

Egypt:

***The Role of Women as
Family Planning Employees***

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This 10-page summary highlights findings from a larger scientific report and includes recommendations from in-country researchers

Egypt. The Role of Women as Family Planning Employees

I Introduction

Most of the workers in family planning organizations in Egypt are women, in both government and private sectors. This study focused on the women employed in 1996 in the Ministry of Health and Population and in five major organizations that provide family planning services in Egypt. The investigation was supported by Family Health International and conducted in collaboration with the Cairo Demographic Center. The research objective was to understand how employment in the field of family planning had affected women's lives. Data were collected on female employees in a variety of occupations – physicians, nurses, social workers, field workers, and others. Where possible, descriptive information on characteristics was recorded including age, marital status, education and length of employment. The study also used focus groups, which included female doctors, nurses, social workers and *dayas*, and in-depth interviews with female leaders in the family planning field to determine how women perceived the effect of family planning employment on their lives.

II Background

The theoretical framework upon which the Women's Studies Project was based¹ suggests that family planning programs may have an impact on the lives of women as users and as employees of family planning programs. Such employment provides women with the opportunity to learn new skills, to improve self-confidence, to earn a living and to gain respect in their communities. Negative effects include suspicion and misunderstanding from opponents of family planning programs.

Previous research on family planning workers in Bangladesh found that women employed as field workers faced hostile attitudes in their communities but became effective agents of change in part, because they believed that their activities promoted positive changes in the lives of families. Field workers were also found to provide social and cultural support for clients in addition to supplying contraceptives. Little research, however, has been directed toward workers in clinics, whose interactions with clients are different from those of field workers.

In 1993, 24 percent of women in Egypt were in the labor force. They comprised varying percentages of workers in different fields – for example, 98 percent of nurses, 70 percent of agricultural workers, 42 percent of dentists and 25 percent of communication workers.² Women have always comprised a large proportion of family planning workers in Egypt, but the percentage of women in each occupation, the characteristics of female employees and differences

¹ Hong S. Seltzer J. *The Impact of Family Planning on Women's Lives: Toward a Conceptual Framework and Research Agenda*. Research Triangle Park, NC: FHI, September 1994.
El-Deeb. *Women's Employment in Small Scale Industries*. National Planning Institute, 1995.

in employment practices among family planning organizations had not been studied. Obtaining information about these topics from each organization was the important first step in analyzing and comparing data. Earlier research on the effect of labor force participation in general on the lives of Egyptian women found that employment did not always increase women's autonomy although in some areas they had more decision-making freedom than nonworking women. One study found that working women had more influence within the family and more independence than women who did not work.

Six organizations in Egypt provide most of the family planning services in the country. They are the Ministry of Health and Population (MOHP), Egyptian Family Planning Association (EFPA), Clinical Services Improvement Project (CSI), Health Insurance Organization (HIO), Coptic Evangelical Organization for Social Services (CEOSS), and Teaching Hospital Organization (THO). Data were collected from the governorate offices of the MOHP and from the national offices of the other organizations. Five occupational groups were examined: physicians, nurses, social workers, *raedat refiat* (field workers) and others (administrators and orderlies). Another category of worker, *dayas* (traditional midwives) was not included in this phase of the study. Although they work in the field of family planning, these workers are trained by the U.S. Agency for International Development (USAID) and the United Nations Children's Fund (UNICEF) and are not employed by family planning organizations themselves.

III Study Objectives

The primary objectives of this study were

- to describe *quantitatively* female labor force participation in family planning programs and compare the participation of women within various categories of employment in different implementing agencies and by geographic location,
- to compare *quantitatively* female participation in family planning programs versus other health services in Egypt,
- to collect *qualitative* data from female family planning workers in a limited number of sites on their perceptions of the impact of their work on self-esteem, health status, economic resources, familial relations and public standing.

IV Study Design

Two methods were used to achieve the study objectives. The first two research questions, which required quantitative data, were investigated by compiling statistical information obtained from the national- and governorate-level family planning offices and from previously conducted studies. For the qualitative part of the study, focus group discussions (FGDs) and in-depth interviews were used.

Statistical data on the MOHP workers were obtained and compiled from all 26 governorate-level government offices in Egypt. For the other five organizations, data were obtained from national headquarters in Cairo. Dummy tables were designed for collection of statistics. Data on the percentage of employees who were female were collected from all six organizations. The characteristics of female physicians, nurses, social workers, *raedat refiat* and others were available from the three largest organizations (MOHP, EFPA and CSI), and detailed information was collected from them on the characteristics of workers, including age, marital status, education and duration of employment.

