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Women's Perceptions of Reproductive Health in Three Communities around Beirut, Lebanon

Afamia Kaddour^a, Raghda Hafez^b, and Huda Zurayk^c

^a Researcher, Centre for Research on Population and Health (CRPH), Faculty of Health Sciences, American University of Beirut, Beirut, Lebanon. E-mail: ak11@aub.edu.lb

^b Anthropologist, CRPH, American University of Beirut, Lebanon

^c Professor and Dean, Faculty of Health Sciences, American University of Beirut, Lebanon

Abstract

The aim of this study was to elicit definitions of the concept of reproductive health among women in three communities around Beirut, Lebanon, as part of the reproductive health component of a larger Urban Health Study. The communities were characterised by poverty, rural-urban mobility and heterogeneous refugee and migrant populations. A random sample of 1,869 women of reproductive age completed a questionnaire, of whom a sub-sample of 201 women were randomly selected. The women's understanding of good reproductive health included three major themes, which were expressed differently in the three communities. Their understanding included good physical and mental health, and underscored the need for activities promoting health. Their ability to reproduce and raise children, practise family planning and birth spacing, and go through pregnancy and motherhood safely were central to their reproductive duties and their social status. Finally, they saw reproductive health within the context of economic status, good marital relations and strength to cope with their lives. These findings point to the need to situate interventions in the life course of women, their health and that of their husbands and families; the importance of reproduction not only from a health services point of view, but also as regards women's roles and responsibilities within marriage and their families; and taking account of the harsh socio-economic conditions in their communities. *A 2005 Reproductive Health Matters*. All rights reserved.

Keywords

reproductive health; socio-economic status; migrants; refugees; women's status

THE past decade has witnessed the emergence of an increased interest in women's reproductive health and development-related programmes to improve reproductive health across the globe. This phenomenon was primarily catalysed by the 1994 International Conference on Population and Development (ICPD), in Cairo. This conference solidified a new, comprehensive understanding of reproductive health, largely owing to the efforts of participating policymakers, researchers, health service providers, scholars, feminists and health advocates from developed and developing countries.^{1,2}

Although substantial discourse on reproductive health and attempts at defining the term preceded ICPD, the new approach represented a radical departure from population rhetoric. Indeed, it has been widely suggested that ICPD produced a paradigm shift, a transformation from a macro-level focus to a micro-level concern, with individuals' rights in relation to sexuality and reproduction gaining ascendancy over the demographic arguments for

population policy.^{3,4} The new concept addressed sensitive areas long ignored, especially in highly patriarchal societies, such as sexual behaviour and reproductive choice,⁵ and focused on how unequal power relations between men and women profoundly influence sexual behaviour and reproductive choices. Among other major accomplishments of the new concept of reproductive health was the inclusion of the needs of a wider age range of women, emphasising a life-cycle approach rather than the childbearing years only,^{6,7} and the incorporation of previously neglected groups, notably men and adolescents.

Numerous scholars and health advocates, particularly in the developing world, have argued that the globally-used concept of reproductive health is not always applicable across cultures.^{6,8} Makhoul-Obermeyer considers that the concept of reproductive health is culturally constructed, that is, a product of specific historical, ethical and legal transformations. Thus, developing and implementing programmes entails “not merely the application of principles and the selection of measures, but a process of translation across cultures”.⁸ For instance, the definition of reproductive health as “the ability of women to live through the reproductive years and beyond with reproductive choice, dignity, and successful childbearing, and to be free of gynaecological disease and risk” advanced by the Reproductive Health Working Group (RHWG), an independent regional network comprising researchers mainly from Egypt, Lebanon, Palestine, Syria and Turkey, emphasises dignity as a component of reproductive health. This is a concept which is absent from the ICPD definition, yet it is construed as central to women in the Arab region as part of their perception of reproductive health.⁹ By implication, the adaptation of a “universal” action plan for reproductive health could only achieve its goals if definitions and concepts - and consequently a specific country's plans - take into consideration women's own definitions of reproductive health and needs in specific settings.

