

WEST BANK AND GAZA
DISABILITY IN THE PALESTINIAN TERRITORIES
Assessing Situation and Services for People with Disabilities (PWD)

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MIDDLE EAST AND NORTH AFRICA REGION
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Acronyms and Abbreviations

CBR	Community-based Rehabilitation
CBM	
CRPD	Convention on the Rights of Persons with Disabilities
CTP	Cash Transfer Program
CWD	Children with Disabilities
DPO	Disabled People's Organization
EDSP	Education Development Strategic Plan
FGD	Focus Group Discussion
ICF	International Classification of Functioning, Disability, and Health
INGO	International Non-Government Organization
MOEHE	Ministry of Education and Higher Education
MOH	Ministry of Health
MOL	Ministry of Labor
MOSA	Ministry of Social Affairs
NAD	Norwegian Association of Disabled
NGO	Nongovernmental Organization
PA	Palestinian Authority
PCBS	Palestinian Central Bureau of Statistics
PWD	People with Disabilities
TVET	Technical and Vocational Education and Training
UN	United Nations
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WHO	World Health Organization
WWD	Women with Disabilities

Regional Vice President	Hafez M. H. Ghanem
Country Director	Steen Jorgensen
Senior Global Practice Director	Arup Banerjee
Practice Manager	Yasser El-Gammal
Task Team Leader	Iqbal Kaur
Task Team	Samira Hillis, Monsterrat Pallares-Miralles

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This assessment was prepared by a World Bank team led by Iqbal Kaur, Senior Social Protection specialist and comprising Samira Hillis (Program Leader for West Bank and Gaza, GSPDR), Ola Abu Al-Ghaib (Senior Consultant, Disability and Development), and Montserrat Pallares-Miralles, Social Protection Specialist (GSPDR). The team is grateful to Steen Jorgensen, Country Director for West Bank and Gaza, World Bank and Yasser El-Gammal, Practice Manager, Social Protection, Middle East and North Africa, for their support and guidance. Peer reviewers, Charlotte McClain Nhlapo (Global Disability Advisor, World Bank) and Philippe O'Keefe (Lead Economist) provided very useful comments and suggestions. Karen Peffley (Operations Analyst, GSPDR) provided special support to the team in reviewing many versions and providing valuable inputs. Finally, the team would particularly like to thank Palestinian counterparts for their time, hospitality, patience, help, and information provided.

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Executive Summary

Background

This assessment originated from the dialogue on reforming the Cash Transfer Program (CTP) managed by the Ministry of Social Affairs (MOSA) to increase monetary support for people with disabilities (PWD). According to the beneficiaries, the current benefit payment is not sufficient to address the special needs of a household with a member with disability. In response to the demand of the beneficiaries, the MOSA considered additional compensation for vulnerable households including PWD; an analysis was conducted to weight the costs and benefits of modifying the targeting formula to accommodate additional compensation for PWD. The results did not support increasing the monetary compensation because the costs of adjustment were expected to outweigh the benefits and do so at the expense of larger number of poor beneficiaries. Furthermore, global evidence suggests that cash transfers are not necessarily the sole or right instrument to address the needs of PWD in an adequate manner. Rather, meeting the needs requires a holistic approach with greater focus on providing services complemented by temporary cash benefits. Also, compensating only by cash is not sustainable.

Against this background, the ministry requested support from the World Bank to assess the situation of and available services for PWD and inform the authorities of the options moving forward. Although the request originated with the demand of disabled CTP beneficiaries to review services for them, the MOSA broadened the scope of the study to assess the situation, needs, and services for all PWD, to fully understand the complexity of needs for CTP households and services for general disability populace. In general, globally or in the Palestinian context, there are no services only for CTP beneficiaries—for example, a school in Jenin will not distinguish between a CTP beneficiary and non-beneficiary during admissions. Therefore, broadening the scope of the study offered a unique opportunity to cover the entire landscape of services, data permitting, and help prioritize the immediate, medium-term, and long-term interventions to meet the needs of households with disabled members, whether they were CTP beneficiaries or not.

Disability Profile and Context

At 7 percent, the prevalence rate of disability is reported to be severely underestimated not only due to cultural, social, and political reasons but also for technical reasons related to drawbacks in the survey questionnaires and data collection methodology. Persons with mobility difficulties account for about one half of all PWD. Mobility is the disability with the highest prevalence, comprising 48.4 percent of disabled individuals in the Palestinian Territory. There is a strong correlation between age and disability prevalence. Disability rates are significantly higher among individuals aged 75 years and above, at 32.0 percent—28.9 percent among males and 34.1 percent among females. Among children, the percentage was 1.5 percent—1.8 percent among males and 1.3 percent among females.

While disability among the older age group is widespread, the development indicators for younger cohorts are not very encouraging. Around 37.6 percent of all disabled individuals aged 15 years and older in the Palestinian Territory have never been enrolled in school. Also, the

majority of disabled persons do not work. During the implementation period of the survey, 87.3 percent of all disabled individuals in the Palestinian Territory were not employed; 85.6 percent in the West Bank and 90.9 percent in the Gaza Strip.

In the 1980s, the *Intifada* raised a sudden interest in disability. The number of persons with permanent disabilities due to war injuries rose and those who were injured were regarded as ‘heroes’. However, while people’s perceptions of war-disabled persons were and still are positive, exclusion of and discrimination against other PWD prevail. The situation of PWD was further exacerbated by recent violence and as a result, the MOSA has come under enormous pressure to increase support for PWD.

The disability movement started in the 1990s with the formation of the General Union for the Disabled in 1993. It received a lot of support from the Palestinian Authority (PA) at that time. Disabled People’s Organizations (DPOs) were motivated during the *Intifada* but over the years, the movement almost collapsed. Since the adoption of the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD), the movement has been experiencing a renaissance, with key actors trying to develop a new generation of actors.

During the last several years, Palestine has adopted a number of strategies targeting disability.

- The **National Strategic Plan for the Disability Sector** adopted in 2012 was developed under the MOSA and covers the areas of policies, rights, poverty, directions, and access. One of its key policy directions is the ‘provision of all basic and vital services for the PWD as a right to enjoy a decent living’. So far no major steps toward its implementation have been taken, largely due to the volatile security situation as well as limited financial resources.
- The **Education Development Strategic Plan (EDSP) 2014–2019** of the Ministry of Education and Higher Education (MOEHE) stipulates key objectives related to disability, including a national policy for inclusive education, professional development in the field of special education, and expanded support to increase the percentage of students with disabilities in public schools. The draft of the **Inclusive Education Policy** aims at eliminating environmental, attitudinal, and resource barriers to access to education and promotes a twin-track approach combining systemic changes with individualized support.
- The **National Health Strategy 2014–2016** of the Ministry of Health (MOH) indicates that the policies will be focused on providing a comprehensive network of health care services that ensures safe and affordable access to different services, with a focus on vulnerable groups, including PWD. The service coverage plan will also focus on the availability of appropriate infrastructure and the strategy highlights the criteria of accessibility to ensure access for PWD. Yet, the MOH does not have a holistic approach for health and rehabilitation services for PWD.
- As far as the **Ministry of Labor (MOL)** is concerned, neither its current strategic plan (2014–2016) nor its **National Strategy for Employment** or the Technical and Vocational Education and Training (TVET) strategy make an explicit reference to or

address PWD. Clear policies, strategies, or programs for the economic empowerment and inclusion of PWD in the labor market are missing.

All of these strategies are accompanied by respective plan of actions but the implementation is generally hampered by continuous conflict, mobility, and budget constraints. A lack of collective action on the part of key players, including the state, donors, and communities, contributes to competition and fragmentation of efforts. The benefits of collective action are often not perceived, which may be the result of historic focus on service provision by the state but also the role of donors.

Main Elements of the Assessment

Conceptual Framework for Assessing and Addressing Disability: Disability Inclusive Service Provision and Twin-track Approach

Disability inclusive service provisions are described within the framework of Availability, Accessibility, Affordability, and Accountability (the 4 As). Inclusive development has gained importance among socially excluded groups as well as development actors due to its strong human rights focus and social dimension. In the context of the disability sector, the framework takes the focus away from small-scale segregated disability services and projects and instead, recognizes the fact that PWD have the same needs to access services as others and the right to specific services to equalize opportunities and ensure their inclusion.

To operationalize the framework, the assessment suggests that a twin-track approach, which combines both mainstream and support interventions, is necessary to equalize the playing field for PWD. The twin-track approach eliminates any erroneous prioritization between mainstream or specific disability services because to achieve the inclusion of PWD in society, both types of services are equally necessary.

