TOWARDS THE FORMULATION OF A REHABILITATION POLICY : DISABILITY IN THE WEST BANK

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We dedicate this study to all the disabled people of Occupied Palestine.

Rita Giacaman
On behalf of the reserach team
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I. Introduction

This study focuses on a sector long neglected by Palestinian society: the disabled. From not having been part of the collective sensibility, the disabled were suddenly catapulted to fame with the escalation of violence inflicted by the Israeli army on the Palestinian population living in the West Bank and Gaza Strip. Since the beginning of the Uprising 21 months ago to date, at least 40000 persons were injured by army violence [1], mostly young adults and children. In one year alone, 2600 children were injured by army or settler gun fire; 11000 were beaten to the degree of requiring medical treatment, and 4000 injured by rubber bullets, also requiring medical treatment [2]. Such devastating events caught the public eye, both Palestinian and at the international level. This in turn led to a process of raising questions regarding the physical and psychological/mental toll and consequences of such injuries on the individual and society.

It is at this stage, when the community's concept of disability was being transformed - from a problem bringing shame to individuals and families to a condition that is brought about by political heroism and therefore, essentially honorable in nature - that some of us seized the opportunity and began to pose questions relating to the disabled in society as a whole that were more general in nature : who are the disabled in our society, where are they, how many, are their needs being met and what is the quality of their lives? This investigation was an outcome of this question raising.

Our purpose in conducting this investigation was primarily to build up a profile of the disabled in Occupied Palestine in order to assist in formulating a coherent policy for the fulfillment of their needs, always keeping in consideration the needs of society at large. In doing so, we were guided by the following principles:

A. Our primary task was to introduce or re-introduce the disabled - both the heroes of the Uprising and the normally disabled population - back into society (social integration)

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[1] This estimate was obtained from al-Haq's data base on the injuries of the Uprising.

[2] These figures were obtained from an as of yet unpublished investigation conducted by Ann Nixon, Jerusalem, on the impact of Israeli army violence on Palestinian children.

B. Given the considerable expenditure one can encounter while providing rehabilitation services to the disabled, and the scarcity and questionable continuity of resources in the Palestinian context, every effort must be made to pool resources, coordinate action, and divide up the tasks based on professional considerations while taking into account health care needs of society at large and the proportional expenditure on rehabilitation relative to overall health care needs.

C. Every effort must be made to ensure the equitable distribution of resources to all the disabled population relative to need, especially children. It is necessary to create links, joint programmes and even mergers among programmes catering to the needs of the heroes of the Uprising and the rest of the disabled population in our country.

D. Given that the process of constructing a Palestinian health infrastructure has already begun, every effort must be made to train local staff to professionally plan for and manage on a long term basis the needs of the disabled in this country.

This study is divided into three parts. The first deals exclusively with a special category of people, those injured by army violence. It examines their injuries in terms of their present and future needs, especially after the unique attention of society and the consequent elation of the heroes fades away. It also raises questions as to the quantity and quality of the services available to this special group of people and delineates the ways in which this group could be rehabilitated [3]. Part Two is a survey of available services for disabled people - both type and quality - on the West Bank. It attempts to estimate amount and type of need by referring to studies on disability prevalence conducted in selected Palestinian populations and worldwide and inferring

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[3] We define rehabilitation as putting back the person into function. As the World Health Organization defines it rehabilitation ' includes all measures aimed at reducing the impact of disabling and handicapping conditions and at enabling the disabled and handicapped to achieve social integration'. See Disability Prevention and Rehabilitation,The World Health Organization Tehcnical Report Series # 668, The World Health Organization, Geneva, Switzerland, 1981. This effectively means that rehabilitation includes measures other than medical/physical manipulation, entailing extramedical measures such as conseling, social work, job placement and the like.

occurrence among Palestinian of the West Bank and Gaza Strip [4]. The second part also assesses available services, delineating guidelines for the rationalization of these services and for the eventual social integration of disabled people. Part three is an attempt at synthesizing parts one and two above in such a way as to arrive at a general policy for dealing with the needs of all disabled in society and a tentative plan of action.

I. Part one : Injuries of the Uprising : A study of disabilities sustained due to violence.

A. The study

1. Design and methods

a. The study was based on a data base collected from the various hospitals of the West Bank as well as data bases obtained from institutions collecting information about the injuries of the Uprising, such as the al-Haq human rights organization.

b. In addition, this part also utilized information obtained from extended interviews conducted with selected expert professionals who have been caring for the injured of the Uprising.

Interviewees included physicians, physiotherapists, psychologists/ counselors and others involved in the field of rehabilitation.

c. The study covers a period of about one year, for which, at the time of the field work, records were available in medical and human rights institutions containing the information necessary to ensure the accuracy of the study . The injuries listed below therefore fall mostly within the period of March, 1988 till march of 1989.

d. About 2500 actual injury cases - those with adequate records available including especially the name of the injured persons - were examined out of a total of approximately

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[4] Given limited resources, the difficult political environment and the need to be practical about our approach to research and surveys, we made the decision favouring focusing on need rather than accurately determining prevalence via research in line with World Health Organization guideliness : ..' it is more important to find out what proportion of the population needs rehabilitation services than to discover prevalence of disability..'. See Disability prevention....., op.cit., p.10

25000 injuries estimated in the period of a year [5]. In other words, the study examines about 10% of the total annual injuries. The cases that were studied were the more severe cases of injury and do not include cases not treated in major hospitals and medical institutions [6]. It is, however, generally agreed that, while hospital records might not reflect actual total injury, the large majority of the serious cases did in fact reach hospitals and were included in the registries of these medical institutions that we examined.

e. Of the total number of cases, 473 cases were identified as having been admitted to hospital for more than one day. They constituted 19% of the total number of injury cases examined . These cases were identified by name, fed into an IMB computer and cross checked to ensure no duplication of admission cases. This was a decisive methodological step in view of the fact that a considerable number of cases were first admitted to a regional hospital and later transferred to Maqassed Hospital in Jerusalem. This holds true not only for admissions from regional West Bank hospitals, such as al-Ittihad hospital in Nablus, but also for admission into Gaza hospitals as we will see when we present the findings.

2. Difficulties and problems : Those were many and included:

a. Difficulties in obtaining complete name lists from all the hospitals because of security reasons. For instance, a major hospital was unwilling to provide us with the names of injured persons admitted to its facility because of 'patient security reasons' and for fear of patient arrest, although these names were crucial for the cross matching process for avoiding duplication. This meant that we were unable to utilize in this study the rest of the materials provided by this hospital because we could not guarantee that these records were not duplicates of others obtained through other means. Fortunately, in the case of this particular hospital, we believe that we can safely assume that the large majority of the serious cases were eventually transferred

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[5] This is in fact a conservative estimate of the total injuries sustained in one year of the Uprising. The estimate was obtained from the records of al-Haq.

[6] It is known that a considerable proportion of those injured refuse to seek assistance in hospitals and medical centres for fear of being arrested by the Israeli army. For further details see Giel, R. et al, Needs Assessment in Respect of Emergency Medical Care in the UNRWA Clinics and Non Governmental Hospitals of the West Bank and Gaza, WHO Short Term Consultancy, 30 April to 20 May, WHO, Geneva, Switzerland, pp.10-12.

to Maqassed hospital , reducing the margin of error to what we think is an acceptable level

b. The suboptimal conditions - to say the least - of some of the records provided by medical institutions. There were cases of vital missing information pertaining to patients, inaccurate recording of information, and duplications spotted on repeated occasions.

c.The inability to reach and survey the Gaza Strip because of security and lack of access reasons. Nonetheless, although we were unable to conduct systematic fieldwork in the Gaza Strip because of the difficult political conditions there and the restriction on movement imposed on both the residents of the West Bank and Gaza Strip in travelling to and from the two regions, some of the data found in this study pertains to injuries originating in the Gaza Strip. This is because some of the serious cases of Gaza injuries were transferred to the more developed West Bank medical facilities. The figures on Gaza, however, do not reflect the actual rate of injury there. This fact should therefore be taken into consideration when making regional comparisons.

d. The unavailability of computer programmes for the data analysis that we required - such as the equivalent of PC-File and the Statistical Package for the Social Sciences 'SPSS' - in Arabic. This meant that all the information, including each patient name had to be transliterated into English, increasing further the possibility of duplication. This was partially solved by a system of multiple cross matching performed by both computer and by sight by more than one member of the study team.

e.Overall, the figures that will be listed below are approximates of reality. This is due to at least the reasons listed above. We estimate that our figures represent around 80-90% of the actual serious injuries for the duration of one Uprising year.

B. The Findings

Table I

Sex of Those Injured

	Number	% of Total
1. Total number injured	473	100
2. Sex		
Male	435	92
Female	38	8

The sex of the injured conform to our expectations. It is true that Palestinian women have been increasingly mobilized during the Uprising and have been much more actively participating in physical confrontation with the army, among other activities, than before. Yet their numbers at the frontline of the barricades continue to be proportionately less than their male counterparts. Although they are indeed occupying roles previously exclusively those of men, their positions continue to be more in the order of secondary line of offence and defence. They might have reached the barricades, but they continue to general play in the backstage rather than centre stage. As a result and as our data corroborates, far fewer women are actually seriously injured by army violence in comparison to men.

