This is all Koosa

Health-seeking for children in a Cairo slum: Balancing need, money and mistrust

Heba Gowayed and Lenka Beňová

The aim of this paper is to present the findings of an ongoing research project conducted in the Cairene slum of Ain Es-Sira. It examines the effects of financial capacity and conceptions of citizenship on the health-seeking behavior of mothers for their children. Ain Es-Sira, a slum neighborhood of approximately 6,000 inhabitants, has been selected to benefit from a pilot study of a conditional cash transfer (CCT) program. Implemented in dozens of countries across the world, CCT programs give families living below the poverty line cash and, in exchange, require that families fulfill certain conditions, which are assumed to facilitate the breakdown of the intergenerational transfer of poverty. In addition to the core conditions pertaining to child education (school attendance until 15 years of age) and health (regular preventive checkups), the Egyptian pilot considers beneficiary families not as aid recipients, but as partners in the development process. Thus, the pilot will encourage and measure progress in families’ community participation, women’s empowerment, intra-familial relationships, and the effects of the beneficiaries’ citizenship engagement vis-à-vis government-provided public services.

The social provision of subsidized education and health care has been engrained in Egyptian law since the 1950s. However, the neglect of public services, compounded by rapid increase in population left these institutions in disarray, accessed by only the poor and marginalized. The quality of services has suffered and, without a transparent and effective citizen-led feedback system to ensure access and accountability, the forced yet unavoidable relationship between poor families and public schools and health centers is rife with suspicion and mistrust.

While designing a CCT pilot for Ain Es-Sira, much of the research has focused on how to assure adherence to conditions related to schooling and health within the existent disconcerting dynamic between the poor and the service system. It was expected that women in the area would lack mobility, health awareness, and trust in modern medical care. However, our team found that women do access health care, are primarily responsible for child health and are not averse to visiting doctors. The main issue that women take into consideration when seeking care for their children is their mistrust of state provided medical care, and the expense of accessing such officially “free” public and paid private care.

This paper describes the results of fieldwork based on focus group discussions with 74 women and 16 men, in addition to five individual in-depth interviews. After briefly introducing the concept of health-seeking and trust within the patient-provider relationship, the paper will examine the perceptions and behavior of mothers in Ain Es-Sira in regards to seeking healthcare for their children. The conclusion provides reflections on and recommendations for the CCT program design and how it could actively be structured to promote progress toward the goal of improving children’s health and health status.
**Health-seeking and Mistrust**

Early theories that attempted to understand why, when and how people seek healthcare centered around economic theories of an individual’s demand for ‘good health.’ Influencing a person’s productivity, efficiency and consumer patterns, good health is an economically sound investment or a durable capital good, which produces an output of healthy time. Patterns and determinants of use of health services began to emerge along this framework. John McKinlay, in his review of methods in studying health-seeking behavior, divided them into six main frameworks (economic, socio-demographic, geographic, socio-psychological, socio-cultural, and organizational/delivery systems). These approaches to studying health utilization are not mutually exclusive, and together aid in the understanding of what factors may prevent or encourage use of health services. Over the past decades, discourses about inequalities in health outcomes have included prioritizing the expansion of health systems and infrastructure to enable, at the minimum, the provision of basic primary care for all (such as the Alma Ata Declaration of 1978). These have progressed to a more comprehensive understanding of health as a human right. Alongside, theories of health-seeking behavior now include assessments of demand and supply-side interventions of multiple actors, such as the state, international organizations, for-profit organizations and civil society to improve population health outcomes.

Notwithstanding the availability of health care, some segments of the population may not benefit from improved health outcomes due to other factors, such as increased environmental/occupational risks or lack of decision-making power about one’s own health-seeking behavior. Addressing the writings of the German pathologist Rudolf Virchow, Whiteford notes that already in the 1840s Virchow recognized ‘that to understand health or illness one must understand the social conditions in which health and illness are created, identified, defined, and continued.’ The real effects and results of the environment in which people are born, live, work and age on their health was recently highlighted by the report of the Commission on Social Determinants of Health (2008). Despite the extended knowledge of the factors influencing the health status and health-seeking for individuals, Anderson found that the three most direct reasons for seeking care, namely predisposition to use services, ability to secure services and need for services, explain only 43% of the variance in total use of health services among individuals.

