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Health Care Services Provided by
Some Private Associations in Egypt

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Introduction:

Various associations (gama'iyat) in Egypt are active in a number of different health-related activities--from offering first aid and family planning training and services to maintaining nurse training schools, providing nutrition supplementation to mothers and infants, rehabilitation for the handicapped, aid to families of patients as well as maintaining facilities (dur el-'alag) which offer direct curative care services. The health care dispensaries, whether these be hospitals, specialized polyclinics (usually designated by the term mostawsafat) or smaller general--charitable--clinics (el-'ivyadat el-khayriyya), are maintained by associations which differ in their origin, purpose, history, size, the level and range of services they can provide and the resources at their disposal.

Despite this diversity, the associations--and the services they provide--often share certain structural features, systemic links and organizational patterns and problems. While reflecting certain features typical of other kinds of health care services available in Egypt, they also possess certain characteristics and possibilities peculiar to themselves.

In the following discussion, my primary concern is to describe the health activities of a number of selected private or volunteer associations. Information on these associations is presented insofar as it was thought to be of interest to the Office of Health at AID/Cairo as it developed its own health sector policy in 1982.

Before turning to the associations selected for discussion, sources of information will be noted and the general administrative framework within which these associations operate will be reviewed briefly. The associations will be described primarily in terms of their activities which are directed toward health care problems. To facilitate further research on private associations, contact lists are included at the end of the report. Also, mention should be made here of the files established on the principal associations noted in this report. These files, which contain annual reports and various other publications, are located in the Health Sector Assessment Collection in the Documentation Information Center, AID/Cairo.

Sources of General Information on Health Care Activities of Private Associations:

Ministry of Social Affairs:

The central office responsible for private associations at the Ministry of Social Affairs has a registrar of mostawsafat and hospitals run by associations throughout Egypt based on data from a 1978 survey conducted in conjunction with the Federation of Private Associations and Institutions. This list is included at the end of this report in English. Data on the health activities corresponding to each of these associations is available in tabular form (in English) in the Health Sector Assessment files of the Documentation Information Center, AID/Cairo. Due to the sheer bulk of the material, it has not been included here.

294 mostawsafat and hospitals run by associations registered with the Ministry of Social Affairs are indicated. Out of this number, 133 are located in Cairo alone--or 158 if Giza is included as a part of Greater Cairo. While the list is now already somewhat dated, fails to note unregistered associations, and does not correspond to other, larger, figures cited by the Ministry of Health, it is nonetheless valuable if one keeps in mind these limitations. First of all, the list constitutes the most comprehensive source of currently available general information on these associations' financial status, services and capacity. Secondly, by comparing it with other data which should eventually become available through AID's Neighborhood Urban Services Project various trends in the private health sector, at least in Cairo and Alexandria, should become evident.

The list includes for each mostawsafa, the date of its establishment, whether the facility is owned or rented, the number of rooms, the number of days and sessions per day it is open, the fees charged for examinations, bed capacity, number of in and out-patients seen during 1978, what type of specialists and other services are available (e.g., lab, X-ray), the number and type of employees and their salaries, revenue (broken down by government, patient, donor and other sources), expenditure (broken down by rent, salaries, medical equipment and drugs), assets, and amount of deficit or profit at the end of the year.

Table 1 shows the number of associations by governorate included in the Ministry of Social Affairs list which can be found at the end of this report. It should be noted that certain deficiencies in the list relate to problems of registration. The list fails to indicate the existence of unregistered associations. Since 1945, all associations have been required to register with the Ministry of Social Affairs. If an association then opens a health facility, that facility is then supposed to be registered with the Ministry of Health which is responsible for its periodic inspection to ensure that the facility meets certain standards.

Therefore, there are two points at which the association may conceivably fail to register. Firstly, the association itself may fail to register with the Ministry of Social Affairs(although officials deny that this occurs). Since there is little money transferred from the Ministry to the associations(see Table 1), there may be minimal financial incentive to do so. However, a registered association is exempt from taxes and receives reductions in transportation, water, lighting and phone facilities.

Secondly, the association may fail to register with the Ministry of Health. At what stage in the development of its health facility the association should and typically does register it is vague from all accounts. Aside from this administrative indifference, there may be concrete reasons why an association chooses not to register. It may fail to meet certain standards required by the Ministry of Health--so rather than comply simply fails to register so that it is not subject to inspection.

In one unregistered clinic I visited, the Board of Directors of the association which established it gave a quite different reason for their failure to register with the Ministry of Health. Their claim was that if the clinic were registered, the young doctors working there would no longer receive the 15 LE/month they receive from the MCH compensating them for not having their own private practise. Apparently(or at least so the members of this association thought), work in such a clinic has the status of private practice for all the doctors involved. Since most doctors only work at these clinics once or a few times a week, and since the fee charged patients(and hence the amount accruing to the doctor) is very low, the doctors are loath to give up their 15 LE/month compensation. The Board of Directors, in this particular instance, was thus "protecting" the doctors working in the clinic.

My impression is that governorates and districts vary in the degree to which they monitor the activities of such associations. Presumably, the better known its facility and services become, the more likely it is the association will come to the attention of the Ministry of Social Affairs or Ministry of Health on the district level, if it has not already done so.

Neighborhood Urban Services Project, USAID/Cairo:

The Ministry of Social Affairs list should be taken as a starting point since the extent to which it reflects the current situation requires further investigation. A thorough investigation should be undertaken by a team of investigators, working in conjunction with the Ministry of Social Affairs, who would collect data district by district--which is exactly what the Neighborhood Urban Services Project intends to do for certain districts.

NUSP is and will be collecting information on the organization, budget, needs and problems of each association in the districts of Cairo. It has designed a questionnaire 3,000 copies of which have already been distributed to the kism levels of the Ministry of Social Affairs in Cairo. By September, 1982, 550 forms had been returned. Apparently, a large number of associations indicated that they provided some sort of health care service. If AID's Office of Health is interested in obtaining this data it should make an arrangement with the Neighborhood Urban Services Project for an ongoing exchange of information.

The collection and analysis of data performed by the NUSP should prove to be a valuable source of current and future information on private voluntary associations located within Cairo, Alexandria, Qalyubiyya and Giza--the areas in which the NUSP is involved. What the NUSP discovers may also help in estimating the reliability of information concerning the other governorates covered by the current MOSA list.

Table 1

<u>Governorate</u>	<u>Number Mostawsafat</u>	<u>Volume of Patients (1978)</u>	<u>Central Governmental Assistance (1978)</u>
Aswan	10	29,350	500 LE for 1
Beni Soueif	7	17,210	30 LE for 1
Ismailia	4	5,729	
Sharqiyya	2	2,765	414 LE for 1
Matruh	1	2,100	700 LE for 1
Giza	36	304,621	
Red Sea	1	1,624	
Qena	1	436	
Port Said	3	2,776	
Menoufiya	1	250	
Fayyum	1	27,156	
Dakaliyya	9	21,704	677 LE for 1
Assiut	8	8,137	137 LE for 1
El Minya	13	61,255	275 LE for 1
Alexandria	46	242,280	2,291 LE for 2
Sohag	14	26,640	
Gharbiyya	<u>4</u>	<u>700+</u>	
<u>Total</u>	161	754,805+	5,324 LE for 9

7 Districts of Cairo
(since reorganized
into 12):

West Cairo	16	398,150	8,224 LE for 2
South Cairo	23	202,076	1,452 LE for 1
Masr Gadida	17	73,068	
East Cairo	26	218,939	
Helwan	15	123,900	
Central Cairo	12	142,348	2,907 LE for 12
North Cairo	<u>34</u>	<u>501,816</u>	<u>3,766 LE for 3</u>
Total for Cairo	133	1,660,297+	16,349 LE for 8
Total for Egypt	294	2,415,102+	21,673 LE for 17

* Nawwal Hassan noted in The Role of Voluntary Associations in Egypt (June, 1981) that in 1979 medical and health care provided by associations dealt with 4,568,361 patients according to MOSA accounts--almost double the number above. The discrepancy between the 1978 figures (in this table) and the 1979 figure she cited may be due to the incompleteness of the above list

Overview of the Administrative Structure Involved with Private Associations:

With Law 52(1964), associations were brought under direct governmental regulation and control. Article 85 calls for the establishment of regional federations of associations on the governorate level. Each association, once approved by and only then registered with the Ministry of Social Affairs, automatically becomes a member in one of the regional federations and in one of seven "Assimilated" federations. A quasi-bureaucratic organization, the General Federation of Social Agencies, was formed in 1969. Structured geographically and functionally at the national and local levels, it is supposed to coordinate among the federations and assist the MOSA by providing it information and guidance.

Although the General Federation falls under the Minister of Social Affairs, it is not formally part of the Ministry of Social Affairs. It functions essentially as a liaison between that Ministry and private associations. The Board of Directors of the central General Federation of Social Agencies is headed by the Minister of Social Affairs. Included on this board are other high ranking officials from other ministries--undersecretaries of state for the Ministries of Education, Waqf, Labor, Local Administration, Health, Youth, Scientific Research, Central Agency for Auditing as well as the Director-General of the Department of Associations at the MOSA. Seven experts (academics) chosen by the Minister of Social Affairs and 15 representatives of the regional federations (elected by the 24 federations every 3 years) and 7 representatives from the assimilated federations are also included as members of the Board.

Each regional federation is responsible for coordinating services among its member associations. It is supposed to study the needs of the environment, evaluate the services of the associations, as well as review their final accounts and assist them in solving their financial problems (e.g., link up donor with suitable association). It is also supposed to organize training programs for administrators and technical personnel working in private associations. It should clarify Law 32 to the associations and assist them in conforming to its regulations. The capacity of each regional federation to carry out these tasks varies considerably from governorate to governorate. Alexandria, for example, is reputed to have an especially active and capable federation whereas the federation in Minya is virtually defunct.

The so-called "Assimilated" federations are divided topically into seven categories--family and child welfare; welfare of the handicapped; prisoners' welfare; federation of local community development; social assistance; federation of cultural, scientific and religious services, federation of administrative development. In theory, each of these assimilated federations is supposed to carry out the planning of programs in its respective field, conduct research, set standards and coordinate and evaluate efforts of member agencies. Like the regional federations, these assimilated federations vary considerably in the degree to which they carry out their functions.

Because the regional federations work with the associations on the local level, they may be more in touch with what goes on in the private sector--including health care services provided by the associations--than is the district or governorate Ministry of Social Affairs. The tasks of each Regional Federation are assigned to a number of standing committees--planning, research, finance, training, public relations, social agency activities including volunteers, conferences, etc. Each committee is supposed to send reports of their meetings to corresponding committees on the national level. Each regional federation maintains records of the associations in its area.

To illustrate the relationship between the private associations, Ministry of Social Affairs and General Federation on the governorate level, we might review briefly how the Regional Federation in Alexandria operates. The General Federation in Alexandria is responsible for coordinating the efforts of the 675 registered social agencies in Alexandria. Of these, at least 46 provide some sort of direct curative health care.

Typically, an association goes directly to the Office of Private Associations at the governorate level MOSA to register itself. The MOSA then requests the Federation to investigate whether or not the community needs the type of service offered by this organization. At the same time, the MOSA office responsible for private associations on the hai level is also instructed to investigate. In Alexandria, the Federation has 4 or 5 workers (trained as social workers) in its Department of Social Agency Activities who are responsible for conducting this research. They go out to the association, visit the area, meet the Board of Directors and talk with local leaders. Based on their reports, the Director of the Federation will recommend that the group be accepted or rejected for registration. If the director finds that the association in question would simply be duplicating a service already provided in the area, she may try to persuade the group to do 1 of 2 things--either offer a different service which the Federation believes the area needs or locate to a different area which needs the service the group originally offered to provide.

