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POLICY RECOMMENDATIONS FOR REHABILITATION SERVICES

PALESTINIAN HEALTH SECTOR REFORM AND DEVELOPMENT PROJECT (THE FLAGSHIP PROJECT)

SHORT-TERM TECHNICAL ASSISTANCE REPORT (FINAL)

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ACRONYMS

CBRP	Community Based Rehabilitation Programs
COMBI	Communication for Behavioral Impact
ILO	International Labor Organization
INGO	International Non-Governmental Organizations
MoH	Ministry of Health
MoE	Ministry of Education
MCH	Mother and Child Health
NAD	Norwegian Association of Disabled
NSR	National Society for Rehabilitation
PMC	Palestine Medical Complex
PA	Palestinian Authority
PCBS	Palestinian Central Bureau of Statistics
PMRS	Palestinian Medical Relief Society
PRCS	Palestinian Red Crescent Society
SOIR	Swedish Organization for Individual Relief
UN	United Nations
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency
WHO	World Health Organization

ABSTRACT

The USAID Palestinian Health Sector Reform and Development Project is supporting the Ministry of Health (MoH) and select non-governmental organizations (NGOs) that provide rehabilitative services to strengthen and improve the rehabilitative services provided to Palestinians. To this end, the Project hired a consultant to provide short-term technical assistance (STTA) in the assessment of current and the planning for future quality rehabilitation interventions. This assessment will support the Ministry of Health (MoH) in strategically planning for its level of involvement in the provision of services in the West Bank and East Jerusalem and in strengthening its monitoring and regulatory role with other service providers.

During the Israeli administration, rehabilitation serviceswere provided by institutions characterized by a medical approach, and usually financed by international non-governmental organizations (INGOs). Prior to the first Intifada, people with disabilities were stigmatized, isolated, and often discriminated against. Since then, the perception of individuals with disabilities among Palestinians has changed. During the first Intifada, thousands of Palestinians became disabled as a result of their injuries, and the attitude towards them changed from ridicule to being viewed as heroes. This attitude is said to have had a positive impact on all people with disabilities, at least on those with physical disabilities, and opened the way to introduce a new type of rehabilitation services to disabled people that is more community based .

Since 1990, the Community Based Rehabilitation Program (CBRP) has been part of a long-term strategy aimed at strengthening the Palestinian rehabilitation sector as a whole in order to address the needs of disabled people. Since 1993, the Norwegian Association of the Disabled (NAD), in partnership with Swedish Diakonia, has provided financial and technical support to 17 NGOs that implement CBRPs with the aim of promoting social inclusion of Palestinians, both children and adults, with disabilities.

Community Based Rehabilitation (CBR) has since been adopted as a national strategy, based on the UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities, approved by the UN General Assembly in 1993. In 1997, the General Union of Palestinian Disabled was created and in 1999, a Disability Law was approved by the Parliament. The law emphasizes equal rights and opportunities for persons with disabilities and defines the role of the government as a provider of the needed services. The Palestinian Ministry of Education (MoE) has adopted this global philosophy and launched Inclusive Education as a pilot project for three years in 1997.

The concept of Human Rights seems to be widely known, as well as Education for All. The fact that CBR has quite a long and successful record is also favorable for Inclusive Education. The sad fact that many people have been disabled as a result of injuries caused during the Intifada may also have contributed to a wider understanding of the right to health, education, and rehabilitation for all, including individuals with special needs.

The CBRP is active in more than 200 localities, covers 60% of the population of the West Bank and Gaza, and has reached more than 35,000 disabled persons and their families since its inception. The program's network of NGO partners have organized themselves into five Regional Committees that have responsibility for planning and implementing the CBRP, and for coordinating the work at both the community and regional levels.

CBR projects cover more than half of the country and most of the rehabilitation services are provided at the community level. At medium or regional level, more than 140 institutions and organizations provide rehabilitation services and a few institutions at national level provide specialized services.

The effort to provide rehabilitation services for Palestinians requiring such services, especially as the need grew dramatically after the first Intifida, evolved without strategic planning on the national level and therefore without a properly designed system. This lack of planning has resulted in shortcomings in the rehabilitation care available to Palestinians, and impedes the advancement of the specialty.

SUMMARY OF RECOMMENDATIONS

IMMEDIATE RECOMMENDATIONS

- Comprehensive on-the-job training for community doctors and use of *"Mother and Child Records & Handbook"* as a tool for early detection of disability.

- Bring short term consultants in Developmental and Behavioral Pediatrics to support, train, and supervise rehabilitation programs of NGOs, UNRWA, and MoH.

SHORT-TERM RECOMMENDATIONS

- Improve national referral system within the three rehabilitation levels, community based rehabilitation (CBR), intermediate level and secondary level. This can be done by setting up a system and strengthening cooperation and coordination among service providers and the MoH.

- Strengthen the regulatory role of the MoH in the provision of proper care of people with disabilities. This can be done through: requiring licensing of professionals, accreditation of institutions, protocols, and guidelines for referral.

- Strengthen programs that build the capacity of rehabilitation workers/ health professionals. This can be done through international visiting professionals programs for specialty areas on a systematic basis.

- Adopt an evidence-based, culturally sensitive approach to service integration while supporting successful initiatives in the field of rehabilitation at all three levels. Field visits and interviews with professionals and beneficiaries revealed successful experiences that should be duplicated.

- The Project's grants program with local NGOs play a strong supporting role for the institutions that provide rehabilitation services to fulfill this gap in the MoH's system.

LONG-TERM RECOMMENDATIONS

- To assure sustainability, policy support and full involvement of governments is essential. Need to establish schemes to support continuous training, advocacy, lobbying, raising awareness about the rights of the disabled, including mental health support component as a comprehensive approach to healthcare services provision, and arrange activities about issues related to gender and disability prevention.

- Encourage the continuous integration of individuals with disabilities into the society, by developing special rehabilitation programs and creating job opportunities. There are good local experiences in the country, which are modest yet worth duplicating, *namely* the *Oasis Project* in BeitSahour.