Table II

Ages of the Injured

	Number	% of Total
3. Age in years		
a. up to 14	63	14
b. 15-19	191	41
c. 20-24	132	28
d. 25-81	78	17
Total	264	100
Missing cases	9	

Clearly, the large majority of the injured are young, with 55% being under the age of 20 years and 83% under the age of 25 years. Quite obviously, then, the younger generation is disproportionately represented among the seriously injured. These results might be reflecting the energy and activism of youth. But it must also be pointed out here that these findings also confirm the demographic composition in this country : about 70% of our population is below the age of 30 years. This is offered as another explanation for the proportions listed above.

Table III

Residence of the Injured

	Number	% of Total
4. Residence		
a. Refugee camp	135	29
b. Town	168	35
c. Village	169	36
Total	472	100
Missing cases	1	

Overall, each of the three locales claim roughly one third of the seriously injured cases.

Table IV

District of Origin of the Injured

	Number	% of Total
5. District		
a. Gaza Strip	82	17
b. Central West Bank	139	30
c. Northern West Bank	172	37
d. Southern West Bank	77	16
Total	470	100
Missing cases	3	

Further data breakdown to locale by district revealed the following:

Table V

Locale of the Injured by District of Origin

	Number	% of Total for the District
The Gaza Strip		
Camp	53	65
Town	22	27
Village	7	8
Total for Gaza	82	100
Central West Bank		
Camp	58	42
Town	26	18
Village	55	40
Total for the Centre	139	100

	Number	% of Total
The North		
Camp	23	13
Town	99	58
Village	50	29
Total North	172	100
The South		
Camp	1	1
Town	21	27
Village	55	72
Total South	77	100
Total West Bank		
Camp	82	21
Town	146	38
Villages	160	41
Total West Bank	388	100

Thus 65% of the serious injuries originating in the Gaza Strip were sustained by camp dwellers who constitute approximately half of the population of the strip. In the West Bank, 21% of the serious injuries were sustained by camp dwellers, when camp dwellers constitute roughly 10% of the population [7]. These findings therefore suggest that refugee camp dwellers might be taking more of the burden of army violence in terms of the toll of serious injury.

The distribution of serious injury by locale within the West Bank is also interesting in that it reveals a 42% rate of injury for camp dwellers in the central region, 58% for town dwellers in the north and 71% for villagers in the south. That is relatively more camp dwellers in the centre, more town dwellers in the north and villagers in the south seems to be injured than the rest of the region's populations.

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[7] UNRWA statistics

6. Severity of injury :

Table VI

Severity of Injury

	Number	% of Total
e. Mild-no perm. dis	103	22
f. Moderate-no perm. dis	183	38
g. Serious with perm dis	187	40
Total disability	472	100
Missing cases	1	

That is, 40% of the total injured will probably end up with a disability requiring long term institutional and community-based rehabilitation, 38% are likely not to suffer from permanent disability but would have to receive some form of rehabilitation for a limited duration. The rest, or 22% might need some rehabilitation, but only for a short period of time and at the community level primarily [8] .

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[8] We have defined the severity of disability in relation to prognosis and have included in our decisions the results of discussions with Sue Waller, consultant physiotherapists to the project and Dr. Rustum Nammari, Consultant orthopedic specialist to the project. So for instance, hemiplegia, paraplegia, amputations and craniotomies were classified as severe injuries, compound fractures and nerve damage - depending on location - as moderate, and simple fractures, muscle damage and tendon damage, among others, as mild injuries.

Table VII

Type of Injury

	Number	% of Total
6. Some serious case types		
a. Paraplegics and quadraplegics	40	9
b. Amputations	7	2
c. Craniotomies and serious head injuries	10	2
d. Nerve damage	31	7
e. Vascular damage	10	2
f. Compound Fractures	76	16
g. Fractures	156	33
j. Other	90	19

(See appendices 1 through 7)

From these figures we note that about 60 persons - the paraplegics and quadraplegics, amputees and those with serious head injuries - will probably be facing serious disability problems and are likely to need some institutional assistance - both short term and longer term, depending on the case - in the very near future. The rest will need rehabilitation services in its various forms, but certainly most importantly at the community level. This second category constitutes 87% of the total number of serious injuries of the study year, that is, the large majority of those who are the focus of this study.

8. We must not forget serious eye injuries leading to enucleation. To date, about 130 enucleations were performed on injured persons originating from the West Bank and Gaza Strip, with a rate of about 70-80 enucleation per year [9]. These too are in need of assistance at the physical (prosthesis), social and psychological levels and must be taken into consideration when planning for the fulfillment of the needs of the disabled.

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[9] This information was obtained from St. John's Ophthalmic Hospital, Jerusalem.

II. Part Two : Disability in society at large and the institutions catering to the needs of the disabled.

A. An estimate of disability prevalence and type in the West Bank and Gaza Strip:

According to the World Health Organization :

> '.. an estimate can be made ... that the disabled comprise about 10% of the world's population' [10]

However, this a figure includes all types of disabilities including minor ones not requiring rehabilitation or other forms of special services. Consequently, if used to assess need, this figure would yield a gross overestimation of actual requirements for rehabilitation services. By focusing on those disabled persons that could benefit from rehabilitation services, WHO more realistically points to about 1.5% of the total population as being in need of rehabilitation [11] and as being the population for whom one must plan services for.

At the developing world level, sample surveys and various other types of studies have revealed figures ranging between 1 to 3% disability among the population, with 1.8% for India, 1% for Venizuela, about 1% for Bangladesh and 3% for Bacolod, the Philippines [12].

Locally-conducted pocket studies of the prevalence of disability in the West Bank and Gaza Strip appear to confirm the more realistic WHO figures. In 1984, Jamal Talab al-'Imleh conducted a house to house survey and found an overall rate of handicapping conditions of 2% in the towns of Bethlehem, Beit Sahur, Beit Jala and the refugee camp of Dheisheh in Bethlehem [13]. Of the total number of disabilities that this study found, 22% were mental retardation, 1.4% mental disease, 29.7% physical disability, 20%

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[10] Disability Prevention..., WHO, op.cit., p.10

[11] Ibid, p.10.

[12] Miles, M., Where There is No REhab Plan, Peshawar, Pakistan, 1985, an unpublished report, p.6

[13] al-'Imleh, Jamal Talab, Al-Bahth al-'Ihsai Haul al-'i'aga Fi al-Diffah al-Gharbiah (Statistical Report on Disability in the West bank), Arab Society for the Physically Handicapped, Patient's Friends Soceity, Palestinian Counseling Centre and the National SOciety for Mental Health, 1984 pp. 23 (in Arabic).

disability in hearing and speech, 9.4% blindness, 3.4% seizure disorders and 14.3% multiple disabilities [14].

Another study was conducted in 1986 in the Gaza Strip, where a house to house survey on a sample of the refugee population was conducted. This study yielded the figure of 2.4% for the prevalence of disability among preschool age and school age children [15]. Of the total disabilities, 4% were for seizure disorders, about 8% related to sight, 11% related to hearing loss, 5% related to poliomyelitis, 6% di-hemi and quadraplegias and the rest a mixture of other types of disabilities [16].

Assuming that the total population of the West Bank and Gaza Strip is in the order of 1.5 million people, and based on the above, we estimate that about 150000 persons suffer from disabilities, ranging from the very mild to the very severe. We also estimate that between 2-2.5% of the population is in need of rehabilitation in one form or another, or between 30000-37500 persons for the West Bank and Gaza Strip - 16000-25000 for the West Bank and 14000-17500 for the Gaza Strip -excluding those injured by army violence.

Based on the two studies described above and assuming that the findings of these studies roughly reflect the situation at the national level ,and given that 25% of all disabilities found in these studies relate to hearing, speech and sight, about 30% are physical in nature, 20% mental in nature and the rest being mixed, we would then expect to have in the order of 9000 disabled persons due to hearing, speech and sight impairments, 11000 physically disabled and 7000 mentally disabled persons, with the rest suffering from mixed and other disorders.

B. The study :

1. Design and methods:

The first task of this part of the study was to construct a list of the institutions delivering services to the disabled, defined as all those suffering from physical, mental or sensory -hearing and seeing - impairments. The list is not comprehensive but does include the majority of the main institutions delivering services

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[14] Ibid, p.9.

[15] Calculated from Saunders, C.A., A STudy of the Prevalence of Handicapping conditions Affecting Children, and a Case Finding Intervention in the Refugee Camp Population of the Gaza Strip, The University of Calgary and the Society for the Care of Handicapped Children, Gaza, 1986, p. 18.

[16] Calculated from ibid, p.18.

to the disabled on a stable/permanent and serious basis [17]. The list pertains to institutions operating only in the West Bank and does not include Gaza for reasons described in Part One of this study.

The study also entailed the construction of a special questionnaire guiding interviewers in conducting interviews with the individuals responsible for these institutions or their spokespersons . Each of the institutions taking part in the study was visited, often on more than one occasion. Discussions were held with responsible staff officers and clinical personnel pertaining to the number served, type of services provided and the problems facing the institution in delivering the service. Whenever possible, the team tried to inspect the premises, talk to the different personnel there and discuss the service with the disabled themselves. However, as we will elaborate later, discussions with the disabled themselves proved to be next to impossible.

Having had the chance to visit all the institutions caring for the disabled in the country , including some on multiple occasions, we were prepared to collect information through observation, and by ensuring that the research team noted a specific set of observations relating to the physical structure of the premises, sanitation, the general condition of the disabled, the number and attitude of the staff, and the general atmosphere of the institution. In addition, selected interviews were conducted with experts in the field of rehabilitation, focusing on their knowledge of these services provided in the area , their quality and the way in which those could be upgraded.

