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FAMILY SUPPORT FOR WOMEN'S HEALTH-SEEKING BEHAVIOR: A QUALITATIVE STUDY IN RURAL SOUTHERN EGYPT (UPPER EGYPT)

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ABSTRACT

This qualitative study investigated the influence of family support for women's health-seeking behavior in rural southern Egypt (Upper Egypt). We carried out separate focus group discussions (FGDs) with 3 groups (6 women with children under 5 years old, 6 men, and 4 elderly women, respectively) in a village in Assiut Governorate, an underprivileged region in Upper Egypt. The FGDs aimed to identify how different types of family support affected these women's health-seeking behavior in areas including maternal health and common illnesses of women and children. Our results showed that maternal health issues were often discussed by husbands and wives, while mothers-in-law had little apparent influence. We also found that women could access support resources more easily than expected through their extended families. Our study showed that husbands had an important role in encouraging women's health in the family, while the effect of mothers-in-law on women's health-seeking behavior was not substantial. The study indicated that women received considerable support from co-resident family members, their natal family, and their neighbors, which helped women for seeking health services.

Key Words: Family support, Women's health, Children's health, Qualitative study, Egypt

INTRODUCTION

To improve women's health in developing countries, women's demand for health services and associated health-seeking behavior must be increased and encouraged, in addition to improving physical access to health services.[1)] It is important to identify and understand the determinants of women's health-seeking behavior.[2, 3, 4)] Social support, especially from spouses and other family members, could be one of those determinants, and improving social support would have the potential to improve women's health.

In Egypt, basic health service coverage has been extended throughout the country.[5, 6, 7)] However, considerable health inequality has been reported among the 4 geographic regions of the country: the Urban Governorates, Upper Egypt, Lower Egypt, and the Frontier Governorates. Upper Egypt, located in the south, or upstream along the Nile River, is known to be

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an underprivileged region, as shown by economic, social, and health indicators. For example, under-five mortality rate in rural Upper Egypt (45.7 per 1,000 live births in 2008) was around 65 % higher than the national average.[8)]

Egyptian women's behaviors, including health-seeking behaviors, were known to be strongly influenced by their husbands and mothers-in-law after marriage.[9, 10)] In addition, it has been reported that girls are much less likely to receive appropriate treatment for diarrhea than boys, *i.e.*, health care providers gave oral rehydration solution to boys more frequently than girls.[11)] A previous cross-sectional study conducted by some of the current authors showed that women are more likely to utilize antenatal care (ANC) if they live with extended family than in a nuclear family.[1)]

To explore this finding further, we conducted focus group discussions (FGDs) to qualitatively assess the influence of family support, especially that of husbands and mothers-in-law, on maternal health, including care during pregnancy and delivery, and health-seeking behavior related to common illnesses of women and children.[12)] The study area was Upper Egypt, where people's health status were poorer and their lifestyles were more conservative than in any other regions of the country.

METHODS

Study design and setting

This qualitative study was conducted in a rural village adjacent to the city of Assiut, the capital of the Assiut Governorate in Upper Egypt, which is located approximately 375 km south of Cairo. The population of the village is around 20,000.

Data collection

We conducted FGDs in November 2009. Three focus groups, consisting of women and those whom we believed to have influence on the women, were organized: (1) women who had given birth within the last 5 years; (2) men with children; and (3) elderly women with grandchildren. A total of 16 people (6 women with children under 5 years old, 6 men, and 4 elderly women) were purposively recruited by the health workers stationed at the health unit in the village. We conducted 3 FGDs at the health unit, one for each group. Each FGD took around 45 minutes, and was facilitated and led by Egyptian investigators and conducted in Arabic. Six Egyptian health professionals and nursing college students took interview notes; each of them recorded the opinions and experiences of a single FGD participant.