SECTION I: INTRODUCTION

The USAID Palestinian Health Sector Reform and Development Project is a five-year initiative funded by the U.S. Agency for International Development (USAID), designed, and implemented in close collaboration with the Palestinian Ministry of Health (MoH). The Project's main objective is to support the MoH, selected non-governmental organizations, and selected educational and professional institutions in strengthening their institutional capacities and performance to support a functional and democratic Palestinian health sector able to meet its priority public health needs. The Project works to achieve this goal through three components: (1) supporting health sector reform and management, (2) strengthening clinical and community-based health, and (3) supporting procurement of health and humanitarian assistance commodities.

This assessment will support the Ministry of Health (MoH) in strategically planning for its level of involvement in the provision of rehabilitative services in the West Bank and East Jerusalem, and in strengthening its monitoring and regulatory role with other service providers. Since MoH involvement is minimal in this field of disability and rehabilitation, the Project is working with the MoH to help structure effective involvement of MoH, improve on its regulatory role in rehabilitation services, and provide support to ensure quality standards for rehabilitation services are adopted at the national level.

This consultancy encompassed the following tasks/activities:

- Situation analysis and needs assessment, and recommendations regarding rehabilitation services
- Review and analysis of existing reports and surveys
- Summarizing key problems attributable to disability service provision
- Interviews with key people in rehabilitation
- Field visits to the main rehabilitation centers in the country
- Review and analysis of the existing training packages, protocols, and guidelines for developing cadres of rehabilitation workers, as well as for pre-services and in-service training for personnel at the different levels.
- Assess the rehabilitation services at the three levels of services
- Work with MoH staff and selected number of NGOs and the Project to develop a strategy for rehabilitation services.

Methodology:

The consultant reviewed relevant literature on the subject, specifically the experiences of other Arab countries, and other developing countries such as Brazil, Chile, South Africa and India. The consultant also made field visits to three rehabilitation projectsJordan, two rehabilitation centers inQatar, and three rehabilitation centers in Dubai.[Note: The consultant made these visits independent from this consultancy however was able to share these experiences to benefit this STTA assignment.]

The consultant was able to access and make use of both published and unpublished analyses by the MoH, including various reviews, studies, and other research on disabilities and rehabilitation in the country. The consultant also conducted interviews with the service

providers, major stakeholders, and beneficiaries during site visits in the West Bank and East Jerusalem.

Based on the information collected, the major issues were identified and subsequently grouped into domains. A set of steering principles for potential actions has been developed, and the relevant actions described.

Literature Review

According to recent estimates, 600 million people worldwide, ten percent of the world's population, experience disabilities of various types and degrees. The challenges faced in daily living and obstacles to participating in common activitiesdo not only affect the disabled individuals, but also their families. If families of people who experience disabilities are taken into account, approximately 25% of the world's population is directly affected. "*World report on disability- WHO- 2009"*

While the living conditions in their homes vary, they all share the same common experience: being exposed to various forms of discrimination and social exclusion, which prevent them from exercising their basic rights and fundamental freedoms and make it difficult for them to participate fully in the activities of their societies.

People with disabilities are under-served by most societal agencies and service systems. Only a small proportion of people with disabilities in developing countries have access to rehabilitation services. This is not only due to the limited number of qualified professionals and restricted resources but it also reflects the choices and priorities of governments and decision-makers at various levels - people with disabilities are not at the top of the agenda.

Background

In principle, rehabilitation can be delivered in a range of settings according to local needs and resources. The objective of the rehabilitation service system is to provide the right service, at the right time, in the right place, to ensure optimal health outcomes for the individual. This includes maximizing restoration and recovery from illness or injury, supporting people in their home environment and within their local communities for as long as possible, and ensuring the most cost-effective service provision across the service system.

Rehabilitation service characteristics:

Primarily, there are two target groups for rehabilitation services:

- Individuals who, as a result of an acute event (an emergency event or planned elective surgery), have a disability that is expected to respond to multidisciplinary rehabilitation;
- Individuals with a chronic illness or disability requiring extended clinical care (intermittent intervention over time).

In rehabilitation, the focus is on functional problems rather than diagnoses and patients require management that includes both a range and a mix of clinical and professional skills rather than management by a single specialty.

Some research has indicated that rehabilitation services are effective in improving short term survival (Evans, R.L., Connis, R.T., Hendricks,R.D., and Haselkorn, J.K., 1995). In addition, research outcomes are fostering an evidenced-based approach to how services are organized and delivered.

Almost all governments and non-governmental organizations in developing countries use a community-based rehabilitation (CBR) approach to work with disabled people. CBR was founded with the intent to make rehabilitation services available to a larger proportion of individuals previously not served (Helander, Legris and Opplestrup**,** 1989), thus making up for a lack of suitably qualified and trained personnel and material resources.

An initiative was tabled at the UN by the Government of Mexico to further strengthen the rights based perspective regarding people with disabilities. This proposal has led to the establishment of an open-ended Ad Hoc Committee "*to consider proposals for a comprehensive and integralinternational convention to protect and promote the rights and dignity of persons with disabilities,based on the holistic approach in the work done in the field of social development, human rightsand non-discrimination, taking into account the recommendations of the Commission of HumanRights and the Commission for Social Development."*

Whereas there may be no blueprint for a CBR national strategy, the principles upon which CBR programs are based are the same. However, each CBR program will require its own specific planning and execution appropriate to the local situation, needs and resources (Ghada Harami et al, Lancet 2010). Furthermore, there are a number of essential elements of such a broad strategy to CBR. These can be summarized as follows:

- Using a multi-sectoral approach: use of agencies and service providers in an integrated one-stop manner, to respond to the needs of involved disabled people
- Decentralizing resources, functions and managerial responsibilities: to various agencies and actors such as people with disabilities themselves, families, communities, local organizations and referral systems
- Adopting a comprehensive and empowering conceptual framework to disability
- Becoming an integral part of community development strategies that consist of several components
- Integrating rehabilitation services: with various health, education, employment and social services
- Involving non-professionals in simple rehabilitation techniques
- Introducing appropriate technology: such as assisting devices widely available and produced in the community from local material
- Raising awareness and mobilizing communities as a key component of the program
- Involving the private sector in supplying credits, employment and technology
- Giving people with disabilities and their families as users a central role in the design and follow up of the program.

While community involvement and community ownership of CBR activities is seen as a necessary element, it remains difficult to reach in many countries. This is a particular challenge when CBR is seen as a program belonging to one particular ministry, or when it is being managed top-down at the national level.

