



Newsletter from the Sierra Madre #24 June 1991



Project PROJIMO: a villager-run rehabilitation program for disabled children in western Mexico

Project PIAXTLA: a villager-run health care network in the mountains of western Mexico

THE HESPERIAN FOUNDATION: a small group committed to health education and informed self-care

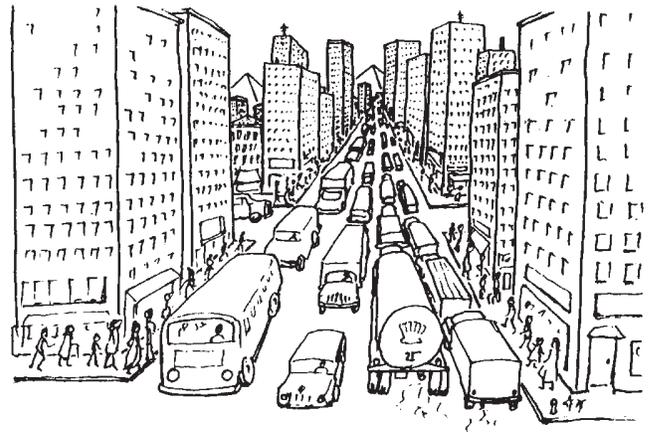
This newsletter is the second half of a two-part report by David Werner on a journey he made to the Middle East in November 1990, on the eve of the Gulf war. The report explores economic, social, and political factors—both national and international—which affect people's current health status in this turbulent region. In Newsletter #23 we focused on the situation in the West Bank and Gaza. In this newsletter we turn our attention to Egypt. The intensification of hardships caused by the Persian Gulf crisis fanned the flames of popular unrest in Egypt (and in other Arab countries allied to the US). Events were moving swiftly toward some form of revolt when Washington launched its preemptive war. But the end of the war did not bring peace to the Middle East. Indeed, the growing gap between rich and poor, coupled with widespread poverty, poor health, and denial of basic rights, may yet lead to a broad-based uprising demanding fairer social structures.

Egypt: Another Approaching Storm on the Desert

David Werner

The paradoxes that underlie the state of health and development in Egypt are graphically symbolized by the urbanization of the pyramids. The pyramids no longer dominate an empty desert, as portrayed in our school-books. Instead, they crouch forlornly on the outskirts of Cairo, the world's second biggest city with a rapidly growing population of about sixteen million. After driving in bumper-to-bumper traffic past miles of massive modern buildings, the visitor at last catches a glimpse through the smog of the tips of the pyramids, which squat like warts beyond the skyscrapers and towering five star hotels.

On reaching the pyramids—which, seen close-up, are indeed colossal—the kaleidoscopic commercialization of these ancient tombs is overwhelming. Venders compete to peddle everything from camel rides to Coca Cola, and a gauntlet of quasigovernmental, quasi-private entrepreneurs sell tickets every step of the way on the approach to the royal tombs. Such despoilment of grandeur is matched only by the equally enterprising desecration of Niagara Falls.



First view of the pyramids, Cairo

In view of Egypt's enormous wealth and the vast amount of US foreign aid it receives (\$2.4 billion in 1990, second only to Israel), the overall health status of its people is quite poor, especially that of its children:

- Infant mortality rate (IMR) is reported by UNICEF as 67 per 1,000 life births compared to 42 in Jordan and 10 in Israel).¹
- Under five mortality rate is 94 per 1,000 (compared to 55 in Jordan and 12 in Israel).²
- Maternal mortality ranges from 190-380 per 100,000 births, depending on the region (compared to 5 per 100,000 in Israel).
- Severe malnutrition is infrequent, affecting about 3% of children. However, mild malnutrition is common among young children, affecting more than 60% of them in some areas, and anemia is a major problem throughout the country.
- One out of three children is moderately to severely stunted.
- Although child mortality has dropped steadily since 1974, the poor nutritional state of children has not improved in the last ten years (in spite of many national and international interventions aimed at child health and survival).

The persistence of poverty and poor health in Egypt despite its considerable wealth and massive foreign aid stems in part from the country's schizophrenic political-economic system.

Egyptians have long been accustomed to centralization and bureaucracy, which were introduced quite early in the country's history. By the time of the Middle Kingdom (1500 B.C.), all land suitable for agriculture had been divided into plots, people were paying taxes in the form of crops, and a system of *corvée* labor (periodic unpaid work required of citizens by local government officials) was in place. It was this level of organization which made possible the building of the pyramids.

Starting in the 1950s, Egypt has been aggressively aided and ideologically influenced, first by the Soviet Union, then by the United States. Unfortunately for most of its people, Egypt has kept some of the worst features of both the Soviet and US ideologies. From the Soviet paradigm, Egypt has retained the centralized, police state structures of social control, while forsaking many of the egalitarian features of socialism. And from the US free market system, it has retained the dog eat-dog profiteering mystique of economic growth regardless of social costs, while never attaining a true democratic process.

After coming to power in 1952, and especially since the 1956 Suez Canal Crisis (when England, France, and Israel jointly invaded Egypt's Sinai region in response to Cairo's national-



Young children in Egypt suffer from a high rate of mild malnutrition, in part due to the custom of not beginning to supplement breast milk with other foods until the child is more than a year old.

ization of the Canal), Gamal Abdel Nasser turned to the USSR for direction and assistance, and adopted what has been called "Arab socialism." As a result, Egypt's constitution contains many progressive mandates, including an extensive program of land redistribution, free health care, and free education. It calls for nationalization of major industries and utilities, and guarantees government jobs to all university graduates. However, under Nasser, in line with the Soviet prototype, every aspect of society was centrally and heavily controlled. Even so, Nasser enjoyed strong popular support thanks to his Pan Arab nationalism and to his efforts to achieve a fairer distribution of resources and services.

After Nasser's death in 1970, his successor Anwar Sadat switched the country's allegiance to the United States, receiving in exchange vast amounts of military and economic aid. Sadat's 'open door policy' led to a large influx of American and European multinationals. Since foreign corporations are legally required to transact their business in the form of joint ventures, this creates an opportunity for a tiny minority of Egyptians to make vast sums of money, much of which they invest abroad.