While these direct reasons for health-seeking address the conventional obstacles to decision-making, to understand “agency” and to work towards women’s empowerment in seeking healthcare for their children, we must also look at indirect but real relational issues such as risk or distrust. In other words, we must place our finger on the intangible 57%. Beyond the broader structural determinants of health-seeking behavior, the issue of trust has found its way to the forefront of discussions on healthcare. A patient is inherently vulnerable when approaching a health-care provider. If that patient is a poor woman residing in a slum, the gap of inequality is stretched even wider. In discussing trust in health-seeking in Sri Lanka, Steven Russell divides trust into two types: face-to-face or “personal” trust and faceless or “institutional” trust. These
two types of trust are inter-related in that they both determine the overall levels of trust towards health-care providers, but they are distinct in that they reflect faith in two different entities: the doctor and the institution, whether public or private. This paper seeks to examine the institutional element of trust, predominantly with regards to public health-care institutions, which reflects trust in the state.

Lucy Gilson defines ‘technical competence, openness, concern, and reliability’ as the behaviors that make health institutions trust worthy. A health-care institution should exemplify that it cares about patients impartially and consistently. However, due to the over-burdening, under-funding and subsequent bloating of public institutions in Egypt, patients are faced with an attitude of apathy when approaching health care institutions. Lacking political clout, the poor are unable to influence change, as no tools are provided to push these institutions to look out for the interest of patients. There are no clearly publicized guidelines of health-services in Egypt. While a complaint box is available in the Ain Es-Sira public polyclinic, most of the women are illiterate and are unable to use it. The institutional lines of accountability are fuzzy, and the system’s transparency is opaque. In this sense, Gilson’s ‘competence, concern and reliability’ cannot be considered strong traits of the Egyptian public health care system.

Being a physician is a prestigious occupation in Egypt, requiring a minimum of eight years of study. However, the reality of becoming a doctor, particularly at a public institution is frustrating. The doctors hired are usually young, make little money, and do not have influence; working two doctors to a shift in a highly populated area. This frustration is exemplified on a national level, with the formation of groups like Doctors Without Rights, calling for higher pay and better conditions. The doctors stay within the borders of the system, trying to advocate for their own rights, and leave the patients to fend for themselves. Nevertheless, this seemingly self-serving approach must be judged in light of the inability of doctors to support their own families, their need to work two jobs, and the difficulties and stress they face daily at work.

Health burden and Health-seeking in Ain Es-Sira

On a national level, at first glance, child health indicators such as immunization coverage and infant mortality rate are improving in Egypt. But gaps in social inequality have been reflected in the health status of the most vulnerable Egyptian children. Stunting and the prevalence of childhood anemia have been on the increase since 2000. While urban Egyptian children, on average, boast better health outcomes than children in rural areas, studies show that the incidence of diarrhea, intestinal parasites and ARI in children of urban slums exceeds that of rural Egypt. A key example of this gap can be found in the slum area of Ain Es-Sira, which exhibits exceptionally high overall incidence of illness, with 60% of families reporting that at least one member is chronically ill or disabled.

Verifying this statistic, when we asked the mothers and fathers in Ain Es-Sira, ‘When was the last time your child was sick?’ they replied ‘Our children are always sick!’ The mothers in the
families make the primary decision as to whether the child is ill enough to be taken to the health provider. These women also carry the burden of taking the child to receive care, and usually must also come up with the money to pay for health expenses. Despite the fact that these women are almost all unemployed or informal seasonal workers, in many cases they have no option but to pay for the cost of healthcare either from their earnings, the allowance from their husband, or in severe cases, through selling their belongings.

The cost of health-seeking for children varies depending on which provider the women choose to access. Based on perception of illness and its severity, women define which course of action to take. Typically, if they recognize the illness and identify it as mild, then the children are treated at home, with over-the-counter medications and herbal remedies. However, if the illness is unknown to the mother, or the symptoms are severe, the mother takes the child to a healthcare provider. Public and private providers are available in the area of Ain Es-Sira. Based on our discussions with the focus group participants we identify four types of healthcare providers accessed by residents of Ain Es-Sira: (1) local public polyclinic, (2) nearby children’s health insurance hospital, (3) local private doctors’ offices, and (4) a public hospital a short bus ride away.

