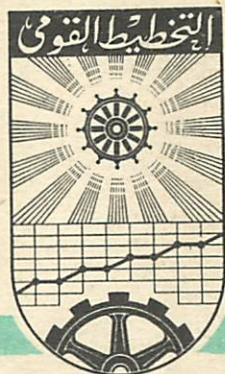


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المدرسة المستقبلية

Memo No. 1115

Beliefs, Practices, Environment and
Services Affecting the Survival, Growth
and Development of Young Egyptian Child-
ren: A Comparative Study in Two Egyp-
tian Governorates.

Part I

By

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Chapter I. Introduction, Background, Objectives and Methodology of the Study

Introduction

Pre-school children aged 0-5 represent 15% of the Egyptian Population which is already more than 36 million. In spite of the fact that this group is the most vulnerable age group it is not receiving enough attention either in planning or implementation of the various social action programs designed to help these children. In Egypt many programs are directed towards this age group at the various stages of their development among which are the following:

1. pre-marital consultations and medical examination;
2. pre-natal care programs offered by MCH centers;
3. Infant care and child care up to 2 years by MCH centers which also provide social assistance to pregnant women and their infants;
4. Nurseries and day care centers;
5. General health care for children above two years by the regular government health services;
6. Legal protection to the mother and her child;
7. Social assistance programs designed to help needy families which in turn affect the young child.

Two main institutions which provide direct care to the pre-school age group are the MCH centers supervised by the Ministry of Health and Day Care Centers supervised by the Ministry of Social Affairs and hence these are given special emphasis in this study.

Background

Tables I through III provide some general statistical background information about maternal and child health in Egypt and about the service-level statistics for health units providing MCH services. The MCH centers are responsible for provision of the following services:

1. Health and social care for mothers during pregnancy, delivery and post partum period;
2. Care of foetus during various stages of pregnancy;
3. Care and treatment of infants, toddlers and pre-school age children;
4. Preventive and curative services for mothers and children suffering from congenital diseases e.g. syphilis;
5. Delivery of pregnant mothers who are registered in the center;
6. Deliveries in the center for cases which require special attention;

7. Care for premature babies whose weight varies between 2 and 2.5 KGM at birth;
8. Care for out of wedlock infants who are abandoned by their parents. Care is provided for these children up to the age of two.
9. Vaccination of children against various infectious diseases;
10. Health education for mothers including practical nutrition classes and family planning guidance;
11. Assistance for needy mothers and their children (food, clothes, etc).

E G Y P T

Total Pop 1/7/73 (Estimates):

Total Pop	
Male (50.8%)	35.3 M
Female (49.2%)	17.9 M
	17.4 M

Age distribution in Millions:

0 - (15.4)	
5 - (13.6%)	5.4 M
10 - (11.0%)	4.8 M
15 - (11.3%)	3.9 M
	4.0 M
20 + (48.7%)	17.2 M

Urban & Rural Distribution:

Urban (128 cities) (42.6 %)	
Rural (4100 villages) (57.4 %)	15.0 M
	20.3 M

Number of Births and Deaths (1971):

Births	
Deaths	1186350
	445193

Vital Rates 1971/1000:

Birth Rate	
Death Rate	34.6
Natural Increase Rate	13.5
Infant Mortality Rate	21.1
Neonatal Mortality Rate	14.0
Still Birth Rate	20.0
	0.6

Table II. Main Causes of Death among young Egyptian Children

A. Main Causes of Infant Deaths 0-1:

Causes	Number	%
Diarrhia & G.E.	66066	48.9
Congenital debility	26318	19.5
Acute & Chronic Bronchitis	24929	18.5
Others.	17754	13.1
Total	135067	100.0

B. Main Causes of Deaths 0-4:

Causes	Number	%
Diarrhia & G.E.	127975	49.6
Lobar Pneumonia	40433	15.7
Acute & Chronic Bronchitis	30098	11.7
Others.	59295	23.0
Total	257801	100.0

Marriage Rate (1971)

10.2

Divorce Rate (1971)

2.1

M.C.H. Centres in Urban Areas (1973)

214

M.C.H. Divisions in Rural Areas (1973)

2022

Table III. Health Units which Provide MCH Services in Urban and Rural Areas in Quena and Domietta Governorates

A. Health Units which provide Maternal and Child Services in Urban Areas 1972

	Damietta Governorate	Quena Gov.	All Egypt
Population	4950	16240	34,942,0
Total Number of Health Units	41	141	2276
Population per unit	12075	11590	12550
Units Providing MCH Services	41	129	2179
Population per unit.	12075	11755	16035

B. MCH Services in Rural Areas 1972

Number of Units	36	124	1909
Visits of Children and pregnant woman	16745	22374	258507
Yearly Average per unit	1021	180	1183
Weekly Average per unit	19.6	3.5	22.7
Deliveries in unit	5652	21516	208859
Yearly Average per unit	15.7	173.5	156.6
Weekly average per unit	0.3	2.3	3

As the following chapters indicate (see Chapter V & VI) Egyptian children are serviced by many providers of health care both traditional and modern. While mothers questioned in this study cited three main reasons for coming to an MCH service they cited six reasons which discouraged them from coming.

Their reasons for coming were to obtain: additional food, vitamins, liver extracts and other medicines; and medical examinations. The extent to which they sought MCH services for pre and post natal care, well-baby services and for preventive services was minimal.

Mothers cited difficulties with: distance and travel; inability to get baby sitters for the other children; unsuitable clinic working hours; long waiting periods; insufficient treatment and crowdeness of the clinic as their main reasons for staying away from MCH centers.

An insight into other reasons for use and non-use of health unit services is provided in Chapter II which gives a penetrating analysis of some aspects of birth, infancy and early training affecting the young Egyptian child.

Egypt is still suffering from high infant and child mortality rates, as the previous tables show, which could be greatly reduced with the present state of medical technology. On the other hand not enough attention is given to nurseries and day care centers

inspite of the climbing rates of employment of women in various jobs and inspite of industrialization which already has absorbed a big proportion of young Girls who used to work as domestic Servants and who usually took care of the young children.

At the planning level the problem stems from the fact that social sector is still treated on a residual basis not only due to shortage of resources but also due the absence of a proper presentation of the problem of young children in a way that enables the planners to incorporate it in their plans. The usual attitude of people responsible for the so called social sector is to ask for more resources either based on a purely humanitarian rationale which can hardly convince a planner or an economic rationale based on the slogan "Man is our real wealth" which may help to tempt a planner to allocate more investments if he is presented with programs which support this slogan. At the implementation level the problem seems to be "coordination" of various programs in a way that maximizes the utilization of available resources and increases their impact on the young child. Coordination is a very interesting concept to talk about but very difficult to implement. The fact that more than one agency is responsible for the various programs directed towards the young child seems to create many implementation problems due to lack of coordination. Unfortunately many administrators in Egypt usually mention "Integration" as the appropriate and only solution for these problems. One should be very careful in interpreting the concept

"integration" when it is used by the administrators in this context since they usually mean that unless all these programs are run by one ministry coordination will be impossible.

At the program level lack of proper management including lack of proper motivation and incentives seems to be the major problem.

Last and not least one should mention the importance of public attitudes and behavior towards social action programs since it is an important element in the proper utilization of these programs.

Effective public participation seems to be of great importance in building positive public attitudes and behavior towards such programs. The experience of Egypt is still new in this area but successful examples encourages one to expect good results.

Objectives of the Study

The Egyptian young child faces many hazards in utero and for at least the first five years of his/her life. A child is at very high risk of dying from diseases which are subject to control and faces this risk in spite of the fact that Egypt is judged to have a fairly adequate health delivery system though there are urban-rural differences.

This dilemma -- a persistent high mortality rate and persistent health problems among children aged 0-5 who do survive coupled with an adjudged adequate health delivery system- forces one to ask why does this exist.

This study is an attempt to answer that question at a level of specificity that will enable Egyptian health and social planners to develop better strategies for solving the problems that continue to beset young Egyptian children. The study first exposes some of the common beliefs and practices with respect to pregnancy, birth, and infancy and psychological and social aspects of early training which intimately and very often directly affect the health status of the young child (Chapters II and III). The focus then shifts to a detailed profile of the two Governorates under study (Chapter IV) and finally in Chapters V and VI a detailed comparative study of the situation of the young Egyptian child and his/her family in the study areas is delineated.

In this study we tried to access the status of the young child aged 0-5 6-5 in two different socioeconomic milieus within Egypt in order to translate the differences into gaps and suggest policy and planning actions to minimize the discovered gaps. Thus the study areas were selected in a way that could demonstrate the gaps between various levels of development within the country.

Two governorates were selected in which to undertake the field study:

1. Quena governorate in Upper Egypt with a population of 1,559,819.
2. Damietta governorate in Lower Egypt with a population of 484,000.

Two districts were selected within these two Governorates:

1. Deshna district in Quena governorate with a population of 178,700 (86.8% rural)
2. Faraskour district in Damietta governorate with a population of 194,500 (65.9% rural). Then during the study a third district from Quena Governorate was added:
3. Quena district in Quena governorate with a population of 270,800 (71.3% rural).

Damietta is considered to be one of the most developed governorates in Egypt while Quena is considered to be one of the most depressed areas.

Damietta is a small governorate of half a million people and they are dependent mainly on agriculture, local industries and fisheries for their livelihood. Damietta lies in the northern most part of the Nile Delta and overlooks the Mediterranean sea. The governorate is spread over 599.2 km^2 of flat land. There are three main cities and a fourth one which is a summer resort and recreation area, "Ras El Bar" meaning the head of the land since it lies at the point where the River Nile "Damietta Branch" meets the Mediterranean sea.

Quena Governorate in Upper Egypt extends about 280 Kilometers (1810 km^2) on both sides of the River Nile forming a narrow cultivated strip valley surrounded by sand and mountains on each side. Its population exceeds a million and half and 81% reside in rural areas (National level 42% rural). Hence it is considered a rural province with an agriculture economy and very few industrial centres scattered in near-by towns. There are 194 villages plus a considerable number of small rural aggregates of 500 inhabitants or less each is called "Nage". The average population village is about 6,000, farming an average of 2,000 feddan (one feddan = 4200 m^2) i.e. 1.7 feddan per one rural family as compared with 2.5 for all rural areas in Egypt. It is obvious that Quena Governorate is considered an economically depressed province.

Methodology:

The field study concentrated on the two governorates of Quena and Damietta in order to collect necessary information about:

1. The people, services and environment in each governorate as a whole,
2. The status of the young child, the environment and services in the three selected districts i.e. Faraskour in Damietta Governorate, Doshna and Quena in Quena Governorate.
3. Policy and planning of social action programs for young children at the national level.

This enabled us to see the problems of the young child through three levels, i.e. National - Provincial and Local.

The main tools used in gathering the necessary information were:

- 1- Questionnaires.
- 2- Unstructured interviews.
- 3- Observations by trained teams.
- 4- Medical Examinations and Psychological tests for the children in the study sample.
- 5- Environmental Health surveys for the study areas.
- 6- Expert opinion
- 7- Published government documents.
- 8- Published and unpublished studies,

Questionnaires:

Four main questionnaires were designed, tested and implemented. Questionnaires 1 and 2 were used to collect information about the socio economic and health status of young children aged 0-5 in the three study areas i.e., Faraskour, Quena and Doshna. These questionnaires were administered to a random sample of 1, 100 young children i.e. through their parents mostly the mother. The sample was drawn in large part from those who visited MCH centers or day care centers. The composition of the sample was 40% urban and 60% rural of which 36.4% were from Damietta and 63.6% from Quena governorate including ages one to six. The ages three, four, and five were heavily represented in the sample. (For details of the sample composition refer to Chapters V and VI).

Questionnaire # 3 was used to collect information about the people, environment and services at the governorate level in each of the governorates under study. This questionnaire was administered to a random sample of 600 adults from the two governorates i.e., 300 from Quena and 300 from Damietta.

Questionnaire # 4 was used to collect information about day care centers: building, equipment, capacity, etc. This was administered to 18 day care centers in Quena governorate and 11 day care centers in Faraskour. In Doshna there was only one day care center and so ten centers from adjacent districts in Quena governorate were added in order to have a reasonable basis for comparison.

Unstructured Interviews:

This tool was used to collect information about folklore methods of treating various diseases and anthropological and cultural information necessary for the study.

Medical Examinations and Psychological Tests:

Two research teams headed by a pediatrician one for each governorate undertook the necessary medical examinations. Also two trained research workers undertook the application of the psychological test on children in day care centres.

Environmental Health Survey:

This was undertaken by a team under the leadership of an environmental health expert from the Ministry of Health.

Expert Opinion:

This was used to interpret and evaluate the collected information.

Chapter II. Some Aspects of Birth, Infancy and Early Training of the Young Egyptian Child

Introduction

The main objective of this chapter is to contribute to a better understanding of the cultural patterns affecting the Egyptian child during his early years of development. One major limitation to such an attempt is the cultural diversity of the country. Egypt is composed of various "social worlds" characterized by different styles of life and it is rather impossible to attribute to it a unified pattern of child-rearing practices. Yet it was noticed that there appears to be a great similarity in child-rearing practices among the residents of some areas in the inner city of Cairo often called old Cairo or medieval Cairo and some villages of Upper and Lower Egypt. The information in this chapter is based primarily on first-hand data gathered through interviews and personal observations of residents in this regions. The information was obtained by a qualified anthropologist trained in the techniques of participant observation.

The physical milieu undoubtedly has its effects on the children of the area. Nevertheless there are other cultural considerations which are equally important and it is on them that this chapter focuses.

Conception and Pregnancy

Child-rearing practices in addition to their importance in personality formation project the roles and value of children in the society. Concern about begetting children starts with the wedding night. There are certain taboos that the married woman should observe in order to insure conception. Breaking of these taboos would cause mushahra which, under these circumstances, prevents pregnancy unless traditional curative measures are taken. Mushahra is a major theme in the Egyptian culture accompanying life cycle crisis.

John Kennedy has analyzed the sociological and psychological implications of mushahra behaviour among the Nubians. He defines mushahra as a "super-natural harm caused to individuals in vulnerable states of other persons" violation of taboos".¹

In the Egyptian society, belief in mushahra is very strong, though it is not the sole cause for a delayed pregnancy. Mushahra as a term is derived from the Arabic shahr meaning month and among Nubians the belief associated with this term, is that if certain actions are engaged in before the appearance of the moon, harm will befall an individual undergoing a "crisis rite". Though the Egyptian women use the word mushahra, yet the word is very seldom associated with actions pertaining to the appearance of the moon. In Egypt, the term kabsa is used interchangeably with mushahra. A woman who is exposed to mushahra is called makbousa. Kabsa denotes that which is pressed or held back. A woman is called makbousa in two situations - if pregnancy is delayed or if the flow of nursing milk is affected. Thus we have the belief, that pregnancy is "held back" or "milk is held back".

