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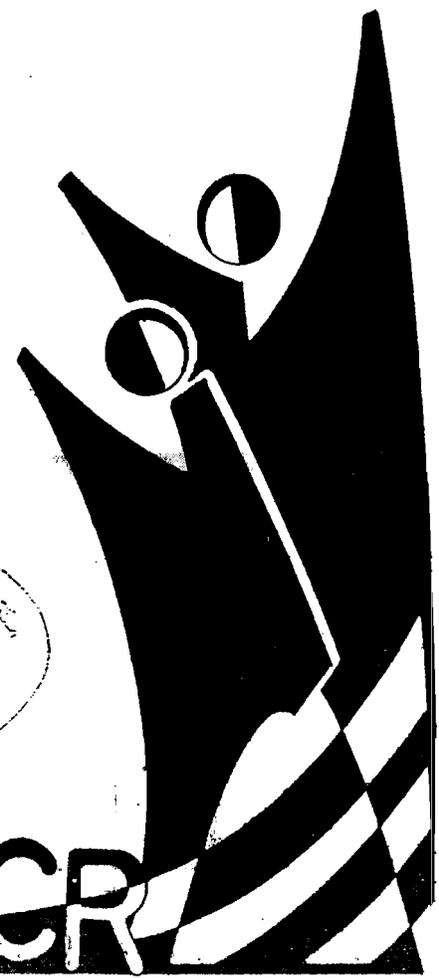
Disability and Rehabilitation Needs in the Gaza Strip:
A Survey Report on Bureij and al-Shati Refugee Camps

Gaza City
1993

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January 1993

*National Committee for Rehabilitation/
Gaza Strip
in cooperation with Diakonia Sweden*

The project described in this report represents an initiative undertaken by the National Committee for Rehabilitation in Gaza, in cooperation with Diakonia Sweden, to help formulate a model programme which could ultimately serve the needs of all the disabled in Gaza. Our initial step was to try and assess, albeit in a broad overview, the most pressing needs of the disabled in two communities in the Gaza Strip. With this report, we present the results of that assessment and the preliminary conclusions reached. The Committee is itself a model of a cooperation body of institutions concerned with care for the disabled. This report is a reflection of the joint efforts we have undertaken thus far. The research for this report not only served as an important component of the rehabilitation workers' training programme, but was a true collective effort. The efforts of the following are gratefully acknowledged:

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I. Introduction

The Gaza Strip is one of the most densely populated regions of the world and, until very recently, one of the most neglected areas of the Israeli-occupied territories. The Strip is about 45 kilometres long and eight kilometres wide. In 1987, the population of the area was estimated at some 600,000, in contrast to 390,000 in 1967¹. Using an annual growth rate of 3%², the 1991 population was estimated at approximately 700,000. Estimates indicate that the current population of the Gaza Strip is close to 800,000.³

Of the total population, some 50% are children under the age of 15 years, 59% are under the age of 19 years, and 77% under the age of 29 years. The population of the Strip is youthful, probably due to a high birth rate combined with a low life expectancy at birth, both of which reflect the generally underdeveloped health and socioeconomic conditions. Of the total population, roughly 500,000 or 70% were registered as refugees with the United Nations Relief and Works Agency (UNRWA) in 1989⁴. Not all refugees live in camps however; some have moved beyond camp boundaries but continue to be eligible, and do receive, UNRWA health, educational and social services.

Since the fall of the Gaza Strip and the West Bank under Israeli military rule in 1967, the Strip has undergone numerous changes and has been forced into dependence on Israel in most aspects of life. In addition to the impact of the Israeli seizure of more than one-third of the available land, Israeli policies introduced changes in the economic sector which in turn had a profound influence on the social structure. Up until the end of the 1960s, agriculture was the largest single economic activity in the Gaza Strip, with an average annual rate of growth of 8.8%; by the early 1980s, this rate had dropped to 0.9%⁵. The industrial sector failed to develop during this same period for a variety of reasons, including unfair competition by Israeli products, restricted export potential, intra-market competition, and lack of investment⁶. By the beginning of the 1980s and continuing until the start of the uprising, an estimated 45% of the labour force was working in Israel, mostly as semi-skilled and unskilled labourers⁷.

The Strip has been ruled by the Israeli military authorities with an 'iron fist' policy. Since the beginning of the occupation, almost 1,000 military orders have been issued which reflect 'the total and discriminatory nature of military control' - 'preventive' detentions for indefinite periods without charge or trial, deportations, curfews and closures as a form of collective punishment, are among some of the measures that have been used against the population⁸. At the same time, local Palestinian institutions have also been subjected to restrictions which severely curtail development and the ability to meet the challenges presented by Israeli policies. Thus, political, legal and administrative measures were used to create 'a system of discrimination and injustice' which has been described as having transformed the Gaza Strip into

the 'Soweto of the State of Israel' and as rendering it 'a potentially explosive area'⁹. Indeed, an explosion did occur in December of 1987, when Gaza witnessed the birth of the Palestinian uprising or *intifada*.

Since the start of the uprising, and particularly since the Gulf crisis, the Strip has suffered even more debilitating economic and political changes. By mid-1991, an estimated 40-50% of the labour force in the Strip was unemployed, and levels of frustration and despair had deepened. It was during this period, the early 1990s, that the Strip was suddenly 'discovered' by international and development agencies, perhaps partially as a result of the international interest generated by the uprising. Unfortunately, it appears that this sudden surge of interest was too swift, and innumerable projects were initiated without sufficient coordination.

It is within this context that the Gaza National Committee for Rehabilitation (the 'Committee') was formed and its first project was conceived and executed. The Committee is forced to work within the restrictions imposed first by the reality of the existing political and economic subjugation to Israel, and then by the Committee's own limited ability to influence, direct, and stabilise the current wave of both local and internationally generated development activity. Almost inevitably, these limitations have already forced compromises and modifications to the Committee's plans, and will continue to do so. For Gaza's chaotic and changeable reality precludes the possibilities of 'normal' development and rehabilitation work, particularly those that are community based. ■

II. The Formation of the Committee

The Committee was formed - as a coordinating body of eight major Palestinian non-governmental organisations operating in the Strip - in an attempt to deal with the problem of the rising rate disability within the population as a result of Israeli army violence. By 1990, several thousand people, mostly young men, had been disabled by army violence and required varying degrees of rehabilitation support. The heroic status that this new category of disabled people gained as a result of their political activism and personal sacrifice became the major impetus that propelled disabled people in this society into greater visibility. The high visibility of those disabled in the uprising brought with it recognition of the needs of the disabled population at large.

The increasingly urgent need to respond to the conditions of those disabled in the uprising led the institutions now comprising the Committee to begin coordinating and planning actions in the summer of 1989. These institutions¹⁰ began the process of learning about Gaza's rehabilitation needs by first focusing on the injured of the uprising, and on building and operating institutional supports for them. The Committee's institutional¹¹ style project proposal was finalised in mid-1990, by which time the Committee had linked up with Diakonia, a Swedish non-governmental organisation interested in rehabilitation, particularly community based rehabilitation (CBR). At that point, discussions were initiated as to the type of rehabilitation projects needed by the entire disabled population, and not only those injured in the uprising. The discussions and the subsequent interaction between the Committee and Diakonia proved to be a learning experience for all involved; concepts were reassessed, new ideas were developed and different possibilities for action examined. Diakonia's May 1991 invitation to the 'father of community based rehabilitation', Einar Helander, to visit the country and provide expertise and advice on the various facets of CBR was crucial in confirming the view that, complementing other forms of institutional support, the assistance and rehabilitation of the disabled within their own communities should be a primary component of any plans formulated. Eventually, the Committee formally adopted CBR as a major component of its activities, without excluding institution-building as an important element in its plans, since within the Gaza Strip's political and socioeconomic context, the development of an infrastructure, through institutional development, that will be ultimately responsible for the needs of the disabled is a necessity.

In this way the new plan emerged. While the defined zone of activities initially included eight areas in the Strip comprising some 200,000 people, the pilot phase of the work was introduced in just two areas, Bureij and al-Shati' refugee camps. Pilot projects in small areas are important, since the concept and practise of CBR is an innovation in the Strip. It was considered necessary to work slowly and build up a local model before measures to scale up could

be implemented. The basic principles used were those developed in the WHO model of CBR. However, the manuals and ideas were studied closely with regard to their local relevance, and adapted versions were developed and tested through a process of trial and error.

Supported by funds donated by international non-governmental organisations including Diakonia, which continues to provide financial and technical support to the project, plans were formulated for the training of 16 CBR workers under the umbrella of Bethlehem University's physiotherapy programme. The technical basis of the course was the WHO manual, but a variety of other topics were formally incorporated in the training curriculum, such as sections on Palestinian society, health conditions in the area, the available health and rehabilitation services, principles of primary health care, principles of community mobilisation and organisation, and communication skills¹². Later, another component was added - that of problem solving - as the importance of this skill became increasingly evident during the training of the CBR workers.

The duration of the training was to be three months, upon completion of which the trainees were to conduct a baseline house-to-house survey in Bureij and al-Shati' in order to broadly identify the number and type of disabilities found in the two communities. The survey was important both as part of the training process and for the formulation of future plans, as well as a key factor in building community awareness and initiating community mobilisation. Once again, WHO guidelines were used to conduct the survey, although modified and adapted to the local setting. Both local and international personnel were recruited as trainers. ■

III. Problems Encountered

1. Conceptual Problems

At present the problems that have affected and appear likely to continue affecting implementation of plans and the further development of the project fall into four categories:

For the purposes of discussion, the various approaches to development/rehabilitation fall into two broad categories. There are those who see the development of institutions and bureaucracy as a necessary step in the process of nation building and in ultimately assigning the responsibility for development/rehabilitation to representative bodies within nations. Such bodies would set guidelines and regulations, and formulate policies and plans for development/rehabilitation work, coordinate activities among the various groups working in the field, monitor and evaluate activities and define future courses of action, among other responsibilities. In return, such bodies would bear the responsibility of addressing the development/rehabilitation needs of the population. This is a centralised approach to strategy formulation and planning, as well as service provision. In contrast, the other style of approach calls for decentralisation, beginning at the bottom and moving upwards, and sees grassroots and community mobilisation and self-help as solutions to the problem of need fulfillment. At the core of this approach is the concept of volunteerism, the formation of local committees and community participation, in addition to the organisation of the disabled themselves to work toward finding solutions to their own problems. This approach places the burden of developmental/rehabilitation need fulfillment on the community, beginning with family and neighbours as well as the disabled themselves.

Our project steers a middle course between these sometimes conflicting ideologies, for reasons relating to the context within which the project is operating. This is a country still in the process of seeking nationhood. Among other factors, it has suffered distortions of normal development and even deliberate de-development as a result of the military rule that has thus far last 25 years. The absence of a national government interested in the welfare of the people has had multiple effects on the political, socioeconomic and developmental situation. What directly concerns us in this sector are those problems related to the absence of legislation, guidelines, regulations and priorities for development/rehabilitation work. Another important factor is the absence of coordinating bodies among the different institutions, both local and international, with sufficient authority to influence and direct the course of actions, restrict duplication and wastefulness, and monitor and evaluate activities, among other tasks.