Furthermore, a regulatory mechanism forms the foundation for improving the service delivery into normative, corrective, and continuous promotion actions. In a country with limited resources, designing and implementing a regulatory system with high-quality exigency or a top-down control system is not realistic. Thus, effective and efficient service delivery with quality inputs remains a long-term goal, rooted in smaller immediate and intermediate actions.

There are three essential stakeholders in promoting and ensuring access to services for PWD: the state (local and national), service providers, and PWD and their representatives. In addition, international donors, policymakers, and organizations are often identified as the fourth key player in ensuring access to services. In certain contexts, such as Palestine, nongovernmental organizations (NGOs) may be important funding and regulatory bodies or partners in implementation.

Assessing Availability, Accessibility, and Affordability of Services

Despite some strategic commitment to disability and PWD, the assessment identified a significant gap at the level of implementation of these commitments.

Availability. Specifically, two areas emerged as big concerns: (a) significant gaps in addressing hearing, intellectual, and severe disabilities and (b) availability of mobility and support devices, which is least addressed by all stakeholders but most critical for social and economic independence. In general, (a) most available services (mainstream services, support services, and specialized services) do not address the diversity of needs (that is, age, gender, type of impairment); (b) available services are unequally distributed between cities and villages/camps and between West Bank and Gaza; (c) sustainability of many of the available services is in jeopardy since most are operated by NGOs without a clear national regulatory framework and dependence on donor funding; and (d) availability of support services¹ is the greatest unmet need.

Accessibility. Lack of physical access to relevant infrastructure remains a key barrier for PWD in accessing services. Inaccessible transport (public and private) is most frequently cited by PWD as a key cause for limited opportunities to reach required services. Complicated and nontransparent eligibility criteria and access procedures (for example, medical assessment, referral mechanism) reduce PWD's access to available services. The absence of accessible information on available services (for example, in Braille, easy reading, and sign language) minimizes their effective usage.

Affordability. Many specialized and most support services for PWD are provided by NGOs and the private sector, which incurs high fees/costs for PWD. Disability-related extra costs (for example, transport) are often high and there is no system in place to address these expenses. Despite the fact that PWD who benefit from the CTP are covered by the national health insurance free of charge, there are still many medical and rehabilitation services that they have to pay for themselves. Since certain services are also not provided by NGOs or are of poor quality, PWD are forced to buy services from the private sector.

Accountability. Decision makers and service providers alike are seldom aware of rules and regulations and often do not feel subject to accountability. Few, if any, service providers have regulations that oblige them to consult users and collect their feedback. PWD and/or their representative organizations are seldom actively involved in monitoring or evaluating these services. There is a lack of official and efficient monitoring and evaluation procedures from local and central authorities. Few of the participating service providers have an anonymous and accessible complaint and appeal system. Even when such a system exists, users and staff indicate that it has to be improved to make it more accountable.

Differences in the West Bank and Gaza Strip

While both regions follow almost the same legal and regulatory frameworks that govern services for PWD, some differences with regard to accessibility, availability, and affordability of services are noted. Additionally, coordination between the implementing bodies in the two areas is weak, which limits exchange of expertise and practices and influences national monitoring and evaluation practices. For example, Gaza has a separate system of Medical Committees for disability assessments, which use the same tool but do not coordinate with the structure in the West Bank. Some services in the West Bank are not accessible for PWD

¹ Sign language interpreters and personal assistants.

in Gaza (for example, Fund for the Rehabilitation of PWD, the 5 percent employment quota in the public sector).

Gatekeeping Mechanisms in Service Delivery

The disability assessments conducted by the Medical Committees are medical in nature, equating disability with a health condition or impairment. The determination of disability and its severity is solely based on medical criteria related to the health condition and impairment of the applicant. There is no evidence for a sufficient evaluation of or linkage to daily activities, participation, and environmental factors, in line with the principles of the CRPD. In addition, the main assessment tool (that is, ICD-10) from 1969 in which the disability percentages for a broad range of conditions are determined is outdated and does not reflect the advances in classification.

The referral mechanisms are generally ad hoc and the success outcomes are never measured and/or unknown. Except for the external referral system through the public system under the national health insurance, many service providers in the West Bank and Gaza have informal mechanisms and ad hoc referral procedures that have become the ‘norm’. Current referral mechanisms are not effective in ensuring timely and effective access to required rehabilitation services, both between mainstream and disability services and from one disability service to another. Furthermore, concerns about the referral mechanisms—such as a lack of user choice, inability to provide a continuum of services, and gaps in service provision—may affect the outcomes of the services.

Funding Social Services for PWD

Evidence collected from all relevant ministries indicates that there are no clear financing strategies and budget allocations to ensure sustainable financing of services for PWD. INGOs (International Non-Government Organization) indicated that they are operating this year with an estimated budget of US\$5 million, which is mainly dedicated to support access to rehabilitation services for PWD in the West Bank and Gaza with specific attention to community-based rehabilitation (CBR) programs. The not-for-profit providers are generally funded by international and local donors and have limited access to public funds. When they do, it is mainly through grants, subsidies, or in-kind support.

Knowledge Gaps

Both the tight timeframe for preparing the study and geopolitical constraints led to challenges in accessing relevant information or informants. Besides the Ministry of Finance, the response rate from the INGOs was particularly low: out of the 20 NGO staff who were contacted for this assessment, only 6 responded and agreed to participate in the assessment. Furthermore, the strikes in the public sector during the time of the assessment (mainly in Gaza) rendered the coordination with relevant ministries and government officials difficult.

The data and knowledge gaps and inconsistencies were apparent throughout the preparation of the study. First, the prevalence data do not seem to tell the story on the ground. NGOs, INGOs, and public/private agencies involved in disability are hesitant to support the results of the Palestinian Central Bureau of Statistics (PCBS) Survey 2011, considering their

firsthand knowledge of the disability situation at the community and household levels. Across ministries, there are several studies that present conflicting information. Thus, it is very challenging to draw a national picture. **Second**, sectoral data on disability have never been collected and managed as part of the national strategy or development plan for the sector. Sector data are available sporadically from the programs itself, which makes it challenging to draw a consistent story or realistic plan of intervention. **Third**, the corrupt nature of disability classification and certification process (which is controlled by the MOH and is often conducted using outdated laws and processes) is a significant factor in the underestimation of the disability situation and accurate profiling of disability numbers and types. **Fourth**, the budget data are not available. The general health and education data do not capture the spending on disability.

Strategic Inclusion Agenda - Prioritizing the Needs of PWD

Moving forward, the overall strategic objectives are (a) significant reduction of exclusion among the disabled; (b) increased access to diversified, good quality, community-based, and family-oriented social care and rehabilitation services; and (c) increased access to services for the disabled, aimed at social and economic empowerment.

The strategy should be embedded in the principles of capturing the ‘low-hanging fruit’ and paving the pathway toward increased inclusion. The UN CRPD recognized that countries would progressively realize the rights that they commit to by ratifying the Convention.² Countries must develop and implement laws, policies, and reforms in “a sequence and at a pace that is practically feasible, given the country’s resources, political system, and social and cultural context.”³ The recommendations below respond to the need for a systematic phased approach for the immediate, medium, and long term.

- **IMMEDIATE** actions that can be taken during the next 12–24 months to lay the foundation for modernizing the institutional support functions and providing direct benefits to PWD.
- **MEDIUM-TERM** actions (2–4 years) are directed at removing basic obstacles in achieving social and economic independence through sector reforms across.
- **LONG-TERM AGENDA** is to promote universal access (accessible public facilities and transport) and inclusion. This is an overarching element with no time constraints. It would seek to involve all stakeholders—the disabled, non-disabled, communities, the public and private sectors—in the design and implementation of accessible infrastructure and facilities. This work also has to be embedded into sector dialogue and operational planning.

This chapter focuses on immediate and medium-term actions under broad two primary areas.

² http://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf.

³ Bickenbach et al. 2015. “Assessing Disability in Working Age Population a Paradigm Shift: from Impairment and Functional Limitation to the Disability Approach.” World Bank. <http://documents.worldbank.org/curated/en/2015/06/24660032/assessing-disability-working-age-population-paradigm-shift-impairment-functional-limitation-disability-approach>

- A. The first area is the **modernization of institutional structures and support services**. Central to this discussion is the disability assessment processes. Subsequently, five building blocks are discussed. The section concludes with gatekeeping procedures.
- B. The second area discussed is **direct support to PWD**, emphasizing specific human development interventions, specifically economic inclusion, health insurance, and educational resources centers.