As the free market system gained increasing sway over the Egyptian economy during Sadat's administration, the egalitarian reforms introduced under Nasser began to erode. This happened in part because Nasser had not succeeded in making major changes in the country's rigid class system. Land and wealth again tended to concentrate into fewer and fewer hands (although land is still distributed more equitably than in many other Third World countries). Prices rose faster than wages, and the earning power of the poor decreased. The gap between rich and poor grew wider.

In response to growing discontent, the centralized government became increasingly repressive. The network of security police expanded and violations of human rights grew

more common. Unauthorized community organization was outlawed. Only government-controlled labor unions ('syndicates') were allowed, and strikes for higher wages or workers' rights were forbidden.

The crisis peaked in 1979, when the government abruptly removed its subsidy on food staples, sugar, and fuel, causing prices to immediately double. The result was the so-called "Bread Revolution." People rioted in the streets and looted public buildings and storehouses. The uprising was quickly and brutally suppressed by the security forces.

The crisis in Egyptian health care stems largely from the bizarre clash between the 'Arab socialist' and 'free market' systems.

Over the last decade the combination of socialist and free market policies, with each obstructing the benefits of the other, has produced a tragicomedy of giant proportions. (To make things worse, the government has been desperately trying to perform a balancing act between, on the one hand, the powerful, conservative forces of foreign and internal big business and, on the other, the radical thrust of two often antagonistic revolutionary groups: Islamic fundamentalists and the remnants of the Nasser left.) The resulting paradox extends to all sectors, but is paramount in health and education.

Egypt's health care crisis

The crisis in Egyptian health care, as in Egyptian society in general, stems largely from the bizarre clash between the 'Arab socialist' and 'free market' systems. Medical care, which under the national health plan launched during Nasser's regime was supposed to be available free to the whole population, has become increasingly costly or unavailable for many people in recent years, in part because of the 'ad hoc privatization' of public services. However, the situation is complex.

From the days of Nasser, medical school, like all forms of schooling up through professional training, theoretically has been free. Selection of who will study for each profession is largely determined by grade-point average in high school. Those who score highest go into medicine; next highest, engineering; next, law, etc. (This system has made possible the entrance of women into these careers—they now make up 50 percent of medical school classes and 30 percent of engineering classes.)

On graduating, all doctors and other professionals are guaranteed a government job. (Even today, in spite of recent divestiture of government-owned businesses and utilities, over 50% of the work force is still employed by the state.)

However, there are not nearly enough government posts to gainfully employ all the doctors graduating from the country's many medical schools. Nor does the government have the money to pay them.

Yet enrollment in Egypt's medical schools remains high, partly because a medical degree brings prestige and higher status. As a result, classrooms are packed. The quality of training, and hence the competence of doctors, suffers severely from the overcrowding. (It is said that more than 60 students must share a cadaver, and that clinical experience is similarly short-changed.)

Behind the health care crisis lies the economic crisis. Like most Third World countries, Egypt has amassed a huge foreign debt. To assure that the country keeps servicing the debt, the IMF (International Monetary Fund) and World Bank have mandated that the government follow an 'economic adjustment policy' which involves cutting back on public spending (including spending on health and education) and turning over state-controlled industries to the private sector. All this, of course, means fewer government jobs.

After graduating, young doctors—like all other professionals—must wait in limbo for a government post. Three years ago the period of unemployment before getting a post was two years. Today graduates must wait for up to seven years!

To make things worse, when young doctors are at last assigned a position in a hospital or clinic, their monthly starting pay is 70 Egyptian pounds (EP) about US\$25. Professors of medicine receive a similarly low salary. No one can adequately care for a family on so little. Doctors are left little choice but to practice private medicine on the side, and many become corrupt.

As this corruption becomes increasingly institutionalized, it erodes the national health plan. Until recently, doctors would practice in their government clinic in the morning, then would practice privately in the afternoon, charging during the latter period both for their services and for government-supplied medicines (which were supposed to be free). Too often, doctors would make it clear to their patients that if they wanted good care, they had better come in the afternoons and pay. While this practice was illegal, the government usually turned a blind eye.

Today the situation is even worse. Even the pretense of an equitable national health service has been abandoned (except on paper and in rhetoric). Doctors are openly permitted to use the government centers as private clinics, charging for their services. This, of course, means that poor families often have little or no access to health care. In sum,

private medical practice has undermined the national plan's goal of equitable and universal health coverage. (The same process has occurred in many other developing countries subject to Northern 'adjustment' mandates.)

To further compound the problem, pharmacies and pharmaceutical companies (formerly owned and managed by the state) have also suffered from the policies of privatization and putting profits before people. Over 35,000 different brand name medicines are currently marketed in Egypt. Most of these products are irrational, dangerous, overpriced, or confusingly duplicative. (The World Health Organization lists only about 250 medicines as essential.) In Egypt—as in Mexico and many other countries where the Government is more concerned with advancing the interests of big business than those of consumers—all prescription drugs except hard narcotics are sold over the counter. To bypass doctors' fees, many sick people consult pharmacists directly. And pharmacists, who are also grievously underpaid, increase their earnings by flagrantly over- and mis-prescribing.

Doctors do the same. It is not uncommon for a child with a common cold or simple diarrhea (neither of which requires any medicine at all) to be given five or more different drugs, often including two or three highly toxic, expensive, and (for these illnesses) useless antibiotics.

The net result of the incompatible mix of socialized and privatized medicine is a situation where neither doctors nor clients are satisfied, quality of care is often very poor (especially for people who cannot pay), and those in greatest need receive the least assistance. Such circumstances help account for Egypt's persistently high mortality rates.

Schooling in Egypt—a war against the poor

The education system in Egypt has suffered a fate similar to the health system, and for similar reasons. School teachers, like doctors, receive a base wage of only 70 EP per month, too little to survive on. Consequently, thousands of the best teachers (like many of the better doctors and other professionals) have left Egypt to work in the oil-rich Gulf states where salaries are 10 to 20 times higher.