The initiative for establishing either an association or a particular service might come from the Federation itself. For example, the Federation might meet with the leaders of a hai, explain to them their assessment of that community's needs and assist in establishing an association which then goes to the MOSA armed with a report from the Federation urging its registration.

The decision to register or not register an association ultimately rests with the mudiriyya (governorate head) of the MOSA. Article 12 of Law 32 specifies the right of the MOSA mudiriyya to refuse to allow a group to form. H/she receives reports and recommendations both from the Federation and from the district MOSA offices responsible for private associations. In Alexandria, the recommendations of the Federation may carry more weight than those of the district MOSA because, so it was claimed, the Federation's reports are well-investigated and written whereas the MOSA reports are very sketchy. The entire process of registering an association may involve 3 or 4 months of formalities (according to Nawal Hassan).

The perspective, and capacity to conduct research, on the needs of the districts and the associations probably varies considerably within each regional federation and each MOSA governorate establishment. The Federation in Alexandria, for instance, maintains a staff of 20 to 25 people who are responsible for coordinating, supervising, and training private associations. That the Federation had maps made which indicate the health services available in each district (which I was told are not available in the MOSA or MOH) suggests a considerable capacity and concern to keep up with the health services provided by private associations.

What little money comes from Cairo is channelled to the associations via a special committee for aid held once a year. This committee includes the official responsible for private associations at the governorate MOSA and 6 members of the Regional Federation's Board of Directors. The money goes only to a few selected associations. Assuming that the list provided by the MOSA is at all valid, it indicates that health care facilities run by associations are generally able to generate the revenue necessary to cover costs through patient receipts. (Note, however, that an association which runs a clinic may yet have received governmental financial assistance--but for purposes other than maintenance of the clinic per se--in which case governmental assistance would not be indicated on the list.)

Introduction to Case Studies:

Having covered the administrative structure briefly, let us turn to a consideration of several different associations involved in providing direct curative health care services. By focussing largely on associations with mostawsafat, I do not mean to suggest that the provision of direct health care services is necessarily the principal function or concern of these associations. These associations were selected on the basis of relative accessibility, their possible relevance to AID's Health Sector Assessment as well as considerations of time. They should not be taken as ideal typical gama'iyat. They simply possess certain features--perhaps forming a national or local network, playing a health educative role, or using innovative techniques or volunteers to deal with health problems--which suggest alternative possibilities for developing health care services in Egypt.

Red Crescent Society:
General Organization and Activities

The Red Crescent Society of Egypt, established in 1912, is a member of the International Federation of Red Cross and Red Crescent Societies. As such it complies with the latter's general principles and policies. Within Egypt, the Red Crescent forms essentially a federation of local associations. However, because of its role in emergency situations, such as in times of war, the Red Crescent--unlike other associations--involves the State much more closely. For example, the President and Vice-President of the Society are appointed directly by the President of Egypt. (Until recently, the President of the Red Crescent had been Mrs. Sadat and the Vice President the Minister of Social Affairs. As far as I know the Red Crescent is the only association whose top executives are stipulated by law to be appointees of the President of the Republic.)

While general policy of the Red Crescent Society is determined by its Supreme Council in Cairo, each branch applies that policy according to its own circumstances. Each branch has its own budget and is registered separately with the MOSA on the district level. Each branch is in fact independent of the Board--raising its own funds, appointing its own personnel. The Central Association advises, and theoretically pays for branch deficits if this should occur. In turn, the branch should comply with Red Crescent by-laws and send minutes of its meetings and annual reports to the Central Association. In principle, the Cairo Office has the right to veto decisions made by provincial Red Crescent branches. Yehya Darwish, the current Secretary General of the association, claimed that in the last eight years, such a veto has only occurred once.

Branches exist in Cairo, Alexandria, Damanhour, Kafr-esh-Sheikh, Menoufiya, Qalyubiyya, Dakahliya, Damiett, Port Said, Suez, Ismailia, Giza, Fayyum, Beni Soueif, Qena, Wadi El Gadid, el-Arish, Assiut, Tanta, Aswan, Sharqiyya, el-Minya, Soha, Matruh and the Red Sea governorate. A branch may have its own chapters (shu'ubat) at the village level, in universities or in any city district which are financially dependent on the branches. Revenues from their facilities are delivered to and controlled by the branch office. For example, under the Cairo branch are chapters in Helwan and an Institute of Social Work. No estimate of the number or distribution of chapters could be provided me at the central office.

Each branch has a paid director who is not a member of the Board. The director prepares documents and items to be reviewed in board meetings and runs the association on a daily basis. He hires personnel with the approval of the local board. Each board is made up of six members elected from the General Assembly of the branch (all volunteers) and 3 non-elected members--the mudiriyya for Health, Social Affairs and Education. Each association has special committees--e.g., health, social affairs, public relations, youth and finance. Heading the health committee, for example, in Alexandria is the MOH mudiriyya. Other members of the committee include the Board directors of each of the health facilities run by the branch association.

The health activities of the branches vary somewhat. Most maintain mostawsafat(see Table 3). In addition to these, many branches provide nurseries, milk distribution, youth leadership and first aid training programs. Some provide family planning and vaccinations, maintain blood bank services or old age homes. Many of these activities take place within the same physical complex. For example, in the Helwan chapter, sewing classes are held in the dispensary itself while a nursery is situated immediately adjacent to it. Sewing classes as well as women's and children's clubs bring in additional revenue for each facility.

The Red Crescent also organizes volunteers(women mostly) to work in hospitals--helping in the distribution of meals, working in reception rooms, assisting in cases of quarantine, in emergency relief work, in vaccination campaigns and in providing information on nutrition, etc. (See Table 4 for a breakdown of the kinds of activities the Red Crescent is involved in nationally.)

The organization of the mostawsafat may vary from branch to branch. For example, in Alexandria, doctors(apparently) receive only 25 LE/month to cover costs of transportation. Maintenance, nursing and clerical staff also receive 25 LE/month as base salary. In the clinic run by the Helwan chapter, each doctor receives half of what he brings in while nurses are paid 35 LE/month. (A general or gynecological exam costs 30 piasters, a dental exams and fillings cost 50 piasters, circumcisions cost 2 or 3 LE, cervical cauterization 3 LE, injections 5 piasters, changing bandages 10 piasters.) The fees, higher than those of the Ministry of Health, are paid by clients willing to pay for better service. Typically, specialists--in gynecology, pediatrics, surgery, dental, ENT--are available for a couple of hours a day depending on their personal schedules.

Each mostawsaf has a volunteer Board of Directors elected by the branch General Assembly. They visit the facility periodically to ensure that the clinic is running smoothly. Usually one of the doctors also works as the director. Meetings of the Board and employed staff are supposed to be held monthly

Revenues from all sources go into a general fund. For example, revenue accruing from nurseries may be used to cover expenses of a clinic or vice versa. In the same complex as the Bakous clinic(the first of the Red Crescent clinics in Alexandria--established in 1950) are a nursery for 150 children(families pay 3 LE/month for each child) and a milk dispensary. As in Alexandria, the nursery in Helwan(for 100 children) brings in revenue significant for the operation of the entire complex.

The director of the Bakous clinic claimed that there are no problems in recruiting doctors. It was implied that since the aim was service to the poor, the clinics depended on the altruism or idealism of the doctors rather than on financial incentives to recruit and maintain their staff. Further, the turnover of staff was very low so that the issue of recruitment rarely came up. The five doctors in this particular clinic have come regularly for many years. In Helwan also, the same doctors have been coming for many years.

Red Crescent Association in Tanta:

An especially active branch of the Red Crescent is the association in Tanta. Besides assisting eight chapters throughout Gharbiyya, this association established in 1970 the only full-fledged hospital currently maintained by the Red Crescent. Significantly, the founder and current director of this hospital, Dr. Tahtawi, was much influenced by his previous experience working in Tanta's Mobarra hospital (formerly a facility belonging to the Marat el Gadida Association, since taken over by the government in 1964 and now run as a Health Insurance Organization facility).

As General Secretary of the Association, Dr. Tahtawi had made tentative plans for building a Red Crescent hospital ever since 1964. Only in 1970, when an acting governor of Gharbiyya (Azza Din) took an active interest in the plan was it realized. The Red Crescent Association of Tanta contributed 8,000 LE of its own funds to the project, and obtained a 20,000 LE loan from the local Mobarra hospital. The governor of Gharbiyya--not the local Ministry of Social Affairs or of Health--contributed the difference. Up-to-date medical equipment was purchased on credit.

The 150-bed hospital was planned since the beginning as a five-storey complex including four operating theaters, a pharmacy, x-ray and clinical labs, intensive care unit, physiotherapy equipment, blood bank, several in-patient sections, and an outpatient unit. At the time of opening in 1970, the outpatient clinic at the Red Crescent Hospital was the only one in the Tanta area to offer specialized services.

Having begun with four full-time doctors, the size of the staff has expanded quickly. Twelve full-time doctors and the other, "visiting", doctors now not only treat in and out-patients but also teach student nurses sent from the Ministry of Health and serve the Red Crescent's two nurseries contiguous to the hospital itself. The hospital now has specialists working in the following fields: General Medicine(3), Surgery(3), pediatrics(2), ENT(2), skin(2), gynecology/obstetrics(1), dental(1), ophthalmology(2), neurology(1), psychiatry(1), bone surgery(2), anesthesiology(1), x-ray(1), lab(1), physiotherapy(1). Four resident doctors live in the hospital. All but two or three of the doctors--and they are part-time--are male.

Among the core staff of doctors, team work and smooth working relationships are stressed. How much this self-conscious sense of "fraternity" or "family" extends to other hospital employees--now over 200--is unclear. Only about half of the workers employed since 1970 have stayed on. Apparently, nurses have been especially difficult to retain. Nurses at the Red Crescent Hospital earn the same salary as Ministry of Health employees. However, they do receive a bonus of one month's pay every 3 months and at Ramadan if they have done their work well.

The core staff of full-time doctors are paid a salary (Ministry of Health rates) plus 25% of whatever they bring in. "Visiting" doctors simply receive 50% of whatever cases they see during the morning or afternoon sessions of the outpatient clinic. The fee for all examinations is one pound. Other doctors from outside the hospital can refer their patients to the hospital as in-patients. In this case, the patient pays the Red Crescent for only the expense of maintenance in the hospital.

The hospital has deluxe, first, second and third class in-patient sections ranging in price from 1 to 7 pounds a day. A large proportion of the hospital's patients are workers (or dependents of workers) from local companies. Contracts with 53 companies account for a significant share of the hospital's income. In 1981, 188,940 LE (almost half of the total cash flow) was brought to the hospital through these contracts with companies.

The following breakdown of revenue during 1981 indicates the proportion of income generated by different services and sources:

In-patient sections	237,059.394 LE
Out-patient section	154,393.019
Polyclinic	6,937.00
Rent	1,305.00
Contributions	3,475.420
Other sources	2,263.902
Total	409,458.315 LE

Since its opening, all patient records have been retained. However, in the current system, records of individual visits for distinct illness episodes are simply collected serially by date and stored in a locked room. Patient records are collected together according to the following categories--student, company or other. No attempt has been made to gather or analyze information from these records concerning either the patient population generally or an individual patient's medical history. If a doctor wants to see the record of a patient's previous visit, either he or the patient must know the date of that visit. Individual doctors frequently maintain books of their own patients but the quality and extent of this record-keeping varies from doctor to doctor. While the system is regarded as inadequate, no attempt has been made or plan proposed to alter it.

The "nursing problem"--the low quality and status of the nurse, and the loss of large numbers of nurses to Arab countries--is regarded as a significant problem by the administration. In an effort to overcome some of the difficulties created by the nursing problem, the hospital initiated a formal nurse training program in 1972-74. However, according to Dr. Tahtawi, having met with resistance from the Ministry of Social Affairs, the attempt was soon abandoned. At the time, the Ministry of Social Affairs apparently felt that such a nursing training program did not fall within the range of activities suitable to a private association--particularly since the Ministry of Health and Higher Education were presumably responsible for meeting such training needs. However, the Red Crescent society never abandoned the idea of eventually re-establishing a nursing training program.

