Youth at risk in Old Cairo

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Abstract

The World Health Organization (WHO) and the Ministry of Health Egypt conducted a socioeconomic and health survey on 1 500 households in Batn al-Baquarah and al-Fawakhir, Cairo, as part of an assessment for the Basic Development Needs project which was introduced to the area in August 2004. The area was chosen due to its low socioeconomic status, 77.3 percent of the households lived under US$ 1 a day and its location as a squatter community within one of the world's largest urban cities.

Due to the marginalized status of these households, the youth and children in these communities lack access to basic needs such as education and health care services. The children living within these households are at risk from increased incidence of infectious diseases, particularly due to unsafe food handling practices, contaminated drinking water, inadequate food safety, airborne pollution, exposure to household's garbage, unsanitary removal of household wastes, and the overcrowded housing as characterized by urban slum environments. High smoking rates have also been found among the youth in this area. The severe degree of poverty of these households has precipitated the need for many of the youth and children to enter the labor market. Additional negative health outcomes are experienced by the youth and children due to their occupational environments. The working children enter into adulthood with few skills, limited educational attainment, and diminished health capacities, thereby contributing to a vicious cycle of poverty.

The proposed paper will seek to describe the differential conditions and challenges faced by female and male children in Batn al Baquarah and al-Fawakhir, Cairo. The programme being implemented in the area by WHO and the Ministry of Health will then be explained, including some case studies of the beneficiaries. Finally, options to reverse the cycle of poverty for these children and youth will be discussed. It is important to highlight the concept of community empowerment and leadership as a factor for sustainability of any development process.

ملخص

قامت منظمة الصحة العالمية بالاشتراك مع وزارة الصحة بمصر بإجراء مسح اجتماعي واقتصادي وصحي على ألف وخمسمئة عائلة في منطقتَيْ بطن البقرة والفواخر بالقاهرة، كجزء من التقييم الخاص بمشروع الاحتياجات الأساسية للتنمية، وهو المشروع الذي بدأ في هذه المنطقة منذ آب/أغسطس من عام ٢٠٠٤. ولقد اختيرت المنطقة بسبب الحالة الاقتصادية والاجتماعية المتردِّية فيها، فنسبة العائلات التي تعيش فيها تحت دولار واحد فقط يومياً وصلت إلى ٧٧,٣%، وبسبب موقعها كمجتمع عشوائي داخل واحدة من أكبر مدن العالم الحضرية.

ونظراً للوضع المهمَّش لتلك العوائل، فإن شباب وأطفال هذه المجتمعات يفتقدون سُبُل الوصول إلى الاحتياجات الأساسية مثل التعليم وخدمات الرعاية الصحية. والأطفال الذين يعيشون وسط هذه العوائل معرَّضون للمخاطر من جرَّاء الوقوعات المتزايدة للأمراض

المُعْدِية، وعلى وجه الخصوص تلك الأمراض الناجمة عن الممارسات غير المأمونة لتداول الطعام، ومياه الشرب الملوثة، والغذاء غير الآمن، والتلوُّث الهوائي، والتعرُّض للقمامة الملقاة من المنازل، والتخلُّص بصورة غير صحية للفضلات الصلبة، إضافةً إلى الازدحام الخانق للمنازل الذي يميِّز البيئة المحيطة بالضواحي الحضرية. أما من يعمل من الأطفال فيصلون إلى مرحلة المراهقة مكتسبين القليل من المهارات، مع حضور تعليمي أو دراسي محدود، وقدرات صحية آخذةٌ في الضَعْف والتدهور، مما يساهم في إيجاد حلقة مفرغة من الفقر.

والورقة البحثية المقترحَة سوف تعمل على وصف الأوضاع والتحدِّيات المتباينة التي تواجه الإناث والذكور من الأطفال في مناطق بطن البقرة والفواخر بالقاهرة. وسوف يتم شرح البرنامج الذي تقوم المنظمة ووزارة الصحة بتنفيذه متضمِّناً بعض دراسات الحالة من المستفيدين. وفي النهاية ، فسوف تكون هنالك مناقشة لما هو متاح من خيارات لتغيير مسار الحلقة المفرغة من الفقر بالنسبة لهؤلاء الأطفال والشباب. ومن الأهمية بمكان التركيز على مفهوم تمكين المجتمعات والقيادة بوصفه عنصراً لاستمرار أي عملية تنموية.

