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The American University in Cairo

School of Global Affairs and Public Policy

Challenges of Social Service Delivery to Persons with Disabilities in Egypt: A Stakeholders' Analysis

A Thesis submitted to

Public Policy and Administration Department

In partial fulfillment of the requirements for

Master of Public Administration

By Amira Ayman El Refaei

Under the supervision of Dr. Ghada Barsoum

January, 2016

The American University in Cairo
School of Global Affairs and Public Policy
Department of Public Policy and Administration

CHALLENGES OF SOCIAL SERVICE DELIVERY TO PERSONS WITH DISABILITIES IN EGYPT: A STAKEHOLDERS' ANALYSIS

Amira Ayman El Refaei
Supervised by Professor Ghada Barsoum

ABSTRACT

Social Rehabilitation Offices are one of the most vital outlets in Egypt that provide services to persons with disabilities (PWDs) under the supervision of the Ministry of Social Solidarity (MoSS). This study seeks to document the performance of Social Rehabilitation Offices from a multi-dimensional perspective; persons with disabilities (beneficiaries), Rehabilitation Offices (service providers), partner non-governmental organizations (NGOs) working in the field of disability, and MoSS (regulators). A mixed methods approach was used to gain an in-depth perspective to the complexity of the issues present in the Egyptian social service delivery system. It was clear that not all Rehabilitation Offices are performing with the same quality, efficiency and effectiveness. The service providers and regulators hold more positive views towards the services provided by the offices than beneficiaries. PWDs are not able to exercise their full rights as a result of receiving little information about the services. More effort can be done regarding the training and employment of PWDs. Also, the study shows lack of clarity of roles and responsibilities for several stakeholders, which had an impact on the quality of services provided. Structural issues such as lack of coordination among multiple stakeholders, poor financial support, a weak monitoring system, and weak social support to PWDs were also found to negatively impact the quality of services. Recommendations for enhancing the performance of these Rehabilitation Offices and the overarching system are listed.

List of Acronyms

MoSS	Ministry of Social Solidarity
CRPD	Convention on the Rights of Persons with Disabilities
SIO	Social Insurance Officers
CAPMAS	Central Agency for Public Mobilization and Statistics
PWDs	Persons with Disabilities
GDSR	General Department of Social Rehabilitation for PWDs
JICA	Japan International Cooperation Agency
SRV	Social Role Valorization
HIO	Health Insurance Organization
RTW	Return To Work
NCDA	National Council for Disability Affairs
NGOs	Non-Governmental Organizations
DPOs	Disabled Persons Organizations
MoHP	Ministry of Health and Population
WHO	World Health Organization
KPIs	Key Performance Indicators

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Chapter One: Introductory Discussions

1.1 Introduction

One of the most pervasive issues affecting the development of nations across various borders is the issue of disability. Providing the disabled with the basic services is the first step to allow for their inclusion and empowerment. Recognizing and meeting the PWDs' needs, working on social protection and rehabilitation programs and equitable access to basic rights is a must. The need to address the issue of disability and the extent to which it affects development become very pressing in light of the first-ever World Report on Disability statistics; which estimates that 15% of the world population, of which 80% hail from developing countries, live with some sort of disability (WHO, 2015). This shows how disability is a very problematic issue for developing countries. Disability contributes to a vicious cycle entangling PWDs into a poverty trap because of the limited access PWDs have to earning livelihood, education, employment and social activities. Not only do PWDs suffer from lack of inclusion in most developing countries but also from poor services. It is estimated that 96-97% of disabled people in developing countries have no access to the rehabilitation services and should be enabled to participate in the society (Integrated Programme to Promote the Rights of Persons with Disabilities in Egypt, 2011). Yet, according to Article 26 in the Convention on the Rights of Persons with Disabilities (CRPD), States Parties shall take effective and appropriate measures, "to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, "States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services" (Convention on the Rights of Persons with Disabilities, 2006).

Although Egypt had signed the CRPD in 2007 and ratified it in 2008, its situation remains similar to many developing countries (United Nations Treaty Collection, 2016). After a long time ignoring the issue of disability, PWDs started voicing their concerns through political mobilization in demand of their basic human rights with the rise of the Arab Spring. With the increased awareness of the need of services that is to be provided to PWDs and the importance of inclusion; assessing and evaluating the current services provided to the disabled is very important. This evaluation is to take place in terms of its scope, quantity, quality and

effectiveness. In this attempt this thesis focuses on the social services provided by Ministry of Social Solidarity (MoSS), since it is a key ministry in running services to PWDs. It is, according to an interview with the Minister Assistant for Social Care and Development at MoSS that 60% of the services provided to the disabled population resides under the Ministry's mandate (MoSS Minister Assistant, 2015). Therefore, this thesis will focus on one of the most vital service delivery outlets; Rehabilitation Offices which are run by NGOs that fall under the authority of MoSS. Given that, an exploratory approach will be adopted attempting to examine the multi-dimensional assessment of the Rehabilitation Offices from a stakeholders' perspective; (1) persons with disabilities (beneficiaries), (2) the Rehabilitation Offices (service providers), (3) Ministry of Social Solidarity's directorate employees (regulator), and (4) other NGOs working in the field of disability. This will be carried out through a mixed methods approach to come up with a stakeholders' analysis for the services provided by the Rehabilitation Offices. The information that would be gathered will allow for a careful assessment of the perception of services based on quantity, quality, its efficiency and availability. It will give an indicative sample of the familiarity of different stakeholders to Rehabilitation Offices and their access to it. This is to help in guiding policy makers (MoSS); acting as an indicator to the wellbeing of the services provided as well as giving room for improvements, better planning and amendments to better suit the public.

1.2 Problem statement

Given the rising voices and anger expressed by PWDs since the Egyptian 2011 revolution, there has to be an assessment of the services provided to PWDs in order to know how it can be improved. Very poor documentation of the services offered by MoSS were found to be published nor were there assessments to have taken place to Rehabilitation Offices serving PWDs since the revolution. This weak documentation of the current services hinders the assessment of the current situation and the analysis of the problems that are to be addressed by civil society or the government.

1.3 Research Question

How are the social services regulated by the government perceived by the public? How are Social Rehabilitation Offices perceived by the different stakeholders; beneficiaries, service providers, regulators and service providers in the same field? What are the gaps hindering a better service provision?

1.4 Background

This section gives an overview of the issue of disability reflecting on some statistical information from Egypt. It also taps onto the different approaches adopted by different countries in tackling the issue of disability, the services they provide and the policies they adopt.

1.4.1 Overview of Disability

The recent high prevalence of disability rates has been traced to patterns of dire circumstances including healthcare conditions, environmental disasters as well as conflicts. The World Bank estimates that PWDs may account for as many as one-fifth of the world's poor. There are at least 400 million disabled people living in developing countries representing a minority of unseen and most vulnerable communities (UN News Centre, 2008). During the high level meeting on disability and development, the UN General Assembly acknowledged that people with disability face a greater risk of living in absolute poverty. According to the UNDAF country report "Integrated Programme to Promote the Rights of Persons with Disabilities in Egypt," "Disabled adults of working age are three times more likely to be unemployed and live in real poverty" (Integrated Programme to Promote the Rights of Persons with Disabilities in Egypt, 2011).

As a result of the absence of inclusion, PWDs suffer from poor health and education outcomes that affect their self-esteem, opportunities for participation and interaction with others, which puts them at higher risk of violence, abuse and exploitation. The statistics from the UNDAF country report reflects that, "Disabled women are 2-3 times more likely to suffer sexual abuse and other forms of exploitation than non-disabled women" (Integrated Programme to Promote the Rights of Persons with Disabilities in Egypt, 2011). During the High Level Meeting (HLM) on 23rd of September 2013; "The way forward: a disability inclusive development agenda towards 2015 and beyond" the barriers that disability face to

equal right and inclusion were discussed (World Report on Disability, 2011). Vulnerable populations such as women, elderly and the poor were found to be excessively affected by disability according to the report.

A lot of factors had been identified as contributors to the dire conditions under which PWDs live. The most important of these are the insufficient policies and standards especially in the field of education inclusion, negative attitudes from key persons (service providers), lack of service provision such as healthcare and rehabilitation, lack of accessibility to transportation, absence of data on disability, poor funding, as well as poor communication, consultation and involvement to PWDs (World Report on Disability, 2011). Although "inclusion" and "empowerment" are two key words continuously cited and referred to in international organizations and countries' announced strategies and policies when dealing with PWDs, countries had approached this differently.

1.4.2 International approaches to meeting the needs of PWDs

Different international approaches had been implemented in order to support people with disability. Services vary between disability benefits (social pensions and monetary benefits), rehabilitation programs, accessibility provision and psychological support. Developed countries such as Taiwan usually provide disability benefits (financial support) as well as social welfare services (parking permits, monetary and social privileges, assistive technology allowances, nursing care and home rehabilitation services) (Wen-Ta Chiu et al., 2013). This is mostly the case in all developed countries, since these are the basic services that ensure social protection of its disabled population. The US has Work Centers or the Community Rehabilitation Programs (CRP) that provide rehabilitations services, training, and employment activities in addition to providing support services such as transportation, therapy and counseling (World Report on Disability, 2011). In addition, the US Department of Labor's wage and Hour Division grants its disabled citizens special minimum wages based on their disability certifications (Employment of People with Disabilities through FLSA Section 14(c), 2016). In Sweden, Norway, and the UK not only does the disabled receive welfare benefits but services are also extended to the "incapacitated for work due to a loss of function that clearly is caused by disease or injury" are entitled to sickness benefits (Reiso, Nygård, Brage, Gulbrandsen, & Tellnes, 2000).

As for developing countries, who are still lagging behind in the inclusion of their disabled populations, it was found that although the rhetoric used and announced attempts a

rights based approach, there is a gap between it and its implementation on the ground. Although India, provides disability monthly pensions, poverty alleviation schemes, travel benefits and aid devices to its disabled populations, other problems may deprive PWDs of these benefits (Kumar, 2014). Since nearly all systems, require medical certifications, for the provision of these services it was found that in India for example, 80% of PWDs were found with no medical certifications due to ignorance or lack of services and therefore with no attainment of these services (Kumar, 2014). In Peru, informal caregivers are much more common than rehabilitation services provided by the government (Bernabe-Ortiz, Diez-Canseco, Vásquez, & Miranda, 2015). Other countries such as Thailand are approaching disability from a medical perspective rather than a rehabilitative one. The disabled tend to be viewed as a cared for group and therefore there was no inclusion for them in policy making and implementation (Bualar, 2010). This approach of "pity" to deal with the issue of disability was revealed through studying the case of Pakistan in "Measuring Support Provisions for People Living with Disabilities in South Asia: An Accessibility Index." It was found that the government had adopted the traditional cost and benefit approach that considered the disabled as "unproductive" or high risk groups (Ahmad & Ahmad, 2011). However, on the other hand a lot of the South Asian countries such as Afghanistan, Bangladesh, India, Nepal, Pakistan, and Sri Lanka had went through legislation reform as well as developed national policies for governing the integration and mainstreaming of the disabled groups in society (Ahmad & Ahmad, 2011). Therefore, as much as it is important to developing the systems for the social service delivery, it is important to assess the problems pertaining to these services in order to allow for an effective mechanism that serves PWDs

Chapter Two: Egypt's Approach to Rehabilitation

The Egyptian context is introduced in terms of the current situation, the political and legal frameworks as well as the governing structure for the social service delivery system. Furthermore, in order to be able to rightly assess the performance of the Social Rehabilitation offices under the supervision of MoSS then one must understand the mandates, roles and responsibilities of the stakeholders involved in this service delivery process. The following section will start explaining the role of MoSS towards the issue of disability as well as its relationship with Rehabilitation Offices, the mandate for these Rehabilitation Offices, the relationship between MoSS, the offices and the directorates. The below information had been gathered through in depth research, interviews with the related stakeholders and a desk review of the laws and bylaws governing the social service delivery system.

2.1 Egypt's Political Framework Concerning Disability

According to the Central Authority for Public Mobilization and Statistics (CAPMAS), the official bureau for statistics in Egypt, the number of PWDs in 1996 was 284,702 which was only 0.48% of the population (El Deeb, 2005). In the "Country Profile on Disability: Arab Republic of Egypt" issued by the Japan International Cooperation Agency (JICA), Planning and Evaluation Department in 2002, it was reported on behalf of CAPMAS that the disabled population was about two million people representing about 3.5% of the total population (Country Profile on Disability Arab Republic of Egypt, 2002). According to the governmental statistical announcement the years of 2006/2007 estimates the number of disabled to be 2.490.126, 2011/2012 estimated for 2.686.476 and 2.899.180 for the years of 2016/2017 (State Information Service, 2009). These nationally reported statistics are far away from the international statistics reported by organizations such as the WHO, World Bank and other international institutions. This exemplifies a huge gap between the local and international statistics on disability rates. This discrepancy in figures could be attributed to a set of factors but not limited to; customs and traditions that find disability shameful and therefore refuse to report them, lack of societal awareness, inefficiency of the data collectors and the debatable definition for disability. However, in light of these gaps, there is no statistics on PWDs living in poverty and their proportion of the 19.6% living below the lower poverty line (World Food Programme, 2016). Egypt is

waiting for its next official census report on the national disability rates, which takes place every 10 years, to be published in 2016 (Population, 2015).

Regardless of the debatable numbers that are announced by the government for PWDS, in 2002 JICA had announced that the Egyptian government delivers services to only 10% of its disabled population (Country Profile on Disability Arab Republic of Egypt, 2002). This figure is very indicative and explanatory of the anger and outrage that has been expressed by PWDs since the 25th of January revolution. Recognizing the rising voices of PWDs after the 2011 revolution, former Prime Minister Kamal El Ganzouri established the National Council for Disability Affairs (NCDA) attempting to respond to the disabled population's needs (Salah, 2012). With more mobilization and calling for the basic rights of PWDs, Egypt had witnessed recognizable changes in its 2014 constitution; where PWDs were mentioned in nine clauses. The most recognizable was clause (81) stating that "The State shall guarantee the health, economic, social, cultural, entertainment, sporting and educational rights of persons with disabilities and dwarves, strive to provide them with job opportunities, allocate a percentage of job opportunities to them, and adapt public facilities and their surrounding environment to their special needs. The State shall also ensure their exercise of all political rights and integration with other citizens in compliance with the principles of equality, justice and equal opportunities" (Constitution of the Arab Republic of Egypt, 2014). This is a very inclusive clause that touches upon all life aspects and cross sectorial rights and services that PWDs are in need of in order to live independently and empowered. However, this clause still needs further translation and detailing in terms of laws that can be enforced.

2.2 Egypt's Legal Framework Concerning Disability

The Egyptian Social Rehabilitation of Disabled Persons law number 39 of 1975, amended in 1982, intended to protect the rights of disabled people had been introduced as the first comprehensive disability law in Egypt, to bring disability policy under one framework. Most of the aspects of these laws, which discuss rehabilitation, training and employment are dedicated to be implemented by one department at MoSS (General Department of Social Rehabilitation for PWDs) and involve other ministries such as the Ministry of Labor and Manpower. Even in the Childhood Law number 12 for the year 1996, the state should provide "rehabilitation services, technical aids and appliances free of charge and according to the budget allocated for this purpose" (Meadows, Bamieh, & Lord, 2015). In addition, the law asserts the MoSS's role in providing rehabilitation through establishing institutions that would

serve Children with disabilities. MoSS is the rule setter and regulator of the whole field of rehabilitation for any institution/ body that attempts to operate. However, not all benefits are acquired from MoSS, reduction on custom duties for specially equipped private vehicles take place through another certification process at the Ministry of Health and Population (MoHP). The Specialized Medical Committees is the concerned entity belonging to MoHP that is mandated to certify the case of disability that would allow a person to receive this benefit.

Since the issue of disability had only been covered comprehensively in the Rehabilitation law number 39, policy makers and other stakeholders tend to attribute the disability rights and issues to rehabilitation only (Hagrass, 2005, p. 158). Clause number two defines a PWD as "any individual who became unable to depend on him/herself in performing his/her work or another [type of] and remains in it. His/her inability to do so is the result of physical, mental, sensory or congenital impairment" (Hagrass, 2005, p.158). Rehabilitation had also been defined in this law; "presenting social, psychological, medical, educational, and professional assistance to all disabled persons and their families to enable them to overcome the negative consequences resulting from impairment" (Meadows, Bamieh, & Lord, 2015). These clauses are the guiding base for social service delivery entitlements and will be discusses later in the conceptual framework.

2.3 Understanding the Governing Structure

2.3.1 The Ministry of Social Solidarity's Mandate

The Ministry of Social Solidarity is mandated to protect and promote social welfare, rehabilitation, protection and empowerment of people with disability in Egypt. It, thus, aims to proffer quality services, empowerment mechanisms and advocacy initiatives to fulfil their rights as equal persons and citizens. It is mandated to "prepare policies to care for persons with disabilities, and issues licenses to non-governmental organizations (NGOs), which provide rehabilitation services, physical therapy, intellectual education, and other social services for persons with disabilities" (Country Profile on Disability Arab Republic of Egypt, 2002). The Ministry is also concerned with issues relating to training and employment, advocacy, education, accessibility, sports and leisure, and is responsible, among others, for the social and economic rehabilitation of PWDs through integration programs.

There are two specific departments inside the Ministry that serve PWDs; General Department for Social Protection and the General Department of Social Rehabilitation for

PWDs (GDSR). The social protection department grants social pensions to the disabled based on a medical certification (if it certifies the applicant of more than a 50% disability degree) that is provided by the client from the Health Insurance Organization based on the Social Security Act No. 87 of 2000 (Social Security Law number 87, 2000). There is also an "inability" pension that is based on the same standards. These pensions are granted as part of the wider pension system that is provided to poor families, widows and the divorced. The General Department of Social Rehabilitation for PWDs is the official authority that is to serve, care for, protect and empower the disabled people in Egypt. According to an official document that talks about the mandate and role of the General Department of Social Rehabilitation for PWDs, the mandate is as follows. It sets, supervises and monitors the general policies of the ministry in the protection and rehabilitation of the PWDs as well as the programs that serves them. Since the ministry itself does not directly provide any direct services, NGOs are delegated for that mission under the authority of the ministry. The Ministry has a supervisory and regulatory role over NGOs in addition to a role that involves assigning projects and allocating budgets to NGOs for its execution, serving a strategic plan. The service delivery mechanisms/ outlets are; Rehabilitation Offices, comprehensive rehabilitation centers, nurseries for children with disabilities, mental education institutions, multiple disabilities' institutions, care and rehabilitation institutions for PWDs, care and rehabilitation institutions for the deaf, prosthetics and orthotics workshops, psychological guidance centers, vocational evaluation centers, and Physio-therapy centers, and a speech therapy center as shown in Figure 2. 1 (GDSR, 2014). According to the General Department for Social Rehabilitation (GDSR) statistics there are 604 rehabilitation institutions that served 199,618 PWDs during the year of 2014 (GDSR, 2015).

The GDSR is mandated to set out its programs and projects with its implementing bodies according to its yearly plan or its 5 year plan. The department is also mandated to manage the financial planning, statistical analysis, quantity and quality of services provided in the social care and rehabilitation services in Egypt. It participates in the research and development of social rehabilitation services on both local and international levels in cooperation with local, regional and international agencies. It also sets and monitors the execution of the Ministries' policies towards PWDs in the field of social care and rehabilitation.

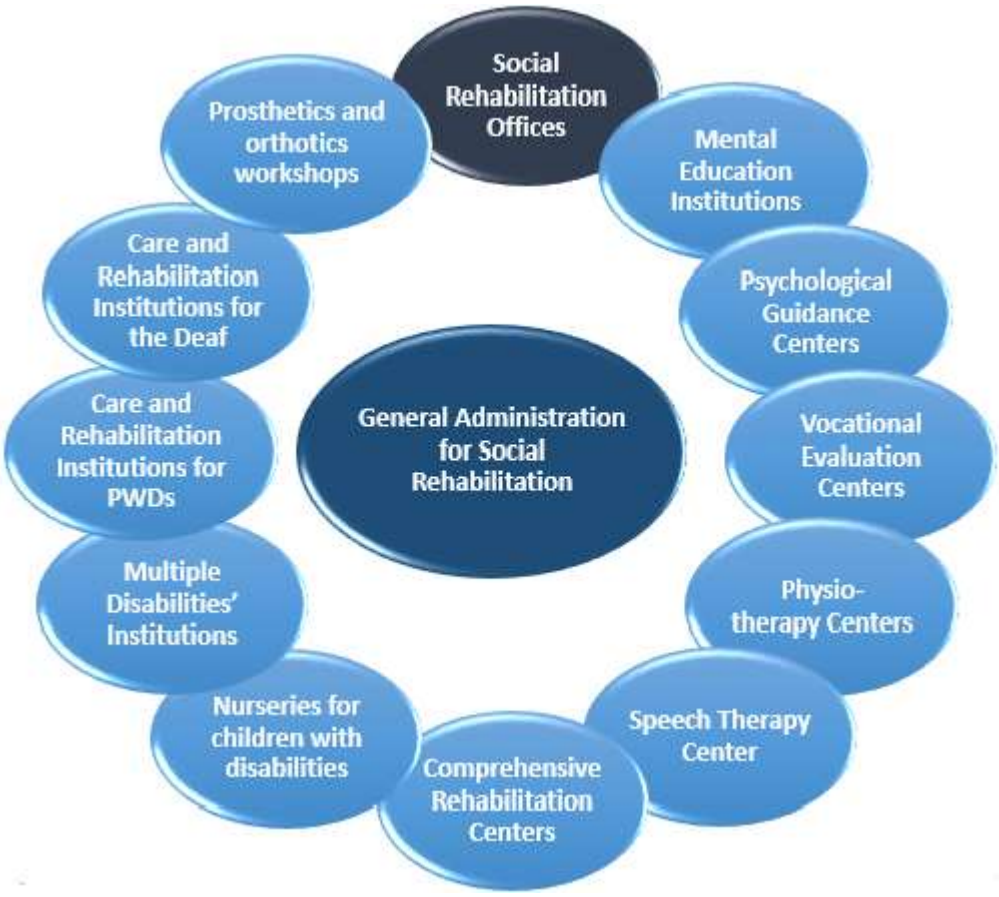

Figure 2. 1 The General Department for Social Rehabilitation Service Outlets

2.3.2 Rehabilitation Offices' mandate and implementation mechanism

Rehabilitation Offices is one of the Ministry's mechanisms for providing services to PWDs. All offices are run by NGOs, however there are two kinds of systems running these offices. There are some NGOs on assigned contracts from the ministry (191 offices) and other NGOs that are self-sustained (16 offices), both with a total of 81,124 beneficiary for the year of 2014 (GDSR employee, 2015). All of the Rehabilitation Offices on assignment contracts receive yearly financial subsidies as well and both types are regulated and supervised by MoSS. Rehabilitation Offices are mandated to provide a range of different services to PWDs and their families:

- Issuing Disability IDs
- Issuing Rehabilitation certifications to degree and non-degree holders for employment purposes
- Provide vocational training for non-degree holders
- Referral services for physical therapy as well as prosthetics services

- Societal awareness activities (symposiums, seminars, etc)
- Holding studies on disability issues (early detection, and dealing with PWDs families)
- Assisting PWDs in employment (public, private sectors as well as productive projects)
- Following up with those who are employed during the first year to solve any problems that they may face and provide monthly reports on their situations to the oversight committee and board of directors

The Disability IDs as well as the rehabilitation certifications gives PWDs an access to some advantages. The Disability ID gives access to benefits such as discounts on transportation and public spaces. As for the rehabilitation certifications, according articles 9, 10 and 11 of the Rehabilitation Law, PWDs are to be employed in 5% of the total number of jobs within any company that has more than fifty workers where this includes the private sector companies, third level administrative system of the state, public bodies, entities and economic units" (Social Rehabilitation Law number 39, 1975). Both the rehabilitation certifications and disability IDs are of the highest usage among PWDs, since they serve all kinds of disabilities. The procedures for gaining these services is as follows; PWDs head to the office and fill an application form, they go through an examination process with a psychologist, a social worker and a vocational specialist. It is then mandatory for the PWD to go for a medical examination at the nearest HIO office for a medical certification. Since, this medical certification is only a guiding one the applicant's file is compiled and sent to a screening committee (formed on the level of each office).This committee assesses the eligibility of applicants for the IDs and rehabilitation certifications. It is composed of a physician, the Rehabilitation Office manager, MoSS directorate representative, a vocational specialist, and two representatives from the Ministry of Manpower (one of them is a work safety specialist). This system reveals the involvement of multiple stakeholders in the process from different ministries (Ministry of Social Solidarity, Ministry of Health and Ministry of Labor and Manpower).

2.3.3 Relationship between MoSS Social Rehabilitation directorates, the General Department of Social Rehabilitation for PWDs and the Rehabilitation Offices

The Ministry of Social Solidarity like other service ministries has branches in every governorate for its representation and monitoring of service delivery. In each of the 27

directorates there is a representative department for the General Department for Social Rehabilitation. The GDSR is to cooperate and coordinate with the social solidarity directorates regarding the performance of institutions/ offices and any related service delivery outlets especially the Social Rehabilitation Unit at the directorate. There is also a representative from Social Solidarity directorate at the Rehabilitation Offices involved in the screening committee for the issuance of disability IDs and rehabilitation certificates as mentioned in the previous section. At the same time MoSS directorates is mandated the oversight of the technical and financial regulation over these Rehabilitation Offices, as part of its oversight over NGOs.

Chapter Three: Literature Review

Systems serving the disabled population differ from one country to another, the structure and governance in place affects the outcome and performance of these systems. Since there has been no exact model that matches that of the Egyptian Social Rehabilitation Offices, looking into similar systems that have the same structure and operating models is very important. This literature review focuses on the impact of organizational contexts, the systems and entities in operation, their administrators that act as mediators between the state's welfare system and the citizens as well as the perception of the beneficiaries. This literature review uncovers the social welfare systems' complexities and the challenges that faces the different stakeholders involved in the process in addition to the effect of some societal factors on the perception of the programs/ systems. These are all tackled in an attempt to spot the different issues affecting the social welfare service delivery.