The hospital now maintains 100% capacity and the pressure of demand has caused the administration to plan for considerable expansion. The blueprints call for a five-floor extension, adding 200 beds to the current capacity. In the current plans to extend the hospital, four rooms have been set aside for an official Secondary Technical Nursing School intended for 75 female students. In-staff doctors and others brought from outside the hospital will be responsible for teaching these nursing students. Because the proposed school will be associated with the Ministry of Health and has the support of the Red Crescent Headquarters, Dr. Tahtawi presumes the program will not face any opposition from the Ministry of Social Affairs. Dr. Tahtawi hopes to make the school highly selective, personally interviewing the prospective girls and their families, so as to maintain high moral and medical standards. His idea is that the best graduates from the school would be motivated and trained to work as smoothly integrated permanent employees of the hospital.

The plans also indicate the importance of nurseries for the association. The Red Crescent of Tanta maintains two nurseries--one on the hospital grounds and another in a nearby apartment. The two nurseries intended for the age groups, 3 months to 3 years and 3 years to 6 years, were initially established to serve the employees of the hospital. Currently, only about a quarter of the 180 children in the nurseries are children of employees. Whether because they generate considerable income (currently families pay 4 or 5 pounds a month per child) or because they serve employees who would find it difficult to work otherwise, the hospital administration regards the nurseries as an important asset. Accordingly, the ground floor of the planned extension has been designated as the new nursery which will accommodate 400 to 500 children.

The extension requires 370,000 LE for construction. The Tanta Association has already raised on its own 100,000 LE. It has asked the Red Crescent headquarters in Cairo for further assistance. Normally, approximately a quarter of Tanta's revenues go to Cairo. Since the enlarged hospital will also generate greater revenues for the Cairo office, Dr. Tahtawi feels fairly secure that Cairo will respond to their request for financial assistance.

It may be worth stressing--given the enormous emphasis sometimes placed on financial incentives or motivation in the Health Sector Assessment reports--that gama'iyyat are usually made up of members who are social activists. They are usually committed to the notion of service and critical of the organization and values of contemporary social institutions. Secondly, certain key staff in these clinics--doctors, board of directors--have been associated with the clinics for many years. This has provided an important continuity of leadership, values and organization which is reflected in the exceptional cleanliness, civility and order of the clinics.

The Red Crescent not only has a national network but also has a long history of training people on the local level--in first aid, nursing, nutrition, disaster relief. In the past, trainees have been students, school health visitors, community leaders, volunteers, social workers. If AID were interested in helping develop community outreach for purposes of health education (or family planning or ORT) the Red Crescent might be an avenue worth exploring. The Red Crescent has an organizational capacity to be more active in health and health education than it is at present--if mobilized and adequately supported.

That the Red Crescent is already interested in expanding its role in health care is evident by the general policy guidelines adopted by the High Council at the end of June, 1982, at their annual meeting. These guidelines call for, among other things:

- 1) the establishing of a Red Crescent Institute for Training and Research in Cairo
- 2) establishing women's committees at provincial hospitals
- 3) establishing 2 permanent training camps--in Alexandria and Fayyum--to train leaders in disaster relief, blood transfusion, first aid nursing and community development
- 4) including Red Crescent materials in the curriculum of primary, preparatory and secondary schools
- 5) establishing Red Crescent chapters in schools, syndicates and labor unions.

I might add that Yehya Darwish, the association's secretary general, is fiercely pro-private. His claim that the private sector is more competent, flexible and efficient than MOH or MOSA services deserves consideration, especially given his long experience in both public and private sector social services (he was formerly undersecretary of State for Social Affairs in the 1960's).

Table 3--Mostawsafat run by the Red Crescent Society
(from 1981 Annual Report)

<u>Area</u>	<u># Patients</u>	<u>Expenses(LE)</u>	<u>Revenue(LE)</u>
Cairo	16,034	11,537	5,870
Alexandria	85,602	16,853	7,517
Beheira	1,400	591	454
Gharbiyya	62,120	20,963	246
Kafr-esh-Sheikh	15,000	5,285	8,252
Dakhaliya	2,500	85	146
Port Said	602	38	82
Ismailiyya	12,512	2,330	3,098
Giza	12,846		
Beni Souief	10,000	839	853
El-Minya	14,692	3,279	3,336
Qena	3,308	780	
Aswan	9,926	1,521	1,191
Sinai	350	350	289
Total	246,932	64,351	31,490

Table 4 Red Crescent Activities for 1981:

<u>Field of Activity</u>	<u>Beneficiaries</u>	<u>Expenses</u>	<u>Revenue</u>
Child Care/Nurseries	2,937	63,192	63,063
Youth	42,337	3,338	4,665
Family Care	23,238	1,162	1,569
Rehabilitation for handicapped	155	2,665	6,000
Productive Families	365	7,349	6,800
Care of the Aged	59	14,559	14,506
Mostawsafat	246,932	64,351	31,490
Children Clubs	?	1,107	2,000

From Annual Report, Red Crescent, 1981(Arabic)

Mosque clinics: An Introduction

Mosque-clinics are another type of health care facility run by gama'iyat which because of their access to local community networks(via the mosques) have a potential health impact greater than the mere provision of curative services at the clinic. The widespread development of the mosque-clinic is a relatively recent phenomena(since the 1960's in Egypt)--associated with the emergence of dispersed Islamic activist groups and the increasing availability of sizeable capital accumulation. It has been estimated that over 2,000 mosques offer some kind of formal health care service.

As with other mostawsafat, the doctors recruited, the clinetele drawn and the services provided at any given mosque-clinic generally reflect the resources--organizational, financial, political--of the core members of the gama'iyya(principally the Board of Directors) as well as the resources of the community to which they cater. By describing three different mosque-clinics here, differences in their resources and services are suggested and similarities in terms of shared themes or structure explored.

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Case 1: An unregistered clinic in Ma'asara, south of Cairo

An unregistered clinic I visited has been open for less than a year. Although the gama'iyya is registered with the Ministry of Social Affairs, the clinic has not yet been registered with the Ministry of Health. The mosque is located in a poor, newly built up area--many of the inhabitants are recent rural emigrants. The clinic is physically attached to the mosque which sits beside a canal of raw sewerage and sludge.

The members of the mosque's Board of Directors decided to build a charitable clinic a couple of years ago. I was told by two members of the Board of Directors of the gama'iyya that no governmental health services were then or are now available in the immediate vicinity aside from one MCH center open only in the mornings. A few doctors work privately in the area. Two other mosques maintain small clinics.

The Board of Directors decided to build a clinic without having made any survey as to community needs. It was simply assumed that health services were a basic unmet need. A single floor--comprising 2 examination rooms, a washroom, medical equipment room and waiting area--have already been built. They hope to build a second floor to accomodate in-patients on an emergency basis in the next few years depending upon availability of adequate funds.

Two members of the Board are particularly active in supervising the clinic. One (call him Ahmed), a factory worker by occupation, devotes most of his afternoons and evenings to supervising the clinic. The doctors are there only to treat clients--they are not involved in administration or policy decision, although their advice is sought. None of the doctors working are members of the association.

There are six doctors currently working in this clinic--four women each of whom comes 2 or 3 times a week and two men each of whom comes every day in the afternoons or evenings. At any given time there is only 1, at most 2, doctors. The doctors are jealous of their time and do not want others encroaching on their time or clients. Each doctor has his "own patients".

Half of the fees charged patients goes to the doctor--the rest to the clinic (to pay for equipment, maintenance costs, etc.) All examinations cost 75 piasters. Other services cost more--for example, cervical cauterization costs 10 LE, male circumcision 3 LE, female circumcision 6 LE, housecalls cost 2 LE. Injections cost 10 or 15 piasters plus the cost of the ampoule. All financial transactions are handled by members of the Board (usually Ahmed)--each doctor is given his due at the end of the month. Records of patients are not kept by the clinic but the records of doctors (the number and type of cases seen) are so that they can be paid what is owed them each month.

The recruitment of the staff is worth remarking upon. When the clinic first began, Ahmed approached Dr. Aisha then working at the MCH Center in the area to see if she would be interested in working at the mosque. He was looking for a good female doctor, a "muhagabba". Dr. Aisha who was frustrated working at the MCH Center and lacked the financial resources to open her own clinic accepted a part-time position at the mosque. The motives she articulated for her working there are several:

- 1) She furthers her reputation in an area she anticipates eventually opening a private clinic in.
- 2) She makes contacts with the community and establishes a clientele.
- 3) She serves God.
- 4) She is able to practice proper medicine and able to gain more experience.

The contrast in working conditions between the mosque-clinic and MOH MCH Center-is very great. In the mosque-clinic, Dr. Aisha typically spends around 10 to 15 minutes with each patient while in the MOH center, she spends a hurried 2 or 3. The mosque clinic is visibly clean and well-ordered, patients are quiet and well-mannered, equipment is available and functioning,. (A simple but poignant example is that in the mosque clinic new gloves are available for every gynecological examination. The same doctor, earlier in the morning at the MCH center, is obliged to use the same glove for literally days, even weeks, at a time with no sterilization in between exams because the necessary equipment is not available--the director of this particular center refused to distribute more gloves because the nursing staff kept stealing them to use for home deliveries).

Dr. Aisha subsequently recruited the remaining 5 doctors--a male colleague from the MOH center, her sister, brother-in-law, and 2 friends from medical school. None of the doctors are yet specialized. An uncle of Aisha, a pharmacist in the area, gives a discount of 5% to all patients coming to his pharmacy from the mosque. The brother-in-law also gives discounts to mosque patients who come to his lab.

Several points are worth underlining:

1. The clinic essentially provides space for individual doctors to practise private medicine. The "overhead" is the share taken by the clinic. The clinic is curative-oriented.
2. No survey of community needs was made beforehand. The need was simply assumed and the decision made by the Board of Directors of the mosque.
3. The clinic develops in a piece-meal fashion. When funds are available, additions will be constructed, equipment bought. Plans are subject to constant change.
4. The clinic depends very much on the energy and organizational ability of certain key activators and on the morale of the doctors who earn little from giving their time.
5. Doctors were recruited through a network of personal relations rather than through advertising. Cultural factors were an important element in recruiting doctors appropriate for the community. Female doctors--and "muhaggaba" to boot--were actively sought and found for women patients coming to the mosque.
6. The mosque helped establish another clinic in a nearby mosque.

Case 2: Mosque Clinic in Masr Gadida(the Abu el-'uyun)

Another new mosque clinic run by a different gama'iyya, this time in Masr Gadida, resembles the unregistered clinic in certain respects but differs radically in the resources at the disposal of the Board of Directors. This mostawsaf is run by a tariqa (religious association) registered in 1976 (but formed in 1974) as the Abu el-'uyun el-Tahsis. Their social services are still in the process of formation. Their explicit aim is to establish a model for the proper life-long care of a person in a modern, Islamic way. To this end, they claim to have established a nursery (for 150 children), an orphanage, old people's home (for around 40), provide aid to students and the poor, run a mostawsaf and are constructing a hospital.

The mostawsaf which they operate was in fact established by another gama'iyya, disbanded in 1981 by the government which seized its property for political reasons. I was told that the Abu el-'uyun were then given the property by the State to manage more properly. This particular association is obviously highly favored by the State. Four of the members of its Board of Directors are high officers in the army (one of whom is a military doctor). The property consists of 6 feddan of prime land in Masr Gadida (estimated by my informant to be worth around 6 million LE) which contains several buildings--a mosque, administrative building, clinic, old people's home, nursery, educational institute connected to el-Azhar, some shops. Since October, 1981, the Abu el-'uyun began to renovate the mostawsaf they inherited at a cost of some 25,000 LE (so it was claimed). This expenditure prevented them from continuing further building of a nearby hospital they had been constructing since 1980.

