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SUPPLEMENT ARTICLE

Do public health services in Egypt help young married women exercise their reproductive rights?

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ABSTRACT

Objective: To assess supply and demand of family planning services from a reproductive rights perspective among young married women (YMW) in Egypt. *Methods:* Data sources related to family planning included structured interviews with service providers (n = 216); an inventory of equipment and supplies (n = 40); exit interviews with YMW (n = 147); and focus group discussions (n = 12) with YMW, husbands, and mothers and/or mothers in law. YMW, husbands and mothers in law were not necessarily related. *Results:* Although family planning services were readily available and affordable, YMW had limited access to information and services. Shortfalls were noted regarding respect for privacy, choice of family planning method, access to fertility services, and premarital counseling. Few YMW had sufficient autonomy to make informed reproductive decisions. Effective accountability mechanisms and processes for redress were also lacking. *Conclusion:* Implementation of a rights-based approach and structural changes to family planning service delivery are recommended to empower YMW in Egypt to demand and exercise their reproductive rights.

1. Introduction

The 20-year Program of Action (PoA) on reproductive health and rights adopted by the International Conference on Population and Development (ICPD) reached its conclusion in 2014. Article 7.3 of the ICPD PoA defined reproductive rights as "the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence …" [1]. In addition, the ICPD PoA incorporated recommendations about male involvement and shared responsibility in the actual practice of family planning [1].

Egypt was a signatory to the ICPD PoA in 1994. This country has developed an effective government-led family planning program since the mid-1960s. Family planning services are provided through a wide network of more than 6000 governmental and non-governmental facilities nationwide. Availability of basic primary health services, including family planning, is now almost universal in Egypt, with 95% of the population living within 5 km of a primary health center [2].

This program has achieved a contraceptive prevalence rate that is among the highest in the region (60%) [3]. Nevertheless, contraceptive use among young married women (YMW) remains low, with rates of 23% and 45% recorded among YMW aged 15–19 years and 20–24 years, respectively [3]. This situation raises questions about the quality of family planning services available for YMW in Egypt, as well as family and community factors that might hinder their access to such care.

The aim of the present study was to examine Egyptian public family planning services from a human rights perspective. The analysis explored whether services were offered in a way that respected the reproductive rights of YMW and the extent to which individual and community factors influenced the ability of YMW to exercise those rights.

2. Participants and methods

A cross-sectional descriptive study was conducted between May 28, 2012 and October 30, 2012 to evaluate family planning services in four Egyptian governorates (Beni Suef, Sohag, Alexandria and Menoufia). The present study protocol review followed the standard institutional review board procedures of the Population Council, New York, USA as well as Ministry of Health and Population, Cairo, Egypt. Written informed consent was obtained from study participants before conducting interviews. Participants who were unable to read and write, or who

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refused to sign the informed consent form but who agreed to participate, provided verbal consent in the presence of a witness.

The present study was conducted in 40 public clinics and selected surrounding communities within the four named governorates. These administrative regions had all implemented a family health model promoted by the Egyptian Ministry of Health and Population [4]. This model is a new system of family-based primary health care that offers a 'basic benefits package' that includes family planning; maternal and child health care; treatment of reproductive tract infections and sexually transmitted infections; and 'youth-friendly' services. Efforts were made when selecting the participating centers to ensure that clinics with various levels of family planning service utilization (low, medium, and high) were included.

Sources of data related to family planning included inventory of clinic infrastructure, equipment, and supplies (n = 40); structured interviews with service providers (n = 216); exit interviews with YMW who had received family planning services in participating facilities (n = 147); and focus group discussions (n = 12) with YMW aged 18–24 years, husbands, and mothers and/or mothers in law.

The present study used a list of criteria for rights-based family planning services that combined items from a WHO list [5] and those developed by Hardee et al. [6]. Reproductive rights examined in the present study were accessibility and acceptability of family planning information and services; choice of family planning methods; informed decision-making; respect for privacy and confidentiality; and accountability of the family planning program to YMW. The data collection team comprised 16 female data collectors, four male data collectors, and four supervisors.

