marriage. That makes two children is much appropriate," reported a man in El Gharbeyia.

One of the alarming issues raised was that the number of children is mainly based on economic condition of parents. "The economical conditions play a major role in identifying the number of children...for example a person who earns 2000 EGP will have no problem to have three children as he is wealthy...but poor families can't afford it," reported a man in El Gharbeyia.

For most of participants, four children was considered a problem as parents would not be able to support them. However, this number and more were acceptable in three scenarios:

1- A farmer who wants to have more and more children to work in the fields.
2- A person who wants to have a male child so they continue to encourage pregnancy or might get married again and again to have the “precious boy.”
3- Those who want to have a girl also might have more than four children.
This issue was a bit difficult to analyze. If we rely upon what participants reported only, we must report that there is no preference. However, if we go beyond what they said, we find a preference for male children. For example when they report that they have five children due to seeking for a boy that means they really prefer to have boys astonishingly, it was unclear to most of the participants the reasons why they favor male children. However, some of the participants reported that the son will be responsible for carrying the family name and will be the breadwinner and the power of his family as parents can rely upon him. As well as he will be the protector of his family against the others.

The majority of the participants reported that they prefer having a girl and a boy. The girl represents a kind heart, "henyenah", who cares for her parents and serves them after getting married. "A girl is so kind...you can feel that...the boy will kick you when he becomes a young man...he will treat you in arrogant but the girl will care for you and visit you," reported a highly educated man in El Gharbeyia Governorate.

The majority of participants prefer to have a combination of three children, with either two boys or two girls. They prefer to have both genders. "I have four boys...I was trying to get a girl but it is the will of God," reported an educated woman in El Gharbeyia Governorate.

Four was considered as the optimal number of children. Yet, some participants reported that their relatives wanted a male child so they had at least seven children until they had a son. It seems that the majority of the participants might have four children until they have a boy or a girl. However, few of them might go beyond this number.

It was notable that the community members play a major role in furthering the parents to have more children. “People told me to have another kid in order not to leave my son alone," reported an educated woman in El Gharbeyia Governorate. Community members
might be relatives, neighbors, family and friends. However, those who have the most influence ones are the mothers-in-law and neighbors.

Some religious participants reported that the preference for a boy over a girl is an act of ignorance. Such preferences were refuted by speeches delivered by prophet Muhammad (PBUH).

### 3.3 Decision Making Regarding Childbearing and Contraception

Control over decision making within the family is crucial as it plays an important role in family planning process. Who has the right to decide to have more children? This person will be the cornerstone for any family planning awareness activities.

Based on the results of the FGDs, decisions about family planning are made by the married couple. "It is mainly based on an agreement between the marriage couple...husband financial situation and the health condition of his wife should be put into consideration. The religion recommends that the wife should consult her husband before using any contraceptive method," reported a highly educated woman in El Gharbeyia. However, some of the male participants reported that it is mainly the husband’s decision. Few participants reported that the wife can sometimes make the decision to use contraceptives or stop using them without informing her husband, particularly if she is not in good health.

Decisions about family planning can be mutual between the spouses. Any decisions about methods of contraception are primarily made by a doctor and the female partner. The doctor decides which method is appropriate. Yet, it is crystal clear that contraceptive use of should be the responsibility of the wife. Consequently, condoms are not acceptable as a form of contraception.

Some of the aforementioned decisions are influenced mainly by the mother-in-law and neighbors. "My mother-in-law gives me hard time due to spacing between children, she wants more and more children or she will threaten me," reported an uneducated woman in El Gharbeyia Governorate.
3.4 ADVANTAGES AND DISADVANTAGES OF BIRTH SPANNING

Birth span is a new term used for family planning. Generally three to five years is the acceptable duration between giving birth to two separate children. However, it was notable that some elements might have influence on spanning between children. They are as follows:

1- Spacing between the marriage date and the first child is not acceptable for the majority of participants as it is thought that using contraceptives after marriage might have a bad effect on the health of mother. Using contraceptives might be acceptable if the wife is not in good health or if she would like to continue schooling. "She can postpone giving birth if she is still go to school...also if she is young 18 years old... she can postpone giving birth until she is ready...if she works as a hostess, she might be in favor to delay birth," reported educated females in El Gharbeyia Governorate. "Also, if she is a cardio patient and the doctor recommended that she should delay birth," reported an educated man in El Gharbeyia Governorate. Another reason for spanning before giving birth is bad treatment from the husband. "In case that the husband treats his wife in nasty way, it will be better not to have children," reported an illiterate woman in El Gharbeyia Governorate. Moreover, some young couples might be in favor of having some time together before having children.

2- Spacing between the first and second child is acceptable but not more than one or two years. In the case of getting married at an older age (30 years), it is not acceptable to span between two children. "In the Holy Quran, God recommends to have two years spanning in order to breastfeed the child for 24 months," reported an educated man in El Gharbeyia Governorate. The decision to span might be affected if the first child is a girl. "If the first child is a girl, the mother will be treated as she has never given birth. Her neighbors will do their best to convince her to have a new baby...maybe before even reaching the forty days after delivery," reported an educated woman in El Gharbeyia Governorate. "Family will definitely do their best to convince the mother to have another child immediately due to inheritance issues...the boy is much more precious especially in rural areas," reported an educated woman in El Gharbeyia Governorate.
3- Spanning between the second and third children is acceptable among the majority of participants. The period might be between a year to five years. This decision may also be influenced if the first and second child are females or if the parents are not young.

4- Spacing between the third and the fourth child is acceptable. The willingness to use permanent contraceptive methods may increase after the third child.

5- Regarding the willingness to span between children among educated and uneducated people, it was notable that the educated group adopted the idea of having differences in spacing based on educational level, however the uneducated groups reported no difference. The reliability of data collected from the uneducated group may be much higher than responses from the educated group as the first party reported their personal experiences while the educated party might follow stereotypical ideas that allegs the willingness of illiterate group to have more children. The majority of uneducated participants reported that there is no difference between the uneducated and educated people regarding spacing now as the only factor that plays a major role in spacing is the economic conditions of the family. "In the past, the illiterate wanted to have more children and the educated wanted only 2-3 children...Nowadays there is no difference between the educated and the illiterate," reported uneducated man in El Gharbeyia Governorate.

### 3.4.1 ADVANTAGES OF BIRTH SPANNING

Regarding the advantage of birth spanning, the majority of participants reported the following advantages:

- **Spanning between children will be healthier for the mother.** "In case of having 2-3 years between each child the mother will be in a good health," reported some women in El Gharbeyia Governorate.

