Optimal Birth Spacing: An In-depth Study of Knowledge, Attitudes and Practices

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1. Introduction

This in-depth study has been commissioned by the Catalyst Consortium as part of the Optimal Birth Spacing Initiative (OBSI) designed to place optimal birth spacing, a three to five-year birth interval, on the global public health agenda. Similar studies have been conducted in Bolivia, Peru, India and Pakistan. The results of these studies will provide the foundation for developing optimal birth spacing guidelines, counseling materials, and training guidelines.

Preliminary results from the Egypt Demographic and Health Survey 2003 (EDHS)\(^1\) reported that Egyptian women bear children early in their reproductive period. By the age of 30, an Egyptian woman will have given birth to two-thirds of her lifetime births.

Although the average birth interval in Egypt is relatively high, a median of 35.5 months, it varies widely by age group and locale. Approximately 40 percent of the women aged 15-19 and almost 30 percent of the women aged 20-29, have birth intervals of less than 24 months. Birth intervals in Upper Egypt tend to be shorter (33.5 months), compared to Lower Egypt and urban governorates where the median intervals are 37.2 months and 39.8 months respectively.

EDHS 2000 data illustrates that the reproductive goals of married women are not being appropriately addressed through contraceptive use. For married women aged 15-19 years, 50.4 percent would like to have another child at a later time and 6.6 percent want no more children at all, while only 22 percent practice family planning. The same holds true for age groups 20-24 and 25-29 years, where those who want to postpone pregnancy or bear no more children exceed the percentage actually using modern contraceptives. There is a substantial gap between words and deeds. Thus it is important to understand the knowledge, attitudes and practices of young mothers and the influences affecting birth spacing.

The results of this study are intended to provide Egyptian policy makers with information to help them achieve optimal birth spacing and improved health for Egyptian women and children through the design and implementation of successful family planning and contraceptive interventions.

While the Egyptian public and health service providers’ knowledge and attitudes about birth spacing were undocumented prior to this study, international research findings in the Summer 2000 Population Reports indicated that:

- Birth intervals longer than two years were beneficial for mother and infant survival and health.
- Children born three to five years after the last birth were about 2.5 times more likely to survive than children born two years or less after the last delivery.

\(^1\) The Egypt Demographic and Health Survey 2003 undertaken by El Zanaty and Way has not been published or officially released. Data quoted from this document should be considered provisional until published.
Mothers with 27 to 32-month birth intervals were found to be 2.5 times more likely to survive childbirth compared to women with 9 to 14-month birth intervals.

Women with longer birth intervals were more likely to avoid anemia and third trimester bleeding, and less likely to experience fetal growth retardation and premature delivery, which result in low birth weight neonates.

2. Study Objectives

The overall purpose of the optimal birth spacing initiative is to make available information that results in improved health for women and children through optimal birth spacing. Thus, the objective of this in-depth research study is to provide decision and policy makers with greater understanding of current attitudes and practices through the collection and analysis of specific data about:

- The knowledge, attitudes and practices of married women regarding birth spacing;
- The roles of husbands and mothers-in-law in decision making regarding birth spacing; and
- The opinions and views of family planning and reproductive health care service providers regarding optimal birth spacing practices.

3. Research Methodology

To realize the study’s purpose and objectives, an exploratory qualitative study was conducted using focus group discussion methodology (FGD). The study was implemented in two peri-urban locations in the Cairo governorate (Matariya and Manshiet Nasser), and one urban and one rural location in each of the Upper Egypt governorates of Minia and Sohag.

Five moderator guides were developed to solicit the knowledge, attitudes and practices of each focus group: married female spacers and non-spacers, their husbands, mothers-in-law, and reproductive health care service providers (physicians and nurses). Married women spacers and non-spacers included two age groups from 15 to 22-years and from 23 to 35-years of age. Husbands were also broken down into two groups: husbands of the younger women in the first age bracket and husbands of the older women in second age bracket. Thus, the findings were derived from 51 focus group discussions.

For the purposes of this study spacers were defined as:

- Women who had spaced their last birth by an interval of at least 24 months from the birth date of one child to the birth date of the next;\(^2\)

\(^2\) A birth interval of 24 months was specified for the purposes of this study based on a review of previous norms in other countries, indicating a two-year recommendation as the most standard existing
Women whose youngest child was at least two years old and intended to have more children; or

Women whose last child was less than 15 months old, but who were currently using a contraceptive with the purpose of delaying pregnancy.

Non-spacers were defined as:

- Women who had a birth interval between the last two deliveries of less than 24 months; or
- Women who gave birth less than 15 months ago and were not currently using a contraceptive.

Fieldwork was conducted between February 26, and March 22, 2003. Two teams, comprised of a researcher experienced in moderating FGDs and a note taker, collected data, screened and recruited participants for the FGDs. Table 1 illustrates the distribution of the FGDs by target groups and locations.

There were 17 focus groups in each governorate, with an average of eight participants per FGD. The local health facilities provided a convenient, pleasant venue for all discussion groups. Sessions ranged in length between 1.5-2 hours and were audio taped. Refreshments were served and transportation costs reimbursed.

Participants were recruited from the local rural health unit or maternal and child health center. Women eligible for screening included those receiving family planning services or medical check-ups and/or immunizations or check-ups for their children. Additional women were screened and recruited through door-to-door canvassing. A purpose-designed screening form was used to determine eligibility for participation in specific focus groups. Ineligible women, or women who didn’t consent but were within the targeted age brackets, were asked for their husband’s and mother’s-in-law names to solicit recruitment and consent. Actual screening and recruitment took place one or two days prior to the FGD session to minimize forgetfulness. The study’s objectives, time and meeting location were communicated when soliciting participant consent. Local staff from the governorate assisted the research teams.

Focus Group Guidelines

Discussion guidelines were structured as follows to gather the same information in the same way from all five focus groups:

- Individual level (knowledge, beliefs/attitudes, practices)
- Cultural level (norms)
- Institutional level (service)
- Information sources

norm for birth spacing. This two-year period was therefore applied in all five other countries where CATALYST conducted this study, as participants would have been only exposed to this earlier norm.
Consent Considerations

Each participant was briefed on the study’s background and objectives. Participant consent was required prior to their inclusion in the study. Participants were informed that their identities would be confidential, but their opinions and views would be included in the study to help improve the health status of Egyptian women and children. Group consent was sought prior to audio taping of sessions.

Data Analysis

Note taker’s transcribed the audiotapes, linking each statement with its participant. Session transcripts were summarized and translated into English. EZ-Text software was used to process data from each focus group. This new software assists researchers to create, manage and analyze semi-structured qualitative databases and helps maintain consistency across interview write-ups by allowing researchers to design a series of qualitative data entry templates tailored to each question.