Both areas of discussion cover an overview of the topics and specific project examples. It should be recognized that country context and disability policy greatly influence both areas of concern.

A. Modernizing Institutional Structure and Support Services

A.1: First Things First—Undertaking Disability Classification/Certification Review and prepare proposal for reforming the outdated system of classification

This is the single most important factor, which hampers PWD from being registered so that they can benefit from government and nongovernment programs. This should be reformed and the disability assessment building on the WHO International Classification of Functioning, Disability, and Health (ICF). Historically, disability assessment has been synonymous with medical assessments of impairment. The understanding of disability has evolved to be broader than individual impairment.

Disability assessment procedures can be judged in terms of validity, reliability, transparency, and standardization; but they will also be judged as fit for the policy for which eligibility is required. Typically, the assessment is used for the determination of employment benefits; however, there are significant implications on educational, health, and transportation benefits as well. Evaluation and reform of the disability assessment processes could build on WHO's ICF. Details provided in the last chapter.

A.2 Getting it Right—Consolidating Disability Data and Improving Targeting

Among the benefits of using the ICF as a basis for establishing disability assessment, is that it provides an international platform for assessment and measurement, an optimal data reporting structure, and an accountability framework, which is increasingly being internationally accepted.⁴

At the country level, the benefits can assist with the consolidation of data, the cooperation across ministries and programs, and better monitoring and evaluation systems. While it should be recognized that different criteria for participation in programs may be necessary, the consistency of data provides an opportunity to base policy decisions on evidence and allow for accommodation or disability-specific factors such as improved targeting and participation by PWD on an equal basis as other persons.

⁴ Bickenbach et al. 2015.

A.3 Unbundling and Clarifying Gatekeeping Procedures

Given that disability certification is necessary to access benefits, gatekeeping procedures are critical to establishing who can become beneficiaries and the type, level, and duration of benefits. While gatekeeping is often seen as a way to restrict access to a specific population for specific services, it has the potential to create transformative opportunities by “aligning services of any type with users who can make best use of them.”^{5,6} There may be different entry paths to programs, but the policies, procedures, and administration must be consistent across gatekeeping functions at the individual, community, and national levels.⁷

Gatekeeping functions include (a) allocation of resources; (b) referrals to service agency; (c) case plan implementation and case management; and (d) case progress reporting, monitoring, and periodic assessment.⁸ A proposal to develop gatekeeping procedures should include licensing and accreditation, quality standards, and monitoring and evaluation of services, as well as the creation of an integrated system of information and feedback.

A.4 Advancing Inter-sectoral Collaboration for Optimizing Resources

Time and again, evidence has shown that lack of coordination among national authorities and between national and international agencies has had costly and adverse outcomes for the eligible and potential beneficiaries. Consistent with the understanding that disability is broader than individual impairment and needs to be reflected in the wide cross-section of sectors that are addressed by the various CRPD articles, collaboration with local government education/health offices and NGOs will be critical to optimize resources and reach those who truly deserve these services.

A.5 Deepen Understanding and Capacity of Decision Makers and Practitioners on Disability Issues and Prejudices

The understanding of disability has been undergoing an evolution at international levels. Understanding disability through the bio-psychosocial model creates opportunities for a wide range of stakeholders to contribute to formulation and implementation of disability policy and programs to enable PWD to participate in the economic and social society. However, a shared understanding is insufficient. Capacity building at all levels is needed to achieve an inclusive society. One must be able to identify barriers to full and equal participation as well as have the tools to remove obstacles. Soliciting input directly from PWD facilitates the identification and removal of barriers and development of accommodations. Sustained positive interaction with

⁵ Evans, Peter (May 12–14, 2009) “Improving Gatekeeping Functions of Child Protection Systems” Background paper prepared for 2nd Child Protection Forum for Central Asia on Child Care system reform. Bishkek, Kyrgyzstan

⁶ WHO, Regional Office for Europe Office (November 26-27, 2010) “Identifying the Needs of Each Child and Young Person” presented at “Better health, better lives: children and young people with intellectual disabilities and their families” Bucharest, Romania, 26–27 November 2010.

http://www.euro.who.int/__data/assets/pdf_file/0009/126567/e94427.pdf

⁷ Evans. *ibid.*

⁸ <http://www.worldbank.org/content/dam/Worldbank/Event/safetynets/1.%20Disability%20and%20SSN%20Decemb er%2011%202013.pdf>

PWD may also serve to lessen stigmatization of PWD. Conversely, a lack of understanding of the experiences of PWD may foster prejudice and lack of action.

B. Planning and Providing Direct Support to PWD—Aligning with Priorities identified

Direct support to PWD and their households can come in many forms. Income support for those unable to work is typically the most common form of support; however, those forms of support also contribute to the integration of PWD into social and economic participation. In some instances, “transfers and other services to target households is even more important for vulnerable groups than for other recipients of social assistance.”⁹ This report recommends three areas for consideration that will, if provided in concert, deliver the direct benefits to PWD. These three areas are (a) economic support of PWD, addressing both inclusion and accommodation of programs; (b) improved health insurance and provision; and (c) inclusive education at the primary and secondary levels. Case studies of each area are provided below as examples of the types of actions that can be taken to lay the foundation for support of PWD.

B.1 Promote Economic Inclusion of PWD

Building on the MOSA’s plans, an attempt will be made to lessen the tension among CTP beneficiaries by boosting the support to beneficiaries through an integrated package of services for PWD.

Contending that “Almost all jobs can be performed by someone with a disability, and given the right environment, most PWD can be productive,” the World Report on Disabilities employment chapter lays out the barriers to entering the labor market and how to address those barriers. Such barriers include lack of education and vocational rehabilitation and training, lack of access to financial resources, disincentives created by disability benefits, the inaccessibility of the workplace, and negative perceptions of disability and disabled people. It offers specific recommendations for action by governments, employers, and other organizations such as microfinance institutions and trade unions. The remedies to overcome the barriers faced by PWD seeking employment include addressing laws and regulations, which may include antidiscrimination and affirmative action regulations, incentives to employers, vocational rehabilitation, and training; self-employment and microfinance; working to change attitudes; and vocational case management.

B.2 Extend Health Insurance Coverage to PWD

The review of the existing MOH health insurance package will be a critical first step toward addressing the issues of limitations for PWD on their coverage. Priority should be given to provide assistive devices (prosthetics and orthotics) to 75 percent of PWD as part of critical service package to prevent the existing mobility, hearing, and vision capacity from deteriorating further. An example of a reform package is the provision of the Basic Package of

⁹ Grosh, M., C. del Ninno, E. Tesliuc, and A. Ouerghi. 2008. “For Protection and Promotion: The Design and Implementation of Effective Safety Nets.” World Bank, Washington, DC.
<https://openknowledge.worldbank.org/bitstream/handle/10986/6582/45496.pdf?sequence=1>

Health Services (BPHS) by the government of Afghanistan.¹⁰ The Ministry of Public Health (MOPH) explicitly expanded coverage to include both mental health services, specifically, (a) community management of mental problems and (b) health facility based treatment of outpatients and inpatients and physical disability services, such as (i) physiotherapy integrated into primary health care services and (ii) orthopedic services expanded to hospital level. The reform took place over 10 years ago. The Bank contributed to this reform, which “expand[ed] the scope, quality and coverage of health services provided to the population, particularly to the poor, in the project areas, and to enhance the stewardship functions of the Ministry of Public Health (MOPH).” through a Results Based Financing Scheme in the amount of US\$100 Million.¹¹

B.3 Extending Education Coverage to PWD—Developing Resource Centers for Inclusive Education

The evidence from the existing resource centers indicates that these resources centers, though limited in number, are having a significant impact in terms increased enrollment among CWD. The objective of the resource centers is to prepare learners for inclusion in mainstream classes although some children may be educated exclusively within the resource centers in primary grades. The UNESCO 2010 Global Monitoring Report¹² presents four examples of support to CWD in schools. “The Lao People’s Democratic Republic has a network of 539 schools - three for each district in every municipality and province - that teach children with disabilities alongside their peers and provide specialized support. In South Africa, the focus has shifted from special schools to inclusive education in mainstream schools. Authorities have to identify the level of support required by individual learners with disabilities (South Africa Department of Education 2005; Stofile 2008)”¹³. Research in Eastern Cape, one of the poorest provinces, found that inclusive education produced significant gains, ranging from improved physical access to support for specialized teaching practices and increased admission of learners with disabilities (Stofile 2008). In 2003, a Bangladeshi NGO, BRAC, established a preschool and primary education program aimed at increasing participation by children with mild special needs. By training teachers, providing equipment, adapting the curriculum, and improving physical access, it had reached about 25,000 children by 2006 (Ryan et al. 2007; UNESCO 2010, 202)¹⁴.