- **It will be also healthy for the child as he/she will be able to receive nutritious breast feeding for a couple of years.** "It is recommended to span between children in order to continue the breast feeding for two years," reported a man in El Gharbeyia Governorate. Additionally, spanning could be good for the psychological health of the child. "The child will be treated kindly and lovingly, it is his right. That only can be achieved through spanning among children," reported a highly educated male in El Gharbeyia Governorate. "In
case of having limited spanning period (one year), the child might be jealous."

Again, it was notable that the health of the child relies mainly upon spanning.
- It might also be useful for parents due in terms of their economic conditions. Raising child costs a lot of money so it often make economic sense to span between children.

3.4.2 DISADVANTAGES OF BIRTH SPANNING
- The majority of the sample was against spanning before giving birth as they believed there was a possibility of suffering from some severe complications. It was also considered inappropriate for older parents who get married at the age of thirty. If they started spanning, they would not be able to give birth. The majority of participants reported that it would be against God’s will.
- The majority of participants believe that they would not be able to give birth after the age of 35. Therefore, the long spanning was not acceptable for them.
- Long spanning was also considered to be harmful to the first child as she/he might feel lonely. It was thought that her/his psychological conditions might be affected due to long spanning.
- Long spanning might affect the ability of woman to give birth. "The woman might be barren due to long spanning," reported an uneducated female. The fear of barrenness might lead women to shorten the spanning period.
3.5 CULTURAL FACTORS AND THEIR IMPACT ON CHILDBEARING AND FP

Through the discussion of this issue, the following questions were highlighted:

1. Is it legitimate (both religiously and socially) to think of childbearing as “controllable”?
2. Is it feasible to control the number of children?
3. What do people think of the “ideal” number of children?
4. Is the increase in the declared ideal number of children with parity a post-rationalization or an admission of the true (rather than the politically-correct) ideal?
5. Is there a real concept of a desired complete number of children, or do childbearing decisions occur piecewise?
6. Who should make the decision to have another child? Who, in reality, does makes the decision?

The participants in the FGDs and in-depth interviews have a clear point of view regarding this issue. It was notable that the pattern of answers reported in the FGDs was exactly the same as the pattern that emerged from the in-depth interviews (with the Ministry of Health and Population, NGOs, religious leaders, health promoters and policy makers). Slight differences were reported among religious leaders.

Regarding the results of the discussion about the legitimacy of considering childbearing controllable, the majority of participants agreed that it is legitimate to think that childbearing might be controllable socially. Yet, it is also considered illegitimate according to both Islamic and Christian codes. "We can control childbearing but if you ask an Islamic Priest Sheikh he will say that childbearing is not controllable, it is mainly based on the will of God," reported a man in Gharbeyia. However, it is worth mentioning that some of participants and policy makers noted that controlling childbearing is acceptable both socially and religiously.

The discussion of the possibility of controlling the number of children concluded with the following:

- Some of the participants reported that the number of children can be controlled due to the financial status and the limitation of monetary resources. One of the women that
attained lower education tried to simplify this issue by saying, "We use contraceptives to control birth, so it is controllable."

It was reported among some of the female participants that women might use a contraceptive but still got pregnant, especially those who used an IUD. "Some of us might use a contraceptive but they got pregnant...I have a relative who was using an IUD but she got pregnant."

Religious Muslims tend to explain that, "The will of God is the main control of birth. In the Holy Quran God says He gives females for some whom he wants and he gives male to those he wants, or he gives both females and males or he makes whom he wants barren." The same perspective was also reported by religious Christians, indicating that the religious belief may become a societal norm.

However, the manager of planning in the MoHP at the central level reported that it is socially acceptable to “plan” birth rather than “controlling” it. According to religion, the word plan is much acceptable than control.

The ideal number of children reported was mainly 2-3 children. However, in Assuit and rural Gharbeyia it was notable that the ideal is 3 children. Regarding the policy makers, they reported that the ideal number is based on ability and means within each family. "Some families think the ideal number is 2, however, others think it is only one child...It mainly depends on family perception." Considering the parity between the post-rationalization and admission of the true ideal, it seems that the majority of the participants were committed to the ideal number. But, some of the participants have more than the ideal number in order to have a boy or a girl, continuing until they have four or five children. The policy maker reported that about 90% of people are committed to their ideal number. Some of the FGD participants reported that families might exceed the ideal number due to the influence of the husband or of his mother.

The last point discussed regarding this issue was the decision making around having a new child. The majority of participants in the FGDs and the in-depth interviews reported that the decision is mainly based on a discussion between the married couple. Yet, the male participants reported that it is mainly the decision of the husband as he is the bread winner and will support the child. "Sorry to say so but the man is the person who supports the family
financially, so it is mainly his decision," reported a man with lower education in Gharbeyia Governorate. The health promoter in Cairo reported that about 90% of the beneficiaries believe that they should ask their husbands opinion about having new child.

CHAPTER FOUR: CONTRACEPTIVES

Originally, the Egyptian Family Planning Program has concentrated on women as the direct recipients and beneficiaries of its services. Specific surveys of women assessed the total fertility rate, the contraceptive prevalence rate, the age at marriage, the social status of women, and knowledge, attitude and practice of fertility control. This information helped policy planners assist women in making "independent choices" regarding the available contraceptive methods. The relative invisibility of men in the debates on fertility control and contraceptive methods was perpetuated by this focus on women. Yet, during the previous decade, a major transformation occurred as the Family Planning and Reproductive Health (FP/RH) directorate of the MOHP focused on improving access to and quality of reproductive health services for underserved and high-risk populations, while also building the institutional capacity of the commercial and non-governmental sectors to provide such services. The overall notion of family planning became a package of integrated services provided to the families to enhance reproductive health conditions of Egyptian society.

Based on such initiatives, it was crucial to comprehend the knowledge, attitudes and behaviors related to family planning contraceptives. This section will discuss opinions related to contraception with different stakeholders: FGD participants, policy makers, NGOs, religious figures, and service providers.

4.1 CONTRACEPTION: KNOWLEDGE AND ATTITUDES

Regardless of the diversity of family planning contraceptive methods, the FGDs participants reported four main types:
1. The IUD was considered the dominant contraceptive as all of FGDs participants reported it as the main contraceptive method. They reported different types of IUDs. Inside the health unit they use lower quality IUDs due the lower costs.

2. The pill was the second main method mentioned. The FGD participants reported two types of pills, one used during breast feeding while the other is used at any time. They mentioned some low cost pills and expensive ones. They were unable to provide the names of the pills.

3. Intravenous contraceptives were the third type mentioned. The FGDs participants reported one type of intravenous contraceptive.

4. The capsules are very rare to be used, but it was feasible that there is only one type of capsules that are planted in the arm.

In addition to the four methods above, another three traditional methods were reported:

1. The castor-oil plant
2. Clean breast feeding
3. Tubal ligation operation performed by the midwife

Very few of the FGDs participants reported knowing about the male condom⁵.