While the social insurance and public hospitals are used for more serious or chronic illnesses, they are not feasibly utilized for acute illness due to their distance from the area of Ain Es-Sira, their unfamiliarity to the women, and the bureaucratic procedures required in accessing them. As this analysis focuses on acute illness, the main health institutions we will discuss are the local public polyclinic and the local private doctors’ offices. Mothers in Ain Es-Sira typically access the public polyclinic as a first option when their children are ill due to its proximity and low cost (charging the equivalent of 0.18 USD before 2pm, 0.54 USD after 2pm and 0.72 USD for commonly requested urine tests), and providing all medication free of cost (if available). Private providers are approached mainly when public provider treatment fails or when seeking second opinion in a difficult diagnosis.

However, mothers stated almost unanimously that they would prefer to take their children to private doctors’ offices from the beginning, but that they are limited by financial resources. The cost of a private doctor visit is equivalent to 5.40-7.20 USD and includes two follow-up appointments, without the cost of medication. They perceive the public clinic to be poor in quality. The women of Ain Es-Sira are not alone in their disillusionment with the public health system. Families in Egypt pay for a larger percentage of all health expenses out-of-pocket than their counterparts in both middle and high-income countries. A shocking 61.8% of spending on health is from private money. Studies show that most people from urban governorates prefer private healthcare for their children in the case of illness. Overall in Egypt, approximately two-thirds of children who were taken to a health provider with diarrhea or symptoms of acute respiratory infection were taken to a private provider. The perceived low quality of public health services, inconsistent availability of basic medicines, and suspicion of malpractice lowers the level of confidence in public health facilities nation-wide. Additionally, a lack of respect for
women clients deters mothers from approaching public health institutions with their children.\textsuperscript{19} Still, private care is clearly not possible for the families of Ain Es-Sira, at least not as the first option.

### Vulnerability of Women in Ain Es-Sira

In explaining the lack of respect women face when approaching health care or public institutions, it is important to look at the dynamics of the situation of women in Ain Es-Sira. The vulnerability of women in Ain Es-Sira is multi-dimensional, as women are vulnerable in the face of poverty, within their family, within their community and within the state.

Poverty is faced by all of the members of the households in Ain Es-Sira, but the heavier burden of poverty falls on the shoulders of the female head of household. As was stated by both men and women respondents, women are not allowed by their husbands to work, particularly outside the home. And yet with a daily allowance, women are expected to cover all household needs. The allowance, which is between 2.70 to 3.60 USD a day, is supposed to cover food consumption for the whole family costing around 2.00 USD a day (without any leeway for meat, chicken, or fruits), private tuition for children which is around 29 USD per month (which students are forced to attend and pay for by the public school teachers), 0.39 USD allowance per child per day (meant to cover breakfast and lunch), in addition to any other expenditures that the family may incur including health care for children.\textsuperscript{20} Burdened with the need to make decisions, without the resources to support them, women describe being caught between the teachers at school, who require that children pay and attend private classes known as “study groups”, and their husbands who claim they do not have money tell them to just ‘keep the kids at home’. The women cited this struggle between needs and resources to be the main reason for domestic abuse.

From a community angle, unskilled and illiterate, women may find it difficult to find “good” formal work, even with their husbands’ blessings. Testament to this, only one woman in the focus group discussions reported that she works formally (see Karima’s story). Additionally, due to the disunity among the residents of Ain Es-Sira, characteristic of slum areas where residents have different backgrounds, the community is fragmented. While women may know or befriend their neighbors, there is not a clear feeling of stability and trust among the residents themselves, and thus there isn’t a strong support system or a sense of collective identity in the area.

Finally, unemployed in the eyes of the state, the women do not have securities, are not covered by any insurance, and cannot claim worker’s rights. The families residing in the slum area of Ain Es-Sira illegally tap government water and electricity services, and thus their area is exposed to open sewage pipes and regular infrastructure problems for which they are responsible. The state does not provide these basic services for them, and garbage is piled outside homes in the area. Furthermore, residents fear that they will be removed from the area, with rumors of
“moving” slum-dwellers and “cleaning up” the city leaving them worried about their livelihoods. Deprived of basic services, securities and stability, the women are more like subjects of the state, rather than citizens.