In a situation such as this, attempts to build local institutions and coordinating bodies should not only be viewed as important, but as a matter of survival, for without these institutions and coordinating bodies, the chaotic development

situation is likely to worsen. In addition, fulfilling developmental/rehabilitation needs must fall at least partially on the shoulders of the nation, or those who can represent it. Placing the burden of development on the very same people who need help most is unjust and impractical as well, since it is always the poorest of the poor who are usually in need of educational, health and rehabilitation services without being able to afford to pay for these services. It is unrealistic to suggest that small communities could completely fulfill these needs and be self-sufficient, although some of these needs can be met through community action and support.

At the same time, building a system of development/rehabilitation work that engages communities in the process of consciousness raising, mobilisation and sharing is highly desirable, and even critical for survival in our context. Grassroots and local community actions have enabled Palestinians to survive to this day under extremely adverse conditions. In addition, community based projects tend to be cost effective and affordable and given the local setting, cost effectiveness is a high priority when establishing development/rehabilitation projects. Thirdly, mobilisation of the disabled is a matter of basic human rights, one of the steps needed to allow them to take their place in society, as is the case with other disadvantaged groups in Palestinian society, such as women. Thus the notions and concepts involved in this approach are not only important for present and future survival, but are important steps toward addressing problems of social injustice.

Consequently, it was considered necessary to use both approaches concurrently, although at times the two conflict, as over the issue of accountability and responsibility. On the one hand, the Committee is emerging as the body that is responsible and accountable for the project. Yet accountability and responsibility are also crucial components in community mobilisation. The assumption of these tasks by the Committee does not negate the role of the community, but it can cause confusion. In this instance, the communities are looking to the Committee for solutions to problems and for resources as well. The Committee has already engaged 16 rehabilitation workers from the communities where the project is to be implemented, which is appropriate for building long-term and continuous services. Yet this raises the question as to what volunteerism and community mobilisation for action mean in this particular setting.

One way to address this problem is through engaging parents, families, neighbours and other interested groups in selected activities as volunteers, and attempting as much as possible to maintain a balance between volunteerism and community engagement on the one hand, and Committee support for the project on the other. This is likely to require a concerted and systematic effort

in examining each and every step taken and its impact on maintaining such a balance.

2. Logistical Problems

The logistical problems stem from the fact that the Gaza Strip remains underdeveloped, isolated and under military siege. While the West Bank and Gaza Strip form two parts of the same country, in fact, crossing to Gaza is much like crossing the border to another country. Israeli territories lie in between the two areas, yet Palestinians from the West Bank and Gaza are not allowed to enter Israel without obtaining permits from the authorities. This is yet another bureaucratic hurdle that curtails movement and interaction between the two areas. Furthermore, since the uprising, and particularly since the Gulf war, Palestinians holding West Bank identity cards have been prohibited from entering Gaza and similarly Gaza Strip residents cannot enter the West Bank without permits from the military authorities.

The initiation and execution of this project required constant movement between the two areas: trainers from the West Bank had to go to Gaza due to the unavailability of local human resources; trainees in turn were brought to the West Bank for, among other things, visits to various rehabilitation institutions that cater to people from both the West Bank and Gaza. Therefore, movement restrictions placed and will continue to place a serious logistical burden on the project, although plans are being formulated to build up local expertise in Gaza in project-related areas. Despite the importance of this step, the dependence on the West Bank for a variety of services, particularly referrals, will inevitably continue and this problem will persist at some level in the future.

The second problem is that both the Gaza Strip and the West Bank are denied access to human resources from Arab countries. Technical training for the project had to be conducted in Arabic since most of the trainees had only a limited knowledge of English. Although an Arabic-speaking WHO technical expert was identified, the time-consuming process of attempting to obtain the necessary permit for this expert to cross into the Gaza Strip was eventually unsuccessful. Although finally at one point, a transit permit was obtained from the authorities, as the expert thereupon attempted to cross the Allenby Bridge dividing Jordan from the West Bank, she was stopped, her training materials were confiscated, and she was ultimately denied entry and forced to return to Jordan. This denial of entry to Arabic-speaking technical experts delayed the start of the training process for approximately one and a half years, and led to the decision to engage a Swedish trainer and a translator instead.

This delay necessitated a constant readjustment of plans. The trainees were becoming increasingly frustrated by the wait, and it was decided that in the

interim they should be trained to conduct the survey prior to beginning the technical training, which explains in part the inflated survey results. The fact that the trainees began their training with a house-to-house survey, however, did result in their greater involvement in the technical training once it finally began, as their practical experience contributed substantially to their awareness of the problems, needs and aspirations of the disabled and their families. In fact, the trainees entered the course far more aware of the scope of the problem than they perhaps would have been otherwise. However, carrying out the survey raised certain expectations on the part of the community which were then unable to be fulfilled until the training period ended. This caused a certain amount of frustration as the logistical problems were interpreted by community members as undue delays in the delivery of services.

A third problem stems from the frequent curfews, strikes and states of siege that occur in Gaza on a routine, almost daily basis. Both the survey and practical work are inevitably compromised by these frequent interruptions and delays, in addition to which the trainees/workers face certain risks when working in communities which can suddenly be placed under siege by the army. Trainees must then quickly be able to move out of the area before they are caught to face injury, arrest or beating. Fortunately, the fact that the trainees come from these communities made it possible for the team to seek shelter or quickly escape the area, depending on the situation.

In summary, the unique political and socioeconomic reality of the Strip make abnormality the rule. This necessitates flexibility and compromise in order to successfully execute the project, and plans must be constantly adjusted to fit a chaotic and changing reality.

3. Cultural/ Contextual Problems

The project in its planning stages incorporated concepts of community based action that have been developed over the years both locally and internationally. For example, originally, CBR workers were not intended to have had a specialised education, but simply to hold a high school graduation certificate. The majority were to be women, since women are better able to penetrate and deal with the household setting in Palestinian culture. However, the economic realities of the Gaza Strip forced certain compromises: after the Gulf war the unemployment level among men was so high that it was impossible to overlook this fact when considering potential employees for the project. These unemployed family breadwinners ranged from unskilled to highly skilled technical people, and included nurses, psychologists and social workers, among others. The Committee had to contend with their presence and their responsibilities because of the fact that in Palestinian society, women still do not comprise a significant portion of the labour force and the

burden of family support rests on the man. There was a tremendous amount of human, social and political pressure on the Committee to employ these men, and they ultimately did. Out of the final 16 trainees, four are women and the remainder are men, the majority of whom are nurses or other professionals.

These compromises had ramifications which continue to pose problems. The nurses and other skilled trainees persist in facing a professional 'identity crisis': while they perceive their abilities to be at a much higher level than that of a 'mere rehabilitation worker', they also have no other alternative if they want to work and therefore must accept their new status. In addition, they have generally been trained within the biomedical institutional framework, and continue to, sometimes dangerously, adapt old principles to the new community based work reality, making training - or rather, re-training - more difficult. Community rehabilitation work is a new idea that has not been tested previously in the Gaza Strip, and the trainees are more likely to favour their nursing skills until such time as their new training and professional identity gain legitimate status in their eyes and the eyes of the community. However, there are those who do try and are succeeding in adapting their old skills to the service of the community. More importantly, some of the nurses who have substantial experience have used their skills and professional knowledge to back the project. These trainees could be upgraded in the future to form the nucleus of a consultancy team in Gaza.

In conclusion, despite training and encouragement, these nurse trainees presently view themselves as nurses first and foremost rather than rehabilitation workers. This is in part responsible for the difficulties experienced in persuading them to use the WHO manual 'Rehabilitation in the Community' as a primary mode of action, or even one of several modes of action; their tendency is to look for 'more sophisticated' services through diagnostic and referral services without considering first what further action they can take within the context of the home and community.

The composition of the training class has generated another pressure - to increase the pay scale. The male workers are supporters of large families and previously earned high incomes. Their present salaries in comparison can only appear unacceptable. However, the project was originally conceived with the aim of safeguarding continuity through cost effectiveness, replication in other communities, and infrastructure building, all for the lowest possible financial outlay. These conflicting pressures are leading once again to potential compromises in terms of the project's original goals.



**4. Problems
Encountered
in Applying
the WHO
Manual**

Unquestionably the WHO manual 'Rehabilitation in the Community' was of crucial importance in the initiation of this project, and in fact served as the starting point. It provided the basic principles, technical skills, survey methodology, and managerial, supervisory and monitoring procedures that were required to begin this project in an area where even the concept of CBR was unknown, and where the institutional biomedical framework was the dominant ideology. In this sense, the manual shaped the project and provided the major impetus for the Committee's bold move into a new and important area of work. However, using the manual in this project highlighted three types of difficulties in application:

Training

While the manual has been translated into Arabic, it has been extremely difficult to find qualified personnel capable of training the students in Arabic. The Committee questioned the efficacy of WHO's efforts to translate the manual while disregarding the need to provide more than one trainer proficient in that language. As noted above, in addition to the problems presented by the conditions in this country, the scarcity of Arabic language trainers resulted in a one and a half year delay in commencing the course. An Arabic speaking trainer has not yet materialised, with the result that the course had to resort to the less than ideal solution of training through translation.

**Potential
Survey
Methodology
Problems**

The survey methodology outlines in the manual provided easily applicable methods for a broad survey of types and levels of disability within communities, information which is critical for realistic planning and project implementation.

The advantage, and simultaneously the potential disadvantage, with the methodology lie in its simplicity and ease of applicability. The fact that the survey method is simple and easy to use made it possible for the trainees to conduct the survey even before their formal training had started and with only a limited amount of training in interviewing. In this sense, the survey methodology is cost effective and allows for flexibility in project implementation. Furthermore, participation in carrying out the survey allowed the trainees the chance to see and think about problems within their communities about which they had been previously unaware. The survey helped the trainees to begin understanding the various dimensions of the problem, while at the same time it served also to raise community awareness.

The simplicity of the methodology, on the other hand, also led to certain inaccuracies in the data collected. As can be seen in the survey results below, the data is somewhat over-inflated. As the ongoing practical work indicates, a disability rate of around 4% in the two subject communities is in fact higher than the reality, approximately 3%. The source of error is primarily the

inclusion of older people with hearing and visual problems that can be corrected relatively easily, and minor physical problems that cannot be defined as disability requiring rehabilitation, such as people with visual acuity problems and other minor deformities such as flat feet. Had the technical training preceded the survey, many of these cases would have been omitted, perhaps because the students would not have been so worried about missing certain cases since, without training, they tended to be overly sensitive. Yet simplicity and broad categorisation inevitably led to areas of confusion, and CBR workers, even after technical training continue to experience difficulties in categorising people. This is clearly a relatively minor problem that is outweighed by the advantages of the WHO method. It does warrant some elaboration in our case, since a combination of context and methodology explain the over-estimations in the results, and as utilising this method can also lead to under-estimating the level of disability in other settings.

Another problem encountered with the methodology was the rather broadly defined disability categories, which created another potential source of error. For example, the category defined as 'strange behaviour' could potentially include a wide variety of problems, affecting the rates of other categories of disability such as learning difficulties or mental retardation. Overlap between categories can also be a problem if, for example, people are categorised as having speech problems when the underlying cause is an element of mental retardation. Once again, these methodological problems are outweighed by the system's advantages and can be corrected rather easily through practical work. However, they must be taken into consideration when examining survey results. In this context, data analysis was based on rather broad categories of disability - such as physical/sensory versus mental disabilities - in order to minimise the effects of this bias or, alternatively, utilising scales of ability, where this bias becomes unimportant.