In situations where there are many sectors and actors involved the managing of CBR programs faces particular challenges. For instance, the government partner has a tendency to follow the culture of top-down management, whereasthe community and the NGO sectorare usually oriented bottom-up.

The top-down ideology assumes that professionals know best what the patients and the community need and prescribe the treatment and seek acceptance from the patient and community to comply with the prescribed treatment.

In the bottom-up approach it is acknowledged that people with disabilities, their families, and communities are in the best position to know what is needed, and, after gaining appropriate skills, can and should control how rehabilitation is to be implemented (Pupulin, 1995). On the other hand, strictly bottom-up programs are frequently not sustainable because they tend to alienate governments.

Enabling communities to climb into the driver's seat of CBR programs requires the real devolution of actual decision making powers to the level of the community, the full involvement of disabled people and their families, and the necessary resources to exercise those powers. Sustainability, on the other hand calls for policy support and full involvement of governments, including emphasis of the role of the MoH as a regulator of the provision of services.

A successful and sustainable CBR initiative requires a serious effort of identifying and pooling community resources commanded by various stakeholders, including the resources of disabled people and their organizations to meet the priority needs of disabled people in the context of the challenges the community as a whole is tackling. The fundamental principle of full and equal participation of disabled people and their organizations has not materialized. Awareness, knowledge, attitudes, and practices (AKAP) regarding disability and the inclusion of people with disabilities remains a challenge for professionals, donors, and other stakeholders, including disabled people themselves and their organizations.

There are various origins of CBR programs. In some cases they are initiated and led by NGOs supported by international partners. In other cases the lead agency is one government ministry. The NGO led option faces difficulties in securing appropriate support and resources by public authorities at all levels. The challenges for the ministry led alternative are the commitment and involvement of the organizations of the necessary partner ministries, local governments and the civil society at various levels.

CBR programs are still often separate operations supported by donors rather than being standard policies included in the national and local government plans and budgets. An externally funded donor push, or government push, seldom results in sustainable programs as the ownership remains undeveloped. Sustainability, and eventual expandability, requires that the program is soundly rooted in its social, cultural, administrative and financial environment.

Evidence-based practice would require clarity of objectives, concrete targets, as well as specification of activities and inputs. The challenge for CBR is to speak the language of policy priorities. The CBR objectives are not well connected to the mainstream of the development dialogue. There is lack of systematic application of the language and logic of the current development talk. There is an urgent need to integrate the CBR approach and objectives to the current development policy debate at all levels, particularly at the national level where those internationally agreed policy frameworks are applied.

CBR in the International Context

CBR has been implemented in many different ways throughout the world. The WHO published a manual to train local supervisors and family members of disabled people to become involved with CBR (Helander, et al., 1989). The WHO model of CBR has placed a strong emphasis on medical rehabilitation. The ILO has placed more emphasis on vocational

rehabilitation and community integration. In 1992, the ILO, UNESCO, and WHO came together and drew up a joint position paper on CBR based on their similarities of approach. Their joint paper defines CBR as:

> "*A strategy within community development for the rehabilitation, equalization of opportunities, and social integration of people with disabilities. It is achieved through the combined efforts of people with disabilities, their families, and communities and the appropriate health, education, vocational and social services," (ILO,UNESCO,WHO,1994,p.1)*

Implementation follows identified principles. Disabled people should participate equally in decision-making and not just as passive recipients of services. Services should be based on needs identified by people with disabilities themselves. Family involvement forms a key aspect of the rehabilitation process. Partnerships between the clients, their family and rehabilitation personnel form the basis of rehabilitation service delivery. Peers support is seen as a central part of the rehabilitation program and the development of peer counseling services receives priority. Rehabilitation services should be provided as close to home possible.

As mentioned, the CBR is a concept, which in practice, varies from place to place, depending on the setting. Unlike institution based approaches, there is no universal model of CBR which is applicable everywhere and each CBR program has to evolve its own strategies and methods as appropriate to its context. It is unlikely that rigid standardization of CBR can ever become possible, as long as there are different cultures. Any attempt at standardization is as good as trying to standardize different cultures and races.

Each country must set its priorities as per the needs of its constituents and regularly review whether the services are meeting such need.

Human Rights:

It is important to develop an understanding of disability as a human rights and development issue, and link that with rehabilitation services. There are a number of universal human rights instruments that are, by definition, intended to be applied to all people. The opportunities for people with disabilities to exercise their basic rights and fundamental freedoms are restricted by factual and hidden discrimination. The existing international human rights instruments may provide much more "tools for power" than what is actually utilized. Most of the contributing organizations recognize the importance and potential of the human rights framework in advancing the opportunities and inclusion of disabled people. While poverty and lack of access to basic services is one of the major phenomena interfering with the human rights of disabled people, only a few organizations explicitly connect the objectives of CBR into the mainstream development policies.

Strategies of networking, promoting education and awareness raising on democratic values and human rights, self organization and participation of marginalized groups in decision making, inclusion of disabled persons into the society is still an urgent priority. Civil society and disabled people's organizations (DPOs) are therefore key players in the rehabilitation sector. Support was provided to institutional medical rehabilitation service. Since then, the program has developed to comprise four main components: the Community Based Rehabilitation Program (CBRP), the referral service provision component, the

empowerment of self organized groups of disabled people organizations and the regional cooperation.

Gender:
Women and girls with disabilities encounter various forms of discrimination due to their gender, disability, and their poverty in all its dimensions and forms .This is still too seldom reflected in the CBR program priorities and design.

There are obligations embedded in the international legal instruments as well as in national legislation of donors and partner countries that imply an improved recognition of gender issues in all areas of life.

Empowerment of Disabled People:
CBR requires the participation of a broad range of stakeholders and partners in order to meet the basic needs of disabled people; CBR addresses social determinants that ensure access to health care, education and livelihood. In order to ensure that people with disabilities and their families can live in harmony with their communities. The shift from a charity to a rights-based approach to disability and the roles that can ensure a prominent place for community-based rehabilitation that builds up inclusive communities for persons with disabilities. CBR is a multi-sectoral, bottom-up strategy.