By analyzing the FGDs, it was understood that the best contraceptive method mentioned is the kind chosen by the gynecologist. However, some reported the IUD regardless of its side effects, followed by birth control pills, injections and capsules. "One woman used an IUD, she said that it is good...while another woman says it caused her bleeding...some

---

⁵ Based on different surveys conducted through the Family Health International in Egypt during the previous two years it was notable that condom is not welcomed in Egyptian society due to the bad connotations of it being associated with illegitimate sexual relations, homosexuality and STIs. Therefore among married couples, the usage of condoms was not so common.
women say injections are good...but others reported no...the pills are also good but they might stop the breast milk..." reported an uneducated woman in Assuit.

The most unfavorable methods are capsules and birth control pills, especially during breastfeeding period, as birth control pills might stop lactation.

Knowledge about contraceptive methods is mainly acquired from the surrounding community: neighbors, relatives and family members. Thus, it was noteworthy that only bad experiences were mentioned.

4.2 SOURCES OF INFORMATION

According to different surveys conducted over the previous two decades, the main source of information about contraceptives is television. However, among the FGD participants it was noted that the main source of information reported was community members including neighbors, relatives and family members. "My neighbor tried the IUD and she bled. However, when she used pills she felt nauseous and wanted to vomit," reported a young woman among an uneducated group who was unwilling to use contraceptives.

The second main source of information was the gynecologist in the private clinic who might be willing to provide some information about the bad unfavorable impacts of contraceptive methods.

The third main source of information, considered more reliable by most participants, was their personal experience. The majority of them practiced some contraceptive methods and had experienced unfavorable and sometimes deadly side effects. This experience played a major role in formulating their perception towards different family planning methods as well as their influence on other surrounding women.

4.3 PREFERENCE

As mentioned in above discussion, the family planning methods are ranked as follows:

1- The IUD was ranked first, as it is accessible and the women rarely face any severe health problem as a result of using an IUD. However, some women were not in favor of the IUD as it might cause severe bleeding.
2- The second method ranked was birth control pills, as they cost less than one EGP. The side effects of birth control pills are considered bearable and pregnancy can occur easily after one stops taking them.

3- The third contraceptive method reported was intravenous contraceptives. However, many women were not in favor of them as it was notable that they might affect the vagina. The usage of intravenous contraceptives is considered more favorable if the woman does want to have any more children.

4- The last method reported was capsules that are not so welcomed in the community.

5- Regarding the condom, it is understood that it is only used under the condition that a woman feels incapable of using any other contraceptive method. The usage of condom is considered socially unacceptable behavior. People who use male condoms are stigmatized either with having illegitimate sexual relations or having a health problem.

4.4 INFLUENCE ON DECISIONS

The husband is primarily responsible for making decisions regarding family planning. However, some of the participants reported the importance of consultation with the wife. "Men don't exert any effort...I am the person who suffers...men don't pay attention to women...I have to remind him that I suffer due to frequent pregnancy...so he might think about stopping giving birth," reported an uneducated woman in Assuit.

Some extremely religious husbands order their wives to have more than five children, otherwise, he might marry another woman. "One of our neighbors is a fundamentalist, he ordered his wife not to use any contraceptive method as the religion banned family planning," reported an uneducated man in Gharbeyia Governorate.

The mother-in-law has great influence on family planning, especially, if the spouses live in her house. "If his mother ordered that his wife shouldn't use a contraceptive, he will order you not to use a contraceptive..." reported an uneducated woman in Assuit. The Christian families experience the same situation. However, the threat of marrying another woman is not common. Yet, the mother-in-law might give the wife a hard time. "Her mother in law makes her life like a hell," reported one of the Christian participants.

Living conditions also heavily influence decisions about family planning. "I swear by God that the living conditions are now harsh...People can't afford having more than two or three
children...People should be thankful to God...Having more children is really unfair...How can we afford paying for their expenses and their education?" reported an uneducated female in Gharbeyia Governorate

Women might feel fragile and vulnerable due to the combination of unemployment, illiteracy and the norms of the community. All these factors together might put limitations on the woman’s contribution to making decisions."We are followers of the husband...if he says give birth we should be obedient...if not we should follow the orders," reported an uneducated woman in Assuit. Nevertheless, some women could manage to act freely, alleging that they had health problems or a reason for not getting pregnant.

4.5 COST

The discussion of cost can be summarized in two main topics namely, the cost of contraceptive methods and the cost of giving birth. The information from the FGDs and the in-depth interviews was analyzed to collect the information needed about these two issues.
4.5.1 COST OF FP

Counting the cost of the family planning methods was not an easy process, as various factors might affect the cost of the different types of contraceptive methods. In order to make the cost estimation more legible, the following table will inform about the cost based on service provider.

Table 4.5 Cost of Contraceptive Methods Based on Service Providers

<table>
<thead>
<tr>
<th>Service Providers</th>
<th>Type of Contraceptives</th>
<th>Capsules</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IUD</td>
<td>Birth Control Pills</td>
</tr>
<tr>
<td>Public Clinic</td>
<td>2-3.5 EGP</td>
<td>65 P.T.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>*11 EGP</td>
<td>2-17 EGP</td>
</tr>
<tr>
<td>Private Doctor</td>
<td>Check up between 20-100 EGP</td>
<td>Check up between 20-100 EGP</td>
</tr>
<tr>
<td></td>
<td>The IUD costs 35-70 EGP</td>
<td>The pills cost 15-17 EGP</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Purchased from the pharmacy to be inserted by a private gynecologist.

In addition to the list above, some of the contraceptive methods are considered free of charge in the eyes of some participants. For example, the castor oil plant costs nothing as it is available in the village. The clean breast feeding also costs nothing. Using safe period⁶ is also free of charge. The female tubal ligation operation performed by the midwife costs nothing as it is administered directly after giving birth.

The majority of the sample surveyed reported that they go to the public service providers as they live under poor conditions that oblige them to use poor quality public services. "It is all I can afford...If I had more money I would go to a private doctor..." reported a woman in Assuit.

4.5.2 COST OF GIVING BIRTH

---

⁶ Safe period is the time when woman is not fertile so she can’t be pregnant. This period can be calculated. Woman can have sexual intercourse without being worried about contraception.
The cost of giving birth varies between urban and rural areas and according to the service providers. Moreover, the first children is totally different from the second and the third regarding the cost

The discussion about the cost of giving birth produced the following observations:

1- In rural areas, midwives are much more favored as service providers. Therefore, the cost of giving birth does not exceed 50 EGP. Some midwives differentiate between birthing male or female children. "If the child is female the midwife takes only 100 EGP…However, if he is male then the midwife gets 200 EGP." The first child also receives different treatment by virtue of being the first baby born to a family. In this situation, they might give more money to the midwife.