In case of pregnancy the kabsa is caused by violating the protocol of facing through a "crisis rite" with another who is also passing through another "crisis rite" himself. For example if a bride is in a room and a child who has passed through the "circumcision rite" enters that room, then the bride's pregnancy will be "held back". Or, if a mother who has recently weaned her child enters a place where there is a mother who has recently given birth, then the latter will be exposed to kabsa.

¹J. Kennedy "Mushahra" Nubian Concept of Supernatural Danger and the Theory of Taboo", American Anthropologist: Vol. 69, No. 6, Dec. 1967, P.1

and in this case her next chances for pregnancy will be affected. The protocol demands that the bride and mother who has given birth should not be intruded upon by others undergoing a "crisis rite" but they should be the newcomers.

There are various ways used for releasing a kabsa. These are known to Egyptian women. They involve the co-operation of the two parties concerned. A very common and simple practice is that the makbousa urinates over the urine of the other who has caused the kabsa. In cases when the other party is not know or is not co-operative or if bad intentions were involved, the daya (traditional midwife) is often consulted. Some dayas have a "mushahra necklace" which they lend to the makbousa to soak overnight in water and to wash herself with that water every Friday until she gets pregnant. The daya also pickles the foetus of miscarriages to use for curing kabsa. In this case, the client is asked to step three times over the foetus - it is the shock of the scene which cures the kabsa.

When the known practices for ending mushahra prove ineffective, or if the woman is sure that she was not exposed to mushahra, a delayed pregnancy is attributed to some illness might have affected the woman's uterus. In such cases she appeals to folk medicine which is usually prescribed by the daya or an elderly woman. These include prescriptions that are for external and internal usage. Of the very common external methods is the daya's edra or pot. It serves the same function as air cups. It is applied on the lower part of the woman's back three or four days after the starting of the menstrual flow. It is believed that the edra absorbs the "cold" which the uterus might have caught. Substances which are applied internally include the soofa, a piece of wool treated with drugs bought from the attar (traditional druggist). This soofa is inserted in the uterus during the day and removed at night. The belief in this method is very strong since it induces the flow of discharge. A rabbit's rennt is often inserted. As the rennt clots milk then it is also effective in the clotting of menstrual blood and the formation of the foetus.

Another method which is applied internally is the insertion of a piece of cotton full of virginal blood. This is usually fulfilled through the aid of the midwife who is in charge of the traditional practice of the consumation of marriage.

Visits to sheikhs tombs are paid for their baraka and asked for fak eloeda to unfasten the knot preventing pregnancy. Living sheikhs are also consulted to break black magic and to "break" its effects.

These were only some of the folk ways known and used by the Egyptian women to meet the problem of a delayed pregnancy. Private doctors and public hospitals are not beyond reach, and are often consulted. It is important to note that all of the above-mentioned practices could be used consecutively or simultaneously whenever pregnancy is delayed. It is also significant to point out that this attitude could start after the second or third month of marriage. Undoubtedly, this great concern is one indication of the value and importance that natural children have for the Egyptian women.

Once a women is pregnant, it is not customary that she consults a doctor or a daya during the months of pregnancy. . . There is a common belief that an observant woman could know exactly when she conceived. The comment is often said that if the woman finds herself dry after sexual intercourse it means that the uterus had absorbed the sperms of the man and this day is counted as the first day of pregnancy. If that particular union happened at night, then the hour of delivery would be expected at night, if during the morning then the delivery will be during the day. Egyptian women believe that the majority of childbirths happen at night since sexual intercourse is more likely to happen at night.

Usually a pregnant woman continues her household activities and responsibilities to the last day of pregnancy. But in cases when pregnancy starts during the first months of marriage the pregnant woman has to be extra careful during the last months of pregnancy. A premature baby subjects the mother to accusation of pre-marital relations.

Time of birth is calculated on the basis of nine months according to the lunar calendar. Egyptian women believe that the calculations of the lunar month are accurate, besides, they do not know the months of the European calendar.¹

Childbirth

Egyptian women are well informed about what actually happens to the mother during childbirth. One can hardly find a girl who has not attended a childbirth of a relative or a neighbour. As most of the births take place in the marital home, a girl or sometimes a boy of six, could be of great help to the mother at such a critical moment.

Very little panic is expressed at the time of birth either by the delivering mother or those surrounding her. These women are fully aware of the fact that childbirth is a natural physical operation and it is in the hands of God, and only God, to 'permit' the child to 'come to life'. It is said that the woman has to wait for saat el farag, the hour of relief or parting.

¹ Egyptian women when counting and naming these months make certain modifications in their names. Months which are known for special celebrations are given the names of these occasions. Thus the month of Muharram is called Ashoura, Shawwal is called the month of El Eid el Soghair, the month of Zul Kaadda is known by Bannat el Aiad, the month of Zul Higah is named after El-Eid el Kabir.

When the birth pains start the expecting mother continues on with her daily activities. She knows that this is going to be a busy day for her and is keen to have the day's meal ready for her husband and children before the real pain starts. Such remarks are often said: "When the pain started I cooked food that would last for two or three days", or "I knew that the kids didn't have clean clothes so I did my washing". It is not necessary that the woman sends for her mother or a relative especially if they live far away. She prefers to wait until the child is born and then notify her relatives. Usually neighbours get involved and they are the ones whom she consults. An experienced woman is often asked to examine the woman in labour to check if the pains are "true" or "not true". As a principle, the woman in labour should be given all the time and encouragement she needs to have a natural delivery and the presence of a person who could convey this feeling is highly appreciated whether she is a neighbour or a daya. A woman in labour is expected and allowed to scream for this is the way they express their pain, but this is different from panic or fear.

Once it is obvious to the woman in labour and her neighbours that this is a case of delivery, one of the following actions is taken;

1. The daya who attends the mother is called and if she is licensed, cuts the umbilical cord
2. The traditional midwife who attends the mother and after the baby is born, calls the mestawsaf to cut the umbilical cords as called.
3. The baby is delivered with the aid of neighbours, and when the baby is born the mestawsaf is called to cut the umbilical cord.
4. The mestawsaf is called to attend the mother and baby.

Resort to private doctors is very uncommon since public hospitals are associated with operations anaesthetics and danger; however, the Egyptian woman knows that the public hospital is the only resort in complicated deliveries. Hospitals are rarely thought of as a place for delivery under normal conditions.

An understanding of these different patterns, and the attitudes associated with each is basic to an evaluation of the agencies of childbirth in the community. Though one does not want to under-estimate the roles that these agencies have in child care, yet it is worth noting that "self-delivery" is very common. It is not feared and the Egyptian woman is in no hurry to call these agencies when the pain starts.

The "Mestawsaf and the "Daya"

The mestawsaf and daya should be considered as two complementary institutions rather than contradictory. Each fulfils certain practical functions for the Egyptian community and the Egyptian women try to maximize them by making use of both institutions.

The mestawsaf is the most economical medium - theoretically, its services are free. The least that they can do is to cut the umbilical cord and register the baby. If they are properly tipped, they will give the mother some cotton, salfa and mercurochrome. One basic reason for appealing to the mestawsaf is that the woman who is registered for delivery in the mestawsaf has the right to get the child care service offered by this institution. To the residents of Medieval Cairo attending the woman in labour is the least important role of the mestawsaf. There are numerous legends associated with the kind of treatment the women in labour receives from the mestawsaf. The most popular of these legends is that

the mestawsaf personnel are government officials - important people. They have no time to waste. Thus, in order to hasten labour it is often said that one must sit over the abdomen of the woman in labour while the other pulls the child out. Another legend says that they slap and beat the woman in labour if she does not obey their orders and instructions. Generally, the lower the income of the family the more they tend to depend solely on the mestawsaf. In such a case neighbours and relatives collaborate to attend to the woman in labour and the mestawsaf is called after the child is born. This group does not engage in elaborate rituals after the birth of the child - i.e. rituals of the seventh day or the sebou. Those who are a little better off prefer to get an unlicensed daya because her fee is less than the licensed one. This daya always advises her clients to register their names with the mestawsaf. She prefers to co-operate informally with the institution to safeguard her illegitimate craft. Thus, she attends to the woman in labour, comforts her, gives her all the time and encouragement she needs and when the baby is born she calls the mestawsaf to cut the umbilical cord, an operation which she knows perfectly how to perform, but she reserves for the mestawsaf as an indication of her loyalty and co-operation. In such cases, the mestawsaf is tipped and the daya is paid, but the whole cost is less than the licensed daya. It should be noted that the cost of the licensed or unlicensed daya is not immediately felt for a large percentage of her fee comes in the forms of nokoot or donations from neighbours, relatives and friends.

Besides childbirth, both the mestawsaf and the daya play a role in the life of the infant. A common attitude among Egyptian women is the belief in the effectiveness of folk medicine but at the same time the importance of medical care is not under-estimated. The mestawsaf clinic is visited for check-ups and cheap medicine. Also, midwives are consulted. I have seen dayas

who have morning clinics for curing certain childhood diseases such as ear and mouth infections.

Nursing

There are two basic principles which are essential to the understanding of cultural patterns associated with nursing:

1. Nursing conforms to no schedule.
2. Every mother should have enough breast milk to nurse her baby.

Each of these principles involves a syndrome of attitudes and practices which are infiltrated in the various spheres of the Egyptian woman's life.

1. Nursing, except in rare cases, follows an extremely permissive pattern. Basically, it conforms to no schedule. As long as the mother is available the child should be given the breast whenever it cries - and the mother is usually available. There is no effort made to train the child to be fed at regular intervals. They follow the rule that "the baby knows when it wants to be fed".

During the first three days after his birth and before the milk flows, whenever the baby cries he is soothed with some sugar and water. If the baby is "greedy" and keeps on crying a nursing mother in the neighbourhood is often asked or volunteers to nurse the baby until his mother's milk flows.

There are two different views as to when the baby is first nursed. The difference is due to the variation in the customs and beliefs regarding the colostrum. While some believe that it is essential for the baby, others think it is unhealthy and should be disposed of. Advocates of the utility of the colostrum nurse the child immediately after birth, they call the colostrum mosmar or nail, and believe that it contributes to strengthening the muscles of the child and helps him to hold his back

straight. Those who believe that the colostrum is unhealthy, to nurse the baby for the first time after the colostrum has been withdrawn. The colostrum in this case is usually squeezed in a cup and thrown next to a wall so that no one steps over it and exposes the child to danger. The colostrum is thrown on the basis of its rotten smell zifr and is believed to bring diarrhoea to the baby if he sucks it.

Day or night, the baby is fed whenever it cries. This principle is made feasible through various cultural traditions which serve this end. For example, there are no restrictions on where the baby could go - simply he is with his mother. If she goes shopping or visiting he accompanies her. (As soon as the baby can support himself, and this can be as early as the third month, he is carried over one shoulder, thus giving the mother freedom of movement for carrying other things.). Accordingly, it is proper to nurse the baby anywhere, it could be in the street, in the bus or while sitting by her house door watching passers-by or talking with a neighbour. The scene of a mother nursing her child does not attract any special attention neither from female or male members of the community.

The nursing mother tries to make nursing a convenient and comfortable process in spite of its irregular time schedule. Dresses with low neck cuts are a must to facilitate nursing at any time. At night, the baby sleeps next to his mother so she does not have to go through the effort of getting out of bed to feed the baby when it cries. By the time the baby is seven months old he can easily search for the breast while she is fast asleep. Women of these quarters do most of their house work while sitting on the floor or on a low chair and it is no problem to nurse the baby while cooking or cleaning the vegetables. It is only washing day which is problematic and a neighbour usually assists the mother. A neighbour's assistance and reach the point that if she is a nursing mother she nurses her

neighbour's baby until his mother has time for it.

Egyptian mothers also use the breast as a pacifier. It is not offered to the baby only when it is hungry, but also whenever the baby is in pain, frightened or wanting to sleep. It is worth noting to find that thumb sucking among the children of these Egyptian women is not prevalent. As early as 1930 S. Freud has found a high correlation between thumb sucking and time schedule feeding.

2. Egyptian women believe that every mother should have enough milk to nurse her baby for at least two years and every child should have this haq or right. It is the right that God gave him. According to the sharia (Islamic law), the mother has to nurse her baby and if she can't for any legitimate reason, the father should hire a wet nurse to enable the child to survive. And in cases where the mother wishes to nurse another's for money or for free she is forbidden to do that if it hurts her own infant.

There is nothing that can prevent the flow of milk except Kabsa, and the mother should be careful to safeguard herself against it. Unlike the kabsa of pregnancy, that of milk is caused by seeing particular foods or scenes rather than seeing other individuals passing through "crisis rites". For example, eggplants and raw meat could hold the flow of milk but this can be avoided if the protocol of entry is followed - as in the case of pregnancy. But there are quick counteractions in cases of mishaps. Washing the breast with the milk of a mother who is very effective in releasing most cases of milk kabsa. Some mothers when they wean their children keep some milk in bottles especially for this purpose and they consider it as sawab (good deed).

Thothh it is said that each child has his "risk" - meaning an amount of milk that God gives to him, yet nursing mothers are keen to improve the quality of their milk. The mother's milk could be either maiz (light) or saman (heavy). Maiz milk is not good for the child, it is light and unnourishing and a mother with such milk will never have a fat baby unless she eats the appropriate food. She should eat halawa, helba, raddishes, lentil soup, and abstain from eating noulukhya and food cooked with oil such as taanya. To have saman milk is a gift from God and is not particularly related to what the mother eats. An undernourished mother could have saman milk and fat babies. Egyptian women believe that an abundant flow of milk is a matter of henia, passion. There are women who are compassionate and these capable of leaking at the sight of an infant even after they have already weaned their own. Some women are hard-hearted and these usually do not have an abundant flow of milk. There is a great correlation between warmth of feeling and breast nursing. Egyptian women believe that the child sucks their tenderness when sucking their milk.

Girls are known to be "greedy" and suck more milk than boys, but they are believed to be more warm and tender and tender and considerate especially towards their mothers.

These women are aware of the nutritional value of mother's milk and they feel that a child who is not breast fed will never be strong. An informant once told me:

:hakowo is a candy made from sesame seeds helba a hot drink noulukhya a green vegetable which when cooked is very viscous It is one of the most common summer foods. Taanya is the deep fried bean and garlic patty which is one of the main Egyptian year round foods.

A child who has not been breast fed would never be a craftsman or a labourer; he won't have enough courage, if pushed he'll fall. Such a man will be fit only for office work - an engineer or a lawyer - and these jobs are not meant for us.