Effective rehabilitation programs should allow people with disabilities to have greater control in the nature of their rehabilitation and ensure that the role of professionals and other stakeholders is one of allies and resources in the rehabilitation process. Moreover, it should promote the participation of community members in the rehabilitation policy.

SECTION II: ACTIVITIES CONDUCTED

As detailed in Annex B, the consultant made numerous site visits to organizations that play key roles in rehabilitation in Palestinian communities. Visits were made to organizations in Hebron, Bethlehem, Jerusalem, Nablus, Jenin, Ramallah, and Al-Bireh.

Interviews were conducted with department heads, project heads, physiotherapists, speech therapists, occupational therapists, CBR workers, social workers, and psychologists. Interviews were also conducted with adult beneficiaries of rehabilitation services, and child beneficiaries along with their parents.

The consultant also participated in the two day Palestine Red Cresent Society's Annual Conference on Disability and the Palestine Medical Relief Society's Community Based Rehabilitation Training Workshop.

SECTION III: FINDINGS, RECOMMENDATIONS, AND NEXT STEPS

Findings

The lack of reliable national data on disability among Palestinians is an indication of the extent of marginalization of disabled people. The most comprehensive data is from a 1996 PCBS health survey that found that 1.7% of children aged 0-14 suffered from some form of disability.

In 2005, there were 3,762,005 Palestinians living in the West Bank and Gaza. Around 2% are reported to have a disability. This means that there are at least 75,000 persons with a disability in need of various services (PCBS).

In a study that was conducted by Jenin CBRP of the PMRS and SOIR in 2009,*"Assessing the Needs of Mentally Disabled People and Their Families,"*the average age of the intellectually disabled in the families that were included in this study was 16.5 years; 55% were children under 15 years. In the same study, first cousin marriage among parents was found to be 42% in Jenin, significantly higher than the national average of 26%. These are important findings in that they point to cousin marriage as a possible determinant of the presence of intellectual disability. Consanguinity, often the result of socio-economic and cultural factors, may account for the higher rate of intellectual disability in Jenin.

While the rights of disabled children are guaranteed under Palestinian laws, including the Child Law and the Law on the Rights of Disabled People, the support and services guaranteed to them under these laws are often unavailable. Particularly problematic is the lack of support for their integration into schools. While the Ministry of Education (MoE) is working to address this problem through its Education for All initiative, much work still needs to be done. As it stands, of 1,577 MoE school buildings, only 523 of them are equipped for disabled children. Furthermore, according to data from the MoE, only 0.6% of students in government schools are disabled.

The very high level of illiteracy among intellectually disabled people is alarming; 69% of the disabled people are completely illiterate.

Assessing the Needs of Mentally Disabled People and Their Families- Jenin – West Bank.
A study by: Jenin Community Based Rehabilitation Program, PMRS, and SOIR, 2009.

Palestinian law has createda progressive jurisdiction regarding the right for persons with disabilities in the society. The law on the rights of persons with disabilities was approved in 1999. Although there is still a long way to go, there have been very positive changes in the attitudes towards disabled people and to their inclusion in the society during the last ten years.

Respondent knowledge of human and disability rights and disability law: 92% had heard about human rights, 88% knew of disabled rights, 60% knew of disability law, 50% membership in union of disabled people.

The Rehabilitation Program in Palestine

The Rehabilitation Program (RP) of the Norwegian Association of the Disabled (NAD) and Swedish Diakonia began as a co-operation between Palestinian NGOs providing rehabilitation services in 1989-90. In the early 1990s this co-operation developed into a long-term strategy aimed at strengthening the rehabilitation sector in Palestine as a whole. Since 1993, NAD/Diakonia'srole has been to facilitate, cooperate, and coordinate rehabilitation activities with a primary focus on Community Based Rehabilitation (CBR) as a means of promoting social inclusion of persons with disability.

In 1997, the "General Union of Disabled" was created, in 1999; a Disability Law was approved by the Parliament. The law emphasizes equal rights and opportunities for persons with disabilities and defines the role of the government as a provider of the needed services.

The Palestinian Rehabilitation Program consists of distinct projects coordinated through a referral system with the dual aims of promoting social inclusion of persons with disabilities and increasing the quality of available services. CBR has since been adopted as a national strategy, providing 60-70% of rehabilitation services at the community level. Approximately 20-30% of services are provided at the regional level and 10-20% by specialist centers at the national level, which are intended to provide intensive, short-term rehabilitation services to disabled persons whose needs cannot be met at the community or district/regional levels. Support of centers providing specialized rehabilitation services that respond to the needs of the community is a part of the RP's holistic approach. The program is implementing activities aimed at further enhancing the quality of services provided by the four centers that are within the structure of the CBR program. This will, in turn, positively contribute to the continued development of the Palestinian rehabilitation sector in general.

The aim of the CBRProgram is to empower the disabled people, to challenge factors that exclude their participation in the society, and to advocate for change towards the government. Referral service provision provides a resource for supporting CBR as well as disseminating knowledge and educating community workers from CBR organizations, who are in direct contact with disabled persons and their families. Empowering the disabled to fight for their own rights, to advocate towards and influence decision and policy makers, to benefit and help themselves, is the key idea behind the self-organized groups of disabled people component. Finally, sharing experience with other organizations in the region is of high priority, as the success of the Palestine CBR model could help changing stereotypes about disability and setting up structures that will improve the life quality of the disabled.

Bearing in mind the fragile political, social and economic situation in Palestine, it is crucial to continue working for change that will add value to every-day life of Palestinian people. The current political situation and difficulties to travel and moving commodities are all contributors to a decline in quality of daily life.

Despite the unfavorable political conditions the CBR program has managed to achieve a lot. The program has empowered individuals and parents, improved basic daily living skills and coping mechanisms, reduced stigma and isolation and increased social inclusion. People with

disabilities are more respected in their families and have become more visible and more vocal. Many have also been able to access education and rehabilitation services.

The Community Based Rehabilitation Program in Palestine offers three levels of services:

- Primary Level: services consist of outreach services and CBR programs provided to communities by various organizations. The Central National Committee for Rehabilitation acts as an umbrella body for the CBR program, with an aim to set standards and coordinate activities of the various implementing NGOs. The CBR program covers 240 localities and has been in contact with 35 000 families.