Finally, the study also involves reading through, grasping and utilizing relevant information, whenever possible, obtained from a considerable amount of information pool of brochures,booklets, leaflets and evaluation reports pertaining to the institutions serving the disabled. It also attempts to assimilate information obtained from eight other studies on the needs of the disabled in the country that have been conducted in the recent past.

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[17] There has been an amazing proliferation in the number of newly opened institutions or sections within existing institutions catering to the needs of those disabled by the Uprising. Most of these institutions, however, focus on the mechanical aspects of physiotherapy. Their long term survival is also questionable.

2. The problems

a. Many of the institutions were initially unwilling to provide the information needed to complete the questionnaire. This necessitated that the team visit the institution at least twice, and on occasions three or even four times [15].

b. It was practically impossible for the team to reach the disabled - in-patients - for interview purposes. In general, those responsible for the institutions found this request rather threatening and expressed a distaste for the idea, to say the least. Consequently, when it transpired that many of questionnaires to be completed by the disabled were to remain unfilled, this part of the study was abandoned for the moment. It does appear, however, that, with the exception of a few, the institutions in question are not used to questioning - regardless of how gentle it is -, are threatened by it and might even consider it an intrusion into their affairs. This raises the question as to the type and quality of supervision to which these institutions are accustomed and their ability to participate in cooperative endeavors with others.

c. Generally, the persons responsible for these institutions who were interviewed appeared to present the best possible image of the institution and its treatment of the disabled -with substantial exaggerations of figures encountered at times . Perhaps this is understandable in view of the competitive spirit prevails. This meant that we had to modify somewhat their responses and estimates pertaining to the services they provide to fit our own observations and knowledge obtained through other means.

3. The findings :

a. The institutions :

We found 57 institutions currently actively providing services to the physically and mentally disabled and to those suffering from sensory disabilities (Appendix 8). Of those there were 8 hospitals providing physiotherapy services on primarily an in-patient basis but also outpatient and as the only form of service provided to the disabled.

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[15] Unfortunately, the Swedish Institute for the Disabled in Jerusalem was among those unwilling to cooperate.

b. Their geographic distribution :

Of the 57 institutions, 35 or 61% were located in the central region of the West Bank (Bethlehem, Jerusalem, Ramallah and Jericho), 16 or 28% in the North (Nablus, Qalqilia, Jenin and Tulkarm) and 4 or 7% in the South. Comparing this distribution with population figures for these regions we find the following :

Table VIII

Institution by Region and Region's Population

Region	% of Institutions in region	% Population in region
Central WB	61	30
Northern WB	28	50
Southern WB	7	20 [19]

Eight were located or provided services in villages, two in refugee camps and the rest were located in towns.In other words, there is an obvious maldistribution of institutions relative to population, with towns and the central region of the country being the most advantaged, as expected.

c. The clientele :

These institutions confirmed that they care for about 900 disabled persons as boarders and about 3300 on an outpatient basis, excluding physiotherapy services provided to hospital patients [20]. These totalled 19000 sessions per year, on the average (Appendix 8). As we will show later, these services are not anywhere near reaching even half of the disabled community of the West Bank.

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[19] These figures are recalculations of figures found in Benvenisti, M. and Khayat, S., The West Bank and Gaza Atlas, West Bank Data Base Project, Jerusalem, 1988, pp. 28-29.

[20] The additions here as well as in the rest of the analysis are based on information obtained form the 43 institutions that we were able to collect adequate information from, and excluding hospitals.

d. The type of clientele :

Table IX

Institutions by Type of Clientele

Type of clientele	Number of institutions	% of Total
Serving both sexes	40	78
Serving males only	2	4
Serving females	4	8
Serving the physically disabled	16	31
Serving the mentally disabled	6	12
Serving both	16	31
Serving the blind, deaf and dumb	12	24

Total institutions in this analysis : 43
(Look at Appendix 8)

d. The type of services :

Table X

Institutions by type of Service

Type of Service	Number of Institutions	% of Total
Boarding	24	56
Curriculum education	12	28
Special education	34	79
Vocational training	17	40
physiotherapy services	22	51
Medical care	23	47
Manufacturing of prosthetics	5	12
Counseling services	7	16
Entertainment	8	19

Total institutions : 43

None of the institutions provided all the services listed above. It was especially striking that none indicated that they provided social work services, although this research team is well aware of the presence of social work divisions/social workers in some of these institutions. Obviously, the persons who provided us with information did not think of this service as particularly important or as a separate and distinctly important activity. Note also that we found that none of the institutions provided all the services listed above, including social work.

e. The problems

Table XI

Institutions by Problems they Face

Problems Faced	Number of Institutions	% of Total
No problems at all	7	16
Financial problems	18	43
Dealing with families of disabled people	12	28
Dealing with employees	6	14
Dealing with patients themselves	3	7
Lack of programmes	3	7
Contacts, marketing transport and follow up	5	12

Total institutions : 43

Table XI indicates that financial problems were the most commonly listed problem that these institutions faced, followed by dealing with the families of disabled people - that is, having difficulties in training families in dealing with the disabled and in helping the disabled in learning skills - , dealing with the employees - that is, having difficulties with the motivation of the employees and the level of their awareness -,and the problems of isolation - lack of communication, follow up and contact with other institutions. Clearly, some awareness is there for the need for a comprehensive programme for the disabled and not just boarding houses. But as we shall see later, whatever awareness was exhibited here did not really reflect itself on attitudes in dealing with the question of the disabled and meeting their needs.

f. Observational material and impressions [21] :

(1) Location :

Many of the institutions were located in isolated places, away from the hub of activities of towns and were found generally difficult to reach.It continues to be unclear to the research team why the institutions catering for the needs of the disabled necessarily need to be located in 'out of sight' sites. This raises the question as to suitability of these locations for active community involvement in these project and the ease of access for parents and families.

(2) Physical condition of premises:

Many of the institutions, especially those dealing with the mentally handicapped, suffered from inadequate physical conditions. Some buildings required major repair, others lack proper sanitation, and others were found simply unsuitable for being inhabited at all. In one case, the mentally disabled ward was located completely underground. It was dark and humid, with a smell of the strong humidity greeting you as you entered the premises, mixed with a stench of human excrement. It was Dickensian .

In contrast, another institution - for the blind - was characterized by a sunny building, well aerated, clean, well painted and generally full of life. It boasted good entertainment facilities,including musical ones, a library for the blind and even a swimming pool. Not only was it habitable, but it was hospitable as well. These contrasts made us think that, in a way, the nature of the physical premises uncovered the way in which those responsible for these institutions really felt and thought about the disabled, their needs and their aspirations. It seemed that it depended in a significant way on the attitudes of those responsible towards rehabilitation work in general and operating their institutions in particular.

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[21] These observations generally hold true for most of the institutions dealing with the disabled that were visited, although a selected few stood out in stark exception to the rest. We chose to make general statements believing that an overall critical assessment might be more productive in pointing out the major problems and stumbling blocks in the way of improvements in the services rendered to the disabled rather than the more embarrassing pointing the finger method.

(3) Programmes :

While some of the institutions organized their activities within the context of well defined and well thought out programmes, in general, the large majority of the institutions that were visited lacked programmatic action. A special weakness was noted in the areas of social work, counseling and entertainment and learning through play. When special programmes were identified, those tended to concentrate around the areas of education and a special variety of physiotherapy - one heavily dependent on mechanical manipulation of patients. At times, it seemed as if the organizers of these projects saw these institutions as merely places to 'physically keep' the disabled, instead of an environment for their education, stimulation and participation in all ways.

(4) Overtechnicalization of disability care:

We noted a strong tendency among these institutions to think of technical solutions to disability problems in contrast to the other forms of care needed by the disabled. An excellent example of this 'biomedical' approach to disability care is the amazing proliferation of mechanical physiotherapy centres in the region, all wanting to provide' machine stimulation and relief' to the injured of the Uprising. Another example is the shamefully low level of counseling services - only seven institutions as listed above - that is found in these institutions. The third is the lack of awareness of these institutions of the importance of social work services as a key element in disability care and rehabilitation. Thus the machine substitutes for problem solving, socially aware, behaviorally oriented programmes in many of these institutions

(5) Personpower :

Although exceptions were clearly evident, the personpower involved in caring for the disabled in these institutions either lacked adequate training or was not trained at all. Some seemed to function more like attendants than persons actively involved in caring for, stimulating and rehabilitating the disabled. Staff were lacking in both knowledge and attitudes especially. Some dealt with the disabled - notably the mentally disabled - in shamefully inhuman ways. In one institution for the mentally disabled located in the South of the country, we saw a group of about 15 children, all with heads almost completely shaven, almost all rather smelly and obviously not receiving even the minimal amount of physical sanitation and care. It took us about half an hour to come to the stunning realization that these children were in fact girls : nothing from their external appearance could have indicated this fact. Nothing, not even the most difficult financial conditions, could justify these unspeakable conditions.

(6) Administration :

In ways similar to the problems faced with personpower, administration generally lacked training in administrative skills- for instance, proper record keeping - as well as a good understanding of disability care, both theoretically and practically. We noted a lack of problem solving orientation. We noted a general lack of interest in making the conditions in the institutions better: many were simply apathetic. It was as if some thought that it was their bad fortune that led them to 'land' their present employment. At times, we also noticed a strong sense of competition with other institutions, and a stark absence of cooperative ventures among the institutions caring for the disabled that were covered by this survey.