The central point here is that the survey is instrumental as a first step in project implementation, but it also has limitations. Therefore, the survey results should only be viewed as a broad data base around which to begin project implementation, rather than exact estimates of types and levels of disability.

*Practical
Work*

It appears that the WHO manual was originally conceived for application in a developing society where resources are scarce and infrastructural support is minimal. Yet even in our particular setting, which is a mixture of under-development and development, the manual is not only applicable, but offers a workable alternative to the strictly institutional model of dealing with the needs of the disabled. For this reason alone, the translation of the manual into Arabic has been invaluable. However, unfortunately, the translation of the text is not accompanied by any adaptation of the images and examples,

and possible courses of action, among other things, to make them relevant to the Middle Eastern developmental setting. The fact that the manual remains Afrocentric creates some problems with two important contributors to the project: the CBR workers and donor agencies.

The CBR workers expressed dissatisfaction with this Afrocentrism, ranging from adverse reactions to the pictures in the manual to raising important questions as to the applicability of suggestions offered in the manual. As a case in point, the manual assumes a state of development which precludes the use of cars for transport and suggests bicycles and animal transport as possible alternatives. In this country, where other institutions working in development and rehabilitation have fleets of vehicles and all sorts of advanced support systems, these suggestions served to alienate the students to a certain extent and contributed to their hesitation in applying the valuable components of the manual in their practise. The donor agencies, meanwhile, sometimes tend to follow the manual too rigidly without considering that the differences in developmental settings require alternative and possibly more advanced methods of transport.

Therefore, in a country where institutional and referral services are more available than in other parts of the developing world, the manual remains an elementary though important tool in rehabilitation work. For the purposes of this project, the use of David Werner's Disabled Village Children as well as other references might be necessary adjuncts. In addition, while the WHO manual appears to be quite good in the area of dealing with the physically disabled, other sections might require strengthening, such as those dealing with seizures and difficulties in hearing and speech.

Our experience in using the WHO manual suggests that it would be worthwhile for WHO to consider strengthening the manual by updating and adding sections as the need is indicated through practical work in different areas of the world. Our experience has also demonstrated the need for the manual to be reworked and adapted to suit the Middle Eastern setting. While the countries in the Middle East are at differing stages of development, the basic characteristics locally, in Jordan, Syria, Lebanon and possibly Egypt are similar nevertheless, perhaps justifying the added investment in adapting the manual to this region's developmental setting. ■

IV. The Initiation of the Project

1. The Formal Beginning

The project formally began in July of 1991 with the training of students to conduct the survey. As the training was taking place, initial contacts with the communities were made, first by the Committee and later on by the trainees themselves. Once local committees had been established, the project team visited the camps and began discussions with these representatives of the communities. The response was good, despite differing expectations on the part of the two groups. Local committees expected assistance in the institutional form, this being what they were accustomed to. Instead, the team was raising the issue of rehabilitation within the communities themselves as a primary mode of action. This serves to illustrate the difference between need and demand; while all parties may agree that there is a need to improve the conditions of the disabled in their communities, often the demand is for institutional services, that demand being shaped by the nature of services received in the past.

Once the endorsement and support of the local committees were obtained, the students went from house to house, administering the questionnaire when one or more members of a family were reported to be disabled. The process took some three months to complete and covered approximately 5,700 households, at least 45,000 people.

2. The Communities:

BUREIJ

Bureij is one of eight refugee camps located in the Gaza Strip; it was established in 1948 as a British army camp and then began receiving refugees from the 1948 Arab-Israeli war. Lying some 10 kilometres southeast of Gaza City, Bureij is considered one of the most congested areas of the Strip, with approximately 17,000 people living in a 1.2 square kilometre area, according to UNRWA sources. An additional 2,000 original inhabitants also live in the area of Bureij and receive basic services from UNRWA. UNRWA estimates the total number of houses in the camp at 2,450, which means an average family size of approximately 7.76 persons¹³.

The adverse socioeconomic conditions of the Strip in general are evident in Bureij. Until recently, most men worked as labourers in Israel, often illegally. The majority of women work within the domestic sphere. Since the Gulf war, working illegally in Israel has become almost impossible and unemployment in the camp has soared. A few families on the outskirts of the camp do own and cultivate land, since they are original inhabitants and not refugees, as is the case with the great majority of Bureij residents. Another small percentage

of the population works within the service sector of UNRWA, mostly in the health and education fields. Of these, some 100 are teachers, 50 work in health-related jobs, and several more in other UNRWA services¹⁴. A few small-scale businesses are operated by families within the camp, primarily sewing workshops, in addition to animal husbandry and food and domestic supply shops. Otherwise, a good proportion of the labour force is currently unemployed. Many families subsist on the monthly financial assistance provided by UNRWA which until the Gulf war was supplemented by remittances sent by family members living in the Gulf states.

UNRWA operates six primary schools in Bureij for boys and girls, as well as two kindergartens. The agency also provides health services, operating the major clinic in the camp although local non-governmental organisations also contribute some basic services. Camp inhabitants continue to face major health and sanitation problems linked to the absence of a closed sewage system and adequate garbage disposal.

Politically, Bureij is considered a bastion of *intifada* activity and thus has been subject to brutal measures by the Israeli authorities: curfews, clashes with the army and siege situations are part of daily life in the camp. These conditions have increased the rate of disability in the camp, disabilities due to army violence, and the subsequent higher visibility of these disabled people has increased awareness of the needs of the entire disabled population.

AL-SHATI

Al-Shati' refugee camp lies northwest of Gaza City on the Mediterranean coast. Established in 1948 after the Arab-Israeli war, al-Shati' provided shelter to some 23,000 refugees from al-Lid, Jaffa, Bir al-Sabi' and the southern coastal plain. Gradually, UNRWA replaced the tents in which families were living with mud-brick shelters, which in turn were replaced in the 1960s with the present cement-block structures. Over the years, the camp population grew. In 1971, the Israeli authorities demolished 2,263 rooms occupied by 804 families to create wide 'security' roads, in an attempt to end the armed revolt that had taken place in the Strip that year. With some 8,000 people having moved out of the camp in the late 1970s, some 42,000 refugees are currently registered with UNRWA as al-Shati' residents¹⁵. However, as will be demonstrated shortly, some of those registered as living in al-Shati' have in fact moved out of the boundaries of the camp to live in nearby Gaza City.

As in the other refugee camps, UNRWA caters to the basic health, educational, sanitation and welfare needs of the population of al-Shati'. There are 11 elementary and three preparatory schools in the camp, with a total estimated enrollment of 7,442 pupils. Children complete secondary-level schooling in government-run schools in the area. UNRWA's health centre is the main provider of health services, although services are also provided by

some non-governmental organisations. As in Bureij, al-Shati's inhabitants face major problems with adequate sewage and garbage disposal, the lack of which are key obstacles to improving the health status of the population.

Until the Gulf war began, the majority of wage earners in al-Shati' were working as illegal day labourers in Israel, primarily in construction, industry and the service sector. In addition, a sizeable proportion of the labour force relied on fishing as a main source of income, with entire families sometimes engaged in professional fishing. However, Israel's tightening restrictions forced the large majority to leave fishing and look for work on the Israeli 'black market'. Until the war, many families also used to rely on remittances sent by relatives in the Gulf. A few families living in al-Shati' have set up cottage industries, mostly sewing workshops producing clothes for Israeli manufacturers. They are normally paid by the piece and rely largely on women workers who are poorly paid and work long hours under strenuous conditions. A few cement factories are also operating in al-Shati at the present time. Some camp inhabitants also work in the UNRWA health, education and service sectors.

As in Bureij, the Gulf war and the consequent restrictions on the movement of labourers across the border, coupled with the sharp reduction in remittances, led to serious unemployment and financial hardship within the community. The standard of living has dropped by an estimated 40%, affecting financial and commercial operations within the camp as well as in the Strip in general.

Conditions in the camp are harsh; beatings, arrests and military sieges are routine, making it difficult to conduct daily activities and operate projects. The insecurity and dangers of daily life undermine the continuity of economic and social activities in the camp, leaving the community in a state of disarray. Yet the people persistently continue to struggle, initiating projects and establishing community groups to respond to the needs of the community as a whole and deprived groups in particular. It is within this setting that this community rehabilitation project is being initiated.

3. The Study Results

General Demographic Information:

BUREIJ

Our house-to-house survey revealed the presence of 2,035 households in Bureij and 219 in the ABC area (around Bureij camp and receiving services from UNRWA, and thus included in the survey). A household was defined as one or more nuclear families sharing kitchens or food arrangements. The total therefore was 2,254 households, of which 582 were found to have at least one disabled person. Of 820 persons identified as disabled, satisfactory information was obtained from 792 living in 582 households. A total of 7,883 persons lived in these households, 49% female and 51% male. Of the total number of inhabitants, 49% were children. The average family size of those families with disabled members was 9.95 persons, higher than the family size calculated from UNRWA estimates for the camp as a whole.

The cause of the discrepancy between UNRWA's estimate of average family size and the average size of families with disabled members is not clear. It could possibly be due to a difference in the definition of family, since in this survey a family or household was defined as all those who eat together and utilise one kitchen, a definition used by most West Bank and Gaza surveys. The discrepancy could also be due to the inclusion in this survey of temporarily absent family members. Finally, it could also reflect actual differences in family size between those families with disabled members and those without.

In order to arrive at a reasonable estimate of the camp's total population, while bearing in mind these differences, we settled on eight persons as the average family size for the camp overall. This figure is closer to UNRWA estimates than that obtained for families with disabled members, as this figure might be more biased toward the particulars of selected groups than that of UNRWA. Utilising our figure of 2,254 households, the total population of Bureij was estimated at around 18,000 and the rate of disability for this camp would thus be 4.5%. However, this estimate includes certain cases of mild and/or temporary disability that do not require long-term rehabilitation, such as hearing and vision impairments that can be easily corrected, given access to appropriate services.

AL-SHATI'

Our survey recorded 3,465 households in al-Shati'. Of these households, there were 861 with at least one disabled member. We identified and interviewed 1,185 disabled persons living in the community. The 861 families recorded as

having at least one disabled member comprised 11,086 persons, of whom 50.1% were male, 49.99% female. Forty-nine percent (49%) were children. The average family size was calculated at 12.8, much higher than the UNRWA estimates for the camp as a whole.

Once again, because of this discrepancy in the average family size and using a similar rationale as in the case of Bureij, the average family size for the camp as a whole was assumed to be around eight persons per family. Based on the number of households visited in the camp - 3,465 - the population of al-Shati' was estimated at 27,720. Al-Shati's rate of disability was 4.3%, close to that of Bureij. As with the data from Bureij, this estimate includes cases of mild disability that probably do not require long-term rehabilitation.

