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USERS' PERSPECTIVE OF HEALTH

with an annotated bibliography
of Arabic and English sources

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Introduction

The social science literature relevant to the users' perspective on health is vast, but dispersed and fragmented. The sources may be divided into two types: the writings that appeared before the 'sixties are mainly published books dealing with traditional beliefs and exotic practices pertaining largely to the supernatural elements in health practices; then come the many research papers and reports that appeared from the 'seventies on. This report is concerned mainly with this second group of more recent studies, which are more problem-oriented and mostly unpublished. They deal with two main categories of the population: village populations and the urban poor.

The social science literature treats the village community as a whole with little attention to class differentiations. This lack of concern is valid to some extent for Egyptian peasants live in a cultural mainstream, having similar health options. Village studies address themselves to health problems and the utilization of rural health centers vis-a-vis the informal traditional health sector in the villages of Lower Egypt. Fewer studies have been made of villages in Upper Egypt. There is also a lack of information about villagers' utilization and perception of urban services.

The literature dealing with the urban situation concentrates

almost exclusively on Cairo and Alexandria. Mostly it describes needs felt by low-income groups who utilize the public services in large cities and the delivery system available to them. Very little is written about the problems of the middle class and the private sector.

With few exceptions, social science studies deal with a specific subject in a limited locale, often in isolation from the general organizational and administrative structure of the country. Another weakness is that social scientists, in the process of analyzing their data, become immersed in the symbolic meaning of the phenomena, and underestimate the practicality of the Egyptian peasant and the urban poor.

Summary of Findings

- Users have a wholistic view of the body, disease and cure. A totality of biological, natural, social and supernatural factors account for a person's health condition.
- As an illness may have several causes, it is thought wise to follow several curative avenues simultaneously.
- Traditional ideas about health and the associated therapeutic practices are not necessarily in agreement with the biomedical reasoning and cosmopolitan medication of the formal delivery system.

- Cosmopolitan medicine is accepted and generally more highly valued than the traditional healing system, but where one contradicts the other, neither is necessarily rejected. Consistency is not a characteristic of beliefs related to health and therapeutic actions, and many practical variables may influence decisions to follow a particular course of action in particular cases.
- Existing dietary habits, sanitation and environmental conditions mitigate against producing a healthy individual.
- Nutrition of infants and young children, pregnant and lactating mothers is inferior to their needs. No special proper diet is allotted to them.
- Traditional practitioners are still existing and in abundance, especially in satellite villages where the availability of the formal system is deficient.
- With the exception of the daya, traditional birth attendant, there is no strong attachment to traditional healing practices. Resorting to traditional healers is more a function of availability, performance and cost rather than belief in the effectiveness of the traditional system.
- The medicine policy in the formal health delivery system is at the core of understanding the utilization problems.

I. Knowledge and Perception of Health, Body Processes and Disease

Health is often referred to as "the most precious possession one has in the world," and when illness occurs, every effort is made to cure it. Cosmopolitan medicine often defines health and the healthy individual from a disease-oriented viewpoint: disease-producing activities or substances are to be avoided. The same philosophy is held by the groups studied, but their perception of what constitutes a healthy individual and their understanding of body processes and the causes of disease are not necessarily those applied by cosmopolitan medicine. Moreover, what may, in their view, indicate good health may not, medically, ward off illness; obesity, for example, is popularly accepted as a sign of physical well-being, though it could in fact be unhealthy.

The groups studied may attribute disease to natural, social and/or supernatural causes. When they give a specific biological interpretation, it is based on popular conceptions of body process which may have no scientific basis.

Body Processes

Body Formation¹

In rural Egypt and among the urban poor, the daya is regarded as having the most knowledge about body formation, and she passes her knowledge on to the members of her community.

Opinions vary as to when conception may occur. Some believe it to be possible at any time between the termination of one menstrual period and the onset of the next. Others claim that for seven to ten days after the menses the uterus is in a state of "disgust" and will not accept a new pregnancy, while for one week before menstruation conception is also impossible because the uterus is too "full" to accept the male seed. Conception is also precluded during the forty days immediately after the birth of a child, as the uterus is still open and in a state of extreme "disgust."

Women who wish to conceive are careful not to violate the protocol of social contact imposed by traditional Egyptian culture, which envisages certain consequences if individuals passing through different life crises meet together. Violation of this code is believed to cause mushahra,² which may only be counteracted by the traditional measures. If a bride, for example, finds herself in the same room with a recently circumcised child, it is believed she will not quickly conceive unless she performs specific ritual activities. Pregnancy may also be delayed if a bride is exposed to cold when she is deflowered, but this situation is remedied if the daya applies air cups to the bride's back.

When folk methods fail to bring about a pregnancy, private doctors and public hospitals are often consulted, sometimes as early as two months after marriage. The possibility of male

sterility is accepted but regarded as remote. A woman must try all social, natural, spiritual and medical opinions and remedies before she can expect her husband to seek any advice, and even then he may never admit his own sterility.

It is believed that an observant woman knows exactly when she conceives. For example, if she finds herself dry after sexual intercourse, it is an indication that her uterus has absorbed the sperm and that she has conceived. It is also thought that if conception occurs at night, delivery will be at night, and if it occurs in the morning delivery will be in daytime. The fact that sexual intercourse is more likely to take place at night accounts for the common belief that more babies are delivered at night than during the day.

Pregnancy is regarded as a natural part of womanhood which does not necessitate professional advice, at least in the early stages. A pregnant woman continues with her daily tasks as normal right up to the time of delivery, especially if it is not her first baby. The exception is in cases where pregnancy occurs in the first month of marriage; the expectant mother has then to take care to avoid an early delivery so as not to be the victim of accusations that she had sexual relations before marriage.

The sex of the unborn child is determined by God, but certain signs are used by the daya to foretell what its sex will be. The abdomen of a woman carrying a girl is expected

to be large and round; in the case of a boy it should be smaller and elongated. Pregnancy with a male child is expected to cause more discomfort and poorer health. When the baby is a girl, the mother is expected to grow prettier and plumper during pregnancy.

The daya can only definitely diagnose pregnancy at the end of the third month, but symptoms such as dizziness, vomiting, paleness, headache, change in the color of nipples and in preferences for particular foods are all regarded as indications of possible pregnancy. The face of the expectant mother is said to glow and grow smaller, her head becomes heavy and her walk distinctive. After the third month, the foetus takes shape as "a piece of flesh" and definite diagnosis can be made. The daya estimates the stage a pregnancy has reached by the position of the foetus in the abdomen. The time of birth is calculated on the basis of a period of nine lunar months, Egyptian women believing the lunar calendar to be more accurate.

Childbirth is regarded as a natural physical process, with God alone being able to "permit" the child to "come to life." This attitude minimizes the panic expressed by the mother and those around her at the time of delivery. It is said she must wait for saat al-farag "the hour of relief."

It is believed that at the time of birth the foetus passes from the "belly" to the uterus. In principle a woman in labor

should be given all the time and encouragement necessary to complete a natural delivery. The presence of anyone who can support her in this is much appreciated. She is expected and allowed to scream, not in fear or panic, but to express and relieve her pain. The birth of a boy is believed to be less painful than that of a girl. It is also expected that a boy will be born with his face towards his mother's back, while a girl turns to face upwards. This belief that a girl faces her mother from the moment of birth is a reflection of the strong bond that is held to exist between a mother and her daughter throughout life.

It is the view of the dayas that all pregnancies are normal and that complications only occur during delivery.

Villagers believe that a miscarriage may be induced if a pregnant woman lifts a heavy load, travels in a car, falls on her back, crosses a wide canal or is beaten by her husband. A miscarriage may also be caused by anger, exhaustion, "weak ovaries," various venereal diseases or a "weak" or "open" back.

Abortion is considered haram or sinful. Those women who do resort to it do so largely to terminate illegitimate pregnancies or, more rarely, to avoid increasing an already-large family.

Body Structure and Function

The perception and knowledge of the groups studied concerning the body's structure, function and processes influence

their perspective on the causes of disease and their utilization and evaluation of existing health services. Three major works have dealt with this subject, one concentrating on a rural village in Sharqiya Governorate, another on baladi (traditional) women in Boulaq, Cairo and the third on middle- and lower-class residents of Alexandria.

The body is seen as divided into three main parts: the head, the trunk and the legs. These three parts are linked together by what are regarded as transitional areas. Any injury or disease may cause a swelling, heil, in these areas, that is, at the sides of the neck, in the armpits and the groin. These spots are the "barriers" and "preventives" that resist any intrusion into the more vital areas of the body.³

Certain parts of the body, such as the arms, hands, legs and feet, are regarded as less important than others. The complementarity of the right and left sides of the body is believed to be a potential compensatory device.⁴ Thus, in spite of the fact that the loss of a limb might seriously impede economic advancement, such situations are often accepted with realistic stoicism, and the confidence that the handicapped individual may well excel in other fields. It is believed that the arm of a one-armed man, for example, is stronger than a normal man's arm, and this compensatory strength enables the individual concerned to find a place in society. It is said that even if one loses his sight, he will develop a fine voice and excel in

reciting the Koran, so that Koranic schools, with their emphasis on memorization as a principle of learning, are geared to absorb the blind. The mentally handicapped also are accepted in the traditional culture, which believes them to be endowed with a particular kind of holiness.

Each part of the body is believed to be made up of certain components and to have certain functions. The body is seen as a biological entity, but it is also part of a spiritual world, and may be viewed as a system of symbols which correspond to a wide symbolic system involving cosmology, medicine and religion.⁵ The eyes, for example, are associated one with good and one with evil. Thus a person who loses both eyes may, in the view of the community, be better off than one who loses one, for the fear exists that it may be the "evil" eye that is left to him.

The sections of the skull are seen as held together by two nails. Headache is a sign that the sections have become dislocated and should be realigned by the use of a particular folk treatment.⁶ The patient is said to suffer from an "open head" and the cure involves the use of a key. Thus the head is wrapped with a cloth and tightened with a key.

The ears, mouth and tongue have social, spiritual and biological functions derived from their structure. The mouth, for example, is seen as the gateway for food, breath and speech. It may also be a trap, for yawning is believed to attract evil spells. The ear may be used by the devil to take hold of a

person, and pus in the ear is an indication of his activity. The tongue is believed not to decay after death and to be too bitter to be eaten by the worms.⁷

Curative powers are attributed to body secretions, such as saliva, urine and sweat. Saliva and sweat, if odorous, are used to treat eyes, while urine is believed to relieve burns.⁸ Menstrual blood and semen are considered unclean and are used in magic.

The internal organs are believed to be the most important parts of the body, but are not conceived of as distinct from each other. A baladi woman perceives the body to be a dynamic organism, whose parts are integrally related and have the heart as their symbolic center which draws things to it. Thus a woman may say that the IUD "rose to her heart." The existence of separate organs such as the womb, liver, stomach, etc. is acknowledged, but they are seen as intercommunicating. One may catch cold, for example, in a particular part of the body and it may then move on to other parts.⁹ Thus the spread of infection is not believed to follow any special course, such as circulation through the blood stream, but to result from a general mobility of microbes from one part of the body to another.

The heart, being conceived of as the center of the body, is also seen as the source of well-being, so when informants complain of a "weak heart," they may not sense an irregular heart beat or heart pains but simply intend to indicate an

elusive dysphoria.¹⁰

This very fluid body not only allows for the transfer of physical entities such as nourishment and microbes from organ to organ, but it also transports spiritual qualities. Breast-feeding is valued partly because the mother's tenderness is transferred to her child through her milk.¹¹ Girls are believed to be tenderer than boys because they are thought to be greedier and suck more milk. If a nursing mother is distressed, she should not feed her baby for this would transfer her distress to him. In addition, children nursed by the same mother are treated as siblings and are not allowed to intermarry.¹²

Another aspect of the perception of the body is that, among villagers, it is regarded as the seat for the crystalization of external social events affecting the individual. That is to say, body changes associated with illness are not explained merely as disruptions in the functioning of specific body parts but also in terms of meaningful social events. A body is not only a physical structure, but an individual-centered depository which mirrors those social events that transcend the individual's physical being. Physical symptoms of illness are significant in that they are associated with psychological and social symptoms indicating a departure from culturally defined normal states of health. The body itself, moreover, is believed also to affect elements in the natural and social environment. From this is drawn the concept of ritual defilement attached to social

interaction after sexual intercourse, during menstruation and after childbirth,¹³ and the practice of ritually purifying objects and places that have been defiled through contact with unclean substances such as menstrual blood.

These perceptions of the human body are important for the understanding of Egyptian perspectives on health issues. As one social scientist states, "Health and disease manifest themselves in the human body. And yet the human body is not the unit of analysis in medical anthropology, but is approached indirectly through parameters of health and disease. Therefore dealing with the anatomical folk classification of body parts, and the conceptions of the diseased body could shed light on some aspects of medical beliefs in Egypt."¹⁴

Causes of Disease

Often, when people are asked what illness they have, or what an individual died of, the answer comes in the form of a biological interpretation, such as diarrhoea, fever, kidney problems, etc. This does not necessarily mean that this biological state is believed to be the real cause of illness or death. It rather singles out the immediate cause — only. The real causes are accounted for by social, natural and supernatural modes of explanation, which answer for the person concerned the riddle of why disease strikes one person and not another.

The information presented in the literature about causes

of disease and death often projects the status of health and disease rather than the people's perception of health and disease. This is in many cases indicative of the gap that exists between the deep-seated belief system of the people and the knowledge they have acquired through exposure to and contact with cosmopolitan medicine.

The perception and knowledge of the groups studied often agrees with cosmopolitan medical understanding of certain diseases, but various environmental and delivery constraints mitigate against effectively combatting the disease. One study points out that "every farmer in Egypt knows that coming in contact with water in the irrigation canal will lead to infection with bilharziasis, but he cannot afford not to get into these waters — they regard getting this disease as something normal."¹⁵ Such constraints reinforce beliefs about real and immediate causes of disease. (Views on constraints in the delivery system and socio-economic conditions, and their effect on the perspective of the users will be discussed in Chapters II, III and IV.) Just as the human body is perceived as a symbol of the natural, social and supernatural, so these same variables are reckoned to cause disease, in addition to the psychological factor which is discussed in recent literature.

Natural Causes of Illness

Certain ailments are reckoned to be caused by various natural elements:

1. Al-hawa (lit: air) is considered a major cause of sickness; it may be interpreted to mean air, atmosphere, wind, draft, climate or weather in general. In specific instances it may be said that illness is the consequence of the patient's warm body being suddenly exposed to the fresh air. Al-hawa may be blamed for a variety of ailments ranging from the common cold to infantile paralysis.¹⁶
2. Rutuba may be translated "dampness or humidity." Peasants complain of rutuba in the head, knees and back, and physicians treating them gain their cooperation by outwardly accepting this diagnosis, especially in cases of rheumatic pain.¹⁷
3. The sun. Villagers who complain of a headache after a day in the fields are believed to have sun stroke. The sun is said to "open" the skull, and it must be "closed" by treatment.
4. Food. Combinations of certain foods are believed to cause sickness. For example, fish and milk should not be eaten in the same day, and very cold food should not be eaten after very hot food.

Supernatural Causes of Illness

The anthropological literature concentrates mostly on supposed supernatural causes of disease at the expense of other less exotic reasons for sickness.

1. Spirit possession. Evil spirits are said to be attracted to and possess certain individuals, causing mental and/or physical illness.
2. 'Amal (spells). The power of magic is acknowledged in the Koran. Magicians utilize spirits and deliberately cast spells to cause harm to specific individuals. Many villagers deny that magic can cause illness, but an accusation of practising it carries a powerful stigma and may cause great tension among the relations and neighbors of the accused person.
3. Failure to fulfil a vow to a saint. Egyptians in desperate situations often pray for the intervention of a saint, vowing to perform some act of charity in return. Sickness is often attributed to failure of meeting such a promise.
4. Envy or the evil eye. These are supernatural powers believed to be inherent in certain individuals who thus have the ability to harm any person for whom they may feel malice. This aspect of culture extends beyond social and class barriers.
5. Mushahra. This is defined as "supernatural harm caused to individuals in vulnerable states of other person's violation of taboos."¹⁸ It is a major theme in the Egyptian culture related to life-cycle crises, and is a reminder of the vulnerability of persons who

do not observe the protocol of "crisis rites."