Data from each of the five focus groups was analyzed and integrated by topic, using group-specific moderator guides. It was then further integrated by comparing the findings of the five focus groups.

4. Study Findings

A: General Perspectives on Birth Spacing

Optimal spacing until the next pregnancy for Egyptian women is generally understood to refer to a 2-3 year “resting period” between pregnancies that allows the mother time to recuperate from pregnancy, labor and lactation; replenish her nutritional stores including calcium, iron, and vitamins; and provide time for the last born to secure his/her rights to comprehensive care and lactation.

The health of the mother, the well-being of the last child and the family’s financial situation are believed to influence the decision for spacing the next birth. While the risks to mother and newborn associated with pregnancies occurring within two years of the last birth were acknowledged when directly solicited, no one automatically responded that the advantages of spacing included preventing problems during pregnancy, delivery and the neonatal period.

All focus group participants, women spacers and non-spacers, their husbands, mothers-in-law and health service providers agreed that it is easier for women to comprehend when to get pregnant than to calculate when the next child should be born. Thus, it was found that birth spacing should be explained in terms of when a woman should consider getting pregnant after the birth of the last child, rather than when the next child should be born. This is called the interpregnancy interval.

Opinions varied on whom, within the couple, actually decide the timing of the next pregnancy. Some believe the woman is the decision maker, others believe it’s a joint decision, while others stated it is the husband’s decision. Participants felt that even if the husband has the final decision, the wife has the responsibility to convince him
otherwise if she does not agree. Thus, women clearly are not the sole decision makers and they often come under intense pressure from their husbands and mothers-in-law, who have their own reasons for wanting to hurry along the next birth.

If partners do not agree about the timing of the next pregnancy, there may be a power struggle between them. The wife may control the timing of her next pregnancy by using or curtailing the use of contraceptives without her husband’s knowledge, and the husband may threaten to return her to her family or remarry if she does not do his bidding.

Younger women are under enormous pressure from their husbands and mothers-in-law, and to a lesser extent their own mothers, not to delay the next pregnancy. They argue that the wife should have children when she is young and healthy, and while her husband is still young and strong enough to be able to control his children. Less educated women and wives from rural areas in Upper Egypt and other regions may have less autonomy, less negotiating power and/or fewer skills to counteract such pressure. Thus it was concluded that to alleviate some of the pressure on child-bearing age women, messages advising about the health hazards of successive pregnancies should also target husbands, mothers-in-law and mothers.

Neither Islam nor Christianity has any religious teachings against spacing, but rather encourage such practice. People are aware that Islam clearly encourages breastfeeding for two years as a minimum spacing time. Hence, the 2-3 year hiatus prior to the next pregnancy ideally allows time for lactation. Yet this waiting period was not found to be realistic for all families. Factors such as the wife’s age and work status, the desired family size, sex of living children and birth order, all affected whether the optimal birth spacing period was considered realistic or not.

The study found that public family planning and reproductive health service providers currently have no written guidelines from the Ministry of Health and Population (MOHP) regarding optimal birth spacing. Physicians stated that they need specific scientific evidence and documentation in order to be persuaded to promote optimal birth spacing.

Participants stated that physicians are their most important source of family planning and reproductive health information for themselves and their families. Nurses, who counsel the women, were also accepted as an important information source. Television was perceived as a powerful information source as it reaches all family members, especially husbands. Recent TV spots encouraging spacing have been aired, but have not addressed at-risk pregnancies, optimal birth spacing or postpartum contraceptives.

**B. Advantages and Disadvantages of Birth Spacing**

**Popular terms for spacing**

The most popular term for the waiting time or spacing between delivery and the next pregnancy was *fatret raha* or “resting period.” This term refers to the period when a woman recuperates her health and the last born child secures his/her right to sufficient lactation and comprehensive care. Some husbands from peri-urban Cairo married to
younger women, added that this is a period for husbands and children to receive
sufficient care from their wives. Other terms used to refer to the waiting period were:
naqah or “period of convalescence,” hudna or “truce, cease-fire, or time off from
crossfire,” hadana or “nursing period” and tanzeem el nassle or “family planning.”

Male physicians were more inclined to refer to this period as tanzeem or
planning/organization as compared to nurses and female physicians who used the more
popular term, fatret raha or “resting time.” Planning or tanzeem was believed to sound
more serious and indicate a longer waiting period, whereas rest or fatret raha was
perceived to indicate only a month or two.

**Advantages of spacing**

No matter what term is used, there is an implicit advantage for waiting or spacing
subsequent pregnancies. The study found the average preferred waiting time between
delivery and the next pregnancy was 2-3 years, even among health providers. In Upper
Egypt, the waiting period was more likely to be two years. A few participants from
each group extended the waiting period up to six years, and a few doctors extended the
waiting period up to four or five years.

The advantages for spacing births were found to affect the mother and husband, the last
born, and the next child, and fell into three main categories: physical, psychological
and financial advantages.

Those who supported the longer waiting time did so to offset the high cost of living
and/or to allow the last born child to enter school before the next child arrived. This
economic rationale led one young non-spacing mother to declare that a financially
secure father, capable of covering all family expenses, has no need to wait for more
than one year before the next pregnancy.

**Advantages for the mother**

There was general agreement among all focus groups that the resting period between
pregnancies allows the mother time to recuperate from pregnancy, labor and lactation;
replenish her nutritional stores including calcium, iron, and vitamins; permits her
uterus to return to its natural state; and provides time for the last born to secure his/her
rights to comprehensive care and lactation. Psychologically, it was felt that the mother
would experience less stress, less exhaustion, be more relaxed and have adequate time
to take care of herself, her last born child, her home and her husband. A healthy,
relaxed mother and wife would be more likely to have a positive affect on the husband
and the well-being of the newborn.

*An older spacer from Upper Egypt said:*

“When a mother is in good health she can have a healthy child and when
she is psychologically well, she can provide her husband with emotional
comfort so he will be able to work and bring good money.”
Advantages for the last born

Participants believed that mothers who space their children have more time to assure their children are clean, well-fed and loved, have adequate clothing and affection and are taken care of when sick. They felt these advantages would ensure that the child grows up healthy and cared for, with greater immunity against physical, mental and emotional illnesses. Thus the inherent advantages for the last born child of a mother who spaces her next pregnancy include: securing her full attention, adequate lactation and comprehensive care. Participants believed the potential for jealousy between young siblings could also be avoided through spacing, as the last born would not be competing with the newborn for his/her mother’s attention. As one Cairo physician summarized, “A good mother equals a good child.”

An older spacer from Cairo described the importance of lactation as follows:

“When a baby is breastfed for two years as God said, he will be good, eat well, wear well, enter school, and be good with his classmates.”

