Chapter 32

Women and Shelter-Related Services and Infrastructure: The Case of a Vulnerable Group

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As a sociologist who has long been involved in field research in Egyptian society, I have written this paper as the outcome of my own experience, most of it being first-hand information from the field. It is based on a number of studies that I have supervised, in addition to published articles in both the Arabic and English languages. Additional information has been included from the Ministry of Health, the Central Agency of Public Mobilization and Statistics, and the study titled *Structural Adjustments in Health Sector to Protect the Vulnerable Groups.* Badran: 1989. The data presented here is somewhat dated, but more recent information is not available.

Women: Citizens with Equal Rights

For the Egyptian woman, the year 1954 marks a significant landmark, because it was then that an official declaration of women's rights was made for the first time. The Egyptian constitution explicitly recognized the status of women as members of society and as such granted them legal rights equal to those that men had always enjoyed. Women came to be legally entitled to education, job opportunities, and all other civil rights which had previously been restricted to the males as their exclusive privileges, if not on the formal, official level, then definitely on the level of actual practice. This declaration of equal rights for women represents a milestone in the Egyptian woman's long struggle for emancipation, which had been thwarted by the strong hold of Egyptian and Islamic tradition. Since then, both educational and job opportunities have opened to women. They have likewise been participating actively in political life in voting, running for office, and being elected. Their salaries are equal to those of men. They do not complain of any form of discrimination at work.

The fact remains, however, that the cultural base of a historically male-dominated society creates a discrepancy between the legal formal situation and the actual informal one. The prevailing norms in society lead, in many cases, to an unequal situation between the sexes, which can be detected clearly on the socio-cultural level where the dynamics controlled by tradition operate. The reflection of such a condition can be seen in many aspects of life. Educational and job opportunities are examples. The area of health is another major illustration of the underprivileged position of women. It is the sad truth that the health conditions of the Egyptian population, like those in most developing countries, are very poor. Morbidity and mortality rates are high; life expectancy is very low; and above all, the infant mortality rate, though significantly reduced in the last

decade, remains very high. Such health problems exist in spite of the intensive and extensive measures taken to deal with them. The position of women as a disadvantaged group in the area of health cannot therefore be understood out of context. It is part and parcel of the broader problem of a poor health status for the population at large, as has already been mentioned.

Why the Bypass?

In an attempt to face that situation, the Egyptian government, since the Alma-Alta declaration, has been developing plans to extend health services to all segments of the population. It has undertaken the task of providing health coverage in the context of a broad and comprehensive program initially started in the mid-fifties with the purpose of extending different services to the underprivileged strata of the population. In line with this policy, the Ministry of Health has been taking measures to increase the number of health facilities throughout the different parts of the country, especially those concerned with maternal and child health. It should be remembered that governmental health centers in Egypt are meant to offer their services free. However, in spite of the many efforts exerted in this respect, the Egyptian Ministry of Health has not succeeded in eradicating many of the existing health problems. Neither has it been able to cover all the population nor improve the health standards. The effectiveness and efficiency of the present health care system are thus open to question.

Studies have shown that some health facilities are underutilized, which raises the question of accessibility. To which segment(s) of the population is the governmental health system meant to cater? If health services are presumed to be available to the population, what intervening variables account for underutilization of these services and continuing poor health standards, specifically, what are the existing conditions among the various communities of intended beneficiaries of health services that might account for bypassing the government health care delivery system? The question is simply: Why the bypass?

To answer this question, a set of complex factors must be understood in the context of the socio cultural milieu. Environmental and urban conditions, socio-economic and demographic characteristics of the population, problems of cost involved in the provision of health care, and the available equipment in the health facilities are but some of the relevant factors that might help explain the pattern of utilization of the health centers. The issue is therefore a multifaceted one, and necessitates a multidimensional perspective.[1]

