

6 Services

6-1 Introduction

Categorization of services catering for the disabled is a very compound problem. Disability by nature requires the inputs of different sectors. These include, health, education, social, labour, transport, ...etc. Within the different sectors, different agencies affect the lives of disabled people in different ways. Some are designed to deal specifically with disability, and others are not. In many instances, those that are not disability-specific, such as: normal schooling or general health services affect the lives of wider sectors of disabled people more than the disability-specific ones.

The scope of the study can hence be very wide or very narrow according to its aims; i.e., which services are to be looked into? In addition, the study of the non-disability specific component, meaning the roles, attitudes and facilities of the non-specialized bodies, acquires a bigger weight if mainstreaming and integration represents the basic approach and goal of the study.

Another problem in the categorization is whether to study the services under the basic sectors; i.e., according to the basic thematic roles, such as: health sector, educational sector or social sector or to categorize them under the general status of providers, such as: governmental, non-governmental and private. To study services under the categories of the different thematic sectors, as most previous studies have done, leads to many confusions. The confusion stems from the overlapping between the inputs of the different providers described under different sectors. For example, although NGOs are usually dealt with under the category of the social sector, one NGO could be providing different sectoral inputs at the same time; i.e., health, education and social. This, also goes for the private sector, and in many instances for the governmental sector.

In this study, we have chosen to categorize services under the main status of the provider; i.e., governmental, non-governmental, and private.

The value of this method of study is that it provides better ground for comparing the potential strength and weaknesses as well as challenges facing the different providers according to their general status; i.e., the governmental sector, the non-governmental sector and the private sector.

Diagram overleaf shows the inputs of the different bodies according to the status of the provider.

6-2 The Governmental services

The most important roles in the area of disability are provided by three ministries, namely: the Ministry of Health (MOH) now the Ministry of Health and Population (MOHP), the Ministry of Education (MOE) and the Ministry of Social Affairs (MOSA). However, several other governmental bodies play an important role, such as: the Army, the Ministry of Labour (MOL), Supreme Council of Youth and Sport (SCOYS), in addition to others which play a lesser role.

6-2-1 The Ministry of Health and Population and other para-ministerial bodies

6-2-1-1 Historical Background

The MOH, is the body entrusted with the task of the overall planning, organization and supervision of the health care system in Egypt, as well as ensuring the provision of health care services for all its people.

It was established in 1936. Prior to its inception, the various state health departments belonged to the Ministry of Interior.

The bulk of its activities was established and directed towards city population, where hospitals were established in addition to health offices, and maternal and child health centres. Rural health care provisions was delivered up till then through mobile health units, which went in campaigns to examine peasants and treat them.

In 1942 the “Improvement Of Village Health” law was declared. The law aimed to establish a health compound for each 15,000 people in the countryside. These included an outpatient clinic and a number of inpatient beds ranging from 15 - 20 beds for the treatment of epidemic diseases and malnutrition.

This stage continues more or less to the sixties. Among many of its characteristics worth mentioning is that all governmental health care facilities came directly under the supervision and control of one structure namely, the MOH. (Khalaf, 1988).

The sixties era or the “socialist oriented era” the role of the state greatly increased in all fields of life. In the area of health care, the following major change took place:

The dramatic extension of the health care facilities provided by the MOH to the countryside, where establishment of health units distributed to the different areas of the countryside took place. The aim was to reach a unit for every 5000 population. Provision of health at this stage was considered a basic right of all people rather than a commodity or a charity (Khalaf, 1988).

Since the open door policy in 1975 and particularly during the past decade, a radical transition in service provision has been taking place. The major characteristic has been the decreasing role of the state in provision of health care services concomitant with a dramatic decrease in governmental expenditure on health services. The share of the MOH from the total governmental administrative spending “budget” in the year 1966 reached a peak of 9.1%, (Khalaf, 1988). From the year 1981/82 to 1992/93 The share of the MOH from the total yearly governmental budget decreased from 3,3% to 1.8% (Shoura Council, 1995). However, among the major results affecting the state health services, particularly those of the MOH has been the dramatic decrease in the real value of wages received by the doctors employed by the state. A fact which led to the demoralization of the staff. This has been instrumental in undermining the quality of the state-provided services and consequently its trust from the public.

6-2-1-2 Services currently provided by the MOHP

The services provided by the ministry include both curative as well as preventive services. These services are provided through a wide network of facilities with nearly 3,936 outlets at the primary, secondary and tertiary levels, both in the Urban and Rural areas.

In spite of the above mentioned changes, the MOH is still the largest provider of health care services. It is estimated that 80% of health facilities are directly provided by the MOH (Khalaf, 1996). This includes two thirds of all hospitals as well as more than 60% of all hospital based beds. This relative weight of the MOH facilities decreases in the urban governorates, where there is a flourishing private sector (of mostly small facilities) and where university teaching, and CCO hospitals are concentrated and increase in the frontier governorates where there are only three private hospitals. The MOH hospitals account for only 25% of all hospitals at the urban areas and nearly 83% of beds in frontier governorates (DDM, 1995).

The facilities provided by the MOH range from Urban Health Units, Maternal and Child Health (MCH) Units and Centres, Health Offices, Rural Health Units, Rural Centres, Rural Hospital to Urban Based Hospitals.

Table 8 Shows breakdown of facilities provided by the Ministry of Health.

Facility Type	Number of Facilities	Number of Beds
Urban based Hospitals	,403	56,815
Rural Hospitals	,135	3,427
Rural Centres	,437	6,252
Rural Health Units	2,209	0
Health Offices	,354	0
M.C.H	,231	,332
Urban Health Units	,167	0
Total	3,936	66,826

Source: Basic Statistical Data, 1994: MOH - IDC from (DDM, 1995).

On the Primary level lies around 3,533 outlets ranging from urban and rural health units and centres, health offices, MCH centres as well as rural hospitals. On the secondary and partially tertiary levels lies around 403 hospitals divided between 202 General and District Hospitals, 81 Fever Hospitals and 100 specialized hospitals such as Maternal & Paediatric Hospitals, psychiatric, Ophthalmic, Dermatology, Cancer, Endemic, Chest and Leprosy (MOH/USAID, 1993).

Probably the most geographically equitably distributed facilities in Egypt are those belonging to the MOH. However, there is bias in favor of Urban and Lower Egypt as compared to Rural and Upper Egypt. There are about 2.3 beds per 1000 population in Urban areas as compared to 0.3 to 1000 population in rural. Delta or Lower Egypt has 1.3 beds per population, Upper Egypt 1.1 while frontier governorates have about 2 beds per 1000 population, (DDM, 1995).

In general there is under-utilization of hospital beds in the governmental sector. National occupancy rate for Egypt is about 49%. The highest is 58% in upper Egypt and the lowest is 25% in frontier governorates. In the countryside occupancy rate does not exceed 2% (DDM, 1995).

The distribution of PHC services shows the same picture. Nationally, there is a health centre for each 11,000 population. 99 % of people live no more than 4 km away from a centre. However, again Lower Egypt fares better than Upper Egypt (DDM, 1995).