Completed questionnaires were reviewed, coded, computerized, and analyzed using STATA version 10 (Stata, College Station, TX, USA). Transcribed focus group discussions from the four governorates were merged and categorized by reproductive rights dimensions using Excel (Microsoft, Redmond, WA, USA).

3. Results

3.1. Participants' characteristics

Intermediate or secondary level schooling was reported by 29% and 33%, respectively, of the YMW who participated in exit interviews (n = 481); most participants (96%) were not working for cash. The average number of children was 1.7 and 71% of the participants indicated a desire for more children in the future.

The main stated purpose for the clinic visit was to receive further supplies of contraceptive (36%), while 29% of the YMW had attended the clinic to start contraception or switch methods. Of the participants who had obtained a family planning method (n = 132), 47% received mini pills and 36% received an intrauterine device (IUD).

Providers who participated in structured interviews (n = 216) were physicians (29%), nurses (31%) and family planning outreach workers (known locally as Raidat Rifyat; 40%). Providers were predominantly female (94%) and had been working in the participating clinic for a median duration of 5 years.

3.2. Accessibility and affordability of services

Physical and financial accessibility (affordability) of health services in the present study facilities was good, with two-thirds of YMW (67%) interviewed reaching the clinic on foot, 81% reporting travel times of 20 minutes or less, and 96% indicating that service hours were convenient for them. Most of the YMW (99%) had paid less than 6 Egyptian pounds (equivalent to less than US $1) for the family planning consultation.

Female doctors were present in 58% of the participating facilities (Table 1). This shortage of female physicians potentially limited access to family planning services and contraceptive options because 95% of the YMW indicated that they would prefer to be examined by a female doctor, and so might opt out of inserting an IUD, which requires a pelvic examination. For example, one participant from Sohag stated "I would rather die and not be examined by a male doctor."

Table 1
Readiness of surveyed family planning clinics (n = 40) to observe the reproductive rights of young married women.[a]

Characteristic	Distribution
Privacy	
Separate rooms for family planning counseling and examination	25
Curtain separates the counseling and examination rooms	70
No curtain or door in the examination room	5
Confidentiality	
Filing cabinet for clients' records	92
Data securely stored	98
Informed decision-making	
Family planning posters	80
Family planning flip chart	100
Family planning leaflet	100
Sign showing the available services and prices	78
IUD leaflet	100
COCs leaflet	98
Mini-pill leaflet	92
3-month injection leaflet	98
Male condom leaflet	85
Sub-dermal implants leaflet	35
Model for demonstrating contraceptive methods	58
Contraceptive sample tray	95
Available choice of family planning method	
IUD	100
COCs	92
3-month injection	95
1-month injection	50
Progestin-only pills	95
Male condoms	98
ECPs	5
Sub-dermal implants	5
Contraceptive stock sufficient for ≥3 mo	54
Service accessibility and availability	
Sign showing the clinic name	88
Clinic has a female doctor	58
Clinic has a family planning nurse	95
Clinic has a Raida Rifya (family planning outreach worker)	92
Acknowledgment of clients' rights	
Clients' rights poster displayed	60

Abbreviations: COCs, combined oral contraceptives; ECPs, emergency contraceptive pills; IUD, intrauterine device.
[a] Values are given as percentage.

Over 90% of the facilities had at least one family planning nurse (95%) and one Raida Rifya (92%). Although Raidat Rifyat are supposed to provide family planning information and follow-up services to women through home visits, nine YMW who participated in the focus group discussions indicated that they did not receive Raidat Rifyat visits on a regular basis.

Women who were newly married had very little access to family planning services as one in two providers (52%) indicated that they would not prescribe contraception to an 18-year-old married girl who wanted to delay her first pregnancy. Additionally, less than half (44%) of Raidat Rifyat indicated that they visited newly married women on the grounds that few husbands and mothers-in-law would accept delay of the first pregnancy.