Introduction

This paper is based on a project started by a number of volunteers who had a vision to give children who work in the pottery industry a better quality of life through art. Today the project continues and the World Health Organization has become a participating member among a team of agencies working to rejuvenate a community and the pottery industry.

The community lies in the center of Old Cairo along a major intersection and what has become known as the religious district, encompassing the three major religions. The area boasts many trades; however, the one that was focused primarily upon was the pottery industry. In 2004, the World Health Organization conducted an extensive needs assessment on the factory owners, the children that work within the industry, and finally their families and again in 2005, the Ministry of Health and Population conducted a medical assessment on entire community. The paper at hand concentrates on the families' needs assessments and the girls that were addressed in the children's needs assessment as well as daily observations and encounters with the mothers and daughters in the area.

The focus of this paper is gender life roles which are adopted as based on traditional practices and economic needs. The female kind in this area is an adaptive chameleon moving with the flow in order to survive. When tradition stops her from any feat she maneuvers her way through to reach her goal without confronting or changing her destiny. The lady, the mother, the baby girl is always the beautiful diplomat waging her battles carefully and systematically, knowing always that she has the survival of her family weighing on her tired and weary shoulders. The men remain as the patriarchs even when they are not economically active, and within the patriarchy lies a hierarchy.

The World Health Organization focuses on empowering, education and improving women's life chances. The Community-based initiative programme focuses on a number of activities including assisting with micro-credits, providing literacy and vocational classes and lastly increasing their

access and use of primary health care services in order to improve their quality of health and that of their children.

A Focus on Women and the Girl Child

A great deal has been written on the plight of the female and male child laborers yet very little has been said about their lives. The girls grow up and take the place of their mothers in their own households and just as their mothers relied on them for help in the household and for financial support the cycle will continue with their children. This cyclical relationship is also referred to as the life cycle of women. The boys are given more opportunities and better nutrition which are meant to prepare them for following in their designated patriarchal roles.

The literature refers to the health and development aspect of female and male child as they grow to maturity, the impact that the environment has upon them, as well as genetics and nutrition. The second focus is on the social relationship that gender roles prescribe within society. It is the carving of the path and coming to terms with their status. The family dynamic within the household is of great importance as it shapes the path in which both the female child and the women must forge ahead.

The household within this study is quite central as it is the reason the female child is sent to work. Thus, an exploration of its meaning is important. The household, although its most common meaning is domestic space, its sociological and economical significance is far greater. "This space is designated both by material structures – walls and roofs – but, perhaps more importantly also by the social activities that are held to be appropriate to it" (Mckie, Bowlby and Gregory: 1999:5). The children see the household as their safe haven even though the girls must work within its walls. The girls see staying home as a luxury they cannot afford but still wish for. The household then becomes a double edge sword for the young girls; on one hand there is safety and comfort on the other hand the children must work hard on the outside to maintain that household.

The female child does grow up, eventually marrying and then reproducing her own children at which point traditional society expects her to remain in the household. For centuries in Egypt women have worked in the shadows of men. They have been traditionally left out of the work force yet have managed to work within its peripheries gaining incomes to sustain their families. "There are workers in traditional occupations, such as hired fieldworkers, weavers, and craft people, midwives and curers, domestic servants and others who do work that goes unremunerated" (Kader: 1984:156).

There is a bias in the family toward not sending the female child to school; boys will need to be educated as they will eventually need to provide for their families, girls on the other hand will traditionally be dependent on their livelihoods from their parents or husbands (UNICEF: 2002). The life cycle of the girl is seen as never intersecting with the production as females are traditionally excluded. Ironically, it is the mother that is left caring for her young and therefore if she is not prepared she is bound to sink deeper into poverty.

Socioeconomic Indicators and Background of Families Living in Old Cairo

The Families living in Batn al-Baqurah and Fawakhir, in Old Cairo, are some of the poorest in Egypt. One thousand five hundred families were surveyed in the two designated areas as part of the Ministry of Health and Population (MOHP) survey. The results found that 77.3 percent of all those living in the area lived under $1 a day. The children's needs assessment was conducted on 267 children who as part of a WHO sample were found working in and around the pottery industry. The

average age of the female child laborers' was 13 years old. The average age of the mother to wed was 17 and the father 25 years of age. The parents conceived their first child after one year of marriage and lost one child from their average of 8 children. Forty-one percent of the girls said that their fathers were the strongest force and mothers were not far behind at 27%. Exactly half the girls had attended school, between the ages of 6 and 7. Only 16% still remained in school the rest that had attended school dropped out at the age of 10. Those that did not attend school were unable to attend for financial reasons. Eighty-four percent of the girls reported that they had no skills.