‘The doctor won’t touch my child’

These dimensions of vulnerability are clear in the relationship women have with the public health institution in Ain Es-Sira. Treated with disrespect, and lacking the money to take their children elsewhere, women approach the public polyclinic with a sense of trepidation. When we visited the public polyclinic unannounced in Ain Es-Sira, nicknamed Mothalathat or Triangles, due to its pyramid shape, we were given a tour by the director of the facilities. The examination rooms were clean and well-equipped. Doctors were sitting at their desks, and patients were waiting their turn in a bright waiting area. Visiting at the end of the month, we were shown a fully-stocked pharmacy as well an archive with color-coded medical histories of 1000 families.

The respondents in Ain Es-Sira paint a different picture of the health clinic. The mothers complain that medication runs out mid-month at most, and that they wait for hours to enter the doctor’s office. They argue that they are required to take a urine test each time they visit the clinic. They find this measure unnecessary and view it as a new way for the clinic to make money off of them. However, when we asked the director about the urine tests, she said that this is a way to curb doctors’ over-prescription of antibiotics and to ensure the proper medication of patients. This is one example of the lack of communication that permeates the relationship between patients and the public healthcare unit. While the polyclinic has an arts and crafts vocational training classroom, only two women visit it regularly. It is not clear whether the polyclinic is taking advantage of the patients, or offering bad care, but undoubtedly the patients are not aware of or do not understand the reasons for the clinic’s actions. In other words, to the mothers, the system “is all koosa;” unpredictable, confusing and frustrating. No one cares to explain, speaking to the lack of the “openness” and “concern,” as described by Gilson.

Beyond this women feel that they are disrespected by doctors. Walking through the door of the office, many women were asked by the doctor ‘What is wrong with your child?’ with the doctor refusing to touch, or thoroughly examine the child up close. Doctors prescribed the mothers medications for their children indicated for other illnesses. The women were yelled at when they asked the doctor for more details about their child’s condition. There is no one to complain to, and no code of conduct by which to judge the doctors. On the other hand, doctors, who are paid little money, and who see many patients a day, cannot be expected to spend much time with each patient. Without support, the women feel that they will only get proper attention if they buy it; they do not feel entitled as citizens to proper public care. While the director of the polyclinic says she checks the complaint box every Wednesday, when we asked if the patients know this, she said ‘No! Why should they? It is not their business to know when I check it.’
Karima’s Story: Buying Care

The women, feeling disrespected in public clinics, sometimes try to compile the resources to approach private providers. This is typically in emergencies, cases of unsuccessful treatment or to confirm a serious diagnosis made by a public clinic. However, the doctors at the private practice in the evenings are the same doctors who are available at public clinics during the day. Thus, by paying extra money the women are not necessarily getting better quality care in the technical sense. It would not be an exaggeration to say that the polyclinic is better equipped than the average private facility, due to better availability of diagnostic tools. However, by paying for care, the women ensure that they will be treated respectfully, given time, and provided with a clear explanation of the disease, treatment and prognosis by the doctor.

During one of the focus group discussions, we met Karima, a mother of three girls and the only woman in all of the discussions who works under a contract. She works three jobs making a total of 52 USD a month. Her husband is only able to work part-time because he is epileptic, requiring medication costing 36 USD per month. As a school teacher in a nearby area he makes 93 USD a month. Together the couple cannot make ends meet due to the medical expenses of their daughter’s condition, caused by private doctor malpractice.

Rawan, their eldest, had a sty infection. To be safe, her parents took her to a private doctor’s office for a check-up. The doctor said that this is a simple matter and put her down on the operating table to remove the infection. Soon after, Rawan came down with a fever and was rushed to a public hospital with bacterial meningitis, which had in turn caused her heart to fail. She was prescribed a multitude of antibiotics and immunity-boosting injections, all of which Karima had to purchase from a nearby pharmacy and take back to the hospital. Over a period of ten days, Karima paid over 630.00 USD out-of-pocket for medication. The hospitalization fees and 179.00 USD of additional medication were covered by the child’s insurance and the hospital social assistance scheme, respectively. The money for the medication was purchased through Karima’s selling of her assets, namely her gold, and borrowing from neighbors. She did not say that her husband had a hand in the fundraising process.