Premarital care can provide an opportunity for prospective couples to learn about family planning; however, it is often not physically or socially accessible to young women. According to the service providers' reports, only 42% of clinics offered premarital care to engaged couples. Furthermore, participants in the focus group discussions reported that such services were typically offered on paper without any real service provision in the clinic. Although mothers-in-law had reservations about providing family planning information to couples before marriage, YMW and husbands supported the idea on condition that separate sessions were held for men and women.

Remote villages in Egypt are entitled to receive family planning through mobile clinics that provide these services free of charge. Nevertheless, reports from YMW and their families indicated that those services were unreliable; for example, "They say it [the mobile clinic] comes on Tuesday but then it does not show up … if I miss my 40th day I may not be able to insert an IUD, thus I go straight to the health unit" (YMW, Menoufia).

3.3. Privacy and confidentiality

Family planning consultation involves exchange of sensitive information between the provider and client, as well as conduct of a gynecologic examination. Thus, the highest standards of auditory and visual privacy should be maintained and measures taken to ensure protection of all information related to the client.

Based on the inventory forms, counseling and physical examination took place in the same room, with a curtain separating the two stations, in 70% of the clinics (Table 1). This arrangement might provide complete privacy if only one client is present in the room. However, according to the data collectors, on some occasions two clients were concurrently present in the room, one receiving counseling while the other underwent examination.

The YMW who participated in exit interviews or focus group discussions confirmed that privacy was maintained in static but not mobile clinics. Furthermore, mobile clinics were often parked on the street at a busy spot, potentially causing embarrassment to YMW: "There would be many men on the street and everybody knows you and knows each other" (YMW, Sohag).

Client files were securely stored in filing cabinets in 98% of the clinics. However, 13% of providers mentioned that they allowed a woman's relatives to view her file. Another possible contributing factor to the lack of confidentiality in the clinics surveyed is that a woman's medical record is part of the combined family health record among facilities participating in the Egyptian family health model.

3.4. Choice

Individuals and couples require adequate information and a range of options to make informed decisions about family planning. Most clinics offered IUDs, combined oral contraceptives, 3-month injections, progestin-only pills, and male condoms (Table 1). Emergency contraceptive pills (ECPs) and sub-dermal implants were available in just 5% of facilities and 1-month injections in 50%. Foaming tablets and female condoms were not available in any of the facilities surveyed.

The family planning options available, although seemingly varied, were quite limited for YMW who were concerned about the effects of contraception on their future fertility; could not tolerate menstrual changes associated with contraception; or had uncooperative husbands.

Coercion or provider bias was uncommon in the clinics studied: 67% of YMW indicated that the provider had spoken to them about other methods. However, 15% of YMW reported that they chose the method of family planning while still on the examination table. In this vulnerable position, a woman might feel unable to discuss other available options or question the provider.

Although 98% of clinics offered male condoms, this method was practically inaccessible to married couples owing to social norms and misconceptions, which consider condom use to be haram (forbidden by Islam), harmful to a man's health, undermining to his masculinity, or even fatal. Such norms, which exempt men from sharing responsibility for family planning, further limit choices for YMW.

Cultural norms also forbid YMW from making an independent decision about contraception. The focus group discussions confirmed the near-universal belief that YMW should not use contraception against their husband's will, claiming that "obeying one's husband is part of obeying God." Also, some participants argued that their husband is the bread-winner; hence, he should be the one to decide on the number of children he can support.

Service providers seemed to abide by the above social norms. For example, 34% of YMW reported that they were asked at the clinic if their husband had approved of their use of contraception. Some providers (6%) even required evidence of the husband's approval (e.g. a copy of his identification card), a measure which they believed "protects young women against divorce."

Delaying the first pregnancy is not an option for YMW who are expected to have the first child shortly after marriage. Focus group participants (YMW, husbands, and mothers-in-law) were generally not supportive of delaying the first pregnancy, stating that children are a gift from God and that they bring a couple closer together. Moreover, 12 participants expressed concern about the effects of contraception on subsequent fertility. However, four YMW indicated that delaying the first pregnancy would allow the new couple to enjoy their life together and to get know each other better.