6. God's will. Illness is often regarded as a divinely ordained test of endurance and fortitude for the faithful. This does not, however, preclude the sufferer from seeking a remedy.

Psych-Social Causes of Illness

Of two people complaining of the same symptoms, one might be accounted genuinely sick and the other not. This variation may be attributed to social differentiation.¹⁹ Villagers often say their diseases are caused by "worry,"²⁰ or fright. This may be attributed to the potentially disruptive effect of the unforeseen.²¹

It is commonly believed that an illness may have several causes, and so it is thought wise to follow several curative avenues simultaneously. The determination of the specific cause of an ailment is a function of its duration, its physical and behavioral manifestations, its response to certain types of treatment, and the types of social and interpersonal relations which surround the afflicted person and his/her significant others.²²

I. Values, Conceptualization and Practices Related to Diet and Nutrition

Egyptians strongly associate food intake with general physical well-being, and indeed specific ailments are believed to be cause or aggravated by certain foods. In practice, however, they follow traditional eating patterns, often without regard to nutritional values, and commonly have an inaccurate understanding of the nutritional value of specific foods and the amounts of each required for a healthy diet. Furthermore, the relation between diet and subtle, chronic diseases, such as malnutrition, is rarely perceived.

Most of the social literature on nutrition, like that on health, deals with rural and deprived urban areas. We may single out certain general dietary patterns which have a specific impact on health.

1. Bread is the staple food for the rural and most of the urban population. It provides up to 75% or 80% of the rural caloric intake and about 50% of protein intake, the daily adult consumption amounting to three pounds or more.²³ A study of a Lower Egyptian village has established that the basis of a villager's diet, regardless of his age, sex or education, is foods that have a mainly carbohydrate content (bread, rice, potatoes, pasta, fava beans).²⁴ In both rural and urban areas, especially among

manual workers, bread is believed to be the source of strength and energy. Obesity is regarded as a sign of health and wealth, especially among women, which encourages carbohydrate consumption. A study of twenty girl athletes in Alexandria shows them to be overweight in relation to international standards. Anaemia and riboflavin deficiency were discovered. These findings indicate faulty diet habits.²⁵

2. Meat, poultry and fish are highly valued, but because of cost are purchased by many only on special occasions. It is common for these foods to be prepared only once a month, but it is interesting to note that on feast days the amount of meat eaten could suffice for two weeks' daily consumption. Villagers and the urban poor live from day to day and, in the absence of refrigeration, cannot regulate the consumption of foods that spoil quickly. The 1978 national nutrition survey identified widespread protein-calorie malnutrition among pre-school children.²⁶
3. Vegetables are consumed in large quantities by the rural and urban population. They are often not adequately cleaned and constitute a major source of intestinal disease.
4. Tea is the main beverage, stimulant and dessert for villagers and the urban poor. It is boiled till dark and highly sweetened and is drunk by all regardless of age or sex.

5. Fat-free cheese is eaten regularly in rural Egypt, while beans (foul) are more favored in urban areas.

6. Pickles and other highly salted foods are very popular.

Although food habits and intake affect nutritional status, the literature does not reveal any instance of actual communal malnutrition. The only exception is the Nubian situation; after the Nubian resettlement in Kom Ombo, medical reports showed protein deficiency, low resistance of infections disease and a rise in the crude death rate.²⁷ This situation arose from the social and psychological consequences of the resettlement rather than from the dietary perspective of the people.

The literature available pays specific attention to two groups: priority is given to infants and pre-school children with analyses of nursing, weaning and feeding practices in rural and urban poor areas. Other sources, though fewer, provide studies of the nutritional status of pregnant women and nursing mothers.

Infant and Child Diet

1. Nursing. Two basic ideas underly the cultural patterns associated with nursing. The first is that nursing does not follow a regular schedule. The second is that every mother is believed to produce enough milk for her baby's needs. Each of these principles is associated with a syndrome of attitudes.

In both rural and urban poor areas nursing begins three

days after birth. During the first three days the baby is given sugar-water, helba, caraway or aniseed tisanes. The colostrum is expressed and thrown away because of its rancid smell and the belief that it causes diarrhoea. In contrast, some urban dwellers recognize the value of colostrum, calling it "nail" (mosmar) and believing it strengthens the muscles and leads to an erect stature.

When nursing begins, the baby is offered the breast whenever he cries, day or night. It is recognized that the more the baby sucks, the more milk will be produced. Both men and women believe that every mother naturally produces enough milk to feed her baby for two years, and may quote the Islamic Sharia to support their assertion that this is his God-given right. The flow of milk can only be stopped, they claim, by a "kabsa," which results from the mother's seeing certain foods or incidents. These are therefore to be avoided, but in case of mishap various measures are recommended as antidotes. Mothers are expected to eat certain foods and avoid others to improve the quality of their milk.

The nutritional value of breast milk is universally recognized. It is believed that a child who is not breast-fed will never be strong enough to be a craftsman or laborer, but will be fit only for office work.

Breast-feeding is avoided if the baby has diarrhoea or measles and when the mother is emotionally distressed.

2. Weaning. Weaning usually takes place during the baby's second year, eighteen months being regarded as the ideal age. By this time mothers feel weakened physically and unable to supply enough milk for the child's needs. Some believe that breast-feeding for more than sixteen or eighteen months adversely affects the child's intelligence. Many women who nurse their babies for longer periods do so for family planning reasons.

Many mothers boast that their children needed no food other than breast milk before they were weaned, but this does not give a true picture. A recent sample study showed that only 15% of rural babies and 2.2% of urban babies were weaned abruptly. The reasons given for weaning are: insufficiency of breast milk, new pregnancy, desire to become pregnant, inability to buy fresh milk, emotional reasons, mother's illness and that the child is old enough to no longer want to breast-feed.²⁸

Solid or semi-solid food is not introduced for the first time as a meal in substitute for a feed from the breast or bottle when weaning begins, but is given to babies from the fourth or fifth month in the form of small tastings. Whenever the mother is eating, she takes a pinch of her own food, crushes it between her fingers and allows her baby to lick her finger. Meat is the only exception; it is not given before the second year because of the belief that it rots the

intestines. In this way the child is introduced to a variety of foods, though no special food is prepared for him and the amount of time he spends at the breast is not diminished. By the time the mother decides to wean, the child has developed likes and dislikes for certain foods. His favorite food is then offered in large quantities so that he has less appetite for milk, and the milk is withdrawn.

After this transition, the child eats meals with the rest of his family. No special food is prepared for him and milk is not regarded as an essential part of his diet.

A major finding of the M.I.T. was that malnutrition is the major health problem affecting children under five, although it is not specifically related to particular seasons of the year. Only 40% of the children examined displayed a normal weight for their age and 5% suffered from third degree malnutrition. Chronic malnutrition, measured by height for age, characterized 40% of the children over two, of whom half displayed more serious stunting and 6% were acutely under-nourished.²⁹

It was also found that, although normal growth (weight-for-age) is maintained through the seventh month, there follows a precipitous decline, which is only partially made up after the first year. Surviving children approach the normal growth curve at age four, but before this the average child is in middle to high first degree malnutrition.³⁰ This could be

accounted for by the cultural patterns related to supplementary feeding of infants and insufficient milk intake for young children after weaning.

Lower Egypt seems to have more, and more serious, malnutrition than Upper Egypt.³¹ This may be attributed to the fact that women in Lower Egypt are more involved in working in the fields and have less time for baby care.

The 1980 national nutrition survey shows the importance of studying short-term undernutrition among pre-school children during the summer months. Patterns of breast-feeding, introduction of supplementary foods and weaning vary from season to season, being least satisfactory during the summer, which is also the high season for diarrhoeal diseases.³²

Pregnant Women and Nursing Mothers

In the traditional Egyptian culture little attention is given to the diet of women during pregnancy. In contrast, great concern is concentrated on the mother immediately after delivery and during the first forty days. This attention is partly directed towards the health of the mother, but the main purpose is to increase the quantity and improve the quality of her milk for the well-being of the child. Chicken in particular is prepared in as large quantities as possible for the mother during the forty-day post-partum period, but after this little attention is given to her diet.

The 1980 nutrition survey revealed that anaemia in mothers with pre-school children constituted a considerable problem. Its causes include inadequate dietary iron, in addition to blood loss, chronic infections and the nutritional demands of pregnancy and lactation.³³

III. Differentiation between the Sexes and Perceptions of Child Morbidity and Mortality

Differentiation between the Sexes

Social science literature in general points out that the over-all tendency in Egyptian society to discriminate against the female is felt as a matter of course in the health sector. The starting point is the initial preference felt by parents for having male children. Family planning studies show a marked increase in the use of contraceptives among couples who already have sons. The esteem given to bearing a son is also reflected in some beliefs concerning pregnancy, such as that the male foetus develops faster than the female and takes a higher position in the womb, and that the female foetus is more deleterious to the mother's health.³⁴ Positive values related to the conception of a female child revolve around stereotyped attitudes towards the female attributes of tenderness and beauty: the mother of a girl is prettier during pregnancy than the mother of a boy; a girl is born facing the mother because of her feelings of tenderness towards her.

As infants, girls are thought to be more greedy than boys and to take more of the mother's milk. While boys are thought to be more finicky, and therefore frailer and more susceptible to disease, they are also thought to be more vulnerable to the evil eye.

These conceptions lead to differentiation between the sexes in practice. A study of 598 families in low-income districts of Cairo found no significant variation between boys and girls in nutritional status till the sixth month of life, up to which time breast-feeding met the dietary needs of both. Around the sixth month $\frac{2}{5}$ of the girls and $\frac{1}{4}$ of the boys showed signs of malnutrition. This gap widened during the remainder of the first year. The nutritional status of female infants also tended to decline with the addition of more daughters to the family. It was found that no boys were deprived of supplementary feeding during the second half of the first year, while only one girl in fifteen received food other than breast milk during the same period.³⁵ A sex distribution study of infants visiting public hospitals and clinics also revealed a statistically significant excess of males (to the extent of 17%).³⁶

These studies indicate that the sex variations in infant deaths are real and not a reflection of incorrect data. They show that the deviation from the normative sex pattern of infant death is so wide that nearly a third of female infant deaths can be attributed to a sex-specific cause, that is the inferior care given to the female child. The study identifies precise forms of child neglect which may account for the relatively lower survival rate of the female infant.³⁷

Sex differentiation with respect to health continues into

adulthood.

Popular attitudes regarding both fertility and contraception place almost total responsibility for both on the female partner. If a woman does not conceive, it is she who is assumed to be infertile; if conception is to be avoided, it is she alone who must take the necessary precautions.

Women more readily identify their husbands as being sick than they do themselves or other female members of the family,³⁸ but it is nevertheless said that more women than men utilize local government health centers.³⁹ There are two relevant comments on this apparent contradiction. Health centers are not considered the most prestigious type of treatment (this evaluation will be discussed later), and so they do not attract large numbers of men. It may also be possible that women resort to sickness as a strategy to gain sympathy and thus strengthen their relatively weak social position. The most indicative factor of the differentiation in treatment, however, is that of cost. A study of illness in an Egyptian village indicates that the average expenditure in cases of illness reported by females was £1.5, while that for males was £2.20. Males as a matter of course resort to more expensive methods of treatment than females: of the males 37% consulted a private physician while only 10% of the females did so.⁴⁰ With regard to hospitalization it was found that women were hospitalized more frequently than men. However, after the exclusion of

hospitalization for obstetric reasons, the reverse was found to be true.

Perception of Child Morbidity and Mortality

Intestinal infections, pneumonia and measles are still the most common childhood diseases in Egypt. Diarrhoeal diseases account for about 50% of child deaths, and bronchial illnesses and pneumonia for a further 20%-30%. (Variations exist in these percentages in different age groups.) The main sociological variable that influences this situation is the mothers' educational status. They are regarded as the guardians of the health of the family in general and the children in particular, and one study indicates that a consistent pattern of relationship exists between child mortality and the mothers' educational level. Of the children of illiterate women 143 per thousand die within the first two years of life. When the mothers have primary education the figure drops to 91 per thousand, when they have secondary education it drops further to 67 per thousand, and when they are university graduates it falls to 52 per thousand.⁴¹ A high rate of female illiteracy exists among the groups studied in this report, whether villagers or the urban poor. Mothers in these situations regard many childhood ailments as inevitable conditions not requiring professional medical attention, and home remedies passed on from mother to daughter are often applied.

If an infant experiences discomfort when his position is changed, he is believed to have a "sprain" as a result of being incorrectly carried, probably by an older child (it being very common for sisters to look after their infant siblings while they themselves are still very young). The home remedy for this condition is either to rub the infant's body with his mother's milk or to wrap him tightly in a sheet to restore the muscles to their correct position.⁴²

Mouth infections are also treated without consulting a doctor. Ground coffee and lemon juice are applied, or else goat's milk, which is considered particularly effective if directed into the child's mouth straight from the udder. In rural areas there are specialists in treating mouth infections who offer their services free.

Initial treatment for diarrhoea in infants is the same in both rural and urban areas: the infant is refused all milk, whether breast or bottle, for about three days. During this time infusions of tea and caraway and rice water are given. If the condition deteriorates, medical advice is sought.

In cases of fever an enema of soapy water is often applied in the belief that this will remove the "dirt" in the intestines responsible for the condition. An aspirin may be given before or after the enema, and it is also common to rub the body, and especially the joints, with vinegar or lime.⁴³

It is expected that every child will contract measles. It

is a disease surrounded by superstitious beliefs related to its complications. Particular fear is attached to a delay in the appearance of the rash, which is attributed to evil power and believed to cause death. The treatment for measles is to have the patient wear a red garment, eat molasses, sleep in a dark room, and to administer an enema of molasses. No bath is given, since it is thought this may cause blindness.

Since the mother is considered the family's therapy manager, she is blamed if a child dies for not taking sufficient care, for example, by taking him to a specialist. She does not, however, hold ultimate responsibility, since fate is invoked as a posterior explanation, though she is considered a facilitator.⁴⁴

The death of a child is no unusual occurrence among the Egyptian poor. Many rural Egyptians believe that every child has a "sister soul" in the spirit world which has the right to take its human counterpart to join it within the first seven days after birth.⁴⁵ As a consequence of this and other similar beliefs, parents often delay registering the birth of a child; if he dies within a few days he is recorded neither as a birth nor a death. This may be correlated with the information provided by one study, which shows that birth registration is uneven across the year. In 1977 more births were registered during the first and last months of the year than in the middle. This may reflect the reality of birth frequency, or the flexibility

of the registration process, or it may be a function of the incidence of gastroenteritis, which increases the infant mortality rate during the summer months.⁴⁶ Variations in registration practice may be due also, apart from fear of the child's death, to such practical factors as the midwife's preference to visit the registrar's office only once a week, or once a month, thus delaying the registration of some deliveries.⁴⁷

Though this study does not review the users' perspective on family planning, it is relevant to note most studies of fertility behavior point to the correlation between the birth rate and the infant mortality rate. The Egyptian peasant still has a deep conviction that at least some of his children will not survive to adulthood.

IV. Environmental Conditions and Sanitation.

Housing Conditions

The Egyptian peasant utilizes every available inch of land for cultivation and allots only the minimum possible for housing space. His dwelling houses all that is precious to him — his family, livestock, farming tools and food stores. As protection against theft, the peasant house has small high windows, which provide inadequate ventilation. The situation is aggravated by the presence of animals, who are stabled inside the house and themselves become victims of the ventilation problem. The house usually contains two rooms apart from the space allocated for stabling; of these, one is often shared by the whole family while the other is used as a food store. Overcrowding coupled with poor ventilation contributes to the deficient health conditions which are minimized only by the fact that the peasant spends his day in the open air.