Any approach to the phenomenon of bypassing the formal health system has therefore to seek an explanation in the cultural base and it is through probing into this cultural base that a major variable of the underutilization of the health services can be highlighted. In the first place, prevailing Egyptian values, beliefs, and norms support the traditional healing system against the formal health services. As is often the case in developing societies, the traditional healing system exists in Egypt side by side with the formal health system. One explanation why the former tends to be more effective in the lives of the people than the latter can be sought in the approach of the traditional healers to their patients. Traditional healers are the midwives (untrained in medical care in most cases), health barbers, and herbalists. A major difference between folk medicine, represented by these traditional healers, and the so-called "scientific modern medicine," represented by physicians, is the perception of causation in illness. In the former, causation is rooted in the interpersonal world of tradition, magic, and the supernatural, whereas in the latter, it is rooted in the non-personal, observable, and predictable natural phenomena of nature. The traditional healer, therefore, interacts with the client through the channel of a shared belief system which is strongly rooted in their culture, and shapes the way of thinking of both healer and clients, which is not the situation with the "modern scientific" interpretation of the causal factors in illness.[2] One interesting paradox that can be noted in the relationship between "modern" and folk medicine is apparent in the utilization of the formal health system for children. In one study in a traditional neighborhood outside Cairo,[3] mothers reported that when their children are ill, they first resort to folk medicine, particularly to elderly women of the household or neighborhood, who offer prescriptions for every ailment. Only after all methods of traditional treatment are exhausted do the mothers finally resort to the health center, and then the child has already become seriously ill.

Mothers do, however, utilize the maternity and child care centers for vaccinating their children. In fact, vaccination ranks as the number one reason for utilization. Of the mothers surveyed, 53% indicated that they visit the centers only for this service. The paradox lies in the fact that mothers tend to seek traditional treatment for their infants under conditions considered "normal," yet resort to the formal system for vaccinations. The paradox can be understood, however, in the light of the

Table 1: Maternal Mortality for Every 100,000 Live Births

Year	Maternal Mortality Rate	Year	Maternal Mortality Rate
1951	16,000	1980	9,310
1955	11,000	1980	7,690
1970	11,000	1982	7,660
1965	9,000	1983	7,490
1970	11,000	1984	5,690
1975	7,360	1985	5,000
1976	8,090	1986	6,500
1977	8,040	1987	6,500
1978	8,220	1988	7,800
1979	7,790		

Source: Ministry of Health Statistics: 1989

Table 2: Causes of Female Mortality

Postpartum hemorrhage	22.8%
Ruptured uterus	12.9%
Antepartum hemorrhage	12.2%
Eclampsia	16.2%
Caesarian section	9.3%

Source: Ministry of Health, "Causes of Maternal Mortality," 1984–87.

motivating factor that leads the mothers to vaccinate the infants. Parents who do not vaccinate their children are fined by the government. It is not so much the acceptance of the "modern" health system, that motivates the rate of utilization, but rather the fear of a penalty. This should not be interpreted as acceptance but as coercion.

Women—The Vulnerable Group

In this drama of underutilized health services in Egyptian society, women are at a greater disadvantage. They represent a broad segment of what can be considered the vulnerable groups. Vulnerability here is defined with reference to the definition adopted by the World Health Organization as including "underprivileged social groups" in society. The Egyptian women can fit into this category very well, since the culture obviously supports male domination and tends to enhance it. It actually extends to all aspects of life. Even as infants, females are at a disadvantage. Studies have shown that the incidence of infant mortality is higher among females. Especially in the traditional subcultures of Egypt, a female infant is of very low value and may be neglected, and her rights denied, even in health care.

Significant in this situation is the high mortality rate among females of reproductive age. Women in this age group represent the most vulnerable of the vulnerable group. They are highly exposed to the incidence of death as a result of pregnancy and childbirth complications. The significance of the problem is clear from the proportion of females at the age of fertility: 21% of the total population.[4] The fact remains, however, that the rate has been decreasing over the years. Table 1 reveals the direction of change for the maternal mortality rate in Egyptian Society.

It must be noted that the table shows some fluctuations in the maternal mortality rate, but there is a downward trend starting in the seventies when there was an expansion in state health services. However, the increase in the mid-eighties is the result of a growing concern and enforcement on the part of the government for the registration of vital statistics. Here can be seen another cultural fact: accurate registration, not only of mortality cases, but also of births is highly doubtful. Again females are highly disadvantaged in this respect.