We employed a printed topic guide to facilitate the discussions. The main topics were: (a) household structure and socioeconomic situation; (b) personal history with regard to pregnancies and deliveries; (c) women's utilization of the health unit in the village (*i.e.*, health conditions that require women and children touse the health unit, preference of doctor's gender); (d) women's health-seeking behavior and family support related to maternal health care (*i.e.*, the decision-making process, choice of treatment, instances of visiting a local health unit or other medical facilities, types of family support, and specific family members who supported women during pregnancies, deliveries, and postpartum); and (e) women's health-seeking behavior and family support related to common illnesses of their own or their children (*i.e.*, the decision-making process, choice of treatment, instances of visiting a local health unit or other medical facilities to treat an illness, types of family support, and specific family members who supported women when these women or their children were ill). The common illnesses mentioned during the discussions included: diarrhea, fever, coughing, and any other illnesses common in the area.

Data analysis

Transcriptions of the interview notes, which were written in Arabic, were translated into English by the Egyptian investigators. The English text was then qualitatively analyzed in depth using the framework approach,[13, 14, 15] which consists of the following 5 steps: (1) familiarization, (2) identifying a thematic framework, (3) indexing, (4) charting, and (5) mapping and interpretation. Following these steps, A.O. and M.H. categorized, summarized, and abstracted the data from the FGDs to determine patterns of behavior and communication.

Ethical considerations

Ethical approval for this study was obtained from the Ethics Review Committee of Nagoya University School of Medicine, Nagoya, Japan, and the Faculty of Nursing, Assiut University, Assiut, Egypt. Written informed consent was obtained from all participants before the discussions.

RESULTS

The characteristics of the participants are shown in Table 1. All participants were born in the village except for one man, who came from a neighboring village. Most participants had an extended family with an average of 7 members; the exception was one solitary elderly woman. All participants were Muslim. All female participants had 1 to 6 children between 1 and 17 years old. All of the women were engaged in household work and were not employed in any work with a cash income, while their husbands were employed in paid jobs, such as governmental work and manual labor. All male participants had 2 to 6 children between 1 and 35 years old, and were employed in paid jobs, such as merchants, governmental employees, and manual workers. The elderly female participants had 1 to 7 grandchildren between 1 and 15 years old. Each participant was recruited from a different family, although we had no information on their distant family relations.

Data from the FGDs were summarized and abstracted according to each group, as shown in Table 2. The following sections give the details of the findings.

Health-seeking behavior

All the women, when they were pregnant, utilized ANC with varying frequency at their own

Table 1. Participant Characteristics

Groups	Age (years)	Home Village	Work	Family Structure	Religion
Women's Group (n = 6)	28–36	This village (n = 6)	Household work (n = 6)	Extended family (n = 6)	Muslim (n = 6)
Men's Group (n = 6)	33–60	This village (n = 5) Neighbor village (n = 1)	Employment (n = 6)	Extended family (n = 6)	Muslim (n = 6)
Elderly Women's Group (n = 4)	52–60	This village (n = 4)	Household work (n = 4)	Extended family (n = 3) Alone (n = 1)	Muslim (n = 4)