(7) Community participation :

In general, we noted an unmistakable absence of participation of families and of the smaller and larger community in assisting, managing, and overseeing the activities of some of these institutions in general. While many have established governing boards, in fact, very little actual community participation is solicited or even encouraged.

(8) Attitudes and approach to disability care:

As with society at large, the attitude of those caring for the disabled in some of these institutions leaves something to be desired. We noted a sense of lethargy, a lack of enthusiasm in dealing with the problems of the disabled and their institutions. We noted a degree of dependence on programme organizers in deciding matters of importance. It felt as if many of those who worked in these institutions, whether employees or administrators, did not have a real commitment to working with the disabled but rather saw their role in terms of a job and livelihood for themselves with very few other incentives, so why 'rock the boat'. Perhaps most importantly, the old 'charitable' in contrast to the 'empowering' orientation of helping the disabled in solving their problems and managing their affairs' approach was strongly felt. Indeed, some of the names of these institutions reflect this approach to the disabled - for instance, the perhaps unwittingly wicked name ' The House of Light' for the blind, or 'the Four Homes of Mercy'and 'al-Ihsan'(the Charity) School.

III. The Road to Building a Strategy : the Needs

1. The profile of those needing rehabilitation :

a. The findings of the first part of this study point to a patient profile that is predominantly male and mostly within the age range of 15-25 years. This is so especially for the cases classified previously as serious . For instance, all paraplegics except two are males; all the amputees are males; and all of those suffering from serious head injuries are also males (appendices 1-8). Additional information obtained from conducting open-ended interviews with selected professionals dealing with the injured of the Uprising also indicates that the injured tend to come from the poorer sectors of society. They are generally either students, not having completed high school yet, or drop outs who have landed jobs as manual labourers on the West Bank or in Israel . It is important to note that, especially for manual labourers, the loss of the use of a limb, part of an appendage, or similar damage, more likely than not means a loss of the means to earn income. Consequently, disabilities that are of perhaps limited negative impact on those who work in the service sector might be catastrophic for this sector of society. Since this sector forms an important proportion of the patient group on whom this study focuses, these findings should have an important bearing on the type of services that must be planned for to meet the medical and rehabilitation needs of these individuals.

b. The findings of the second part of the study point to a wide ranging population of disabled - physically, mentally and in sensory terms- of all ages, but predominantly children and of both sexes. Unlike the population injured by army violence, this population needs extensive and long term rehabilitation services to meet its needs. Many are capable of vocational training and social integration and only the very few indeed are in need of permanent institutionalization.

2. The number of individuals needing rehabilitation services :

a. Assuming that the total number of individuals injured during the second year of the Uprising is at least equal to the first [22], we must plan for fulfilling the needs of at least 1000 injuries requiring rehabilitation in one form or another. Of

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[22] Al-Haq figures indicate that, in fact, the degree and severity of injuries sustained by the population of the West Bank and Gaza Strip in the first part of the second year of the Uprising is considerably more than the first. So our estimates are rather conservative.

those, we expect to have to deal with the needs of at least 100 paraplegics alone. We must also add the need to manage an expected 160-200 cases of enucleation.

b. As elaborated by this study, we estimate that between 30000-37000 persons are in need of rehabilitation services in the West Bank and Gaza Strip - excluding those injured in the Uprising - and 16000-25000 for the West Bank alone. Of those, our findings indicate about 900 are cared for as boarders and that some form of service reaches about 3300 on an outpatient basis (Appendix 8). That is, it does appear that the large majority of the disabled in West Bank - or almost 80% - are still not being reached by services that they need.

3. The levels of rehabilitation services needed

a. For at least two thirds of the cases of injuries due to army violence, and probably the majority of the rest of the disabled, rehabilitation services provided at the level of the injured's own community is recommended. Thus the first level of services is that of the primary health/rehabilitation care, to be always integrally linked to primary health care and community based projects existing in the area where the injured lives, and in line with WHO policy :

> '... every effort should be made to integrate disability prevention and rehabilitation into existing community services, particularly primary health care services '[23].

After all, the question of properly planning these services from the start is important not only in terms of fulfilling the needs of the disabled satisfactorily, but also in terms of the costs of such provision on society at large. Once again, as WHO has already discovered :

> '.. if a shift is made from institutional care to community-based rehabilitation, and if the relatives of the disabled undertake to look after their disabled family members, equally good, if not better, care can be provided at a much lower cost to society as a whole '[24].

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[23] Disability prevention...., WHO, op.cit., p.30.

[24] Disability Prevention..., op.cit., p.20.

b. The second level of services includes cases where no permanent disability is expected or when the permanent disability is not very serious and where the injured person is in need of medical and rehabilitative assistance for a period of time longer than necessary to remain in hospital. To relieve hospital beds and at the same time provide the patients with the necessary variety of rehabilitation facilities , in patient rehabilitation facilities for short periods - a week to 2-3 months - is recommended,followed by rehabilitation on an out-patient or home-based basis as necessary.

It is also possible to envisage the need for a half-way secondary level of service that is between extended in patient treatment and community based care. Here a housing arrangement that simulates normal life as much as possible should be established and linked to the in patient centre. This can perhaps come in the form of a special apartment equipped to house of a group of those permanently disabled - such as paraplegics - who are unable to adjust back into their societies and cannot achieve social integration there but who could be helped to live as much of a normal life as possible. This normality includes holding employment and other daily ordinary activities. Such disabled people could have the benefit of living together in ' fitted apartments' which are close to the regular medical care that they might be needing (for instance urological services, physiotherapy, occupational therapy and counseling).

c. The third level of service includes cases that require institutionalization for extended periods of time - months to about one year- where the injury and the disability is of the serious variety, such as paraplegics. This type of injury requires the establishment of inpatient services equipped to handle patients for extended, but preferably not permanent, periods of time. It might be necessary here to provide separate services for those injured in the Uprising because of differences in need between the two groups of disabled.

Finally, a community-oriented or community-centered facilities responding to known demands of the community is also another major level of service. As these 'user-friendly' institutions are described :

> '....modest sized, inexpensive rehabilitation day-centres, with strong community roots, using locally available materials, with local staff having adequate but inexpensive training, providing affordable rehabilitation services to large numbers of disabled persons' [25].

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[25] Miles, M., Where There....op.cit., p.10.

Such facilities could very conceivably fulfil an important role in the pooling of resources and effective service delivery to the disabled without undue cost. An example of how this model could be used would be to solve the problem of the education of the disabled, given the relatively small numbers of disabled people at the village and refugee camp level and should the school system prove to be unable to absorb such individuals. Here pooling for day care from several localities could prove to be an effective option [24].

4. The type of rehabilitation services needed :

a. Although the two groups of disabled - Uprising injuries and the others - are in need of similar medical specialties, the approach to their treatment and care can at times be very different. This can be well expressed in terms of the difference between rehabilitation and habilitation.

b. If the eventual social integration of the disabled is the ultimate goal of rehabilitation, then it follows that the services provided must be multisectoral and interdisciplinary. Those can be roughly categorized into the following :

(1) Medical and healing professions :

(a) General practitioner medical services
(b) General nursing services
(c) Village health worker services with special training in primary health care rehabilitation.
(d) Specialty urology and gastroenterology
(e) Specialty orthopedics
(f) specialty neurology
(g) Specialty internal medicine
(h) specialty psychiatric services
(i) Physiotherapy services, in-patient, institutional and community based
(j) Occupation therapy services, in-patient, institutional and community based.

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[24] We know of several local institutions already utilizing this option effectively, including al-Nahda al-Nisa'ia in Ramallah and the Union of Palestinian Medical Relief Committees Biddu Community Physiotherapy/Rehabilitation Project.

(2) Other professional services

(a) Speech therapy and audiology
(b) Prosthesis
(c) Social work services
(d) Psychology/ counseling services

(3) Education and miscellaneous services

(a) Regular schooling
(b) Special education (for the mentally retarded, for those with speech impairments and individuals with multiple handicaps including training to walk with crutches, to write with the other hand for amputees and to manage wheelchairs etc.)
(c) Vocational training
(d) Job placement services
(e) Parent and family education/training
(f) Public education and campaigning
(g) Recreational services
(h) Transportation systems for the disabled

Needless to say these services must be coordinated for maximum benefit to the disabled and for minimal expenditure.

III. The Contours of a Plan of Action

A. Some Principles :

1. The first step in building a realistic plan of action is to recognize that the different institutions and communities in the area have different levels of interest and resourcefulness in dealing with the problem of the disabled . It must be acknowledged that :

> '... community involvement ... never begins effectively in reality prior to communities reaching a certain threshold in economic, social and educational development' [27].

2. The second point deals with the great need for flexibility in planning for rehabilitation programmes among different communities, for as Lena Saleh has expressed It :

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[27] Where there is no rehab.... op.ci.t, p.12.

'... When studying national planning for handicapped individuals it is clear that there is no single pattern of service delivery that can fit all areas '.

3. The third point is one dealing with the realization that the utmost must be done to promote cooperation and coordination among the various institutions dealing with the disabled as the only means to realistically fulfil the needs of the disabled without undue cost to society. Such cooperation involves a division of labour based on experience in the field, technical expertise and ability to reach and involve communities in planned action.

4. The final point is a reiteration of the need to link decentralized community-based rehabilitation services to existing primary health care or community based-programmes and to link the different levels of rehabilitation services discussed above with each other in a network of support and cooperation.