TABLE 1

General Demographic Information: Bureij and al-Shati'

| | BUREIJ | AL-SHATI' |
|--|---------------|------------------|
| Total households | 2,035 | 3,465 |
| Households with at least one disabled member | 682 | 861 |
| Percentage of households with at least one disabled member | 26% | 25% |
| Total number of disabled | 820 | 1,185 |
| Estimated population (based on an average family size of eight persons) | 18,000 | 27,720 |
| Rate of disability | 4.5% | 4.3% |

***Wealth Status
and
Employment***

Of the total number of disabled living in Bureij, 73% lived in houses made of asbestos - denoting a mid-level wealth status by camp standards; 10% in old UNRWA or Zinc makeshift houses - denoting poverty; and 17% in concrete houses - indicating a relatively elevated wealth status. However, the state of housing alone does not determine present wealth status. The present financial difficulties have impoverished many families. For this reason, we combined information on housing with that obtained from selected key informants to arrive at an approximate wealth index. According to this index, 35% of the disabled in Bureij camp are from poor homes, 38% from middle income homes, and 27% are well off by camp standards. Overall however, the camp suffers such financial hardship that even those considered well off are having difficulty coping with the demands of daily life, let alone the special needs of the disabled.

By contrast, 83% of the disabled in al-Shati' lived in asbestos housing, 3% in old UNRWA mud-brick houses, and 12% in concrete houses. According to the wealth index, 45% of these families were poor, 39% were in the middle-income category, and 16% were considered well off. Although at 45% the percentage of poor was higher in al-Shati' than in Bureij (35%), comparisons between the two communities are not feasible since substantive data proved impossible to obtain.

Employment patterns of the heads of those households¹⁶ with disabled members reveal what appears to serious financial problems in both camps:

TABLE 2

Type of Work of Heads of Households with Disabled Members

| TYPE OF WORK | PERCENTAGE OF TOTAL | |
|-----------------------------------|---------------------|------------|
| | Bureij | al-Shati' |
| Semi-skilled and unskilled labour | 28 | 37 |
| Private employment | 9 | 3 |
| Farming | 1 | 1 |
| Other | 4 | 16 |
| Unemployed | 58 | 43 |
| TOTAL | 100 | 100 |

Thus the heads of households with disabled family members are generally either workers (28% in Bureij and 37% in al-Shati'), or unemployed (58% in Bureij and 43% in al-Shati'), perhaps indicating a higher poverty level in the households with disabled family members than in the camp communities overall. In Bureij and al-Shati', 95% and 94% of female heads of households respectively were found not working outside the home; the remainder were doing menial jobs as domestics, farmers and workers. In al-Shati', and to a lesser extent in Bureij, some women work in the small sewing industries in the communities. However, these women tend to be younger, often unmarried and with fewer household responsibilities.

*Educational
Levels Within
Households*

Of the male heads of households in each of the communities, 22% in Bureij and 24% in al-Shati' respectively had no formal education. Thirty percent (30%) in Bureij and 33% in al-Shati' had up to six years of schooling, while 40% in Bureij and 33% in al-Shati' had up to 12 years, and 8% in Bureij and 10% in al-Shati' had 13 years or more of education. As shown in Table 3, the

educational levels of male household heads in the two communities are comparable, but contrast sharply with the educational levels of female heads of households. Forty percent (40%) of female household heads in Bureij and 39% in al-Shati' had never been to school, 16% and 18% in Bureij and al-Shati' respectively had up to six years of schooling, 41% and 40% respectively had up to 12 years, and only 3% in both camps had more than 12 years of education.

TABLE 3

Level of Education of Heads of Households

| EDUCATIONAL LEVEL | PERCENTAGE OF MALES | | PERCENTAGE OF FEMALES | |
|---------------------------|---------------------|-----------|-----------------------|----------|
| | Bureij | al-Shati' | Bureij | al-Shati |
| No education | 22 | 24 | 40 | 39 |
| Up to six years of school | 30 | 33 | 16 | 18 |
| Seven to twelve years | 40 | 33 | 41 | 40 |
| 13 years or more | 8 | 10 | 3 | 3 |
| TOTAL | 100 | 100 | 100 | 100 |

As indicated by Table 3, females compared unfavourably to males in education levels. However, females tended to be divided into two broad categories, those that had no education and those that had up to 12 years of schooling. These categories reflect age differences in education, with older women not having had any education and younger women having had the chance to attend UNRWA schools nearby. The data suggests a rising level of education among females over the years.

The Disabled

There were 495 disabled males in Bureij, 58% of the camp's total disabled population, while in al-Shati' there were 650 disabled males or 55% of the total. This difference in the frequency of disability between males and females in both camps raises questions as to why disabled females are under-represented. The difference could be due to natural or social causes, a selective pattern of neglect of disabled females which would be consistent with the observed pattern of selective neglect of females in general. However, given the scope of this study it is impossible to definitively identify the root cause. The observation indicates the need for further investigation at a later date.

As Table 4 indicates, the age distribution of the disabled was similar in the two communities, with 11% of the disabled in Bureij and 10% in al-Shati' under the age of five years, 24% in Bureij and 25% in al-Shati' between the ages of 6 and 15 years, 50% of the disabled in both camps between 16 and 64, and 15% in both camps aged 65 years or older. Overall, 35% of the disabled were children under the age of 15 years in both communities. This percentage is less than that found in the communities at large and is probably due in part to the inclusion in the survey results of older people with disabilities that do not require long-term rehabilitation.

TABLE 4

Disability by Age: Percentage of the Disabled Population

| AGE | BUREIJ | AL-SHATI' |
|---------------|--------|-----------|
| 0 - 4 years | 11 | 10 |
| 5 - 14 years | 24 | 25 |
| 15 - 64 years | 50 | 50 |
| 65 and older | 15 | 15 |

***Disability
Types***

Sixty-four percent (64%) of the disabled in Bureij and 73% in al-Shati' suffered physical/sensory disabilities, while 34% in Bureij and 27% in al-Shati' were mentally disabled or had combined mental and physical disabilities. In Bureij, 623 persons or 79% of the camp's disabled population had a single disability, while in al-Shati' the figure was slightly higher at 969 persons, or 82% of the disabled population. One hundred sixty-six persons or 21% of the total disabled population in Bureij and 216 or 18% in al-Shati' had compound or multiple disabilities.

Table 5 is a summary of the types of disabilities encountered while carrying out the survey. It should be noted that some of those surveyed suffered from more than one type of disability, with one disability at times occurring as a consequence of another, increasing the totals in Table 5 to figures higher than the actual number of individuals identified as disabled:

TABLE 5

Disabilities by Type

| DISABILITY TYPE | NUMBER | | PERCENTAGE OF TOTAL | |
|-----------------------|-------------|-------------|---------------------|------------|
| | Bureij | al-Shati' | Bureij | al-Shati' |
| Movement | 372 | 435 | 29 | 28 |
| Vision | 246 | 386 | 20 | 24 |
| Hearing | 120 | 170 | 10 | 11 |
| Speech | 118 | 152 | 9 | 10 |
| Strange behaviour | 98 | 93 | 8 | 6 |
| Learning difficulties | 107 | 69 | 9 | 5 |
| Seizures | 53 | 62 | 4 | 4 |
| Feeling/sensory | 19 | 6 | 2 | 0.4 |
| Other | 113 | 178 | 9 | 12 |
| TOTAL | 1246 | 1551 | 100 | 100 |

Average number of disabilities per person = $1246/792 = 1.6$ for Bureij and $1551/1185 \times 100 = 1.3$ for al-Shati'.

The interpretation of Table 5 should be approached with caution, as these disabilities appear independent of each other, when in fact some are related. For instance, speech problems comprise 9% and 10% respectively of the total disabilities in Bureij and al-Shati', when some of these accompany and are the result of mental retardation. Table 5 also indicates that 20% and 24% of disabilities in Bureij and al-Shati' respectively are visual. These figures are probably somewhat over-inflated, resulting from the inclusion in the survey of older people with correctable visual problems. A further complication stems from the category 'strange behaviour', representing 8% and 6% of the disabled in Bureij and al-Shati' respectively; this category can include mental retardation problems as well as learning difficulties, which would result in a reduction of the figures in those categories. Similarly, the category 'other' might also include some cases of mental disability which should have been typed as 'learning difficulties'.

In general, however, Table 5 indicates that the types of disabilities found in these communities are similar and occur in comparable frequencies, with certain notable exceptions. Impairment of movement appears to be the most

prevalent disability, followed by visual, hearing and then other disabilities. A 4% rate of seizures was reported in both Bureij and 'al-Shati'. The most pronounced difference between the two communities was in the level of learning difficulties, a reported 9% in Bureij compared to 5% in al-Shati'. However, this difference may stem from a methodological problem; more children with learning difficulties in al-Shati', including some with mental disabilities, were included by interviewers under the heading 'other' than in Bureij. The difference could also be due to an under-reporting of some 50 learning disabled children in al-Shati' who have already joined the Sun Day Care Centre's programme for slow learners.

Abilities

Tables 6 and 7 detail the daily living skills of the disabled surveyed; particular cases in which the questions were not applicable were removed from this analysis. Table 8 is a comparison of the daily living skills of the disabled in the two communities.

TABLE 6

Performance of Daily Living Skills: Bureij

| DAILY LIVING SKILL | NUMBER OF DISABLED | | | |
|------------------------------|--------------------|------------------------|-----------|--------|
| | Alone | Alone w/ Difficulty | With Help | Unable |
| Eats | 608 | 3 | 80 | 24 |
| Cleans self | 423 | 5 | 230 | 54 |
| Dresses | 426 | 13 | 221 | 46 |
| Uses toilet | 488 | 19 | 154 | 51 |
| Sits | 328 | 74 | 129 | 28 |
| Stands | 302 | 77 | 142 | 41 |
| Moves inside home | 385 | 45 | 104 | 58 |
| Moves around in community | 340 | 60 | 87 | 128 |
| Walks ten steps | 365 | 52 | 115 | 14 |
| Understands instruction | 339 | 101 | 5 | 28 |
| Expresses needs | 323 | 110 | 7 | 33 |
| Communicates | 130 | 53 | 5 | 30 |
| Uses signs | 118 | 49 | | 39 |
| Lipreads | 100 | 33 | | 45 |

TABLE 7

Performance of Daily Living Skills: al-Shati'

| DAILY LIVING SKILL | NUMBER OF DISABLED | | | |
|------------------------------|--------------------|------------------------|-----------|--------|
| | Alone | Alone w/ Difficulty | With Help | Unable |
| Eats | 744 | 10 | 83 | 44 |
| Cleans self | 526 | 14 | 289 | 82 |
| Dresses | 553 | 26 | 251 | 90 |
| Uses toilet | 630 | 35 | 164 | 86 |
| Sits | 401 | 95 | 127 | 42 |
| Stands | 369 | 105 | 121 | 76 |
| Moves inside home | 458 | 102 | 71 | 84 |
| Moves around in community | 402 | 112 | 69 | 153 |
| Walks ten steps | 441 | 107 | 62 | 36 |
| Understands instruction | 355 | 163 | 8 | 46 |
| Expresses needs | 309 | 159 | 7 | 49 |
| Communicates | 192 | 93 | 2 | 53 |
| Uses signs | 175 | 82 | | 65 |
| Lipreads | 126 | 67 | | 79 |

Tables 6 and 7 serve to establish the specific training needs in the two communities, with an accumulated 2592 daily living skills to be acquired and/or improved among the disabled in Bureij, and 3409 in al-Shati'. Table 8, which follows, indicates that while differences exist among the disabled in the two communities, overall patterns of ability are quite similar.