Besides nursing, the breast milk has other auxiliary usages for these Egyptian women. If a foreign body enters a child's eye (or even an adult) a drop of milk from a nursing mother is used as eye drops. In this case, it is preferable that the nursing mother be dark skinned for dark women are known to have purer hearts. Some mothers spray breast milk on their baby's face and body and use it as a cleansing lotion. When the child is metlaweh i.e. a sprain in the abdominal muscles, the child's body is massaged with mother's milk and then wrapped in a piece of cloth - the milk will penetrate the child's veins and cure the sprained muscle. This prescription is used with a child who is less than six months. A known appetizer for babies is soaking mehlab, oriental frankincense, rock candy and cumin in half a coffee cup full of mother's ^{milk}. This recipe is given to the child daily after he is forty days old and he continues taking it until he is weaned. The milk of the weaning mother is also believed to cure the kahsa if the breast is massaged with it.

There are specific times when the mother should not nurse her child. A child who has diarrhoea or measles should not be nursed. If the mother is sad/^{she} would not nurse her child. One woman said:

Once my husband beat me and I was very sad, I nursed my baby. After two days we buried the baby.

Another said:

When my brother died I was very sad and every time I nursed my baby it would scream with fits of colics. this baby weaned itself and refused to suck my breast.

In such cases, the milk should be withdrawn by squeezing it by hand. Egyptian women are very much against canned milk. They say it causes diarrhoea and infantile paralysis. Furthermore, the child who is used to milk from a bottle is felt to be always subject to the evil eye. In these quarters privacy is not always possible and usually the baby is fed in front of others. However, with breast milk no one knows how much the child has had. It is interesting to note that in these quarters women who are forced, due to special circumstances, to give milk from a bottle, choose a brown bottle so that the amount of milk is not noticed. Bottle feeding is also inconvenient especially if we take into account the belief that the child should not cry very often.

Introduction of Solid Food and Weaning

Most of the Egyptian women know that the Moslem law gives the child the right to be nursed until he is two years old. The verse of the Qur'an in Surah el Bakara says:

Mothers shall suckle their children for two whole years; i.e., for those who wish to complete the suckling.

Nevertheless, the majority of these women wean their children before they are two years old. Mothers feel that they are getting physically weak and cannot supply the two year old child with sufficient milk. Also, nursing a child for more than 16 or 18 months will adversely affect his intelligence. Among these women, the ideal age of weaning is 18 months, but there are variations. One main reason for the variations is the woman's desire for pregnancy. These women are fully aware that for some, there is a correlation between nursing and pregnancy. When weaning is delayed until the age of two or more, it is usually done for family planning purposes.

M.A. Mohamed carried out research on nursing and weaning practices among a sample of 216 women in Giza. In this study he found out that about 44% of his sample adopted "gradual weaning" which he defines as exchanging a meal of food (whether it is solid or half solid by means of a cup or through chewing) for a nursing meal either through the bottle or the breast. This exchange of meals increases until the child gets used to the solid food. He also found out that 20% of the sample women stop nursing abruptly, while 32.4% apply bitter or unpleasant substances to the nipple.

The women of "Medieval Cairo" also in a high percentage of cases, wean their children abruptly. Women find a value in saying that their children depend entirely on their breast milk. They also insist that their children were not helped with other meals prior to weaning. Closer observation proved that such statements, though accurate from the point of view of Egyptian women, can be explained from another perspective. If we relate weaning to the pattern of introducing solid food to children we get an explanation for why children depend entirely on their breast milk.

These women are not used to introducing one full solid or half solid meal of food instead of a meal from the breast or the bottle. But in fact, as early as the child is three or four months old, he is introduced to solid food. This is done through a common practice known by the term talhees i.e. licking. Whenever the mother is eating she takes a pinch of her food, crushes it between her fingers and allows the baby to lick her finger. At breakfast time she does that with egg yolk, fowl medamis or cheese. At lunch or dinner she does the same with cooked potatoes, squash, rice, lentils or any kind of cooked vegetable or beans. Meat is not introduced except after the child is one year old. Meat is believed to rot the intestines. Whenever the mother drinks tea, the child is allowed a sip.

Very often a piece of bread or biscuit is soaked in the tea.

Gradually the child is introduced to solid food, but no special food is cooked for him. With cooked vegetables the mother tries to pick up some from the pan when it is boiling so that it will not have lots of fat.

This pattern of introducing solid food does not interfere with the number of meals the child gets from the breast. No one meal is exchanged for another. He is still nursed whenever he cries and whenever he wants. As the child grows, the breast means to him more than just satisfying his hunger. Very often one sees a child asking for his mother's breast, sucking it for a minute or two, then leaving it and crawling around for some time, then coming back for it and the mother giving it readily to him. Solid foods are introduced in the same pattern, i.e a pinch of this and a pinch of that at irregular intervals. To the mother these pinches of food are not considered as meals:

The child has only been tasting the different kinds of food.

By the time the mother decides to wean her child, he will have developed likes and dislikes of certain solid foods. The food that the child is known to have liked is bought in abundance at the time of weaning. For example, mothers would say "she weaned him on mangoes", or "she was weaned on dates or sugar". Thus the breast milk is switched with the "other" most favourite food for the child. Though this pattern helps to soften the abruptness of the act of weaning, yet, it is still a severe action and the child suffers during this period. The most troublesome period is during night time. It is not the change from liquid to solid food which is bothering the child, but it is changing his sleeping pattern.

He continues on sleeping with his mother but he is prevented from sucking her breast. Mothers often say that when they weaned their children they did not sleep for four or five nights and they try all means to sooth and comfort them.

Mothers realize that weaning is an extremely critical period for the child. They feel the deprivation which he is suffering. They often cry for him. There is an arabic proverb which is said at times when an adult insists on not approaching or taking something that has been offered to him.

Once the mother decides to wean her child she never weakens. It is a one-way decision. It is a common belief that a mother who weakens in front of the demands of her child and gives him the breast after depriving him of it will bring him harm. This child when he grows will be instrumental in giving the evil eye to others. Also it is believed that if the mother weakens, the child will never obey her orders.

Several actions are taken to help the mother and the child to go through this process. Some send their children to a relative whom the child likes, until he forgets his mother's breast. Others put bitter or disgusting substances over the nipple so that the child hates its taste and appearance. Another common process is that a grandmother or an elderly relative who lives with the family gives the baby her own breast to suck whenever he gets very angry. There is a protocol among neighbours and relatives with regard to weaning. If two neighbours have babies of similar age, they make it a point to wean both children at the same time so as not to break the heart of one of them. Usually, mothers prefer to wean their children in summer because there are many fruits and they could comfort the child with them. Also, Ramadan is considered as a good month for weaning.

People stay late at night and the mother can find assistance from others with a disturbed child. Also during this month there are lots of "goodies" in the house which could please the weaned baby.

As a general pattern, parents and relatives are extremely permissive with the child when he is being weaned. He is deprived only of the breast, but he has all the liberty he wants. He is permitted to insult or beat others and no one is allowed to make him sad or angry.

Once this stage has passed, the child has regular meals with the other members of the family. No special food is made for him, and milk is not an essential part of his diet. If he is given fresh milk it is mixed with tea (milk composing three quarters of the quantity)

In order to dry her milk the mother hangs seven wet lupines (turmus) on her breast. She is expected to be sad. Such a woman is said to cause Kabsa to others and she has to be careful to where she moves. After four days they dry and once they dry, the breast milk will also dry. If this is not done, the mother will be subject to complications and breast pains.

Major Childhood Illnesses and Reactions to them

Since his birth, there are no prohibitions against holding or carrying the newly born baby either by neighbours or by relatives. A baby is often carried by another who is only three or four years older. With the soft muscles of the baby, this subjects him to muscle sprains very often. A child who is sprained is called motlawah. The cause of this is known to be that the baby was carried by another child who did not carry him properly.

One indication that this illness is a common one is the number of prescriptions available for curing it. One method is rubbing the body with the mother's milk. Another is rolling him in a sheet and hold it forwards or back wards and roll him on it. This is believed to bring the muscles back to their normal position. Another method is to crack a raw egg over the back of the child. The egg will keep on moving till it reaches the sprained part, and then the yolk will break. This same spot is massaged with flour and the egg.

Another major illness of children prior to weaning, and which Egyptian women do not see any ^{reason} for consulting a doctor, is the mouth infections. These are treated with coffee and lemon. Also goat's milk is considered as very useful. It is important that the child be nursed directly from the goat for three consecutive days.

Diarrhoea is treated by preventing the breast milk for three days. During these days the child is given careway, rice water and tea. After the third day the child is given cooked starch.

Fever is treated mainly with enema water and soap. The soap should be a new one and of the "nabulsi" brand. The enema is to pull all the dirt in the intestines causing the fever. If the fever remains after the enema an aspirine is given.

Tonsillitis is treated by grinding black olives with their stones and applying it on the child's neck and wrap it with a piece of cloth.

Measles is called mabrouka. A child with should wear a red garment, and be kept in a dark room so as to preserve his sight. He should be prevented from eating anything but molasses. He is also treated with an enema of molasses. A child with measles should be kept alone. Any woman who is not ritually pure (menstruating or uncleared after sexual intercourse) should be prevented from entering the sick child's room. The presence of such a woman is capable of preventing the measles rash from coming out and thus exposing the child to death. For fifteen days the child is expected to eat molasses, then he eats osbit el mehasab. This meal is composed of ground wheat boiled in water and molasses. If the child does not eat this meal after the fifteenth day his hands and feet will swell. Once he eats this meal then he could eat any other food.

When the child complains of pain in his ear an onion crushed with salt is applied inside it. Coffee powder is also used for curing ear infection.

Bronchitis is cured mainly by applying a warm insulator on the chest of the child. It could be a piece of newspaper or a piece of cotton perfumed with incense. Some massage the chest of the child with warm kerosene.

There are two main skin diseases which are common among children of this area - scabby and ringworm. Scabby is treated by shaving the hair. An ointment composed of ground coriander and sesame oil (tahina) is applied on the head. A head cover is worn. Every two days the head is washed and the ointment is applied again until cured. Scabby is treated with kabrit gimal (sulfur) mixed with oil.

Child's Bath

The child receives his first bath immediately after birth. The daya or the hakina are responsible for his first bath. It is common that the child is not bathed again until he is forty days old, especially if it is winter time. Many of the mothers living in these quarters still keep the custom of having the bath of the fortieth day at the public bath. There they find a specialist who purifies them ritually from birth impurity.

It is during this day (whether she has her bath in public bath or at home) that the mother usually gives her baby his second bath. After that, he is bathed every 15 or 30 days until he is a year. After the first year the child is bathed more often. At the age of six and when he starts going to school the pattern is to have a bath every Friday. (Daily baths are nearly lacking at any age).

This Chapter delineates several practices which offer at least a partial explanation for the high mortality and generally poor health status of young Egyptian children in the inner city of Cairo and in the villages. In summary they are:

1. Strong adherence to notions of causation concerning pregnancy, birth and childhood disorders and disturbances which are not well founded in fact;
2. Utilization of modern medical approaches and personnel for pre-natal, birth, post-natal and early childhood care only as a method of last resort;
3. Prolonged and permissive breast feeding without adequate supplementation of breast milk with nutritious foods coupled with rigid and abrupt weaning practices;
4. Lack of proper supervision over the mobile child and delegation of baby sitting functions to other children who are in general of an age that they cannot be expected

to know how to care for an infant properly, resulting in exposure to sources of disease and improper handling resulting in sprains and more serious accidents;

5. Treatment of childhood diseases with inappropriate and ineffective methods;
6. In sufficient and infrequent bathing of the infant and child and probable exposure to disease because of poor bathing facilities.

The detailed study conducted in Faraskour, Deshna and Quena districts reported in the following chapters strongly reinforces the observations presented in this chapter.

Many of the effects of these practices as listed in 1 through 6 above were found to exist in the study areas.

Chapter III. Psychological and Social Aspects of Child Development
in Egypt and Study of Day-Care Centere in Quena and
Demiетta Governorates.

INTRODUCTION

In the Arabic culture children are referred to as "Ahbab Allah" or "God's beloved". In more than one verse of the Holy Koran children or offsprings have been glorified. In one of the verses children and wealth have been idenfified as the two basic glories of life on earth. This besides other social and economic factors have affected the role of children and attitudes towards child bearing throughout the ages in Egypt.

Besides the religious aspects children represented an economic need in the agricultural society. Socially they are proofs of virility and fertility of the parents, both concepts of deep rooted value in the Egyptian culture.

In spite of the rapidly changing society and the rapid industrial expansion and the increasing needs and burdens of large families, the concepts regarding child bearing have not changed much among the majority of the population.

While the emphasis previously was on the participation of children, specially males, agriculturally and economically they were looked upon as a labour force. At present, the emphasis, especially in urban but also in villages, is on education with a view of a governmental job

or a professional career which will not only contribute economically to the family income but will also move it along the social ladder.

This study attempts to provide a framework for developing and dealing with the human and social conditions which affect the young child.

The demands of society compel us to see the significance of the first years of life which should claim a certain priority in all social planning.

The environmental conditions which surround the pre-school children of the nation vary enormously. Many of these children are born and grow up without the protection of medical service or medical supervision, they are reared by parents who have received no guidance from the community in the most elementary principles of child care.

With this in view, the present discussion tries to give a brief description of the environmental surroundings that have a direct relation and effect on the young child in our society. Observations of gatherings of children and mothers in MCH centres and day-care centres are stated as objectively as possible to provide an understanding of the situation and a guideline for planning for the young child, as we must organize our social provisions for the pre-school years in new patterns which preserve the constructive forces of home life and vitalize both parental and governmental responsibility.

Adequate protection of the pre-school child demands continuous safeguards, beginning with birth and the pre-natal period; such protection can be achieved only through a co-ordination of medical supervision, parental guidance, preparental education and special educational provisions in health and day-care centres.

PSYCHOLOGICAL AND SOCIAL ASPECTS OF CHILD DEVELOPMENT

Theoretical Background

In a normal environment, the child is usually handled by one person, the mother; as he grows older he learns to distinguish between the members of his family and to learn what to expect of them and what they expect of him, his knowledge of people gradually widens and both his emotions and the type and intensity of his relationships become differentiated and he learns to interact with his peers; by the time he is of school-age he is beginning to deal with others in a wide variety of social situations, he has acquired a number of skills, particularly that of verbal communication and shows capacity for differential emotional attachments to other individuals.

Besides interacting with and learning from adults, the child interacts with other children and gradually through his play learns to co-operate, a skill basic to becoming integrated in any group, observation of children play traces the degree of social participation and the growing interest of the child in others.

For any attempt towards an understanding of the pre-school child, it is difficult to separate cause and effect however impersonal and diverse social forces seem to be. It is certain that our understanding and evaluation of the pre-school child should have a determining effect upon the form of the environment which is ultimately created for him. So how can we specify the optimal environmental needs of the pre-school child? No social programme can be really functional unless we define the behaviour characteristics and the developmental requirements of children at varying ages.