While Rawan got better, she suffers from respiratory problems and heart weakness, in addition to setbacks in mental development. Karima takes her daughter to a psychiatrist weekly and purchased a home respirator, after finding that going to the hospital to use a respirator is more costly. Visits to the psychiatrist are covered by a state-supported charity which saves her about 10.00 USD per month on private psychiatrist cost. Karima told us that she blames herself for Rawan’s psychological problems because she does not have the ability to take the kids out, and for worries about Rawan’s health she kept her indoors and did not let her play with other children. For her family to go to the local park, she would need to pay one dollar for entrance
fees, not including the cost of sandwiches and sweets, which she estimated will cost an additional 2.00 USD, extra money that she does not have.

When Rawan was hospitalized, Karima’s husband was infuriated and along with a group of his friends and family, he stormed the private doctor’s office intending to physically assault him. However, he calmed down at the insistence of other patients. Karima, four years after Rawan’s hospitalization, still carries around all of the paperwork proving her daughter’s condition, to show to people who may have the power to help her, and who may not believe her without this proof. Private doctor malpractice is a serious issue within the healthcare system in Egypt. Without an overseeing regulatory framework, doctors within their private practice cannot realistically be held accountable for their actions by poor families who are not able to afford a lawyer to pursue a case. This tragedy of maltreatment, almost having caused the death of a child, goes unpunished and uncontested by Karima’s family, fell into debt due to health expenses incurred. The actions of Karima and her husband show the extent of their powerlessness – where she carries a file full of papers in case she needs to substantiate her story, he resorted to physical violence, as the only avenue to right the wrongs against his daughter. At the same time, the doctor in question continues to practice within both the public and private systems, potentially causing harm to other patients. Thus, in the case of private doctors the issue of trust and quality is not only within the face-to-face interaction, but also reflects the systemic problems in healthcare providers in Egypt.

Conclusion and Recommendations

One important lesson from this study is that when designing social interventions, it is crucial to analyze not only national level data but to survey beneficiary communities in-depth about their needs, knowledge and behavior. There are several crucial elements of health-seeking behavior for children in Ain Es-Sira that influence the potential design of the CCT pilot program.

Firstly, children’s health status in this urban slum is characterized by high incidence of preventable disease and poor nutrition. Social determinants of child illness, such as parents’ education, environment, water and sanitation, nutrition, and lack of safe spaces all influence the health status of children and must be taken into consideration while planning a program intended to improve health outcomes. At the same time, health-seeking behavior for children is largely influenced by financial considerations and mistrust in public health providers. We noticed an almost complete lack of utilization of preventive care while at the same time ‘provider-shopping’ in curative care potentially causes both overmedication and interruptions in courses of medications. Families in Ain Es-Sira seem to delay health visits to public providers and despite their wishes are unable to routinely consult private providers where the payment may equal three to four days’ worth of food for the family.

Secondly, women in Ain Es-Sira have nearly absolute and very independent decision-making power in all steps of health-seeking for their children: identifying illness, deciding when to visit a
health provider, choosing the health provider, and paying for health services. Nonetheless, from the vulnerable position of the mother, more money may buy more respect, but not even money can always buy quality health care. Mothers must be considered equal partners in attempts to improve children’s health status, as they are doing all they can for the welfare of their children. Their choices are based not on irrational fears or mysterious beliefs, but on very rational and economic grounds. Therefore, an increase in their health awareness alongside an improvement in their knowledge of their rights as beneficiaries of state-funded programs to respect and quality may improve the current ‘only-in-emergencies’ attitude to seeking medical care.

