The intersectionality of women's access to sexual and reproductive health services and information in Ismailia, Egypt

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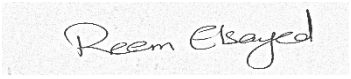
DECLARATION

I declare that 'The intersectionality of women's access to sexual and reproductive health services and information in Ismailia, Egypt' is my own work, which it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full Name: REEM YEHIA KAMEL ELSAYED Date: October, 2020

Signed: 

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CEDAW	The Convention on the Elimination of Discrimination against Women
FGM	Female Genital Mutilation
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
MoH	Ministry of Health
NGO	Non-Government Organization
SRH	Sexual and reproductive health
STIs	Sexual transmitted infections
STD	Sexually Transmitted Disease
SRHR	Sexual and Reproductive Health and Rights
OHCHR	The Office of the United Nations High Commissioner for Human Rights
UNAIDS	Joint United Nations Programme on HIV/ Acquired Immune Deficiency Syndrome
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
WHO	World Health Organization

Keywords: Sexual health, reproductive health, Sexuality, Sexual and reproductive health services, information, married women, Intersectionality, HIV prevention, Sexually transmitted infections, Egypt

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Abstract

Background: Sexual and reproductive health (SRH) is a right that should be guaranteed to every woman worldwide in order to have a healthy and safe sex life. In most Arab countries, including Egypt, there are different cultural, political, and religious factors that have contributed significantly to the manner that the society views and treats women's bodies and sexuality. As a result, it is difficult to provide solid data and information to guide policymakers, policies, and to implement awareness and preventive programs. This thesis sought to address this gap by conducting a study looking at the intersectionality of women's access to sexual and reproductive health services and information in Ismailia, Egypt.

Methods: The relevant information was collected using qualitative methods. Semi-structured interviews were conducted with twelve married women and two key informant interviews with health professionals in the study area.

Results: Intersectional theory was used to critically examine the various interacting factors such as gender, patriarchy, economic disadvantages, and other discriminatory systems that that can undermine women's access to SRH information and services. The study revealed that married women suffer from the lack of access to proper SRH services and information.

Conclusion: Married women's experiences of accessing SRH services and information were affected by different intersecting factors. These factors are socio-economic, policy, cultural norms, power structure contexts, and privilege structures, and religious institutions. Recommendations were drafted to add more information and evidence related to Egyptian women and their SRH rights.

1.0 Introduction

1.1 Contextualization and Background

According to Giami (2002), the first time the concept of sexual health was used in a public policy context was in 1975 at the conference of the World Health Organization (WHO). This concept has been used since then to build national public health programs around the world targeting women and men's health (Giami, 2002). The concept of sexual health evolved as a result of political compromises and is now considered a public health matter (Coleman, 2002). Giami (2002) indicated that the concept of sexuality was initially used in the field of reproductive health where the institutions of public health were committed to providing the best services for reproduction in the marriage context, and thus the focus was on the biological function and preservation of morality in the society. In the 1960s, this point of view changed when oral contraceptives were introduced, thereby influencing the social and legal perspective for non-procreative sexual intercourse, both inside and outside marriage contexts (Giami, 2002). More recently, knowledge surrounding reproductive health has been cultivated to respond to the HIV and AIDS epidemic, and this process has highlighted the diversity of sexual cultures (Frank, 1994).

The Regional Conference on Population and Development, "Development Challenges and Population Dynamics in a Changing Arab World", took place in Cairo in June in 2013, organized by the League of Arab States in cooperation with United Nations Population Fund (UNFPA) and others. The conference acknowledged that the advancement and protection of SRH rights are not only fundamental to the recognition of social justice and assuring a healthy and secure life but are fundamental to achieve the national and global sustainable development goals (UN, 2014). Sexual and reproductive health rights are crucial because they are important elements within public health, as well as for an individual's wellbeing. As such there is a recognizable need for allocations of appropriate resources and expenditures to ensure quality SRH services (Kismödi, Cottingham, Gruskin, & Miller, 2015; Temmerman, Khosla, & Say, 2014).

Female genital mutilation, child marriage, sexual violence, sexually transmitted infections (STIs) and unpredicted pregnancies are the most significant threats to adolescents and young women's SRH in Egypt. Moreover, adolescents and young women are considered the least

informed and the most under-served cohort with regard to access to SRH services and information in the country (Feki, 2015).

The Arab Spring, which rocked Egypt in January 2011, was the first wide-reaching protest in the modern history of the country since the 1970s. Egyptians protested against President Mubarak who ruled the nation for 30 years. People protested poverty, unemployment, negligence, autocratic governance, and corruption (Shaw, 2018). The topic of sexual health has been sensitive and controversial in Egypt as it is considered one of the main taboos in the country. Mohamed Mustafa (Shaw, 2018), a lawyer of one of the feminist organizations in Egypt, states that the different violent sexual practices against women such as sexual harassment and domestic violence in Egypt serve a political purpose, which discourage women from political participation (Shaw, 2018). Moreover, women's sexual health and wellbeing are intentionally overlooked by both Egyptian society and the state who consider themselves the guardians of religion in the country. The state thus dictates the quality and quantity of women's SRH services and information which is used as a mechanism to intimidate and dominate the power dynamics between men and women (Shaw, 2018). This approach is used to maintain male prestige structures and their rootedness in the male-dominated public sphere of social activity which, in turn, affects the culture notions of both sexes in Egyptian society (Devi, 2013; Ortner & Whitehead, 1981; Shaw, 2018). Eltahawy stated in her book "Headscarves and Hymens" that a revolution to liberate women from suffering at the hand of their families and societies is more demanding than political liberation and may be a more urgent and worthy cause (Shaw, 2018).

The study presented in this dissertation focuses on the intersectionality of women's access to SRH services and information in Egypt. The concept of intersectionality was first used to express the racialized experiences of women of colour in the United States. It was a result of the early criticisms of the artificial separation of gender and ethnicity in women's lives by black and Latina feminist movements during 1970s and early 1980s, which debated that mainstream feminism ameliorates the cause for white women while silencing and ignoring the voices of minority women (Veenstra, 2011; Patty, 2006).

Intersectionality refers to a concept that views the structural and dynamic implications of the interaction between two or more kinds of discrimination or subordination systems (Hankivsky, 2012; Hankivsky & Cormier, 2011). Intersectionality, in particular, addresses issues such as

gender, ethnicity, racism, patriarchy, economic disadvantages and other discriminatory systems that generate inequality (Hankivsky & Cormier, 2011; Shields, 2008). More specifically, linking the concept of intersectionality with its impact on women in Egypt, there has been rising public concern regarding SRH and well-being since the advent of the 21st century. This concern is manifested by continuous endeavours by the Egyptian government and civil society to boost family planning services and information, enhance women's mental health, and to eradicate violent practices such as female genital mutilation (Devi, 2013; EIPR, 2009). Furthermore, in Egypt young people, in particular females, are considered to be more susceptible to incursions on their SRH and rights than any other group (DeJong, Shepard, Roudi-Fahimi, & Ashford, 2007).

1.2 Rationale and Significance of the Study

DeJong, and El-Khoury (2006), Feki (2015), and El Kak (2013) concur that the issues of sexuality and SRH care in Egypt are under-researched and there is limited data and information on these topics. Further, they note that there are taboos surrounding public discussions about women's sexuality and SRH and topics related to them such as STIs, female dysfunction and the psychological effects of different violent practices. These issues play a crucial role in shaping and influencing women's sexuality as well as their sexual health (DeJong & El-Khoury, 2006; El-Kak, 2013; Feki, 2015). In this regard, Shaw (2018) states that the understanding of sexual health in Egypt is clouded by misconceptions and strong cultural stigma that jeopardizes women's sexual health and discourages them from seeking medical care. It is for this reason that this research intends to address some of these gaps to provide insight and understanding into the reasons and consequences of the lack of women's accessibility to SRH services and information. Furthermore, this research will throw light on the issue of taboos and the culture of shame and silence that are related to women's bodies, sexuality, their sexual health and well-being, as well as reveal the power dimensions between men and women in the hegemonic society in Egypt.

1.3 Delineation of the Study Area

The study area is the city of Ismailia, which is located on the west bank of the Suez Canal region in North Eastern Egypt (see Figure 1) (Briney, 2018). The Suez Canal connects the Mediterranean Sea with the Indian Ocean and Red Sea and was opened in 1869. The city of Ismailia is located 115 kilometres from the capital city, Cairo. The city was founded during the

construction of the Suez Canal in 1863 (History.com, 2018).

Figure 1 The City of Ismailia in Egypt (CitiesTips.com, 2018)

Egypt comprises of 27 governorates, which are constituted for purposes of administration. A governor, selected by the President, administers each governorate. The Ismailia governorate is one of the Canal Zone governorates and its capital is the city of Ismailia (Ismailia Governorate, 2018). The Canal region includes three governorates, Port Said, Ismailia, and Suez. The three were built in the 19th century during the construction of the Suez Canal. Port Said is located in the northern entrance of the Canal, and Suez lies at the canal southern end (Alrahalah, 2011). The city of Ismailia has limited job opportunities and the percentage of people who lived below the poverty line was estimated at 24.1% in 2015 (Osman, 2017).

1.4 Problem Statement

There are several cultural, religious and political challenges that hinder women's access to SRH in Egypt. SRH and the related issues such as early marriage, female genital mutilation (FGM), and sexual transmitted infections (STIs) are still considered cultural taboos. Women still suffer from a culture of ignorance and shame for seeking such services, which globally are considered basic rights for every female to have a healthy and safe sex life (Bashour et al., 2015; Devi, 2013; Fadel, 2015; Shaw, 2018; WHO, 2006). Furthermore, Stephan (2006) states that religion plays a significant role in forming the mentality of Egyptians with regard to women's bodies

and their sexuality, with both being monitored and policed by the state and society. Stephan (2006) noted that in some countries and societies both Muslims and Christians endorse and sanction certain beliefs and conventions that encourage the practice of justified violence and oppression against women, including their SRH.

Devi (2013) postulates that men and women in the Egyptian society have cultivated their personal interpretations of religion in regard to women's bodies, sexuality, and sexual health. Society and the state presume that women's access to these services and information would lead to sexual freedom, as well as giving them the right to consider abortion (Devi, 2013). Ahu Khali (1997) argues that women's sexuality and sexual desire in Arab society are being neglected intentionally. The author states that women are treated as subordinate properties in order to serve the sexual power dimension that is socially constructed in Arab society (Abukhalil, 1997). Scholars like Stephan (2006), Devi (2013), El Gelany (2016) and Shaw (2018) conclude that Arab society and the state play a major hegemonic role in dictating and limiting the quantity and the quality of information and services that women receive regarding their own bodies and SRH, all of which constrain and compromise their right to health.

An examination of existing literature has indicated an urgent need for more research to be conducted to generate a deeper knowledge and understanding of this issue. Such research should focus on highlighting the taboos that surround women's SRH as well as the practice of justified violence against their bodies and sexuality which put the psychological and physical health of women at risk.

In the thesis, the research study explored the intersections between the various factors that influence women's access to SRH services and information in order to understand the complexity of Egyptian women accessing reproductive health services and information (Dejong & El-khoury, 2006; Feki, 2015). It is hoped that the findings and related recommendations will add to the information and evidence base available regarding the status of Egyptian women and their right to access SRH information and services whenever it is needed.

1.5 Research Aims and Objectives

The overall aim of this research is to explore the intersectionality of factors related to women's accessibility to SRH information and services in in Ismailia, Egypt to understand the various reasons and implications on their sexual health and wellbeing.

Specific Objectives of this research are to:

1-Explore women's understanding of the concept of sexual and reproductive health and rights.

2-Explore women's awareness of sexual and reproductive health services available in the study area.

3-Describe how women access sexual and reproductive services and information in the study area.

4-Identify the facilitators, barriers and challenges that women face with regard to accessing reproductive services and information.

5-Explore how these various factors intersect to influence women's access to sexual and reproductive health services and information.

6-Derive recommendations on how access to sexual and reproductive health services and information can be enhanced to ensure women's rights to adequate sexual and reproductive health and wellbeing.

1.6 Research Questions

What are the intersection factors that influence women's access to sexual and reproductive health services and information?

1- What are women's understanding of their sexual and reproductive health and rights?

2-How aware are women of the available sexual and reproductive health services and information in the study area?

3- How are sexual and reproductive health services and information being accessed by women in the study area?

4-What are the facilitators and challenges that women face with regard to their accessing sexual and reproductive services and information?

5-How do the different factors intersect and influence women's access to sexual and reproductive services and information?

6-How can women's access to sexual and reproductive health services and information be enhanced to ensure their sexual health rights and wellbeing?

1.7 Research Design

A research design is the blueprint of the research that guides the researcher through the study by articulating the data that is required and the methods that will be used to gather and analyze this data as well as how this will answer the research questions (Congdon, River, Drawer, & Dunham, 1999). This research will use a qualitative methodology approach because it is considered the most suitable method to collect the required information to achieve the study's purpose as this research is a very sensitive topic in Egypt. The qualitative approach falls within the interpretive paradigm, which supports personal descriptions and interpretations of the reality such as that of being women in a conservative Arab world. The rationale for choosing such a method is that it focuses on investigating the phenomena in an in-depth manner in an attempt to gain information of the dynamics experienced by women and their day-to-day reality. It provides in-depth information about the social phenomenon being investigated (Mouton & Babbie, 2001). Qualitative research further improves the quality of data through revealing more sensitive information which might not be possible with quantitative research. It focuses on understanding, not measuring, the phenomenon and the study participants are conceived as self-directing, who are constantly changing and reconstructing their own priorities, assumptions and interpretations about the world (Rice & Ezzy, 1999).

1.8 Thesis Outline

This study was arranged into seven chapters.

Chapter One introduces the study. It then contextualizes the research and presents background information to place the research in its broader context. It outlines the problem statement, research aim and objectives and presents the research design.

Chapter Two provides a comprehensive literature review on access to sexual and reproductive health services and information and the issues related to them.

Chapter Three focuses on a discussion of intersectionality theory and its use in the field of women sexuality and sexual and reproductive health.

Chapter Four focuses on the research design and methodology of the study. This chapter outlines the qualitative method that was used to gather the data through in-depth interviews and participants observation. The chapter further provides detailed information of 'who' was interviewed. The chapter ends with providing the ethical statement.

Chapter Five provides an overview of the study area and presents the findings and the discussion of the findings.

Chapter six provides a discussion of the results and discusses similar literature review.

Chapter seven provides a summary of the findings, conclusions, and recommendations obtained from the research findings.

Chapter Two: Literature Review

2.1 Introduction

This chapter reviews the existing literature on SRH, and its intersectionality at the global, regional and national level. Sexual and reproductive health is an essential right that must be granted to every female in the world to have a safe and satisfying sexual life. Sexual health demands the right approach to develop an understanding of its complexity as this informs sexual behaviour. Sexual health influences the expression of sexuality, whether in terms of a healthy sexual relationship, the well-being of the people, or the risk to be susceptible to physical, physiological, sexual and reproductive ill-health (WHO, 2006). This chapter emphasizes the different dimensions such as the cultural, religious, political and legal factors that directly and indirectly contribute to shaping the mindset of society regarding sexuality and SRH rights.

2.2 Sexual and Reproductive health and sexuality issues on the global level

According to the World Health Organization (WHO, 2006), the sexual health of women is defined as a physical, mental, and emotional state of being, as well as social well-being related to sexuality. Sexual health demands a positive and deferential approach towards sexual relationships and sexuality. It also indicates the potential of an individual having a pleasant and safe sexual relationship that is free of being violated or discriminated against.

There are different factors that influence women's sexual health, such as physical, psychological, interpersonal and social factors (WHO, 2006). Sexuality is an essential element of being a human being, which includes sex, gender identities, sexual orientation, pleasure, and intimacy. It is also affected by different aspects such as physical, hormonal, psychological, economic, social, cultural, religious, legal, political and ethical issues (Ibrahim, Ahmed, & Ahmed, 2012; Ilkkaracan & Jolly, 2007; WHO, 2006). Reproductive health, which is part of sexual health, can be defined as the ability to have a desirable and safe sexual life with the capability to reproduce and having the freedom to determine if, when, and how to do so. Reproductive health also refers to the right to access proper health care services that enable women to have a safe pregnancy and delivery, and that give parents better chances to have a

healthy child (WHO, 2006). Reproductive health has been included as part of sexual health and refers to the provision of appropriate care and consultation in relation to reproduction and sexually transmitted diseases (WHO, 2006).

According to the Office of the United Nations High Commissioner for Human Rights (OHCHR) (2015), Article (16) in The Convention on the Elimination of Discrimination Against Women (CEDAW) assures women equal rights to decide the number of children that they want to have freely and responsibly, and the ability to access information and education that would help them practice their rights. CEDAW Article (10) also stresses that women's rights for education involve having the ability to have access to particular educational information to promote the well-being and health of their families which include knowledge and services on family planning (OHCHR, 2015).

According to WHO (2008), the International Conference for Population and Development (ICPD) in 1994 acknowledged that "universal access to reproductive health" is a development goal that should be accomplished. After that, the World Health Assembly that was conducted in 2004 assured that the international community would show commitment and support to promote SRH and rights through adopting global health strategies to achieve the development goals (WHO, 2008:5). The World Health Assembly in 2004 reassured the international community committed to promoting SRH through fostering reproductive health strategies globally in order to achieve the development goals (WHO, 2008:5).

Tiefer (2001) stated that globally, many people think that sex is a purely biological matter but she argued that there are several factors such as socio cultural, religious, economic and political, that play a huge role in affecting sexuality, in particular sexual activity and expressing sexual motives and body comfort, such as those aspects accompanied with a culture of embarrassment, ignorance, and silence in many countries. As a result, such cultural and religious aspects have not been discussed or negotiated. She also argued that women and men do not have the same equal political sexual rights or the same personal sexual power. She acknowledged that women have inherited a legacy of political and economic subordination which could be seen in the inadequate access to health care such as insufficient access to abortion or contraceptive coverage insurance. Moreover, there are a number of issues that drive women to depression and low self-esteem. For example, in conservative societies women face tremendous pressure and a social burden to marry, and the social sanctions placed on non-

marital sex can put their reputation in danger, thereby increasing the chance of them being exposed to sexual violence which could lead to losing their personal sexual power; (Tiefer, 2001).

2.2.1 The Sexual and Reproductive health in Iran

Iran serves as a global example of limited SRH rights for women even though it is not an Arab country. According to Khalesi, Simbar, and Azin (2017), sexual health is considered a sensitive topic in Iran despite the fact it's identified internationally as a human right and essential for human development. There are several reasons that play a crucial role for young people, in particular, women, not to access or receive proper sexual health knowledge and services. For instance, families, teachers, and policymakers do not allow women and girls to get the proper knowledge and services as they are afraid that they might have premarital sex as well as corrupt girls' innocence. This shows the importance that the society places on women and girl's bodies, sexuality, and virginity. The cultural taboos, patriarchal traditions, social norms, gender roles, and religious misconceptions contribute in the manner that the family and the state act to oppress women and practice gender-based violence against them in Iran (Khalesi, Simbar, & Azin, 2017).

2.3 Sexual and reproductive health in the Arab world

2.3.1 The Cultural and religion framework

Most Arab countries including Algeria, Bahrain, Djibouti, Kuwait, Jordan, Libya, Morocco, Oman, Qatar, Saudi Arabia, Palestine, Sudan, Syria and Lebanon address SRH in accordance with religious values and societal traditions. These deeply rooted values and traditions play a vital role in formulating and shaping the identity and the mindset of Arab society (DeJong, Jawad, Mortagy, & Shepard, 2005; DeJong et al., 2007). For example, Stephan (2006) argues that religion plays a crucial role in shaping the mindset of the Arab regarding women's bodies, their sexuality and SRH. She indicated that both Muslims and Christians in the Middle East have adopted traditions and beliefs in order to justify violence and oppression against women (Stephan, 2006). Stephan (2006) and Sensenig (2002) further state that both men and women have created their own interpretation of what the religious values are regarding women's bodies and sexuality and the cultural framework has significantly contributed to the manner in which society views women's sexuality and the value of their virginity and honour. These authors

further note that the state and the family have implicit consent on women's sexuality through dictating the amount of SRH information and services that they should know or receive. They acknowledged that due to the misinterpretation of religion and patriarchal foundations in the Arab society, it makes it difficult to achieve significant change to promote women's rights and address gender-based violence (Sensenig, 2002; Stephan, 2006). According to the WHO, young people account for around 90 million of the population which shows that the Middle Eastern region has the second youngest population of young people in the world (El-Kak, 2013). Djong (2005) and El-Kak (2013) targeted a group of Arab young people from age 10 to 24 and studied the different factors such as socioeconomic, cultural, political and legal and religious conditions, information technology and global factors and migration, which shape their SRH and the issues related to them, such as lack of sexual awareness, FGM, early marriage, and sexually transmitted diseases (DeJong et al., 2005; El-Kak, 2013).