¹⁰ Transitional Islamic Government of Afghanistan. 2003. “A Basic Package of Health Services for Afghanistan” <http://unpan1.un.org/intradoc/groups/public/documents/APCITY/UNPAN018852.pdf>.

¹¹ Afghanistan: System Enhancement for Health Action in Transition Project (P129663). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/02/21/000442464_20130221131427/Rend ered/PDF/736450PJPR0P120Official0Use0Only090.pdf.

¹² UNESCO. 2010. “EFA Global Monitoring Report: Reaching the Marginalized.” <http://unesdoc.unesco.org/images/0018/001866/186606E.pdf>

¹³ http://etd.uwc.ac.za/xmlui/bitstream/handle/11394/2827/Stofile_PHD_2008.pdf?sequence

¹⁴ www.niaslinc.dk/gateway_to_asia/nordic_webpublications/x506033235.pdf

A. Introduction

This report presents an assessment of supply and demand of services for PWD, at the heart of which is to protect and support development of PWD through adequate provision of social and economic services, as formulated in the government's key strategic documents, national plans, and programs.

The origin of this assessment is rooted in the reform of the CTP managed by the MOSA. The CTP is the largest social assistance program and provides cash transfers to extremely poor and vulnerable households, including those with disabled family members. In 2014, of the 26.4 percent (21,729) of beneficiary households, the head of the family was a person with disability. Recently, an increasing number of beneficiary households with a disabled family member have requested an increase in their benefits to cope with additional financial costs related to the disability. The 2014 Targeting Assessment of the CTP - Phase II showed that beneficiary households with one or more PWD spend less on education but a higher share of their income on food while their health expenses increase with the number of disabled members in the household. An analysis of the modified benefit structure showed no evidence that an increase in the benefit amount would effectively address the extra cost of disability-related needs. To better meet these needs, the MOSA now considers strengthening the access to relevant services for PWD.

The objective of this report is twofold: (a) understand the nature and scope of available services for PWD (supply) and (b) understand the demand for these services from a beneficiary perspective with a specific focus on the gaps in existing services and structural and other barriers in accessing them. To achieve this objective, the scope of the assessment extended to the following two levels.

- (a) **Supply-side assessment**, which included a review of the existing services and programs relevant to PWD and their needs. Specifically, the activities included the mapping and analysis of available programs and services, including but not limited to education, health-related rehabilitation, employment, and business incubation programs and opportunities.
- (b) **Demand-side assessment**, which included gathering feedback and the perspectives of beneficiaries with disabilities on their service needs and priorities, their access to services, and perceived service gaps.

The primary audience for this report is the PA that has specifically requested the Bank's assistance in understanding the nature and scope of services to provide an underpinning for improving provision of services for PWD. Other audience includes local and donor agencies involved in the analysis or implementation of various aspects of the disability services. Aligned with the MOSA's request, the objective of the task is to understand the nature and scope of available services for PWD and inform the authorities on options to improve provision of services.

The outline. The note comprises four parts. The **first** part presents the framework for assessment embedded in **availability, accessibility, and affordability of services** and discusses the general context and the legal and institutional framework of disability in Palestine. The **second** part

presents a detailed discussion on supply of services and mapping and analysis of available programs and services, including but not limited to education, health-related rehabilitation, employment, and business incubation programs and opportunities. The **third** part presents a demand-side assessment, which includes the essence of the feedback and perspectives of beneficiaries with disabilities on their needs and priorities, their access to services, and perceived service gaps. The **fourth** part presents the social expenditure of disability services and some guidelines for effective financial governance.

Methodology

The design and implementation of this assessment examines the whole spectrum of the selected social services in the light of the provisions and aforementioned principles of Accessibility, Affordability, Availability, and Accountability. Based on a theoretical framework, an assessment matrix was assembled, which identified key questions and indicators for data collection to guide the information gathering and analysis. An effort was made to involve the broad range of the aforementioned key stakeholders to identify and reflect on the current services and processes. Ensuring their participation was crucial in creating ownership and acceptance of the findings and enhancing the quality of the outcome of the assignment.

Supply-side assessment

- **Literature review.** The literature review covered available policy and strategic documents as well as documentation, reports, surveys, and research on the different programs and services for PWD across all sectors (that is, employment, education, and medical rehabilitation).
- **Key informant interviews.** Based on the findings of the desk review, semi-structured face-to-face interviews were conducted with key informants including representatives of the four relevant ministries (MOL, MOSA, MOEHE, and MOH); DPO leader; key service providers; INGOs; and UN agencies (see annex 1 for the list of key informants). The selection of informants was guided by the principle of participation of all actors involved in the social services for PWD, representation of all regions, sectors, and types of services.

Demand-side assessment

The methods for collecting the information relevant for the demand-side assessment included the following:

- **Key informant interviews.** A total of 47 semi-structured interviews were conducted with representatives of 37 organizations and five ministries, ensuring representation of all regions and sectors and the perspectives of both state and non-state actors (see annex 1 for the list of key informants).
- **Focus group discussions (FGDs).** To gather beneficiaries' perspectives on access to services, related gaps, barriers, and needs, 14 FGDs (see annex 2 for composition) were conducted with a total of 152 participants: 8 FGDs in West Bank with a total of 80

participants and 6 FGDs in Gaza with a total of 72 participants. Participants included PWD above 18 years of age or parents of children with disabilities (CWD) from CTP beneficiary households. Further selection criteria ensured representation of groups below and above the national poverty line; of different types of disabilities (except mental disability); and of different geographical locations (47 percent from urban areas, 32 percent from rural areas, and 21 percent from camps), as well as equal representation of women with disabilities (WWD).

- **Questionnaire survey** was administered for PWD who participated in the FGDs to collect more demographic information on respondents (n = 132) and identify 'trends' with regard to service demands, needs, priorities, and gaps in the areas of health, education, employment, and costs for services and resources that PWD need to achieve an equal standard of living.

Caveats on Preparing the Study

The tight time frame for preparing the study and geopolitical constraints led to challenges in accessing relevant information or informants. Besides the Ministry of Finance, the response rate from INGOs was particularly low: out of the 20 INGO staff who were contacted for this assessment, only 6 responded and agreed to participate in the assessment. Furthermore, the strikes in the public sector during the time of the assessment (mainly in Gaza) rendered coordination with relevant ministries and government officials difficult.

Given the sensitive nature of, at times, personal needs and prevailing cultural/social norms, some experiences, concerns, and priorities may not have been shared or vocalized adequately by PWD and/or family members during the FGDs. Including PWD in the team as part of the facilitation of the FGDs aimed at mitigating this challenge. Due to its exploratory nature and the limited sample size, the quantitative data collection part was not intended to produce results that are representative of the whole population living with a disability or draw comparisons between different impairment types.

B. Framework and Methodology

1. Conceptual Framework: Disability Inclusive Service Provision and Twin-track Approach

The main elements of disability inclusive service provision are usefully described within the framework of **Availability, Accessibility, Affordability, and Accountability (the 4 As)**. Inclusive development has gained importance among socially excluded groups as well as development actors due to its strong human rights focus and social dimension. In the context of the disability sector, it takes the focus away from small-scale segregated disability services and projects and instead, recognizes the fact that PWD have the same needs to access services as others and the right to specific services to equalize opportunities and ensure their inclusion.

Services have to be available at all levels—from household and community levels to the national level—accessible and affordable to all people, and accountable, thereby ensuring financial and organizational transparency and good governance. The services need to be organized in a way that responds to the choices and interests of PWD. The 4 As, together with the quality component, can be considered as a starting point, a basic reference to assess and improve access to services for PWD, and determine their effectiveness and inclusiveness.