The mostawsaf now has two floors, an in-patient section(15 beds), kitchen, an operating theater, lab, physiotherapy room, and several examination rooms. It is open in the morning and evenings. An average of 200 patients are seen daily. All exams cost 75 piasters. I was told that 30 doctors(all specialists including 3 university lecturers and several military doctors) work part-time. It was estimated that less than half of the doctors have their own clinic. Lab and X-ray specialists, for instance, work the longest hours because they have no equipment elsewhere.

Other staff include 15 nurses, 6 cleaners, 7 clerical and 2 guards. Most of the medical staff working there were there before the Abu-el'uyun took over. When the management changed, the standard wage was raised to 25 LE/month--a governmental standard with which associations need not comply if both parties agree. Incentives for workers include promotion and gifts as well as disincentives such as docking pay. Like the other mosque-clinic, fees are split 50/50 between the clinic and doctors. No general clinic patient records are kept although a doctor may have records of his own patients.

The hospital under construction(a block away from the clinic) is intended to be three floors. The first floor, already built, was estimated to cost 80,000 LE but in the end cost 115,000 LE. The second floor(partially built) and third floor(still in the planning stage) are estimated to cost an additional 150,000. The hospital is designed to include deluxe suites and a room for premature babies. Once the hospital is finished, the technical equipment presently in the clinic will be transferred to the hospital. At that point, the mostawsaf will become an entirely out-patient unit for uncomplicated cases and the hospital will care for in-patients and provide special examinations.

In other words, the association is amply endowed either with funds or ambition. What became clear during the course of discussion with the engineer(and Board member) was that plans were still in flux. For instance, the purpose for the third floor has not yet been decided. My informant declined to offer even an estimated date for the hospital's opening because he could not foresee when funds for its completion might become available. Like the unregistered clinic, progress in construction continues in a piece-meal fashion, proceeding whenever financial resources become available.

Case 3: Sidi Gaber Mosque in Alexandria

A third mosque-clinic, established in Alexandria 7 years ago by a gama'iyya only 2 years older, was initially created specifically to serve dependents of workers--for those who were not covered by the Health Insurance Organization and who found the free MOH services too humiliating and private practice too expensive. The number of clinics run by associations serving Alexandria may be one reason accounting for the failure of the recent HIO experiment to interest beneficiaries in extending insurance coverage to their families. In any case, this issue could bear further investigation.

All exams are performed by specialists and cost 1 LE. Doctors come, as in the other clinics, for 2 or 3 hours depending on their own schedules. Doctors receive 60% of what they bring in. The remaining 40% goes, as in the other clinics, to cover costs of nurses' and workers' salaries, expenses, etc. The mostawsaf saw some 15,000 patients last year. The clinic, open from 11 to 6:00, has a physiotherapy unit, lab, 2 x-ray machines. The doctor-director claimed that the cost of x-rays covered only the cost of film and accessories. He claimed, for instance, that a kidney X-ray which would cost 30 to 50 LE elsewhere only costs 15 LE here. Records of each doctor and patient are kept for 5 years.

The association plans to open a 60 bed in-patient section within the next 2 years. Since the opening of the clinic 7 years ago, 2 daughter branches associated with other mosques have been established. One established 3 years ago in Maamoura (open only during the summer) caters to well-to-do vacationers. It costs 4 LE for an exam. Another mosque in Abu Kir developed a clinic geared to the dependents of workers. There the same system as in the mother mosque operates only the number of doctors and equipment available are less. There is some overlapping of staff among the three clinics. Staff were recruited through personal contacts, visits to university departments (of the 16 doctors working there at least 4 are university lecturers). Advertising is the last resort.

The head of the Board of Directors of this particular mostawsaf is a man who works in the Office responsible for private associations in the governorate MOSA. He spends many afternoons after work helping to supervise the clinic. The mosque is well-known and apparently well-endowed. The association has been fortunate to be able to maintain a continuity of leadership (the same people are involved now as in the beginning).

While anecdotal in nature, these descriptions suggest social processes which both characterize Egyptian society generally and influence the type of health care services available in Egypt. Certain points may be worth emphasizing.

1. Social and political resources of core members of the association's board of directors are critical to the development of these privately run health care facilities. Board members are frequently officials who not only legitimize the association but bring with them a cluster of additional contacts and resources.
2. Mosque-clinics may be more vulnerable or at least more politically prominent than other types of mostawsafat.
3. Activators--committed individuals on the Board of Directors who take on the personal responsibility of the clinic's services--are important in maintaining morale, efficiency, continuity.
4. Mosque clinics, able to accumulate private capital, have been able to expand their services and facilities fairly quickly.
5. Mosque clinics often do create networks with other mosques and help each other to establish new health facilities.

Coptic Evangelical Organization for Social Services--CEOSS:

Reverend Samwil Habib, Director of Board of Administration
Cairo Headquarters: 4 Halim Square, Fourth Floor (telephone
906683/902667/904995)

Minya Headquarters: 86 26th July St., Minya (telephone 3371/2003)

One of the most unusual, highly organized and effective private associations currently in Egypt is CEOSS, an offshoot of the Coptic Evangelical Church. Unlike the other associations noted in this report which deal primarily with health problems in urban areas, CEOSS principally focusses on a range of social problems experienced by villagers in Minya and Assiut. Although the organization may not be replicable throughout Egypt, its principles for organizing social action suggest ways in which private associations may be most effective in Egypt. If atypical, its method of developing and using volunteers points to how other associations might develop a comparable volunteer manpower potential.

The organization originally arose out of an adult literacy campaign initiated by an American Presbyterian missionary in a village in Minya in 1952. From this experience, certain principles concerning the organization of community development effort emerged which have since guided CEOSS in its various activities.

The first principle is that its activities must be focussed, that is, concentrated in a small geographical area so as to be effectively managed by the association. Although CEOSS has expanded considerably since its founding, it continues to concentrate on a few villages at any single time within the area of Minya and Assiut. Initiating broader social changes by effectively developing local leadership and volunteer capabilities as well as mobilizing general community support for specific projects also continues to be a guiding policy of the association. Further, CEOSS will only enter an area at the request of a local community group--in other words, they respond to requests for help from people who are already conscious of, concerned about and prepared to work to solve, some given problem.

In addition to the effectiveness of CEOSS's internal organization, the Church's ability to acquire outside funding is an important factor in its capacity to maintain its activities. Because of its connection with the United Presbyterian Church in America and with the World Council of Churches, CEOSS has been able to draw on financial resources far beyond the bounds of the local Coptic community. Also largely through these connections to institutions outside of Egypt, CEOSS has also been oriented toward developing its own leadership potential--for example, training some of its staff in community development programs in the United States.

In 1960, the loosely coordinated teams working in the Church formed a single organization, CEOSS, which registered with the Ministry of Social Affairs as a gama'iyya belonging to the Coptic Evangelical Church. Since then, CEOSS has been engaged in a number of community development activities almost entirely within rural communities--projects involving adult education, home economics, agricultural development, biblical studies, local income generation, leadership and vocational training, home economics, family planning, nutrition and health care.

CEOSS enters a village at the request of some particular group. A team of six temporary staff (three men/three women) plus a village coordinator are provided housing by the village. Typically, the members of this team are recent secondary school graduates, 18 to 20 years old, from the city of Minya. During this time, the staff are paid wages commensurate with Ministry salaries. The temporary staff usually stays in a village between three and five years--usually the time it takes before they are given a Ministry job. A period of three to five years is also the amount of time CEOSS allots to undertaking and completing a given project within a village. At the end of this period, the team leaves and the activities generated by the project are in theory supposed to continue through the work put in by CEOSS-trained local volunteers. The village then becomes a "follow up" village--a CEOSS supervisor coming only periodically to check up, advise and otherwise assist the village volunteer leaders.

Nabil Samwil claimed that about 45% of the male members of these teams continue to stay on in CEOSS (rather than accept a Ministry job) to work in another project in another village. The young women do not stay on longer for various reasons--Ministry work is easier and pays the same and because CEOSS regulations require that any female team member who marries must quit her job.

The work is regarded as arduous by all concerned since the staff works and lives in the village. Morale is generally high, however, since the staff meet periodically and receive support and advice from each other. It should be noted that the village teams are made up of active urban Christians who regard their work as a kind of mission. (Some village youth, but no Muslims, have been motivated to join CEOSS--in which case they are assigned to a village other than their own.) CEOSS's effort to maintain good relations with Islamic groups is always asserted--they claim to respond to any group which is concerned with social problems.

CEOSS in Minya currently has a paid staff of around 25 working in the central headquarters. Another 45 work as field staff in approximately 5 principal villages and follow up earlier projects conducted in many other villages. It operates on its own with little contact and no support from the Ministry of Social Affairs or Ministry of Health. Significantly, the staff had never heard of the Federation of Associations.

Its health care services--the plan for which is still in the process of development--reflect a flexibility characteristic of the organization generally. At present, CEOSS is directly involved in health care through a number of channels. Firstly, a curative care program has been established involving contracts with private doctors. As part of its preventive health care program, CEOSS helps villagers to build latrines and spray their homes for flies and mosquitoes. A Health Committee (Unit) is active in educating villagers through discussion, meetings, "health rallies", and publications about various health problems. A family planning program brings doctors to the villages and the home economics program includes an important nutrition/hygiene component. In addition, CEOSS has given financial support to other cooperative groups to establish dispensaries (mostawsafat) in certain villages. Taking each in turn, these health activities illustrate the flexibility of approach and variety of method CEOSS uses to tackle interrelated health and social problems.

Currently, CEOSS contracts with eleven specialists in Minya--specialists in chest(2), eyes(3), and general medicine(3) as well as 3 dentists--to accept certain patients at a reduced rate. The contracts vary from doctor to doctor. Doctors apply to CEOSS, presenting a proposed list of reduced prices for exams, various tests and operations. In return for this reduction, the doctors are guaranteed a large volume of patients. Of the doctors under contract, only one is Muslim. Most current arrangements stipulate that each initial exam will cost 1.25 LE. The patient pays 25 piasters while CEOSS makes up the difference. CEOSS also arranges to pay 50% of the cost of drugs prescribed by these doctors under contract.

The volume of cases seen through these contractual arrangements is indicated in the following table drawn from their 1981 Annual Report. The table also indicates something of the health education efforts exerted by the various health and family education programs conducted in the villages:

Type of Program	# of Exams	(Approximate) # of Villages	# of Operations	Glasses	False Teeth	Meetings	Films
Eye Care	2183	76	193	407		30	29
Dental	482	21	115		24		
Maternal	1181	28	6			5	5
Child Care	1487		3			5	5
Family Planning	2704	25	65			24	24
Abdominal	645		23				
Chest	157						
Total	9469		405	407	24	64	63

Between 1970(when the Eye Care Project began)and 1977, CEOSS claims that over 13,000 people in 32 villages had received treatment at greatly reduced cost. Since 1974, CEOSS claims to have treated a total of 14,073 women in the maternity care program, and 16,056 children through the child care program.

The preventive health program conducts health education through a variety of means. In 1981, "health rallies" were held in some 28 villages. Posters are set up in CEOSS villages in the streets and in public places--the topics cover the danger and means of getting rid of flies, eye and dental care, the date of vaccination campaigns, the importance of latrines. A number of free or low cost tracts written in simple Arabic on proper dental care, family planning, eye care and the danger of flies are published by CEOSS in Cairo and distributed to the villages. An audiovisual unit in Cairo also enables films to be shown in the villages on the prevention and treatment of contagious diseases, the danger of flies and how to combat them, children's diseases and vaccinations, schistosomiasis and anklistoma, hygiene in the homes and streets, personal cleanliness, the danger of contaminated water.

