CATALYST Consortium/ TAHSEEN Project

تحسين

تحسين صحتنا بتنظيم أسرتنا

Reproductive Health Services for Young, Engaged and Newly Married Couples

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Acronyms

BCC	Behavioral change communication
FGD	Focus group discussion
FP	Family planning
IEC	Information, education and communication
IUD	Intrauterine device
KAP	Knowledge, attitudes and practice
MCH	Maternal and Child Health
MOE	Ministry of Education
MOHP	Ministry of Health and Population
RH	Reproductive health
Rh	Rhesus (i.e., Rhesus factor)
SDP	Service delivery point
SIS	State Information Services
STDs	Sexually transmitted diseases
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

An important goal of the TAHSEEN/CATALYST Project is to increase access to and use of family planning and reproductive health (FP/RH) services. A main strategy of this USAID-funded project focuses on youth as clients in need of these services. To this end, the present study provides information to support the provision of quality RH services and appropriate behavioral change communication (BCC) messages that would improve the health and well-being of young, engaged and newly married couples.

The main objectives of this study are to:

1. Assess BCC coverage and availability of reproductive health services for youth, engaged and newly married couples;
2. Investigate the attitudes of health providers, couples and those who influence them toward providing reproductive health services to youth; and
3. Explore the knowledge, attitudes and practices of young, engaged and newly married couples.

Research Methodology

The analysis is a cross-sectional, descriptive study utilizing both qualitative and quantitative data. Conducted in Minia and Sharkiya, it reports findings from both urban and rural locations in these governorates.

An initial literature review integrates the findings from a number of surveys that included married and unmarried adolescents, older youth and comparisons with married non-adolescent women.

The study brings together data collected from CSI clinics, MCH centers, urban health centers, rural health units and hospitals, and NGO clinics, including those run by Christian and Muslim NGOs. In addition, the study interviewed all staff in the sample clinics as well as private sector physicians and pharmacists using a structured survey. Focus group discussions with secondary students, engaged youth, newly married couples and mothers and mothers-in-laws provide important data concerning the knowledge, attitudes and practices of these groups.

In-depth interviews held with community leaders who influence youth, including male and female secondary school teachers, *sheikhs*, *maazouns*, Christian religious leaders, *omda*s and local Popular Council members, document the attitudes of community leaders toward providing reproductive health services to youth. Interviews with local officials involved in information, education and communication activities, including Ministry of Health and Population officials, Youth Center officials, Cultural Palace officials, State Information Services officials and NGO officials provide data for analysis of the materials and activities available for youth to increase their understanding of FP/RH issues.

Findings

Youth, whether adolescent, engaged or newly married, have a relatively adequate knowledge of their reproductive health (RH) but there remain a number of issues that they need to know better. Not all youth have a clear understanding of what the concept of reproductive health entails, the physiology of reproduction of males and females and other topics related to marital reproductive and sexual health. Hence, they could have heard of issues but they are not necessarily well informed. Even if informed, some may not be convinced. Additionally, in certain cases when some are convinced, they may not take the necessary action either out of embarrassment, fear of results, or lack of knowledge of where help or service can be obtained.

The desire, the necessity, and the usefulness of increased knowledge are general attitudes among the youth, family and community leaders who influence decisions and health providers. Knowing more is considered a first step toward self protection and a vehicle to ensure marital health and satisfaction. However, determining what type of knowledge should be acquired at which age cycle is controversial due to a general concern over societal acceptance of opening such topics to youth before they are engaged, and concern over the potential negative effects of discussing such matters with adolescents and opening up ideas in their minds.

Those individuals from whom youth seek accurate information also require increased knowledge of reproductive health and family planning issues. Identified sources are parents, teachers, religious and community leaders and health care providers. Teachers acknowledge that they need more training. Health care providers need greater awareness of the risks associated with early pregnancies and knowledge about family planning methods that are suitable for young couples.

Access of youth to RH services is almost nonexistent with the exception of FP and antenatal care services to young married women. FP services may be limited for those who consider postponing their first pregnancy even due to attitudes of health providers and others who influence their decisions, due to fear of the effects of contraceptives on fecundity. A number of factors limit access of youth to RH services. These factors include embarrassment of youth in declaring such ailments, fear of parents for the reputation of their children, as well as limited availability of such services to youth in RH clinics, especially in rural areas and for males.

As for information, education and communication resources, agencies and institutions such as NGOs, MOHP IEC services, youth centers, cultural palaces as well as religious institutions and schools are all available resources that have not yet been adequately tapped in addressing the needs of adolescents, engaged and newly married youth. A few IEC materials are available in the form of a book (*I've Grown*) and pamphlets on adolescence, STDs and early marriage and pregnancy. They are all informational and not really targeting behavioral change and have limited circulation. There is a great expressed need for more behavioral change communication materials that assist youth in knowing more about their reproductive system and how to protect it, the benefits of premarital examination and postponing early pregnancies and how to achieve these benefits, and on healthy marital relationships including sexual health. Such materials are

also needed for those who influence youth such as parents, teachers, IEC officials and religious leaders so that they may increase their knowledge and awareness and reduce the overall societal tendency to be embarrassed from discussing such topics.

Recommendations

1. To increase access of youth to needed information and reproductive health services, it is recommended that a number of activities be implemented at the national level to initiate the process and set the scene that will facilitate such accessibility.
2. It is recommended that a national communication strategy and plan be developed and implemented targeting the general public to increase general awareness and convince the public of the necessity and benefits of informing adolescents and youth of all topics related to their reproductive health. Such a campaign, if successful, will reduce the overall societal taboo and embarrassment of discussing such topics, and make parents more knowledgeable, willing and capable of discussing such issues with their children and seek counseling and health services when needed.
3. Officials of ministries of Health and Population, Education, Information, Social Affairs, Youth, Culture and Awqaf should be assisted in having roundtable meetings to discuss and agree on their roles in increasing access of youth to reproductive health information and services. Such agreement will assist in integrating planned activities within their respective ministries and in providing greater support to their field staff to address informational and service needs of adolescents and the young engaged and newly married.
4. MOHP should consider addressing the need of engaged and newly married youth for reproductive health premarital counseling as well as the need of male youth for reproductive health services, especially in rural areas where private physicians may not exist.
5. A comprehensive training curriculum and training manual need to be developed and used for training health clinics outreach workers and health providers, officials of youth centers, cultural palaces and NGOs, IEC officers of MOHP and State Information Services, religious leaders and relevant radio and television staff. Such training should include necessary scientific information on issues related to reproductive health and healthy marital relationships. This will increase access of adolescents and the young engaged to accurate information needed to secure their reproductive health.
6. Additionally, ministries have to be supported in developing IEC and BCC materials needed for their planned activities. Such materials could be in the form of booklets and pamphlets for distribution, books to be put on sale and videotapes to support seminars for youth and parents. Such materials should provide sound, culturally acceptable information and guidance that would support youth to enter adulthood with knowledge and information about sexual and reproductive health to become, healthy, satisfied and responsible parents.

Introduction and Methodology

Introduction

The TAHSEEN/CATALYST Project seeks to increase access to and use of family planning and reproductive health (FP/RH) services. Two of the four interlocking themes of this USAID-funded project are focused attention to priority groups and improved quality for the customer. The current study provides information to support the provision of quality reproductive health (RH) services and appropriate behavioral change communication (BCC) messages that would improve the health and well-being of young, engaged and newly married couples.

For the last twenty years, the World Health Organization (WHO) has recognized the importance of adolescents' reproductive health. In May of 1985, the World Health Assembly passed a resolution urging all member states to: 1) act immediately to promote the delays of childbearing until prospective parents reach maturity in adulthood; 2) provide adequate information and guidance for responsible parenthood to adolescents, and 3) ensure that health, education and social service providers provide sound and culturally acceptable information and guidance. Additionally, the 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt, and its Programme of Action, drew attention to the unmet needs of adolescents in the field of family planning and reproductive health. Young people under the age of twenty are the parents and the leaders of the future; investing in their well-being is important to make sure that young people enter adulthood with appropriate knowledge and accurate information about sexual and reproductive health to become responsible parents.

At 21 percent of the total population, the number of young people in Egypt between the ages of 15 and 24 is the largest it has ever been.[1] Such a relatively high percentage of young people has enormous social, educational, health and economic needs, including a wide range of FP/RH information and services.

Surveys and research in Egypt still find evidence of early marriages, before the age of 20, with their accompanying poor pregnancy and birth outcomes. Egyptian culture places significant pressure on newly married couples to quickly have their first child in order to confirm their fertility. The use of contraception before the first child is strongly discouraged by both parents and in-laws. The negative physical, social and psychological consequences of early marriage and childbearing for young couples, their children and society make it essential to understand the social norms and values that influence behavior of this demographic group.

Additionally, young, engaged and newly married couples have significant information needs. They often know very little or have incorrect information about fertility,

[1] El-Zanaty, Fatma and A. Way. *Demographic Health Survey*. National Population Council. Cario, Egypt: 2000.

contraception and sexually transmitted diseases.[2] Furthermore, as a result of the social taboos around the discussion of sex, these couples may have misconceptions about their bodies and about ways to achieve sexual satisfaction with their spouses.[3] This group of young people also receive very little guidance from their parents, school curricula or the media about gender roles and responsibilities, child rearing and similar issues to prepare them for their new life as husbands and wives e.g., understanding of gender roles and responsibilities, child rearing skills, etc.

Recently, a number of governmental organizations have taken on the challenge to fill the gaps in youths' knowledge about FP/RH issues through awareness raising and community mobilization activities; these activities, however, have seldom been documented. Counseling for young, engaged and newly married couples is now part of a service package that is provided by some public, NGO and private clinics, but there is evidence to suggest that this service is severely underutilized.

Study Objectives

The overall goals of the study are to assess BCC coverage and the availability of reproductive health services for youth, engaged and newly married couples and to investigate the attitudes of health providers, couples and familial and community leaders toward providing reproductive health services to youth. The results of this study serve as a foundation for the provision of better quality services and design of appropriate BCC messages to address this demographic group. Furthermore, understanding the reproductive health behavior of young couples will help to target program and policy interventions aimed at reducing the prevalence of early marriages and improving conditions of those who marry at an early age.

The specific objectives are to:

- Identify reproductive health services available for this target group at public, private and NGO service delivery points (SDPs), which include clinics, hospitals and pharmacies;
- Assess the knowledge, attitudes and practice (KAP) of health providers in different SDPs about the reproductive health needs of this target group;
- Assess the availability of BCC materials for this target group at the different SDPs;
- Identify the types and content of awareness raising/community mobilization activities undertaken to address the needs of this target group;
- Identify social and psychological behaviors that prevent this target group from seeking medical advice regarding FP/RH issues.

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[2] Ibrahim, Barbara, *et al*. *Transitions to Adulthood: A National Survey of Egyptian Adolescents*. Population Council. Cairo, Egypt: 1999.

[3] Abdel Tawab, Nahla, Laila Nawar, Hala Youssef, and Dale Huntington. *Integrating Issues of Sexuality into Egyptian Family Planning Counseling*. Population Council, Frontiers in the Productive Health Program. Cairo, Egypt: 2000.

Methodology[4]

This analysis is a cross-sectional, descriptive study utilizing both qualitative and quantitative data. It is based on data collected in Minia and Sharkiya Governorates in both urban and rural locations within two districts, including one embracing the capital city of each governorate. In Minia, the two districts selected are Minia and Beni Mazar, and the rural locations are Zahraa and Ibshak villages respectively. In Sharkiya, the two districts selected are Zagazig and Minia El Kamh and the two villages selected are Om El Zein and El Judida respectively.

An initial literature review integrated the findings from a number of surveys that included married and unmarried adolescents, older youth and comparisons with married non-adolescent women.

The study encompasses data collected with a number of research techniques. The research team used clinic data sheets to collect information from CSI clinics, MCH centers, urban health centers, rural health units and hospitals and NGO clinics, including those run by Christian and Muslim NGOs. All staff in each of the sample clinics, private sector physicians and pharmacists and their assistants were interviewed using a structured survey. Focus group discussions (FGDs) with male and female secondary students, male and female engaged youth, male and female newly married youth and mothers and mothers-in-law of engaged or newly married couples provided important data concerning the knowledge, attitudes and practices of these groups.

In-depth interviews held with community leaders who influence youth, including male and female secondary school teachers, *sheikhs*, *maazouns* and Christian religious leaders, *omda*s and local Popular Council members document the attitudes of community leaders toward providing reproductive health services to youth. In-depth interviews with local officials involved in information, education and communication (IEC) activities, including Ministry of Health and Population (MOHP) IEC officials, Youth Center officials, Cultural Palace officials, State Information Services IEC officials and NGO officials provided data for analysis of the materials and activities available for youth to increase their understanding of FP/RH issues.

Data collectors received training that included two days of practical experience and pre-testing the data collection tools. Data collection took place from July 26 to August 18, 2003. The quantitative data was processed using SPSS and EPI Info software, while the qualitative data was processed using EZ Text.

[4]See Appendix for for details on the total sample by type of data collection tools and details on interviewees.

Reproductive Health Knowledge, Attitudes and Practices of Young, Engaged and Newly Married Youth

Understanding Reproductive Health

According to young, engaged and newly married youth, reproductive health is a combination of interventions designed to safeguard the health of the father, mother and child. Different groups mentioned a variety of issues they considered qualified as reproductive health issues. General issues mentioned by all groups are family planning (consulting a physician to use appropriate contraceptives, limiting the number of children, appropriate spacing between pregnancies), premarital examinations, antenatal and postpartum health care, suitable age for marriage and pregnancy, avoidance of consanguineous marriages to avoid hereditary diseases in children, child care and immunizations.

To the list of aspects of reproductive health, engaged males add female circumcision, female education, unofficial (*orphy*) marriages, protection from reproductive track diseases and selection of an appropriate wife. Some engaged females add breastfeeding, avoidance of medicines during pregnancy and maintaining mothers' nutritional status by drinking milk and eating honey. Newly married males include building healthy marital relationships where the rights of each partner were seriously considered and maintaining a good psychological state for the mother while she is pregnant. Similarly, newly married females mention the need for maintaining pregnant mothers' mental health and child hygiene as important reproductive health issues.

The variety of issues mentioned by the different groups reveals a broad understanding of reproductive health.

Physiological Changes During Puberty

The study only asked secondary students if they had known about the physiological changes that occur at puberty prior to experiencing them. All female secondary students say that they knew about menstruation before experiencing it. They also knew about the growth in their bodies and development breasts, the appearance of hair in different parts of the body and changes in mental development and ambitions.

In rural Minia, female students cite that menstruation would occur every twenty-eight days and last for four to five days. Other students from urban Minia mention that menstruation starts with puberty and ends with menopause, that it could cause a gloomy mental state and that it occurs every twenty days and lasts from two to seven days as a manifestation of ovulation. They also report that hormonal changes cause the appearance of hair.

Students in rural Sharkiya view menstruation as sometimes being accompanied by stomach aches, headaches and acne and that menstrual blood is "*dirty*" blood. Students

in urban Sharkiya believe that such changes were normal signs of puberty and are the result of the release of estrogen. They report learning about puberty and menstruation from their mothers, female neighbors, relatives and science teachers, as well as from observing changes in older sisters. In urban Sharkiya, the introduction of a text book called *I've Grown*, which explains puberty change, contributes to the knowledge of students in the third preparatory year.

As for male students, some report that they did not know about puberty changes before experiencing them, but the majority was aware of such changes. Predictably, this group reacts to questions about changes during puberty with astonishment and shyness. Those who know about puberty are aware of hair growth on the body, particularly facial hair, voice changes, enlargement of the genitals and discharge of semen. A few students in urban Sharkiya mention wet dreams and increased sexual interest in females. They identify their sources of information as older boys and textbooks. Parents are not cited as a source of information regarding puberty. A few urban students from Minia and Sharkiya point to the Internet, television satellite channels, and sex videos and CD-ROMS as other sources of information.

All students, with the exception of a few male students, agree that boys and girls should learn about the changes that they will experience during puberty. Female students believe that girls should learn about menstruation in order to avoid confusion, shock and worry the first time they see menstrual blood. Learning this information from knowledgeable sources would preclude girls from spreading incorrect information amongst their peers. Male students also express concern that a lack of understanding about puberty would cause boys to be taken aback by the changes in their bodies and they would receive inaccurate information from the wrong sources.

The few male students who did not approve of boys being told about puberty-related changes before they occur think that the information may cause boys to be eager to "*try things*," daydream about such issues or "*waste their time*." They add that Egyptian culture does not yet allow boys to speak freely about such issues. One male secondary student from rural Minia expressed this view saying, "*My father would spank me if I speak with him on issues related to puberty. He would tell me that I am still young.*"

According to female students, appropriate sources for learning about such issues are mothers, older sisters and aunts. Urban Sharkiya students also suggest seminars as a way to spread information about reproductive health. Perhaps this suggestion arises because they had attended a seminar during which Always sanitary napkins were distributed. Physicians, teachers and textbooks are also considered valid sources of information. Opinions differ about the role of religious leaders in providing such information. Some students feel that it would be embarrassing, while others expressed "*no embarrassment in religion.*" It is thought that religious leaders could offer advice on how to wash and fast after menstruating, and the reading of the Quran during menstruation.

Although male students have varied opinions on the best sources of information about puberty-related changes, they state that reliable and scientific sources of information are necessary. Books, videos, teachers, fathers talking to sons and mothers talking to

daughters, seminars with physicians or religious leaders, television spots and serials, friends, Ask/Consult pharmacists and hospitals are listed by the students as appropriate sources of information. Some students, however, object to books as a valid source of information because they often present issues in a complicated manner; they object to teachers because they do not really explain such issues in a clear and concise manner (and when they do, students are likely to take things lightly and joke about them); they object to parents because they may be embarrassed or too shy to talk to their children about such issues; and they object to educational seminars because they may not be convincing. The consensus, however, is that the information should be presented in a simple, clear, accurate and convincing manner.

Physiology of Reproduction

School children in the third grade learn about the physiology of reproduction for males and females, although teachers may not explain the material. Rural students from Sharkiya note that similar information is taught in Al Azhar preparatory school. Although embarrassment and giggles are common during FGDs with male and female secondary school students, their knowledge of the physiology of reproduction is relatively high. In general, one or two students would talk and a few would add additional information with the rest agreeing without explaining what they actually knew before the discussion. Knowledge seems to be gender-specific; girls know more about female reproductive physiology than male physiology and vice versa.

Female students know of the uterus, vagina, ovaries and fallopian tubes. Students in urban Minia add that when they start menstruating, they are ready to reproduce. All are familiar with sperm, and urban and rural students in Minia also mention testicles. One student mentioned that the physiological process of the male is similar to that of the female. The rest agreed until one participant complained that she has not heard this before. Then they agreed that the genital organs of the male secrete the sperm that fertilize the ova and that sperm are formed in the testicles and go through a canal in the penis, the male genital organ.

Male students know of sperm, testicles and the penis. They are less clear, however, about the physiological process. Students in rural Minia, do not mention anything about the process. Among students in urban Minia and Sharkiya, when one student mentioned that semen fertilizes the ova to form the fetus, none of the other participants objected. Students in rural Sharkiya do not mention semen but rather refer to "*hormones coming out of the testicles are responsible for pregnancy*." As for the female reproductive physiology, male students know of the uterus, ova and vagina. Urban and rural students in Sharkiya are the only ones to mention ovaries; urban students in Sharkiya are the only ones to mention fallopian tubes, where one student adds, "*Ovaries alternate every twenty-eight days*."

The study also questioned secondary students about their knowledge of masturbation, causing much embarrassment. All male students say they know about masturbation. They cite friends, videos, the Internet, boy scouts, teachers and social workers as sources of information on masturbation. Some students refer to it as massaging the male genital organ to release semen, but others confuse it with wet dreams and a sign of

puberty. Only two advantages of masturbation are mentioned: the release of sexual desire and the protection from "*committing sins*," i.e., having illegitimate intercourse. On the other hand, all students consider masturbation an "*unhealthy practice*," believing that it affects one's capacity to procreate and lowers long-term sexual desire, affects eyesight, causes general weakness, back and joint pains and arthritis, affects one's appetite, causes swelling of testicles, and affects the morals of youth as a result of guilt feelings and abandonment of prayer.

Although masturbation is an unknown concept for most female students, a few students in urban Minia mention that it was a male practice to help them ejaculate. One student adds she has read in a religious book that females also masturbate. Two girls guess that masturbation is what happened on the wedding night, or that masturbation is a secret between a boy and a girl based on the fact that masturbation in Arabic is translated as "*the secret habit*." Since none of the students really know what masturbation is, they could not report any advantages or disadvantages. The general feeling is, however, that it had no benefits.

Secondary students, engaged and newly married couples were asked if they knew how a child's gender is determined. There is general awareness among all groups that men are responsible for the sex of the child, but few students are aware of the XY chromosome concept. Engaged and newly married males imagine, *"A woman is like the land and the man throws the seeds*." Females sound relieved that they are not responsible for determining the child's gender. Television, families and textbooks were identified as the students' sources of information on sex determination. A few newly married men, however, that did not know how the sex of a child is determined. Additionally, a few engaged and newly married men offer the perspective that if the man reaches orgasm first then the child will be a boy, but if the woman reaches orgasm first then the child will be a female. A few male students also believe that both parents are responsible for the sex of their child, based on the fact that the fetus carries genetic properties of both parents.

Adolescent Reproductive Health Problems

All participants knew that adolescents, both male and female, could suffer from reproductive health problems in the reproductive tract.

Female Reproductive Health Problems

When asked to identify examples of such problems, female secondary students note delayed puberty, amenorrhea for two to three months, excessive menstrual bleeding, lengthy menstrual period (eight to nine days), excessive pains and vomiting accompanying menstruation. Rural Minia students do not know that young women could suffer ailments with the reproductive tract with the exception of ailments related to genital anomalies at birth, such as a weak uterus, ovaries and vagina that could be diagnosed in premarital examinations. They do, however, know of menstrual problems. Female students from urban Sharkiya add problems such as "*enlarged ovaries*," vaginal discharge and itching.

A few engaged females add delay in pregnancy after marriage due to having milk in the breasts, inflammations and skin disease. One engaged female from rural Minia stated that a nurse told her, *"Girls should not worry about menstrual problems as menstruation becomes more regular after marriage."*

Among engaged males, a few from rural Minia could not comprehend how girls could know about ailments in their reproductive tract when they are still unmarried; they understood that problems would arise after marriage, not before. All other engaged males know that young women could experience menstrual problems and some identify other problems like painful urination, excessive sexual desire, and problems from *"excessive circumcision*."

While newly married females are cognizant of girls suffering from menstrual problems, delayed puberty and excessive vaginal discharges, a few newly married males from rural Minia and Sharkiya shyly declare that they know nothing about women's health. In addition to stated menstrual problems, a few talk about "*incorrectly*" done circumcision, thickness of the hymen causing menstrual pains, girls suffering from syphilis and secretion of milk from the breast.