Focus groups were held in four governorates, which were selected to provide geographic diversity. They were Cairo, Kafr El Sheikh, Beni Suef and Sohag. In this phase of the study, women were chosen from among four occupational categories: physicians, nurses, social workers and *dayas*. Additional selection categories were location (urban versus rural) and years of experience (more than five years versus less than five years). Thus, focus group composition was homogeneous with respect to governorate, occupation, location and years of experience. One focus group was conducted in each governorate for each of the 16 possible category combinations, resulting in a total of 64 focus group discussions. The numbers of women in each category varied between four and 11, depending on the availability of women in each category in each site. Female data collection assistants with previous focus group experience and who were trained specifically for this study as well, conducted the focus groups. Before each focus group, field staff visited the sites to obtain the necessary approvals and to make logistical arrangements.

Guidelines were prepared for focus group discussions. Topics included behavior and attitudes toward marriage and family planning; difficulties related to family planning usage in the community; women's perceptions of the impact of working as an employee in family planning programs (including self-confidence, skills gained by working in family planning, community respect and economic benefits); support from others; problems or constraints of the job; and recommendations for changes. Information was collected about each participant (age, occupation, education, number of children and years of experience). Data were also collected on the context of the community, including local prices, availability of goods and services, health care and family planning facilities, and availability of work opportunities.

In-depth interviews were held with 19 persons (14 women and 5 men) who were considered to be leaders in Egypt's family planning program. The list was compiled by the investigator and later revised according to suggestions of the technical committee. All but one were married or had been married and most had one or two children. Twelve of the leaders had a medical education, and seven had backgrounds in the social sciences. The interviews were conducted by the principal investigator at the convenience of each family planning leader, usually in the office of the person being interviewed. Topics included roles and achievements in the field of family planning, support from colleagues and relatives, perceived influence of her/his role in family planning on herself/himself and on other females in her/his life, constraints in the family planning system and recommendations for overcoming them, and the future of family planning efforts in Egypt.

Data analysis involved aggregating the information collected into regional and national-level data. The data were descriptive, no statistical tests were performed to compare data by profession, region or organization. A consultant with focus group experience analyzed data from focus group discussions. Separate reports were prepared for each governorate, and the research staff prepared a synthesis report covering all focus groups. In-depth interview data were analyzed separately from the focus groups, and the results were summarized in a separate report.

The most critical limitation of the study was a lack of comparison data for men in the statistical analysis and in the focus groups. In addition, the effects of employment in the family planning field cannot be compared with employment in other sectors or even in other health sectors. Moreover, women who work in professions that offer female-oriented services may differ from other female workers.

V Results

By far the largest employer of family planning workers in Egypt was the government's Ministry of Health and Population, with more than 87 percent of paid workers. The Egyptian Family Planning Association, a nongovernmental organization, employed 7 percent, and the remaining four organizations employed less than 3 percent each. Nurses constituted the largest occupational group of family planning workers, with 30 percent of the overall total, followed by physicians and *raedat refiat* (25 percent each), social workers (8 percent) and others (12 percent).

Of the 19,610 employees in the six family planning organizations, 82 percent were female. Eighty-three percent of the workers at MOHP were female, as were 72 percent of EFPA's workers. CEOSS, the smallest organization, had the highest percentage of female workers (93 percent), HIO had the lowest percentage (42 percent). Two occupational categories, nurses and *raedat refiat* consisted entirely of female workers, and three-quarters of social workers were female. Overall, 48 percent of the physicians employed by the six organizations were female, but the proportion varied widely by organization, from 13 to 93 percent. At MOHP, which employed most of the physicians, 46 percent were female, but only 27 percent of gynecologists were women. The "other" occupational category, which included administrators and orderlies, was 79 percent female.

Data on age, marital status, work experience and education were collected on female workers in the three largest family planning organizations, – MOHP, EFPA and CSI. Some variations were seen by profession and organization. Physicians were slightly older and more experienced at EFPA. Nearly half the nurses at MOHP were 30 to 44 years old and had worked at MOHP for less than five years. By contrast, 46 percent of the nurses at EFPA were 45 years old or older and more than half had worked there between five and 10 years. *Raedat refiat* are employed only by MOHP, their work is in the field, where they visit women in the community to encourage them to begin or maintain family planning use. Compared with social workers in the MOHP, who work in clinics, they were younger, had less experience and were more educated.

