DOWNLOAD PDF WOMEN, REPRODUCTION, AND HEALTH IN RURAL EGYPT THE GIZA STUDY

Chapter 1 : Projects for Rural Areas

Get this from a library! Women, reproduction, and health in rural Egypt: the Giza study. [Hind A S Khattab; Nabil Younis; Huda Zurayk; Reproductive Health Working Group.] -- "The research body on which this volume is based has been internationally recognized as a pioneering example of interdisciplinary collaboration.

Egypt has recently completed its RH strategy in with a main objective of providing quality services to beneficiaries. Since the late s, there has been several attempts to provide good quality RH services at the primary health care level in Egypt. These earlier initiatives included, among other components, a training component to train physicians to raise their RH knowledge. The focus of this study is to assess the RH knowledge of physicians working under these two settings and compare them with a control group of RH physicians working in the regular MOHP PHC clinics outside these two interventions. This assessment is carried out to ultimately assist MOHP to support the RH component in its current efforts to improve RH services especially the training component. Although the need for assessing the knowledge is important, little is known in this field in the Egyptian literature of assessment of RH knowledge among physicians. This study attempts to fill this literature gap. Family planning was emphasized as an integrated component of RH services Farag et al. RH training did not exceed 3 days, some broad concepts and skills were introduced. The control group did not receive any specific RH training programs. First, a questionnaire was designed to test several aspects of RH knowledge. The questionnaire included twenty five multiple-choice questions and two problem solving questions. The questions were intended to test the following: This questionnaire was self administered where physicians of each governorate were gathered in geographical groups and answered the questions under the supervision of several fieldworkers and a public health specialist. The form took on average 45 minutes to complete. Second, a specially designed in-depth interview schedule was used to collect detailed information from the physicians. The interview schedule included closed-ended questions about background, medical education and training, and work experience. These two tools were developed using the knowledge, learning skills and core competencies adopted in both the integrated and the self-standing models of teaching sexual and reproductive health to physicians working at the primary health care. The literature about these models are available in Haslegrave and Olatunbosun and the World Health Organization In the control group, 56 physicians, drawn from all health districts where the other two groups came from, were randomly selected. Results The demographic characteristics of the three groups of physicians were very similar. The median age of physicians ranged between years. The majority in all groups were married and had between 1 to 3 children with median 2 children. The proportions of physicians in the three study groups who had graduate studies after medical school were 59 percent, 33 percent, and 55 percent for the HSR, the intervention, and the control groups respectively. Out of those who have acquired graduate degrees, 86 percent of the intervention group studied gynecology, 43 percent of the control group studied maternal and child healthcare MCH , while in the HSR group physicians received their graduate degrees in different medical fields, e. The results of the in-depth interviews showed that a larger percentage of physicians -one-third- in the ESPSRH intervention group mentioned health conditions specific to women in answer to a general question about health problems in the served communities, compared to one fifth in the other groups. These conditions included reproductive tract infections RTIs , post-partum problems, lack of knowledge of contraceptive methods, and repeated pregnancies. Prolapse of genital organs was also mentioned by the three groups with a slightly higher percentage for the intervention group. A greater proportion of the HSR group 31 percent mentioned anemia as a health condition frequently affecting women, and more of the HSR group also mentioned infertility. As for the control group, they had the largest proportions of those mentioning bleeding and frequent pregnancies 31 percent. Small proportions of all groups mentioned problems with contraceptive methods. Few of both the HSR and control groups mentioned tumors of the genital tract, and some of the control group mentioned delayed pregnancy and abortion. Three-quarters of the intervention physicians thought that women in rural