The MOH is the biggest employer of physicians. In 1992 it employed around 48,239 physicians which constitutes about half the total number of physicians in Egypt. The ratio of MOH physicians to the total population was 1:1134, with bias towards urban governorates rather than frontier governorates. In Urban governorates the ratio is 1:755 while in Frontier governorates the ratio is 1:1573. While the ratio between Upper and Lower Egypt is nearly the same.

About 80% of physicians practice in private clinics in addition to their work in the ministry, (DDM, 1995).

6-2-1-3 Teaching hospitals and institutes

Closely related to the MOH, an important role is played by the Teaching Hospitals And Institutes (THAI). These facilities were developed within the Ministry of Health, but due to their educational and training role, they became under the technical supervision of a special organization called "The Teaching Hospitals and Institutes Organization" which was organized as a separate body within the MOH, and responsible to the Minister of Health directly.

Outside the University hospitals, the (THAI) represents an important source for tertiary level care in Egypt. It accounts for about 4% of the total number of beds.

It is financed directly through transfers from the Ministry Of Finance (MOF), as well as some occasional grants from international donors. They recover approximately 6-7% of their costs through patient fees. (Ranan, R., 1995) There are about 16 teaching hospitals and institutes. They are all urban based. Cairo fares with 8 of these and Urban Giza 4, and Qalyoubia 1. This in reality makes the share of greater Cairo to be 13 out of the 16. The last three are distributed in the cities of the governorates Behira, Menoufia and Sohag. The share of Upper Egypt without Giza, would be only one out of the 16, (DDM, 1995).

The Teaching Hospital Organization operates 8 General Teaching Hospitals and 8 Research Institutes, including the Institute for Tropical Medicine, Heart & Chest Surgery Institute, Hearing and Speech Institute, Poliomyelitis Institute, Entomology Research Institute, Memorial Ophthalmology Institute, Nutrition Institute, and Diabetes Institute. In the disability field some of these institutes have come to play an important role as will be discussed later. Among them stand examples such as the Polio-Institute, the Imbaba Hearing and Speech Institute and the Ophthalmology institute.

6-2-1-4 The Curative Care Organizations

This organization was established in 1964 as a result of the nationalisation of several private hospitals. There are six of them which run autonomously but come under the jurisdiction of the MOH. They are hospital-based and account for about 4% of all hospital beds. They are basically self financing for recurrent cost through the services provided to individuals and companies on contracts. The fees are charged on the basis of four classes of rooms. A small number of beds are kept for free (DDM, 1995).

6-2-1-5 The Health Insurance Organization (HIO)

The HIO represents a significant actor in the field of health care in general and disability in particular. This role currently acquires a new dimension as the HIO has dramatically expanded in 1993 to include school children.

Although the development of health insurance as a system for health provision in Egypt has gradually evolved, when the HIO was established in 1964, the aim of the government was to create it as the major umbrella for health care provision. The idea was that a national health insurance model would eventually cover all the population.. Certainly, this tendency seems to have become a dominant one in the past few years and the one directing the current health policies of the government. Among the three directing pillars of the current policy, as identified by the MOH - IDC report, is the preparation of the social health insurance for expanded population coverage. This expansion is expected to cover new groups such as families of currently enrolled

workers, and currently uncovered parts of the labor force, as well as other formal sector employers which are currently exempted.

Since 1965 the health insurance beneficiaries increased from 140,000 to 4,895,000 persons in 1992. In 1995 with the addition of school children another 15 million were added.

Services of the HIO is provided currently through 25 hospitals and 116 clinics. They cover around 16 governorates. The number of beds are around 5,000. During the next coming five years another six hospitals belonging to the MOH are to be added with another 500 additional beds. Nine of these hospitals lie in the Urban governorates, 8 in lower Egypt and none in upper Egypt or frontier governorates (DDM, 1995).

Organizationally, the HIO seems to be one of the best systematically hierarchically structured. All patients have to go first through the entry point of a General Practitioner who is hired or contracted by the HIO before being referred to secondary or tertiary care levels.

This organization, created for the sake of keeping accounts of the premiums and for the sake of the cost effectiveness of keeping the scheme have led to a more logical system for referrals.

Services provided by the HIO are basically curative and on the secondary and tertiary levels. However, with the addition of school health services, preventive and primary care level roles have increasingly been put on the organization. This includes, the serial examination of all children entering school and during school years for disease and impairments.

6-2-2 Ministry of research (MOR)

6-2-2-1 The National Research Centre (NRC), Department of Human Genetics (DHG)

The DHG of the NRC represents another very important national facility in the field of childhood disability.

The department's role can basically be divided into a research component in the area of congenital abnormalities, a service component in the area of early detection, an awareness-raising component and an advisory role for planning.

The research component contained different masters and doctoral degrees in the area of human genetics in addition to several hospital- and community-based epidemiological surveys on the prevalence and causes of certain disabilities particularly Mental Retardation.

The service component, contains; Genetic Guidance service to families of disabled children referred to from any outside sources; Preconception examination of families to estimate possibilities of disabilities in their children; and early detection through conducting bio-chemical and chromosomal analysis to pregnant mothers and new born children, such as Guthrie's test to new born babies and Alfa Feto protein in pregnant mothers.

The significance of the centre is that it is among the very few centres capable of conducting high quality investigations in the area of early detection. In addition, to its role in the production of medical expertise in the field of Human Genetics (Dr. Temtami, cited in AHED - UNICEF, Workshop Report, 1995).

6-2-3 The Ministry of Education (MOE):

6-2-3-1 *Services Provided by the MOE:*

The MOE is the governmental body entrusted with the overall responsibility of supervising, providing and certifying training and education in Egypt.

In the area of disability the MOE provides the following major inputs:

- An important input in health through its control over the Medical faculties and University Hospital..
- Its direct input in providing special education for different groups of disabled children
- Its role in the production of different level cadres, their training, certification, designing and supervising the different curriculae.
- A supervisory role which includes setting the standards and supervising curriculae given by other bodies such as NGOs who provide special education.

6-2-3-1-1 Medical faculties and University Hospitals

During the sixties the University hospital were separated from the MOH and came under the direction and control of the Ministry of Education, (Khalaf A, 1988).

There are 13 medical schools in Egypt (Faculties of Medicine) which are affiliated to the major Universities. The Number of hospitals in 1992 belonging to the Universities was 31 out of which 22 were in urban governorates, 7 in lower Egypt and only 2 in Upper Egypt. Out of the 22 urban situated ones, 17 are in Cairo alone, (DDM, 1995).

University Hospitals provide secondary and tertiary level of services. In general they contain the most technologically advanced centres for tertiary care.

Due to their high specialization, University hospitals have developed over the years several centres of excellence which became important tertiary level facilities in certain branches of disability. The Ain-Shams Audiology and the Phoniatic units under the department of Ear, Nose and Throat, has the capability of providing very highly sophisticated management procedures starting from very sophisticated hearing and speech disorders assessment up to Cochlear implants introduced lately. The first operation took place in 1996. In addition, these departments have played a role in developing many specialized medical and paramedical cadres with a specific role in disability, such as speech therapists physiotherapists and audiologists. (Shukrallah, personal interview 1996).

Other departments which have become famous for their input with disabled children are the Genetic Centre in Ain-Shams University, the Abu El Rish Hospital for Children, Cairo University. In addition, the genetic department of Ain-Shams university. The Orthopedic department of Assiout University for several years provided a tertiary level support for a Community Based Rehabilitation project in Upper Egypt provided by the Organization Terres des hommes for polio children.