B. What is already available in the West Bank :

1. Maqassed Hospital Medical Centre in Jerusalem, Mt. David Orthopedic Hospital in Bethlehem and al-Amira Basma Hospital in Jerusalem are all currently catering to the orthopedic and rehabilitation needs of the disabled at the tertiary level primarily but also at the secondary level. In addition the 17 hospitals of the West Bank are also caring for the injured of the Uprising in a general way.

2. Two major rehabilitation institution are currently providing or planning to provide the disabled with integrated secondary level services primarily in addition to selected tertiary care services: Patient's Friend's Society in Ramallah and the Arab Society for the Handicapped in Bethlehem. Both institutions could adequately fulfil the institutional needs at the secondary level of both those injured in the Uprising and the rest of the disabled population in the area.

3. A variety of institutions already establishing primary and some secondary level rehabilitation services such as UNRWA , the Union of Palestinian Medical Relief Committees , Patient's Friends Societies and Red Crescent societies operating in the various parts of the West Bank. Those also operate primary health

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27 Saleh, L., Initiating Action , Proceedings of the 7th World Congress of the ILSMH on Mental Handicap, Vienna, 1978, ILSMH, Brussels, quoted in Where there is no Rehab...., op.cit., p.13.

care and/or community based projects and have linked their rehabilitation services to the delivery of primary health care and community service.

4. A variety of institutions operating single projects for a specific group of disabled, such as schools for the blind, deaf and dumb, that separate from other types of disability service.

C. Immediate needs :

1. The coordinating capabilities of a body of people representing institutions working in the field of rehabilitation to guide research activities, collectively formulate strategy, plan for implementation and evaluation of rehabilitation projects at the country level. It would also be the responsibility of this committee to define the guidelines for training needs of local professionals both locally and abroad, assist institutions working in rehabilitation in upgrading the level and quality of their services, provide technical and other pertinent information to such institutions and generally function as a resource at the service of those who serve the disabled.

2. Through this committee, begin the process of linking all the institutions of the area into a network of cooperation, perhaps beginning with discussion workshops, leading to identification of problem areas and further needs, leading in turn to attempts to upgrade the sometimes abominable quality of existing services, and eventually leading to the amelioration of the level of disability service provision in the area. This of course should include planning for fulfilling the unmet needs of all those who are still not touched by any form of disability service.

3. Through this committee, conduct further in-depth action oriented research in the area of training needs and in establishing the specific needs of selected disabled populations. Such studies could be invaluable for further planning and for the implementation of projects based on actual need.

4. Simultaneously, divide tasks among institutions providing tertiary,secondary and primary level services to the disabled so that a coherent plan of action for each is drawn out in relation to the others. Proceed to support each in accordance with scientifically-defined needs.

Finally, we do hope that this study has succeeded in providing planners with basic information and with the foundations for a coherent policy for disability and rehabilitation work in Occupied Palestine.

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PAR/QUADRAPLEGICS- 9% OF TOTAL INJURIES · Appendix 1

RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
18	M	17	SP	PAR	4C
23	M	19	SP	P PAR	4C
24	M	16	SP	PAR	4V
50	M	18	HN	PAR	4V
223	M	20	BN	PAR	4C
225	M	19	SP	PAR	4V
228	M	21	SP	PAR	4C
230	M	26	SP	QAD	4T
231	M	21	LG	PAR	4V
234	M	22	CHST	PAR	4V
248	M	21	SP	PAR	4C
258	M	21	SP	PAR	4C
262	M	26	SP	QUAD	4T
292	M	17	SP	PAR	2C
322	M	24	SP	PAR	4T
340	M	13	SP	PAR	4V
342	M	19	HU	PAR	4V
344	M	16	SP	PAR	4C
367	M	26	SP	PAR	4T
374	M	16	P	PARA	4C
397	M	17	SH	PAR	4C
409	M	17	RL/LL	PAR	4C
431	M	22	LG	PAR	4V
445	M	14	SP	PAR	4V
460	M	28	SP	PAR	4V
469	M	17	SP	PAR	4T
477	#	18	SP	PAR	4C
481	M	13	SP	PAR	4C
509	M	24	SP	PARA	4V
516	M	28	SP	PAR	4T
517	F	45	LG	PAR	4V
520	M	15	SP	PAR	1V
525	M	25	SP	PAR	4T
538	M	21	CHEST	PAR	4T
546	M	19	SP	PAR	4V
566	M	51	SP	PAR	4T
569	M	51	SP	PAR	4T
583	M	24	LG	PAR	4V
588	M	17	SP	PAR	4C
599	F	18	SP	PAR	4V

TOTAL

Printed 40 of the 473 records.

Key:

S = Sex

AG = AGE

SEV = SEVERITY 1 = mild 4 = serio

L = location

C = camp

V = village

T = Tacon

AMPUTEES- 2% OF TOTAL INJURIES - Appendix 2

RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
43	M	15	KIDNEY	AMP	4V
278	M	23	LF	AMP	4C
420	M	18	RL	AMP	4V
464	M	24	LF	AMP	4V
467	M	24	LG	AMP	1V
510	M	26	TOUNG	AMP	4V
523	M	9	LF	AMP	4C

TOTAL

Printed 7 of the 473 records.

HEAD INJURY/CRATIOTOMIES-6% OF INJURIES - Appendix 3

RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
36	M	56	HD	F/CRANIO	3T
49	M	27	LEYE	CRANIOTOMY	4V
52	M	27	EYE/HD	REM/CRANIO	3V
240	M	29	HD/BODY	COMA	4V
253	M	20	HD	TRAUMA	2C
279	M	24	BR	CRANIOTOMY	5T
371	M	41	RLARM/HD	F/BRD	1T
387	M	18	HD	BRD	4C
450	M	17	HD	CRANIOTOMY	4V
491	M	54	HD	HAEMATOMA	2T

TOTAL

Printed 10 of the 473 records.

NERVE DAMAGE - 7% OF TOTAL INJURIES - Appendix 4

RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
26	M	30	NK	NERVE/BD	4C
38	F	12	BR	ND	1C
54	M	17	LHM	NERVE	4C
211	M	19	SP	ND	4C
213	M	19	TH	ND	3V
214	M	16	AX	ND	3C
224	M	16	FI	ND	2C
245	M	16	AX	NERVE	4C
264	M	22	CHEST	NERVE	4V
288	M	13	RAX	NERVE	4T
294	M	15	LG	ND	2V
299	M	20	HD	NERVE	4V
305	M	18	RARM	NERVE	4V
317	M	26	LWR	NERVE	4T
321	M	18	HND	TND	1C
329	F	11	FE	NERVE	4C
338	M	16	RARM	NERVE	4V
343	M	14	SH	ND	3T
349	M	19	FE	ND	2V
368	M	17	RELB	NERVE	4V
392	M	14	SP	NERVE D	4V
416	M	20	RBT	NERVE/DF	4C
456	M	18	LWR	NERVE	4T
466	M	21	TH	ND	4C
487	M	14	UL	NERVE/CF	3V
493	M	14	ULNA	ND	2V
498	M	24	LARM	NERVE	4V
515	M	18	HU	F/NERVE	4V
545	M	14	HD	NERVE D	4T
563	M	17	SP	ND	4V
578	M	19	RELB	TND	2V

TOTAL

Printed 31 of the 473 records.

VASCULAR DAMAGE - 2% OF TOTAL INJURIES - Appendix 5

RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
15	M	25	RWR	VASD TD	2C
40	M	23	LL	VASD	2T
68	M	22	RF	VSD	4C
70	M	22	FE	VD	2C
286	M	15	RJR	VASD	2V
289	M	15	PLV	VD	3V
319	M	20	RF	VAS	4T
531	F	15	LARM	VASD/NERVE	4V
554	M	16	RL	VASD	2V
556	M	40	FE	VD	2T

TOTAL

Printed 10 of the 473 records.

CPD FRACTURES - 16% OF TOTAL INJURIES - Appendix 6

RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
8	M	17	TI	CF	3C
16	M	20	RTB/FB	CF	4C
19	M	14	SH/ARM	CF	3T
27	M	27	HU	CF	3V
41	M	14	FE	CF	3T
42	M	40	FB/TB	CF	3T
47	M	18	TI FI	CF	2C
51	M	23	FE	CF	2T
58	M	24	FE	CF	2V
72	M	18	FE	CF	2T
200	M	17	LTB	CF	2C
203	M	22	TI	CF	2V
207	M	21	FE	CF	3V
210	M	20	HN	CF	2V
216	F	30	FE	CF	2C
226	M	19	EL	CF	2T
232	M	21	FE	CF	2T
239	M	22	LTB	CF	2V
247	F	30	FE	CF	4C
250	M	26	LF	CMPD	3C
263	M	21	LF	CF	2T
266	F	19	TB	CF/VASD	3C
280	M	24	TB	CF	2C
283	M	19	LG	CF	2V
290	F	48	ULNA	CF	2T
293	M	18	FT	CF	3T
307	M	19	FE	CF	2C
308	M	22	FE	CF	2T
310	M	22	TI	CF	3C
311	M	24	LF	CF	2V
312	M	28	FE	CF	2V
313	M	24	FE	CF	2C
318	M	18	FE	CF	2T
332	M	16	RF	CMPD	2T
333	M	18	RLND	CF	2T
352	M	17	FE	CF	2V
355	M	17	FE	CF	2C
357	M	20	ULNA	CF	2V
361	M	18	HD	CF	3T
363	F	20	FE	CF	2T
365	M	8	HD	CF	2T
366	M	34	RL/LL	CF	2T
372	M	23	HU	CF	3V
377	M	26	FE	CF	2T
381	M	22	RF	CF	2V
385	M	17	FE	CF	2V
395	M	16	LF	CF/NERVE	4C
403	M	22	HU	CF	2C
404	M	22	HU	CMPD	3C
422	M	34	TI FI	CF	2T
427	M	21	EL	CF	2C
428	M	22	FE	CF	2T
443	M	15	TB	CF	2V

CPD FRACTURES - 16% OF TOTAL INJURIES

RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
448	M	19	FE	CF	2C
449	M	23	FE	CF	2T
451	M	45	FE	CF	2T
454	M	16	TI FI	CF	2V
463	F	18	HN	CF	2V
475	M	16	FE	CF	2T
478	M	21	FE	CF	2T
482	M	20	FE	CF	2C
487	M	14	UL	NERVE/CF	3V
500	M	22	LTB	CF	2C
518	M	22	FE	CF	2C
529	M	15	TI	CF	2C
535	M	17	HN	CF	2V
541	M	10	FE	CF	1T
547	M	22	LSH/HU	CMPD	2T
558	M	40	RF	CF/VASD	4T
562	M	24	FE	CMPD	3V
576	M	27	TI FI	CF	2C
581	M	11	FE	CF	2C
584	M	21	TB/ANK	CF	2V
589	M	24	FE	CF	2V
594	M	18	AR	CF	2V
597	M	40	FE	CF	2T

TOTAL

Printed 76 of the 473 records.