3.1 Literature on impact of the organizational context on the performance of social welfare administrators

Some research argues that for a country to be able to improve the effectiveness in implementation of institutions, the organizational based social contexts have to be examined (Glisson et al., 2007). Other research suggests assessing the capacity of institutions and the factors that can enable the environments that would unleash these capacities (Mirzoev, Green, & Van Kalliecharan, 2015). In a more case specific perspective to analyzing organizational context, Sweden and Norway were studied. In the 1990s, Social insurance offices' scope had been broadened in both Sweden and Norway after the "wok- line" principle reform took place (Söderberg & Alexanderson, 2005). The tasks of Social Insurance Officers (SIOs) included the measures to facilitate Return to Work programs (RTW) for the recipients of long term sickness benefits besides making decisions about sickness benefits. Yet the expansion in the work of social officers had took place without the sufficient education and training leaving most of their work to a trial and error mechanism instead of a scientific adopted methodology (Hensing, Timpka, & Alexanderson, 1997). This can be a very similar situation to that of the Egyptian system, where the vocational specialist working inside Rehabilitation Offices is the one to decide what kind or type of work suits the PWDs and based on that he/ she receives vocational training. Building the capacity of the administrators is an essential cornerstone to the success

of the programs, since they are the direct service providers and most effective stakeholder. Yet little discussion took place regarding the training and education of the social insurance officers' workers (street level bureaucrats). The next section looks deeper into the specifics of the involvement of different stakeholders in the service delivery process and its effect on the end result.

3.2 Literature on problems of multiple stakeholders in service delivery

The Egyptian system similar to many other countries, involves different stakeholders in the decision making process of granting welfare services. Both the Scandinavian countries and Egypt require a medical certification from a separate health institution in order to verify and help social workers/ committees make the right decisions regarding the clients applying for a service. Although both systems have committees/ boards for the assessment of the entitlements to applicants, they use all information collected from social workers in addition to the medical certifications as an essential guide to make their decisions. The cooperation between different stakeholders involved in the process becomes problematic during the execution since each has its own goals and routines. (Ydreborg, Ekberg, & Nilsson, 2007). In a study using an evaluative literature review for research, it was found out that it is a complex system that involves several stakeholders with different roles, objectives and priorities (Baril, Clarke, Friesen, Stock, & Cole, 2003). Conflicts between different groups such as employers, healthcare professionals, social insurance officers and employability institute officers, arises as a result of their involvement in the rehabilitation of long-term sickness beneficiaries (Östlund, Borg, Wide, Hensing, & Alexanderson, 2003). Therefore, this involvement of the different actors in the decision making process may sometimes result in disharmonized system.

This section will focus on the challenges faced during the Return to Work (RTW) as well as sickness pension programs in Sweden since it applies a very similar operational model as the Egyptian Rehabilitation Offices. In an interview study that attempts to uncover the difficulties that arise for the social insurance officers when assessing applications after this policy change; it was found that although social insurance boards are given all information by the social insurance officers in order to make the final decisions, 90% of the board's decisions follow the physicians' recommendations (Ydreborg, Ekberg, & Nilsson, 2007). This shows how important is the physicians' perspective in the decision making process. However, since each system has its different policies, procedures, routines and values that influence their

practices, this influences the perception of the clients to the specific welfare program they are dealing with. Having to wait for the medical examination certificates to be issued by physicians affected the performance or at least the perception of performance negatively. The waiting times or lengthy procedure that applicants may face, although was dependent on another entity, was attributed to the Social Insurance offices (Ydreborg, Ekberg, & Nilsson, 2007).

In a study by Hensing in 1997, SIOs also showed lack of motivation since their work process involved returning incomplete medical certificates which consumed more of their time and lengthening of the process (Söderberg & Alexanderson, 2005). This lack of time is said to have been another reason behind the SIOs acceptance to physicians' recommendations (Söderberg & Alexanderson, 2005). The time allocated to each case has been discussed in the literature as one of the reasons that affects the SIO assessment and entitlement process. According to the rubber stamping concept developed by Lipsky (1980), public institutions tend to adopt others' judgements due to the work overload and time constraints they suffer from (Hensing, Timpka, & Alexanderson, 1997). This leads to a newly developed culture, that is more reliant on the system rather than the efforts in customizing the service to clients based on their needs in light of the rules and regulations in place. However, it could also be that SIOs had limited information to base their judgements on since the only input they have to base their judgements is the medical certifications.

In other studies regarding RTW measures, the SIO expressed feelings of ambiguity when handling clients cases (Söderberg & Alexanderson, 2005). This as well may very much affect the performance of SIO in serving PWDs. Although, it is the SIOs job to make the final decision regarding granting the sickness/ disability benefits, and the physician's is only a guiding one, SIOs either follow the physicians recommendations blindly through a wait and see strategy or they use coping mechanisms that may cause them frustration. In a study in 1997, examining the daily dilemmas facing social insurance officers, it was recommended for physicians and social officers to know more about the work of each other's system and requirements in order to be able to make the best decision in favor of their clients (Hensing, Timpka, & Alexanderson, 1997). The same happens with physicians who determine the kind of disability, its grade, capacity to work, duration of reduced work ability, and rehabilitation measures. In the Swedish system, physicians have an even bigger role than the physicians involved in the assessment process the Egyptian Rehabilitation Offices; they do not only grant medical certifications that covers diagnosis, treatment and work capacity only but also the clients' plans for rehabilitation measures. Same applies to Norway, where general practitioners

(GPs) issue more than 80% of sickness certificates (Reiso, Nygård, Brage, Gulbrandsen, & Tellnes, 2000).

The physicians may sometimes need more information such as insurance legislation and measures recommended by other professionals. It is not clear in the literature how do physicians obtain this information in this complex context (Söderberg & Alexanderson, 2003). In other studies, SIOs expressed that physicians sometimes put clients on the sick list when they believed they were healthy enough to work (Hensing, Timpka, & Alexanderson, 1997). Although the evidence in the research would not corner the physicians nor the healthcare professionals as wrong doers, yet it gives an indication of the fragmentation that exists in the system of coordination between both parties. Therefore, it is clear that there is a huge problem of coordination between the different public organizations serving in the welfare system. In a 2007 research conducted on "Swedish social insurance officers' experiences of difficulties in assessing applications for disability pensions," it was suggested that having the SIOs and physicians coordinating more closely would raise the quality of assessment as well as reduce waiting times for patients (Ydreborg, Ekberg, & Nilsson, 2007).

3.3 Literature on subjectivity of service providers

Since social officers/ workers are in direct contact with clients they are considered as street level bureaucrats and so have flexibility and freedom in making decisions that affect the lives of their clients as well as their economy's status. In order to grant clients any benefits from welfare systems, several factors are to be examined and determined before making this decision. This is a very problematic issue especially in giving percentages for disability levels, sickness levels and work capacities. Again, the model of the Scandinavian countries concerning this issue has been studied extensively in the literature, which surely gives a very indicative sense of the problems that may exist in the Egyptian Rehabilitation Offices. The dual function that the SIO plays as a coordinator as well as a gatekeeper creates uncertainty in the decision making process (Söderberg & Alexanderson, 2005). Scandinavian countries, just like the Egyptian, are mandated to assess the work capacity of their applicants. In Sweden, it is used for granting the entitled social pensions and at the Egyptian Rehabilitation Offices they are used for granting the rehabilitation certification as well as determining the work that best suits the applicant. Social workers or social committees in both countries are faced with the challenge to determine the entitlement of the disability benefit to the applicant based on factors that can be viewed differently. The literature goes deep into studying this issue that is claimed

to be a subjective process, which is based on employees' perspective as a result of the interchangeable factors involved in this process instead of a common basis to make this assessment. The literature shows that in Western Europe it was difficult to find a unified assessment (criteria) for disability pension since most had their own assessment tools for this assessment. The other very important issue is that disability is not classified and set where PWDs should be blindly classified into, but instead the disabled are very heterogeneous and their disability differs from one person to the other.

When reassessing the system in place, it was found that in order to decrease sickness rates in Sweden, those with long term sickness were granted social pensions instead of sickness pensions (Ydreborg, Ekberg, & Nilsson, 2007). In the 1990s, the social insurance system was suffering from a huge increase in the number of disabled beneficiaries, which can be attributed to the subjectivity of SIOs, which led the government to cut down its costs to improve its economic situation (Ydreborg, Ekberg, & Nilsson, 2007). The disability pension is given due to reduced work capacity as a result of a medically defined illness. The Swedish legislation states that people whose work capacity is permanently reduced by 25% are entitled to disability pensions (Ydreborg, Ekberg, & Nilsson, 2007). Therefore, the need for restructuring this social system was a must to combat the very high numbers of disabled beneficiaries as a result of the absence of a solid, clear and comprehensive basis for assessment of the disabled or the sick applicants. Yet even determining this work incompetency by 25%, for the sickness benefit entitlement, is still a problematic issue since clients as mentioned before, experience different kinds of disabilities, living and working environments and socioeconomic contexts. This means that even by having a criteria it is not a clear cut issue, but one that involves several factors. Work capacity appears to be a very vague concept with no accurate criteria for assessment used on behalf of physicians nor SIOs. The assessment of an individual is not solely concerned with his/her functional abilities but also with his/ her occupation and employment situation (Hensing, Timpka, & Alexanderson, 1997). The complications of each client's case, the changing labor market and unemployment were all factors that further complicate this assessment. All of these different factors make the assessment system complicated and leave the entitlements to the subjectivity of service providers being social workers or physicians. They, furthermore, jeopardize the quality of work and outcome of these social insurance offices that act as vital decision makers affecting both the daily lives of PWDs and the state's economy.

3.4 Literature on perception of the direct service providers/ gatekeeper

The perception and challenges faced by the gatekeepers (whether social workers or social committees) needs to be taken in considerations since they are the direct administrators of the process. Understanding their experiences in the social welfare system is essential to the improvements of service delivery and effectiveness of the process. In a literature review study made by Soderberg and Alexanderson in 2005, "Gatekeepers in Sickness insurance: a systematic review of the literature on practices of social insurance officers" it was found that although 16 studies dealt with different dimensions of managing clients, only two tapped on the problems experienced by SIOs in the process of granting sickness benefits (Söderberg & Alexanderson, 2005). More research needs to be made in this field to be able to identify the challenges and address them. Although some of the SIOs felt that they have limited control over the process and the decision making others had felt they had too much freedom in making decisions and expressed their need for guidance and leadership (Söderberg & Alexanderson, 2005). The need for a more organized framework from higher authority was expressed on behalf of SIOs to help in governing relations with other professionals and entities such as physicians, employers as well as employees. This point very much relates to the earlier section discussing the effect of having a disharmonized system in place.

In a study that was based on 24 meetings with SIOs and clients by Jonsson in 1997, it was found that there are four approaches that were used by SIOs with clients. These approaches were between "being the caring professional, the caring amateur, the bureaucratic administrator, or the coordinator" and clients that did not adhere to the expectations of the SIOs were found to be challenging to them (Söderberg & Alexanderson, 2005). The "socio-technical model of organizational effectiveness", proves that the social context of an organization becomes deeply rooted to become part of its identity, shaping the expectations, perceptions and attitudes of its workers (Glisson et al., 2007). This is said to affect the responsiveness, availability and quality of service delivery to the beneficiaries. This is not only among different actors but also among professionals belonging to the same institution. The decision making regarding the entitlements was found to have been attributed to some of the employees' characteristics. Work ability was found to be related to the age of physicians in Norway, older GPs are more compassionate with their patients than the younger ones (Reiso, Nygård, Brage, Gulbrandsen, & Tellnes, 2000). Therefore, this suggests that personal characteristics and

acquired organizational approaches' effect differ from one service provider to the other. This means that since service providers act differently, they will not be perceived the same way by their clients.

3.5 Literature on clients' perception

Clients' satisfaction is a key indicator to the quality of services the public/ private sectors are providing. This part of the literature focuses on the perception of clients and the relationship that exists between them and the social welfare administrators. The sex, disability status, rehabilitation measures and pensions of beneficiaries were all factors that are said to affect the perception of clients towards SIOs. Women beneficiaries perceive SIOs and healthcare professionals to be more supportive to them than men find them to be (Östlund, Borg, Wide, Hensing, & Alexanderson, 2003). Furthermore, those who received disability pensions had more positive views on SIOs than those without disability pensions and those who had returned to work (Östlund, Borg, Wide, Hensing, & Alexanderson, 2003). It was found that positive experiences of encounters with rehabilitation professionals from clients may facilitate return to work by individuals on sick leave (Klanghed, Svensson, & Alexanderson, 2004). However, more research is needed regarding these positive experiences and what they carry of empowerment to beneficiaries.

Other literature examines how having disabilities is worse for women than men and how the poor with disabilities are alienated (Ahmad & Ahmad, 2011). This issue of gender bias was deeply investigated in the literature especially in social insurance offices RTW measures. Men were granted more expensive measures for rehabilitation than women and workers were more responsive to their suggestions (Söderberg & Alexanderson, 2005). Women usually stayed longer on sick leaves and were given disability pensions after a short period of their absence (Borg et al, 2001). However, in the healthcare sector gender bias has been an issue of study for long, since gender bias in medical practice exists. In a comparative literature review study that was conducted in 2005, some of the findings were as follows, SIOs regarded themselves extremely neutral and that rehabilitation measures were due to external factors that was not up to them to decide. However, they had acknowledged that women were more difficult to rehabilitate. It was a common factor that men felt more in control of their situation than women.

Yet, other factors that were attributed to the quality and quantity of services found in the literature relating to customer satisfaction were waiting times, process and length of service

delivery, amenities/ facilities cleanliness, hygiene, affordability, transparency, privacy, trust, quantity and quality of direct service providers. On a more general level, clients undergoing rehabilitation were said to have expressed negative attitudes and perceptions towards the rehabilitation process. However, this has not been further studied in the literature, so the reasons behind this negative attitudes cannot be fully claimed.

3.6 Literature on the effect of social support on the perception of services

Other important factors that had been explored in the literature had been the importance of social capital and its impact on the satisfaction of the disabled groups. Some research shows that disabled groups are more satisfied with informal social support rather than institutional support that is received through governmental or NGOs services. A study that was carried out in Croatia revealed that the disabled satisfaction is highly related to the amount of social support they receive from their community and circle; being family and friends. Social Valorization theory has been developed and discussed a lot in the literature on disability. "The use of culturally valued means to enable, establish, enhance, maintain, and/or defend valued social roles for people at value risk" (Wolfensberger, 1985, 1998, 2000) (Aubry, Flynn, Virley, & Neri, 2013). Social valorization has to do more with the social image of the disabled by society and the effect that this has on the disabled groups and how they derive their satisfaction from the perceived image. Self-esteem, satisfaction and expansion of personal competencies is said to be derived from moving from being de-valued to develop relationships with non-devalued individuals, through social and physical support outside of the treatment settings (Aubry, Flynn, Virley, & Neri, 2013). There has been a developed tool for assessing the degree to which programs and service settings are in line with normalization and SRV principles (Aubry, Flynn, Virley, & Neri, 2013). This proves the importance of psychological integration to inclusion and empowerment and its important effect on PWDs perception of services. Research extends in this area to draw linkages between social roles and social images, where those who are perceived with positive social roles will be treated well by others while those who are perceived with negative social roles will be treated badly by others (Wolfensberger, 2000). This could be linked to the way service providers or street level bureaucrats deal with their clients/ beneficiaries during service delivery. The professional treatment of the social administrators affects the PWDs perception of services and therefore, the social image created by the social welfare administrators is very important to take into consideration.

3.7 Literature gap

The literature uncovers that the performance of the social welfare systems is very much determined by a combination of factors and multiple actors. Although different perspectives and factors affecting social welfare program have been discussed in the literature, it was mainly focused on the experience of Scandinavian countries. There appears to be a literature gap in covering the Middle Eastern countries experiences and specifically Egypt. Furthermore, more research needs to consider a holistic approach to the assessment of services by the different stakeholders; and the perception of the quality of the social services. This will help in determining the gaps, flaws and challenges in the existing system as well as give space for solutions to be made.

In light of this research, this thesis attempts to build on the existing literature in the area of social welfare system performance as well as expand on it by tackling the assessment of services provided from a multi-dimensional perspective to gain a better understanding of the services provided to PWDs. Specific factors affecting the perception of services will be deeply examined in order to determine the current challenges facing the service delivery system and the possible proposals for solution. This study aims to cover for the dearth of published literature on Egypt and the Arab/Middle East region.

Chapter Four: Conceptual Framework and Methodology

4.1 Conceptual Framework

Since the "lack of access to rehabilitation services can increase the effects and consequences of disease or injury; delay discharge; limit activities; restrict participation; cause deterioration in health; decrease quality of life and increase use of health and rehabilitation services", having a wrong perception of "rehabilitation" could also lead to these same outcomes (World Report on Disability, 2011). Therefore, setting the right understanding of the concept of "rehabilitation" is very important. The current Egyptian Rehabilitation law number 39 for the year of 1975, which has been last amended in 1982, 34 years ago, uses an outdated approach in tackling the concept of "rehabilitation" failing to see it as one that involves a comprehensive and integrated humanitarian and social process. In the Social Rehabilitation Offices bylaws issued by MoSS in 1997, clause (2) states that the office aims to qualify all categories of PWDs in a manner that is fit to the abilities they have left, being physical, mental or psychological (MoSS, 1997). The linguistics in use, "fit to the abilities they have left", reflect a care based approach with little attention to empowering the PWD to realize his/ her full capacities. This definition reflects the traditional perspective to disability, which attempts to tackle the issue for a medical or an individual perspective. It attributes disability to a loss of function which usually result in the segregation of disabled people since they cannot exercise their lives in a normal manner. This is very clear in how "rehabilitation" is defined in the Egyptian Social Rehabilitation Law number 39 as "presenting social, psychological, medical, educational, and professional assistance to all disabled persons and their families to enable them to overcome the negative consequences resulting from impairment" (Hagrass, 2005, p. 158). This is a very different definition than what the Convention on Rights of persons with Disabilities gives to rehabilitation; "enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life" (World Report on Disability, 2011). In addition to what it also gives to PWDs; which is to work on regaining the lost or compromised skills and abilities of PWDs and provide them with the necessary tools and environment for their full inclusion and empowerment. These definitions that were given by the CRPD remarks a shift in viewing PWDs from a group that requires care and protection to a group that holds equal rights to other citizens. This "rights-based approach to disability seeks to empower disabled persons, and to ensure their active

participation in political, economic, social, and cultural life in a way that is respectful and accommodating of their difference" (UN HRBA, 2016). A visual comparison is illustrated in Figure 4. 1 by the researcher to better convey the difference between the Egyptian approach and the CRPD's in tackling the issue of disability.

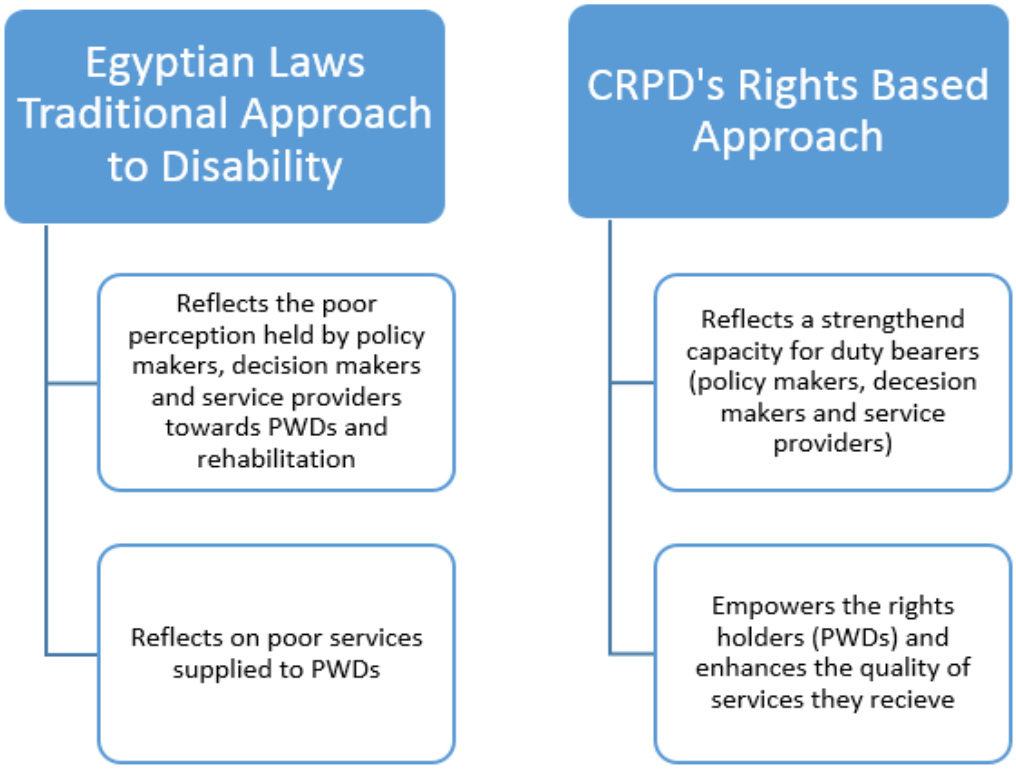

Figure 4. 1 A comparison between the Egyptian Legal framework and the CRPD's Legal framework

A rights based approach is not one that is to be used on the legislation level only, but one that can be adopted on an institutional and program levels as well. The United Nations Development group had adopted the UN Statement of Common Understanding on Human Rights-Based Approaches to Development Cooperation and Programming (the Common Understanding) in 2003 (UNICEF, 2016). According to UNICEF, a rights based approach is "a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights. It seeks to analyze inequalities which lie at the heart of development problems and redress discriminatory practices and unjust distributions of power that impede development progress" (UNICEF, 2016). Therefore, analyzing the institutional capacities from a multi-stakeholders perspective is very important to assessing the gaps in the system. In the

researcher's attempt to use a rights based approach certain measures needs to be taken to realize that and to reach a better service delivery mechanism. Figure 4. 2 reflects the researcher's perspective to institutionalizing a rights based approach and its adoption by NGOs, being Rehabilitation Offices or any other service delivery outlet in order to deliver full rights and empower PWDs. The process needs to start with an evaluation assessment of the situation in order to uncover the capacity of the duty bearer (being the service provider as well as the regulator of the services). This will allow for the adoption of new organizational concepts and beliefs that will surely reflect on the activities and measures taken to achieve a rights based approach.

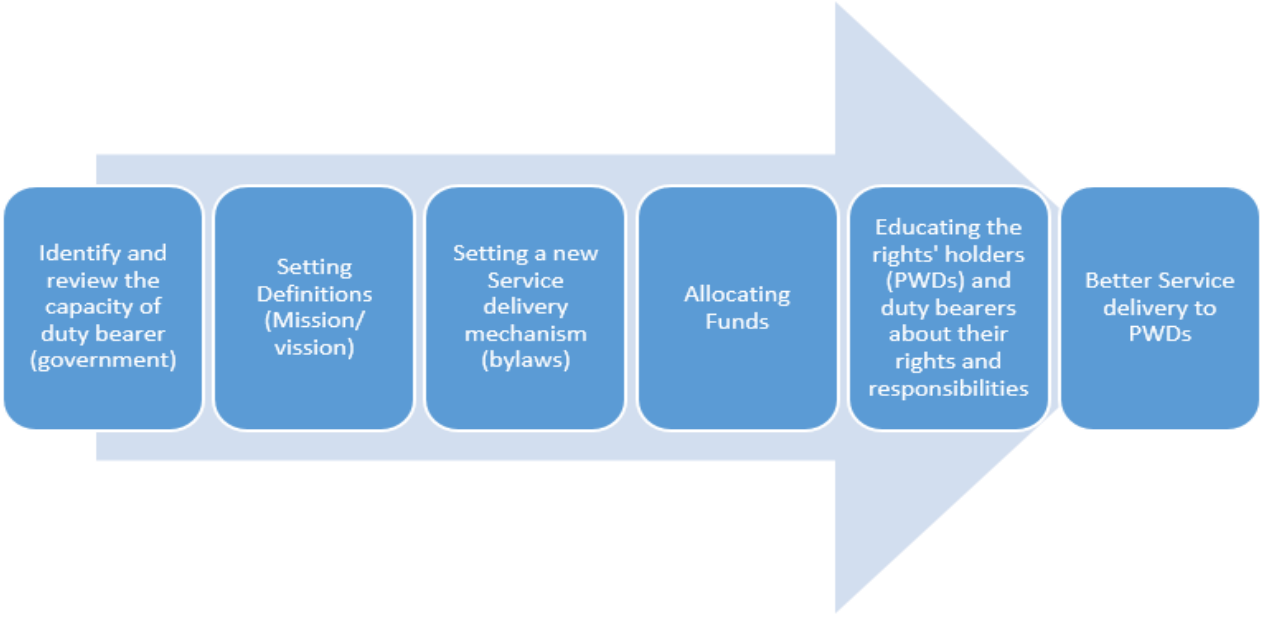

Figure 4. 2 A process model for Institutionalizing a Rights Based Approach

4.2 Methodology

This study attempts to carry out an exploratory study to examine the multi-dimensional assessment of the Rehabilitation Offices from the perspective of its stakeholders; (1) persons with disabilities (beneficiaries), (2) the Rehabilitation Offices (service providers), (3) Ministry of Social Solidarity's directorate employees (regulator), and (4) other NGOs working in the field of disability.