2- In some rural areas, families go to the clinic or public hospital which costs between 200 EGP-500 EGP.

3- The private doctors are much more expensive. The cost of giving birth varies between 600-1500 EGP depending on the whether the private doctor’s office is in an urban or rural area.

4- Another unseen cost is the clothing for the first child which might be more expensive as children born later can wear their siblings’ clothes.

5- It is worth mentioning that the majority of participants are unemployed women. Therefore, they are not covered under health insurance.

6- The majority of participants reported that they are obliged to go to the midwife or to use public healthcare due to the limitations of their financial resources, regardless of the bad treatment and inappropriate service they receive there. "They don't treat us nicely... Sometimes they are neglectful...the place is not clean...but this what we can afford," reported an uneducated woman in Assuit.
4.6 ACCESSIBILITY

Before the discussion of service accessibility, it must be noted that the sample was selected from urban, rural and semi-urban areas in Assuit and Gharbeyia Governorates. The service providers were investigated in different areas. The participants reported that both private and public service providers are close to their areas though the public hospitals are not accessible in the rural areas due to the regulation of the hospital catchment area. Regarding the midwives, they are more accessible in the rural areas, especially after they were permitted to work under the supervision of the Ministry of Health. None of the participants reported facing any problems with accessing health services, primarily due to the diversity of service providers.

---

7 In order to construct a hospital, it should serve a total number of population exceeds 5,000 people in the catchment area.

8 Due to the high percentage of woman who give birth with the assistance of midwives, the Ministry of Health started enhancing the capacity of midwives through the "Clean Birth" program.
4.7 USAGE OF CONTRACEPTIVES

The measuring the usage of contraceptives is important in order to be able to trace groups that are unwilling to use the contraceptives and in trying to develop the appropriate strategy to raise their awareness of the importance of using family planning methods.

4.7.1 WHO USES CONTRACEPTIVES

The main question raised by the study team was who uses contraceptive methods? This issue was discussed with different participants and it was gathered that there is no clear pattern denoting those who use contraceptives. This is due to the fact that women of different social classes might use contraceptives after giving birth to their first child while others may use it after the second child and so on.

Woman of all ages used contraceptive methods. However, after the age of 35 years, they might stop using contraceptives as there is a main misconception in the community where women older than 35 are not fertile enough to give birth. One of the main assumptions of the study was that employed women would be one of the main groups that would use contraceptives more than unemployed women. However, some highly educated women have more than four children.

Another hypothesis of the study was that people living under poor conditions might have fewer children due to their economic status. Yet, there were people from all economic classes willing to have up to three children.

The discussion lead to the following conclusions:
1- It is not one factor that determines the usage of contraceptives but rather a combination of factors including education, economic status and level of support from the spouse and family members.
2- Another factor that might put limits on having many children is having high expectations for children (educating them, building apartments for them and assisting them when they get married). Everyone who reported their willingness to provide the aforementioned items had between 2-3 children only.
3- Another group of people who use contraceptives are the ones who had more than six children. "If a woman had more than seven or eight children she became more willing to use contraceptive," reported the majority of participants in Assuit and Gharbeyia Governorates.

### 4.7.2 OBSTACLES TO CONTRACEPTIVE USE

Finally, it was crucial to highlight the obstacles that hinder women from using contraceptives. This issue was discussed with the majority of the sample surveyed through in-depth interviews and FGDs and can be summarized as follows:

1. **Lack of information about contraceptives**
   
   1. "Clean breast feeding", meaning that a woman does not menstruate during the breast feeding, was considered a form of natural family planning. One of the most common misconceptions is that having no menstruation period might affect the fertility of woman. "I used to have a clean breastfeeding, so I don't need to use a contraceptive method," reported an uneducated woman in Assuit.
   
   2. It was notable that the misconceptions related to the side effects of the contraceptive methods form a main barrier to their use. Community members discussed side effects and provided incorrect information about the different methods, because they had not received any clear information from the service providers.

2. **Facing a health problem**

   3. It was reported that contraception was not used because there was a health problem that affected giving birth, especially for those who never given birth. "I have a problem in my vagina, so there is no need to use a contraceptive method," reported an uneducated woman in Assuit.

   4. Other health problems were reported to render women unable to use contraception. "I have a problem in my leg so I can't take any injections or pills," reported an educated woman in Assuit.

3. **Refusal of the husband**

   The husband is sometimes totally unwilling to use contraceptive methods due to different reasons:
• His mother’s refusal to allow his wife to use contraceptives, stopping him from implementing family planning methods.
• The desire of the husband to have more children to support him when he is older.
• The husband sometimes wants to have a male child or more male children "Husbands might be willing to get more boys...she should have more than one boy...I have three daughters and one boy...he wants me to have another boy," reported an educated woman in Assuit.
• The desire of a husband to have more children due to religious beliefs.

4. Reasons related to the contraceptive methods

5. The belief that using contraceptives for an extended period of time might affect the ability to give birth so women are not willing to use contraceptives again after they have stopped. "I used contraceptives for seven years...after a long time I could hardly have a child...Now I am old to use a contraceptive," reported an educated woman in Assuit.

6. Side effects of using different contraceptive methods. "I used the IUD which made me bleed...then during the usage of it I got pregnant," reported an educated woman in Assuit. Another woman said, "The pills made me bloated and the period became infrequent...and the injections might have made me barren." "After my giving birth I used injections...they made my body bloated...I stopped them then I used the IUD it caused me severe pain in the uterus...then I used the pills that cost 65 piaster," reported a third woman.

7. The male condom is still one of the most stigmatized contraceptive methods. One educated woman reported using it, "I am shy to share that me and my husband sometimes use male condom." It is socially unaccepted "E’ib" to use it due to the following reasons:
   a. Family planning is the responsibility of women not men.
   b. The condom is associated with illegitimate sexual intercourse.
   c. It is also notorious with the health problems a woman faces (any problems related to her reproductive system). Therefore, the husband is obliged to use it

5. Other reasons
8. The husband travels to work abroad so there is no sexual intercourse. "My husband lives abroad, I had my first child then my husband travelled for two years...then he came back I could have another child but since then, it is nine years now, and I could not manage to have any other children." reported an educated woman in Assuit.

9. Using natural contraceptives i.e. safe period during which woman can’t be pregnant "I tried once the safe period method..." reported an educated woman in Assuit.

10. Another reason to have more male children is the norm of revenge (Tar) killings, a tradition still practiced in some rural Upper Egyptian areas. It is the tradition that to extract revenge for an extreme wrongdoing, a man will be killed rather than a woman. Therefore, families favor having more boys.

11. The beneficiaries in waiting areas in the clinics are used to exchanging advice related to different contraceptive methods. "While sitting in the clinic, women advised me not to use injections due to their severe effect on the body..." reported an educated woman in Assuit.