6-2-3-1-2 Special Education and the MOE

The Ministry of Education is the biggest provider of educational services for several groups of disabled children.

Up till the 1952 revolution the ministry provisions were limited to the blind and to a lesser extent the deaf. These activities were under the jurisdiction of the “**Section for the Abnormal**” within the ministry, which followed the department of primary education. In 1964 this section became an independent department and

renamed the “Special Education Department”. (Kamal, cited in AHED - UNICEF Workshop report 1995)

In 1969 the presidential decree number 156 re-organized the state of education for the disabled children, creating three departments each caring for a type of disability. However the three are under the auspices of the “Special Education Department”.

- **The department of education and training for the visually impaired.** This department overviews education and training of the visually handicapped. Training is provided in special schools for two categories; namely, the Blind, and the partially sighted. (Kamal, cited in AHED - UNICEF Workshop Report, 1995)
- **The department of education for the hearing impaired:** This overviews the education and training of two categories of the hearing impaired namely, the deaf and the partially deaf, in two types of special schools. The deaf has both day care as well as residential facilities. It includes three stages of education namely: primary, preparatory, as well as vocational training for three years and technical secondary schools for three years. The partially deaf: follows the normal curricula of the ministry, while providing special facilities for the students. (Kamal, cited in AHED - UNICEF Workshop Report, 1995)
- **The department of the educable mentally retarded children with IQ between (50-70):** This received children with mild mental retardation only, who are mobile and have no other psychological or physical handicaps. Education is conducted on two stages (Primary for 8 years including two preparatory years and a vocational stage for three years) (Kamal, cited in AHED - UNICEF Workshop Report, 1995).
- **The department of the physically and visceral handicaps:** This groups includes the motor disabilities as well as the visceral such as Rheumatic heart children. The department overviews education of these children and their examination in hospitals or a sanitarium (Kamal, cited in AHED - UNICEF Workshop Report, 1995).

Table 9 shows the types of disabilities and educational provisions for each as well as the number of students covered.³

Types of disability	No of Special Schools	Schools with attached special classes	Number of classes divided according to different levels and types of education provided					
			Primary	General Prep	Vocational preparatory	2ndry Normal	2ndry Technical	Total
Visual	20	10	123	57	-	44	-	224
Hearing	40	46	562	-	125	-	66	752
Mental	70	37	823	-	169	-	-	992
Total	130	93	1508	57	294	44	66	1968

Table 10 shows development in the number of schools and special education classes from the early eighties to mid-nineties

³ Mr. M. K. Abdel-Lateef, MOH Expert. Presentation to Unicef-AHED workshop January 1995. Workshop report.

Year	Special schools	Schools with attached special classes	Number of classes	Number of students served
1980/1981	24	-	860	7314
1994/1995	130	93	1968	21806

Table 11 shows number of students served according to the type of disability (1994-1995)

Disability	Primary	Preparatory	Preparatory vocational	Secondary General	Secondary Technical	Total
Visual	1114	498	-	548	-	
Hearing	9257	-	1323	-	906	
Mental	6865	-	1304	-	-	
Total	17236	489	2627	548	906	21806

Table 12 Shows number of staff working in special education including: teachers, psychologists, and social workers (1994/1995):

Disability	Teachers			Specialists			Total
	Specialized	non-Specialized	Sub Total	Psychologists	Social workers	Sub Total	
Visual	262	326	588	36	48	84	672
Hearing	619	1130	1749	72	41	113	1862
Mental	521	1226	1747	120	128	248	1995
Total	1402	2682	4084	228	217	445	4529

Total number of students in special education schools or classes = **21806**

The ratio of students to all teachers employed = 5.34

The ratio of students to number of specialized teachers = 15.55

Summary

The MOE is the biggest provider of special education in Egypt. However, this is relative to other types of providers such as NGOs or the private sector rather than to coverage of the target population i.e. disabled children at school age. If total population of children at school age (between the ages 6-14) is about 14 million, and if the most modest estimate of disabilities serious enough to require special education is taken at 4%, this yields approximately 560,000 child at school age who are in need of special education. Hence, the estimated coverage by the MOE would be around 3.89%; i.e. only about 4% of those in need are covered by the services. The reasons for this low coverage vary from lack of geographical accessibility especially for the countryside, low availability as shown by long waiting lists, lack of knowledge especially for disadvantaged people, attitudes of parents of disabled children, bad quality and bad reputation of these schools, in addition to the limitations in the types of disabilities served. Several groups of disabled such as the multiply handicapped as well as the moderate to severe mental retardation are not provided for by the ministry of education.

6-2-3-1-3 Training of the trainers or Personnel in special Education

One of the major problems facing efforts spent in the field of special education is the shortage of specialized and well trained personnel. MOE data indicates that trained teachers in the field do not exceed 1/3 of the total number working. The rest 2/3 get their training on the job. The same applies for other personnel such as psychologists, social workers, vocational trainers as well as the administrative staff.

Types of Special Education teachers and Certificates

- *The Special Education Certificate (One year internship in special education):* Up till this year special education teachers, i.e. the “trained teachers” hired by the MOE to staff its special schools were primary school teachers who received one internship year in one of the three fields of disability that the MOE deals with, namely, the blind, the deaf, and the intellectually disabled. The educational background of these teachers was three years to become primary school teachers, after they finish preparatory school + three years experience in addition to one year of internship. However, the whole system of preparing the primary school teachers have been reviewed since 1992. Primary schools, were to be staffed with teachers who have a qualification equal to a college or a university degree. (Magdi, interview, 1996)
- **Undergraduate Degree in Special Education:** As a response to the feeling of inadequacy of the quality of education provided in the field of special education by the MOE, a new undergraduate degree in special education has been established in Ain-Shams University, Faculty of Education. The degree is a four year university degree equivalent to a BA The course started in 1994-1995 and the first group of students are due to graduate in the year 1998 (Magdi, personal interviews, 1996).
- **Undergraduate degree in for Nursery teachers with a course in special education:** Another root of special educators have developed since 1990 as the old schools for the preparation of primary school teachers were turned into the Faculty of Nursery Teachers belonging to the University. The degree is a four year degree. It is being offered by the Universities of Menia, Alexandria and Helwan. A course in special Education has also been introduced, for those interested in pursuing education in the field of disability (Magdi, personal interviews, 1996).
- **Post graduate diplomas in special education:** Alongside the above mentioned undergraduate courses, several universities offer a post graduate diploma for teachers of special education. The course is a one year and is provided in the area of Intellectual disability. The course is provided by the University of AIAZHAR, through the faculty of Education and Human Sciences and the Ain-Shams University, Faculty of Education. (Magdi, personal interviews, 1996)

Conclusion

The state of special education seems to be going through a transitional stage. The old degree for primary school teachers has been stopped and new degrees for the preparation of the Cadres by the Ministry of Education has opened ranging from undergraduate training for four years up to post graduate diplomas. However, graduates from the higher education mentioned do not as of yet staff the governmental schools due to the low salaries given to the staff. The new cadres usually look for places in private institutions or is taken by the Gulf countries for higher pay due to the shortage of special educators.