- Intermediate Level: offers intermediate services such as physiotherapy, appliances and speech therapy etc. There are around 114 such governmental and nongovernmental institutions in the West Bank (62) and Gaza Strip (52) that provide services to disabled persons.

- Secondary Level: available at medical centers with facilities that offer sophisticated and specialized rehabilitation services for persons with disabilities. There are three such specialized centers in the West Bank; Khalil Abu Raya Rehabilitation Centre in Ramallah, the Jerusalem Centre for Disabled Children and the Bethlehem Arab Society for Rehabilitation (BASR) in BeitJala. In Gaza there is the El Wafa Centre, which provides specialized medical and rehabilitation services.

AbuRayaRehabilitationCenter in Ramallah, Bethlehem Arab Society for Rehabilitation in BeitJala, JerusalemCenter for Disabled Children in Jerusalem, and El Wafa Rehabilitation Hospital in GazaCity constitute the four Palestinian rehabilitation hospitals. They are an important part of the national rehabilitation sector and the only providers of specialized rehabilitation services to disabled Palestinians in the West Bank, Gaza and Jerusalem. The hospitals have divided the specialties between them and are all part of a national referral system. Yet, there is a need to make these services more affordable for patients, as the national health insurance policy has several gaps in coverage outside the basic healthcare services. Financial implications are a critical issue as poverty is an increasingly major problem in the West Bank and Gaza.

Living for so many years under military occupation, Palestinian people have developed their own “challenging resilience strategy”, which made the Palestinian case a specific one.

Specificity of Palestinian Case:

- Many individuals have been disabled as a result of injuries incurred during the Intifada; this has contributed to a wider understanding and acceptance of disability among Palestinians.
- Concept of Human Rights seems to be well known and appreciated.
- Solidarity and support is another positive issue that Palestinian people have.
- The movement by grassroots organizations and NGOs has developed over the past several years to fulfill the gap in rehabilitation services.
- NGOsseem to be very creative in finding ways to reach people in remote areas, which in itself strengthens their ties with their communities and empowered them.
- Community Based Rehabilitation (CBR) has a long and successful record.
- The fact that the country is small and densely populated favors a rapid spread of new ideas.
- Palestinian civil society is amongst the most developed in the Middle East region. Public institutions have only existed for about a decade, while the civil society has, during many years, fulfilled the role of a social services provider.

Key problems attributable to disability service provision in Palestine:

- After so many years of emergency there is still no comprehensive national program for rehabilitation in the country.However, there are many successful experiences on a smaller scale that can be replicated. A key obstacle for such a national program is the unsettled political situation.
- Lack of sufficient number of qualified professionals and paraprofessionals in the field of disability and rehabilitation.
- Although there are no reliable statistics, it is well-know that there are few Palestinians specialized in physiotherapy, speech therapy, occupational therapy, and special education.
- There are few institutions with programs in these specialties in the country. Bethlehem University, ArabAmericanUniversity in Jenin, Al-Quds University offer Bachelor's programs, and the UNRWA Women's Vocational Training Centre has a Certificate Program. Although it is beyond the scope of this report to evaluate the curriculum, it was found that there are no PhD holders in any of the above mentioned specialties locally. A quick review of existing curriculum and training programs specialized for rehabilitation, as well as, the interviews with responsible people in these institutions expressed their concerns about the quality of the teachings. They also expressed their interest in upgrading and capacity development of existing programs.
- There is lack of coordination between the three levels of rehabilitation on the national level.
- According to the MoH National Strategic Health Plan 2008 there was a specific shortage of type of beds and health care services for patients requiring rehabilitative hospital care.

An essential missing element is an objective estimate of the burden of disability in Palestine including frequency, forms, and needs. The numbers presented seem unreliable and it is difficult to walk away with a clear vision of needs and priorities in the face of limited resources. Yet, the consultant would propose the following:

Proposal for Actions and Recommendations

Immediate :

- Capacity development of faculty members, as well as of primary health care (PHC) doctors and nurses of MoH and UNRWA.
- Strengthen the capacities of the CBR workers as known program towards the development of a national rehabilitation program.
- Strong recommendation to use the "Mother and Child Health Records & Handbook" in all MoH and UNRWA, MCH clinics, as a tool for Newborn Screening for early detection of disabilities in newborn babies.
- Bring short term consultants in developmental pediatrics to support, train and supervise rehabilitation programs of NGOs, UNRWA and MoH.
- Develop the 'capacity' of health professionals within the service across service settings.

Short Term:

- Consider the training programs in physiotherapy, occupational therapy, speech therapy and other allied health professions.
- Upgrade existing university training programs available in the country.
- Set up a system for follow up of children with disabilities from the community level to the intermediate and tertiary levels, in order to get proper early intervention.
- Develop strategies to recruit, retain, and support staff.
- Develop patient management protocols, admission/discharge criteria and rehabilitation care plans.
- Improve communication and service co-ordination with general practitioners.
- Integrate child development services with multidisciplinary team at the PHC level.
- Grants program to support institutions that support the MoH by providing rehabilitation services, a gap in the MoH's current health services structure.

Long Term:

- Develop a comprehensive National Health Insurance System that takes into consideration meeting the needs of disabled people.
- Improve national referral system by creating a sustainable referrals mechanism and promote coordination between the three levels of rehabilitation in the country.
- Training regular school teachers to accommodate children with disability in regular classrooms; this is the only way of achieving education for all.
- Develop a clinical governance framework that defines roles and links between service components and accountability to each other.
- Adopt a population 'needs' based approach for decision-making about resource distribution across the country, and priorities for future service development. *Nablus*

could be a future development on the National level, to serve the Northern area through Al Amal Centre.

- Adopt an evidence-based approach to service integration while supporting successful initiatives in the field of rehabilitation in all three levels.
- Utilize service level agreements/partnerships with clear specification of roles, responsibilities and expectations.
- Create new projects to involve people with disability as people with potential, or encourage and support organizations that employ a specific proportion of people with disability.