Photo ( ) : In-depth Interview with an NGO Representative
It was expected that financial conditions would not affect the willingness of people to use contraceptive methods due to the variety of contraceptive methods and prices. Some contraceptive methods cost less than one EGP and service providers in the public health units and hospitals provide their services almost free of charge.

Regarding service provider accessibility, the discussion suggested that service is available almost everywhere, through permanent or mobile units.

Community members played a major role in encouraging or discouraging women to use contraceptives, regardless of their education, economic status or employment status. A mother, mother-in-law, sisters, neighbors, friends, and those who sit in the waiting areas in clinics have a great influence on a woman’s willingness to use contraceptives.
CHAPTER FIVE : DISCONTINUATION OF FAMILY PLANNING METHODS

The discontinuation of contraceptive use is one of the most problematic behaviors related to family planning. Some questions raised during the discussion of this issue in the FGDs and in-depth interviews were as follows:

1. What are the motives for discontinuation?
2. Who make the decision regarding discontinuation behaviors?
3. What are the actions carried out after discontinuation?

It is worth mentioning that discontinuation did not necessarily occur due to problems faced during periods of contraceptive use. Sometimes it was just the desire to have a child. Therefore, we should differentiate between the discontinued use of contraceptives due to different reasons excluding the willingness to have a child.

5.1 REASONS FOR DISCONTINUATION

Obviously, the reasons for discontinuation are influenced by the contraceptive methods used. Therefore, the discussion was mainly based on the type of contraceptive used. The most common contraceptives mentioned were the IUD, birth control pills, intravenous contraceptives and capsules. Due to the fact that none of FGD participants ever used capsules, only three of the main methods were discussed.

5.1.1 REASONS FOR DISCONTINUATION OF IUD USE

The participants in the FGD that discussed and discontinued IUD use reported that their neighbors advised them not to use the IUD before going to the gynecologist. Such advice paved the road for discontinuation, as psychologically woman became suspicious towards the IUD. Consequently in any side effects occurred, they were ready to discontinue use. Some of the advice reported by the FGD participants includes:

- "Some of my female neighbors advised me not to use the IUD as it might cause severe bleeding."
- "They told me that it might get into the uterus."
• "They told me that people might get pregnant regardless of using the IUD. The doctor can't extract it during pregnancy. Therefore, he should wait until labor then he could get it out of the uterus."

• "I was terrified to use it, so I asked some people who used it before, they told me it might cause some pain in the backbone."

Some gynecologists might not be able to provide information about the side effects of the IUD in appropriate way due to their lack of how to communicate with villagers and thus women might be concerned due to the information provided by the gynecologist. "I went to a doctor, she informed me that the IUD might cause some irritations or pains in the backbone. Also she noted to the possibility of having discharges."

The main reasons for discontinuation of IUD use can be summarized as follows:

1. Facing some health problem due to IUD use (i.e. bleeding, irritation, etc.)
2. Getting pregnant during IUD use
3. Extracting it due to health problems and based on doctor's advice
4. The moving of the IUD "I used it but I didn't find the small string so I made x-ray and I didn't find it."

Wrapping up the discussion, we ended with the reasons for discontinuation as facing health problems, being pregnant and advice from the doctor.

5.1.2 REASONS FOR THE DISCONTINUATION OF BIRTH CONTROL PILLS

Regarding the discontinuation of birth control pills, it was notable that the influence of community members was effective. They informed the women that birth control pills have some unfavorable side effects such as bloating in the body, headache, nausea, dizziness and weakness. Therefore, some respondents reported receiving advice about eating nutritious food while on the pill. Yet, a majority of them live under poverty line and cannot afford nutritious food that is high in protein (i.e. meat, egg and chicken).

The main reasons of discontinuation of the pills were as follow:

1. Health problem due to using birth control pills:
   a. "When I took the pills only five minutes late, immediately I had blood, so the menstruation period was continuous."
Chapter Five : Discontinuation of Family planning methods

5.1.3 REASONS FOR THE DISCONTINUATION OF INTRAVENOUS CONTRACEPTIVES

It was notable that those who used injections also had experience using IUDs and birth control pills. The reasons for discontinuation were mainly due to the health problems associated with each type of contraceptive. The study team gathered the following experiences of the problems faced during the contraceptive usage in order to develop an appropriate strategy later in this report.

a. "After giving birth, I used injections...I was bloated...my body became swollen...I stopped the injections...I used the IUD that caused me severe pain in my uterus...It was continuous pain...I stopped the IUD and used pills that cost 65 piaster."

b. "The injections caused severe pain in my whole body... I couldn't stand up...the period also stopped that caused me pain in my back and my leg."

c. "The injections cause bloating and result water under the skin."
d. "I used the injections first then I gained weight...Later on I used pills that cost 2.5 EGP...I felt headache and lost my appetite...then I used the IUD that made me have my period twice a month."

e. "I used the IUD and it was useless...then the pills that I forget to take most of time...then I had to use the injections that were a catastrophe and disastrous."

f. "I was checked by a gynecologist. I asked her about the appropriate method because the IUD was not working appropriately. What do you think about the injections? She replied it is ok...but some people used to complain...I can't force you to use them...I told her that I can't remember to take the pills and the IUD made me bleed...then she advised me to try them under one condition that I should stop them if they cause me any problems...I used them for few months and I started suffering...I went to the gynecologist who weighed me and told me to stop the injections."

The injections, IUDs and birth control pills were considered the only three options for contraceptives. It was notable the male condom and capsules were not an option and thus discontinuation was limited to these three contraceptives

5.2 DECISION TO DISCONTINUE CONTRACEPTIVE USE

Who make the decision to discontinue contraceptive use? That was one of the main questions raised in this study as these people will be the main target group for any potential awareness raising initiatives. The discussion of this point resulted in the following observations:

1- The woman taking the contraceptives is the person primarily responsible for discontinuation. "When I felt tired I stopped using the contraceptive method". The contraceptives have so many health problems that affect any decision and the woman bears the suffering due to these problems.

2- The second decision makers are the gynecologist and the physician, as they can judge the severity of the side effects. In most cases, they propose some alternatives. If the gynecologist noticed that woman suffers due to the injections he asks her to stop using them and proposes using an IUD instead. Yet, some do not propose any alternatives as the woman has tried the three main methods.

3- The third main decision maker is the husband who is not totally involved in the process of family planning. If severe health problems occur due to contraceptive use, the couple might start using the male condom. However, some husbands demands
their wives not use such types of contraceptives, especially, the IUD which may cause bleeding (so he might be unable to have sexual intercourse). Moreover, some husbands want to have many children. "My husband used to say why should you use IUD... I want to have more children... he doesn't care about my health...but I should obey him," reported one of the women in Assuit.