In addition, there is a clear lack of uniformity in the types of certificates and cadres produced. The different courses are offered by different faculties with no higher auditing relevant to the needs of the current schools and available systems.

6-2-4 Ministry of Social Affairs (MOSA)

6-2-4-1 Historical Background

The Ministry of Social Affairs was established in the year 1936. The responsibility entrusted to it then was the supervision of the different prisons, institutions, asylums made to correct criminals, and orphanages for the poor and the handicapped and disfigured.

In 1950 the law number 116 entrusted the ministry with “taking necessary actions for the establishment and organization of the necessary institutions to provide services for the management, cure and training of the handicapped and their preparation for work”.

In 1952 the first model rehabilitation office was established for the guidance, care and training of the disabled and to help them in acquisition of jobs in cooperation with governmental and non-governmental bodies. The priority set for the office was to help the victims of war. In 1953 the Ministry incorporated the office to a centre for the rehabilitation of the disabled. The centre was incorporated into the “Hospitals Day Organization” which became the “Hospitals Day Organization and Vocational Rehabilitation”. The organization was the first technical organization for the vocational rehabilitation of the physically disabled in Egypt.

In 1962 the MOSA was re-organized according to the presidential decree and care for the disabled came under the “General Department of Rehabilitation” in Cairo.

(Osman H, 1988)

In 1964 all non-governmental organizations came under the Law 32. The Law put severe restrictions on the freedom of civil life and put all associations under very strong control from the MOSA. The law made the MOSA both the judge as well as the executioner over the NGOs. Not only did it give the MOSA the power to accept or refuse the establishment of any NGO it also gave it the right to disband any NGO at will. (Kandil, 1993). Moreover, under this law the demarcation line between the role of the MOSA and that of many NGOs became very hazy and unclear. In many instances as will be discussed later, NGOs were in reality a mere extension of the ministry.

6-2-4-2 Services Provided by the MOSA

The ministry’s input in the area of disability carried out through the “Department of Social Rehabilitation” can be probably divided into the following categories:

- Development of general policies and strategies and the follow-up of their implementation.
- The participation in the conduction of research in the area of disability.
- The preparation of legislation to be presented to the parliament concerning the rights of disabled people.
- Financial, technical and managerial support or assistance upon request to NGOs working in the field. This is conducted through different ways among which is the seconding of people from the DOSR to NGOs working in the area of care of disabled as well as providing small grants (up to 3000 L.E.) per year to these organizations upon request.
- Supervision and legal control over all NGOs in Egypt.
- Provision of services through its direct involvement, i.e. financing, managing and staffing as well as providing premises and equipment, and later on to incorporate these facilities under or into existing NGOs.

- Developing and collecting information on disability and the disabled people for planning purposes.

In sum, the MOSA in the field of disability and within the context of the Law 32 the MOSA does not only play the role of the National planner and supervisor of services in the field of disability, but in reality is the widest provider. Albeit, this role is carried out under the umbrella of numerous NGOs. This fact leads to great confusions whereby the same facilities that are cited as belonging to the MOSA are in other places cited as belonging to NGOs. This fact is clearly manifested in the case of the “Rehabilitation Offices” and the “Sheltered Workshops” and the “Rehabilitation Centres”. The three institutions which are distributed over nearly all Egypt were established originally by the MOSA, staffed by personnel and financed from it, while at the same time taking the umbrella of the ministry.

6-2-5 Ministry of Labor (MOL)

6-2-5-1 Services Provided by the MOL

The MOL is the ministry entrusted with the task of implementing and supervising the implementation of the Labour Laws concerning the rights for employment of disabled people.

As mentioned before, the first piece of Legislature concerning compulsory allocation of jobs for the disabled was enacted in the year 1959. The 1975 Law identified the duties and responsibilities of the MOL concerning disabled adults and the new Law of 1996 (not yet enacted) identified these duties for the employment of children. (The articles of these laws have been previously mentioned in chapter 3.

The major duties of the MOL towards the disabled could be summarized as follows:

- To register the name of every disabled who has received a rehabilitation certificate from the MOSA in a special register in the Labour offices which belong to that person's district.
- To nominate the registered disabled to work in the private sector which employs more than 50% as well as in the state governmental sector within the 5% quota.
- To supervise the priority of employing disabled who were victims of war.
- To supervise the registration of employers of the disabled working in their firms and all information regarding them including the type of jobs and system of enumeration to guarantee against discrimination.
- To identify jointly with the MOSA the types of jobs which disabled persons could acquire in governmental services. (Osman, 1988).

6-2-6 The Supreme Council of Youth and Sports (SCYS)

The SCYS lies directly under the jurisdiction of the Council of Ministers. It is responsible for all youth and sports activities.

In 1988 all sports activities of the disabled were transferred under its jurisdiction and the Union for Sports of the Disabled was established within the council.

The role of the Union is:

- To organize sports activities and sports tournaments for disabled persons, particularly youth according to international and local rules in this sphere.
- To supervise and prepare the sports teams from disabled persons and to form the teams which represent Egypt in the International Sports Olympics. (Osman, 1988).

6-2-7 Discussion: The contribution of the Governmental Services in disability

Governmental or state-owned and directed services play a major role in service provision in Egypt. Although state control in Egypt over the different productive activities of the society and the different social domains has always been very powerful, during the sixties the state nearly monopolized all types of activities whether political, economical or in the area of service provision. However, state hegemony particularly in the economic and service provision has been declining in favour of a bigger role for the private and non-profit NGO sectors, while keeping a strict control over political and social life. This tendency has been strongly encouraged by the International Monetary Fund Bank and the World Bank.

In the area of service provision in general and disability services in particular the state provides the widest infrastructure of health, educational and social facilities which have the most equitable distribution.

However, historically, these services developed mainly in an ad-hoc and patchy manner. Different structures developing at a certain era with the aim of replacing the previous and embodying it, ended by staying side by side with the old. This condition developed a multipluralistic structural system which lacks in integration, cooperation and with a wide area of overlapping and unnecessary duplication of roles within the same sector and sometimes between the different sectors.

Meanwhile, state services have been undergoing important cuts in expenditures which were reflected on the moral efficiency and commitment of the majority of personnel. Government employees, whether in the health, social or educational sector, over the years have become highly demoralized and lack in incentive due to the dramatic and continuous decline in their real earnings during the past two decades in particular. In face of this situation the vast majority of government employees work in more than one institution beside their original governmental jobs. The latter usually in the private sector. In certain cases the same governmental facilities have been used by employees for private gains, this is particularly true in the case of physicians who utilize the health units for private practice creating a dual system with natural preference for those who are capable of paying fees to those who can not.

Generally, real incomes become totally unrelated to wages, creating a condition where in many instances government work has become a mere token of security and a stepping stone for private practice rather than a reality.

All in all, the consequences of the resulting conditions have and continue to undermine the effectiveness and efficiency of all governmental facilities and services. Complains of bad quality and lack of trust from public to governmental services is very common.