Due to this extensive 'brain drain', the average class size in primary and secondary schools is now 42 children (up from 23 just a few years ago). This makes effective teaching difficult, especially for the less capable teachers left behind after the exodus to the Gulf.

As with doctors, the low salaries of Egyptian public school teachers force them into 'private practice'. Many purposely do not teach their pupils well at school, so that those who

want to pass their exams have to come for private tutoring after hours.

This *de facto* privatization of public schooling means that only those children whose parents can afford lessons are able to pass exams. This fact partly explains the high dropout rate (34%) in the first years of primary school and the prevalence of low literacy rates (boys 65%, girls 35%) despite high initial enrollment. *Egypt's literacy rate has not improved in the past ten years.*

Enforcing underdevelopment: the consequences of authoritarian rule

The sad state of Egypt's health services and public education is in part due to the free market system and the 'economic adjustment policies' foisted on Egypt by the Western powers. But it is also in part the result of the Egyptian government's highly centralized, authoritarian system of social control. The people are allowed very little say in the events that determine their health and lives. The state has absolute authority, which it enforces with a heavy hand through a massive, costly system of 'security police'.

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I was told that one of every five Egyptians is in some way part of the security network, either as a member of the army, the police, or the secret police, or as a guard or informer. Others have told me that this is an exaggeration, but agree that the security system is immense and all-pervasive.



Because their families cannot afford to pay for the private tutoring sessions necessary to pass exams, most poor children drop out and illiteracy rates remain high, especially for girls.

It became clear during my visit that the security forces are very efficient at preventing effective popular organization. Given the severity of underdevelopment, the deterioration of health, education, and other public services, and the growing gap between rich and poor, it is no wonder that the Egyptian government relies so much on its security police to keep the people in line. Indeed, only such a repressive system can explain why poor and working class people—not to mention doctors, school teachers, and other professionals—tolerate such high underemployment and low wages without organizing and fighting for a fairer system.

Egypt's diarrhea control program: a 'success story' headed for disaster

In view of the failure of the national health plan to provide affordable health care to all citizens, the Egyptian Ministry of Health was forced to look for stopgap alternatives. With advice and funding from the United States Agency for International Development (USAID), it launched a series of 'vertical' (top-down) programs, each of which focused on a single high-priority health problem and targeted a specific high-risk population, usually children. The programs' objective—dictated more by the needs of politicians and consultants than by those of families—is to reduce mortality rates, with little concern for improving children's overall quality of life. For (as public health workers learn early) it is the quantitative rather than qualitative results that count on the game board of the international health and development establishment.

The two major Child Survival campaigns in Egypt have been Immunization and Oral Rehydration Therapy.

The death rate from diarrhea can be significantly reduced over the long term only by an approach that addresses the problem of child undernutrition.

The Oral Rehydration Therapy (ORT) campaign aims at reducing child death from diarrhea. Since children mostly die from diarrhea because too much liquid drains out of their bodies (dehydration), the ORT campaign focuses on teaching mothers to give plenty of liquid to children with diarrhea. In Egypt's ORT campaign this is done by providing mothers small packets of 'ORS' ('oral rehydration salts') to mix with water and give to the sick child.

The campaign has taught Egyptian mothers about ORS through health centers, schools, and a blitz of one-minute television spots. This form of 'social marketing' through



Security police stand in the doorway of a village school where an adult literacy course organized with the help of medical students is taking place.

television has been highly effective, since 85 % of families have TV sets—even those living in cardboard shacks.

There has been a lot of debate about the appropriateness of Egypt's ORT program. On the one hand, it has been heralded internationally as one of the greatest success stories of the 'Child Survival Revolution'. The most recent studies show a 51% usage rate by mothers, and child mortality from diarrhea in Egypt is reported to have dropped markedly since the program began.

On the other hand, the cost of Egypt's ORT program has been exceptionally—and, many argue, unrealistically—high. This raises the question of whether the advances can be sustained.

A related problem is that the ORT program has done little or nothing to correct the unsatisfactory nutritional status of Egyptian children. A vicious cycle exists between diarrhea and malnutrition, each making the other worse. A successful ORT program—which necessarily emphasizes the importance of giving food as well as drink to children with diarrhea—should bring about improvement in the nutritional level of children as well as a decline in mortality. However, as mentioned earlier, the poor nutritional status of Egypt's young children has not improved in the last ten years. This raises concern about the overall effectiveness of the ORS program and its likelihood of sustaining a decline in child mortality. Clearly, the death rate from diarrhea can be significantly reduced over the long term only by an approach that addresses the problem of child undernutrition.

Perhaps the greatest barrier to the sustainability of Egypt's diarrhea control program is that it centers around ORS packets, which to facilitate marketing have been promoted as if they were medicine. Many critics feel that teaching mothers to prepare appropriate drinks at home (which can be made with sugar or a cereal, combined with a little salt) is a far more sustainable, empowering approach, since it avoids incurring the costs of factory-produced ORS packets and instead encourages self-reliance.

Up to now, ORS has been heavily subsidized by USAID. A 'ten-pack' of ORS packets (enough to manage the average case of child diarrhea) now costs a family less than half an Egyptian pound (EP). However, when USAID terminates its multi-million dollar support of Egypt's ORT program in September 1991, the subsidy will end. At that time the Ministry of Health hopes to make the program 'economically sustainable' by selling the ORS packets at cost. This means that the price of the ORS 'ten-pack' will jump to 1.50 EP. When one considers that many Egyptian families earn as little as 600 EPs per year (or under 2 EPs per day), it becomes clear that charging mothers 1.50 EPs for ORS is unrealistic. That kind of expense each time a child has diarrhea (which for a large family may be one third of the time) could cut so deeply into a poor family's food budget that 'pushing the packets' might actually have a negative impact on child nutrition and survival.