5.3 BEHAVIOR AFTER DISCONTINUATION

It was notable that the behavior after discontinuation changes according to the type of contraceptive used. The following is the summary of the discussion:

1- In the case of IUD use or injections, the woman might start taking birth control pills.
2- In case of using the three main methods, the woman might stop using any contraceptives.
3- After giving birth, the woman might not use any contraceptive methods as they rely upon the clean breastfeeding.
4- Women are not willing to use male condom unless they have tried other alternatives.

It is worth mentioning that women might wait a long time (6-24 months) until they start acting to change or discontinue their methods of contraception. "My brother's wife used the
monthly injections for three years...the injections caused her severe bleeding...The gynecologist tried to stop the bleeding...It was very difficult situation... Her body didn't accept the injections," reported a woman in Assuit.

In conclusion, the attitudes of the woman after discontinuation vary according to the type of contraceptive used and the willingness of a woman to give birth. Discontinuation does not carry forward any implications for the use of the male condom by the husband. It is thought that husbands should not be obliged to use condom as alternative to the failure of other methods. However, in the case of a wife’s critical health condition, her husband might be willing to use the male condom.

Some gynecologists might not be supportive of a female client using another contraceptive method, instead suggested that women stop using unfavorable contraceptives without suggesting an alternative.

The attitudes and actions taken after discontinuation drew our attention to the problematic situation women face after having tried more than one contraceptive method. Moreover, woman are strongly in favor of applying the natural family planning methods i.e. clean breast feeding. Therefore, we should pay more attention to the family planning techniques that do not necessitate any further medical contraceptive methods.
CHAPTER SIX: FAMILY PLANNING NEEDS ASSESSMENT

What do women need in order to be motivated to use family planning methods? That was the main issue covered by this study. Different family planning services are already provided to women in different communities. Health units, hospitals and gynecologist (both public and private) provide different levels of services of different costs. Practically, the issue of services needed should be highlighted on the level of community members and decision makers. The following is the discussion of that issue:

6.1 NEEDS FOR FAMILY PLANNING

Community members and policy makers reported the following needs that might encourage woman to pursue family planning. It was crucial to highlight these needs in order to have a clear vision for future plans. Moreover, some of these needs are already fulfilled or at least discussed on the national level. Therefore, the fulfillment of these needs will be highlighted later on.

6.1.1 HEALTH NEEDS

Regarding the health needs, the following were recommended by the community members and decision makers:

1. Provision of an appropriate health checkup is crucial for women.
2. The state should provide the health services completely free of charge.
3. Provision of different types of contraceptives in the units and hospitals. Moreover, doctors should be encouraged to accompany mobile units to provide contraceptives to people.

6.1.2 INFORMATION AND KNOWLEDGE NEEDS

1. It was necessary to provide information about each contraceptive method, in efforts to raise awareness about the different types of contraceptives.
2. Information about the misconceptions should be provided, particularly the ones related to the common IUD.
3. Clear information about the side effects should be discussed with community members in order to allow them to choose the least risky contraceptive method and to be prepared to handle any side effects.

4. Information should be provided about the male condom. The stigma surrounding the male condom should also be addressed as it was considered one of the least favorable methods.

5. The benefits of family planning should be presented to the community.

6. Religious leaders should have conferences in different areas of Egypt in order to discuss religious misconceptions regarding family planning.

7. Specialized doctors should conduct different conferences or seminars to raise community awareness (among mothers-in-law, husbands, wives, etc.)

8. The community should be informed about the problems related to the frequent births.

9. Provision of clear information about the different contraceptives, including which ones to use for long and short term spanning.

10. Young girl awareness programs should be provided to inform them about reproductive health.

11. Long term behavior changing programs should be implemented. However, it is recommended that the desire to have children (generally at least 2-3 children) be taken into consideration as many people want to become parents.

12. School curricula should encourage the idea of having fewer children (possibly included in comprehension and writing topics).

6.2.3 NEEDS RELATED TO SERVICE PROVIDERS

The service providers should provide appropriate services for the people and the following are needed:

1- The service providers should be qualified, not only with medical information but also as to how to treat people. Good communication skills should be required of qualified service providers.

2- The service provider in some rural areas should be a female as it remains unacceptable in some rural areas to be checked by a male gynecologist.
3- Appropriate treatment in the hospitals and public health units will encourage women to access the services.

4- A psychologist should provide needed help to the community in order to encourage them to use contraceptives.

5- The service provider should provide the needed information in a simple and clear manner so the community has no trouble understanding the material. A comprehensive service should be provided (i.e. mother and child healthcare).

6.2 WHY NEEDS HAVE NOT BEEN MET

1. Community needs versus services provided

Based on the discussions mentioned above, it is crucial to discuss whether the needs have been met or not in order to address the reasons for unfulfilled needs. The following table highlights the needs.

<table>
<thead>
<tr>
<th>Community Needs</th>
<th>Service Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of an appropriate health checkup</td>
<td>Available through the different services, but considered unacceptable in the public facilities by beneficiaries</td>
</tr>
<tr>
<td>The state should provide the health services completely free of charge</td>
<td>The state already provides services at a low cost</td>
</tr>
<tr>
<td>Provision of different types of contraceptives in the units and hospitals</td>
<td>Only a few types</td>
</tr>
<tr>
<td>Provide information about each contraceptive methods</td>
<td>Information provided is limited and not understood by the community</td>
</tr>
<tr>
<td>Information about misconceptions</td>
<td>Not provided</td>
</tr>
<tr>
<td>Clear information about the side effects</td>
<td>Limited information</td>
</tr>
<tr>
<td>Information about male condom.</td>
<td>Not provided</td>
</tr>
<tr>
<td>Information about the benefits of family planning</td>
<td>Provided in awareness raising programs</td>
</tr>
<tr>
<td>Seminars and conferences provided by the religious leaders</td>
<td>It is common in some rural areas</td>
</tr>
<tr>
<td>Specialized doctors should conduct different conferences</td>
<td>Doctors provide information through the NGOs and medical caravans</td>
</tr>
<tr>
<td>Inform the community about the problems related to the frequent births</td>
<td>Information is provided through the NGOs and service providers</td>
</tr>
<tr>
<td>Young girl awareness programs</td>
<td>Not tailored for young girls but rather are for</td>
</tr>
<tr>
<td>Community Needs</td>
<td>Service Provided</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Long term behavior changing programs should be applied</td>
<td>Limited behavior changing</td>
</tr>
<tr>
<td>School curriculums should encourage the idea of having fewer children</td>
<td>No discussion at schools</td>
</tr>
<tr>
<td>The service providers should be qualified</td>
<td>The private service providers are more qualified than the public ones</td>
</tr>
<tr>
<td>Provision of female gynecologist</td>
<td>Available in some clinics</td>
</tr>
<tr>
<td>Appropriate treatment in the hospitals and public health units</td>
<td>Bad treatment reported</td>
</tr>
<tr>
<td>Consultancy should be provided needed help to the community people</td>
<td>Not available</td>
</tr>
<tr>
<td>The service provider should provide the needed information with no trouble</td>
<td>Sometimes they provide limited information</td>
</tr>
<tr>
<td>A comprehensive service should be provided i.e. mother and child healthcare</td>
<td>Provided in some limited areas</td>
</tr>
</tbody>
</table>

It was obvious that some of the needs have not been met at all while some others have been fulfilled but not in acceptable way. Thus, it was crucial to know the reasons for unfulfilled needs.