Advantages for the husband/father

In general, participants also thought that advantages of delaying pregnancy would consequently spill over to the father/husband. They noted that, psychologically he would be more relaxed at home. When he returns from work he would find a calm and tidy home, a relaxed, healthy and attentive wife capable of supporting his needs and demands. The newborn would be satisfied and healthy. Financially, he would not be overwhelmed by the needs of his growing family. Some mothers-in-law added that by spacing the next birth, husbands might have an opportunity to save and/or provide a better living for the family without the stress of another child too soon.

There was an underlying recurrent theme, mentioned occasionally by participants in all focus groups, that if the husband did not receive the attention and comforts he expected following the birth of his child, he might consider taking another wife to provide the care and comfort missing from the relationship with his current partner.

Advantages for the newborn

Advantages for the newborn or neonate were not immediately evident to focus group participants, not even health service providers, until they were asked to directly address specific advantages and/or disadvantages of the “resting period” for the newborn. In other words, in discussing why a woman should wait the specified period between the last birth and the following pregnancy no one voluntarily related the advantages for the newborn.

Advantages for the next born

Advantages for the next to be born child are related to the renewed health status of the mother, the nutritional quality of the milk and the general status of the family. A mother who has recuperated her health is more likely to deliver a full term healthy baby with a normal birth weight. Low birth weight babies may need incubators and be more susceptible to illnesses due to a lower immunity. Participants noted that healthy
newborns would not suffer from rickets, jaundice, anemia or insufficient calcium and that a well-nourished and relaxed mother would produce a sufficient quantity of breast milk for her newborn.

An older spacer from rural Upper Egypt said:

“She (the mother) would be breastfeeding the first child for many months and if she is pregnant again, the second baby’s milk will be weak.”

Participants felt that by delaying the birth of the next to be born, the newborn would be welcomed into a family that is better prepared to receive him/her, as if “he is the first child,” his/her mother would be more experienced and available to take good care of him/her, the newborn’s father would be better prepared financially, and even the newborn’s siblings would be old enough to develop a good relationship with him/her.

No one, not even health service providers, mentioned preventing complications during pregnancy and delivery as an advantage of adequate spacing until directly asked. Once asked, an array of problems was reported including the possibility of maternal and/or neonatal mortality. Participants listed miscarriage due to a weak uterus, pregnancy toxemia, edema of the legs caused by excess albumin, hypertension and premature delivery as possible complications of pregnancy. Complications cited during delivery included difficult and prolonged labor due to weakness during pushing, breech presentation, rupture of the uterus, or cesarean section. Some women might suffer from septicemia. Participants stated that after delivery, non-spacing mothers might suffer from general weaknesses, dizziness, hypotension, weight loss, headaches, and/or back pain.

Mothers-in-law listed the greatest variety of problems and ailments that may arise for women who do not “rest” and gave concrete examples of the consequences. The following are a selected few:

- “A woman was delivering when her uterus fell. They removed the uterus along with the baby.”
- “One woman usually had babies within a year of her last delivery. She experienced difficult labor, high blood pressure and inflammation in her kidney.”
- “One woman suffered from bleeding in her sixth month of pregnancy and had to take injections until the bleeding stopped.”

Despite potential ailments listed by the focus groups, a few participants counter argued that these ailments were insignificant, as adequate nutrition and the mother’s health status were the prime determining factors. They based this view on their knowledge of women who had become pregnant after 40 days of delivery and experienced no health problems. Several physicians and nurses shared this view and stated that complications depended on the number of pregnancies the woman had experienced.

Hence, most participants believed that conditions were variable and that some women actually could become pregnant without a “resting period” or significant health risks
and problems. As one physician from peri-urban Cairo stated, “In reality, some women become pregnant after 40 days and they deliver a very healthy child.”

**Disadvantages of birth spacing**

Very few disadvantages were stated. Some younger women spacers from peri-urban Cairo mentioned that after a long “resting period,” the last born might be more jealous of the newborn. Some spacers and non-spacers suggested that side effects from contraceptives were a potential problem, including some older women who worried that conception or delivery might be difficult after a long spacing interval. Some participants believed that husbands favoring large families would find extended spacing an adequate excuse to remarry; while some rural Sohag participants commented that husbands who’s wives gave birth to girls might be harassed and pressured by statements like: “You did not get a boy, there must be something wrong with your wife.”

**C. Spacing the Next Birth: The Decision Making Process**

Couples’ decision-making processes regarding the timing of new pregnancies have no set pattern. Variations on who decides the timing of the next pregnancy ranged from joint decision making, to sole decision making, to God’s will. Overall, women appeared to have greater autonomy for sole or joint decision-making based on age, spacing experience and urban residence.

**Wives**

As a group, the majority of female spacers and non-spacers in urban and peri-urban areas of Minia, Sohag and Cairo, stated that spacing births was a joint decision between husband and wife. This was especially true among the older groups. A few put greater emphasis on the wife as decision maker. Some young non-spacers from urban areas also felt it was a joint-decision. As a group, older non-spacers from urban and rural areas emphasized the roles of husband and wife as joint decision makers and to a lesser extent, the woman as primary decision maker.

Yet among the younger groups of urban spacers and the majority of rural non-spacers there was a greater tendency for the husband to be the decision maker. Older non-spacers from rural areas tended to name the husband as primary decision maker and were joined by a few of their urban cohorts in this opinion.

**Husbands**

While husbands of older women were more inclined to profess that spacing the next pregnancy was a joint decision, husbands of younger women stressed the husband’s decision making role was dictated by the nature of his family responsibilities and not due to his authority within the household. A few husbands, mostly married to older women, stated that spacing decisions were the woman’s domain because they were the ones using the contraceptives and bearing the discomfort of pregnancy. Only one husband from urban Minia stated that pregnancy is neither a husband or wife’s decision, but rather the will of God.
Husbands had mixed opinions on planned versus unplanned pregnancies. Husbands of younger women in rural Upper Egypt were more likely to believe that pregnancies just happen. All others, with few exceptions, agreed that couples should decide together when a pregnancy should occur. Some agreed with the concept of “planned pregnancy” or artificially postponing pregnancies by using some form of contraception. They also believed that couples that value children as ezwa or “family power and support,” those who believe pregnancy is God’s will, and those that believe every child is born with its fortune or rizk, should not plan their pregnancies. These couples were more likely come from illiterate communities or newly married younger couples. One husband married to an older wife, said “Women couldn’t stand not getting pregnant once their children reached the age of two.”