The success of reproductive health programmes is thought to rely largely on involving women in the process of prioritising health issues in order for services to be relevant to their lives and culturally acceptable.¹⁰ This, in turn, can be empowering for women, paving the way for them to mobilise to attain their reproductive rights.¹¹ Moreover, following the 1994 ICPD, several studies have investigated women's perceptions of reproductive health issues which emanate from the ICPD definition.^{6,12-15}

Our research asked women living in three impoverished communities located on the outskirts of Beirut, Lebanon, for their own definitions of the concept of reproductive health. This study was a preliminary attempt at exploring poor women's understanding of reproductive health, based on the assumption that women attach meaning to the concept within specific socioeconomic and cultural contexts. Our aim was to contribute to the incorporation of women's views into useful definitions of reproductive health in order to make community-level strategies used to improve reproductive health more relevant to women in those communities.

The present research is part of a larger Urban Health Study undertaken in 2002 by the Centre for Research on Population and Health (CRPH), Faculty of Health Sciences, American University of Beirut. The study surveyed three population groups within the household: adolescents (boys and girls), ever-married women, and older people (men and women). Specifically, it explored the social, economic and environmental conditions influencing various dimensions of health for these three groups, with a focus on poverty, social capital, the gendered division of labour, work of women, displacement and migration.

The three communities

Three communities - Hay Sellom, the Bourj El Barajneh camp and Nabaa - located close to each other on the outskirts of Beirut, the capital of Lebanon, were selected based on the

following criteria: densely populated, impoverished, characterised by rural-urban mobility, including war-displaced populations, lacking basic infrastructure, and having a heterogeneous population.

Hay Sellom* is the largest Lebanese informal settlement, located on the fringes of the southern suburbs of Beirut. It is a very poor area, densely populated by mostly Shiite migrants, mainly displaced from southern Lebanon and the Bekaa district of eastern Lebanon due to war and poor economic conditions.¹⁶ Access to basic civic and governmental services is very limited in this community, which suffers from poor infrastructure, congestion of buildings, very poor housing conditions and environmental problems created by the dumping of garbage and industrial waste in the al-Ghadir River from neighbouring factories. Private health services are available in the area, in addition to the public health services, including reproductive health services, mainly maternal and child health and family planning, offered by a limited number of local, family-oriented NGOs and the community development centre of the Ministry of Social Affairs. However, the Hezbollah Health Committee remains the main provider of various types of health services.

The Bourj El Barajneh refugee camp, located to the south of central Beirut, is one of the largest Palestinian refugee camps, established in 1949 to house Palestinian refugees mainly from the Galilee in what is now northern Israel. The socioeconomic conditions in the camp are generally poor, with a high population density, inadequate basic infrastructure and cramped living conditions. Considered as foreigners, the camp dwellers are legally prohibited from working in more than 60 professions and trades. They also have very limited or no access to the government's public health and social services or educational facilities. They rely to a large extent on the United Nations Relief and Work Agency (UNRWA) for these services, which have been subject to budgetary cuts.¹⁶ UNRWA's community-based health centres provide women with educational workshops and awareness-raising sessions on reproductive health and its components, which are not available to women in the other communities. UNRWA centres also provide reproductive health services, mainly family planning and maternal and child health.

Nabaa is part of the eastern outskirts of the capital, which grew as a result of migration from south Lebanon and the Bekaa area. Home to a highly mobile migrant population, it is characterised by poor infrastructure, overcrowding and sub-standard living conditions. As part of the urbanisation process, displacement into Nabaa started before the civil war, as rural Shiite and Christian migrants sought employment in and around the city. In the post-war period, the community has witnessed an influx of foreign labourers (Asian, Syrian and Egyptian) as the Lebanese labour market is absorbing low-paid labour. Many local NGOs provide social and health services, including maternal and child health and family planning, in the area. The Ministry of Social Affairs has a community-based development centre in Nabaa, which provides health and social services. However, due to limited funds and the diversity of health problems in the community, these services cannot cover all needs.¹⁶

Data and methods

The Urban Health Study

The Urban Health Study was conducted in two phases and included four large structured questionnaires in colloquial Arabic. Three thousand households were sampled using a two-stage cluster random sampling, out of which 2,781 (92.7% response rate) completed the household questionnaire in Phase I (May to July 2002). The household questionnaire

*Since this community is relatively large (100,000 inhabitants¹⁶) only the most vulnerable neighbourhood, located by the river, was included.

solicited information about every member in the household, covering demographics, education, income, migration, labour and division of household work, largely obtained from the wife of the household head. In Phase II (October 2002 to January 2003), individuals were interviewed in all the sampled households. The reproductive health questionnaire was administered to all ever-married women aged 15-59. The adolescent health questionnaire was administered to all unmarried boys and girls aged 13-19. The older people's health questionnaire was administered to all men and women aged 60 and above. Both the latter two questionnaires included questions for the girls and women on reproductive health.