TOTAL INJURIES - Appendix 7

RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
1					
2	M	21	KN	TD	2V
3	M	18	TB/FB	F/DIS	4T
4	M	14	EL	TD	2C
5	M	18	LG	F	1V
6	M	22	KN	F	3T
7	M	20	FE	F	4T
8	M	17	TI	CF	3C
9	M	25	FT	F	1T
10	M	18	FE	F	4V
11	M	20	FT	F	3V
12	M	20	EL	TD	2V
13	M	18	HD/HND	F	2V
14	M	20	FT	F	1V
15	M	25	RWR	VASD TD	2C
16	M	20	RTB/FB	CF	4C
17	M	18	TH	TD	2T
18	M	17	SP	PAR	4C
19	M	14	SH/ARM	CF	3T
20	M	20	RANK	F	2V
21	M	17	LL	F	1C
22	M	20	LELB	JOINT	4V
23	M	19	SP	P PAR	4C
24	M	16	SP	PAR	4V
25	M	14	RELB	TD	2C
26	M	30	NK	NERVE/BD	4C
27	M	27	HU	CF	3V
28	M	20	FE	F	3V
29	M	15	RKN	JOINT	2C
30	M	33	RUL/LHU	F	1C
31	M	19	KN	TD	2C
32	M	20	EL	TD	3T
33	M	23	KN	F	3T
34	M	16	KN	F	2C
35	M	18	TH		2T
36	M	56	HD	F/CRANIO	3T
37	M	16	FE	F	2T
38	F	12	BR	ND	1C
39	M	20	KN	TD	3C
40	M	23	LL	VASD	2T
41	M	14	FE	CF	3T
42	M	40	FB/TB	CF	3T
43	M	15	KIDNEY	AMP	4V
44	M	17	HN	F	5T
45	M	4	ABD	DAM	2V
46	M	15	KID/ABD	NEPHRECT	4V
47	M	18	TI FI	CF	2C
48	M	18	CHST		2V
49	M	27	LEYE	CRANIOTOMY	4V
50	M	18	HN	PAR	4V
51	M	23	FE	CF	2T
52	M	27	EYE/HD	REM/CRANIO	3V
53	M	19	KN	F	4T

TOTAL INJURIES

RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
54	M	17	LHM	NERVE	4C
55	M	18	TH	TD	3V
56	M		ELB		2C
57	M	12	LG	TD	3V
58	M	24	FE	CF	2V
59	M	41	WR	TD	4C
60	M	14	RLL		2T
61	M	26	FE	F	3T
62	F	81	FE	F	4T
63	M	19	FE	F	2C
64	M	22	PLV	F	5C
65	M	18	RWR	TEN	2V
66	M	22	HD		2C
67	M	31	ABD	BURN	2C
68	M	22	RF	VSD	4C
69	M	17	ABD/ARM/L		3T
70	M	22	FE	VD	2C
71	M	39	FE	F	2C
72	M	18	FE	CF	2T
73	M	26	FE	F	3C
200	M	17	LTB	CF	2C
201	M	14	EYE	TD	3C
202	M	17	ABD	LOSS INT	4C
203	M	22	TI	CF	2V
204	M	15	PLV	F	2V
205	M	28	HU	F	1V
206	M	17	EL	TD	1C
207	M	21	FE	CF	3V
208	M	36	FT	F	1T
209	M	16	FE	F	2T
210	M	20	HN	CF	2V
211	M	19	SP	ND	4C
212	M	36	EYE	TD	3V
213	M	19	TH	ND	3V
214	M	16	AX	ND	3C
215	M	14	TI FI	F	1V
216	F	30	FE	CF	2C
217	M	18	KIDNEY	DAMAGE	4V
218	M	22	TH	DAMAGE	4V
219	M	24	KN	DAMAGE	4T
220	M	20	SK	F	2V
221	M	17	LG	TD	3T
222	M	22	EYE	DAMAGE	3V
223	M	20	BN	PAR	4C
224	M	16	FI	ND	2C
225	M	19	SP	PAR	4V
226	M	19	EL	CF	2T
227	M	20	SP	F	2T
228	M	21	SP	PAR	4C
229	M	10	RADIUS	F	4V
230	M	26	SP	QAD	4T
231	M	21	LG	PAR	4V
232	M	21	FE	CF	2T

TOTAL INJURIES

RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
233	M	20	LG	F	1T
234	M	22	CHST	PAR	4V
235	M	20	HN	F	1V
236	M	13	WR	F	2T
237	M	14	EYE/BODY		2C
238	M	17	ABD	LOSS INST	4C
239	M	22	LTB	CF	2V
240	M	29	HD/BODY	COMA	4V
241	M	25		F	1T
242	M	22	NK/LHP		2V
243	M	36	LEYE	LAC	2V
244	M	19	RHP	DF	4V
245	M	16	AX	NERVE	4C
246	M	14	RTB/FB		4V
247	F	30	FE	CF	4C
248	M	21	SP	PAR	4C
249	M	20	BR		4V
250	M	26	LF	CMPD	3C
251	M	17	LL/RL	MD	2T
252	F	11	LARM		2T
253	M	20	HD	TRAUMA	2C
254	M	16	LFB	DF	4C
255	M	18	HD	F	1T
256	M	19	RELB	BD/JOINT	3T
257	M	20	LWR/RWR	F	2T
258	M	21	SP	PAR	4C
259	M	27	ELB		1T
260	M	23	RTB	BD	1T
261	M	10	RARM	F	1V
262	M	26	SP	QUAD	4T
263	M	21	LF	CF	2T
264	M	22	CHEST	NERVE	4V
265	M	18	CHT		2T
266	F	19	TB	CF/VASD	3C
267	M	16	LF		4T
268	F	14	RELB		2C
269	M	14	EL	TD	3C
270	M	17	KN	F	2T
271	M	22	TI	F	1C
272	M	16	LG	F	2V
273	M	22	LTB	F	1C
274	M	32	TH	APM	1T
275	M		FE	F	1T
276	M	20	FE	F	1T
277	M	17	FE	F	1C
278	M	23	LF	AMP	4C
279	M	24	BR	CRANIOTOMY	5T
280	M	24	TB	CF	2C
281	M	10	HD	F	2T
282	M		WR	F	3C
283	M	19	LG	CF	2V
284	M	18	KN	F	2T
285	M	22	SK	F	2T

TOTAL INJURIES

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RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
286	M	15	RJR	VASD	2V
287	M	14	FT	TD	5C
288	M	13	RAX	NERVE	4T
289	M	15	PLV	VD	3V
290	F	48	ULNA	CF	2T
291	M	10	KN	F	3T
292	M	17	SP	PAR	2C
293	M	18	FT	CF	3T
294	M	15	LG	ND	2V
295	M	18	KN	F	2C
296	M	18	LKN	DAMAGE	3T
297	M	25	LG	F	1V
298	M	18	FE	F	3C
299	M	20	HD	NERVE	4V
300	F	45	LARM	F	2V
301	F	54	HU	F	1V
302	M	12	TI	F	1V
303	M	20	RF/KN	JOINT	4C
304	M	12	RTB	BD	2T
305	M	18	RARM	NERVE	4V
306	M	19	KN	F	1T
307	M	19	FE	CF	2C
308	M	22	FE	CF	2T
309	M		FT	F	1C
310	M	22	TI	CF	3C
311	M	24	LF	CF	2V
312	M	28	FE	CF	2V
313	M	24	FE	CF	2C
314	M	12	RHND		1T
315	M	15	FE	FF	3T
316	M	22	EYE/BR	ED	4T
317	M	26	LWR	NERVE	4T
318	M	18	FE	CF	2T
319	M	20	RF	VAS	4T
320	F	51	F		2C
321	M	18	HND	TND	1C
322	M	24	SP	PAR	4T
323	M	27	BK		2V
324	M	17	SK	F	1C
325	M	37	FE	F	1T
326	M	20	FE	F	1C
327	M	16	FE	F	1C
328	M	20	LG	TD	5T
329	F	11	FE	NERVE	4C
330	F	17	CHST		4V
331	M	17	KIDNEY	TD	4T
332	M	16	RF	CMPD	2T
333	M	18	RLND	CF	2T
334	M	28	LELB/HU		1T
335	M	20	LF	F	2T
336	M	15	RTH		2T
337	F	18	RHND		2V
338	M	16	RARM	NERVE	4V