SWOT[1] analysis of the proposed actions

ACTIONS	STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
Establish the first National Diagnostic Center	Building a system for early diagnosis of disability. Saves money, efforts and suffering	Insufficient funds: -Extra funding needed for the services -Resistance of staff	Felt the need and importance of such a centre by MoH and health professionals It will be available to a larger group	Resistance of private Drs. Lack of sustainability
Training for community doctors and use of *"Mother and Child Handbook" as a diagnostic tool*	Proper use of the Handbook as a diagnostic tool will improve early detection of disability Integrate child development services with multidisciplinary team at the PHC level.	-Short duration of training might be insufficient for real impact	-Felt need by authorities and community doctors (have already expressed the need for this training)	-Lack of commitment -Restricted mobility of candidates and national trainers
Upgrading existing university training programs	Train nationally qualified professionals in needed fields such as physiotherapy, speech and occupational therapy, would be very beneficial.	-Limited qualified tutors locally	-Felt the need and importance of support professions by MoH and other health professionals	-No system of quality improvement and continuous education to assure upgrading.
Bring short term consultants in Developmental and Behavioral Pediatrics to support, train and supervise rehabilitation programs of NGOs, UNRWA and MoH	-Training of local Drs. In the field of Developmental and behavioral Pediatrics for the first time in the country. Empowerment of community Drs. Improve knowledge, skills and motivation of community Drs. Improve quality of rehabilitation services	-Short duration of training might be insufficient for real impact. -Dependency on outside consultants, although TOT might be the alternative.	-Felt the importance of rehabilitation. Felt the importance of early detection of disability in children.	-Resistance of local Drs. -Lack of follow up and sustainability Political instability to bring consultants.
Adopt an evidence-based approach to service integration while supporting successful initiatives in the field of rehabilitation in all three levels	Comprehensive approach, reaching people in need, Proved to be successful. Proved to be culturally sensitive	Competitive. Insufficient funding	-Community support -Full support by authorities -Development of a novel model	Resistance of staff of existing programs to be confronted with the reality

[1] The SWOT analysis looks into 2 criteria that are internal to the project, such as the STRENTGHS and the WEAKNESSES inherent to the project; and to 2 criteria that are external to the project, such as the favorable circumstances (OPPORTUNITIES) and the negative circumstance (THREATS)

ACTIONS	STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
Integration of People with disability by creating job opportunities	Empowerment of people with disability and recognition of their rights Set up good example for acceptance of the other	Expenses Might not be sustainable	Ideal way for integration and acceptance of people with disability	Lack of commitment of the authority and fear of outcome.
Improve national referral system within the three rehabilitation levels.	Improve quality of life for people with disability, Improve services. On time intervention	Resistance of different levels of rehabilitation. Takes long time to apply.	Community support, Support by authority	Lack of commitment , and lack of financial resources.

a) Success stories from the field

The Palestinian CBR program has had a pronounced impact on individuals with disabilities and their families. The program has also had a positive impact on awareness, attitudes and practice towards individual people with disabilities in their local communities. The impact can be demonstrated (on a practical level) in the success stories shown below, which demonstrate the different levels of success, as noted from the field visits conducted as part of the assessment.

Success Stories:

An example of CBR

The foundation for setting up self organized support groups for disabled people and operating such groups already exist in CBR Jenin, which can be seen as a support group that can be built on and expanded.
If I was not able to get this wheelchair from CBRP Nablus I could've not been able to attend school.
"I 1 years old child with disability"

An example of the Intermediate level:

My job satisfaction is immeasurable, as I believe that I'm making a difference in the life of a disabled child.

Senior speech therapist – PHCC

A father with tears in his eyes, for the first time in my life someone is telling me that my child is special and he has a potential, he's worth loving, giving and living with dignity.

A father of a child with Dawn Syndrome at the PHCC

I feel not alone in this world with such a painful path I'm going with my precious daughter, mothers of other children and PHCC staff are very supportive. They respect the needs of

my special child.

A mother of a child with Autism at the PHCC

At least our kids are not left alone in the streets, there is a place where they can go to and learn something useful. They teach them how to read and write in a simple way to be able take care of themselves. This program is specially built to meet the needs of our children with Intellectual disabilities.

A mother of a child with Intellectual Disability at Al Raja'a Rehabilitation Centre in Hebron

An Example of the Tertiary Level:

My child was give all what she needs at once; I was trained to help her after we go home, with some physiotherapy and occupational therapy tools. This three weeks comprehensive program is very useful for my child.

A mother of a child with CP at the Jerusalem Centre for Disabled Children in Jerusalem

After I became paralyzed as a result of a severe injury during the second Intifada, my only choice was to be admitted to Abu Raya Rehabilitation Centre in Ramallah to get the long and painful treatment that I need. But I miss my family in Jenin, they can't come often to visit me!

A young man with spinal cord injury.
Abu Raya Rehabilitation Centre-Ramallah

An Example of a successful Rehabilitation and Vocational Training Project

-I'm so happy here, for the first time in my life I could buy myself this new sweater for The Eid, I bought it from my own money! I also bought this dress and a box of make-up, it was my dream to get one!

They give us money here for the work we do. We were bord at home, but here we made friends and we live as a family.

A 20 years old young man with Down Syndrome and a 23 years old young woman with Intellectual disability, at The Oasis Project for disabled people in BeitSahour.

b) Conclusion: A Multilevel Action Plan

In conclusion, given considerations of time and perceived priorities, a multi-level plan of actions is necessary.

Priority 1:Training for primary health care "PHC" doctors and nurses using of *"Mother and Child Records & Handbook",* as a tool for early detection of disability! In order to assure

collection of systematic information on the frequency, nature, and needs of disabled people from as early as possible in life.

The consultant would highly recommend to introduce the WHO method of training, Communication for Behavioral Impact "COMBI", which offers a comprehensive and innovative managerial insight to planning social mobilization. ***"Annex C"***

There is growing evidence to suggest that babies born with low birth weight were at greater risk of childhood disability. 6% of total births in the West Bank and Gaza were born with low birth weight. (Health Status in Palestine, Annual Report 2005). Prenatal screening programs, immunization, maternal and child health services, integrated child development services, nutrition programs combined with early stimulation constitutes early intervention. Therefore, it should be integrated into the Primary Health Care Services.

Priority 2: Bring short term consultants in Developmental and Behavioral Pediatrics to support, train and supervise rehabilitation programs of NGOs, UNRWA and MoH. The only alternative for the lack of developmental pediatricians is to bring experts and learn from their experiences, with adaptation to the culture and the needs.