4.2.1 Study Framework

Since the researcher is working for MoSS, as a consultant for Disability Affairs, this study takes place during workshops held by the ministry, targeting the different stakeholder participants. The aim of holding these workshops was to come up with MoSS's disability strategy for the coming three to five years. MoSS launched 16 participatory workshops, during the months of November and December 2015, four in four different governorates, Cairo, Alexandria, Assiut and Ismailia, in order to formulate a participatory "Disability Strategy". The workshops were based on a classification of four main types of disability; physical disability, visual impairment, deaf and hard of hearing and intellectually disabled. The rationale behind that was to have a workshop for each of these groups in each of these four governorates. The invitation of the workshop participants took place according to the geographical location, age, background and affiliation representation where each workshop was attended by 30 to 40 participants. As for the PWDs they were picked according to their level of activism in the field or based on the recommendations of prominent NGOs. Since this is a public forum held by MoSS the researcher attended all workshops, observed and documented the discussions and issues that pertained to this thesis area of focus.

The researcher gained the approval of the IRB on 4 December, 2015 for using the appropriate procedures to minimize the risks to human subjects as well as protect their confidentiality. Since the researcher had to wait for the IRB approval before collecting data, the questionnaire was used in 12 of the workshops only, starting 6 December, 2015 ; four at Cairo, four at Assiut, two at Ismailiya and two at Alexandria. The researcher appealed to the workshop participants to participate in full consent of their will and without any pressure, coercion and undue inducements, each according to his/ her affiliation. The participants were informed of having the right to withdraw from the research at any point of time without any penalty.

The researcher, holding a position of a consultant to the Ministry of Social Solidarity, attained the approval of the Ministry before starting with the research. Since the researchers is not an employee at MoSS but instead a consultant, this gives the research an objective perspective and avoids any conflict of interest during this study.

4.2.2 Research Method

This thesis aims to use a mixed methods approach that adopts the "convergent parallel design" designed by Wittinik, Barg and Gallo (2006) which collects and analyzes the findings of the quantitative and qualitative simultaneously (Creswell & Clark, 2011). The results are then combined and laid down to find relationships complementing or contradicting one another. The idea behind the use of this approach is to map out the complexity of the issues that overlap in the Egyptian social service delivery system. The collected data will be analyzed and integrated in this manner to add to the richness of the study and address the complexity of the manifold challenges that these Rehabilitation Offices exist within. The quantitative method was used to highlight the shared experiences while the qualitative one was in use to gain the in depth view of some of the important issues.

Quantitative Component

Before designing the questionnaires that will be in use, the researcher conducted a desk review to grasp a good understanding of the nature of these offices, the laws and regulations in use as well as the different stakeholders involved. In order to gain a deeper understanding of the nature of the work of these offices and their on-the-ground work, three visits were made to three offices (one in Cairo and two in Giza governorate). The selection of these offices was randomly selected based on their geographical proximity as well as the recommendation of the GDSR. Based on this outcome, four self-administered questionnaires were then designed for the four different stakeholders; PWDs, Rehabilitation Offices employees, NGOs and social rehabilitation directorate employees (see Annex 1, 2, 3 & 4). The data was deconstructed and quantified to be able to assess the importance of issues, concerns and views based on the frequencies. The data gathered was analyzed in a comparative manner to allow for the withdrawal of analysis from the different perspectives of the different respondents.

Quantitative Sampling

There has been 177 questionnaires distributed during these workshops; 26 answered by the Social Rehabilitation Offices, 19 by directorate employees, 50 PWDs (45 directly answered by PWDs and 5 by their guardians with no representation of the intellectually disabled) and 82 by NGOs working in the field of disability (after 3 of the NGOs were eliminated from the surveys). These NGOs' applications were eliminated from the surveys since they were filled

by NGOs holding/ running Rehabilitation Offices. The reason for that is to maintain the neutrality of the "NGOs" grouping as a beneficiary (applies for its beneficiaries for benefits) or a party in the same filed that could provide an evaluation of the Rehabilitation Offices performance. Of course, there has been a difference between the representations of the different stakeholders as a result of their proportionate representation to their original size. For example the rehabilitation directorate employees in one governorate can be an average of two while NGOs can be around 25 or more in the same governorate.

In regards to the participation of persons with disabilities, only the physically disabled, visually impaired, deaf and hard of hearing and guardians of the intellectually disabled were targeted to participate in the "PWDs" questionnaire. Intellectually disabled persons were not directly included in this study in respect and protection of their rights. Some questionnaires may be addressed to persons with disabilities using the help of the researcher or a volunteer due to the incapacity of the disabled to administer the questionnaire on his/her own. These groups may be some of the physically disabled (upper body limb amputations), the visually impaired and the illiterate (if any). When communicating with the deaf and hard of hearing participants a sign language instructor that is also attending the Ministry of Social Solidarity's workshops will be used as an intermediate to getting the consent of the targeted participant and explaining the situation. The deaf and hard of hearing person will be doing the questionnaire by himself/ herself only asking for the sign instructor's help in case he /she needs any kind of clarification from the researcher.

The questionnaire addressed to persons with disabilities was designed to allow for drawing correlations based on the kind of disability, gender, age, and education level. It will also give an indicator of the most common services that is in need or in use by the PWDs. It will touch upon what is expected of these Rehabilitation Offices by PWDs. The second questionnaire, addressed to the Rehabilitation Offices employees, will draw correlations based on the NGO the office belongs to and the characteristics that pertain to the employee being surveyed. It will also allow to compare some aspects such as the communication of information (ex: the explanation of the benefits of Disability IDs) with the PWDs receiving the services from the side of the service provider and the side of the beneficiary. It examines the additional kind of support that these Rehabilitation Offices is in need of, the biggest challenges they face and how can they overcome it. As for the third questionnaire, MoSS directorate employees, takes the perspective of the regulator and how they assess the work done by the Rehabilitation Offices. It also focuses on how the directorate is fulfilling the role that is assigned to it by monitoring the performance of Rehabilitation Offices, customer's satisfaction and the kind of

support it provides to these offices. The perception of the "assignment contracts" is another issue that is explored from the perspective of MoSS directorate as well as the NGOs working in this field (the fourth questionnaire). This last set of questions address the perception of other NGOs working in the field of disability to Rehabilitation Offices in terms of their popularity, efficiency, importance as well as the most important is the system's operating framework. Table 4. 1 reflects the basic data gathered about the stakeholders' sample number, representation, their geographic distribution and gender.

Table 4. 1 Stakeholders' Data

Stakeholder	**Sample number**	**Sample representation**	**Geographic grouping of the sample**	**Gender representation of the sample**
PWDs	50 PWDs	Respondents type of disability: Physical: 48% Deaf and hard of hearing: 38% Visually impaired: 14% Intellectually disabled: 0%	Representation of 17 governorates Greater Cairo: 32% Alexandria: 22% Suez Canal and Delta region: 12% Upper Egypt: 34%	Males: 74% Females: 24%
Social Rehabilitation Offices	26 employees	These employees represented 25 Rehabilitation Office from all over Egypt which is 11.7% of all offices (204 offices)	Representation of 14 governorates Greater Cairo: 35% (9 offices) Alexandria: 15% (4 offices)	Males: 73% Females: 27%

			Suez Canal and Delta region: 23% (6 offices) Upper Egypt: 27% (7 offices)	
Directorate	19 directorate employees	These employees representation covered 12 governorates which is 44.4% of the governorates (27 governorates)	Greater Cairo: 36.8% Alexandria: 36.8% Suez canal and Delta region: 15.8% Upper Egypt: 10.5%	Males: 36.8% Females: 57.8% No answer: 5.3%
NGOs	82 employees/ representatives of NGOs and DPOs	Both NGOs and DPOs were represented. Their field of work varied between charity, capacity building, providing basic services, human rights, research, awareness, education, employment, rehabilitation, early intervention,	Representation of 22 governorates Greater Cairo: 38% Alexandria: 16% Suez Canal and Delta region: 13% Upper Egypt: 33%	Males: 45% Females: 38% No Answer: 25.5%

Qualitative Component

The surveys' open-ended questions were coded and grouped based on the common use of words and meanings. All data will be analyzed using the SPSS program and the results will

be analyzed in a thematic manner. The different themes will be drawn out in a selective manner and would be integrated based on the relations and areas that were mostly discussed/ mentioned or of concern to the stakeholders. As part of this data transformation model in use, the qualitative data in the survey will be coded and interpreted. In addition to the questionnaires extracted data, observations were closely made during the convened workshops regarding the discussions concerning Rehabilitation Offices. The discussions and comments made by the related participants were carefully monitored and noted to add to the data analysis process to add richness and a wider perspective to the issues in hand. Notes and observations were taken by the researcher during the three field visits that took place at the Cairo and Giza offices during the data gathering stage (preparatory phase). A total of six Rehabilitation Offices' employees were interviewed, a manager and a social worker at each of the offices, where the questions that were addressed were semi-structured. The selection of the interviewees was dependent on the availability of these employees' during the researcher's visit. They were asked about the offices' mandates, the services they provide, and the cycle the clients go through for receiving the services, the benefits of the services given out to clients as well as the challenges that they may be facing.

A further analysis was drawn out based on unstructured interviews with three officials, a manager and two senior rehabilitation specialists, at the General Department of Social Rehabilitation for PWDs (MoSS), which is mandated to support and monitor the work of the Rehabilitation Offices. These interviewees were picked based on their seniority and understanding of the system and its multidimensional aspects. The questions addressed to these interviewees include inquiring and investigating some of the responses of the stakeholders' surveys to understand the issues deeper and be able to provide a stronger analysis in presence of all information. The analysis would also include the use of the bylaws governing the work of the Rehabilitation Offices and any other relevant documents that is to be made available by the GDSR. Therefore, the use of this combination of quantitative and qualitative methods will shed light on the important issues and give a full perspective to the current situation and problems of the Rehabilitation Offices.

4.2.3 Study Limitations

The plan was to have the representation of the four kinds of disability (physical, visual, hearing and intellectual), however there was no representation to the intellectually disabled by their guardians when the data was analyzed. This could have been a result of the attendance of

guardians as NGO representatives. It is very much common for the family members especially mothers to have an active role in the field of disability and therefore a lot of the attendees were members of NGOs which responded to the stakeholders' survey as an NGO instead of a guardian of an intellectually disabled. Also the workshops held by the Ministry were on a full day schedule, which might have affected the respondents' quality of answers as they may have been in a hurry to leave due to other commitments that they may have.

Due to the researcher's position at the Ministry of Social Solidarity, the respondents may be negatively affected especially those of the directorates and the Rehabilitation offices. It may be that they would answer more positively than they would really think so, holding back from sharing information that might have added to the richness of the study. They may have been uncomfortable in sharing some of the information so as to avoid any problems or complexities with their superiors/ seniors. However, the researcher has explained to each and every respondent before the study that it is an anonymous as well as confidential one and all his/ her rights is to be protected. Other, possible limitations could also be misunderstandings regarding the framing of questions or unclear terms to the respondent. An avoidable restrictive weakness in the study design could exist as a result of the complexity of the issue being studied and the multiple involvement of stakeholders'.

Chapter Five: Study Findings on Perceptions of Services and Human Resource Issues

Chapters five and six present the findings, discussions and analysis of the study. Since the findings of the questionnaires resulted in a lot of information, the researcher was selective to the recurrent issues and important themes. A comparative analysis had been drawn between respondents of the same questionnaires as well as between different stakeholders. The discussions and analysis in this chapter starts with the stakeholders' evaluation of the Rehabilitation Offices services then would examine the human resource dynamics affecting the service delivery outcome.

5.1 Evaluating Rehabilitation Offices' Services

5.1.1 Stakeholders' Perspectives on the performance of social Rehabilitation Offices

A common question that was addressed to all four stakeholders in the surveys was rating their experience at the office or their perspective regarding the quality of services. Figure 5. 1 shows the different ratings that each of the stakeholders gave to the services according to their experience and individual perspective. The PWDs whom are the direct beneficiaries for the services of the Rehabilitation Offices gave a better rating along the positive spectrum than what the NGOs gave when asked about their perspective regarding the experience of PWDs at Rehabilitation Offices. However, along the negative spectrum PWDs had an 18% (for the weak and poor services) as opposed to the NGOs that had an 11%. Although this shows that there is a lot of variance among the answers given by PWDs, half of the respondents find it either very good/ good.

The Rehabilitation Offices (service providers) and the directorate employees (regulator) gave more positive rating to the services provided by the Rehabilitation Offices. The offices' employees gave a "very good" rating of 46% when asked to evaluate the services they provide to PWDs. The overall rating of the offices was much better by the offices' employees than what the directorate employees gave to the offices under their supervision when asked to rate the efficiency and effectiveness of these offices. Although the directorate employees are the service regulators, who are supposed to supervise and monitor the work of these offices, the director of the rehabilitation unit at the directorate is also the decision maker

in the entitlement process. The director of the Social Rehabilitation directorate is represented on the committee that is to assess the applications and come out with the final decision of whether the applicant is worthy or unworthy of the entitlements. This is problematic in the sense that the Rehabilitation Office combines between two positions which may lead to conflict of interest. In light of this, directorate employees' involvement with the offices' vary according to the number of offices in the geographic location of where the directorate supervises. For those interviewed, 3 of the directorate employees supervise over 3 to 6 offices, 11 supervise from 8 to 11 offices and 5 employees supervise from 12 to 18 offices. Since the majority of directorate employees are delegated authority over 8 to 11 offices, this could be too much work to be done being represented on the entitlement committees as well as having a supervisory role at the same time. Furthermore, the subordinates of the director of MoSS rehabilitation directorate could fear to take any actions of investigation against their own managers in case of any violations.

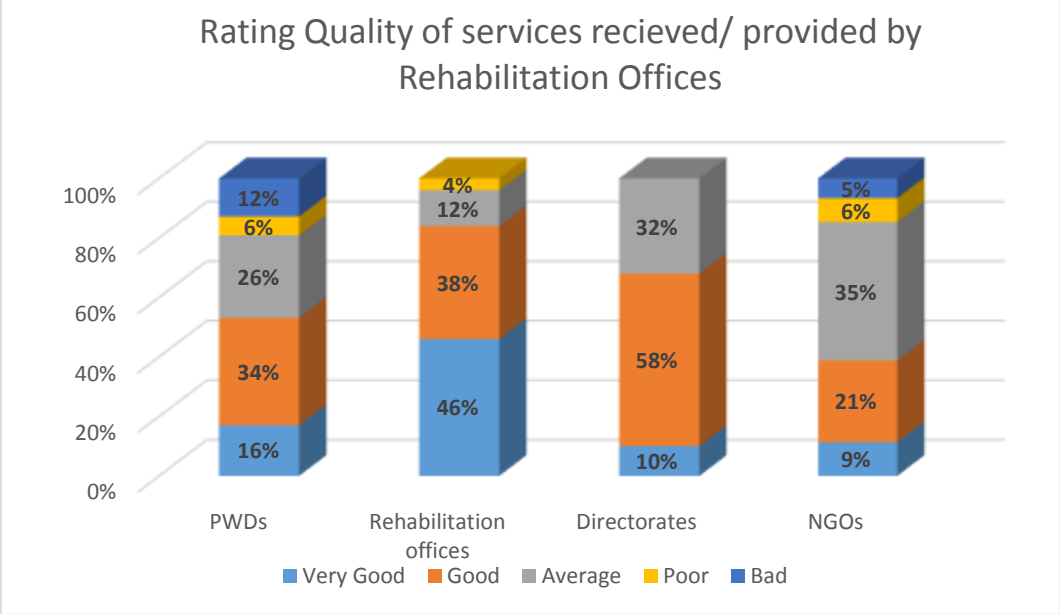

Figure 5. 1 Stakeholders' rating to the Rehabilitation Offices quality of services

5.1.2 Responsiveness to Clients' Needs

It was found that 65% of the Rehabilitation Offices' employees think that the services and benefits provided by the Rehabilitation Offices to PWDs are not enough (Figure 5. 2). This means that more than half of those interviewed believe that there is more that can be done and there is a huge room for improvement that can be achieved. However, there was no expansion from there side on that since the researcher did not address a direct question for that. This will

be reflected upon more in depth in the vocational training and employment section that will be discussed and analyzed later.

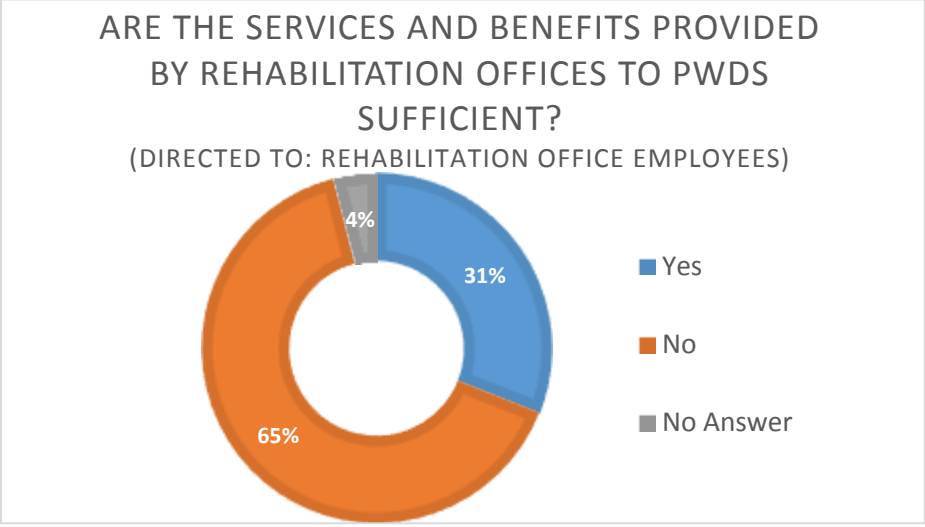

Figure 5. 2 Are the services and benefits provided by Rehabilitation Offices to PWDs sufficient? (Directed to Rehabilitation Offices)

In support of this view, when NGOs were asked about their views regarding the satisfaction of PWDs towards Rehabilitation Offices, 59% believed they were unsatisfied (Figure 5. 3). Looking deeper into the rationale behind these ratings, 11 respondents believed that the services provided does not meet the PWDs needs due to its poor quality and 13 respondents attributed this dissatisfaction to human resource issues. The answers mainly revolved around the employees' poor capacities to provide the services needed, their failure to understand how to deal with PWDs and complicating the procedures PWDs need to receive the services. Whereas 11 respondents believed that it was the complicated procedures that cause this dissatisfaction among the PWDs.

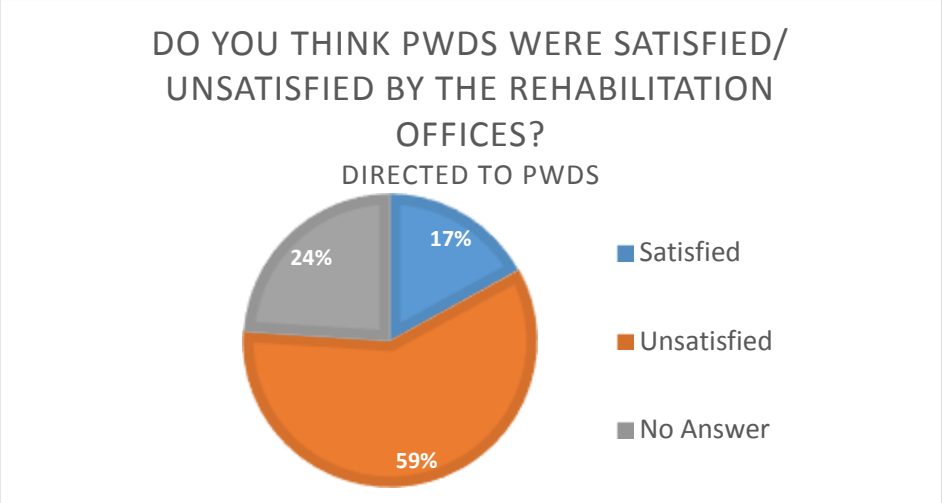

Figure 5. 3 Do you think PWDs were satisfied/ unsatisfied by Rehabilitation Offices? (Directed to PWDs)

5.1.3 Factors of Variation

Some of the addressed issues had been found to have variations in their ratings such as the accessibility and the amenities/ facilities cleanliness, hygiene and quality of appearance as evident in Figure 5. 4. It is those factors in addition to others such as waiting times, process and length of service delivery, affordability, transparency, privacy, trust, quantity and quality of direct service providers that attribute to customer's satisfaction and therefore their perception on the quality and quantity of services provided. This shows that these factors can depend on every office's environment, capabilities, competency and friendliness of its employees. During one of Cairo's workshops, one of the leading NGOs working on the training and employment of PWDs, said that

> *We were dealing with an office at Heliopolis that was really good and very cooperative when we send those requests for disability IDs for our beneficiaries, but the problem appeared when we had to deal with other offices that weren't as cooperative.*

The interviewee explained that some of the new offices that they started dealing with could take from two to three months to issue the IDs, whereas this hadn't been the case with Heliopolis office she was dealing with before. This shows that there is a variation between the performances of offices, each seems to have its own organizational based social contexts, since all offices are governed by the same bylaws.

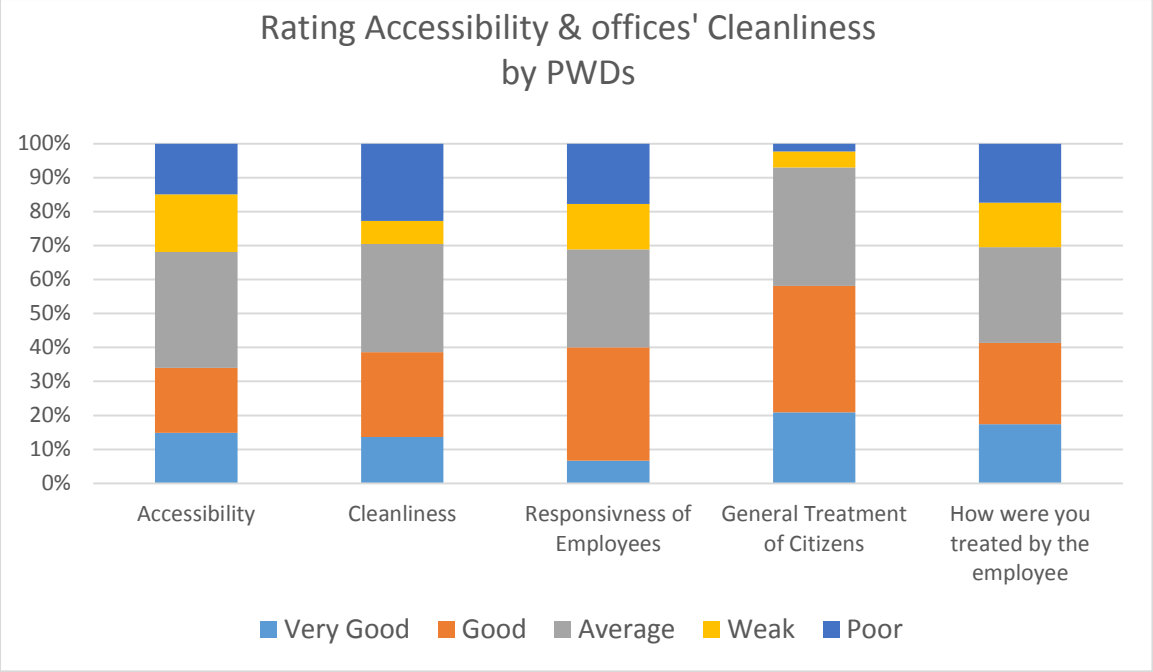

Figure 5. 4 PWDs rating Rehabilitation Offices accessibility & cleanliness

Although a variation had also existed for the treatment of employees to citizens at the Rehabilitation Offices and their responsiveness towards citizens' requests, the treatment of citizens' had been given lower negative ratings than the responsiveness of employees towards citizens' requests/ needs. This very well suits the "socio-technical model of organizational effectiveness" which is built on the idea that the social context are constructed by employees sharing "expectations, perceptions and attitudes that affect the adoption and implementation of evidence-based practices, the nature of the relationships that develop between service provider and consumers, and the overall availability, responsiveness, and continuity of the services (Aarons and Palinkas 2007; Grol and Grimshaw 2003; Nelson and Steele 2007; Nelson et al. 2006)" (Glisson et al., 2007). Therefore, the success of service delivery very much depends on the social constructs and contexts as much as they do on the technical capabilities. They can actually be a stronger force to shaping service providers behaviors and attitudes towards PWDs more than the rules and regulations set to drive the service delivery model. These direct administrators or who were earlier referred to in the literature as "street level bureaucrats" have a relative degree of flexibility and freedom in making decisions that affect the lives of their customers. The perceptions that the employees of Rehabilitation Offices (service providers) hold towards the environment they work in and the challenges they face seem to be contributing to their overall performance. Therefore, this suggests that personal characteristics and acquired organizational approaches affect the quality of service

provided, which also means that this can differ from one service provider (Rehabilitation Offices) to another.

5.1.4 Evaluating Rehabilitation Offices' services for the Employment of PWDs

"Physiotherapy, occupational therapy, adjustment of the work place, shorter periods of retraining and investigation of the working capacity at private or public departments" are all rehabilitation measures that address the needs and capacities of PWDs (Hensing, Timpka, & Alexanderson, 1997). All of these services are ought to be provided by the Rehabilitation Offices however, the quality they are provided with needs examination. When looking at the age groups that were surveyed, most of them were of working age, where 32% of them were between the ages 18 to 30, 46% were 30 to 45 years of age, and 22% were above 45 years of age. This implies that they must have had contact with the Rehabilitation Offices to make use of its services. Given the type of respondents and their age, 92% of them had visited Rehabilitation Offices seeking its services, the highest need appears to be for the rehabilitation certificates followed by Disability IDs as shown in Figure 5. 5. However, it was not expected that the use of Disability IDs would be lower than that of rehabilitation certifications since any PWD is entitled to a Disability ID regardless of his/ her age, gender or kind of disability. Yet, this low use of disability ID could be due to the weak benefits that it grants its holders and therefore there is little motivation for PWDs to apply for. As for the referral services (physical therapy and prosthetics), its services are mostly provided to the physically disabled and therefore it only serves a certain segment of PWDs. Also the vocational training mainly takes place for the non-degree holders and the sample that was surveyed had been mostly degree holders. Since the highest use of services had been for rehabilitation certifications this shows the importance of receiving these certifications for employment opportunities. Therefore, this section will focus on what the office provides to PWDs to achieve that. This will take place through focusing on the kind of vocational training offered to non-degree holders, assisting in finding employment opportunities and following up with the beneficiaries who received rehabilitation certifications whether they were degree or non-degree holders.