The Concept of Growth

The multiple patterns of behaviour observed in a child since birth grow very rapidly and undergo such ceaseless continuous transformations. There are laws of sequence and of maturation which account for the general similarities and the basic trends of child has a tempo and a style of growth which is related to and a result of biological endowments, social surroundings and psychological experience. Yet the behaviour traits and the maturity status of a typical normal child are characterized for each age. For the sake of ease and convenience areas of behavioural development are divided into four basic branches:

- a) motor behaviour
- b) adaptive behaviour
- c) language behaviour
- d) personal social behaviour.

It is important to note, however, that mental and psychological growth is a process of organization; it manifests itself in patterned wholes. A child does not grow by simple linear extension, he has a persisting individuality and his outlook in life and on himself changes as he matures. His personality, sense, his appreciation of his own personal status, his assertiveness of his status undergo profound developmental changes evidenced particularly in his personal social behaviour but also in language and in adaptive behaviour, and thus in this attempt to understand the pre-school child, we need to focus our attention not only on his abilities but upon the organizing process of growth.

Motor Behaviour

Age norms that show what a child can do at different age levels exist and a lot of detailed studies dealing with child development have taken place. In the motor area, for example, we know how development gradually takes place from gross random movements to highly skilled purposive behaviour. Though a great part of this development is related to maturation, yet the impact it has on all other aspects of development cannot but be observed. Development of motor behaviour gives the child a degree of independence that allows him first to move around and get acquainted with his environment and then gradually engage in all other purposeful movements to reach specific goals.

It is not the intention of this paper to discuss motor development in detail since this can be referred to in any textbook in child

development, yet it is important that nurses, paediatricians and supervisors in day-care centres and nurseries should be acquainted with patterns of different motor behaviour at different age levels to be able to detect any specific deficits or retardation that might hinder a child in his future life.

Adaptive Behaviour

Adaptivity is reflected in all modes of behaviour whether motor, language or personal-social. A child may have a motor deficiency, a language defect or inadequate social adjustment and yet performs with relatively superior adaptivity in situations which minimize the influence of his handicap. Adaptive behaviour has been defined as "a convenient category for those varied adjustments, perceptual, orientational, manual and verbal which reflect the child's capacity to initiate new experience and to profit by past experience". Intelligence plays a great part in the development of adaptive behaviour; however, failure to conform to the usual pattern of behaviour does necessarily signify inability, as in its non-conformity it reflects a particular way of responding.

Language Behaviour:

The integration of language with other areas of behaviour which allows most conscientious activity to be verbalized does not exist from the start. It is a gradual process taking place at an accelerating rate near the end of the pre-school period with a wide range of individual variations.

Spoken language appears first as a relatively independent activity, engaged in as play for its own sake as in the babbling stage, or as an accompaniment to other types of behaviour, or as a social response without a specific communicative aspect.

The first words and simple phrases occur as response to familiar objects or situations. Verbalization of wants follows towards the end of the second year. The narration of simple experiences develops between two and three years. The answering of simple questions dealing with non-present situations might not develop till after the third year.

During these early stages, the development of speech may show retardation of varying degrees without a necessary corresponding retardation in other areas of behaviour, but these even out in the normal child with increasing age.

As the child develops, not only does his vocabulary increase but his articulation also becomes clearer; he uses different parts of speech and grammatically his sentences are better constructed, and before a child is ready to read he should have acquired a degree of organization of his language behaviour that can allow for his acquisition of this new skill.

Like in all other areas of development there is a deal of varia-

tions between individuals, between children belonging to different sexes, socio-economic and cultural groups in their rate of acquisition as well as their manipulation of language.

Personal Social Behaviour

Personal social behaviour includes not only primarily social behaviour but the modes of behaviour which characterizes the child's own personality and individuality. Personal social behaviour^{is} in evidence whenever we have a child responding to any situation whatsoever. We see it in motor, language and adaptive behaviour, we see it in the home, in the day-care centre, in school and in the street.

The personal social development of the pre-school child does not depend on himself alone. It is most sensitive to environmental influence. Developing personal and social behaviour follows a basic maturational sequence but it needs guidance. It is usually the mother who is the child's guide during these years and she should be acquainted with the general route of this area of development. A mother or a nurse who is too demanding usually is so because she does not know what to expect at a certain age. One rule a mother should observe is that the child learns backwards rather than forwards. He learns to undress before he learns to dress, to take a morsel out of his mouth before he puts one in.

Personal social behaviour is patterned out for each age level in all areas of day-to-day living, eating, sleeping, elimination, dressing,

communication, play, etc. Development in those areas depends to a great extent on training, yet the child should be ready to respond to this training before it can be effective. Orientation of parents to the sequential patterns of development should be given a lot of attention whenever provisions for child care are being planned.

Field Observation

As stated, the above observation of children and mothers was carried out in MCH centres and day-care centres. Such observations as stated here will be limited only to those aspects that are of relevance to the points under discussion, i.e. psychological and social development of the young child.

The emphasis in the MCH centres is based upon the mother-child relationship and general patterns of handling. In day-care centres, the emphasis is on the child among his peers and the effect of his presence in the centre and among other children on different aspects of development.

Mother and Child Health Centres

Children up to the age of two years are taken to the MCH centre either for follow up or for minor ailments. There is usually a long waiting period before they are seen. The place is very crowded and due to the lack of space, children are carried most of the time. They get irritable and fidgety and very noisy. Mothers' attempts towards soothing

the child fall into several categories according to the age of the child and the predisposition of the mother.

1. Breast feeding.
2. Fondling and rocking
3. Threatening (usually using the doctor or nurse as the threatening weapon).
4. Smacking.

Needless to say the last two methods bring the reverse effect. These reactions towards crying children are very common even under different circumstances whatever the cause of crying might be.

Rarely do mothers exchange experience around the children, and if they do they usually play down the abilities of their children or over-emphasize his poor health in fear of the evil eye. The children are all cluttered up with charms.

Such gatherings are hardly ever used to impart knowledge and education on child development and training. This is due to one or more of these reasons:

1. Lack of space and facilities.
2. Shortage of staff in general and trained staff in particular.
3. Lack of integrated planning and actual understanding of the importance of such information and the complete role of the MCH centre.

Day-Care Centres

It is interesting to note that a high percentage of the mothers who attend day-care centres do not work.

In a very small study on mothers of children in a day-care centre in a crowded urban community, about 80% of the mothers stated that they send their children to the centres to gain some educational foundation before the children go to school. Second to that was not having someone to look after the child while the mother is at work. Again, the most outstanding complaint the day-care centres was that the child did not achieve "education" as the parents or mother had expected.

In urban areas, day-care centres are very crowded and lack a playground. The programmes are geared to formal education. Even young three year-old children are subjected to such a programme. Teachers and attendants take great pride in children of three or four who can recite their tables or a verse of the koran. One day-care centre in a very deprived area became particularly popular because it taught English and French!!

Activities other than formal teaching of the three Rs are practically non-existent except for some sessions of story-telling or play activities are very limited due to lack of space. Play has a very low priority for both teachers and parents. There is no special awareness of the role of play in development or in socialization. In

more spacious day-care centres, there is no equipment or play material and the activities in the playground depends very much on the attendents. Even in one day-care centre where some play equipment was provided there was no obvious attempt to organize play among the children, but a lot of quarrelling and it was clear that the children were not trained to share or take turns in using the toys, and in spite of the very strict discipline exercised in the classroom, things went completely out of hand when faced with a new situation.

Development of interests and special abilities is not given a chance as free expression is not encouraged in any way. On the whole, teachers and supervisors are neither qualified nor properly trained for their jobs.

The Ministry of Social Affairs runs a training course for workers in day-care centres but that is not sufficient since the initial choice is not selective at all, and most of the workers are of moderate education who had no chance for further education.

There is a great deal of individual variation found among them. Some are more imaginative than others and these can occasionally attract the children's interest and attention through the way they tell a story or their personal sympathetic touch as they teach.

As usual in a classroom the more advanced children get most of the attention. They act as ego boosters for their teachers. They are

continuously being pointed to as clever children exhibited to visitors and supervisors.

A Study on Perceptual Motor Development of Children in Day-Care Centres

A small study on the development of perceptual motor abilities was carried out on a number of children in day-care centres in different areas in Egypt.

200 children between the ages of 4 to 6 were given a simple drawing test. Each child was asked to draw a boy and then draw a girl. The group was divided into four sub-groups according to age

All the children were free of any physical handicap or obvious mental handicap.

As expected, children's behaviour follows a sequential pattern. One is not expected to notice great variations from the known norms as long as the group under observation represents a normal distribution.

Results of the study did represent a normal distribution in every age group. The children's ability improved as they grew older. This is expected. A few findings, however, are worth noting: (Refer to Tables I through III)

1. All results were significantly lower than the expected norms for the different age groups.
2. Children's performance correlated positively with the standard of the day-Care centre.

3. Children's performance correlated positively with the standard of education of the father.
4. Girls' performance was higher than that of the boys.

Apart from the analysis of the results some further observations should be mentioned: A number of children of all ages were unable to use the pencil properly and some of them have never attempted drawing before. Some children used the rubber to draw and then their attention was drawn to the pencil, a number of children refused to make any attempts and were not encouraged by the rest of the group drawing.

Table I. COMPARISON OF PERFORMANCE OF BOYS
AND GIRLS IN BOTH DAMIETTA AND QUENA
GOVERNORATES ON A DRAWING TASK

	Damietta Governorate				Quena Governorate			
	Girls		Boys		Girls		Boys	
	M	S.D.	M	S.D.	M	S.D.	M	S.D.
Drawing of a boy	50.553	10.807	48.000	8.914	41.176	16.432	39.048	13.604
Drawing of a girl	53.234	8.032	47.433	9.752	44.294	16.872	39.919	14.302
Chronological age	59.468	6.683	58.000	6.267	58.000	6.630	57.806	6.490

Performance level calculated in months.

TABLE (II)

Comparison of Performance of Children
of Different Age Groups in Damietta &
Quena Governorates on a Drawing Task

AGES		Damietta Governorate		Quena Governorate	
		M	S.D.	M	S.D.
4 yrs	drawing a boy	43.440	6.320	37.758	13.927
	drawing a girl	48.120	11.324	39.206	13.251
4 1/2yrs	drawing a boy	50.520	6.555	33.000	10.478
	drawing a girl	48.480	11.246	34.400	10.753
5 yrs	drawing a boy	53.520	8.299	33.333	13.349
	drawing a girl	54.120	7.845	38.000	13.976
5 1/2yrs	drawing a boy	49.320	10.042	55.333	10.780
	drawing a girl	49.920	10.283	58.555	11.780

Performanse level calculated in months.

TABLE (III)

Means & Standard Deviation of
Performance levels of the Whole Group in Damietta &
Quena Shown by Drawing of A boy & a girl

	Damietta		Quena	
	Performance Level		Performance Level	
	M.	S.D.	M.	S.D.
Drawing a girl	50.160	9.440	41.893	15.667
Drawing a boy	49.200	9.931	40.008	14.984
Chronological age	58.690	6.507	57.893	6.554

Interpretation and Significance of Results

Though development as a whole follows a general pattern yet specific abilities are enhanced and developed by training and stimulation. Lack of training is reflected by the present results, and though on the whole performance is lower than expected for the different age levels it is slightly higher under better circumstances and when the home is more stimulating. The better performance of girls can be due to the more household responsibilities that are given to the girls, even at such a young age in the household like cleaning and washing. Though these are not the ideal situations for developing such abilities yet they provide some training and stimulation and enhance the child's ability to observe details.

The preceptual motor development study dealt with only one small aspect of development but it emphasized the importance and need of reviewing the programmes of day-care centres and the value of putting a basis for the minimal standard of qualifications, training and personality traits needed for the staff. Accordingly a detailed study on day-care centers in Damietta and Quena governorates was under taken.

Day Care Centres in Quena and Damietta Governorates

A detailed study was carried out on day-care centres in both Damietta and Quena Governorates to assess the condition and functioning level of these centres. In Damietta Governorate, the study was limited to Faraskour district since it contained eleven day-care centres, while in Quena Governorate the study included 18 centres in more than one district since Deshna had only one day-care centre. The twenty-nine centres in the two Governorates were visited by two teams of research workers who collected information about each centre using Questionnaire No. 4 in addition to unstructured interviews with several workers in these centres and their own observations.

RESULTS OF THE STUDY

Table IV shows that in Damietta Governorate, 45.5% of the eleven surveyed day-care centres have a capacity which can serve 25 to 49 children. Twenty-seven percent of the centres can serve 50 to 74 children and 18.2% can serve 100 to 149 children. In Quena Governorate 50% of the centres can serve 50 to 74 children while one centre (5.5%) can serve more than 300 children.

Table V shows that most (66.7%) of the day-care centres in Quena Governorate were specially built for this purpose, while in Damietta Governorate only 36.4% were specially built as day-care centres. The reason for this difference is due to the fact that most of the day-care centres in Quena Governorate are part of a Combined Unit or a Social Centre, and both are governmental centres originally designed with a day-care centre include. This is also reflected in Table VI which shows that 61.1% of the surveyed day-care centres were found to be owned, while only 54.5% in Damietta Governorate are owned. In both Governorates, centres housed in rented premises belong to voluntary or charity organizations and are supervised by the Ministry of Social Affairs.

The study revealed that more than 80% of the day-care centres in both Governorates have piped in clean water (Table VII), while in Quena Governorate (77.8%) are connected to a sewage system and in Damietta Governorate only 63.6% are connected to such a system (Table VIII).

As regards electricity, 83.3% of the centres in Quena Governorate have electricity while 72.7% of the centres in Damietta have electricity (Table IX). Yet electricity is not really used by these centres since they are only functioning during the day and none of them have a tape recorder or record player or any other electrical equipment.

Table X shows the lack in toilet facilities of most of the centres in both Governorates; 81.8% Damietta and 50% in Quena have only one W.C. which is not sufficient since the average occupancy of these centres is 40 to 50 children. Only one centre in Quena Governorate has 9 W.C.S. This centre is owned by the Islamic Welfare Society. Again most of the centres, 100% in Damietta and 55.5% in Quena have only one bathroom (Table XI). It was noticed that in most centres bathrooms are used as a W.C. especially for girls. In six of the centres (33.3%) in Quena there are no bathrooms.

Table XII shows that in 81.8% of the centres in Damietta Governorate and 72.2% in Quena Governorate, the centre requires a pre-enrollment medical examination which is usually done in the nearest governmental health unit. It was also found that only 18.9% of the centres in Damietta Governorate and 44.4% in Quena Governorate have access to a physician's service who is usually the physician of the nearest governmental health unit (Table XIII). In Damietta Governorate, it was found that the same percentage of centres which have access to a physician's service have also access to the service of a nurse or a health visitor, while in Quena none of the centres have access to such service (Table XIV).