Male Reproductive Health Problems

Male students are less knowledgeable of ailments that could they could experience in their reproductive tract; yet, they gave remarkable examples of ailments that were caused by mishaps mainly. Urban Minia students mention blood in urine from bilharzias (schistosomiasis), urine retention, and painful urination and gonorrhea caused by excessive masturbation. Students from rural Minia mentioned only urine tract problems and sterility caused by injuries in their genitals. Urban Sharkiya male students report problems they individually experienced or knew from others like atrophy of the male organ caused by excessive masturbation, enlargement of the testicles from carrying heavy weights and, in one case, problems resulting from an operation on the testicles of a seven year old boy. All male students agree that injuries to the testicles caused by hitting each other could create serious problems. Students from rural Sharkiya gave a multitude of examples: a football player becoming sterile after being hit in his genitals; a boy losing one of his testicles as he was "*having sex with a dog and the dog bit him*;" a boy who was hit in his genitals while having sex with another boy; and someone being born with mixed male and female reproductive organs.

Engaged females are not familiar with genital ailments that could be faced by male adolescents, but they mention inflammations, prostate and testicle problems, congenital anomalies, weakness of sperm, and dysuria.

Engaged males, on the other hand, mention a larger list of potential ailments that slightly differed by location. Problems mentioned in rural Minia are related to premature ejaculation and penis erection problems caused by relaxation of muscles. One participant responded to latter with the opinion that is a psychological condition that should be dealt with after marriage, but another engaged male insisted that the problem should be checked and treated before marriage. Urban Minia engaged males also mention premature ejaculation but note other problems such as varicosity of the

testicles, wet dreaming and small or large size of the penis. In addition to premature ejaculation and wet dreaming, engaged males from rural Sharkiya add frigidity and hereditary disease. Urban Sharkiya engaged males stress the effects of masturbation.

Some newly married females are unfamiliar with male genital problems. Those with some knowledge mention problems related to the urinary tract such as bilharzias (schistosomiasis), painful urination, changes in color of urine and urinary stones. Problems actually related to genital problems mentioned are "*weak genital organ*," weak sperm, weak erection, premature ejaculation, inflammations and delayed puberty.

Newly married males itemize the ill effects of masturbation as premature ejaculation, erectile dysfunction and "*killing*" of sperm. They note other genital problems such as congenital anomalies of the penis, syphilis, varicose veins, testicle problems, absence of sexual desire and continuous semen flow with any stimulation.

Access to Treatment

Secondary school female students are aware that female ailments should be checked and treated by a physician at a hospital or health unit. Ask-Consult pharmacists, mothers or older women are also mentioned as sources of preliminary consultation. Obstacles to seeking treatment include shyness, embarrassment, fear of discovering serious problems, limited financial resources and fear of public tarnishing a female's image. Peer pressure is another obstacle, as one student in rural Sharkiya said, *"Her friends would say all girls are healthy and she is the one that has problems."* The supportive role of parents, especially mothers, depends on their education and cultural norms and beliefs. Literate parents may encourage medical treatment out of concern for their daughter's health. Illiterate parents, on the other hand, may take the ailment lightly as a normal problem or refuse to seek medical care out of tradition. A student in rural Minia said, *"They would beat me immediately and that would force me do things without telling them."* Most female students prefer consulting a female physician and, ideally, a female specialist working in a private clinic. They go to the doctor with their mothers, older sisters or aunts to avoid people knowing who has a problem and the older women help them understand their medical conditions and the physician's advice for treatment.

Engaged females confirm the views of the students that some parents may not approve of a medical checkup and girls may be too shy to confess problems to their parents because some parents believe that girls should never go to a gynecologist before marriage. Engaged females from rural Sharkiya felt that ailments are usually discussed privately between a girl and her mother. Newly married females share these views, and stress that families would insist on external examinations only. They believe that families proscribe consultations with gynecologists for fear that the examination might tear the hymen or the visit would blemish the girl's reputation.

When asked to identify factors that affect girls' access to medical checkups, engaged and newly married males also note the level of education of the mother and the family's socio-cultural background because rural families tend to be more traditional than urban families. They stress the importance of the relationship between the girl and her mother.

Privacy has to be ensured and they view female physicians working in private clinics as the best person to consult, if the family could afford the fees.

Female students note that they would be deterred from seeking treatment by negligence, uncleanness of the clinic, absence of appropriate equipment for accurate diagnosis and insensitive physicians. They appreciate physicians who are easily accessible, friendly, listen to the patient, do not cause discomfort and reasonably priced.

Male secondary students think that male access to medical treatment for genital ailments is deterred mainly by the young man's fears and his embarrassment to tell his father or older male family member about his problem. They note that the relationship between the boy and his father would be the determining factor. Mothers are not consulted in these matters. These students prefer to consult a male physician working in a private clinic and accompanied by their father, older brother or a friend. They acknowledge their greatest fear as being told that they are sterile. They are deterred by crowdedness of the clinic, lack of privacy, order and cleanliness, and ineffective treatment. They feel more comfortable with an experienced, calm and honest physician who is friendly, cheerful and provides effective treatment and with a clean clinic that provides privacy.

Among engaged and newly married males and females, there is a general feeling that young men are treated differently from young women. They confirm the opinions of male secondary students that if a boy controls his fears and embarrassment, he will have access to medical services because fathers do not usually object. Young men also have the option to visit the physician with a friend or alone if they desire total privacy. They note that male health services are not as plentiful as for females but andrologists are available.

General consensus among all groups emphasizes the importance of knowledge of reproductive health for both adolescent males and females to reduce their worry and confusion and help them to better protect themselves. Sources for such information include: textbooks, separate seminars for males and females at youth centers, schools, universities and health units, as well as reports on television, radio and in the press. Physicians, religious leaders, mothers and fathers are singled out as reliable sources of information. For this reason, parents, too, must be well informed.

Premarital Examinations

It is encouraging that all male and female secondary students are aware of premarital examinations, consider it of great importance and, with the exception of a few male and female students, are determined to do it themselves before they are married. Their answers, however, did not indicate that both partners must have the premarital examinations. Students of both sexes know that this examination involves analyses of blood, urine and semen. Female students also list analyses of stools and Rh factor while male students add a checkup for AIDS. Both male and female students consider the two most important results of premarital examinations to be confirmation of fertility and detection of any problems with consanguineous marriages that may result in transmission of hereditary diseases to children. Female students from rural Minia add detection of other problems like hemophilia or color blindness. All agree that early

detection of problems could allow prompt treatment and prevent problems between married couples. One girl from rural Minia said: *"My cousin was supposed to marry one of her relatives, but when she did the examinations they discovered that it can not work out."*

Most students agree that they would undergo premarital examinations. One male student from urban Sharkiya states that he would not have the examination for fear of discovering problems that would prevent him from marrying the girl he loves. Two other male students are also concerned about results so they planned to have the examination a week after the wedding. Two female students reject premarital examinations: one from rural Sharkiya thinks her parents would not permit it and another from urban Minia says that if she marries at the right age and suffers from no health problems that she *"would be better to leave it to God."*

Likewise, all engaged and newly married participants know about premarital examinations but, surprisingly, they seemed slightly less knowledgeable of what the examination involves, its purpose and components. Engaged and newly married females think that the purpose of the examination is to check the reproductive system to detect congenital anomalies. They know that the examinations involve blood analyses for the Rh factor, diabetes and hemoglobin as well as urine analyses. They state that the main reason for this test is to check fertility and avoid deformed children caused by consanguineous marriages. A few add that the examination also involved choosing appropriate contraceptive methods.

Only one engaged female in the group had undergone the examination. Others state that they would do so before the wedding. Some comment that if they visit a physician, they will go with their mothers. Some say that they need to ask their fiancé first. Among the newly married women, only one from rural Sharkiya had a premarital examination and she only requested the Rh factor analysis after her marriage. The justification among the newly married women for not carrying out such examinations is that they do not know anybody who has done it and they do not suffer from any problems, so there is no need. Parents are not viewed as an obstacle if the couple wanted to carry out the examinations, especially the more educated and open minded parents. One newly married female from rural Sharkiya thinks that the engaged partners should go together for the examinations to match results.

To the list of tests comprising the premarital examination, engaged and newly married men add semen analysis. Only one of the engaged men had been tested previous to the focus group discussion (FGD): he was from urban Sharkiya and had requested the Rh factor analysis. All members of the group are willing to undertake the examination but think that it is very expensive and should be provided at lower cost by MOHP clinics. Engaged males say that they found it difficult to ask their fiancés to go through such examinations before marriage. Among the four groups of newly married males, only three men from Sharkiya had undergone premarital examinations: one wanted to ensure he had no medical problems; one was marrying a relative and so requested hereditary gene analysis; and the third tested the Rh factor with his fiancé. Others provide different reasons for not taking premarital examinations. Some think their families would not have agreed due to lack of awareness and thought it would have been difficult to

convince their fiancé's families. Others fear the tests might reveal a problem that would cancel their marriage. Lastly, some evaluate such services as "*inaccessible*" in villages or think the price too high for an examination that they feel they really don't need. They consider it easier to leave the whole matter to God.

When asked about their premarital examination experience, none of the three had any complaints about the examination. However, a man from urban Sharkiya explained that he first went to a private physician who asked for a list of laboratory analyses and then he went to Ain Shams University to complete the check-up. In the process, he went to four different places for blood analysis, urine and stool analyses, semen analysis and finally to a surgeon for the diagnosis. This experience points to the need for easy access to a comprehensive service at one location at a reasonable cost. There is also a need to build increased awareness among the young and their parents so that they understand that such examinations are not only important — they are essential.

Consanguineous Marriages

The study learned that all secondary school students had been informed about the ill effects of consanguineous marriages on children. Some students accept the information viewed on television or heard in seminars but the most effective means that convinced the youth of the veracity of medical information was personal experience. Most students acknowledge the link between consanguineous marriages and birth defects because they observe the reality of such problems. Some students remain unconvinced of the cause-and-effect relationship because they see marriages between relatives whose children seem healthy. Others prefer to leave the outcome of human actions to the will of God.

Sexually Transmitted Diseases

Most students attribute sexually transmitted diseases (STDs), such as AIDS, gonorrhea and syphilis, to illicit sexual relationships. To the list of STDs, some female students from rural Sharkiya incorrectly add liver diseases, malaria, polio, heart disease, cancer and schistosomiasis. All knew that AIDS is a very dangerous and incurable disease that decreases the body's immunity and a few students mentioned that the disease could be transmitted through blood transfusion as well. Students cannot describe the symptoms of every STD accurately although male students had learned about STDs in preparatory school textbooks, as well as radio and television spots.

When asked how spouses might protect themselves from the transmission of such diseases, female students stress immediate treatment. One girl from each of the rural and urban Sharkiya groups mentions abstinence from sexual intercourse, but they regard divorce as the only solution for AIDS. Male students stress avoidance of non-marital sexual relations, detection of illness through the premarital examinations, medical treatment and abstention from sexual intercourse. A few suggest that couples should divorce; others suggested separation, and a few said that couples should avoid using each other's food utensils.

The degree to which engaged and newly married women understand STDs is varied. While most have some knowledge of AIDS, not everyone knows of syphilis or

gonorrhea and some list cancer, typhoid, renal failure and diabetes as STDs. Knowledge of STD symptoms is limited. In response to questioning about how to protect oneself from STDs, they indicate medical treatment as necessary. Some mention cleanliness, others abstinence from intercourse, and a few mention the use of condoms.

Similarly, engaged and newly married men know of AIDS but some do not know syphilis or gonorrhea. They believe that STDs can be transmitted through "*abnormal*" sexual relationships, having sex with many women or having sexual intercourse "*with a wife who is menstruating*." They do not know STD symptoms. This group proposes treatment, abstinence from sexual intercourse especially while women are menstruating, and divorce as methods of protection between spouses. A few men mention condoms, but others consider them ineffective.

Early Pregnancies

Female secondary students are aware that early pregnancies pose health risks to both mother and child, yet their level of conviction is not very high as they noted cases of healthy early pregnancies. A few students believe that problems associated with early pregnancies are, in fact, dependant on the health status and physical strength of the mother. The students note the importance of antenatal care for early pregnancies. Most students consider it acceptable to postpone the first pregnancy for one to three years after marriage, if done in consultation with a physician. They note several advantages in postponing pregnancy: the couple would have a period for enjoying married life, learning better their marital responsibilities and developing mutual understanding. They emphasize that both partners must agree to the postponement and that family pressure would have to be ignored. They note one disadvantage to postponement: they believe that the use of contraceptives might reduce fecundity.

Male students share similar views. A few suggest that the first pregnancy should be postponed for only a few months so that the couple is not subjected to family pressure. The boys are of the opinion that it was the husband's responsibility to convince his parents that postponing the first pregnancy was in his interest.

Similarly, engaged males and females know that early pregnancies, especially before 18 years of age, pose health risks for the mother and child; yet, almost all would not consider delaying their first pregnancies. They cite a number of reasons. Both dread familial pressure and fear that the use of contraceptives might cause sterility. Engaged males do not want to postpone the first pregnancy because they look forward to the joy that the first child brings and the bond it creates between the newly married couple. A few engaged females think the first pregnancy can be postponed until the age of 20 for financial reasons. Some females and males think that the first pregnancy might be delayed so that the newly married couple could establish themselves morally and financially. They suggest that mutual agreement between the couple and consultation with a physician should be preconditions for such a postponement.

In rural Minia, newly married men insist that by age 16 women are ready for pregnancy because this is the legal age for a female to marry. All other newly married men in the FGD advise 19 or 20 years as a suitable age for pregnancy because before this age the

woman's body is not mature and she will not be wise enough to raise children. This group did not mention the health risks of early pregnancies to the child. They all refuse the idea of postponing their own first child because they viewed children as the cornerstone of marriage and religion, and the source of joy to the family. These men believe that couples must prove their fertility and then they could postpone the second pregnancy. One questions, *"Why did I get married if I postpone pregnancy? It would have been better not to be married."* Another said, *"Pregnancy is a gift from God. We do not prevent it so God will not prevent us from it."* Only a few newly married males in urban Sharkiya say the first pregnancy could be postponed with the couple's mutual consent. They note that the couple would certainly be put under pressure from the rest of the family and they express fear that contraceptives might cause sterility.

Newly married women also think that age 20 is the best age for pregnancy for both mother and child. Generally speaking they accept postponement of the first pregnancy for reasons such as financial stability, maturity of the wife, or completion of the wife's studies. Nevertheless, only two participants declare that they considered delaying their first pregnancy. One of these women could only postpone pregnancy for six months due to family pressure. Reasons stated for not delaying their own pregnancies are: children should not be stopped because they are from God, fecundity needed to be tested, and the family's eagerness for grandchildren had be satisfied. They, too, fear the effects of contraceptives on fecundity.

The FGDs asked the various groups to suggest ways to postpone first pregnancy. In general, the answers demonstrate a complete lack of knowledge of the various contraceptives, their use and their potential side effects. Oral pills, IUDs, injectables, implants are all mentioned with a variety of misconceptions about each type.

Birth Spacing

FGDs asked participants to identify the optimal spacing time between the birth of a child and a subsequent pregnancy. Both male and female students think two to three years is optimal as it would give the mother's body time to rest, she could regain her health, and it would ensure the child sufficient care and lactation. Male students, however, mention that if a family does not have a boy then this spacing will not be achieved because the mother will continue producing children until she bears a boy.

Engaged and newly married males and females hold similar opinions regarding birth spacing. Additionally, they were asked about the ovulation period. Their answers indicate that this group does not really know when in the female menstrual cycle that a woman is susceptible to becoming pregnant. Most admit that they do not know. Others guess with wide-ranging answers. This is one reproductive health topic that is rarely presented in the media, seminars or textbooks making natural family planning futile.

Interpersonal Communication Between Partners

Engaged and newly married males and females generally agree that couples can and should discuss issues related to children before or immediately after marriage. In their opinion, such discussion is essential to arrive at mutual decisions and avoid

misunderstandings. Moreover, they note that such discussion leads to successful marital relations for the long-term. They feel that consensus between partners on when and how many children they will have is a guarantee for proper care for children and proper health for the family. Engaged females add that early discussions would create a model for the couple for sharing decisions. Engaged males believe that the extent of discussion during the engagement period depends on the degree of understanding between couple and the level of awareness of the engaged girl because some may refuse to talk about such things. Only one engaged male from rural Minia remarked jokingly that such decisions are ultimately the man's decision.

The disparity between words and deeds became evident as the FGDs delved further into the possibility of couples discussing such issues to reach mutual agreement. Although all females, whether engaged or married, declare that they had already discussed issues related to children with their partners, most engaged men acknowledge that they have not broached the topic with their partners. Some said their partners are unwilling to discuss such issues during the engagement period, preferring to wait until just before marriage, or to leave such matters to God. All newly married men say they had discussed such issues with their wives but had not reached mutual agreement on some issues.

Reproductive Health Informational Needs of Adolescents

Male and female secondary students were asked if they felt they needed more information on any of the topics included in the FGD. All agree that it is very important for youth to know about all the topics discussed during the FGD. They think that such knowledge would help youth to protect themselves, react correctly, not be shocked or confused by the unknowns, and gain experiences and skills for their future lives. Male students in rural Sharkiya also add that such knowledge would help them raise other people's awareness.

In addition to the topics discussed during the FGD, female students also want to know more about raising children, healthy sexual relationships, pregnancy and childbirth. Male students want to know about the symptoms of puberty, diseases of the reproductive tract, sexual intercourse, masturbation (including religious views and how to inhibit it), family planning, STDs and wet dreams.

Opinions differ about the appropriate age for receiving different types of information. Participants seemed to give answers without due consideration. Most probably they never faced such a question before. Female students generally think that girls should be at least 15-16 years old because they are able to marry at this age in rural areas. However, most think that information about pregnancy and childbirth, etc., should be postponed until girls are more mature and before marriage. Male students judge that reproductive health information should be provided to youth older than 14-16 years of age; that is, around the age of puberty.

Girls and boys both express the need for simple, easy to read and understand books that also provide information on the concerns of the other gender. As an example, they note the *I've Grown* book that has been distributed in schools. They also mention the need

for seminars at schools, awareness campaigns at health centers and television programs, serials and spots, such as Ask/Consult. They recommend holding seminars at cultural palaces, clubs, NGOs, schools, mosques and churches. Youth centers could be used for seminars for males, but some female students judge such centers as inappropriate for female seminars because there is no privacy. Both male and female students think that religious leaders, social workers and physicians could provide the information. It is interesting to note that the female students in urban Minia recommend that speakers for female seminars sit first with male adolescents to know what information the boys wish to hear. Female adolescents feel a need to know what males think and what they need to know. In an existence of gender separation, this seems a viable and practical request.

Reproductive Health Information Needs of Engaged and Newly Married Couples

All newly married males and females report that before their wedding night they had wanted to know about sexual intercourse, especially in preparation for the first night and the breaking of the hymen. They wanted to know how to prevent problems. Women said that they had also needed to know more about sexual orgasm and pregnancy. The main sources for such information cited by newlyweds are older married siblings and married friends. They consider the information they received very useful because it reflected real experiences. Male participants from urban Minia say that they themselves now serve as educators by discussing such issues with men who are about to be married.

It is an Egyptian tradition that families of both partners visit the newlyweds on the morning after the wedding night to ensure the virility of the man and the virginity of the bride. The FGD asked participants if they had experienced any unexpected problems after marriage. The question was received with embarrassment by newly married females and most replied negatively, with the exception of one woman from urban Minia who noted that she had experienced some inflammation. Two problems that may occur are no evidence of bleeding from the hymen for the bride and erectile dysfunction for the bridegroom. Regarding the former, newly married females report that they had heard of the *Dokhla Baladi,* a traditional practice that still persists among some rural communities in Upper Egypt that entails manually breaking the hymen on the wedding night to publicly declare the bride's virginity. Such practices can cause severe bleeding. Regarding the latter, some rural communities believe that erectile dysfunction is caused by *rabt,* or the tying of the male organ by witchcraft which necessitates intervention by *sheikhs* and reading of the Quran or by employing fortunetellers to undo the "*tying*." Males in the FGDs knew that such a problem has nothing to do with being "*tied*." A few men mention a third potential problem for newly married couples: the refusal of the bride to have sexual intercourse.

Newly married females list a number of topics that are important for women to know before marriage. These include: sexual intercourse; sexual relationships; related hygiene; dealing with bleeding; developing mutual understanding and consideration; dealing with sexual embarrassment and nervousness between partners; procedures and benefits of premarital examinations, and family planning.

The participants believe that sources for such information should be mothers, sisters, friends and relatives in addition to physicians in seminars and booklets. There is no consensus among the group regarding the use of television and school textbooks to disseminate information to unmarried female adolescents. Participants from urban Minia do not approve of presenting such information on television or at schools. Those from rural Minia did not mention television but approve of girls learning these topics at school. All others consider television and textbooks as important sources of information.

Newly married males agree that young men should have knowledge of all topics addressed during the FGD before marrying. They recommend a number of specific topics, including: STDs and how to avoid them; awareness of sexual health; disadvantages of early pregnancies; reproductive and psychological health of women; healthy sexual intercourse; masturbation, and premarital examinations. Similar to their female counterparts, newly married males from urban Minia do not approve of television as a suitable media for such information. With the exception of men from rural Sharkiya, the group view religious leaders as having a role in providing such information at schools. They also consider physician seminars and knowledgeable parents as sources of reliable information. Booklets, books and mass media are also mentioned. In urban Sharkiya, the youth-to-youth process of education is not considered an effective means of communicating information because the seriousness of the information may be lost. With the exception of issues related to sexual intercourse, they suggest that reproductive health information should be provided to adolescents who are high school age. Topics related to sexual intercourse, they feel, was more suitable for dissemination just before marriage.

Almost all engaged and newly married participants, males and females, indicate that if premarital counseling services had been provided at health clinics they would have attended to become more knowledgeable. A few admit they would not have attended because of embarrassment for females and preference to hear the information from friends and relations. Males stress proximity of the clinic, cost and quality of the service as factors that would promote demand for premarital counseling. They have no objection to young women receiving the service provided that the physician is female and there is no gender mix. Married participants from Sharkiya indicate that couples might attend counseling together provided that the physician is female. Minia participants are divided between those who would attend alone and those who would go with their partner.

Views on Health Services Available to Engaged and Newly Married Couples

The FGD asked engaged females to identify sources of health services for youth in their communities. Engaged females from urban Minia point to the FP clinics, the Suzanne Mubarak hospital, the NGO El Mabara clinic and the University hospital. In rural Minia, the health unit provides services for married females only. In urban Sharkiya, services for youth are available at FP clinics, MOHP's Gold Star clinics and private

clinics. Similarly, females from rural Sharkiya mention private physicians and the health unit.

Participants were asked their opinion of public and private health clinics. Response from participants indicates that private clinics rate far superior than their public counterparts. Participants state that although public clinics charge lower fees, they are more crowded, do not give adequate care to clients, provide less privacy and clients cannot know before the examination who the attending physician will be and whether the physician is male or female. In comparison, participants judge private clinics to provide better care and treatment, prescribe more effective treatment, dedicate full attention to clients and answer their questions, are cleaner and provide privacy. In addition, clients know who the physician is before they go to the clinic.