The fathers of the girls worked in construction (17%), pottery (19.1) and as simple workers (11%). Half the fathers were skilled, 19.1% were semi-skilled and 30% were unskilled. The mothers on the other hand were all unskilled, 75% of whom were housewives. Thirty-five percent of the girls reported that their mothers were the decision makers while 47% stated that their fathers were the decision makers. The results showed that 61% of all family members were illiterate, 42% were employed and 53% were unemployed. Fifty percent of the fathers were skilled compared to one percent of the mothers. Ninety-eight percent of the mothers were unskilled while only 38% of the fathers were. The top five occupations for fathers were: 32 construction, 28 pottery, 17 bakers, 15 Garbage collector and, 15 doorman. Two hundred and thirty mothers not surprisingly were housewives. Decisions were made mostly by the fathers, 60% of fathers were the primary decision makers in the household and mothers at 29% came a distant second.

Most of the children started school at the age of six, another 35 started at the age of seven, and 86 did not know or could not be accounted for. One hundred and Eighty-five children attended school as opposed to 78 that had not. Only 63 children were still enrolled in school as opposed to 116 who had left school and 83 that were not accounted for their school activities. One hundred and seventy-six children reported that they had failed a grade due to work, because of playing around but a large portion for being absent from school. There were 121 children who reported how old they were when they dropped out; the average age for dropping out was 10, which would be in grade 4. Money was the most significant reason why the children never attended school as well as a lack of importance given to education.

The World Health Organization's Community Based Initiatives

Since the eighties, Eastern Mediterranean Regional Office (EMRO) of WHO has been advocating poverty alleviation as the most potent strategy to facilitate equitable development for achieving the health-related goals. This strategy is based on the realization that ill health and poverty are mutually reinforcing. It was recognized that to have real impact on the quality of life of the people and to gain substantial and sustainable health gains, it was necessary to address all determinants of health and to support the individuals, families and communities to attain self sufficiency and self reliance through integrated and comprehensive development. In support of this strategy EMRO is actively promoting community based initiatives like Basic Development Needs (BDN), Healthy Cities Programme (HCP), Healthy Villages Programme (HVP) and Women in Health and Development (WHD) among Member States. Countries in the Eastern Mediterranean Region that have implemented at least one of these initiatives have demonstrated significant improvements in quality of life indices pertaining to a wide range of fields including health, nutrition and other social sectors as well as economic development.

The CBI programmes support the Member States in the integration of health policies and programmes in the national strategic development agendas aimed at health improvement, poverty reduction and better quality of life through the attainment of the Millennium Development Goals. CBI adds value to the Member States by focusing on promoting equity, especially within the human rights perspective, gender mainstreaming in WHO and national programmes, analyzing the

effects of globalization and emerging technologies on health, social mobilization and enhancing the role of women in health and sustainable development. Currently, CBI is being implemented in 17 countries[1] covering a population of 18 million people and over 1700 communities. The programme has been widely accepted by many countries, with many countries beginning to formally recognize and adopt the elements of the community-based approach within their development strategies and policies. Although, CBI focuses on the community as a whole, women, youth and children due their vulnerability become the focus of the programme. Women become literate and gain knowledge that empowers them to improve their lives and that of their children. The youth in the community join in as cluster representatives, learning valuable skills that they take with them in their daily lives and use to improve their community.

In Egypt the programme was introduced in 2001 and is still under a demonstration phase. The programme was first introduced in Alexandria and then was piloted in Cairo in two areas, Marg (2001) and Old Cairo (2005). Both areas were urban centers with significant population from rural areas. The BDN programme seek to mobilize and organize communities while promoting self-management, self-reliance and self-dependence. BDN programmes support leadership development and seeks to identify and promote the use of appropriate, health-friendly technologies for community development and adoption of healthy lifestyles within the communities. Objectives of the BDN programme include enhancing the health and academic literacy of the people, giving them greater options for sustainable development and making them responsible partners of society. Improvement of health indicators is achieved through comprehensive health services that are the central feature of the BDN programme. BDN functions by mobilizing, organizing, training and empowering a community to play a proactive role in self-development. Using a bottom-up planning approach, the community identifies and prepares feasible plans in order to address the priority issues. The community then carries out integrated multidisciplinary interventions, based upon local needs and targets outlined in the social contract and in harmony with national and regional plans. The participatory process leads to integrated and sustainable development.