The information also indicates that although some of the disabled can manage the activities of daily life, either because their disabilities are not so severe, or through personal and family initiative, some 15% to 45% of the total disabled population is unable to cope without great difficulty or without assistance from family members. Clearly, there exists a need for rehabilitation programmes that would allow these disabled people greater freedom to cope independently with their needs and would encourage families to assist the disabled to free themselves from the burden of disability.

TABLE 8

Comparison of Abilities of the Disabled in the Two Communities

| DAILY LIVING SKILL | Percentage Bureij | Percentage al-Shati' | Inapplicable Bureij | Inapplicable al-Shati' |
|---|-------------------|----------------------|---------------------|------------------------|
| Eat | 85 | 84 | 77 | 304 |
| Clean self | 59 | 58 | 80 | 274 |
| Use toilet | 69 | 69 | 80 | 270 |
| Dress | 60 | 60 | 86 | 265 |
| Understand instruction | 71 | 62 | 317 | 613 |
| Understand instructions w/ difficulty or w/ sign language | 22 | 30 | 317 | 613 |
| Do not understand instructions | 6 | 8 | 317 | 613 |
| Express needs | 68 | 59 | 319 | 660 |
| Express needs w/ difficulty or w/ sign language | 25 | 31 | 319 | 660 |
| Cannot express needs | 4 | 9 | 319 | 660 |
| Communicate | 60 | 57 | 575 | 845 |
| Communicate w/ difficulty or w/ sign language | 26 | 28 | 575 | 845 |
| Cannot communicate | 2 | 16 | 575 | 845 |
| Use sign language | 57 | 54 | 586 | 863 |
| Use sign language w/ difficulty | 24 | 26 | 586 | 863 |
| Cannot use sign language | 19 | 20 | 586 | 863 |
| Lipread | 56 | 46 | 612 | 913 |
| Lipread w/ difficulty | 19 | 25 | 612 | 913 |
| Cannot lipread | 25 | 29 | 612 | 913 |

| | | | | |
|---|-----|----|-----|-----|
| Speak | 54 | 43 | 395 | 749 |
| Speak w/ difficulty | 33 | 39 | 395 | 749 |
| Cannot speak | 13 | 18 | 395 | 749 |
| Sit | 59 | 60 | 233 | 520 |
| Sit w/ difficulty or w/ help | 36 | 33 | 233 | 520 |
| Cannot sit | 5 | 6 | 233 | 520 |
| Stand | 54 | 55 | 230 | 514 |
| Stand w/ difficulty or w/ help | 39 | 34 | 230 | 514 |
| Cannot stand | 14 | 11 | 230 | 514 |
| Move about in home | 65 | 64 | 200 | 470 |
| Move about in home w/ difficulty or w/ help | 25 | 24 | 200 | 470 |
| Cannot move | 110 | 12 | 200 | 470 |
| Move about in community | 55 | 55 | 177 | 449 |
| Move in community w/ difficulty or w/ help | 24 | 25 | 177 | 449 |
| Cannot move about outside | 21 | 21 | 177 | 449 |
| Walk ten steps | 67 | 68 | 245 | 539 |
| Walk ten steps w/ difficulty, help or crutches | 30 | 27 | 245 | 539 |

Table 9 indicates the level at which disabled in the two camps participate in social activities, which serves as an indicator of their integration into their community.

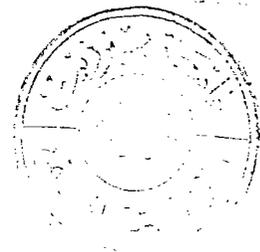


TABLE 9

Selected Social Activities of the Disabled

| ACTIVITY | NUMBER | | PERCENTAGE | | N/A | |
|-------------------------------------|--------|-------|------------|-------|-----|-------|
| | Bur | al-Sh | Bur | al-Sh | Bur | al-Sh |
| Play | 178 | 268 | 71 | 69 | 540 | 795 |
| Play with younger children | 48 | 31 | 19 | 20 | 540 | 795 |
| Do not play | 26 | 46 | 10 | 12 | 540 | 795 |
| Go to school | 95 | 169 | 38 | 68 | 540 | 937 |
| Attend school with younger children | 67 | 31 | 27 | 13 | 540 | 937 |
| No schooling | 90 | 48 | 36 | 19 | 540 | 937 |
| Join family activities | 335 | 427 | 48 | 42 | 98 | 171 |
| Sometimes join family activities | 181 | 294 | 26 | 29 | 98 | 171 |
| No family activities | 178 | 293 | 26 | 29 | 98 | 171 |
| Join social activities | 270 | 364 | 41 | 37 | 135 | 197 |
| Sometimes join social activities | 162 | 293 | 25 | 30 | 135 | 197 |
| No social activities | 225 | 331 | 34 | 34 | 135 | 197 |
| Join in work around house | 170 | 229 | 27 | 23 | 150 | 198 |
| Sometimes join in work around house | 200 | 314 | 31 | 32 | 150 | 198 |
| No housework | 272 | 444 | 42 | 45 | 150 | 198 |
| Have job or income | 47 | 98 | 10 | 13 | 332 | 445 |
| Receive social assistance | 21 | 16 | 5 | 2 | 332 | 445 |
| No job or other income | 392 | 626 | 85 | 85 | 332 | 445 |

As Table 9 indicates, in those cases where the questions were relevant, 10% of the disabled children in Bureij and 12% in al-Shati do not play at all. Over

one-third, 36%, of the children in Bureij do not attend school at all, compared to 19% in al-Shati', and most of these had not even attended school when younger. Over one-fourth of the disabled, 26% in Bureij and 29% in al-Shati', were found to not participate at all in family activity, 34% in both Bureij and al-Shati' are excluded from social activity, and 42% in Bureij and 45% in al-Shati' do not participate in household activities at all. Of the entire disabled population in the two camps, only 10% in Bureij and 13% in al-Shati' have full or part-time jobs, while 5% in Bureij and 2% in al-Shati' live on social assistance. Eighty-five percent (85%) of the disabled in both Bureij and al-Shati' have neither job nor income and are therefore completely dependent on their families.

In general, the results of the survey in the two camps were fairly similar, with the exception of the level of disabled children not in school (35% in Bureij vs 19% in al-Shati'). The difference is probably due to the presence of a special 'integrated schooling' programme for the children of al-Shati' in the camp itself; no such programme exists in Bureij. This is a fairly reliable indicator of the need for special educational programmes in Bureij, since our results imply that when programmes are available within the community, families respond by enrolling their children. When such programmes are inaccessible because of distance or other reasons, disabled children are usually left staying at home. Overall, the information shown in the above tables points to the need for rehabilitation programmes geared towards the reintegration of the disabled into social, educational and employment activities in their communities.

*The Receipt
of Care*

Table 10 indicates that of the total disabled in each community, 240 persons (31%) in Bureij and 411 (35%) in al-Shati' were reported as not having been seen by any medical professional. The remainder have been exposed to some elements of medical treatment linked to their disability, usually combined with physiotherapy, some type of rehabilitation therapy, or traditional medical treatment, in at least 33 institutions in Gaza, the West Bank and abroad:

TABLE 10

Treatment by Type

| TYPE OF TREATMENT | NUMBER | | PERCENTAGE | |
|---|--------|-----------|------------|-----------|
| | Bureij | al-Shati' | Bureij | al-Shati' |
| Physiotherapy | 29 | 39 | 4 | 3 |
| Modern medical* | 282 | 442 | 37 | 38 |
| Modern medical + physiotherapy | 130 | 124 | 17 | 11 |
| Rehabilitation (employment) | 35 | 98 | 4 | 8 |
| Modern medical + rehabilitation | 15 | 43 | 2 | 4 |
| Traditional medical + physiotherapy | 26 | 2 | 3 | 0.2 |
| Modern medical, traditional medical + physiotherapy | 10 | 11 | 1 | 1 |
| Physiotherapy + rehabilitation | 6 | 5 | 1 | 1 |
| No treatment | 240 | 411 | 31 | 35 |
| Unknown | 19 | 10 | | |

* Modern medical treatment consists generally of diagnosis, provision of medication, surgery and physiotherapy, received in relation to disability.

Overall, 37% of the disabled in Bureij and 38% in al-Shati' have been exposed to modern medical treatment as least once, 32% in Bureij and 27% in al-Shati' have had a combination of various types of treatment, primarily modern medical plus some physiotherapy (with little rehabilitation other than physiotherapy). Thirty-one percent (31%) in Bureij and 35% in al-Shati' had received no treatment whatsoever. This information suggests the need to initiate non-medical rehabilitation programmes for the disabled in these communities, supplemented by continuous, high quality medical treatment, as most respondents reported that the medical treatment received had been erratic and of undetermined quality.

Problems Encountered by Families of Disabled

Only 2% of the parents interviewed in both Bureij and al-Shati' stated that they encountered no problems in dealing with the disabled in their families. The rest were divided as follows:

TABLE 11

Problems of Parents in Dealing With the Disabled

| TYPE OF PROBLEM | NUMBER | | PERCENTAGE | |
|------------------------------------|--------|-----------|------------|-----------|
| | Bureij | al-Shati' | Bureij | al-Shati' |
| Psychosocial | 216 | 337 | 33 | 34 |
| Financial/work | 29 | 35 | 4 | 4 |
| Medical | 154 | 117 | 24 | 12 |
| Psychosocial + financial + medical | 22 | 92 | 3 | 9 |
| Psychosocial/medical | 169 | 195 | 26 | 19 |
| Psychosocial/financial | 20 | 131 | 3 | 13 |
| No problems | 15 | 21 | 2 | 2 |
| Unknown | 133 | 182 | | |

Table 11 indicates that 65% of respondents in Bureij and 64% in al-Shati' listed psychosocial problems - stress, anxiety and stigma - either alone or combined with other complaints, as major problems affecting family life, while 58% in Bureij and 48% in al-Shati' listed medical problems alone or together with other complaints as major problems. Fifteen percent (15%) in Bureij and 34% in al-Shati' listed the financial burden as their prime concern in having a disabled family member. The needs of these two communities as expressed by the parents surveyed appear to differ, with medical problems considered more pressing in Bureij and financial strain considered more problematic in al-Shati'.

Interestingly, a significantly higher percentage (73%) of parents in Bureij who were considered well off by camp standards were concerned with psychosocial problems, compared to poor families (64%, chi square = 6.549, p = 0.03). In al-Shati', middle class families appeared to be more concerned with psychosocial problems, with 81% of parents in this category listing psychosocial problems as a priority, compared with 72% among the poor and

74% among the well off (chi square = 11.60441, $p = 0.003$). In both communities, parents of the mentally disabled appeared to be more affected by social stigma than parents of the physically disabled. In Bureij, 56% of parents of the physically disabled listed psychosocial problems as their major difficulty, compared with 79% among parents of the mentally disabled (chi square = 37.1290, $p = 0.0000$). A similar significant difference between these two groups was found in al-Shati', with 71% of parents of the physically disabled listing psychosocial problems as their major difficulty, compared with 87% among parents of the mentally disabled (chi square = 28.9790, $p = 0.0000$).