6-3 Non-Governmental (non-profit - civil initiatives)

6-3-1 Introduction

The term Non-Governmental sector is a very broad term. For many researchers it includes the private profit-oriented sector. For the government, the non-governmental sector is defined as that sector which is organized under the law 32 and comes under the control of the MOSA. However, this definition also strongly narrows the sector and does not reflect other civil initiatives which takes other forms of organization to prevent the control of the MOSA, such as the "Civil non-profit companies" for example. For the purpose of this study, the term NGOs is used to describe all non-governmental, non-profit oriented, civil initiatives. It hence, includes all those that come under law 32 as well as those initiatives which have taken other legal forms. It

naturally excludes the private profit oriented sector. Saying that, the bulk of NGOs still come under the control of the MOSA and the law 32.

However, the line of demarcation between the MOSA and those NGOs which are registered under the law 32, in many instances, is extremely confused and hazy. The difference between supervision by the MOSA and take-over is not always clear. In fact in many instances NGOs are made as mere extensions of the ministry. In fact, many of the activities carried out under the banner of NGOs is officially reported by the ministry as their own activities. This fact will be more clarified in the area of disability.

This case was not always there, prior to the law 32 of 1964, and particularly before the 1952 revolution, most organizations were truly genuine organizations which stemmed out of spontaneous civil initiatives. However, the 1952 revolution was from the first day very distrustful of NGO movements (Kandil, 1993). In fact independent non governmental or non-state initiatives were gradually either taken over or became under severe and strict state control. It should also be mentioned here, that control over this NGO sector during the post 1952 revolution period represented two facets of the regime's nature at the time: on the one hand, its increasing role in service provision and its commitment to "equitable distribution of services for all". On the other, its non-democratic and distrustful nature of all outside its state apparatus. This relationship culminated in 1964 where all NGOs came under very strict control and supervision from the MOSA. In fact, in many instances many organizations were completely taken over by the ministry.

However, since the 1974 open door policy and particularly during the eighties and nineties, the relationship of the state to NGOs witnessed important changes. The tendency to radically decrease the role of the state in service provision, produced a strong need for the NGO and private sector to fill the increasing gap in service provision. This process has been strongly encouraged by the foreign donors and the World Bank. However, while realizing the need for a stronger role of the NGO sector in service provision, the government has not relented in its strict legal and administrative control over NGOs and their activities. This fact makes the relationship of the NGO sector and the MOSA fraught with tensions and difficulties. The Law 32 has become an important issue for debate at the moment.

6-3-1-1 Status and affiliations of NGOs in the field of disability

In the area of disability, among the most difficult issues to identify is the exact type or status of NGOs providing services in the field. A more in-depth study is needed in this area. However, personal conversations with representatives of the NGOs, and study of the register of NGOs made by the union of NGOs working in the disability field (Emam, 1981) gives a fair idea from which the major categories were discerned. It must be noted however, that all these categorizations and deductions are personally induced from a database that was made for disability-related NGOs.

Among the different status of providers three major groups or categories of providers can be identified.

1. Quasi governmental organizations.
2. Religious organizations.
3. Secular independent organizations.

1. To the first category, belong those organizations which, though have the title of NGO were in reality established or taken over, completely by the MOSA. These

organizations, are run, staffed, and financed by the MOSA. Important examples of these organizations are the “Social Rehabilitation Association” and “the Intellectual Development Association”. The former provides assessment and provision of certificates of disability to disabled people entitling them to special social, educational and health benefits; the latter works in the field of education and training of Mental Retarded Children. Organizations identified as Quasi-governmental constitute approximately 51% of all organizations, and are the most equitably distributed as they have been part of an overall national plan.

2. The religious organizations: (Organizations with religious affiliations)

To this group belong a variety of organizations with Moslem and/or Christian affiliations. These organizations do not necessarily work in the area of religion or cater only for one religious group but are originally part of a bigger religious institution.

This group constitutes about 16% of registered organizations. About 9% belong to Christian organizations, among which stand such organizations as Caritas (Catholic organization with international affiliations), CEOSS, an Evangelical Protestant organization, and Dar El Karmah and others which belong to the Coptic Church. While about 7% belong to Moslem organizations identified as working in the disability field, such as the Moslem Youth organization. However, the number of organizations does not reflect its real weight or the number of beneficiaries. The Moslem organizations have probably more outlets and serve a larger audience, yet its work is mainly in the area of provision of equipment and health care rather than training and education. This case does not seem to be in AlSaeed (South Egypt).

To those identified as secular independent initiatives belong about 7% of the organizations. Among these organizations three major groups could be discerned. To the first belong those whose input is mainly in research and provision of specialized services, such as the “Egyptian Association for Speech and Cure of Language Disorders” and the “Association of Friends of the Genetically Diseased”. Such organizations owe their origin to initiatives of personnel belonging to the academic and University staff. To the second category belong other professional organizations whose input is in broad service provision in the areas of health care and management, education and training of the disabled. This group owes its origin to professionals working in the disability field, such as doctors, psychologists and social workers. To the third group belong those associations which were originally formed by the initiative of families of disabled children. To this group belongs organizations such as “Right to Live” and “Fathers and Sons”.

In addition about 21% need to be further studied since there is not enough information about them.

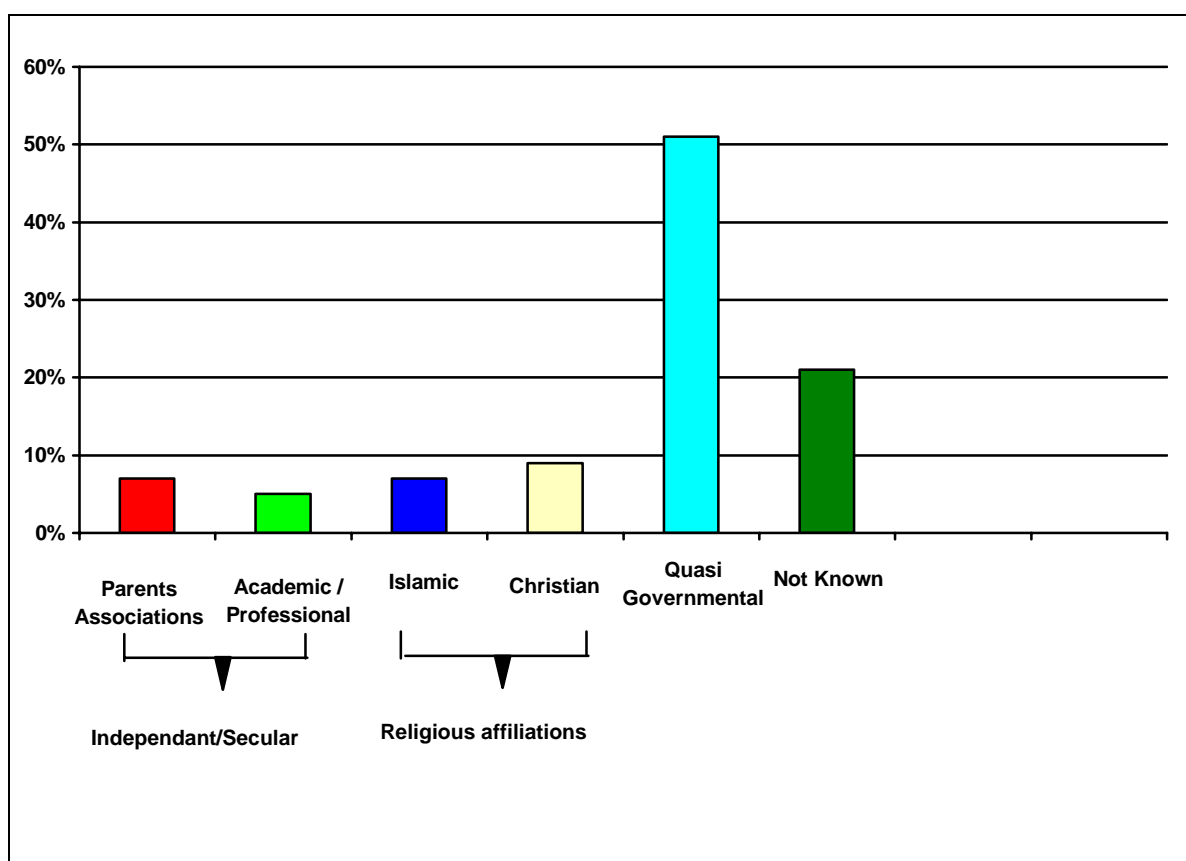
The table and chart below show an estimate of the status of the different organizations working in the field of disability. This is built upon personal knowledge and study of the origins of many of these organizations as well as their charter, their structural make-up and history.