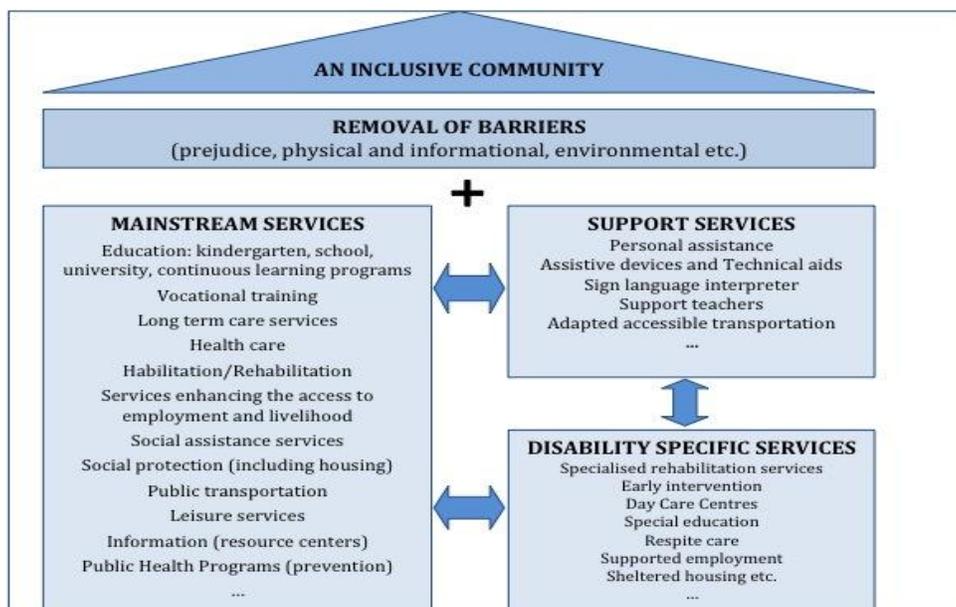
The aim is to illustrate the link between the 4 As and the use of these four dimensions in identifying the barriers and interventions to address these barriers. The findings suggest that a combination of interventions is required to tackle specific access barriers but that their effectiveness can be influenced by contextual factors. It is also necessary to address demand-side and supply-side barriers concurrently. The framework can be used both to identify interventions that effectively address particular access barriers and to analyze why certain interventions fail to tackle specific barriers.

Figure 1. 4 As for Access to Social Services



To enhance the practical utilization of this framework, a twin-track approach (see figure 2) is necessary to equalize the playing field for PWD.

Figure 2. Twin-track Approach in Service Provision



Source: The scheme is based on the twin-track approach defined by the U.K. Department for International Development in Disability, Poverty and Development, 2000, which was adapted for the Disability Monitor Initiative (Handicap International, Sarajevo, 2006).

The twin-track approach eliminates any erroneous prioritization between mainstream or specific disability services because to achieve the inclusion of PWD in society, both types of services are equally necessary.

Mainstream (welfare) services should be available and accessible to the whole population including PWD, to promote social cohesion and ensure fulfilment of basic human rights. To facilitate this process, specific services for PWD are required, that is, support services and disability-specific services. Support services facilitate the access of PWD to mainstream and disability-specific services and resources in the community, addressing specific disability-related barriers. Support services involve face-to-face interaction (for example, a personal assistant) while reasonable accommodation is a (institutional) measure to ensure equal participation in different activities (for example, provision of textbooks in Braille for students with visual impairments).¹⁵ Lastly, disability-specific services are an extended category of mainstream welfare services and address disability-related specific or more complex needs of PWD (for example, rehabilitation/rehabilitation services, community-based residential care, and day care centers).

¹⁵ Axelsson, C., and D. Barrett. 2009. *Access to Social Services for Persons with Disabilities in the Middle East – Multi-stakeholder Reflections for Policy Reform*. Amman: Disability Monitor Initiative-Middle East, CBM (Christian Blind Mission) and Handicap International.

2. Regulatory Framework: Guaranteeing Delivery of Services

To ensure that social services meet the needs of the people and are provided in an effective and efficient manner, the state has to define regulatory frameworks that guarantee and coordinate:

- access of users to the system of services, according to their need and demands;
- offer (supply) of services responding to these needs;
- service delivery, abiding by principles such as accessibility, accountability, affordability, and quality.¹⁶

Such regulatory frameworks vary, depending on legislation, resources and capacities, and cultures of social welfare, but their overarching goal is to ensure that it serves the needs and rights of PWDs, and that services are provided in an efficient and effective manner. They are not new, neither for the Middle East nor Palestine, and exist for many public services such as education and health. What is new is the idea to base such a framework on a rights-based approach in the disability sector. With an increased mix of social welfare providers, NGOs, private and public, it becomes important to regulate and control who is doing what to avoid overlapping services or that some areas become underserved. It also helps to (re) direct scarce resources to where they make best use.

Any regulatory mechanism may fulfil three key functions, depending on the socioeconomic and political situation: normative, corrective, or related to the promotion and continuous improvement of service delivery. In a country with limited resources, designing and implementing a regulatory system with high-quality exigency or a top-down control system is not realistic. Here, a **normative function** is a good starting point, which can ensure minimal quality standards for all users and aim to ensure basic community services or to coordinate the external flow of aid. A country that is in a reform stage or in ‘transformation’ from one system to another may focus more on the **corrective function** of the regulatory system. It can facilitate and promote quicker appropriation and implementation of new practices and principles among all key stakeholders (the state, service providers, and users and their representatives). The function related to **continuous improvement** of the quality of services and innovation has a more significant weight in more advanced systems of welfare services. It can facilitate modernization of the sector and promote excellent practices among the providers.

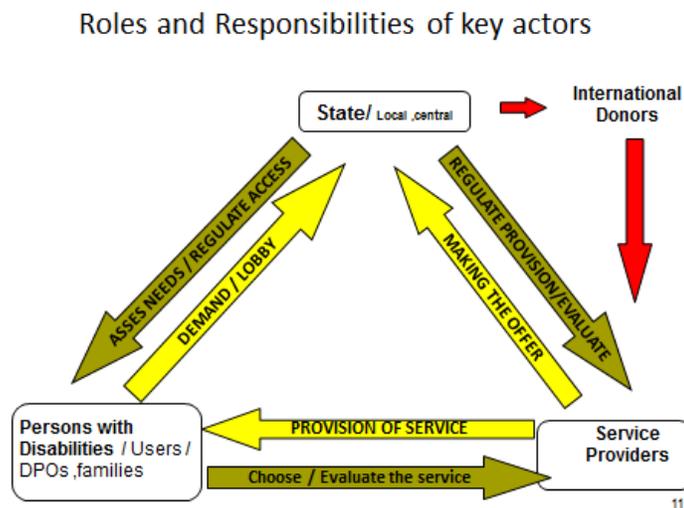
While the MOSA has taken some measures toward developing a regulatory framework that is embedded in normative and corrective functions, the MOSA needs significant help in developing regulatory mechanisms that are effective, cost-efficient, implementable, and acceptable to the needs of the PWD in Palestine.

¹⁶ Axelsson, C., and D. Barret. 2009. *Access to Social Services for Persons with Disabilities in the Middle East*, Amman: Disability Monitor Initiative-Middle East, Handicap International and CBM: 87.

C. Accountability in Service Delivery

There are three essential stakeholders in promoting and ensuring access to services for PWD, namely the state (local and national), service providers, and its users and their representatives. In addition, international donors, policymakers, and organizations are often identified as the fourth key player in ensuring access to services. In certain contexts such as Palestine, they may be important funding and regulatory bodies or partners in implementation. Figure 3 summarizes their roles and responsibilities.

Figure 3. Roles and Responsibilities of Key Actors in Ensuring (Social) Services for PWD



Source: Axelsson, C., and D. Barrett. 2009. *Access to Social Services for Persons with Disabilities in the Middle East - Multi-stakeholder Reflections for Policy Reform*, Disability Monitor Initiative-Middle East, (CBM and Handicap International: Amman).

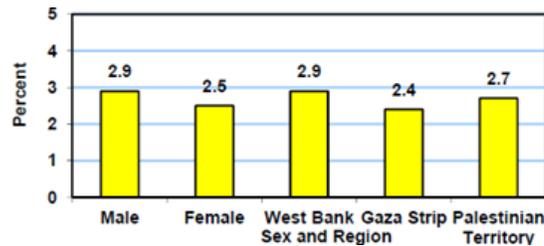
In countries where the state has limited resources and lacks the political will and/or is in a situation of conflict or political instability, PWD may try to organize themselves to make these services accessible and available to them. This is true, for example, in Palestine where the direct link between users and providers allows the former to demand the latter’s accountability in service delivery rather than putting the pressure on the state to ensure equal access.

D. Context and Profile of Disability in Palestine

1. Disability Profile

According to the 2011 Disability Survey by the PCBS and MOSA, disability prevalence in Palestine was about 7 percent using the wide definition of disability, with similar prevalence in both the West Bank and Gaza.¹⁷ Using the narrow definition (which includes only persons with significant disabilities), the prevalence of disability according to region and age was as given in figure 4.