Among the urban poor more extreme conditions of overcrowding prevail, and in addition most of the women raise poultry, and may also keep a sheep or goat, no matter how small their dwelling. It is not uncommon to find families of ten or fifteen sharing one room and using it as kitchen, bathroom and living area.

Water, Sewage and Health

The absence of potable water in many of the houses of both villagers and the urban poor is a major contributory factor to inadequate sanitation. When every drop of water has to be carried from the source to the house, and waste water then has to be carried out for disposal, it is to be expected that water consumption will be kept to a minimum. This results in inadequate personal hygiene and inadequate washing of food and cooking and eating utensils. Contamination may also occur through improper water storage.

Egyptians are very concerned with ritual purity, which is related to personal cleanliness. For example, both men and women are obliged to bathe after sexual intercourse, which is an important factor influencing the bathing habits of the groups studied. Women must also purify themselves by bathing after menstruation and forty days after childbirth. Those Muslims who pray perform a ritual ablution involving cleansing with water several times a day.

In both rural and urban areas infants are normally bathed immediately after delivery, but then not until the fortieth day for fear of chilling. As they grow they are normally bathed once a week at home, while in villages during the summer months they bathe frequently in irrigation canals, risking exposure to parasites.

In both rural and urban areas salad vegetables are often

eaten without being washed or after being rinsed in a canal. Peasants also find it more convenient to wash kitchen utensils and clothes at the canal bank, and carry potable water to their houses only for drinking purposes.

A further health hazard is constituted by the storing of drinking water. A survey carried out in rural Egypt shows that every home has one large clay water jar (zir) or more.⁴⁸ The water in these was found to be easily and probably frequently contaminated regardless of the source from which it was obtained. Even in houses with a mains water supply the zir is still used to cool the water.

In urban areas tin containers (bastilla) are used to carry water. One may be used to fetch water from the mains pipe, another for pump water and a third to store waste water until disposal. Drinking water is poured from the bastilla into small clay jars to cool, and these are used directly for drinking by all members of the family.

Diseases related to poor sanitation are known to be among the important causes of morbidity and mortality. In rural Egypt over 90% of waste water is discharged directly into the street or some adjacent empty spot, where stagnant pools quickly form constituting a significant sanitary problem. This situation is often exacerbated by poor drainage at standpipes and hand pumps.⁴⁹ Similarly, it was found that in urban areas without a mains water supply and sewage system, about 40% of the

population dispose of waste water directly into the street, while others use nearby canals or drains.⁵⁰

In both rural and urban areas the main playground for children is the street, while both children and adults use canals and open drains for washing, cleaning and various other purposes. Canals in particular thus become a source of contamination for they are used for the disposal of sewage, garbage and industrial chemical waste, as well as being the natural habitat for certain parasites.⁵¹

Several studies carried out in rural Egypt confirm that latrines exist in 30%-90% of homes, depending on the village. These are mostly used by women for the sake of privacy. It is not clear whether sanitation was a further aim.⁵² In urban poor areas most households have access to toilets.

One study blames existing conditions on the attitudes and perception of the general public, from the peasant to the government planner, in the belief that there will be no significant improvement in sanitary conditions in Egypt until the peasant recognizes sanitation as having a direct bearing on his life and health, becomes aware of the links between contaminated waste, human excrement and disease, and is made to understand the aim of the systems intended to improve the situation.⁵³ This view is unduly pessimistic. In both rural and urban areas there is a popular awareness of the problems that can be caused by inadequate sewage and drainage, to the extent

that in some areas of Cairo with no access to mains services in the homes, residents have indicated that they give priority to a sewage system over a potable water supply.⁵⁴ Also houses in rural areas originally constructed without toilet facilities have had a toilet added.⁵⁵ It is important to note that the behavioral changes taking place in Egypt among the poor are limited by the lack of appropriate technology available to them.

Public health is given little attention in the literature. There is reference to health inspectors trained by the Ministry of Health whose work consists of checking food stores, insuring environmental cleanliness, combatting epidemics and education in health awareness. Foodstuff merchants are aware of the health inspector's role, but the ordinary people are not and see him only as one of the team that appears to control epidemics. His effectiveness needs, therefore, to be investigated; his role in insuring environmental cleanliness seems virtually negligible, and his effectiveness as a whole needs further attention and study.

V. Users' Perspective of the Health Delivery System

The previous section has discussed local perceptions of the body, disease and death, and then ideas concerning everyday events relevant to preventative measures against disease. This section concentrates on therapeutic actions and the effect on them of these local ideas.

Traditional ideas about health and the associated therapeutic practices are not necessarily in agreement with the biomedical reasoning and cosmopolitan medication to which the formal delivery system exposes the communities in which they exist. The questions that must be asked are: to what extent do local perceptions of health influence the response to and effectiveness of the cosmopolitan health care services? and, what are the people's perspectives on these services?

The social science literature recognizes the coexistence of two major health delivery systems. One is labeled traditional/informal/baladi, and the other is labeled modern/formal/afrangi. Together these systems constitute the healing world view of the groups studied. Each is perceived as having its strengths and weaknesses, advantages and disadvantages. Just as people believe in the multiple causality of disease, so they are open to try various healing systems, sometimes resorting exclusively to one or the other, but at other times utilizing both either concurrently or consecutively.

Cosmopolitan medicine is accepted and generally more highly valued than the traditional healing system, but where one contradicts the other, neither is necessarily rejected. Consistency is not a characteristic of beliefs related to health and therapeutic actions, and many practical variables may influence decisions to follow a particular course of action in particular cases.

With regard to perceptions of health there is a clear cultural resemblance between the rural and urban groups studied. There are, however, differences in the therapeutic actions each group tends to choose because of the difference in the situational conditions experienced by them. It is therefore more appropriate to discuss the perspectives of peasants and urbanites separately.

Villagers' Perspective of Health Delivery

Four major practical variables influence the user's choice and utilization of a particular service or treatment: availability, performance, effectiveness and cost.

Availability

Certain options are open to Egyptian villagers with health needs.

The first is the government health centers. These constitute the major and most important delivery system available

in rural areas. A health unit usually is located in a central village and also serves the surrounding communities. It is composed of an outpatient clinic, maternal and child health services, family planning clinic, birth and death registration office, immunization facilities, dispensary and laboratory. It is staffed by a number of formally-trained personnel such as the doctor, nurses, assistant midwives, laboratory technicians, health officer and health inspector, as well as a group of self-trained staff such as clerks, stores assistants, cleaners and laboratory and dispensary assistants.

Second, large villages often have one or more private medical practices, and sometimes a pharmacy. These serve the central village and surrounding communities.

Third, practitioners within the traditional, informal health system include birth attendants (daya), barber-surgeons, bone setters, and healers of eye and mouth infections, sun-stroke and dog bites, as well as magico-religious healers.

Fourth, wealthier villagers may choose to go for medication to a nearby urban center or the provincial capital.

Thus both cosmopolitan and traditional health systems are available. This report assumes that as the formal system of medical care develops in the village, the traditional system declines, but for the public health services to be considered "available," there must be enough health centers, personnel

and medicine.

When a health center is established, it is reckoned to serve a population of 20,000 who might be divided between four or five satellite villages, each some kilometers away from the central village where the center is situated. Given the condition of rural roads, transportation problems, population inadequacy and the physical conditions of the patient, it cannot be claimed that the formal public health service is equally available to all peasant communities. The satellite villages are the most deprived.

The health centers are structured to function with a number of professionals theoretically sufficient to meet the needs of the population assigned to them. In fact these professionals are frequently not available. In villages close to towns or cities they often commute daily and are in attendance at the center only two or three hours each day. In these circumstances evening and night emergencies must be served elsewhere. It is noteworthy that in poorer and more isolated governorates problems of personnel availability are less acute and the health service is better disseminated. This pattern reflects conscious policy, but it is not to be inferred that the health status in these areas is higher than elsewhere, for when villages are closer to urban centers alternative sources of treatment are only a short journey away.

The relatively high turnover of professional personnel is

another factor affecting their availability. Many doctors work in the villages for a year or two to complete their obligatory service period and then apply for a transfer to a "better" position. This creates a situation of instability, even if on paper the number of personnel in attendance remains constant. Doctors who are looking forward to a new appointment do not concentrate on developing the health centers, and doctors who are newly-arrived need some time to establish themselves.

A third personnel problem is caused by the shortage of certain cadres in the medical profession. Functioning nurses' training colleges, for example, exist only in Lower Egypt. Their graduates are too few to meet the needs of even their own governorates, but they also have to supply Upper Egypt. A recent article in October Journal states that Egypt has 44,000 nurses while actually there is a need for 100,000 nurses. The result is that many health centers in Upper Egypt are without qualified nursing staff, and this restricts the effective working of the services.

Even when professional personnel are available in person, their time is not necessarily available for curative and preventative medical activities, for they are burdened with many administrative tasks. The following table shows the distribution of the working hours of professional personnel:⁵⁶

TIME OF PERSONNEL DISPERSED AMONG OTHER THINGS

Activities	M.D.	Dentist	Head nurse	Assist. nurse midwife	Sanitar.	Assist. sanitar.	Health visitor	Lab assist.	Clerk	Total*
Comm. Dis. Control	2.48%	-	0.4%	0.39%	3.27%	5.70%	-	0.20%	1.79%	2.65%
Environ. Sanitation	0.26%	-	-	-	22.32%	3.15%	3.05%	0.34%	0.26%	4.42%
M.C.H.	7.65%	-	17.20%	15.95%	-	-	-	0.79%	0.22%	16.52%
Medical Care	27.82%	18.65%	12.24%	13.94%	-	0.93%	19.87%	23.74%	2.00%	30.17%
Admin. & Clerical	18.21%	2.56%	10.52%	10.43%	7.96%	22.11%	17.56%	19.31%	37.01%	32.18%
Vital & Health Stats.	1.28%	0.14%	2.38%	1.10%	1.95%	11.05%	0.60%	1.92%	12.61%	6.32%
Off Station	14.27%	36.28%	28.57%	22.49%	33.48%	27.13%	25.82%	32.74%	23.70%	-
Non Productive	22.31%	12.82%	27.45%	30.01%	13.39%	16.50%	18.08%	18.58%	19.16%	-
On Leave	2.39%	23.33%	-	4.39%	8.33%	9.52%	4.16%	-	-	-
Other Productive	3.33%	6.22%	1.26%	1.30%	9.30%	3.91%	10.86%	2.38%	3.25%	7.74%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: Elaborated from Gadalla and Khalil, 1979, as presented in El Torky Ph.D. dissertation, 1980.

*Percent of total time used to perform task by all personnel relative to the total productive time.

From the users' perspective it may be that the shortage of medicines in the rural health centers constitutes the major shortcoming of the formal delivery system. Villagers equate treatment with medicine and if they know no medicine is available, they see no point in visiting the center. A 1979 study of a health center serving more than 15,000 people shows a budget of £200 per month for medicine. This amount meets the actual needs of a maximum of three days.⁵⁷ This leads to a complexity of problems. When the medicine is finished, patients do not attend. When patients do not attend, the medical staff feel their own attendance is unimportant and are available less often. This reinforces the users' lack of enthusiasm to attend. There is also a tendency to overutilize the service at the times when medicine is available. Clients visit the center even with very minor ailments in order not to miss what they see as their share of the medicine.

The private doctor and traditional practitioners share the common advantage of being constantly available in the community and being members of it. They are ready to attend a patient in another village when called, although they often stipulate the provision of a donkey for transport. It is mainly the fees of the private doctor which prevent the peasant from calling him when in need.

The role of the traditional practitioner in rural areas should not be minimized. Their number alone indicates their

importance. No census figures are available, but individual studies are indicative. One study shows a Menufia village to be served by 14 dayas,⁵⁸ while another study shows a Qalyubia village to have 11 dayas, 3 barber-surgeons, 2 bone setters, 4 women specializing in mouth infections, and several women known to have expertise in treating sunstroke.⁵⁹ A third study carried out in 20 villages in Daqahlia and Fayum presents information in the chart on the following page.⁶⁰

Performance⁶¹

Rural health centers are often characterized by a scarcity of professional staff and an excess of non-professional personnel such as attendants, assistants and cleaners. Villagers who were drafted into the army before and after the 1973 war spent several years in military service and lost the opportunity to train for civilian work. In compensation, these men were granted employment in one or another of the government services in the village. One of the results was the over-staffing of the health centers.

With the exception of the doctor and sometimes the nurse or midwife, it is common for the staff of the health center to come from the immediate vicinity. This situation creates interesting performance patterns. The doctor is the senior administrator in the center, but his staff know the local community much better than he and so are able to influence him to gear

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FOLK HEALERS IN VILLAGES STUDIED

Village	District	Pop.	Barb. Heal.	Dayas	Eye Heal.	Child Heal.	Magi- cian	DogBite Heal.	Tot
Kafr Tanah	Mansoura	1486	2	3		1	2		8
Salamon	Mansoura	8793	10	15	1	1	1		28
Bedeem	Mansoura	6002	4	5		2	2		13
El Faraka	Aga	2000	5	3			1		9
Mit El Amel	Aga	14199	20	25	3	4	11		63
Kafr El Bahateen	Mit Ghamr	1540	2	3			2		7
Kafr Mit El Ghor	Mit Ghamr	3028	4	8	1	1	3		17
Mit Hassan	Mit Ghamr	8556	8	11	1	3	6		29
Shoubra Kebala	Senbelawin	2000	2	6		1	2		11
Tag El Ezz	Senbelawin	5207	8	5			4		17
Kafr El Tawila	Talkha	3049	5	4					9
Nesha	Talkha	7415	7	9	1	2	1		20
Kafr El Hatba	Sherbeen	3505	2	4		1	1		8
Abou Sherif	Belgas	5650	10	8	1	1	2		22
El Baglat	De Kernes	9462	12	6	1		3		22
El Genina	De Kernes	2800	2	2					4
El Erian	Manzala	1265	3	2	1	1	1		8
Satr El Baharia	Ebshway	2874	2	3	1	2	3		11
Shakshouk	Ebshway	2500	3	2	1		1		7
El Hagar	Etssa	5590	4	9	1	1	4	4	23
Total		96932	115	133	13	21	50	4	336

Source: El Kholi Ph.D. Dissertation, 1981.

policies to meet their values and needs. This disadvantage of over-staffing is balanced by the fact that the health center workers function as liaison officers between the official and bureaucratic procedures and the villagers. They advise the doctor on the handling of certain situations and at the same time provide a link by which the villagers can become familiar with the logic of modern medical technology.

The local employees of the health center receive numerous benefits from their positions which affect their performance. They have first-hand contact with the doctor and so gain experience and pick up information. This leads to the development of their own role, for the villagers perceive them as an extension of the doctor and accord them similar status. By listening and watching, they learn what medicines are prescribed for specific symptoms. The absence of modern medical equipment in the centers lessens the gap between the doctors and the auxiliary workers, at least in the eyes of the workers themselves and the patients, and so they begin to feel competent to diagnose and treat certain complaints.

Health center doctors rarely administer injections; this is a job assigned to the auxiliary staff and is a skill which is very beneficial to them. Injections are a highly valued form of medication among villagers, and those with the skill to give them are much sought after and accorded a certain

prestige. Thus almost every health center employee gains extra income from giving injections and many teach their spouses the skill in order to attract patients who prefer to go to someone of their own sex. This service extends to constitute the "injection syndrome," in which the ailment is diagnosed and the injection prescribed, purchased and administered by the same officially unqualified person.

A final benefit of employment at the health center is that it facilitates access to customers. A barber-surgeon, for example, who works in the center has more customers than one who does not.

In some ways this extension of the role of the doctor to his assistants is advantageous. Without it there is no way that the doctor alone could possibly meet the needs of the whole population in his area. A symbiotic relationship exists between doctor and auxiliary staff. The doctor fulfills his official responsibility for medical care by eagerly giving information to his staff, encouraging them to report problems, and providing general support. The relationship becomes more pragmatic than a straightforward superior-subordinate relationship.