Mothers-in-law

The majority of mothers-in-law believed that husbands and wives should decide together. The few who stated it was the husband’s decision and the wife should obey were from rural areas. Those who argued it was the wives’ decision did so because women can hide facts about their contraceptive practices from their husbands. They can use or curtail use of contraceptives behind her husband’s back and then claim, “It was a mistake.” One mother-in-law said it was a wife’s decision “to tie the man with children.” Only one mother-in-law from rural Sohag said, “It was no one’s decision, it was God’s will.”

Health service providers

Among providers there was no real consensus on who makes the decisions regarding spacing. The majority of urban and rural health service providers from Upper Egypt believed the husband had the decision-making role regarding the timing of subsequent pregnancies. If he had the final say it was based on his financial position within the family. They believed that only if women were educated, had suffered complications during previous pregnancies and/or deliveries, or if they were adamant about having another child immediately would they have a role in decision making. A rural physician from Sohag offered the mothers-in-law as possible decision makers. A few mentioned that the couple decide together or that the wife decides because she is the one that will become pregnant.

Cairo health service providers were split between those who though it was a joint decision and those who thought the husbands decide. Some tended to view the woman’s decision-making role as indicative of the type of relationship the couple enjoyed. Nurses tended to say that it was the husband’s decision. Only one nurse said it was a woman’s decision and one physician emphasized the strength of the wife’s character as a critical factor in who makes the decision within the couple. One physician from peri-urban Cairo expressed the husband’s role in these terms, “A woman came to the clinic the day after she had inserted an IUD to remove it, according to her husband’s will.”
The power of persuasion

Regardless of who has the upper hand in decision-making, it was reported that planning and discussion accompany the final decision. Even if opinions differ, each partner has to persuade the other that if pregnancy does not occur naturally, it is the “will of God.” A few participants mentioned that if a husband’s mother influences his desire for children or he is motivated by ezwa, he may continue to nag his wife until she becomes pregnant.

Women spacers and non-spacers reported that even if they do not have the final word on spacing the next birth, they must be entirely persuaded by their husband’s opinion. Conversely, if they want to delay the next pregnancy and their partner disagrees they must be able to persuade him. A few spacers, non-spacers and mothers-in-law noted that women can if necessary, use contraceptives without their husband’s knowledge; but one spacer from urban Minia feared her religion forbid betraying her husband, and other non-spacers said they might just give up because they “can not say no.” Other urban women from Minia said they would never use contraceptives without their husbands’ knowledge. Only two women, one urban and one rural from Sohag, mentioned anything that demonstrated thoughtfulness on the part of their husbands. They commented that their husbands would never insist on a pregnancy if they saw that their wives needed to rest, commenting, “Find a [contraceptive] method to use if you are tired.”

Consequently, husbands view their decision as the final word and the wives’ role as trying to persuade him to adopt her viewpoint if they are not in agreement. In this way they may reach consensus on the timing of the next pregnancy. Only a few husbands from rural Minia acknowledged the women’s real decision-making power lies in their ability to continue or discontinue the use of contraceptives without their husband’s knowledge.

One peri-urban husband of a younger wife from Cairo said:

“If my wife has a say, then there is no need for me.”

A peri-urban husband of an older woman from Cairo offered:

“If she has a different opinion, I would go and marry another.”

An urban husband of a younger wife from Minia commented:

“If she does not follow her husband’s decision, they may end in separation.”

In brief, decisions regarding the timing of the next pregnancy are a function of both partners. If opinions differ, the responsibility is on the wife to convince her husband of her viewpoint. If consensus is not reached, each partner has access to a power strategy. The husband can remarry or separate, and the wife can control her fertility through secretly taking or discontinuing contraceptives.
D. Actual Birth Spacing Practices

Women, husbands and mothers-in-law preferred to calculate the resting period in terms of the next pregnancy, as once the new pregnancy took place, the rest was effectively over. For those concerned about the timing of delivery in order to calculate sibling age differences or school entry, providers suggested calculating the date of conception by counting back nine months from the preferred delivery date.

Egyptian women rely on two main methods for spacing births; modern contraceptive methods and lactational amenorrhea, known as “clean lactation.” Neither method is foolproof nor allows women to achieve their goals with reliability. Additionally women cited three main constraints to their capacity to control the time between pregnancies; adverse side effects from contraceptive use and subsequent encouragement to stop their use, reliance on “clean lactation” without a back-up contraceptive method, and the desires of husbands or mothers-in-law.

Wives

Most spacers relied on modern contraceptive practices and had occasionally switched contraceptive methods for various reasons. A few spacers from peri-urban and urban focus groups relied on “clean lactation.” The term clean lactation means that the woman is not menstruating, due to ammenorrhea associated with lactation. During this period women, erroneously, do not consider themselves to be at risk for pregnancy because there has been no menses following delivery. Spacers who would have liked to wait longer were mostly from Upper Egypt, and said they had either been influenced by their husbands, mothers-in-law or mothers, had suffered contraceptive side effects or had experienced method failure. Five young participants from rural Sohag experienced unintentional spacing and considered it to be “from God.”

Most non-spacers said they would have preferred to wait longer between pregnancies for health reasons. They said that if they had been more familiar with available contraceptive methods or experienced fewer side effects they might have been able to postpone their pregnancies longer. Those who depended on “clean lactation” for protection from pregnancy and became pregnant earlier than desired said counseling about the reliability of lactational ammenorrhea (LAM) as a contraceptive method could have helped.

Non-spacers also mentioned that husbands and mothers-in-law needed to be convinced of the benefits of adequate spacing. They commented that certain ideas had to be abandoned if they were to succeed; ideas such as children bonding men to their families, the preference for male children, and the urgent need to have children while young.

3 For LAM method to be most effective breastfeeding must be exclusive. Women may not supplement their newborn’s diet with any other food or fluid, including water. An interruption in the suckling process for an extended period could influence the prolactin hormone level, stimulating ovulation. These conditions, as well as the fact that LAM is never 100% effective as a contraceptive method, must be included in counseling.
Three older non-spacers from urban Minia stated that if men would accept using condoms, women would not be subject to the negative side effects of contraceptive use. They hastened to add that Egyptian men reject condom use. Only four non-spacers from rural Upper Egypt wanted to have children “one after the other” or wanted a child of a specific sex.

**Husbands**

While husbands blame their wives for not waiting a reasonable amount of time between pregnancies, husbands remain the primary decision-makers regarding the spacing of pregnancies. Therefore a woman may choose not to space in order to satisfy her husband’s desire for ezwa or for a son. She may also seek to tie him down or limit his desire to “look around” or remarry by increasing the number of children as rapidly as possible. A few husbands added that forgetting oral contraceptives or injectables unintentionally could be the “will of God.” Some rural husbands married to older women added that some women prefer having their children when they are young; others do not realize the dangers to their health from frequent child bearing and become pregnant while lactating, or stop contraceptives because of side effects.