Data were analyzed by region to determine if female participation in family planning programs reflected the need for services in those areas. Nearly 71 percent of married women live in Lower Egypt, and 62 percent of the target group of women at risk of unwanted pregnancy live there. It was found that 62 percent of the female family planning workers overall work in Lower Egypt, and the regional distribution by occupation is similar.

Statistical data were compared with a survey conducted in seven governorates as part of the 1993 Child Survival Project of the MOHP, which examined the gender of workers in 123 urban health units and 141 rural health facilities. There is some overlap in the employees in the earlier and current surveys. The MCH units were found to have a higher percentage of physicians who were women than the family planning units (81 percent versus 48 percent), as well as a higher percentage of gynecologists (77 percent) who were women.

Results of the focus groups and in-depth interviews were analyzed to determine how women perceived the effect of family planning employment on their lives. In many ways, their responses were similar to those that one might expect women working in any kind of employment could identify as the effects of being in the labor force, especially with regard to time and role stress. Women in all occupations felt that they had too little time to take care of their families and to tend to their own needs. They also felt that it was difficult to do a job in an area that had too few material resources and too many people to be served. However, most women were able to identify aspects of their jobs that gave them pride and satisfaction.

Some discussion in the focus groups centered on women's decision-making power, compared with that of their husbands, with regard to children's education, daughter's engagement, family budget and expenditure and visits to relatives. Most women considered that decisions were made jointly between husband and wife, although the husband's opinion often prevailed when there was a serious disagreement. Many women felt that their expertise in reproductive health-related matters gave them increased credibility when making decisions about a daughter's age at marriage, her premarital examination and family planning decisions. In more conservative geographic areas such as Sohag and Kafr El Sheikh, "religious necessity" was mentioned by nurses as a reason for consulting husbands about the children's education. Social workers in Cairo said that their mothers-in-law insisted on sharing this decision with them.

Some women felt that their work in family planning and the need to organize their work lives carried over to planning in other areas of their lives, such as organizing the family budget and handling the family's money. Autonomy in the use of income from their jobs varied by occupation and income. Women with more income – physicians as compared with nurses or *dayas* – tended to perceive that they had more autonomy. Women in more traditional areas such as Sohag, were more likely to consult their husbands about expenditures.

With regard to women's autonomy of movement, the practice of *pardah* varies in different areas of the country. Freedom of movement has an impact on many aspects of women's lives. Most focus group participants said that they got their husbands' permission before going outside the home, the limitations on movement, however, apparently did not cause any difficulty related to their jobs. Many women said that their work in family planning helped them gain respect from

their clients and people in their community. They felt that they acquired self-confidence and self-esteem from the skills and knowledge they learned through their jobs. Their work also provided them with a concept of themselves as someone who was helpful to others and provided a social good.

By contrast, some women, especially nurses, experienced negative attitudes and felt that people had a low opinion of them because of their jobs. Social workers in Upper Egypt complained that they were not respected in their communities and that husbands and mothers of clients blamed them when women experienced side effects. Some in Cairo said that they had been verbally abused when they made home visits.

With regard to family life, women in all occupations felt that their jobs had made an impact on their family lives, in addition to their increased decision-making power. In many cases, this impact was negative and reflected the difficulties encountered everywhere by women and men who try to combine work and family life. Many domestic duties continued to be the responsibility of the woman, and women mentioned difficulties in dealing with children's illnesses, being late to pick up children, organizing time for work and household duties and arranging for child care. Some aspects of working in family planning programs required them to be away from home long hours (with mobile clinics, for example). Most respondents said that they had had support and encouragement from their husbands and family members. Women liked working with other women, and their husbands also approved of a job that involved interaction mostly with women.

Women in all occupations mentioned the professional and technical skills acquired by working in family planning programs. They learned not only about family planning and contraceptives but also about women's health issues, counseling, infection control, problem solving and other skills. Many women mentioned that they had learned more about their communities and were able to work with many types of people as a result of their work in family planning programs. Financial benefits were also discussed in focus groups, with some women, especially social workers, complaining that they did not receive the same incentives as physicians and nurses. *Dayas*, who do not distribute contraceptives and therefore do not receive incentives, are paid for each IUD referral, and this income contributes significantly to their income and is perceived as a benefit of working in family planning.