When I talked about this with the team of the National Control of Diarrheal Diseases Project (NCDDP) in Cairo, they acknowledged that ending the subsidy on ORS packets would create a problem. But, faced with their economic constraints, they saw no alternative. Some of the team leaders questioned whether the promotion of ORS packets might not have been a mistake, not only because of difficulties with cost and sustainability, but also because promoting ORS rather than homemade rehydration drinks creates dependency on a product that may not always be available.

Indeed, in some parts of Egypt this has already proven a problem. On my visit to the province of Beni Suef I was told that ORS packets had not been available for a year because the health officer in charge of supply had not got around to reordering them.

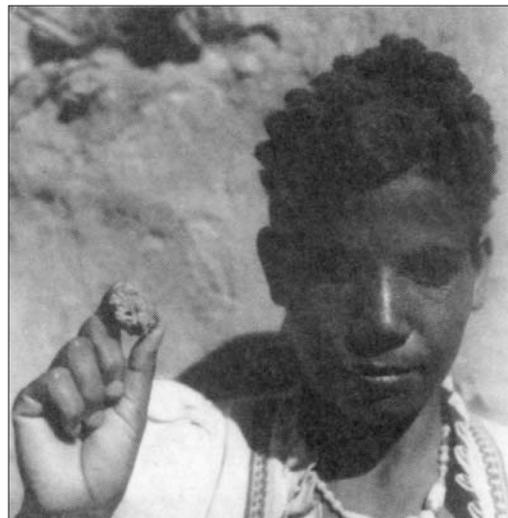
The argument for homemade rehydration drinks has been strengthened by recent research in several countries showing that *cereal-based rehydration drinks are more effective in combating dehydration and reducing stool volume than are sugar- or glucose-based drinks*. Also, these homemade drinks are safer than ORS (which can be dangerous if not enough water is added) and are nutritionally superior (provide more calories).

Building on local traditions

One of the best strategies for promoting health is to build on local traditions. Before selecting which method of oral rehydration therapy to use, it makes sense to investigate the traditional ways that mothers care for children with diarrhea and to look for ways to build on these local customs.

In Egypt mothers traditionally give certain drinks to children with diarrhea. These include teas made with seeds of *hulba* (fenugreek) or with mint leaves, and 'rice water'. Interestingly, these same drinks are used by mothers in many parts of the world. Rice water is now recognized as an effective rehydration drink. It can be made even more effective if mothers learn to leave enough of the rice in the water to form a thin gruel. Such a drink is cheaper, safer, more effective, and more nutritious than a sugar-based drink or than the glucose-based drink made from ORS packets.

Another Egyptian home remedy for diarrhea presents an even more exciting possibility. I learned about this while visiting a small, nongovernmental health and development program in Beni Suef, in the relatively disadvantaged east bank area of the Nile. When a village health worker told me that children often dislike the taste of ORS and refuse to drink it, I asked her what she gives them instead. She said she asks mothers to prepare a drink made with *kishk neshif*.



Village health worker in Beni Suef holds a piece of *kishk neshif*—possibly the most appropriate local basis for oral rehydration therapy.

Kishk is a traditional food made with wheat and the whey of water buffalo milk. The whey is separated from the curd by placing it in the stomach of a young goat for a while. In the process the whey becomes 'fermented' and develops a sharp smell and acid taste, something like yogurt. When the fermented whey is ready, the wheat grain is washed, pounded just a little (not enough to destroy the form of the grains), boiled, and then mixed with the fermented whey. The resulting *kishk* is rolled into little spheres the size of golf balls and placed in the sun to dry. This *kishk neshif* (dried *kishk*) has the advantage that it can be kept for up to a year without spoiling. As the health worker explained, "The wheat alone will spoil. The whey alone will spoil. But put together and dried they do not spoil." For the treatment of diarrhea, the rock-hard *kishk neshif* is ground up and boiled in water to form a thin gruel.

Kishk is apparently widely recognized by villagers as a good treatment for diarrhea. A taxi driver in Cairo, hearing us talk of *kishk neshif*, commented that it is "good for an upset stomach." And a Lebanese participant in the workshop on Primary Health Care said that he had given *kishk* to his child as a weaning food and for diarrhea.

Nutritionists and diarrhea control researchers have apparently overlooked *kishk neshif* because educated persons look down on it as 'primitive' and 'disgusting'. When I first mentioned it to the NCDDP staff, everyone laughed.

To arrive at a cheaper, healthier, more sustainable approach, the image of ORS as a magic medicine will have to be undone.

But *kishk neshif* deserves careful study. Until recently, nutritionists in Southern Africa discouraged mothers from giving fermented or 'soured' millet or maize porridges to their children because they thought these traditional weaning foods were disgusting, bad-smelling, and presumably unhealthy. But at last somebody got around to studying them and discovered that soured gruels are, in fact, ideal weaning foods. The acidity that comes with fermentation delays spoilage, so that the gruels can be kept safely for up to a week. Also, the fermentation process makes the grain easier for young children to digest. And, perhaps most important, fermentation decreases the gruel's viscosity, making a mushy mixture that is more energy-rich. This is important because with many cereal gruels a child's stomach fills up before she eats enough to provide the energy (calories) she needs for adequate nutrition. Soured gruels, which have proportionately more calories for the same volume, help get around this problem.

In Mozambique mothers traditionally use similar sour porridges for treatment of their children's diarrhea, often with excellent results. There is growing interest in conducting further research. Evidence suggests that in areas where soured porridges are customarily used as weaning foods, they may be by far the best solution for oral rehydration. They are 'ready and waiting' in most homes with young children, last up to a week without spoiling, and tend to be more readily accepted by children than ORS. There is also a possibility (still unproven) that the bacteriostatic effect of the soured gruel helps to combat the infectious agents causing the diarrhea.

Kishk neshif is the Egyptian equivalent of the traditional soured gruels in Southern Africa. Its potential both as a weaning food and for oral rehydration deserves serious study. In the areas where it is traditionally used, it could

possibly provide a cheaper, more effective, more sustainable solution for oral rehydration—one that makes people more self-reliant, and that not only combats dehydration but also helps overcome the problem of child malnutrition, which is the underlying cause of the high death rate from diarrhea.