El-Kak, (2013) and Obermeyer (2015) concurred that the huge value that the Arab society places on the virginity of unmarried girls and their sexuality plays a crucial role in subjecting them to extreme social stigma, judgment and discrimination by health practitioners if they attempt to obtain contraceptives or seek information regarding sexuality and sexual health. As a result, young married and unmarried women suffer from scarcity of both SRH knowledge and access to contraceptive services (El-Kak, 2013; Obermeyer, 2015).

DeJong, and Khoury (2006) state that, there have not been proper health services provided by the government. Policy makers do not think that there is an urgent need for young people to learn about sexual health and issues related to them, nor do they create an atmosphere to support them. Subsequently, young people seek such knowledge from private health service places if they can afford them; still, social barriers persist. The authors conducted a small qualitative study on Jordanian young people from age 10 to 24 and found that the majority thought that health centres were providing health services for maternal and child health only. One of the respondents who was 25 years old said if they asked a nurse or doctor about sexual information, they would laugh and tell them to wait until they get older (Dejong & El-khoury, 2006).

Marzouk (2017) highlighted the importance that religious and cultural beliefs give to virginity that is associated with "hymen intactness" and is considered the honour of the unmarried girl and the symbol of her purity. For such reasons, in Egypt, most girls who lose their virginity before marriage are compelled to restore it before the night of the wedding because some of

them have to pass a virginity test and others have to prove their virginity with the show of blood. Young girls who are found not to be virgins are condemned with family dishonour, societal shame or could be subjected to extreme violence and honour killing (Marzouk, 2017b, 2017c, 2017a).

Marzouk (2017), El-Kak (2013), and Fei (2015) state that despite the fact that religion orders both males and females to keep their virginity until marriage, patriarchal communities tend to turn a blind eye on men when they have sex before marriage. On the other hand, women in Arab countries like Egypt are expected to keep their virginity until marriage because women's sexuality and sexual health are thought of as a collective interest. Their bodies belong to family men before marriage and their husbands after marriage. Consequently, women are subjected to genital mutilation, virginity testing, early marriage, sexual abuse, and sexual disease (El-Kak, 2013; Feki, 2015; Marzouk, 2017b, 2017a, 2017c).

2.3.2 Female genital mutilation (FGM) in the Arab countries

According to WHO (2016) and UNICEF (2013), female genital mutilation (FGM) is a violent practice that is recognized internationally as a violation of the human rights of girls and women. It shows the deep inequality between the sexes, and extreme discrimination against women. Such practices violate a female's rights to health, security and physical integrity, the right to be free from inhuman treatment, as well as the right to live because this practice can lead to death. FGM is practiced globally in general, but in the Arab region in particular due to insufficient awareness of SRH service and information (UNICEF, 2013). These practices are performed to reduce female sexuality by avoiding premarital sex to preserve virginity for family honour and to increase a man's entertainment during intercourse after marriage and religious obligation (WHO, 2016). While serving no medical purpose, FGM causes damage to female genital organs and tissues and causes many short and long term complications (UNICEF, 2013). There are also psychological trauma as well as psychosexual functioning disorders and other sexual issues related to such a traumatic act (Fahmy & El-mouelhy, 2010; UNICEF, 2013).

According to WHO (2016) and UNICEF (2013), FGM is one of the most violent practices in the world in general and the Arab region in particular due to the lack of access to sexual and reproductive health. FGM could be partial or the total cutting of the external female genitalia

as well as other damage to female genital organs and tissues for no medical purpose (UNICEF, 2013). These practices could cause many instant and long -term complications. For instance, FGM could cause severe bleeding, urine retention, massiveness in the genital organs and several infections that in some cases could lead to death, and to significant consequences during delivery.

According to UNICEF (2013), the highest rates of FGM in the Arab region have been centred mainly in three countries: Yemen, Sudan, and Egypt. Sudan was one of the early countries that provided population-based data on FGM which indicated that the rate of women and girls from 15 to 49-year-old who underwent this procedure was 89% in 1990 while Yemen's rate was 22.6% to the same age category based on DHS of 1997. On the other hand, Egypt had the largest proportion of the same age group with 97.3% including both Muslims and Christians girls and women according to DHS 2000 (DeJong et al., 2005; UNICEF, 2013).

DeJong (2005) stated that in Sudan, there have been several collaborations between NGOs and universities to tackle FGM. For example, the Sudanese Minister of Health declared in a conference in Khartoum that the government would exert no efforts to eradicate FGM through making policies and cultivating laws to prohibit such violent practice alongside with awareness campaigns and health programs to educate people and increase their sexual health awareness in 2003. In Yemen, the Ministry of Health has also committed to conduct studies and implement awareness programmes to fight FGM (DeJong et al., 2005).

2.3.3 Early Marriage in the Arab countries

Child marriage is a form of sexual exploitation that could lead to serious physical, physiological and mental complications for early married young girls. For instance, the bodies of young girls cannot bear adult sexual intercourse which might lead to tissue rupture, severe bleeding, and sexually transmitted diseases, obstetric fistula in addition to higher rates of maternal and child mortality, particularly for girls who deliver a child before the age of 15 years (Bearat, 2006; ICMEC, 2013).

Peronti, Das and Sawyer (2019) assert that parents are protective over their adolescent daughters' virginity as they fear the stigma that is associated with their daughters having premarital sex. As a result, most parents opt for early marriage in Arab countries. The authors

claim that if parents had knowledge of the negative consequences of early marriage to their daughter's sexual and reproductive health, they would not participate in such practices (Petroni, Das, & Sawyer, 2019).

In Arab countries, poor and less educated girls who live in rural areas with tough conditions are more susceptible to early marriage (Feki, 2015). Studies showed that early marriage is decreasing in the Arab world, but the percentage of teenage marriage is still high. For example, the rates of girls from age 15 to19 year old who got married were estimated for about 200.000 young women dropped from 27% to 17% from 1997 to 2003 in Yemen (Rashad, Osman, & Roudi-fahimi, 2004). According to Rashad et al (2004), a survey conducted in Yemen illustrated that 60% and 40% of women who live in rural and urban areas, respectively, said that they marry their daughters before their twenties for early pregnancy and high fertility which negatively undermine women sexual and reproductive health. As very young married women do not know much about sexually transmitted diseases and contraceptives, this could lead to death or living with HIV/AIDS because of the different sexual infections and complications during pregnancy and delivery (Rashad et al., 2004).

2.3.4 Sexually transmitted infections in the Arab countries

Feki (2015) has stated that sexually transmitted infections (STIs) could occur because of inaccessibility to access SRH services. For example, biologically, women are highly susceptible to sexually transmitted diseases such HIV and AIDS and different viral, bacterial and fungal infections because they have a thin membrane which is susceptible to infections and could become a good incubator for such diseases (Valadez et al., 2013). In a study conducted in Morocco, around 70% of married women claimed that they are living with HIV, having been infected by their husbands (Feki, 2015).

2.3.5 The regional policy and legal framework for sexual health and reproductive health

The WHO stated that managers of health programs, policy makers and health care practitioners are required to develop understanding and promote the positive role that sexuality and sexual health play in human lives as well as improve health care services to promote healthy sexual communities (WHO, 2006).

According to El-Kak (2013), and Bashour (2015) the current policies and health systems in the Arab world are still not enough to promote sexual and reproductive health. They also stress

that efforts should be made to set up national preventive programs like scanning for sexually transmitted diseases (STIs), comprehensive sexual knowledge and programmes, in addition to friendly youth services (Bashour et al., 2015; El-Kak, 2013). According to Dejong (2006) and Bashour (2015) there have been many efforts to adjust family laws in order to be more convenient for women and young people. For example, countries like Jordan and Algeria as well as Morocco have initiated reforms to increase the legal age for marriage (Bashour et al., 2015; DeJong & El-khoury, 2006).

Feki (2015) has assured that advanced laws which address women's sexuality and sexual health or the issues related to them, are difficult to implement because of the various social and cultural resistance that intersect together that could include the legal system a well (Feki, 2015). For example, Fadel (2015) said that genital mutilation is gradually decreasing with two-thirds of girls from 15-17-year old circumcised, decline by around quarter since 2008 in Egypt. The issue is that it took about six years before the legal system in Egypt passed a law to condemn such practice as well as to be implemented (Fadel, 2015).

2.4 Tunisia: The exceptional model in the Arab region

Tunisia represents an exceptional model with gender issues, including SRH and rights. Tunisia has a national programme on young people's SRH. As Tunisia has started sponsoring research on young people's SRH from the early 1990s as well in the recent years initiating health clinics for adolescents which open for unmarried young people in urban areas. These places provide knowledge and consultations about SRH and turn clients to more professional consultations, if needed (Bashour et al., 2015). In addition to that the government has also worked side by side with NGOs to provide peer education university dormitories. Tunisia has also legalised abortion and outlawed polygamy (Bashour et al., 2015; DeJong et al., 2005).

2.5 Sexual and Reproductive health and marriage in Egypt

2.5.1 The local cultural and religion framework:

DeJonge (2007) claimed that the family in the Arab world in general and Egypt in particular, has changed because of reasons such as migration, globalization, urbanization, capitalism and lifestyles promoted by the mass media. DeJonge said that there has been a noticeable increase in education access rates, and the openness to knowledge through the influence of the global media, which created a huge gap between the generations of parents and their children. It has

also changed the ways that young people obtain and understand information. For instance, the different studies have shown that young people would like to learn about puberty and sexual health from their parents, but unfortunately, many parents do not have enough information or knowledge of how to deliver such information in a scientific manner. In Egypt, a national survey was conducted with both young people and their parents at the end of the 1990s. It was found that, despite the fact that fathers confirmed talking to their adolescent sons about puberty and the changes in occurrence to it, only 7% of the boys confirmed learning about it from their fathers (DeJong et al., 2007).

A study was conducted by the Egyptian Initiative for Personal Rights (EIPR) and Center for Reproductive Rights (CRR) in the Upper rural areas in Egypt in 2007, showed that the scarcity of the resources for SRH information and services is a result of the culture of shame that has been adopted. Girls there are not allowed to have access to such information until they are married (EIPR &CRR, 2009). The researchers claim that the state in Egypt is determined to continue their culture of silence regarding provision of SRH services that is meant to include family planning, sexual and gender-based violence clinical management, maternal health care, HIV and sexually transmitted diseases management, reproductive system cancers and infertility (EIPR & CRR, 2009).

Abdel Tawab (2016) indicates that around 34% of males between 13 to 35 years in Egypt claimed that they spoke with one or both parents about sexual health and puberty changes. While only 21% of females from the same age group spoke to their parents regarding this matter, Tawab concluded that this happens because of inadequate communication between parents and children and also some parents do not create a safe space and show support to share and discuss such matters. As a result, young people tend to access such information in other places such as friends or the internet. Research further indicated that around 60% of parents have never had a conversation with their children about SRH matters (El-Akkad, 2016).

El Gelany (2016) conducted a study on 520 Egyptian female students from various Egyptian governorates to measure their knowledge about SRH, the barriers that prevent them from accessing such information, and how to overcome those barriers. He found that around 60% of female students heard about SRH but only a few of them knew the essential services that should be provided before marriage. These students also assumed that reproductive health services would only be provided to married women and 85% of them acknowledged that there have

been barriers that hinder them from accessing the existing services such as cultural taboos, religious misconception, gender discrimination, inadequate knowledge of the available services and family's disapproval (El Gelany, 2016).

Feki (2015) and Devi (2013) noted that there has been a general deficiency in providing adequate service and information about SRH not only in Egypt but in most Arab countries (Devi, 2013). This suggests that there is a wide implicit reluctance to provide such education in schools and even where sexuality education is included in the school or university curriculum, teachers tend to avoid teaching it because they are too embarrassed to do so (Abd El Hameed, 2015; DeJong & El-khoury, 2006; Feki, 2015; Ghattass, Abdel-tawab, & Hussein, 2016). One of the results of the culture of silence is that Egypt has more than half of the recognized sexually transmitted infections (STI) among young single men, who ultimately transfer the infection to their partners (Feki, 2015).

2.5.2 Female genital mutilation (FGM) in Egypt

According to Devi (2013), women and girls in Egypt still suffer from female genital mutilation (FGM) that has been prohibited by Islam but is still widely conducted. She stated that such acts are considered as violence against women. She also argues that the 25th of January revolution in 2011 did not achieve an actual change in health in general and women's health in particular (Devi, 2013). According to UNICEF (2013), FGM in Egypt is severe, where mothers stated that three out of four young girls underwent FGM. They also said that such practices were operated by medical professionals. This indicates that health professionals, who are supposed to provide proper SRH information and services, participate in such harmful acts without any fear of punishment (Ghattass et al., 2016; UNICEF, 2013). Despite the fact that laws have prohibited this practice since 2008, many doctors still perform it because the laws are hardly implemented. For instance, there was a doctor who mistakenly killed a young girl during a FGM procedure in 2013 and he was the first doctor to be convicted for only two years for such an act and then he continued practicing his job as a licensed doctor afterward (Fadel, 2015; Ghattass et al., 2016).

There have been small awareness campaigns initiated by the Cairo Family Planning Association that fought such practices since the 1950s . By 1990, different NGOs, International Conference on Population and Development (ICPD) and Demographic and Health Survey (DHS) provided solid data and gathered together to take it to the government to initiate

programmes and make policies and laws to condemn such violent practices. The complications related to this practice affect both married and unmarried women due to the deficiency of access to SRH information and services which ultimately negatively affects their sexuality. There are programmes that have been conducted by governmental intuitions such as The National Council for Childhood and Motherhood to increase society's awareness to decrease FGM (DeJong et al., 2005; UNICEF, 2013).

2.5.3 Early marriage in Egypt

Rashad (2004) stated that early marriage in Egypt is no difference from other Arab countries as there are 385.000 from age 15 to 19 who have gotten married already. The cultural perspective about girl's virginity and the honour of the family is still embedded in the mindset of society (Rashad et al., 2004). According to the National Council for Childhood & Motherhood (NCCM), young girls who marry before 18 are more vulnerable to catch STIs because they do not have access to sexual or reproductive health before marriage (NCCM, 2017).

2.5.4 The policy and legal framework

The Egyptian space has been so resistant to make an actual change on the ground in regard to cultivating, formulating, and implementing policies and legislation. The policy of silence still persists despite the international pressure because of the complexity of SRH information and services as there are multiple intersection factors such as socioeconomic, religious, political as well as cultural factors that play a huge role in shaping the manner through which such matters are addressed in Egyptian society (Bashour et al., 2015; DeJong et al., 2005; Fadel, 2015). For example, Egypt has cultivated laws to prohibit FGM since 2008 (Bashour et al., 2015; Fadel, 2015), but the law was only implemented in 2013 when a medical doctor killed a young girl while performing female genital mutilation (Fadel, 2015). In another example, in 2008, Egypt set up a child law in order to raise the minimum marriage age for both males and females to 18 year old (NCCM, 2017). Despite, these laws, FGM and early marriage are still being practiced in different areas in the state till now (NCCM, 2017).

2.6 Chapter summary

This chapter has investigated and reviewed the existing literature on sexual and reproductive health. It presented a global perspective on SRH and sexuality and then emphasized on their intersectionality in the Arab region as well as Egypt. Notably, women's SRH and the issues related to them are crucial elements that affect and shape female's sexuality and sexual wellbeing worldwide. There are several factors that influence SRH in the Arab world and Egypt such as the economic, political, cultural, religious and societal ones (Bashour et al., 2015; El-Kak, 2013). These factors intersect and influence how society views women's bodies, sexuality and sexual behaviour.

There has been insufficient literature on women's access to SRH and their sexuality in marriage in Egypt, Ismailia. Therefore, the aim of this dissertation was to investigate intersectionality between women's access to SRH services and information and its influence on their sexual health, sexuality and sexual wellbeing. This study hoped to fill the gap in the literature to break taboos around sexual health and to tackle the culture of shame and silence, and to enhance understanding on the reasons and ways in which Egyptian society and the state objectify women and justify gender-based violence against them and use their bodies and health as battle fields. Feki raised a very important question when she asked: how can Egyptian women make a positive difference, lead and decide their own destiny if they cannot control their own bodies? (Feki, 2015).

Chapter Three: Theoretical Framework

3.0 Theoretical framework

This chapter presents the theoretical framework for the study. An explanation of intersectionality theory is first given. Thereafter, intersectionality as a methodology is discussed, followed by an outline of some applications of intersectionality in different domains.

3.1 Understanding Intersectionality Theory

Intersectionality thinking emerged from the writings of women of colour between the 1960s and 1970s and has been employed as a tool for studies on gender and economic justice (Symington, 2004). However, the term intersectionality was first coined by the American critical legal race scholar Kimberlé Williams Crenshaw in 1989. In her writings, she described how race and gender engage to form multiple dimensions of African American women's employment experiences (Brown, 2012; Cole, 2008; Gopaldas, 2013). Intersectionality theory was inspired by feminist and anti-racist conventions and demands that race, gender, class and sexuality inequalities should be considered in tandem and not distinctly (Patty, 2006; Veenstra, 2011). Intersectionality theory invites scholars to be inclusive in their gender analysis as well as in defining what feminism is. The theory identifies the various factors that intersect that could lead to racism, classism and other threats thereby further promoting inequalities against women (Samuels & Ross-Sheriff, 2008).

Intersectionality theory was cultivated in order to address the various factors of sex, gender, race, ethnicity, identity, social positions, oppression, and privilege processes, as well as policies and institutional practices (Bauer, 2014). Expounding on the framework further, Hankivsky and Cormier (2011) stated that intersectionality is not a pre-decided or pre-hierarchical concept and that it is also not an additive tool. It promotes an understanding of what is cultivated and experienced at the intersection of two or more oppression dimensions (Hankivsky, 2012; Hankivsky & Cormier, 2011).

Intersectionality theory fosters an understanding of human beings as shaped by their interactions with various social locations such as race, ethnicity, indignity, gender, class, sexuality, geography, age, disability, ability, migration status, and religion. This is illustrated in Figure 3.1. These interactions take place within connected systems and power structure

contexts such as laws, policies, governments states, political and economic unions, religious institutions, and media (Carastathis, 2014; Hankivsky, 2014). Through these interactions, interdependent privilege and oppression types are shaped and created by colonialism, imperialism, racism, homophobia, ableism, and patriarchy (Hankivsky, 2014; Mccall, 2005; Patty, 2006; Simien, 2007).

McCall's (2005) has described the "intercategorical" intersectionality term as it expresses multiple inequality relations within existing social groups in order to explicate those relations and the manner in which they operate within and across analytical categories, as the author noted that inequalities are not inequalities in a homogenous manner (Tariq & Syed, 2017).

Figure 3.1 The Wheel of Intersectionality (Hankivsky, 2014:8).

3.2 Intersectionality as a methodology

Intersectionality conceptualizes knowledge, taking into consideration both political and economic power (Hunting, 2014). Intersectionality is usually accompanied by qualitative research methods as the main vehicle of giving voice and to capture the complexities of inequalities, formulated through focus groups, narrative interviews, action research and observations (Hunting, 2014; Rogers & Kelly, 2011). Intersectionality is also increasingly

being accompanied by quantitative and statistical methods, which contribute to the perspective by assisting us to grasp and interpret the individual and combined effects of different categories. It is employed as a perspective, not as a theory on research, in order to drive the research question (Malmusi & Borrell, 2014; Shields, 2008).

3.3 Applications of Intersectionality Theory

Intersectionality theorists acknowledge that studying gender cannot be approached using a single analytical framework, but other issues such as race, migration status, history, and social class should be taken into consideration and investigated, especially how these issues impact on women's experiences because of their gender (Samuels & Ross-Sheriff, 2008; Shields, 2008). For example, Tariq and Syed (2017) used the intersectionality lens to take into consideration interconnected and overlapping factors such as gender, ethnicity, religion, and family status that impact on the challenges that women encounter in the labour force. The authors also considered women's individual agency and the strategies they employ to overcome the barriers in the way of their employment and career. The research highlights the urgent need for policymakers and employers to consider intersectionality in order to empower ethnic minority women as well as ensuring women's inclusion and leadership within and outside the workplace (Tariq & Syed, 2017).