Table 13 shows the distribution of NGOs according to status:

<i>Quasi Governmental</i>	51%
<i>Organizations with Religious Affiliations</i>	

Islamic	7%
Christian	9%
<i>Independent / Secular</i>	
Academic and Professional	7%
Disabled Parents organizations	5%
<i>Not Known</i>	21%

Figure 9 shows distribution of NGOs according to status of provider:



6-3-1-2 Geographical distribution of NGOs

A big geographical discrepancy exists in the availability of disability services in Egypt.

This fact is probably more so in the case of NGOs, where central planning is poorer than governmental one.

Up till 1952 nearly all organizations existed in Cairo and Alexandria. Only in the sixties did this picture start changing with the socio-economic development that took place during the Nasserist era of Egypt.

Extension to other governorates was both through governmental drives as well as spontaneous NGO initiatives. However, the main provider of services in the other governorates, particularly the poorer and more distant ones from the centre, became increasingly the government and its Quasi-governmental NGOs.

However, despite of these developments, bias to the large cities particularly Cairo and Alexandria is still great.

Lower Egypt (the Delta) takes about 65% of the share, Upper Egypt (South Egypt) takes about only 22% of the share of NGOs this is followed by the Canal Zone and then the peripheries.

Figure 10 below shows the distribution of services between Greater Cairo and the rest of Egypt.

Comparison of the distribution of NGOs working in the field of disability between Cairo and the rest of Egypt.



Greater Cairo contains Cairo in addition to a greater part of Giza and Qaliohia

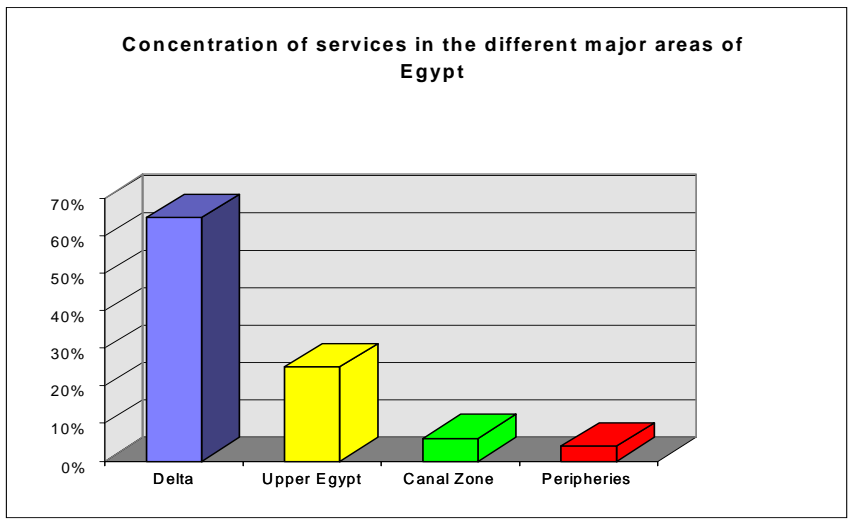


Figure 11 above: The concentration of NGOs within the four major geographical areas of Egypt below.

6-3-1-3 The Role of NGOs in the field of disability

By the year 1994, about 220 organizations were registered with the MOSA and worked in the disability field.

Approximately 76 of these work in areas of Loco-motor, Visual, Hearing and Speech, and Mental Retardation. Another 71 organizations provide services which cater for all disabilities without specialization (Mixed). The bulk of these work in providing “disability certificates” for disabled people entitling them to disability benefits. The

latter service is provided through the rehabilitation bureaus which belong mainly to the Quasi-governmental organizations. Approximately another 70 organizations all over Egypt cater for chronic disabling ill health conditions such as Cancer, Rheumatic heart, Diabetes, Leprosy and Tuberculosis.

However, as can be seen from the table below, the greatest majority of outlets from the different organizations provide services in the areas of registration, guidance of disabled and vocational rehabilitation. These activities are provided mainly through the Rehabilitation Bureaus. In reality the real function of these “Bureaus” is the registration of the disabled and providing them with certificates entitling them to rights to special provisions, for medical and therapeutic rehabilitation, aids and appliances, vocational rehabilitation and jobs. Their direct role in providing rehabilitation services is minimal. These bureaus belong to the quasi-governmental group of organizations.

Generally, the majority of services are either charity and / or professionally oriented. Their main field of interest is on rehabilitation of the disabled individual rather than on rehabilitating the society. Even those organizations which were formed by parents of disabled children as will be discussed in more details later, their main input has been to fill the gap in providing specialized services particularly in the area of special education more than in advocacy or rights of the disabled. In addition, aside from some of the new experiments at CBR the majority are institutional in nature.

Table 14 shows distribution of NGOs facilities according to type of activity:

Type of activities	Number of outlets	%
Advocacy and awareness raising	18	3
Aids & appliances	19	3
Residential care	28	5
Cultural and Sports	62	10
Medical and therapeutic	66	11
Educational	36	6
Registration, Guidance & social help	144	24
Research and Genetic counseling	11	2
Workshops and factories	11	2
Vocational Training	162	27
Training of trainers	9	2
CBR	8	1
Others	26	4
Total	600	100

6-3-2 Conclusion

- The role of the NGO sector in the field of disabilities is of great importance. Aside from the few educational facilities provided by the MOE for certain particular groups of disabled children, the bulk of other services, particularly in the care, social support, training, vocational, advocacy and rights of disabled, provision of aids and appliances, certificates of disability... etc. are in the hands of the “NGO” sector.