The biggest problem in promoting the use of *kishk neshif* or any other homemade rehydration drink is that oral rehydration has already been medicalized and mystified. To arrive at a cheaper, healthier, more sustainable approach, the image of ORS as a magic medicine will have to be undone. A major education effort will be required to help people regain confidence in their capacity for self-care and recognize that spending their money on needless medicine rather than food can be hazardous to their health. Such education must be part of a whole new, more empowering, more people-centered approach to meeting health needs. For a long-term solution to the problem of death from diarrhea, this sort of liberating approach is essential.

What will it take to bring about lasting health improvements in Egypt?

The main reason for my trip to Egypt was to participate in a training program led by the Institute of Cultural Affairs and AMIDEAST and sponsored by UNICEF and the Arab Council for Childhood and Development. Titled "Primary Health Care through Effective Participation," the program was based on the premise that "when people work together to analyze and satisfy their own health needs, major improvements in health can take place." There was a lot of vague talk about empowerment, but when it came down to pinpointing in such an open forum the socio-political factors perpetuating poor health, the leaders of the training program—who live and work in Egypt—were reluctant to get very specific.

To attempt any sort of autonomous community activity without official approval is to subject oneself to harsh reprisal.

Considering the fact that a 'plant' from the Egyptian security police was almost certainly among the participants, such precaution on the part of the organizers is understandable. But there was a certain irony—and counterproductiveness—in holding a 'participatory' training program in which the obstacles to taking a people-centered approach to health care could not be candidly discussed.

Getting to the root of health needs in Egypt will certainly take more than cautiously sanitized workshops on "Effec-

tive Participation." In this centralized, authoritarian state, with its rigid, hierarchical power structures exercising stultifying social control all the way down to the village level, neither Primary Health Care nor 'effective participation' by disadvantaged people is possible, at least not in the fullest sense. Health action and people's 'participation' are officially approved only if they are stripped of their empowering and liberating potential. To attempt any sort of autonomous community activity without official approval is to subject oneself to harsh reprisal.

So what are the alternatives? The national health plan, with its goal of 'health for all', has failed. And, as we have seen, selective, 'vertical' health interventions, for all their large outside funding, are unlikely to have a major or lasting impact on health. Technological solutions such as ORS, although they may provide measurable short-term benefits, hold little long-term promise because they do nothing to correct (and may even help to perpetuate) the underlying social causes of poor health.

Egypt's dismal health status is unlikely to improve much without far-reaching social and political change. Substantial improvements will only be possible in a freer, more democratic society—not the sham democracy of a free market system run by a wealthy elite. Lasting gains can only be achieved through a mass movement that demands an approach to health and development based on equity, self-determination, and true participation.

The Brewing Storm

Far-reaching socio-political change appears to be farther away in Egypt than in some other underdeveloped parts of the world such as Central America, South Africa, and the Philippines. But there are a number of converging major trends in Egypt that may precipitate a broad-based struggle for change more quickly than expected:

- **First, the socio-economic situation in Egypt is fast approaching the breaking point.** The purchasing power of the poor is decreasing, while there is an explosion in the number of marginalized people subsisting in rural areas and in the vast, largely hidden urban slums. (I say 'hidden' because, instead of living in huge encampments as in Bombay, the urban poor of Egypt are ubiquitously scattered in alleyways and crevices among the towering buildings of the 'formal sector'. Plastered to the backside of skyscrapers and apartment buildings are countless tiny mud hovels, like termite dens, surrounded by a motley array of chickens, donkeys, goats, and pot-bellied children.) Poverty is becoming increasingly severe and apparent.

- **Second, the free market, growth-oriented, trickle-down model of development has backfired.** More doctors and medicines have brought higher costs and poorer quality of care. More professionals and officials have brought a rising tide of bureaucracy, mismanagement, and corruption. More foreign aid has brought increased militarization, along with debt and adjustment mandates to cut back on public services and subsidies, further depriving the poor. Bigger and better 'development' projects—such as the Aswan and High Dams—have brought epidemics of disease (schistosomiasis), devastating climatic changes (rise in temperature), and grave environmental damage (salinity of agricultural land, etc.). More security measures have brought less security and growing social unrest.

The blend of growing unrest among the middle class and growing deprivation among the poor majority is the breeding ground of revolution.

- **Third, the hierarchical, centralized system not only further underdevelops the poor, it is also having an increasingly negative impact on the middle class.** University graduates tolerate the long wait for employment and paltry wages, and frustrated citizens tolerate corruption and privatization of public services, only because the overbearing security system prevents popular organization and strikes. (A recent attempt at a strike led to the jailing of 200 workers.) Torture of political prisoners is standard practice.

- **Fourth, the Persian Gulf crisis and the war it culminated in have put an end to the 'safety valve' of emigration of skilled workers to the oil rich countries.** Until recently, the economy of Egypt had been kept afloat with the money migrant workers in the Gulf send home to their families. But now, instead of sending money back, the workers have been coming back themselves to compete on the already glutted skilled labor market. Further aggravating this recession is a slump in the tourist industry, which has long been a major source of income for Egypt. Due first to the specter and then to the reality of war, along with the associated threat of terrorism, tourism has fallen off drastically. When I was in Egypt in November, the five star hotels of Cairo and Alexandria looked like ghost towns. As a result, unemployment has been further exacerbated.

The blend of growing unrest among the middle class and growing deprivation among the poor majority is the breeding ground of revolution. In an attempt to nip such a possibility in the bud, the Egyptian government took steps to make the November 1990 national elections appear more

democratic. But the opposition parties, certain that the voting would be rigged as usual, boycotted the election. As a silent expression of protest (and perhaps a more genuinely participatory action than actually voting), only 25 % of the registered voters went to the polls. This untallied vote of 'no confidence' must be very disquieting to those in positions of power.