Table 2. Content of Focus Group Discussions

Topic	Group	Women	Men	Elderly Women
Maternal health	ANC[a)]	•"I underwent ANC at a health unit for follow-ups during pregnancy, and I was vaccinated during pregnancy [tetanus toxoid]." •"In my last pregnancy, I went to a health unit twice and a private clinic 6 times." •"I didn't undergo follow-up care for my last pregnancy."	•"She usually went to the obstetrician for follow-up care."	•Daughter-in-law went to the obstetrician (private clinic) for follow-ups. •Health unit for vaccinations
	Decision-making for ANC	None[b)]	•"My wife decides this issue."	•"The woman's husband is responsible for this decision." •"The woman is responsible for this decision." •"I decided this issue [for them]."
	Place of last delivery	•"I went to the Assiut University Hospital because this was a precious baby; it came after a period of 8 years during which I had three abortions."	•"She had the last delivery at home with the help of a midwife, as is normal." •"[She went to] hospital. "	•"[She went to] hospital. "
	Decision-making regarding delivery	•"Usually, I decide this matter by myself. " •" I discussed with husband, deciding together •"[I was] asked by husband to follow a certain course of action. "	•"I asked her to go to the hospital, but she refused and delivered at home." •"She decided this issue." •"Usually, any decision about whether she delivered at home or at the hospital would depend on her health during pregnancy, but I'm still responsible for that." •"[I have a] discussion with wife.	•"I advised my son to take his wife to the hospital."
	Person who support during pregnancy and post-partum	•Natal mother, •sister •brother's wife •mother-in-law •husband's sisters •husband's brother's wife •elder daughter, neighbors (1 week–1 month after birth)	•"When my wife has any medical problem during pregnancy or at any other time, her mother takes care of her and does all of the household tasks for her." •"Because we have a big party for the new baby on the 7th day after delivery, the wife's mother is usually with her after delivery." •Wife's mother, wife's sister, my sister (1 week–2 months)	•woman's own mother •my granddaughter •myself (7–40 days)
	Illness during pregnancy	•"I know I should go to the physician; I heard about that from TV, as well as advice given by the hospital during ANC and vaccinations." •"I would quickly seek the doctor's advice."	•"If my wife's illness was very severe, she should go the hospital."	None

Children's illness	Behavior for treating children's illness	•"If they have diarrhea, I give them an intestinal antiseptic from the pharmacy, or an oral hydration solution; if there is no improvement, I take them to the hospital." •"If there is any medical problem, I try to make them feel better; if there is no response, I go see the doctor."	•"If they're ill, I treat their symptoms, and if they're still suffering after that, I'd take them to the hospital." •"I didn't give my son any medical treatment, I just left him to get better on his own." •"[We take] children to a health unit, physician, or hospital."	•"If my grandchild is ill, I ask my son to take him to the physician."
	Decision-making for children's illness	•"I would go with my husband to see the doctor." •"Usually, I decide this issue."	None	•"Usually my son asks my advice on this issue, and I advise him to take [the child] to the hospital."
Women's illness	Behavior for treating women's illness	•"In the case of mild fever, I usually take a cold bath and an antipyretic." •"In the case of cough, I drink hot drinks and take a natural anti-tussive." •"I go to the pharmacist". •"I go to the physician or hospital."	•"I usually ask her to go to the hospital, because she does all of the household tasks—she is very important to us." •"If I have the money at that time, I would ask her to see the doctor; if I don't have the money, she will go to the pharmacy to treat her symptoms."	•"I advise her to eat traditional food, to take symptomatic treatment from the pharmacy, or go to the physician."
	Decision-making for women's illness	•"If my husband sees that I'm not getting better after taking medicine, he asks me to go to the doctor." •"It's my decision."	•"I ask her to go to the hospital, but sometimes she doesn't."	•" I ask my son to give her money to see the doctor."
	Person who support during woman's illness	•mother •sister •elder daughter •brother's wife •brother's daughter •husband's brother's wife •neighbors	•"If she is admitted to the hospital, I do the household tasks instead of her." •Sister, wife's mother, older daughter all help support family and do household tasks	•"I and my daughter (husband's sister) do the necessary household tasks."
	Concern about wife's health	not applicable	•"I usually ask her to go and see the doctor." •"I encourage my wife to visit the local health unit."	not applicable

a) ANC: antenatal care
b) None: no relevant discussion took place about this topic.

discretion. All women participants delivered their children at hospitals. When the women or their children felt ill, they often tried medicine from pharmacist or some manners of self-medication. If they saw no change for better, they would visit a medical facility, such as a health unit, clinic, or hospital.

> *In case of cough, I try to drink hot drinks together with any natural anti-tussive. If there's no response, usually I go to the physician.* (Woman in her 20s)

Communication patterns surrounding health-seeking behavior

Typical communication patterns respectively related to maternal health care and to care for common illnesses of women and children are illustrated in Figure 1. Mothers-in-law played little part in the health care decision-making process. For example, decisions regarding ANC visits and delivery were mostly a matter of consultation between the husband and wife, but mothers-in-law had little weight in this area.