Most engaged females have no preference concerning the time that services are offered. Some prefer services to be provided in the mornings in order to keep their evenings free and to ensure the availability of the physician; but others thought afternoon appointments offered a more suitable time, less crowded clinics and less conspicuous entry into the clinic.

Engaged females define good and comfortable service as experienced specialists, availability of modern equipment, privacy, customer care, chance to talk and ask questions, and warm reception. Clearly, the client-provider interaction skills of the health care providers are very important.

The FGDs with engaged males determined that health service options available for young males are almost non-existent. In some cases, services may be available in the capital city of the Governorate. Only in urban Sharkiya, did participants mention MOHP's Gold Star clinics, private clinics and Ask/Consult pharmacies. Young engaged males hold similar opinions to those expressed above regarding public and private clinics. Private clinics are considered superior to public clinics in the quality of service provided. But in rural Minia, participants noted that public clinics were better equipped, and one participant stated that public clinics were becoming more caring of their clients. All engaged males prefer to obtain services during the afternoon. They define good quality service in terms similar to those of engaged females, albeit with less emphasis on the need for time to ask questions.

Newly married females identified points of service for young women at FP clinics, rural health units and centers, hospitals, NGO and private clinics, with two exceptions: there are no private clinics in rural Sharkiya and no health services for young unmarried women in rural Minia. This group has the same preference for private clinics and for the same reasons as stated by engaged females. Most newly married females in the FGDs prefer morning shifts for medical visits. In rural Minia, they prefer afternoon visits. This group defines good and comfortable service as offering warm reception and customer care, thorough examinations, sufficient care, effective treatment and time to ask questions and receive understandable answers. To this list, the women in rural Minia add the prescription of suitable contraceptive methods. Traits that define poor service for newly married females include poor customer care, no chance to ask questions,

verbal checkup rather than physical examination, ineffective prescribed treatment, and bluntness when discussing health problems with a minimum of sensitivity.

Newly married males report no knowledge of options for service in urban or rural areas. They emphasize that CSI clinics limit their services to women while rural health units only provide women with FP, antenatal care services and Rh factor analysis. These participants did not mention private clinics as a source for health service yet they consider private clinics as superior to public clinics. It seems that they can say nothing good about public clinics. All prefer afternoon shifts for medical visits. Their definitions of good and poor service align with the opinions stated above.

Support of Family and Community Leaders for Youth Reproductive Health Services

Mothers and Mothers-in-Law

Definition of Reproductive Health

Focus group discussions asked mothers and mothers-in-law to define reproductive health. Positively, premarital examination as a medical component was mentioned in all groups with the exception of those from rural Sharkiya. The latter group limits the definition of RH to antenatal health care including vaccinations and nutrition, postpartum care for the mothers' nutrition and health and infant weighing and immunization, as well as family planning. The definition of RH for the rural Minia group includes age at marriage of the female, prohibition of female circumcision and family planning in terms of limiting the size of families to two or three children. In urban Minia, participants include birth spacing and breastfeeding and one participant added delay of first pregnancy. The urban Sharkiya group add female health care before marriage, cleanliness and hygiene.

Early Pregnancies

The majority of mothers and mothers-in-law consider the ages between 20 and 25 as the best time for pregnancy in order to avert problems. In rural Minia, participants quoted age 18 years but they also gave a range of 20 to 21 years. Three rural participants (one in Minia and two in Sharkiya) offered their opinion that 16 is a suitable age for pregnancy but their groups rejected this age as too young. Participants reasoned that by age 20 a woman's body and reproductive system are mature and she should be in a fit physical and mental state to raise a child. Also the child is more likely to be born healthy. Before age 20, they assert that the pregnancy may be risky. The mother could suffer from anemia, bleeding, and prolonged and difficult delivery and have to deliver by Caesarian section. She may not be able to breastfeed the child who may be born weak or immature, or even stillborn. Their knowledge of the risks posed by early pregnancies is commendable.

The study found that mothers and mothers-in-law want grandchildren as soon as couples are married if there are no good reasons to postpone. When questioned about the possibility of postponing the first pregnancy, many rural participants and those in urban Minia did not accept any delay as permissible. They stated that newly married couples had to have the first child immediately, or else family members would worry. In urban areas, delay of the first pregnancy could be accepted if circumstances required. Such circumstances include poor health of the mother and unsuitable financial conditions of the couple. Participants in urban Sharkiya feel that pregnancy can be delayed if the couple is under 20 years of age. A participant from rural Minia presented her own family as an example: Her older son, in agreement with his wife, postponed the first pregnancy for three years because of his unstable work conditions. Her younger son did

the same due to poor finances; but his wife was not pleased because she wanted a child to create a bond with her husband who she feared would leave her. Participants assessed that a postponement of one to three years before the first pregnancy could be tolerated until financial or health circumstances improve. In rural Sharkiya, participants thought that a maximum of two years would be allowed for postponement before familial pressure would begin.

Mothers and mothers-in-law believe that the use of contraceptives is the only means to postpone the first pregnancy. The IUD, pills, injectables, condoms and fertility awareness are preferred methods by different groups. Only participants in urban Minia suggest consultation with a physician before using any of the method. FGDs revealed limited knowledge and many misconceptions about the different types of contraceptives available. Some participants recommend IUDs because upon removal the woman can become pregnant with no side effects. Others recommend against IUDs, although they only mentioned bleeding as a potential problem with this contraceptive. In addition, IUDs cause cervical erosion, inflammations, backaches and infections that can move to the heart. In addition pregnancy can occur while inserted—potentially ectopic pregnancy. Pills, particularly the more expensive type costing L.E. 7.5, are recommended by mothers and mothers-in-law because the duration of their contraceptive effect is limited and they regulate the menstrual cycle; but some participants would not recommend them because they cause "*weak ovulation*" and "*sterility*." Pills also suppress lactation and can cause edema, bleeding, hypotension and hypertension. Also, the group does not recommend injectables and implants because, *"They cause complications and may lead to sterility."* Although suitable for lactating mothers and could prevent cancer, injectables also cause edema, headaches, amenorrhea and bleeding. Not much is known about implants. They explained the fertility awareness method, which they call "*Safe period*," as the middle ten days of the menstrual cycle when pregnancy cannot occur. They did not note its ineffectiveness, particularly if the "*safe period*" is based on calendar reckoning rather than monitoring basal body temperature and cervical mucus. Condoms are risky because they can be torn during intercourse.

Birth Spacing

After the first pregnancy, mothers and mothers-in-law become more relaxed. The group reports that they could wait for more than two years for the next pregnancy and they would be willing to wait three or even up to five years without applying pressure on the couple to produce additional children. Mothers and mothers-in-law in urban Sharkiya, however, believe that a maximum of two years should pass between pregnancies so that the age difference between the children would be about three years. This spacing would allow the mother to regain her health, rest her body and uterus and not become weak from successive pregnancies. Also, this spacing would give the child sufficient care and lactation and time to become more independent before the next child arrives.

Reproductive Health Problems

This group believes that mothers should be the first point of inquiry for young unmarried women who have concerns about their reproductive health. The group considers the mother to be the closest person to a daughter. A few participants from rural Sharkiya mentioned one constraint against mothers being the first source of information: a young woman may feel too embarrassed to discuss her problem with her mother and therefore choose to avoid dealing with the problem.

Generally, the group accepts that unmarried young women could receive medical care for reproductive health problems from a public health clinic or a private physician. Only one participant from rural Minia considers it improper and unnecessary for unmarried young women to visit doctors because required medication can be purchased from pharmacies without exposing girls to doctors. Only in urban Minia did mothers and mothers-in-law emphasize that the physician should be female. Others feel that consultation with a physician is more important than the physician's gender. It is counseled, however, that mothers, aunts, sisters or friends should accompany young women to doctors.

Most participants state that young males experiencing genital problems before marriage should first consult their fathers, uncles, older brothers or friends. Their confidantes should be well known and close to the young man, sympathetic and caring. Participants from rural Sharkiya, however, held a contrary view. They recommend that young men go directly to a physician with their problems. In the event that youth feel embarrassed by the problem, then talking to fathers or mothers could provide the needed sensitivity.

All mothers and mothers-in-law believe that male youth have easy access to medical checkups and treatment. The obstacles to access are related to the youth's condition, rather than the medical system; that is, shyness, fear of discovering a serious problem, laziness, negligence and lack of money. Participants in urban Sharkiya propose an additional obstacle: an engaged male might fear that knowledge of his health problem would cause his fiancé to postpone or cancel their marriage.

STDs

Mothers and mothers-in-law state that they are aware of diseases that are transmitted between the husband and wife. Some of the diseases they list are STDs, such as AIDS, syphilis and gonorrhea; the latter being mentioned only in Minia. Other diseases that they list are not STDs, such as scabies, inflammations, schistosomiasis, skin infections and cancer. This group view analysis and treatment as the means to prevent transmission. [TU2]Also, some recommend that couples defer sexual intercourse and others proposed use of condoms. Their discussion in the FGD indicates that they understood STDs as infectious and suggested isolation.

Premarital Examinations

All participants are aware of premarital examinations and their importance. Some said they learned about premarital examinations from the television. They clearly understand that premarital examinations include complete physical examinations for both males and

females. When asked to identify the components of premarital examinations, they list analyses of blood, urine, stools, semen and the Rh factor. They state that the physical examination includes the reproductive tract for males and females to test fertility in addition to the lungs and heart. They think the Rh factor analysis is done to protect offspring from suffering from genital anomalies and indicated that it is also important for couples who are related. During the FGDs, a participant from urban Minia reported her personal experience of marrying a relative and her children inheriting many health problems related to their eyes and chest.

With the exception of two participants from rural Sharkiya, all mothers and mothers-in-law agree that premarital examinations are important because they can prevent many problems that might arise after marriage and they also protect future generations. These women reason that marriages nowadays are not easy and are expensive; therefore, it is important to check and treat problems before they harm the family. The two participants from rural Sharkiya wish to qualify the importance of marital examinations as subject to an individual's health: Only individuals who believe they might have a problem should have the examinations.

Yet, despite all this knowledge and stated appreciation for premarital examinations, not one participant could report that any of her married children were tested. They argued that such a service was not available when their children married. Promisingly, they all state that their unmarried children will undertake the examination.

Reproductive Health Information

Mothers and mothers-in-law generally agree that it is important that male and female youth be aware of reproductive systems and related health issues before problems arise. Awareness will reduce fear. According to this group, females should learn about reproductive health from their mothers and between the ages of 12 and 15; while male youth should learn from fathers, friends or cousins and not until the age of 18 to 20. Some participants prefer that the information be provided only after the male became engaged. In addition to mothers, fathers, uncles, older brothers and even grandfathers, they also consider physicians a good source of information for youth. In urban Minia, one participant objects to a father being a source of such information because fathers play a respectful role and therefore should not discuss such issues. Television could be used to disseminate information in addition to gender specific seminars where religious leaders provide the information. This group did not mention books as an appropriate medium for this information.

Premarital Information and Counseling

Mothers and mothers-in-law consider that parents are capable of providing information on any marital issue to their children. The general consensus is that such topics are easy and normal for parents to discuss with their children; mothers talking to their daughters and fathers to their sons. Additionally, all agree that if premarital counseling is available in a clinic they would encourage their children to attend because it would be beneficial. Young men could go alone, but young women should be accompanied by their mothers. They identify the following issues as necessary for couples to know: premarital

examinations, cleanliness and hygiene, washing after sexual intercourse, "*not to drink after intercourse*" and family planning.

Information on Healthy Marital Sexual Relations

During FGDs, mothers and mothers-in-law strongly negated the traditional notion that young men and women should not talk with adults regarding reproductive health issues before marriage. Shame is no longer attached to the topic. Youth now see the issues played out on television and young women are less sheltered and now exposed to ideas at schools and universities. Among the benefits of increased awareness among youth, this group cites building better understanding between married partners and reducing female anxiety on their wedding night. Only one mother from rural Minia prefers that her son not learn about reproduction and reproductive health before marriage.

Information on STDs

There is general agreement that youth should learn about STDs so as to build awareness, guard themselves against infection and seek early treatment.

Information on Family Planning and Contraceptives

Opinions vary among mothers and mothers-in-law concerning when girls should receive information about contraceptives and postponement of pregnancy. Generally, they agree that this information should be provided when young women are engaged and about to marry. Yet, younger ages were mentioned and not opposed, such as between 15 and 18 years. Some think that intelligent girls need to know the information earlier. Mothers, aunts, and older sisters are considered viable sources for this information for girls. Other potential sources include television, seminars at FP clinics, health units, and schools, and books for literate girls.

There is general consensus that boys should know about contraceptives and birth spacing so they do not face problems when married and have the information to manage their lives. If information is given to both boys and girls, it will help them to develop mutual understanding and be better able to make decisions in their lives. Mothers also mentioned that it is better for boys to get the right information from the right sources rather than getting the wrong information from the wrong sources. The group in rural Sharkiya noted that boys who received such knowledge would probably allow their wives to go to rural health units to postpone pregnancy.

Available Medical Services for Youth

Mothers and mothers-in-law were asked to identify the best center or clinic in their area that provides medical services to male and female youth before they marry. Participants from urban Minia point to FP clinics because they conduct all types of examinations and analyses for both males and females. In rural Minia, the rural health unit and the hospital are distinguished. Urban Sharkiya participants said that they had not heard about such services except at private clinics. They praise the physicians in these private clinics, noting that clients can talk with them easily and the doctors listen. In rural Sharkiya, participants consider the rural health unit to be quite good, saying that the

doctors are understanding and the nurses are good. Other advantages include client familiarity with the staff physician, client familiarity with the clinic because immunizations are done there, close proximity and affordable fees.

This group judged that it is permissible for male youth to go alone to such clinics for medical service. If shy, they could be accompanied by their fathers, brothers or friends. The group, however, believes that in the case of counseling young men should go alone. As for young women, the group considers that it is impermissible for them to go alone to the clinic—they must be escorted by their mothers or sisters because only these relations will guard their secrets.

Teachers and Other Community Leaders

Views on Early Pregnancies

Most female teachers are aware that "*early pregnancy*" means pregnancy before age 20. They know that pregnancy before this age poses risks. They attribute the risks to the female body not being fully mature, noting that the body and bones would still be weak. Thus, they understand that it is beneficial to postpone pregnancy until after age of 20. It should be noted that two teachers from rural Minia and Sharkiya defined "*early pregnancy*" as pregnancy occurring directly after marriage when the woman is not yet well prepared for motherhood.

Some male teachers correctly understand "*early pregnancy*" in terms of the development and maturation of the woman's body. Some, however, understood "*early pregnancy*" as occurring before the newly married couple had time to know and understand each other and enjoy life together. Only one male teacher from urban Sharkiya censured the concept of "*early pregnancy*" saying it was contrary to tradition.

Most religious leaders and *maazouns* are aware of the concept "*early pregnancy*." Two leaders noted that Islam does not prescribe a specific age for marriage and pregnancy; rather, the conditions for marriage are that the couple has reached puberty and their parents consent to the marriage. They added that pregnancy is God's will. For this reason, postponing pregnancy with contraceptive methods may have negative effects and early pregnancy may well be a blessing from God.

*Omda*s and members of the Popular Local Council understand "*early*" as meaning before the body is fully mature. Hence, they recommend that first pregnancies occur between the ages of 22 and 25 years. Notably, one Local Popular Council member stated that he understood the importance of the reproductive system's maturity before pregnancy because he had received training on reproductive health.

When asked to identify advantages for postponing the first pregnancy, both male and female teachers note that couples need the first year of marriage to build understanding between them. Similarly, the interviewed community leaders mention stabilization of marital relationships and improvement of existing financial conditions. The health of mother and child was not mentioned. They consider that couples could postpone pregnancy for a year, but for not more than two years. Two female teachers from urban

Minia and Sharkiya believe that in circumstances of health or financial problems a couple might postpone the first pregnancy.

For all participants, the main disadvantage to postponing the first pregnancy is the potential ill effect of contraceptive methods, particularly sterility. One female teacher commented that contraceptives are not manufactured in Egypt and she linked sterility to this foreign manufacture. Another teacher stated that contraceptives contain hormones and, that as a punishment from God, couples who have used them will not have any children. One Christian leader reinforced this notion with the example of his cousin who used a FP method to postpone the first pregnancy and subsequently was never able to get pregnant. Another disadvantage to postponing the first pregnancy, mentioned by all participants, is family pressure, which can really disturb couple's life and even lead to separation.

When asked to identify the means for facilitating delay among newly married couples who choose to postpone their pregnancy, most members of the group point to the promotion of FP awareness. One female teacher commented that a new FP method with no side effects needs to be invented. Religious leaders who oppose postponing pregnancy obviously do not accept promotion of such practice. One Christian and one Muslim leader commented:

"How can I prohibit what God has allowed? I will be contradicting myself."

"There is no good reason for delaying pregnancy. It is a Western cultural invasion to reduce the number of people in Islamic countries and that is why these messages exist only in Islamic countries."

Among their suggestions for raising awareness is the education of couples, especially husbands. The participants recommend that FP meetings be held between religious leaders and engaged youth and their families as frequently as once a month. This group figure that healthcare facilities have a limited role in raising awareness, but they should advise on the most appropriate contraceptive method. Home visits by *raedat* could encourage women to visit health facilities.

Participants who are familiar with the State Information Services (SIS) see a role for this agency in raising awareness. They note that a large knowledge gap exists and it needs to be filled. As one religious leader observed, most people believe that delaying pregnancy affects the women's fecundity because there is insufficient information being disseminated to refute this belief.

NGOs have a very important role in raising awareness, according to this group. They stress that local NGOs should make FP issues a priority in their agenda of seminars and awareness sessions. Such events should be targeted especially to engaged and newly married couples. Schools, too, have a role in providing guidance and raising awareness of students before they marry. The subject could be included in the school curriculum or information could be disseminated through guest speakers invited to the school once a week.

Views on the role of television differ. Female teachers do not recommend television to promote awareness of contraceptives and first pregnancy deferral. Some participants

believe that television spots do not attract the attention of a broad spectrum of people; rather, they mainly target more educated people who are already aware of FP issues. However, one teacher from urban Minia complained that television spots are initiating curiosity among children who then ask questions that she does not wish to answer. She believes that children should not be exposed to such topics . Others believe that television could produce advocacy campaigns on reproductive health issues. Also, in addition to FP spots, television series or dramas could explain the advantages and disadvantages of postponing the first pregnancy.

Only one male teacher suggested the important role of the youth themselves, who, after training, can work to raise the awareness of their contemporaries. Youth have energy that should be invested and targeted.

Youth Access to Reproductive Health Services

The FGDs with community leaders revealed a lack of understanding in the group concerning the types of counseling and medical services that are available or needed to help youth attain marital happiness and reproductive health. Suggestions tended to address the general conditions of local health facilities rather than the specific topic at hand.

To better meet needs of married youth, they recommend raising awareness of the services to increase demand, improving availability of FP contraceptives, training health providers in reproductive health, hiring specialized physicians (males for male youth and females for female youth), renovating clinics and improving supervision. Most participants share the opinion that clinics are not well prepared to handle these issues, regardless of ongoing improvements. As one female teacher from urban Sharkiya remarked, *"When I enter a public hospital, I am sure that I will not be offered good service. I do not trust it. Physicians in these places are not qualified.*" A male teacher from the same location, however, thinks that the quality of health services is good and that clinics could handle FP issues.

Reproductive Health Information to Engaged Youth

Information on Premarital Examinations and Counseling

Generally, teachers in the FGDs concur on the importance of providing youth with information about premarital examinations. Female teachers from Minia believe that such information needs to be emphasized so that youth will request the examination. The request must come from the youth themselves because many families believe that health is subject to God's will. Also, families will not support premarital examinations for fear of discovering sterility, which would cancel proposed marriages. Hence, youth must want the examinations for reasons of their own health and for the health of their offspring. Female teachers from Sharkiya said that engaged youth should know about the identification of hereditary problems through premarital examinations, blood type differences and the hazards of consanguineous marriages. They believe that knowledge of the latter could reduce the divorce rate. In concurrence, male teachers emphasize that

youth will request examinations if they understand that early detection of health problems prevents jeopardizing one's marriage later on.

The main barrier to providing such information at schools is the discomfort of teachers to talk liberally about such issues. When curriculum touches upon any topic related to reproduction, female teachers become embarrassed, and so ask students to read it alone at home. This approach enforces the notion of shame, embarrassment and taboo in discussion of such issues.

Male and female teachers recommend promoting marriage at the right age, delay of the first pregnancy and avoidance of marriage to relatives. Two female teachers suggest that engaged youth examine the meaning of marriage, the responsibilities of both partners, and the disadvantages of early pregnancies and inadequate birth spacing. One male teacher from rural Sharkiya adds that youth also need information on family relationships as well as reproductive health and sexual relationships. Another one from urban Sharkiya stressed the importance of such knowledge as means to offset the effect of media that broadcast love stories that could lead to *orphy* marriages.

Community leaders support the importance of disseminating information on premarital examinations to engaged youth. Other topics proposed are the disadvantages of early marriages, life's responsibilities, promotion of physical health, and breastfeeding. Religious leaders state that such information should be presented through health facilities and NGOs but with the support of religious institutions. All community leaders emphasize the important role of religious leaders and institutions in the dissemination of information.

Teachers and community leaders overwhelmingly agree that engaged males and females should receive premarital examinations or counseling separately. Two male teachers, two religious leaders (one Moslem and one Christian) and a few other community leaders judged that engaged couples should go together. Those who supported separate visits expressed concern that should a health problem be identified, the other partner might react and cancel the marriage. Also, they reasoned, it would be embarrassing to both partners to listen to sexual issues together. On the other hand, those who encouraged couples to visit a clinic together stated that engaged couples should be aware of their problems from the beginning and that having the same exposure to information on reproductive health would mean they would work mutually to prevent problems after marriage.

The group offer several suggestions on how best to convince engaged youth to go for premarital examinations and counseling. First, television, public meetings and seminars should stress the advantages of premarital examinations as well as discuss potential difficulties that may arise. Home visits by *raedat* are also considered important because the face-to-face communication can involve youth and other family members. Additionally, as with all other RH topics, this group suggests that seminars be conducted in mosques, churches, NGOs, and health facilities and that they observe the combination of medical knowledge and religious teachings. Lastly, a male teacher, a *maazoun*, an *omda* and a Christian leader all suggest that a law be issued necessitating a medical certificate before completion of marriage procedures.

Information on Problems in the Reproductive Tract

All community leaders agree that engaged youth of both genders should have knowledge about potential health problems related to the reproductive system. This knowledge enables youth to be able to protect themselves, avoid harmful practices and address problems by seeking early diagnosis and treatment before complications arise. One female teacher from urban Minia stressed that such information should be provided separately for males and females to avoid embarrassment. Other leaders recommend that physicians provide such information during premarital examinations.

Information on Healthy Marital Sexual Relations

With the exception of one female teacher from urban Sharkiya, all teachers agree that youth should receive basic information regarding healthy sexual relationships. Community leaders supported the notion of informing youth in a "*scientific*" manner. Providing youth with correct information would prevent them from getting into unhealthy relationships. The opposing opinion contends that such information would motivate youth to experiment with the information in harmful ways. Therefore, according to this view, youth should learn by experience in marriage, following the example of older generations.