Interrogation of the literature indicates that intersectionality theory has been increasingly utilized in business and management studies, especially in critical organizational studies to highlight systematic power dynamics (Atewologun, Sealy, & Vinnicombe, 2015; Holvino, 2008; Showunmi, Atewologun, & Bebbington, 2015). Within this field, the intersectionality approach examines the differences between multiple groups and the shift in inequality configurations within different dimensions (Atewologun et al., 2015; Mccall, 2005).

Intersectionality theory has also been applied in the field of health. Green, Evans and Subramanian (2017) and Hankivsky (2012) declared that contextual forces like sexism or racism do not operate separately but they interact with one another in the process of producing health inequalities. Green, Evans and Subramanian (2017) employed intersectionality theory to examine the potential dimensions of intersectionality to applications related to epidemiology and health-related fields in order to reveal the power structures and social identities that generate inequalities.

Viruell-fuentes, Miranda, and Abdulrahim (2012) used intersectionality theory to address how multiple dimensions of inequality intersect to impact immigrant's health outcomes and not only the culture dimension. They also suggest particular inquiries in regard to immigrants' experiences with discrimination, in addition to the role of immigration policies that inform immigrant health outcomes (Rogers & Kelly, 2011; Viruell-fuentes, Miranda, & Abdulrahim, 2012).

Hankivsy and Cormier (2011) applied the intersectionality approach in public policy to recognize and address the manner through which particular acts and policies address the inequalities experienced by different social groups. The authors also considered different social identities like race, gender, class, capacity, age and geography that intersect to shape unique meanings and complex experiences within and between groups in society (Hankivsky & Cormier, 2011).

3.4 Application of intersectionality to sexuality and sexual and reproductive health

Mann (2013) stated that intersectionality addresses how social construction perceives women's bodies as an object subject through the convergence of discourses of the intersection of gender, class, sexuality, power dimensions, oppression, shame, ignorance, as well as the silence across, many social fields created by patriarchy and state power, thereby limiting women's access to services and safe discussions about SRH. Mann (2013) said that young women's sexualities are regulated through the type of SRH health care provision which only focuses on family planning clinics. Mann (2013) also addressed how educators instruct Latina girls in schools to be "good girls" through restraining themselves from having sex and stopping them from displaying curiosity or knowledge about sex in the classroom as it is assumed that Latina girls are culturally predisposed to be "bad girls" (Mann, 2013).

Midoun (2017) discussed how intersectionality theory examines identity construction as composed of multiple social vectors that include gender, class, race, and sexuality, among other identity vectors that form a person's sense of self. Such theory views identity operating beyond singular dimensions, and drives questions about multiple dimensions that shape human experience and health. Intersectionality explores how cultural oppression patterns are linked together and affected by intersecting systems of society (e.g., family, gender, religion, and

economics, state). Midoun (2017) explored the multiple identity axes among Kenyan men who have sex with men as it can provide insights in the manners in which both social forces and lived experiences contribute to HIV and other health risks (Midoun et al., 2017).

Monor and Richardson (2010) have used intersectionality theory, in particular, to explore the sexuality equalities initiatives field in local government in the United Kingdom (UK). It establishes sexuality and explores the meaning of intersectional sexuality equalities- focused analysis in order to understand inequality, identity as well as differences within a specific social context. Monor and Richardson stated that local authorities play a vital role in the UK's political and social life by providing a various range of services as well as their political representation role. The government provides services which include social care, housing as well as youth work in which they interface and intersect with gays, lesbians, bisexual and the transgender (LGBT) community. Monor and Richardson stressed how inclusion, or erasure, of LGBT identities and interests, are considered a concern by local authorities and at the same time they set within a complex context with raising questions of legitimacy and endowments, amongst and within various "equalities" groups and others (Richardson & Monor, 2010).

Ritchie (2012) discussed how the United Nations should take intersectionality into consideration when it addresses SRH and rights. Ritchie (2012) argued that there was not enough adoption of intersectionality at the international policy level even though it is a central component of the mainstream development discourse such as human rights, women's empowerment, as well as men's involvement. Ritchie said that intersectionality premised on empowerment is about whose voices are heard and whose positions are acknowledged. Intersectionality is a beneficial framework as it links the discrimination grounds to the social, political, economic, legal environment which contributes to discrimination, oppression, and privilege structures experiences. Ritchie stressed that there is a need to rethink power, identity as well as equality through a bottom-up approach to research, planning, and analysis. Ritchie discussed the term "interlocking oppression" which should recognize the intersection of race, class, religion and gender to uncover the oppressive norms that expands beyond dominating masculine values. Ritchie argued that focusing on such a combination would strengthen the challenges that gender mainstreaming poses to the status quo (Ritchie, 2012).

Ritchie (2012) emphasized that not only the masculinity standards would be contested but also a neo-colonial system that human rights premised approach gives a way of escaping neo-liberal macro-economic agendas as well as racist worldviews. Ritchie mentioned that studies indicate that reproductive rights are significantly related to reproductive health and suggesting that the rights-based approach is the most useful in order to achieve the SRHR goals. Most rights, as well as those rights fulfilment, are dependent upon each other, in a similar vein to the manner, a person's experience and access to their rights are provisional on intersection oppression systems as well as dependent factors. Reproductive rights are human rights and it could be fulfilled through understanding the role of human rights as well as intersectional structural and social factors. As such, these factors could hinder women's capability to exert these rights which are co-dependent systems of achieving progress in SRHR (Ritchie, 2012).

Rosenthal and Lobel (2018) stated that intersectionality is a social justice framework that is premised on the intersecting individual's identities as well as their relation to interlocking oppressive systems. Rosenthal and Lobel (2018) also mentioned how intersectionality is a very beneficial theory that is utilized to understand racial and ethnic inequalities in women's SRH outcomes. As it gives a lens to explore the unique types of oppression which women of colour experience because of the intersection of race, class, gender, ethnicity, sexism as well as other identities and oppressive systems within the context of healthcare. It also calls for transforming societal structures which harm and oppress marginalized groups through providing a foundation to translate research into actual action to reduce inequalities (Rosenthal & Lobel, 2018).

Rosenthal and Lobel (2018) showed that the latest studies have found that gendered racism to be accompanied by raised psychological distress among African American women. These studies have not emphasized stereotypes and aspects of gendered racism, particularly in relation to pregnancy and motherhood. The study also focuses on birth control-related mistrust, which is the continuing implications of historical and present gendered racism. It focusses on Black and Latina women in the U.S particularly, given the disproportionate percentages of adverse sexual and reproductive results that those groups encounter as well as their intertwined or collective experiences of gendered racism (Rosenthal & Lobel, 2018).

Brown (2012) has discussed how intersectionality has been used to address the geographies of sexualities, and discussed unevenness across class, gender, religion race, age, and disability. As a result, a series of anxieties have been elevated by this inequality and how many various intersections are considered as well as the ironic implications of such choices. Brown (2012) said that intersectionality was placed on the map for feminist geographies by linking sexualities to other identities. Brown also stated that Crenshaw herself utilized the subject standing in regards to the spatial metaphor at the intersection of a variety of 'streets' of structures (Brown, 2012).

Sutherland (2016) has used the intersectional framework as an attempt to focus on the macro-levels that drive HIV/AIDS and STIs in the ESC region. They examined the HIV/AIDS and STIs drivers and risk factors for 15- to 24-year-old youth which includes also macro-level drivers of poverty and income inequality, low educational status, imbalances in gender power, stigmatized sexual behaviour, socio-cultural norms, and governmental policies. On the other hand, the micro-level drivers, that includes dynamics in the family, sexual abuse, risky sexual behaviour, and hormonal neurobiological processes. This framework simultaneously explores also both the intersection between macro and micro-level factors and monitor the combined influences of these variables (Sutherland, 2016).

Sutherland (2016) stated that there is a relationship between intersectionality and public health as there are multiple intersecting identities that are considered the first step in order to understand the health disparities complexities for populations from many oppressed groups historically. The framework has also been used to link HIV infection with the social and economic pressure relations of inequality. The macro structural-social dynamics intersect at the micro-level of a person's experiences to shape sexual behaviour and attitudes that put young people at risk for HIV/AIDS and STIs infections. Sutherland discussed how at the micro-level multiple interlocking identities reflect multiple and interlocking structural-level disparities at the societal macro-levels (Sutherland, 2016).

Intersectionality theory examines the interactions between the multiple social identities and adolescents' psychosocial attributes such as gender, socioeconomic status, age, perceptions, behaviour, and attitudes, and health-related outcomes. It emphasizes one of the biopsychological aspects and on the broader cultural, societal, and institutional effects that

form young people's sexualized behaviour and attitudes. Intersectionality also focuses on the marginalized and disadvantaged social groups. Economically challenged English-speaking Caribbean (ESC) youths that encountered multiple oppression systems such as insufficient education, lack of health care, and pressure on a household with a single parent have been significantly overlooked in research related to public health (Sutherland, 2016).

Many published studies on Caribbean youth's susceptibility to STIs and HIV and prevention and treatment strategies tend to depend on individual-level approaches, even though social determinants of health models, as well as the ecological system theory, have insightful investigations in the Caribbean region on nature as well as the quality of complex social relationships and the social context that form adolescents' sexual behaviour and attitudes with emphasis on intervention and prevention strategies. While those frameworks permit bidirectional contacts and interactions between individuals and their social contexts, there is inadequate attention to various individual factors as well as a psychological correlation that are possible to be accompanied by ESC adolescents' sexual behaviour and attitudes. In addition to the influence and the complexity of multiple systems and their collective effects on youth behaviour and attitudes that have not been sufficiently addressed. For such reasons, the intersectional framework is the most appropriate as it is considered a multisystemic conceptual framework as it provides a better understanding to the various aspects in order to prohibit sexually risky adolescent behaviour (Sutherland, 2016).

Martinez and Phillips (2008) have explored the extent to which school-based sex education programmes have assisted adolescents to understand both intersections of SRH with gender, ethnicity/race, as well as sexual identities, and have challenged sexual inequities and ethnocultural in manners that would assist youth to declare and maintain their rights in the areas comprehended by SRH in one region of Ontario (Martinez & Phillips, 2008).

Martinez and Phillips (2008) stated that effective sexual health education should be provided in culturally as well as age-appropriate which would be respecting individual choice. Sexual health education (SHE) should not be discriminating against any race, gender, ethnicity, religious background, sexual orientation, or disability in relation to accessing the related information. It also endorses critical thinking in regard to gender role stereotyping. It acknowledges the significance of gender-related matters in the society as well as the increasing

variation of choices available to individuals. Such a theoretical framework also helps to recognize and respond to precise SHE of particular groups like seniors, adults, people who are developmentally and physically disabled as well as children and adults who have been exposed to sexual abuse and marginalized populations like Aboriginal people, lesbian, immigrants, gay, youth, street youth, and transgendered people (Martinez & Phillips, 2008).

3.4 Conclusion

The research used intersectionality theory as its conceptual framework in order to examine the power dimensions in Egyptian society as well as explore the various layered issues and challenges that women face regarding their access to SRH services and information in Ismailia. The research drew on the intersecting gendered experiences within the various power structures, the shapes of oppression and privilege structures, age, class, educational level, that are created by the patriarchal society, religion, and the state. Intersectionality theory is considered an appropriate theory as it reveals the inequalities, and the various multiple dimensions that form married women's experiences related to their SRH and their sexualities, such as their families, socio-economic status as well as gender discrimination. The theory informed the thesis and was used to analyse and interpret the findings.

Chapter Four: Methodology

4.1 Introduction

This chapter outlines the methodology employed in this research study. It discusses the study design, the study population study setting, and sampling procedures utilized. It also describes the data collection tools as well as the data collection process. It also outlines the coding of the data and analysis procedures. It elaborates on rigour and the limitations of the methodology utilized. Finally, the study's ethical considerations are emphasized.

4.2 Research methodology

The research methodology provides a logic behind the different steps that took place in the process of studying the research problem. It takes into consideration the research problem, the context and explains the utilization of a specific technique. In research, there are two main research methodologies, namely, qualitative and quantitative. Qualitative research methodology encompasses a high level of detail, discovery as well as the participant's opinions (Mfaku, 2019). While the qualitative approach underpins a "thick description", the quantitative approach explicates the phenomena utilizing a numerical explanation and manipulating the interpretation (Apuke, 2017). For this study, a qualitative method was followed. The motive for using this method is to explore the phenomena in-depth to understand the lived experience of participants.

4.3 Study design

A research design is the blueprint of the research that guides the researcher through the study by articulating the data that is required and the methods that were used to gather and analyse this data, as well as how this answered the research questions (Congdon, River, Drawer, & Dunham, 1999).

An exploratory qualitative design was utilized for this study. Utilising an exploratory approach for this study was appropriate to understand in greater depth the perceptions, experiences, as well as feelings of married women as regards the challenges and barriers that impact their access to and utilization of SRH service and information in Ismailia, a topic that had not been adequately explored before.

This research used a qualitative methodology because it was considered the most suitable method to collect the required information to achieve the study's purpose, as the study is a very sensitive topic in Egypt. The qualitative approach falls within the interpretive paradigm, which supports personal descriptions and interpretations of social reality such as that of being a woman in a conservative Arab world. The rationale for choosing such a method was that it investigated the phenomena in an in-depth manner in an attempt to gain information about the social dynamics of SRH experienced by women in Egypt and their day-to-day reality. The methodology provided a way for obtaining in-depth information about the social phenomenon being investigated (Chikovore, 2004; Mouton & Babbie, 2001).

Qualitative research further improves the quality of data through revealing more sensitive information which might not be possible with quantitative research. It is focused on understanding, not measuring the phenomenon, and the study participants are conceived as self-directing, and who are constantly changing and reconstructing their own priorities, assumptions, and interpretations about the world (Rice & Ezzy, 1999). Exploratory qualitative studies are intended for investigating the phenomenon's full nature in new areas, through gaining an in-depth understanding of the respondents' lived experiences (Chikovore, 2004). A qualitative approach permits for free, unstructured expressions and is not restricted by predetermined limitations that characterize the quantitative approach. It also allows the researcher to assess the complexity of what is being studied as well as attempts to make explicit the fundamental structures underlying the research problem in order to understand its complexity (Nmadu, 2017). The focus on qualitative research is on wide and deep descriptions, which is a comprehensive description of events as they are occurring and putting them in their context (Mouton & Babbie, 2001).

4.4 Semi-structured individual interviews

There are various forms of interviews, namely, semi-structured, structured and unstructured interviews. Face-to-face semi-structured interviews are related to the anticipation that the participant's opinions will be expressed more than they would be in a non-face-to-face questionnaire. Semi-structured individual interviews were conducted to gather the data from married women. This qualitative data collection method usually encompasses a set of open-ended questions to explore in-depth the phenomenon under study to attain data from participants' meanings, how persons perceive their world, and how to explicate or make sense

of the significant events in their lives (Balushi, 2018). In the research undertaken for this thesis, the semi-structured interviews are the research data technique carried out for the specific purpose of data gathering through means of spoken words and via utilizing a planned sequence of questions.

Questions must be easily and clearly understood by interviewees in relation to their personal experiences since the study is culturally sensitive, and they also need to be asked and framed in a way that will help answer the research questions. The participants may not be able to provide a straight answer to a technical question; however, skilfully constructed questions can be combined to provide the required information. An important benefit of semi-structured interviews is the opportunity for unknown information to emerge. Such an approach permits for data extraction (Balushi, 2018; O'Keeffe, Buytaert, Mijic, Brozovic, & Sinha, 2015).

4.5 Participant observation

This method was used to observe and describe behaviour, facial expressions or physical changes, being upset or irritated, exciting events, as well as artefacts in the social setting selected for the study in order to reveal more information and data. Observations allowed the researcher to describe current situations through using the five senses, offering a "written photograph" of the situation under study. Participant observation includes improving memory, actively looking, detailed field note writing, informal interviewing, as well as patience. Participant observation is categorized by actions such a projecting an open, non-judgmental behaviour and attitude, an excitement to learn more about others, having awareness of the tendency for feeling culture shock and for making mistakes, being a good listener and a careful observer, as well as being open to the unpredictable in what is learned (Kawulich, 2005).

4.6 Sampling

In qualitative research, researchers do not have the time or resources to analyse the whole population. To address this problem, qualitative sampling techniques are applied in order to reduce the sample size which enables the gathering of data from a selected group of research participants (Taherdoost, 2016). Moreover, unlike quantitative research which seeks to generalize finding based on a large random sample, qualitative researchers gather data from a small group of research participants who are selected or sampled based on certain criteria

(Taherdoost, 2016) and have no obligation to prove representativity and generalisation. There are various sampling techniques which are divided into probability and non-probability sampling. Probability sampling or the random sampling is considered a quantitative methods technique. It means that every member in the population has an equal opportunity of being selected in the sample. Probability or random sampling is free from bias but it consumes more money and time. Probability sampling includes simple random, systematic, cluster, and stratified sampling. On the other hand, non-probability sampling is a qualitative technique that includes quota, snowball, convenience, and purposive sampling (Taherdoost, 2016). This research used the purposive sampling and snowballing sampling because they were considered the most appropriate sampling techniques for collecting the suitable data that serves the research purpose as well as the nature of the study (Taherdoost, 2016).

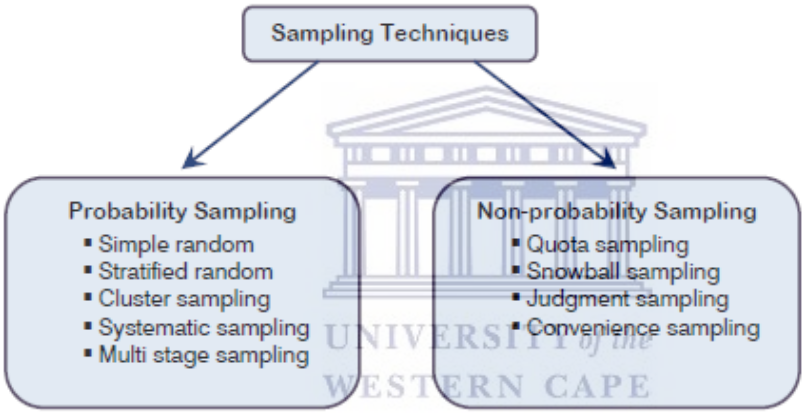

Figure 4.1 demonstrates sampling techniques for probability and non-probability sampling (Taherdoost, 2016).

4.6.1 Sampling Technique undertaken for the thesis study

Semi-structured in-depth individual interviews were conducted with twelve married women in the study area, Ismailia. The researcher used purposive sampling to recruit women who had to be married and sexually active and therefore are meant to access SRH services and information. Through these women, the researcher had other married women who are sexually referred to her in order to recruit them through a process of the snowball sampling. Snowball sampling was well suited for the thesis study as it focused on a sensitive issue and therefore it was difficult to recruit participants any other way (Biernacki & Waldorf, 1981). This technique

relied on referrals, where one participant recruits subsequent others. The researcher made use of her existing informal networks to access married women. The snowballing technique was additionally considered to be the appropriate method for the study as it required few cases to assist in encouraging other cases to participate in the study in order to increase the sample size. This approach is most appropriate in small populations that are hard to access because of their closed nature (Taherdoost, 2016). However, the researcher kept in mind that the quality of data using snowballing sampling might be biased. This might limit the sample validity because the study participants were based on the subjective choices of the participants first accessed (Bryman, 2012). However, for qualitative research methods it is not necessary to maintain sample validity, as the nature of the methodology does not require generalisation beyond the studied population.

The other method of data collection that was employed in the thesis study was key informant interviews with health professionals. This method was used in order to cover the various aspects of the phenomenon from a professional and expert point of view (Tongco, 2007). For the key informants, purposive sampling was employed to recruit two health professionals, in the case study area. With this sampling method, the researcher had to put specific criteria for inclusion. Health professionals who deal specifically with SRH issues, such as male gynaecologists and female pharmacists, were approached for inclusion. A male gynaecologist was interviewed as gynaecologists are the specialists who mainly provide SRH services in Egypt and there aren't many female gynaecologists in this context and those who are there mainly practice part-time. The main gynaecologist that was interviewed is very prominent and experienced in the study setting. Purposive sampling was chosen as it selected possible respondents who have experience, knowledge, and perception of the specific phenomenon under study, in order to answer the research question (Nmadu, 2017; Tongco, 2007).