TOTAL INJURIES

RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
339	M	35	KN	CART	1V
340	M	13	SP	PAR	4V
341	M	25	FE	DF	4V
342	M	19	HU	PAR	4V
343	M	14	SH	ND	3T
344	M	16	SP	PAR	4C
345	M	24	KN	TD	2C
346	M	22	HN	TD	2T
347	M	20	CHT/LUNG	DAM	4C
348	M	12	FE	F	1T
349	M	19	FE	ND	2V
350	M	20	D	TD	4T
351	M	18	KN	F	1V
352	M	17	FE	CF	2V
353	M	15	EL	F	1T
354	M	27	FE	F	1C
355	M	17	FE	CF	2C
356	M	20	TH	TD	2V
357	M	20	ULNA	CF	2V
358	M	16	BK		1V
359	M	18	HD	F	2C
360	M	20	RHND/RKN		2T
361	M	18	HD	CF	3T
362	F	70	NK/FE	F	2V
363	F	20	FE	CF	2T
364	F	12	BR	CRANIO	4C
365	M	8	HD	CF	2T
366	M	34	RL/LL	CF	2T
367	M	26	SP	PAR	4T
368	M	17	RELB	NERVE	4V
369	M	22	SH	F	1V
370	M	19	KN	F	1V
371	M	41	RLARM/HD	F/BRD	1T
372	M	23	HU	CF	3V
373	M	13	EL	F	2C
374	M	16	P	PARA	4C
375	M	22	LL		1V
376	M	26	FE	F	1T
377	M	26	FE	CF	2T
378	M	23	SH	F	1V
379	M	17	FE	F	4T
380	M	17	HU	F	1V
381	M	22	RF	CF	2V
382	M	17	H		2V
383	M	22	KN	F	2T
384	M	24	ARM	F	1C
385	M	17	FE	CF	2V
386	M	16	HN	F	1T
387	M	18	HD	BRD	4C
388	M	21	MANDIBLE	F	5V
389	M	19	TH		2C
390	F	70	TB/FB	F	2C
391	M	16	TH	TD	2C

TOTAL INJURIES

RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
392	M	14	SP	NERVE D	4V
393	M	10	EL	F	1V
394	M	22	FE	F	1V
395	M	16	LF	CF/NERVE	4C
396	M	21	HD	F	2T
397	M	17	SH	PAR	4C
398	M	15	LG	TD	1C
399	M	16	RTH		2T
400	M	21	SH		3T
401	M	19	KIDNEY	DAMAGE	4V
402	M	17	TH	F	1T
403	M	22	HU	CF	2C
404	M	22	HU	CMPD	3C
405	M	23	FE	F	1T
406	M	20	FE	F	1T
407	M	25		F	1T
408	M	17	KN	F	1T
409	M	17	RL/LL	PAR	4C
410	M	18	LHP	JOINT	2C
411	M	18	HD	F	2V
412	M	19	LL		1C
413	M	17	TB/FB	F	2V
414	M	15	SH	TD	2V
415	M	18	KN	F	3T
416	M	20	RBT	NERVE/DF	4C
417	M	9	KN	F	1T
418	M	18	FE	F	1V
419	M	20	KN	TD	3C
420	M	18	RL	AMP	4V
421	M	18	FT	F	1T
422	M	34	TI FI	CF	2T
423	M	14	RL/LL		2T
424	M	24	LG	TD	1V
425	M	18	HN	F	1T
426	M	18	RHND		2C
427	M	21	EL	CF	2C
428	M	22	FE	CF	2T
429	M	17	HD	CRANIO	4T
430	F	45	LKN		2T
431	M	22	LG	PAR	4V
432	M	17	TH	TD	2T
433	M	14	LF	DF	2V
434	M	19	LHM		2T
435	F	19	FT	F	1T
436	M	22	HU	F	1T
437	M	17	FE	F	1V
438	M	20	HN	F	1V
439	M		LHND/CHT		2T
440	M	18	WR	F	2C
441	M	13	KN	TD	3C
442	M	15	TI FI	F	3C
443	M	15	TB	CF	2V
444	M	21	SP	F	3T

RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
445	M	14	SP	PAR	4V
446	M	17	FT	F	1T
447	M	24	FE	F	1T
448	M	19	FE	CF	2C
449	M	23	FE	CF	2T
450	M	17	HD	CRANIOTOMY	4V
451	M	45	FE	CF	2T
452	M	17	LF	F	2V
453	M	19	HD	F	1T
454	M	16	TI FI	CF	2V
455	M	17	EL	F	3T
456	M	18	LWR	NERVE	4T
457	M	18	KN	F	2V
458	F	22	KIDNEY	TD	3C
459	M		FE	F	1V
460	M	28	SP	PAR	4V
461	M	16	LANK	JOINT/F	2C
462	M	16	HN	TD	4V
463	F	18	HN	CF	2V
464	M	24	LF	AMP	4V
465	F	50	HD	CRANIO	4V
466	M	21	TH	ND	4C
467	M	24	LG	AMP	1V
468	M	20	KN	TD	3C
469	M	17	SP	PAR	4T
470	M	18	RL/LL/TB	F	3T
471	M	19	LL	F	2T
472	M	12	FE	F	3T
473	M	18	HU	F	1T
474	F	19	RF		2V
475	M	16	FE	CF	2T
476	M	18	HN	F	2V
477	#	18	SP	PAR	4C
478	M	21	FE	CF	2T
479	M	18	HD		4C
480	M	32	SK	F	4V
481	M	13	SP	PAR	4C
482	M	20	FE	CF	2C
483	M	32	HD	F	2V
484	M	18	HD/NEK/LH	F	2C
485	M	11	HD		2C
486	M	16	RL		1V
487	M	14	UL	NERVE/CF	3V
488	M	13	TH	TD	2T
489	M	23	EL	TD	3C
490	M	54	HD		2T
491	M	54	HD	HAEMATOMA	2T
492	M	16	LG	TD	2V
493	M	14	ULNA	ND	2V
494	M	15	KN	F	2C
495	M	13	SH		2T
496	M	12	RKN		1T
497	M	13	LL	BURN	4V

TOTAL INJURIES

RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
498	M	24	LARM	NERVE	4V
499	M	13	RL		2T
500	M	22	LTB	CF	2C
501	M	17	FE	F	1V
502	M	25	TH	TD	1V
503	F	13	LG	BURN	5V
504	M	13	RTH		1T
505	M	15	FB	F	2T
506	M	17	RF/LL/RHND		3V
507	M	16	BN	HEM	4T
508	M	10	RARM	F	2T
509	M	24	SP	PARA	4V
510	M	26	TOUNG	AMP	4V
511	M	19	RL		1C
512	M	25	FE	FC	2V
513	M	18	FE	F	1C
514	F		NK	F	1T
515	M	18	HU	F/NERVE	4V
516	M	28	SP	PAR	4T
517	F	45	LG	PAR	4V
518	M	22	FE	CF	2C
519	M	17	HU	F	5V
520	M	15	SP	PAR	1V
521	F	40	LHAND		2T
522	M	17	RL		2V
523	M	9	LF	AMP	4C
524	M	60	RAD	F	1T
525	M	25	SP	PAR	4T
526	F	18	EL	F	4C
527	M	17	EYE		1C
528	M	21	KN	TD	2V
529	M	15	TI	CF	2C
530	M	23	JAW	F	3V
531	F	15	LARM	VASD/NERVE	4V
532	M	23	JAW		2V
533	M	25	TB	F	2C
534	M	29	LG	TD	2V
535	M	17	HN	CF	2V
536	M	17	RF	F	2C
537	F	17	CHST		2C
538	M	21	CHEST	PAR	4T
539	M	10	FT	F	2V
540	M	17	FT	TD	1C
541	M	10	FE	CF	1T
542	M	13	HD/NK	F	2C
543	F	43	HD/NK		2V
544	M	13	EYE		2T
545	M	14	HD	NERVE D	4T
546	M	19	SP	PAR	4V
547	M	22	LSH/HU	CMPD	2T
548	M	19	FE	F	3C
549	M	16	EYE	TD	4C
550	M		FE	F	1C

RCD.	S	AG	INJURY	DESCRIPTIO	SEV-L
551	F	20	WR	TD	3V
552	M	15	HD/NK/LARM		2V
553	M	10	LRHND/L		3V
554	M	16	RL	VASD	2V
555	M	21	LG	TD	1V
556	M	40	FE	VD	2T
557	M	23	TI	F	1T
558	M	40	RF	CF/VASD	4T
559	M	21	RAD/ULN		3V
560	M	23	AR	TD	1T
561	M	15	ABD	F	2C
562	M	24	FE	CMPD	3V
563	M	17	SP	ND	4V
564	M	21	HU	F	1V
565	M	17	FE	F	1T
566	M	51	SP	PAR	4T
567	M	18	TH	TD	1V
568	M	22	FE	F	3V
569	M	51	SP	PAR	4T
570	M	20	BODY		4V
571	M	3	HD		2C
572	M	18	RL/TB	F	2T
573	M	19	RSH		2T
574	F	17	TB/FB	F	2T
575	M	14	ABD	DAM	4T
576	M	27	TI FI	CF	2C
577	M	20	FT	F	1T
578	M	19	RELB	TND	2V
579	M	30	FT	TD	1T
580	M	13	KN	F	1T
581	M	11	FE	CF	2C
582	M	20	HN	F	1T
583	M	24	LG	PAR	4V
584	M	21	TB/ANK	CF	2V
585	M	19	TB/FB	F	2V
586	M	22	LELB/BK		2V
587	M	17	FE	F	1V
588	M	17	SP	PAR	4C
589	M	24	FE	CF	2V
590	M	18	KN	TD	1C
591	M	39	PLV	TD	1T
592	M	17	FT	TD	1C
593	M	24	RRAD	F	1V
594	M	18	AR	CF	2V
595	M	25	WR	F	2T
596	M	20	RARM/PLV	F	2T
597	M	40	FE	CF	2T
598	F	17	EYE	TD	4V
599	F	18	SP	PAR	4V

TOTAL

Printed 473 of the 473 records.