A great deal of dialogue was generated around this issue. One female teacher supports dissemination of this information but notes that such endeavor would be quite difficult due to traditions and culture. A male teacher recommends that, due to cultural sensitivities, physicians should provide information concerning sexual relationships in an indirect, rather than direct, manner. Another female teacher stressed the need for proper information by explaining that although young women usually learn from their mothers and young men from their fathers, the information may be incorrect. This led a third female teacher to add that educational sessions should address unhealthy traditional practices, especially *dokhla baladi*, which is still practiced among some families in rural communities.

Views differ concerning how and when such information should be provided to youth. Again, there is general agreement that a combination of physicians and religious leaders conduct the seminars. One sheikh thinks that the MOHP should produce booklets designed separately for males and females. Others insist that such information should be presented only to engaged youth so as not to stimulate sexual desires at earlier ages.

Information on STDs

Everyone agrees that engaged youth should know about STDs so as to protect themselves and refrain from harmful practices. Religious leaders suggest that such information be provided during premarital examinations. Some mention that physicians or religious leaders could provide lectures or seminars about STDs at schools with separate sessions for males and females. During the FGD of this topic, one sheikh added that youth should also be informed not to practice sexual intercourse during menstruation and after childbirth.

Information on Family Planning Contraceptives

With the exception of one local Popular Council member, all teachers and community leaders agree that engaged youth should learn the advantages and disadvantages of all contraceptive methods, including those used by men. Such information will assist them if they want to postpone first pregnancy or space succeeding pregnancies. Religious leaders emphasize the role of physicians and nurses in providing such information. The Popular Council member who opposed the provision of such information to engaged youth reasoned that they are not yet ready for such information.

Role of Institutions in Reproductive Health Education to Youth

The FGD asked teachers and community leaders if they saw a role for their institutions or profession in the process of educating engaged or newly married youth in reproductive health topics. Further, the FGD asked them to identify constraints and to suggest ways to address these constraints.

Secondary Schools and Teachers

There is general consensus among teachers that schools have an important role to play in the dissemination of RH information. Opinions regarding the form that role would take are somewhat varied. Schools could provide lectures on RH and add relevant books to the school library. Seminars by invited specialists and religious speakers could be offered as well. Schools could also help in the distribution of brochures and bulletins. Also, computer lessons are suggested as being of value as audiovisual aids.

AAA number of obstacles that could hamper the effectiveness of the schools' role are considered. First, students may resist if they are not ready or willing to hear such information. Second, parents, too, may oppose such seminars at schools due to their own lack of awareness of the importance of such information. Third, teachers could pose obstacles if they are too embarrassed to discuss RH topics with students. Even the school administration may not support the discussion of such topics in school seminars. Another obstacle mentioned is the unavailability of appropriate places in schools for conducting the seminars.

One female teacher from urban Sharkiya is, however, optimistic that all obstacles could vanish if people are committed, work hard and collaborate well. Teachers note that schools need the support of the Ministries of Education (MOE) and of Health and Population to implement their role efficiently and effectively. These ministries need to provide support in selecting and making available the right specialized people to present such subjects, finance the activities, provide necessary equipment and produce the necessary IEC printed materials and videos. A realistic program for implementation needs to be planned and developed. School administration could facilitate matters by making spaces available for conducting meetings and seminars. Additionally, teachers expressed a need for training to prepare them for teaching such topics by increasing their knowledge base and developing new skills to communicate the right information in the right way. Furthermore, a teacher from urban Sharkiya points to the need for planning and implementing IEC programs that address the societal beliefs that stand as obstacles to youth access to FP/RH information and services.

In addition to collaboration with the MOE and MOHP, teachers see an important role for the Ministry of Information with its media network and the Ministry of Youth and Sports with its various youth activities and centers, as well as religious leaders and their institutions.

Religious Institutions

Christian leaders indicate that the Church could play a role in the dissemination of RH information but, as one priest mentions, involvement of the Church in such topics may not be appreciated by church congregations because such issues may be embarrassing to people. Another priest thinks that the Church could organize seminars for youth but that priests should not be involved because physicians and social workers should provide the information.

Similarly, Moslem leaders have divided opinions. One rejects the idea of mosques holding such information seminars, while another states that mosques could address such information during Friday prayers.

Maazouns say they can play a role if they receive instructions from MOHP and the Ministry of Justice. But one *maazoun* from rural Minia declares that he could never play such a role: *"If I tell the couple something like this, they will ask, 'Are you coming to give us a lecture or to marry us?'"*

The greatest obstacle to religious institutions playing an effective role in the dissemination of FP/RH information is the cultural background of the public and their potential opposition to the involvement of religious institutions in such topics. Additionally, some consider it difficult to target only youth at religious places because all socio-economic and age categories attend prayers.

Religious leaders say that to overcome the obstacles, they need access to other locations for holding the seminars, such as youth centers and social clubs. Leaders who would be involved in the seminars require training, audiovisuals and brochures, and well prepared agendas. It is also stressed that health facilities must provide the needed FP/RH services so that leaders can be assured that they are encouraging people to seek services that actually exist in the community. For these reasons, religious leaders see a very important supportive role for the Ministry of Al Awkaf, the MOHP and the Ministry of Youth and Sports.

Other Community Leaders

*Omda*s and Local Popular Council members do not see a role for themselves in the dissemination of FP/RH knowledge. *Omda*s feel assured that they can speak on the subject at any time and could ask *imams* for help. They do not think they need any support, but general support is probably required from relevant ministries and agencies such as the MOE and MOHP. One *omda* refers to possible support coming from the Ministry of Internal Affairs, local councils and the National Democratic Party through seminars and lectures. Another *omda* thinks *imams* in mosques, priests in churches and youth centers could assist in raising awareness and conducting seminars.

Council members provide no clear answers to the questions of their role, potential obstacles and support. They stress the important role of religious leaders, governors, MOHP, Al Azhar, Al Awkaf, the National Democratic Party and NGOs. All these agencies are needed to provide relevant and accurate medical and religious services, address meetings and seminars and make available meeting places.

Suitable Time for Youth and Reproductive Health Information

Most teachers affirm that youth should know about issues related to the reproductive system and STDs. Male teachers think that sex education is also required but qualify the opinion by saying that the topic needs to be taught in a "*conservative*" manner. Female teachers prefer to postpone sex education until the university level and to restrict it to engaged women and to topics of premarital examination and FP methods. On the other hand, one male teacher from rural Minia suggests that some information could be introduced even at the primary school level because children are curious to know how they came into the world and they need an honest answer that is suitable to their age.

During the FGDs Christian leaders spoke openly with diverse opinions. One leader mentions that youth should learn FP/RH information when they are engaged so that they know their responsibilities in marriage. Prior to engagement, adolescents should learn about the changes occurring in their maturing bodies but that the topic must be handled with sensitivity to the conservative nature of rural communities. Another leader stresses that virtue *(effa)* should be explained to adolescents and that new high school graduates should receive counseling and information on premarital examinations and its importance. The other two Christian leaders suggest that such information should be provided in preparatory and secondary school levels with the information tailored to the needs of each age group. The latter view is based on the fact that nowadays youth can access the wrong information on CD-ROMs and the Internet and so it is better that they be exposed to basic and correct information in school.

Only one Moslem religious leader does not support the dissemination of FP/RH information to adolescents because he feels such information might elicit their sexual desires and instincts and they might want to experiment with sex. But all other Moslem leaders encourage the provision to adolescents of information that is needed to protect them. They identify the important topics as STDs, genital problems and harmful practices. When engaged, youth should be informed about premarital examinations, the disadvantages of early marriages and pregnancies. When married, they should be informed about the correct use of contraceptive methods and birth spacing. One leader adds that, after marriage, youth need to learn the responsibilities of each partner because most divorces result from ignorance of such matters. Such information should be published in a booklet.

It should be noted that one Moslem leader reported that he heard that a topic called "*sexual studies*" was being taught as part of the school curriculum. He opinioned that such information is dangerous and should be provided in religious places such as mosques and churches in order to curtail its negative and dangerous results. Another leader added that adolescents should not think about sexual relations; rather, they need

to concentrate on sports to stop harmful habits such as masturbation, which weakens them.

Maazouns agree that youth should start receiving such information during adolescence, but they agree for different reasons: the need to protect themselves, to avert social problems caused by images broadcast on satellite channels, to prevent them from committing sins and, finally, to curtail their irresponsibility and craziness.

*Omda*s endorse the idea of initiating education with adolescents. They recommend beginning with the topic of the characteristics of puberty and then advance to the topics of STDs, advantages of family planning and FP methods. One *omda* adds that because society may not accept open discussion of sexual relations, such information might be titled *"marital life"* or *"marital happiness."* Furthermore, he underscores that the role of the family in providing youth with correct sexual information should be supported.

The two political leaders in the FGD were split in opinion: One endorses the provision of FP/RH information to adolescents, while the other thinks that it is more appropriate to wait until they are 20-30 years old, especially with regard to males.

To summarize, the generally shared opinion is that students should be provided with information on puberty changes, potential ailments of the reproductive system, harmful practices, STDs and protection methods, disadvantages of early marriages and early pregnancies, as well as basic information on the types of contraceptives. Other information, which is relevant to sexual and marital well-being, should be provided at older ages or when the young men and women are engaged.

Reproductive Health Services for Youth

Readiness of Different Types of Clinics for Providing Services to Engaged and Newly Married Youth

Introduction

Using a specially designed data sheet, the study collected information concerning facilities and services at twenty FP/RH clinics that represent the capital city, a secondary city and two villages in each of the Minia and Sharkiya governorates. These health clinics include two urban health clinics, two MCH centers, two rural health centers/hospitals, two rural health units, four CSI clinics and eight NGO health clinics.

Reproductive Health Services Provided

Table 1 presents the distribution of these centers by the RH services they provide. All types of clinics surveyed provide FP services, antenatal care services and other gynecological services for women. Only three NGO clinics provide RH services to men. All MOHP clinics in urban and rural areas provide natal and postpartum care as well as laboratory analysis services. All rural health centers and units provide home visits and group meetings inside clinics; however, not all urban clinics offer these services. NGO clinics differ in terms of services provided, as only one provides natal care, four provide postnatal care, two provide home visits and/or group meetings and six clinics provide laboratory services. Premarital examinations for females are provided by all CSI clinics and four NGO clinics and only three NGO clinics provide premarital examination services to men. Hence, all MOHP, CSI and NGO clinics provide antenatal care and gynecological care services. RH services for males and premarital examinations for females are covered by only the CSI and some NGO clinics. Premarital examinations for males are provided by only a few NGO clinics. Natal and postnatal care services are provided mainly by MOHP clinics.

Table 1: Health Clinics by Reproductive Health Service Supplied

	Urban Health Centers (2)	MCH Clinics (2)	Rural Health Centers (2)	Rural Health Units (2)	CSI Clinics (4)	NGO Clinics (8)
Family planning	2	2	2	2	4	8
Antenatal care	2	2	2	2	4	8
Natal care	2	2	2	2	-	1
Other gyn. services	2	2	2	2	4	8
Postnatal care	2	2	2	2	3	4
RH services for males	-	-	-	-	-	3
Premarital exams for females	-	-	-	-	4	4
Premarital exams for males	-	-	-	-	-	3
Home visits	1	1	2	2	4	2
Group meetings inside clinic	1	1	2	2	3	2
Lab analysis	2	2	2	2	4	6

Service Statistics

FP Services

Almost all clinics, with the exception of six NGO clinics, keep service statistics for FP clients. Statistics for one CSI clinic were not available due to the absence of the clinic's coordinator. Unfortunately, not all clinics keep statistics regarding the age of their clients. If young married females, under the age of 25 years, are to be adequately targeted for FP services, this age group requires separate recording in service statistics of clinics to assess how well this age group is served. Most statistics reported herein are for the year 2002; however, the two NGO clinics that keep statistics did not open until November 2002 and April 2003 so their statistics reflect different periods.

These two NGO clinics report a range of clients between 17 and 218, with an average of 117 clients per clinic. The range is wide because one clinic had newly opened at the time of the survey. Only this clinic, the Alliance of Arab Women Clinic in Minia City, has statistics on numbers of clients under the age of 25 years: 6 out of a total 17 clients are under the age of 25 years.

The numbers of clients served by CSI clinics ranges from 1,636 to 7,083, with an average of 3,480 clients per clinic per year. None of the CSI clinics keep age statistics for clients.

Urban health centers served a range of 2,485 to 4,131 clients, with an average of 1,233 clients per clinic. Only one center, the General Health Center in Minia El Kamh City, has statistics regarding clients under 25 years of age. This center reports 378 clients under the age of 25, which represents 11 percent of the average number of clients for this clinic type .

The number of FP clients served at MCH centers ranges between 1,179 (Beni Mazar Child Care – Minia Governorate) and 1,288 clients (Child Care # 3 – Zagazig City) with an average of 1,233 clients per clinic. Clients under the age of 25 years represent 24 percent of the annual average.

Rural health centers/hospitals served between 2,202 and 3,461 clients, with an average of 2,831 clients per clinic. Clients under the age of 25 years represent 20 percent of this average.

Rural health units served between 242 and 996 clients, with an average of 819 clients per the year. Similar to rural health centers/hospitals, clients under the age of 25 years represent 21 percent of the client base in rural health units.

Table 2: Clinics by Number of Family Planning Clients

	Urban Health Centers (2)	MCH Clinics (2)	Rural Health Centers (2)	Rural Health Units (2)	CSI Clinics (4)	NGO Clinics (8)
<1000	-	-	-	2	-	2
1000 to 1999	-	2	-	-	2	-
2000 to 2999	1	-	1	-	-	-
3000 to 3999	-	-	1	-	-	-
4000 to 4999	1	-	-	-	-	-
7000 to 7100	-	-	-	-	1	-
No Data	-	-	-	-	1	6

Antenatal Care Services

For antenatal care services, the number of clients served per clinic varies, ranging from 13 clients in one recently opened NGO clinic to over 1000 clients in the two MCH clinics, one rural health clinic/hospital and one rural health unit. The two urban health centers average 762 clients per clinic per the year, and one rural health unit served 327 clients. CSI clinics and 7 NGO clinics keep no separate records of antenatal clients as their numbers were recorded with other gynecological services.

As for clients under the age of 25 years, one NGO clinic that opened in late 2002 reports that 10 out of a total of 13 antenatal cases belong to this age group. All MOHP clinics in rural and urban areas keep separate service statistics for antenatal care services, but only one MCH center has age statistics and reports that 18 percent of its clients are under the age of 25 years. The average number of cases per clinic type during 2002 is 762 cases per urban health center, 2,033 per MCH center, 1,736 per rural health center/hospital and 675 per rural health unit.

Natal, Postpartum and Other Gynecological Care Services

All MOHP clinics provide natal, postpartum and other gynecological care services. In three clinics, the number of clients who receive natal services balance the number receiving postpartum care, but in all other clinics the number of clients receiving natal services is much less than for postpartum services. None of the clinics could report statistics related to the age of clients.

Three out of four CSI clinics offer postnatal care with other gynecological services.

Among NGO clinics, only one provides natal, postpartum and gynecological services, while three provide postpartum and gynecological services, and four provide only gynecological services. With only one exception, NGO clinics do not keep client/service statistics. The exception served 65 clients for gynecological services in the short period since its opening in late 2002.

Home Visits

All MOHP rural clinics provide home visit services, but only one of each type of urban clinic provide such a service. The numbers of home visits done through urban centers ranges from 75 to 1,200 visits for antenatal and postpartum clients. At rural clinics the number of home visits ranges from 2,671 to 4,650 but these numbers may be distorted due to individual reporting.

Among the NGO clinics, only two provide home visit services. They do not, however, keep statistics because they do not pay the *raedat* based on the number of home visits conducted, but rather a percentage of the fees charged to clients whom she brings to the clinic.

Laboratory Tests Services

With the exception of two NGO clinics, all clinics provide laboratory services. Some provide more elaborate tests than others. CSI clinics conduct the most sophisticated

tests but one provides the service on a contract basis with an outside laboratory. Another CSI clinic was not able to provide sophisticated laboratory services to its clients during a vacancy in its laboratory technician position (see Annex Table 5).

Among the clinics that provide laboratory services, all conduct urine analyses. Most clinics conduct pregnancy tests, Rh factor analyses and urine albumin analyses. Only CSI clinics provide semen analyses and two NGO clinics provide premarital examination services. Stool analyses are provided at CSI clinics, three NGO clinics and at the rural clinics, but not at urban clinics. In summary, there is little consistency in the types of laboratory services offered, even within the same clinic type.

Counseling Rooms

All CSI clinics have separate rooms for counseling to ensure privacy. Among other types of clinics, only one MCH center and one NGO clinic have separate rooms. All others have counseling rooms, but they are not separate. Clients are assured of privacy during counseling sessions in all CSI clinics, five NGO clinics, two MCH clinics and one rural health center. Only in one urban center is privacy totally lacking during counseling.

Availability of IEC Materials

With the exception of NGO clinics, all clinics have a flip chart specifically designed for family planning counseling. It explains the importance of FP with emphasis on the health of mother and child and presents all types of contraceptives. NGO clinics were also exceptional in not having at least one FP pamphlet available for distribution. Most pamphlets discuss different contraceptive methods. CSI clinics have one or two additional pamphlet to promote CSI clinics. One NGO clinic offers pamphlets explaining specific contraceptives, adolescence and menopause. A few MOHP centers offer pamphlets on topics other than contraceptives, such as safe motherhood, FP/RH services, STDs, adolescence, menopause, diarrhea, dehydration and hygiene.

Similarly, posters decorate all but six NGO clinics. Posters usually present family planning related messages, promote the clinic's quality of service, or inform clients of available services and prices. Only one or two clinics have posters on the clients' right to ask, choose and receive the most suitable contraceptive or on adolescence, premarital examinations, safe pregnancy, postpartum care, STDs, early detection of cancer and violence against women.

Other IEC materials available at clinics include FP related videos, contraceptives trays and charts presenting information about the clinic.

Employment Structure

Table 3 presents the staffing patterns by clinic type. All reviewed clinics except for some NGO clinics, are reasonably well staffed with a high representation of females. Four NGO clinics have no nurses and one clinic has a male nurse.

Table 3: Distribution of Professional Staff by Clinic Type

	Urban Health Centers (2)	MCH Clinics (2)	Rural Health Centers (2)	Rural Health Units (2)	CSI Clinics (4)	NGO Clinics (8)
	Physicians					
Female	6	5	2	2	5	7
Full Time	6	6	2	2	5	8
Total Physicians	7	6	4	2	5	10
	Nurses					
Female	16	13	14	8	11	5
Full Time	14	13	14	8	9	4
Total Nurses	16	13	14	8	11	6
	Raedat					
Number with No *Raedat*	2	2	-	-	1	6
Full Time	-	-	6	3	6	4
Total	-	-	6	3	9	6
	Lab Technicians					
Number with No Lab Technicians	-	-	-	-	2	5
Female	3	3	1	2	-	1
Full Time	5	3	7	3	1	2
Total	5	3	7	3	2	4

Working Times

All MOHP clinics are open from Saturday to Thursday, but not all have evening sessions and opening and closing times differ by clinic. For these reasons such as these, average working hours per week differ even within the same type of clinic. For example, one rural health unit reported working six days a week, 11.5 hours per day (see Table 4).

Similarly, CSI clinics are open Saturday through Thursday. They, too, have varying opening and closing times and two clinics offer longer hours one day per week.

Each NGO clinic schedules its own hours of operation. Three NGO clinics do not have morning sessions. The other clinics work different days a week, such as Sunday through

Saturday, Saturday through Thursday, or specific days such as Sunday and Wednesday. One clinic opens only one day a week for four hours in the evening.

Table 4: Working Times for Clinics

	Urban Health Centers (2)	MCH Clinics (2)	Rural Health Centers (2)	Rural Health Units (2)	CSI Clinics (4)	NGO Clinics (8)
Number of days morning sessions	6	6	6	6	6	2-7
Number of days evening session	-	6	-	6	5	1-7
Clinics with additional sessions	-	-	-	-	2	-
Clinics with no evening session	2	1	2	1	-	2
Average hours per week per clinic	28	36	24	53	37	22

Views of Health Clinic Staff on Youth Reproductive Health Services

Introduction

The study interviewed all available staff at each clinic including male and female physicians, nurses, *raedat*, laboratory technicians, CSI clinic coordinators and janitors. In addition, the study interviewed eight private physicians and fourteen pharmacists and assistants to solicit their knowledge, attitudes and practices vis-à-vis RH services for youth.

Background Characteristics of Interviewed Staff

Tables 5 and 5.1 demonstrate the distribution of all interviewees in terms of their duration of employment at their clinics or pharmacies. More than half the staff at CSI, NGO clinics and pharmacies has worked there for less than five years. Physicians in these clinics have the lowest employment duration: 54 percent have worked less than five years in the clinics. In comparison, four of the eight private physicians interviewed have worked in their private clinics for ten years or more. In MOHP clinics, except urban health centers, approximately 30 percent of the interviewed staff have worked in the clinic for ten years or more.

Table 5: Duration of Employment at Clinic, by Clinic Type (Percent)

	Urban Health Centers (31)	MCH Clinics (25)	Rural Health Centers (32)	Rural Health Units (17)	CSI Clinics (24)	NGO Clinics (27)	Private Clinics (8)	Pharmacies (14)
< 1 year	3	-	-	6	17	22	-	14
1-4 years	42	36	34	29	37	44	37	57
5-9 years	39	32	34	35	21	15	13	21
10-14 years	6	4	13	12	25	15	37	-
> 15 years	10	28	19	18	-	4	12	7

Table 5.1: Duration of Employment at Clinic, by Profession (Percent)

	Physicians (41)	Nurses / *Raedat* (82)	Support Staff (41)	Pharmacists (14)	Average
< 1 year	10	7	5	14	7
1-4 years	44	37	34	57	39
5-9 years	19	37	22	21	28
10-14 years	15	11	17	-	12
> 15 years	12	8	22	7	13

As for age, marital status and number of children (see Table 6), most physicians are between the ages of 35 to 44 years (63 percent) and have three to four living children (58 percent). Most nurses and *raedat* are 25 to 34 years old (44 percent) and have one to four living children. Surprisingly, a few of the support staff, mainly janitors, have 7-9 living children, keeping in mind that they work at clinics that provide FP services. More than one-third of the interviewed pharmacists/assistants are under the age of 25 years, that is, they are youth, and one-half of them are unmarried.

Table 6: Age and Number of Living Children of Clinic Staff, by Profession (Percent)

	Physicians (41)	Nurses / *Raedat* (82)	Support Staff (41)	Pharmacists (14)
	Age in Years			
< 25 years	-	17	7	36
25-34 years	15	44	29	21
34-44 years	63	21	20	14
	Number of Living Children			
Not married	7	17	15	50
No children	7	6	7	7
1-2 children	27	37	19	14
3-4 children	58	34	29	21
5-6 children	--	6	24	7
7-9 children	--	--	5	--

In terms of work responsibilities, all laboratory technicians take urine and blood samples and carry out laboratory analyses. *Raedat* carry out home visits, counsel women and promote use of contraceptives. Two *raedat* working in a NGO clinic also take part in registration tasks. The interviewed CSI coordinator is responsible for marketing activities. All janitors are responsible for cleaning but about one-quarter of them assist in taking samples for analysis, and one female janitor assists in child deliveries.