Another advantage is that the wide cultural gap between the doctor and his patients, which might tend to prevent communication, is minimized by the mediation of the auxiliary personnel. There are some doctors, mostly those who have been forced by circumstances to take a rural position and who intend

to move on as soon as possible, who refuse to integrate themselves into the village community. These are becoming fewer in number, however, because the housing shortage and high cost of living in the cities is leading more young doctors to choose a career in a rural area. These doctors then make deliberate efforts to gain the confidence and support of the local inhabitants.

Some specific criticisms are made by patients. Physicians who merely interview the patient are thought not to be taking the case seriously; physical examination with the hand or an instrument does much to boost the patient's confidence. Medical attendants can play an important role here by informing the doctor of which patients are persistent malingerers out to take advantage of free medication, and which are likely to have a genuine problem. They can also abuse the system by ensuring that their relatives and close friends are given preferential treatment. Certain studies indicate that physicians do in fact give preferential treatment to patients who will pay a fee. A general physical examination is not usually carried out and the average time taken to see a patient is as little as 1.1 to 2.5 minutes.⁶²

The major disadvantage of the cooperation between doctors and non-professional staff is that these auxiliaries often exploit the customers in order to benefit from facilitating their way to the doctor.

Effectiveness

Rural people recognize that modern medicine is more effective than traditional methods if it is honestly prescribed.

Different types of medication are accorded various degrees of prestige. The most favored are injections, which are considered more effective than any other medication. In a study which experimented with MPA injectables as a family planning method among villagers, it was found that about half of the post-partum cases in the village accepted the injections in the belief that they were more beneficial to the health than pills. Foreign medicines are preferred to those produced locally. Syrups, especially those made up in the health center, are believed to be diluted and ineffective. Coated pills are thought to be "better" than uncoated ones. Health center medicines in general are thought to be cheap, adulterated and ineffective; the ministry is believed to supply a limited number of general medications which the doctors may prescribe for all or any illness. As a result, a patient might visit the center to be examined but ask for a prescription that he can take to a private pharmacy.

There is also a general lack of confidence in the equipment at the health center. Frequent power failures lead people to assume that vaccines, for example, spoil for lack of proper refrigeration. When a fresh batch of vaccine arrives, the local staff of the health center immediately notify the villagers so

that they will bring their children with confidence to be vaccinated.

Weighing machines and scales are also frequently not in working order, and even when they are, only haphazard records are kept of the growth rates of infants and toddlers.⁶³

There are three areas in which peasants believe the traditional delivery system to be far superior to that of the health center. These are childbirth, circumcision and mental disturbance.

For many years dayas were recognized by the Ministry of Health. A training program was prepared for them, and on completion of the course they were given a license. In 1969, however, the Ministry discontinued this system and introduced a new program. In 1970 this produced 2,400 professionally trained midwives (hakima) and 11,000 assistants. It was believed that these would replace the dayas, but this expectation was not fulfilled. Childbirth in rural Egypt is still almost totally in the hands of the daya. In spite of the statistics issued by the Ministry, individual field studies find that dayas are the attendants at about 90% of deliveries. Childbirth is considered a normal process, and the midwife is expected to play a merely supportive role. The following account from the literature describes what this involves:

The *dayas* believed that at the time of birth the fetus passes from the "stomach" into the uterus (*beit al weld*). If the *daya* is able to feel that the head of the child has entered the uterus, she then knows that the mother will soon give birth.

A *daya's* task during delivery is composed of a number of duties. She endeavours to give support, encouragement, and instructions to the woman. After the *daya* has examined the woman, she sits by her side, supporting her back if she prefers a sitting position or holding her hand if she wishes to give birth while lying down. In the early stages of labour the *daya* will advise the woman not to push too strongly as she should conserve her strength. One *daya* was taught by her mother to give the expectant mother an enema of warm water and soap during labour so that she will not "mess" the newborn child.

One *daya* explained her role during delivery as follows: "While she is giving birth, I help her with only two fingers to widen the uterus opening. At the same time, I support her anus with my hand and a piece of cloth so that all the pushing will be directed toward the uterus." When the time of delivery approaches, the *daya* attempts to quicken the contractions by asking the woman to eat some sugar and two boiled eggs. It was mentioned that at times a woman will object to eating the eggs and consume only the sugar. An enema is sometimes used to speed up the contractions.

Once the child is born, the *daya* presses on the woman's abdomen to force the afterbirth out. "We should not cut the afterbirth before the baby comes out, for the cord could be pulled up and then the uterus might close up again, making it impossible to take out the afterbirth except in a hospital," said one *daya*.

If the newborn child does not cry, the *daya* places the afterbirth in cold water in an attempt to induce the child's breathing. If this technique fails, then the midwife knows that the child is stillborn. Some of the *dayas* explained that they would turn the newborn upside down and slap him on his or her bottom or hold a raw onion under his nose to induce crying.

The proper place for cutting the umbilical cord varies from one child to another. A weak, thin umbilical cord should be cut four fingers' width from the child's stomach, and a thicker cord may be cut as short as one or two fingers' width. Several *dayas* also stated that they tie the umbilical cord twice, one knot being at a distance of a finger's width from the other.

The *dayas* commented that most villagers prefer not to bathe the newborn, as they fear that the child might catch cold. In general, therefore, the *daya* simply dresses the baby and places him or her in a large woven sieve beside the mother. The mouth of the child is then wiped in case blood has penetrated inside.

The *daya* then turns to care for the mother, massaging her body and pressing upon her abdomen so as to force all remaining blood out. In addition, the *daya* lifts the woman onto her back so that her back and the woman's stomach meet. She then jumps, holding the woman in this position, allowing all remaining blood to drain from the woman. The woman is then washed and left to sleep.

The *daya* places no restrictions on who is present at the delivery. Generally, the *dayas* agreed that they did not mind the presence of many villagers as they might be of assistance. The *dayas'* desires to accommodate the expectant mother's wishes are clear from the following quotation:

...It is not my business to tell them (visiting villagers) to stay or go away. It is up to the woman herself. Some women prefer to be alone during childbirth. However, the woman could have as many people around as she wants. She could gather the whole village. I don't want to make enemies with anyone.

All *dayas* outlined a series of complications possible during delivery and agreed on the treatment of such cases. A normal birth was defined as one in which the child's head emerged first; however, a case in which the baby's legs appear first is considered normal if the uterus does not close before the child's head comes down. A child born in any other position requires that the *daya* either try to turn the child in the womb or seek the assistance of another professional. For example, if the child is born with legs entwined, a doctor is needed. The *daya* either calls the doctor to come to the home of the woman or, if this is impossible, accompanies the woman to the doctor's clinic (20 km away in the nearest town). If one leg of the child comes out first, the *daya* tries to pull out the other leg. Great care is necessary in turning or pulling the child to avoid extracting the umbilical cord first, possibly delaying delivery, and allowing the child to catch cold and die in the womb. The *daya*, therefore, attempts to "put the cord back."

When a baby is born in the squatting position (bottom emerging first), the *daya* attempts to grab the child's legs and pull them out first. However, if the legs are already stretched, a doctor is needed. Problems also arise if the baby's face fills the vagina first. If the *daya* is able to pull the jaw first, a safe delivery is assured. Otherwise, a doctor is summoned. Similarly, when the ear of the baby appears first, the *daya* attempts to turn the baby in the womb to lead the head out first. A child born arm first is considered stillborn, as the baby does not have enough control over its body to move into a proper birth position. In such cases, "any part of the body may come out first," and the *daya* does "not come near the mother." The *daya* rushes the woman to the hospital if there is excessive bleeding when the woman's uterus is still narrow or otherwise not ready for delivery.

Clearly, the *dayas* do everything in their power to correct the position of the child in the womb. However, when a *daya* feels that she is incapable of handling a delivery, she consults with the woman and her family. At times, the woman asks to be given more time, refusing to contact a doctor. The *dayas* said that such cases are rare and that generally the relatives of the woman are ready to follow the midwife's advice once she announces that she is no longer in control of the situation. In all cases, the *daya* accompanies the woman to the hospital, as there is a possibility of delivery en route.

In general, the *dayas* prefer the assistance of a private doctor, although this is the most expensive alternative available for helping with complicated deliveries. Many of the private doctors encourage — even urge — the *dayas* to bring complicated cases to them. A private doctor is also preferred because often the *daya* is allowed to assist with the birth. Through the exchange of conversation, the *daya* often receives additional medical knowledge. The doctor might tell her, for instance, that the woman needs a cesarean section and should have been brought sooner. While performing the operation, the doctor may also point out various aspects of the anatomy of the human body.

The *daya* has several roles during delivery, and all of her technical skills are directed toward safe delivery of the child. In addition, she mediates between the mother and the mother's family, as well as between the family and outside medical assistance in complicated cases. After delivery, she becomes involved in the care of the baby and performs related rituals.

Most of the *dayas* stated that they visit the mother on the 3rd day after delivery. Occasionally, a *daya* may visit the mother on the 2nd day if she lives close by or has some other reason for returning. A few *dayas* claimed to visit the mother every day. In fact, such visitation varies with the prestige and proximity of the family. The general expectation is that the *daya* will return on the 3rd day to

beautify the baby's eyes with *kohl*, which is believed to promote better vision. She bathes the baby if requested to do so but generally simply rubs the infant with butter to prevent the irritation of lice. In addition, she inspects the child's navel. If the umbilical cord is not yet dry, she applies talcum powder. *Kohl* is used as a substitute if powder is unavailable. The *daya* also helps the mother wash her vaginal area with warm water and advises her to drink *helba* with molasses if she complains of cramps.

In terms of the *daya's* technical skills, her assistance to both mother and child is minimal during this visit. The main reason for the visit is to find out whether the family will celebrate the *sebou*, or the 7th day. During the *sebou* the *daya* plays her most important ritual role, and she receives large sums of money for it. In poorer families unable to bear the expenses of this ritual, the *daya's* role after the delivery is minimal, and she receives her fee during the 3rd-day visit.

In families capable of financing the *sebou*, the *daya* performs rituals believed to protect the mother and child from evil spirits and the evil eye. Traditionally, the *sebou* is held on the 7th day following birth, but the timing may be changed if the family wishes. For instance, the date may be changed to ensure the attendance of an absent family member, to permit the purchase of an adequate supply of meat, or to placate a mother who has lost an earlier child after the *sebou*.

The flexibility regarding the date of the *sebou* and the possibility of dispensing with it entirely indicate that the ritual's social and economic significance for the *daya* and for the child's family outweighs its religious or protective significance. The *daya* is very active in the preparations for the carrying out of the *sebou*. She joins in the cooking of the food and sweets to be presented to the guests, bathes and dresses the child, makes charms for the child to wear, fumigates the house with incense, chants protective verses, meets and welcomes the guests, etc. Moreover, the *daya* receives from each guest a *noqta*, or small sum of money, and it is expected that the family of the child will reciprocate with a similar donation.

This account shows that in cases of normal delivery the doctor could not compete with the midwife, but it is accepted that the doctor's presence is needed when complications arise. Indeed, a midwife who admits in time that a case is beyond her capabilities is highly respected, and many dayas have developed cooperative relationships with doctors in nearby townships whom they call in emergencies. The doctors encourage them in this.

Probably one hundred percent of village girls are circumcised. This is an illegal practice always carried out by local practitioners. The circumcision of boys is universal and is carried out by barber-surgeons, who have acquired a reputation for great skill, even among educated people. Clients believe this skill is the result of experience rather than formal training. In fact physicians generally have a negative attitude towards barber-surgeons, though the role of the daya is beginning to be reacknowledged in official government circles.

Mental disorders are always attributed to supernatural powers, and they are therefore believed to be beyond the scope of modern medicine to cure. Indeed, they are not even seen as illnesses with any biological aspect at all, so cures are always sought from folk healers rather than from doctors.

Cost

It is clear that the rural health center, if used to the exclusion of everything else, provides the cheapest medical

care available. The patient pays five piastres for an examination and then is provided with the prescribed medication free of charge. Those who depend entirely on this service are the poorest of the rural poor, who are not infrequently helped by the staff of the center to utilize its resources to the full. The theoretically free health service provided by the center, however, may become in practice more expensive than the services of traditional practitioners if the medication prescribed is unavailable and has to be procured from a private pharmacy.

The wealthiest of the poor families are more likely to consult a private doctor, but it is rare for medical care to have a regular place in the domestic budget, and financial resources are too limited to enable all members of the family to have private medical treatment. A system of priority exists with men, especially household heads, consulting private doctors more frequently than women. Since they support the family, their illness is reckoned to be more detrimental than that of other members, and so the best available medical treatment is procured for them.

The most expensive form of treatment in the village is a home examination by a private doctor, or by the health center doctor, who when he makes home visits may charge the same fee. In Upper Egypt this may amount to £5.

The fees charged by traditional practitioners are not fixed, and they depend on an individual agreement between

practitioner and client based on the financial resources of the later. The amount paid is sometimes related to social prestige. A wealthy family would tend to reward a midwife or barber generously, more as an expression of joy and thankfulness than as the simple payment of a fee. This is particularly true after the birth or circumcision of a son. Informal practitioners may also derive an income from individuals other than their immediate customers, especially after childbirth. An agreed fee would be paid, amounting to between £2 and £5 by the parents of the baby, but at the celebration traditionally held on the seventh day after the delivery the midwife would attend and receive a donation from all those present, perhaps thus doubling the original amount.

The Healing Process in Rural Areas

Given these alternatives, what courses of action do peasants normally follow in time of illness?

The villagers' ideal choice when seeking medical care is the physician, but in spite of the respect they have for modern medicine and the prestige attached to its use, the inaccessibility of such services often obliges them to try other alternatives. Peasants may well resort first to a local healer, who may or may not be attached to the health center. If the ailment is within his competence, he prescribes treatment, but if it is not he becomes a referral resource to either the health

center or a private doctor.

If functioning, the health center is normally the next system to be tried. In this case the doctor examines the patient and if he diagnoses a simple ailment, he prescribes medication from the center's dispensary. In more serious cases, when the appropriate medicine is not available at the center, he may, at the patient's request, prescribe medicine to be purchased from a private pharmacy. The patients, especially the poor and illiterate, often go to the local members of the health center personnel or to a local healer, to ask the effectiveness of the medication prescribed and how to administer it. If the illness does not improve they consult a private doctor in the nearest town.

The following account of a male farmer illustrates the interplay and trust among villagers, traditional healers and medical doctors.

...My boy fell while playing in school with his friends. When he came home he complained of pain in his arm. I sent for the bone-settler. While massaging the arm the boy pointed out to me a spot under his arm where pain was localized. I looked at it and found that it was swollen. The bone-settler said that it was due to the fall, but I instructed him to stop massaging and let the child alone. I immediately took the boy to the health unit to see the doctor. I found out that he was on holiday, so I went to the health barber. He said that the boy had an internal abscess and he could operate on it. I told him don't do that, but just give him something to relieve the pain. He gave him some pills and an injection, and we waited until the next day when the doctor came and operated. Afterwards we went several times to another health barber who also works in the health unit's clinic to dress the wound and give the boy some penicillin injections.⁶⁴

It is significant to note that patients allow more time for the treatment of a physician to take effect than they do for that of a local healer.

It is clear that the informal or traditional health delivery system is still an important aspect of the rural health system. One reason for this is that it is so readily available, and another that the traditional practitioners excel in the area of performance. An irreplaceable function of the informal health sector is the humanization of the health process which manifests itself in several ways:

1. Members of the formal medical service are evaluated on the basis of their examination performance or length of service, while local healers are valued not so much for their competence as for their friendliness, helpfulness and cheerfulness.
2. Informal practitioners relate to their clients not only in sickness, but also in health. A midwife may help on ceremonial occasions and perform domestic chores for women in childbed. The barber-surgeon's non-medical services may include bathing a bridegroom in preparation for his wedding!
3. A doctor concentrates on the somatic factors when dealing with disease, but the local healer is sensitive to other aspects of the situation.
4. Being conscious of their limitations, informal therapists

do not bind their patients to the line of treatment they prescribe.