The researcher met the identified married women and key informants individually. They were given a verbal explanation of the research purpose, how and why they were selected, and what the research process would entail. They were given a participant information sheet with the relevant information as well as a consent form in Arabic. The participants were informed of the date when the signed consent forms would be collected to give them enough time to make an informed decision as to whether they would like to participate in the study. The dates for the interviews were communicated to the participants after making arrangements with them.

Each interview took about 45 minutes to one hour depending on the responsiveness of the interviewee. At the start of each interview, the motivation for conducting the study and the importance of gaining an understanding from their own perspective were explained to each participant again. The importance of being able to share their experiences, suggestions, questions and reservations freely and truthfully to attain information that can assist with improvement of SRH services and information in Ismailia, was explained to the participants.

The researcher conducted all the interviews herself in Arabic, which is the local language spoken. The researcher is fluent in this language. All interviews were audio-recorded with the permission of the interviewees. In instances where participants did not want to be recorded then the researcher respected their wishes and relied on notes only.

4.7 Data analysis

Qualitative data analysis (QDA) is a process that brings order, meaning, and structure to the collected mass of data (Khalesi et al., 2017). QDA is ambiguous, messy, and time-consuming, but it is also a fascinating and creative process. It incorporates a range of procedures and processes that are used to give the collected qualitative data some interpretation, understanding, and explanation of the situations that were explored and the people that were investigated. QDA is premised on an interpretative philosophy (Bester, 2011).

The researcher, with the help of a research assistant, transcribed and translated the interviews verbatim. Thereafter, it was coded and analysed by employing thematic analysis. Thematic analysis was used as it is a process of recognizing themes or patterns within qualitative data. It is considered to be simple, flexible, and clear. The themes and the patterns identified through thematic analysis were used to address the research topic. This is considered much more than just summarizing the data; rather, it interprets and makes sense of the data (Maguire & Delahunt, 2017).

Intersectionality theory was utilized to analyse the empirical findings. The theory explored different social locations such as gender, class, sexuality, geography, family status, age, and religion and their impact on women's access to sexual and reproductive service and information and their intersections (Carastathis, 2014; Hankivsky, 2014). The data was presented using descriptions and quotations for illustration. The researcher used qualitative data analysis

software, Atlas.ti, which is a useful workbench for analysing qualitative data, particularly visual, text, and audio data. This software provided help and support to the researcher during the process of data analysis, in which texts were interpreted and analysed using annotating and coding activities. In addition, it offered a comprehensive overview of the research project, that is called the Hermeneutic Unit (HU) in Atlas.ti as well as facilitating retrieval functions and immediate search. Atlas.ti also has network-building features that permitted the researcher to visually connect chosen memos, texts and codes through means of diagrams (Smit, 2002).

Piloting was conducted in order to refine the research tools to gain more information and reveal more useful questions and probes to use in subsequent interviews. The researcher was guided by the participants themselves. After refining the tools, they were shared with the supervisor. Piloting was a very useful process that gave validity to the study.

4.8 Ethical statement

The research took place only after approval was granted by the relevant authorities that included the University of the Western Cape's Senate Research Committee, the Faculty of Economic and Management Sciences (EMS) Higher Degrees Committee, the Senate Higher Degrees Committee, and the Institute for Social Development. Before the commencement of the research, voluntary consent was sought from participants. Participants were informed about the study purpose and that they had the right to withdraw from participating at any stage of the research. They were informed that pseudonyms were used to protect their own identity. The researcher ensured that the dignity of participants would not be violated throughout the duration of the study and participants would not be betrayed in any way. The information gathered was confidentially treated and was used for the intended purpose of research only. Digital data such as recordings, among others, were stored in a password protected folder in a computer, inhibiting access by any unauthorized person/s. In year five, after the candidate has graduated, the data will be permanently deleted. Hard copy data such as interview transcripts will be kept in a locked drawer, only accessible to the researcher and supervisor. In year five, the data will be shredded.

CHAPTER Five: Findings

5.1 Introduction

This chapter presents the analysis of data and the findings that emerged from the process. The chapter outlines the participants' characteristics, followed by a description of the findings. The findings are captured under the following themes:

1. Participants' characteristics;
2. How it feels to be a woman living in Egypt;
3. Married women's understanding of sexual and reproductive health;
4. Women's access to sexual and reproductive health services and information;
5. The facilitating factors that make it easy for women to access SRH services and information;
6. The challenges that make it difficult for women to access SRH services and information;
7. Married women's perception of female genital mutilation (FGM);
8. Married women's suggestions for improving their access to SRH services and information to ensure their sexual health and sexual wellbeing
9. Health professionals' perceptions of married women's understanding of sexual and reproductive health.

5.2 The Characteristics of the study participants

Table 5.1 shows the characteristics of the 12 married women with whom semi-structured interviews were conducted in this study. The married women's ages were between 25 and 55. These married women had children between the ages of a year and a half to 30. The majority of the married women interviewed had formal education. In regard to their employment status, 10 of the interviewees were government employees and two were unemployed. This chapter mentions the class, education, age, religion, employment status, and the interview place for the interviewees.

Two health professionals (a pharmacist and a gynaecologist) were also interviewed; they were purposely sampled because of their expertise in providing SRH services and information.

Table 5.1 Demographic Characteristics of Married Women Interviewees

Socio-demographic		Frequency	Percentage
Age group	20-30	3	25%
	30-40	5	41.6%
	40-50	1	8.3%
	50-60	3	25%
	Total	**12**	**100**
Marital status	Single	0	0
	Married	12	100
	Total	**12**	**100**
Educational status	No formal education	0	0
	Secondary education	1	8.3%
	Tertiary education	11	91.6%
	Total	**12**	**100**
Employment status	Formally employed	10	83.3%
	Informal employed	0	0
	Unemployed	2	16.6%
	Total	**12**	**100**

Source: Field Data

5.4 How it feels to be a woman living in Egypt

Most of the women that participated in this study indicated that they were oppressed, felt unequal to their husbands or male colleagues at work, and struggled to get the same rights that men have in Egyptian society. For example, Participant D (52, middle class, educated, employed, Muslim), reflects on the marginalized status of women's rights in Egypt, stating that:

> *I do not get my rights as a woman. I do feel that women in Egypt are oppressed and do not obtain their rights. They do both women and men's work. They work like a nurse and a doctor and teacher for their families and a woman for their husbands at night. … The responsibility is too much for women in Egypt. No one helps her and carry that full responsibility.*

Another respondent, Participant G (55, middle class, educated, Muslim, her private house) highlights the role of gender inequities, patriarchy, and structural factors in the marginal status of women in Egyptian society:

> *It feels like you are a subordinate citizen as if both women and men have the same qualifications and skills, and there is an opportunity, men are the ones to be considered because of their sex "male", despite the fact that the woman could be much better than them. This happens in both work and the household level as well. …um There is certain inequality and injustice because of the patriarchal society where the men are thought of to be in the privilege structure who responsible for everything and can do anything while women are considered wrong all the time even if they are right.*

Participant B who is 28 years old, middle class, educated, employed, and Muslim agreed with Participant G's description of the inequities and injustice that women in Egypt suffer from, stating that, *"Desperate Umm … There are no rights at all. …. such as political, social, and every other right, women are oppressed, no matter their social status."*

While most of the respondents criticised the subordinate status of women in Egypt, three women (25% of the sample) stated that they were satisfied and fine with their situation in both the work and home environments. For example, Participant H, a middle aged, 54 years old and

university educated woman who works in a government department, states that she does not feel marginalised as a woman:

> *It depends on the situation and the people that you are dealing with. I do feel like I am different from other women, I can manage the situation that I am in as I feel like I have my rights or I am trying to get my rights and I do not feel like I am weak. I am a woman because I want to be one. Thank god that I do have the belief and the ability that I can be the woman that I want. That is why I do not allow anyone to oppress me as well as I have a good education and a good job. On the other hand, I do know that the majority of women are oppressed because we live in a patriarchal society.* (Participant H, Muslim, Middle class, 54, middle class, educated, employed, her private house).

Participant H feels that because she has a good education and hence a good job she is in a better position to exercise her rights or fight for her rights. However, she also acknowledges that – unlike her – most women are oppressed because of patriarchal power relations. By contrast, Participant E, a young (25 years old), lower middle-class woman who is educated but unemployed stated that:

> *I am fine. I do not suffer from psychological traumas or complications as well as its very comforting thing in particular in marriage. For example, when I came to conduct the interview, my husband was very understanding. On the other hand, another person could cause trouble.* (Participant E, lower middle class, 25, educated, unemployed, park).

5.5 Married women's understanding of sexual and reproductive health

Most of the participants did not understand what is meant by SRH. The researcher had to explain the meaning first in order for them to share their experience in regards to SRH. When Participant B, a young (28), middle class and educated Muslim woman was asked what her understanding of SRH was, she stated that *"According to us, sex is only for making children only [with low voice when mentioning the word "sex"] and only within legal marriage, nothing more."*

Participant E similarly noted a lack of access to SRH information, saying that *"I do not know anything about SRH as no one talked to me about it."* (Participant E, lower middle class, 25, educated, unemployed, park).

In an interesting interview, Participant F, 39, a lower-middle class Muslim woman pointedly highlights that a lack access to SRH information meant that her experience of sexual intercourse was felt in a negative and a disgusting manner; however, when she had more SRH information, she experienced sex in a more pleasing and satisfied manner. Participant F explains:

> *Before marriage, talking about SRH was indecent and improper. .... As our parents taught us not to talk about and even if they saw us speaking to males' neighbours, they beat us. ... After marriage. As I married three times, ummm my first marriage, my SRH understanding was terrible, I could not sexually respond to him as I did not know anything about the sexual intercourse and my sexuality ...and he also did not tell me anything. ... I felt disgusted about the whole sexual intercourse. ……well, I married three times, the first two times, I was really disgusted the by sex and sexual intercourse and my previous two husbands said about me that they married a man not a woman .... but the third one made understand my sexual health and sexual wellbeing, and sexual intercourse in a good way so I liked the intercourse and was satisfied sexually with him, that when I was 36. ... [with a sad and bitter voice], I only understood what is women's sexual health means, I really felt so sad for all the past years that I did not understand my sexuality and sexual well-being and that I was disgusted from the sexual relationship that God created in order to please men and women. That is why I got divorced from my first two husbands.* (Participant F, her workplace place)

Participant F's quote above raises the importance of access to SRH information and how this opens up possibilities for understanding women's sexuality and "sexual well-being."

Participant G describes her understanding about SRH: *"I only know that I have to maintain my own personal hygiene and my body especially during my period, have a good nutrient during pregnancy and delivery."* (Participant G, Muslim, 55, middle class, her private house).

5.6 Women's access to sexual and reproductive health services and information

The majority of women said that they access information from sources such as social media, TV, friends, and family. Moreover, they only approach a gynaecologist when they face serious health problems. Participant C, a working-class woman, when asked where she got access to SRH services and information, said that she got her information from:

> *The internet and I ask my female friends and older people. ...As in Egypt, everybody has something to say about everything. For instance, if a woman does not have a background about pregnancy and knows that you are pregnant, she is still going to advise you to take care and do not carry heavy stuff. ....so, you get information from everybody and its similar information, so I do not need to visit a doctor as everybody is doctors themselves.* (Participant C, working class, Muslim, employed, her workplace).

Participant E, similarly says that she accesses SRH information through research on the internet.

> *I only get information from Facebook and friends but I do not take what I read or know from them for granted but I like to search myself for something that is guaranteed…um I get the information from Medical websites but still do not know if such information is right or not.* (Participant E, 25, educated, unemployed, Muslim, Park).

Participant A, an educated middle-aged woman (age 54) highlights the role of culture in inhibiting discussions of SRH. Even though she is educated, the cultural taboo of talking about SRH at the household level in Egypt meant that even when her daughter got married, she could not bring herself to enlighten her daughter:

> *I did not get any information or services related to my SRH .... Umm, my older married sister only spoke to me about a few things to do, two days before marriage ... even my mother was too shy to tell. Even when my daughter got married, I asked one of my female neighbours to tell her as I was too shy myself. As such a topic is too sensitive, there is not a sexual culture in Egyptian society. We have been raised that such topic is*

taboo, girls were not allowed to sit with married women when they are speaking about sex or SRH. (Participant A, 54, middle class, educated, Muslim, her workplace).

Women in Egypt get information on SRH through many avenues. For instance, Participant C describes how her husband received information on sexual intercourse through the medium of pornographic movies; however, because this information was not about SRH, she did not know what health complications this had until after the fact. She explains that:

Before marriage, I did not get any information and my mother was shy to tell me, after marriage …. my husband was telling me what should I do ….um as he has been bold since we got married, he is not shy person…um he gets that information from porn websites and movies and he still watches them till now and sometimes I watch too. I used to practice anal sex with my husband, I enjoyed it at the beginning but I did not know it is complications until I had anal fraction, bleeding and conceptions and the process of getting rid of the material waste from my body was very painful. (Participant C, working class, educated, Muslim, her workplace).

Participant H also stated she got her information from her husband

Before marriage, I did not know a slightest information about my SRH and no one told me what to do and what not to do. And the only source of information was my husband as he taught me what to do. … He is a man, maybe he got it from movies or read it because his culture and community gave him the space to do whatever he wanted" (Participant H, Muslim, 54, middle class, educated, employed, her private house).

5.7 Married women's Knowledge of the Reproductive Health Services (RHS)

Married women acknowledged that they have knowledge of certain reproductive health services such as antenatal care, and delivery care but they did not have sufficient awareness or information about family planning, screening and treatment of STDs, that include virus C and HIV. They also had knowledge about various contraceptives methods like contraceptive pills and IUCDs, but without knowing the advantages or disadvantages of using these methods. On the other hand, women did not mention condoms as a method for contraception as it alleged to reduces men's pleasure during the sexual intercourse. Some of them prefer to ask their friends and use the internet to get that information as Participant's C and K, respectively, state:

> *There is a need to have health professionals in particular nurses to treat us humanly and with respect and not mocking us when we ask questions in relation to our SRH as some of us not educated enough and do not have information about the advantage and disadvantages of the contraceptives from IUCDs or pills as I do not with the proper method to use and will not harm me physically as well as the need to learn about birth control and family planning.* (Participant C, working class, Muslim, employed, her workplace).

> *I do not know enough information about the different contraceptives methods, and the different advantages and disadvantages s of each them, and also do not know enough about STDs as I found out that I have Virus C and I did not know that could be transmitted sexually.* (Participant K, 43, middle class, educated, Muslim, her workplace).

5.8 Facilitating factors for women to access SRH services and information

5.8.1 Education

From the data it is apparent that education plays a vital role in women's access to SRH knowledge and information as it is through education they get SRH knowledge and information from the internet, social media, books, and medical websites. For example, Participant E, a

young (25), educated, unemployed woman, says that she receives her SRH information from the internet:

> *I only get information from Facebook and friends but I do not take what I read or know from them for granted but I like to search myself for something that is guaranteed…Um I get the information from Medical websites but still do not know if such information is right or not.* (Participant E, lower middle class, 25, educated, unemployed, park).

Participant E highlights an important point which is that even when she gets information from medical websites, she still does not know how accurate and safe this information is.

5.8.2 Socio-economic factors

All the participants agreed that socio-economic factors play a vital role in women's access to SRH services and information. Women mentioned that the more your socio-economic status rises, the more they could afford to access to SRH. One's social class and hence financial status in some ways determine access to SRH services and information, although as noted in some of the interviews above, being from the middle class does not mean that you have more information as cultural taboos can prevent some women from discussing issues related to sexual and reproductive health. However, if one has knowledge and the financial means, then it is easier to purchase or access SRH services. As Participant A, a middle class, employed woman states: *"Off course, as money is a vital factor for women to access to proper SRH services and information, it's an engine not only in individual's life but in nation's lives."* (Participant A, 54, middle class, educated, Muslim, her workplace).

Participant H captures how one's class position can determine access to SRH services:

> *The socio-economic factors play a vital role in women's access to SRH services and information as the more that women have money and belong to a wealthy class the more that it is easy to access such services. On the other hand, women's that belong to working-class suffer from access to any kind of services related to SRH and they are treated in an inhuman manner and as an object which causes serious consequences to their health*. (Participant H, Muslim, Middle class, 54, middle class, educated, employed, her private house).

5.8.3 Age

Most of the participants stated that age also played a role in their access to SRH services and information. They indicated that the more that they get older, the more that they can access SRH services and information. For instance, Participant B (28), a middle class, educated, and employed anticipated that her access to more SRH information and services would improve with age: *"In my situation, the more that I am getting old, the more that I can gradually access that information and services."* (Participant B, 28, middle class, educated, Muslim, social club).

5.9 The challenges that make it difficult for women to access SRH services and information

5.9.1 The power dimensions intersecting with cultural and religious aspects

Cultural and religious norms have been the most notable barrier acknowledged by married women and health professionals which influences women's access to SRH services and information. Societal and cultural traditions and norms prohibit women from accessing SRH services and information as well as mentioning and discussing SRH issues. SRH are considered taboos and a shameful matter, especially talking about them before marriage. Several participants noted that speaking about sex was not allowed and if any of them did, they would be considered bad girls. Moreover, all the participant's mothers did not speak to their daughters about sex and sexual intercourse before marriage. In a similar vein, participants themselves did not speak to their daughters about sex and SRH before marriage as they were too shy. Participant A, a middle-aged (54) educated woman, succinctly captures how deeply entrenched cultural taboos such as talking about sex and SRH can lead to feelings of shame among girls and women:

> *Traditions and social norms are one of the significant reasons that represent a huge challenge for girls and women as SRH and sexual relationships are considered taboo and shameful to talk about, even if this could harm women's SRH. As she could neglect her sexual health and physical and psychological health because she is shy and shameful to visit a health professional.* (Participant A, 54, middle class, educated, Muslim, her workplace).

Cultural taboos seem to perpetuate a sense of fear and of stigma around SRH problems, as Participant A stated that even when she suffered from a serious and painful health problem around her genitals, she was too scared to visit a doctor because of the fear of societal stigma.

Participant B, a young a 28-year-old middle class, educated, and Muslim reflected on the fear that young women live with before marriage, especially women losing their virginity because of how the society perceives it in media, movies, and books:

> *I have never obtained SRH services and information before marriage but after marriage, I got some information from videos of Dr. Heba Kotb (Egyptian doctor that is specialist of SRH from the Islamic point of view) on TV and some pages on social media such as "love culture'' page) on the internet and that is it. … In addition to that, I was getting information from relatives and this was the worst way to get such information because they were also ignorant in relation to such information and they are not medical professionals and some of them were doctors but not specialists in SRH. That is why they could not help us and this led to an increase in the suffering period between me and husband during our sexual intercourse. For such reasons, before marriage, it was so scared to lose my virginity and how did I deal with it, well, I could not deal with it at all but I was trying to get information from the internet but I did not dare to visit a female gynaecologist to make sure of my virginity despite that fact that I did not have any sexual experiences before marriage. I felt so scared because of the fear that was passed to us from society, movies, and culture. After marriage, the problem was that I did not have the slightest information about the nature of the sexual relationship (intercourse) between a married couple which caused me a serious problem at the beginning of my marriage*. (Participant B, 28, middle class, educated, Muslim, social club).

Participant B, a young (28) married and educated middle class Muslim woman, similarly highlights how "societal shame" in discussing sex and SRH issues leads to a fear of raising sexual health issues with health professionals:

> *First of all, because of the societal shame we have been so scared to and ask psychiatrist and visit gynaecologist especially when I was still virgin [never married] in regards to ask about my sexual health and sexual well-being. The second thing*

women's financial status plays a role in hindering her opportunity to access SRH. (Participant B, 28, middle class, educated, Muslim, social club).

Participant H laments the role that outdated cultural taboos continue to exercise in the lives of girls and women, stating that: *"The society created a taboo out of the sex as it is shameful to talk about or to learn about your sexual health and sexual well-being. They are outdated traditions that are still implemented till now."* (Participant H, Muslim, Middle class, 54, middle class, educated, employed, her private house).