The responsibilities of physicians and nurses, in their own view, are shown in Table 7. Noteworthy is the fact that only one-quarter of all physicians mentioned counseling as one of their responsibilities, and none of these physicians are female. About one-quarter of male and female physicians mention they have administrative responsibilities. Other responsibilities for physicians include health services to children, taking blood pressure and weighing clients. Nurses tend to have highly varied responsibilities. Some are involved in sterilization of instruments (15 percent), counseling clients (27 percent), home visits (15 percent), and taking samples and conducting simple analyses (6 percent). In addition, nurses support physicians in provision of medical care services.

Table 7: Stated Work Responsibilities of Physicians and Nurses (Percent)*

	Physicians (41)		Nurses (66)
	Male (18)	*Female (23)*	
Cleaning the clinic	-	-	-
Counseling clients	11	-	27
FP-related services	50	70	29
Deliveries	17	13	15
Gynecological services	67	52	8
Immunization (women and children)	11	23	41
Administration	22	26	30
Taking samples for analysis	6	-	6
Other services	6	4	12
Home visits	-	-	15

*Totals do not add to 100 due to multiple answers

Views on Reproductive Health Services for Youth

Premarital Examinations

As noted earlier, premarital examinations for females are offered in all CSI clinics and in half of the NGO clinics. For males, premarital examinations are only available at three NGO clinics. Thus, 48 percent of interviewed NGO clinic staff and all CSI clinic staff state that the service is offered at their clinic. Two of the interviewed physicians working in private clinics provide this service and only one provides the service to both males and females.

According to established standards, premarital examinations should include the following: a total blood picture including hemoglobin analysis and bleeding and clotting time; Rh factor analysis; blood analysis for STDs (syphilis, AIDS) and hepatitis B & C; urine analysis for diabetes, puss and albumin; semen analysis, and chest x-ray. Tables 8, 8.1 and 8.2 present the physicians' account of analyses included in premarital examinations in their respective clinics. Clearly, not all clinic staff know all purposes for each analysis, or not all clinics provide the same package of analyses. Even among private physicians, the components of their premarital examinations are highly varied. Other components included at some clinics as part of premarital examinations are: analysis for toxoplasmosis, menstrual history, internal check, stool analysis and virus and hereditary disease analysis.

Table 8: Services Performed in Premarital Examinations for Female Clients (Percent)*, by Clinic Type (Number of Staff Reporting)

	CSI Clinics (24)	NGO Clinics (13)	Private Physicians (2)
Total blood picture analysis	25	23	50
Hemoglobin analysis	29	46	50
Bleeding and clotting time test	17	-	-
Rh factor analysis	75	85	50
STDs test	4	15	-
Liver analysis	8	-	-
Urine analysis	67	23	50
Reproductive organs check	29	53	100
Other	33	8	-

*Totals do not add to 100 due to multiple answers

Table 8.1: Services Performed in Premarital Examinations for Male Clients (Percent)*, by Clinic Type (Number of Staff Reporting)

	CSI Clinics (24)	NGO Clinics (13)	Private Physicians (2)
Total blood picture analysis	17	23	50
Hemoglobin analysis	33	-	-
Semen analysis	92	61	50
Rh factor analysis	50	54	-
STDs test	8	23	-
Liver analysis	4	8	-
Urine analysis	17	-	-
Reproductive organs check	-	31	50
Other	12	-	-

*Totals do not add to 100 due to multiple answers

Table 8.2: Staff Opinions Regarding Demand for Premarital Exams (Percent), by Clinic Type (Number of Staff Reporting)

	CSI Clinics (24)	NGO Clinics (13)	Private Physicians (2)
There is a demand	75	38	50
Demand is weak	21	54	50
There is no demand	4	8	-

While most CSI staff (75%) believe that there is demand for the premarital examination service, more than half of the NGO clinic staff (54%) believe that the demand is weak. Only a few are of the opinion that there is no demand for the service. Even the two private physicians who offer the service had differing opinions on the level of demand. All fourteen pharmacists interviewed believe that there is no demand for the service at their locations.

Table 9: Reasons for Low Demand for Premarital Examinations and Suggestions for Action*

	CSI Staff	NGO Staff	Private Physicians	Pharmacists
	Reason for Low Demand			
(Number)	(6)	(8)	(1)	(14)
No awareness of importance	67	100	100	86
Feeling of embarrassment	33	12	-	29
Fear of facing problems	17	25	-	36
No knowledge of the service	-	37	-	14
	Suggestions for Action			
Nothing at clinic level	-	-	100	14
Advertising at health service points	67	37	-	86
Mass media promotion	83	50	100	21
Promotion at religious institutions	-	25	-	-
Government enforcement	-	12	-	-
Greater privacy	-	12	-	-

*Totals do not add to 100 due to multiple answers

Most staff reason that low demand for this service is due to a lack of awareness of the examination's importance among the public. Other reasons include fear of results, embarrassment and lack of knowledge that such a service exists (see Table 9).

Suggestions for increasing demand are split between those that should be implemented by clinics and those that should be implemented by the government. It is suggested that clinics that provide the service should advertise its availability. Nevertheless, the majority of interviewees see an important role for mass promotion of the service through the mass media. One nurse stresses the importance of government enforcement of premarital examinations.

All interviewed staff, regardless of whether their clinics provide the service, were asked to explain the importance of premarital examinations. As shown in Table 10, physicians are more knowledgeable about the importance than other staff, yet their knowledge is limited considering their medical background. The highest proportion of physicians (90 percent) mentioned detection of hereditary diseases as the purpose of premarital examinations; this is followed by identification of the Rh factor (73 percent), assessment of fertility (63 percent) and detection of STDs (58 percent). The opinions of nurses follow almost the same order as physicians but a smaller proportion (28 percent) mention detection of STDs. Pharmacists' knowledge is somewhat similar to that of physicians though a smaller proportion (57%) know about the Rh factor. Other purposes of the premarital examination that are considered important are related to analysis for toxoplasmosis and early detection for any current diseases or health problems. Three-quarters of the support staff mention only the assessment of fertility.

Table 10: Health Staff Views on the Importance of Premarital Examinations (Percent)*

	Physicians (41)	Nurses / *Raedat* (82)	Support Staff (41)	Pharmacists (14)
Detection of STDs	58	28	19	50
Assessment of fertility	63	63	76	64
Identification of Rh factor	73	61	49	57
Detection of hereditary diseases	90	73	46	86
Other	17	16	15	21

*Totals do not add to 100 due to multiple answers

Youth Reproductive Health Ailments

Physicians and pharmacists were asked if unmarried males and females come to their clinics/pharmacies for RH services to treat ailments. As shown in Table 11, unmarried females seem to have greater chances for treatment of reproductive health ailments than

males. The lowest opportunities are in urban Minia (74%) as per reporting of physicians compared to rural Minia and urban Sharkiya. Also, reports from pharmacists indicate that it is easier to receive service from pharmacists than from health clinics.

Table 11: Physicians' and Pharmacists' Opinions on Reproductive Health Care for Males and Females (Percent)*

	Profession		Location			
	Physicians (41)	Pharmacists (14)	Urban Minia (14)	Rural Minia (8)	Urban Sharkiya (10)	Rural Sharkiya (9)
	RH for Females (Types of Problems)					
(Number)	(36)	(13)	(14)	(8)	(18)	(9)
Unmarried females request gynecological services	88	93	74	100	100	90
Menstrual pains	81	85	93	87	78	67
Irregular menstruation	83	85	93	87	89	56
Excessive menstrual bleeding	53	23	57	12	61	22
Inflammations	78	46	79	62	67	67
Other	31	15	36	25	33	-
Believe society approves	58	71	68	75	61	44
	RH for Males					
(Number)	(41)	(14)	(14)	(8)	(10)	(9)
Males can request RH services	34	29	26	50	44	10
Believe society approves	71	71	74	50	83	60

*Totals do not add to 100 due to multiple answers

The most frequently mentioned types of female reproductive health problems by physicians and pharmacists are irregular menstruation and menstrual pains., Physicians, however, more frequently mention excessive menstrual bleeding and vaginal inflammation. Other ailments for which females requested treatment were Rh factor checks, delayed puberty, assurance of intact hymen and unmarried pregnancies.

More pharmacists than physicians believe that society approves of unmarried women requesting reproductive health care. More medical professionals from rural Minia discern societal approval than in other areas. Similarly, rural Minia posts the highest percentage of medical professionals reporting young men requesting RH services from their health facilities (see Table 11). Physicians think that society approves of young men seeking RH care. Yet, although more medical professionals believe that the community they work in approves of young men receiving RH care, fewer actually experience such requests.

As for the other interviewed staff (nurses, *raedat*, laboratory technicians and janitors), almost all agree that unmarried young women need a RH checkup (refer to Table 12).

Almost two-thirds are of the opinion that society approves of unmarried girls with gynecological ailments receiving health care from local clinics, but approximately one-quarter hold the opposite opinion. Again, clinic staff from urban Minia are less confident with society approval. A few staff members comment that such approval depends on the educational level of the family and their degree of awareness.

As with physicians and pharmacists, lower proportions of clinic staff agree that unmarried males need RH care. However, if a need exists, more of these professionals believe that society will approve of males receiving the required health care.

Table 12: Health Staff Views on Reproductive Health Care for Male and Female Youth

	Profession		Location			
	Nurses/ Raedat (82)	*Other Staff (41)*	*Urban Minia (34)*	*Rural Minia (26)*	*Urban Sharkiya (37)*	*Rural Sharkiya (26)*
	Female Youth Could Need Gynecological Care					
Agree (Number)	(80)	(37)	(30)	(25)	(36)	(26)
%	98	90	88	96	97	100
	Perceptions of Societal Approval					
Society approves	64	65	50	60	83	58
Society does not approve	27	24	30	28	14	38
Approval depends on degree of discomfort	6	8	10	12	3	4
Other answers	2	3	10	-	-	-
	Male Youth Could Need Gynecological Care					
Agree (Number)	(30)	(20)	(12)	(16)	(14)	(8)
%	37	49	35	61	38	31
	Perceptions of Societal Approval					
Society approves	72	68	53	77	81	73
Society does not approve	21	29	29	19	19	27
Approval depends on degree of discomfort	6	2	15	4	-	-
Other answers	1	-	3	-	-	-

STDs

Only physicians and pharmacists were questioned about their knowledge of STDs. Physicians have more knowledge than pharmacists (see Table 13). Among both professions, AIDS is the most well known disease followed by gonorrhea and syphilis. Herpes is the least known STD. Hepatitis, potent viruses, vaginal infections, scabies, fungi and early pregnancies were mentioned as STDs. A majority of physicians (83 percent) thought their clients may be infected or carriers of STDs, while the remaining 17 percent negated the possibility.

Table 13: Physicians and Pharmacists by Knowledge of STDs (Percent)*

	Physicians (41)	Pharmacists (14)
AIDS	100	93
Syphilis	90	79
Gonorrhea	98	64
Herpes	39	14
Cited other diseases as STDs	63	100

*Totals do not add to 100 due to multiple answers

Early pregnancies

The study asked clinic staff to identify the potential harmful health effects of early pregnancies for both the mother and child. More nurses and *raedat* (87 percent) than pharmacists know that pregnancies before age 20 pose serious risks for the mother and child. As shown in Table 14, more than half of interviewed pharmacists/assistants (57 percent) do not think that early pregnancies pose a health risk and a few think that only the mother is at risk.

The most frequently mentioned negative health effect for the mother is anemia. Other health effects, in a descending order of frequency mentioned by physicians, are: increased probability of bleeding, difficulty in childbirth, abortion, reproductive system problems such as uterine prolapse, difficulty in becoming pregnant again and uterine atrophy, and osteoporosis. Physicians also mention that young mothers may suffer from an inability to bear the responsibility for children. Other effects mentioned include the probability of suffering from pregnancy toxemia, high blood pressure and emotional disturbance.

The mostly commonly mentioned health effects on the child are low birth weight, short-term birth, slow growth, lower immunity and deformation. A few nurses mention mortality as well as "*light*" breast milk, which could affect the growth of the child.

Clearly, greater awareness of the risks associated with early pregnancies is required among health care providers.

Delay of First Pregnancy

Physicians and pharmacists report low demand among newly married couples for methods to postpone the first pregnancy; yet, more than half of the physicians report that newlywed women had consulted them about delaying the first pregnancy.

Table 14: Knowledge and Attitudes of Health Service Staff Toward Early Pregnancy (Percent)*

	Cited Potential Health Affects of Pregnancy Before Age 20			
	Physicians (41)	***Nurses/Raedat (82)***	***Support Staff (41)***	***Pharmacists (14)***
Health of mother and child	76	87	63	29
Health of mother only	7	1	15	14
Health of child only	-	-	2	-
Does not affect health of mother or child	17	12	17	57
	Cited Potential Health Affects on Mothers			
	Physicians (34)	***Nurses/Raedat (72)***	***Support Staff (32)***	***Pharmacists (6)***
Anemia	56	54	72	83
Abortion	29	26	6	-
Bleeding	53	49	25	-
Delivery difficulties	44	28	16	-
Calcium deficiency	12	14	16	33
RH problems	21	25	22	33
Maternal mortality	6	10	-	-
Unable to bear responsibility	6	11	12	33
Other	23	18	16	-
	Health Affects on Children			
	Physicians (31)	***Nurses/Raedat (71)***	***Support Staff (27)***	***Pharmacists (4)***
Low birth weight	55	59	56	100
Suffers from an inexperienced mother	-	7	4	-
Light breast milk	-	7	-	-
Short term birth	55	42	37	50
Mortality	3	13	4	-
Weak body development	23	15	15	25
Low immunity	23	27	44	-
Deformation	23	22	7	-

*Totals do not add to 100 due to multiple answers

As shown in Table 15, the reasons given for the low demand are many in number and largely reflect the staff's own perceptions. Some medical professionals disapprove of delaying the first pregnancy even if clients request such support. In overwhelming proportions, nurses/*raedat*, pharmacists, clinic support staff and, to a lesser extent, physicians state that the main reason for the lack of demand for postponing the first pregnancy is fear of negative effects on fecundity caused by contraceptive use. Many physicians report that couples opt to confirm their fertility by having the first child as soon as possible. Other perceived reasons for the low demand for postponement strategies include religious disapproval, lack of encouragement from physicians, lack of financial and health reasons to support postponement and fear of side effects on the health of newly married women due to contraceptive use.

Reasons given by health providers and clinic support staff for opposing postponement of the first pregnancy even when requested by newlywed couples are similar to the reasons given above: fertility problems would not be promptly treated; contraceptives may delay pregnancy after discontinuing their use, and couples need first to enjoy having children and then consider delaying subsequent pregnancies. A few others think that contraceptives may cause health problems, newlywed women older than 30 years need to complete their desired fertility in due time, couples lack strong reasons that are required for postponing the first pregnancy and promotion of pregnancy delay is a form of controlling, not planning, fertility which is against religious teachings.

Table 15: Opinions Concerning Delay of First Pregnancy (Percent)*

	General Demand for Delay of First Pregnancy			
	Physicians ***(41)***	***Nurses/ Raedat*** ***(82)***	***Support Staff*** ***(41)***	***Pharmacists*** ***(14)***
Newlywed women request FP services	58	39	37	14
Demand exists	29	27	24	14
Do not know	2	1	10	7
No demand	68	72	66	79

Cont.

	Reasons for Low Demand			
	Physicians ***(28)***	***Nurses/ Raedat*** ***(59)***	***Support Staff*** ***(27)***	***Pharmacists*** ***(11)***
Contraceptives could cause sterility	46	81	78	91
Choose not to delay	14	12	18	36
Difficult to confirm fertility without first pregnancy	71	29	18	9
Not religiously approved	4	-	7	-
Not encouraged by physicians	4	2	-	-
No financial / health Reasons to delay	7	-	-	-
Contraceptive could affect health	7	8	4	9
	Attitudes Toward Delaying First Pregnancy			
	Physicians ***(41)***	***Nurses/ Raedat*** ***(82)***	***Support Staff*** ***(41)***	***Pharmacists*** ***(14)***
Approve	63	56	56	21
Disapprove	37	42	44	79
Other	-	1	-	-

Cont.

	Reasons for Disapproval			
	Physicians ***(15)***	***Nurses/ Raedat*** ***(36)***	***Support Staff*** ***(18)***	***Pharmacists*** ***(11)***
Parents enjoy first child	33	14	17	36
Infertility could be treated promptly	33	53	44	36
Contraceptives may delay pregnancy after discontinuation	27	50	50	64
Women aged 30 should be pregnant during highly fertile period	-	8	-	-
Not religiously approved	7	-	6	-
Strong reasons are necessary	13	-	-	-
Could cause health problems	13	8	-	9

*Totals do not add to 100 due to multiple answers

Table 16 presents staff views on the most suitable contraceptives for use by newly married couples wanting to postpone pregnancy. Most physicians recommend pills and condoms, followed by contraceptive creams and the fertility awareness method. Though pharmacists recommend condoms for postponing the first pregnancy, half recommend IUDs and only about one-third recommend pills. Also, more nurses recommend condoms over pills or creams or the fertility awareness method. Supporting staff (janitors and laboratory technicians) most frequently recommend IUDs and less frequently recommend condoms, pills, contraceptive creams and the fertility awareness method. Their recommendations indicate a lower level of knowledge of contraceptives.

Table 16: Views of Clinic Staff on Recommended Contraceptives for Postponing First Pregnancy (Percent)*

	Physicians (41)	Nurses / *Raedat* (82)	Support Staff (16)	Pharmacists (14)	Total (178)
Pills	71	43	29	36	45
Injectables	7	2	2	7	4
IUDs	17	40	51	50	38
Implants	2	4	7	-	4
Condoms	71	52	34	71	54
Creams	41	26	17	14	26
Natural FP	39	21	15	21	24

*Totals do not add to 100 due to multiple answers

About half of the physicians who recommend pills reasoned that pills have limited side effects and that some types do not affect fecundity. Those physicians who do not recommend oral pills are concerned about hormonal effects and temporary sterility. Most physicians do not recommend injectables because they may cause temporary sterility and have hormonal effects. Physicians have similar concerns regarding implants. They do not recommend IUDs because of difficulty with insertion and they considered them unhealthy for the uterus. About one-quarter of physicians do not recommend condoms because of their limited effectiveness, and difficulty of use. Similar reasoning opposes the recommendation of contraceptive creams, which may also cause vaginal inflammations, and the fertility awareness method (see Annex Tables 6 to 6.6).

After the first child, all service providers become less cautious about recommending contraceptives to couples, as demonstrated in Table 17. Almost all recommend IUDs, followed by oral pills and condoms. Fewer recommend injectables, the fertility awareness method and creams. Injectables and implants are mainly not recommended because they may cause temporary sterility, while creams and the fertility awareness method are not recommended because of their low reliability (see Annex Tables 7 to 7.7).

Table 17: Views of Clinic Staff on Suitable Contraceptives for Women Under 25 Years of Age with One Child (Percent)*

	Physicians (41)	Nurses/ *Raedat* (82)	Support Staff (16)	Pharmacists (14)	Total (178)
Pills	88	57	68	57	67
Injectables	22	16	22	21	19
IUDs	98	100	95	93	98
Implants	15	18	12	-	15
Condoms	49	40	32	43	40
Creams	32	23	19	30	25
Natural FP	29	17	17	21	20

*Totals do not add to 100 due to multiple answers

Counseling Services for Youth

The study asked all health care providers if their clinics/pharmacies provide FP/RH counseling services to engaged and newly married youth (see Annex Table 8). All report that FP counseling is provided for newly married youth. Engaged youth receive FP counseling only at CSI clinics, some urban health clinics and at private clinics. At all types of clinics, nurses are the main providers of counseling except at NGO clinics where physicians are the main providers. Almost all staff prefers to provide the counseling jointly with partners.

Counseling on RH issues is less common. For example, only about half of the staff from CSI, NGO and private clinics reports counseling newly married youth on STDs. Around one-third of CSI clinic staff indicates that their clinics also provide such counseling to engaged youth.

Newly married youth have more access to sexual health counseling than their engaged counterparts. Among staff whose clinics/pharmacies provide this service, not all prefer joint counseling with both partners.

Antenatal and postpartum counseling is mainly provided to newly married youth. This counseling service is also available for the engaged youth at a few clinics, which may mean it is available on an as-requested basis. Similarly, counseling in breastfeeding is offered mainly to the newly married youth but some CSI, NGO and private clinics offer it to engaged youth.

Counseling in premarital examinations is the only RH topic provided mainly for engaged youth. Such service is available only at CSI clinics, a few NGO clinics and half of private clinics and pharmacies. Most staff at these service points prefer counseling both partners.

The study asked each staff member if they have a role in the provision of sexual health counseling for engaged and newly married youth. Eight out of ten physicians responded affirmatively. Most stated that they need training in such counseling. As shown in Table 18, half of the nurses/ *raedat* and pharmacists also affirm their role for both engaged and newly married youth. Most nurses and *raedat* stated that they need training in counseling youth but less than half of the pharmacists indentify such a need.

Table 18: Views of Clinic Staff on Their Role in Sexual Health Counseling for Youth and Their Need for Training (Percent)

	Physicians (41)	Nurses/ *Raedat* (82)	Support Staff (16)	Pharmacists (14)	Average
	Role in Sexual Health Counseling				
Has role for newly married only	5	13	6	-	5
Has role for engaged youth only	5	7	6	7	5
Has role for both groups	80	51	37	50	80
Has no role	7	26	50	43	7
	Staff Need for Training				
Needs training	78	77	50	43	-
Does not need training	22	23	50	57	-

Views on IEC Services

IEC Materials

The study learned that private physicians and pharmacists have no IEC materials available for promotion of RH among engaged and newly married youth. NGO clinics are also inadequately equipped with IEC materials. The four types of clinics operated by MOHP all have low availability of materials, but urban health centers and rural health units had even less materials than rural health centers/clinics and MCH clinics. Most staff members of these MOHP clinics express a need for the materials. CSI clinics are noteworthy for their high frequency of availability of materials. CSI staff confirms making regular use of the IEC materials designed for youth. Nonetheless, half acknowledge a need for more materials. As shown in Table 19, most employees from all clinic types believe there is a need for such materials, but some think there is no need because there is no demand for RH information.

Table 19: Views of Clinic Staff on Availability of and Expressed Need for IEC Materials for Engaged and Newly Married Youth (Percent)

	Urban Health Center (26)	MCH Clinic (22)	Rural Health Centers / Hos (25)	Rural Health Unit (14)	CSI Clinic (20)	NGO Clinic (24)	Private Phys (8)	Pharm (14)
Have materials	23	50	44	29	80	4	-	-
Need more materials	81	73	72	57	50	75	62	71
Do not need	19	27	28	43	50	25	37	29

The additional IEC materials could take various forms. More than half of all interviewees noted a need for posters. Half of the staff of MCH, CSI and private clinics and pharmacies request booklets. Some 40 percent of staff of rural health units and centers, CSI and NGO clinics and pharmacies identify a need for pamphlets. CSI staff and private physicians more frequently mention television spots. In a descending order of frequency, staff from rural health units, rural health centers, hospitals, MCH clinics, NGO clinics, urban health centers and CSI clinics think more group seminars are needed to raise RH awareness. A few suggest radio spots, flip charts and other media forms such CD-ROMS, secondary school textbooks, home visits and magazines.