In 1981, at the the request of their village councils, CEOSS helped three villages spray their houses. The villagers were taught how to operate the spraying equipment and contributed 35% of the total cost. During 1981, CEOSS also helped install 110 latrines in 3 villages (an additional 12 were scattered in 8 other villages). After hearing CEOSS propaganda, 39 other individual villagers installed their own.

CEOSS, on occasion, also coordinates First Aid training courses with the Red Crescent Society. In April, 1981, for example, CEOSS recruited 9 village women from 7 villages, brought them to Minya and accomodated them so that they could attend an 8 session training course in First Aid. These women were in turn responsible for applying their first aid training in the villages and informing villagers of what they had learned. In addition, all CEOSS field staff receive Red Crescent First Aid training.

As part of a still emerging program to develop income-generating activities in rural areas, CEOSS has helped village-level associations by providing them direct financial assistance. This initial financing allows these small associations to set up specific projects or services in the village--for example, schools, economic projects or health care dispensaries.

Nabil Samwil, a member of the Board of Directors, estimated that approximately 4 to 5% of direct economic assistance given out in the past few years has been for health care projects. Within the last few years, CEOSS has been approached by a number of village associations seeking money to establish or equip mostawsafat in their villages. Five made formal applications--CEOSS accepted the terms of two, rejected two and will probably award the fifth the money requested.

When a group applies for financial assistance, CEOSS sends out researchers to make an economic/need survey of the area and assess the viability and capabilities of the group requesting the assistance. Such financial assistance is available to any group, whether Muslim or Christian. In the case of the groups requesting financial assistance for mostawsafat, only one is Christian--a church group in Mattiya (an urban area) which has asked for a 4,000 LE grant. Although economic assistance is generally awarded to village groups, this particular association will probably receive the funds requested.

In 1981, CEOSS gave grants of 1,500 LE and 1,000 LE to two village-level Islamic societies for the purpose of purchasing basic equipment and furniture for the mostawsafat they were organizing. In one of the villages in question, a Ministry of Health facility is available. CEOSS had established programs in both villages some years ago during which time relations between CEOSS and the people involved in these village-associations formed. Although CEOSS has since left the villages, relations of cooperation have continued between CEOSS and the Islamic groups as part of their "follow up" activities--the aim of generating community change and initiative having been started.

Female field staff work with the women of the villages in various programs--home economics, bible study, literacy classes, family planning. As a regular part of the home economics program, women are taught how to prepare healthy meals and to introduce supplementary feeding from the fourth month of their baby's life. As part of their adult literacy classes, CEOSS uses brochures, written in simple Arabic, which deal with health issues and family planning.

Family planning efforts began in 1974 in two villages and by 1982 has reached 28 villages. From the beginning of the program until the end of 1981, 19,587 women have been examined in this program. CEOSS stays in a village until at least 35% of the eligible women become contraceptors.

Ten female doctors, specialized in gynecology and obstetrics, visit "their" villages in turn once a week to give physical exams. They also examine and treat barren women or perform simple operations. All these doctors work in the Ministry of Health and maintain their own private practice. They visit the villages once a week in the afternoon. Once a village becomes a "follow up" village, the doctor no longer goes to the village, but typically the village women continue to seek out that same doctor in Minya in her private clinic. As CEOSS moves into another village, the doctor becomes known to a new set of potential clients. Working in CEOSS clearly expands the range of a doctor's clientele and constitutes an important factor in motivating these doctors to work part-time for CEOSS..

Aside from enlarging her clientele, the doctor also receives a monthly sum depending on the number and kind of cases she has treated. Each of the doctors receives 1.25 LE per exam--25 piasters is contributed by the patient while the difference is paid by CEOSS. If an operation is required, the patient pays one third of the cost, CEOSS two thirds.

Village women(including some dayas) have attended training sessions on family planning sponsored by CEOSS with an eye toward motivating these volunteer leaders to persuade other women to enrol in the family planning program. The sessions covered family planning problems, benefits, and methods and developed communication skills. In 1981, four such training sessions were held at CEOSS's Itsa Development Center. Attendance varied from 9 to 18 women coming from 7 to 12 different villages per session.

In February, 1981, a special conference was held for midwives(12 women from 10 villages) to teach them proper methods of delivering a baby and about family planning. The training sessions were conducted by a female gynecologist. At the end of the session, the women(including dayas) were given a small medical kit including two pairs of stainless steel scissors, a clamp, and five pairs of gloves so as to continue their work in a more hygienic manner. By working with the local dayas, CEOSS hopes to increase family planning acceptance in the area and to reduce infant mortality in the villages.

Apparently, CEOSSS intends to expand its health care service program. It is presently trying to develop a plan for providing effective health care services which will not duplicate Ministry of Health or private practitioner activities in the area. For example, it is currently working on a health project to establish a health care program targeted to under-fives children and their mothers. Their intention is to establish initially two clinics which will cover three villages. A doctor, nurse and social worker are to spend two days a week in each. They hope to hire a full-time doctor on a fixed salary but recognize that their chances of finding a doctor willing to accept these terms may be difficult.

Gama'iyya Mobara el-Marat el Gadida--the Charitable Association of the New Woman (the Welfare Modern Woman Society)

Headquarters: 19 Kasr el Nil St.

School for Nurses: 1 Sharia el Gama'iyya Mumaridat el Gadida, Masr Qadima, telephone 843203

Chairwoman of the Board: Leila Barakat(telephone 729973)

The history of this association not merely reflects but exemplifies the magnitude of the social and cultural changes that has taken place in Egypt since the turn of the century. Now radically reduced in scope, the activities and resources of this particular association nevertheless continue to be directed by a Board which attempts to address social welfare problems thought to be neglected by the government.

Established in 1919 by a group of wealthy, elite women--including two princesses as well as Hoda Sharawi--the association was in large part an extension of an earlier social service association(Mohammed Aly the Great Society) established in 1909 under royal patronage. The current head of the present Board of Directors is the daughter of one of the founding members lending a distinct continuity to the character and aims of the association. The association initially established in 1919 a school for girls to teach them reading, writing, embroidery, sewing and carpetmaking. Schools for nurses and nannies, as well as a nursery, kindergarten and(recently) an old people's home have been established at different times in response to social needs felt by the association to be neglected by other welfare agencies.

Eventually, the association was responsible for a network of twelve hospitals and eighteen out-patient clinics throughout Egypt. During the 1950's and 60's all these facilities were seized by the government. The Curative Care Organization and Health Insurance Organization are now responsible for most, if not all, the hospitals established by this association. In any given locale throughout Egypt, a hospital named Mobara usually designates one of the 12 hospitals once owned by this association.

Some time after the revolution, the previous leaders of the association were asked to resume their volunteer work but the association never recovered control over any of the health facilities. They do, however, continue to be responsible for the Secondary Technical Nursing program they established in 1951. Since 1972, the school has followed the same curriculum and regulations as other Ministry of Health nursing schools. Student nurses frequently do their practical training in a nearby hospital which formerly belonged to the Association. Graduates, as in any other nursing school, are obliged to work in Ministry of Health facilities upon completion of their nursing studies.

Mrs. Barakat claimed that in recent years, the number of admissions (now 120 down from 200 students seven years ago) have been declining and consequently the standard of admissions has also been lowered. Nonetheless, the institute is reputed to be one of the best nursing schools in Egypt. Mrs. Barakat attributes this to the close supervision the association continues to maintain over the school. Students are examined monthly in contrast to other schools in which students are only examined at the end of the term. If the class showing in any given monthly exam is poor, the doctor can be changed. If an individual student is not doing well, the parents are contacted. If a doctor has been repeatedly tardy or absent, his contract is not extended. In short, the association's Board of Directors continues to play a concerned and active role in supervising the school's operation.

Tanzim el-Usra(Family Planning Association):

The Family Planning Association in Alexandria, a federation of some 26 family planning associations which together operate 35 family planning clinics, established a model clinic some 4 years ago. This clinic serves as a medical referral center for the clinics overseen by the FPA. In addition to offering pediatric, gynecological, and obstretrical services, the clinic aims to offer all forms of contraception possible--for instance, it performs sterilizations and abortions. It also conducts antenatal classes. It is run by a doctor who has been the association's medical consultant since 1962. The center trains the staff of the 35 family planning clinics, each category of worker training his own counterpart.

The Family Planning Association has been active in seeking ways to educate people to think in terms of family planning. It has established a series of programs introducing family planning to different groups involving four to six-day long mini-courses. In 1981, for example, different sessions were conducted for teachers(21 attended), 'ulama(religious men--23 attended), members of development associations(16), workers(12), doctors working in family planning clinics(6), officials responsible for implementing family planning in Alexandria(4), and "pioneers" and "natural leaders"(21). The aim of the sessions was to introduce the basic concepts and techniques of family planning in a way most appropriate to different audiences.

One project the FPA has carried out, apparently with considerable success, has been recruiting women to attend postnatal clinics. The idea was that women would be most receptive to family planning after the birth of a baby. Since June, 1977, women who registered the birth of their babies were contacted by the FPA urging them to visit a family planning clinic. Social workers and natural leaders would visit these women at home to convince them to come.

The FPA has used volunteers in an innovative way to reach different groups. Natural leaders(volunteers) are initially selected by the social worker from among those women who have come to a family planning clinic. The social worker sends the woman to the FPA central office for training on how to teach others about family planning and hygiene.

It is claimed that some 6,000 women have been trained as "natural leaders". They use cards with simple symbols and figures to get a certain message across. For example, the cards indicate the concept behind barrier methods of contraception, the need for dental hygiene, personal cleanliness, the importance of teaching children good hygiene habits.

While the efficacy of their methods to reach the community could not be assessed given the brevity of my visit, certainly the possibilities for community outreach were evident. For purposes of health education or teaching oral rehydration therapy, the use of volunteers in some similar fashion could be a cost-efficient and persuasive means of reaching large audiences.

Summary:

While the diversity of the associations explored here may be more immediately evident than similarities, the reader should not forget the extent to which problems, concerns and methods are frequently shared by these various groups. The more salient commonalities generally refer to the form of direct health care delivery offered by the different associations.

Once an association enters the field of health care, doctors tend to dominate that area of activity. Physicians frequently supervise and operate the health care services which usually follow clinical lines typical of Egypt. Direct health care services are doctor-oriented and controlled. As in other health care systems in Egypt, nurses and social workers are underutilized and record-keeping systems are inadequate and uninformative.

Those associations which engage in outreach and health education are also those with considerable funding and input from nongovernmental sources--CEOSS, the Red Crescent, the Family Planning Association. These associations also benefit from ideas and expertise drawn from outside Egypt. Their principles are explicit, their resources diverse. Their ultimate aim is to develop and activate local community leadership by changing patterns of community and individual behavior. To this end, their programs are designed in such a way as to recruit and effectively use local volunteers who are trained and supervised by their own staff.

Those associations whose health-care services are primarily clinic-based (the mosque clinics, the direct health care services of the Red Crescent) vary less in their approach to health problems. These health care services typically form a collective private practice. The fees for a medical exam, cheaper than private practice but more expensive than Ministry of Health service fees, largely depend on the minimal amount acceptable to doctors as a commission. Doctors earn--and are recruited on the basis of--a fixed commission for the cases they treat. The rest of the revenue goes to the general fund of the facility or to the association itself in which case it can be invested in the health facility or used to cover costs of some other service provided by the association. In addition, the hours available for exams depend on the personal schedules of doctors.

These facilities do not typically undertake health or nutrition education as an integral part of their services. The extent to which health education is disseminated depends on the effort of individual doctors treating individual clients. Doctors perform no more and no less than they would in their own private practice. The health service is regarded as a kind of charity which implicitly accepts the status quo insofar as effort is not directed toward changing client behavior in a programmatic way. At most, the health service may draw persons potentially interested in the association itself--e.g., a taxiqa may attract prospective adherents through its community and health care activities.