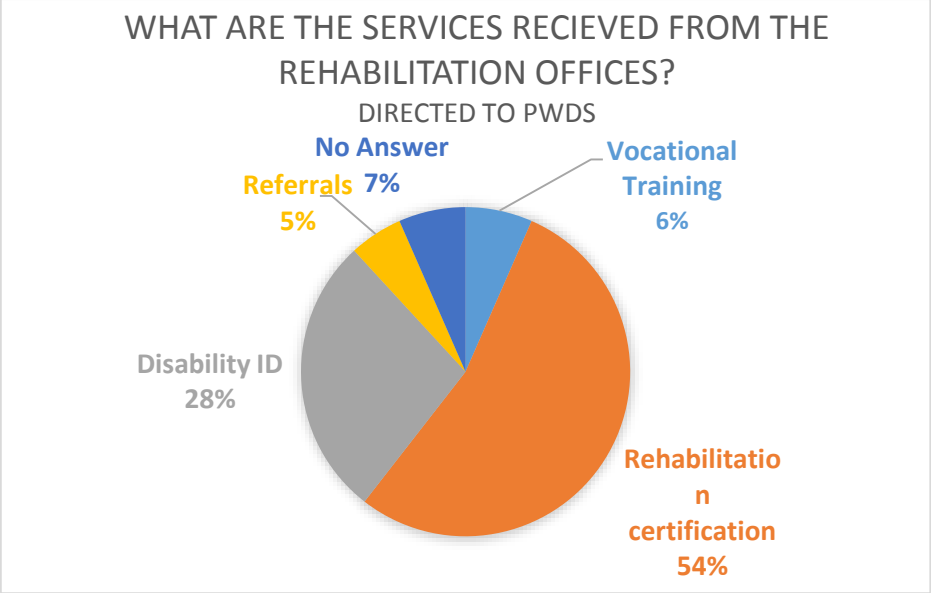

Figure 5. 5 The kinds of services received by PWDs from Rehabilitation Offices

One of the most discussed topics during the workshops was the kind of training that the Rehabilitation Offices offer to its non-degree holders. This was only a problem for non-degree holders since degree holders are granted rehabilitation certifications based on the degree they hold, involving no training. Attempting to understand the situation more, when the Rehabilitation Offices' employees were asked about the existence of a guide that describes the suitable jobs for different kinds of disability, 62% said they existed. However, during my visits to the Rehabilitation Offices no guide was said to be available but it was explained that decisions were made by the vocational specialist in accordance with the skills of the PWD. Furthermore, when Rehabilitation Offices' employees' were asked about the measures taken to determine the kind of jobs that suits the different kinds of disability, none of them mentioned anything regarding the guide as shown in Figure 5. 6. The vocational specialist is ought to discuss the skills and qualifications of the PWD with him/her. This is very much a similar situation to the assessment of work capacities that social workers go through since it takes place with no accurate criteria for assessment but rather depends on the skills, experience and knowledge that the vocational specialist holds. Based on that the PWD either receives the suitable training or if he/she believes they have a certain skill they will be tested on it. A rehabilitation certification is then issued with the kind of training received or according to the vocation the person had been tested on.

Upon further investigation of the situation, the bylaws guiding the Rehabilitation Offices were studied. Clause number 18 (Y) states that the training should take place in

accordance to the occupations listed by Ministerial Decree No. 135 of 1984, taking in considerations other popular professions in the market and private projects (MoSS, 1997). It is apparent by the answers and the visits that took place to those offices, that there is a set of available professions that the vocational specialists are familiar with and had been in use for quite a long time. Through a closer interview with the office managers, they explained that usually there is a set of entities that they may be dealing with to provide the training for PWDs. According to an interview with a vocational specialist from Giza Rehabilitation Office, the training that takes place usually varies between a set of professions such as packaging, carpentry, plumbing and house painting (Giza Rehabilitation office, 2015). This explains and shows the limitations that the Rehabilitation Offices have regarding the kinds of jobs that can be offered to PWDs. There is a dependability on the availability of the employment places, qualified trainers and willingness of private and public sector entities to make this training program available. However, not only is the availability of training services a challenge but the complications of each client's case, the changing labor market and the country's high unemployment rate are all factors that further complicates this process.

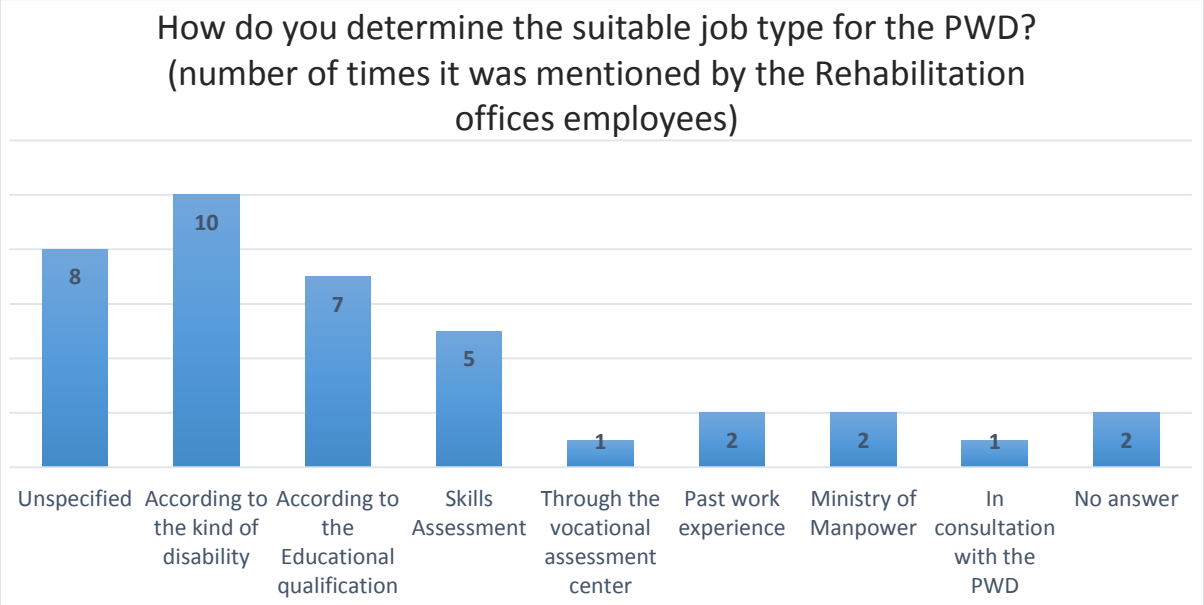

Figure 5. 6 How do Rehabilitation Office employees determine the suitable job type for the PWDs

Although only five of the 41 respondents who were said to have received a rehabilitation certification from the Rehabilitation Office were directed to vocational training, the qualification/ level of education question in the PWDs survey shows that 12 of the respondents were non-degree holders (illiterate, primary & preparatory graduates). 19 of the

respondents were holders of Technical Education Diploma and the rest varied between technical bachelors, bachelors and master degree holders as shown in Figure 5. *7*. This sample is affected by MoSS's selection of the PWD participants as reflected in the methodology.

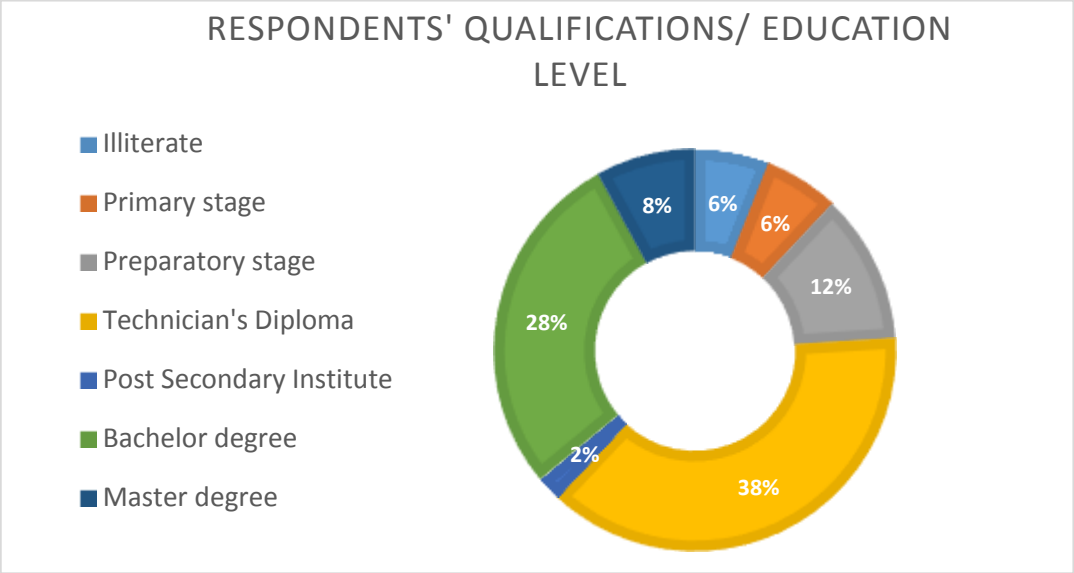

Figure 5. 7 PWDs (respondents) qualification/ education level

However, when asked about the profession that they received training on, professions varied between assistant technicians, technicians and services/ cleaners (11 responders). Furthermore, they were asked to rate the effectiveness of the training they received or received by someone they know. There were 32 responders to that question where the majority of the ratings varied between average and poor (Figure 5. 8). This reflects how the majority of the respondents, whether they received training or not, perceived the quality, appropriateness and usefulness of the training provided by the Rehabilitation Offices to non-degree holders. Meeting the expectations of the beneficiaries and empowering them to reach their full potential and independence should be addressed. Therefore, a lot of effort needs to be exerted on behalf of the Rehabilitation Office employees in order to build connections with the private sector to make available a variety of training available. Different jobs are needed to suit the different kinds of disability, different educational levels, geographic locations and gender of the PWDs. Not only that but when adopting a rights based approach PWDs should be allowed self-determination and an informed choice. PWDs should make their own choices and should be made aware of all the employment options and potential opportunities. An individualized employment plan can also be developed with each after career counseling takes place.

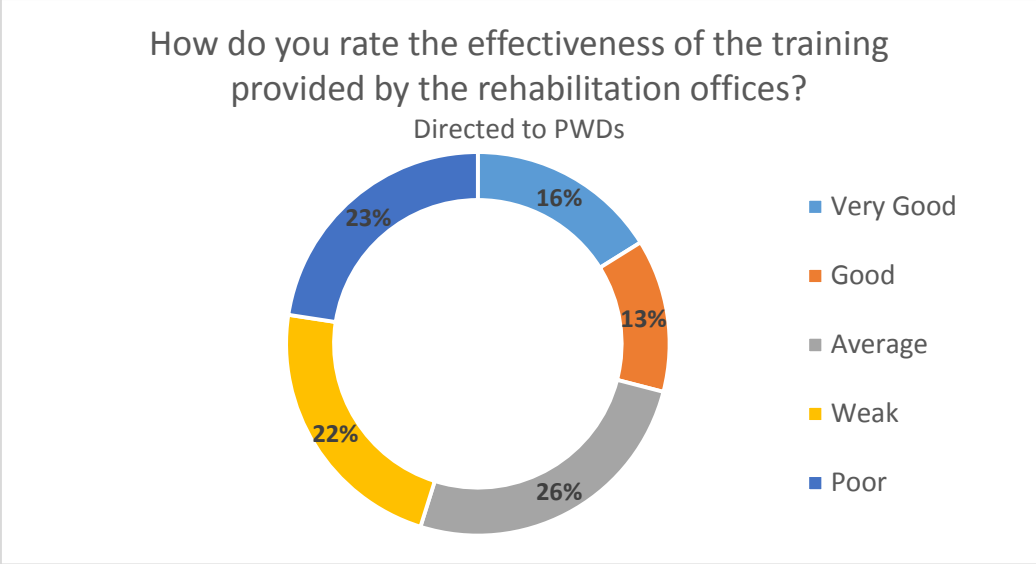

Figure 5. 8 How do you (PWDs) rate the effectiveness of the training provided by the Rehabilitation Offices?

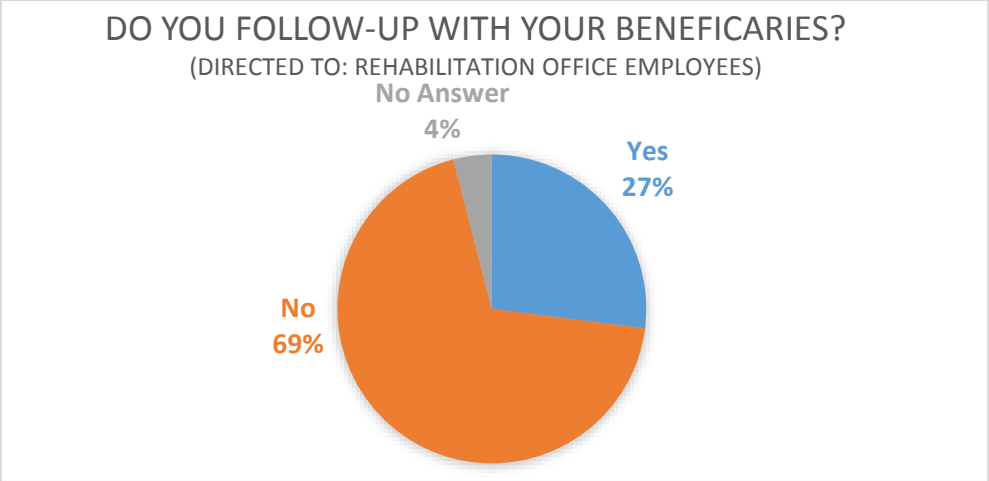

Figure 5. 9 Do you (Rehabilitation Offices' employees) follow-up with your beneficiaries?

The majority of the Rehabilitation Offices employees (69%) acknowledged that they do not follow-up with their beneficiaries as shown in Figure 5. 9 whether they were degree or non-degree holders. According to the offices bylaws, the vocational therapists are to follow up with the work place upon the hiring of PWDs during the first year. This takes place so as to know the suitability of the work environment to the PWDs and provide them with any needed support to enhance their inclusion. Confirming that the effort done by Rehabilitation Offices employees is not enough in the area of rehabilitation certification, vocational training and employment, 43% of the Rehabilitation Offices employees said that the services provided to PWDs doesn't make them dependent but instead reliant on the government. It is only 9% of

the Rehabilitation Offices employees that feel PWDs are empowered by those services, since they think it makes them live independently as shown in Figure 5. 10. More research should be carried out targeting the non-degree holders among the PWDs to know more of the kinds of training they received, their job search and job placement that took place in order to understand the system and its gaps better.

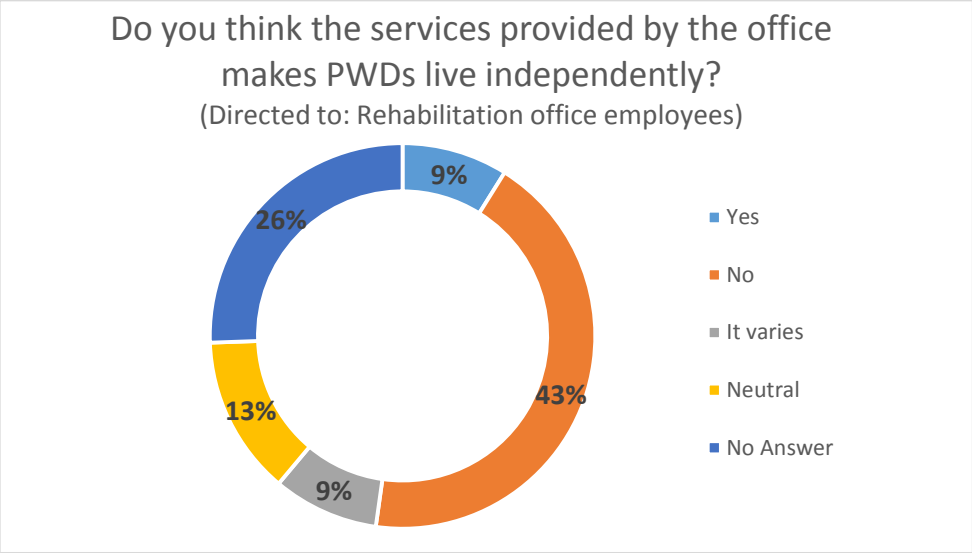

Figure 5. 10 Do you think the services provided by the offices makes PWDs live independently? (Directed to Rehabilitation Offices' employees)

5.2 Issues relating to Human Resources

5.2.1 Disparity in Knowledge

As stated earlier, this thesis attempts to use a rights based approach in evaluating the performance of the Rehabilitation Offices. Questions regarding explaining the procedures, process and benefits of the services provided to PWDs is a cornerstone to the assessment of these services. Of the 26 Rehabilitation Office employees surveyed 92% of them said that they explain the benefits of disability IDs to PWDs receiving the services. However, when the employees themselves were asked in the same survey about the benefits that the disability ID grants its user, the answers were very weak (Figure 5. 11). First of all, there had been variation in listing the benefits of the disability ID for those who mentioned the transportation benefits, some employees mentioned that there is a discount on the metro and public transportation fees and others said that it is totally for free. The same variation existed when mentioning benefits received on plane tickets, where some mentioned a 25% discount while others did not mention

it at all. Although one of the responders mentioned that PWDs would receive a "better treatment at police stations", when the GDSR department was asked about that there was no indicative answer of a composed benefit that the card gives regarding that matter. This weakness that was clear from the answers given in the surveys shows that employees do not have an equal knowledge of the benefits being provided to PWDs through the disability ID cards and therefore, would either be giving its users few information about its benefits or inaccurate ones.

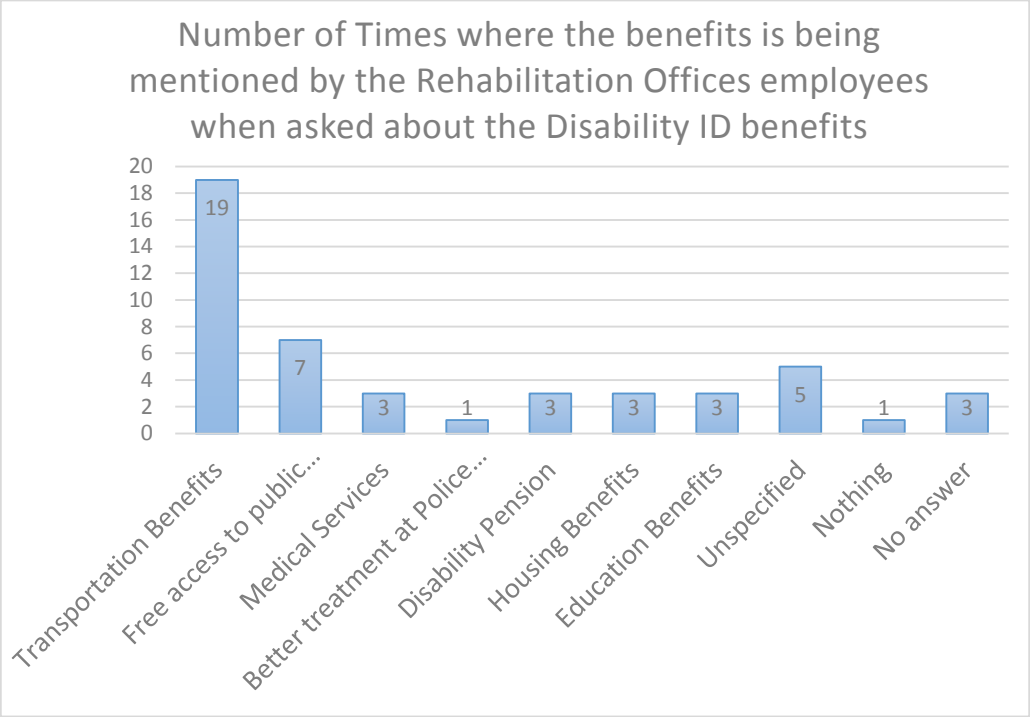

Figure 5. 11 The benefits of Disability ID as mentioned by Rehabilitation Offices

This very much agrees to the dissatisfaction that is shown by PWDs when asked about the information they are given at the Rehabilitation Offices, where 56% of the respondents claimed that no one explained the benefits of the disability ID cards (Figure 5. 12). Also, when the PWDs were asked to list the kinds of benefits that the disability ID gives them access to, the majority of answers were not applicable to the questions asked and the second majority believed that it did not give them access to any benefits as shown in Figure 5. 13. This shows that its either that the PWDs thought that the ID cards gives them access to nothing or they are not aware of its benefits since the Rehabilitation Offices' employees did not inform them about it.

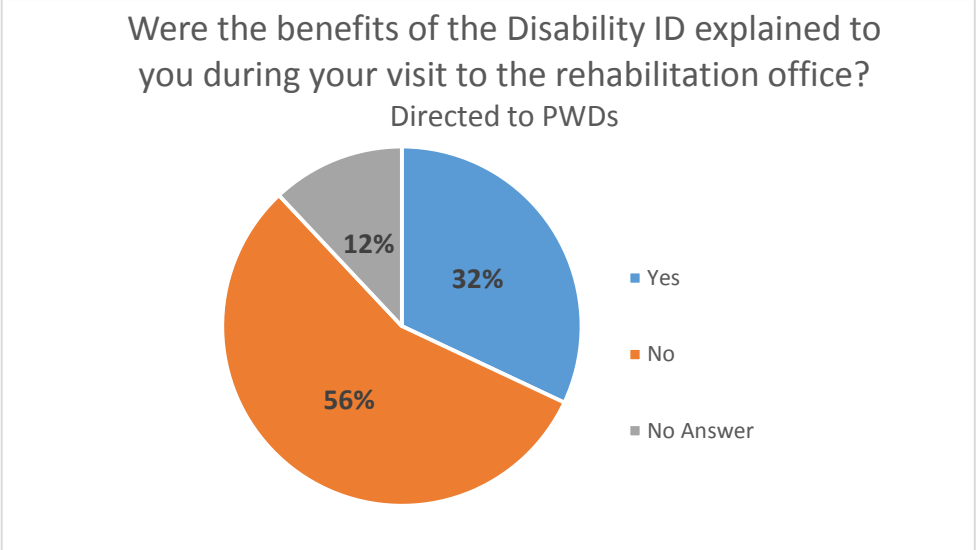

Figure 5. 12 Were the benefits of the Disability ID explained to you (PWDs) during your visit to the Rehabilitation Offices?

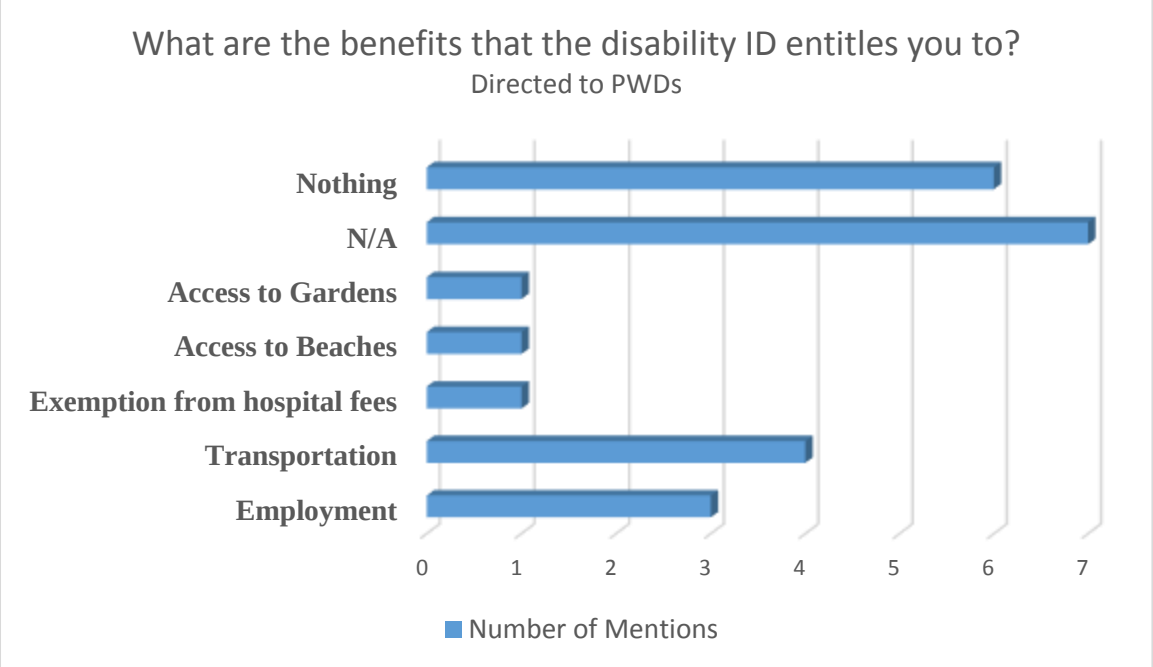

Figure 5. 13 What are the benefits that the Disability ID entitles you (PWDs) to?

The researcher of this thesis visited three Rehabilitation Offices (two in Giza governorate and one in Cairo). None of the offices had any signs on the walls listing neither the services nor the procedures needed to complete the procedures for receiving services. However, this is not an indicative sample to base a judgment on, especially that 92% of the offices' respondents said that the procedures were made available on a poster on sight. In

addition to that 78% of the office respondents claimed that they had a list of the disability ID benefits hanged on the wall. Yet also, this does not really go in accordance of the fact that the Rehabilitation Offices' employees are not fully aware of all benefits provided and its accuracy. Also, when the PWDs were asked about whether the procedures are explained to them in transparency when they go to the office for a service, the majority of the respondents denied as evident in Figure 5. 14. This gives room for making a conclusion, that Rehabilitation Offices' employees were not equally aware neither did they give the same information regarding the procedures and benefits of services to their clients.