Some of the participants complained about the behaviour and attitudes of health providers. They mentioned how they have been treated inhumanly and suffered from unprofessional behaviour from nurses and doctors in primary health units who should provide them with proper services and information. While cultural norms clearly hold back women's access to SRH services and information, there have been many instances where public health professionals who should be promoters of information actually undermine access to SRH services and knowledge. Participant C and Participant E, respectively, describe the challenges they faced in accessing SRH services:

I have tried several times to go to the primary health care units to get services and information. I went to get contraceptives and the nurses made fun of me. For instance, I told the nurse that I do not want to implant the IUCDs because I am afraid of it so she made fun of me when I was talking with her and asked me when the last time your period came and I said that I do not remember so she said go and when the period comes again come. Then I said that I am sure that nothing happened between me and my husband at this time. Um … The same situation happened to me again after giving birth to my second child and the nurse shouted at me twice when I was asking about the proper contraceptives for me but they did not understand me and I could not get proper information about the best contraceptive methods for me every time I was asking and I was treated like a stupid person. (Participant C, 34, working-class, educated, Muslim, her workplace).

Even the health units that should provide SRH services and information was really bad. As I go and they ask me what kind of contraceptives do I want to take without telling me about the advantages and disadvantages of each one. For example, they could give

me bills without asking me about my family history. Before marriage, I went to a gynaecologist with my mother and asked her about the infections that could affect my female genital system and she did not only not provide me with medical information but also, she asked my mother to fill my free time and make me busy so that I would not think about such things. I was shocked when she said that. (Participant E, lower middle class, 25, educated, unemployed, park).

Most of the participants mentioned how religion, in particular Islam, is misused by men and religious men to serve the patriarchal society in order to oppress women and force them to achieve all their desires. On the other hand, women mentioned how "Islam" is a tolerant religion that encourages people to learn and seek knowledge, and how Islamic teachings call on husbands to treat their wives with love and kindness. Participant B speaks to how Islam has been abused to reinforce patriarchal relations when it actually promotes access to information for both genders:

The right understanding of religion would significantly help in increasing society's awareness of women's access to SRH services and information. But unfortunately, there is no right understanding of the Islamic religion in society. Ummm... some of the religious men take only some of the provisions and principles of Islamic laws that serve patriarchy which serve men only. Despite the fact that both Islam and Christianity provide equal rights for both sexes. There is a quote in the Islamic religion which is "there is no shame in religion" that means there is no shame in asking for information and knowledge in all aspects of life even the sexual ones. (Participant B, 28, middle class, educated, Muslim, social club).

Participant E and Participant H, respectively, explain how religion has been misused but also argue that religion can exercise an important role in accessing SRH services and information:

I think religion plays a role for women to access SRH services and information as some people misunderstand the religion and use only parts of it to serve their interest. For example, they only take half of the verse like you can marry four wives without the rest of it. (Participant E, lower middle class, 25, educated, unemployed, park).

Um … Also, the missuses and misconceptions of religion give men absolute power in the sexual relationship. For example, I only knew in the recent years that I can say no to my husband when he wants to have sex with me when I am physically or emotionally not well as I used to be forced to have sex with him even him if I used to be tired or do not want it because of the fear of God as he ordered women to obey their husbands. (Participant H, Muslim, Middle class, 54, middle class, educated, employed).

5.9.2 Power structures and socio-economic factors

All the Participants agreed that socioeconomic factors play a vital role in women's access to SRH services and information. Women mentioned that the more your socio-economic status rises, the more they could afford to access SRH services. For example, Participant B said that socio-economic status determines how women are treated in Egyptian society and determines the level of freedom that they have to obtain their rights:

The second thing women's financial status play a role in hindering her opportunity to access to SRH… umm, I have seen this myself in real life, women belong to working-class, beneath, and under poverty line, they are treated inhumanly and like objects that could be violated easily and no one would help them. That is why, with the increase of women's socioeconomic status and their financial independence from their husbands due to their jobs, the more that influence positively their level of freedom. (Participant B, 28, middle class, educated, Muslim, social club).

Participant C agrees with Participant B, that the financial status could affect women's choice to seek SRH services and information from health professionals:

Of, course the fees to visit a doctor in his practice is so high so women save that money to buy things that her family needs rather than going to a doctor who will say a couple of information that she can from anyone around her. (Participant C, 34, working-class, educated, Muslim, her workplace).

I think that money plays an important role in women's access to SRH services and information. For example, if I cannot feed my children, do you think that I would able to visit a doctor? As the Egyptian woman only visits a doctor when she is already done "meaning when something is really serious affected her". For example, before

menopause, she needs to start taking supplements and visits the doctor regularly but this does not happen. .... And also, did you see men taking their wives out or asking their children to leave their mother to sleep when the hormones influence her moods? (Participant D, 52, middle class, educated, Muslim, her workplace).

5.9.3 Power dimensions and the role of the state

The research participants indicated that the state also has a vital role to play in the realisation of women's health and women rights. They believe that the state should cultivate policies and adopt more laws and initiatives concerning women's health, and in particular SRH services and information. In this regard, Participant B says that:

Of, course ... the state is responsible for cultivating laws and legislations and turns a blind eye with regards to the implementation of specific rules in relation to women's rights and women's health. For example, I used to work as a pharmacist in a health care facility in a village and I have seen young girls who under the marriage legal age were getting married with the help of health care facility and doctors working there, society and the religious men who are responsible for getting people married. The state is significantly complacent in relation to cultivating and implementing laws to protect women and girls as well as there is no monitor and evaluation of such bodies. Such neglect causes serious issues for those young girls who suffer as well as their children. There are also no laws that prohibit rap inside marriage. (Participant B, 28, middle class, educated, employed, Muslim, social club).

5.10 Married women's perceptions and experiences of Female Genital Mutilation (FGM) and the power dimensions in the Egyptian society

Ten of the twelve married women who were interviewed experienced female genital mutilation (FGM) and some of them shared their experiences with the researcher. It is notable that most of the women showed significant awareness of the consequences of the FGM from their personal experience and did not allow their daughters and the other females to go through it. For example, Participants' F and G, respectively, describe their experience of FGM, with Participant F explaining how this "bad experience" affected her and later influenced her to fight against it:

It is very bad as I …. had a very bad experience in regards to FGM. I went through FGM when I was 9 and they cut an artery and suffered from severe bleeding and was transferred to a hospital and stayed for almost a month. … This caused me sexual frigidity for a long time and it is very difficult to reach sexual arousal. … when I grow up and understood how bad the FGM, I was upset with my parents and stood up with my younger sister when I was 18 to stop my parents from doing the same thing to her as I was badly affected and stayed in the hospital and the doctor wanted to report the incident to the police because I almost was going to die. I also stand up for my friend's daughters and for my own daughters. …now I convince people not to do it to their children with words and if they insisted … I have to threaten that I would report them as I badly suffered from FGM. (Participant F, 39, low middle class, educated, Muslim, her workplace).

It was such a horrible experience, I had to go through FGM twice when I was a little girl… the first time was conducted by a doctor and he only cut small piece of genital tissues but my mother was not convinced that the cut was enough so she took me without my knowledge, and …we went to our relatives in the village and mom put me in cow house (corral)with other young girls and a woman from the village came and cut more of my genital tissues as with the other girls …and it caused me trauma till now so I do not want to talk about it anymore. (Participant G, 55, middle class, educated, Muslim, her private house).

Participant C, a working-class woman, describes what impact cultural practises that promote FGM in households in Egypt have on girls later in married life, the injustice that she felt, and how this experience has built her resolve not to allow this to happen to her daughters:

My mother took me, my brother, and my older sister to Cairo to her parents' house, the atmosphere was so stressful in the house as we waited for someone who turned to be a barber or a nurse I did not know who was this man. My mother did not tell me anything, the family put me in a salon room that has a table. I was placed in that table, and my uncle asked me to sleep and there were other men in the room too and that man drugged me and I lost my conscience. When I wake up, I found myself in another room and asked me to stay on a big plate with warm water and disinfectant and they bought me dolls and toys. My brother and my older sister went through the same experience. It took me

a long time to know what happened was FGM (taharah). I had nine years old and I was only happy that I got a doll despite the fact that I felt that the operation did not go well because I felt that I lost my female feelings that I used to feel. Um… I do not have a sexual desire y or I mean I am trying not to lose it. I do not look forward to having sex like other women but if I feel like my husband has a sexual desire, I pretend that I have a sexual desire 10 times more than him. …I felt injustice that I had to go through FGM and my younger sister did not go through it whom I consider luckier than me because of the media and the new culture that spoke about FGM consequences. …and I have never thought to do it to my daughters and I will not. (Participant C, 34, working-class, educated, Muslim, her workplace).

Participant C highlights how the "new culture" that bans and speaks out against FGM has created greater awareness of the public health consequences of the practise.

5.11 Health professionals' perceptions of married women's understanding of sexual and reproductive health

This section discusses the health care professionals' perceptions about women's understanding of sexual and reproductive health. Health professionals claimed that women do not have enough understanding and awareness about SRH due the intersection of social norms, gender roles, religious misconception, and socio-economic factors. For example, one of my key informant interviewees, the gynaecologist, stated that:

The Egyptian society does not have sexual health in Egypt. For example, please get any woman who belongs to a conservative community and you will find out that her mother explains to her about her sexual health and sex only a day or two before she gets married. …um and some do not know anything after quite some time into marriage, only when serious problems happen that could lead to divorce…For instance, we have a serious problem in Egypt which is some of the female gynaecologists. When some of those cases visit them at the beginning of their marriage, they (female gynaecologists) think of them as spoiled women and not only do they not take them seriously but they make fun of them too, of how they cannot have sexual intercourse with their husbands. For example, one of those women came to me and said that one of the female gynaecologists told her if she was her daughter she would beat her with a shoe as how

come you do not know how to have sexual intercourse with your husband and she almost got divorced because of that. And when I started talking to the woman and her husband and analysed the situation to find out where is the defect, we could solve it and they had satisfying sexual intercourse and had children too. (Gynaecologist, his private clinic).

Another serious issue that we face in Egypt which is the virginity as we do not have sexual experiences before marriage so they start exploring it after marriage that is why it's a scary story for them…um, for instance, some of the females come and say I did not think that I am going to lose my virginity after I get married, such issue cause to them a physiological problems as no one told them accurate information of how this is normal to have sexual intercourse. Another issue, some females think that one of the types of the family planning is that defloration does not happen and they come to you after 6 months with serious problems with their husbands and after you analyses such cases you find out that the female patients did not have sexual intercourse and they are still virgin and they think that this is a way for delaying pregnancy. ….um women get such information through asking their friends who are not specialists and they tell them to make the sexual intercourse from outside and they do not tell them what does this mean and the female patient comes to you with her husband after 6 or 7 months with the husband complaining that his wife prevented him from having sexual intercourse that his male friends told him about and all of that because she wants to delay getting pregnant. So, if women go and ask their mothers they would be shy to tell them and if the man asks his friends they could explain to him the wrong way. (Gynaecologist, his private clinic).

In regards to sexual health, women only get information about their SH after getting married only when they face delay in regards to their pregnancy. Doctors ask some questions regarding women's SH, the sexual intercourse, the timing of it (intercourse), and the positions and some others do not ask. As the majority of women cannot understand why the doctor asks such questions and their husbands could pick a fight with the doctor for asking such questions. I have met people in my professional career and my other colleagues too, who could not know how to implement sexual intercourse. For example, I met women and after more than two or three months from their

marriage, they were still virgins as they do not know how to have sexual intercourse. As when those people want to get information, they get it from the wrong places. In regards to reproductive health, women visit to ask about the delay of pregnancy, contraceptives, and prenatal screening. (Gynaecologist, his private clinic).

The pharmacist that was interviewed stated that the majority of people, particularly women, come to the pharmacy to ask about SRH information and that most of the time they needed to be referred to a health specialist (e.g. a gynaecologist) to respond to their questions. The pharmacist noted that: *"The people, especially women that visit the pharmacy do not have any sexual culture and only get their knowledge from friends and neighbours, they do not have any right medical information about their SRH from any sources like books or gynaecologists*" (Pharmacist, her workplace).

The pharmacist further indicated that clients generally ask SRH information related questions which illustrate a hunger for knowledge, and notes that:

They come to get SRH information such as how to increase the duration of the sexual intercourse or delaying the duration of the intercourse, physical problems after the intercourse, electives. They also ask about the proper contraceptives to delay pregnancy and their personal hygiene. (Pharmacist, her workplace).

5.12 Married women's suggestions for improving their access to SRH services and information

Both married women and health workers were asked to suggest ways to improve women's access and utilization of SRH services and information and the major themes which emerged were in relation to increasing the society's awareness and health system changes.

5.12.1 Raising SRH awareness in Egyptian society

Both of the married women and the health professionals who were interviewed agreed on the need for raising the community's awareness in regard to SRH and rights. Married women reported that they did not have sufficient information about SRH services and information before and after marriage. They suggested that consistent awareness campaigns in the primary and secondary and tertiary health care units be promoted through TV programs, and YouTube

channels run by health specialists. They also suggested encouraging religious leaders to address the SRH and rights and women's rights in their messages to the public

Participant I similarly proposed a broad educational and communication strategy that captures rural and urban communities and, more importantly, targets the clergy. She states that:

> *I think that society should change the way that they perceive sex and sexual health through initiating awareness and educational campaigns in the hospitals and rural health units especially for women that are getting married soon. Also using media and social media to increase people's awareness. Initiating religious awareness campaigns that teach both men and women their rights in a fair manner. As the majority of the religious men in Egypt use religion to serve the patriarchal society in order to oppress women's rights and sexuality. Especially religion said that there is no shame in knowledge.* (Participant I, 54, Muslim, Middle class, 54, educated, employed, her private house).

Participant J also agreed with Participant I on using various media channels to address SRH issues and increase the society awareness. She mentioned that: *"channels could be created on social media such as YouTube or Facebook or creating a group on Facebook that involve health specialists to respond to people's SRH questions"* (Participant J, Muslim, Middle class, 49, educated, employed, her workplace). Many of the interviewees had strong views on the need to increase access to SRH information and services. Participant H, for example, called for a change in mindsets and for a gendered approach to spreading knowledge:

> *I think that changing the mindset of society about SRH and how it is very important for both men and women to have sexual information. And correcting the religious misconception about sex and sexual relationship as well as the rights for both men and women.* (Participant H, Muslim, Middle class, 54, middle class, educated, employed, her private house).

Health professionals also recommended regular SRH educational seminars as well as introducing sexuality education and women's rights in schools. They also indicated the need to change social norms and discriminatory traditions such as early marriage and FGM. The participants further argued that sex and sexual health should not be considered a taboo or seen

as shameful. These challenges could be addressed through educational and information programmes in the media, schools, and universities. For example, the pharmacist recommends that:

> *[E]ducational course should be put in the curriculum to be studied in schools because this would benefit the adolescents, on the other hand, the older people, educational seminars could be conducted whether in their neighbourhood or town to learn and go for check up to ensure their sexual health, sexual-wellbeing, and to learn about FGM, and early marriage. I also think that such topics should be addressed in media, schools, and universities.* (Pharmacist, her workplace).

Married women also indicated an urgent need to increase parents' awareness and knowledge, especially mothers, in order to raise their children's awareness particularly daughters on their SRH and rights and gender-based violence. In this regard, Participant F states that:

> *I think that there is need to have trusted institution that have trained health professionals that would provide a confident information and I am sure that women would definitely go to. For me, I do not have a trusted source to get the right information. Such step would create a generation of SRH educated mothers that would educate their children in particular girls*. (Participant F, Muslim, lower middle class, 39, educated, employed, her workplace).

Married women also indicated that policies related to women's health should be considered from the state and legislation as a priority, in particular women's sexual and reproductive and sexual wellbeing. Here, Participant B suggests that:

> *First of all, the state should admit that women have a special body nature which is a different form of men. This means that we should not decrease their rights because of that but admit that women suffer from severe pain every month [period] that hinders her from performing her job. Countries like China, women take leave but Egypt does not admit such a right and also people make fun of her pain. Secondly, increasing the society's awareness of the Premenstrual syndrome [PMS] and the depression that women suffer from as well as after labour… Such service could be enhanced through providing more gynaecologists and psychiatrists physiatrists, media and magazines*

that increase the society's awareness of the women's nature and taking leave during her period and providing some help to her during pregnancy and after giving birth as well taking maternity leave whether she works in private or public sector. (Participant B, 28, middle class, educated, Muslim, social club).

The health professionals recommend raising the marriage age to late twenties to make sure that women have become mature enough to be wives and mothers. The health professional said that: *"I think there is a need to raise the marriage age to late twenties to make sure that women have become informed and mature to be wives and mothers"* (gynaecologist, his private clinic).

5.11.2 Health system reforms

The married women and health professionals who participated in the study suggested several recommendations to reform the health system. The married women felt the health system needs to not only provide proper, safe, affordable, and efficient SRH services and information, but also felt the health system in Egypt should train the health workers to be sensitive and friendly to the needs of women. Participants stressed that health professionals should provide SRH services bearing in mind the social, economic, educational, and biological aspects of the patients (social determinants of health) of their patients. Participants addressed that they do not want be treated in an ignorant and inhumane manner when they ask sensitive questions about their SRH issues, especially before marriage. The gynaecologist recommended that:

There is a need to have well- trained health professionals from nurses, and doctors in order to provide proper and sensitive SRH services and information to meet women's needs and fears in regards to SRH, keeping in mind their social determinant of health of the patient not only the physiological aspect. (Gynaecologist, his private clinic)

Married women felt there is a need to obtain proper and acceptable contraceptive methods through learning about the advantages and disadvantages of every method. The participants encouraged also establishing health care centres, specifically for SRH services and information and provide information sessions about women's SRH in particular before marriage and after marriage. Participants should be advised that they have the right to decide when they have children, safe pregnancy, and delivery of a healthy child. Participant C stressed that:

We do need health professionals in particular nurses to treat us humanly and with respect and not mocking us when we ask questions in relation to our SRH as some of us not educated enough and do not have information about the advantage and disadvantages of the contraceptives from IUCDs or pills as I do not with the proper method to use and will not harm me physically as well as the need to learn about birth control and family planning. (Participant C, 34, working-class, educated, Muslim, her workplace).

The Participants also need to ensure that the marriage tests which include blood group testing, genetic, infectious diseases testing as well as fertility testing which should be done before marriage are implemented properly. The Participants also strongly endorsed that men should attend such sessions as they think that men are considered to be dominant in the sexual relationship. The married women emphasized the need to be empowered and informed about sexually transmitted infections and their personal hygiene. Participant J strongly endorsed that, stating that:

I think special centres should be created to address and educate women about their SRH such as information about our personal hygiene, sexual transmitted diseases, in particular, the young women who are getting married, which is better because many young women get divorced recently because they do not have any information or knowledge in regards to their SRH. (Participant J, 49, middle class, educated, Muslim, her workplace).

5.12 Conclusion

The study findings reveal that there are various intersection factors that influence women's access to SRH services and information in Egypt. The research used intersectionality theory as its conceptual framework that explored the intersecting factors that influence women's access to SRH services and information in Egypt. The intersectionality analysis examined the power dimensions and power structures in Egyptian society and explored the various layered issues and challenges that women face regarding their access to SRH services and information in Ismailia. The research draws on the intersecting gendered experiences within the various power structures, the shape of oppression and privilege structures, age, class, educational level, socio-economic factors, cultural norms, and religious misconception and ignorance that have been created by the patriarchal society, religion, and the state.

Chapter Six: Discussion

6.0 DISCUSSION

The study aimed to explore the various intersectional factors that influence women's access to SRH services and information in Ismailia, Egypt. As mentioned before, intersectionality theory was used to foster an understanding of human beings as shaped by their interactions with various social locations such as race, ethnicity, indignity, gender, class, sexuality, geography, age, disability, ability, and religion with the help of the literature review. These interactions take place within interconnected systems and power structures which affect women's ability to access SRH services and information such as cultural, socio-economic status, laws, policies, political interests and economic inequalities, religious institutions, and media (Carastathis, 2014; Hankivsky, 2014).

The main findings of this thesis are that the majority of women that were interviewed in the study felt that they were denied their basic rights, and were oppressed and discriminated against based on their gender as a result of the power dynamics and structures in a patriarchal country like Egypt.

Married women who were interviewed in the study stated that they did not have enough understanding of sexual and reproductive health. They also revealed that they were not provided with proper and adequate information and appropriate access to SRH services before marriage and only access basic services after marriage (e.g. from a gynecologist in primary health units and private practices).

This chapter highlights what has been highlighted in similar literature around the world and it also links the findings to the theoretical framework in order to explain those findings. The chapter reveals the important themes that have been found in the data analysis chapter.