The Basic Development Needs Project in Old Cairo

The people living in the selected area of old Cairo have limited access to health care, proper nutrition, education, safe drinking water and sanitation, jobs and sufficient income due to extreme poverty. The population living in the urban slums of Cairo is increasing on daily basis. Most of them live in very congested and unhygienic places. By visiting the Old Cairo area one can easily understand that awareness of the families about necessity of mother and child care, including Expanded Program on Immunization (EPI), growth monitoring, antenatal, natal and postnatal care, family planning, prevention of diarrhea and Acute Respiratory Infections (ARI) is badly needed. As in many poverty stricken areas child labor is on the increase placing children in hazardous environments that hinder their physiological and mental development.

MOHP, WHO and Rotary el-Fustat organized a joint visit to the target area during the summer of 2004. This resulted in the development of a plan of action based on the BDN approach. In addition, a Memorandum of Cooperation was signed between WRO Egypt and Rotary el-Fustat during which Rotary el-Fustat pledged US$ 12,000 and the World Health Organization pledged US$ 57,326 for implementation of socioeconomic and health related projects in the same area. The Old Cairo BDN project was introduced in 2 communities (Batn El Baqara and al-Fawakhir) based on the interest of

[1] CBI is being implemented in Afghanistan (BDN, HCP), Bahrain (HCP), Djibouti (BDN), Egypt (BDN), Islamic Republic of Iran (BDN, HVP, HCP), Iraq (BDN, HCP), Jordan (HVP), Lebanon (BDN), Morocco (BDN), Oman (BDN, HVP, HCP), Pakistan (BDN, HCP), Saudi Arabia (HCP), Somalia (BDN, HCP), Sudan (BDN, HCP), Syria (HVP), Tunisia (HCP), Yemen (BDN).

the community leaders. New Horizon Association for Social Development (NHASD, a local NGO) partnered with the programme. The community elected a community development committee (CDC is composed of notables and elders in the community) along with cluster representatives who volunteered their time and were responsible for 30-50 families each. NHASD was responsible for implantation of the programme in coordination with MOHP who carried out an extensive baseline survey measuring the socioeconomic and health status of the community as well as conducting health awareness classes. All cluster representatives and CDC were trained on the principles of BDN and subsequently, the CDC has applied to become an NGO in order to be able to request their own funding from both public and private sources to improve the conditions in the community.

Based on the results of the survey a number of priorities were identified by the community such as access to primary health care and children's education. Due to the fact the community resides in an area that was considered a squatter neighborhood most public services were not provided, such as clean water and sanitation. Within the community, 1 square kilometer was being used as a garbage dump for municipality of Cairo. The women of the community were also not receiving adequate health care, specifically neo-natal and post-natal care. The children of the community needed to be bused to the local school and this was also a source for concern as their was no organized manner to do so. Illiteracy and a lack of skills was also a major concern for the community as it contributed to unemployment and subsequently a status quo in their impoverished state. Thus, to address all these priorities the CDC prepared a plan which included funding children's education, connecting clean water to the dwellings and fixing the sanitation in the alleys between the residential areas, income-generating projects for the most needy in the community, removing the garbage dump and supporting literacy and skill training. The community was keen to focus on the needs of the women and female children as they were seen as the most vulnerable in the community, thus a number of projects were directed towards them.

Nutrition awareness classes were directed at women and youth as well as micro-credits. One woman in particular who had lost her husband and was raising two teenagers was given a loan to re-open her husbands electrical supply store. Her daughter who had helped out with the family business continued to do so. She had acquired a few skills from her father who was a local electrician and was hoping to expand the store by hiring a fulltime electrician to assist them in house calls. The young girls in primary school were the focus of a fund raising campaign by the community that raised $ 2,112, which was enough to put 110 girls through the 2006-07 academic year, instead of dropping out and joining the labor force.

Options to reverse the cycle of poverty for children and youth

The concept of teaching men, women and youth through a holistic approach is the basis of the literacy, life skills and health curriculums. WHO/EMRO initiated 6 trial curriculums that include the following life skills: plumbing, interior decorating, carpentry, electric circuitry, early child development, and mechanics. WHO/EMRO commissioned the New Horizon Association for Development to devise these curriculums.