The seriousness of maternal mortality and its related aspects can be further highlighted by the following table which shows the female mortality rate as the result of different causes. Table 2 is based on a field study conducted in Egypt in an attempt to investigate prevalent causes of maternal mortality.

In studies done by the Ministry of Health in Egypt it was found that one out of eight women died of postpartum complications, the incidence being highest among the poor, illiterate women who delivered at home and who lived far from the available health services.[5] Another study showed that the incidence of mortality among women under 20 reached 2–5 per thousand and among those above 35, was 3 per thousand.[6] Both studies were conducted by the Ministry of Health. Relevant to these results is the traditional culture in which women are expected to marry at an early age; both family and societal pressures are strong. In addition, a woman's fertility is a major part of her identity as a female and guarantees her security in marriage. Consequently, females marry early and start having babies as soon as

possible. They continue to reproduce until a late age. A barren woman or one who loses her fertility culturally represents very good grounds for divorce. In a society where most women are economically dependent on their husbands, divorce is a tragedy and a threat of insecurity. Such an attitude toward women's fertility is one important variable in the prevailing high birth rate and is one major constraint in family planning programs.

Relevant Variables

The above situation, serious as it appears, is a reflection of the inadequacy and also inefficiency of the health system, especially in the area of maternal care. One major reason here can be seen in the discrepancy between village and city in this respect. The unavailability of sufficient maternal care in the countryside is in large part responsible for the high female mortality rate. The results in a demographic survey of the Egyptian population have revealed that the overall percentage of women who receive maternal care does not exceed 14%. The village women receiving this care represent only 5% of the total, while those in the urban centers that seek such a service are 34% at best.[7] Moreover, as has already been mentioned, utilization of the health facility is largely determined by the individual's concept of illness. Therefore, neither pregnancy nor childbirth, including prenatal and postnatal care, is defined as requiring the services of the health facility. Such conditions are perceived as normal events and taken care of in the context of the traditional system. The midwife thus appears as an important figure in the community. Not only is her credibility high in the indigenous culture, but what is more is her affiliation with this culture as a member and equal in a network of close relationships.

A childbirth which may be initially complicated because of medical reasons during pregnancy or one that might develop complications during delivery cannot be handled by the midwife in most cases, and the condition may be far beyond her limited skills and knowledge. Consequently, it is common in such situations that the mother is transferred to a health facility after such complications arise. It may happen that because of the delay in transfer or deterioration of the condition, the arrival at the facility is too late and death occurs, whether of mother or infant. Such an outcome is in many cases attributed to the health facility's failure to handle the patient, and is responsible for the negative perception of the formal health system. The women therefore bypass the factors/problems preceding the transferal to the health facility and associate the death/complications with its provided service. Such a negative image on the part of the potential beneficiaries of the health system, common as it is, is one important variable in its under utilization.

Table 3: Incidence of Anemia Among Mothers

Status	Percent	No. of Cases Investigated
Not pregnant	17.0	402
Breast feeding	25.0	823
Pregnant	22.1	253
TOTAL	22.4	1478

Source: "The Egyptian Child," Central Agency for Mobilization and Statistics (CAPMAS) and Unicef, *June 1988.*

In some traditional subcultures in Egypt, a husband may deny his wife health care if it is provided by a man. A female provider is sought, which may well explain the importance of the traditional midwife among a large segment of the population. The formal health system has realized this cultural fact and has consequently been utilizing the services of female medical doctors in large numbers. In general, there is a growing demand in society for female physicians, especially as gynecologists-obstetricians, in particular with the growing movement of Islamic revival. The result is that home deliveries are frequent. A demographic survey in 1988 revealed that 77% of the deliveries that took place between 1984 and 1988 were at home, only one-third by a doctor or nurse; the rest were handled by the traditional midwives. The percentage of home deliveries is definitely higher in rural than in urban areas, reaching as high as 89% in the former and 59% in the latter.[8]

Nutrition also stands out as a major variable affecting the high maternal mortality rate, related, of course, to economic conditions. A significantly high proportion of the population is living under the poverty line. Moreover, women in a traditionally male-dominated society are underprivileged in matters of nutrition. The following table shows the incidence of anemia among mothers as revealed by a study on children.