5. Informal health agents act as intermediaries between the community and the formal health structure. For example, a midwife may accompany her client to the MCH unit; many barber-surgeons have joined government health centers as cleaners or porters, but in fact they function as counsellors, interpreting the patients problems to the doctor, explaining and legitimizing the doctor's line of treatment and procuring such medical attention as may reassure the patient.

Users' Perspective of Delivery Systems in Urban Areas

Though the urban poor share many of the perspectives of the rural population, certain variations exist owing to the options available and the living conditions in urban centers. The discussion put forward in this section is based mainly on Cairo and Alexandria, which are the locales studied in the available social science literature.

Urban areas have a heirarchy of services. Public facilities include maternity and child health centers, health offices, health centers, government hospitals, university hospitals, insurance services and medical care organizations. The private sector covers a wide range of general practitioners and specialists, hospitals and pharmacies. Private voluntary health

organizations are gaining in popularity. In addition to all of these, traditional healers still practice.

As with the rural areas, we shall discuss the four practical variables that affect the users' perspective.

Availability

The exact number and distribution of the various services are beyond the scope of this paper which will discuss only the way in which their distribution influences the users' utilization of the services.

In Cairo the urban poor complain of the inadequacy of services in general. Public health services are least well developed in peripheral areas and most concentrated in central and north Cairo and Giza, where many hospitals, including university hospitals, as well as medical care organizations, are located. Zeitoun, Dal-el-Salam, Helwan and Embaba, however, complain of the lack of facilities and have made urgent requests for the situation to be remedied. It is relevant to note that among a sample group in Cairo, 54.6% of patients in government hospitals were residents of the area around the hospital, while 38% were there because no similar service existed in their own locality.⁶⁵

MCH centers are more in evidence in poorer areas and the majority of those using them are from the same locality. They consider the services offered to be appropriate for minor

ailments and routine procedures such as vaccination, family planning and antenatal care. The users do not differentiate between MCH centers and almost invariably attend whichever is closest to their home.

Participants in health insurance services and medical care organizations usually have to go outside their own area to utilize them,⁶⁶ but do not complain about this. These services are geared to serve occupational groups rather than localities and are situated close to places of work rather than residential areas.

Non-availability of personnel does not constitute as great a problem in the city as in rural areas. Regular hours are observed by the clinics, but in government clinics these hours coincide with the working hours of most of the urban poor, and so preference is given to the services of the private voluntary organizations which function in the evenings.

As in rural areas, urban facilities, especially hospitals, suffer from a shortage of nursing personnel. Users are aware of the situation, and in both public and private hospitals companions of the patients cooperate with the nurses in many routine services such as feeding, cleaning and administering oral medication.

A further problem with hospitalization is the number of beds. A study undertaken in Alexandria shows a constant decline in the patient:bed ratio due to the rise in population

without a compensatory increase in the number of hospital beds available.⁶⁷ In some university hospitals patients have to share a bed.⁶⁸

The availability of free medicine is as critical as in rural areas. Medicine runs out a few days after its arrival. This affects the utilization of the clinic, but not to the same degree as in the villages since there are many private pharmacies available. Patients therefore often go to be examined at the health center and then buy their medicine privately.

Informal health practitioners are less in evidence in urban areas. No study has shown their numbers, distribution and specializations, but individual studies indicate that the daya is still a viable resource person. Her clients are not necessarily residents of a particular locality, but tend to be the members of certain families with whom she has a relationship. When labor begins, a neighbor attends the mother until the daya can be called.

Female circumcision is still widespread in urban poor areas and is performed by midwives or specialists in this operation.

Barber-surgeons are mostly responsible for the circumcision of boys. Before 1952 Jewish specialists would perform this operation for the middle and upper classes. It is usually carried out in the customers' homes. During saint's day celebrations barber-surgeons perform the operation in booths erected in public squares and streets and attract many customers owing

to the practice of making a vow to circumcise a boy on a particular saint's day if he survives. It is not known if these practitioners are mostly urbanites or whether they come in from country districts specially for the occasion.

Magico-religious therapies of various kinds are more widespread in the city than in the town. The pressures of city life cause more mental disturbances, and the practitioners themselves make use of the anonymity of the city to engage in magical practices forbidden by law.

Performance

Relationships between patients and health delivery agents vary between town and country. Neither the physician nor other personnel, nor indeed many of the patients themselves, are members of the local community, so training, money, class and influence are more relevant to the performance of all concerned than community and kinship relations.

Physicians

Physicians are evaluated on the basis of their academic qualifications, affiliation to an academic institution, length of time spent in examining the patient and the extent to which they use medical equipment. Patients, especially the educated, prefer a specialist to a general practitioner, though a study carried out among general practitioners participating in the health insurance program showed them to lack high academic

qualifications. But the study also showed no significant relationship between the level of post-graduate training acquired and the performance of the doctor.⁶⁹ Of specialists, those who hold a university post receive most confidence from patients. University hospital patients claimed that the service they received from these university specialists was better than that provided by any other channel they had approached. Many doctors serving in public or university hospitals also operate a private clinic. The clinics of doctors who hold a university post are likely to be better equipped than others, and the confidence their patients have in them is further increased by the specialized services they are able to offer. Patients may also use their services as a way of gaining admittance to a university hospital; 46.3% of patients in university hospitals in Alexandria claimed they had been referred to the hospital by their own doctors.⁷⁰

The urban poor, like the rural population, evaluate the performance of a physician according to whether he conducts a physical or merely oral examination, and according to how sophisticated and varied his equipment is. The physician in the public sector is usually regarded as being above question, and any failings are attributed to the lack of equipment available to the doctors in health centers rather than to the doctor's performance itself.

Patients at MCH centers prefer to relate to the doctor

rather than to other personnel, though good relations with auxiliary personnel must be established in order to gain access to him. Thus, despite the distancing effects of bureaucracy, MCH clinic staff are incorporated into various networks of relationships within the community.⁷¹ The fact that the doctor alone does not accept tips gives him a higher status and makes him more respected than any other members of the clinic staff. Women patients value the time the doctor gives them and advise each other on the best approach to him to adopt; some believe one should describe every detail as fast as possible, but with due respect, while others think it is best to let the illness speak for itself.⁷² The doctors for their part understand the psychology of their patients, and though they may conduct only brief examinations at the public clinics, they give more time in their private practices, and so many patients by-pass the MCH clinic altogether.

Nurses

The social science literature relates the performance of the nurse to the low status she is accorded in Egyptian society. Nursing is one of the most devalued of female occupations, being closely associated with prostitution and servitude. Society has not come to terms with the necessity for a nurse to deal with the unclean aspects of the body and to be exposed to naked males,⁷³ and has not overcome the fact that in the early eighteenth century the first recruits to the nursing school were

slaves. Because of its associations, girls from a middle class or traditional rural background do not enter the profession, while better-off families who encourage their daughters to get nursing training expect them to acquire higher degrees in nursing. One study notes that the higher a nurse's qualifications, the less direct contact she has with patients, and that Egypt has a higher proportion of nurses with Ph.D.s than any country except the United States.⁷⁴

Thus a high proportion of nursing personnel come from poor urban families and are therefore of the same social class as the patients they serve in the public clinics and hospitals. Nevertheless, they acquire power through their association with the formal health system and their exploitation of this leads to constant complaints of rough and humiliating treatment and negligence on the part of MCH center nursing staff.

The hakima (a professional midwife who has received nine years of general schooling and a three-year diploma course) ranks after the doctor in the MCH clinic. She and her assistant are regarded as "licensed" dayas, but their performance is less highly rated. They are accused of impatience and of inducing delivery or speeding it by pressing the mother's abdomen in order to same time. It is accepted that they are efficient and knowledgeable, but they are known to give preferential treatment to the wealthier local women with whom they form ties outside the clinic system.

A number of female attendants (tamargiyat) are also employed at the MCH clinics, officially to assist the hakima. They order the queues and fetch files, and, like the hakima, accept tips to speed the turn of patients, who may have to wait for as long as two hours.

The performance of nursing staff also plays a critical part in the hospital system; lack of appropriate nursing resources is often regarded as the main weakness of Egyptian hospitals. The doctors themselves do not have confidence in the nursing staff's capabilities, and the involvement of the patient's relatives to take over some nursing responsibilities is one inevitable result of the problem. A survey carried out in a public hospital in Alexandria shows that the nursing personnel depend heavily on the companions of infant patients, most of them uneducated. An experiment was conducted in which these companions were given a course on planned health education from the moment of hospitalization, including such simple matters as washing of hands. Fewer deaths occurred among the experimental group than among the control group.⁷⁵

Effectiveness

All groups of the urban population believe the treatment provided by the private specialists is the most effective. When financial resources are limited, the private clinics of voluntary associations are ranked next. These clinics are

regarded as very effective unless the ailment is very serious or requires surgery. The outpatient clinics of university hospitals are considered the best of the free services and are accordingly overutilized.

The fact that low income groups resort to private clinics and physicians indicates their lack of faith in the MOH primary facilities. Patients feel that when they attend them, they expend too much energy for too little result, and so primary care centers are often adequately staffed but underutilized. MCH centers are used more for vaccinations than for actual pediatric or antenatal health care. A sample survey undertaken in Cairo showed that 78% of respondents reported utilizing MCH clinics for the care of sick children, while 78% used them for vaccinations. This study indicates that users of these centers are more concerned with the form than the content of the service.⁷⁶

One may say that MCH clinics cater to three groups of women: mothers of young children who cannot afford private doctors; local residents of mixed income who use their relationships with the clinic staff to obtain preferential treatment; and, women with young babies who attend private clinics but need the birth certificate and inoculation services provided by MCH centers.⁷⁷

This situation is not only a reaction to the low performance level of the staff, but also a result of lack of trust

in the effectiveness of the medicines provided. Users observe that the same medication is prescribed for different illnesses, and their observation of on-site preparation of medicines leads them to believe as well that the mixtures are diluted.

Many patients who attend MCH centers do so to double check another option already taken. Since the clinics provide free medical examinations and medication, why should they not make use of them? is their attitude. This is believed to increase the chance of an effective cure and complies with the belief of multiple causation to be followed by multiple medication.

Sometime the effectiveness of medication is believed to be increased by increasing the dose taken. Thus an overdose of contraceptive pills may be taken to procure an abortion.⁷⁸

The users' perspective on the effectiveness of hospitalization is bound up with certain cultural values.

The provision of food for patients is one cultural variable which has some influence. Hospital fare is considered insipid, being prepared without the accustomed clarified butter and tomatoe sauce. Patients therefore refuse to eat it, and their relatives bring food from home to sustain them. Hospital attendants are often invited to share this food in return for not reporting to the doctors.

Fear of hospitalization is related to a fear of surgery, which is associated with it. Hospital treatment is therefore often postponed by the patient until his case is so critical

that medication is ineffective. This simply serves to reinforce the original fear. As a particular example, a study of two Cairene maternity hospitals attributes maternal death to late arrival at the hospital,⁷⁹ which many physicians in turn attribute to the use of a daya as a first option. Dayas still attend many deliveries in poorer areas; they are preferred for the personal quality of the service they give, their patience, post-natal care, concern for the household and good personal relations.

Cost

In the users' view there is a significant correlation between the cost and quality of medicine and medical services. The higher the charge, the better the service and result, even though the same doctor examines patients free in a health center and for a fee in his private clinic. The daya is not an exception to this rule as she charges more than a public clinic for a delivery.

The Healing Process

Unlike the village setting, where the peasant chooses between one health unit or a traditional alternative, the healing process for the urban poor involves many trials and errors, experience and consultation with others.

Not all patients seek medical treatment as soon as they

feel ill. Excluding cases that begin with extreme pain, severe hemorrhage, unconsciousness or other alarming symptoms, a pattern for seeking treatment may be perceived. It involves two phases, the first exploratory involving certain alternative approaches made either simultaneously or consecutively, and the second constituting real therapeutic action which also includes various options.

The Exploratory Phase

This involves such measures as self-treatment and home remedies, consultation with neighbors and relatives, visits to primary health care facilities and the purchase of medication from a herbalist (attar) or pharmacy.

Women are considered to be in charge of family health, but men are consulted whenever money is involved or if a case seems serious enough to warrant "real therapeutic action." Certain home remedies are applied when symptoms are mild, the seriousness of the symptom being relative to the patient's age. In children, low fever, cough, colic, cold and mild diarrhoea are all considered mild symptoms treatable at home. The treatments administered include infusions of cumin for stomach ache, aspirin for headache, natural gum for a cough and cornstarch pudding for diarrhoea. A socio-cultural survey undertaken in Cairo indicates that parents do not pay particular attention to swollen eyes, sinuses, loss of appetite, sleeplessness, stunted growth, delayed speech or intestinal worms. Mild

symptoms in women include headache, fever, general weakness, vomiting and mild hemorrhage, all of which may be treated at home. This probably arises from the low priority accorded to women's health in relation to children's by society and by women themselves.⁸⁰

The most extreme cases of women's self-neglect occur during pregnancy and childbirth. Antenatal care is often completely ignored, and during childbirth help is often not sought until the last moment. Cases of self-delivery are not uncommon, and it is normal for an elderly neighbor to attend the birth and then call the clinic midwife to cut the umbilical cord.

The MCH clinic may be one of the avenues explored in the preliminary phase. It is regarded as a testing process, for the woman has not much faith in the treatment she will receive, but if she senses from the doctor that her case is serious, she will begin to take "real therapeutic measures."

Another avenue might be to seek a cure from the herbalist or pharmacist, the choice depending on which is nearer and more cooperative. Also, a woman consulting a herbalist is probably thinking more in terms of home remedies and traditional healing. The herbalist may be preferred too because his remedies are readily available, inexpensive and known to be effective, and he himself will not insult or ignore one.⁸¹ When a woman seeks out a pharmacist, it may be a sign that she wants to try modern medicine but by-pass the physician. Pharmacists are expected

to diagnose and prescribe over the counter and are consulted on the correctness of any projected treatment, from penicillin injections for pneumonia to aspirin for a headache. They may retain an assistant to give shots on the spot but often refer the customer to a specialist. If someone cuts himself, he will run first to the pharmacist who may bandage the wound or else advise that it be stitched at the hospital; this illustration gives a simple picture of the role the pharmacist may play.

Real Therapeutic Action

A survey of hospital patients revealed that they had waited anywhere from one day to thirty-six months after the appearance of symptoms before seeking medical advice. On the whole, pediatric cases and to a less extent orthopaedic cases tended to seek care earlier than cases needing obstetric or gynaecological treatment.⁸²

Seeking "real therapeutic action" commits the urban poor to making many potentially critical decisions which are influenced by economic considerations, past experience of various delivery systems, personal contracts and the perceived severity of the case. The poorest of the poor resort to primary health facilities; they utilize either the examination and the medication provided by the clinic, or the examination alone, and purchase the medication prescribed from a pharmacy. Those who can afford the fees charged by voluntary association clinics use these either as "real therapeutic action" or as a means of

referral to a specialist or hospital if necessary.

Specialists are highly valued and numerous, but because of the fees they charge, the urban poor feel obliged to select a doctor very carefully, and the selection process may lead to a considerable delay in taking action.