2. **Reasons for unmet needs**

Regarding the discussion of this issue, it is crucial to differentiate between the reasons for not using contraceptives and the analytical part that discuss why the needs have not been met. That was discussed mainly with decision makers who reported some reasons for not fulfilling the needs of community women.

Based on the table above, it was understood that some of the needs that would enhance the acceptance of family planning have not been fulfilled. It was crucial to highlight the barriers related to different unmet needs:

1- Limited budgets allocated for awareness raising programs played a major role in limiting the information provided. “*We have limited resources due to not having any further financial support from the USAID. Now we rely only upon the governmental budget which is limited*” reported the representative of MOHP. It seems that the limited budget is also the problem of the NGOs “*In case we have a donor we can implement our activities without problems, but if not we had to slow down*” reported a representative of an NGO.
2- Insufficient salaries and unacceptable work conditions in the public facilities made the service providers unwilling to provide appropriate services and the treatment was not acceptable for the majority of the FGD participants. “The doctor treats us very bad in the health unit but in his private clinic he is ready to speak and to provide the needed service. it is the money what some of them seek for” reported more than one participant in both Governorates

3- The majority of ministries (Education, Endowment, etc.) believe that it is not their responsibility to work on family planning. Therefore, no educational curriculum contains information about family planning. “The ministries think that family planning is not their task, it is only the Ministry of health responsibility, and therefore, they don’t support us. Not only that but educational institutes think that the discussion of family planning with student is taboo” reported the representative of MOHP

4- The influence of some religious leaders works against family planning,

5- Limited sources of funding through different donors might affect the sustainability of the awareness raising programs. “Due to the withdrawal of USAID funds all our activities regarding population and family planning” reported a representative of Social Fund for Development

6- There were no supportive rules and regulations for the family planning process as Egyptian communities, especially religious figures and some decision makers, were against having laws that ban having more than two children or even extract the social benefits of the children more than two. “The Egyptian Law is fully anti abortion and tubal ligation or male sterilization. Also it is against putting limitation to giving birth. As well as it is forbidden to say that if someone has more than two children the other children will be deprived of free education and health care. We are not like China and Iran. Our people are not obliged to have two children” reported the representative of MOHP

7- A lack of understanding about the culture and individuality of each community is one of the main reasons that needs go unfulfilled.

3. How to meet these needs

1- Allocate sufficient budgets for awareness raising activities through different media facilities.
2- Enhance the performance of the public health sector in order to achieve the appropriate work conditions potentially enhancing the performance of the service providers.

3- Apply a multi-level monitoring and evaluation systems in order to achieve better performance in health sector.

4- The majority of ministries should bear responsibility for the family planning activities rather than just the Ministry of Health and Population.

5- Long discussions with religious figures should be carried out by El Azhar scientists in order to have a common perception towards family planning according to religious beliefs.

6- Fund raising should be carried out on different levels, both in the public and non-governmental sector, in order to enhance the service provided.

7- Family planning programs should be modified according to the target groups. The family planning awareness programs should be tailored for husbands, wives, young adolescents and old parents. Moreover, the information should be tailored for different audiences (i.e. educated vs. non educated groups of people).
7.1 INTRODUCTION

On the demographic front, Egypt has passed the peak of the demographic bulge due to the decline in fertility of two decades ago. However, more needs to be done to further reduce the pace of fertility decline which has leveled at about 3.1 for almost a decade. The fertility rate cited in the 2008 Egyptian Demographic and Health Survey (EDHS) was 3.0 births per woman, only slightly lower than the rate observed in the 2005 EDHS (3.1 births per woman). In rural areas, the fertility rate is 3.2 births, around 20 percent higher than the rate in urban areas (2.7 births). Fertility levels are highest in Upper Egypt (3.4 births) and in the Frontier Governorates (3.3 births) and lowest in the Urban Governorates (2.6 births). Education is strongly associated with lower fertility, as is wealth. The fertility rate decreased from a level of 3.4 births among women in the lowest wealth quintile to 2.7 births among women in the highest quintile.

In Egypt, rapid repeat birth (RRB) has been identified as a risk factor for adverse prenatal outcomes. RRB is defined as a birth occurring within 24 months after a previous birth, or for an adolescent mother, a repeat birth while still a teen, regardless of the interval between the two births.

Understanding the motives and factors that form the attitudes, behaviors and actions taken to control birth among the community is necessary to reach the fertility rate goals. It is worth mentioning that many studies have been developed in different Egyptian governorates to investigate the obstacles facing fertility reduction. The government is involved in providing public family planning services, literacy programs and employment opportunities for women. The remedies for a fertility plateau lie in the subtle manipulation of these factors, encouraging a decline in fertility trends and allowing countries to complete their fertility transitions.

---

9 Egypt Human Development Report, 2010
The Egyptian state adopted many initiatives to reduce the fertility rate, mainly carried out through the Ministry of Health (MoH), NGOs and funding agencies. In conclusion, many initiatives, programs, and organizations work to enhance reproductive health in Egypt by trying to reduce fertility rates. It is helpful and thus recommended to highlight all factors that reduce the fertility rate.

Religion plays a central role in shaping the social norms of many Egyptians. It was crucial to investigate the religions perceptions in Egypt towards the family planning issue.

7.2 OBSTACLES AND BARRIERS

Many researchers have investigated the different factors that can be categorized as barriers and constrains to reducing the fertility rate. They can be clustered as follows:

1- Norms and traditions that support families having more children in order to be responsible for supporting the family and “support ” them.

2- Norms that discriminate between males and females, especially in rural, poorer areas. These norms suggest that having male children is more desirable and encourage some families to continue having children until a son is born.

3- Poor socioeconomic conditions that might make people willing to have more children to support the family financially, especially in rural areas where most work is related to agriculture.

4- Religious fanatics who still believe that family planning goes against the will of God.

5- Inappropriate and unsatisfactory family planning services.

6- Inaccessible services as some communities, especially nomads and those living in remote areas, cannot afford to traverse the long distances required to receive service.

7- The influence of parents and community members who advise that married people have at least three or four children who will provide them with companionship and support in the future.