On the whole, it appears that the social stigma and medical problems rank first and second in parents' priorities. What the families meant precisely by 'medical' is an issue that needs to be addressed at a later stage, once the practical programmes have been initiated. Quite often while conducting the survey, we noted that parents expected modern medicine to miraculously cure their disabled son or daughter. While understandable, this attitude may indicate an element of maladjustment on the part of the families to the fact of disability; rather than accepting it and trying to improve those skills the disabled person may have, expectations seemed to focus instead on a miracle cure. It may also be representative of a certain level of medicalisation of the society in general, or a lack of knowledge of alternative forms of therapy.

As for those disabled that were able to express themselves or were old enough to express their opinions (58% in Bureij and 52% in al-Shati'), 45% and 47% of these respectively indicated that psychosocial problems were of major concern to them, while 58% in Bureij and 45% in al-Shati' listed medical problems (specifically, the need for further treatment/cure) as important problems faced. Clearly, treatment and social stigma are key problems that need to be addressed in any future planning for rehabilitation programmes in these communities.

*An Attempt
to Identify
High Risk
Groups*

Although thus far we feel fairly certain that we have been able to identify the majority of the disabled in these two communities and the range of disabilities present, and we have generally defined areas of need and requirements for future rehabilitation activities, further analysis of the data is required in order to identify the high risk groups among the disabled. This is essential in order to outline more comprehensive priorities and plans for future action, taking into consideration those of the disabled whose needs are not as evident or 'visible' as those of others. Such information is also valuable for the purposes of community education: through discussion of the survey results, one can begin to raise the question of disability at large as well as focusing attention on those most in need of assistance.

Financial Status

The dominant questions at this point are: who are those at highest risk of further complications? What, if any, characteristics do they have in common? Are they physically or mentally disabled, children or adults, male or female? What activities should be initiated before others? What activities are realisable and important for the improvement of the lives of disabled people? This type of question led to a re-examination of the data with the aim of locating determinants of social integration and coping and, when possible, determinants of disability within these communities.

When disability type was correlated with financial status there was a significant relationship between mental disability and poverty in both communities:

TABLE 12

Disability Type by Financial Status

| DISABILITY TYPE | FINANCIAL STATUS OF FAMILY OF DISABLED | | | | | |
|-----------------|--|-----------|---------------|-----------|--------------|-----------|
| | POOR (%) | | MID-LEVEL (%) | | WELL OFF (%) | |
| | Bureij | al-Shati' | Bureij | al-Shati' | Bureij | al-Shati' |
| Physical | 32 | 44 | 41 | 41 | 27 | 15 |
| Mental/combined | 42 | 50 | 32 | 33 | 26 | 17 |

Bureij: chi square = 8.40324, p = 0.015

al-Shati': chi square = 5.8979, p = 0.05

As Table 12 indicates, the prevalence of mental or combined disabilities among the poor - 42% in Bureij and 50% in al-Shati' - is significantly higher than the well off - 32% in Bureij and 17% in al-Shati'. In addition, the rate of mental/combined disability increases from poor to mid-level to well off families. Apart from a reinforced notion of similarity between these communities, these results point to the association with poverty of mental or combined disabilities but not physical disabilities. Whether these disabilities are a cause of poverty or whether poverty is a determinant of mental/combined disability is impossible to ascertain utilising this data. What we can at least conclude here is that families of disabled people suffering from mental or combined disabilities are more in need of assistance than those with physical disabilities.

We then examined the relationship between financial status and the total number of disabled members in a family:

TABLE 13

Total Disabled Family Members vs Family Financial Status

| NO. OF DISABLED IN FAMILY | FINANCIAL STATUS OF FAMILY | | | | | |
|------------------------------------|----------------------------|-----------|---------------|-----------|--------------|-----------|
| | POOR (%) | | MID-LEVEL (%) | | WELL OFF (%) | |
| | Bureij | al-Shati' | Bureij | al-Shati' | Bureij | al-Shati' |
| One | 31 | 40 | 41 | 42 | 28 | 18 |
| Two | 32 | 43 | 43 | 43 | 25 | 14 |
| Three | 48 | 66 | 25 | 23 | 27 | 11 |

Bureij: chi square = 20.03357, p = 0.005
 al-Shati': chi square = 45.35005, p = 0.0000

An association was observed between poverty and the number of disabled in each family. As can be seen from Table 13, 31% of those families with one disabled member in Bureij and 40% in al-Shati' are poor. The percentages rise, with 32% in Bureij and 43% in al-Shati' of families with two disabled members, and 49% in Bureij, 66% in al-Shati' with three or more disabled members, all classified as poor. In Bureij only, Table 13 shows a clear pattern of wealth status improving as the number of disabled family members decreases. However, the strong association between the number of disabled family members and level of impoverishment highlights the need for prioritising assistance to those families with more than one disabled member. No relationship was found between poverty and age of the disabled, that is, differences in wealth status of families with disabled children as opposed to disabled adults who could potentially earn income for the family.

We then examined the various levels of ability of the disabled in relation to financial status. We found no relationship in either community between poverty and the ability to clean oneself, dress, use the toilet, understand instruction, express needs, communicate, use sign language, lipread, sit or stand. A positive association was discovered in Bureij camp, however, between poverty and the inability to speak; 21% of the poor in Bureij were unable to speak at all, decreasing to 8% in both the mid-level and well off categories (chi square = 16.42205, p = 0.0025).

The other significant difference between the two communities related to the receipt of treatment. Whereas no association was found between the receipt of treatment and wealth status in Bureij, a significant association was evident in al-Shati' - 19% of the poor reported not having had any treatment at all,

compared to 17% of the disabled in the mid-level category, and 13% in the well off category (chi square = 17.07107, $p = 0.009$). Thus, the poor in al-Shati' were found to have less access to treatment than the well off. While the cause of such a difference in access between the two communities is difficult to ascertain, these results indicate the need to pay particular attention to the difficulties of access to medical and health care of the disabled poor in al-Shati' camp.

These results can be interpreted in various ways. What they indicate is that financial status in this community does not play a major role in determining level of ability inasmuch as ability can be associated at least partially with rehabilitation education. That is, it is conceivable to suggest that these communities are generally in need of rehabilitation services and selected medical treatment in order to improve the abilities of both the disabled and their families in coping with daily life.

Social integration indicators were then related to financial status in the two communities and no relationship was found between financial status and movement at home or in the community, participation in family activities, housework or, surprisingly, schooling. (Our original hypothesis had been that the poor might be less inclined to send their disabled children to school.) When we separated the disability categories of physical/sensory from mental/combined and did the cross-tabulation in relation to schooling, there was again no difference between those in the poor and well off categories. Thus financial status is not a determinant of schooling of the disabled in these communities. However, social activities and play appear to be influenced by socioeconomic status in Bureij but not in al-Shati'. Of the poor in Bureij, 39% reported not participating in social activities at all, in contrast to 27% among the mid-level category, and 38% among the well off (chi square = 10.75947, $p = 0.029$). It appears that poor and rich children in Bureij are less likely to participate in social activities than children in the mid-level income category. Similarly, a pattern emerged of play decreasing as the rate of impoverishment increased; in Bureij 20% of the poor disabled children, 6% of the mid-level income children and 7% of the well off reported not playing at all. Clearly, social or other differences do exist between the two communities that can account for the difference in social integration indicators observed. Attention must therefore be paid to the specifics of relations and attitudes between the two communities.

We first distributed the gender categories by age:

TABLE 14

Gender of Disabled vs Age (I)

| GENDER | PERCENTAGE OF TOTAL | | | | | | | |
|--------|---------------------|-------|------------|-------|-------------|-------|-----------|-------|
| | 0-4 YEARS | | 5-15 YEARS | | 15-64 YEARS | | 65+ YEARS | |
| | Bur | al-Sh | Bur | al-Sh | Bur | al-Sh | Bur | al-Sh |
| Male | 6 | 5 | 15 | 13 | 30 | 28 | 8 | 7 |
| Female | 5 | 5 | 9 | 11 | 20 | 22 | 8 | 8 |

Total males: Bureij 457 (58%)
al-Shati' 649 (55%)
Total females: Bureij 331 (42%)
al-Shati' 535 (45%)

The above table demonstrates that the percentage of disabled boys in the 0-4 year age group in Bureij is slightly higher than the percentage of girls, 6% and 5% respectively, while in al-Shati' the rates are equal. Assuming the initial difference between the sexes is due to genetic/non-social reasons - that is, this ratio of disabled males/females is assumed to exist at birth - and looking at the percentage differences within each age group:

TABLE 15

Gender of Disabled vs Age (II)

| GENDER | PERCENTAGE OF AGE CATEGORY | | | | | | | |
|--------|----------------------------|-------|------------|-------|-------------|-------|-----------|-------|
| | 0-4 YEARS | | 5-14 YEARS | | 15-64 YEARS | | 65+ YEARS | |
| | Bur | al-Sh | Bur | al-Sh | Bur | al-Sh | Bur | al-Sh |
| Male | 57 | 54 | 62 | 54 | 60 | 57 | 47 | 50 |
| Female | 43 | 46 | 39 | 46 | 40 | 43 | 53 | 50 |

Table 15 demonstrates that the percentage difference between boys and girls in the 0-4 age group - our control group - is about 14% in Bureij and 8% in al-Shati'. If these assumed genetic factors are in operation alone, we should find a consistent 14% and 8% difference between the sexes across the different age groups for Bureij and al-Shati' respectively. However, the above

table indicates a variation, increasing with age and up to the point of old age, where it reverses. The difference between genders is 23% among the 5-14 year age group in Bureij and remains 8% in al-Shati', drops to 20% among the 15-64 age group in Bureij and rises to 14% in al-Shati'. The pattern eventually reverses to a 5% difference in favour of females for the 65+ age group in Bureij and to equality in rates between the sexes in al-Shati'. Thus the data suggests that gender differences in the rate of disability in this community are not explained by genetic factors alone, and other determinants, probably social, appear to be in operation. It raises the question of selective neglect of disabled females which would be consistent with the general selective neglect noted by local researchers in terms of general health status, as a possible factor influencing this difference in the communities. As for the higher rate of disability among women in relation to men in the 65+ age group noted in Bureij, this can be explained at least in part by the longer lifespan of females in Palestinian society at large.

Rates of physical/sensory vs mental/combined disabilities were almost the same between males and females in Bureij. There was no difference between the genders in their levels of ability to eat, clean themselves, dress, use the toilet, understand instruction, communicate, use sign language, talk, sit, stand, walk ten steps, move about at home, and participate in family activities and household tasks in Bureij. Yet, despite this parity in level of ability, the level of ability to participate in public life was much higher among males than females. Thirteen percent (13%) of disabled males do not move about in their community at all, a sharp contrast to the reported 31% for disabled females. Furthermore, while 64% of disabled males move about by themselves in the community, only 44% of disabled females do so (chi square = 36.14959, p = 0.0000).

Similarly, 28% of disabled males do not attend school, 31% attend at a lower class level, and the remainder attend school normally. By contrast, 48% - almost half - of disabled females do not go to school by themselves, 19% attend at a lower class level, and 33% attend school normally (chi square = 10.50871, p = 0.005). The same differences in favour of boys were noted with regard to participation in social activity; 41% of disabled girls compared with 29% of disabled boys do not participate in social activities at all (chi square = 21.53889, p = 0.000).