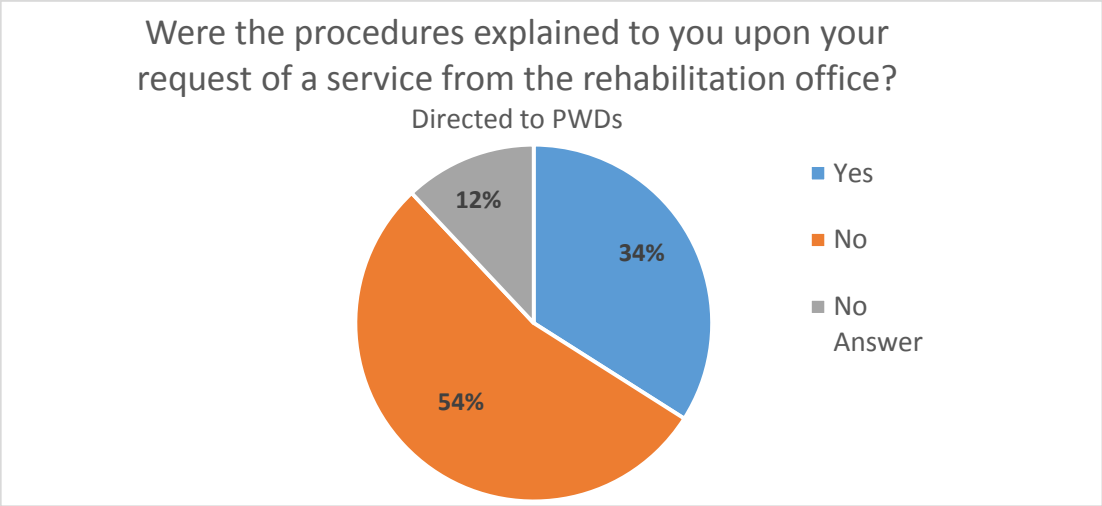

Figure 5. 14 Were the procedures explained to you (PWDs) upon your request of a service from the Rehabilitation Office?

5.2.2 Clarity of roles and responsibilities: Rehabilitation Offices' responsibilities

This section discusses the clarity of roles and responsibilities to rehabilitation offices' employees. Rehabilitation offices' employees, directorate employees and NGOs seem to all have a misunderstanding regarding the mandate of the Rehabilitation Offices' and what its employees' roles and responsibilities are about. When Rehabilitation Offices' employees asked about the additional services that the offices can provide, existing services which are listed in the Rehabilitation Offices' regulations (mandates) had been mentioned ten times in the surveys (Figure 5. 15). The answers varied between referring PWDs to the Ministry of Manpower offices for assisting in employment opportunities, conducting social awareness, guiding/ referring PWDs to other services, provision of prosthetics services, and conducting awareness sessions for PWDs and assisting PWDs in receiving disability pensions. All of these services are ought to be part of the services that is to be provided by the Rehabilitation Offices. In

addition to that, employment and the provision of better training opportunities to PWDs were also mentioned, although stipulated on in clauses 18 and 19 (MoSS, 1997). This means that it is either that the Rehabilitation Offices are not aware of their role or that they are incapable of doing that. In anyway, this reflects that the Rehabilitation Offices are not doing their work as they should.

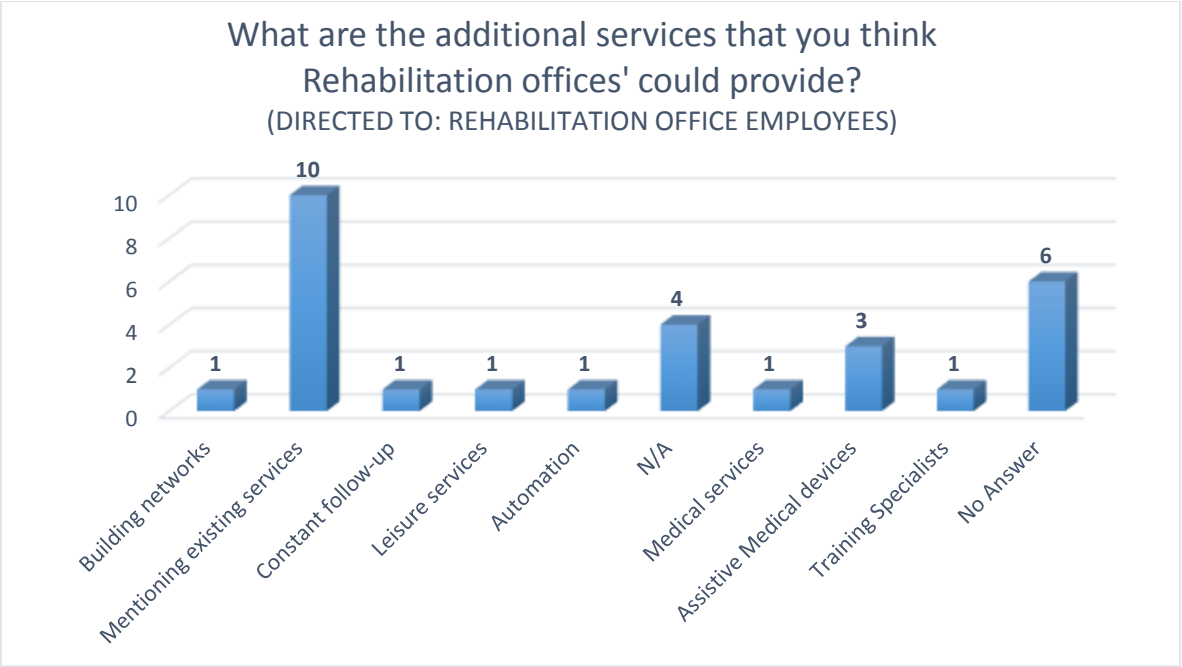

Figure 5. 15 What are the additional services that you (Rehab offices' employees) think Rehabilitation Offices' could provide?

Yet at the same time, when employees were asked about the ways to achieve that, financial subsidies was of the highest mentions as shown in Figure 5. 16. This could imply that the budget constraints had hindered the offices from doing their work and on the long run disregarding their mandate. However, some of the tasks that employees should perform does not require financial allocations such as assisting PWDs in getting disability pensions.

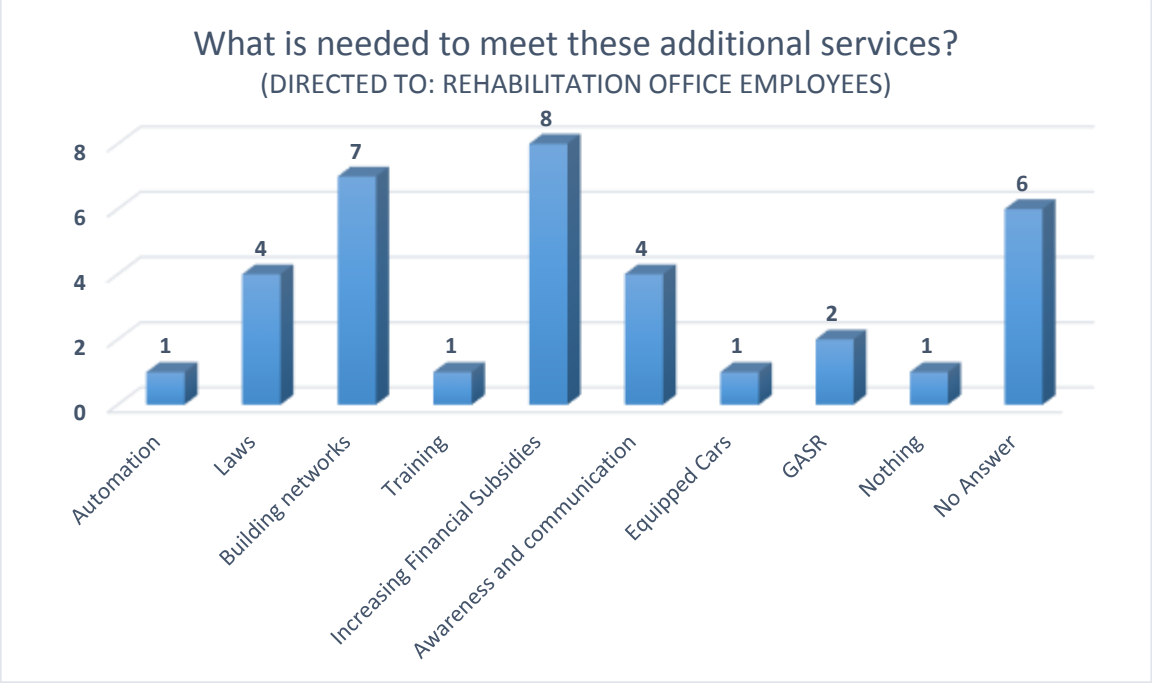

Figure 5. 16 What is needed to meet these additional services? (Directed to Rehabilitation Offices employees)

Not only had the clarity of roles and responsibilities for Rehabilitation Offices' employees been problematic for them but also for the directorates' employees. When the directorate employees' were asked about the additional services that the Rehabilitation Offices can provide, 53% of the answers given were discussing current services that are stipulated on in the Rehabilitation Offices mandate (Figure 5. 17). These services ranged between; holding awareness seminars targeting PWDs, their families and society, contacting Ministry of Manpower employment offices for the recruitment of PWDs, contacting private sector businesses for finding vacant job opportunities for PWDs, providing prosthetics services and determining the suitable training for PWDs according to their kind of disability, which are all part of the Rehabilitation Offices current mandate. However, the fact that the need for the same services were mentioned by the Rehabilitation Offices' employees as well as the directorate employees indicates the need for these services, which therefore needs to be addressed by decision makers.

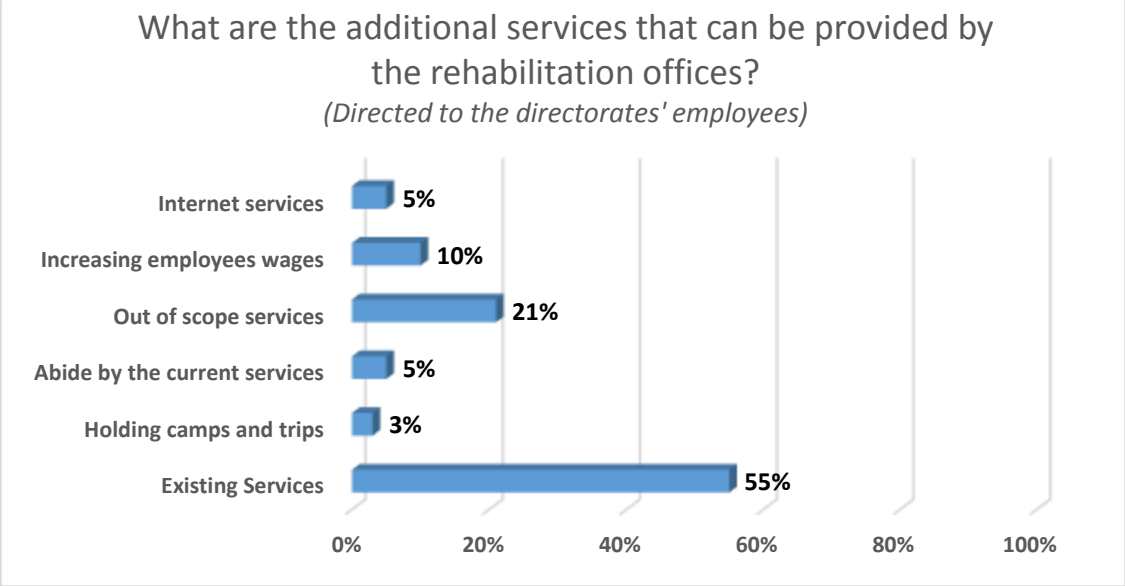

Figure 5. 17 What are the additional services that can be provided by the Rehabilitation Offices? Directed to the directorates' employees

Since the Rehabilitation Offices and the directorates themselves being service providers and regulators suffer from a misperception to the services needed, the same situation would exist for other NGOs working in the field. When the NGOs were asked about the additional services that the Rehabilitation Offices need to provide to PWDs, 21 of the respondents mentioned services that already existed in the mandate of the Rehabilitation Offices (Figure 5. 18). The answers discussed the proper and suitable training to PWDs, ID cards, prosthetics services, awareness and employment. Of the new services that were mentioned was having a guide for the kinds of jobs that suits the different kinds of disability as well as a announcing the services of these Rehabilitation Offices among the people.

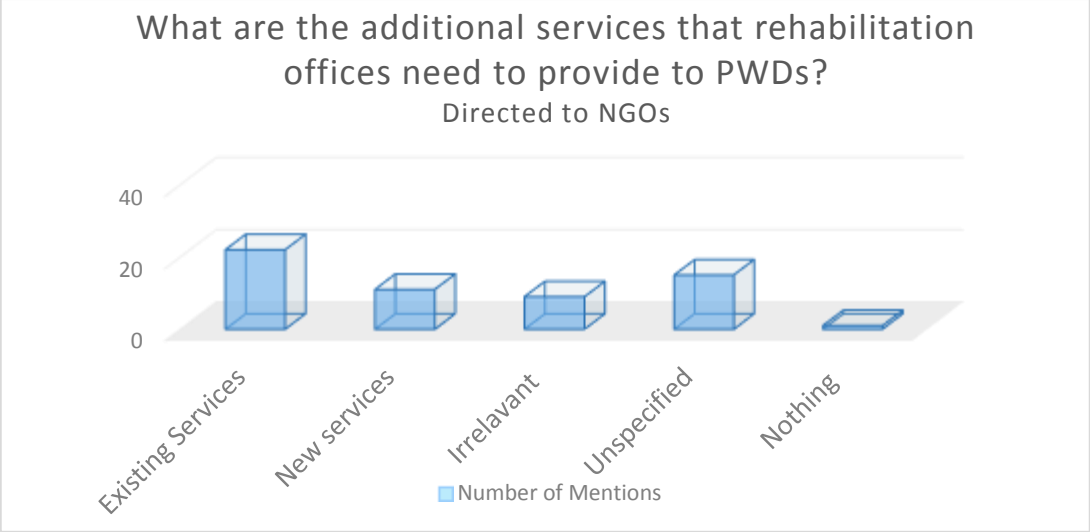

Figure 5. 18 What are the additional services that Rehabilitation Offices need to provide to PWDs? Directed to NGOs

5.2.3 The need to invest in service providers

When the PWDs were asked about the needed improvements or change measures to be taken for providing better services at Rehabilitation Offices, the highest mentions revolved around the human resources as can be seen in Figure 5. 19. PWDs talked about hiring the right employees for the job, training employees on how to deal with PWDs was the highest in mentioning and re-training employees to understand the value of what they do.

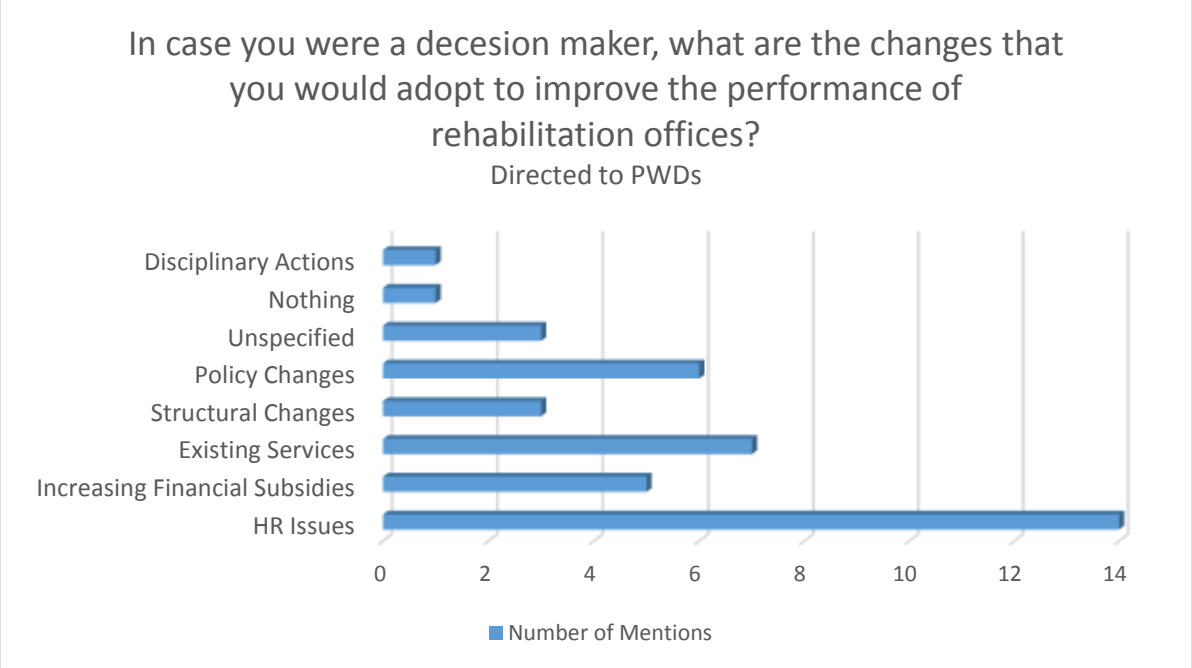

Figure 5. 19 In case you (PWDs) were a decision maker, what are the changes that you would adopt to improve the performance of Rehabilitation Offices?

The same case took place when NGOs were asked about the ways to improve the performance of the Rehabilitation Offices. Human resources were mentioned 24 times in the context of; a need for ongoing training programs, enhancement of their communication skills, building their technical capacities, training them on sign language to be able to deal with deaf and hard of hearing customers and treating PWDs in a decent manner (Figure 5. 20). There were also several very important mentions to training employees on adopting a rights based approach when dealing with PWDs and building their capacities to have equal opportunities and chances as any other citizen to access his/ her rights. According to the CRPD, that Egypt signed, "States Parties shall promote the development of initial and continuing training for professionals and staff working in rehabilitation and rehabilitation services." (Convention on the Rights of Persons with Disabilities, 2006). Since Egypt had also ratified the treaty it is ought to invest in its employees to be able to serve and empower PWDs from a rights based approach.

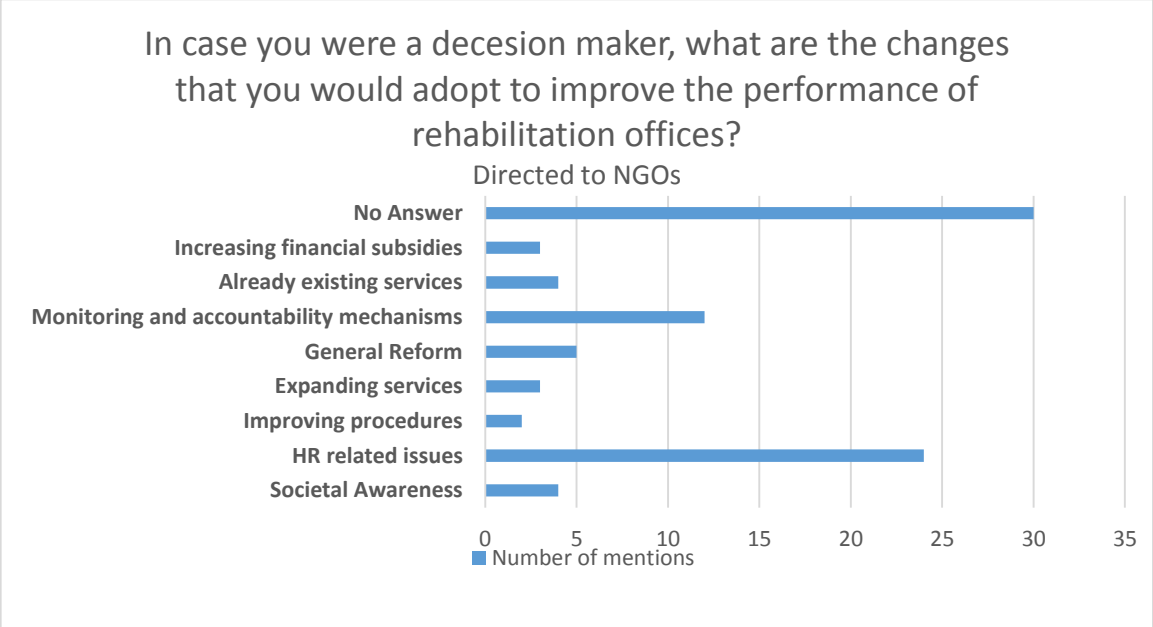

Figure 5. 20 In case you (NGO employee) were a decision maker, what are the changes that you would adopt to improve the performance of Rehabilitation Offices?

In order to better understand the background of Rehabilitation Offices' employees whom were surveyed, they were asked about their level of seniority and the number of years they spent working in Rehabilitation Offices. The majority of the respondents, 69%, are the offices' directors themselves, whereas the number of working years spent in the offices was from 3 to 6 years, which means that they are fairly new as reflected in Figure 5. 21. Although 58% of the office employees' responders said that they receive periodic training from the NGOs they are affiliated to or from the

directorates or even from MoSS, 92% of the respondents did not determine the providers when asked. Only 8% of all respondents said that it is provided by the GDSR. When asked about the training the senior rehabilitation specialist who was interviewed said the following:

> *Training to the offices should take place from the GDSR part as well as from the directorates. We (GDSR) send the training unit at MoSS the needed training modules and ask for the allocation of budget to execute the needed training to Rehabilitation Offices.*

She further explained how recently a training program took place targeting all employees in all offices all over the governorates, yet only 42 of the employees showed up. According to her, this training revolved around updating the Rehabilitation Offices' employees with the latest ministerial decree as well as the Community Based Rehabilitation (CBR) approach. It is part of the GDSR's roles to work on addressing the knowledge gaps that the office employees suffer from, yet we too face challenges regarding that issue. She added that,

> *The low turnout numbers were a result of the shortage in the training budget as well as the lack of motivation from the Rehabilitation Offices to attend due to their location at the distant governorates.*

For Rehabilitation Offices' employees to attend such training programs they need to be given some sort of motivation or at least a per diem that can cover their transportation costs. The GDSR can also tailor an on the job training program that can suit them at their office locations. However, to best decide on that matter the GDSR can approach the Rehabilitation Offices' with surveys to understand more about the reasons behind their low turnout rates as well as their motivation and interests in the kind of training they are interested to receive. Also, when NGOs were asked about opening communication channels between the specialized NGOs in the field and the NGOs holding Rehabilitation Offices for the development/ reform of the offices, 78% welcomed that. Therefore, the training that can be provided to the offices' human resources can take place in collaboration with the specialized NGOs in the field.

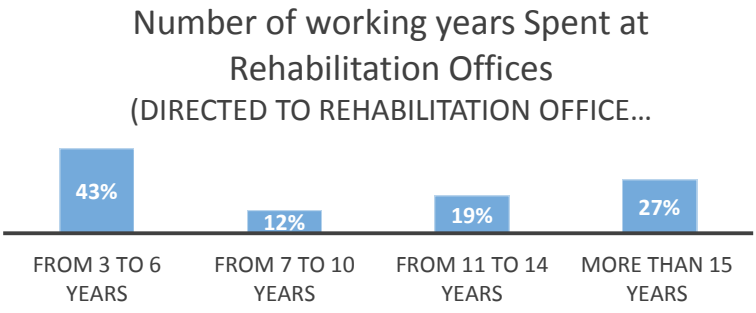

Figure 5. 21 Number of working years rehabilitation employees spent in Rehabilitation Offices

Chapter Six: Study Findings on Structural Issues Affecting Service Delivery

6.1 The involvement of multiple stakeholders

The involvement of several stakeholders in granting clients' benefits had been deeply discussed in the literature review, specifically the involvement of Ministry of Health and Population (MOHP) in the process of entitlements. When the offices were asked about them finding difficulties in defining and specifying the disability, 73% of them answered by a no. Yet, based on an interview with the Minister Assistant for Social Protection and Development, she said that there is a huge problem in determining the disability (MoSS Minister Assistant, 2015). There appears to be no clear and updated guide in use by the physicians assisting in the process of medical examination, leaving this process to the subjectivity of physicians. The Minister Assistant said that this issue is worked on now by a National Task Force committee that aims to tackle the examination process to become more objective and fair. In the same survey directed to the Rehabilitation Offices employees, 39% of the respondents were concerned with the regulations and laws relating to the medical examination. The regulations varied between determining the visually impaired (depending on his/her degree of sight), ministerial decision 138 (MoHP) and other comments regarding the process of the medial examination. These respondents are not aligned with the answer given earlier that no problems arise in determining the kind or degree of disability.

On the other hand, 77% of the Rehabilitation Offices employees issue the certifications based on the recommendations of the medical commission. 23% of those who answered said that the medical examination is only guiding and not binding, since the process involves a social examination as well as a medical examination. This shows how the process for entitlements varies from an employee to another or an office to another in following the recommendations of the medical commission. This has been a common problem discussed in the literature and shows that the involvement of more than one stakeholder can create variations in the perception of roles. This links back to the rubber stamping concept (Lipsky, 1980) since the majority of Rehabilitation Offices employees surveyed adopt a phenomenon of adopting the medical commission judgements due to the work overload, time constraints or poor competency to make the right decisions.

In addition to that, the survey directed to the directorate employees shows that the directorate had coordinated with the medical commission as a result of problems and complaints from citizens (58%). These problems varied between insufficient or unclear medical reports, mistakes in the diagnosis or corruption incidence, complaints by PWDs and the long waiting lists. When the PWDs were asked about the length of times to receive the services, 46% received the service in more than a month (Figure 6. 1). This can lead to dissatisfaction from the PWDs end since it is quite a long time for one to receive a service. Any delays or inconvenience experienced during the process from the medical examiners may be easily blamed on the direct service providers (Rehabilitation Offices). Therefore, working out any issues with MoHP may be very much needed for ensuring the satisfaction of clients to the services provided.