Thirdly, the health system, despite its overstretched nature, has almost all the necessary staff, supplies and systems to serve the community’s primary care needs. Yet, the lack of accountability and fair rewards has permeated through the structure to individual health staff and allowed the level of service to slide to an unacceptable level. Mothers doubt the capacity and willingness of the health provider to serve the needs of individual children and the community has reached a stage where even improvements within the health center are misinterpreted by the patients. Doctors and administrators of the facility are detached from the community and lack the awareness that they are serving a poor neighborhood. It is imperative that they attempt to understand its structure, culture, problems and values in order to approximate the health services to fit the needs. When we asked the director of Mthalathat, herself a mother and a medical doctor, whether she lived in the area, she drew her eyebrows in shock at the thought of the possibility, and answered ‘Of course not!’

These broad findings warrant consideration within the CCT program design. Marginalized families invent creative survival strategies that must be explored, understood and used as a stepping stone to implement suitable and effective social interventions. As one of the main goals of the project is to improve child health, this is clearly not possible without the improvement of the relationship between mothers and the main primary health provider in the area, Mthalathat. How does the program intend to tackle such systematic failure with its limited finances and powers to intervene in state-provided public services? In addition to requiring the fulfillment of the health conditions (see Appendix A), the Ain Es-Sira pilot will target these three cross-cutting relationships in order to tackle the many interrelated factors influencing child health:

1. State ⇔ State

The program is initiated and coordinated by the Ministry of Social Solidarity (MOSS) on the governmental level, and the program team communicates about the health service needs through this Ministry. The MOSS then contacts the Ministry of Health and Population (MOHP), which defers the request to the local health directorate, responsible for running the Mthalathat facility. This process is often tedious and leads to many delays. Nevertheless, by keeping the lines of communication open between these state ministries and frankly addressing the shortfalls and concerns, the research team raises the awareness of the problems in supplying proper care by the facility. The leadership and staff of the MOSS is also constantly reminded of the influence of
health on poverty and vice versa, in an effort to broaden the intersectoral communication and cooperation on initiatives related to poverty alleviation.

In addition, by working within the public health provision structures as opposed to circumventing them, this program may improve the top-down relationship of higher-level authorities at the MOHP with community-level facilities. The facility visibly suffers from neglect, and also suffers from some shortage of medical or financial resources and health staff needed in order to perform its function properly. In building effective channels of communication between the facility and the supervisory structure at the MOHP, the facility may take advantage of the new experience by expanding and continuing a closer and more productive feedback system with the directorate.

2. Citizen ⇔ Citizen

By making the mother responsible for the health of her children in an official contract (signed by her and a social worker representing the MOSS) and giving her a monthly cash transfers for this purpose, not only will the health status of the be prioritized in family discussions and priorities, but the status of the mother will also improve with the recognition that she holds the main responsibility for the health of children. Monthly health awareness sessions will be organized as a part of the program. Several topics related to child’s health are included on the schedule: pregnancy, childbirth and breastfeeding; immunization and common childhood diseases; child nutrition; first aid and female genital mutilation. Unlike other CCT programs worldwide, fathers will also be required to attend these health awareness sessions, improving the health knowledge within the family as a unit and establishing both parents as jointly responsible for the health of their children. As fathers have primary access to employment opportunities and thus to income, their understanding of the importance of health within child development and of the mother’s role in securing healthcare may promote this goal in the family decision-making on health expenditures.

3. State ⇔ Citizen

The overarching concern of the program is bringing transparency and accountability back into the relationship between families and public service providers (health as well as education). It is with this goal in mind that the CCT design does not avoid or replace the Mothalathat facility, but instead makes it a partner with a responsibility to meet the program beneficiaries’ needs. The facility administration, health staff and participating families will attend sessions explaining the goals of the program and their involvement and responsibilities within it. Mothalathat as a health service provider, should think of patients as clients; people with choices, entitlements and power. A clear explanation will be given to families about what procedures and services they should expect and demand, and provided with avenues to voice their concerns or complaints. The research team will organize monthly feedback sessions for mothers, where they can share their experiences as beneficiaries of the program with each other and the research team. Social workers responsible for following the progress of the beneficiary families, as well as
representatives of the health center, shall participate in these sessions and receive feedback first-hand. By making those responsible also accountable to their constituency, the program intends to show the mothers the extent of their rights as citizens, are not diminished due to their gender or poverty. If anything, children growing up in vulnerable slum families deserve more, not less attention by the public service providers. By engaging the facility and mothers in a constructive dialogue as partners in the process of improving children’s health, the program hopes to initiate a long-term change in this important dynamic.