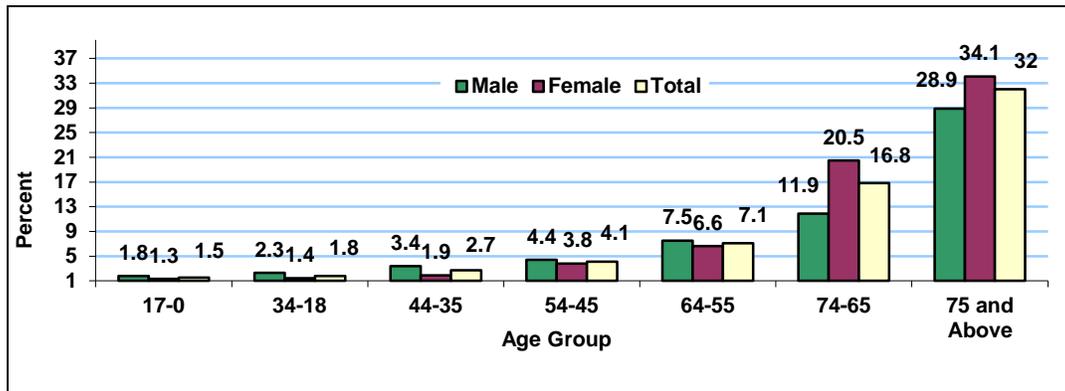
Figure 4. Prevalence of Disability, Using the Narrow Disability Definition



Source: Palestinian Central Bureau of Statistics and Ministry of Social Affairs. 2011. *Disability Survey*. Ramallah: Palestine.

The prevalence of disability is strongly correlated with age. Disability rates are significantly higher among individuals aged 75 years and above at 32.0 percent: 28.9 percent among males and 34.1 percent among females. Among children, the percentage was 1.5 percent: 1.8 percent among males and 1.3 percent among females.

Figure 5. Percentage of Disabled Individuals by Gender and Age Group, 2011

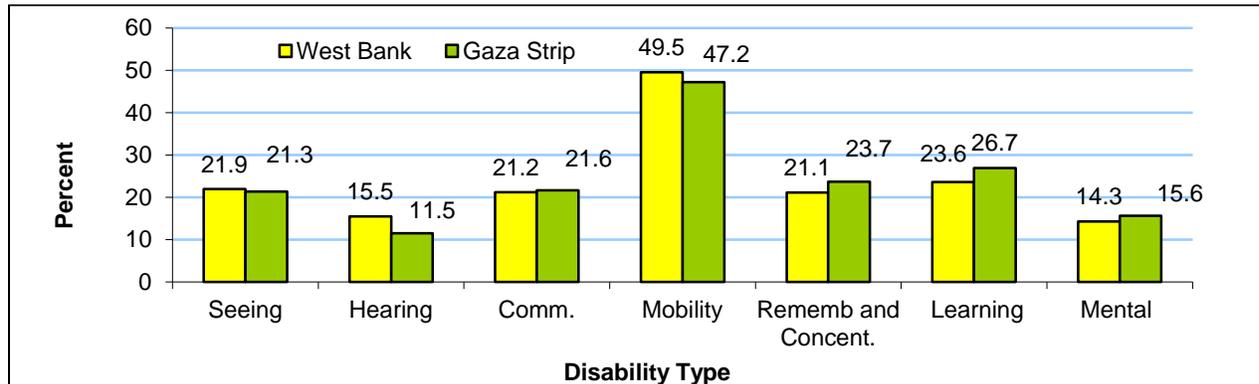


With regard to the prevalence of disability according to region and age, 31.4 percent of individuals aged 75 and above were in the West Bank and 33.6 percent were in the Gaza Strip. Among children aged 0–17 years, the rates were 1.6 percent in the West Bank and 1.4 percent in the Gaza Strip.

¹⁷ Palestinian Central Bureau of Statistics and Ministry of Social Affairs. 2011. *Disability Survey*. Ramallah: Palestine.

Persons with mobility difficulties account for about one half of all PWD. Mobility is the disability with the highest prevalence comprising 48.4 percent of disabled individuals in the Palestinian Territory: 49.5 percent in the West Bank compared to 47.2 percent in the Gaza Strip. Learning disability is second with 24.7 percent: 23.6 percent in the West Bank and 26.7 percent in the Gaza Strip. It should be noted that an individual may have more than one disability.

Figure 6. Distribution of Disabilities by Region, 2011



While disability among the older age group is widespread, the development indicators for younger cohorts is not very encouraging. Around 37.6 percent of all disabled individuals aged 15 years and older in the Palestinian Territory have never been enrolled at a school: 35.5 percent in the West Bank and 42.2 percent in the Gaza Strip. In addition, 33.8 percent of all disabled individuals had dropped out of school: 37.0 percent in the West Bank and 27.1 percent in the Gaza Strip. Illiteracy rate of all disabled individuals was 53.1 percent: 51.5 percent in the West Bank and 56.3 percent in the Gaza Strip.

The majority of the disabled do not work. During the implementation period of the survey, 87.3 percent of all disabled individuals in the Palestinian Territory were not working: 85.6 percent in the West Bank and 90.9 percent in the Gaza Strip. Compared to global and regional averages, PWD in the West Bank and Gaza have a higher unemployment rate and lower enrollment and health outcomes. Around 37.6 percent of PWD aged 15 years or older were never enrolled in school and 33.8 percent were enrolled and dropped out; 53.1 percent of the same group of population is illiterate and 88 percent of disabled people are unemployed.

Illness is identified as the main cause for all types of disabilities. The rate is high with 43.7 percent for seeing disabilities; 29.1 percent for hearing disabilities; 42.9 percent for mobility disabilities; 28.7 percent for disabilities relating to remembering and concentrating; 27.6 percent for learning disabilities; and 27.2 percent for mental disabilities. Congenital problems were the main cause of communication disabilities, with 33.6 percent.

2. Disability Context

In the 1980s, the *Intifada* raised a sudden interest in disability. The number of persons with permanent disabilities due to war injuries rose and those who were injured were regarded as ‘heroes’. However, while people’s perceptions of war-disabled persons were and still are positive, exclusion of and discrimination against other PWD prevail. Despite changes in the

social attitudes toward disability in the last two decades, large social segments still attach stigma to disability, especially intellectual and mental disability. Degrading terminology and charity-based notions are still common. Coupled with the many environmental obstacles, these attitudes make it difficult for PWD to join educational institutions, access services, and apply for jobs/earn an income and prevent them from obtaining their rights to political participation.

The Palestinian disability movement started in the 1990s with the formation of the General Union for the Disabled in 1993. It received a lot of support from the PA at that time. The DPOs were motivated during the *Intifada* but over the years, the movement almost collapsed. Since the adoption of the CRPD, it has been experiencing a renaissance with key actors trying to develop a new generation of actors. The DPOs are growing in number and capacity, parent groups have formed, and the DPOs increasingly embrace the rights-based approach, start to demand their participation in service development as well as policy formulations, and cooperate with other NGOs.

Still, competition and fragmentation weaken the movement. The benefits of collective action are often not perceived, which may be the result of historic focus on service provision by the state but also the role of donors. The DPOs are largely based in big cities and led by persons with physical impairments, which led to a focus on physical disabilities while the profile of other types of disabilities has remained low. This, together with the absence of a common agenda, affects the DPOs' legitimacy and prevents them from making bigger voices heard. Consequentially, stakeholders highlight the low level of participation of the DPOs in policy processes—reflected, for example, in their poor representation in the Higher Council on Disability. As such, the major challenge for the DPOs currently is to get recognition from the government and improve cooperation—the latter being complicated by the geopolitical situation/separation.

3. Legislative and Institutional Framework

From 1999 when the CRPD was adopted, a variety of strategies and plans were developed with weak implementation and ownership, which may not be any different from much of the developing world. The Basic Law amended in 2005 states in Article 22 that the national authority shall guarantee PWD education, health, and social insurance. In 1999, Law Number 4 Concerning the Rights of the Disabled was adopted. The law names the MOSA as the leading government body in charge of disability. In this capacity, the MOSA adopted a number of executive bylaws in 2004 to enforce the law. However, little has been achieved so far in the application of the law, citing the lack of financial resources as the main restrictive factor. Yet, the government's failure to include PWD in its planning frameworks may also reflect a lack of political will.