The following topics are identified as requiring IEC materials:

- Importance of family planning and the use of contraceptives
- Antenatal care and the importance of follow-up medical visits
- STDs and their prevention
- Value and importance of premarital examinations
- Healthy and unhealthy sexual practices and the reproductive physiology of males and females
- Suitable age for a healthy marriage and pregnancy and health effects of early pregnancies on mother and child
- Exclusive breastfeeding and its importance for the health of the mother and child
- Harmful effects of female circumcision

Other recommendations for IEC topics include: puberty, adolescence, consanguineous marriages, general health and hygiene especially of the genitals, malnutrition and hereditary diseases (see Annex Tables 9 to 9.10).

Outreach Services

Raedat and home health educators were asked if they make home visits to the newly married and the engaged. Around one half reported that they visit both these groups, while about one-third said they visit newly married youth only, and about ten percent did not visit either group. Topics discussed during these visits are largely related to FP. The second most frequently discussed topic is child rearing and immunization. Other topics include the effects of malnutrition, health problems associated with genital mutilation, and importance of periodic medical checkups.

Some *raedat* use IEC materials during home visits, while others do not (see Table 20). In general, the majority acknowledges the importance of using IEC materials to communicate messages. Some *raedat* consider IEC materials as helping to convince clients; some find the pictures helpful in explaining contraceptives or other issues, and others appreciate IEC materials because they facilitate presentation of topics that are difficult to discuss.

Three-quarters of the *raedat* identify a need for IEC materials specially designed for engaged youth. They judge the most important topic for new IEC materials for home visits to be the importance of premarital examinations. They also suggest new materials explaining the importance of FP and birth spacing, contraceptives and their potential side effects, issues related to sexual health, STDs and their prevention and appropriate age for marriage and first pregnancy.

But *raedat* believe there is a greater need for IEC materials for newly married youth. They suggest topics ranging from FP and contraceptives to antenatal care, healthy and unhealthy sexual practices, breastfeeding and its importance, malnutrition health problems and general public health and hygiene issues.

Most *raedat* need further training in order to communicate effectively with engaged and newly married youth. Only two *raedat*, one from a rural health clinic and another from an NGO clinic, stated that they had sufficient knowledge and previous training to deal with the FP/RH issues of youth. Those who wished further training identify a need for additional information about FP and contraceptives that addresses newly married couples in addition to sex education and sexual health. Also, over one-third of *raedat* identify a need to develop their interaction skills so as to accurately assess the information needs of the young clients and target counseling to address those needs. A few mention training on the educational needs of newly married youth and on best methods to advocate gender equality.

Table 20: Home Visits Conducted by *Raedat*, by Clinic Type (Percent)

	Rural Health Centers / Hospital (5)	Rural Health Units (3)	CSI Clinics (2)	NGO Clinics (6)	Average
	Home Visits to Engaged and Newly Married				
Visits both engaged and newly married youth	100	33	50	33	56
Visits newly married youth only	-	67	50	33	31
Does not visit either group	-	-	-	33	12
	Topics Covered During Contact				
Family planning	80	100	50	100	87
Child rearing and immunization	40	67	-	33	37
Problems caused by genital mutilation	20	-	-	-	6
Malnutrition problems	-	-	-	33	12
Importance of visiting clinics	20	-	50	-	12

Table 20.1: Opinions of *Raedat* Regarding IEC Materials, by Clinic Type (Percent)

	Rural Health Centers / Hospital	Rural Health Units	CSI Clinics	NGO Clinics	Average
	(5)	(3)	(2)	(6)	
	Use of IEC Materials During Visits				
Distribute IEC materials	-	-	50	-	6
Does not communicate	20	-	-	-	6
Uses IEC materials during visits	40	67	100	17	44
Needs training in use of IEC materials	80	100	100	83	87
	Impact of IEC Materials in Visits				
No importance	20	-	-	17	12
Important for FP contraceptives	60	33	-	-	25
Help convince clients	40	33	-	50	37
Demonstrate topics difficult to discuss	-	-	100	-	12
Assist in clarifying & explaining issues	-	33	-	50	25
	IEC Materials Needed for Engaged				
No need for materials	60	-	-	17	25
FP and contraception	20	-	100	-	19
STDs and protection	20	-	-	-	6
Importance of premarital exams	40	-	50	67	44
Appropriateness of premarital exams	20	-	-	-	6
Sexual health issues	-	67	-	17	19
Other topics	-	33	-	17	12
	IEC Materials Needed for Newly Married				
No need for materials	20	-	-	17	12
FP and contraception	60	67	100	67	69
Antenatal care	20	33	-	17	19
Sex education issues	-	33	-	-	6

Breastfeeding	20	33	-	-	12
Other topics	20	-	-	17	12
	Training Needs				
Number who need training	4	3	2	5	14
Counsel to client needs	25	33	50	40	36
Sex education	25	67	-	-	21
FP and contraceptives	75	33	50	40	50
Sexual health	-	33	-	40	21
Assess needs of newly married	-	33	-	-	7
Promote gender equality	-	-	-	20	7

Information, Education and Communication Efforts Addressed to Youth

Ministry of Health and Population

Among IEC activities for youth, the MOHP mainly supports seminars. Target audiences and topics vary from district to district. Generally, seminars targeting adolescents are held in secondary schools and youth centers, although some districts offer seminars in local government health units and other educational institutes. In the city of Minia, MOHP's IEC officer states that seminars targeting adolescents and those who influence them, mainly parents, cover issues such as STDs, the physiological, psychological and social changes at puberty, consequences of over population, family planning, female circumcision and good nutrition. In the secondary city of Minia El Kamh, the MOHP conducts a monthly seminar hosted by physicians and religious leaders to discuss RH topics ranging from adolescence through pregnancy and delivery. The IEC official from Beni Mazar indicates that seminars for adolescents in this district related to smoking and addiction. In Zagazig, an urban center in Sharkiya governorate, the MOHP conducts seminars on the importance of premarital examination, STDs and harmful effects of female circumcision.

When the target audience is engaged youth, the seminars usually promote premarital examinations. One official commented that health centers and units in urban Minia do not offer this service so they ask engaged youth to receive the service from hospitals. Similarly, the official from the secondary city in Minia states that all IEC efforts for engaged youth relate to FP issues. The Zagazig official notes that seminars at secondary schools and literacy classes that target adolescents might also have engaged or newly married youth in the audience. This Zagazig district also targets engaged and pregnant women for seminars in MCH centers and, to a lesser extent, youth centers on such topics as the meaning of RH starting with marriage, antenatal care, birth spacing and breastfeeding. Only the official at Sharkiya secondary city did not mention premarital examinations as a topic when targeting engaged youth. Here they cover issues such as at-risk pregnancies, including early pregnancies.

All MOHP officials mention seminars targeting married women, but the age range of the audience was unclear. Also, the study did not determine the extent to which MOHP targets IEC activities to married men. One official of Minia secondary city mentioned that male attendance at seminars is very low, never exceeding 2 percent. For this reason, he relies on interpersonal communications with his male friends to promote FP/RH issues.

All IEC officials note that they rely on a mixture of medical and religious speakers for seminars. Only Sharkiya officials mention use of brochures and flip charts in lectures and seminars. Opinions regarding the impact and effectiveness of IEC activities are vague. It seems that IEC activities in contraceptive use and antenatal care are quite successful. Flip charts, brochures, television spots and promotion of services are

additional achievements. All officials are of the opinion that the costs of IEC activities, relative to the numbers of people reached, are quite reasonable.

A few constraints to success are mentioned. First is the difficulty to target the right audience because non-school seminars are publicly announced and a wide range of people attend. Other identified constraints are: insufficient transportation facilities; lack of IEC materials, particularly audiovisual aids and equipment, and lack of MOHP appreciation of the efforts exerted to undertake IEC activities.

IEC officials believe that youth need additional information before marriage. Information concerning sexual problems between couples could be discussed in small groups of 10 persons. Information concerning STDs, premarital bad habits and unhealthy sexual relationships should be discussed privately, or in groups gender specific groups. Other necessary topics include consanguineous marriages and drug abuse. It is suggested that issues discussed in the mass media should take the form of panel discussions and should include a *sheikh*.

IEC officials note that newly married youth need to be informed about antenatal and postnatal care, child immunization, and FP. This information could be provided through television spots. They also need to know more about healthy relationships between partners, the meaning of family, rearing healthy children and the importance of checkups for early detection and treatment of genital diseases. Information could be disseminated through group meetings. Mass media can also be used to inform the public regarding the availability of such medical services. Lectures and seminars for both engaged and newly married youth should bring together physicians, religious leaders and older youth in a discussion. Videos would also be an effective IEC tool, but they need to be created so as not to embarrass members of the targeted audience.

State Information Services

IEC activities are also organized by the State Information Service. The study interviewed one SIS official in each of Minia and Sharkiya governorates. Activities include public meetings, school programs, seminars and training sessions. SIS activities are conducted in close collaboration with MOHP, local government units, local NGOs at villages and districts and school administrations.

FP/RH Topics and Target Audiences

In 1992, SIS and MOHP collaborated in a project called the “Minia Initiative for Population Communication” which involved five types of activities implemented in villages: activities for the general public, activities for youth, discussion group activities, school activities, and educational activities in village councils and youth centers. They produced a film based on a short story comparing a large and small family. Topics targeted at youth in schools were female circumcision, mother and child health and premarital examinations. These initiatives had great results.

When the project concluded, it was replaced by “Quarterly Programs.” In each quarter, a program is developed and approved by the SIS and implemented with MOHP.

Programs mainly comprised public meetings at health units/centers to motivate women to use contraceptives. This activity is not conducted currently. A three-day training program on the population problem is being implemented. Trainees from this program participate in awareness activities in villages.

The SIS official in Sharkiya state that they implement instructions from the Cairo SIS/IEC Center concerning messages for target audiences on topics such as health effects of early marriages, early pregnancies, contraceptive use, female circumcision, relationship between partners and determination of child gender. Messages are communicated to target audiences through religious leaders, physicians and social scientists. Additionally, teams of trained agricultural extension workers, public service youth and *raedat* deliver messages to housewives. Sharkiya youth are targeted through seminars held at schools, youth centers and public meeting at local NGOs. At these seminars, physicians present information on early marriages and premarital examinations. Other activities take place at health facilities to target married women of reproductive age.

Youth Meetings

In Minia, the criteria of success for youth meetings are attendance, participation in discussions and attention through to the meeting's conclusion. Success could be enhanced with good solid preparation for the meeting, use of audiovisual aids to visually enhance the meeting's message and use of brainstorming activities with small prizes to encourage participation. Youth meetings have the challenge of encouraging participants to stay until the meeting's end. Such a challenge does not exist for school meetings where students are obliged to stay or training sessions where participants have made a commitment to learn. To motivate audiences of youth meetings to remain until the end, booklets could be distributed at the meeting's conclusion. In Sharkiya, the criteria for success are good preparation and coordination and the number present. The only problem noted is attendance of Islamic fundamentalists at these public meetings because they ask questions that embarrass the religious leader because fundamentalists have different ways of understanding religious teachings.

Youth-to-Youth

Opinion concerning the efficacy of the youth-to-youth method for delivering information is divided. In Minia, this method is considered very effective. Trained youth act as mobile communication units able to deliver information and convince people of the target messages. But in Sharkiya, the official is not convinced that the approach is effective. He believes that speakers should be well known and influential in order to convince audiences of the message's importance and the information's veracity.

Future Development

Among SIS activities in Minia, the most effective are training programs and group discussion meetings at schools, especially those offered at vocational schools. With the addition of new films describing current concepts, audiovisual equipment and printed IEC materials for information recall after the seminars, their effectiveness would be

superior. Sharkiya seminars are accompanied by audiovisuals and pamphlets are distributed among the audience to further strengthen the message's impact.

AIDS ranks high among RH topics suggested for future youth activities. The SIS official in Minia recommends that this topic be communicated interpersonally (i.e., face-to-face) and not through mass media. Also, engaged newly married youth need to know about healthy marital, social and sexual relationships, the rights of women and men within the family and the rights of children. All these topics, important as they are, have been neglected in the past. Seminars are considered an appropriate communication channel for these topics. The Minia official proposes that both partners attend, except when sexual relations are discussed. In the latter case, separate meetings should be offered for males and females. A social scientist is recommended as the speaker. The official in Sharkiya emphasizes that the messages need to come from reliable sources presenting scientific information in an indirect manner to counter the obscene sexual programs seen by youth on the satellite networks. He notes that television already covers a number of topics in programs such as *"If We Stop Dreaming"* and *"Maspero."* Furthermore, SIS Cairo/IEC Center has recently instructed the Sharkiya office that new topics will include equitable gender treatment of children, male preference, role of husband in determining the sex of the infant and health effects of early pregnancy.

NGOs

Family Planning Association in Minia

Between 1996 and 1998 the Family Planning Association participated in a youth-to-youth project. They carefully selected thirty youth leaders and trained them. In the study interview, the Association's director did not recall details of topics covered but remembered that the project targeted secondary school students and university students with an emphasis on secondary vocational schools because they usually marry a year after graduation. Youth leaders requested the Association to help organize seminars and select speakers based on selected topics and contents, which included reproductive and sexual health. This project targeted engaged youth and married men.

At approximately the same time, the Association was involved in another project that was directed at married men as partners and concentrated on ways to protect the woman's health. Seminars were held at syndicates, factories and agricultural cooperatives.

Beni Mazar Community Development Association

The Beni Mazar Community Development Association addresses issues related to RH, female circumcision and infant and pregnancy care. FP topics focus mainly on raising awareness of over population and its economic and social consequences. The Association organizes seminars for engaged youth, carries out home visits and targets grandmothers as important guides for the youth. Female and male volunteers conduct the home visits. The Association's director thinks that sex education is needed for youth

but that it is a difficult topic to address because of societal norms and values. In addition, engaged youth need information on premarital examinations.

Family Planning Association in Zagazig

This Association works only in the area of FP. It organizes two or three public meetings per year in which a religious leader and a physician participate. Women and female youth attend these meetings that concentrate on FP issues (including birth spacing) and mothers' health. In the past, some meetings have been held at youth centers similar topics and but targeted to male youth; audience numbers, however, were low. The Association believes that these meetings are more effective than lectures in mosques because the meetings offer a dialogue of questions and answers rather than a one-way flow of information.

The Association's representative sees a need for youth information on sexual issues because it is important for youth to avoid danger. Such awareness-raising should begin with the adolescents at preparatory schools. General reproductive health information should be provided in meetings. Youth with specific information needs can speak with the lecturer after the meeting. Mass media also has an important role to play in the provision of information, particularly for engaged youth, and facilitating activities at the local level.

The representative notes that additional topics related to mother and child health issues are needed for the newly married youth. These issues could be addressed through seminars and distributed printed materials. Programs on CD-ROMS and videotapes would support lecturers and attract more youth to the presentations.

Al Azizia Community Development Association

This Association is affiliated with and implements the programs of the Egyptian Family Planning Association. The Association began working with youth over five years ago to make them aware of the negative consequences of over population. Later it began raising awareness among the youth about the dangers of drug abuse and STDs. They conducted a series of youth meetings at the university and in youth centers on dangers of drug abuse. The project targeted male youth and was implemented for only a year before ceasing due to a lack of finances.

Last year, with the support of the Alexandria Institute for Training and Research in Family Planning (ITRFP), the Association developed a program to use female facilitators to educate girls between the ages of eight and twenty. Topics range from personal hygiene and basic nutrition to FP contraceptives, harms of circumcision and other RH issues that are of interest to adolescents. The Association has trained 21 volunteer facilitators, each of whom becomes responsible for fifteen girls for a one-year period. The first group of trainee facilitators has graduated, and a second training session has commenced. In the respondent's opinion, this is the Association's most effective activity as the year-long process had a greater impact than attending a seminar for one day.

Another activity directed to male and female youth is a set of seminars in which religious leaders trained at ITRFP in Alexandria and physicians talk about STDs, female circumcision and other current RH topics.

The FP centers operated by the Association do offer awareness raising activities and services, including discussion of topics on the health effects of repeated pregnancies. The centers provide individual and small group (10 women) counseling. Counseling is offered in a cycle, starting with women's first pregnancy and guiding them through to postpartum care and then birth spacing. The Association has requested that premarital examination services be offered at their FP clinics; as yet the services have not yet been introduced so requests for premarital examinations are referred to CSI clinics.

The Association also has a car with a loudspeaker to promote services offered at the FP center as well as to announce seminars. It also relies heavily on word-of-mouth: it encourages individuals who have been exposed to awareness-raising meetings and seminars to spread the information among their friends and family.

The two main constraints to the Association's work are the lack of coordination between different agencies working in the field of FP awareness and insufficient funds. It seems that once a project is complete there are no funds to sustain the activities that have been introduced.

Cultural Palaces

In the 1990s, the activities offered by the Minia City Cultural Palace were in collaboration with the "Minia Initiative for Population Communication," as described above by the Minia SIS official. The Cultural Palace participated on artistic endeavors of this project; for example, the music department/section of the Minia Cultural Palace created the slogan for the project. The Palace's contribution involved eight weeks of intensive activity over a two-year period. It presented a play, or *mawal*, highlighting the advantages of small families and the disadvantages of large families. A lecture preceeded the play and a discussion followed. An outcome of this play is a set of recommendations that youth should learn the meaning of reproductive health, the need for premarital examinations, health protection for females, etc.

However, the Minia Cultural Palace considers its most notable activity to be the production of a play in 2000 called "Warda and the Rabbit" about female circumcision and early marriage. MOHP financed the play and the Minia Theatre Troupe produced and presented it. Originally, the play was scheduled for presentation in Metay district only; but due to its great success, the play went on to engage audiences in other villages. In total, there were fifty performances reaching some 100,000 people of all ages as it did not target any specific age group or category.

The Beni Mazar Cultural Palace also presented "Warda and the Rabbit" in its district. Again, it was a huge success with a confirmed attendance of approximately 2000 people. The Beni Mazar Cultural Palace also holds art exhibitions occasionally and hosts lectures and seminars, particularly during the summer. The lectures and seminars are hosted by *sheikhs*, priests, university professors and physicians and are held in the

local council units or in schools. The local *omda* is informed and asked to prepare the place and to publicize the event at mosques and churches. These lectures and seminars also attract a number of people: about 30–40 people per session and about 1500 in total. These lectures do not specifically target a youth group, but sometimes the topics addressed are relevant issues such as female circumcision and school dropout. Seminars for newlywed couples are planned.

In Zagazig, the Cultural Palace offers general seminars dealing with cultural, scientific and health issues. Seminars do not address RH issues specifically and their activities do not target youth specifically. In the past, a folklore troupe presented a dance *(raasat el seboaa)* that could be said to promote FP. The Cultural Palace official notes that a women's club that meets at the Palace has offered many educational activities (sewing, cooking, etc.) to enable participants to be productive members of their families.

The Minia El Kamh Cultural Palace hosts an annual lecture series entitled "Population and Health." Specialist physicians and writers in this area present lectures that are targeted to young, engaged women and those who influence their decisions (e.g., mothers and men who have authority in their lives). Topics focus on the need for premarital examinations and the advantages of small families. An official with the Cultural Palace thinks that the most effective seminars are those given by gynecologists who use pictures and brochures to enhance their presentations. Another popular seminar addressed the upbringing of Moslem adolescents, which was attended by students and youth of a marriageable age. This seminar involved a discussion of a booklet for adolescents with information on topics such as how to live a proper life, pollution and health.

Youth Centers

The youth center in Minia City offered one seminar on population, family planning and "*reproductive health*." Presented by a gynecologist, the seminar specifically targeted young women as it was given under the auspices of the Women's Club. It covered topics such as population increases, population and health, family planning, birth spacing, etc. Apart from that one seminar, as described by an official of the center, the only other activities that specifically target youth are sports activities.

In contrast, the Beni Mazar youth center holds regular seminars on family planning as a result of a very good relationship with MOHP. Seminars are held at least once every month that cover FP topics such as the impact of repeated pregnancies on the health of the mother. Seminars do not deal with RH topics. They jointly target male and female youth of marriageable age and married couples and attract approximately 50–75 attendees to each seminar. The youth center also has a nutrition education project, which teaches mothers how to rear their children, covering the different stages including adolescence, in addition to basic first aid. The target group for this activity is young women above 13 years of age.

An official with the Zagazig City youth center states that the center received instructions to form "*population awareness groups*." Consequently, in the past year they have held ten seminars on different aspects of the population problem. Topics include

the role of women in society, family planning, the concern for reproductive health, female circumcision and the illegality of *orphy* marriages. They target both males and females between the ages of 15 and 35 years, without distinction between married and unmarried. In the beginning, attendance was low with only about 14 people attending. It was determined that this age group is not interested in lectures but in work opportunities or sports. As a result, the youth center held the lectures in the playground/courts or combined them with other activities such as a trip or a special occasion. The lecture format was transformed into a discussion group and attendance increased. In total, about 400–500 people attended the "*lectures*" over a one-year period.

The Om El Zein youth center has not held any seminars specifically related to RH. They offer general cultural and religious seminars that target youth in the 15–30 age group. One seminar did address the issue of early marriage, but this was primarily a religious seminar.

General Attitudes

The study asked IEC officials about their attitudes toward premarital counseling, premarital examinations, delay of first pregnancy and youth knowledge of STDs. All agree that premarital counseling services for engaged youth are very important to ensure stable and healthy marital relationships and healthy children. One cultural palace official notes that he learned of the counseling services offered by FP centers through promotional television spots.

IEC officials also consider premarital examinations as very important and require promotion through television spots, seminars, brochures and face-to-face communication. In some locations, the services do not yet exist and so promotion must wait. Some officials suggest that promotion campaigns highlight the cases of real families who suffer as a consequence of not having the examination. Campaigns could emphasize that premarital examinations will save engaged youth from such emotional and financial strains. They also need to know where the service is available. These officials consider that a law is needed to make a certificate of premarital examination a prerequisite for completing the official marriage papers.

The group adamantly does not accept delay of the first pregnancy for a number of stated reasons. First, couples must establish their fecundity by having the first pregnancy after which they can postpone subsequent pregnancies. Second, family pressure would be great because mothers and mothers-in-law want pregnancy to occur on the wedding night. Third, contraceptives used to delay the first pregnancy may cause sterility and physicians may not agree to prescribe contraceptives. Lastly, they emphasize, in the absence of serious health or financial reasons, there is no need to postpone pregnancy. Only one youth center official endorses delay of the first pregnancy, pending on couple's approval, to improve the quality of life of the family. Also one SIS official says that delay could be encouraged if safe contraceptives that do not cause sterility are available at reasonable prices.