The mounting discontent in Egypt and other Middle East countries allied to the US may be one of the reasons that the US government rushed so quickly into the Gulf war. On November 28 former Secretary of State Henry Kissinger warned the US Senate Armed Services Committee that a delay in the use of force against Iraq would be a mistake because the continuing standoff in the Gulf would "destabilize ...the moderate Arab states."³

Kissinger was right. A prolonged standoff in the Persian Gulf certainly would have had a destabilizing effect on Egypt and the other oil-poor Arab states. However, whether the precipitous war and the Iraqi defeat will stem the rising tide of popular revolt remains to be seen. The reduction of migrant employment in the oil-rich countries—entailing the return of millions of *nouveau riche* skilled workers to the depressed economies and corrupt bureaucracies of their homelands—is a likely formula for popular uprising. In Egypt, as in other oil-poor Arab nations, a new 'bread revolution' is in the oven, and this time it will be led by the huge pool of unemployed university graduates, underpaid professionals, and jobless repatriated workers.

The still-festered Gulf war may yet prove to be the straw that breaks the camel's back, sparking a long overdue popular struggle for a healthier, more equitable, and more truly democratic society.

New winds of change

My first impressions of Egypt led me to believe that the far-reaching social and political changes needed for widespread improvement in health were still a long way off. In spite of (or perhaps because of) growing hardships and the heavy-handed police state, people in Egypt seemed more submissive, more resigned, than their counterparts in many of the countries of Latin America, the Far East, or Southern Africa.

But I gradually discovered that in Egypt, too, there is a groundswell of momentum for change. At present it is fairly inconspicuous, like the hidden but pervasive squatter settlements of Cairo. However, things are clearly not as dormant in Egypt as they appeared at first glance.

One of the fronts for progressive change in Egypt is the province of Ismailia, which borders the Suez Canal. Ismailia

has been compared to the state of Kerala in India, for although it is one of the poorest provinces, its health statistics, school enrollment, and other indicators of social well-being are better than in most other Egyptian provinces. Also, like Kerala, Ismailia provides more public services to its citizenry and has a somewhat more equitable distribution of land and wealth than do many other regions.

The governor of Ismailia is famous—or, in some circles, infamous—for his informal, very human approach. (When the leaders of our regional training program went to see him, they pressured me into wearing a tie—an act of conformity I childishly resist. When the governor came out of his office to greet us, he was so casual and sloppily dressed that we thought he was a janitor. He soon put us at ease. When I laughingly told him how I had been hounded into wearing a tie, he insisted I take it off, which I happily did.)

The reason that the workshop on 'Primary Health Care through Effective Participation' was held in Ismailia was that the governor of Beni Suef, where the organizers have established a community program, had refused to permit the workshop in his state. (Such flat refusal in Egypt is par for the course. To most of the ruling class, 'effective participation', even for the purpose of improving health, smacks of subversion.) By contrast, the governor of Ismailia welcomed the potentially progressive workshop with open arms.

Because he has responded to the needs of the common people, the governor of Ismailia is immensely popular, and—a rarity in Egypt—has been elected to a third term in office. An unusual man in his mid-forties, he is in many ways out of sync with the Egyptian political system. In his spare time, he is studying for a doctorate in political science. His dissertation is on the impact of foreign debt on poor countries.



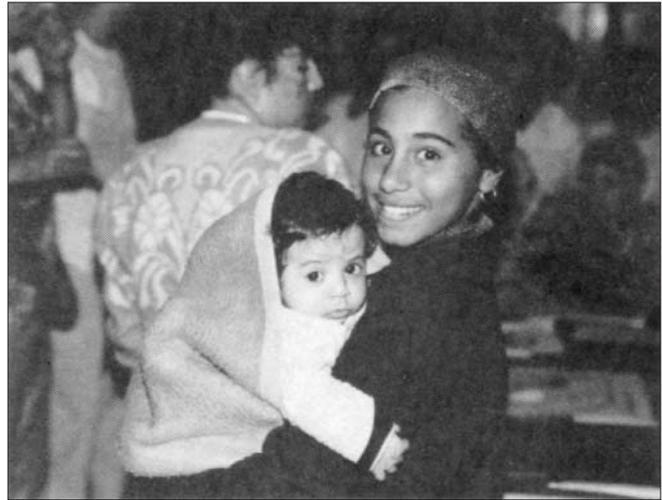
Medical students from Suez University have organized a village literacy program for young women. The teachers use the methods of Paulo Freire, using "key words" that are especially relevant to people's health and wellbeing to spark discussion. Animated teaching aids enliven the classes.

This remarkable governor has lent support to many progressive measures in Ismailia. One of these is the unique approach of the medical school at Suez University. In sharp contrast to most medical schools in Egypt, which are huge and overcrowded, Suez Medical School accepts a small number of students. It recognizes that the country needs not more but better doctors. Learning is strongly community-oriented and 'problem-based'. No formal lectures are given. Rather, students do their own studies in small groups, using the instructors as resource persons and advisors. I was delighted to learn that *Where There Is No Doctor* and *Helping Health Workers Learn* (in both English and Arabic) are being used as basic textbooks in the training program for community health at Suez Medical School.

We had a chance to visit one of the villages where graduate students from the Suez Medical School were doing a 'field project' to earn a certificate in community practice. The program was exceptional because, in spite of the hierarchical power structure of Egyptian society, the visiting team had managed to foster a degree of active and organized participation among several sub-groups in the community. I was enormously impressed by the commitment and integrity of the young doctors. Unlike so many physicians, who usually have a hard time relating to other people as equals and not imposing their ideas, the group really did listen to the villagers—and had redesigned their initial plans accordingly.

For example, the medical team had originally planned to train a group of older girls as community health workers. But, on meeting with the villagers, they found to their surprise that neither the girls nor their parents were interested in their becoming health workers. The girls said that what they wanted was to learn to read and write. So the young doctors shelved their earlier plans and started a literacy program for young women.

Using the liberating methodology of Paulo Freire, they started by focusing on a few 'key words' that are critical to the well-being of women and children, such as 'mother', 'breastfeeding', 'water', and 'food'. The key words became themes of discussion, not only for promoting literacy, but also for increasing social awareness and teaching health skills. As the young women gained confidence in expressing their ideas and concerns, they gradually showed more interest in becoming health workers. (Tellingly, the villagers may have had a truer sense of their health-related needs than the doctors. Studies in many countries have shown a strong correlation between 'female literacy' and a drop in child mortality.)