The majority of husbands stated a three-year waiting period was preferable. Husbands of younger wives were more likely to indicate a two-year waiting period was sufficient. Husbands with four children were not interested in having more children and those with older wives actually advocated a four-year waiting period between pregnancies, with modern contraceptives used to prevent or space pregnancy.

The majority of husbands stated that in practice, their wives were already using contraceptives to space or prevent child bearing. More than one third stated that their wives were using IUDs, around one-fourth commented their wives were using injectables, less than one-fourth were using oral pills and one husband stated that his wife inserted capsules. Of those whose wives were not using any modern methods, two were already pregnant, three intended to seek contraception, one was lactating “clean,” and two stated that they were not pregnant “naturally” or rabani.

To exemplify a husband’s power over his wife, one young spacer from urban Sohag shared, “My husband threw the pill from the window and told me, ‘I want children.’”

Another husband married to a younger woman commented, “That is deficiency in women’s thinking, but their husbands did not slaughter a cat for them.” Slaughtering the cat is an Egyptian expression referring to the success of the newly married husband to sufficiently scare his bride into conforming to his expectations.

**Mothers-in-law**

In response to the question whether they thought their daughters-in-law should postpone the next pregnancy, mothers-in-law generally stated that while they have their own opinions, their daughters-in-law do not listen to them so they do not interfere and let the couple decide on birth spacing themselves. Some mothers-in-law were satisfied that their daughters-in-law waited, while others wanted to have grandchildren quickly saying, “I want to see my son’s children before I die.”
In Upper Egypt, most mothers-in-law stated they would have liked their daughters-in-law to wait longer between births in order to take better care of themselves, their husbands, and their children. They said it was up to their daughters-in-law to heed their advice or not, and that their daughters-in-law would be more likely to listen to their own mother’s opinion instead.

None of the mothers-in-law mentioned influencing the decision by persuading their sons, yet most wives acknowledged the strong influence of their mothers-in-law. One young peri-urban non-spacer from Cairo said, “I told my husband I wanted to have an IUD inserted, and he agreed. Then he went to visit his mother in the morning, and when he returned home he told me to forget about the IUD.”

Health service providers

Health providers confirmed that there are a variety of practices within their communities. Some women in their communities wait 2-3 years and others only 1-2 years before the next birth. Providers believed the type of contraceptive used, its side effects, and the efficacy of “clean lactation” affected the length of the waiting period. They also noted the strong influence of the husbands and mothers-in-law.

Contrary to the opinion that younger women tended to wait less time between pregnancies, health providers said that older women were more anxious to begin the next pregnancy for fear of losing fecundity, especially if they had not achieved their childbearing targets.

All providers agreed that postponing pregnancy for longer periods usually occurs following the second child, when the woman feels “satisfied and not hungry” rather than after the first. Nurses from urban Sohag stated that there were still families who wanted to have a child every two years regardless of the child’s birth order. A physician from rural Sohag stated it this way, “In the locality where I live, 80 percent are satisfied after the third child and 90 percent are satisfied after the fourth child. The fifth child is usually a mistake.”

Contraceptive method failures and side effects

Women experienced a variety of side effects related to their chosen contraceptive method. Those practicing “clean lactation” assumed they were safely amenorrheic and that this would reliably protect them from pregnancy. It is however possible for postpartum women to become pregnant prior to recommencing menstrual periods. Oral pills were reported to affect lactation, were often forgotten, caused bleeding or made women feel weak. IUDs caused bleeding, inflammation or, as one older participant from rural Minia related, her IUD “moved up” and had to be removed after an x-ray was taken. Injectables were said to cause bleeding, amenorrhea, weakness, headaches and high blood pressure.
E. Frequently Recommended and Requested Contraceptive Methods

The majority of health providers in Cairo agreed that the IUD is the preferred method among women because it is effective, non-hormonal and does not interfere with lactation. Additionally, IUDs are easy to remove when clients are ready to become pregnant.

Women who request injectables are usually those who have experienced bleeding with IUDs or heard of women who have experienced these side effects. They usually have more than one child and are comfortable receiving an injection only once every three months. A few nurses added that use of injectables could result in delayed return to fecundity.

In Upper Egypt, health service providers agreed that women prefer injectables and oral contraceptives to IUDs. Many women have misconceptions about IUDs and were less likely to have IUDs inserted as a first choice, especially if it were to be inserted by a male physician.

Providers stated that injectables were popular because they are cheap, readily available, do not affect lactation and are promoted on television. Those who prefer the oral pills stated that they were cheap, widely available, and convenient, enabling them to stop whenever they chose and become pregnant immediately.

Husbands’ married to older women

When husbands were asked about their preferred methods, those married to older women agreed that physicians should determine the best method based on the individual’s health needs. Less than half of those who responded preferred injectables because they “prevent menstruation” and their wives were unlikely to forget them, unlike oral pills. More than one third of the husband’s preferred the IUD because it is safe and effective up to 10 years. One in six husbands preferred oral pills because they are convenient and inexpensive. One husband from rural Sohag mentioned that some men prefer methods that do not prolong menstrual bleeding, because it affects sexual relations between husband and wife.

Husbands married to younger women

A few husbands married to younger women from Upper Egypt mentioned that physicians should decide which method to use because they are familiar with the advantages and disadvantages of modern contraceptives. Of those husbands who stated a preference, less than half preferred the IUD, more than one third preferred injectables, and more than one fourth preferred oral pills, because they are inexpensive and have no side effects for men during intercourse.

The IUD was preferred by the highest percentage of men because it is effective over a long period of time, reversible, cannot be forgotten, is less expensive than injectables and does not have the same type of side effects as pills. Some husbands from urban Sohag agreed with some husbands of older women, and said that IUDs restrict their
sexual relations as they prolong menstrual bleeding and disturb them during intercourse.

Husbands from urban Minia commented that it was degrading and shameful for men to use contraceptives such as condoms.

Thus from the husbands’ viewpoint, IUDs and injectables were equally popular first and second choices. Oral pills were the third most popular choice because of their low cost and ease of reversibility.

**Health providers’ opinions**

Family planning service providers are convinced of the appropriateness of IUDs and highly recommend them. For them, the IUD is an effective, non-hormonal, localized method that is long lasting, and does not affect lactation. They consider side effects minor and easily managed. They also believe that IUDs do not affect sexual relations between men and women. Additionally, health providers find that once an IUD is removed pregnancy can occur immediately.

Some providers promote capsules (implants) and are not aware of any serious side effects. Injectables are often recommended only for older women who have already achieved their intended family size, because many nurses believe that injectables affect fecundity, and that women may wait a long time before becoming pregnant.