In addition, giving the mothers a substantial monthly allowance also means giving them the power to decide how and where this money will be spent. Aside for the conditions on preventive visits at the Mothalathat, a mother may decide to spend her allowance on a private provider visit if the child is sick. This choice, taking trust and money away from the public provider, may drive needed change in the public clinic simply by the law of demand and supply. However, the public facility will have many opportunities to show the beneficiary families whether their services and approach have improved and thus restore the level of health-seeking and trust to a point where mothers do not have to spend their yearly earnings or family jewelry just to seek a second opinion in the private sector.

To conclude, we are convinced that gaining back the belief that the state is working to the benefit of the poor must start with individuals representing the state. In the Ain Es-Sira program, these individuals are MOSS social workers and Mothalathat health staff. Thus, the training, partnerships and new opportunities for reestablishing a relationship of trust between the mothers and health workers as individuals will be provided. Within the health segment, the program will continue assessing, analyzing and improving the rapport between mothers on one hand and doctors, nurses and laboratory technicians working at Mothalathat on the other.
Appendix A: **Detailed description of CCT conditions on health**

**Maternal and child health**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women’s reproductive health</strong></td>
<td>Minimum <em>once per year</em> preventive visit to a gynecologist (or other reproductive health specialist).</td>
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<tr>
<td>Preventive appointments for all women of reproductive age (15 – 45 years)</td>
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<tr>
<td><strong>Pregnancy care</strong></td>
<td>Attend minimum <em>4 ante-natal visits</em> during pregnancy.</td>
</tr>
<tr>
<td>All women to receive complete ante-natal care (ANC) during pregnancy</td>
<td>Unless in exceptional circumstances, women must <strong>deliver in a health facility</strong> with assistance of skilled personnel.</td>
</tr>
<tr>
<td>Encouragement of institutional delivery with skilled personnel</td>
<td>Mother to attend at least <em>2 post-natal care</em> appointments.</td>
</tr>
<tr>
<td>Receive complete post-natal care (PNC)</td>
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<tr>
<td><strong>Child preventive care</strong></td>
<td>All children must have a health/vaccination card.</td>
</tr>
<tr>
<td>Attendance of regular preventive appointments for children</td>
<td>Children to receive preventive checkups according to age group.</td>
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<tr>
<td><strong>Newborn:</strong> Two checkups within 6 weeks of delivery</td>
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<tr>
<td><strong>2 – 24 months:</strong> Once every two months</td>
<td></td>
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<tr>
<td><strong>2 – 5 years:</strong> Once every four months</td>
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<tr>
<td><strong>6-15 years:</strong> Once per year</td>
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</tr>
<tr>
<td><strong>Adult and family health</strong></td>
<td>Minimum <em>once per year</em> preventive checkup.</td>
</tr>
<tr>
<td>Preventive appointments for all men and women starting at age 15.</td>
<td>Attend all <strong>14 awareness sessions</strong> during the first months of the program.</td>
</tr>
<tr>
<td>Attendance of awareness sessions for all men and women heads of participating families.</td>
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Endnotes

1 The word *koosa* literally means the vegetable squash or courgette. In the colloquial Egyptian language it is used to denote a corrupt system or a way of obtaining things through unofficial connections. In this case, one mother was referring to her inability to obtain, for one of her daughters, medications that were supposed to be available in the public clinic.


10 L Gilson, 2003, p. 1454.


15 Baseline assessment conducted in Ain es Sira in 2007 (N=398 families) by the Social Research Center.


17 Egypt DHS, 2005, p. 144-146.

18 Egypt DHS, 2005, p. 144-146.


20 Teachers, who are paid low salaries, require students to attend “study groups”. Legally, teachers are allowed to give study groups after class for students who are struggling with material. However, these study groups have made free education very costly. Groups are given during the school day, and students who chose not to attend and pay are publicly humiliated and physically reprimanded, or failed in end of the year exams. Studies show that the main reason students drop out of school is due to the cost of school, as opposed to the opportunity cost of working.
Bibliography