Treatment through public and university hospitals may be through the outpatient or inpatient delivery system. Outpatient clinics are readily utilized, but there is great reluctance to join the inpatient section. A study undertaken in Alexandria shows that 76.6% of inpatients had sought medical care elsewhere before being hospitalized, and that 19.3% had been to more than one source. Less than one-fifth had consulted general practitioners, 46.4% had consulted specialists, 24.3% had consulted specialists with university posts, 8.9% had been treated in the outpatient department first and 15% in other hospitals. Only 6.8% had attended specialized clinics.⁸³

Areas Needing Social Science Research

1. Perspectives of the educated and middle class users of the available health services need investigation.
2. Educational and training programs on the nutritional values of certain foods and body needs at different periods of the life cycle are essential.
3. The role of the health inspector needs to be studied, utilized and reformulated to encourage community participation.
4. Investigation of the possibility of utilizing informal practitioners as health educators is needed.
5. The role of the nurse and auxiliary health personnel needs systematic assessment.
6. Attitudes and practices of visitors to hospitalized patients and their effect on the healing process need to be studied.
7. Development of training programs to promote the traditional daya.
8. A public opinion survey on users' attitudes and acceptance of health insurance policies is needed.

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Abd El-Rahman, Hanim Attiya, "Social Factors which cause the Spread of Schistosomiasis, a plan for controlling it," M. A. Thesis, Faculty of Social Work, Helwan University, 1976.

The research is a study of the behavioral patterns which lead to the spread of schistosomiasis, in order that appropriate programs could be carried out to modify these behavior patterns through the improvement of the individual's environmental health conditions. The research was carried out in Mannial Shiha village, Giza Governorate.

Research Results

- The Health Unit is the only health service available for the village. Its outpatient clinic receives annually 2367 clients (total adult population of the village is 15,000). This indicates that a low percentage of the population utilizes the unit's services. The researcher considers that the bureaucracy of the work system at the unit is the cause of such a low utilization rate. Tickets are sold until 9 a.m.; those who come after that time cannot have a medical examination. A large percentage of the villagers said that they do not go to the health unit because it wastes their time.
- 80% have eye diseases due to the presence of garbage in the streets and the defective drainage methods. Environmental diseases such as schistosomiasis, ancylostoma, ascariasis and contagious diseases such as typhoid, measles and dysentery are prevalent due to the spread of flies and insects.
- Also, a large portion of the population suffers from the consequences of malnutrition. Malnutrition is a result of low family income and the spread of harmful habits such as drug addiction, over smoking and overdrinking tea. Malnutrition is also a consequence of lack of awareness of sound nutrition basics. Villagers concentrate on carbohydrates intake because it is inexpensive and ignore proteins. Although milk is available, villagers do not drink it but sell it or use it for dairy production.

- One of the shortcomings of the health unit is that it does not have a full medical examination which indicates the extent of schistosomiasis damage.
- The research covers some of the habits which accelerate in one way or another the spread of schistosomiasis. One of these habits is abolition which takes place more than once daily. Villagers use canal water for abolition because they consider it pure, clean, running and without disease.
- Also the researcher covered eight agricultural processes which the peasants use, six of which expose him to schistosomiasis from canal water. The highest exposure rate comes from the process of changing the direction of the water wheels. In this process the peasant's body is exposed for a long time to the irrigation water as he walks in the water path. He does not wear anything on his feet during this time.
- Villagers know that canal water carries schistosomiasis, yet they are not aware how schistosomiasis is transmitted to them. As a consequence of this ignorance, they just avoid drinking canal water.
- Villagers lack awareness of how schistosomiasis is transmitted. Since they think it is only transmitted through drinking, they do not drink from the canal yet use it to wash their clothes and kitchen utensils. They also use this water for bathing.
- Urination and defecation in the canals is also a source of transmittal. 63% of the villagers urinate and defecate in the canal. 11.7% of those who do not use the canal are aware that it causes water pollution. The other 25% do not use the canal because it is not proper.
- The villagers are very aware of the need to improve their environment in order to improve their health status:
 - a large number of them approve of having water closets at their homes;
 - they approve of public washing places in order to abolish the habit of washing at canals;
 - they think it is important to wear shoes during work;
 - they want buildings to be solid enough to allow potable water pipe systems.

- Treatment habits of schistosomiasis:
 - 53% go to the health unit because it provides free treatment;
 - 46% do not go to the health unit for treatment because it wastes their time and the treatment prescribed for schistosomiasis weakens them;
 - the women go to the unit more frequently because there is a doctor whom they trust;
 - the nature of the men's work is a hinderance to their regular attendance for treatment. Also, their lack of treatment awareness in the case of schistosomiasis is reflected in their discontinuing treatment when they notice that they stop bleeding at urination and defecation. They consider that they have recovered which is not the case.
- Only 26% of the children do not swim in canals to avoid getting schistosomiasis.
- 71% of the villagers use canal water whether at home or at the canals for bathing. Only a small portion of the villagers use tap water for bathing.
- Even those who have potable water sources at home are obliged to use canal water more than once daily due to their presence all day in the field.
- The research indicates the groups which have a role in changing the social factors and creating awareness. These groups are the social workers, the doctors at the health unit, health home visitors, school principals and teachers, agricultural engineers, Imams and youth volunteers.

Badawy, Hoda Abd El-Halim Ahmed, "A Study of the Effect of the Mothers' Nutrition Status on their Health during Pregnancy; and the relation of their nutritious and health status to the child's development standards," M. A. Thesis, Faculty of Agriculture, Alexandria University, 1977.

The study took place at maternity hospitals in the mid-district area of Alexandria Governorate.

The research aims at evaluating the health status of the pregnant mothers, the degree of nutrition

awareness of those mothers, and the relation between the degree of nutrition awareness and the nutrition status.

Research Results

- 45.3% of the pregnant women have anemia and a low nutrition status as a result of their low nutrition awareness. 44% lack awareness of sound nutrition needs.
- There is a correlation between the awareness state and the socio-economic status. Also, it is affected by the number of the family members. The family which is composed of two members has more awareness than that composed of five members.
- 25.9% of deliveries take place at home, 69.4% at the hospital and 4.7% at the MCH center.
- The researcher studied the relation between the frequency of going to the hospital or doctor during pregnancy and good nutrition to avoid anemia.
- The husband's occupation affects the kind of nutrition and nutrition awareness. Officials have more awareness than merchants, and workers lack nutrition awareness.

Dagidy, Abd Al-Rahman Ali, "A Plan for Modifying the Role of the Social Worker in the Field of Medicine," M. A. Thesis, Faculty of Social Work, Helwan University, 1977.

The study presents the social workers' perception of their role in the field of medicine. The research is carried out on the social workers at their different places of assignment within Cairo, Giza and Menofiya Governorates. They are assigned in public hospitals, specialized central hospitals, MCH centers, school health groups, eye infection hospitals, grievance departments at ministries, governorate health directorates, and departments of public relations at ministries.

Research Results

- Those responsible in the field of medicine do not consider the role of the social worker to be important. Doctors view the patient from a restricted medical focus and ignore the human side. As a result, social workers are assigned different work than that of social services.
- Social workers concentrate on the preventive side which is not given enough emphasis by the ministry. The preventive side includes health awareness, and environmental pollution.
- For different reasons 57% of the social workers do not participate in the programs for creating health awareness. Some do not participate because they consider these programs in their present state are useless. Others do not participate because they were not asked to participate or because they do not have experience in that field.
- The social workers consider that their role in the rural areas should focus on creating health awareness.
- The social workers suggest that they should have a role in receiving the patient at his arrival at the hospital and at his departure to get acquainted with the patient's social circumstances.
- There should be a budget for social financial aid.
- Transportation facilities or transportation allowance should be provided for social workers to facilitate visits to the patients' homes.

Fadly, Wafaa Mohamed, "Hindrances to the Fulfillment of the Social Worker's Role in the Psychiatric Clinics," M. A. Thesis, Faculty of Social Work, Helwan University, 1978.

The study aims at presenting the role of the social worker at psychiatric clinics and the hindrances to fulfilling this role with recommendations for overcoming them. The study is carried out in Cairo's governmental psychiatric clinics which have social

workers. The 14 clinics are distributed as follows:

- clinics attached to public hospitals at Ahmed Maher, Shubra, Boulaq and Helwan;
- a clinic attached to Dar El Shifa Wa El Siha El Nafsiya at Madinat Nasr;
- clinics attached to the school of health in Garden City, Hadaik El Kouba, Gizirat Badran and El Hilmiya El Gidida;
- university hospital clinics (Kasr El Aini and Dimirdash);
- some university faculty clinics (Faculty of Education, Ain Shams University)

Research Results

- 25% of the social workers at the governmental psychiatric clinics were appointed on the basis of their efficiency and desire for work. The rest were appointed by the Labor Force or were transferred from other institutions.
- The social workers are trained before getting their job, yet this training is insufficient both in duration and kind. The training concentrates on theoretical lecturing and discussion of cases; practical training through field visits is given a short period.
- 70% of the cases which frequent the psychiatric clinics first meet the social worker, but this meeting is a regular one to get information about the patient, his family and his psychic case. Due to the limited number of social workers in relation to the work load, there is no time to carry out a comprehensive social study for each case. Each social worker meets about 13-16 case daily which is considered a large number in relation to the requirements of the work.
- Also, the social workers rarely do home visits although they consider it very important. The researcher considers that financial facilities should be provided for these visits.
- The social workers complain of the lack of institutions which help them in performing their role. Also, those responsible at the places where they work assign them administrative work which is not closely related to their field.

- It is generally noticed that the medical administration does not give much attention to the role of the social worker which reflects inadequate awareness of that role. This is clear in the lack of a special budget at psychiatric clinics, lack of a proper place for the social worker at the clinic to perform his work, low financial incentives, the regular shortage in number of social research schedules, and no specially assigned place for keeping patients' files in order to refer to them easily.
- The research indicates an increasing number of patients at the psychiatric clinics which requires an increase in the number of psychiatrists.
- The patients' perception of the role of the social worker is as follows:
 - solving the patient's problems;
 - studying the social environment of the patient;
 - collecting data on the patient.

The researcher considers that a large number of the patients do not have a correct idea about the work of the social worker.

- The relation between the social worker and the patient:
 - the research indicates positive trends towards the home visits of the social worker. Only a small number of the patients object to these visits because they went to the psychiatric clinics without informing their families or because the family disapproves of psychiatric treatment.

Fahmy, Noha El-Sayed Hamed, "The Urbanized Village; a social study at El-Hawamdiya," Ph.D. Dissertation, Faculty of Arts, Ain Shams University, 1973.

The research was carried out in El-Hawamdiya city, Giza Governorate. It is a study of the social changes which took place in a rural society in the process of urbanization as a consequence of industrialization. The society is divided into an agrarian and an industrial part.

The transformation into an industrial society did not change the health and treatment values of the population

concerning delivery and the age for marriage. Change took place in the people's perception of the required healthy environment, the healthy house and its services and utilities.

Research Results

- Early marriage age is more prevalent among rural families than industrial ones. 24% of the industrial families marry before the age of 20. This rate is 44% for the rural families. Also, while 44% of industrial families marry after the age of 25, only 8% of rural families marry after that age.
- Although there is an increasing number of doctors, deliveries are carried out by dayas or relatives and neighbors with experience.
- Although 98.9% of the population are aware of family planning, 57% do not try to practice it. Wives refuse the use of contraceptives for fear of their side effects.
- There is a high awareness of the effect of the house and its utilities on health. People would like to improve the condition of their houses and utilities. 60% consider that it is important to improve the sewage system.
- 93.3% of the families do not budget for medicine. One reason for that is the Sugar Company's health insurance program for their workers.
- Sanitation and environmental conditions:
 - homes are crowded, 38% of the industrial families and 48% of the rural families have five persons per room;
 - 25.6% of the houses for those working in industry and 10% of the houses for those working in agriculture have bathrooms;
 - 55% of the buildings do not have potable water;
 - Only 16.2% of the buildings have a kitchen within the apartment.

Fouad, Ilham Hussein, "Work Groups in the Area of Social Services and their Role in Handicapped Rehabilitation," M. A. Thesis, Faculty of Social Work, Helwan University, 1978.

The study assesses the role of the group as a means for individual development for the handicapped, especially helping the handicapped to advance with treatment through the group work.

An experimental and a control group were used in the research. The study took 13 weeks and was carried out in a vocational rehabilitation center.

The study indicates that the handicapped's participation through group work in discussing their problems and suggesting solutions for them leads to their acceptance of their handicap. Their practice of complex activities and acceptance of vocational training programs is increased.

El-Hamide, Magdi Abdallah Abd, "An Exploratory Study on the Social Problems of Cancer Patients in Cairo," M. A. Thesis, Faculty of Social Work, Helwan University, 1973.

The research discusses the social problems which face cancer patients. These problems include family problems, social relations, economic problems, work and free time, religious aspects, social services and medical services. The research was carried out at the Cancer Institute and the Association of Cancer among patients and their families.

The medical aspect of the study was covered in one chapter; the other problems were presented in the remaining parts of the research, including those which indirectly affect the health aspect such as leisure time and social services.

The research sample is not representative; it is selected from the married male patients who have a regular income and have the ability to read and write.

Research Results

- The patients complain of bad treatment from the nurses. This indicates the nurses' low level of training in programs on human relations and ways of treating patients.
- The patients consider that the social services provided are insufficient. For example, the social workers do not give much attention to patient home visits; the patient is not helped by facilitating the treatment procedures; creating treatment awareness is not given enough attention; and, patient problems are not kept confidential during discussions.
- The research indicates a low awareness level about cancer, i.e., ignorance of its causes, its early symptoms and preventive methods.
- Also, there is, relatively, a trend towards modern medical treatment. 54% of the patients indicated that they do not use folk methods for treatment, while 46% use folk methods in varying degrees.
- The patients emphasized that the doctors do not give attention to post-recovery period. This is illustrated by doctors not giving medical instructions, not hearing patient complaints, and not carrying on continuous regular medical examinations. Also, the hospital stops distributing medication.
- The low economic capabilities of the patients' families force a large number of them to look for work although work is difficult and tiring for them due to their health status.
- 90% do not receive financial aid from any source because they did not apply for aid either from ignorance of these resources or distrust that they would receive assistance.

Hefni, Kadir, "Patterns of Awareness and Behavior of Egyptian Farmers in Relation to Family Planning," (summary of Arabic text), Population Studies, Population and Family Planning Board, 1981.

This is a review of field studies dealing with population problems in rural Egypt with the aim of identifying the patterns of awareness and the attitudes of Egyptian farmers towards the various aspects related to family planning.

Ismail, Farouk Mostafa, "Social Change in the Desert Society; A study of Marriyot area," M. A. Thesis, Faculty of Arts, Alexandria University, 1970.

The study was carried out in Marriyot area, kilometers 37 through 68 east of Alexandria. This area is divided into two sectors, the coastal sector whose population had intermingled with people from relatively urban areas in the Nile Valley, and the interior sector whose population was not affected by external factors.

The study did not concentrate on health values and norms, but it did touch on them indirectly.

Research Results

- The coastal and interior sectors have different health environments.
- 94.6% of the houses in the coastal area are modern ones built of bricks, while 89.2% of the population of the interior sector live in tents.
- 96% of the coastal population get potable water from public taps; wells are the source of potable water for 81% of the interior population.
- Between 33-37% of the coastal area houses have water closets; in the interior sector between 96-100% of the residences lack water closets.
- Folk methods, herbs and burning are used in treatment.
- The age of marriage is delayed in the coastal sector relative to that in the interior area.
- Both populations have no idea about family planning. In the coastal sector in rare cases they have heard about it but there is no trend towards it.

El-Khodary, Laila Mohamed Ibrahim, "A Study of the Effect of Some Economic, Social and Nutrition Factors on Child Development," M. A. Thesis, Faculty of Agriculture, Alexandria University, 1976.

The study took place in three villages, Marriyot District, Alexandria Governorate. The research concentrates on nutrition, studying the available health facilities and residents' utilization of the health services. The study includes discussion of environmental factors which affect health, family planning awareness, predominant diseases and child mortality.