In Egypt, as in other underdeveloped countries, the main care providers for children are often their older sisters. This is why CHILD-to-child activities—which train older children to help meet the health needs of their younger brothers and sisters—are so important.

Another exciting component of the village project was a "CHILD-to-child" program. The young doctors had established a relaxed and friendly relationship with the village children. A group of children met twice a week in the evenings and took turns teaching each other under the doctors' guidance about the health needs of their younger brothers and sisters. On my second visit to the village (I played hooky from the regional training program in order to go) I led a session teaching the children—and the young doctors—about dehydration and rehydration using a 'gourd baby'. The response of the children to this hands-on process of 'discovery-based learning' was overwhelmingly enthusiastic. What a refreshing change after days of overly structured adult meetings!



The CHILD-to-child approach in action. With the guidance of a visiting Egyptian doctor, a village boy helps classmates learn about the importance of breastfeeding and of introducing supplementary foods at four to six months of age.

I learned that, despite Egypt's massive security apparatus, there are many progressive groups active in the country, including human rights groups, groups defending the rights of women, and groups working for more democratic government.

There are also Islamic fundamentalist groups, some of which take a militant stand against the present regime (and are subjected to violent reprisals by the security police). These tend to be rather fanatic and often ultra-conservative. As one social activist put it,

The fundamentalists are in part a positive force because they are critical of the government and are striving for radical change. But they are also a negative force, since their vision of the 'new society' resembles that of Iran under the Ayatollah Khomeini.



In workshops in Egypt and the Occupied Territories, I used this 'gourd baby' to help health workers learn how to teach families to use oral rehydration therapy in managing diarrhea—the world's biggest killer of children.

Far more promising, I believe, is a progressive movement that might be called the Islamic version of 'liberation theology'. Adherents of this school of thought are reviewing the Quran and emphasizing passages that promote the health of women and children, highlight the importance of sharing, and call for equity and fairness in human relations.

The Quran, for example, recommends that women breast-feed their babies for two years.⁴ And it calls on the father—if the mother dies or cannot breastfeed—to assume responsibility and find a 'wet nurse' for the baby.

The Quran further counsels, in the 'rule of seven households', that each family is responsible for the well-being of those living in the seven houses nearest by. If a household

has nothing to eat or needs help, it is Allah's will that neighbors offer food and assistance. Also, all good Muslims are expected to tithe (give one tenth of their income) to those who are hungry, sick, disabled, old, or otherwise disadvantaged.

Remarkably, the incidence of abject poverty accompanied by severe malnutrition in children is comparatively low in Egypt, as in much of the Arab world. This is true in spite of the high incidence of landlessness, unemployment, low wages, and mild undernutrition in children. It has been suggested that one of the reasons for this relative lack of extreme deprivation is the Islamic 'good Samaritan' practice.

All in all, some encouraging things are happening in Egypt. The winds of change are beginning to blow. A grassroots movement is sprouting in the heat of this socio-political desert.

What can we do?

Those of us from the West who care about health and social justice can help by putting pressure on our own governments—especially the US government—to stop propping up tyrannical regimes and imposing our neocolonial, profiteering model of development. One crucial step is to withdraw all US armed forces from the region and to prevent the establishment of a permanent American military base there. Another is to drastically reduce outside arms transfers to local powers.

It is time we give the people of the Middle East—and the entire Third World—a chance to construct their own healthier, more equitable, more independent societies.

Endnotes

1. Figures for 1989 given in UNICEF, *The State of the World's Children*, 1991, pp. 102-103.
2. *Ibid.*, pp. 102-103.
3. Michael Gordon, "Two Ex-Military Chiefs Urge Bush to Delay Gulf War . . . Kissinger Dissents," *New York Times*, November 29, 1990.
4. Al Hussein Abdel Maguid Hashim et al., *Child Care in Islam*, p. 35.

Backlash of the 'Green Revolution' and Western 'Development'



According to this Bedouin boy, Ali, his family is one of 10,000 that have been forced to resume a nomadic lifestyle as a result of the 'Green Revolution' in Egypt. The high-yield hybrid grains that were introduced in the fertile farmland of the Nile Delta are dependent on high doses of pesticides, which are often sprayed by air. The pesticides drift beyond the farmland and fall on vegetation that goats and sheep browse on, thus poisoning the animals. Therefore, during the planting season sheep and goat herders are forced to move out of the Delta with their animals. Twice a year Ali and his father, along with hundreds of others, make a 120-mile journey on foot with their flocks to the Suez area, where—although the pickings are slim—vegetation for grazing is uncontaminated. The family sends the women and younger children ahead by bus.

Although bright and eager to study, Ali still cannot read and write. The pattern of biannual migration made necessary by big landholders' devastating use of pesticides makes formal education and an escape from poverty almost impossible. The boy wanted to enroll in the adult literacy program, but so far only girls are being allowed to participate in it.

With its demands for costly fertilizers and pesticides, *the Green Revolution has driven poor farmers off the land practically everywhere it has been introduced*, including in Asia, Africa, and Latin America. What is happening to Ali and his family is one of countless examples of how Western-conceived technologies imposed on underdeveloped countries without adequate concern for social and political factors and long-term environmental consequences often lead to the further underdevelopment and impoverishment of both the land and its people. Almost invariably, major development policies imposed by the North have widened the gap between rich and poor.

Huge dams are another example of a development strategy that causes incalculable human and environmental disasters. Egypt is no exception. The High and Aswan Dams have done far less than was hoped to increase the total agricultural production of the Nile flood plains. Instead, they have deprived the flood plains of the seasonal deposit of silt which formerly made the Nile Valley one of the richest agricultural lands in the world. Today this silt is uselessly filling up the reservoirs behind the dams, reducing their effectiveness as water reserves. Deprived of the natural fertilizer that comes with seasonal flooding, farmers must depend increasingly on chemical fertilizers. The high cost of fertilizers and pesticides drives many small farmers off the land, concentrating land and wealth in fewer hands. For those subsistence farmers who remain, the decreasing fertility of the Delta means that to produce the same amount of food today, people must put in twice the work and expense as they did before the dams were built. What is more, without the seasonal flooding the average climatic temperature of the Nile valley has risen to a stifling and unhealthy extent, increasing the incidence and mortality rates of many diseases, especially diarrhea and dehydration.