The reproductive health component included about 300 open and closed-ended questions, covering general perceptions of health, current health and reproductive health problems, pregnancy history, childbirth, infertility, family formation, contraceptive use, menopause and use of reproductive health services. The open-ended questions aimed to gain insight into women's perceptions, beliefs and practices regarding their own health, reproductive health and related issues.

The data were collected in face-to-face interviews by female fieldworkers, recruited mainly from the three communities, to gain acceptance in the communities and households, to benefit in the design phase from their local knowledge, and to provide skills and employment for people from the communities. All fieldworkers had finished at least high school and had some experience in field surveys. They underwent training prior to both study phases, to develop their interviewing skills, hold in-depth discussions on the study aims and instruments and carry out pilot testing in the communities. Pilot testing of the reproductive health questionnaire aimed also to ensure the use of proper language comprehensible to women. Informed consent was sought from all respondents. Of the 2,400 eligible women, a total of 1,869 completed the questionnaire (77.8%). Non-response was mainly due to people moving outside the communities.

The question on women's understanding of reproductive health

This paper is based on one open-ended question, soliciting women's understanding of reproductive health. The format of the question was pilot tested with 40 women living in communities similar to the ones under study, using different versions of the question to ensure that women's answers were about the concept itself. The question in its final format was: "What does it mean to you that a woman has good reproductive health?"

It is important to underscore that the term "reproductive health" is not part of the daily language of women in our region. They use instead the term "women's health" - *الصحة النسائية*. However, our question used "reproductive health" - *الصحة الإنجابية* - which is commonly used by experts in the Arab world, specifically to understand what this concept means to women.

A sub-sample of 201 of the 1,869 women who completed the reproductive health questionnaire, stratified by community, were randomly selected to explore the data. Their mean age was 37 (range 19-59), and the vast majority (92.5%) were currently married. Forty-four per cent had had 12 or more years of schooling, 39% up to elementary education, and 17% no schooling at all. They were mostly housewives; only 10% were working outside the home. The three communities were similar for all these variables, except that women from Nabaa had a higher mean age. The sub-sample was very similar to the total sample of women who completed the reproductive health questionnaire as regards sociodemographic variables.

Probing by the interviewers was limited, in line with our exploratory purpose and setting the ground for further in-depth qualitative research. Our sample was small for convenience and

feasibility reasons, but even though the answers cannot be generalised they do give a good sense of the women's understandings in these communities.

The data were analysed in Arabic using thematic analysis. Women's responses consisted mostly of several short statements, limiting the possibility of investigating underlying meanings. Final themes were analysed and translated into English.

Results

Nine themes (listed in Table 1) emerged in answer to the question: “What does it mean to you that a woman has good reproductive health?”, grouped into three categories covering health, reproduction and social context. Twenty-four women (12% of the 201 women) said they did not know what “reproductive health” meant.* These women come mostly from Nabaa, are older and had less education than the rest of the sample.

Good health

Most women considered health as their point of departure in explaining their understanding of good reproductive health, including good health more broadly, good mental and psychological health and activities that promote health.

The need for good health generally was expressed by 97 women (48%) and was a significant response in all three communities. Twenty-two women explained their understanding of the notion of “good health”. Among the women in Hay Sellom and the Bourj El Barajneh camp, good health was described as the “lifetime absence of disease - physical, psychological and mental”. In Hey Sellom, it was further described as the absence of pain, complaints and harmful exposures, as well as having the strength to work.† In Nabaa, the dominant explanation was related to being thin and having a healthy body.

Good health was linked by 24 women to a specific understanding of women's role in society. Reproduction was why good health was of the utmost necessity. It was the means of fulfilling their primary role within the domestic sphere as wives and mothers.