As regards periodical medical examinations, it was found that only 36.4% of the centres in Damietta Governorate do perform periodical medical examinations, while 44.4% in Quena Governorate do the same for their children (Table XV).

It was found that 90.9% of the centres in Damietta Governorate have a unified dress for their children and 94.4% in Quena Governorate have the same (Table XVI) requirement.

One of the most important findings in this study was that there was an almost total lack of educational toys or audio-visual aids or musical instruments and many did not have regular pencils or paper or colouring pencils. Table XVII A, B & C, shows the number of swings, slides and balls in the centres of both governorates. It should be noticed that Table XVIII shows the number of children in various day-care centres in both Governorates. In Damietta Governorate, 45.5% of the centres have 25 to 49 children while 27.3% of the centres have 50 to 74 children. In Quena Governorate, 50% of the centres have 50 to 49 children while 16.66% have 100 to 149 children. In general, the research workers observed that Quena Governorate centres are less crowded than Damietta Governorate centres. As regards meals for children in the day-care centres, Table XIX shows that only one day-care centre in Quena did not give any meals to the children, while 72.7% of the centres in Damietta Governorate gave one meal and 27.3% gave two meals. In Quena Governorate, 94.4% of the centres gave one meal. The research workers observed that the meals were all of the dry type in sandwich form using native bread stuffed with cheese, halawa, fried beans (falafel) or cooked beans (foul medames). In some cases, biscuits or candy are given.

Another sobering finding of the study was that the educational level of workers in these centres is very low. Most centres are staffed with two to three persons. Centres run by private or charitable organizations were found to be staffed with more personnel than those of the Ministry of Social Affairs Table XX. In most of the centres, the educational level of the supervisors did not exceed the preparatory level, and very few were secondary or university level Table XXI. Further almost no proper training in early childhood development was given to the staff of the centres and the staff in large part perpetuated inadequate or unsuitable child rearing practices.

(V) 51847
TABLE IV
CAPACITY OF DAY-CARE CENTRES

No. of centres/ No. of children	Damiötta Governorate		Quenaa Governorate	
	No.	%	No.	%
Not recorded	1	9.0	2	11.1
25 -	5	45.5	-	-
50 -	3	27.3	9	50.0
75 -	-	-	2	11.2
100 -	2	18.2	3	16.7
150 -	-	-	1	5.5
200 -	-	-	-	-
300 -	-	-	1	5.5
TOTAL	11	100	18	100.0

TABLE (V)

Comparison Between Day-Care Centres
Specially Built for This Purpose or not

	Damietta Governorate		Queña Governorate	
	No.	%	No.	%
Specially Built	4	36.4	12	66.7
Not Specially Built	7	63.6	6	33.3
TOTAL	11	100.0	18	100.0

TABLE (VI)

Owned, Rented & Donated Day-Care
Centres

	Damietta Governorate		Queña Governorate	
	No.	%	No.	%
Owned	6	54.5	11	61.1
Rented	5	45.5	7	38.9
Donated	-	-	-	-
TOTAL	11	100.0	18	100.0

(XI) TABLE (VII)

Clean Piped Water in Centre

	Damietta Governorate		Quena Governorate	
	No.	%	No.	%
Piped water	9	81.8	15	83.3
No piped water	2	18.2	3	16.7
TOTAL	11	100.0	18	100.0

TABLE (VIII)

Connection to Sewage System

	Damietta Governorate		Quena Governorate	
	No.	%	No.	%
Connected	7	63.6	14	77.8
Not connected	4	36.4	4	22.2
TOTAL	11	100.0	18	100.0

TABLE (IX)
Electricity in Centres

	Damietta Governorate		Quena Governorate	
	No.	%	No.	%
Electricity	8	72.7	15	83.3
No Electricity	3	27.3	3	16.7
TOTAL	11	100.0	18	100.0

TABLE (X)
Number of Water Closets

	Damietta Governorate		Quena Governorate	
	No.	%	No.	%
One W.C.	9	81.8	9	50.0
Two W.C.s	-	-	6	33.3
Three W.C.s	2	18.2	2	11.1
Nine W.C.s	-	-	-	5.6
TOTAL	11	100.0	18	100.0

TABLE (XI)
Number of Bathrooms

	Damietta Governorate		Quena Governorate	
	No.	%	No.	%
No bathrooms	-	-	6	33.3
One bathroom	11	100.0	10	55.5
Two bathrooms	-	-	1	5.6
Three bathrooms	-	-	1	5.6
TOTAL	11	100.0	18	100.0

TABLE (XII)
Pre-Enrollment Medical Examination

	Damietta Governorate		Quena Governorate	
	No.	%	No.	%
Medical examination	9	81.8	13	72.2
No medical examination	2	18.2	5	27.8
TOTAL	11	100.0	18	100.0

TABLE (XII)

Physician's Service

	Damietta Governorate		Quena Governorate	
	No.	%	No.	%
Physician's service	2	18.9	8	44.4
No physician's service	9	81.1	10	55.6
TOTAL	11	100.0	18	100.0

TABLE(XIV)

Nurse or Health Visitor's Service

	Damietta Governorate		Quena Governorate	
	No.	%	No.	%
Nurse or Health Visitor's Service	2	18.2	0	0
No service	9	81.8	18	100
TOTAL	11	100.0	18	100

TABLE (XV)

Periodical Medical Examination

	Damietta Governorate		Quena Governorate	
	No.	%	No.	%
Periodical medical examination	4	36.4	8	44.4
No periodical medical examination	7	63.4	10	55.6
TOTAL	11	100.0	18	100.0

TABLE (XVI)

Unified Dress for Children

	Damietta Governorate		Quena Governorate	
	No.	%	No.	%
Unified dress	10	90.9	17	94.4
No unified dress	1	9.1	1	5.6
TOTAL	11	100.0	18	100.0

TABLE (XVII)

Playing Equipment

A. Swings

	Damietta Governorate		Quena Governorate	
	No.	%	No.	%
None	3	27.3	2	11.1
One swing	1	9.1	2	11.1
Two swings	4	36.4	10	55.6
Three swings	1	9.1	1	5.6
Four swings	2	18.2	2	11.1
Six swings	-	-	1	5.6
TOTAL	11	100.0	18	100.0

B. Slides

	Damietta Governorate		Quena Governorate	
	No.	%	No.	%
None	7	63.6	16	88.9
One	0	0.0	2	11.1
Two	2	18.2	-	-
Three	0	0.0	-	-
Four	1	9.1	-	-
Nine	1	9.1	-	-
TOTAL	11	100.0	18	100.0

C. Balls

	Damietta Governorate		Quena Governorate	
	No.	%	No.	%
No balls	1	9.1	-	-
One	-	-	1	5.6
Two	-	-	2	11.1
Three	-	-	1	5.6
Four	-	-	2	11.1
Five	2	18.2	1	5.6
Six	1	9.1	4	22.2
Seven	-	-	-	-
Eight	2	18.2	7	38.9
Nine	5	45.5	-	-
TOTAL	11	100.0	18	100.0

Conclusions and Recommendations

This brief expose reflects the immense need of reviewing the services and facilities offered to the social and psychological aspects of development of the young child. The whole field is limited and lacking and inadequate in both research and planning.

The development of studies in the field of child psychology in Egypt dates back to the thirties, when Dr. Ismail El Khasbany attempted to standardize the Simon-Benet tests of intelligence on Egyptian school children. Since then, a number of educational psychologists had followed suit in individual attempts towards adaptation and standardization of other intelligence and ability tests on school children. Most of the work done was in the areas of educational psychology.

Studies in the area of child development attracted very little attention. Some attempts to study specific traits can be found in some desertation, M.A. & Ph. D. theses. However, most of these are isolated attempts and do not furnish the field with any integrated studies especially on the pre-school child.

In 1970, the National Institute for Social and Criminological Studies carried out a detailed study on children's needs. Most of the previous work reviewed in this study deals with adolescents. The study itself defines childhood from conceptions till the age of 18, which is a very wide range if we care to look in particular at the pre-school child; and though this study furnishes the basis for some interesting notions and ideas especially when it deals with parental attitudes, it does not really spell out the actual needs of the pre-school child.

The study of day care centers in Quena and Damietta Governorates clearly shows the need for a scheme or an integrated programme for studies on psychological and social aspects of development of the young child and his need in Egypt is of immense importance at present if a well-integrated national policy for the welfare of the young child is to be functional and effective.

Chapter IV. A Profile of People, Environment and Services in Quena and Damietta Governorates

The purpose of this chapter is to give the reader an insight into the people, environment and services in the two governorates in which the young child study was conducted.

The information presented here is based on the results of the application of Questionnaire 443 to 300 persons in each governorate.

Roughly 65% of the 600 people interviewed in these two governorates were between the ages of 30 and 50. Ninetyfive percent of them were males and 5% females but the women were all interviewed in Damietta governorate and hence they constituted 10% of those interviewed in Damietta governorate.

Overall, most people came from rural areas in the two governorates (63%) and as would also be expected most of them were muslim (90% of the overall sample). The ten percent of the sample who were christians happened all to be residents of Quena governorate reflecting the heavier concentration of christians in Upper Egypt.

The vast majority of persons were married (98%).

About half said they could read and write but only 6.6% of the overall sample had attained intermediate education and an even smaller percentage had attained education beyond the intermediate stage. The apparent high percentage literate

is due to the heavy over representation of males in the sample.

Almost half the sample classified themselves as unskilled labourers (44%) but the over whelming majority said that they had permanent employment. When comparing the two governorates it was found that agriculture as a principal source of employment was cited by 26% of the Damietta sample and by 20% of the Quena sample. Technical/scientific, administrative and clerical jobs were primary jobs for 16% of the Damietta sample and 24% of the Quena sample thus again indicating the over representation of males in the sample.

In terms of income most of the sampled persons had an average family monthly income of roughly twelve Egyptian pounds (£E12) (44% in Damietta and 43% in Quena).

In considering living conditions of the sample it was found that:

1. most (58%) said that they lived in a 2-3 room dwelling; 68% said they owned their dwelling unit though 82% out of the 68% owners were from rural areas where the quality of the dwelling unit may not have been very good.
2. Most people sampled (67%) obtained their clean water from public water taps and relatively few had piped in water. The Damietta sample had relatively more dwellings with piped in water than the Quena sample.

3. Three-fourths of the overall sample lived in dwelling units which were not connected to public sewers but there were sharp differences between the two governorates in this respect with 32% of the Damietta sample being connected as opposed to only 8.8% of the Quena sample.

4. A relatively small proportion of the Quena sample (28%) reported that they had electricity in their homes while roughly 40% of the Damietta sample had electricity in their dwelling units.

In terms of their exposure to and use of mass media (newspapers, radios, T.V. and attendance at movies) it was found that:

1. Out of the 600 persons interviewed in both governorates 186 (31%) said they regularly read newspapers while 49% said they did not read newspapers at all. Almost 20% of the sample said they read newspapers occasionally. Naturally the highest percentage of those who do not read newspapers at all or those who read them occasionally were in rural areas of both governorates. Yet there were relatively more readers in Damietta.
2. More than 68% of the interviewed persons said that they regularly listen to the radio and 24% said that they sometimes listen to the radio. Only 8% said they never listen to the radio. Of those who reported listening regularly to the radio a higher percentage were from Damietta.

3. Out of the 600 persons in the sample only 140(23%) said that they regularly watch T.V. which is almost equal to 1/3 of those who regularly listen to the radio. The percentage of those who said that they sometimes watched T.V. amounted to 21%. In general these results mean that the radio should be given more attention than T.V. as a mass communication means. Only 82 persons (8.6%) of the sample owned a T.V. set while the rest who said they do watch T.V. are doing so through relatives, friends, clubs, information centers or coffee shops. T.V. watchers were more prominent in the Damietta sample.

4. Only 19 persons out of hte 600 (3%) said that they regularly go to the movies, while 11% said they occasionally go to the movies, and 87% said they never go. Those who did go tended to be residents of Damietta.

It is worth noting that most people said that they spend their leisure time at home (67%) while only 10% cited the coffee shop as the site of their leisure time. Interestingly, 13% of the overall sample stated that they spent their leisure time in the mosque or church. Only 18% of the overall sample said that they went regularly to a club but the highest percentage of those who did so were in urban Damietta.

Hence we can conclude that though the persons sampled in Quena and Damietta are roughly of the same composition in terms of age, sex, literacy, education, income and employment, the Damietta people were relatively better off in terms of living conditions as indicated by dwelling unit amenities. The Damietta sample also exhibited slightly more exposure to mass media than the Quena sample and tended to give places other than the home as sites for spending leisure time slightly more than did the Quena respondents.

The 600 persons constituting the Damietta and Quena governorate sample were asked questions pertaining to:

1. The closeness of health services to their residence;
2. Most common methods of transportation they used;
3. The health services they most commonly used;
4. Whether or not they were using Birth control pills and where they obtained their pill supplies;
5. Their opinion about the day care centers;
6. Their attitudes toward primary and post primary education for children.

In order to obtain information about their utilization of health services and their attitudes toward existing services for young children.

1. Closeness of Health Service Facilities :

It was found that 79.3% of interviewed person said

that health facilities are close to their homes while 20.7% said the opposite. It is interesting that in Damietta Governorate the percentage of those who said that the health facilities were not close to their houses is (1%) in urban areas and (30%) in rural areas while in Quena the opposite situation was demonstrated by the analysis of the interviewed responses of the persons in this governorate.

2. The public bus was most frequently cited as the most common means of transportation used by the overall sample. But just about half of the rural residents in Quena cited animal back as their most common means of transportation.

3. Health Services most commonly used :

It was found that 510 out of the 600 persons interviewed i.e. 85% use government health facilities either hospitals or health units. It should be noted that in rural areas health units represent the main government health facility while in urban areas hospitals are the main government health facility. In Damietta governorate the percentage of persons who said they use the services of a private physician is much higher than the same category of persons in Quena governorate 19% in urban Damietta & 10.5% in rural Damietta compared to (0.25%) in urban Quena and 6.6% in rural Quena. A very small percentage of person not exceeding 0.25 of the interviewed

persons in both governorates said that they still use the services of barbers and other traditional healers for health problems (Table I).

4. It was interesting to note that 48% of the Damietta respondents said they are using Birth control pills as opposed to only 16% of the Quena respondents. In Damietta out of those reporting birth control pill usage, 73% said they get their supplies from the family planning service while only 32% of Quena pill users cited the family planning service as their source of supply. Since the respondents were not asked about other methods of birth control they might be using information on IUD wearers or users of other methods was not available.

5. Opinion about day-care centres :

(Table 11) shows that 62.8% of interviewed persons indicated that day-care centres services were satisfactory, while 37.2% said it was not satisfactory. The reasons mentioned for the services being unsatisfactory centred around:

1. Lack of educational activities
2. inadequacy of meals given in the day care centres.

The highest percentage of unsatisfied persons were in Damietta urban, rural & Quena rural 42%, 23.3% and 38.8% respectively.