> *Usually, my wife makes a decision whether she delivers at home or at hospital, according*

to her pregnancy state, but I'm still responsible for that. (Man in his 50s)

Regarding illnesses commonly experienced by these women, the final decisions were made between the husbands and wives, while the mothers-in-law mainly offered suggestions to their sons with regard to medical payments, and to some degree advised their daughters-in-law on medical care. With regard to illnesses commonly faced by the children, there were consultations reported between husbands and wives, as well as between mothers-in-law and sons. However, the mothers-in-law had relatively minor roles, and the husbands appeared to facilitate communication between their mothers and wives. Other family members did not seem to be involved in these discussions, although one participant mentioned that her father-in-law had some influence.

Her husband [my son] is responsible for the decisions, after asking my advice. (Elderly woman in her 60s)

Generally, husbands did not appear to show much interest in their children's illnesses; in such cases, women made their own decisions regarding their children's health rather than relying on their mothers-in-law.

I decided (things) about our children by myself. (Woman in her 30s)

At the same time, there was no common seat of decision-making authority that we could observe, making it difficult to extract any definable patterns.

Differences in family support for women's health

Family support differed between the situations of maternal health care and common illnesses in women or children. During pregnancy and delivery as well as postpartum, the women of childbearing age were mainly supported by their blood relatives. One man explained the breakdown between family members in terms of support offered during the postpartum period:

There is a big birth ceremony seven days after delivery here. The woman's relatives are responsible for arranging the ceremony and the banquet. The man's relatives pay for it. (Man in his 60s)

Ill women were often supported by their husbands' female relatives, their own natal female relatives, or female neighbors, although some of the men and the elderly women told that women should do the domestic chores, even if they were ill. In addition, a few men expressed concern about their wives' health and considered that women were worthy of receiving appropriate treatment.

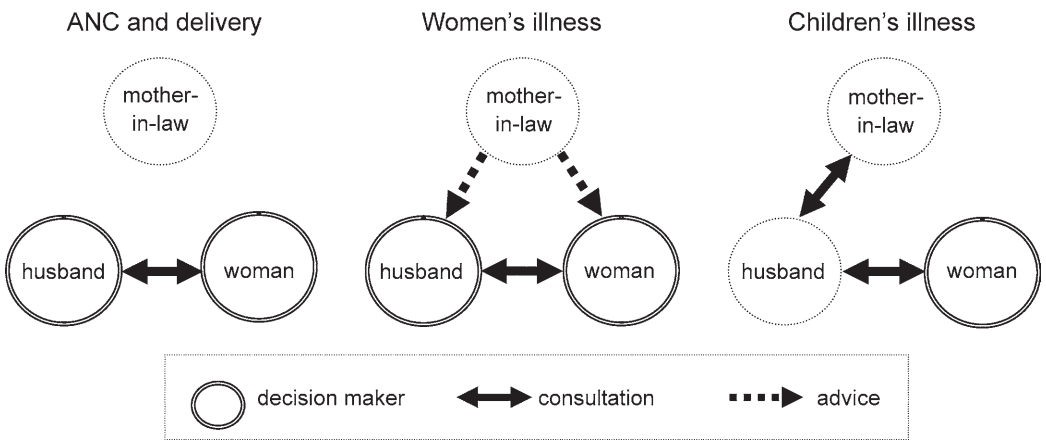

Figure 1. Patterns of Communication

Because my wife has a very important role in our family, when she is ill, I suggest that she should go to a hospital. (Man in his 30s)

DISCUSSION

The present study showed that family members were willing to support women during pregnancy or illness, thus enabled women to visit health facilities. These findings are consistent with the findings of concurrently conducted questionnaire survey, which showed that personal or cultural barriers, such as time allocation and family permission, had not prevented women from using health services significantly.[16] This study has also confirmed the findings of our previous study, which indicated that women living with an extended family were more likely to utilize ANC than women in a nuclear family.[1] Furthermore, because we used a qualitative design, we were able to explore family support for women's health seeking-behavior in detail; the FGDs stimulated participants to express their views and experiences to each other, and these interactions allowed us to obtain in-depth information. Thus, the present study added several important findings.