Priority 3: Adopt an evidence-based, culturally sensitive approach to service integration while supporting successful initiatives in the field of rehabilitation in all three levels. The consultant has had conducted several field visits, interviews with professionals, as well as beneficiaries and came up with a conclusion that there are some successful experiences in the country that are unique and worth replicating in other areas.
Research outcomes are fostering an evidenced-based approach to how services are organized and delivered.
Earlier research (Pichette, Garrett, Kusciulek and Rosenthal, 1999) has noted that culture can affect the types and quality of rehabilitation services identified for individuals with disabilities. By exploring culturally- based stories, traditions, the ways that values are expressed, and how the people express their hopes for their children, (De Fede and Fiore (2002), found that culture and traditions can mobilize parents to identify and meet their children's needs.

Priority 4: Integration of People with disability by creating job opportunities. There are good local experiences in the country, which are worth replicating, *namely the Oasis Project in BeitSahour.*

Priority 5: Improve national referral system within the three rehabilitation levels. This can be done by setting up a system and strengthening cooperation and coordination within service providers and the MoH.

ANNEX A: BIBLIOGRAPHY OF DOCUMENTS COLLECTED AND REVIEWED

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ANNEX B: FIELD VISITS AND MEETINGS CONDUCTED

1. Al Ehsan Charitable Society for the Disabled – Hebron
2. CBR - Jenin, including two home visits to beneficiaries
3. CBR – Nablus, including one home visit to a beneficiary
4. CBR – Ramallah, including interviews with mothers of children beneficiaries
5. Farah Centre for Rehabilitation – Nablus - PMRS
6. Khalil Abu Raya Rehabilitation Centre – Ramallah
7. MOH – MCH department - Ramallah
8. Oasis Project for Disabled People – BeitSahour
9. PalestinianRedCrescentSocietySchool for Children with Special Needs – Hebron
10. PRCS Rehabilitation Project – Jericho
11. The Bethlehem Arab Society for Rehabilitation (BASR) - BeitJala
12. The Jerusalem Centre for Disabled Children "Princes Bassma Centre" - Jerusalem
13. Yasmin Centre for disabled children- Al Bireh

Several interviews were conducted in each center with responsible persons and key people in the area of disability and rehabilitation in Palestine. As an example, Dr. AllamJarrar, Mrs. Ghada Harami, Dr. WaddahMalheis, Madam Majaj, Mrs. MahaYasmineh, Mrs. MajidaJibril, Mrs. AblaDeibis, Mrs. MaheraNassar and others.

Semi structural interviews were conducted with:

a. Heads of departments or Projects,

b. Professionals in the fields, such as physiotherapists, speech therapists, occupational therapists, CBR workers, social workers & psychologists

c. Beneficiaries and parents of children beneficiaries.

The answers were analyzed and reflected in the findings and the recommendations.

The consultant also participated in the two days PRCS Annual Conference on Disability in Ramallah – 16th& 17th of December,and the PMRS – CBR Training workshop in Ramallah – 17th-20th of February.

ANNEX C: COMMUNICATION FOR BEHAVIORAL IMPACT – COMBI

Summary:
COMBI focuses on strategic communication planning for behavioral impact in health and social development. A core principle of the approach is that "behavioral results are the primary end-goals of health and social development programs" and as such it stresses that behavioral impact comes with effective communication programs purposefully planned for behavioral results, and not directed just at awareness creation, advocacy, or public education. It applies in an integrated way the disciplines of marketing (including village-level marketing traditions), public relations and public advocacy, administrative mobilization, advertising, counseling, personal selling, community mobilization, health education, mass communication, folk media, and market research - dedicated to the ultimate behavioral outcome.

What is COMBI?
"COMBI is social mobilization directed at the task of mobilizing all societal and personal influences with the aim of prompting individual and family action. It is a process which blends strategically a variety of communication interventions intended to engage individuals and families in considering recommended healthy behaviors and to encourage the adoption and maintenance of those behaviors. COMBI incorporates the many lessons of the past 50 years of health education and communication in a behaviorally-focused, people-centered strategy. COMBI also draws substantially from the experience of the private sector in consumer communication."

- It is critical to measure actual changes in behavior, not just assume it has occurred
- Believethattheactionswillhave positiveresults and benefits
- It is a methodology for planning sustained actions in communication and social mobilization.
- COMBI focuses on measurable changes in behavior, NOT JUST changes in knowledge or attitude.

COMBI begins with the "people" (clients, beneficiaries, consumers, family member..) and their health needs, or wanted, or desires, and a precise focus on the behavioral result expected in relation to these needs, wants and desires.

Why do we need COMBI?
The most challenge in confronting diseases is having the individuals, within the context of families and communities, adopt and maintain healthy behaviors.
If it is intended to have a more profound impact on controlling, preventing and eliminating communication diseases, then definitely we need strategically planned , behaviorally focused social mobilization and communication efforts. This is what COMBI offers..

The fundamental part of COMBI is:
The situational market analysis vis-à-vis the precise behavioral goal: a "consumer orientated" exploration of the factors influencing the attainment of the behavioral objectives that will inform the strategy and the communication mix.
The situational market analysis involves listening to people and learning about their perceptions and grasp of the offered behavior(s) through tools such as TOMA (Top of the Mind Analysis), and DILO (Day in the Life Of). Their sense of the costs (time, effort, money)

in relation to their perception of value of the behavior to their lives is explored through a Cost vs Value calculation. Other tools such as the Force Field Analysis, help community members, field staff, local experts, and the COMBI specialist to analyze the social, political, ecological, moral, legal, and cultural factors that could constrain or facilitate adoption of the behavior. The situational market analysis also examines where and from whom people seek information and advice on the particular health problem and why they use these information sources. The concept of positioning (used extensively in the advertising world), also helps the development of appropriate messages and communication approaches. Areas that require further investigation are also highlighted. Finally, issues not substantially amenable to communication solutions, such as the ready availability of services, are documented so that appropriate organizational change or political action can be taken.

We want to

- Influence a decision/behavior/social norm
- Reinforce a decision/behavior/social norm
- Mobilize various sectors of society to take action on a common issue
- Create a sense of sharedresponsibility

COMBI CORE PRINCIPLES

- Do nothing – produce no T-shirts, no posters, no leaflets, no videos - do nothinguntilyouhave a specificbehaviouralobjective
- Do nothing – untilanappropriatesituationmarketanalysisuncoversthespecificbehaviouraloutcomesrequired.