These data were consistent with an earlier study by the Nutrition Institute in 1981, which revealed that 22.2% of urban families and 33% of rural families distribute food unequally among their members, with women and

children receiving the least shares.[9] In 1987, the World Health Organization and the Egyptian Ministry of Health studying maternal mortality, found out that protein calories were very low in women's nutrition. In both situations the rural women ranked even lower than urban women.[10]

The role of environmental conditions cannot be underestimated in the prevailing health problems. Sanitation is poor, especially in villages. Water and sewage problems persist in spite of increasing concern, simply because of the inability of the supply market to meet the growing demand. Intensive water and sanitation projects are launched both through government and foreign funds, but cannot meet the increasing needs in this respect. The 1986 census showed that only 73.8% of households had running water, 55.9% of which were rural and 92.4%, urban. Only 87% of urban households had electricity. According to the World Health Organization in 1987 only 80% of urban households had sewage disposal; but in 1990 the percentage reached 100% in the cities and 65% in the villages.

A Final Word

In the multitude of factors that affect women's health, education is a significant variable, as it is in the inferior status of women in general. Education, or rather the absence of education, is the underlying factor behind the high maternal mortality rate and the high incidence of disease among women, among other health problems. Education can likewise be seen as both cause and effect of women's underprivileged status. A lack of awareness of their rights not only on the level of the family but on that of society at large is the result of a lack of educational opportunities. At the same time their inferior position in the culture leads to a denial of many of their rights, education being only one among them. In a traditionally male-dominated culture with limited resources, preference usually goes to educating the male rather than the female child. In 1991 the overall female illiteracy rate was 62.5%; in the rural areas, 77%. The dropout rate from school among females is likewise high, especially when girls reach puberty.

The demographic survey mentioned above showed that education plays a role in reducing the proportion of home deliveries among illiterate women. The percentage of home deliveries was as high as 87%, while among those with a high school degree, it was 43%. Moreover, response to family planning programs has been higher among women with more education. For this reason, any approach to improve women's status has to start with extending educational opportunities to cover all the female population.

Opportunities to work are another relevant variable in women's pursuit of equality. But a large segment of Egyptian women are exploited. Because of their dual role in society, women are currently undergoing a role conflict which has not helped in their vulnerability. As is true elsewhere, working women without education find it very difficult to escape their disadvantages.

The state has tried to make education available to all the female population. And health services are being upgraded, in both quantity and quality. In addition, the Egyptian Ministry of Health, following the 1978 Alma-Ata declaration, has attempted to incorporate the traditional health system into the formal one by initiating a training program for the traditional midwives. This program is to teach health awareness and upgrade the midwife techniques of prenatal/postnatal care for their practice, while maintaining the midwives' role within the cultural milieu as accepted providers of medical care. This policy, as undertaken by the Ministry of Health, is a step toward promoting primary health care in Egypt. It remains to be seen how far these measures can affect women's lives to eradicate, or at least reduce, vulnerability.

Notes

1 El Safty, "Planning for Primary Health Care: Socio Economic Factors Influencing Utilization of Health Services in Egypt," in: *Women Health and Development, The Cairo Papers for the Social Sciences.* Cynthia Nelson, ed., vol. 1, Monograph 1, 2nd edition, Sept. 1983, pp. 111–114.

2 Ibid., p. 115.

3 El Safty, "The Attitudes of Traditional Mothers towards the Treatment of Diarrheal Diseases," unpublished paper for the National Program for Combating Diarrheal Diseases in Cairo, p. 9, May, 1983.

4 Egyptian Ministry of Health Statistics: 1990.

5 Ministry of Health, "Causes of Maternal Mortality," 1983–85, p. 11.

6 Ministry of Health, "Causes of Maternal Mortality," 1981–83, p. 3.

7 Ministry of Health, Demographic Survey, 1989, p. 23.

8 National Population Council Demographic Survey, 1988, p. 35.

9 Nutrition Institute, *Report on Food Consumption and Patterns in Egypt,* 1981, p. 11.

10 A. Badran, *Structural Adjustments in Health Sector to Protect the Vulnerable Groups UNICEF,* 1989.