- However, the line of demarcation between Governmental and truly non-governmental organizations belonging to this sector is very confused and hazy. In addition, the state exercises very strict control over all NGO initiatives.
- Geographically the majority of NGOs work in the metropolis and large cities, with bias to the north of Egypt (the Delta) as compared to the south of Egypt. The countryside has hardly any services at all.
- According to their affiliations or status, NGOs could be divided into two major categories, Quasi-Governmental and Independent. Within the independent group the majority belong to organizations with religious affiliations, followed by professional and academic organizations and, newly, organizations from families of the disabled.
- The role of organizations working in the field of disability is directed mainly at service provision. It is mainly institutionally and professionally oriented.
- However, during the past ten years, two important developments have taken place. The first is the emergence of organizations from parents of disabled children.
- The second is the development of a number of initiatives which propagate a new approach to rehabilitation, namely the Community Based Approach (CBR).
- Nonetheless, in spite of the important achievement represented by the mere emergence of the above two developments, the first (the parents associations) are still captive to the institutional professional model of service. Being mainly an outcome of the experience of rich parents, whose real aim is to fill a service gap in the quality of services provided by the governmental and quasi-governmental sector and caters for a small number of children. The second (the CBR models), have attempted to overcome many of the short-comings of the institutional model of rehabilitation. Many are related to organizations working in community development in general which were influenced by international experience and international donors' agendas. Generally however, their coverage is poor and are still on the level of models in small isolated islands. They are not yet a part of a national system, and many questions are raised about their sustainability.
- In summary, the social sector can be divided into two main categories. To the first belongs the MOSA with the Quasi-governmental NGOs, and to the second belong the different independent truly non-governmental NGOs. The former have the widest and the better geographically distributed infrastructure, their quality of work is very poor. This is particularly due to the lack of financial incentive of their personnel, their poor orientation and commitment and the bureaucratic regulations governing their work.
- The latter are the more independent organizations are more dynamic, more committed and more in touch with people in their communities, however, they are much fewer in number, and poorly distributed geographically.

6-4 Private services (profit oriented services)

6-4-1 Introduction

The input of the private sector in Egypt in the field of disability covers mainly two types of service provisions, namely, the contribution of private health facilities and the contribution of educational ones.

6-4-1-1 The contribution of the private medical and health services

As in the governmental services, in the majority of cases, the contribution of the health and medical services has to be identified through the different medical outlets.

These outlets include private hospitals and polyclinics, accounting for 9% of total hospital beds in 1992 and private practitioners (60-80,000) running their private clinics. (DDM, 1995).

The private hospitals range from large “five star investment hospitals” to smaller and more moderate ones. With some exceptions that will be mentioned later, these hospitals do not cater for disability per se but rather as part of management of disease through the different specialized departments, such as Neurology, ENT, and Paediatric departments ...etc. In addition, some of these hospitals, have come to include other therapeutic interventions such as Physical therapy sessions which cater mainly for adult stroke patients and to a lesser extent children, while fewer have come to include speech therapy.

Alongside these hospitals, stand a huge army of polyclinics and mainly individual practitioners. These mainly provide outpatient services. They provide the usual first point of contact for the majority of ill people in general and, in this case also families of disabled children. They range from General Practitioners (GP) to different specialists. Private General Practitioners are usually the first sought, while the most commonly utilized after the first point of contact is made, are the specialists, particularly university professors of such specializations as Neurology, Psychiatry and Pediatricians. These are followed by individual physical therapists and speech therapists.

The majority of the G.P clinics are staffed with newly graduate physicians who either have their own private clinics or work on the basis of a percentage of the income generated by their work. The doctors staffing these clinics are usually working in the governmental hospitals and departments, along their private clinics. It is estimated that around 80% of all government-employed doctors have their own private clinics. (DDM, 1995).

In addition to the general private health care facilities, several more disability-oriented private centres and hospitals have opened, particularly during the past ten years. A fact which was stimulated by the increasing awareness to the problem and the gap in the quality of available services.

Among the first to function were hospitals for the mentally ill which opened units for mentally retarded children. In addition, a few number of specialized centres were opened during the past few years catering for both mentally retarded as well as physically disabled children. These centres were opened through the initiative of practitioners which gained experience in the governmental and non-governmental sector in the area of disability during that decade. Both the specialized hospitals and centres are geographically concentrated in the metropolis and mostly in Cairo.

6-4-1-2 The contribution of the Private Sector in Education

The second main contribution of the private sector following health is in the field of education and training of disabled children.

This role is very new, and again has been stimulated by the growing need and awareness to the question and the demand for filling the gap in coverage and mainly in the quality of services provided by the governmental sector. However, this is in response mainly to the needs of rich Egyptian families or families from the rich Arab oil countries, who sought services for their children in the Arab world after experience in the Western countries.

Educational services provided by private institutions range from special nursery classes in ordinary schools as well as special classes in ordinary primary schools to special education schools. They all cater for intellectual disabilities (Mental Retardation). (Shukrallah, Personal interview, 1996)

The majority - about six schools - provide integrated classes on the level of kindergarten and primary education. Some have special units within their schools and some provide integrated classes.

In addition, three new special education schools were opened during the past few years.

In general, all these schools serve only mentally retarded children. Nearly all are English speaking or French speaking schools.

They are concentrated mainly in Cairo and to a lesser degree in Alexandria.

At the moment there are approximately four private schools which provide special education. All cater for intellectual disabilities. (Shukrallah, Personal interview, 1996)

6-4-1-3 The Contribution of the private sector in the field of Technical Aids and Prosthesis

Aside from the provision of eye glasses which the private sector plays the most important role, the private sector has had an important contribution in the production of technical aids and prosthesis for the physically disabled. In fact the role played by small manufacturers goes a long way back. These shops belong to old artisans who pass their professions over to their sons and are not produced in mass production. In many cases they are more appropriate to the community and cheaper than imported ones.

Recently, other medical companies and specialized import companies have opened to cater for importing Technical Aids for the disabled from different western countries. These are very few in number and also very recent in origin.

6-4-2 Discussion and conclusion

The role of the private sector can be divided into the three major areas: namely, medical, educational as well as the production of technical aids.

The medical is the widest. It is the first sought by the families of disabled and the most frequently used. However, the medical contribution of the private sector in general is quite problematic.

Although private medical professionals are the first, most probable, point of contact, in many case, there is lack of orientation to the subject among them. Disabilities are usually discovered late after severe complications have set it. When they are discovered the introduction of the news to the parents are reported by many as being

insensitive and traumatic. The private motivation of physicians in the absence of cure, encourages many acts of abuse. Unnecessary, long and sometimes harmful medical and surgical interventions are probably the commonest symptom of such abuse.

Although a few private hospitals and centres became more interested in providing more specialized help to disabled children, they are quite expensive, institutional and segregatory in nature. Their coverage is very minimal and are concentrated purely in the metropolis.

6-5 Discussion and conclusion of the state of services in childhood disability

6-5-1 Stages of development of services and their characteristics

In studying the state of services in the area of childhood disability, three major categories were followed, namely, the Governmental or state owned and directed services, the Non-governmental (non-profit oriented civil initiatives), and the private sector.

The contribution of the different sectors have differed according to the different stages of social and economic development. Ancient history shows that there was evidence of great indigenous schools dealing with disability starting from the Pharaonic times through the Coptic to the Moslem - Arab times. This stage came to an end with the beginning of the dark era of our region. According to many historians this era starts with the Ottoman invasion in the 16th century.

The modern era of development of services starts at the beginning of the 19th century with Mohammad Ali's attempts to modernize the Egyptian society through importing western know-how and services. This era prevails with the British occupation of Egypt.