6. Attitude Towards Post Primary Education for Children:

Table 111 shows that roughly 78% of total answers obtained in both governorates indicated a positive attitude towards post primary education of their children. Only 6.1% of the answers reflected negative attitudes while 15.7% were indifferent. The highest percentage of those who showed positive attitudes was in urban Damietta (94%) followed by rural Damietta (86.5%) then urban Quena (84.2%) and lastly rural Quena (81.1%). These results certainly reflect the high value that people attach to education nowadays in Egypt.

In general then we can conclude that in a representative sample (except for the overrepresentation of males) of rural and urban residents in Damietta and Quena governorates:

1. More than 85% of the respondents tend to use government health facilities and clinics or if they can afford it private doctors;
2. The majority reported that health facilities are relatively close to their place of residence and that public buses and animals are their major means of transportation;
3. Less than half of the overall sample was using birth control pills but that more than half of the users obtained their pills from the family planning service;

4. Almost twothirds reported being satisfied with Day Care Center services but that those who were dissatisfied had very specific complaints i.e., lack of educational activities and inadequacy of meals, indicating that at least among the minority there is an awareness of the generally poor programs of most day care centers in these governorates.
5. More than three fourths of the sample indicated that they were in favour of primary and post-primary education for their children.
The limitations of this profile study are mainly that: information on what the respondents used the government health services for was not collected; information on whether those who expressed a positive attitude toward primary and post-primary education for their children actually had children currently enrolled at these levels or not was lacking.

Governorate		District Governorate	
U (%)	R (%)	U (%)	R (%)
35 (38)	117 (28.2)	35 (38)	117 (28.2)
45 (45)	83 (41.2)	45 (45)	83 (41.2)
100 (100)	200 (100)	100 (100)	200 (100)

Table 1.

HEALTH SERVICES MOST COMMONLY

USED

	<u>Damietta Governorate</u>		<u>Quena Governorate</u>	
	U (%)	R(%)	U (%)	R (%)
Government Hospital	60 (60)	95 (47.5)	87 (72.5)	45(25.0)
Government Health Unit	2 (2)	97 (48.5)	2 (1.66)	122(67.0)
Factories' physician	19 (19)	4 (2)	1 (0.83)	0(0)
Private physician	19 (19)	21 (10.5)	30 (0.25)	12(6.6)
Barber other traditional healers	0 (0)	1 (0.5)	0(0)	1(0.5)
	100 (100)	200 (100)	120(100)	180(100)

Table 11.

OPINION ABOUT DAY-CARE CENTRES

	<u>Damietta Governorate</u>		<u>Quena Governorate</u>	
	U (%)	R (%)	U (%)	R (%)
Satisfactory	58 (58)	117 (58.5)	92(76.66)	110(61.0)
Not satisfactory	42 (42)	83 (41.5)	28(23.33)	70(38.0)
	100(100)	200 (100)	120(100)	180(100)

Table 111.

Attitude Towards Post Primary Education
for Children

Attitude	Damietta Governorate				Quena Governorate			
	Urban		Rural		Urban		Rural	
	H	%	H	%	H	%	H	%
Positive	94	(94)	173	(86.5)	101	(84.2)	146	(81.1)
Negative	4	(04)	18	(09.0)	3	(02.5)	12	(06.6)
Indifferent	2	(02)	9	(04.5)	16	(13.3)	22	(12.3)
TOTAL	100	(100)	200	(100.0)	120	(100.0)	180	(100.0)

- 30 -

Chapter V. Environmental Profile of

Faraskour and Doshna

Faraskour City, Damietta Governorate

There are three main cities in Damietta Province. One of them is Faraskour with ^{21,200} people or 15.8% of the total urban population.

Table I- Population in Damietta Province
as of 1971

	<u>Urban</u>	<u>Rural</u>	<u>Total</u>
Damietta	101,100	123,200	224,300
Faraskour	21,200	132,100	153,300
Kafr-Saad	12,000	94,400	106,400
T O T A L	134,300	349,700	484,000

The natural rate of population growth was about 1.88% in 1969 but there are in addition 5,000 migrants from the Suez Canal region. Most of the 4,000 housing units in the city are built of burned bricks which resist the humidity due to the high subsoil water level. Although a great proportion of the production manpower in the city work in commerce or local industries, yet the community has the semi-rural features. The median family income is relatively higher than Doshna in Quena Province. First grade roads and railways link the city

with other provincial cities as well as with other provinces. City streets are wider than those of Dushna town and about 42% of the total city street area are paved. A total of 87,000 sq.m. of streets exist inside the city. The unpaved streets are considered to be of better condition than those in Dushna City. Electricity is available for governmental as well as private use.

Existing Governmental Services:

Numbers

- 1 Health Administration
- 1 Health Office
- 1 General Hospital
- 1 Tropical Disease Hospital
- 1 Tropical Disease Hospital
- 1 MCH Centre
- 1 School Health Unit
- 1 Bilharzial Control Unit
- 1 Malaria Control Unit
- 9 Primary Schools
- 2 General Secondary Schools
- 2 General Preparatory Schools
- 3 Technical Secondary Schools
- 1 Fire Station
- 1 Police Station
- 1 City Council

Existing Basic Sanitary Measures:

A. Water Supply:

Surface treated chlorinated water from a treatment plant located near Daniotta city, is the main source for drinking water and of water for other domestic uses. Water meets the drinking water standards set by the health authority. Underground sources are not suitable for such purposes because of quality problems due to high salt content of such waters. There is a distribution network pipe system which covers most parts of the city. About 85% of housing units are connected to the network. There are 8 public water stands scattered all over the city used by the inhabitants.

B. Sewage Disposal:

There is no public sewage system in the city. Because of the high subsoil water level, the local authority has established a sub-soil tile system covering various parts of the city to lower the water level but the inhabitants misused the system and tied their homes to the tile system. About 30% of the homes are tied to the subsoil drainage system and hence it has been converted illegally and is actually a sewerage system carrying human wastes of 50% of the total inhabitants. The subsoil tile systems end at 2 points each at one of the irrigation drains which converge to one main drain that pass finally to a brackish lake "Manzala", 6 kilometres north of

the city. Other homes which have no connections to the tile systems use either septic tanks or an impermeable type of latrine. Due to the high level of subsoil water, overflow of sewage is a common complaint. The city council is responsible for hauling-away the overflow of sewage in homes or streets. The council has 4 animal-driven cars each of one cubic metre capacity and 2 motor vehicles each of 4 cu.m. capacity. There are no sanitary methods for final disposal of the hauled-away sewage except by discharging them into the irrigation drains causing pollutional problems and health hazards.

• Municipal Solid Wastes:

Municipal solid waste disposal is the responsibility of the local city council, including street sweeping and waste collection. Twenty-five collection personnel use 8 animal-driven cars and one motor vehicle for collection and transportation of wastes. Dumping and open burning in a public dumping area, are the methods of disposal and another method is filling-in low lands.

• Other Facilities:

1. Due to the absence of public toilets for public use, people deprived of toilet facilities use those present in 14 mosques inside the city.
2. There is one slaughter house.

Current Sanitary Problems:

1. 15% of inhabitants have their have their homes unconnected to the water distribution system.
2. The Number of public water stands is not sufficient.
3. Lack of public sewerage system.
4. Overflow of sewage.
5. Lack of hauling-away sewage facilities.
6. Absence of public toilets.
7. Insufficient number of municipal solid waste collection personnel.
8. Lack of public refuse containers.
9. Insufficient collection equipment.
10. Water pollution problems in the drains and the lake of Manzala
11. Breeding problems of mosquitoes and flie.
12. Unsanitary disposal of sewage and refuse.

Deshna, Quena Governorate

Deshna town is one of eight cities and towns in Quena Governorate and is located 30 km. north of Quena City, the capital. It has 25,000 inhabitants or 8% of the total urban population in the Governorate. The main occupation is agriculture followed by trade. The town has transportation facilities to other parts of the governorate by railways and roads. There are several governmental services including health services, curative and preventive. Most of the

private buildings in the town are constructed from unburned bricks and mud with few multi story buildings. Streets and roads inside the town are dusty, unpaved and narrow with the exception of main roads. Despite the presence of a newly constructed sugar-cane industrial complex in the most southern part of the town, Doshna is basically semi-rural.

The town is 3 km long and one km wide and is located along the main railway and road connecting the town with other governorates. There are about 3,000 houses. The principal services are as follows: 1 general hospital; 1 MCH center; 1 school health unit; 1 health office; 7 primary schools; 2 preparatory schools; 1 secondary school; 1 fire station; 1 city council and other local services; 1 police station; 1 sugar-cane industrial complex. There are 18,000 sq. meters of paved roads.

BASIC SANITARY FACILITIES:

A- Water Supply:

The main water supply for public uses is from underground sources. Waters are meeting drinking water standards but there are some quality problems related to taste and salt content. For this reason inhabitants occasionally use unsafe sources for example untreated waters from canals. The distribution net-work covers most of the town but due to the nature of building materials and lack of a public sewerage system

Only 10% of the homes are connected to the distribution system.

It is estimated that 80% of the homes are built from mud and unburned bricks which are not suitable for connections. For this reason there are five public water stands scattered in the town for public usage or 1 public stand for 800 families. Moreover, not all of them are in good operating condition due to lack of maintenance and this fact raises the number of families per one public stand. Per capita water consumption amounts to 60 liters per day compared with 35 in villages and 120 in other towns.

B- Sewage Disposal Measures:

There is no public sewerage system in the town nor in the governorate. Homes with running water, have septic tanks systems for sewage disposal, 25% of homes have latrines of Rockfler type, and the remaining have no sanitary means for sewage disposal. Due to the high level of sub-soil water, over-flow of sewage from septic tanks is a problem inside the town. Hauling-away sewage equipment is difficult. There are only 2 animal driven cars each of 1 cu.m. capacity and are not coping with quantity of sewage to be hauled-away. Moreover, there are no special local nor sanitary way for disposal of the hauled-away sewage usually it is dumped in the organic fertilizer, but this method results in breeding of flies. Moreover, pollution of the existing water-ways is

an fact. Usage of dried sewage as fertilizer causes the spread of parasitic disease; Ascariasis, soil and vegetable contamination.

C- Solid Wastes Disposal Facilities:

Municipal solid waste disposal is the responsibility of local city council, including street sweeping and waste collection. Collection personnel are 85 in number or one person for 2500 sq.m. and 3 collecting cars. There is no special dumping area, but refuse is disposed by filling-in low land.

D- Other Facilities:

1. There are two public water closets for public use together with fourteen toilets in mosques.
2. There is one slaughter house which needs repair and maintenance of the existing waste treatment facilities.
3. There are three water-spray cars used in wetting the dust in the unpaved streets.

E- Health Aspects:

The following figures shows some of the health indices in the town:

Table II. Health Indices - Deshna Town Quena Governorate

	1971	1972
Population	24,000	25,000
Births/1,000	42.5	51
Infant mortality due to diarrheal diseases	160	159
Deaths from diarrheal diseases as percent of total infant deaths	82%	61%
Crude death rate	17.1	18
Infant deaths as percent of total deaths	39%	35.2%
Prevalence of infectious hepatitis	1.13	1.64
Prevalence of Bilharzia	15.5	22
Prevalence of Ascariasis%	0.9	0.6
Prevalence of Ankylostomiasis%	18.2	10.3
Prevalence of other parasitic diseases	8.2	7.3
Prevalence of all parasitic diseases	27.3	18.2

Table III. Vital Health Indices in Deshna and Faraskour and other Egyptian Cities (1969)

	Danietta	Governorate	Quena G.	Cairo G.
	Danietta	Faraskour	Deshna	Cairo
Population	93,200	19,400	24,000	4,502,900
Births/1,000	30.6	27.5	42.5	32.5
Infant mortality/1,000	86	86	192	142
Infant deaths as % of total deaths	27%	27%	39%	38%

Discussion

Deshna has a lower level of sanitation than Faraskour. It appears that health indices in Faraskour are better even than those in Cairo, the capital city. Faraskour has a lower ratio of infant deaths to total deaths. This can in part be attributed to the higher level of family income and education and relatively higher level of sanitation. Table III gives some vital health indices for Faraskour and Deshna as well as for other Egyptian cities.

The most prevalent and problematic diseases in the study areas of Deshna and Faraskour are those of the oral-fecal type namely, typhoid, infectious hepatitis, diarrheal diseases parasitic diseases and bilharziasis. The prevalence of such diseases is indicative of the low level of sanitation, inadequate sanitary measures and the need for more health education to change the behaviour and attitudes of the populations at risk. Table IV indicates that Faraskour has higher rates than the other two cities in Danielta Province and in other cities as well.

Table IV. Prevalent Diseases in Selected Cities. Cases/100, 000(1972)

	Danielta G.			Quena G.	Cairo G.	ALL
	Faraskour	Danielta	Kafr Saad	Deshna	Cairo	EGYPT
Typhoid	237	50	33	600	116	29
Infectious						
Hepatitis	770	170	210	113	55	58

From Table IV one can compare the cities of Danielta governorate with Doshna and the national prevalence figures. In the cities of Danielta viral hepatitis is considered a major problem. Probably this is due to a water pollution problem where chlorine added to the drinking water is not present in sufficient quantities to inactivate the virus.

Faraskour with a relatively low level of sanitation adds to the problems. Only Doshna has a typhoid rate higher than Faraskour. This is most probably due to the fact that Doshna residents use untreated surface waters from which the risk of incurring water borne diseases is much higher.

The low level of sanitation in most of the cities is a potential source of contamination of soil, food and water with fecal materials that contain the ova of parasitic diseases. Unfortunately figures for parasitic diseases in Faraskour were not obtained but Table V gives some idea of their prevalence using Danielta Governorate as a whole and comparing it with Doshna.

Table V. Prevalence of Parasitic Diseases in Danielta Governorate and Doshna Town in Quena Governorate (1972)

	<u>Danietta Governorate</u>		<u>Doshna Town Quena G.</u>	
	<u>Rural</u>	<u>Urban</u>	<u>Rural</u>	<u>Urban</u>
Bilharziasis %	41.5	7.6	22	14
Intestinal Parasitic Diseases	46.8	53.5	18.2	2.4

This brief profile of environmental conditions in the two areas under study indicate that young Egyptian children in these areas will be subject to the ravages of infectious and parasitic diseases which are due to the relatively poor level of environmental sanitation and to inappropriate health behaviour patterns which exacerbate the poor environmental conditions.

Chapter VI

The Young Egyptian Child in Doshna, Quena and Faraskour Districts: A Comparative Study

Introduction

The basic hypothesis of the study is that the independent variables: family socioeconomic level; environmental and family living conditions; family health history; and beliefs and practices associated with major life crises (e.g. pregnancy, birth, infancy and childhood) are the principle factors which can be used to explain and predict the health status of the young Egyptian child aged 0-5.