**F. Influences on Next Pregnancies**

**Family influences**

Spacers and non-spacers reported that the family has an enormous influence on spacing the next pregnancy, especially for younger wives. Women stated that the pressure comes primarily from mothers-in-law, who pressure their young daughters-in-law to get pregnant quickly (alatool), convince their sons they want to see their grandchildren right away and believe that children should be close in age or “grow together.” Wives commented that their own mothers tended to be more concerned about their daughters health and well-being than were their mothers-in-law.

In general, women spacers reported that their families tended to support a waiting period of two to three years between pregnancies, although rural families from Sohag agreed that if the last born was a girl, an 18-month waiting period was acceptable compared to a two-year waiting period if the last born was a boy.

Women non-spacers were split in terms of the accepted waiting periods within their families. In peri-urban Cairo, waiting time ranged from 18 months to four years, with the majority waiting about two years. In Sohag waiting time for non-spacing families ranged from 40 days to a maximum of three years.

In Minia, all young urban non-spacers declared their families wanted children one after the other or wara baad, which would mean becoming pregnant on the 40th day of delivery or within two months. Older non-spacers in urban Minia preferred an average waiting time between two to four years. In rural Minia the majority of younger non-
spacers mentioned their families preferred a two-year waiting time, and older non-spacers preferred a three-year waiting time. One 22-year old woman reported her mother-in-law told her just one month after delivery:

“Collect your strength (helek) and bring him a brother (khaweeh) before you get up from this bed (farsha) you are sleeping on.”

Thus, if there is pressure on the wife for more frequent pregnancies, it is exerted by the constant nagging of mothers-in-law, husbands, and to lesser extent sisters-in-law and mothers. Mothers-in-law were reported to say things like, “Children support the father’s back” or “Women who do not get many children are like barren land (boor).”

Continuous nagging can cause immense psychological stress on the wife. Women who do not meet expectations for birthing are subject to threats that her husband might remarry or return her to her family. Some husbands confessed that if their wives do not bear children or wait for more than two years between pregnancies, the mothers-in-law intimidate them with threats like, “We got you here to eat, sleep and reproduce or else I will get my son another wife.”

Most husbands negated the influence of their mothers and felt only “weak men are influenced by their mothers.” Yet husbands felt their wives’ mothers exerted influence over their daughters in terms of “binding” their husbands to the family through children. Husbands also confirmed the preference of mothers-in-law to see their grandchildren and strengthen the family power or ezwa.

Mothers-in-law rejected all allegations that they influenced their son’s decision making regarding the waiting period and rejected the idea the families’ exert pressure on couples. Some mothers-in-law from peri-urban Cairo admitted that families are concerned when pregnancy is delayed and may take the wife to a physician for a medical check up.

Health providers confirmed women are subject to pressure and threats from husbands and mothers-in-law. In their opinions, mothers-in-law influence the timing of the next pregnancy 50-90 percent of the time, husbands 90 percent of the time, and the wives’ mothers, 10 percent of the time. Family influence was found to be greater in Upper Egypt. Nevertheless, it was agreed that as women become better educated and gain greater autonomy and skills that aid them influencing their husbands opinions; family pressure is decreasing.

**Extended family and community**

Family pressure is more dominant in societies where extended families live with, or close to, nuclear families such as in rural Upper Egypt. Some of the arguments used to influence women to shorten the waiting period include:

- It is better to raise all of the children at once, while the mother is still young; then she can rest.
- If the children are close in age, when they grow up they will look like the mothers’ siblings rather than her sons and daughters.
When the age difference between siblings is small, there will be close ties; they can play together and take care of one another.

More frequent births tie the husband to the family.

Community pressure is not an issue, with the exception of women comparing notes among themselves and petty jealousies.

**Cultural Influences**

Clear cultural influences encourage or discourage optimal spacing. The husband’s authority as the family's financial provider and his power to “send the wife back to her family” or remarry if the wife does not conform to his demands puts the wife in a position to please her husband by reducing the waiting time between pregnancies if he desires. Giving birth to a boy could lower the pressure to become pregnant immediately, while giving birth to a girl may have the opposite effect.

Strong extended family relationships may reduce a woman’s autonomy within the nuclear family, especially among young, uneducated women. While the extended family provides social, emotional and economic support to the nuclear family, extended family members may feel responsible for ensuring that a couple stays on the accepted track, and therefore interfere in a couple’s private affairs.

Unintentional pregnancies also arise when couples rely on “clean lactation.” Although the majority of participants believe that breastfeeding is a natural contraceptive only until the occurrence of the first menstrual period, there are a few, mostly men, that think breast milk is a gift from God and it will be a God-given contraceptive method for as long as it flows (*wassila rabani*).

Finally, the societal norm that permits dissatisfied husbands to easily put aside a wife and remarry, increases a woman’s anxiety to conform, regardless of the consequences. An obedient, energetic, healthy, fertile and easy-going wife reduces her chances of being exposed to such a humiliating experience. This norm also increases the mothers-in-law influence over her daughter-in-law, as she can flare this red flag to ensure obedience and conformity at any time.

**Religious Beliefs**

There was general agreement among women, husbands, mothers-in-law and health service providers that Islam and Christianity both encourage a resting period for the health of the mother and the last born child. Christianity encourages spacing but does not specify time. Islam, however, clearly specifies breastfeeding for two years. Islamic Sunna specifies, that becoming pregnant while lactating is not accepted because it affects the health of the lactating child and the fetus. Here consensus ends.

Some participants, including all participating health providers, were aware that Islam states two years of lactation followed by a nine-month pregnancy ensures a 3-year

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4 Sunna that states, “Do not secretly kill your children by becoming pregnant while lactating (El- Ghile) causes weakness.” Oun El Maaboud, part 10 p. 364.
waiting period prior to the next delivery.\footnote{Suret El Baqarah, verse 232 specifies 24 months of breastfeeding.} Others were convinced that Islam only specifies a two-year breastfeeding period and does not specifically address the duration of waiting or timing of conception.

**G. Health Services and Birth Spacing Information**

The majority of participants in all focus groups indicated they received health services from public health clinics. Some stated using private health services for antenatal care and to a lesser extent for deliveries. A few used NGO clinics or mostawsaf.

**Wives**

Younger and older spacers and non-spacers from peri-urban Cairo said they did not receive any information about spacing during their health service visits. One participant said she was told waiting prevents complications of pregnancy, but nothing was mentioned about labor complications or the effects of waiting on the newborn. Sohag and Minia women reported they were informed that the next birth should be postponed 2-3 years in order to recuperate their physical and psychological health and provide the last born with needed care and lactation. Some spacers were specifically advised to space because they had already suffered health problems. Contraceptive use was promoted to postpone pregnancy. Service providers discussed the IUD with all women advised to use contraceptives, but only explained the advantages, disadvantages and side effects of other methods to some of the women.