ANNEX D: Consultant SoW and Biography

Palestinian Health Sector Reform & Development Project
(The Flagship Project)
Scope of Work

Position: Short Term Rehabilitation Consultant.

Flagship Project Objective

The Flagship Project is a five-year initiative funded by the U.S. Agency of International Development (USAID), and designed in close collaboration with the Palestinian Ministry of Health (MoH). The Project's main objective is to support the MoH, select non-governmental organizations, and select educational and professional institutions in strengthening their institutional capacities and performance to support a functional, democratic Palestinian health sector able to meet its priority public health needs. The project works to achieve this goal through three components: (1) supporting health sector reform and management, (2) strengthening clinical and community-based health, and (3) supporting procurement of health and humanitarian assistance commodities.

The Flagship Project will support the MoH implement health sector reforms needed for quality, sustainability, and equity in the health sector. By addressing key issues in governance, health finance, human resources, health service delivery, pharmaceutical management, and health information systems, the Ministry will strengthen its dual role as a regulator and main health service provider. The Flagship Project will also focus on improving the health status of Palestinians in priority areas to the Ministry and public, including mother and child health, chronic diseases, injury prevention, safe hygiene and water use, and breast cancer screening for women.

Technical Background and Purpose/Need for ST Consultancy

The Project seeks the services of a highly-qualified Disability and Rehabilitation expert to assist in the analysis and planning for quality Rehabilitation interventions based on the existing level of services and evidence base information on the right approach to achieve social integration of People with disability. This assessment will support the MoH in strategically planning for its level of involvement in the service provision in the West Bank and East Jerusalem and in strengthening its monitoring and regulatory role with other service providers.

The expert must have substantial experience in rehabilitation work in Palestine, especially with respect to training manuals, guidelines and protocols and how to address key rehabilitation and disability problems.
The purpose of this consultancy is that Dr. Odeh will conduct a situation analysis and needs assessment and propose a policy framework through which MoH can develop a five-year national strategy for rehabilitation services. She will also be tasked with proposing to the MoH working models that can be used at different levels of rehabilitation services.

Specific Tasks

Review and analyze existing reports, surveys and summarize key problems attributable to disability service provision, gaps and areas of concerns.
Review and analyze the existing training packages, protocols and guidelines for developing cadres of rehabilitation workers, as well as for pre-service and in-service training for personnel at the different levels.

Assess the Rehabilitation service at the three levels of services and to work with MoH staff and selected number of NGO's and Flagship leadership to develop a strategy for rehabilitation services.
Since MOH involvement is minimal in this field, consultant should work to structure involvement of MOH, improve on its regulatory role in such a manner that quality of Rehabilitation services can be supported and adopted at National level.
A Final Report summarizing the above tasks

Deliverables
Consultant must submit a detailed assignment report upon the completion of the consultancy. The report should include:

- Situation analysis and needs assessment and recommendation on the rehabilitation services.
- Policy framework and recommendation to improve quality of rehabilitation services.

Dr. Jumana Odeh - Biography

A pediatrician, public health expert and director of the Palestinian Happy Child Centre "PHCC", Jumana Odeh is an acknowledged health leader in the PalestinianOccupiedTerritory. Commencing her medical service to the Palestinian people in 1981, Dr. Odeh chose not to go into private practice but rather to work for low wages at government hospitals in the West Bank, following this with seven years service as a hospital pediatrician at AugustaVictoriaHospital and then MakessedHospital, the largest public hospitals in Jerusalem. Dr. Odeh next volunteered as a primary health pediatrician and project manager for the Union of Palestinian Medical Relief Committees, a well respected grassroots organization which focused on the delivery of medical services to hard-to-reach West Bank villages and communities. She followed this with three years employment as a team leader/pediatrician with CaritasBabyHospital's Rural Health project in the city of Bethlehem, then with two years as the director of the Women's Mental Health project/Child &FamilyConsultationCenter in Jerusalem. After this Dr. Odeh cooperated with UNICEF, participating in their national programming to improve the quality of medical care given to Palestinian children, following this with a series of consultancies with Western organizations, including Save the Children/USA, the Swiss Development Cooperation, the Australian Red Cross, OXFAM, the International Development Research Center/Canada, Medical Aid for Palestinians,"MAP-UK" and Belgian Technical Cooperation" BTC" – Jerusalem.

During 1997 and 1998, Dr. Odeh was a visiting pediatrician in the Child Neurology Department at Sha'areZadek Hospital in West Jerusalem. Next Dr. Odeh worked as a consultant for Norwegian People's Aid, conducting an external evaluation at the Gaza Community Mental Health Programme. In 2000, Dr. Odeh joined the faculty of the School of Medicine& the School of Public Health at Al-QudsUniversity as a lecturer, a position she continues to this day. In 2001, Dr. Odeh began a four year consultancy as Senior Child Health Advisor with MARAM, a public health project funded by Pricewaterhouse Coopers/USAid. In 2004, Dr. Odeh joined the Royal College of Pediatrics and Child Health in London as a child care advisor in the fields of child development, disability & rehabilitation, a position she also holds to this day. And in 1994 Dr. Odeh founded and assumed the directorship of the Palestinian Happy Child Centre, a centre dealing mainly with children with special needs. Dr. Odeh was a founding member of the Union of Palestinian Medical Relief Committees, of the Palestinian Emergency Medical Service Council, of the International Federation of Health & Human Rights "IFHHRO" & of Juzoor Foundation for Health & Social Development. She served as president of Physicians for Human Rights/Palestine and as a board member of Atta Services/Aid to the Aged.

Dr. Odeh has participated as an expert at more than 40 international workshops and conferences, and in numerous "evidence based" studies of the psychological impact of military occupation on children and youth. She is a frequent writer for the International Herald Tribune and for the Israeli newspaper, Ha'aretz, and has appeared as a child/health expert on Al-Jazeera, Abu Dhabi TV, CNN, BBC and Ted Koppel's "Night Line." Dr. Odeh has been recently selected as 2008 honoree of the World of Children Health Award, "Children's Nobel Prize", to become the first Arab in receiving such an important Award. Dr. Odeh is married with two daughters.

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