INSTITUTIONS SERVING THE DISABLED/WBANK – Appendix 8

RCD.	LOCAT	INSTITUTION	# B	# O	PATI	TYPE	EDU	SPE	VOC	PHY	MED	PRO	COU	ENT
1		UPMRC VILLAGE OUTREACH		50	BOTH	BOTH	NO	YES	NO	YES	YES	NO	YES	YES
2	?	LARCEH COMMUNITY HOME	YES	?	?	?	?	?	?	?	?	?	?	?
3	BETHL	AL'ALA'IEH SCHOOL BETHLEHEM	?	?	?	?	?	?	?	?	?	?	?	?
4	BETHL	AL-SALWA SOCEITY	18		BOTH	PHYS	YES	YES	NO	YES	YES	NO	NO	YES
5	BETHL	ALNUR SCHOOL FOR BLIND WOMEN	YES		FEM	BLND	YES	YES	YES	NO	?	?	?	?
6	BETHL	BETH ARAB SOCIETY- ALKHADER		?	BOTH	MENT	NO	YES	NO	YES	NO	NO	YES	NO
7	BETHL	BETHLEHEM ARAB SOCIETY	100	2TH	BOTH	BOTH	NO	YES	YES	YES	YES	YES	NO	NO
8	BETHL	HNDCRAFTS TRAIN WORK FOR GIRLS		120	FEM	PHYS	NO	NO	YES	NO	NO	YES	NO	NO
9	BETHL	HOUSE OF HOPE BLND MENTAL HDCP	52	20	BOTH	BLND	NO	NO	YES	NO	YES	NO	NO	NO
10	BETHL	IFTA SCHOOL FOR THE DEAF/DUMB	?	NO	?	DD	YES	YES	YES	?	?	?	?	?
11	BETHL	JEDDA ISNTITUTE	?	?	?	?	?	?	?	YES	?	?	?	?
12	BETHL	MT DAVID ORTHOPEDIC HOSPITAL	876	13T	BOTH	PHYS	NO	NO	NO	YES	YES	YES	NO	NO
13	BETHL	SIRA	?	?	BOTH	MENT	YES	YES	NO	NO	YES	NO	NO	NO
14	BETHL	YAMIMA SCHOOL BEIT JALA	YES	YES	?	MENT	?	?	?	?	?	?	?	?
15	BETHL	YMCA BEIT SAHUR	150		BOTH	PHYS	NO	NO	YES	YES	YES	NO	YES	YES
16	HBRN	AL-AMAL SOCIETY FOR THE DEAF		22	BOTH	DEAF	YES	YES	NO	NO	NO	NO	NO	NO
17	HBRN	AL-IHSAN SCHOOL	25		BOTH	BOTH	NO	NO	NO	NO	NO	NO	NO	NO
18	HBRN	AL-RAJA CENTREFOR SPECIAL EDU	15	45	BOTH	BOTH	NO	YES	YES	NO	NO	NO	NO	NO
19	HBRN	RED CRESCENT PHYSIOTHERAPY		537	BOTH	PHYS	NO	YES	NO	YES	NO	NO	NO	NO
20	JENIN	ALHANAN SCHOOL FOR THE DEAF		?	BOTH	DEAF	YES	YES	NO	NO	NO	NO	NO	NO
21	JENIN	CHILD DEVELOPMENT CENTRE		850	BOTH	BOTH	NO	YES	NO	YES	YES	NO	YES	NO
22	JENIN	PAT FRIENDS VILLAGE INREACH		900	BOTH	BOTH	NO	YES	NO	NO	YES	NO	YES	NO
23	JENIN	PATIENT'S FRIENDS ALAMAL SCHOO		20	BOTH	BOTH	YES	YES	YES	YES	NO	NO	NO	NO
24	JERCO	JERICHO GOVERNMENTAL HOSPITAL	?	?	BOTH	BOTH	NO	NO	NO	YES	YES	NO	NO	NO
25	JERCO	JERICHO HANDICAPPED SOCIETY	47		BOTH	PHYS			NO	NO	YES	NO	NO	NO
26	JRLM	ALNUR SCHOOL JERUSALEM	?	?	?	BLND	?	?	?	?	?	?	?	?
27	JRSLM	AL-SHURUK SCHOOL FOR BLIND	3	59	BOTH	BLND	YES	YES	YES	NO	YES	NO	NO	NO
28	JRSLM	ARAB SCOEITY FOR BLIND JERUSAL		30	MALE	BLND	NO	YES	YES	NO	NO	NO	NO	NO
29	JRSLM	ARAB SOCIETY FOR PHYS HANDICAP		600	BOTH	PHYS	NO	YES	YES	NO	NO	YES	NO	NO
30	JRSLM	AUGUSTA VICTORIA HOSPITAL		185	BOTH	PHYS	NO	NO	NO	YES	YES	NO	NO	NO
31	JRSLM	CATHOLIC RELIEF OUTREACH PROGR		40	BOTH	BOTH	NO	YES	NO	NO	NO	NO	YES	YES
32	JRSLM	LUTHERAN WORLD FED WORKSHOPS	?	?	?	BLND	?	?	?	?	?	?	?	?
33	JRSLM	PEACE CENTRE FOR THE BLIND	25		F	BLND	YES	YES	YES	NO	YES	NO	NO	YES
34	JRSLM	PRINCESS BASMA CRIP CHILD CTR	80	30	BOTH	BOTH	NO	YES	NO	YES	YES	YES	NO	YES
35	JRSLM	SPAFFORD HOSPITAL	?	?	BOTH	BOTH	?	?	?	YES	YES	?	?	?
36	JRSLM	SWEDISH INST MENT HDCP	YES	NO	BOTH	BOTH	NO	YES	YES	?	?	?	?	?
37	JRSLM	THE FOUR HOMES OF MERCY	120		BOTH	BOTH	NO	YES	NO	NO	NO	NO	NO	NO
38	NBLS	AL-WATANI GOVERNMENT HOSPITAL	?	?	BOTH	PHYS	NO	NO	NO	YES	YES	NO	NO	NO
39	NBLS	ALDAR ALBAIDAT SALFIT CENTRE	50		BOTH	MENT	YES	YES	NO	NO	NO	NO	NO	YES
40	NBLS	ITTIHAD HOSPITAL NABLUS	1TH	1T5	BOTH	PHYS	NO	NO	NO	YES	YES	NO	NO	NO
41	NBLS	MEDICAL RELIEF PHYSIO CENTRE		400	BOTH	PHYS	NO	YES	NO	YES	YES	NO	YES	NO
42	NBLS	RAFIDIAH GOVERNMENTAL HOSPITAL	1T5	1TH	BOTH	PHYS	NO	NO	NO	YES	YES	NO	NO	NO
43	NBLS	RED CRESCENT SOCIETY PHYSIOTHE	7	143	BOTH	PHYS	NO	YES	NO	YES	NO	NO	NO	NO
44	NBLS	ST. LUKE'S HOSPITAL		2TH	BOTH	PHYS	NO	NO	NO	YES	YES	NO	NO	NO
45	NBLS	UNRWA BALATA CAMP		?	BOTH	BOTH	NO	YES		YES	NO	NO	NO	NO
46	QALQ	ALMURABITAT SOCIETY	27	3	BOTH	BOTH	NO	YES	YES	NO	NO	NO	NO	NO
47	RMLH	ALNAHDA WOMEN'S ASSOCIATION	10	57	BOTH	MENT	NO	YES	YES	NO	NO	NO	NO	NO
48	RMLH	ALWATANIEH SCHOOL FR THE BLIND	70		FEM	BLND	YES	YES	NO	NO	NO	NO	NO	NO
49	RMLH	CHILD DEVELOPMENT SOCIETY		350	BOTH	BOTH	NO	YES	NO	YES	YES	NO	NO	NO
50	RMLH	FRACISCAN SISTERS VIL REH PRGR	?	?	?	?	?	?	?	YES	?	?	?	?
51	RMLH	ISLAM CHART SOCEITY ALBIREH	23	9	BOTH	DD	YES	YES	NO	NO	NO	NO	NO	NO
52	RMLH	PATIENT'S FRIENDS SOCIETY		500	BOTH	PHYS	NO	NO	NO	YES	NO	NO	NO	NO
53	RMLH	STAR MOUNTAIN REHABIL ABU KASH	14	8	FEM	MENT	NO	YES	YES	NO	YES	NO	NO	YES

KEY:

B = Borders

O = outpatients

Pati = Patients sex

Type = Disability Type

Edu = Curriculum educat

SPE = Special Education

Voc = Vocational trainin

phy = physiotherapy

Med. = Medical care

Pro = Prosthesis

Cou = Counselling.

Ent. = Entertainment