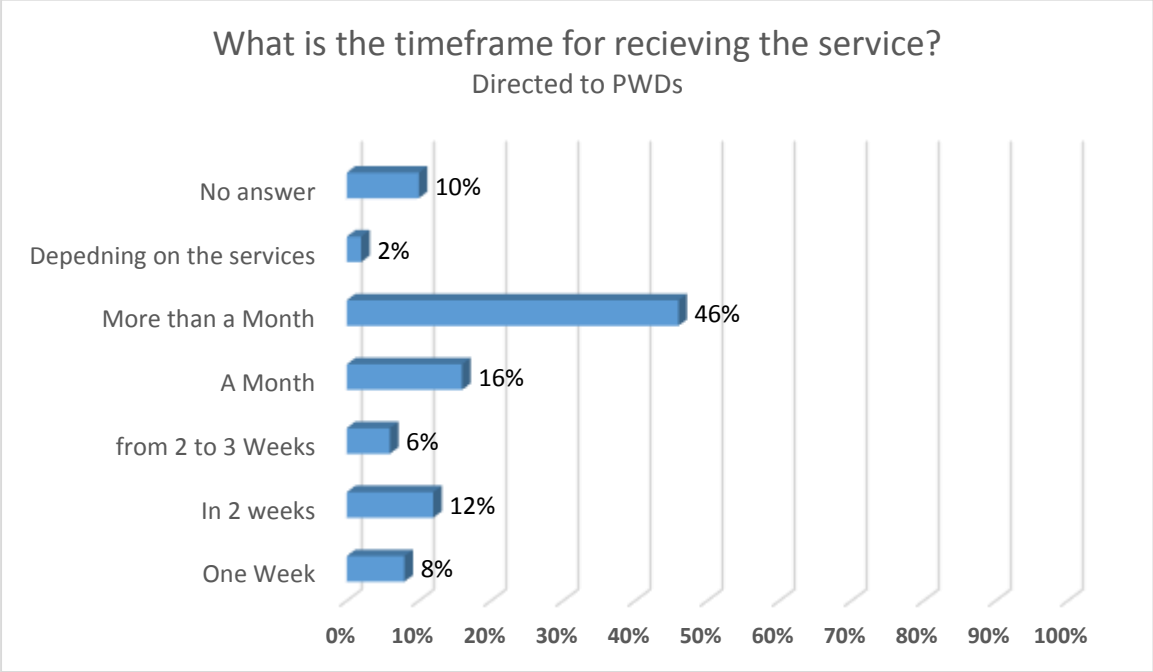

Figure 6. 1What is the timeframe that took PWDs to receive the services?

6.2 Poor financial subsidies

The problem of inadequate funding is a very common one in the Egyptian social service sector. "The lack of effective financing is a major obstacle to sustainable services across all income settings" (World Report on Disability, 2011). The financial subsidies were an issue that was recurrently mentioned especially in the survey forms directed towards the Rehabilitation Offices' employees and the directorate employees (Figure 6. 2 & Figure 6. 3). Financial

resources was mentioned 18 times out of 26 by different Rehabilitation Offices' employees as an additional resource that would enable the delivery of better services. In reference to the point made earlier about finding the suitable training opportunities, motivations must be given to private sector companies in order to open its doors to training PWDs. Until there is a societal awareness regarding the value of the PWDs in the job market, maybe higher financial offerings can be provided to private sector companies to provide the training for PWDs on their premises. This can be a temporary solution or a complementary one until there is more awareness from society regarding the perception of PWDs capabilities and capacities. According to a vocational specialist at Giza office;

> *We give the trainer 20 LE for the training provided to PWDs as well as 2 LE daily to the PWD to cover his/ her transportation costs during the training period.*

The financial allocations set for the training is very low, where the 2 LE would surely not be able to cover for transportation costs especially that the trainees are PWDs who would endure higher cost due to the inaccessibility of the transportation system in Egypt. Also for the compensation that the trainer receives, 20 LE, is a low amount given his/ her capabilities and experience in dealing with PWDs and providing them with training opportunities. Therefore, the low financial allocations can certainly lead to a bad service delivery.

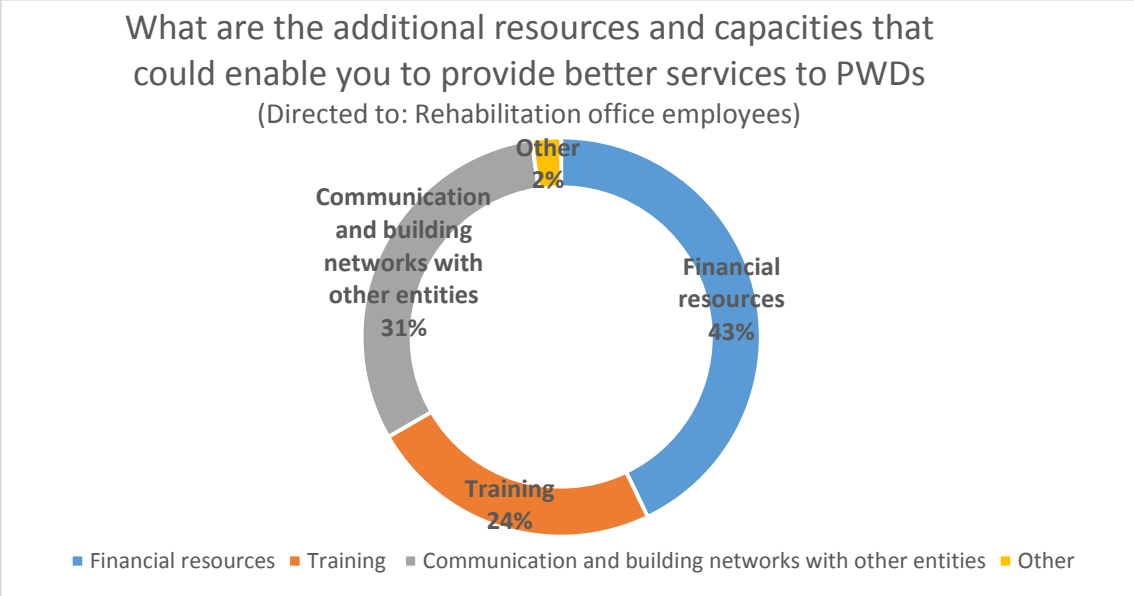

Figure 6. 2 What are the additional resources and capacities that could enable you (Rehab office employees) to provide better services to PWDs?

During a visit to one of the offices in Cairo (El Sabaq, Heliopolis) the office director said that

> *Today is our last working day, we will shut down tomorrow since we have no money tomorrow to pay for the workers' wages.*

Upon further questioning of the interviewee she explained that this was a result of the new civil service law that has being adopted, ending the intergovernmental secondment (Rehabilitation office manager, 2015). This means that the Rehabilitation Office was to recruit employees and specialists which it cannot afford to pay for their wages. Although a couple of weeks after this interview took place the new parliament of 2016 initially rejected the law, understanding this issue is very important to understanding the loop holes in the system (Al Ahram Weekly, 2016). The interviewee added that,

> *This office only receives a yearly subsidy of 4,000 LE to cover for rent, wages, bills, supplies and all other expenditures. We were supposed to receive a yearly subsidy of 30,000 LE yet we received nothing until now.*

Upon that, a senior rehabilitation specialist at GDSR was interviewed where she explained that all the old established offices had been receiving very weak subsidies however the Ministry decided that for the financial year 2015/ 2016 all subsidies will be raised to 30,000 LE a year for those offices. The current subsidies for assigned projects now range from 30,000 LE to 100,000 LE depending on the year that these offices were issues. Even though this is a very important step for a better service provision at these Rehabilitation Offices; ensuring its implementation needs to take place as soon as possible, due to its important need. Another problem that was spotted during the interviews with the GDSR management was that the subsidy system is a fixed one that is not subjected to performance, offices' needs or inflation rates. This explains why some offices had been receiving 4,000 LE since the 1950s. This creates a weak checks and balances system, as it disregards the needs of the offices nor equips them with the tools they need to better perform.

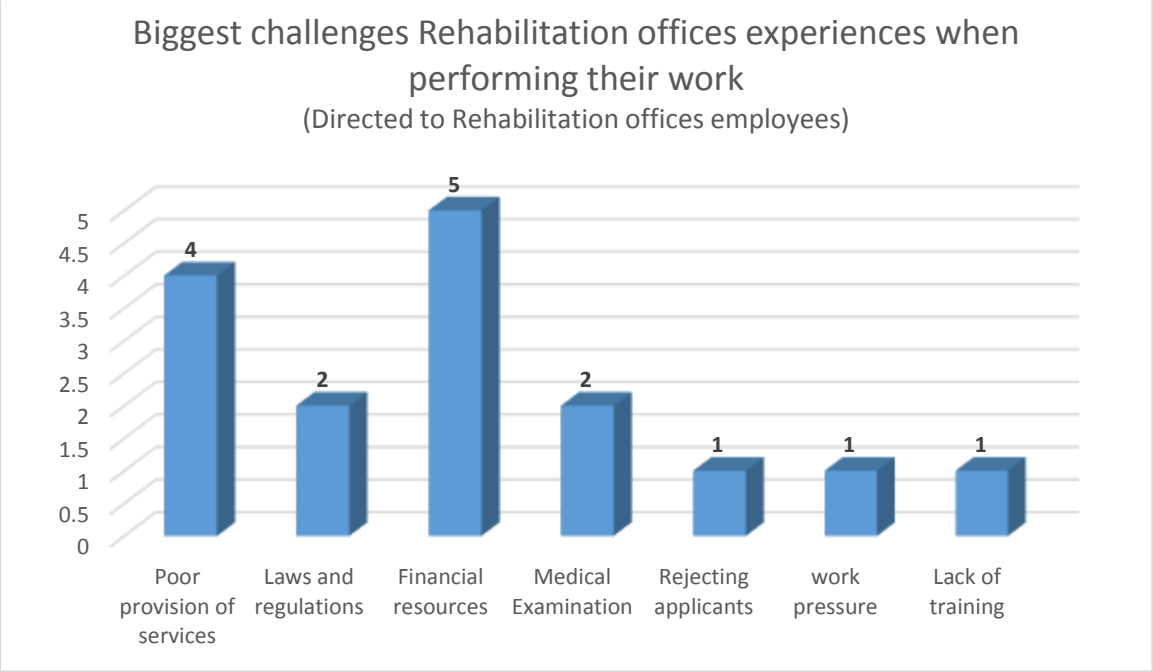

Figure 6. 3 Biggest Challenges you (Rehabilitation Offices employees) face during your work?

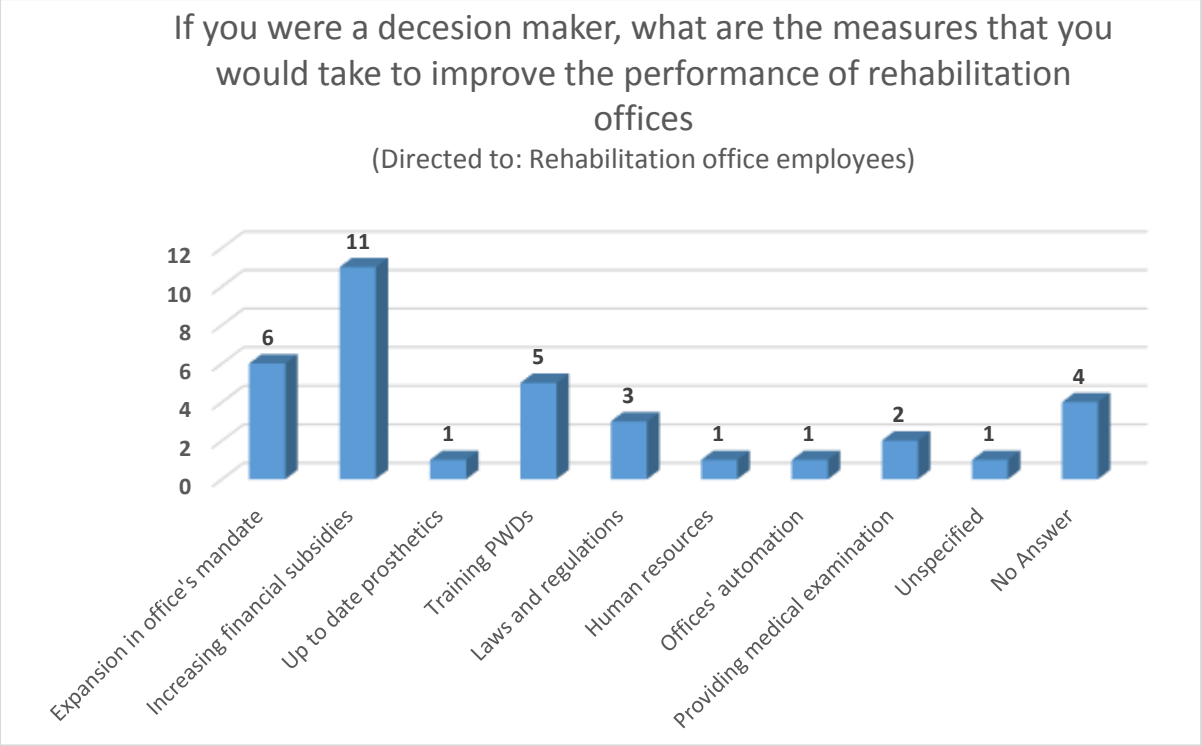

Figure 6. 4 If you were a decision maker, what are the measures that you (Rehabilitation Office employees) would take to improve the performance of Rehabilitation Offices?

According to the Rehabilitation Offices' employees, financial subsidies were determined to be the measure that needs to be taken in order to improve the performance of the Rehabilitation Offices (mentioned 11 times by different respondents as shown in Figure 6. 4). This was very

much confirmed on by the directorates, who is the responsible entity to collaborate with the offices regarding the needed subsidies and their financial plans. The rehabilitation directorate is mandated to gather the financial needs of the assigned projects and send them to the Ministry of Finance requesting the financial allocations. Also when asked about the kind of support that the directorate can offer to Rehabilitation Offices, the majority of 45% said that this can be made through financial support and 29% expressed the need for technical support such as the provision of training courses and information regarding the latest ministerial decisions that concerns their works as evident in Figure 6. 5.

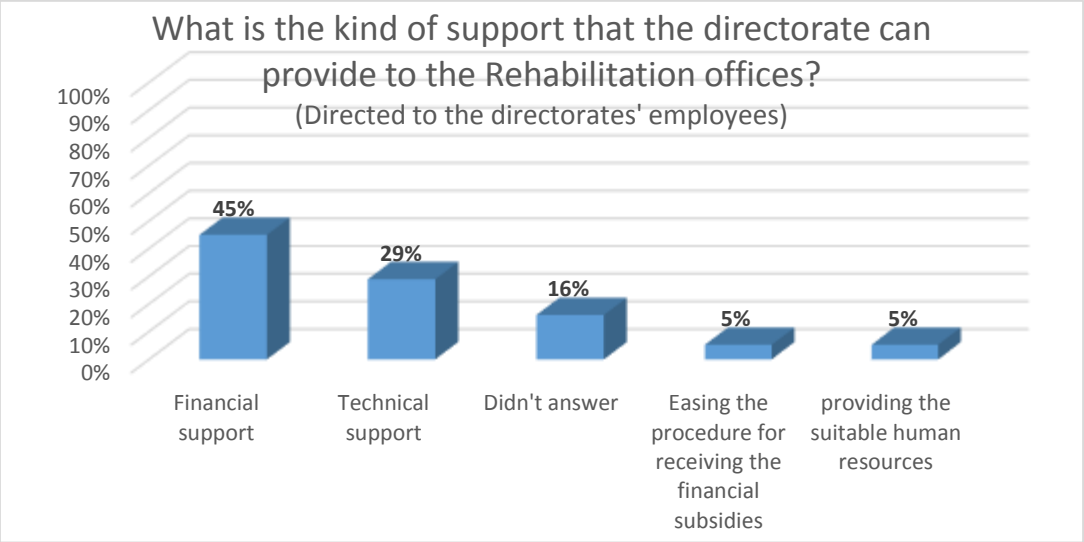

Figure 6. 5 What is the kind of support that the directorate can provide to the Rehabilitation Offices? Directed to directorates' employees

The question addressing the biggest challenge that face the performance of Rehabilitation Offices further adds to the understanding of the directorate's perspective towards Rehabilitation Offices (Figure 6. 6). Financial support was again the major obstacle that is believed to affect the performance of Rehabilitation Offices, which is then followed by human resources problems that vary between weak salaries and the employees' weak technical capabilities. This means that the directorate employees also acknowledge the need for additional financial resources but as was explained by a senior rehabilitation specialist at GDSR, the final decision in determining the allocations is up to the Ministry of Finance. However, upon an interview with the Minister Assistant for social protection and development, she explained that:

> *MoSS acknowledges the weak financial subsidies that the Rehabilitation Offices receives, but in order to increase these allocations there needs to be a well-studied plan put by these offices as well as a set of Key Performance Indicators (KPIs) in which this money*

can be granted based upon. And that is what the Ministry is working on this period. (MoSS Minister Assistant, 2015)

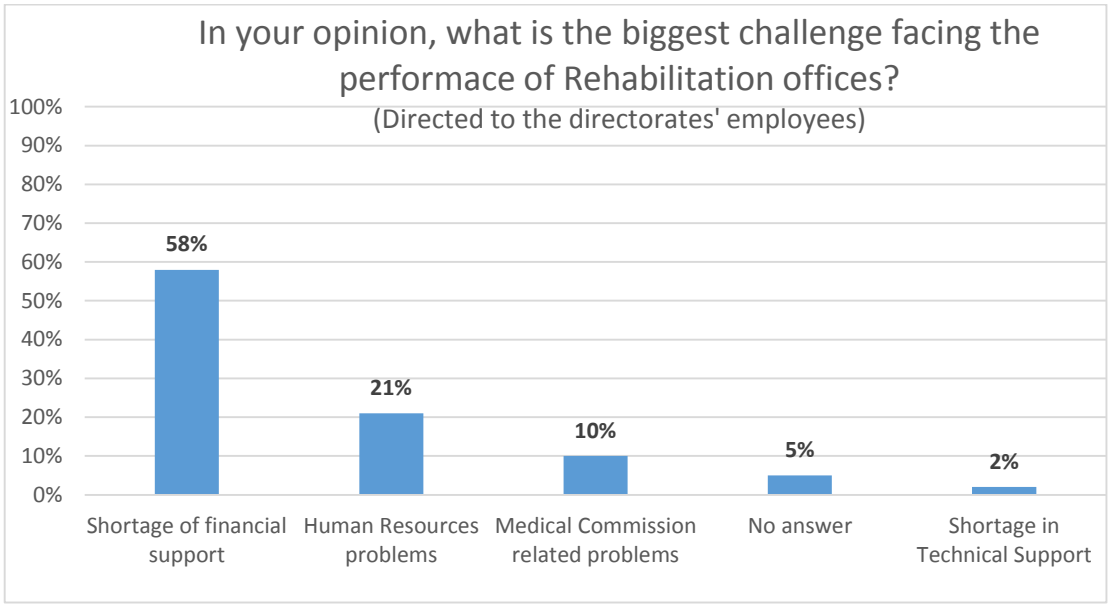

Figure 6. 6 What is the biggest Challenge facing the performance of Rehabilitation offices? Directed to directorates' employees

Raising the financial subsidies based on criteria of KPIs would be a good investment in the sector of social services. The provision of good services to the disabled would improve the social and economic participation of people as well as their caregivers, which would contribute to poverty reduction. This will as well result in a lower dependency on medical and welfare services and will cause an increase in the labor market participation as a result of improved functioning and independence.

6.3 Weak Monitoring system

The directorates are supposed to be the GDSR's arm at each governorate. Their role should not solely rely on looking for the wrongdoings and violations of the offices, but it should also be one that works on enhancing offices' performance. When asked about investigating the citizens' satisfaction regarding the services provided by the offices, 53% said yes while 47% expressed their dissatisfaction. To allow for making an analysis in light of this very close percentage, the senior rehabilitation specialist at the GDSR explained that there is no current system at the directorates that test for customer satisfaction. This was very much confirmed when the directorate employees were asked about the methodology to do so, 60% did not answer, 21% said that they undertake this investigation through assessing complaints and 21%

said that they do that by directly talking to customers or conducting meetings with them. There has been no specification of the methodology used in asking customers and whether these customers are the ones that visit the directorates or whether this takes place during the employees' visits to the Rehabilitation Offices. Therefore, this confirms the senior rehabilitation specialists' response, that there is no clear system for testing customers' satisfaction. Also, 53% of the directorate employees said that there are no complaint boxes as opposed to 47% who says there is. The monitoring of the complaints were said to take place as follows; 47% follow up with the Rehabilitation Offices that the complaints came from, 37% investigate the complaints at the directorates and 10.5% said that the complaints are sent to the GDSR to be investigated (Figure 6. 7).

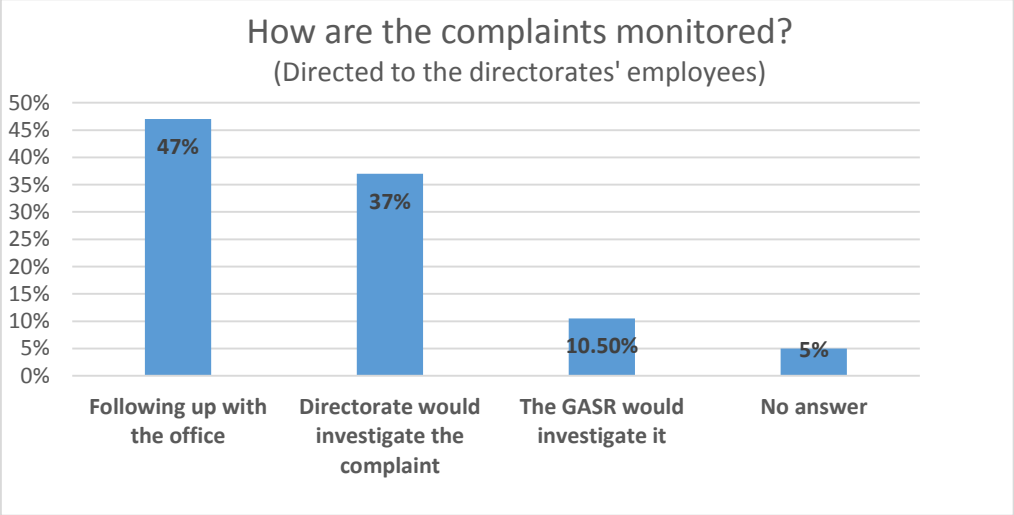

Figure 6. 7 How are the complaints monitored? Directed to the directorates' employees

Through a deeper investigation of the Rehabilitation Offices' monitoring and evaluation systems, when asked about how they evaluate their performance; 25 % said that they do it through follow-ups, 27 % through visits that included the investigation of the services provided and writing of reports, 15% through the services provided (not specified) as shows in Figure 6. 8. The follow up and visits are part of the directorates' routinely tasks, these would include periodic evaluations as well as investigating complaints. In the researcher's effort to know more about the directorate's mandate, another Senior Rehabilitation Specialist at GDSR was interviewed. He explained that the directorate employees are to inspect the number of PWDs served, number of committees that were convened, collaborate with the offices' in solving their problems and is supposed to conduct training for the office's employees (Senior Rehabilitation Specialist at GDSR, 2015). One very interesting reply that was repeated nearly five times by employees in their answers was the use of statistics. The answers included the

number of PWDs served as stated by the office, the number of prosthetic devices being given out and also the statistics given out by the Ministry of Manpower that shows the number of PWDs in the job market. This shows how services are very much quantified in their evaluation and less focus is given to the quality of services in terms of the treatment of employees to PWDs for example.

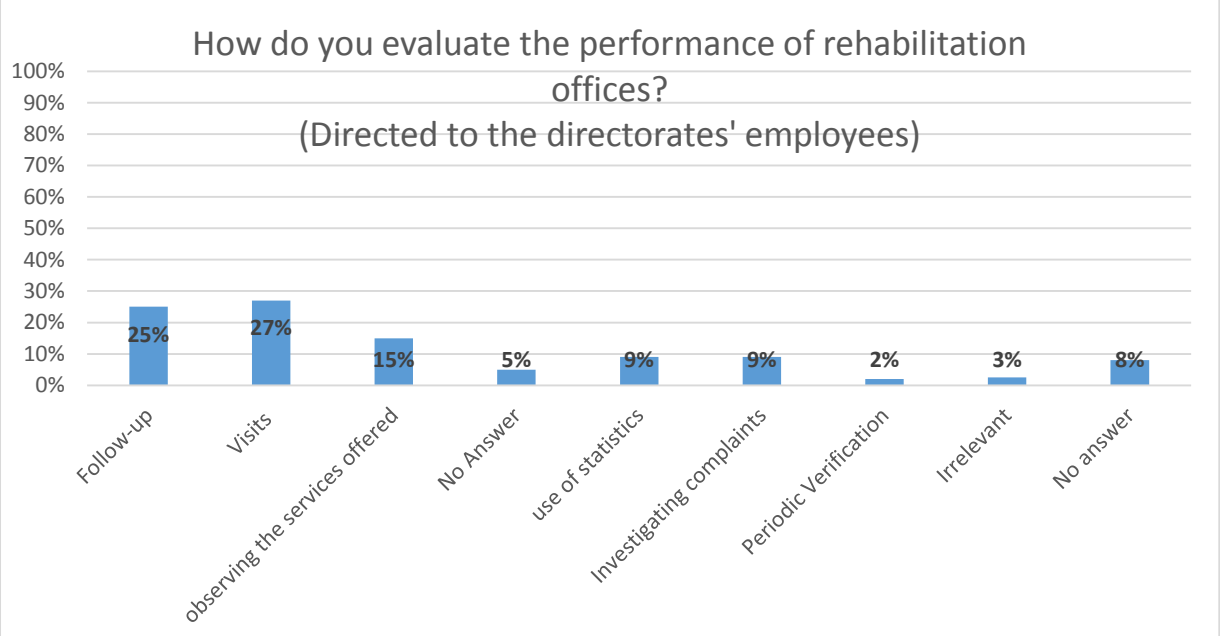

Figure 6. 8 How do you (directorates' employees) evaluate the performance of Rehabilitation Offices?