**Husbands and mothers-in-law**

Most mothers-in-law either did not know what kinds of information their daughters-in-law had received or stated they were not informed at all. Statements provided by mothers-in-law about contraceptives largely reflected their level of knowledge. Some recalled advice such as “pills reduce milk, IUDs cause bleeding and insertion depends on uterine size, or she is safe for two years because she is lactating clean;” but it was difficult to confirm if it was actually the health providers who gave this advice or if it was what the mothers-in-law who recalled hearing. One mother-in-law from rural Sohag reported the doctor told her daughter-in-law, who became pregnant before adequately resting, “This is wrong and will be difficult (wa’ar) on you.”

Husbands, however, were better informed. More than half of all participants and more than half the husbands married to younger women confirmed that their wives had received information related to the duration, advantages and/or disadvantages of the resting period. Some reported that their wives were told to rest for a minimum of 2-3 years, which they considered to be realistic, but a few husbands thought that a couple’s desire to have children would make such advice impractical. A few husbands believed that pregnancy is from God; hence nobody knows when pregnancy will occur. All others stated that their wives had received no information on spacing.
Health service providers

All health service providers stated that they always gave women information on spacing, including the advantages for herself and her child, and the importance of lactation. Nurses stressed that they explained the different contraceptive methods for spacing. Nurses from rural Minia preferred to let the women decide on the appropriate spacing period according to her individual circumstances and therefore did not specify a waiting period before the next pregnancy. All other nurses and physicians advised women to wait at least 2-3 years before the next pregnancy.

Providers said they prefer to talk to women about spacing after delivery when they “still remember the pain,” again 40 days post-delivery if they come for a postpartum check up, during counseling for contraception, and/or when women come to the clinic with their babies for immunizations. A few mentioned talking to women during antenatal care services.

Providers considered a two-year waiting period realistic under most conditions permitting the mother to complete a two-year period of lactation, allowing the last born to enter nursery school if the mother is working and permitting the family to be ready socially and financially for the next child. There were some situations or circumstances that they felt would warrant a shorter waiting period. These included:

- Marrying late, when lengthy waiting periods may affect their capacity to achieve their reproductive goals;
- Unemployed women who enjoy having children at home;
- Women who have experienced negative contraceptive side effects; or
- Women who have lost a child.

Providers mostly agreed that describing the waiting period as time until the next pregnancy would sound shorter and more acceptable than measuring time between deliveries. Only a few nurses preferred explaining the time between the two deliveries as the time for a woman to “take her breath and regain her health,” and take into consideration both the risks associated with frequent pregnancies and the strain of caring for children.

According to the providers one surprise finding of this study was the absence of MOHP- written guidelines regarding birth spacing, save a few words scattered in the family planning service guidelines, that did not specifically address or endorse a recommended resting period between pregnancies.

Providers were more willing to agree to a 3-4 year waiting period than a 5-year waiting period, especially for women who start bearing children in their twenties. However, physicians insisted on receiving scientific documentation authorized from the Ministry before changing current recommendations. Nurses thought a responsible person from the Ministry and preferably the Minister himself should announce such information. Nurses from Sohag suggested that a ministerial decree would be better.

Before implementing new recommendations at their health units and clinics, providers preferred to participate in training workshops or scientific conferences or receive
booklets and brochures that supplied the Ministry-endorsed research results. In other words, providers needed to be persuaded and empowered before actually endorsing changes.

Opinions differed among husbands, wives and mothers-in-law regarding preferred health service providers. Some saw no differences between public and private health services because they felt quality depends on the provider, not the place. Some preferred public health providers because they found the counseling was better, they received more information, their blood pressure and weight were measured and public health service providers seemed more concerned about their clients. Those who thought private services were preferable did so because they felt the doctor’s fees eliminated the crowds found at public clinics and therefore clients received more attention, better care, and more information. A woman from Minia mentioned that private clinics have facilities such as ultrasound.

H. Preferred Information Sources

Almost all participants in all focus groups cited physicians as the most important source of information for women and their families. According to the women, physicians provide the “correct information and opinions” because they have studied medicine, have experience and are familiar with the health needs of women. Nurses are also an acceptable information source. Only one husband from peri-urban Cairo shared the proverb, “Ask an experienced person rather than a physician.”

Television came second as a trustworthy and powerful information source as it reaches all family members, especially husbands. Radio was not found as effective or powerful as television. One young spacer stated, “TV makes one aware and shows the husband also, instead of being ignorant.” The majority of participants, including health service providers, had seen television spots on Channel 1 and Channels 7 and 8, broadcast from Upper Egypt. Spots they had seen included “Ask/Consult,” “The Wise Zeina” (Agla), “Zaki” and “Sehetna Bein Edena.”

Dayas and midwives were not considered trustworthy information sources nor were pharmacists, except those displaying the “Ask/Consult” sign. No one had received information from pharmacists, but a few found the instructions in contraceptive packages to be helpful for themselves as well as their husbands.

A few participants said they would listen to relatives and friends if they were knowledgeable, experienced and concerned. Leaflets and posters were also considered acceptable information sources especially when endorsed by the Ministry. Even providers thought that was a good idea to support advice given by providers by publicizing spacing information.

5. Conclusions: Knowledge versus Conviction

The knowledge and awareness levels of all focus groups concerning the advantages of resting for the mother, the last born, the next child and the father are relatively high, most probably a function of the counseling and television spots. All participants
including health service providers, responded when asked directly, that repeated pregnancies without sufficient waiting time were considered “at-risk,” with potentially serious consequences for the health of the mother, fetus and newborn. Although no one volunteered this information most respondents were aware of such cases through their own observations.

Despite the high awareness level of the focus group participants, the conviction level is low. When mothers become pregnant after 40 days of delivery or after a waiting period less than two years without complications for herself or the newborn, they are exposed to what is termed as “circular reinforcement.” They are aware of the negative consequences but do not believe the risks outweigh the benefits. Hence, the following counter arguments are made:

- Pregnancies are not planned, they happen according to God’s will.
- Women who wait “too long” for the next child are considered “barren” and not necessarily wise.
- Couples who are financially comfortable can afford to have children and do not need to have a “resting” period.
- If the mother is healthy and well nourished, she can afford not to wait.
- Waiting for more than two years for the next pregnancy is more suitable for a working woman than a non-working woman.
- Giving birth to a girl will justify becoming pregnant quickly, to increase the chances of having a boy.