6.1 Women's understanding of sexual and reproductive health

The study showed that in Egypt many married women did not have sufficient and accurate understanding of their SRH rights and struggled to access SRH services before and after marriage. The findings in this research speak to what has been highlighted in Rawson and

Liamputtong's (2010) study in Vietnam which stated that young women are considered to be vulnerable in regards to their SRH due to their lack of knowledge and experiences of SRH. Even though the Vietnamese study focused on young people, parallels with the findings of this research in Egypt can be drawn. In fact, some of the interviewees in this study in Egypt got married very young and hence face similar challenges to young women in Vietnam.

Lack of knowledge and understanding about SRH could lead to serious health problems, regardless of age or population group. The Vietnamese study also argues that cultural factors play a significant role in how that society perceives sex and sexuality, and highlights that the main aspect of young people's development is the emergence of their sexuality. The cultural, religious, class, and socio-economic aspects intersect and formed boundaries that influence the physical and emotional process of young people's sexual maturation. Rawson and Liamputtong (2010) argued that sexuality in conservative communities is constructed by the interaction between the social structures (e.g. the family) and the individuals. The family is considered a significant influence in determining the sexual behaviors of young people. Rawson and Liamputtong (2010) also stated that due to the lack of understanding and knowledge of their SRH in accordance with their sexual maturation could lead them to unsafe sexual practices and consequences such as unplanned pregnancies and sexually transmitted infections (STIs). Such outcomes could lead to serious consequences for health and well-being in adulthood. As such, access to safe, and sufficient sexual health information even in childhood and adolescence is necessary for improved sexual reproductive health outcomes in adulthood. The women in the thesis study could have benefited from accessing such information when they were younger.

6.2 Women's access to SRH services and information

Similar to SRH understanding and knowledge discussed in the preceding section, the thesis study findings show that women's access to SRH services and information in Egypt is sorely lacking. SRH services which are affective but poorly available include freely available sex education programmes and accurate SRH information and services. Rawson and Liamputtong's (2010) argued that the lack of sex education programmes among young people leads to insufficient knowledge of STIs and contraceptives. In order to maintain the moral code that condemns premarital sex, particularly, preserve the chastity of young women, they are denied access to SRH information. The study argued that young women's sexuality and the denial of access to SRH information, is a strategy that aims to control women, sexuality, and

their bodies. Thus, sex and sexuality are considered to have a sensitive nature in Vietnamese culture and any discussion about those topics is considered taboo and uncommon.

Elemo (2006) argued that family planning (FP) and reproductive health services (RHS) in Ethiopia are limited according to the geographic coverage and scope. Elemo mentioned that most of the existing services are mainly in the major cities and the services were described as inappropriate, insufficient, inaccessible, and largely not available (Elemo, 2006).

Bashour et al (2015) mentioned that Sudan and Morocco, SRH services are in general available as well as physically accessible to women. Nevertheless, many significant SRH services stay neglected by the public sector. Problems such as services lack of integration and continuity of care such as poor postnatal and lack of clear illustration that last persistently. Bashour et al (2015) claimed that there are inequalities in service access premised on geographical location (rural and urban) and wealth/income need to be discussed to promote equity. Generally, the lack of integration, sub-standard quality of free health services, private sector dominance, fragile health systems and the proliferation of vertical health programs all present a risk to the optimum of health care service in the Arab world (Bashour et al., 2015).

Strong cultural taboos thus undermine discussions of SRH, which, in turn, means that a lack of knowledge has created public health problems for women and society at large. Cultural taboos seem to perpetuate a sense of fear of stigma around SRH problems.

6.3 Facilitating factors for women to access SRH services and information

The current study showed that there were facilitating factors that enhanced women's access to SRH services and information. Education is one of the facilitators as it is considered a resource that through which women could obtain accurate information about their SRH and rights. Education is a key to get employed and involved in social activities in order to be empowered. Women interviewees also mentioned that they access SRH information through the internet, social media, books, and medical websites. In a similar vein, a study that was conducted in the Mara region in Tanzania showed that young women get information about SRH such contraceptives from both formal (e.g. health care units) and informal (e.g. like internet and mobile phones, TV, radio, friends) sources; however, they prefer to get it from informal sources (Pirvu, n.d.). In the current study educated women comprised a small proportion of the sample and this represents the Egyptian reality where the majority of women have little

education and are thus unable to access SRH information via multiple platforms, and SRH information is not widely circulated through health facilities and other channels that women with no access to multimedia platforms could access.

Another study that was conducted in Myanmar, indicated that young people, in particular women, access SRH information from friends, classmates, and social media such as Facebook, blogs, and webpages (Hein, 2013). Rawson and Liamputtong (2010) showed that young Vietnamese women access information from magazines as it has been considered a popular source to get such information from as a way to obtain sufficient and proper knowledge and information in regard to sexual issues. The authors explained that through using such a source, they filled the gap between lack of sex education in schools and a culture of silence about sexual matters at home. It was easier to access information on SRH outside the house and share its content with friends and classmates (Rawson & Liamputtong, 2010).

On the other hand, Tunisia showed a very progressive model in facilitating women's access to SRH information and services from adolescence to adulthood. The Tunisian model has implemented a preventive and supportive multi-dimensional plan which includes translating SRH knowledge into responsible health attitudes and behaviour. In doing so, the model created an enabling environment through which to initiate and explore a dialogue among people from both sexes about risky behaviour that should be avoided (Bashour et al., 2015).

It could be noted that both Tunisia and Egypt are Arab Muslim societies, but Tunisia took transformative actions to empower women in regards to their civil rights, while Egypt is still suffering from the influence of patriarchal traditions, gender norms, and religious misconceptions, all of which tremendously affect women's SRH negatively.

6.4 The challenges that women face in accessing sexual and reproductive health services and information

One of the key findings to emerge from the data concerns challenges women face in accessing SRH services and information, and in particular, the ways in which power dynamics intersect with socio-economic factors, education, cultural and religious aspects, the role of the state, age, class, and media.

6.4.1The power dynamic intersecting with socio-economic factors and education

The current study findings revealed that socio-economic factors such as class, and education play significant roles in women's access to SRH services and information. The study identified these factors as challenges that intersect together and hinder women from accessing SRH services and information, and create an inequal and oppressive environment.

A similar study conducted by Aldosari (2017) in Saudi Arabia found that socioeconomic inequalities play a crucial role in undermining Saudi women from accessing health services more than others in many countries. According to Aldosari (2017), women's health is strongly affiliated with the type and the level of women's education, their financial ability, and their autonomy in making informed decisions on their bodies and health. The intersection in social class, education position, or political representation restrict women from accessing much needed health care services even when such services are already available.

Intersectionality theory helps analyze these findings. Through intersectionality theory, it can be understood how all these factors intersect together to limit access to information and services, thereby increasing the gender inequality gap and gender-based violence. As such, the ability to practice sexual and reproductive rights is neither universal nor equitable (Aldosari, 2017).

Similarly, Hamzaev (2008) conducted research on Uzbek women, which revealed that women cannot access proper SRH information and services without obtaining their social and economic rights as well as proper education. For instance, Hamzaev (2008) noted that since

the Soviet Union collapsed Uzbek women's status has been negatively influenced by social traditions. It became hard for women to practice their sexual and reproductive rights as an outcome of invigorated gender ideology which increases women's responsibilities in family reproduction and in the sphere of the household. The study also found that despite the fact that Uzbek women have a high level of knowledge of their reproductive rights, they cannot practice those rights unless they attain social and economic power. Women's educational status also plays a vital role in mediating the relationship between their empowerment and the application of their reproductive rights (Hamzaev, 2008). Media also plays a role in Uzbekistan; it portrays women as affectionate, gentle, and obedient creatures who are meant to serve like loyal wives and mothers.

It can be noticed that Uzbek women have knowledge of reproductive rights in contrast with Egyptian women who were interviewed, but similarly, they cannot practice those rights as there are various factors like socio-economic, culture, media, and education that intersect and create an unequal situation that disempowers women from accessing SRH service and information. In Egypt, women who were interviewed had a low-income status which could affect them to support their expense in relation to access SRH care, despite the fact that they had good education. Most women in Egypt tend to apply for low responsibility positions to have more time for their household and children, which make them earn less money than men. Social empowerment plays also a vital role as women would be thought of as subordinate, so they would neglect their own health and do not go for health consultations unless they suffer from serious SRH problems.

In a similar vein, research conducted in Laos and Cambodia stated that young women face health problems like dying prematurely, contracting infectious diseases like HIV/AIDS, maternal mortality and sexual violence as a result of their social and economic status such as poverty, lack of education, unemployment and other socioeconomic concerns (Kirkwood, 2009).

The findings of the present study highlight the significance of creating a conducive social environment. Such an environment supports SRH services and rights with serious interventions that emphasize the role of social norms and social stigma in SRH issues. This increased the impetus for interventions to empower women in regard to their socio-economic rights too.

6.4.2 The power relations and dimensions intersecting with cultural and religious aspects

The findings related to power relations revealed the important role that cultural and religious norms, parental power relations, gender dynamics, and the role of the state play in women's access to SRH services and information. These factors intersect and deepen the inequalities.

6.4.2.1 Cultural norms

The current study has revealed that there is an intersection of power relations and structures like cultural and religious ones. Women are influenced individually through their interaction with their families, communities, and religion. Such influences play significant roles in women's access to SRH services and information before and after marriage, starting from adolescence to adulthood. Most of the women who were interviewed stated that their parents, particularly their mothers did not speak to them about sex and SRH as they are caught in social norms that promote women as subordinate. These social norms are related to social identities that influence young people's sexual behaviors and their SRH, and determine their behaviors, attitudes, and decision making towards their such issues. As the result of the fear of social stigma, people are afraid to break these social norms (Nmadu, 2017).

In a similar study, Zahra Khalesi, Simbar and Azin (2017) demonstrated how sexual health education (SHE) is a sensitive topic to be discussed in public in Iran, a predominantly Muslim country. However, sexual health is globally considered a human right and is crucial for human development. The study stated that there are many reasons that play an essential role in hindering women from accessing appropriate sexual health services and information. Muslim societies consist of teachers, families, and policymakers who do not permit women and girls from accessing quality SRH services and information as they are afraid that they would have premarital sex, as well as diminish girls' innocence. This demonstrates the importance that such societies place on women's bodies, sexuality, and virginity. The patriarchal traditions, cultural taboos, gender and social norms, as well as religious misconceptions play a part in the way that the family, society, and the state perceive women. In Iran, women are treated like objects and are oppressed and subjected to intentional violence and are denied their rights to make decisions about their bodies, their sexual health and sexualities (Khalesi, Simbar, & Azin, 2017).

In Morocco, a predominantly Muslim and conservative society, family planning (FP) services by the ministry of health target only married women while unmarried women are denied those rights because in a conservative community it is inconceivable to provide such services to unmarried women. However, a study conducted by the MOH in 2007 found that 12% of unmarried young women between aged 15-24 had unplanned pregnancies (Bashour et al., 2015). This study highlights the importance of providing all women – whether married or not – with SRH services.

6.4.2.2 Parental power relations intersecting with cultural norms

This study revealed that parents have powers over their children, especially over their daughters. Since parents are influenced by patriarchal cultural traditions as well as social and gender norms, Rawson and Liamputtong (2010) highlight how cultural aspects intersect with power relations between the parents their daughters in in Vietnam . The study showed that virginity was significant for a girl's marriage prospects as well as her family's reputation. The study also addressed how the value system and the structure of the family influence Vietnamese society and culture. Such influence controls their daughters' sexual orientations and sexual choices as their parents are considered the guardians of young women's chastity (Rawson & Liamputtong, 2010). Some of the parents do not even know about SRH information which perpetuates the cycle of ignorance in the society as talking about sex is taboo and opening any discussion about sex could lead to the sexual revolution and lead to premarital sex (Rawson & Liamputtong, 2010).

It can be noticed that both the Vietnamese and Egyptians are similar in relation to the power relations between parents and their children, as parents in both societies demonstrate resistance to openly talking with and about their children's sexual and reproductive health, especially with girls, as parents are caught up in traditional social norms. As such, one of the key outcomes of the current study focuses on the need for parental programs that are designed to enlighten and educate parents with comprehensive and detailed information. This could empower parents to support and assist their children and provide parents with the knowledge to effectively communicate with their children on sensitive SRH matters. Nmadu (2017) has mentioned that in various studies that have been conducted in similar topics, some of the intervention studies were designed to develop parents' capacity to communicate with their

children and the result showed that there were immense improvements in the efficacy and the quality of SRH communication (Nmadu, 2017).

6.4.2.3 Religious Norms

The current study showed that religious interpretations play a significant role in women's access to SRH services and information as the misuse and regressive interpretation of verses from the Quran and Hadith. The Hadith is an Arabic word for "Story" or "News" and reflects a record of the sayings and the traditions of the Prophet Muhammad that are revered as a main source of moral guidance and religious law. These verses are misused to oppress women and deny them their rights about making decision about their bodies, sexuality, and their SRH rights. Similarly, Aldosari (2017) stated that there is a need to recognize and address the reliance on cultural ordering and religious interpretations which used to curtail the human rights of women in Saudi Arabia. These conservative religious norms reinforce the prevalent gender roles and norms, premised on religious justifications which put them in danger and risk (Aldosari, 2017).

A study conducted by Riyani (2016) in Indonesia, a predominantly Muslim country, that revealed that Muslim societies put a high value on women's virginity before marriage. It also mentioned that women's sexuality has seldom found freedom of expression, as the essential concerns of Islam are fear of women's sexual conduct and their seductive capacity. These concerns have raised the problem of curbing women's sexual ability via practices like FGM, and governing their bodies through surveillance in the family (e.g. through the father or brother), the society, and the state through the law. The study shows the power dimensions intersecting with religion norms which results in a sexual hierarchy and recognizes women as sexual objects whose main duty is to serve their husband's sexual desire (Riyani, 2016).

The study that was conducted in Vietnam stated that religion – in this case Confucianism - called for premarital female chastity to be cherished above all things (Rawson & Liamputtong, 2010). This shows that religious norms, in particular, the narrow interpretation of the scriptures of the various religions limit an open discussion on SRH issues which are considered as religious taboos. There is therefore a need to involve diverse religious leaders on the necessity of talking about SRH from a religious point of view to empower and enlighten women from

adolescence to adulthood. Therefore, providing quality SRH services and information in a way that incorporates prevailing religious norms, is needed for women to make appropriate decisions about their bodies, sexuality, and SRH rights.

6.4.2.4 Power dynamics and patriarchy within gender dynamics

The findings of the current study show that men are dominating the sexual relationships with their female's partners. Men are dominant in selecting contraceptive methods, the timing, and positions of sexual intercourse. Such dominance causes women SRH problems such as bleeding, mental and psychological or sexual diseases, and the number of the children to have. The current study shows that women lacked power over their bodies, sexualities, and decision making as regards to their sexual and reproductive health, as well as their psychological and mental wellbeing. Likewise, Aldosari (2017) mentioned in her study that she conducted on women in Saudi Arabia that power relations and gender roles affect the rate of women's exposure to specific influences and their susceptibility to adverse health situations. She stated that identifying the norms and the roles assigned to women in a specific country – and their influence in health – permits for a better understanding of the opportunities and barriers in planning for improving women's health care (Aldosari, 2017).

Fall (2010) conducted research on young women to examine their sexual health behaviour in rural Gujarat in India. The study noted that men often determine women's reproductive health chances. Even when women have knowledge of SRH and information of contraceptives, they often cannot negotiate safe sexual relations with their partners as they lack social power. Women also exhibit restricted use of contraceptives as they are afraid that they would lose their partners or raise their anger. The study also stated that women are considered to be four times susceptible than men to catching STDs as women lack the social power over their sexual relations. Women also do not have the capacity to access knowledge about SRH and methods to protect themselves from infection. The study demonstrates that the majority of primary schools in developing countries provide little to no health education (Fall, 2010). Such findings endorse critical thinking in regard to gender role stereotyping. It acknowledges the significance of gender-related matters in society as well as the increasing variation of choices available to individuals, particularly women.

In addition, Ritchie (2012) asserted that reproductive health is significantly related to reproductive rights and the rights for making decisions about women bodies, sexuality, the time for having children as well as the number of children to have. Women should have the right to decide on the type of contraceptives to be used and prevent unplanned pregnancies. All these factors play a role and are dependent upon each other. Therefore, women's experience to be an agent in their own lives and to access their rights are provisional on an intersection with oppression systems and dependent factors. Reproductive rights are considered human rights, which is why there is a need for understanding human rights in the context of intersectional structural and societal factors such as social norms and gender roles which hinder women's ability to obtain those rights (Ritchie, 2012). More importantly, these studies demonstrate how access to SRH knowledge from an understanding and enlightened sexual partner can lead to improving women's sexual health. What this suggests is that SRH information should not just be targeted at women, but men as well.

6.4.2.5 Mental health intersecting with cultural norms

The present study revealed that the lack of access to mental health services for women as well as the manner that the society perceives mental health issues through describing women as crazy or they do not be taken seriously. Conversely, Bashour et al (2015) claimed that Tunisia ensured counseling and psychological care as they are considered an important service by the National Board for Family and Population. These services are free and fast and privacy is ensured and accessible to both males and females.

These experiences highlight the importance of mainstreaming SRH information to both men and women. In a context, such as in Egypt, where conservative social norms and patriarchal relations dominate, mainstreaming SRH will not be easy, but creative ways will have to be found to do this.

6.4.2.6 The power dynamics and the role of the state

The current study showed that there are not enough laws and legislation, and public policies that focus on gender equality, health equity, and women's health in Egypt. Even in situations where policies exist, they are hardly implemented. The study findings also suggest that there is an implicit agreement to serve patriarchal ideologies, traditions, cultural norms, gender roles,

patriarchal laws, and religious misconception within Egyptian society. In a similar vein, Aldosari (2017) claims that the state in Saudi Arabia formulated public policies and laws, decided to whom and when health care services would be provided, and determined what kind of services would be provided or withheld. In other words, women have little to no autonomy in shaping policies that concern them in using SRH services.

In another similar study, (Hein, 2013) found that the Myanmar state plays an implicit role in hindering women's access to SRH. Before 2010, the Myanmar state set a strict policy on accessing websites related to sexual health information, a policy that changed after 2010. On the other hand, some Arab countries such as Tunisia and Morocco exhibited exceptional models in developing health policies that addressed issues such as women's health and SRH issues (Bashour et al., 2015; DeJong et al., 2005). For instance, the Tunisian government worked with NGOs to provide peer education in universities. Tunisia also made abortion legal and outlawed polygamy. In addition, Morocco made SRH education available to the youth. Both countries consider SRHR as central to human dignity, and equalizing power relations in order to achieve social justice for everyone (Bashour et al., 2015; DeJong et al., 2005).

Lebanon has also worked with civil society organizations to develop national youth policies and promote the youth's role in the society. Lebanon also has made pre-marital testing mandatory for some genetic diseases and HIV. Some of the main achievements of these collaborations include establishing youth forums for developing policies and recommendations that were approved by the government in 2012 (Bashour et al., 2015).

6.5 Married women's experiences of Female Genital Mutilation (FGM) and the power dynamics in Egyptian society

The present study showed that many women in Egyptian society have undergone female genital mutilation during their upbringing. The female participants also said how FGM affected their physical and mental health and their personal and sexual lives. FGM was intended to control women's and girl's bodies, sexuality, and SRH to preserve their chastity and they would not dominate their partners during sexual intercourse. This is similar to the various studies that have been implemented in Muslim and Arab countries. For instance, in Sudan, a study showed

that 89% of girls and women from 15-49-year-old have undergone FGM in 1990 (Bashour et al., 2015).

Bashour et al (2015) asserted that a similar study with the same age category in Yemen found that in 1997 22.6% were forced to go through the FGM procedure (DeJong et al., 2005; UNICEF, 2013). There was also a study was conducted in Oman where around 53% of women undergone this procedure in 2000. These countries have passed laws to prohibit such practice; yet, it is still practiced due to the original cultural roots.

Despite the huge efforts made by those countries to ban FGM, it is still widely practiced. For instance, in 2005 Sudan made several efforts such as cultivating collaborations between universities and NGOs in order to tackle FGM public policies and laws were developed to ban such violent practices. Moreover, health programs and awareness campaigns were implemented to educate people on their sexual health, in particular, female genital mutilation (FGM) and female genital cutting (FGC). Yemen also committed to implement awareness programs and conduct research, as well as passing a law to fight FGM (DeJong et al., 2005).