Research Results

- Health Institutions: There are health units within each village. There is no hospital for this district, the nearest hospital is in Al Amiriya District.
- Health Units: Although 81% of the mothers go to the health unit for medical treatment of their children, they have negative attitudes towards the value of the services which these units provide.
- Only 36.5% consider the health services provided by the health units to be good; the rest consider them to be either of a low or moderate level.
- 13.4% go to a private doctor for treatment although they have to travel a long distance whether at Alexandria or Al Amiriya.
- Only 1.9% go to the hospital for treatment.
- 3.5% use folk methods for treatment.
- Nutrition Habits: The following are prevalent:
 - the main meal is dinner;
 - the nutritious food stuffs are distributed among all members of the family without preference for the children;
 - there is more consumption of vegetables, fruits and energy-providing food groups and less of dairy and proteins.
- The general standard of cleanliness is low to moderate:
 - potable water is provided by public taps which are outside the building;

- there is an animal enclosure within the house's yard;
 - there is no specific place for cooking which can take place in any room of the house;
 - drainage is unhealthy due to the lack of a sewage system;
 - fertilizers are stored in the house.
- Prevalent diseases:
 - 58.5% of the people suffer from malnutrition;
 - 41.4% suffer from environmental diseases such as parasites and eye infections;
 - 1.1% have infantile paralysis.
 - The child mortality rate is high for the pre-school age group.
 - 50% of the people approve of family planning, yet only 11.1% practice it. A large number of them start practicing family planning after the fourth child.
 - There is a negative attitude towards the health institutions, as indicated by the lack of much difference between children whose parents treat them at health units and those who are treated by folk methods. The health units do not perform their role.
 - 72% of the children did not complete their vaccinations for contagious diseases do to lassitude of the health institutions and low awareness of mothers.

El-Kholi, Hassan Ahmed, "The Rural-Urban Differences in Some Elements of the Folk Tradition; a social study on Saints and Folk Medicine in rural and urban areas," Ph.D. Dissertation, Faculty of Arts, Sociology Department, Cairo University, 1981.

Research Results

- There is a relation between the ecological characteristics and the nature of the geographical area on one hand, and the state of folk medicine, its predominance and the continuity of some of its elements on the other hand.
- There is a struggle between folk medicine and modern medicine, yet the existence of folk medicine is dependent on the standard of living of the people, better

health care systems, formal health delivery system and the spread of education.

- There are folk treatments which are basically rural while others are purely urban. That is to say, there is specialization among urban and rural folk healers. The midwife, the barber and the magician provide healing and treatment services for many health problems, yet there are some who specialize in the treatment of specific diseases at the village, e.g., treatment of eyes by licking, treatment of children by mouth wiping, and treatment of dog bite. The treatment of scab is one of the urban treatment specialities.
- There is a rural-urban interchange of folk healers' specialized services. Some urbanites receive eye treatment and magic treatment services by rural folk healers, while many rural people go to the city to get treatment for scab.
- Folk healers in rural and urban areas acquire skills and treatment knowledge from one generation to another.
- The fee of the professional folk healer is related to the degree of urbanization. Urban healers are paid in cash, while rural healers in urbanized villages are usually paid in cash but in some cases are paid in kind. In small villages which are less urbanized healers are usually paid in kind and in some cases in cash, especially when clients are urbans. Some rural healers delay receiving their fee if the client is poor and unable to pay for the treatment service when he receives it. The client pays the fee when his economic conditions improve.
- The elements of the folk medicine used correlate with the nature of the local environment. The local plant and animal character is predominant in the elements used in the rural areas, while the urban environment character is predominant in the elements used in urban areas, such as substances from the atar and manufactured elements like starch and tar.
- The individual's behavior to treatment and facing illness is relative to such dimensions as poverty, the standard of education and place of residence. There are rich individuals whose behavior in this area does not differ much from the behavior of the poor. Also,

there are some poor individuals who in the face of poverty lack the choice among alternative treatment services available. This forces them to select the less expensive folk treatment. Some educated rich individuals seek folk treatment when modern medicine fails to achieve noticeable results for some diseases.

- There are differences in the practice of folk treatment with regard to socio-economic status and the standard of education. However, the religious and magic dimensions of folk medicine are practiced equally by the poor and the rich and the educated and the uneducated in rural and urban areas.

Ministry of Health, Arab Republic of Egypt, "Public Opinion Towards Health Services," Health Profile of Egypt: Memo No. 2, 1978.

This memo points out that to form public opinion about health services in Egypt, the Ministry of Health must expose to the public a comprehensive interpretation of the health policies, plans, services, achievements and difficulties in implementation through all the channels of mass media. Then the Ministry examines the complaints and the positive attitudes towards health services offered in order to put them into action and correct the views and opinions of the public.

Mohamed, Yousriya Ahmed Abdel Monim, "A Study of the Effect of the Social and Economic Factors on the Acceptance of the Working Wives for Some Preserved Foods," M. A. Thesis, Faculty of Agriculture, Alexandria University, 1975.

The study was carried out on a sample of working wives at Alexandria University.

Research Results

- 33% of the working wives consider income as the main factor which determines the kind of the nutritious meal.
- 37.6% of the working wives consider that the reason for non-acceptance of preserved food stuffs is its

nutritious value is relatively lower than the fresh one.

- One of the conclusions is that the kind of food is not selected on the basis of its nutritious value.

Morcoos, Widad Soliman, "Social Factors which Affect the Fertility of the Working Woman," M. A. Thesis, Faculty of Arts, Cairo University, 1973.

The study is carried out in Kism El Wayli, Cairo Governorate. Using two groups, an experimental and a control group, the research studies the effect of the rise in the woman's status on her fertility rate.

The research proves that the woman's work outside home causes a delay in the age of marriage and gives her new interests. It also increases her influence at home, especially on the decision of the number of children. The research proves that woman's work causes a change in the traditional division of work among husband and wife which provides a larger chance for discussion between them.

Research Results

- The wives who work have a lower fertility rate. The research indicates that 37% of the wives who work have four children or more while this percentage is 57% for the non-working wives.
- Work has an effect on the number of births if the woman is educated. In the case where the woman is not educated, the difference is not large between those who work and those who do not. Thus, education has a more important effect on the number of births than the woman's work outside the home.
- Wives from both groups, the experimental and the control groups, approve of family planning.
- The most important factor which affects the success of family planning is the discussion of this issue by the married couple. The research has indicated that 85% of the wives who work discussed this issue with their husbands. 94% of the husbands of the wives who work approve of the idea of family planning.

- Abortion rates are high for the working woman.
- The basic conclusion of this research is that the woman's view of family planning is shaped by her education more than her work. Also, the woman who works starts practising family planning at a relatively earlier age than the woman who does not work.

Mostafa, Badreya Shawky Abd El Wehab, "Decision Making in Family Planning; a field study at Minia city," Ph.D. Dissertation, Faculty of Arts, Minia University, 1979.

This is a study of the trends which influence family planning as reflected in the process of decision making on this issue. The study was carried out at the family planning centers in the city of Minia. The sample is composed of participants at family planning centers who practice family planning and non-participants who do not practice family planning.

Statistics at family planning centers during the period 1971 through 1975 indicate a continuous yearly decrease in the number of participants at family planning centers. While in 1971 there were 1255 participants, in 1975 the figure was 1207 participants.

The research draws a correlation between the standard of education, the ages of husband and wife, income, number of male children and the practice of family planning.

Research Results

- The research illustrates that the husband's opinion has a great deal of influence in taking a decision on the issue of family planning. The male power is still dominant in marital relations. 93% of the couples practice family planning with the approval of the husband.
- The efforts of those working at the centers failed to attract women to practice family planning because they were not aware of the above fact. They addressed the women only. Another reason their efforts failed was because they used advertising only without direct face-to-face communication.

- Reasons for non-practice of family planning:
 - confusion between family planning and sterilization; many of the women believe that contraception means sterility;
 - fear of using contraceptives because these are new things which they have not used before;
 - the spread of rumors about the side effects of using contraceptives;
 - fear of disobeying their husbands;
 - the influence of values and traditions on the importance of a large number of children.
- Families who do not practice family planning:
 - 19% have not heard about family planning centers at all;
 - 74% have moderate information about family planning centers;
 - the remainder did not go to the centers because of the aforementioned reasons.

El-Sayed, Mostafa Kamel Mohamed, "A Social Study of the Rural Health Institutions at Abu Homos Markez, Beheira Governorate," M. A. Thesis, Faculty of Agriculture, Alexandria University, 1975.

The study took place in Markez Abu Homos which has 13 health facilities, two health centers and nine health units. The study concentrated on the health institutions and the doctor's view of the clients and trends of utilization.

Research Results

- 46% of the pregnant women do not visit the health unit regularly.
- 59% of the deliveries are carried out with the help of a mother or relative.
- 25% of the deliveries are undertaken by the daya.
- 9% of the deliveries are done by the health unit midwife.
- 7% of the deliveries are done by the private doctor.

- Health services are provided by 12 doctors, seven males and five females.
- Easy transportation facilities positively affect pregnant women's utilization of MCH services.
- The villagers do not accept that the circumcision of their male children should be carried out at the health unit but prefer that the health barber does it.
- Due to lack of facilities, surgical operations do not take place at the health units, while small surgical operations are carried out illegally at the health departments of the multi-purpose units.
- Student benefits from school health is very low due to the lack of cooperation of the families with it.
- There is a low attendance frequency at health units during agricultural work seasons and during winter because of transportation difficulties.
- Acceptance of medicine and drugs is low. 52% do not believe in it and do not use the complete prescription recommended for them, and 27% do not use any of the prescription.

El-Tablawi, Madiha Said Taha, "The Effect of the Mother's Economic, Social, Biological and Nutrition Factors on the Child's Development," M. A. Thesis, Faculty of Agriculture, Alexandria University, 1976.

The study took place in the eighth village at Abbis area. The selection of the research locale was not selected on the basis of a representative sample but due to the researcher's easy access from residence.

Research Results

- Utilization of health services for prenatal care: 51.6% use the health center, 2.3% go to a private doctor and 46.1% seek no health care.
- When a child is sick, 37.4% of the mothers use folk medicine, 46.1% use health centers and 16.5% go to private doctors.

- 65.5% of the children did not complete their vaccinations and 32.5% were not vaccinated at all.
- 82.4% of the children were found to be anemic.
- 92.8% of the deliveries take place at home, 65% of which are carried out with the help of the daya, 17.7% under the supervision of the health unit, and 9.6% with the help of the neighbors; only 1.7% take place at the health unit.
- Although there is a high rate of family planning awareness (97.7%), only a small group practices it (18.6%).
- Reasons for non-practice of family planning are non-approval of the husband and fear of the side effects of contraceptives on health. Also, due to irregular use of contraceptives, the intended results were not achieved.
- Sanitation and environmental conditions:
 - 67.5% of the houses are dirty;
 - 99.1% of the houses do not have a bathroom;
 - 90% of the houses have water closets;
 - 95.1% of the houses do not have a kitchen;
 - 45.2% of the houses are crowded, i.e., four or more individuals per room;
 - 0.9% of the houses are well ventilated and well lighted.
- 53.6% of the houses have animal barns which share the same entrance as the house; only 2.9% have separate barn entrances.
- 65.8% of the poultry raising takes place in the bedrooms, or living rooms.
- 28% of the villagers wash their vegetables in the canals, and 20% bathe in the canals.

ENGLISH ANNOTATED BIBLIOGRAPHY

Abdel Fattah, el-Amin, et al., "Bed Supply, Hospital Utilization and Bed Requirements: Experience under the Alexandria Health Insurance Programme," Bulletin of the High Institute of Public Health, Vol. VIII, No. 1, 1978.

The study investigates the relationship between bed supply and hospital utilization under the National Health Insurance Programme in Alexandria as well as to estimate the number of beds required to meet the demand of the insured population.

Abdella, Mohammed, et al., "The Role of Housing in the Egyptian Village Community Development," Bulletin of the High Institute of Public Health, Alexandria, 1975.

This study investigates two parts of one village in the New Valley; one part was built for the farmers by a governmental agency and the other part was built by the farmers themselves. Comparing both sides, an optimal situation is reached in remodelling the farmer's house which is a basic step in the village community development.

Ahmed, Wajeh, et al., "Female Infant in Egypt: Mortality and Child Care," Population Sciences, No. Two, Al Azhar University, 1981.

This study emphasizes that sex differences in infant deaths reported in vital statistics is real and not a reflection of untrue data. It shows that deviation from the normative sex-pattern of infant death is so large that nearly one-third of female deaths can be attributed to a sex-specific cause: lesser care of the female child.

El-Amin, M., et al., "Diagnostic Pattern of General Hospital Inpatients: The National Picture in Egypt," Bulletin of the High Institute of Public Health, Vol. VIII, No. 1, 1978.

The study investigates the diagnostic pattern of patients discharged from central and district hospitals, controlled by the Ministry of Health, Egypt, and relates this pattern to the age and sex of the population.

Anderson, J. E., et al., "Family Planning Use and Child Health in the Arab Republic of Egypt," unpublished paper, 1979.

The study attempts to utilize the 1978 Nutrition Survey of Egypt to link anthropometric and medical measurements of the nutritional status of children with the contraceptive practice of their mothers.

Assaad, Marie, and Samiha El-Katsha, "Formal and Informal Health Practices — Babel Wa 'Kafr Hammam," Population Council Regional Papers, Cairo, 1981.

This study examines the various types of formal and informal health care provided in one Egyptian village in the Menoufia Governorate and the response of villages to these services. Basically an ethnographic account of health-seeking and health-providing behavior in the village, the study investigates in depth the extent of complementarity and interchangeability among the services as reflected by the utilization behavior of individual villagers.

Awaad, S., et al., "A Field Survey on Child Health in Rural Community in Egypt," Journal of Tropical Medicine. Cairo, 1975.

The survey, undertaken in Bani Shebl village in Sharkiah Province to study the child health in rural areas, examines 256 children whose ages ranged between 15 months and 12 years.

Baasher, T. A., "Primary Mental Health Care," The Learner, Vol. 9, No. 2, 1981.

A rural area in Senures district, Fayum Governorate was chosen for exploring the possibility to improve rural mental health care. The basic strategy focuses on training general health workers posted in health units at the district level.

Baker, R. W., "Rural Health Care," Egypt's Uncertain Revolution Under Nasser and Sadat, Cambridge, Harvard University, 1978.

The writer gives an account of the administrative structure of rural health and the goals of the revolution and the reasons for the failure of the health sector to meet the goals of the revolution.

El-Bishry, Iglal, The Perception and Utilization of Health Care Services by the Poor in a Government Free Hospital, M. A. Thesis, American University in Cairo, 1979.

This thesis reports the findings of an ethnomedical study of poor patients and their doctors in a government free hospital in Cairo. An emic approach, based on participant observation techniques, was used to elicit and analyze poor people's cultural framework of beliefs regarding illness and care.

Burkhardt, R., et al., "Supplementary Feeding in Rural Egypt: A Summary Profile of the Health System in Action," MIT Health Care Delivery System Project, Monograph 5, 1980.

This monograph is the outcome of a sample study of 130 rural health centers and units in both lower and upper Egypt. It addresses the Ministry of Health's experience with supplementary feeding in rural Egypt:

Committee of the Institute of Medicine Division of International Health, Health in Egypt: Recommendation for USA Assistance, National Academy of Sciences, Westinghouse, unpublished report, 1979.

This report presents a study of Egyptian health problems and programs and plans for improving the health and nutritional status and for reducing the population growth rate of the people of Egypt. The purpose of the report was to identify opportunities for effective action that would be particularly appropriate for future United States support.

Darwish, O., et al, "Weaning Practices in Urban and Rural Egypt," Japan, The UN University, 1982.

The study investigates some of the factors related to weaning practices and the effect of current weaning practices on the growth of infants in some rural and urban areas in Egypt. The study was done on a sample of villages in lower and upper Egypt as well as two residential areas in Cairo.

Early, Evelyne, "Str tegies of Marginal Urbanites: Therapeutic and Economic Action," paper prepared for the AAA, Cincinnati, Ohio, 1979.

This paper examines therapeutic and economic fields of action of low income women in a popular quarter in Cairo. The paper seeks to understand medical practices as an integral part of the social, economic and political situation of these women.