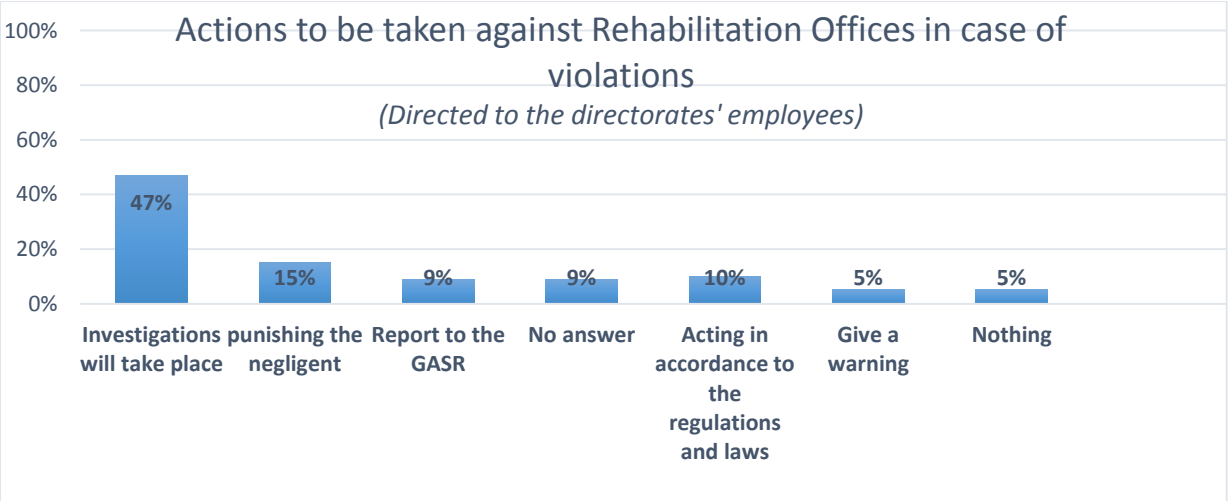

Figure 6. 9 Actions taken against Rehabilitation Offices in case of violations (directed to the directorates' employees)

Out of few actions that were listed to be taken against Rehabilitation Offices as evident in case of their violations; 47% did not specify any action to be taken, 11% did not answer and 5% said that they will do nothing as shown in Figure 6. 9 directed to directorates' employees. This reveals that the majority of the directorate employees are to take no concrete action or clear measures against the Rehabilitation Offices in cases of violations. There has been a set of questions directed to the directorate employees in order to understand more regarding the role of the directorate in the service delivery and performance of Rehabilitation Offices. Although 74% of the employees said that they support the Social Rehabilitation Offices to perform better, 53% didn't give any answer when asked how. In light of this same topic, 12 of 46 PWDs filed complaints at Rehabilitation Offices and 14 of 40 PWDs filed complaints against Rehabilitation Offices. When asked about the way these complaints were handled only 14 people responded, where 71% of them claimed that nothing happened and no actions had been taken (Figure 6. 10).

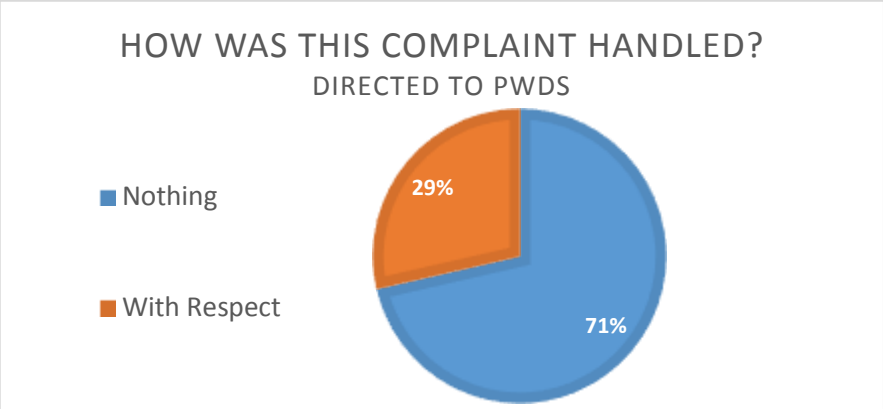

Figure 6. 10 How was this complaint handled? Directed to PWDs

Attempting to know the kind of support or collaboration that could be taking place between the directorates and Rehabilitation Offices, 58% said that they provide support to the offices by connecting them with companies and bodies that can provide the suitable training for PWDs. The difference between both responses is again a close one that shows that it is not an installed regulation but one that may depend on what each directorate provides its offices with. A further analysis can take place in later studies to know if the kind of support provided to Rehabilitation Offices (besides the financial support) was subjective to personal characteristics.

Lastly when NGOs were asked about the reasons behind the weak performance of Rehabilitation Offices, the weak role of the government as a regulator was of the highest frequency as shown in Figure 6. 11. Although MoSS isn't the direct body delivering services

to citizens, it is the regulator of these services. MoSS is supposed to follow up through its GDSR, its General Administration for NGOs (regarding any financial violations) and its Social Solidarity directorates to ensure that Rehabilitation Offices are abiding by the regulations and are maintaining the quality of services provided.

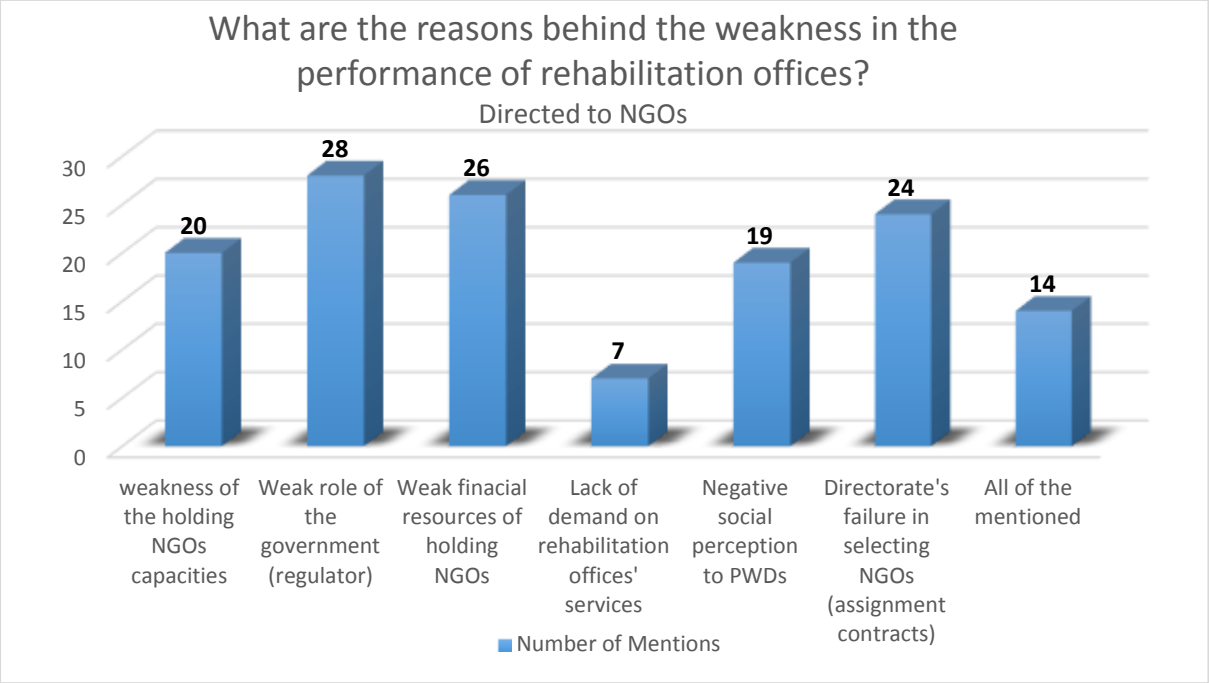

Figure 6. 11 What are the reasons behind the weakness in the performance of Rehabilitation Offices? Directed to NGOs

6.4 Reviewing assignment contracts and providing equal opportunities

During the observations made while attending MoSS's workshops, a lot of the NGOs attending were unaware of the relationship governing the Ministry and NGOs holding/ running Rehabilitation Offices. It was a surprise to many who got to know that the Ministry itself does not implement itself direct projects, but instead does it through an NGO. In the survey, there was a question directed to NGOs regarding their knowledge of the governing relations between the NGOs and MoSS where half of the respondents said that they are not familiar with it. When asked about the system of assigning projects by contract to NGOs for running long term services (contracting out to NGOs) in return of financial subsidization, the majority of responses were negative (Figure 6. 12).

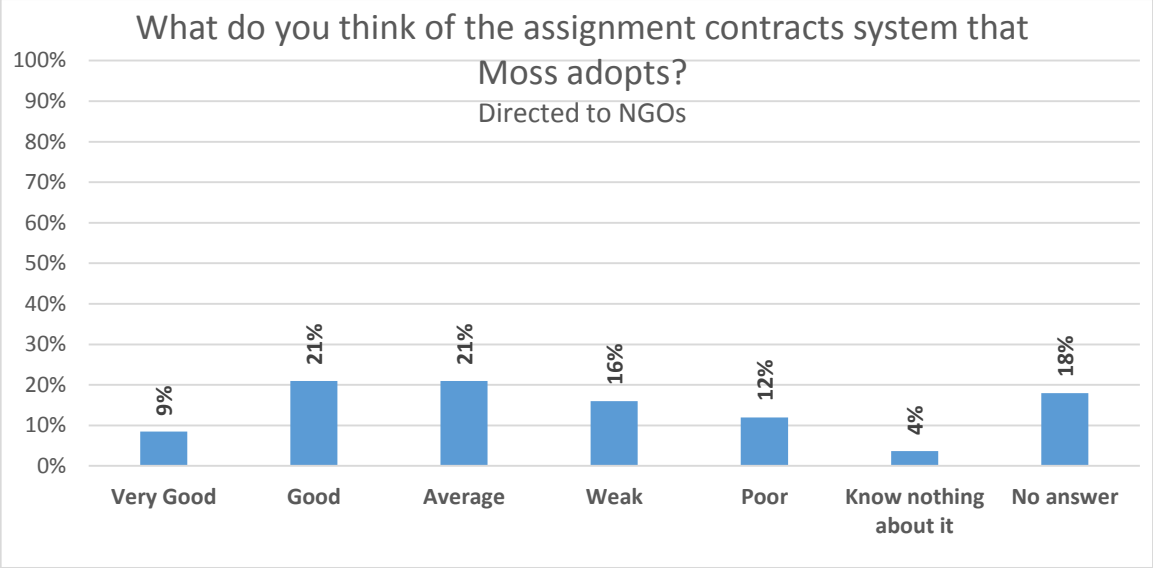

Figure 6. 12 What do you think of the assignment contracts system that MoSS adopts? Directed to NGOs

However, there is a misunderstanding regarding the government's role in protecting and empowering PWDs; where a lot of NGOs believe that the Ministry should be the direct entity executing the projects/ programs and delivering services. This could be as a result of the disappointment of these NGOs in the services provided by the assigned NGOs and therefore, they believe that if the government directly delivers services it could be of a better quality. Yet, 57% of the respondents emphasized over the government's role as a policy maker, rule setting and regulator to the whole process according to the results in Figure 6. 13.

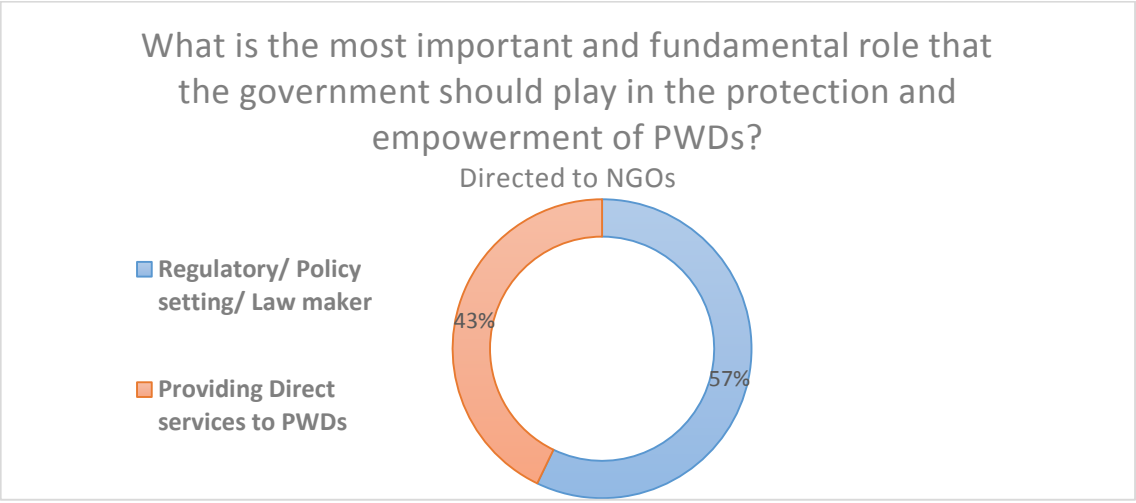

Figure 6. 13 What is the most important and fundamental role that the government should play in the protection and empowerment of PWDs? Directed to NGOs

75% of the respondents expressed their willingness to apply for an assignment contract in case the government is open for that. However, when talking to the GDSR director, she explained that this application process is always open for any NGO that has a status of public benefit from the directorate. It was also clear during the workshops that NGOs were not aware of their rights to apply for an assignment contract. The GDSR and the directorates are ought to raise the NGOs awareness regarding their right to apply for assignment projects. The majority of directorate employees (74%) believe that the assignment contracts which are given to current NGOs (running Rehabilitation Offices) should be re-evaluated and reviewed. This is very much needed as it would raise the sense of competition among NGOs which will enhance the quality of services provided to PWDs. However, this does not only mean a revision to the current NGOs on the assignment contracts but also to the content of the contracts itself. Some of the rules governing some of the contracts are as old as the 1960s and didn't witness any changes since then. With a new approach to assignment contracts, new clauses needs to be drafted to suit the current context.

The application process mechanism guiding assignment projects was addressed in the surveys and the following suggestions were made by NGOs; opening competition between NGOs in a public advertisement, clear conditions, choosing NGOs based on the directorates' recommendations, forming a consultative committee of civil society (made up of civil society) and reforming its assigned role as proportionately listed in Figure 6. 14.

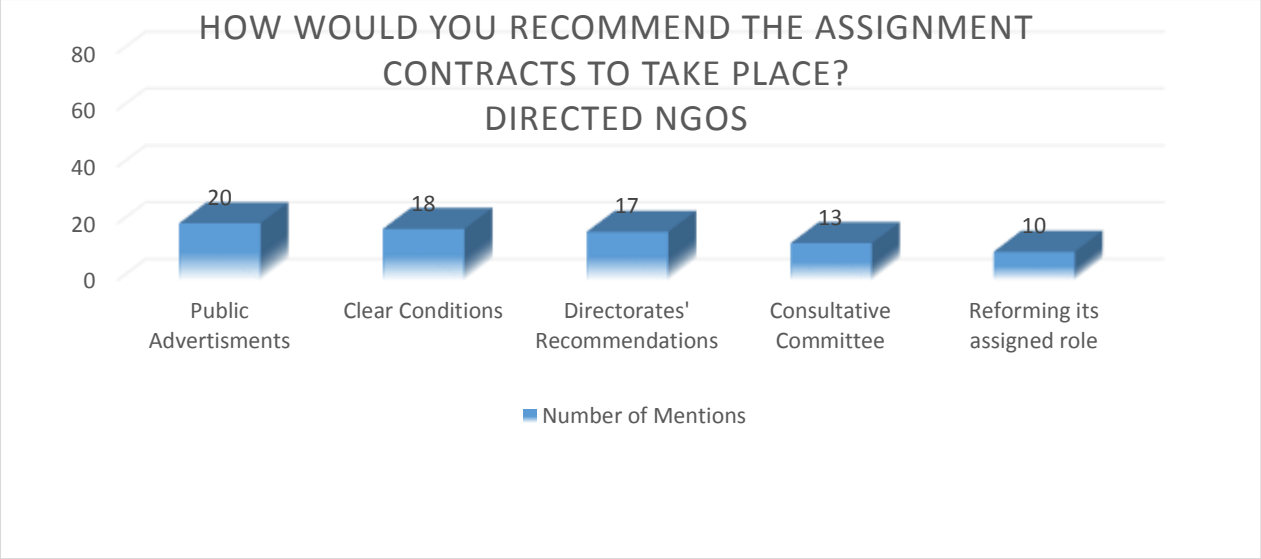

Figure 6. 14 How would you recommend the assignment contracts to take place? Directed to NGOs

However, the NGOs expressed that they would need support from the government to do so. Most of the mentioned issues had been raised by current Rehabilitation Offices as needs to be provided by MoSS as a mean of support as shown in Figure 6. 15. Therefore, this shows that MoSS should not be only providing financial assistance to NGOs on assigned contracts but also technical support is very much necessary for these NGOs. In case the GDSR does not have the sufficient capacities to do so, building connections with specialized NGOs in order to build capacities of the NGOs on assigned contract would be a good alternative. Opening the door to specialized and successful NGOs to apply for assigned contracts in a public manner together with raising the financial subsidies (to be appealing) would very much raise the sense of competition between NGOs to perform better. "The more limited the competition, the less incentive an industry or economy has to meet different market segment needs" (Johnson, Herrmann, & Gustafsson, 2002). Moving away from the poor competition that exists in the private sector, PWDs should be given better options so as not to feel trapped into accepting the poor services provided by NGOs that existed from as long ago as the 1950s.

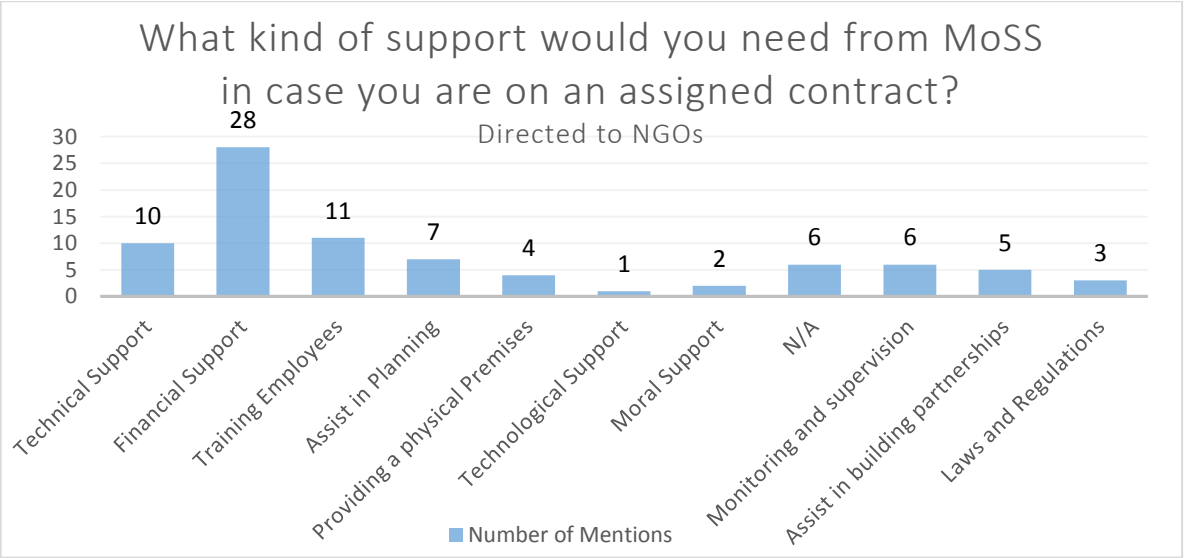

Figure 6. 15 What is the kind of support that you would need from MoSS in case you are on assigned contracts? Directed to NGOs

6.5 Weak Social Support to PWDs

Social constructionist views on disability that is located in the minds of society, which includes service providers and policymakers, very much affect their attitudes or policies (Oliver, 1990). When PWDS were asked about the reasons for the weak services, in case they

believe so, the highest frequency was for the social perception (negative attitudes) towards the issue of disability (Figure 6. 16). According to the World Disability report, "beliefs and prejudices constitute barriers to education, employment, health care, and social participation" (World Report on Disability, 2011). Also, when the NGOs were also asked about the reasons behind the weakness of services provided (in case they do), 19 of the answers were about society's perception to PWDs that affect the overall interest in the issue. In reference to the Social Valorization theory that was discussed in the literature review, the negative perception that society holds of PWDs may be affecting how PWDs view/ perceive the services provided by Rehabilitation Offices.

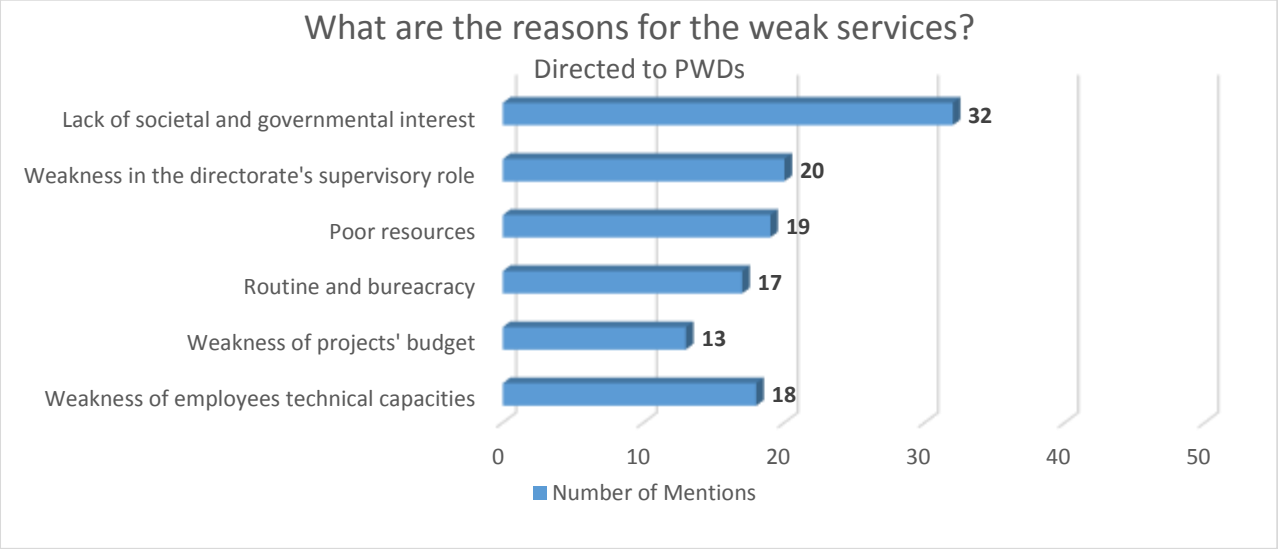

Figure 6. 16 What are the reasons for the provision of weak services by Rehabilitation Offices? Directed to PWDs

These negative social attitudes to disability could be a reason affecting the quality of services that is provided to PWDs by these offices as well as their inclusion in the job market. As proven in the literature by Wolfensberger, those who are perceived with positive social roles will be treated well by Rehabilitation Offices' employees, while those who are perceived with negative social roles will be treated badly by them. Furthermore, the quality of training that is made available to PWDs at Rehabilitation Offices could be a result of their false perception that PWDs are incompetent to perform. This is even evident in the use of linguistics in the Rehabilitation law number 39 and the Rehabilitation Offices bylaws as has been discussed earlier; "states that the office aims to qualify all categories of PWDs in a manner that is fit to the abilities they have left, being physical, mental or psychological" (MoSS, 1997). This

reflects the perception of the law setters/ makers as well as the policy makers to the issue of rehabilitation.

Also regarding employment, there were several mentions of the corruption that takes place from business owners who register PWDs on their companies' payroll to meet the quota without them taking part in real work (Nancy, 2012). This has been mentioned several times as well during the workshops. Business owners maybe holding a misconception (part of the wider misconception that exist in society) that people with disabilities are less productive than the non-disabled employees that they can hire. This may also be one of the factors why most of them do not fulfil the 5% quota that is stated in the law. PWDs receive poor/ unsuitable training, do not suit the job market and therefore are not employed. Using the SRV tool for assessing the degree to which programs and service settings are in line with normalization principles may be beneficial as it would determine the weak points that needs to be worked on by policy makers. However, it seems clear in the case of Egypt that there is weak awareness among the public regarding PWDs. An intense awareness campaign that can be led by the government and the specialized NGOs could help change the negative attitudes.

Chapter Seven: Conclusion and Recommendations

7.1 Conclusion

Assessing the performance of Social Rehabilitation Offices from a multidimensional perspective resulted in very fruitful conclusions. It gives the reader an in-depth perspective of the perceptions of each of the stakeholders' views as well as the challenges that face a better performance. The service providers (Rehabilitation Offices) and regulators (rehabilitation directorate) had more positive perceptions of the services provided by the Rehabilitation Offices than the direct beneficiaries (PWDs) and NGOs working in the field. After analysing the questionnaires' responses given by PWDs and NGOs' it was concluded that not all Rehabilitation Offices are performing with the same quality, efficiency and effectiveness. There may be a lot of variation in how these offices are perceived by their beneficiaries, especially in issues pertaining to accessibility, cleanliness as well as the treatment and responsiveness of employees to citizens. However, most of the respondents from the rehabilitation offices believe that more services and benefits can be provided to PWDs from the offices, which means that they see more room for improvement.

There was a clear deficiency in the knowledge of the Rehabilitation Offices' employees regarding the benefits of the disability IDs given out to PWDs. This resulted in PWDs receiving little information regarding the rights they are entitled to which therefore would lead them not to exercise their full rights. PWDs are not given full information regarding the process and procedures needed to receive the services which can lead to their disappointment. Regarding the rehabilitation certification, highest service in use, more effort could be exerted by the offices to establish connections and networks with employers for finding better training opportunities to non-degree holders and employment opportunities to PWDs who received rehabilitation certifications. This is to result in lower dependency by PWDs on the government and help in achieving their independence.