areas lacked health awareness compared to one-half of the HSR and control groups. When asked about other factors that may affect the health status of women and their health-seeking behavior, physicians in all study groups pointed out different socio-economic factors. The first factor mentioned by a great majority of physicians was poor economic status, followed by traditions and customs such as influence of mothers-in-law on younger women, early marriage, and having many children. All these factors were mentioned by larger proportions of physicians in the intervention group 74 percent than those in the other two groups. Physicians also emphasized the impact of environmental problems such as garbage and sewage disposal on health. Physicians responded unanimously positively regarding entitlement of clients to certain rights. The control physicians clearly stressed on the importance of provision of good medical service, i. ESPSRH Intervention and HSR groups reported the right of clients to courteous treatment and securing privacy and confidentiality as important as good medical services if not more important. At least 50 percent of both groups confirmed the rights of respect and privacy. Giving the client sufficient time for the encounter with the physician came third for both the HSR and intervention groups more than 15 percent. The right to have the diagnosis and treatment explained was also mentioned by some physicians in all groups, especially the HSR 14 percent and intervention 10 percent groups of physicians. The right to file a complaint was mentioned by some of the physicians in the control and ESPSRH intervention groups 8 and 5 percent respectively. Surprisingly, HSR physicians failed to mention this right. Table 1 shows the mean of incorrect answers for the five categories in the questionnaire. The lower the mean the higher is the percentage of correct answers. The means of incorrect answers were around 9 out of 27 questions. The likelihood of getting the answer wrong was almost one-third regardless of the group. No significant differences were observed among the three groups, with the exception of the FP group of questions. Some significance was only detected between the control and intervention groups. The FP knowledge was slightly better among the control group but the Intervention physicians were more able to answer gynecology and systematic questions better, as shown in Table 1. Again this format clearly confirmed the findings of Table 1. First, there is no significant differences among the three groups in 19 out of the 27 questions in the test. In the cases of significant differences, 4 questions showed that the ESPSRH intervention physicians had more chances of getting the answers correct. Two of these four questions belonged to the group of questions detecting systematic way of treating RH clients with specific complaints. Two out of the three questions that the control group of physicians showed higher percent of correct answers belonged to the family planning section. Percent of correct answers 4. Discussion and Concluding Remarks Despite the fact that the three groups received training courses but with varying degrees of content and frequency, their learning level was low. None of the training settings had a significant influence on the physicians learning levels of RH knowledge unlike the situations in other countries such as Turkey Ozek et al. Findings clearly indicated that the training of the HSR group of physicians was lagging in various components of RH. However, since HSR program in Egypt is an irreversible route and to guarantee technical RH quality of care, all theoretical training components of RH should be revised very carefully, especially those of the HSR program. It is expected that the amount of training time given to RH needs to be expanded. It is recommended that MOHP continuously conduct pre and post assessment of knowledge and analyze results to identify weak points in its training programs. Physicians need more frequent training as well as to attend weekly seminars to keep them up to date. HSR needs to be more aware of RH goals and becomes an effective advocate for these goals. RH training within HSR should reflect this approach. There were some indications that ESPSRH physicians were slightly more aware of the RH problems in their served areas, probably because of its context focus. It is recommended that HSR RH training programs be more area specific to emphasize local challenges in addition to general challenges facing Egypt. Findings also showed that the control group of physicians showed higher percent of correct answers within the family planning section. This is another area HSR needs to support as a horizontal program when it tackles all health challenges facing Egypt to have a demographic eye rather than diluting family planning efforts within its other instruments. Another aspect that is usually missed in the literature of reproductive health in Egypt is that the lack of RH knowledge among physicians

may have negative psychological effects on beneficiaries as shown in various studies such as British Medical Association BMA Science and Education Empirical evidence is emerging on the psychosocial, and physical costs of not meeting the needs of beneficiaries in general and RH beneficiaries in particular, and on the positive psychological effects of changing the way and the environment in which the care is provided. Positive results will be gained if the service is offered in a positive environment and vice versa. Providing the right service will definitely add to the well-being of the woman seeking RH services. At the same time, missing the need of this woman via lack of knowledge among physicians will certainly have adverse psychological effects as well as demographic implications. The author wishes to express his special thanks to the Ministry of Health and Population for their full cooperation, to FORD foundation for their generous support, and to Drs. Hind Khattab and Dina Galal for their valuable assistance to produce this article. References [1] Becker, D. Findings from a literature review", Perspect Sex Reprod Health, 39 4: What have we learned? The four levels 3rd ed ".

Chapter 2 : Giza - Howling Pixel

This book presents an interdisciplinary study conducted in which examined the reproductive health of women (n=) living in an economically deprived rural area in Egypt's Giza governorate.