For reasons cited previously Doshna, Quena, and Faraskour districts were chosen as the sites for the study. This chapter contains an analytical description of the areas with respect to the variables listed above. Conclusions about the effect of these variables on the survival, growth and development of the young child in Faraskour, Doshna and Quena districts are based on the results obtained in the interviews with the mothers and on the medical evaluation of the children sampled.

In the comparative study of Faraskour, Quena and Doshna districts an attempt has been made to study beliefs, practices and environment affecting the birth, infancy and early childhood of the young Egyptian child. Hence the analysis of the data proceeds in the following order:

(1) Socioeconomic status of the families with which the young child lives as indicated by:

- a. parent's level of education;
- b. Job of Head of household - father;
- c. mothers job;
- d. monthly family income;
- e. sources of income;
- f. number of children per family;
- g. Housing :
 1. ownership.
 2. rooms per house.
 3. amount of house rent.

(2) Family living conditions as indicated by:

- a. source of clean water;
- b. method of sewage disposal;
- c. Breeding of poultry inside dwelling unit;
- d. breeding of other domestic animals & location of animal shed (s);
- e. means of lighting;
- f. cooking methods and utensils.

(3) Health Status of the Family

- a. family health status
 1. history of family diseases
 2. congenital diseases
- b. pregnancy and birth and beliefs and practices associated with these two events
- c. child rearing practices.

(4) Health status of the young child as indicated by:

- a. height and weight analysis;
- b. vaccinations;
- c. history of gastro-intestinal diseases and diarrheal diseases;
- d. prevalent diseases.

Methodology

The information presented below ^{was} obtained by applying a questionnaire to obtain data on 1,250 young children in Faraskour, Quena, and Doshna districts. The sample was drawn mainly from MCH centers, rural health units and day care centers since these are the main sites at which one can get a reasonable number of children. The mothers of the children were interviewed by the physician, the nurse and the social worker who formed the core of the field research team assisted by a lab technician. The team visited the different centers in each of the three districts and used a micro-bus for transportation. One team worked in each district throughout the one and a half months during which the field work was conducted. Both teams were given a two day orientation by the Director of the study and two research assistants joined the team during the field work in order to review the collected information and prepare it for data processing. At the end of the study the size of the sample was reduced to 1,100 since 150 questionnaires had to be discarded due to the fact that they lacked five or more items of information. Thus the results presented here are derived from the interviews (with child's mother) and examinations of the children included in the sample.

Home observations by social workers were very limited since they did not exceed 10% of the Faraskour sample nor 5% of the Doshna sample. It should be mentioned that in case a child was examined and found to need medical treatment such treatment was provided by the examining physician. In addition Supramine was given to those children who needed it. It was also used to attract mothers to the MCH centers.

Table I shows the classification of the sample by age groups in Faraskour, Quena and Doshna. The research team in Quena governorate did not report cases below one year of age while in Faraskour 28 cases were examined in urban areas and 50 cases in rural areas. The table shows that 79% of the cases in urban areas fall between the ages 3,4 and 5 while in the rural areas 67.8% of the cases fell in the same age groups.

Table I. CLASSIFICATION BY AGE GROUP

A G E (years)	Faraskour		Quena		Deshna		Sub- Total		GRAND TOTAL		
	U	R	U	R	U	R	U	R	U	R	Total
1	28 (20.6)	50 (18.9)	-	-	-	-	-	-	28 (6.3)	50 (7.6)	78 (7.2)
2	26 (19.1)	22 (8.3)	2 (1.5)	14 (5.4)	4	18 (13.4)	6 (2)	32 (8.1)	32 (7.2)	54 (8.2)	86 (7.8)
3	16 (11.7)	32 (12.1)	42 (30.0)	80 (30.8)	22 (13.2)	36 (26.9)	64 (20.9)	116 (29.4)	80 (18.0)	148 (22.5)	228 (20.7)
4	18 (13.2)	30 (11.4)	60 (42.8)	86 (33.0)	46 (27.7)	32 (23.9)	106 (34.6)	118 (29.9)	124 (28.0)	148 (22.5)	272 (24.7)
5	16 (11.6)	34 (12.9)	36 (25.7)	80 (30.8)	94 (56.6)	36 (26.9)	130 (42.5)	116 (29.9)	146 (33.0)	150 (22.8)	296 (25.9)
6	6 (4.4)	18 (6.8)	-	-	-	12 (8.9)	-	12 (3.2)	6 (1.6)	30 (4.5)	36 (3.3)
N.K.	26	78 (29.6)	-	-	-	-	-	-	26 (5.9)	78 (11.9)	104 (9.4)
TOTAL	136 (100)	264 (100)	140 (100)	260 (100)	166 (100)	134 (100)	306 (100)	394 (100)	442 (100)	658 (100)	1100 (100)

Socioeconomic Status of Families of the Young Child in Doshna,
Quena and Faraskour Districts

Parent's level of education - Table II shows that illiteracy among mothers varied between 32.8% and 83.8% in Quena and Faraskour urban, and between 83.6% and 96.9% in Doshna and Quena rural respectively. In all urban areas of the study 58.4% of the mothers were illiterate while in rural areas the percentage increased to 89.4% of the cases. Illiterate fathers in urban areas represented 24.4% of the cases and 54.4% of the cases in the rural areas. The percentage of parents with middle level education in urban areas was 7.2% among the mothers and 21.3% among the fathers, i.e., almost triple that for the mothers. In rural areas the percentage was 6% for fathers and 1.2% for mothers. University level education of the sample included 9% of the fathers in urban areas, most of them in Quena (7%) and Doshna (2%). In rural areas the percentage of fathers with university education did not exceed 1.8% and for mothers did not exceed 0.6%.

Job of Family Supporter - Table III shows that 31.6% of the fathers in the total sample were non-skilled workers while 30.7% were working in agriculture as farmers and 11.8% in commercial activities. Both Faraskour (47.0%) and Doshna (42%) samples showed a high component of unskilled workers while Quena sample showed a high percentage of farmers working on their own farms. Doshna sample showed a relatively high percentage of persons working in commerce (25%). Unemployment in the sample did not exceed 2%.

Mother's Job - Table IV shows that only 18% of the mothers were employed outside the home. Eighty-two percent were housewives. Out of the 198 women with jobs in the total sample 26.3% were in urban areas and 83.7% in rural areas. The highest percentage of employed women lived in Faraskour rural while the lowest percentage were from Quena urban.

Monthly Family Income in Egyptian Pounds (£E) - The distribution of the sample according to family income per month revealed that 62% of the sample from rural Quena had a monthly family income of less than £E 5 per month as compared to 20% in rural Faraskour. The following figures represent the average income of 50% of the families included in the sample:

Study area	Average Monthly Family Income
Quena rural	4.5 £E
Faraskour rural	8.0
Faraskour Urban	9.5
Deshna urban	19.0
Quena urban	28.0
Deshna rural	30.0

The relatively high income in Deshna urban and rural and in urban Quena is due to the high percentage of farm owners and merchants as well as government employees included in the samples drawn from these areas.

Source of Income - Most of the people in the study sample (74.7% urban and 92.5% rural) earned their total family income from work only. Slightly less than 3% derived their incomes from pensions alone. Social assistance provided income for 2.3% of the families in the urban areas and 1.5% in the rural areas. Only 2.3% in the urban areas and 2% in the rural areas stated that they drew their income from private ownership along.

Further analysis of source-of-income data for the three study areas showed that the highest percentage of families in the sample who have income from special sources live in urban Doshna (37.3%) followed by urban Faraskour (16.2%). Most (87%) of the families in the study sample stated that they lived on their incomes only while 13% stated that they received financial assistance from time to time. Seventy-nine percent of the respondents in urban Faraskour and 68.2% in rural Faraskour have irregular income while 91.5% in rural Qena and 47.8% in rural Doshna have irregular income.

Number of Children per Family - Table V presents a frequency distribution of the number of children per family of the various study families. An analysis of the average family size showed that rural Qena had the biggest family size (4 children) while Qena urban had the smallest (3.1 children). Faraskour's urban average was 3.75 children per family and 3.9 for the rural areas while Doshna urban areas had 3.64 and rural areas 3.36.

Housing - Table VI shows that in the total sample 59% owned and 40.2% rented their homes. The highest percentage of home owners lived in urban Doshna and the lowest in Quena urban areas.

Most of the families in the sample (59.4% see Table VII) lived in dwelling units of between 2-4 rooms while 28.4% lived in one room dwelling units and 9% in 5-6 room units. The average number of rooms per family was found to be 2.42 for the overall sample. For Faraskour rural the average was 1.87 and for Doshna rural it reached 4.22. In urban Faraskour 51.5% of the study sample lived in two room dwelling units while 40.9% of the rural Faraskour respondents lived in the same type of houses. In urban Quena 62.9% lived in three room dwelling units while in rural Quena 75.3% lived in one room dwelling units. In urban Doshna 24.2% lived in two room dwelling units while 41.7% of the rural sample of Doshna lived in 4 room dwelling units. The percentage of families which lived in dwelling units of 5-6 rooms was 2.5% in Faraskour urban and rural, 1% in Quena and 28.7% in Doshna urban and rural. In Doshna rural sample 38.8% lived in 5 room dwelling units. Another way of looking at the number of rooms in which families included in the sample lived in is as follows:

In urban areas:

1. 66% lived in 2 or 3 room houses out of whom 43% were in Quena 30% in Faraskour and 27% in Doshna.
2. 11% lived in 1 room out of whom 64% were in Faraskour, 36% in Doshna and none in Quena.

3. 9% lived in 4 rooms of whom 50% were in Doshna, 35% in Quena and 15% in Faraskour.

4. 7% lived in 5 rooms or more ^{of} whom 94% were in Doshna.

In rural areas%

1. 40% lived in one room of whom 75% were in Quena and 25% in Faraskour.

2. 38% lived in 2-3 rooms of whom 70% were in Faraskour.

3. 12% lived in 4 rooms of whom 72% were in Doshna.

4. 10% lived in 5 rooms or more of whom 82% were in Doshna.

Not all dwelling units were of the same quality of course. Some attempt is made to indicate different qualities of dwelling in the section entitled Living Conditions.

House Rent - Another measure of socioeconomic status was considered. Analysis showed that:

50% of the cases of renting families included in the sample from rural Faraskour and rural Doshna paid on the average of one pound per month rent for their dwelling unit; that

50% of the renters in urban Faraskour and rural Quena paid one and a half pounds per month on the average; that

50% of the renters from urban Doshna paid on the average two and a half pounds rent; and that

50% of the renters from urban Quena paid on the average three and a half pounds monthly rent.

Comparison of Study Area Families in Terms of Socioeconomic
Status Using a Composite Index

If one makes a compound index using the data presented in Table VIII which compares the study areas in terms of family size (i.e. average number of children/family); per capita income per month; and average number of rooms per family, and assigns the highest number of points to the least desirable situation (e.g. 6 points for the largest average number of children) and the lowest number of points to the most desirable situation one can rank the study areas and score them according to their least-best overall socioeconomic status.

Table II. LEVEL OF EDUCATION

	URBAN						RURAL					
	Faraskour		Quena		Deshna		Farakour		Quena		Deshna	
	F [±]	M ^{±±}	F	M	F	M	F	M	F	M	F	M
Illiterate	82 (60.2)	114 (83.8)	8 (5.7)	46 (32.8)	18 (10.3)	98 (59.0)	142 (53.8)	224 (84.8)	202 (77.7)	252 (96.9)	14 (10.4)	112 (83.6)
Read & Write	50 (36.8)	20 (14.7)	38 (27.1)	62 (44.3)	102 61.4	60 (36.1)	110 41.7	34 (12.9)	10 (3.8)	6 (2.3)	84 (62.7)	16 (11.9)
Middle certificate	2 (1.5)	2 (1.5)	64 (45.7)	22 (15.7)	28 16.9	8 (4.9)	4 (1.5)	4 (1.5)	14 (5.4)	-	22 (16.4)	4 (2.9)
University certificate	-	-	28 (20.0)	6 (4.2)	12 (7.2)	-	-	-	2 (0.8)	2 (0.8)	10 (7.5)	2 (1.6)
N.K.	2 (1.5)	-	2 (1.5)	4 (3.0)	6 (3.7)	-	8 (3.0)	2 (0.8)	32 (12.3)	-	4 (3.0)	-
T O T A L	136 (100)	136 (100)	140 (100)	140 (100)	166 (100)	166 (100)	264 (100)	264 (100)	264 (100)	264 (100)	134 (100)	134 (100)

Table III. JOB OF FAMILY SUPPORTER "FATHER"

	Faraskour			Quena			Deshna			Total		
	U	R	S.T.	U	R	S.T.	U.	R	S.T.	U	R	G.T.
Scientific	-	-	-	24	6	30	12	4	16	36	10	46
Administrative	-	-	-	26	-	26	10	8	18	36	8	44
Clerical	2	6	6	40	8	48	16	12	28	58	26	84
Commercial	20	16	36	16	2	18	34	42	76	70	60	130
	(14.7)	6.0	(9.0)	(11.4)	0.8	(4.5)	(20.5)	(31.3)	25.3	(15.8)	9.1	(11.8)
Agricultural	22	112	134	2	194	396	2	6	8	26	312	338
	(16.2)	42.4	33.5	(1.4)	74.6	(99.0)	(1.2)	(4.5)	(2.7)	(5.9)	(47.4)	(30.7)
Worker	80	108	188	22	12	34	70	56	126	172	176	348
	(58.8)	40.9	47.0	(15.7)	4.5	(8.5)	(42.1)	(41.8)	42.0	(38.9)	(26.7)	(31.6)
Milit/Police	2	12	14	8	-	8	4	2	6	14	14	28
Pension	-	2	2	-	-	-	4	-	4	4	2	6
Jobless	8	-	8	-	6	6	8	-	8	16	6	22
N.K.	2	8	10	2	32	34	6	4	10	10	44	54
TOTAL	136	264	400	140	260	400	166	134	300	442	658	1100
	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)

Table IV. MOTHER'S JOB

	With Job			Jobless			T O T A L		
	U	R	S.T.	U	R	S.T.	U.	R	G.T.
Faraskour	8 (20)	32 (80)	40 (100)	128 (35.5)	232 (64.5)	360 (100)	136 (34)	264 (66)	400 (36.4)
Quena	34 (24.6)	104 (75.4)	138 (100)	106 (40.5)	156 (59.5)	262 (100)	140 (35)	260 (65)	400 (36.4)
Deshna	10 (50.0)	10 (50.0)	20 (100)	156 (55.7)	124 (44.3)	280 (100)	166 (55.3)	134 (44.7)	300 (27.2)
T O T A L	52 (26.3)	146 (73.7)	198 (100)	390 (43.2)	512 (56.8)	902 (100)	442 (40.2)	658 (59.8)	1100 (100)