Feki (2015) argues that despite the advanced laws and policies that address women's sexuality and sexual health, particularly FGM, many people still force women and girls to undergo this procedure. As a result of various intersecting factors such cultural, religious, the health system as well as the legal system play roles in their decision making (Feki, 2015). Policies banning FGM are having some effect. Fadel (2015) shows that female genital mutilation is gradually declining, with two-thirds of girls from 15-17-year decreased by approximately a quarter since 2008 in Egypt. The issue is that it took the legal system around 6 years to pass a law to prohibit this practice and implementing this policy has proved to be difficult as deeply held cultural practices has forced FGM underground (Fadel, 2015).

Egypt banned FGM in 2009, but doctors in the health care system still practice it privately. For example, there was a doctor who killed a young girl unintentionally during a FGM procedure in 2013. This doctor was considered the first health professional to be convicted for this act since the law was passed on 2009, and was sentenced to 2 years in prison, and then he continued practicing his job afterward (Fadel, 2015; Ghattass et al., 2016). Adverse cultural practices, however, are not static and can change through concerted government and societal action.

Aldosari (2017) in her research on women's health in Saudi Arabia found that religious factors intersect with the gendered health system. The official religious edicts allow FGM practice as Sunnah (an Arabic word, which means "tradition" or "way"). For Muslims, Sunnah means "the way of the prophet", and is a literature that discusses and prescribes traditional practices and customs of the Islamic community, both social and legal. The Sunnah described as a preferred act but not obligatory. Despite an official ban on performing FGM in hospitals, it is still performed in remote places by unlicensed traditional practitioners or in private medical clinics as there is exploitation of the weak enforcement of health policies, regulations, and societal acceptance (Aldosari, 2017).

The study also matches the findings of the current study about the positive correlation between sexual dysfunction in women with all kinds of FGM, even mild cases. The physical and psychological traumas that these women have to live with for their entire lives because of this violent act against their bodies. The intersection of religious norms and its influence on the health attitudes and beliefs could be positively changed through culturally sensitive health education and developing health programmes designed to educate the public and to criminalize harmful cultural practices (Aldosari, 2017).

6.6 Married women's knowledge of the different types of reproductive health services

As with all aspects related to SRH services and information, the current study shows that married women lack knowledge about the various types of reproductive health services available to them. For instance, the advantages and disadvantages of each type, as well as the family planning programmes, which reflects on low service utilization. In addition, the poor treatment by health personnel of women and young women when they seek SRH knowledge and information which affects their SRH negatively. Aldosari's (2017) study on public health issues in Saudi Arabia revealed that the health system is gendered which influences women's health through treating women as objects rather than agents. As the regulations restrict women's capacity to seek medical support for unintended or unwanted pregnancy as they ask for their husband's permission in the regulations of MOH for a lifesaving abortion, although the clear religious edict, is indicative of the impact of the patriarchal norms on the Saudi health system.

DeJong and El Khoury's (2006) conducted a study on Jordanian girls and young women who seek SRH services and information from the age group of 10 to 24-year-old. The study found that the majority of health care units only provide health care services in regards to child and maternal health. The study also revealed that one of the participants stated that if they asked a doctor or a nurse in those health care centers for sexual health information, they would laugh at them and tell they would know when they become older. This was similar to the findings of the current study that some of the participants were made fun of and treated inhumanely by health care providers when looking for getting SRH care services (Dejong & El-khoury, 2006).

In contrast, according to Bashour et al (2015), Tunisia has started to sponsor research on young people's SRH from early 1990 and in recent years initiated health clinics for adolescents and unmarried woman in urban places. Tunisia also has made sure to facilitate access to RH services in all health units, schools, and universities. It also ensured the training of health care providers on active communication, education and providing quality service to young people. It also worked on reinforcing collaboration and partnership with all the organizations and sectors working on youth.

Fall (2010) explained in a study that took place in India that women were unable to seek help from health care professionals because of the lack of understanding and help that health care providers provide to these women as well as the cultural norms which lead to serious negative consequences on individuals. This leads to a delay in asking for medical support which perpetuates the sexual problem with their partners. The study also stated that young people, in particular young women, do not approach health care providers to ask about their SRH as they would be mistreated or ignored. Even though the study dealt with young people and young women, there are clear parallels with the findings of this study which also shows women as being mistreated by health care providers, which discourages young married and unmarried women from seeking SRH care services that they need. The issue this presents is that untreated women could suffer from serious health problems like ectopic pregnancies, cervical cancer, as well as sepsis. The large mucosal area in women would be susceptible to contract STDs, which would make their cervical cells more vulnerable to gonorrhea, chlamydia, and HIV (Fall, 2010). Egypt and other countries can learn from the Tunisian experience where SRH services have been made available to young and older women, as well as married and unmarried women.

More importantly, the Tunisian experiences shows that health care providers can also be trained to support women's access to SRH services and information in a respectful manner.

Similarly, a study conducted by Sokoto (2017) in Kenya showed that health care providers played a positive significant role in enhancing the SRH attitudes of people, and women's choices for contraceptives which were affected by family planning services provided by the health care providers in the post-natal clinics. The study also demonstrated the importance of a good relationship between health care providers and their clients, as the health care providers usually greeted their clients, as well as introducing themselves to their clients in the service delivery process (Sokoto, 2017).

In the Egyptian context, health professionals influence the health outcomes of women and have an important role to play in order to help them to be informed and empowered in relation to SRH services and rights. Such treatment from health professionals would contribute to building the capacity of women to make appropriate decisions about their own bodies, sexuality, and their SRH.

Finally, the limited knowledge of women in the present study about the various types of SRH and the advantages and disadvantages of each method highlights the need to emphasize educational programs, media awareness campaigns, and educational tools to equip women with information and knowledge about their SRH services and information. This could help females from adolescence to adulthood to make informed decisions about their SRH and improving their utilization of the services. The women in the present study exhibited very good attitudes and responses about introducing SRH programs.

6.6.1 The interpretation of the health care oppression

Intersectionality is demonstrated in this thesis as a beneficial theory that is used to understand the cultural, religious, socio-economic, education, age, class, identities, and gender dimensions that intersect together to produce inequalities in women's SRH outcomes. It provides a lens to explore various unique kinds of oppression of women's experiences. It also promotes changing and transforming societal structures that badly influence and oppress disadvantaged groups through the provision of a foundation to translate research into real change to diminish inequalities (Rosenthal & Lobel, 2018).

6.7 Conclusion

The discussion chapter has highlighted the essential factors that influence women from adolescence to adulthood in regards to access to SRH services and information. This chapter draws on the various types of literature that is similar or different to the findings of the study. The theoretical framework was utilized to obtain an understanding of the findings through triangulating the factors that influence women to access to proper, safe, and affordable SRH services and information. The cultural patriarchal traditions, religious misinterpretation, state role, class, education, socio-economic, and age intersect together to create an inequal situation and produce gender-based violence. The intersectionality theory explored the micro and macro factors to help look beyond a singular layer and to instead explore the multi-dimensional layers that affect women's access to SRH services and information.

CHAPTER 7: CONCLUSION AND RECOMMENDATIONS

The study explored the intersectionality of women's access to SRH services and information in Ismailia, Egypt. The study discussed the various factors that intersect together such as the structural power dimensions and the social relations within Egyptian society that hinder or enable women's access to SRH services and information.

The study was conducted because there is a gap in the available evidence that speaks to the intersecting factors that influence married women's access to SRH services and information in the city of Ismaila in Egypt. The study aimed to explore the intersecting factors that influence married women's access to SRH services and information. The study objectives were to:

- Explore women's understanding of the concept of sexual and reproductive health and rights.
- Explore women's awareness of sexual and reproductive health services available in the study area.
- Describe how women access sexual and reproductive services and information in the study area.
- Identify the facilitators and challenges that women face with regard to accessing reproductive services and information.
- Explore how these factors intersect to influence women's access to sexual and reproductive health services and information.
- Derive recommendations on how access to sexual and reproductive health services and information can be enhanced to ensure women's rights to adequate sexual and reproductive health and wellbeing.

The study findings revealed that married women's access to and utilization of SRH information and services was low in Ismailia, Egypt. Married women's experiences of accessing SRH services and information were influenced by various intersecting factors located at the micro and macro levels that intersected with power structure contexts, and privilege structures such as cultural traditions, religious institutions, laws, policies, governments states, media, and political and economic unions (Carastathis, 2014; Hankivsky, 2014). The challenges that married women faced in accessing and using SRH services and information were explored across micro and macro levels. The micro factors included lack of information about SRH,

sexuality, age, and limited knowledge of reproductive health services and the advantages and disadvantages of the various contraceptive types. For example, the study found that most of women that were interviewed had little knowledge and information about their SRH and rights and the advantages and disadvantages of the available contraceptives which affected their sexuality and SRH. The macro level factors included gender roles and parental power relations which intersected with cultural and religious norms as well as power dimensions and patriarchy. The study revealed the intersecting of parental power relations with social and religious norms, as well as patriarchy and these negatively affected access to SRH services and information. The gender dynamics and mental health intersecting with cultural norms, the power dimensions, the role of the state and policy, and socio-economic factors have also negatively affected women's SRH.

These micro and macro factors intersect to produce an unequal and oppressive environment for women to exercise their SRH rights. Through understanding the intersectional factors, meaningful interventions could be adopted to provide and enhance the quality and quantity of SRH services and information as well as address SRH accessibility, rights, and needs.

7.1 Recommendations

The study revealed that women did not have adequate understanding of SRH. Women lacked sufficient information about SRH before and after marriage due to several intersecting factors. These intersecting factors are social and cultural norms, gender roles and patriarchal traditions, gendered power dimensions as well as the power structures. There are also religious misconceptions, socioeconomic factors, class, age, education, the role of the state, policy, and the gendered health system. These intersecting factors played crucial roles in hindering or enabling women to access to proper, safe, and affordable SRH services and information. Based on the findings of this study, the following recommendations should be considered to improve women's access to SRH services and information in Ismailia, Egypt.

7.1.1 Providing women with SRH information and education before and after marriage

There is an urgent need to empower women before and after marriage with accurate, safe, and affordable SRH services and information that could have life-long benefits to protect them. Schools could be utilized to make sexuality education and information about SRH accessible to both young men and young women. There is an urgent need for developing a comprehensive culturally sensitive SRH school-based education programme that goes beyond SRH issues but also address issues such as gender equality, power relations within gender dynamics, body image, consent, and sexual violence. Such programmes could assist in addressing the gaps in knowledge about SRH information and services. In addition, these programmes should have information that include the involvement of parents and address sensitive topics and taboos, such as cultural and religious norms, and gender-based violence.

The Egyptian Ministry of Health is urged to cooperate with all the relevant stakeholders to disseminate accurate and safe SRH information and services through utilizing social media, mass media, mosques, churches, health facilities, education materials, and workshops for people, young and old, from both sexes. There is a need to develop programmes that provide community-based SRH education and services such as conducting health awareness training about SRH for both males and females in primary health care units in communities. Also, there is a need to address such topics in religious places to teach both men and women about their SRH rights, as well as implementing awareness meeting in the community to teach girls and women about their SRH and rights.

7.1.2 Promoting a supportive atmosphere for developing positive SRH services and information

There is a need for building quality parental relationships for women before and after marriage in order to promote positive SRH attitudes and behaviour. This starts with building strong relationships between young women and their parents through fostering active listening and mutual understanding about SRH issues. As the findings of the study showed, women before marriage struggled to get proper SRH information from their parents because discussing such topics is considered taboo and socially unacceptable. These women's mothers did not have adequate SRH information due to the same reasons. As a result, women suffered from a lack of proper SRH information which in some cases led to physical and mental health problems. The married women who were interviewed in this study also mentioned that in order to practice

their sexual and reproductive rights, there is a need to bring their males partners into the discussion to ensure the effectiveness of these interventions. Therefore, providing a healthy atmosphere for family interventions that include both girls and boys would ensure the effectiveness of the outcome and raise boys in a proper manner to treat girls with decency and respect. This highlights the importance of parental education on SRH issues which is facilitated through parent-child communication and involves both parents and their children in planning SRH programmes.

7.1.3 Improving the quality of SRH services

There is a need to improve the quality of SRH services that are provided in the primary health care units in a way that takes into consideration the social determinants of women's health, both before and after marriage. The study revealed that some of the participants suffered from inhumane and disrespectful treatment and attitudes from some health care workers. That is why training should be provided for health workers on how to provide quality professional care that emphasizes respect and dignity. Sexual and reproductive health clinics should be established and the government should provide sufficient financial and human resources for delivering proper SRH services and information such as contraceptives, drugs, and educational materials. This brings to the fore the importance of a well-functioning health system that guarantees sufficient and equitable access to essential vaccines, medical products, and technologies. Every Egyptian woman should have a right to select a lifestyle she desires to live, with whom and when to marry, and when and how many children she would like to have.

7.1.4 Sexual and reproductive health information and services and technology

It is recommended that the Ministry of Health collaborate with international and national organizations to create a digital platform to provide accurate, safe, and accredited scientific information about women's SRH and provide services. Through this platform, women could obtain online information and they could be referred to the nearest high quality SRH services. A well-functioning health information system will guarantee the production, analysis, dissemination, and the use of reliable data.

7.1.5 Future research implications

The study has explored a significant global health issue through focusing on SRH, and the findings contribute to information that could assist in narrowing the gap between the intersecting factors that affect women's access to SRH services and information in Ismailia, Egypt. Meeting the United Nations' sustainable development goals is vital in order to achieve Egypt's vision for 2030 to ensure good health and well-being. For these reasons, there is an urgent need to refocus national policies and ensure serious commitment from the various stakeholders to improve women's health, particularly their SRH, mental, and physical health.

7.1.6 Revising the Egyptian national Guidelines

The Egyptian government should consider revising its policy on women's health in regards to their SRH to align it with the recommendations of the WHO. These recommendations call for universal access to reproductive health and invite the international community to show commitment and support to promote SRH and rights through adoption of global health strategies to achieve the development goals (WHO, 2008:5). These health strategies include exerting efforts to diminish preventable and maternal neonatal mortality, and assure quality SRH services, such as providing contraceptives services (WHO, 2008). This will ensure the efficacy in the policy implementation and sharpen the punishing laws in regard to sexual violence, FGM, and gender-based violence. This study revealed that there is a scarcity in the relevant policies and poor implementation of existing ones.

7.2 Expected Obstacles in realizing some of the recommendations

Some of these recommendations will face certain challenges to be achieved in Egypt. Egypt is a patriarchal and conservative society and hence there is very likely to be strong resistance to some recommendations such as providing sexuality education in schools and designing programmes for family interventions. The political environment, social norms, gender roles, religious norms, socioeconomic aspects could intersect and form an oppositional atmosphere that would hinder achieving some of these recommendations, deepen gender inequality and increase gender-based violence.

However, culture and political environments are not static and can change. For example, Tunisia is an example of progressive Arab Muslim country that introduced many women's rights and acknowledged women's role in the development and welfare of their country.

Tunisia was the first country in the Middle East and North Africa (MENA) region to abolish polygamy as early as 1956, the first to legalise abortion in 1973, and has managed a successful family planning programme since 1966 (Amroussia, Goicolea, and Hernandez, 2016). While it is not possible to directly translate or transfer the Tunisian experience to Egypt, this transformative Arab Muslim model nonetheless shows that there is hope that transformation is possible in a society that once was a conservative highly religious community within a patriarchal setting. Perhaps future research that investigates SRH in comparative contexts across the MENA region might shed more light on how to expand SRH services and information in particular and women's rights in general.

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Appendix 1

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E-mail: pkippie@uwc.ac.za

UNIVERSITY of the WESTERN CAPE

LETTER OF CONSENT:

SEMI-STRUCTURED INTERVIEW WITH HEALTH PROFESSIONALS

I……., have had the opportunity to ask any questions related to this study, and received satisfactory answers to my questions, and any additional details I wanted.

I agree to take part in this research.

I understand that my participation in this study is voluntary. I am free not to participate and have the right to withdraw from the study at any time, without having to explain myself.

I am aware that the information I provide in this interview might result in research which may be published, but my name will not be used.

I understand that my anonymity will be guaranteed by the researcher.

I understand that my signature on this form indicates that I understand the information on the information sheet.

I agree to answer the questions to the best of my ability.

I may also refuse to answer any questions that I do not want to answer.

I agree that I will not disclose any information discussed from the interviews undertaken.

I agree/ don't agree to the audio recording of my response and its use in this research.

By signing this letter, I give free and informed consent to participate in this research study.

This research project has received ethical approval from the Humanities and Social Sciences Research Ethics Committee (*HSSREC*) of the University of the Western Cape*, Research Development, Tel: 021 959 4111, email:* research-ethics@uwc.ac.za

Date: _____

Participant Name: _____

Participant Signature: _____

Interviewer name: _____

Interviewer Signature: _____

Appendix 2

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UNIVERSITY of the WESTERN CAPE

خطاب الموافقه:

من أجل المقابلات مع مقدمي الخدمات الصحيه

أنا.....لقد تسنت لدي الفرصه كي أسئل أي سؤال يتعلق بالدراسه وحصلت علي إجابات كافيه علي أسئلتي وأي تفاصيل أضافيه سئلتها .

أنا أوافق علي المشاركه في هذا الدراسه البحثيه.

أنا أتفهم أن مشاركتي في هذه الدراسه البحثيه هي تطوعيه كاملا, وأنا لدي الحريه بعدم المشاركه ولدي الحق في الأنسحاب من الدراسه في أي وقت من غير توضيح أسباب الإنسحاب .

أنا لدي الوعي أن المعلومات الكامل أن المعلومات التي سوف أشاركها في الدراسه البحثيه، قد تنشر ولكن أسمي لن يتم أستخدامه بأي حال من الأحوال.

أنا أتفهم أن توقيعي علي خطاب الموافقه هذا دلاله علي أنني أتفهم المعلومات المتعلقه بالبحث في بيان المعلومات.

أنا أوافق علي الإجابه علي الأسئله المتعلقه بالدراسه البحثيه بقدر استطاعتي .

أنا أتفهم أنني إذا لم أكن أريد أن يتم استخدام اسمي في الدراسه يجب التأكيد هلي هذا مع الباحث.

أنا يمكنني أن أرفض الإجابه علي أي سؤال من الأسئله التي لا أريد أن أجاوب عليها.

أنا أوافق أنني لن أعلن عن أي معلومه تمت مناقشتها خلال المقابله.

أنا أوافق / لا أوافق علي تسجيل المقابله وأن يتم أستخدامها في البحث.

من خلال التوقيع علي خطاب الموافقه هذا، أعطي الموافقه بكامل الحريه والأراده والوعي للمشاركه في هذه الدراسه البحثيه.

أن هذا البحث قد حصل علي تصاريح الأخلاقيه من قبل لجنه الأخلاق البحثيه للعلوم الإجتماعيه والأنسانيه من قبل جامعه غرب كيب بجنوب أفريقيا

، تليفون 0219594111

research-ethics@uwc.ac.za

التاريخ:.....

اسم المشارك:.....

توقيع المشارك:.....

اسم المقابل:.....

توقيع
المقابل:.....

هذا البحث تم بواسطه **ريم السيد** ، طالبه ماجيستر في جامعه غرب كيب، بجنوب أفريقيا، ورقم تليفونها

Tel: + 27631889203

Email: 3879447@myuwc.ac.za

وإذا كان لديك أي أسئله متعلقه بالدراسه نفسها ، يمكنك الأتصال د/ وانجه زيمبي مركز الأبحاث الطبيه ل معاها
Email: wanga.Zembe@mrc.ac.za

أو د/ عبدالرزاق كريم في معهد التنميه الأجتماعيه ، ، بجامعه غرب كيب ورقم التواصل معاه
Tel: **+27 (21) 959 3853**
Email: akarriem@uwc.ac.za

Appendix 3

ISD

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E-mail: pkippie@uwc.ac.za

UNIVERSITY of the WESTERN CAPE

LETTER OF CONSENT:

SEMI-STRUCTURED INTERVIEW WITH MARRIED WOMEN

I……., have had the opportunity to ask any questions related to this study, and received satisfactory answers to my questions, and any additional details I wanted.

I agree to take part in this research.

I understand that my participation in this study is voluntary. I am free not to participate and have the right to withdraw from the study at any time, without having to explain myself.

I am aware that the information I provide in this interview might result in research which may be published, but my name will not be used.

I understand that my anonymity will be guaranteed by the researcher.

I understand that my signature on this form indicates that I understand the information on the information sheet.

I agree to answer the questions to the best of my ability.

I may also refuse to answer any questions that I do not want to answer.

I agree that I will not disclose any information discussed from the interviews undertaken.

I agree/don't agree to the audio recording of my response and its use in this research. Please tick.