The conceptual idea behind the curriculums is to give men, women and youth a chance to not only become literate but also earn a living by acquiring a skill. Women in Egypt rank at a literacy rate of 60% and all have no skills. The average national drop-out age is 10 years old, and while many of these children do take up employment very few gain a life skill during their menial work. Included in the curriculums is the aspect of work ethics, personal hygiene and health. The introduction of a work ethics, personal hygiene and health is fairly unique to any curriculums but is aimed at producing a healthy and productive member of the global work force. Today, we strive toward a global ideal of a healthy worker who produces quality goods.

Although, many of the curriculums are not traditionally geared toward women, they are however showing a keen interest and signing up for classes. Women tend to deal with many of the household chores in the home and are in need of any skill to aid them in repairing items in their owm homes as well as that of their neighbors. By learning skills such as plumbing, electric circuitry, mechanics, etc… women can diversify their skills which will allow them to gain an income in their community. By learning a skill, women will also feel empowered in their homes and in their communities. In addition by teaching them personal hygiene, health and work ethics we will allow them to be a force in combating diseases in their homes and in their communities.

The curriculums are divided into 27 lesson in a classroom geared toward a theoretical approach regarding each life skill, literacy, health, personal hygiene, and work ethics. A further 27 lessons, which will be held in workshops and will be geared toward a practical knowledge of the 6 skills. Local factories and tradesmen have already been approached to conduct classes in their workspaces. The theory is that using local resources will sustain the programme and increase community involvement.

There are two components involved in interventions reversing the cycle of poverty through health for children and youth. The first involves achieving better health for the community across the life cycle through mechanisms such as increasing the health literacy of the community, and ensuring health facilities that are sufficient to meet the communities' needs, as well as affordable, accessible, and acceptable by the community. The other component involves addressing poverty as a key determinant in unhealthy outcomes, by increasing literacy and empowering the community, increasing the income skill capacity of the community, and providing income generation loans to propel action by the community.

The literacy and vocational curriculums developed by the women in health and development (WHD) unit in coordination with the community based initiative (CBI) unit at EMRO WHO address these components by raising capacity in health literacy, academic literacy, and income skill capacity. One set of curricula teaches the participants academic literacy while incorporating health concepts, community responsibility, and life and vocational skills. Another set of curricula provides an in depth knowledge of environmental health, including components of communicable disease, mother/child care, elderly care etc. The final set of curricula orients the participant to a particular vocation, which currently include; electrical skills, plumbing, carpentry, small appliance mechanics, interior painting, and early childhood care provision and education. All the curricula are targeted at both males and females, and representation of both sexes, albeit not in even distribution, is required for administration of the courses.

These courses have completed some initial piloting in Old Cairo and the following observations were made by the students and teachers. The vocational orientation nature of the six literacy manuals was highly appreciated by both the learners and the facilitators. Facilitators expressed interest of the Health Education Manual in the package. Most facilitators preferred it to some of the existing health education materials available for them. They saw it as comprehensive, easy to go through and responding to their information needs as well as that of the average literacy learners. In general, the length of lessons and of the curriculum was suitable and accepted by the facilitators and learners.

The vocational curricula are now being offered in Batn El Baqara and al-Fawakhir. The community has chosen electricity and interior painting as their first priorities. Both males and females are taking the training, ranging in age from 15 to 27. Forty students thus far have signed up for two curricula (electricity and interior painting). Classes are segregated and each class holds 10 students.

The female classes are held at the local primary health care clinic and include a nursery for children up to the age of 5. No incentives are offered for either men or women, except transportation costs (a small bus was hired to transport them with their children) and snacks.

As the vocational curricula have been offered only for the past 2 months, it is too early to assess what impact this will have on the community. However, one of the plans for the graduates is to apprentice with local tradesman or to feed into existing industries. Students will graduate from the literacy and health component within three months and based on their performance in the national literacy examination they will be offered a place in the life-skill component of the curricula, which will conclude after 6 months. Women and youths enrollment and participation has been considerably strong and we expect all 20 women who initially attended to graduate from the complete vocational curricula by May 2007.

Conclusion

The programme is still within its infancy in Egypt and therefore it is impossible to judge how successful it has been in bringing a better quality of life to the communities it has tried to help. Political commitment and intersectoral collaboration are important, key components that are lacking within the structure of the programme in Egypt but plans to improve this are already underway with support from the Ministry of Social Solidarity having been pledged. Furthermore, an increase in women's utilization of the local primary health care centre has been facilitated by the establishment of family files (organized by Rotary al-Fustat and MOHP) and the vocational curricula. Already, women and youth's knowledge of preventive health issues has increased dramatically.

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