All the private associations described here have active members in their volunteer Board of Directors. Specific individuals within the Board are typically most concerned with and responsible for the health care activities of the association. They are committed to the principles and activities of their association. Their concern and active supervision are important factors determining the comparative order and high personnel morale of their association's health care services.

Suggestions

If the Office of Health at AID is interested in pursuing further information about or contacts with associations active in health, I would suggest that it coordinate its research and efforts with the Neighborhood Urban Services Project which is just getting off the ground. Minimally, the Office should be familiar with the intentions and possibilities of this project--and keep abreast of information it will gather on private associations. Depending on the strategy the Health Office develops, different kinds of assistance for associations active in health might be worth exploring.

By October, 1982, the NUSP will have gone through an initial evaluation of private associations in Cairo and Alexandria. At a later date(unspeified as of yet), they should have completed a more thorough assessment of the capabilities and services of these associations. The project will be working with local communities to develop the administrative and technical capacity of private associations. It intends to establish 900 separate service activities and assist in the activities of another 2,500 private associations. Presumably, the NUSP and Health Office would both benefit from a mutual exchange of ideas and informations.

It may be worth bringing to the attention of the Health Office, especially as it enters its final phase of the Health Sector Assessment, that a tentative list of projects submitted by local councils in Alexandria and Cairo to NUSP for funding included a large number directly related to health. (See Table 5). In a list of 65 projects in Alexandria approved for funding, 17 were aimed specifically at health facilities. Cairo's districts also submitted requests for substantial assistance in health projects.

Table 5:
Projects Submitted by Local Councils to NUSP:

Alexandria:

East:

1. Equipment for el-Talaba Hospital	8,000 LE
2. " for el-Montaza Clinic	10,000 LE
3. " for Bakous Clinic	10,000 LE
4. Establish al-Matar Health Center	<u>30,000 LE</u>
	58,000 LE out of 415,000 designated for this district

Central:

1. Apparatus for Photographing Eye	25,000 LE
2. " " " with Sonic Waves	40,000
3. 3 Operating Tables	30,000
4. Emergency Dept. at el-Hamiet Hospital	<u>48,000</u>
	143,000 out of 375,000

West:

1. Support for Ras-el-Tin Hospital	26,000 LE
2. Support for al-Anfashy Hospital	22,000
3. Support for al-Gomhuria Hospital	22,000
4. Rehabilitation for Karmoz Health Center	5,000
5. X-Ray for el-Sadr Hospital	24,000
6. Support for Dar Ismail Hospital	15,000
7. Health Center Equipment (el-Sayadin)	10,000
8. Health Center " (el Shamary)	<u>10,000</u>
	134,000 out of 375,000

Al-Ameriya

1. Development Health Center in Alkabawy School	25,000 out of 375,000
--	-----------------------

Cairo:

West Cairo

- | | |
|---------------------------------------|-----------------------|
| 1. Construction--Boulac Health Center | 8,000 LE |
| 2. Medical Equipment--Boulac | <u>50,000 LE</u> |
| | 58,000 out of 200,000 |

Masr Gadida

- | | |
|-----------|--------------------------|
| 1. Clinic | 50,000 out of 125,000 LE |
|-----------|--------------------------|

North Cairo

- | | |
|-----------------------------------|--------------------------|
| 1. Equipment for General Hospital | 70,000 out of 210,000 LE |
|-----------------------------------|--------------------------|

Shoubra

- | | |
|---|-------------------------------------|
| 1. Equipment for Shoubra Health Center | 100,000 |
| 2. Equipment for Shoubra General Hospital | <u>129,300</u> |
| | 229,300 out of 300,000
allocated |

Addresses of Regional Federations of Private Associations:

1. Cairo--31 Sharia el-Galaa. Director, Mr. Said Zaki
2. Alex--32 Sh. Saad Zaghloul. Director, Mrs. Emal Fouad
3. Port Said--Sh. Salah Salam el-Qala'oun (Behind Masjid Rahma)
POB 389, Port Said
4. Suez--Governorate Building of Social Affairs, Suez
5. Ismailiyya--Red Crescent Building--Sharia Tahrir in Midan
el-Mahatta, Ismailiyya
6. Damiett--Sh. Tahrir
7. Sharqiyya--Midan Arabi in Zagazig
8. Qalyubiyya--11 Midan Saad Zaghloul #5 in Benha
9. Kafr esh-Sheikh--Building 20, Apt. 2, Economic Building, Kafr
esh-Sheikh
10. Gharbiyya--1 Sh. al-Awqaf, Awqaf Building, Tanta
11. Menoufiya--Sharia Khalid bin el-Walid
12. Beheira--13 Sh. Ismail Sidqy
el-Kawfy Building, #2 in Damanhour
13. Giza--529 Sh. el-Ahram, Giza
14. Fayyoun--POB 52, Fayyoun
15. Beni Souief--42 Medinat Beni Soueif Gadida
16. Minya--4 Midan Abdel Moneim, el-Minya
17. Assiut--East Building, #46
18. Sohag--5 Sh. al-Gihad
19. Qena--Sh. el Mushtashfiyat--Building Doctor Maxwell
20. Aswan--POB 14, Aswan
21. Red Sea--Social Unit in Hurghada in front of Socialist Federation
22. Wadi el-Gadid--Social Unit in Kharaga, Sh. Port Said, Kharaga
23. Marsa Matruh--Mudirriyya of Social Affairs

Addresses of "Assimilated" Federations:

1. Federation of Family and Infant Care Organizations
14 Sharia Arabi, Cairo
2. Federation of Social Assistance Organizations
29 Sh. Sheikh Rihan, Cairo
3. Federation of Organizations for the Handicapped and Abnormal
22 Sh. Sabri Abul 'alem, Bab el Louq, Cairo
4. Federation of Development of Local Communities
Mahmud Tantawi
5. Federation of Service Organizations(Cultural, Scientific,
Religious)--12 Sh. Ramsis, Cairo
6. Federation of Associations for Administrative Development
2 Sh. Al-Shawarbi, Cairo
7. Federation of Organizations for Care of Prisoners
130 Sh. 26 July, Zamalek

Contacts

General Federation of Private Associations

15 Emad ed Din St., near Ramsis

Director, Ibtisam Abdel Wahab

911543/704121(home)

Emal Fouad

Director of Regional Federation in Alexandria

Olfat Kamel

Vice President of Federation of Family and Child Care

Zahya Marzouk

President of Federation in Alexandria

Ministry of Social Affairs

Mr. el-Mahi

Undersecretary of MOSA

24660/28466.

Ibrahim Iman

General Director of Private Associations Dept.

28257

Fathi Khalifa

Director of Alexandria mudiriyya

18 Sh. Kulliyat at-Tibb

Wagdi Fayad

Director of Office for Associations, MOSA

29921

Mr. Marai

Asst. Director of Office for Association, Alexandria

802417/23417

Red Crescent Society

Yehya Darwish, Secretary General

750317/752995

Yusuf el-Agg, Director, Cairo branch

Mme. Makharin, Board member

Mohammed Hassan Oukda

Director, Alexandria branch

55 Sh. el Horreya, Alexandria

23713

Dr. Zeinab al-Soubky
Director, Blood Bank and Clinic, Cairo

Dr. Tahtawi
Director, Red Crescent Hospital in Tartu

CEOSS

Nabil Samwil
Board of Directors, Minya branch

3371/2003(Minya)

Reverend Samwil Habib
Director of Board of Administration

906683/902667/904995
(Cairo)

The New Woman Welfare Society

Mrs. Leila Barakat
Director, Board of Administration

843203/729973

Family Planning Association

Sawsan Esh-Sheikh, Director, Alexandria

Dr. Hafiz Yusuf
Director of Medical Clinic for FPA in Alexandria

Abu el-'ayun el'Tahsis

Ustaz Farouk Suleiman

Sidi Gaber Mosque mostawsaf

Dr. Abd Shekour
General Manager

45632

Neighborhood Urban Services Project

Ray MacGuire, AID

Dr. Isis Istiphan(of Wilbur Smith and Associates)
117 el Thawra St., Masr Gadida
668711/668621

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1. Delta Business Services International
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Associations in Cairo and Alexandria, June 1982
2. Hassan, Nawal
The Role of Voluntary Associations in Egypt
Center for Egyptian Civilization Studies
June, 1981
3. See ECTOR Health Sector Assessment to be finished by
October 31, 1982
4. Moore, Clement
"Authoritarian Politics in Unincorporated Society
The Case of Nasser's Egypt", Comparative Politics
January, 1974
5. Elliott, Veronica
Egyptian Voluntary Associations and the Health Sector
USAID Health Sector Assessment Report, 1982

Giza Associations/Addresses of Mostawsafat

1. Tereit el Ahram: Masgid el Khulafaa el Rashidin--Faisal Highway
2. Al Markaz al Islamiyya bil-Haram
3. El-Khayriyya el Bayyoumi: el Namr St.
4. El Khayriyya el-Masihyya: 13 el Hakima St.
5. Tanmiyat el Mogtama el Mahaly: Bi-abi Horerira, El Masaken el Sha'abiyya in Giza
6. Red Crescent Society--El-Kawmia St., Sakiet Heki
7. Gama'iyya el-'alag: 24 Ali Refa'i St.
8. Gama'iyya el-'alag: Mabna Gama Sidi Mahmud, Haret el-Eweis
9. Gama'iyya el-alag,: 15 el Nur St., Dokki
10. Gama'iyya el alag:
11. Gama'iyya ash-Sharbia bil-Giza: 509 Al Ahram St.
12. Gama'iyya ash-Sharbia bil Giza: El-Sanadily St.
13. Red Crescent bil Giza: 7 Hemdan St., Giza
14. Ibna Geziret Dakahlia, Kamel Abdel Hafez St., Umraniya
15. El Sayeda El Azra el-Khayriyya, El-Thalathin St., Umraniya
16. Ibna Muhafazet Beni Soueif: 1 Fahim St.
17. El Kepteia el Khayriyya el Orthozoksia: 12 Zaki Misr St., Imbaba
18. El Radwan el Diniyya Wal Igtima'iyya: Masgid el Radwan, Zbeida Square
19. Ibn el Hassan el Shagie el-Itima'iyya: 11 Said Ibn el Hassan el-Shagei, Imbaba
20. Abna' Shanshour el Khayriyya: Zaki Okaoud St.
21. Gama'iyyat el Ber Wal Massaken el'Sha'biyya, Imbaba
22. As-Sihhiya bi Giza: Nazlet el Seman
23. As-Sihhiya bi Giza: Madinet el Umal
24. As-Sihhiya bi Giza: Mit Oqba
25. As-Sihhiya el Muhafiz bil Giza: 49 Ahmed Maher St., Giza
26. Gama'iyya Shabab al-Muslimin: 15 Sharia Hussein Kamel al-Din
27. Gama'iyya Tanmiyya al Mugtama'a al Mahali bil Giza: Mohammed Hegazi St.
28. al-Gamaiyya el-Khayriyya al-Islamiyya li-Shabab: Mit Oqba Zayer el Nahia St.
29. al-Musldata al-igtima'iyya: 18 Sharia Bayoumi Salam, Imbaba
30. Al Musldat al-Igtima'iyya: 2 Sharia Gamil Salem
31. " " : 5 Sharia Moheir el Hindi
32. " " " "
33. el Dokki el-Keptiyya el Orthozoksiyya: 12 Sh. el Mathaf el Zer'ei
34. Tarmiyya el-Mugtama' al Mahaly al Madina al Umal wal Tahrir Imbaba
35. Tarmiyya el-mugtama' " " Sharia Wadi Imbaba el Riyadi
36. El-Khayriyya li-Ahly Shenway Menoufiyya: 8 Sharia el Madrassa, Imbaba

East Cairo:

1. El-Gama'iyyat el-Shariya li-Atwen el Amelin bil-Kitab, Matariyya
2. El Gama'iyyat Khaled Ibn el Walid el Khayriyya: 134 Sharia Mathaf, Matariyya
3. El-Gama'iyya Badr el Khayriyya: 9 Sharia Kasr Diafa
4. El-Gama'iyya Masgid Ain Shams el-Khayriyya: 53 Sharia Ain Shams
5. El Khayriyya el Islamiyya bi Ain Shams: Sharia Mubarak: Masgid Osman Ibn Afar
6. Wehdet el Waily El Sakaniya: Massaken el Waily, Block 13
7. Gama'iyyat el Barnawany: 8 Sharia Bahgat
8. Gama'iyyat Omar Ibn el Khatab el-Khayriyya: 2 Sharia 21, Masaken el Hilmiyya
9. El Gama'iyyet el-Sharia, Manshiet el Bakry--87 Sharia Mathaf el Matariyya
10. El-Riaya el Igtima'iyya bil Akad: 24 Sharia el Terolly
11. El Gama'iyyet el-Khayriyya li-Masaken el-Matariyya--Masaken el Matariyya el Gedida.
12. El Gama'iyya Manshiet el Zahra el Khayriyya: Midan Ahmed Ismail
13. El-Gama'iyyet el Akbat el Orthozoksia: 9 Sharia Midan Maher
14. El-Gama'iyyet el Tawen el Islamiya: 233 Sharia Teret el Gabal
15. " " " : Masaken Barid Ghamra, Block 115
16. Bahgat el Islam el Khayriyya: Sharia Ahmed Bassiouni
17. Gama'iyyet el Tadamon el Itima'iyya: 2 Midan Ahmed Naguib
18. Gama'iyya Kobri el Ataba: 23 Sharia 26 July
19. Nahdat el Shahid Mary Guirguis: 187 Sharia Tereti El Gabal
20. Gama'iyyat Abi Sefein
21. Gama'iyyat Abi Sefein: 26 Sharia Ali Sharawi
22. Gama'iyyat el Sanabel: 13 Sharia Hefni Nasef
23. Gama'iyyet el Khadamat el Islamiyya: 8 Sharia Hassan
24. Gama'iyyet Wahda el Sakaniyya bil Amyria: El Massaken el Amyria, Block 14
25. Gama'iyyet el Takwa el Khairiyya: 38 Sharia Kamel el Din Hussein
26. Gama'iyyet el Bir Wal Takwa el Khayriyya: 15 Sharia Ahmed Ibrahim Attia

North Cairo:

1. El Sayed el Azra: 10 Sharia Khamarawait
2. El Nashat el Nessaëi: 336 Sharia el Taraa
3. El Sayed El Azra: 2 Sharia Aly Bakloul
4. El Takwa el Khayriyya: 40 Sharia Fouad Broud el Farag
5. El Nahda el Rouheya el Kebteya: 5 Sharia Fouad
6. El Sayeda el Azra Wa Malgaaa el Azara: Adher el Malek el Salah
7. Magd el Islam: 17 Sharia el Tahra
8. El-Enaya Wal Ishad: 86 Sharia el Hafziyya
9. Al Hoda al Islami: 32 Sharia Abdel Khalek Wasfy
10. Rais el Malak al Galil Mikhael: 84 Sh. Mikhael
11. Al Shaid al Azim
12. Nadat el Malak Mikhael: 32 Sharia Mikhael
13. El Shahida Demiana: 18 Sharia Mohammed Abdel Metal
14. Deir el Ganadela: 30 Sharia el Soufi
15. Rabetat el Khadamat li-Kafat el Manteka: Iskan el Zawia
16. El Nasr lil'ilag was khadamat el Biea: Haret Ahmed Khalil Hashim
17. El Nasr lil-'ilag wa khadamat el Biea: 31 Sh. El Hadad, Shorabia
18. Nahdat el Shabab el Kobra: 50 Sharia
19. El Khayriyya li-Ibnaa Bandar el Sharqiyya: 5 Sharia Abdel Rahman
20. El Khayriyya li-Ibnaa Nagei: 94 Sharia Youssef Zalat
21. El Sayda el Azra el Kebteya el Orthozoksia: 3 Sharia Mohammed Ismail
22. El Salam el Kebteya el Khayriyya bi-Shubra: 15 Sharia el Gioushi
23. El Ber el Orthozoksia lil Ri'aya el-'igtimaiyya: 10 Sharia Zein el Din bil Tara el Boulakiyya
24. El Raei el Saleh: 121 Sharia Shubrah
25. El Shahid Istafamous el Kebteya el Orthozoksia: 19 Sharia Taha
26. Gama'iyat el Tarbiya el Islamiya: 13 Sharia Madraset el Tewfikia
27. Gama'iyat el Tarbiya el Islamiya: Sharia Ahmed Helmy
28. " " " : 95 Sharia Geziret Badran
29. " " " : 27 Sharia el Bakry
30. El Raafa el Kebteya: 362 Sharia el Tera
31. El Kedeisa Hilana: 52 Sharia Mostafa Ramadan
32. El Khayriyya el Islamiyya: 34 Sharia Attia bil Tara
33. El Musaadat, Shiakhet el Attar: 46 Sharia el Attar
34. Nahdat el Akbat: 7 Sharia el Attar, Shubra

West Cairo:

1. Mostawsaf el Madbouli: 31 Sharia el Galaa
2. Ibnaa el Kom el-Khayriyya: 21 Sharia el Kom
3. Gama'iyyat el Shuban el Muslemat: 21 Sharia Ramsis
4. Al Haiya al-Kebteya el Engeba: Ramsis
5. Al Gama'iyya al Shariya al ama li-Ahli Abu Handal
6. Gama'iyya Tanmiet el Mogtama bi-Raml Boulaq: Masaken Ramlet
7. Gamaiyya Mustashfa Wal 'ilag el Mouazafin: 35 Sharia Galaa,
Boulaq
8. Gama'iyya Luxor el Khayriya: 31 Sharia el-Genaien: Bir el Malak
9. Gama'iyya el Nahda el-Khayriyya li Nashr el-'ilag el Ishraki: 10
Sharia zein el Abeddin
10. Gama'iyya Riayet Marda el Saratan wa Usrahim: 16 Sharia el
Moneira, Sayida Zeinab
11. Gama'iyyat Kartias: Markaz Boulac
12. Gama'iyya Riayet al Umahat wal Atfal: 32 Sharia Ramsis, al
Madbouli
13. Gama'iyya Riayet al Umahat wal atfal: Sharia Hussein al Akbar
14. Gama'iyya " " " " : Sharia El Sabtiya
15. Gama'iyya Kartias: Al Umranya
16. Gama'iyya Kartias: Al Haram

Helwan:

1. Al-Shareya bil Basatin: 55 Sh. al-Wuzara'
2. Tanmiet el-Mugtama'a al-Mahali bil Bassatin: Sh. Hamouda
3. Al-Riaya al-Islamiyya li-Ibnaa al Tarika al Muhamadiyya bil Bassatin: Masjid el Nur el Muhamadiyya
4. Al-Khariyya bi-Helwan: 7 Sh. el-Egba
5. Al Khariyya wal Khadamat al Ama bil-Madaris: Road 77 Maadi
6. Atbaa al Mahaba al-Kebtiyya al-Orthozoksia: 64 Sh. Mahmud el-Masri
7. Tanmiet el-Mogtama'a el Masr bil-Masara
8. Al Jihad el-Kebtya al-Engiliyya: el-Sharei el-Gharbi bil-Masaken esh-Shabliyya
9. Al-Khayriyya bi-Geziret Dar el Salam:
10. Tanmiet el-Mogtama el-Mahali bil-Tebin: Masaken
11. Masaken Madinet el-Solb: 32 Sharia Mohammed Salim, Maadi
12. Al Hadid wal Solb: Madinet el'Solb el-Kadima
13. Al-Khayriyya li-Ibnaa Shirket el KOK
- 14.
15. El Shareya(el-Fatah)

Central Cairo:

1. Reayet el-Usra: 9 Darb Mahmud
2. El-Gamaliyya el-Igtima'iyya: 12 Zukak Jaefar
3. El Kedis Guirgis; 5 Sharia el-Taha
- 4.
- 5.
- 6.
7. El-Ama li-Reaya al-Igtimaiyya: 2 Sharia el Hassan el Akbar
8. El-Riaya el-Igtima'iyya: 23 Sharia Sherif
9. Dar el-Shafaa: 41 Sharia Kamel Sedki
10. El-Karma el-Kebteya: 3 Sharia el-Sobky
11. Ibnaa el Hassan: 241 Sharia el-Geish
12. El Ashir el-Mohameddin: 26 Sharia el-Serougia

South Cairo:

1. El-Imamin Wal Tonsi: Al Imamin Wal Tonsi
2. El-Riaya el-Igtima'iyya bil Khalifa: 35 Sh. el Hagib bil Khalifa
3. Rabetat Umal el-Iskan
4. Gama'iyya MU sadat el Marda bil Hilmiyya: 57 Sh. Mohammed Shaker
5. El Gama'iyya el-Khayriyya el-Islamiyya: 31 Sh. el-Sioufiya bil Kalaa
6. El-Riaya el-Igtimaiyya bil Khalifa: Sh. el Kadriya
7. El-Riaya el " " " : Sh. el Ishraf bil Khalifa
- 8.
9. Gama'iyya el-Hegd el-Khayriyya: 4 Sh. el-Sheikh Saleh
10. El-Gama'iyya el-Ama bil Ibagia: Masaken el-Ibagia
11. El-Gama-iyya el-Khayriyya al Islamiyya lilben wal Islah: 58 Sh. Imam el-Shafei
12. Gama'iyya Tanmiet el-Mogtama'a bain al-Sira: Ain al-Sira
13. Gama'iyya el Sayedat el-Kebteya: 33 Sh. Maglis el-Uma
14. Brock el-Khairi Hospital: 2 Sh. Biram el Tonsi
15. El-Iman el-Kebtya al-Khayriyya el-Orthozoksia: 80 Sh. el Daboura el-Khali
16. El Riaya el-Igtima'iyya bil Khalifa: Hilmiyya
17. " " " : Sharia el Qadesia
18. " " " : Sharia el Khalifa
19. " " " : El Imam el Shafei
20. " " " :
21. Gama'iyyat el Marhem el-Islamiyya: 155 Sh. Athar el Nabi
22. Gama'iyyat el-Khadamat bi Form el Khalig: 124 Sharia Absefin
23. Gama'iyya Rais el Salam: 26 Sharia Mohammed el-Saghir

Masr Gadida(in fact Zeitoun only):

1. El Akbat bil Zeitoun: 37 Sharia Kasr el Diafa
2. El Rabeta el-Islamiyya lil-Tawgih el-Itima'iyya: 9 Sharia Sayed Aly, Zeitoun
3. El Amr bil Ma'rouf: Masgid Omar Ibn el Khattab
4. Gama'iyyat el Khadamat el-Igtima'iyya bil Zeitoun: 5 Sharia Salem Hegazi
5. El-Aziz bilah bil Zeitoun: 20 Sharia el Azia Bilah
6. Gama'iyya Sayed Atris el Khayriyyah: 10 Sharia el Nawawi bil Zeitoun

Masr Gadida:

<u>Name of Association</u>	<u>Address</u>
1. Abu Bakr es-Sadiq	Sharia Nakhla el Mutayi, Masr Gadida
2. Abu Bakr es-Sadiq	21 Sharia Ismail el Falaki, Masr Gadida
3. Ei Tigania el Khayriyya	Roxi
4. " " " "	Roxi: Kulaf el Natura, Masr Gadida
5. Kayat el Khadamat lil Tamin	80 Sharia el Mumalik, Masr Gadida
6. Door el Nasr el- Alagiyya	52 Sharia el Haya Sadis, Madinat Nasr
7. "	16 Sharia Othman ibn Afan, Masr Gadida
8. "	173 Sharia el Nozha, Masr Gadida
9. "	33 Sharia Umar ibn el Khattab, Masr Gadida
10. El-Aml el Islamiyya	Gama'iyat Abu Bakr es-Sadiq, Sant Fatima
11. Masagid el Khulafa Rashidin	1 Sharia es-Sebaa, Masr Gadida

* Note that #11 was taken over by the Abu el-'uyun el-Tahsis tariqa in 1981.