All favor raising youth awareness of STDs and protection methods. Actually, it was not clear that they really know much about STDs themselves, with the exception of AIDS. Only one official mentioned gonorrhea.

Evaluation of Efforts

The study asked officials to identify additional activities to increase youth knowledge so as to protect their sexual and reproductive health. Their responses are very varied based on their varied experiences.

IEC officials with the MOHP suggest panel discussions concerning a variety of topics. They believe that panel discussions are more attractive for youth and are more effective than lectures. They also recommend more seminars should be implemented in schools, better health services should be provided and trained people should implement seminars.

SIS officials suggest an activity where youth are encouraged to conduct their own research to learn how to search for information. They also suggest contests to reward youth who give the best answers to topical questions.

NGO officers suffer from an inability to maintain project activities after funding stops; therefore, they need greater support from the government. They also suggest empowering *raedat* for personal, face-to-face communication and increasing the numbers of seminars, conferences and meetings with specialists.

Youth center officials mention expansion of topics and training seminars led by specialists. One stresses the need for a raised level of awareness of the importance of FP/RH to youth among officials at the Ministry of Youth and Sports so that they will be more supportive of such activities.

Cultural palace officials suggest that the MOHP open youth counseling offices in villages. Also, the number of meetings and seminars for university and secondary school students should be increased and the same information should be present to their parents so they might support the development of their own youth.

Officials of all types of institutions note the important need for funds to cover activity costs. They also concur on the need for additional IEC materials and equipment including brochures, videos, CD-ROMS, slides and booklets. Printed materials must be designed in an attractive way and need to be widely distributed to school libraries. Training, it is noted, is only required by those who will manage and follow-up on seminars, as well as for speakers and educators so that they may become more knowledgeable of all issues related to sexual and reproductive health of youth. There is also an expressed need for better coordination between ministries of Health and Population, Culture, Information, and Youth and Sports to pool their resources, to provide the needed support and to support and approve the development of local programs.

Factors that Lead to Seminar Success

Success of FP/RH seminars is dependent on a number of factors, according to the IEC officials. First, good preparation for the seminar and effective coordination of all parties concerned is a must. Part of preparation is to select appropriate places to hold the seminar. The place needs to be comfortable and have seating for all who attend. No one should need to sit on the floor. Another criterion for selecting the place is proximity to the targeted audiences of the community.

Selection of topic and speakers are also of high importance to the success of seminars. The repetition of topics reduces motivation to attend. Topics should be selected on the basis of what youth want to know about. For this reason, the participation of youth in the selection of topics would lend greater success to the seminar. The quality of selected speakers is another success factor. Selected speakers must be knowledgeable in the subject matter, have presentation skills and be capable of opening up discussions from the floor to increase interaction with the audience rather than have a one-way flow of information. It is recommended that a combination of medical specialists and religious leaders who are well informed of the topic causes the audience to be more convinced of the seminar's messages.

Another dimension of good preparation is to accurately define the target audience and the messages to be conveyed. Finally, advertising and promotion activities for the seminar are of vital importance to increase motivation to attend the seminar. The selected time for holding the seminar should be suitable for the targeted audience.

During the seminar, audiovisual aids make presentations more attractive and comprehensible. Encouraging dialogue with the audience is important. The audience will come to the seminar with questions and concerns that need to be addressed. It is important for the lecturer to know how youth think and problems they encounter and provide participants with opportunities to share their concerns and find answers to their questions. One youth center official adds that discussions during seminars often lead to success because youth become more relaxed and get to know each other and become less embarrassed to discuss issues of mutual interest. Distributing brochures at the end of the seminar adds value because youth can share their new knowledge with others and can refer to the distributed materials to refresh their memory.

Available IEC Materials for Youth Reproductive Health

MOHP has pamphlets on adolescence, available FP/RH services, STDs and early marriages and pregnancy. These pamphlets are available at MOHP directorates and departments and from IEC specialists. SIS officials only have pamphlets on FP. Youth centers have no IEC materials regarding youth reproductive health. Similarly, cultural palaces do not have this information, with the exception of a theatre play on female circumcision and pictures brought in by lecturers.

Only one NGO had one picture on each of the topics of family planning, over population and consanguineous marriage. They provide plays and folklore dances to promote FP and RH and the disadvantages of early marriage.

In terms of additional IEC materials needed, NGOs request booklets on premarital examinations, counseling and STDs. Posters with specific messages are considered useful for posting at youth centers, NGOs, universities and schools. Videos for use in seminars and television spots are also mentioned. Only one MOHP IEC official reports that additional IEC materials are not required because a number of pamphlets had been received recently. Other MOHP offices request brochures to be distributed, with the addition of booklets and videos on RH issues for all life stages including adolescence, husband/wife selection and relationship, premarital examinations and FP methods. They also stress the important role of television programs, series and spots. Youth center and cultural palaces officials request the same materials.

Conclusion and Recommendations

Conclusion

Youth, whether adolescent, engaged or newly married, have a relatively adequate knowledge of their reproductive health (RH) but there remain a number of issues that they need to know better. Not all youth have a clear understanding of what the concept of reproductive health entails, the physiology of reproduction of males and females and other topics related to marital reproductive and sexual health. Hence, they could have heard of issues but they are not necessarily well informed. Even if informed, some may not be convinced. Additionally, in certain cases when some are convinced, they may not take the necessary action either out of embarrassment, fear of results, or lack of knowledge of where help or service can be obtained.

The desire, the necessity, and the usefulness of increased knowledge are general attitudes among the youth, family and community leaders who influence decisions and health providers. Knowing more is considered a first step toward self protection and a vehicle to ensure marital health and satisfaction. However, determining what type of knowledge should be acquired at which age cycle is controversial due to a general concern over societal acceptance of opening such topics to youth before they are engaged, and concern over the potential negative effects of discussing such matters with adolescents and opening up ideas in their minds.

Access of youth to RH services is almost non-existent with the exception of FP and antenatal care services to young married women. Even FP services may be limited for those who consider postponing their first pregnancy due to attitudes of health providers and others who influence their decisions, due to fear of the effects of contraceptives on fecundity. A number of factors limit access of youth to RH services. These factors include embarrassment of youth in declaring such ailments, fear of parents for the reputation of their children, as well as limited availability of such services to youth in RH clinics, especially in rural areas and for males.

As for information, education and communication resources, agencies and institutions such as NGOs, MOHP IEC services, youth centers, cultural palaces as well as religious institutions and schools are all available resources that have not yet been adequately tapped in addressing the needs of adolescents, engaged and newly married youth. A few IEC materials are available in the form of a book titled, *I've Grown* and pamphlets on adolescence, STDs and early marriage and pregnancy. They are all informational and not really targeting behavioral change and have limited circulation. There is a great expressed need for more behavioral change communication materials that assist youth in knowing more about their reproductive system and how to protect it, the benefits of premarital examination and postponing early pregnancies and how to achieve these benefits, and on healthy marital relationships including sexual health. Such materials are also needed for those who influence youth such as parents, teachers, IEC officials and

religious leaders so that they may increase their knowledge and awareness and reduce the overall societal tendency to be embarrassed from discussing such topics.

General Recommendations

1. To increase access of youth to needed information and reproductive health services, it is recommended that a number of activities be implemented at the national level to initiate the process and set the scene that will facilitate such accessibility.
2. It is recommended that a national communication strategy and plan be developed and implemented targeting the general public to increase general awareness and convince the public of the necessity and benefits of informing adolescents and youth of all topics related to their reproductive health. Such a campaign, if successful, will reduce the overall societal taboo and embarrassment of discussing such topics, and make parents more knowledgeable, willing and capable of discussing such issues with their children and seek counseling and health services when needed.
3. Officials of ministries of Health and Population, Education, Information, Social Affairs, Youth, Culture and Awqaf should be assisted in having roundtable meetings to discuss and agree on their roles in increasing access of youth to reproductive health information and services. Such agreement will assist in integrating planned activities within their respective ministries and in providing greater support to their field staff to address informational and service needs of adolescents and the young engaged and newly married.
4. MOHP should consider addressing the need of engaged and newly married youth for reproductive health premarital counseling as well as the need of male youth for reproductive health services, especially in rural areas where private physicians may not exist.
5. A comprehensive training curriculum and training manual need to be developed and used for training health clinics outreach workers and health providers, officials of youth centers, cultural palaces and NGOs, IEC officers of MOHP and State Information Services, religious leaders and relevant radio and television staff. Such training should include necessary scientific information on issues related to reproductive health and healthy marital relationships. This will increase access of adolescents and the young engaged to accurate information needed to secure their reproductive health.
6. Additionally, ministries have to be supported in developing IEC and BCC materials needed for their planned activities. Such materials could be in the form of booklets and pamphlets for distribution, books to be put on sale and videos to support seminars for youth and parents. Such materials should provide sound, culturally acceptable information and guidance that would support youth to enter adulthood with knowledge and information about sexual and reproductive health to become, healthy, satisfied and responsible parents.

Annex

Annex Table 1: Summary Table of the Total Sample by Type of Data Collection Tools

Clinic Data Sheets (20)	
Urban Health Clinics	2
MCH Centers	2
Rural Health Center/Hospitals	2
Rural Health Units	2
CSI Clinics	4
NGO Health Clinics	8
Clinic Staff Structured Interviews (186)	
Physicians	41
Nurses and *Raedat*	82
Support staff (lab technicians, clinic coordinators and janitors)	41
Private sector physicians	8
Pharmacists and assistants	14
Focus Group Discussions (28)	
Female secondary students	4
Engaged females (15-24 years of age)	4
Newlywed females (15-24 years of age)	4
Male secondary students	4
Engaged males (< 30 years of age)	4
Newlywed males (< 30 years of age and married less than 3 years)	4
Mothers and mothers-in-law	4

Cont.

In Depth Interviews (46)	
Female teachers	6
Male teachers	6
Christian leaders	4
Muslim leaders	4
Maazouns	4
Omda	2
Local Popular Council members	2
MOHP IEC officials	4
SIS IEC officials	2
Youth center officials	4
Cultural Palace officials	4
NGO officials	4

Annex Table 2: Clinic Data Sheet and Number of Interviews with Staff in Minia and Sharkiya Governorates

	Minia Governorate				Sharkiya Governorate			
	Districts		*Villages*		*Cities*		*Villages*	
	Minia	*Beni Mazar*	*Zahra*	*Ibshak*	*Zagazig*	*Minia El Kamh*	*Om El Zein*	*El Judida*
CSI Clinic	5	8	-	-	6	5	-	-
Urban Health Center	17	-	-	-	-	13	-	-
Rural Hospital	-	-	17	-	-	-	-	15
Health Unit	-	-	-	6	-	-	11	-
NGO Clinic	3	-	12	-	-	3	-	2
Christian NGO Clinic	-	4	-	-	4	-	-	-
Muslim NGO Clinic	-	-	-	6	4	-	-	-
Private Physicians	2	1	-	1	1	1	1	1
Pharmacists	4*	1	-	2*	3*	1	2	1
MCH Clinic	-	8	-	-	17	-	-	-

* Pharmacists and Assistants

Annex Table 3: Categories of Participants in Focus Group Discussions

	Minia Governorate				Sharkiya Governorate			
	Districts		*Villages*		*Cities*		*Villages*	
	Minia	*Beni Mazar*	*Zahra*	*Ibshak*	*Zagazig*	*Minia El Kamh*	*Om El Zein*	*El Judida*
Male secondary students	7	-	-	8	7	-	-	7
Female secondary students	-	7	8	-	-	7	9	-
Engaged males	-	6	8	-	-	8	8	-
Engaged females	7	-	-	8	7	-	-	7
Newly married males	-	7	7	-	7	-	-	9
Newly married females	8	-	-	8	-	7	8	-
Mothers and mothers-in-law	-	8	7	-	-	7	-	7

Annex Table 4: In-depth Interviews with Community and Religious Leaders Who Influence Youth

	Minia Governorate				Sharkiya Governorate			
	Districts		*Villages*		*Cities*		*Villages*	
	Minia	*Beni Mazar*	*Zahra*	*Ibshak*	*Zagazig*	*Minia El Kamh*	*Om El Zein*	*El Judida*
Male teacher	✔	✔	✔		✔	✔		✔
Female teacher	✔	✔		✔	✔	✔	✔	
Muslim religious leader	✔							
Christian religious leader		✔	✔		✔			✔
Local Popular Council member	✔				✔			
Maazoun		✔	✔			✔	✔	
Sheikh				✔		✔	✔	
Omda				✔				✔

Annex Table 4.1: In-depth Interviews with Information, Education and Communication (IEC) Officials

	Minia Governorate				Sharkiya Governorate			
	Districts		*Villages*		*Cities*		*Villages*	
	Minia	*Beni Mazar*	*Zahra*	*Ibshak*	*Zagazig*	*Minia El Kamh*	*Om El Zein*	*El Judida*
MOHP	✔				✔	✔		
Youth Center	✔	✔			✔		✔	
Cultural Palace	✔	✔			✔	✔		
SIS	✔				✔			
Family Planning Association	✔							
Community Development Association		✔						
Health Directorate		✔						
NGO					✔	✔		

Annex Table 5: Laboratory Services Available, by Clinic Type (Number Used/Available)

	Urban Health Centers (2)	MCH Clinics (2)	Rural Health Centers / Hospitals (2)	Rural Health Units (2)	CSI Clinics (4)	NGO Clinics (8)
Urine	2/2	2/2	2/2	2/2	4/4	6/6
Total blood picture	0/1	1/1	1/1	0/0	2/4	3/3
Stool	2/2	0/0	2/2	2/2	2/4	2/3
Semen	0/0	0/0	0/0	0/0	2/4	2/2
Sedimentation rate	1/1	0/0	1/2	0/1	2/4	3/4
Bleeding time	2/2	1/1	1/2	1/1	2/4	3/3
Coagulation time	2/2	1/1	1/2	1/1	2/4	3/3
Vaginal secretion	0/0	0/0	0/0	0/0	2/4	0/0
Pregnancy tests	1/2	2/2	2/2	1/1	4/4	6/6
Rh factor	1/1	2/2	2/2	2/2	4/4	3/5
Urine albumin	2/2	2/2	2/2	2/2	4/4	4/4
Gonorrhea test	1/1	1/1	1/2	1/1	1/3	1/1
Blood type	0/0	2/2	0/0	1/1	3/4	3/4
Diabetes	2/2	2/2	1/1	0/0	3/4	3/3

Annex Table 6: Views of Clinic Staff (N) on Suitability of Using Contraceptive Pills to Delay First Pregnancy (Percent)

	Physicians (41)	Nurses/ Outreach Workers (82)	Pharmacists (14)	Other Support Staff (41)	Average
Recommend (Number)	71 (29)	43 (37)	36 (5)	29 (12)	45 Total = 83
Does not recommend (Number)	27 (11)	51 (44)	57 (8)	49 (20)	45 Total = 83
Depends on situation	-	2	-	-	1
Does not know	2	4	7	22	8
	Reasons for Recommending				
Some types do not affect fecundity	24	51	40	8	35
Limited side effects	45	24	20	42	34
Easy to use	14	5	-	42	13
Regulates the menstrual cycle	3	5	-	8	5
Prompt pregnancy following discontinuation	14	14	40	-	13
	Reasons for Not Recommending				
Hormones are harmful	36	41	50	45	42
Side effects (dizziness, weakness)	9	9	-	5	7
Causes temporary sterility	36	14	25	20	20
Causes irregular menstruation	-	4	-	5	4
Could be used incorrectly	-	7	12	-	5
Causes allergies	-	2	-	-	1
Causes sterility	18	23	12	25	22

Annex Table 6.1: Views of Clinic Staff (N) on Suitability of Using Injectables to Delay First Pregnancy (Percent)

	Physicians (41)	Nurses / Outreach Workers (82)	Pharmacists (14)	Other Support Staff (41)	Average
Recommend (Number)	7 (3)	2 (2)	7 (1)	2 (1)	4 Total=7
Does not recommend (Number)	90 (37)	95 (79)	86 (12)	78 (32)	89 Total=160
Depends on situation	-	1	-	-	1
Does not know	2	1	7	19	6
	Reasons for Recommending				
Some types do not affect fecundity	67	-	-	-	29
Limited side effects	33	50	-	-	29
Easy to use	-	50	100	-	29
Prompt pregnancy following discontinuation	-	-	-	100	14
	Reasons for Not Recommending				
Hormones are harmful	22	16	17	16	18
Side effects (dizziness, weakness)	-	-	-	6	1
Causes temporary sterility	60	44	42	28	44
Causes irregular menstruation	8	8	25	9	9
Causes sterility	11	30	17	37	26
Other reasons	-	1	-	3	1

Annex Table 6.2: Views of Clinic Staff on Suitability of Using IUDs to Delay First Pregnancy (Percent)

	Physicians (41)	Nurses / Outreach Workers (82)	Pharmacists (14)	Other Support Staff (41)	Average
Recommend	17	40	50	51	38
(Number)	(8)	(34)	(7)	(22)	Total=71
Does not recommend	78	57	50	27	54
(Number)	(32)	(48)	(7)	(12)	Total = 99
Depends on situation	2	1	-	2	2
Does not know	2	1	-	20	6
	Reasons for Recommending				
Does not affect fecundity	37	30	29	23	28
No side effects	25	29	14	23	25
No hormones	37	21	14	27	24
Suits everyone	-	-	14	4	3
Effective	-	21	29	23	20
	Reasons for Not Recommending				
Not effective	-	-	-	8	1
Uncomfortable for men	-	4	14	-	3
Uterus cannot tolerate	19	31	29	25	26
Difficult to insert	53	29	-	17	33
Causes bleeding	6	19	29	17	15
Uterine problems	6	6	29	17	9
Not accepted for use	3	-	-	8	2
Other	12	10	-	8	10

Annex Table 6.3: Views of Clinic Staff on Suitability of Using Implants to Delay First Pregnancy (Percent)

	Physicians	Nurses/ Outreach Workers	Pharmacists	Other Support Staff	Average
	(41)	(82)	(14)	(41)	
Recommend (Number)	2 (1)	4 (3)	- (-)	7 (3)	4 Total=7
Does not recommend (Number)	95 (39)	85 (71)	64 (9)	54 (22)	79 Total = 141
Depends on situation	-	1	-	-	1
Does not know	2	10	36	39	17
	Reasons for Recommending				
Some types do not affect fecundity	100	33	-	-	29
Limited side effects	-	-	-	100	43
Other	-	66	-	-	28
	Reasons for Not Recommending				
Hormones are harmful	13	25	22	18	21
Side effects (dizziness, weakness)	3	-	-	4	1
Causes temporary sterility	67	38	33	23	43
Causes irregular menstruation	5	6	11	4	6
Causes allergies	-	-	-	4	1
Causes sterility	13	30	22	36	25
Other	-	1	11	9	3

Annex Table 6.4: Views of Clinic Staff on Suitability of Using Condoms to Delay First Pregnancy (Percent)

	Physicians (41)	Nurses/ Outreach Workers (82)	Pharmacists (14)	Other Support Staff (41)	Average
Recommend (Number)	71 (30)	52 (44)	71 (10)	34 (14)	54 Total=98
Does not recommend (Number)	24 (11)	41 (34)	14 (2)	44 (18)	36 Total = 65
Depends on situation	2	1	-	-	1
Does not know	2	5	14	22	9
	Reasons for Recommending				
Does not affect fecundity	13	20	-	7	14
Suitable to use for short periods	-	2	-	-	1
Suits everyone	-	-	-	7	1
Effective	10	4.5	-	7	6
No side effects	40	39	40	71	44
No hormones	33	34	60	7	33
Other	3	-	-	-	1
	Reasons for Not Recommending				
Not effective	64	71	-	56	63
Uncomfortable for men	27	18	-	39	25
Affects uterus	-	3	-	-	1
Not accepted for use	9	3	50	-	5
Other	-	6	50	6	6

Annex Table 6.5: Views of Clinic Staff on Suitability of Using Creams to Delay First Pregnancy (Percent)

	Physicians (41)	Nurses/ Outreach Workers (82)	Pharmacists (14)	Other Support Staff (41)	Average
Recommend	41	26	14	17	26
(Number)	(18)	(23)	(2)	(7)	Total=50
Does not recommend	51	52	43	22	44
(Number)	(22)	(44)	(6)	(9)	Total=81
Depends on situation	2	2	-	-	2
Does not know	5	19	43	61	27
	Reasons for Recommending				
Does not affect fecundity	33	13	-	14	20
Effective	-	4	-	-	2
No side effects	44	35	100	86	48
No hormones	17	43	-	-	26
Other	6	4	-	-	4
	Reasons for Not Recommending				
Not effective	64	52	33	56	54
Difficult to use	-	-	17	-	1
Causes bleeding	-	2	-	-	1
Affects uterus	9	2	-	-	3
Not accepted for use	4	7	-	-	5
Other	23	36	50	44	35

Annex Table 6.6: Views of Clinic Staff on Suitability of Using Fertility Awareness Method to Delay First Pregnancy (Percent)

	Physicians	Nurses / Outreach Workers	Pharmacists	Other Support Staff	Average
	(41)	(82)	(14)	(41)	
Recommends	39	21	21	15	24
(Number)	(21)	(27)	(3)	(6)	Total=57
Does not recommend	44	56	29	34	46
(Number)	(22)	(56)	(4)	(15)	Total=97
Depends on situation	12	12	-	2	9
Does not know	5	11	50	49	21
	Reasons for Recommending				
No side effects	67	67	33	67	65
No hormones	9	11	33	17	12
Does not affect fecundity	9	4	-	-	5
Suits everyone	-	-	33	-	2
Effective	5	7	-	17	7
Other	9	11	-	-	9
	Reasons for Not Recommending				
Not effective	95	95	100	100	96
Uncomfortable for men	4	-	-	-	1
Causes bleeding	-	2	-	-	1
Difficult to use	-	4	-	-	2

Annex Table 7: Views of Clinic Staff on Suitability of Using Oral Contraceptives for Birth Spacing (Percent)

	Physicians (41)	Nurses / Outreach Workers (82)	Pharmacists (14)	Other Support Staff (41)	Average
Recommends	88	57	57	68	67
(Number)	(36)	(50)	(8)	(29)	Total=123
Does not recommend	12	39	21	24	28
(Number)	(5)	(35)	(3)	(11)	Total=54
Depends on situation	-	4	7	2	3
Does not know	-	-	14	5	2
	Reasons for Recommending				
Some types do not affect fecundity	22	22	25	17	21
Limited side effects	36	42	37	41	40
Ease of use	-	-	12	14	4
Regulates the menstruation cycle	6	4	-	-	3
Prompt pregnancy after discontinuation	8	14	12	10	11
Does not affect breastfeeding	25	14	12	14	17
Other	3	4	-	3	3
	Reasons for Not Recommending				
Hormones are harmful	40	20	67	27	26
Side effects (dizziness, weakness)	40	17	33	-	17
Causes temporary sterility	-	9	-	27	11
Causes irregular menstruation	-	-	-	9	2
Could be used incorrectly	-	14	-	-	9
Causes allergies	-	-	-	9	2
Other	20	40	-	27	33

Annex Table 7.1: Views of Clinic Staff on Suitability of Using Injectables for Birth Spacing (Percent)