TABLE 16

Participation in Social Activities vs Gender: Bureij

| TYPE OF ACTIVITY | PERCENTAGE OF GENDER CATEGORY | |
|-------------------------------------|-------------------------------|--------|
| | MALE | FEMALE |
| Move about in community alone | 64 | 44 |
| No movement in community | 13 | 31 |
| Chi square = 36.14959, p = 0.000 | | |
| Attend school normally | 41 | 33 |
| Attend school at lower level | 31 | 19 |
| Do not attend school | 28 | 48 |
| Chi square = 10.50871, p = 0.005 | | |
| Participate in social activity | 49 | 31 |
| No participation in social activity | 29 | 41 |
| Chi square = 21.53889, p = 0.000 | | |

Clearly, despite similar types of disability and comparable levels of skill in daily living activities, disabled women in Bureij appear to be much less integrated in social life than men. That is, although social integration seems to be a problem afflicting the entire disabled community, disabled women appear to have a more difficult time than their male counterparts in dealing with society. This problem must be given serious consideration particularly when working with young girls, as the denial of schooling possibilities seriously hinders their further development.

The differences in levels of societal integration between males and females can be explained by prevailing social and parental attitudes toward females. Families may be less inclined to let their daughters go outside the home for fear that they would encounter difficulties that as females they are incapable of dealing with. Parents might also be more conscious of social stigma from the presence of a disabled female in the family. Rather than risk letting this stigma affect the marriage potential of their other daughters, therefore, they keep the disabled daughter 'hidden' from the community. Curiously enough, however, such attitudes did not reflect themselves in the discussions of problems with parents, nor in patterns of treatment; overall there was no difference between the genders in relation to problems encountered by parents in dealing with disability nor the level and type of treatment obtained. But such attitudes exist, and can lead to unconscious behaviour by parents

that will not be reflected in data obtained by simply interviewing. There are other possible explanations, a feeling on the part of parents that investing time and energy in female children is not worthwhile since there would be no future financial or status return on such an investment given that girls become part of another household when they marry and thus are not a guarantee for their parents' social security in old age. However, whatever the explanation, disabled females, particularly girls, have emerged as a priority group for whom action must be taken.

Patterns of social integration differed somewhat in al-Shati'. Significantly more females than males were found to suffer from physical/sensory disabilities, 78% vs 68% respectively (chi square = 12.6928, $p = 0.0004$). Levels of ability were almost equal between the gender groups in eating, using the toilet, getting dressed, talking, sitting, and walking ten steps. There was also no difference between the gender groups in levels of school attendance. However, differences emerged with relation to movement; 69% of disabled males moved about by themselves at home in contrast to 58% of disabled females. Eight percent (8%) of disabled males as opposed to 15% of disabled females reportedly did not move about at all (chi square = 11.82541, $p = 0.008$). The same marked difference appeared in relation to movement in the community, with 60% of males but only 48% of females moving about by themselves (chi square = 25.82714, $p = 0.0000$). However, women were found to participate in housework and family activities at significantly higher levels than disabled men; 60% of disabled men did not participate at all in household activities compared with 32% of females (chi square = 79.81941, $p = 0.0000$). Similarly, only 24% of disabled females were did not participate in family activities, while the rate for males was 33% (chi square = 23.36332, $p = 0.0000$).

Clearly, disabled women were considered more able than men to participate in in-house activities and capable of assisting in household chores, yet were restricted to these home activities and generally faced more serious social integration problems than men. It should be noted that most women in Palestinian society, not simply the disabled, have difficulty in terms of free access to social life, which can explain these specific differences in survey results. Yet the fact that disabled females were found to be significantly more concerned with psychosocial problems than males (56% vs 45%) (chi square = 6.81636, $p = 0.009$) raises the additional question of societal stigma affecting to a greater degree the ability of disabled women in al-Shati' to participate in social life than it affected disabled men, or women in general.

*Physical vs
Mental/
Combined
Disabilities*

As noted previously, 64% of the disabled in Bureij and 73% in al-Shati' suffered from physical disabilities, and 36% in Bureij and 27% in al-Shati' from mental/combined disabilities. Families of the mentally disabled were found to be significantly poorer than other families of disabled. An

examination of disability type in relation to parent kinship revealed a significant association in Bureij only between mental/combined disability and cousin marriage among parents:

TABLE 17

Disability Type vs Parent Kinship: Bureij

| DISABILITY TYPE | RELATIONSHIP BETWEEN PARENTS | | |
|-----------------|------------------------------|-------|------|
| | FIRST COUSINS | OTHER | NONE |
| Physical | 57 | 60 | 70 |
| Mental/combined | 43 | 40 | 30 |

Chi square = 10.87253, p = 0.004

The above table indicates a decreasing rate of mental/combined disability as genetic distance between the parents increased. Thus, marriage between cousins appears to contribute to the problem of mental disability in this community, although it remains only one contributing factor among others.

Differences in level of skill in performing daily living activities were also noted between the physically and mentally disabled:

TABLE 18

Level of Skill vs Disability Type: Bureij

| DAILY LIVING ACTIVITY | PERCENTAGE OF DISABILITY TYPE | | | | | | | |
|-----------------------------------|-------------------------------|--------|---------------------|--------|-----------|--------|----------|--------|
| | ALONE | | ALONE W/ DIFFICULTY | | WITH HELP | | NOT ABLE | |
| | Physical | Mental | Physical | Mental | Physical | Mental | Physical | Mental |
| Eating | 88 | 81 | 1 | 1 | 10 | 13 | 2 | 6 |
| Chi square = 11.2913, p = 0.013 | | | | | | | | |
| Clean self | 65 | 51 | 1 | 0 | 30 | 37 | 5 | 13 |
| Chi square = 25.2208, p = 0.000 | | | | | | | | |
| Use toilet | 72 | 62 | 3 | 2 | 20 | 25 | 5 | 12 |
| Chi square = 19.73028, p = 0.0002 | | | | | | | | |

Table 18 indicates a significant difference between the physically and mentally disabled in levels of skill in managing the tasks of eating, cleaning themselves, and using the toilet. Six percent (6%) of the mentally disabled cannot eat without the attendance of a care provider, compared with only 2% of the physically disabled. Of the mentally disabled, 13% cannot clean themselves, but of the physically disabled only 5% are not able to perform this task. Similarly, 12% of the mentally disabled cannot use the toilet by themselves, compared with 5% of the physically disabled.

Differences between the physically and mentally disabled were also pronounced in terms of their ability to express themselves. The physically disabled fared better in this respect than the mentally disabled, and therefore, as expected, social integration indicators showed the mentally disabled at a significant disadvantage. Twenty-eight percent (28%) reported not going out in the community at all, compared with only 17% of the physically disabled (chi square 19.27835, $p = 0.0002$). Similarly, 15% of mentally disabled children did not engage in play activities, compared with 7% of physically disabled children (chi square = 19.8747, $p = 0.000$), and 30% of physically disabled children did not attend school compared with a much higher rate of 45% among mentally disabled children (chi square = 43.98373, $p = 0.0000$). While 20% of the physically disabled did not participate in any family activities, the rate among the mentally disabled was much higher at 36% (chi square = 42.14424, $p = 0.0000$). Participation in other social activities showed an even greater difference, with 54% of the mentally disabled not participating at all, compared with 23% of the physically disabled.

The same differences between the physically and mentally disabled were evident in the data on receipt of medical and other types of treatment, as well, with the physically disabled having received far more treatment than the mentally disabled. Specifically, it was discovered that 60% of the physically disabled were exposed to treatment once, 27% more than once, and 13% were never treated. By contrast, only 54% of the mentally disabled had been exposed to treatment once, 25% more than once, and 21% had never had any treatment (chi square = 9.32969, $p = 0.009$). The mentally disabled appear to be a clear priority group for future action, as demonstrated by their levels of ability, social integration indicators, and the rates of treatment and rehabilitation.

The Elderly

In Bureij camp, a total of 124 disabled people reported being 65 years of age or older; 59 were male and 65 female. A considerable percentage of this group was discovered to be unable to cope with the activities of daily life. Seventy-eight percent (78%) were able to eat alone, but the remainder needed some or a great deal of assistance. Less than half, 44%, were able to clean themselves, 46% to dress themselves, 47% to use the toilet without

assistance, 30% to sit up without help, 25% to stand by themselves, 32% to move about the house by themselves, and 18% to move around in the community independently. Of the total elderly disabled population, only 29% participate in family activities regularly, 21% in other social activities, and 8% in household tasks. All reported suffering joint pain. Of the total, 89% have no source of income except for family support, often insufficient for their needs.

These results indicate that the aged disabled, as a group by themselves, are in need of action aimed at improving the quality of their lives and reducing the burden their disability creates for their families. This burden rests particularly on the female heads of households, who normally function as the providers of care for children, the aged and the disabled. There is much that can be done to improve the ability of the aged disabled to cope independently with daily life, and to stimulate their participation in family and social activities. As the role of breadwinner and provider of care is lost to the elderly as they advance in age, they too become relegated to a socially 'invisible' sector of the population. They must be a focus of future rehabilitation programmes in this community. □

V. Summary of Major Findings

A total of 792 disabled persons in Bureij and 1195 in al-Shati' were identified and interviewed. These groups comprised approximately 4% of the total population in both communities. In general, 35% of these disabled people and 45% came from households designated as poor by camp standards. Disabled males outnumbered disabled females in both communities, with males comprising 58% and 55% respectively of the disabled population in Bureij and al-Shati', which raises the question as to the origin of this variance. The age distribution of the disabled in both communities was quite similar, with 35% of the disabled under the age of 15 years.

Overall, 64% of the disabled population in Bureij and 73% in al-Shati' had physical/sensory disabilities, and 34% in Bureij and 27% in al-Shati' had mental/combined disabilities. Seventy-nine percent (79%) of the disabled in Bureij and 82% in al-Shati' had one type of disability only, and the remainder had more than one.

Of the disabled cases where the questions were relevant, 85% in Bureij and 84% in al-Shati' were able to eat by themselves, 69% in Bureij and al-Shati' both were able to dress themselves, 71% in Bureij and 62% in al-Shati' understand instruction, 68% in Bureij and 59% in al-Shati' can express their needs, 60% in Bureij and 57% in al-Shati' are able to communicate, and 54% in Bureij and 43% in al-Shati' can speak. In addition, 59% in Bureij and 60% in al-Shati' are able to sit up, 54% in Bureij and 55% in al-Shati' can stand alone, 65% in Bureij and 64% in al-Shati' are able to move about in their homes, 55% in Bureij and al-Shati' both can move around in the community, and 67% in Bureij and 68% in al-Shati' are able to walk ten steps. These results indicate that a good proportion of the disabled population in the two communities are in need of rehabilitation assistance in coping with daily life.

Social integration indicators highlight the need for intervention in this area as well. Seventy-one percent (71%) of the disabled population in Bureij and 69% in al-Shati' reported playing normally, of the cases where the question was relevant. Thirty-eight percent (38%) in Bureij and 68% in al-Shati' attend school normally, and an additional 27% and 13% respectively attend school at a lower class level. Almost half the disabled, 48% in Bureij and 42% in al-Shati' participate in family activities, 41% and 37% respectively join in other social activities, and 27% in Bureij and 23% in al-Shati' take part in household tasks. Of the total disabled population in each community, 10% in Bureij and 13% in al-Shati' have either a job or an income of their own.