Even when married women have been advised to wait by health service providers, their conviction rate may be low, as they must resist pressure from their husbands and mothers-in-law or take it upon themselves to persuade them otherwise. This is difficult for young and uneducated women. While married women may receive persuasive counseling during family planning and/or reproductive health visits, husbands, mothers-in-law and mothers do not.

There are a myriad of arguments why families are reluctant to wait the recommended 3-5 years between pregnancies. If health service providers, married women of reproductive age, husbands and mothers-in-law are to accept optimal birth spacing practices, convincing arguments must be made to counter views like those expressed below:

- Young non-spacers feared that their husbands would reject the advice, that their uteri would become narrow, or that they might forget the pain associated with delivery and need to give birth by cesarean section.
- A few mothers-in-law from Upper Egypt reiterated this by stating that spacing a pregnancy for three years or more after the last birth could endanger the life of the wife.
- Some husbands of younger women from Upper Egypt thought a long waiting period would deprive them of having their children while they were still young enough to control them, not when their hair “is white.”
Some young spacers from Upper Egypt shared the concern that a man would be less capable of caring for his children if he were older and a woman would not have enough time to bear all her projected children before reaching the age of 35.

Even some health providers argued that spacing births for five years would mean that a woman bearing her first child at age 25 would be 35-years old before she had her third child.

One nurse from Upper Egypt added that waiting for five years would make the woman feel as if it were her first pregnancy, and that she would experience all the associated problems.

Obstacles to Achieving the Desired Spacing Time

The two most serious obstacles preventing women from reaching their goals are reliance on “clean lactation” and the negative side effects of contraceptive use, which tend to make women partially or completely stop using them and experience method failure. Just the fear of side effects deters some women from using contraceptives.

Despite the fact that the National Family Planning Program has successfully achieved a “cafeteria-like” system of contraceptives, in practice women do not have access to a wide variety of options. Health providers tend to promote IUDs over other contraceptive methods. They believe that injectables affect fecundity and therefore only recommend them to older women who do not want more children. Oral pills are not regularly recommended because forgetting to take them means method failure. Condoms are neither accepted by husbands nor promoted by health providers except for short durations, and only if necessary. Implants are still relatively new and unknown in Egypt, and therefore not popular.

Postpartum contraceptives were not widely discussed by the health providers during their focus group discussions. Not surprisingly only a few women reported being advised postpartum to return for IUD insertion after six months. The majority of women said they would not advise using IUDs postpartum because the uterus would still be open, bleeding would increase, the uterus and the ovaries would be weakened and/or the milk might be affected. A few stated it might be safe if prescribed by a physician.

While almost all women, save a few younger women from Sohag, had heard of lactation oral pills that could be used safely without affecting breast milk, some health providers and especially nurses, were of the opinion that “clean” lactation prevents pregnancy for six months. This belief may be one reason why providers do not seriously think about providing postpartum contraceptives. Other nurses said that pregnancy could only be prevented during this period if the mother breastfed exclusively, meaning breastfeeding on demand, day and night with no extra food or drink for a full six months. To overcome these obstacles, lactation pills and postpartum contraceptives must be promoted, even while women are lactating “clean.”
Providers reiterated that they lack specific MOHP-endorsed written guidelines on optimum birth spacing time, suitable contraceptives and or spacing, and are therefore reluctant to actively advocate postpartum contraceptives.

### 6. Study Recommendations

For women to succeed in influencing and achieving an optimal birth spacing of at least three to five years, they need the conviction and support of their significant family members (husbands, mothers-in-law and mothers) and health service providers. Hence, behavioral change communications (BBC) should target all those who have a direct or indirect influence on pregnancy decisions. The following actions are recommended to address the advantages of optimal birth spacing and the risks associated with frequent pregnancies:

**For the public**

- Health messages, disseminated at health care clinics and through the mass media, should target husbands and mothers-in-law; especially those of younger women, since the former are the main decision makers with regards to timing of pregnancy.

- The risks associated with frequent pregnancies that may affect the mother, fetus and/or neonate, should be described using scientific documentation and disseminated to wives, husbands, mothers-in-law, and other community leaders.

- Integrate OBS-related topics into NGOs’ and women’s micro-credit and literacy programs, as well as the health education programs of agricultural associations.

- Islamic teachings about the effects of lactation on both the breastfed child and the fetus should be disseminated to the public, not only to mothers.

- Encourage religious leaders to disseminate accurate messages about birth spacing by providing them with RH training that includes scientific information about OBS.

- People need to understand that the capacity of lactation to prevent pregnancy is only effective when the newborn is under a strict regimen of exclusive breastfeeding and is effective a maximum of six months; otherwise, the woman may become pregnant before experiencing postpartum menstrual bleeding.

- The advantages of optimum birth spacing for younger women should be well documented to successfully negate misconceptions about the erroneous effects of longer spacing to dry out or narrow the uterus.

**For health care providers**

- Intensified promotion of postpartum contraception and increased emphasis on counseling should better support women in achieving their desired spacing
objectives and reproductive goals. Emphasis should be placed on eliminating provider bias for specific methods, the limitations of LAM as a contraceptive method, and managing contraceptive methods’ side effects, especially those related to menstrual changes.

- Physicians and nurses should be trained in state-of-the-art counseling techniques and the recognition, treatment and management of side effects from all types and brands of contraceptive methods. Particular attention should be placed on menstrual changes.

- Service providers should promote OBS during FP/RH and MCH client consultations and examinations. Posters, brochures and videotapes highlighting the advantages of OBS should be available at all service delivery points. Open group discussions on OBS can be held at health facilities.

- Written guidelines regarding optimal birth spacing should be developed and disseminated to increase providers’ conviction. Basic knowledge and awareness of optimal birth spacing on the part of providers is not enough. Health care providers will resort to guidelines when in doubt or when opinions vary.

- Close follow up of guideline implementation is important to ensure that appropriate actions are taken and sustained.

- Include OBS messages in the raedat nifiat, nurses and service provider training and counseling workshops.

- Scientific workshops should be organized for physicians and nurses to present and discuss interpregnancy spacing and scientific evidence of “at-risk” factors for closely spaced pregnancies.

- Scientific information related to the risk of contraceptive method failure associated with lactational ammenorrhea should be included in medical and nursing school curricula.

- OBS concepts should be integrated into the health service delivery system including medical and nursing school curricula, postgraduate studies for OB/GYN specialists, and the RH/MCH Integrated Standards of Practice.

- Initiating meetings between regional health officials, local physicians and nurses to discuss and exchange experiences may build health care provider commitment to the cause of optimal birth spacing.
# Annex

## Table 1 Distribution of Focus Groups

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<th>Category</th>
<th>Location</th>
<th>Age</th>
<th>FGD Number</th>
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