The human resources at the Rehabilitation Offices were discussed by all stakeholders' as an important issue affecting the performance of the offices. More investment in training these employees needs to take place so that they would be able to provide better quality services to citizens. Rehabilitation Offices and rehabilitation directorates seemed to have a confusion regarding what their institutions are mandated to do, which affects the perceptions of the beneficiaries (PWDs and NGOs) to the services received. All of this confusion in roles and

responsibilities were found to affect the quality of services provided as well as the efficiency and effectiveness of the system in place.

Some factors were identified during the research, to be of structural nature that affect the quality of service delivery; multiple stakeholders, poor financial subsidies, weak monitoring system, assignment contracts and weak social support to PWDs. The involvement of multiple stakeholders in the service delivery process was found to affect the perception of the Rehabilitation Offices' employees, which affects their understanding of the system and the quality of the services they provide. Furthermore, it affects the beneficiaries' (PWDs) as well as the direct service providers' (Rehabilitation Offices) perception of the services offered. Financial subsidies were found to be very low compared to the expectations different stakeholders hold of what these Rehabilitation Offices should be providing to its clients. There is a weak monitoring and evaluation system in place, where the Social Solidarity directorates are not fully aware of the role it should be performing. Another very important issue that affected the quality of services provided was the structure of the system that pertained to assignment contracts. Reviewing assignment contracts and opening new channels between MoSS and experienced NGOs in the market was found to be needed for better service delivery. Last but not least, the social awareness comes about as a problem affecting the services provided to PWDs, their perception of these services, how they are positioned in the job market and therefore their general self- esteem.

More issues can be examined in depth in later studies, such as the status of uneducated PWDs, the kind of training they receive from Rehabilitation Offices, on what basis they are assigned to it, as well as its effectiveness in finding job opportunities. Each of the factors and issues that were found to affect the quality or perception of services can be separately studied in depth to allow for a better detailed understanding of the system and the factors affecting the quality of services. In order to draw deeper correlational analysis between the perceptions of Rehabilitation Offices and factors such as the geographic location, gender of responder and age; a bigger sample needs to be studied.

7.2 Recommendations

After this stakeholders' analysis has been complete, there is a lot that can be done to enhancing the performance of these Rehabilitation Offices. A first step to attracting the required attention to the issue of disability and the provision of services that is necessary for the empowerment and inclusion of PWDs in society, will be through credible national statistics.

In order to raise the awareness of society, policy makers and service providers; data and evidence indicative of the situation should be made available. "A lack of rigorous and comparable data on disability and evidence on programmes that work can impede understanding and action" (World Report on Disability, 2011). Therefore, working on a national database that would be reflective of PWDs numbers, kinds of disability, causes of disability, geographic distribution and many other factors will be a step forward in the exerted efforts to removing barriers facing PWDs. In the existence of this database, good and comprehensive policies can be derived to address the real needs of PWDs.

"Problems with service delivery, poor coordination of services, inadequate staffing, and weak staff competencies can affect the quality, accessibility, and adequacy of services for persons with disabilities" were all identified as disability barriers (World Report on Disability, 2011). Building the capacity of these offices not only on the level of the personal capacities of employees' but also of the institutional and societal manner will guarantee sustainability (Mirzoev, Green, & Van Kalliecharan, 2015). A societal awareness that includes institutions and service providers needs to be built regarding the importance of economic participation of PWDs. It is through the provision of good training that suits the labor market that PWDs can reach their full capacities and genuinely participate in the job market. This will very much reduce dependency as well as the overall poverty rate of Egypt.

The role of the regulator is very important at this stage, where a lot of work needs to be exerted on behalf of the GDSR for the enhancement of the system. As a duty bearer, the regulator, is to take the necessary measures to help in building the capacity of these parties. Training needs to target the directorate employees first, regarding their role as a regulator as well as their role to build the capacities of these Rehabilitation Offices. They need to also be informed regarding the mandate of the Rehabilitation Offices, what is expected of them and how should the service delivery process take place. Key performance indicators need to be put by the NGOs holding/ running the Rehabilitation Offices and shared with the directorate's as well as the GDSR. Based on that, the directorates should be following up with these offices, working with them to solve their problems and providing them with the technical support needed. Directorate employees needs to pay more attention to citizen's satisfaction through carrying out surveys and reaching out to get their perspectives on services.

The Rehabilitation Offices' employees needs to receive training sessions regarding their roles and responsibilities. The GDSR needs to verify the information that has to do with the benefits of the disability IDs with the related stakeholders. After that a publication should

be made with all the benefits that PWDs are entitled to upon receiving their IDs and should be made available to every Rehabilitation Offices of the 207 offices. The GDSR should make it mandatory for Rehabilitation Offices to post the guiding procedures for receiving a service as well as the benefits of the IDs inside the offices.

Connections needs to be built on the governorate level of every office with private and public sector companies and NGOs working in the field of disability. There needs to be a coordination with the public and private sector businesses regarding the vacant jobs available and providing the suitable and needed training for PWDs. The GDSR could work on providing incentives to these companies, which does not have to necessarily be through monetary benefits but can be through recognition. This will ensure the steering of efforts in the needed direction. Similar to the Community Based Rehabilitation approach, a good referral system can be made available at each office connecting PWDs with the NGOs that provide services in the same district. For example, during the workshops one of the NGOs serving the physically disabled had announced that in case there is any PWD in need of a chair; the foundation will provide it along with capacity building and empowering services. Making the connections between the service providers that may not be able to reach out to all PWDs and the PWDs that suffer from poor services from the government counterpart would definitely narrow the existing gap in services.

Meanwhile, MoSS should start an awareness program targeting PWDs and NGOs working in the field of disability regarding the services it offers. PWDs should receive awareness regarding the services available at MoSS and more specifically that the Rehabilitation Offices should be providing. This will cause raising awareness that will increase the demand of PWDs to the services and therefore will push the supply (Rehabilitation Offices services) to meet this demand. A reassessment is to be made to the clauses guiding the assignment contracts as well as the financial subsidies provided based on this contract to attract skilled specialists (employees) and specialized NGOs (service providers). Making a public announcement to NGOs that are interested in applying for an assignment contract should take place to allow for good competition in the field. Based on the set KPIs a yearly competition can take place between all offices, where one office for each governorate can be chosen for its best practices to receive a financial award for its employees as an incentive. There is a huge potential in Social Rehabilitation Offices that can be further utilized by adopting these recommendations for better service delivery and empowerment of PWDs.

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Annex

Annex I: PWDs Questionnaire

إستبيان خاص بذوي الإعاقة

البيانات الأساسية

الصفة؟	**1) شخص ذوي إعاقة** **2) ولي أمر لشخص ذوي إعاقة**
النوع	**1) ذكر** **2) انثى**
المحافظة	
المركز/ حى	
طبيعة المنطقة السكنية؟	**1) ريفية** **2) حضرية** **3) صحراوية**
ما هو نوع السكن الذي تقيم به؟	**1) منزل منفصل** **2) شقة** **3) غرفة/ غرفتين بمبنى** **4) منزل مهدم.** **5) عشة صفيح/ خشب**

وضع المسكن؟	**1) ملك** **2) ملك مشترك** **3) إيجار جديد** **4) إيجار قديم** **5) هبة**
الوظيفة (إن وجد)	
المؤهل	**1) أمى** **2) إبتدائية** **3) إعدادية** **4) ثانوية** **5) معهد** **6) جامعى** **7) فوق الجامعى**
الحالة الإجتماعية	**1) دون السن** **2) أعزب** **3) متزوج** **4) ارمل** **5) مطلق**
العمر	**1) أقل من 18** **2) من 18 – 30**

	3) من30 - 45 4) من 45- 50 5) فوق 60
نوع الإعاقة	1) حركي 2) سمعي 3) عضوي 4) بصري 5) ذهني

م	السؤال	البنود
101	هل تم سؤالك عن درجة الإعاقة من قبل ؟ أو تحديدها من جهة طبية متخصصة	1) نعم 2) لا (فى حالة لا انتقل للسؤال 103)
102	في حالة الرد بنعم، ما هي؟	
103	هل سبق وزرت مكاتب التأهيل؟	1) نعم 2) لا (فى حالة لا انتقل للسؤال 127)
104	لماذا	
105	هل تم تلقي خدمة من مكاتب التأهيل ؟	1) نعم 2) لا (فى حالة لا انتقل للسؤال 127)
106	اي مكتب؟	

107	**هل تعرف احد تلقى خدمة من مكاتب التأهيل؟**	**1. نعم** **2. لا**
قياس رضا المواطن عن خدمات مكاتب التأهيل:		
108	**ما الخدمات المتلقى منهم**	**1) تدريب مهني** **2) شهادة تأهيل** **3) كارنيه إعاقة** **4) تحويل** **5) اخرى ، حدد ؟**
109	**كيف كانت تجربتك؟ أو تجربة من قام بتلقي الخدمة من معارفك ؟**	**1) جيدة جداً** **2) جيده** **3) متوسطة** **4) ضعيفة** **5) سيئة**
110	**ماهى الطريقة التى تم التعامل معك؟ أو تجربة من قام بتلقي الخدمة من معارفك ؟ من قبل مقدم الخدمة هل هى ؟**	**1) جيدة جداً** **2) جيده** **3) متوسطة** **4) ضعيفة** **5) سيئة**
111	**في حالة انك تلقيت تدريب، هل كان التدريب المهني المتلقي مؤثر؟ أو من قام بتلقي الخدمة من معارفك ؟**	**1) جيدة جداً** **2) جيده** **3) متوسطة** **4) ضعيفة**

		5) سيئة
112	على اي مهنة؟	
113	في حالة انك ترى ان الخدمات المقدمة ضعيفة، هل تعتقد ان ضعف الخدمات المقدمة بسبب؟	1) ضعف إمكانيات العاملين الفنية 2) ضعف الميزانية الخاصة المشاريع 3) الروتين والدورة المكتبية 4) ضعف الموارد 5) تقصير من المدرية في الإشراف 6) عدم الإهتمام بمشكلة الإعاقة في مصر من قبل المجتمع والحكومة
114	المكتب كائن في مكان يسهل الوصول له (الإتاحة)؟	1) جيدة جداً 2) جيده 3) متوسطة 4) ضعيفة 5) سيئة
115	جودة المكان من ناحية النظافة والمظهر العام ؟	1) جيدة جداً 2) جيده 3) متوسطة 4) ضعيفة 5) سيئة

116	**إستجابة مقدمي الخدمة لطلبات المواطنين ؟**	**1) جيدة جداً** **2) جيده** **3) متوسطة** **4) ضعيفة** **5) سيئة**
117	**هل يتم شرح الحالة والتعامل مع المواطن بشفافية؟**	**1) نعم** **2) لا**
118	**هل حاول مقدم الخدمة دلك على خدمات اخرى؟**	**1) نعم** **2) لا**
119	**هل تم شرح مميزات الخدمة التي تحصل عليها (مثل كارنيه الإعاقة)؟**	**1) نعم** **2) لا**
120	**ماهى**	
121	**ما المدة الزمنية لتلقى الخدمة؟**	**1) أسبوع** **2) في حدود أسبوعين** **3) من أسبوعين – 3 اسابيع** **4) شهر** **5) أكثر من شهر**
122	**هل طلب منك دفع اي رسوم لتلقى الخدمة بشكل سريع**	**1) نعم** **2) لا**

123	**في حالة نعم، كم كانت ؟**	
124	**وبأي صيغة؟أو ماهو الأسلوب الذى تم طلبه منك**	
125	**هل تم معاملتك بأي شكل من أشكال التمييز أثناء تلقيك الخدمة ؟**	
126	**حدد**	
127	**هل حاولت تقديم أي شكاوي لمكاتب التأهيل من قبل؟**	**1) نعم** **2) لا**
128	**أو ضد هذه المكاتب؟**	**1) نعم** **2) لا**
129	**كيف تم التعامل مع هذه الشكاوى ؟**	
130	**في إعتقادك ما هي نشاطات مكتب التأهيل ؟**	**1) شهادات تأهيل (للعمل)** **2) تدريب وتشغيل ذوي الإعاقة** **3) كارنيه الإعاقة** **4) تحويل لعلاج الطبيعي** **5) تحويلات للأطراف الصناعية**

		6) ندوات وتوعية **7) أخرى**
131	**ما هي الخدمات الإضافية التي تتوقع تلقيها منهم؟**	
132	**في حالة انك صانع قرار كيف تتقترح التحسين أو التغيير في طريقة مكاتب التأهيل؟**	
133	**أي تعليقات إضافية؟**	

Annex II: Social Rehabilitation Offices Questionnaire

إستبيان خاص بالعاملين بمكاتب التأهيل

البيانات الأساسية

المحافظة	
المركز/ حى	
اسم المكتب التابع له	
اسم الجمعية التابع له	
النوع	**3) ذكر** **4) انثى**
الوظيفة	
الدرجة الوظيفية	
المؤهل	**8) أمى** **9) إبتدائية** **10) إعدادية** **11) ثانوية** **12) معهد** **13) جامعى**

	14) فوق الجامعى
عدد السنوات العمل في مكاتب الإعاقة	عدد سنوات العمل : .....
عدد ساعات العمل اليومى ؟	عدد الساعات : .....

م	السؤال	البنود
101	كيف تقيم خدمات مكاتب التأهيل لذوي الإعاقة ؟	6) جيدة جداً 7) جيده 8) متوسطة 9) ضعيفة 10) سيئة 5
102	عدد المترددين يومياً على المكتب؟	1) أقل من 5 2) 5- 7 3) 7 -10 4) أكثر
103	هل ترى مشكلة في التعرف وتحديد الإعاقة من قبل الكشف الطبي او مكتب التأهيل ؟	1) نعم 2) لا
104	هل يتم استخراج كارنيه الإعاقة بناءً على نسبة أو درجة إعاقة معينة من قبل القومسيون الطبي؟	

105	هل يتم شرح المزايا للمواطن في حالة منحه كارنيه إعاقة؟	1) نعم 2) لا 3) فقط اذا سأل المتلقى
106	هل يوجد اي ملصقات بالمكتب توضح إجراءات الحصول على الخدمة؟	1) نعم 2) لا
107	هل يوجد اي ملصقات بالمكتب توضح المزايا الحصول على كارنيه الإعاقة؟	1) نعم 2) لا
108	ما المزايا التي يحصل عليها ذوي الإعاقة بالحصول على هذا الكارنيه؟	
109	بخصوص شهادات التأهيل، هل يوجد دليل يوضح انواع العمل المناسبة لأنواع الإعاقة المختلفة؟	1) نعم 2) لا
110	كيف يتم تحديد نوع العمل المناسب للمتقدم؟	
111	هل تعتقد ان اللوائح والقوانين تمنح لغير المستحقين المزايا المعطاة للأشخاص ذوي الإعاقة؟	1) نعم 2) لا
112	هل تعتقد ان اللوائح والقوانين تمنع المستحقين من تلقي الخدمات؟	1) نعم 2) لا
113	هل يتم المتابعة مع متلقين الخدمة (مثل التوظيف؟)	1) نعم 2) لا

114	هل يتم حفظ ملفات المواطنين؟	3) نعم 4) لا (فى حالة لا انتقل للسؤال 118)
115	فى حالة نعم كيف ؟	
116	من له الحق في الإطلاع عليها؟	
117	هل يتم مشاركتها مع المدرية بشكل منتظم ؟	1) نعم 2) لا 3) فقط ان طلب
118	هل تعتقد ان الخدمات والمزايا المقدمة لذوي الإعاقة من مكاتب التأهيل كافية؟	1) نعم 2) لا
119	هل تعتقد انها تمكنهم من ممارسة حياتهم بشكل افضل أم تجعلهم معتمدين على الحكومة؟	
120	في حالة رفض منح المتقدم للبطاقات او الشهادات، هل يتم شرح الاسباب لهم؟	1) نعم 2) لا (فى حالة لا انتقل للسؤال 122)
121	في حالة نعم هل يتم ورقي؟ شفوي؟	1) ورقى

		2) شفوى
122	ماهى السبل لتقديم التظلمات أو الشكاوى ؟	
123	هل يتم تدريبكم بشكل دوري من قبل الجمعيات التابعين لها؟ وزارة التضامن الإجتماعي؟ او اي جهات اخرى؟	1) نعم 2) لا حدد:
124	هل يوجد سهولة فى التواصل والتنسيق مع المدريات ؟	6) جيدة جداً 7) جيده 8) متوسطة 9) ضعيفة 10) سيئة
125	ما اللوائح والقوانين التي تخص مكاتب التأهيل ترى ضرورة تغييرها؟	
126	ما الإمكانيات او الموارد الإضافية التي قد تمكنك من تقديم خدمات أفضل للأشخاص ذوي الإعاقة؟	1) موارد مالية 2) تدريبات

		3) التواصل والتشبيك مع جهات الخدمات المختلفة 4) أخرى ، حدد
127	ما هي أكبر التحديات التي تواجهك اثناء تأدية عملك؟	
128	إذا كنت صانع سيايات ما الأجراءات التي ستقوم بها لتحسين الخدمة بمكاتب التأهيل ؟	
129	ما الخدمات الإضافية التي تعتقد من الممكن ان تقدمها مكاتب التأهيل للمعاقين؟	
130	أليات تحقيق هذه الاقتراحات؟	

Annex III: Rehabilitation Directorate Employees Questionnaire

إستبيان خاص بمديريات التضامن الإجتماعي

البيانات الأساسية

المحافظة المديرية التابعة لها	
النوع	**5) ذكر** **6) انثى**
الوظيفة	
الدرجة الوظيفية	
المؤهل	**15) أمى** **16) إبتدائية** **17) إعدادية** **18) ثانوية** **19) معهد** **20) جامعى** **21) فوق الجامعى**
عدد مكاتب التأهيل التابعة لهذه المديرية	**عدد المكاتب : .....**

م	السؤال	البنود
101	كيف تقيم كفاءة وفاعلية مكاتب التأهيل التابعة للمدرية؟	11) جيدة جداً 12) جيده 13) متوسطة 14) ضعيفة 15) سيئة
102	هل يتم قياس رضا المواطنين عن الخدمة؟	1) نعم 2) لا (فى حالة لا انتقل للسؤال 104)
103	كيف	
104	كيف يتم تقييم أداء مكاتب التأهيل ؟	
105	كيف تقييم علاقة المدرية بالجمعيات المنفذة لنشاطات مكاتب التأهيل؟	1) جيدة جداً 2) جيده 3) متوسطة 4) ضعيفة 5) سيئة
106	هل يتم الإستفادة بالبيانات المجمعة من مكاتب التأهبل الخاصة بالأشخاص ذوي الإعاقة؟ إستخدامها في دراسات؟	3. نعم 4. لا

107	هل يتم تدريب الموظفين على آليات التقييم و المتابعة لمكاتب التأهيل؟	1) نعم 2) لا
108	هل هناك صندوق خاص للشكاوى؟	3) نعم 4) لا
109	كيف يتم تتبع الشكاوى؟	
110	ما الإجراءات المتخذة ضد مكاتب التأهيل في حال الإبلاغ عن أي تجاوزات؟	
111	هل يتم التحقق من الاستحقاقات المعطاة للمواطنين المتقدمين؟	1) نعم 2) لا (فى حالة لا انتقل للسؤال 114)
112	في حالة نعم كيف يحدث هذا؟	
113	وهل يحدث بشكل دوري؟	1) نعم 2) لا
114	هل يتم دعم مكاتب التأهيل للقيام بعملهم بشكل افضل؟	1) نعم 2) لا (فى حالة لا انتقل للسؤال 117)
115	فى حالة نعم كيف ؟	

116	ما أنواع الدعم التي من الممكن أن تقدمها المديرية للمكاتب؟	
117	هل يتم التعاون مع مكاتب التأهيل لتشبيكها مع الشركات والهيئات من أجل توفير التدريب المناسب للأشخاص ذوي الإعاقة؟	1) نعم 2) لا
118	هل يتم إرسال تقارير عن عمل المكاتب من الجمعية المنفذة لهذا النشاط الى المديرية؟	1) نعم 2) لا
119	هل سبق وتم التنسيق مع مدرية الصحة في حالة حدوث أي مشاكل مع القومسيون الطبي أو التقدم بالشكاوى من قبل المواطنين ؟	1) نعم 2) لا (فى حالة لا انتقل للسؤال 121)
120	فى حالة نعم أذكر الواقعة	
121	في رأيك هل من المفروض ان يتم إعادة النظر في عقود الإسناد الخاصة بالجمعيات المنفذة لنشاطات مكاتب التأهيل ؟	1) نعم 2) لا
122	في رأيك ما هي اكبر التحديات التي تواجه عمل مكاتب التأهيل؟	
123	ما هي الخدمات الإضافية التي من الممكن أن توفرها مكاتب التأهيل؟	

124	في حالة انك صانع قرار كيف تقترح التحسين أو التغيير في طريقة مكاتب التأهيل؟	
125	أي تعليقات إضافية؟	

Annex IV: NGOs Questionnaire

إستبيان خاص بالجمعيات العاملة في مجال الإعاقة

البيانات الأساسية

المحافظة	
اسم الجمعية	
عنوان الجمعية	
تاريخ إنشاء الجمعية	
مجال عمل الجمعية	
نوع الخدمات المقدمة	
العنوان	
النوع	**7) ذكر** **8) انثى**
العمر	**6) أقل من 18** **7) من 18 – 30** **8) من30 - 45** **9) من 45- 50**

	10) فوق 60

م	السؤال	البنود
101	هل سبق وسمعت عن اي نشاطات تعقدها مكاتب التأهيل ؟	1) شهادات تأهيل (للعمل) 2) تدريب وتشغيل ذوي الإعاقة 3) كارنيه الإعاقة 4) تحويل للعلاج الطبيعي 5) تحويلات للأطراف الصناعية 6) ندوات وحملات توعية 7) أخرى
102	هل سبق وزرت مكاتب التأهيل؟	3) نعم 4) لا (فى حالة لا انتقل للسؤال 104)
103	لماذا ؟	
104	هل تعرف احد تلقى خدمة من مكاتب التأهيل؟	3) نعم 4) لا (فى حالة لا انتقل للسؤال 112)
105	هل الجمعية/ المؤسسة تعاملت مع أي من مكاتب التأهيل؟	5. نعم 6. لا
106	ما الخدمات المتلقى منهم	6) تدريب مهني 7) شهادة تأهيل

		8) كارنيه إعاقة 9) تحويل 10) اخرى ، حدد ؟
107	كيف تظن كانت تجربة الأشخاص ذوي الإعاقة في مكاتب التأهيل؟	16) جيدة جداً 17) جيده 18) متوسطة 19) ضعيفة 20) سيئة
108	هل تعتقد أن الناس من الممكن أن يكونوا راضين أو غير راضين عن مكاتب التأهيل ؟	1) راضيين 2) غير راضيين
109	لماذا؟	
110	هل تعتقد ان ضعف الخدمات المقدمة بسبب؟ (يمكن اختيار أكثر من سبب)	1) ضعف قدرات الجمعيات 2) ضعف الدور الرقابي للحكومة 3) ضعف الموارد المالية للجمعية 4) عدم وجود إقبال على خدمات المكتب 5) نظرة المجتمع للأشخاص ذوى الإعاقة يؤثر على الاهتمام العام بالقضية 6) تقصير المدريات في إختيار الجمعيات ورفعها للوزارة في خطة العمل المقترحة

		7) كل ماسبق
111	في رأيك ما أهمية الدور التي تؤديه مكاتب التأهيل؟	1) جيدة جداً 2) جيده 3) متوسطة 4) ضعيفة 5) سيئة
112	ما هي الخدمات الإضافية التي تتوقع تقديمها لذوي الإعاقة من مكاتب التأهيل؟	
113	في حالة انك صانع قرار كيف تقترح التحسين أو التغيير في طريقة عمل مكاتب التأهيل؟	
114	هل تعلم النظم الحاكمة لعلاقة الجمعيات التابع لها مكاتب التأهيل بوزارة التضامن (خطة، دعم، إعانة)؟	1) نعم 2) لا
115	ما رأيك في نظام الحكومة المتبع: إسناد مشاريع للجمعيات للإدارة والتنفيذ في مقابل تقديم الدعم المالي للجمعيات ؟	1) جيدة جداً 2) جيده 3) متوسطة 4) ضعيفة 5) سيئة 6) لا أعرف ما هو

116	كيف تقترح ان يتم إسناد المشاريع للجمعيات ؟	1) التنافسية بين الجمعيات في شكل إعلان رسمي للتقدم 2) شروط واضحة 3) إختيار الجمعيات العاملة في المجال بناءً على توصيات من المديرية 4) لجنة تشاورية تضم ممثلين مجتمع المدني 5) إعادة هيكلة الدور المخطط لها
117	في حال إعلان وزارة التضامن عن فتح باب التقدم في إسناد مشاريع "مكاتب التأهيل" الى جمعيات أهلية أخرى، هل من الممكن أن تتقدم جمعيتكم لإدارة مكتب تأهيل؟ في حالة الرفض وضح الأسباب؟	1) نعم 2) لا
118	ما هي سبل الدعم التي تود الحصول عليها من وزارة التضامن الإجتماعي في هذه الحالة؟	
119	هل ترى ضرورة فتح سبل تعاون بين الجمعيات المتخصصة في مجال	1) نعم

	الإعاقة والجمعيات المالكة لمكاتب التأهيل من أجل التطوير؟	**2) لا**
120	**في رأيك ما هو الدور الأساسي والاهم للحكومة في حماية وتمكين الأشخاص ذوي الإعاقة؟**	**1) رقابي وتنظيمي من خلال الإشراف والدعم وصياغة اللوائح والقوانين** **2) تقديم خدمات مباشرة للأشخاص ذوي الإعاقة**