By signing this letter, I give free and informed consent to participate in this research study.This research project has received ethical approval from the Humanities and Social Sciences

Research Ethics Committee (*HSSREC*) of the University of the Western Cape*, Research Development, Tel: 021 959 4111, email:* research-ethics@uwc.ac.za

Date: _____

Participant Name: _____

Participant Signature: _____

Interviewer name: _____

Interviewer Signature: _____

Appendix 4

Private Bag X17, Bellville 7535, Cape Town, South Africa
Telephone: (021) 959 3858/6 Fax: (021) 959 3865
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UNIVERSITY of the WESTERN CAPE

خطاب الموافقه:

من أجل المقابلات مع النساء المتزوجات

أنا.....لقد تسنت لدي الفرصه كي أسئل أي سؤال يتعلق بالدراسه وحصلت علي إجابات كافيه علي أسئلتي وأي تفاصيل أضافيه سئلتها .

أنا أوافق علي المشاركه في هذا الدراسه البحثيه.

أنا أتفهم أن مشاركتي في هذه الدراسه البحثيه هي تطوعيه كاملا, وأنا لدي الحريه بعدم المشاركه ولدي الحق في الأنسحاب من الدراسه في أي وقت من غير توضيح أسباب الإنسحاب .

أنا لدي الوعي أن المعلومات الكامل أن المعلومات التي سوف أشاركها في الدراسه البحثيه، قد تنشر ولكن أسمي لن يتم أستخدامه بأي حال من الأحوال.

أنا أتفهم أن توقيعي علي خطاب الموافقه هذا دلاله علي أنني أتفهم المعلومات المتعلقه بالبحث في بيان المعلومات.

أنا أوافق علي الإجابه علي الأسئله المتعلقه بالدراسه البحثيه بقدر استطاعتي .

أنا أتفهم أنني إذا لم أكن أريد أن يتم استخدام اسمي في الدراسه يجب التأكيد هلي هذا مع الباحث.

أنا يمكنني أن أرفض الإجابه علي أي سؤال من الأسئله التي لا أريد أن أجاوب عليها

أنا أوافق أنني لن أعلن عن أي معلومه تمت مناقشتها خلال المقابله.

أنا أوافق / لا أوافق علي تسجيل المقابله وأن يتم أستخدامها في البحث.

من خلال التوقيع علي خطاب الموافقه هذا، أعطي الموافقه بكامل الحريه والأراده والوعي للمشاركه في هذه الدراسه البحثيه.

أن هذا البحث قد حصل علي تصاريح الأخلاقيه من قبل لجنه الأخلاق البحثيه للعلوم الإجتماعيه والأنسانيه من قبل جامعه غرب كيب بجنوب أفريقيا، تليفون 0219594111

research-ethics@uwc.ac.za

التاريخ:.....

اسم المشارك:.....

توقيع المشارك:.....

اسم المقابل:.....

توقيع المقابل:.....

هذا البحث تم بواسطه **ريم السيد** ، طالبه ماجيستر في جامعه غرب كيب، بجنوب أفريقيا، ورقم تليفونها

Tel: + 27631889203

Email: 3879447@myuwc.ac.za

ورقم التواصل معاها د/ وانجه زيمبي ، مركز البحوث وإذا كان لديك أي أسئله متعلقه بالدراسه نفسها ، يمكنك الأتصال الطبيه

Email: wanga.Zembe@mrc.ac.za

أو د/ عبدالرزاق كريم في معهد التنميه الأجتماعيه ، ، بجامعه غرب كيب ورقم التواصل معاه

Tel: **+27 (21) 959 3853**

Email: akarriem@uwc.ac.za

Appendix 5

Private Bag X17, Bellville 7535, Cape Town, South Africa

Telephone :(021) 959 3858/6 Fax: (021) 959 3865

E-mail: ***pkippie@uwc.ac.za*** *or* *mdinbabo@uwc.ac.za*

INFORMATION SHEET
For
Health Professionals Interviews

Project Title:
The intersectionality of women's access to sexual and reproductive health services and information in Ismailia, Egypt

What is this study about?

The research seeks to explore women's understanding of sexual and reproductive health and the factors that influence their access to sexual and reproductive health services and information in the two study areas. The intersections between the different factorswill be critically examined to gain insight into how these issues could be addressed to enhance women's sexual and reproductive health.

What is the interview about?

The interviews seek to gain your expert opinion with regard to women's access to sexual and reproductive health services and information.

Would my participation in this study be kept confidential?
All your personal information will be kept confidential and will remain anonymous if that is your choice. You will be required to sign a consent form to protect your privacy and confidentiality while participating in this study. The researcher shall not reveal your identity and will safeguard the confidential information obtained in the course of the study.

What are the risks of this research?
The researcher endeavours to conduct the research with great care and sensitivity. However, should the interview questions cause an emotional response; the researcher will advise the interviewee that free counselling services are available at a local public health facility in my study areas, Ismailia.

Ismailia, Dr Mustafa Hassan Ewias , Tel: +201226828412 Address: El- Far building, Army Street, Ismailia.

What are the benefits of this research?
There are no material benefits from the interview to you the participant and myself. However, it is my hope that policymakers will take up recommendations made from this study.

Do I have to complete the interview and may I stop participating at any time?
Your participation in this research is completely voluntary. You may choose not to participate in the interview and to stop participating at any time you want. If you stop or decide not to participate,there will be no repercussions for you.

How long will it take to complete the interview?
The interview will take about thirty to sixty minutes

Do I need to bring anything to the interview?
You do not have to bring anything.

Is any assistance available if I am negatively affected by participating in this study?

The researcher will advise the interviewee that free counselling services are available at a local public health facility in my study area, Ismailia.

Ismailia, Dr Mustafa Hassan Ewias, Tel: +201226828412 Address: El- Far building, Army Street, Ismailia.

What if I have questions?
This research is being conducted by **Reem Elsayed,** a student at the University of the Western Cape. Her contact number is +27631889203 and email address3879447@myuwc.ac.za

If you have any questions about the research study itself, please contact **Dr Wanga Zembe** at the Medical research Council, her and email wanga.Zembe@mrc.ac.za
OR
Dr Abdulrazak Karriem at The Institute for Social Development (ISD), University of the Western Cape, his contact number is +27 (21) 959 3853 and email akarriem@uwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Professor Mulugeta Dinbabo
Acting Director
Institute for Social Development
School of Government
University of the Western Cape
Private Bag X17
Bellville 7535
Tel: +2721 959 3855
Email: mdinbabo@uwc.ac.za

UNIVERSITY of the WESTERN CAPE

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Appendix 6

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بيان المعلومات من أجل المقابلات مع مقدمي الخدمات الصحيه

عنوان المشروع

استخدم نظريه التشابك في حصول النساء علي الخدمات والمعلومات الصحيه الجنسيه والإنجابيه في الإسماعيليه في مصر.

ماهو موضوع الدراسه:

إن البحث يسعي مدي فهم النساء لصحه الجنسيه والإنجابيه وإلي جانب العوامل المختلفه المؤثره علي حصولهم علي تلك المعلومات و الخدمات الصحيه في الإسماعيليه والقاهره. سوف يتم بحث التقاطع ما بين العوامل المختلفه المؤثره علي حصولهن علي هذ الخدمات والمعلومات ، من أجل الحصول علي معلومات مستنيره يمكن من خلال تناول المشكلات المتعلقه بهذا الموضوع من أجل تحسين الصحه الجنسيه والإنجابيه للنساء.

ماهو موضوع المقابله :

إن المقابلات تسعي للحصول علي أراء الخبراء فما يتعلق بالعوامل التي تؤثر علي حصولهم علي الخدمات والمعلومات الصحيه والإنجابيه في منطقتهم .

هل مشاركتي في الدراسه سوف يبقي قيد السريه؟

كل معلوماتك الشخصيه سوف تبقي قيد السريه وسوف تبقي غير معلومه إذا كان هذا اختبيارك . سوف يتعين عليك بيان موافقه لحمايه خصوصيتك والحفاظ علي سريتك أثناء المشاركه في الدراسه . الباحث لن يقوم بأي شكل من الإشكال الكشف عن هويتك وسيقوم بحمايه المعلومات التي سوف يتم الحصول عليها من الدراسه .

ما هي مخاطر المشاركه في هذه الدراسه؟

سوف يسعي الباحث إلي القيام بالبحث بحرص وعنايه شديده . ولكن في حاله أن سببت المقابله أي استجابات انفعاليه، سوف ينصح الباحث بالحصول علي خدمات صحيه مجانيه متاحه في وحدات صحيه عامه في القاهره والإسماعيليه

الإسماعيليه: د/ مصطفي حسن عويس

Tel : +201226828412

العنوان : عماره الفار ، شارع الجيش , الإسماعيليه

ماهي فؤاد المشاركه في هذا البحث ؟

لا توجد أي فوائد ماديه من المقابله سواء في حالتك أو حالتي، ولكن نأمل أن صناع القرار يأخذوا التوصيات في هذه الدراسه بعين الأعتبار.

هل يجب علي أن أكمل المقابله أو يمكنني الأنسحاب في أي وقت منها؟

مشاركتك في هذه الدراسه تطوعيه بالكامل ، يمكنك أختيار الا تشارك في المقابله، ويمكنك أن تتوقف عن المشاركه في أي وقت ، إذا قررت أن تتوقف أو أنك لن تشارك ، لن يكون هناك أي عواقب لهذا.

ما هي المده التي سوف تأخذها المقابله حتي تنتهي ؟

المقابله سوف تأخذ من نصف ساعه إلي ساعه كي تنتهي .

هل يجب علي أن أحضر أي شئ أثناء المقابله؟

ليس عليك أحضار أي شئ أثناء المقابله .

هل هناك أي مساعده في حاله التعرض الي أثار سلبيه أثناء المقابله؟

الباحث أثناء المقابله سوف ينصح بخدمات استشاريه مجانيه من خلال مركز للصحه العامه بالقاهره والاسماعيليه

الإسماعيليه: د/ مصطفي حسن عويس

Tel : +201226828412

العنوان : عماره الفار ، شارع الجيش , الإسماعيليه

ماذا إذا كان لدي أي أسئله ؟

هذا البحث تم بواسطه **ريم السيد** ، طالبه ماجيستر في جامعه غرب كيب، بجنوب أفريقيا، ورقم تليفونها

Tel: + 27631889203

Email: 3879447@myuwc.ac.za

وإذا كان لديك أي أسئله متعلقه بالدراسه نفسها ، يمكنك الأتصال د/ وانجه زيمبي في مركز الأبحاث الطبيه ، ورقم التواصل معاها

والايميل الخاص بها :

wanga.Zembe@mrc.ac.za

أو د/ عبدالرزاق كريم في معهد التنميه الأجتماعيه ، ، بجامعه غرب كيب ورقم التواصل معاه

Tel: **+27 (21) 959 3853**

والايميل الخاص به :

akarriem@uwc.ac.za

وأيضا اذا كان لديك أي تساؤل يتعلق بالدراسه أو حقوقك كمشارك فيها ، أو
ترغب في الشكوي عن أي مشكله مررت بها أثناء المشاركه في الدراسه ، من فضلك تواصل مع
أ/د مولجيته دينبابو
ير معهد التنميه الأجتماعيه
جامعه غرب كيب

Private Bag X17
Bellville 7535
Tel:+2721 959 3855
Email: mdinbabo@uwc.ac.za

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Appendix 7

ISD INSTITUTE FOR SOCIAL DEVELOPMENT
University of the Western Cape

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INFORMATION SHEET

For

Semi-structured interview with the married women

Project Title:
The intersectionality of women's access to sexual and reproductive health services and information in Ismailia, Egypt

What is this study about?
The research seeks to explore women's understanding of sexual and reproductive health and the factors that influence their access to sexual and reproductive health services and information in the two study areas. The intersections between the different factorswill be critically examined to gain insight into how these issues could be addressed to enhance women's sexual and reproductive health.

What is the interview about?
The interviews seek to gain opinions from women on the factors that influence their access to sexual and reproductive health services and information in your area.

Would my participation in this study be kept confidential?
All your personal information will be kept confidential and will remain anonymous. You will be required to sign a consent form to protect your privacy and confidentiality while participating in this study. The researcher will not reveal your identity and will safeguard the confidential information obtained in the course of the study.

What are the risks of this research?
The researcher endeavours to conduct the research with great care and sensitivity. However, should the interview questions cause an emotional response, the researcher will advise the interviewee that free counselling services are available at a local public health facility in my study area, Ismailia.
Ismailia, Dr Mustafa Hassan Ewias , Tel: +201226828412 Address: El- Far building, Army Street, Ismailia

What are the benefits of this research?
There are no material benefits for the interview to you the participant and myself. However, it is my hope that policymakers will take up the recommendations made from this study.
Do I have to complete the interview and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to participate in the in the interview and to stop participating at any time you want. If you stop or decide not to participate, there will be no negative repercussions for you.

How long will it take to complete the interview?
The interview will take about thirty to sixty minutes

Do I need to bring anything to the interview?
You do not have to bring anything.

Is any assistance available if I am negatively affected by participating in this study?
The researcher will advise the interviewee that free counselling services are available at a local public health facility in my study area, Ismailia.

Ismailia, Dr Mustafa Hassan Ewias, Tel: +201226828412 Address: El- Far building, Army Street, Ismailia, Egypt.

What if I have questions?
This research is being conducted by **Reem Elsayed**, a student at the University of the Western Cape. Her contact number is +27631889203 and email address 3879447@myuwc.ac.za

If you have any questions about the research study itself, please contact **Dr Wanga Zembe** at the Medical research Council, her and email wanga.Zembe@mrc.ac.za
OR
Dr Abdulrazak Karriem at The Institute for Social Development (ISD), University of the Western Cape, his contact number is +27 (21) 959 3853 and email akarriem@uwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:
Professor Mulugeta Dinbabo
Acting Director

Institute for Social Development
School of Government
University of t e
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Email: mdinbabo@uwc.ac.za

Appendix 8

University of the Western Cape

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E-mail: ***pkippie@uwc.ac.za*** *or* *mdinbabo@uwc.ac.za*

بيان المعلومات من أجل المقابلات مع النساء المتزوجات

عنوان المشروع

استخدم نظريه التشابك في حصول النساء علي الخدمات والمعلومات الصحيه الجنسيه والإنجابيه في الإسماعيليه في مصر.

ماهو موضوع الدراسه:

إن البحث يسعي مدي فهم النساء لصحه الجنسيه والإنجابيه وإلي جانب العوامل المختلفه المؤثره علي حصولهم علي تلك المعلومات و الخدمات الصحيه في الإسماعيليه والقاهره. سوف يتم بحث التقاطع ما بين العوامل المختلفه المؤثره علي حصولهم علي هذه الخدمات والمعلومات من أجل الحصول علي معلومات مستنيره يمكن من خلال تناول المشكلات المتعلقه بهذا الموضوع من أجل تحسين الصحه الجنسيه والإنجابيه للنساء.

ماهو موضوع المقابله :

إن المقابلات تسعي للحصول علي أراء النساء فما يتعلق بالعوامل التي تؤثر علي حصولهم علي الخدمات والمعلومات الصحيه والإنجابيه في منطقتهم .

هل مشاركتي في الدراسه سوف يبقي قيد السريه؟

كل معلوماتك الشخصيه سوف تبقي قيد السريه وسوف تبقي غير معلومه إذا كان هذا اختيبارك . سوف يتعين عليك بيان موافقه لحمايه خصوصيتك والحفاظ علي سريتك أثناء المشاركه في الدراسه . الباحث لن يقوم بأي شكل من الإشكال الكشف عن هويتك وسيقوم بحمايه المعلومات التي سوف يتم الحصول عليها من الدراسه .

ما هي مخاطر المشاركه في هذه الدراسه؟

سوف يسعي الباحث إلي القيام بالبحث بحرص وعنايه شديده . ولكن في حاله أن سببت المقابله أي استجابات انفعاليه، سوف ينصح الباحث بالحصول علي خدمات صحيه مجانيه متاحه في وحدات صحيه عامه في القاهره والإسماعيليه .

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Tel : +201226828412
العنوان : عماره الفار ، شارع الجيش , الإسماعيليه

ا

ماهي فؤاد المشاركه في هذا البحث؟

لا توجد أي فوائد ماديه من المقابله سواء في حالتك أو حالتي، ولكن نأمل أن صناع القرار يأخذوا التوصيات في هذه الدراسه بعين الأعتبار.

هل يجب علي أن أكمل المقابله أو يمكنني الأنسحاب في أي وقت منها؟

مشاركتك في هذه الدراسه تطوعيه بالكامل ، يمكنك أختيار الا تشارك في المقابله، ويمكنك أن تتوقف عن المشاركه في أي وقت ، إذا قررت أن تتوقف أو أنك لن تشارك ، لن يكون هناك أي عواقب .

ما هي المده التي سوف تأخذها المقابله حتي تنتهي ؟
المقابله سوف تأخذ من نصف ساعه إلي ساعه كي تنتهي .

هل يجب علي أن أحضر أي شئ أثناء المقابله؟
ليس عليك أحضار أي شئ أثناء المقابله .

هل هناك أي مساعده في حاله التعرض الي أثار سلبيه أثناء المقابله؟
الباحث أثناء المقابله سوف ينصح بخدمات استشاريه مجانيه من خلال مركز للصحه العامه بالقاهره والاسماعيليه .

الإسماعيليه: د/ مصطفي حسن عويس
Tel: +201226828412
العنوان : عماره الفار ، شارع الجيش , الإسماعيليه

ماذا إذا كان لدي أي أسئله ؟

هذا البحث تم بواسطه **ريم السيد** ، طالبه ماجيستر في جامعه غرب كيب، بجنوب أفريقيا، ورقم تليفونها والايميل الخاص بها **Tel: + 27631889203**
Email: 3879447@myuwc.ac.za

وإذا كان لديك أي أسئله متعلقه بالدراسه نفسها ، يمكنك الأتصال د/ وانجه زيمبي في مركز الأبحاث الطبيه، والايميل الخاص بها :
wanga.Zembe@mrc.ac.za
أو د/ عبدالرزاق كريم في معهد التنميه الأجتماعيه ، ، بجامعه غرب كيب ورقم التواصل معاه
Tel: **+27 (21) 959 3853**
والايميل الخاص بها :
akarriem@uwc.ac.za

وأيضا اذا كان لديك أي تساؤل يتعلق بالدراسه أو حقوقك كمشارك فيها ، أو ترغب في الشكوي عن أي مشكله مررت بها أثناء المشاركه في الدراسه ، من فضلك تواصل مع

أ/د مولجيته دينبابو
مدير معهد التنميه الأجتماعيه
جامعه غرب كيب
Private Bag X17
Bellville 7535
Tel:+2721 959 3855
Email: mdinbabo@uwc.ac.za

Appendix 9

Interview guide for key informant interview

1- How do you experience women's understanding of sexual and reproductive health?
2- How do women in your area access sexual and reproductive health services and information?

3-What kind of information do they come to you for?

4- What kind of services do they come to you for?

5-What are the facilitators in regard to women accessing sexual and reproductive health services and information?

6- What are the challenges that women face in accessing sexual and reproductive services and information?

7-How can women's access to sexual and reproductive health be enhanced to ensure their sexual health and sexual wellbeing?

Appendix 10

Semi-structured interview guide with married women in Ismailia, Egypt

Introduction of the researcher (giving information about the research and its aims)
Introduction of participants

1-Could you tell me how long have you been married?

2- Do you have any children?

3- Could you tell me how it feels to be a woman in Egypt? Why do you feel this way?

4- What is your understanding of sexual and reproductive health?

5- How do you access sexual and reproductive health services and information?

6- Are there things that make it easy for you to access sexual and reproductive services and information? If yes, tell me about them

7- Are there things that make it difficult for you to access sexual and reproductive services and information? If yes, tell me about them

8- How can women's access to sexual and reproductive health be enhanced to ensure their sexual health and sexual wellbeing?

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Appendix 11

OFFICE OF THE DIRECTOR: RESEARCH RESEARCH AND INNOVATION DIVISION

HSSREC REGISTRATION NUMBER - 130416-049

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09 October 2019

Mr R Elsayed

Institute for Social Development

Faculty of Economics and Management Sciences

Ethics Reference Number: HS19/8/14

Project Title: The intersectionality of woman's access to sexual and reproductive health services and information in Ismailia, Egypt.

Approval Period: 09 October 2019 – 09 October 2020

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above-mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias

Research Ethics Committee Officer

University of the Western Cape