Data on exposure to medical treatment indicated that 31% of the disabled in Bureij and 35% in al-Shati' had not had any treatment whatsoever, and the remainder have had combined treatment, primarily medical and physiotherapy services. Social stigma, followed by medical problems, were the major

complaints of parents, again indicating the need for intervention in terms of expansion of the range of services available to the disabled and attempting to integrate them as much as possible into society.

In order to formulate a plan of action, priority groups among this relatively large number of disabled had to be identified. A statistically significant relationship was found between mental disability and poverty, and between gender and the rate of disability. The data suggests that this difference cannot be explained by genetic factors alone, and that probably social factors, such as the preference for males, might be contributing to this disparity. Furthermore, although the level of skill in performing daily living activities was similar for both males and females, social integration indicators - schooling, play, movement in the home and outside - show a clear advantage of boys over girls, reinforcing the need to incorporate this gender difference into future plans of action. Similarly with the mentally disabled, social integration indicators show a consistent advantage of the physically disabled over those with mental disabilities, leading to the conclusion that this category of disabled must also be taken into special consideration when planning future rehabilitation activities.

Finally, although some of the elderly people, aged 65 and older, who were included in this study are probably not in need of long-term rehabilitation, some were found to be in great need of rehabilitation services in the home. There were 124 and 186 older people in Bureij and al-Shati' respectively, and of these 72% in Bureij and 64% in al-Shati' were unable to eat by themselves. Forty percent (40%) in Bureij and 30% in al-Shati' were unable to clean themselves, 43% and 34% respectively were unable to use the toilet without help, and 42% and 30% could not dress themselves. Furthermore, 25% in Bureij and 21% in al-Shati' were not able to sit by themselves, 21% and 22% respectively were unable to stand by themselves, and 28% in both communities were unable to move around in their homes alone. Fifteen percent (15%) in Bureij and 19% in al-Shati' could not move around in the camp by themselves, 27% and 28% respectively were not able to join in family activities, 20% and 24% could not participate in other social activities, and 7% from Bureij and 13% from al-Shati' were incapable of assisting in household tasks. The results of the survey indicate clearly that the elderly are another priority group whose needs must be considered when planning future action. ■

VI. The Plan of Action

The initial aim of the project is to break new ground by establishing a model for community based rehabilitation in the Gaza Strip through work in two pilot areas. The ultimate goal is to expand to other areas of the Strip, while keeping expenses to a minimum. It is anticipated that the 16 trainees will eventually work in different locations, beginning by working together within a learning framework in the two pilot areas, then slowly expanding to new areas as knowledge and experience increase. Accordingly, the plan outlined below pertains to the pilot phase only, which will most probably continue for the coming one or two years, depending on the situation in the Strip.

There were two key elements which served as the foundation for our plan of action. The first centred around the results of the survey. The mentally disabled, children, girls, and families with more than one disabled member were identified as priority groups by the measurement of daily living skills and the indicators of social integration. Early intervention in the area of schooling was identified as a priority also, particularly in the case of children, in order to prevent or at least contain any possible future deterioration in the state of the disabled in question. Older people were included as another priority group, for two reasons. Older people in general and the disabled elderly in particular appear to experience increasing difficulty having their needs met as they gradually lose their productivity and consequently their power and social visibility. Secondly, in addition to the quantitative data discussed above, the survey also yielded qualitative data indicating that much can be done in the area of rehabilitation in the homes of the elderly to assist them in dealing with their daily lives. This would take a relatively small expenditure of human and financial resources, but would have a huge impact on the lives of the older disabled and their families. Given the almost total lack of geriatric care in the area, such rehabilitation work was also targeted as a priority.

The second element which helped to define the plan was the belief that in order to gain the support and involvement of the community, the rehab team had to produce tangible results relatively rapidly. Such a view necessarily entailed an initial concentration on those with only mild and moderate disabilities and on what was found to be practicable, given the setting both in the pilot areas and the Strip as a whole. However, the team was also acutely conscious of the need to eventually address the problem of the more severely disabled, since these people are often neglected for precisely the same reasons that led us not to focus on them at the outset of our practical work. These considerations eventually led the team to opt for the middle ground by focusing on activities for children from every type of disability category and for older people as well.

From the beginning, our approach to designing the project entailed the concept of planning as a continuous process. Such a concept necessitates the

establishment of a monitoring system to allow for periodic updating of plans and formulation of policy, regular revisions of design based on the results of the practical work and the newly emerging needs in the field. The plan was never intended to be inflexible, but was perceived instead as a guideline which allowed us to focus energies on selected activities that extend from the policy foundations that we used in designing the project, pending assessment. Meanwhile, because of the lack of human resources in the Strip with expertise in rehabilitation, the team decided to begin working in one of the camps with children and older people until the trainee workers were upgraded and local expertise developed sufficiently to expand into new areas. Accordingly the team's plan of action includes the following components:

practical Work

This should begin in Bureij, and focus on children and older people. Activities include:

a. Detailed assessment of individuals, seeking diagnosis of conditions when necessary, the identification of needs, immediate objectives and longer-term plans of action for each case. These assessments were thought to be crucial not only to plan activities with individuals, but for evaluation purposes at a later date.

b. Study the feasibility and plan for a special education programme geared toward the middle range mental disabilities and learning difficulties. This component was considered quite important for the purposes of community mobilisation as well, gaining the high visibility needed for additional support and helping to mobilise parents, families, and neighbours around the project. At the same time, a decision was taken to work with those suffering mild mental disabilities or learning difficulties to reincorporate them into regular schools.

c. Assist in establishing a referral system including diagnostic care, physiotherapy, the provision of technical aids and hospitalisation, among other services. Such a system entails the active cooperation of the Gaza Rehabilitation Committee until such time when the team itself is known and has gained credibility in the society.

d. Work with disabled people in the two categories utilising the WHO manual, beginning with the activities of daily life and progressing to other tasks while monitoring and evaluating progress.

*Further
Training*

Clearly, a three-month training period in our context is just the beginning. The plan includes periodic visits by local and international experts in order to upgrade the programme and help workers to acquire new skills to respond to the needs arising from the practical work. This learning process is anticipated to take approximately two years. It is also anticipated that some workers might be trained further in specialised fields in the future, in order to build up a team of local experts in Gaza.

*Management
System*

Building up a management and supervisory system from the outset is a central component of the planned activities. Currently, a manager as well as four technical coordinator/supervisor posts have been created. The post of manager has already been filled by a person requiring further skills upgrading in the field of management. The four coordinators/supervisors have been identified, based on assessments made by the teachers of the course. These assessments included technical comprehension and skills, general intellectual openness and ability to deal with and lead the team. Over time and as these coordinators' skills are developed, they will be upgraded as well, perhaps in different areas, thus creating a mini-referral system within the team itself.

The other component of this managerial system involves the development of a monitoring and assessment system. Utilising report sheets that the team generates daily, monthly and every six months, the plan is to computerise this information for quick and easy accessibility. This information system is important not only for monitoring and assessment, but also for future planning and policy formulation for this project as well as for the area in general.

Coordination

The team is aware of the need to coordinate the actions taken in the course of this project with those occurring in the area of rehabilitation in the Gaza Strip overall. In the face of mounting interest in the disabled, various institutions are initiating projects for the disabled. Such a situation is likely to create duplicate projects and to waste resources and potentially distract this project into competing with other groups. For this reason, the plan has always centred around the idea of coordinating with others by finding out what kind of work they are involved in and what they are planning to do in the future, and to investigate how this project could link with other projects in such a way as to complement what is already there and/or what is being planned. The tremendous effort by the National Committee to establish itself as a coordinating body is a testimony to the potential success of coordination efforts, despite the problems which may exist.

*Community
Mobilisation
and
Mobilisation
of the
Disabled*

Although local committees have been formed already within the communities where the project is working, there is still much that remains to be done in the area of community mobilisation. Families, friends, schoolteachers, shopkeepers, taxi drivers, and others are among those who could be mobilised to partially fulfill the needs of the disabled in the communities. Similarly, although the concept of the disabled speaking for themselves and taking on the responsibility of their own rehabilitation project is still relatively new, this team will do its utmost to act as a catalyst for such a scheme. Toward this goal, selected disabled people with leadership potential can be assisted to adapt to their disability and, with further work, can be prepared for the assumption of a mobilising, educational and leadership role. A possible second step might be to assist in the formation of a group of disabled people who might eventually be incorporated into the decision-making process of this project. ■

**VII.
Conclusion**

Rehabilitation within the community is a new concept in this country, both in principle and in practise. There are numerous obstacles: a highly biomedicalised society seeking a miracle cure through an injection, operation or medication; a population that has over the years unfortunately become used to the 'hand-out' mentality that leaves little room for personal and collective initiative in service provision but not, oddly enough, in other aspects of life; severe stigmatising of the disabled that often affects the families of the disabled as well; a lack of or insufficiently or badly trained human resources. These are just some of the internal problems faced by this project. On the other hand, the external pressures include the continuation of military rule and all its policies, including curfews, states of siege, collective punishment in all its forms, the absence of Palestinian authority or control over their projects, institutions, the development of their society, and even their daily lives, and the flood of uncoordinated development aid to Gaza that threatens to cause even more disruptions in Gaza society.

It is within this context that the National Committee and its project team are attempting to address the issue of rehabilitation in the community. These working conditions are far from ideal for project implementation purposes. Nonetheless the working team as well as the Committee are ready to meet this challenge. ■

1. Benvenisti, M. and Khayat, S., The West Bank and Gaza Atlas. The Jerusalem Post: Jerusalem, 1988, p.109.
2. Health Status and Health Services in the West Bank and Gaza Strip. Policy Research Incorporated and American Near East Refugee Aid/Clarksville, Maryland: Washington DC and Jerusalem, 1989, p.3.
3. Health Development Information Project, unpublished statistics: Ramallah, 1992.
4. United Nations Relief and Works Agency for Palestinian Refugees in the Near East, Annual Report of the Director of Health, 1990, p.1.
5. Roy, S., The Gaza Strip Survey, The West Bank Data Base Project, The Jerusalem Post: Jerusalem, 1986, p.38.
6. Ibid., pp.63-74.
7. Benvenisti, op. cit., p.109.
8. Roy, S., op. cit., p.124.
9. Roy, S., op. cit.
10. These institutions had already been informally coordinating their activities, and so forming the Committee was simply an extension and development of their coordination efforts. The member institutions of the Committee are: the Red Crescent Society, al-Ahli Hospital, the Gaza Blood Bank, the Arab Women's Union, the Gaza Medical Society, the Young Men's Christian Association (YMCA), the Near East Council of Churches (NECC), and the United Nations Relief and Works Agency (UNRWA).
11. Medical care within clinics, physiotherapy services within centres, and in-patient institutional care are examples of this style.
12. UNRWA, "Fact Sheet on Bureij", 1990.
13. Ibid.
14. UNRWA, "Palestine Refugee Camp Information Sheet, Beach Camp (Gaza Strip)".
15. Male heads of households are defined as those who generate the primary income of the family, and who control the income and the method of expenditure of family income generated by others in the family, for instance, working children.