Medinat Nasr:

1. Gama'iyat el Hodi-el-Mohammediyya: 2 Sharia Shahid Mohammed Abdul Moneim, Medinat Nasr

This is the current list (August, 1982) for Masr Gadida:

Name of Association, Address, Chairman of Board of Directors

1. Dour el Nasr el-'Ilag: 23 Sharia Omar Bin Khateb, Lt. Gen. Saad el Din el Sharif
2. Gama'iyet el Tahrir: 5 Sharia el Riaydh, Fathi Lotfy el Rafaei
3. Abu el 'uyun el-Khayriyya, 1 Sharia el Sabae, Lt. General Ahmed Awad
4. El Gama'iyet el-Islamiyya li-Tanmiet el Mogtama'a, 28 Sharia Manshiet el Bakri, Dr. Mahmud Khalifa
5. El Amal el Islamiyya, 113 Sharia el Hegaz, Major General Salah Khairy
6. Abu Bakr el Sedik, 21 Sharia Ismail el Falaki, Lt. General Saad el Din el Shef
7. El Shareiya bi-Masr el Gadida, Sharia el Roda wa Damanhour, Ahmed Aly el Laban
8. Ibnaa el Hai el Sadeq, Masjid Ibna el Hai el Sadeq, Elock 95, Mahmud Askar
9. El Gama'iyet el Tiganiyya el Khayriyya, 8 Sharia Abu Ebeid, El Bakri, Broksi: Engineer Abdel Meguid
10. Abu Bakr el Sadik, Sharia el Imam Aly: Lt. General Saad el Din el Sherif

Beni Souief:

1. El Shareiya
2. Tarmiet el-Mogtama'a el Mahali(Development of Local Community): Demoshia
3. Tanmiet el-Mogtama'a el Mahali: Agami: Masgid el-Kadi
4. Red Crescent: 4 Sharia Wahba
5. Tanmiet El-Mogtama'a el Mahali: Bani Haroun
6. Tanmiet el-Mogtama'a el-Mahali: Ghamrani: Sharia Thabet bil-Ghamrawi
7. El-Gama'iyya al Sharia: Sharia el-Mudaris: Masgid el-Sabteya

Aswan:

1. Tahsin el-Siha, (Improvement of Health)Edfo
2. Tanmiet el-Mogtama'a bil Seika el Hadid: 52 El Seika el Hadid
3. El Hilal el Khayriyya li-Tanmiet ei-Mogtama'a (Charitable Crescent for the development of Society)
4. El Khayriyya al-Islamiyya li-Tanmiet el-Mogtama'a: Sharia Patris Domemba(Islamic Charity for the Development of Society)
5. Ibnaa Muhafazet Assiut(Sons of the District of Assiut)
6. Tanmiet el-Mogtama'a
7. El-Gama'iyya el-Nesabiyya li-Tahsin el-Siha(Society for the Improvement of Health)
8. El Hadawin el-Khayriyya: Sharia el-Hadawin
9. Al-Khayriyya el-Kebteya:
10. Al-Shabab al-Muslemat

El-Minya:

1. Al-gama'iyya al-khayriya: Next to Begwar el-Mahkama el-Shariyya
2. Al-gama'iyya al-Islamiyya: 37 Sh. Amin
3. Al-gama'iyya el Wahda el Sakanya: Masaken Thalma, Building 8, Apartment 2
4. el-Mahaba el-Kebteya bi-Samalout
5. El-Bor el Khayriyya el-Shariyya: Midan el-Saa, el Minya
6. El Tadamon al-Islamiyya: Sharia el-Jihad
7. El-'ilm wal Iman al-Islamiyya: Under the el-Ali Bridge
- 8.
9. Al-Gama'iyya al-Shareya: 7 Sharia el-hilmiya
10. El Urwa el-Wouthka: Sh. el Hussein
11. El-Khayriyya el-Rifa'iyya bi-Tala
12. Al Shareya li-taawen el Amelin bil-Kitabl wal Sunna
13. El Tanzim al Nessai bi-Maghagha

Name of Association/Address of mostawsafat in Alexandria:

1. ash-Shabab al-Muslimin (Muslim Youth): ash-Shatby
2. Tarmiat el Mogamma el Mahaly (Local Development Association):
Moharam Bey Blocks--Masaken Moharem Bek
3. Fagr el Islam: Sporting
4. Red Crescent Society: 14 Masgid el Berens Ibrahim St.
5. Red Crescent Society: Mehatet el Souk St., Bakous
6. Red Crescent Society: 78, Shagaret el Dor St., Moharam Bek.
7. Masgid el-Khayriyya el-Islamiyya: Masaken Mohammed Farid, Bokley
(Charitable Islamic Mosque)
8. El Khayriyya li-Ahly Hai el Sour (Charity for the People of the
District of el Sour): Masgid el Sour Wel-Merghani
9. Zein el Abdin Imam: 4 Wabour el Hai
10. Rabetat Feryal el-Kepteia: 48 Ahmed Naguib St.
11. Masgid el Tarika el Merghania: 21 el-Merghani St.
12. El Khayriyya li-Omal Maslahat el Gamarek: Dar el Salam St.,
Gomrok
13. Ibn Khaldun: el Nasr St.
14. Nali el Said el Am: 27 Sherif St., Mina el Basal
15. Masgid Sidi Beshr el-Khayriyya: 9 Mohammed Hussein St., Sidi
Beshr
16. Masgid Ibn Serga: (faces Abu Serga Bridge)
17. el-Sharia li-atwen el-Amelin Bilkitab: 251 El Ramad St.
18. Masgid Shaarawi el-Khayriyya: el-Quran Masgid el-Sharawi
19. el-Farouk Omar el-Khayriyya el Islamiyya: El-Aman St.
20. Masgid Sidi Gaber
21. Tarmiet el mogtama bilmazamel (Local Development Association):
Masaken el-Mazamel
22. El Rahma: Haret Ayoub Youssef
23. Masgid Sidi Gaber, el Maamoura
24. Tarmiet Souk el Gama'iyya: Masaken Souk el-Gama'iyya
25. Tarmiet Toson: Masaken Toson, Block C
26. Tarmiet el Abari: Masaken el Maghreura, Abari
27. Tarmiet Ard el Ghad: 8 Abari, Block 3
28. El Naseria: Masaken Wabour el Ghaz, Block 3
29. Masgid el Abari el Khayriyya: Fleming, Raml el Askandriyya
30. El Makrousa el Gadida: El Makrousa El Gadida
31. Baby Care: El Tefoula--Ghubrial St.
32. El Mozha el-Khayriyya: El Hadra--Ibrahim Hosny St.
33. El Khayriyya Iereaiet el Emouma Wal Tefoula: 114 el Anher St.
34. Shabab el Eslah: El Gebti el-Orthozoksi
35. Islam el-Khayriyya el Islamiyya Bilmandara: Masged El-Fouli St.
36. Moharme Bek El Khayriyya El-Islamiyya: Masgid el Marhoum
Suleiman el Sheikh St.
37. El Sadak el Khayriyya el Islamiyya: Masgid el Sadaqa St.
38. Omar Ibn el Khatab: Ezbet Wadi el Tahrir
39. Rabetat Ghrobal
40. Youssef el Shazli, 16 el-Amri St., Karmouz
41. El Ikhlas el-Khayriyya el Islamiyya, El-Ikhlat St.
42. Ali Ben Abi Taleb: next to Masgid el Nasser, Samouha
43. Tanzim el Osra (Family Planning)
44. Tarmiet el Mogtama (Development Association): Eastern District
45. Tarmiet el Mogtama: El Raas el Sawda
46. Tarmiet el Mogtama: Backous

Sohag:

1. Al Gama'iyya el-Khayriyya al-Islamiyya: Sharia Sheikh Khahdar
2. Gama'iyya Ansar as-Sanna al-Mohamediyya: Sh. Gamal Abdel Nasser
3. Asdiqa'iel-kitab el-muqaddis bi-Balina: el-Balina
4. Gama'iyya el-Arit billah: Masgid el-'arif billah
5. Gama'iyya el-Islamiyyah: Sh. el-Horreya
6. al-Khadamat al-Igtima'iyya(Social Services): Sh. el-Ghayasha
7. Khalas el Nefous: 21 Sh. Mazen
8. Al-Shabab al-Muslimin: Sh. Mostafa Kamel
9. Tanmiyya al-mugtama'a of West Sohy
- 10: Tanmiyya al-mugtama'a of Sheikh Atta
11. 'eid el-usra(Family Assistance)
12. Gama'iyya ash-Shabab al-Muslimin
13. 'eid al usra(Family Assistance)

Gharbiyya:

1. Gehaz Tanmiet el-Mugtama'a Bedayer el Nahia: Zayer el Nania, Mehalla al Kobra
2. Red Crescent
3. Al Shuban al-Muslimin bi-Tanta, Midan el Sayed el Badawi, Tanta
4. Qatour

Matruh:

1. Al Khayriyyah al-Islamiyya bi-Matruh, Sharia Port Said

Ismaliyya:

1. Tanmiet el Mogtama'a bi-Fayed: Fayed
2. Red Crescent: 110 Sharia Waadly
3. Tanmiet el-Mogtama'a bil Sheik Zayed: Massaken el-Herafin
4. Ibnaa Aswan el-Khayriyya

Sharqiyya:

1. Nadet Thamaret el-Iman al-Kebeteya: Sharia Karoun
2. Al-Khayriyya al-Islamiyya bi-Manial Amr: Al-Massaken al-Sha'abiyya

Assiut:

1. Al Gama'iyya al-Khayriyya al-Islamiyya al Walidiyya: Sh. el Bakr
2. " al-Ajami: 74. Sh. Port Said
3. Al-Khayriyya al-Islamiyya
4. Shabab al-Muslimin: Sh. Mahmud Ibrahim
5. Gama'iyya Tarmiyya al-Mugtama'a: Sharia 26 July, Assiut
6. Al-Jihad el-Orthhozoksia
7. Gama'iyya ash-Shabab al-Muslimin: Sharia 26 July
8. Al Ramli'al-Islamiyya

Dakahliyya:

1. El Shareiya li-Atwen el Amalin bil Kitabl wal Sunna: El Mansoura
2. Red Crescent
3. El Masaei el-Khayriyya al-Islamiyya, Mansoura
4. Ash-Shabab al-Muslimin: Sharia el-Gaysh, Mansoura
5. Tarmiyya Mit Mahmud: Mit Me' ud
6. Muhafiz ali al-Quran al-Karim: Sharia el-Hoderiyya, Mansoura
7. al-Nada al-Islamiyya: Sharia el-Shahid Hassouna
8. Gama'iyya Tanmiyya al-Mugtama'a bi-Sherbin: Sherbin

Fayoum:

1. Muhafiz Ali al-Quran: Sharia el-Mudarris

Qena:

1. El Sharia bi Azaziyet Deshna, Azaziyat Deshna
2. Red Crescent in Qena

Port Said:

1. El Hegayra el-Khayriyya
2. Gama'iyya el-Islamiyya li Tanmiyyat al-Mugtama'a: Adly wa Saad Zaghloul
3. Red Crescent Branch: Sharia Abdul Salam Aref

Red Sea:

1. Al-Khayriyya al-Islamiyya: el Gosayr

Menoufiyya:

1. Ash-Shabab al-Muslimin: ? (Quesna?)