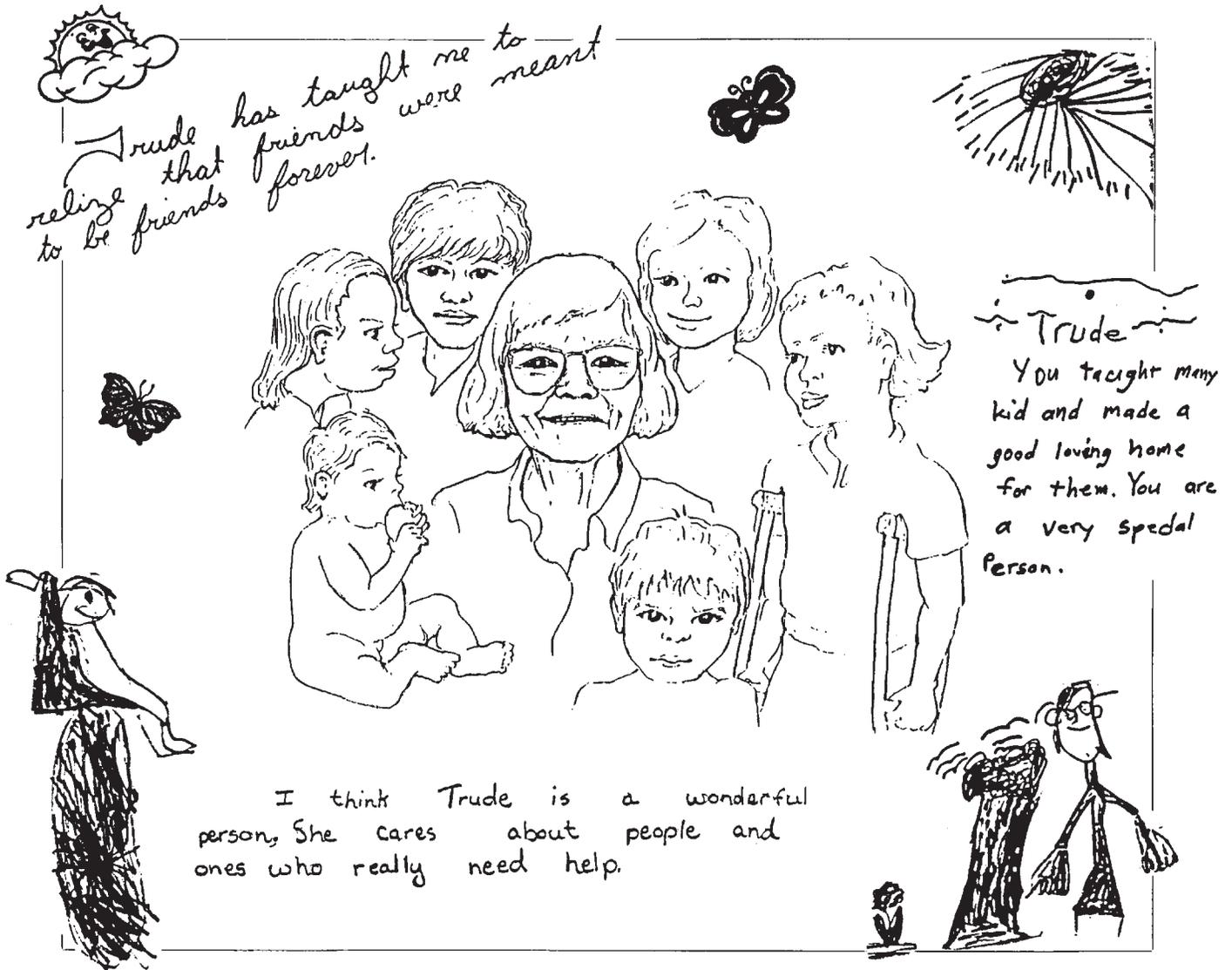
But the worst consequence of the dams and the vast network of irrigation canals has been a devastating pandemic of Bilharzia (schistosomiasis, a disease caused by a type of blood fluke for which the intermediate host is a water snail). In some communities more than half of the population is infected with this chronic, severely debilitating disease.

Big dams throughout the developing world have led to displacement of native peoples, ecological devastation, suffocating debt burden, and ravaging increase in diseases ranging from Bilharzia to river blindness. Yet the World Bank, International Monetary Fund, USAID, and other major development agencies continue to promote these giant dams. In the short run they benefit the privileged few at the expense of the many. But in the long run they diminish and endanger us all.

One of the biggest and potentially most disastrous giant dam projects today—sponsored in part by the World Bank—is on the tributaries of the Narmada River in India. To support the efforts of the local people to stop this misguided mega-development project, write to Baba Amte/Maharogi Sewa Samiti, Warora/At. & Post: ANANDWAN/Via Warora, 442 914/Dist. Chandrapur, Maharashtra/India.

On April 21, we celebrated the 70th birthday of Trude Bock. The occasion also marked Trude's sixteenth year of coordinating the care of disabled Mexican children referred to the Bay Area for treatment (among many other tasks, and all on a volunteer basis!). We join Trude's many friends, young and old, in saying:

Happy Birthday and Thank you Trude!



P.S. Now that Trude is 70, we have promised her to find people who can assume some of the responsibility that she has carried out so well for so long. If you, or someone you know, is interested in helping out, please contact us.



Newsletter from the Sierra Madre #24

June, 1991

In This Issue:

A discussion of the social,
economic, and political factors
affecting people health in Egypt

and more...



In spite of the severity of conditions in Egypt, the spirit of these village children remains unquenchable.

Suggested Reading on Egypt

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