Women considered the health of their families as another important aspect of good health, even though the question specifically asked them about themselves. This implies that women's perceptions went beyond their own individual health to include that of their families, which constitutes a connective view of the self.¹⁷

Four women (one from Hey Sellom and three from Nabaa) considered good health to be a gift from God.

Good mental and psychological health

Thirty-two women, mostly from Hey Sellom, focused on psychological health in their explanation of good reproductive health, by which they meant “psychologically comfortable”, “having no worries”, and “leading a comfortable life”. Women from the Bourj El Barajneh camp emphasised the absence of worries and familial problems, while women from Nabaa identified a woman with good reproductive health as being “a woman who is relaxed and has no problems.”

*Fieldworkers were instructed to avoid providing explanations of reproductive health to women, so as not to defeat the purpose of the question, which aimed at soliciting women's understanding. If the woman insisted that she had never heard the concept and did not know what it meant, the fieldworker moved on to the next question.

†Women are mostly referring to household work here since most are not employed outside the home.

Activities that promote health

Activity that promotes health was another theme that emerged, mostly from women from Nabaa. This is about women's responsibility and the fact that health is not merely granted but must be attained through their own efforts. These women focused mostly on physical health, and the need for preventive measures, such as going regularly to physicians and following their recommendations, having a yearly Pap smear, avoiding communicable diseases and cold weather, having a good diet, eating nutritious food and exercising. They should be energetic, rest and not exhaust themselves. They should not be overweight, smoke or drink. The importance of health promotion was again related to the fulfillment of household duties and ensuring the overall well-being of the family.

Seven women from the three communities mentioned the importance of psychological health, described as better management of their lives, not dwelling on problems, coping and not getting angry, having internal strength and being patient and avoiding stressful events.

Reproduction

Reproduction was the second most frequent point of departure to explain the concept of reproductive health. It was used mostly by women from the Bourj El Barajneh camp and their definitions of it come closest to the ICPD definition. It consisted mainly of the ability to bear and raise children, planning and spacing births and safe pregnancy and motherhood. A prevalent perception among women in most Arab societies is that childless women face a difficult old age, as children function in lieu of social security. Many childless women are threatened by divorce and consequent destitution, especially in the context of poverty.¹⁸ Hence, a woman capable of having many healthy children was considered "healthier" than other women, and this capacity grants her power and authority within her surroundings.

Ability to bear and raise children

Motherhood or procreation represented an important aspect of the expressed meaning of reproductive health for women in these three communities, especially in Hey Sellom. The women considered motherhood as the fulfillment of the fundamental role of women to bear children, and more specifically healthy children. Having the capacity to bear children is considered both essential and desirable, because children are the basis for happiness in marital life. The ability to get pregnant without medical intervention was crucial for two women in Hey Sellom; delayed pregnancy means being disgraced in the eyes of the community.

Reproduction was seen as a duty women need to fulfill in order to secure good reproductive health. Choice, in terms of bearing children and women's role, was not articulated as important. This is not to suggest that choices and rights are not relevant to the women, but choices were made in relation to the consequences for their future, especially old age security, and their status within their communities. As such, their choices were dictated by the duty of women to have a lot of children.

This finding is in line with what has been reported in the literature. Winkvist and Akhtar¹⁹ report that having children is central to women's identities, and the only route to (authentic) womanhood. Harris and Smyth²⁰ found that women gain social status through their reproductive functions, so that their reproductive health has considerable repercussions on their overall existence.

Four women from the Bourj El Barajneh camp added women's ability to raise their children properly as complementary to their understanding of good reproductive health. This was deemed important because properly raised children become good citizens who are able to

better serve their society and the generations that follow. Another woman from the camp emphasised the significance of having her own dwelling, separate from her extended family, in order to enjoy autonomy in child-rearing.

Family planning

Family planning was another theme that emerged, mainly in statements by women from the Bourj El Barajneh camp. Women identified limiting the number of births, as well as spacing pregnancies, as important elements of good reproductive health.

The significance of family planning was related to the effect of many births on women's bodies and their current and future health status, which might become a burden on their children. Family planning was also seen as important because women have to take into consideration the current economic and political situation, both unfavourable for excessive births.