First, mothers-in-law were not as influential as we had expected. Decisions on issues related to pregnancy or delivery were often made through communication between wives and husbands, while mothers-in-law exerted only indirect influence through their sons. Most women had female relatives who supported them for their domestic duties during pregnancy and the postpartum period. This finding is in contrast to a previous report, which indicated that mothers-in-law have a strong influence on their daughters-in-law's health decision-making in Egypt.[9, 10]

Egyptian married couples live near or with the husbands' parents. This marriage tradition and family system is similar to those in countries like Nepal and Pakistan, where mothers-in-law had the authority over decision making on women's maternal issues.[17, 18, 19] Women in those countries usually had no support from their mothers-in-law to do domestic chores or utilizing ANC, primarily because the mothers-in-law have no experiences of their own that allowed them to recognize the importance of ANC. In contrast, in societies where married couples generally live near or with the wives' parents, such as Thailand, it is easier for women to get support during pregnancy and the postpartum period from their own mothers and relatives.[20]

Thus, we presumed that rural Egyptian women would also get little support from their husbands' female relatives during pregnancy or the postpartum period. However, both our previous study and this study have revealed that women with access to extended families get more support than women in nuclear families.[1] Further, the current study showed that women were supported not only by female in-laws, such as their husbands' sisters or wives of their husbands' brothers, but also by their own mothers, female relatives, and female neighbors. This suggests that the husbands' families are not considered to have primary authority in this area, but women's own family and in the wider village community are important for obtaining support.

Second, this study showed that the quality of women's domestic relations had an influence on maternal health-seeking behavior. A previous study in India showed that the household structure—nuclear or extended—was a key factor in women's decisions on maternal health care, and another report from India indicated that the quality of women's domestic relations was also a factor in the utilization of maternal health care.[21, 22, 23] Women living in nuclear families who had better relationships with their husbands used ANC more frequently and had a higher percentage of institutional deliveries than did those living in extended families. Furthermore, women in extended families who had better relations with their husbands' relatives used ANC more frequently, and husband's female relatives were very influential in leading women to use ANC.

The results of our study agree with these studies in India. In our study, all of the women of childbearing age were married to men from the same village, meaning that they could get family support from not only their husbands' female relatives, but also their own female relatives. This social background helped local women establish strong family and community relationships, and seems to be one of the factors promoting women's health-seeking behavior in this village.

Third, the present study revealed men's concerns and support for their wives' health, along with their roles as mediators between their wives and other female family members on health matters. This reconfirmed the importance of men's roles in promoting women's health,[24] although there are few studies to verify men's influence on maternal health in rural Egypt. In this study, issues related to maternal health seemed to be situated in the women's domain, and most men did not really influence on their wives' seeking ANC or postnatal care. The situation was different from that in Pakistan, where men hold most of the authority in families and sometimes discourage women from seeking health care.[17] It seems that children's common illnesses are also situated in the women's domain, and men are not involved in decision-making.

Due to the constraints of traditional culture in the area of study, our research activities had several limitations. Although we had planned to compare users and non-users of health units, we were only allowed to recruit participants through medical staff at the local health unit. Therefore, we might have obtained information regarding health-seeking behaviors only from frequent users of the local health unit, who were likely to have positive perceptions of the health unit. In addition, local authorities did not allow us to tape-record the FGDs. Finally, while the village we chose was categorized as a "rural area," it may not be an entirely typical rural area due to recent rapid socioeconomic changes in rural Egypt, as shown by the fact that most male participants were salaried workers, and not farmers.

This qualitative study showed that husbands in rural Upper Egypt had an important role in encouraging their wives to seek health services, but mothers-in-law had little influence on women's health-seeking behavior. Furthermore, we have shown that women in Egypt receive considerable support from co-resident in-laws, their natal family, and their neighbors during pregnancy, delivery, and the postpartum period, as well as for their own or their common children's illnesses.

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