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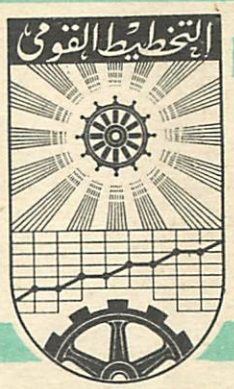

الرسالة التعليمية

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Beliefs, Practices, Environment and Services Affecting the Survival, Growth and Development of Young Egyptian Children: A Comparative Study in Two Egyptian 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. Inspite of the fact that this group is the most vulnerable age group it is not receiving enough attention either inplanning 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 failies 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 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 infections 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).

Table 1. General Information about Maternal & Child Health

E G Y P T

Total Pop 1/7/73 (Estimates):

Total Pop
Male (50.8%)
Female (49.2%)

Age distribution in Millions:

0 - (15.4)
5 - (13.6%)
10 - (11.0%)
15 - (11.3%)
20 + (48.7%)

Urban & Rural Distribution:

Urban (128 cities) (42.6 %)
Rural (4100 villages (57.4 %)

Number of Births and Deaths (1971):

Births
Deaths

Vital Rates 1971/1000:

Birth Rate
Death Rate
Natural Increase Rate
Infant Mortality Rate
Neonatal Mortality Rate
Still Birth Rate

Table II. Main Causes of Death among young Egyptian Children

A. Main Causes of Infant Deaths 0-1:

Causes	Number
Diarrhia & G.E.	66066
Congenital debility	26318
Acute & Chronic Bronchitis	24929
Others.	17754
Total	135067

B. Main Causes of Deaths 0-4:

Causes	Number
Diarrhia & G.E.	127975
Lobar Pneumonia	40433
Acute & Chronic Bronchitis	30098
Others.	59295
Total	257801

Marriage Rate (1971)

Divorce Rate (1971)

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

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

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

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

	Damietta Governorate	Quena Gov
Population	4950	16240
Total Number of Health Units	41	141
Population per unit	12075	11590
Units Providing MCH Services	41	129
Population per unit.	12075	11755

B. MCH Services in Rural Areas 1972

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

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 peasons 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 it 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 sl "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 maxmizes the utillization 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 yo 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 ajudged 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 0-5 in two different socioeconomic milieus within Egypt inorder 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 were the River Nile "Damietta Branch" meets the Mediterranean sea.

. Quena Governorate in Upper Egypt extends about 280 Kilometers (1810 7km^2) on both sides of the River Nile forming a narrow cultivated strip valley surrounded by sand and mountains on each side. Its population exceeded 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 2,000feddan (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.