A Higher Council for Persons with Disabilities has been created under the MOSA. Although the council was nominally established by decree in 2004, it was only functional in 2012. One of the mechanisms being planned is the establishment of a Disability Card, based on the basket of services that a person with disability is entitled to. The council in itself is an independent body although it is chaired by the MOSA. There have been various issues surrounding the composition, mandate, and functioning of the council and it still remains to be seen if it can meet its potential to accelerate efforts on disability rights.

Besides the 1999 disability law and the ratification of the CRPD in May 2014, the PA adopted the National Strategic Plan for the Disability Sector in 2012 for the Supreme Council of the Affairs of Persons with Disabilities. It was developed under the MOSA, with input from the DPOs and other organizations in the disability terrain. It is based on the CRPD, considers disability as a prime development issue, and aims to unify national efforts and community vision in the services provided for PWD and ensure that there is no duplication and fragmentation. It covers five strategic issues: policies, rights, poverty, directions, and access.¹⁸ One of the key policy directions of the strategy is the ‘provision of all basic and vital services for the PWD as a right to enjoy a decent living’.¹⁹ While the strategy is ambitious on paper, recent consultations with the Higher Council on Disability in 2014 revealed that so far no major steps toward its implementation have been taken, with a major factor being the volatile security situation as well as donor dependence with regard to related resources.

4. General State of Access to Services

As in most of the developed world, to date, disability is largely excluded from mainstream legislation, national plans, and programs with a historic focus on service provision in the field of medical rehabilitation. The government plays only a minor role in service provision. Also, linked with the high level of donor aid flowing to civil society organizations, the NGOs and the private sector are the most important players in providing social and employment services in the disability sector—reasonably well funded and often subcontracted by the government. The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) is responsible for the provision of services to registered refugees. It is the role of the MOSA to register the NGOs. However, once they are registered, the NGOs are free to decide where and on what they will work. This led to an unequal distribution of service providers in Palestine; in Gaza, for example, most service providers are concentrated in Gaza City.

PWD’s access to services is additionally hampered by a number of factors. Together with poor enforcement mechanisms, the geopolitical situation severely affects service delivery and hinders the implementation of the abovementioned commitments in the West Bank and Gaza to varying degrees. The Hamas created their own systems under the existing laws, and the political affiliation of the NGOs in Gaza is scrutinized and leads to discrimination with regard to funding. The administration of the sector is complicated by the involvement of many NGOs with poor coordination among themselves and with the PA, lack of clear references, and the often competitive relationship between NGOs, which hinders a strategically coherent approach.

A largely inaccessible environment, where physical, environmental, and attitudinal barriers strongly limit the (independent) mobility of PWD presents another key factor. Particularly, inaccessible transport and infrastructure are frequently cited as key barriers for reaching health and educational services, employment possibilities, and social events on an equal basis with others. With regard to health care and rehabilitation, the key factors that restrict access are scarcity of services, downsizing of INGO-led programs, and difficulties in obtaining relevant referrals outside the public sector.

¹⁸ Ministry of Social Affairs. 2011. *National Strategic Plan of the Disability Sector in the Occupied Palestinian Territories*. Palestine.

¹⁹ Ibid.

E. Assessing Supply of Services

1. Education Sector

Education Facts and Figures

Despite more than 16 years of an inclusive education policy in public schools, the enrolment among CWD remains limited.²⁰ More than one-third of PWD aged 15 years and older had never enrolled in a school and more than half were illiterate. In comparison, total illiteracy among Palestinians above the age of 15 years is only 4.1 percent according to the PCBS statistics from 2013.

Table 1. Percentage Distribution of PWD Aged 15 Years and Older

Demographic Variables	West Bank	Gaza Strip	Palestinian Territory
Educational Enrollment Status			
Currently enrolled	5.9	5.9 ²¹	5.9
Enrolled and dropped out	37.0	27.1	33.8
Enrolled and graduated	21.6	24.8	22.7
Never enrolled	35.5	42.2	37.6
Educational Status			
Illiterate	51.5	56.3	53.1
Lower than secondary	36.6	29.3	34.2
Secondary	6.7	8.7	7.4
Higher education	5.2	5.7	5.3

Source: Palestinian Central Bureau of Statistics, and Ministry of Social Affairs. 2011. *Disability Survey*. Ramallah: Palestine.

The Independent Commission for Human Rights (ICHR) noted in its 20th Annual Report²² that students with disabilities in primary education accounted for only 0.3 percent of the total number of students enrolled in the educational system. The majority of those who do enroll often do not complete basic education (up to grade 10). The 2011 Disability Survey found that 22.2 percent of disabled persons aged 18 years and older dropped out of school due to their disability.²³ Students aged 0–17 years with disabilities who are currently enrolled in schools prioritized the following adaptations to facilitate continuation of their education.

²⁰ 2011 Disability Survey by the MOSA and the PCBS.

²¹ During a meeting, the MOEHE in Gaza stated that, currently, 220 students with disabilities are enrolled in mainstream schools, 200 students with hearing impairment are enrolled in a special governmental school, and 98 students with visual impairment are enrolled in a special governmental school.

²² ICHR. 2015. *ICHR 20th Annual Report*. Palestine.

²³ Palestinian Central Bureau of Statistics, and Ministry of Social Affairs. 2011. *Disability Survey*. Ramallah: Palestine.

Table 2. Percentage of PWD Aged 10–17 Years Needing Accessibility to Continue Their Education, by Main Disability, 2011

Variable	Visual	Hearing	Communication	Mobility	Remembering and Concentrating	Learning
Accessible transportation	24.5	15.2	12.5	50.0	25.0	3.8
Adapted building	25.0	12.5	6.3	46.3	20.0	1.9
Adapted classrooms	38.5	24.2	12.5	50	21.1	5.8
Adapted bathrooms	11.5	3.1	12.5	52.8	10.5	1.9

Source: Palestinian Central Bureau of Statistics, and Ministry of Social Affairs. 2011. *Disability Survey*. Ramallah: Palestine.

According to recent information from the MOEHE in Ramallah, 1,013 schools in West Bank were equipped with ramps, while 492 schools are still unequipped and 64 schools cannot be equipped at all.²⁴

Table 3. No. of Accessible Schools for CWD in the Gaza Strip, 2014/2015

Area	No. of Schools	Fully Accessible	Partially Accessible	Not Accessible
North Gaza	48	42	6	0
East Gaza	49	32	15	2
West Gaza	62	13	26	23
Mid Area	30	5	19	6
Khanyounis	30	14	14	2
East Khanyounis	27	20	7	0
Rafah	25	21	3	1

The abovementioned statistics, retrieved during a discussion with the deputy director of the Disability Unit in the MOSA in Gaza, show that not even half of the education infrastructure in Gaza accommodates the needs of students with various disabilities.

Education Service Providers

MOEHE

Inclusive education was launched in 1997 on a trial basis for children aged 1–4 years and has continued under the General Directorate of Special Education. It has reached some of the government schools, targeting all types of disabilities. The key components of the program are the resource rooms and resource centers.

- **Inclusive education resource rooms.** Out of 1,800 public schools, 188 have so-called resource rooms. Their purpose is to assess slow learners or children with intellectual or mental disabilities in grade 1 to 4 and support them accordingly in the areas of reading, writing, mathematics, and daily life skills in addition to their regular classes. Resource rooms are usually staffed with two members who have a background in general and special education and speech therapy. Technical support is offered by 35 inclusive

²⁴ Interview with the director of the Inclusive Education Unit, Ramallah.

education counsellors who are attached to the MOEHE district offices and three coordinators on inclusive education (one in Gaza and two in the West Bank).

- **Inclusive education resources centers.** The objective of the three resource centers is to support the inclusion of CWD in mainstream public schools.²⁵ The centers are staffed with a multidisciplinary team (social worker, speech therapist, physiotherapist, and special education specialist). The resource center in Ramallah covers about 25 schools with around 100 students per year and the MOEHE determines the area to be covered each semester. Based on a preselection of students with disabilities by the disability focal points of the targeted schools, the process of the resource centers involves three visits, including general and more specific assessments of identified children, the development of follow-up plans to address the findings of the assessments, and follow-up with parents and teachers on progress and gaps.

Inclusive education also includes a program for students with impaired vision in Palestine and is a collaborative venture between the MOEHE, the International Council for Education of People with Visual Impairment, and the CBM. It was launched in 2014 and focuses on measures to improve education through resourcing and equipping students and education personnel, enhancing physical accessibility, developing quality health provision, and forging strong partnerships among those who undertake inclusive initiatives.