	Physicians (41)	Nurses / Outreach Workers (82)	Pharmacists (14)	Other Support Staff (41)	Average
Recommends	22	16	21	22	19
(Number)	(10)	(13)	(3)	(9)	Total=35
Does not recommend	73	83	64	71	76
(Number)	(32)	(69)	(10)	(29)	Total=140
Depends on situation	5	1	7	-	2
Does not know	-	-	7	7	2
	Reasons for Recommending				
Some types do not affect fecundity	30	23	-	22	23
Limited side effects	20	54	33	44	40
Ease of use	30	-	33	33	20
Regulates the menstruation cycle	-	15	-	-	6
Prompt pregnancy after discontinuation	10	8	-	-	6
Does not affect breastfeeding	10	-	33	-	6
	Reasons for Not Recommending				
Hormones are harmful	22	17	10	14	17
Side effects (dizziness, weakness)	-	4	-	10	4
Causes temporary sterility	56	43	70	28	45
Causes irregular menstruation	6	10	10	7	9
Causes sterility	16	25	10	31	23
Other	-	-	-	10	2

Annex Table 7.2: Views of Clinic Staff on Suitability of Using Capsules for Birth Spacing (Percent)

	Physicians (41)	Nurses / Outreach Workers (82)	Pharmacists (14)	Other Support Staff (41)	Average
Recommends (Number)	15 (7)	18 (15)	- (-)	12 (5)	15 Total=27
Does not recommend (Number)	80 (35)	73 (61)	57 (9)	56 (23)	70 Total=128
Depends on situation	5	1	7	-	2
Does not know	-	7	36	32	13
	Reasons for Recommending				
Some types do not affect fecundity	14	13	-	-	11
Limited side effects	29	53	-	100	56
Ease of use	14	20	-	-	15
Prompt pregnancy after discontinuation	43	7	-	-	15
Other reasons	-	7	-	-	4
	Reasons for Not Recommending				
Hormones are harmful	11	16	22	13	15
Side effects (dizziness, weakness)	-	-	-	9	2
Causes temporary sterility	69	46	56	22	48
Causes irregular menstruation	3	2	11	-	2
Causes allergies	-	-	-	4	1
Causes sterility	17	33	11	39	28
Other	-	3	-	13	4

Annex Table 7.3: Views of Clinic Staff on Suitability of Using Condoms for Birth Spacing

	Physicians (41)	Nurses/ Outreach Workers (82)	Pharmacists (14)	Other Support Staff (41)	Average
Recommends (Number)	49 (20)	40 (35)	43 (6)	32 (14)	40 Total=75
Does not recommend (Number)	51 (21)	54 (46)	29 (6)	46 (20)	50 Total=93
Depends on situation	-	2	14	2	3
Does not know	-	4	14	19	7
	Reasons for Recommending				
No side effects	45	40	33	71	47
No hormones	35	43	50	14	32
Does not affect fecundity	5	6	-	7	5
Effective	15	20	17	-	15
Other	-	-	-	7	1
	Reasons for Not Recommending				
Not effective	76	85	50	60	75
Uncomfortable for men	19	13	17	40	20
May cause inflammations	5	-	17	-	2
Not accepted for use	-	-	17	-	1
Other	-	2	-	-	1

Annex Table 7.4: Views of Clinic Staff on Suitability of Using IUDs for Birth Spacing

	Physicians	Nurses / Outreach Workers	Pharmacists	Other Support Staff	Average
	(41)	**(82)**	**(14)**	**(41)**	
Recommends	98	100	93	95	98
(Number)	(20)	(35)	(6)	(14)	Total=75
Does not recommend	2	-	7	2	2
(Number)	(21)	(46)	(6)	(20)	Total=93
Does not know	-	-	-	2	1
	Reasons for Recommending				
No side effects	30	24	38	41	30
No hormones	-	13	8	5	8
Does not affect fecundity	10	19	8	18	16
Suits everyone	10	6	-	3	6
Effective	50	35	46	33	39
Other	-	1	-	-	1
	Reasons for Not Recommending				
Not effective	100	-	-	-	33
Uncomfortable for men	-	-	-	100	33
May cause inflammations	-	-	100	-	33

Annex Table 7.5: Views of Clinic Staff on Suitability of Using Creams for Birth Spacing (Percent)

	Physicians (41)	Nurses / Outreach Workers (82)	Pharmacists (14)	Other Support Staff (41)	Average
Recommends (Number)	32 (15)	23 (22)	30 (4)	19 (9)	25 Total=50
Does not recommend (Number)	61 (28)	56 (49)	29 (4)	17 (8)	46 Total=89
Depends on situation	7	4	-	2	4
Does not know	-	17	43	61	25
	Reasons for Recommending				
No side effects	40	32	75	78	46
No hormones	33	32	-	11	26
Does not affect fecundity	7	4	-	-	4
Suitable to use for short periods	-	-	-	11	2
Effective	7	23	25	-	14
Other	13	9	-	-	8
	Reasons for Not Recommending				
Not effective	82	69	75	62	73
Causes bleeding	-	2	-	-	1
Affects uterus	-	2	-	12	2
Not accepted for use	4	2	-	-	2
Other	14	24	25	25	21

Annex Table 7.6: Views of Clinic Staff on Suitability of Using Fertility Awareness Method for Birth Spacing (Percent)

	Physicians	Nurses / Outreach Workers	Pharmacists	Other Support Staff	Average
	(41)	(82)	(14)	(41)	
Recommends	29	17	21	17	20
(Number)	(17)	(23)	(3)	(7)	Total=50
Does Not Recommend	54	63	29	37	52
(Number)	(28)	(62)	(4)	(16)	Total=110
Depends on Situation	15	12	-	2	10
Does not Know	2	7	50	44	18
	Reasons for Recommending				
No side effects	59	48	33	86	56
No hormones	18	17	33	-	16
Does not affect fecundity	6	4	-	-	4
Effective	-	9	33	14	8
Other	18	22	-	-	16
	Reasons for Not Recommending				
Not effective	100	98	100	100	99
Other	-	2	-	-	1

Annex Table 7.7: Views of Clinic Staff on Suitability of Using Other Contraceptive Methods for Birth Spacing

	Physicians	Nurses/ Outreach Workers	Pharmacists	Other Support Staff	Average
	(41)	(82)	(14)	(41)	
Recommends	-	-	-	-	-
(Number)	-	(1)	-	-	Total=1
	Reasons for Recommending				
Effective	-	1	-	-	1

Annex Table 8: Reports of Clinic Staff on Availability of Different Types of Counseling by Clinic Type (Percent)

	Urban Health Centers	MCH Clinics	Rural Health Centers	Rural Health Units	CSI Clinics	NGO Clinics	Private Clinics	Pharm
	(26)	(22)	(25)	(14)	(20)	(24)	(8)	(14)
	Family Planning Counseling Available							
For the engaged	38	4	4	-	80	8	25	-
For the newly married	100	100	100	100	100	100	100	57
Provided by:								
nurse	81	77	64	71	65	12	-	-
physician	19	23	36	29	35	71	100	-
outreach worker	-	-	-	-	-	17	-	-
Preferred for both partners	92	91	76	100	90	79	100	-
	Antenatal Care Counseling Available							
For the engaged	-	-	12	-	15	8	12	-
For the newly married	100	100	96	100	80	100	87	14
Provided by:								
nurse	42	36	24	36	60	8	-	-
physician	58	64	76	64	20	71	100	-
outreach worker	-	-	-	-	-	21	-	-
Preferred for both partners	38	64	56	43	50	46	75	-

Annex Table 8 (continued): Reports of Clinic Staff on Availability of Different Types of Counseling by Clinic Type (Percent)

	Urban Health Centers (26)	MCH Clinics (22)	Rural Health Centers (25)	Rural Health Units (14)	CSI Clinics (20)	NGO Clinics (24)	Private Clinics (8)	Pharm (14)
	Breastfeeding Counseling Available							
For the engaged	-	-	8	-	25	42	12	7
For the newly married	100	100	88	100	100	96	87	29
Provided by:								
nurse	77	82	60	86	40	8	-	-
physician	23	18	32	14	60	67	87	-
outreach worker	-	-	-	-	-	21	-	-
Preferred for both partners	19	23	8	21	35	21	50	-
	STD Counseling Available							
For the engaged	-	4	4	-	30	8	12	7
For the newly married	23	23	12	7	55	46	62	14
Provided by:								
nurse	4	9	4	7	25	4	-	-
physician	19	18	8	-	30	42	62	-
outreach worker	-	-	-	-	-	-	-	-
Preferred for both partners	4	23	4	-	35	25	62	-

Annex Table 8 (continued): Reports of Clinic Staff on Availability of Different Types of Counseling by Clinic Type (Percent)

	Urban Health Centers (26)	MCH Clinics (22)	Rural Health Centers (25)	Rural Health Units (14)	CSI Clinics (20)	NGO Clinics (24)	Private Clinics (8)	Pharm (14)
	Sexual Health Counseling Available							
For the engaged	8	-	-	-	20	-	12	-
For the newly married	27	14	4	-	40	37	75	14
Provided by:								
nurse	11	4	-	-	5	4	-	-
physician	15	9	4	-	35	33	75	-
outreach worker	-	-	-	-	-	-	-	-
Preferred for both partners	4	9	4	-	30	17	62	-
	Postpartum Care Available							
For the engaged	-	-	8	-	5	-	12	-
For the newly married	100	100	96	100	40	92	87	14
Provided by:								
nurse	81	82	48	43	25	4	-	-
physician	19	18	52	57	15	79	100	-
outreach worker	-	-	-	-	-	8	-	-
Preferred for both partners	8	32	16	21	5	12	75	-

Annex Table 8 (continued): Reports of Clinic Staff on Availability of Different Types of Counseling by Clinic Type (Percent)

	Urban Health Centers	MCH Clinics	Rural Health Centers	Rural Health Units	CSI Clinics	NGO Clinics	Private Clinics	Pharm
	(26)	(22)	(25)	(14)	(20)	(24)	(8)	(14)
	Premarital Examination Available							
For the engaged	-	-	-	-	95	25	12	7
For the newly married	-	-	4	-	30	12	37	-
Provided by:								
nurse	-	-	-	-	60	-	-	-
physician	-	-	-	-	30	21	50	-
outreach worker	-	-	-	-	-	-	-	-
Preferred for both partners	-	-	4	-	90	17	50	-

Annex Table 9: Reports of Clinic Staff on Types of IEC Materials Needed

	Urban Health Centers (26)	MCH Clinics (22)	Rural Health Centers (25)	Rural Health Units (14)	CSI Clinics (20)	NGO Clinics (24)	Private Clinics (8)	Pharm (14)
Need IEC Materials/ Activities	81	73	72	57	50	75	62	71
(Number)	(21)	(16)	(18)	(8)	(10)	(18)	(5)	(10)
Posters	62	50	50	37	20	50	60	70
(Number)	(13)	(8)	(9)	(3)	(2)	(9)	(3)	(10)
Pamphlets	29	31	50	50	40	56	20	40
(Number)	(6)	(5)	(9)	(4)	(4)	(10)	(1)	(4)
Flip Charts	5	-	11	-	-	22	20	-
(Number)	1	-	2	-	-	4	1	-
Booklets	38	56	33	12	50	33	60	80
(Number)	(8)	(9)	(6)	(1)	(5)	(6)	(3)	(8)
Cassettes	-	-	-	12	-	-	-	-
(Number)	-	-	-	(1)	-	-	-	-
Videos	14	6	22	25	40	33	-	-
(Number)	(3)	(1)	(4)	(2)	(4)	(6)	-	-
Seminars	38	44	44	62	20	39	-	-
(Number)	(8)	(7)	(8)	(5)	(2)	(7)	-	-
Radio Spots	-	6	6	12	-	-	20	20
(Number)	-	(1)	(1)	(1)	-	-	(1)	(1)
TV Spots	19	12	17	12	70	22	40	10
(Number)	(4)	(2)	(3)	(1)	(7)	(4)	(2)	(1)

Annex Table 9.1: Reports of Clinic Staff on Poster Topics Needed by Clinic (Percent)

	Urban Health Centers (26)	MCH Clinics (22)	Rural Health Centers (25)	Rural Health Units (14)	CSI Clinics (20)	NGO Clinics (24)	Private Clinics (8)	Pharm (14)
(Number who requested posters)	(13)	(8)	(9)	(3)	(2)	(9)	(3)	(10)
Family planning (methods and importance)	54	25	33	-	-	33	-	30
Pregnancy care and follow-up	23	25	11	-	-	33	-	-
STDs and prevention methods	31	37	33	-	50	44	33	20
Importance of premarital examination	46	50	56	67	50	33	67	50
Safe and unsafe sex and Body physiology	8	25	44	33	50	22	-	-
Right marriage age and Hazards of early pregnancy	15	-	11	33	-	-	33	10
Breastfeeding and its importance	-	-	11	-	-	-	33	-
Female circumcision and its harmful effects	8	-	-	-	50	-	-	-
Other Topics	8	-	-	-	-	11	33	-

Annex Table 9.2: Reports of Clinic Staff on Pamphlet Topics Needed by Clinics (Percent)

	Urban Health Centers (26)	MCH Clinics (22)	Rural Health Centers (25)	Rural Health Units (14)	CSI Clinics (20)	NGO Clinics (24)	Private Clinics (8)	Pharm (14)
(Number who requested pamphlets)	(6)	(5)	(9)	(4)	(4)	(10)	(1)	(4)
Family planning (methods and importance)	50	100	33	25	-	60	-	10
Pregnancy care and follow-up	33	20	11	-	25	20	-	-
STDs and prevention methods	17	40	11	25	50	20	-	10
Importance of premarital examination	33	-	78	25	75	40	100	20
Safe and unsafe sex, body physiology	17	20	33	25	25	20	-	-
Right marriage age and Hazards of early pregnancy	17	-	11	-	-	10	-	-
Breastfeeding and its importance	-	-	-	25	-	10	-	-
Female circumcision and its harmful effects	17	-	-	25	-	-	-	-
Other topics	-	-	11	-	-	20	100	20

Annex Table 9.3: Reports of Clinic Staff on Flip Chart Topics Needed by Clinics (Percent)

	Urban Health Centers (26)	MCH Clinics (22)	Rural Health Centers (25)	Rural Health Units (14)	CSI Clinics (20)	NGO Clinics (24)	Private Clinics (8)	Pharm (14)
(Number who requested flip charts)	(1)	(-)	(2)	(-)	(-)	(4)	(1)	(-)
Family planning (methods and importance)	-	-	-	-	-	100	100	-
Pregnancy care and follow-up	100	-	-	-	-	-	-	-
STDs and prevention methods	100	-	50	-	-	25	-	-
Importance of premarital examination	-	-	50	-	-	25	100	-
Safe and unsafe sex and Body physiology	-	-	-	-	-	25	-	-
Breastfeeding and its importance	-	-	50	-	-	-	-	-

Annex Table 9.4: Reports of Clinic Staff on Booklet Topics Needed by Clinics (Percent)

	Urban Health Centers (26)	MCH Clinics (22)	Rural Health Centers (25)	Rural Health Units (14)	CSI Clinics (20)	NGO Clinics (24)	Private Clinics (8)	Pharm (14)
(Number who requested booklets)	(8)	(9)	(6)	(1)	(5)	(6)	(3)	(8)
Family Planning (methods and importance)	50	33	17	-	20	66	-	10
Pregnancy care and follow-up	62	44	33	100	-	50	-	10
STDs and prevention methods	-	33	33	-	20	-	-	30
Importance of premarital examination	37	33	67	-	10	67	67	50
Safe and unsafe Sex, and Body physiology	-	22	17	-	60	-	33	20
Right marriage age and Hazards of early pregnancy	12	-	-	100	-	-	33	20
Breastfeeding and its importance	12	11	17	-	-	-	-	-
Other Topics	25	11	-	-	-	-	-	10

Annex Table 9.5: Reports of Clinic Staff on Cassette Topics Needed by Clinics (Percent)

	Urban Health Centers (26)	MCH Clinics (22)	Rural Health Centers (25)	Rural Health Units (14)	CSI Clinics (20)	NGO Clinics (24)	Private Clinics (8)	Pharm (14)
(Number who requested cassettes)	-	-	-	(1)	-	-	-	-
STDs and prevention methods	-	-	-	100	-	-	-	-
Right marriage age and Hazards of early pregnancy	-	-	-	100	-	-	-	-

Annex Table 9.6: Reports of Clinic Staff on Video Topics Needed by Clinics (Percent)

	Urban Health Centers (26)	MCH Clinics (22)	Rural Health Centers (25)	Rural Health Units (14)	CSI Clinics (20)	NGO Clinics (24)	Private Clinics (8)	Pharm (14)
(Number who requested videos)	(3)	(1)	(4)	(2)	(4)	(6)	(-)	(-)
Family planning (methods and importance)	33	100	25	-	-	83	-	-
Pregnancy care and follow-up	67	-	-	-	25	17	-	-
STDs and prevention methods	-	-	50	-	-	33	-	-
Importance of premarital examination	33	100	50	100	25	33	-	-
Safe and unsafe sex, and Body physiology	-	-	25	50	100	33	-	-
Right marriage age and Hazards of early pregnancy	-	-	25	-	-	-	-	-
Female circumcision and its harmful effects	33	-	-	-	-	-	-	-
Other topics	33	-	-	-	-	-	-	-

Annex Table 9.7: Reports of Clinic Staff on Seminar Topics Needed by Clinics (Percent)

	Urban Health Centers (26)	MCH Clinics (22)	Rural Health Centers (25)	Rural Health Units (14)	CSI Clinics (20)	NGO Clinics (24)	Private Clinics (8)	Pharm (14)
(Number who requested seminars)	(8)	(7)	(8)	(5)	(2)	(7)	-	-
Family planning (methods and importance)	37	43	37	-	100	86	-	-
Pregnancy care and follow-up	50	14	12	-	-	-	-	
STDs and prevention methods	-	14	25	20	-	29	-	-
Importance of premarital examination	-	29	62	40	-	-	-	-
Safe and unsafe Sex, and Body physiology	12	14	25	20	-	29	-	-
Right marriage age and Hazards of early pregnancy	25	-	-	20	-	29	-	-
Breastfeeding and its importance	50	-	12	20	-	-	-	-
Other topics	12	14	25	20	-	-	-	-

Annex Table 9.8: Reports of Clinic Staff on Radio Spots Needed by Clinics (Percent)

	Urban Health Centers (26)	MCH Clinics (22)	Rural Health Centers (25)	Rural Health Units (14)	CSI Clinics (20)	NGO Clinics (24)	Private Clinics (8)	Pharm (14)
(Number who requested radio spots)	-	(1)	(1)	(1)	-	-	(1)	(1)
Family planning (methods and importance)	-	-	-	-	-	-	-	10
STDs and prevention methods	-	100	-	-	-	-	-	-
Importance of premarital examination	-	-	-	-	-	-	-	10
Safe And unsafe sex, and Body physiology	-	-	-	-	-	-	100	-
Right marriage age and Hazards of early pregnancy	-	-	-	-	-	-	100	-
Breastfeeding and its importance	-	-	100	-	-	-	-	-
Other Topics	-	-	-	100	-	-	-	-

Annex Table 9.9: Reports of Clinic Staff on Television Spots Needed by Clinics (Percent)

	Urban Health Centers (26)	MCH Clinics (22)	Rural Health Centers (25)	Rural Health Units (14)	CSI Clinics (20)	NGO Clinics (24)	Private Clinics (8)	Pharm (14)
(Number who requested television spots)	(4)	(2)	(3)	(1)	(7)	(4)	(2)	(1)
Family planning (methods and importance)	75	-	33	-	43	75	-	40
Pregnancy care and follow-up	-	100	-	-	-	-	50	-
STDs and prevention methods	-	50	33	-	-	25	-	-
Importance of premarital examination	25	-	33	-	71	50	100	10
Safe and unsafe sex, and Body physiology	25	-	33	-	-	-	50	-
Right marriage age and Hazards of early pregnancy	-	-	-	-	14	25	-	-
Breastfeeding and its importance	-	-	33	-	-	-	-	-
Female circumcision and its harmful effects	-	-	-	-	14	-	-	-
Other topics	-	-	33.3	100	14	-	-	-

Annex Table 9.10: Reports of Clinic Staff on Other IEC Items Needed by Clinics (Percent)

	Urban Health Centers (26)	MCH Clinics (22)	Rural Health Centers (25)	Rural Health Units (14)	CSI Clinics (20)	NGO Clinics (24)	Private Clinics (8)	Pharm (14)
(Number who requested other IEC items)	(5)	(1)	(1)	-	(1)	(2)	(1)	-
Family planning (methods and importance)	20	100	-	-	-	100	-	-
Pregnancy care and follow-up	40	-	-	-	-	-	-	-
Right marriage age and Hazards of early pregnancy	-	-	100	-	-	-	-	-
Female circumcision and its harmful effects	-	-	100	-	-	-	-	-
Other topics	60	-	-	-	100	-	100	-

Annex Table 10: Characteristics of Focus Group Discussion Participants

	Engaged Males		Newly wed Males		Engaged Females		Newly wed Females		Male Students		Female Students		Mothers/ Mothers-in-law	
Urban/Rural	*U*	*R*	*U*	*R*	*U*	*R*	*U*	*R*	*U*	*R*	*U*	*R*	*U*	*R*
Focus group discussions	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Participants	16	16	14	16	14	15	15	16	14	15	14	17	13	15
	Age in Years													
Minimum	18	19	27	23	19	16	17	17	15	15	15	15	43	45
Maximum	29	29	30	30	24	21	24	24	17	17	17	17	64	65
Average	22.1	25.4	28.8	26.5	21.9	18.4	21.2	21.6	16	16.7	16	16.1	54.3	54.3
	Education Levels (Percent)													
Illiterate	-	6	-	19	7	20	40	19	-	-	-	-	62	73
Primary	-	-	-	12	-	-	7	-	-	-	-	-	8	7
Inter-mediate	6	-	-	12	-	-	-	6	-	-	-	-	-	-
Secondary	75	63	79	38	21	80	53	69	100	100	100	100	30	20
University	19	31	21	19	71	-	-	6	-	-	-	-	-	-
	Work Status (Percent)													
Not working	6	25	-	-	35	87	100	62	-	-	-	-	77	80
Wage earner	-	-	-	5	-	-	-	-	-	-	-	-	-	-
Farmer	-	12	-	2	-	6	-	-	-	-	-	-	-	-
Salaried	37	37	78	7	57	-	-	38	-	-	-	-	15	20
Private enterprise	44	-	21	2	-	-	-	-	-	-	-	-	8	-
University student	12	25	-	-	7	6	-	-	-	-	-	-	-	-
	Number of Children (Percent)													
None	-	-	36	44	-	-	33	44	-	-	-	-	-	-
One	-	-	64	44	-	-	67	56	-	-	-	-	-	7
Two	-	-	-	12	-	-	-	-	-	-	-	-	15	13
More than two	-	-	-	-	-	-	-	-	-	-	-	-	85	80

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[NP1]Was introduced (recently)? Or is introduced, has been for a long time?

ddPage: 23

[TU2]I assumed prevention of transmission, not prevention of the disease.