This qualitative study was conducted in order to assess and investigate the current attitudes and perceptions toward the two child norm in Egypt. However, due to the limitations of qualitative sample as it is not acceptable to generalize the results, it was crucial to investigate the aforementioned topics on different levels and socioeconomic groups in the community.
7.3 FINDINGS

1. Egyptian perceptions and attitudes towards the two child norm

- It was observed that the perception towards the two child norm is positive as the majority of sample reported 2-3 children as an acceptable number.
- The attitudes were different from the perceptions as some of the participants reported having more than three children.
- Childbearing as an act that can be controlled is socially acceptable for the majority of the sample. However, it is not acceptable according to religious points of view.
- Whatever decision was made regarding the number of desired children might change according to the gender of children, the socioeconomic conditions and the influence of community.
- Decision making was clearly based on the opinions of the husband and wife. However, mothers and mothers-in-law seem to have a strong influence on couples.

2. Reasons behind the attitudes towards the two child norm

- Norms and traditions that support families having more children so the children can be responsible for supporting the family.
- Norms that discriminate between males and females, especially in rural, poorer areas. These norms suggest that having male children is more desirable and encourage some families to continue having children until a son is born.
- Poor socioeconomic conditions that might make people willing to have more children to support the family financially, especially in rural areas where most work is related to agriculture.
- Extremely religious people who still believe that family planning goes against the will of God.
- Inappropriate and unsatisfactory family planning services.
- Inaccessible services as some communities, especially nomads and those living in remote areas, cannot afford to traverse the long distances required to receive service.
• The influence of parents and community members who advise that married people have at least three or four children who will provide them with companionship and support in the future.

3. Influence of women's empowerment on the attitudes towards the two child norm

Regardless of the education level and employment status of the wives, it was observed that the willingness of husbands and other family members play major roles in decisions made about family planning methods. However, it was notable that the educated women were more willing to have up to three children. Nevertheless, they might change their opinion if they do not having a female or male among their three children.

Interestingly, employed women had up to four children while some unemployed women had only 2-3 children. It seems that the type of policy related to maternal leave does not prevent a willingness to have children.

4. Reasons for the higher level of unmet need for family planning

1- Limited budgets allocated for awareness raising programs played a major role in limiting the information provided.

2- Insufficient salaries and unacceptable work conditions in the public facilities made the service providers unwilling to provide an appropriate service and the treatment was not acceptable for the majority of the FGD participants.

3- The majority of ministries (Education, Endowment, etc.) believe that it is not their responsibility to work on family planning and therefore, no educational curriculum contains information about family planning.

4- The influence of some religious leaders works against family planning.

5- Limited sources of funding through different donors might affect the sustainability of the awareness raising programs.

6- There are no supportive rules and regulations for the family planning process as Egyptian communities, especially religious people and some decision makers, were against having laws that ban having more than two children or even extract the social benefits (free of charge health care, education …etc) of the third children and more,
A lack of understanding about the culture and individuality of each community is one of the main reasons that family planning needs go unfulfilled.

### 7.4 RECOMMENDATIONS

It is now crucial to discuss the recommendations to create demand among community people for family planning.

- A married couple should be encouraged to engage in family planning by highlighting the benefits of family planning.
- Uncommon methods of contraception (i.e. the condom) should not be stigmatized within the community as couples might need to use it.
- Educational institutes should be supportive of family planning initiatives.
- Mass media should discuss the idea of family planning in the movies, soup operas, and plays.
- Information should be provided through conferences and seminars that encourage people to plan their families.

The following are some recommendations needed to achieve the appropriate level of family planning usage.

**a. Family Planning Services**

1. Provision of appropriate health services before the consultation about using a contraceptive.
2. The state should provide the health services completely free of charge.
3. Provision of different types of contraceptives in the units and hospitals. Moreover, doctors should be encouraged to accompany mobile units while providing contraceptives to people.

**b. Advocacy**

1. Stakeholders and natural leaders should provide the needed support for family planning initiatives.
2. Popular religious leaders should be supportive of family planning and integrated into activities that encourage family planning.
3. Provision of accurate and comprehensive information about contraceptive methods, benefits, side effects, etc.

4. Young students should be encouraged to develop some initiatives to provide information to their peers.

c. Communication channels

1. More commercials should be broadcast about family planning. However, they should be prepared by highly qualified team that includes gynecologists, psychologists and media representatives.

2. The internet can be a useful channel for providing the needed information through chat rooms and other sites, particularly for younger educated groups.

3. SMSs should be sent to mobile phones.

d. Communication objectives and message

Having clear communication strategy objectives are essential in order to reach the target groups. The following objectives are recommended:

**BELIEF OBJECTIVES**

- Change the perceptions towards family planning methods.
- Try to fight misconceptions about family planning and contraceptives.
- Increase acceptance of other family planning methods and raise the confidence in the service.
- Change the perception of condom.

**BEHAVIORAL OBJECTIVES**

- Encourage people to seek family planning health services.
- Visits will be made either to a mobile or stand-alone site for additional information.
- Target groups should be counseled and the appropriate family planning method should be suggested.

e. Community Mobilization and Participation

1. NGOs should play a role in mobilizing different community members to access services.

2. They should provide the needed support to host the mobile units and mobilize community members.
3. Unemployed women should be employed and educated at work about family planning.

4. Pharmacists, physicians and religious leaders should play a role in raising community awareness.

**f. Printed materials**

1. Brochures and booklets should be written in nice colorful way to attract people.
2. Newspapers and magazines advertisements should only appear during the weekly copy and in the most popular papers.
3. Depending on materials provided by the NGOs, schools and universities should support discussions about family planning issues.

**How family planning needs can be met**

1. Allocate sufficient budgets for awareness raising activities through different media facilities.
2. Enhance the performance of the public health sector in order to achieve the appropriate work conditions which could enhance the performance of the service providers.
3. Apply a multi-level monitoring and evaluation systems in order to achieve better performance in health sector.
4. The majority of ministries should bear responsibility for family planning activities, not only the Ministry of Health and Population.
5. Long discussions with religious figures should be held with El Azhar scientists in order to have a common perception towards family planning according to religious beliefs.
6. Fund raising should be carried out on different levels, in both the public and non-governmental sector, in order to enhance the services provided.
7. Family planning programs should be modified according to the target groups. The family planning awareness programs should be tailored for husbands, wives, young adolescents and old parents. Moreover, the information should be tailored for different audiences (i.e. educated vs. non educated groups).

**f. Features of family planning programs that could be improved**
1- Awareness raising programs that should be conducted through seminars and conferences attended by religious figures and specialized gynecologists are one of the main features of proposed programs.

2- Hiring more service providers who are qualified both professionally and have excellent communication skills that allow them to be able to provide the needed information to all potential target groups easily and clearly.

Providing different types of family planning methods in order not to reach the point where the women cannot find an alternative.