, Baladi Women of Cairo, Egypt: Sociability and Therapeutic Action, unpublished dissertation, Chicago University, 1980.

This study considers the texture of woman's life in an urban popular quarter, Bulaq, in Cairo. Besides being an analysis of field of action, it also analyzes the "baladi" identity and the "baladi" etiological-curative system.

Eid Emad, et al., "Effect on an Antenatal Home Visiting Programme on the Utilization of Maternal and Child Health Delivery Services," Bulletin of the High Institute for Public Health, Vol. VII, No. 3, Alexandria, 1977.

A home visiting program in Alexandria was instituted by student nurses where various health topics were discussed. The program had brought a favorable effect on the attitude of mothers towards preference for delivery by MCH personnel and on the place of the present confinement. The degree of utilization of the MCH delivery service had risen from 32.2% in 1972 to 73.3% in the sample studied.

Field, Osgood, "Health Care Delivery System Project: Rationale, Activities, and Principal Findings," MIT Technological Planning Program, unpublished paper, Cairo, 1979.

This project focuses on health care delivery with an emphasis on addressing malnutrition. It attempts to illuminate some of the linkages involved in health care delivery as it pertains to malnutrition while assisting the Ministry in identifying operationally feasible approaches for dealing with the problem.

Gallaher, N., and P. Gran, "Medical Conflicts in the Early Modern Near East: A Social Interpretation," unpublished paper, after 1975 (no date).

This paper places aspects of the medical experiences of the eighteenth and nineteenth centuries in a perspective based on social and economic developments of the age.

Good, B. J., "The Comparative Study of Medicine in Islamic Societies: Social, Cultural, and Historical Issues from an Anthropological Perspective," unpublished paper, 1977.

The paper criticizes some of the common frameworks used for cross-cultural and comparative studies of

medicine. It suggests the need to reinterpret various aspects of the Galenic-Islamic tradition in light of efforts by classical physicians to achieve professional dominance. It also suggests an interpretation of Prophetic medicine as a popular culture genre of medical literature that played an important role in the popularization of Galenic-Islamic medicine. It also suggests some directions for comparative studies of medical modernization in Islamic societies.

El-Hamamsy Laila, The Dayas of Egypt: Survival in a Modernizing Society, Caltech Population Program, Series No. 8, Occasional Paper, 1973.

This study of traditional midwives discusses their status, function and attitudes toward conception, pregnancy and child delivery as well as family planning and its effect on their clients.

Hammam, M., et al., "Human Factors as a Pivot in Community Development Programs in the Rural Area in Egypt," Bulletin of High Institute for Public Health, Vol. VIII, No. 1, 1977.

This paper is a product of some of the efforts done in the Abnub Center for Public Health Research and Training. The paper deals specifically with environmental sanitation problems of the village as well as investigating problems related to KAP of the family planning.

Hanafy, Mamdouh, et al., "Health Education Programs to Mothers: An Enforcement to Nursing Care Programs of Hospitalized Infants," Bulletin of High Institute for Public Health, Vol. VII, No. 3, 1977.

This article presents the results of a nursing care program which was applied to a group of hospitalized infants suffering from moderate or severe gastroenteritis. The program included the participation of mothers or mothers' substitutes in nursing their infants with a concurrent regularity scheduled health education program.

Hassouna, W. A., ed., "Beliefs, Practices, Environment and Services Affecting the Survival, Growth and Development of Young Egyptian Children: A Comparative Study in Two Egyptian Governorates," Institute of National Planning, Memo. No. 1115, Cairo, 1975.

This study exposes some of the common beliefs and practices with respect to pregnancy, birth, infancy

and early childhood. It gives a detailed profile of the health of children in the Governorates of Domietta and Qena.

_____, "Perception and Utilization of Health Care Services in the Greater Cairo Area," Institute of National Planning, Cairo, 1978.

This study is based on a survey of 3500 individuals from selected outpatient facilities in Cairo including hospitals and general health units, NCH and pediatric facilities in governmental health units, private health units, health insurance organization and medical care organization. It discusses the extent and degree of utilization of these facilities.

Health Sector Assessment, "Urban Health Delivery System Project: Helwan Zone," mimeographed papers for USAID, 1981.

This project is a profile of the Helwan area health situation. It is presented in seven monographs including: Community Studies Compiled Data, Health Care Delivery System Compiled Data, Environmental Urban Compiled Data, Analysis and Recommendation, Policy Analysis and Development, Conceptualization and Data Processing and Executive Summary.

Hussien, Fahim, "Community-Health Aspects of Nubian Resettlement in Egypt," From Tzintzuntzan to the Imagine of Limited Good, M. Clerk and C. Nelson (editors), Kroeber Anthropological Association, Berkley, California, 1979.

In this article the author stresses that relocation affects not only Nubians' physical health but also their mental health. He stresses the importance of health planning prior to relocation of any population.

Ibrahim, A. S., "Statistics for Health Palnning," DPA, Technical Papers, The American University in Cairo, 1975.

This paper is an attempt to explore and evaluate the problem of statistics for health planning. It studies sources and means of collection of information, statistics on demographic data, environmental health statistics, indices of health, social indicators and health service statistics.

Kamel, Nahid, et al., "Antenatal Care, A Comparative Study," Bulletin of the High Institute of Public Health, Vol. VIII, No. 2, 1977.

The study compares the characteristics of the consumers of maternal and child health centers with those using the hospitals as well as finding out whether there are any differences in the antenatal care rendered in the city of Alexandria.

_____, "Tetanus: A Public Health Problem in Alexandria," Bulletin of the High Institute of Public Health, Vol. VII, No. 2, 1977.

This study aims at portraying features of tetanus cases in Alexandria and using this incidence as an index reflecting the standard of living.

_____, "The Range of Health Care Services: Private and Governmental Approaches by Inpatients of University Hospitals in Alexandria before Admission and their Experience and Views about their Hospitalization," Department of Public Health, Faculty of Medicine, Alexandria, 1980.

This study is an attempt to reveal the standards of services rendered by the four university hospitals in Alexandria. The study also shows the degree of overlap in the utilization of different health resources available. It attempts to show the consumers' point of view, their degree of satisfaction or frustration and the problems they face in demanding the university inpatient services. It also shows why patients seeking first medical care from other sources shift to the university inpatient hospitals and what channels they approach.

Kuhnke, Laverne, "The 'Doctress' on a Donkey: Women Health Officers in the Nineteenth Century Egypt," Clio Medica, Vol. 9, No. 3, Amsterdam, 1974.

The article offers an interesting historical example of an attempt to institutionalize paramedical personnel in a developing country. It gives an account of the reasons for this innovation, recruitment procedures of trainees, training program, scope of work, limitations and development of the institution.

El-Mehairy, "Medical Doctors: Managerial Abilities and Role Definitions," Middle East Management Review, Vol. II, No. 1, Cairo, 1977.

This study attempts to examine the self-conception of managerial capabilities, role definitions, and job satisfactions and dissatisfactions of physicians in rural Egypt. Twenty physicians working in the Governorate of Menoufia participated in the study.

Miller, F. Dewolfe, "Analysis of Environmental Data from Rural Egyptian Villages," unpublished report for USAID, 1981.

This report is an analysis of environmental health data collected from 35 rural villages and hamlets located in the three major geographical regions of rural Egypt. The broad base of the data collection provides useful information on the current status of a number of environmental health conditions.

Morsy, Sohair, "Sex Roles, Power and Illness in an Egyptian Village," paper presented at the Annual Meeting of the AAA, Washington, D.C., 1976.

This paper questions the utility of approaching the study of sex roles in terms of individual strategies and competition of power. This is pursued within the context of the study of health related behavior.

"Health and Illness as Symbols of Social Differentiation in an Egyptian Village," Anthropological Quarterly, Vol. 53, No. 3, 1980.

This study of an Egyptian village focuses on the medical system as a probe of social life, notably patterns of social differentiation.

_____, "Body Concepts and Health Care: Illustrations from an Egyptian Village," Human Organization, Vol. 39, No. 1, 1980.

This study emphasizes the importance of concepts of bodily functioning for the effective delivery of cosmopolitan health care in the context of an Egyptian peasant community.

_____, "Towards a Political Economy of Health: A Critical Note on the Medical Anthropology of the Middle East," Social Science Medicine, Vol. 15B, 1981.

This paper critically reviews certain trends in the medical anthropological literature on the Middle East. It identifies and analyzes the dominant theoretical orientation found in the study of medical beliefs, folk illness, healing and competing medical systems. Illustrations from an Egyptian village in Sharkiya Governorate are presented.

Mussallam, B. F., "Birth Control in Society and Medicine," The Kaplan Lectures, University of Pennsylvania, unpublished paper, 1977.

A study of premodern Arabic discussions of contraception and abortion in Islamic jurisprudence, fatawa, Arabic medicine, materia medica, and erotica. The study reveals that birth control was sanctioned by Islamic law and opinion.

Nadim, A. et al., Living Without Water, Cairo Papers Publication, Cairo, 1981.

This monograph is a socio-economic survey of residential areas in Greater Cairo lacking potable water. It has information on nine kisms in Cairo, describing their population characteristics and the services available in these areas. The study shows socio-economic differences between owners and renters and their patterns of consumption of water. It describes methods of obtaining and disposing of water and problems and needs of the communities.

Nadim, Nawal el Messiri, "Some Aspects of Birth, Infancy and Early Training of the Young Child in Egypt," Memo No. 1115, Institute of National Planning, ed. W. A. Hassouna, 1975.

This study describes the beliefs and practices related to children's nursing, weaning and feeding patterns. It also describes major infancy illnesses and methods of curing them. The study took place in Al Darb al Hamar quarter of Cairo.

 , Rural Health Care in Egypt, IDRC publication, Ottawa, 1980.

This monograph on interrelationships between formal health services and traditional medicine in rural communities in the Qalubeya Governorate in Egypt identifies the occupational qualifications of traditional and auxiliary health workers, particularly midwives

(dayas). It presents medical personnel and modern health centers and the attitudes of village population towards illness and treatment.

Nelson, Cynthia, "Reconceptualizing Health Care," Women and Their Health: Research Implications for a New Era, ed. Virginia Olesen, DHEW Publication No. (HRA), 1975.

This paper deals with various conceptual frameworks for thinking about health care and how they influence the ways for restoring health to the sick and the research perspectives and strategies. Special emphasis is given to women healers in Egypt including the daya, hakimet and mumarida.

The Nutrition Institute, Nutrition Status Survey, Cairo, 1980.

A follow-up nutrition status survey was performed in 1980 in two of the six universes originally surveyed in the 1978 National Nutrition Survey. This follow-up survey was carried out during a period of suspected high incidence of diarrheal illness in August and September. This follow-up provided an opportunity to search for temporal changes in anemia prevalence among both children and mothers and in breast-feeding and weaning practices. Information was also collected to evaluate country-wide efforts to improve the mother's awareness of oral rehydration methods as a treatment of acute diarrheal diseases and to determine the availability and utilization of oral rehydration salts.

Pediatric and Public Health Departments, "Community Development of Barogil Village," Medical Part, Faculty of Medicine, Cairo University, Cairo, 1976.

This is a study of the distribution of infants by their present complaint, incidence of disease and level of nutritional status as measured by weight and age.

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El-Rafie, M. and Shafika Naser, "Health Status and Menstrual Pattern of Young Egyptian Female Athletes," Bulletin of the High Institute of Public Health, Alexandria, 1977.

This paper shows the relation of body weight and height as an index of growth and the menstrual cycle among female athletic students of physical education in a school in Alexandria.

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Pillsbury, Barbara, "Traditional Health Care in the Near East," Report prepared for USAID, 1978.

This report has a section on Egypt. It is mostly a review of literature of the available social science literature on traditional health practices.

Report of a Study Group, "Health and Mortality in Infancy and Early Childhood," Population Council Regional Papers, 1980.

The paper discusses a framework for conceptualizing the determinants of health and mortality among children. It discusses the problem in developing countries in general with some examples from Egypt.

Salama, Samira, "Sex Education in Nursing Schools," Bulletin of the High Institute of Public Health, 1975.

The study shows the capacity of the senior students of the High Institute of Nursing in Alexandria to handle patients having sexual health problems. It also points out the knowledge of the students of human sexual life, their acceptance of sexual urge of the individual within the social norm and their self-acceptance as females.

Shams, Sohair Ahmed, Evaluating the Nursing Care Given in MCH Centers of Giza Province, M. Sc. Thesis, The Higher Institute of Nursing, Alexandria University, Alexandria, 1975.

This study attempts to reveal the pattern of midwifery activities in MCH centers located in Giza city, their time distribution between nursing and non-nursing activities, the average various categories of personnel, as well as evaluate whether the maternity services are fulfilling their objectives and the utilization of these centers.

Shehata, M. Ibrahim, A Study of General Practitioners' Services Under the Health Insurance Programme in Alexandria, M.P.H. Thesis, High Institute of Public Health, Alexandria University, Alexandria, 1977.

This thesis studies the conditions and problems of general practice under the Health Insurance Scheme in Alexandria. The field work began in 1973, nine years after the beginning of the insurance scheme. The purpose was to investigate the characteristics, opinions and attitudes of the general practitioners and the insured population, the basic features of general practice, the type, nature and volume of the work, and the utilization of the general practitioner services.

Simon, Dagmar, Dayas in Urban Health Care: Activities, Problems and Prospects for the Future, M. A. Thesis, American University in Cairo, Cairo, 1981.

This research explores the actual contribution of the MCH clinic to health care: medical services, outreach of patients, food distribution and house calls. Parellel is a description of the dayas' activities and functions within the community and her aptitude as an informal provider of health care. The author examines also the cooperation and agreement existing between MCH services and dayas and their symbiotic relationships.

Sukkary, Soheir, "Traditional Midwives in Egypt," unpublished paper, 1979?

This study addresses itself to the competitive role between the traditional midwife and the physician. It also points at the changing methods of the traditional midwife and the importance of upgrading and licensing her.

Tadros, Fawzia, A View from Within: Students' Perspectives on Medical Education and Medical Practice in Egypt, M. A. Thesis, American University in Cairo, Cairo, 1979.

This is a study of the socialization of doctors into the profession of medicine including career selection and orientation, medical school experience, learning the role, style of practice in addition to the students' evaluation of the health services offered.

Thorne, Melvyn, and Joel Montague, "Role and Function of the Traditional Midwife in Islamic Societies," draft paper, 1978?

This paper deals with the traditional midwives, why they are important, what roles and functions they typically perform in Islamic societies, what is special about them as providers of social services, how they are different in Islamic societies, and what roles they may play in modernization.

El-Torky, M. A., Alternatives for Delivering Primary Health Care in Rural Egypt, Ph.D. Dissertation, University of Pittsburgh, Pennsylvania, 1980.

This study examines the organization, structure and delivery pattern of the Egyptian rural health system. It identifies issues of concern that should be dealt with in order to improve the health conditions in rural areas.

Varisco, Daniel, "Rural Sanitation in the Arab Republic of Egypt, unpublished paper for USAID, 1981.

This paper presents the result of field work done in the villages of Menoufia and Assiut. The purpose of the research was to examine the behavior of individuals and groups in rural Egypt with regard to sanitation, i.e., water supply and water disposal, and an assessment of the existing facilities and services.

Wassef, M. K., The Perception of the Human Body, M. A. Thesis, Sociology-Anthropology-Psychology Department, American University in Cairo, Cairo, 1981.

The study attempts to view the human body as made up of body, soul and spiritual parts, as well as a means of communication of these things. The body is also viewed as a system of symbols. Special emphasis is given to the Coptic beliefs. Field work was undertaken in Alexandria.

Younis, Nabil, et al., "Analysis of Maternal Deaths in Egyptian Maternity Hospitals," Population Sciences, No. 1, Al Azhar University, Cairo, 1979.

The study analyzes the maternal deaths in Al-Hussien University Hospital and al-Galaa Maternity Hospital during the years 1975 and 1976 from hospital records. The study identifies the causes of deaths.