3.5. Informed decision-making

Knowledge, beliefs, and perceptions of individuals and their families about reproduction and family planning have a great influence on the ability of YMW to exercise their reproductive rights. Virtually all of the focus group discussion participants were aware of more than one method of family planning and the fact that different methods were good for different women. However, husbands were clearly misinformed, with some believing that most family planning methods have serious adverse effects. The YMW also voiced some misconceptions, such as the belief that implants migrate in the body and 3-month injections reduce women's fertility. Only one focus group discussion participant was aware of ECPs but he was not aware of their mechanism of action.

Exit interviews with YMW suggested that the information given to them about the received method of family planning might not be sufficient. Only 44% received information about adverse effects, 20% were informed about effectiveness of the chosen method, and 7% were told how the method works. Although most clinics surveyed had leaflets available on IUDs (100%), combined oral contraceptives (98%), or 3-month injections (98%), only half of YMW (49%) received a leaflet about the method they received.

3.6. Acceptability

Client satisfaction is essential for continued utilization of services. The YMW and their families were generally satisfied with the family planning services as they appreciated the fact that these public services were accessible and affordable, although some believed that the quality was inferior to private clinics.

3.7. Accountability

Women and men who are not satisfied with the quality of services should be able to address their complaints to a higher authority and should not suffer any negative consequences as a result of filing a complaint. However, only 3% of providers mentioned that clients had a right to complain about quality of services, whereas 12% mentioned the existence of a form to measure satisfaction. Most focus group discussion participants were unclear about where and how to complain and were skeptical of the usefulness of filing such complaints.

4. Discussion

The findings of the present study cannot be generalized to the whole country; however, they do shed light on gaps that might be prevalent in other parts of Egypt. Despite extensive availability of family planning services, current services did not meet the needs of YMW nor help them overcome social barriers that prevented them from exercising

their reproductive rights. Consequently, a rights-based approach to family planning service delivery is needed. The essence of this approach is interacting with people as individuals who have the right to control their own lives, rather than regarding them as a target of a particular program [7]. The new paradigm should shift away from a one size fits all strategy to a client-centered model that takes into account variations owing to age, socio-economic status, or living conditions. Family planning programs also need to address the factors that make it difficult for YMW to utilize reproductive health services.

Access barriers related to recruiting and deploying female doctors in rural clinics should be addressed. Examples of effective initiatives include incentives for rural service, scholarships linked to rural service, and assigning of health personnel to their home communities [7]. Task sharing (e.g. a nurse taking part in the provision of family planning services) and task shifting (e.g. moving family planning tasks entirely to nurses) are promising practices that should be considered to fill human resource gaps in remote areas [8].

Additional contraceptive choices should be made available for YMW, especially ECPs, the diaphragm, and female condom. These women and their families need to receive adequate information and counseling to rectify misconceptions and dispel rumors about the available methods of family planning. In the long term, investments should be made in developing new contraceptives that can be controlled by women, do not cause systemic adverse effects, and do not require husband participation [9].

Young couples need to receive information about their body, sexuality, and reproductive health before they get married. Educating young people about their reproductive health should be the responsibility of parents, schools, mass media, religious institutions, and the national health system [10]. Mandatory premarital care would provide a unique opportunity to introduce family planning information to prospective couples before they start married life. Innovative means of conveying information to young people, such as social media and mobile telephones, should be investigated [11].

Health staff and supervisors should be provided with evidence-based service delivery guidelines and be trained in providing rights-based reproductive health services. Rather than being denied access to contraception, any YMW whose husband is not supportive of family planning should be empowered with negotiation and communication skills to be able to exercise her right to plan their family. Furthermore, YMW need to be made aware of their rights to quality services that respect their autonomy, privacy, confidentiality, information, and choice, as well as mechanisms to influence service performance.