Most women in the focus groups felt that reducing population growth and providing women with the means to control their fertility were worthy goals and that their work enhanced the respect and standing they had in the community. In conservative communities, however, some felt threatened by criticism. Unlike community leaders, few women in the focus groups had time for participation in community politics, although they considered it a good thing and felt no resistance from their families to participate. Family planning workers felt job satisfaction because of the important service they shared with their community, the knowledge they gained and their pride in helping families. The dissatisfaction that was mentioned stemmed primarily from not having enough time and supplies to serve their clients and from the stress of role conflict. The most serious reports of dissatisfaction came from social workers. Whereas most physicians and nurses said that they had chosen to work in family planning programs, most

social workers were assigned to family planning through the Ministry of Labor. They expressed dissatisfaction with irregular payment and lack of training specifically related to family planning. Many social workers thought they would have had better jobs (more pay and less controversy) if they had been assigned to the Ministry of Education.

The in-depth interviews with leaders also produced responses related to self-esteem and self-confidence. Some saw themselves as pioneers and leaders in their field. Their work required great effort and strength of character in what was often a negative political climate. They acknowledged that they had been criticized for their work, but in general, the positive image their work created for them outweighed the negative experiences. As was true in the focus group discussions, family planning leaders mentioned difficulties with combining work and family life. Some said they had little time for community activities, and others said that they sometimes felt depressed because the impact of their work was small in comparison with their efforts. Political participation was an important component of the job for leaders.

VI Conclusions and Recommendations

The high percentage of female workers in family planning programs in Egypt makes gender an important consideration in defining work roles. This has implications about the conditions in which women perform their jobs and the services that should be provided to help them balance work and family roles. Given the highly feminine nature of family planning programs, services that are designed with the needs of women workers and clients in mind will help them achieve their goals more effectively.

An important ongoing controversy in Egypt is the question of how women's preference for female physicians affects their use of family planning clinics. Some consider that more women physicians would attract more family planning clients, especially in areas where fundamentalist Islamic beliefs are strong. The statistics collected from family planning organizations in Egypt show that the proportion of female physicians is lower than that of other occupations, especially in MOHP, which employs the largest number of physicians. However, physicians are the service providers who perform the most intimate procedures. Attracting female physicians to work in rural areas, where the need is greatest, remains a difficult problem. In Egypt, the proportion of physicians who are female is higher for MCH clinics than it is for family planning clinics. Given that the clients for both types of clinics are primarily female, why are female physicians more likely to be attracted to MCH clinics rather than to family planning clinics?

Generally, women in the programs found satisfaction in providing a service that they thought was appreciated by most women in Egypt. They were satisfied with their role and standing in the community. The financial benefits were about the same as those received by other women in government service, although many women perceived their incomes to be inadequate, given the time and effort they invested in their jobs. Women reported the stresses felt by many working women – not enough time for themselves and their families for relaxation and for outside activities.

The number of family planning employees is small when compared with the number of women who use family planning services, therefore, the impact of employees on users can be great. Two important questions suggested by this research are

- What are the implications for what we now know about the characteristics of women working in family planning programs for management and service delivery?
- How are the effects of family planning employment different from any other type of employment, and what are the policy implications of these differences?

The first question should be examined by organizations that employ family planning workers. It could affect placement of employees and the scheduling of clinic hours to make clinic use more convenient for both female employees and female clients. Accommodations for women with small or school-aged children should be taken into consideration as well as a way of addressing much of the role stress expressed in these focus groups. It is likely that the women who work in family planning programs and the women who are their clients share similar characteristics and have similar needs and responsibilities. By listening to the voices of these women, ways may be found to improve working conditions and services without incurring high costs.

Answers to the second question are more speculative, since little comparison could be made between the women in this study and their counterparts in other types of employment. Family planning work differs from other employment sectors in that it carries some stigma and controversy. On the other hand, women who work in family planning may feel more empowered to influence the lives of their peers than women in other types of employment. With regard to financial benefits and the effects working has on family life, family planning employment is probably similar to other types of employment. To the extent that financial benefits could be improved and working conditions made less difficult, family planning employment could be seen to yield marginal benefits over other types of employment.

Further research is needed on the effects on women of employment in family planning programs. This could be accomplished through a population-based survey that includes questions based on the qualitative findings from this study. Women in other employment sectors should be included in future research as a control group. It would also be useful to ask women and men in the family planning field about ways that gender affects their work and ways in which their jobs could be modified to improve their lives. Small operations research projects could be conducted to determine whether the proposed modifications would actually make a difference.