United Nations, World Population Prospects: The Revision and the World Urbanization Prospects: These disparities seem to begin at the age of reproduction. In fact, one of the most significant health improvements in the MENA region has been in the area of infant mortality defined as death before the first birthday , whose rates have declined rapidly for both boys and girls throughout the region see table. Even in Yemen, the least developed country in the region, there has been minimal gender disparity in infant mortality rates over a year period. A landmark year study in rural Egypt published in known as the Giza study found that perceptions women held about their own health were the single most important factor governing their utilization of health services. One-half of the women participating in the study had a reproductive tract infection RTI , 56 percent had genital prolapse, and 63 percent were anemic. Yet the majority did not seek health care services for these conditions, and most of the women saw these conditions as normal. Developing community-based health promotion programs can be an effective way to increase the health awareness of women in communities and encourage earlier health-seeking behaviors. Addressing gender bias can be initiated by prioritizing health expenditures to secure the health care services that women need, such as supplies of contraceptive methods and a system for follow up on users satisfaction. Health sector reforms such as the reprioritization of national budgets through the National Health Accounts processâ€”a process that has been underway in MENA countries for over a decadeâ€”could provide one opportunity to include these voices and reallocate support to the services that women require. To a varying degree, access to family planning services has been expanded throughout the MENA region: But although fertility rates have generally declined, there remains a large unmet need for quality family planning services in the region. Above all, women must be encouraged to recognize and speak about their health care needs. As Huda Zurayk, dean of the faculty of health sciences of the American University of Beruit, puts it: Oona Campbell et al. The Revision and World Urbanization Prospects: The Revision, accessed online at http: American University Press, Nabil Younis et al. Maha Talaat et al. NHAs trace all the resources that flow through the health system over time and across countries and are designed to capture the full range of information contained in these resource flows and to reflect the main functions of health care financing: NHAs are a tool specifically designed to inform the health policy process, including policy design and implementation, policy dialogue, and the monitoring and evaluation of health care interventions. They provide the evidence to help policymakers, nongovernmental stakeholders, and managers to make better decisions in their efforts to improve health system performance. Population Reference Bureau, , accessed online at www.

Chapter 3 : 90% of Egyptian Women Suffer From Female Genital Cutting Despite Ban | Egyptian Streets

Utilizing innovative field methods that combine the best of clinical medicine, epidemiology, and anthropology, the study examines the reproductive health of women living in an economically deprived rural area in Egypt's Giza governorate.

However, these variables did not show a significant association with deliveries attended by skilled health professionals and deliveries at health facilities. Participation in household decision-making such as purchases and availability of assistance with household chores had no significant association with the three variables. Marriage to husbands with secondary or higher levels of education was significantly associated with the increase of regular ANC attendance, deliveries attended by skilled health professionals, and deliveries at health facilities, as was residence in extended families. This result was similar to or a little better than an earlier nationwide survey in However, as mentioned previously, even though such services are affordable and accessible, women do not always use them because of various social constraints. Our study seeks to identify the social factors that influence the use of maternal health services in rural Egypt. Our findings suggest that women who married before the age of 18 and who received insufficient formal education were less likely to use maternal health services than the women who married later. Thus, they were able to seek health services according to their own needs; in other words, their demands for such services increased. The reason for this association with ANC attendance is not clear. However, since childbirths were major family events, and the outcome could be easily recognized by anyone in the family, household decision-makers might opt for seeking proper delivery care, regardless of the status of women. However, in the case of attending ANC, pregnant women might need to make decisions by themselves or to convince household decision-makers to permit such attendance, even though they had no serious symptoms. This fact indicates that regular attendance at ANC required women to understand the importance of preventive care, enjoy a good status in the household, and be allowed to go out freely. Women with a good familial status could easily obtain information outside the household and participate freely in community activities. Participating in them allowed women to attain greater self-esteem and self-confidence through social achievement and the enhancement of their decision-making abilities. Consequently, such women were likely to understand the importance of preventive maternal health care. In addition, the availability of assistance with household chores was not significantly associated with a reliance on maternal health services. Our results suggest that members of extended families were likely to encourage women to seek health care, rather than to share household work. Therefore, two factors, the educational levels of husbands and extended family households pointed to the existence of moral and not just physical or economic support for women. Childbirth would be an important family event; thus, all family members might be willing to give moral support to pregnant women seeking medical supervision. The attitude of family members might be different in case the women suffered from other illnesses. Further studies are required in this regard. We expected that the use of maternal health services would increase, if women could make various household decisions or had cash income that they could freely spend. Previous studies show that women with authority and economic autonomy in the family could decide and act according to their own needs, including medical ones. This result may be explained by similar reasons to those for family moral support. In addition, the fees of maternal health services in rural Egypt might be too low to be influenced by household income. As our findings indicate, currently younger generation made greater use of maternal health services, perhaps because they had fewer childbirth experiences than older women. The Egypt Demographic and Health Survey reveals that lower birth order is associated with more involvement with maternal health services. However, as our sample size is not big enough to stratify the results by age group, further studies are needed to exclude the influence of age. Our results suggested that improved status of women in the household, as well as moral support from family members, contribute to the greater reliance of women on maternal health services and particularly on regular ANC attendance. Road map towards the implementation of United Nations Millennium Declaration: Report of the Secretary-General. Research and the empowerment of women. Health