Finally, young girls should have equal access to free education; be free from early marriage, childbearing, and all forms of gender-based violence; have equal opportunities for safe paid employment; and be allowed political participation [12]. Only when young women feel empowered to make free and informed decisions about various aspects of their lives, will they be able to demand and receive quality services that enable them to have control over their body and fertility.

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Conflict of interest

No conflict of interest exists for any of the authors.

References

[1] United Nations Population Fund. Programme of Action adopted at the International Conference on Population and Development Cairo, 5–13 September 1994. 20th Anniversary Edition. 2014 http://www.unfpa.org/sites/default/files/pub-pdf/ICPD%20PoA%20English.pdf. Accessed February 25, 2015.
[2] UNFPA-Egypt. Indicators. http://egypt.unfpa.org/english/Staticpage/54790f72-6e8b-4f77-99e2-4c5b78c20d5c/indicators.aspx. Accessed February 25, 2015.
[3] El-Zanaty F, Way A. Egypt Demographic and Health Survey 2008. http://dhsprogram.com/pubs/pdf/fr220/fr220.pdf. Published 2009. Accessed February 5, 2015.
[4] El-Zanaty and Associates. Study on reproductive health impact of family health model pilots in Egypt. http://egypt.unfpa.org/Images/Publication/2011_01/1828cf97-c4b3-46bb-b5fa-d845a127ca8f.pdf. Published 2009. Accessed February 25, 2015.
[5] World Health Organization. Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations. http://apps.who.int/iris/bitstream/10665/102539/1/9789241506748_eng.pdf. Published 2014. Accessed February 5, 2015.
[6] Hardee K, Newman K, Bakamjian L, Kumar J, Harris S, Rodríguez M, et al. Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Conceptual Framework. http://futuresgroup.com/files/documents/Voluntary_Rights-Based_FP_Conceptual_Framework_Paper_8_12_13_FINAL.pdf. Published 2013. Accessed February 5, 2015.
[7] Rabie T, Boehmova Z, Hawkins L, Abdel-Tawab N, Saher S, El-Shitany A. Transforming Family Planning Outlook and Practice in Egypt: A Rights-Based Approach. https://openknowledge.worldbank.org/bitstream/handle/10986/20418/905960WP0Box3800July0160FINAL0PROOF.pdf?sequence=1. Published 2013. Accessed February 5.
[8] Bongaarts J, Cleland J, Townsend JW, Bertrand JT, Das Gupta M. Family Planning Programs for the 21st Century: Rationale and Design. http://www.popcouncil.org/uploads/pdfs/2012_FPfor21stCentury.pdf. Published 2012. Accessed February 5, 2015.
[9] Darroch JE, Sedgh G, Ball H. Contraceptive Technologies: Responding to Women's Needs. http://www.guttmacher.org/pubs/Contraceptive-Technologies.pdf. Published 2011. Accessed February 5, 2015.
[10] Abdel-Tawab N. Overview: Building Capacity to Conduct Research on Youth Sexual and Reproductive Health in Egypt. In: Abdel-Tawab N, Saher S, El Nawawi N, editors. Breaking the Silence: Learning about Youth Sexual and Reproductive Health in Egypt; 2013 http://www.popcouncil.org/uploads/pdfs/2013PGY_YouthSRHEgypt.pdf. Published in 2013. Accessed February 25, 2015.
[11] Askew I, Brady M. Reviewing the Evidence and Identifying Gaps in Family Planning Research: The unfinished Agenda to Meet FP2020 Goals. http://www.popcouncil.org/uploads/pdfs/2013RH_ReviewingEvidenceFP-Research.pdf. Published 2013. Accessed February 5, 2015.
[12] Kowalski S. What the Post-2015 High Level Panel Report Means for Women and Girls. http://iwhc.org/2013/05/what-the-post-2015-high-level-panel-report-means-for-women-and-girls/. Published 2013. Accessed February 5, 2015.