Table V: Number of Children per Family

No. of Children	F a r a s k o u z			U R B A N			D e s h n a		
	N	CF	%	N	CF	%	N	CF	%
1	12	12	(9)	8	8	(6)	-	-	(0)
2	30	42	(31)	36	44	(32)	50	50	(30)
3	22	64	(47)	52	96	(69)	42	92	(56)
4	30	94	(69)	26	122	(87)	32	124	(75)
5	14	108	(80)	16	138	(98)	16	140	(85)
6	12	120	(88)	-	138	(98)	16	156	(94)
7	4	124	(92)	2	140	(100)	6	162	(98)
8	6	130	(96)	-	140	(100)	4	166	(100)
9	6	136	(100)	-	140	(100)	-	166	(100)
TOTAL	136			140			166		
R U R A L									
1	32	32	(12)	4	4	(2)	14	14	(10)
2	60	92	(35)	38	42	(16)	28	42	(31)
3	36	128	(49)	54	96	(37)	42	84	(63)
4	56	184	(70)	68	164	(63)	22	104	(79)
5	22	206	(78)	64	228	(87)	10	116	(87)
6	30	236	(90)	22	250	(96)	12	128	(96)
7	14	250	(95)	8	258	(99)	4	132	(99)
8	8	258	(98)	-	258	(99)	2	134	(100)
9	6	264	(100)	2	260	(100)	-	134	(100)
TOTAL	264			260			134		

Table VI. HOUSING

	Faraskour		Quena		Deshna		T O T A L		
	U	R	U	R	U	R	U	R	G.T.
N.K	-	-	-	-	-	8 (5.9)	-	8 (1.3)	8 (0.8)
Owned	60 (44.1)	188 (71.2)	6 (4.3)	142 (44.6)	130 (78.4)	124 (92.5)	196 (44.4)	454 (68.9)	650 (59.0)
Rented	76 (55.9)	76 (28.8)	134 (95.7)	118 (45.4)	36 (21.6)	2 (1.6)	246 (55.6)	196 (29.8)	442 (40.2)
T O T A L	136 (100)	264 (100)	140 (100)	260 (100)	166 (100)	134 (100)	442 (100)	658 (100)	1100 (100)

Table VII. ROOMS PER HOUSE

R o o m s	Faraskour			Quena			Dechna			T O T A L		
	U	R	S.T.	U	R	S.T.	U	R	S.T.	U	R	S.T.
N.K.	10	2	12	-	-	-	20	2	22	30	4	34
1	32 (23.5)	66 (25.0)	98 (24.5)	-	196 (75.3)	196 (49.0)	18	-	18 (6.0)	50 (11.3)	262 (39.8)	312 (28.4)
2	70 (51.5)	108 (40.9)	178 (44.5)	38 (27.1)	4	42 (10.5)	40 (24.2)	2	42 (14.2)	148 (33.5)	114 (17.3)	262 (23.8)
3	16 (11.8)	64 (24.2)	80 (20.0)	88 (62.9)	50	138 (34.5)	38	18	56 (18.6)	142 (32.1)	132 (20.0)	274 (24.9)
4	6	16 (6.0)	22	14	6	20 (5.0)	20	56 (41.7)	76 (25.3)	40 (9.0)	78 (11.8)	118 (10.7)
5	2	2	4 (1.0)	-	-	-	22	12	74 (24.6)	24 (5.4)	54 (8.2)	78 (7.0)
6	-	6	6 (1.5)	-	4	4 (1.0)	8	4	12 (4.0)	8 (1.8)	14 (2.1)	22 (2.0)
T O T A L	136 100	264 100	400 100	140 100	260 100	400 100	166 100	134 100	300 100	442 100	658 100	1100 100

Table VIII: Comparison of Study Areas

	Faraskour		Quena		Deshna		Total Sample
Family Size	3.75 ^U	3.90 ^R	3.10 ^U	4.00 ^R	3.84 ^U	3.36 ^R	U/R 3.68
Per capita income Per month, L.E.	2.22	2.48	4.43	1.61	3.49	4.19	2.82
Average number of rooms per family	2.22	1.87	2.83	1.56	2.71	4.22	2.42

COMMENTS :

- Largest family size is in Quena Rural followed by Deshna Urban.
- Highest per capita income per month is in Quena Urban followed by Deshna Rural.
- Highest number of rooms per housing unit is in Deshna Rural followed by Deshna Urban.

Table IX. Ranking of Study Areas According to a Combined Measure Indicating the least-best area in Terms of Socioeconomic Status based on data from Table VIII.

Area	Score for Size	Score for Income	Score for Number of Rooms	Combined Measure
Faraskour U	4	5	4	13
Faraskour R	5	4	5	14
Quena U	1	1	2	4
Quena R	6	6	6	18
Deshna U	3	3	3	9
Deshna R	2	2	1	5

One can conclude this section on socioeconomic status of sample families therefore by noting that Quena urban families in the sample were in the most favorable situation situation in terms of the three measures chosen for this study with Deshna rural in the next most favourable situation followed by Deshna urban. Faraskour, both rural and urban areas, were much less well off than the urban Quena and Deshna respondents while the Quena rural sample families were least well off in terms of the measures chosen.

Family Living Conditions

The above section dealing with socioeconomic status needs to be supplemented by an analysis of the living conditions of the families in the study areas. This is especially necessary in order to access

the quality of the dwelling unit in which the young child lives. Hence the previous analysis given above can best be viewed as expressive of quantity factors of family status while this section attempts to give an insight into the quality of the home environment.

Source of Clean Water:

Table X shows that only 30.5% of the interviewed persons in the study sample stated that their houses were connected to a public water network (i.e. piped-in water) of whom 73.8% lived in urban areas and 26.2% lived in rural areas. The highest percentage of dwellings connected to a public water network was in Quena which represented 32.7% of all connected dwellings in the sample, and the lowest was in Faraskour 19.0%. In the study sample 44.4% said they have to get clean water through public tap while 17.8% said they get their water from private water pumps. Only 7.3% stated that they get their water from the river or a small water stream of whom 2.5% were in rural Faraskour, 67.5% in rural Quena and 30.0% in rural Doshna.

Clean water from	N	%
Public net work	336	30.5
Public tap	488	44.4
Private Pump	196	17.8
Water stream	80	7.3

Sewage Disposal

Table XI shows that in the study sample dwellings using a water carried system represented 50.4% of the total sample while dwellings using dry methods represented 45.3% of the sample and

those with no sewage disposal system whatsoever did not exceed 4.3% of the total sample.

The table shows that 23.5% of the dwellings served by water carried system were in urban Quena and 23.1% in rural Faraskour. The lowest percentage is in Quena rural. Out of the dwellings using the dry method 43.8% were in Quena rural and 26.9% in Faraskour rural. The lowest percentage is in Quena urban. The highest percentage of dwellings with no sewage disposal system is in rural Quena 62.5%.

Table XII shows that the pit hole is most common in rural Quena 84.4% of dwellings in the sample while Rockflor type latrine is most common in rural Faraskour 100% of dwellings in the sample. This is mainly due to the level of subsoil water which is much higher in Faraskour than in Quena.

Breeding Poultry Inside Residence:

Analysis showed that in the total sample 59% of the interviewed individuals stated that they breed poultry inside their residence, while 41% answered in the negative. The highest percentage of those who said they breed poultry in their homes was in rural Quena (96.9), while the lowest percentage was in rural Doshna (19.4).

Breeding Domestic Animals and the Location of Animal Shed:

Table XIII (A+B) shows that 296 individuals i.e. 26.9% stated that they breed domestic animals out of whom 42.5% were in urban areas and 57.5% in rural areas. In urban areas Doshna sample included the

highest percentage of individuals breeding domestic animals while Quena rural came next 46.9% and the lowest percentage was in Faraskour urban 10.3. As regards the location of the animal shed in urban areas 54% said that their animal shed was outside their houses and 46% said it was inside their houses. In rural areas the percentages were 73.5 for inside the house and 26.5 for outside the house. The highest percentages of animal sheds outside houses was found to be in Faraskour urban (100) and Doshna urban (87.5)

Means of Lighting:

Table ^{XIV} shows the following:

1. 66% of urban dwellings included in the sample use electricity while only 31% use electricity in rural areas.
2. Out of the total rural dwellings which have electricity 54% are in Doshna and 46% are in Faraskour.
3. Out of the total urban dwellings using electricity 43% are in Doshna, 40% in Quena and 14% in Faraskour.
4. Almost all rural dwellings in Quena are without electricity.
5. 33.5% of the dwellings of the urban sample and 69.3% of the rural sample use Kerosene Lamps.
6. Two cases 1.3% in rural Doshna said they were using Gas Lamps (Golob in Arabic).

Cooking Method :

Table XV shows that :

1. Only 17.0% of the total sample use Butane Gaz stoves for cooking out of whom 12.5% are in urban areas and 5.8% in rural areas.
2. Of those using stoves in rural areas 76% are in Deshna, 20% in Faraskour and 4% in Quena.
3. Of those using stoves in urban areas 20% were in Quena, 19% in Deshna and 1% in Faraskour.
4. Mud ovens are used by 13% of the total sample out of which 21.9% were in urban areas and 78.1% were in rural areas.
5. Kerosene stoves were said to be used by 69.6% of the total sample out of whom 35.5% were in urban areas and 64.5% in rural areas.

Cooking Utensils:

Table XVI shows that 83% of total sample said they were using Aluminium made utensils, while only 14.5% were using copper made utensils. In Deshna rural 67% of interviewed individuals said they use copper utensils more than aluminium made utensils. Only 26% of the total sample said they were using clay pots for cooking. It should be noted that copper made utensils are considered to be a sign of wealth.

Level of House Cleanliness:

Table/XVII shows the results of the analysis of factors which effect the level of house cleanliness. The sample used was 50 houses in the three study areas selected These houses were visited by a team composed of a public health physicians and a social worker. The factors included were:

1. Connection to Public water system.
2. Poultry inside houses.
3. Animal shed inside house.
4. Connection to a public sewerage system (means for drainage).

The observations of both members of team were recorded and analysed. The results of the analysis showed that statistical association exists only between the observed level of cleanliness and the connection of the house to a public sewerage system.

Table X. Source of Clean Water

	Faraskour				Quena				Deshna			
	U		R		U		R		U		R	
	N	%	N	%	N	%	N	%	N	%	N	%
Connected to Public Net work (Piped in water)	64	(47.0)	36	(13.6)	110	(78.6)	4	(1.6)	74	(44.6)	48	(35.8)
Public Tap (Near to house)	46	(33.8)	106	(40.2)	14	(10.0)	194	(74.6)	74	(44.6)	54	(40.3)
Private Pump (Near to house)	26	(19.2)	120	(45.4)	16	(11.4)	8	(3.0)	18	(10.8)	8	(6.0)
Water Stream	-		2	(0.8)	-		54	(20.8)	-		24	(17.9)
	136	(100)	264	(100)	140	(100)	260	(100)	166	(100)	134	(100)

Table XI. Sewage Disposal

	Faraskour				Quena				Deshna			
	U		R		U		R		U		R	
	N	%	N	%	N	%	N	%	N	%	N	%
A. Water carried system	80	(58.8)	128	(48.5)	130	(92.8)	12	(4.6)	122	(73.5)	82	(61.2)
1. Sewers	52	(65.0)	34	(26.6)	94	(72.3)	4	(33.3)	24	(19.7)	44	(53.6)
2. Septic tanks	28	(35.0)	94	(73.4)	36	(27.7)	8	(66.7)	98	(80.3)	38	(45.4)
B. Dry Methods	46	(33.8)	134	(50.7)	10	(7.2)	218	(83.8)	44	(26.5)	46	(34.3)
1. Double vault latrine	2	(4.3)	-		10	(100)	10	(4.6)	23	(52.3)	34	(73.9)
2. Rockfler latrine	42	(91.4)	134	(100)	-		24	(11.0)	-		-	
3. Pit hole latrine	2	(4.3)	-		-		184	(84.4)	21	(47.7)	12	(26.1)
C. N O N E	10	(7.4)	264	(100)	140	(100)	260	(100)	166	(100)	134	(100)

Table XII: Water carried Systems & Dry Method

Water Carried System	TOTAL		URBAN		RURAL	
	N	%	N	%	N	%
Water Carried System	554	(50.4)				
Faraskour			80	(14.14)	128	(23.1)
Quena			130	(23.5)	12	(2.2)
Deshna			122	(22.0)	82	(14.8)
Dry Method	498	(45.3)				
Faraskour			46	(9.2)	134	(26.9)
Quena			10	(2.0)	218	(43.8)
Deshna			44	(8.8)	46	(9.3)
None	48	(4.3)				
Faraskour			10	(20.8)	2	(4.2)
Quena			-	-	30	(62.5)
Deshna			-	-	6	(12.5)

Table XII

A. Breeding Domestic Animals

	<u>U R B A N</u>				<u>R U R A L</u>			
	Domestic	Animal	No.	Total	Domestic	Animal	No.	Total
	N	%	N	%	N	%	N	%
Faraskour	14	(10.3)	122	136 (100)	32	(12.1)	232	264 (100)
Quena	20	(14.3)	120	140 (100)	122	(46.9)	138	260 (100)
Deshna	92	(55.4)	74	166 (100)	16	(11.9)	118	134 (100)
TOTAL	126	(28.5)	316	442 (100)	170	(25.8)	488	658 (100)

B. Breeding Domestic AnimalsLocation of Animal Shed

	<u>U R B A N</u>				<u>R U R A L</u>			
	Domestic		Animal		Domestic		Animals	
	shed Inside		shed Outside	Total %	Shed Inside		Shed Outside	Total %
	N	%	N	%	N	%	N	%
Faraskour	-		14	(100)	5	(15.36)	27	(84.4)
Quena	-		20	(100)	106	(86.9)	16	(13.1)
Deshna	58	(63.0)	74	(100)	14	(87.5)	2	(12.5)
TOTAL	58	(46.0)	72	(54)	125	(73.5)	45	(26.5)

Table XIV: MEANS OF LIGHTING

	Faraskour		Quena		Deshna		T O T A L	
	U	R	U	R	U	R	U	R
N. K.	-	-	-	-	-	-	-	-
Electricity	50 (36.8)	92 (34.8)	108 (77.1)	2 (0.8)	124 (74.7)	108 (80.)	292 (66.0)	202 (30.7)
Kerosene lamps	86 (63.2)	172 (65.2)	22 (22.9)	258 (99.2)	40 (24.0)	26 (19.4)	148 (33.5)	456 (69.3)
Gaz lamp	-	-	-	-	2 (1.3)	-	2 (100)	-
T O T A L	136 (100)	264 (100)	140 (100)	260 (100)	166 (100)	134 (100)	442 (100)	658 (100)