Care Women Int, ; 24 The role of institutions of power in Pakistan. East Mediterr Health J, ; 13 6: National maternal mortality ratio in Egypt halved between â€”93 and B World Health Organ, ; 83 6: Maternal mortality rate at delivery. The trend of maternal mortality in Egypt from â€” An emphasis on regional differences. Matern Child Healt J, ; 9 1: The Arab Human Development Report Toward the Rise of Women in the Arab World. East Mediterr Health J, ; 14 Suppl: Women, reproduction, and health in rural Egypt: Egypt demographic and health survey WHO antenatal care randomized trial: Manual for the implementation of the new model. Stud Fam Plann, ; 25 2: In The Measuring empowerment: Cross-disciplinary perspectives, edited by Narayan D. Int Fam Plan Perspec, ; 32 1: Asia Pac Popul J, ; 16 1: A harmful traditional practice. State of World Population The promise of equality, gender equity, reproductive health and the Millennium Development Goals. Socio-cultural factors influencing adolescent pregnancy in rural Nepal. Int J Adolesc Med Health, ; 14 2: Demography, ; 38 1: Individual- and community-level effects. Demography, ; 40 2: Exploring the links in Nepal. Gender, Technology and Development, ; 10 2: Antenatal care, attitudes, and practices. J Trop Pediatr, ; 41 Suppl 1: Empowerment of women for health promotion: Soc Sci Med, ; 49 Int J Qual Health C, ; 19 4: Education and the use of maternal health care in Thailand. Soc Sci Med, ; 43 4: Utilization of maternal health care services in Southern India. Soc Sci Med, ; 55 The role of mothers-in-law in antenatal care decision-making in Nepal: BMC Pregnancy Childbirth, ; Does type of household affect maternal health? J Biosoc Sci, ; 41 3:

Chapter 4 : Giza - Wikipedia

A review of 'Women, Reproduction and Health in Rural Egypt', the culmination of ten years of research on reproductive health by a multidisciplinary group of researchers.

Chapter 5 : IMPROVEMENTS IN THE STATUS OF WOMEN AND INCREASED USE OF MATERNAL HE

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The study examines the reproductive health of women living in an economically deprived area in Egypt's Giza governorate by utilizing innovative field methods that combine the best clinical medicine, epidemiology, and anthropology.

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Title: Women, Reproduction, and Health in Rural Egypt: The Giza Study: Authors: Khattab, Hind A.S. Zurayk, Juda Younis, Nabil: Year: Notes: Cairo: American.

Chapter 8 : AfricaBib | Women, Reproduction, and Health in Rural Egypt: The Giza Study

Our study seeks to identify the social factors that influence the use of maternal health services in rural Egypt. Our findings suggest that women who married before the age of 18 and who received insufficient formal education were less likely to use maternal health services than the women who married later.

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When the Giza Reproductive Morbidity Study indicated a high burden of sexually transmitted diseases among women surveyed, a sexuality study was undertaken among a stratified sample of 41 of the respondents of the broader study to gain insight into the knowledge, perception, and practices of rural women in preparation for creation of a health education intervention package.