Safe pregnancy and motherhood

This theme also emerged largely in the Bourj El Barajneh camp. Women considered having healthy bodies, bodies free from disease (cardiovascular disease, diabetes, gynaecological or hereditary problems), as necessary in order to be able to pass safely through the years of childbearing. A woman also needs to be active to ensure her general and psychological health to avoid problems during pregnancy, such as avoiding stress and hard work. Some women stressed the importance of antenatal care and compliance with the physician's recommendations. Getting pregnant at an appropriate age, not later than 35, was identified as an important factor to ensure safe pregnancy and delivery. Breastfeeding and having social support in performing household work were identified as important for post-partum health.

The social context

Women situated reproductive health within the broader social, economic and familial context of their lives, and as inseparable from them. Overcoming economic problems, as well as having a good home and a socially favourable environment, were thus integral elements of the meaning of reproductive health for them. As Harris and Smyth note: "Reproductive health cannot be separated from the conditions of poverty and insecurity in which many men and women in developing countries live."²⁰

Good economic status

Rather than directly stating what reproductive health means for them, women, particularly in the Bourj El Barajneh camp, identified lack of economic hardship as a prerequisite for having good reproductive health. Economic problems prevented them from meeting their needs and wants, including getting medical care during childbirth, and carrying out their responsibilities as mothers in taking care of the needs of their children (clothing, food, nappies, medical care and education).

Good marital relations

Good marital relations resonated more for women in Hay Sellom than other communities as a requirement for good reproductive health.

By "good marital relations" women implied mutual understanding, comfort, happiness, optimism about life, good sexual relations and overall satisfaction with marital life. Women

reported that good marital relations mean that the husband treats his wife well, ensuring her comfort and happiness.

Strong character and personality of women

Five women from Hey Sellom and two women from Bourj El Barajneh camp associated reproductive health with a woman's ability to enjoy her womanhood. They related reproductive health to women making decisions, possessing a strong personality in order to live, manage their personal and family life and cope with difficulties. Thus, a woman with good reproductive health thinks and acts properly and is useful to society as well.

Discussion and recommendations

Information like this is a prerequisite for implementing successful intervention projects. Without a thorough understanding of women's perceptions of reproductive health in specific contexts, we run the risk of incorrectly homogenising and universalising women and their needs, which would weaken the effectiveness of reproductive health programmes.

The women's understanding of reproductive health in this study points to the need to situate interventions to improve reproductive health in the life course of women and their health more broadly, in the importance of reproduction not only from a health point of view as regards essential services such as maternity services and family planning, but also as regards their own health and roles and responsibilities within their marriages and families, and in the harsh socioeconomic conditions in which they and their families and communities are living.

Raising the awareness of women about the definition of reproductive health within the framework of ICPD may introduce the concept of choice to the women's understanding of their own reproductive health and contribute to their acceptance and utilisation of available reproductive health services.

For researchers, this translates into the need for more qualitative research that examines the contextual details of what women consider as “reproductive health”, whether their perceptions change over time, in which direction and as a result of which influences, as well as how their perceptions relate to their reproductive health practices.

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Apartment building damaged during civil war, Beirut, 1998.

Table 1.

Ever-married women's definitions of the concept of reproductive health (n=201)

Definition	Hey Sellom	Bourj El Barajneh camp	Nabaa	Total	% of total statements (n=384)	% of total sample (n=201)
Health						
Good health	39	29	29	97	25.3	48.3
Good mental and psychological health	20	4	8	32	8.3	15.9
Activities that promote health	8	8	17	33	8.6	16.4
Sub-total	67	41	54	162	42.2	80.6
Reproduction						
Ability to bear and raise children	37	15	11	63	16.4	31.3
Family planning	1	37	5	43	11.2	21.4
Safe pregnancy and motherhood	1	26	0	27	7.0	13.4
Sub-total	39	78	16	133	34.6	66.2
Social context						
Good financial status	7	34	3	44	11.5	21.9
Good marital relations	10	2	2	14	3.6	7.0
Strong character and personality	5	2	0	7	1.8	3.5
Sub-total	22	38	5	65	16.9	32.3
Don't know	6	2	16	24	6.3	11.9