From then on services have more or less developed along the western models. They were characterized by being built with a bottom-down approach, superimposed and alienated from pre-existing social structures and indigenous services. In most instances, the new services were developed in antagonism to the old ones.

In the modern era, three basic stages of development of services could be discerned. From the 19th century up to the 1952 army take-over, from 1952 up to 1974 (The Nasserist Era) policy, from 1974 to date, starts with Sadat's open door and continues with privatization and economic restructuring.

6-5-1-1 The first stage of service development: (The colonial stage)

The first stage can be characterized by the following:

- Western style importation of services within a free western oriented market economy society.
- Concentration of services in the cities serving a small elite. The countryside has hardly any services whatsoever.
- Governmental provision in services is very minimal.
- The major service providers are the private sector followed by the NGO sector.
- The NGO sector was quite active, "Golden age after 1928 constitution". Its roots belonged to three major groups; namely, expatriate communities - particularly Greeks and Italians, missionary origin organizations, religious associations (both Christian and Moslem) and rich businessmen and women charity organizations.

- Disability is dealt with purely from the point of view of charity. Most organizations dealt mainly with visceral types such as T.B. and Leprosy. This was followed by services for the Blind and the Deaf. Mental retardation is dealt with as part of mental illness. No special facilities existed for it at all.

6-5-1-2 The second stage of service development: The Nasserist or Post 1952 army revolution stage

This stage can be characterized by the following:

- Growing national feelings and tendency towards bigger state planning and direction of economy.
- The state becomes the biggest provider of services and the role of both private and NGO sector in service provision is relatively strongly reduced, but does not end.
- NGOs and civil life becomes under strict state control, Law 32 for the year 1964. Many organizations are taken over by the state. The emergence of the quasi governmental sector within the NGO structure.
- Expansion of services (health, education, social) and their coverage witnesses dramatic increase. The countryside is invaded by many modern services, particularly health.
- The governmental services provides the largest and most widely and equitably distributed infrastructure of services.
- Disability is dealt with more as a medical and professional problem. Laws for rights of work strongly develop.
- State services increase greatly in the provision for the disabled. Services for the physically handicapped are stimulated by wars. State educational services enter the disability fields. In the sixties, “Intellectual disabilities”, or mental retardation are recognized and special education by the state is provided for mildly mentally retarded children.

6-5-1-3 The third stage to date (the market-oriented restructuring stage)

The post 1974 open door policy stage is characterized by:

- The presence and development of opposing tendencies directing the relationship of the state to services. These could be described as:
 - Tendency to a declining role of the state in all spheres related to economic control, production as well as service provision.
 - Tendency to keep strict administrative control over activities of the NGO sector and to a lesser degree, the private sector.
- The first is to be left primarily to the private sector, while the latter is to be split between the private and the NGO sector.
- The Private would serve the rich stratas of the society while the NGO sector would increasingly take the responsibility of providing for the poorer stratas.
- The state within the framework of the new orientation and particularly under pressures from the IMF and World Bank had to increasingly cut on its control over economic life and production as well as its expenditure on services. This led to a dramatic increase in the prices of goods, on the one hand, concomitant with decrease in expenditure on governmental services on the other. This is particularly true for health, education and social services. The impact of these policies has been most dramatic on both providers and users of governmental services; i.e. the staff of these services as well as the public utilizing them. Both quantity of services provided and particularly quality became increasingly deficient.

- The Private sector's role within this atmosphere greatly increased particularly in the provision of health and education services. However, its facilities are concentrated mostly in the cities and serve mainly the upper stratas of the society. It covers only a very small infinitesimal fraction of the disabled children. In disability in particular, the role of the private sector has been highly questioned. Motivated by profit in an activity where cure is not the usual outcome, the private sector has been accused of an important role in the unnecessary and sometimes harmful abuse of medical and surgical interventions.
- The role of the NGO sector has dramatically increased during the past twenty years. This is particularly true in the field of disability; however, this role is scattered and represents isolated islands. It lacks a national vision. It is in the main dependent on foreign donations and hence its replicability and sustainability is questioned. Moreover, its dependency makes it vulnerable to compromising its agendas and the needs of its communities to the agendas of foreign donors and their priorities.

6-5-2 Summary of gaps and challenges of current services in the field of childhood disability

6-5-2-1 Problems related to current types of providers

The governmental services still constitute by far the most widely spread institution with the highest coverage. Its infrastructure particularly in the health care services and on the primary health care level is the most geographically equitably distributed. Its hierarchical organizations and existing routes constitute a very favourable network for referrals between the different levels of required care.

However, to a great extent all the above is more on paper rather than in reality. The effectiveness of the governmental services, has for long been on the down slide. Cuts in government expenditures on services in general and health, education and social in particular has for long been playing an undermining and demoralizing role.

The ills of this condition do not reflect themselves only on the level of the **staff's spirit** but also on **the policy making process** within these institutions. Policies are being exceedingly made without a clear national strategy. They are, more often than none, short term and affected by availability of funds (whether external or internal) and persons responsible. Hence, short term projects within the system are replacing the presence of an integrated coherent system. Such projects usually continue as long as funds are available and usually decline and dwindle when these funds drain.

Moreover, governmental services suffer from bureaucratic and administrative problems which add their toll to hampering the effective utilization of resources on the one hand and hinder the take-off and sustainability of projects.

In addition, governmental services are blamed for being divorced from the needs of the people on the local community level. They are mainly top to bottom, and built on the basis of providers - receivers, they do not involve communities or call on their participation at any level of service delivery and are not in any way accountable to them.

Non-governmental organizations, on the other hand, in many instances, are merited with stronger commitment and zeal as well as more sensitivity to the needs of people on the community level.

However, their coverage and impact is extremely poor, they lack a national and strategic vision and perspective to their roles and activities.

In the meantime, the scarcity of local resources and dependency on outside funding has tended to affect NGOs agendas. These agendas are being increasingly changed and tailored according to the requirements of outside funding agencies and new fashions in the development world.

Private profit oriented: its role is increasing, yet it is still infinitesimal as compared to the population in need. It serves only the rich and nearly all is concentrated in the cities. Its conduct in many instances, in the lack of a system and supervision in the field of disability, has been highly questioned (Shukrallah, 1997).

6-5-2-2 Problems related to coordination and integration

As mentioned before, among the major problems facing efficient utilization of services lies the question of lack of integration between the services. Services born isolated in a patchy, fill-in-the-gap manner, stand side by side with hardly any form of cooperation or collaboration. Instead of complementing one another, services tend to compete and replicate roles. This fact has been shown to greatly augment the burden of families, particularly disabled families, where multiple disciplines and types of services are essential (Shukrallah and Magdi, 1993).

The bodies established, as mentioned before, with the aim of providing a national umbrella for coordination have failed to play an effective role so far.

Among the major reasons for this failure seems to be the lack of a clear strategy among these bodies as well as the lack of statutory power to monitor and enforce implementation.

In addition, existing bodies limit cooperation to top level officials. Such cooperation is usually kept very superficial. It turns into mere exchange of views with no consequence on the level of policy formation nor on implementation on the ground.

Without building a mechanism for forging links between different service providers on the **practical ground level, and the district levels**, top level collaboration efforts, cannot, and will not, surpass being limited to mere club meetings of top officials.