Yet, in view of the demand and the total number of schools, the current capacity (number of inclusive education counsellors, resource rooms, and resource centers) is insufficient. Often schools lack relevant resources (for example, teaching materials) to follow the recommendations of inclusive education counsellors and resource centers.

The MOEHE in partnership with nine UN agencies²⁶ launched the EFA (Education for All) Package for Palestine to focus on inclusive and child-friendly education and early childhood development, which are key areas to ensure the right to quality education for all Palestinian children, including CWD. This joint UN/MOEHE initiative, piloted in 70 schools in the West Bank and Gaza, is responding to the MOEHE's vision to increase access and retention of school-aged children in the education system and improve the quality of teaching and learning. Through the EFA Package, education personnel have been trained on inclusive and child-friendly education.

The MOEHE also made an effort to increase the availability and choice of technical courses opportunities for PWD through cooperation with the MOSA's TVET Department. Under its TVET initiatives, the MOSA operates 12 rehabilitation centers that target dropouts, slow learners, and so-called 'social cases'. Yet, it is unknown to what extent PWD benefit from these programs. Lack of awareness and qualified staff along with limited resources are the main obstacles. The General Directorate for Special Education through its vocational counsellors

²⁵ The centers are located at the MOEHE Ramallah, in Gaza (nonfunctional), and Hebron (serves only a small area).

²⁶ Food and Agriculture Organization; United Nations Development Programme; United Nations Population Fund; United Nations Children's Fund (UNICEF); UNRWA, United Nations Educational, Scientific, and Cultural Organization (UNESCO); World Food Programme; and World Health Organization (WHO) - coordinated by UNESCO.

provides support for students regarding vocational education. However, their role requires strengthening.

In addition to public schools, the MOEHE supports around 15 nongovernmental special schools targeting children with Down syndrome and those with hearing or visual impairments. The MOEHE provides supervision and currently covers the salaries of around 30 teachers in Gaza alone.

The MOEHE established formal and informal referral systems with local NGOs in the field of disability to facilitate the exchange of information and knowledge transfer, including capacity building of its teachers. Yet, through such cooperation with the NGOs, the MOEHE also ensures access to assistive devices for their students, support in increasing physical accessibility of their public schools, and accessible transportation for CWD.

Other Ministries

Career guidance and counselling services are offered by the MOSA and TVET in parallel with the aforementioned vocational training program of the MOEHE and the TVET. The courses' effectiveness with regard to financial results is limited as they mainly focus on small income-generating activities provided by poorly qualified trainers. Those are neither recognized by the MOEHE nor are they designed to promote individuals' professionalism. Consequently, according to the DPO representatives, they have accomplished little with regard to qualification and employment possibilities.

The MOSA is also operating two schools for CWD in the West Bank. These include (a) the **Al-Qabs School** which was established in 1978 and provides education and residential facilities for blind students from kindergarten till 12th grade and (b) the **Alalayiha School for the Blind** in Beit Jala which was founded in 1938 and provides education for visually impaired students from ages 6 to 16 years and facilitates their inclusion into the public mainstream education system once the students turn 16 years old.

UNRWA Education Program for Palestinian Refugees

The UNRWA is mandated with the provision of education services for Palestinian refugees. While only 8 percent of schools in the West Bank are run by the UNRWA, the percentage increases to 50 percent in Gaza.²⁷ Statistics on the number of students with disabilities in the UNRWA schools were not available and while they accept students with different types of disabilities, they do not run special education programs. The UNRWA has an education department which aims to identify PWD and support them to be included in the educational process. In 2013, the UNRWA adopted an Inclusive Education Policy as part of its education reform, which applies to all UNRWA schools. In late 2014, the UNRWA launched a 14-month project to train teachers on inclusive education to support injured and disabled refugee students in Gaza at the UNRWA schools and, if necessary, at their homes to receive education.

²⁷ In 2010/11, there were 2,653 schools in the OPT: 74.4 percent were public schools, 12.8 percent were UNRWA schools, and 13 percent were private schools (MOEHE 2011).

Most of the UNRWA schools offer accessibility features such as ramps and, reportedly, an evaluation of UNRWA buildings in this regard is under way. They provide regular screening of students in their schools and facilitate access to rehabilitation services and assistive devices through strategic relations with NGOs that are specialized in rehabilitation and special education inside the camps. The MOEHE and UNRWA have moved toward more child-friendly approaches within the school setting, including special-needs-friendly criteria (access for CWD). Yet, like the public schools, the UNRWA also faces the need for teacher training, more appropriate teaching aids, and resources classes to increase the schools' capacity to respond to the needs of students with disabilities.

Education Services by the NGOs

Since the MOEHE is not in a position to fully meet the educational needs of all children and youth with disabilities, the NGO sector plays a vital role in the provision of (special) education services for CWD, albeit coordination with the MOEHE is limited. Many of these NGOs have good technical expertise and resources to address disability issues. Yet, many still fail to fully embrace the concept of inclusion with a long history of special education.

Over 20 NGOs, in the West Bank and Gaza combined, offer a variety of educational programs for different types of disabilities while others target only certain types of disabilities. For example, there are about 12 special schools that offer education for hearing impaired students and 11 special schools for students with visual impairments in Palestine that are run by the NGOs: 9 in the West Bank and 2 in Gaza. They have been providing education and boarding for children with visual disabilities for the past 60 years. A study in 2011 found that 51 percent of students with impaired vision would rather continue their education in NGO special schools due to the lack of appropriate conditions at government mainstream schools.²⁸ Financial support for these special schools includes private donations, international and local funding, and in some cases, government assistance with regard to teachers' salaries and textbooks. Still, they are far from meeting the actual demand. Moreover, not all families can afford the related expenses (fees, transportation) and thus, keep their child at home. The NGOs feel that they are technically more experienced than the Ministry of Education.

Support for Education Services by the INGOs and UN Agencies

Both UNICEF and UNESCO support inclusive education in the West Bank and Gaza, combining direct support to the MOEHE with support to the NGOs working in the field of inclusive education (for example, Atfaluna in Gaza). UNICEF will also provide technical support to the MOEHE in the planning, implementation, and monitoring of inclusive education through the newly developed school management information system. The UNICEF Country Strategy 2015–2016 clearly indicates support toward inclusive education policies. UNESCO supported 70 mainstream public schools in the West Bank and Gaza to inclusive education (assessment and teacher training). They are members of the technical group that drafted the new inclusive education policy.

²⁸ Study Analysis: Needs of Students with Visual Disabilities, West Bank, 2011/12.

Support of other bilateral and INGOs to inclusive education is noteworthy as well. Terre des Hommes Italy started working on inclusive education in East Jerusalem in 2012 and currently supports 12 public schools and 1 NGO school to support the development of an inclusive education system in East Jerusalem in close collaboration with the MOEHE and the Jerusalem Directorate of Education. Save the Children provides the MOEHE with technical and financial support to develop national strategies, quality indicators, and standards on inclusive education and other social services. In 2014, they financed school equipment to support disability mainstreaming. Welfare Association supports NGO initiatives in the West Bank and Gaza to provide education services for CWD (school renovation, provision of technical aids, training teachers, and purchase of equipment) in coordination with the MOEHE. Dianokia/Norwegian Association of Disabled is supporting the development of the national inclusive education policy.

Analysis of Education Services

Palestine successfully developed an Education Development Plan and a framework to promote education for all, including CWD. The report of the national assessment for Education for All by the MOEHE²⁹ ensured that CWD and the relevance of their inclusion in the education system became the sixth priority for the development of education beyond 2015.

Yet, there is a significant gap at the level of application of these commitments. The school enrollment rates of children and youth with disabilities remain dramatically low while illiteracy and dropout rates among this group are still very high. Enrollment rates for those with intellectual or mental disabilities are even lower, and at the implementation level, inclusion often targets only children with mild and moderate disabilities.

In Gaza, the volatile situation renders the educational inclusion of children and youth with disabilities even more difficult with makeshift classrooms, ad hoc solutions, and severe overcrowding with as many as 45–50 pupils per classroom. One of the main challenges in the design, implementation, and monitoring of effective interventions may be the fact that the actual number of CWD is not available. Thus, the real scope and need or demand is unknown. It may exceed the current official figures since social and cultural norms and related response bias, the phrasing of survey questions, and the absence of a unified definition of disability in Palestine all contribute to significant under-reporting. In addition, according to the MOEHE, limited financial and human resources, poor knowledge exchange with external parties, and an internal division in the MOEHE may restrict its role as the focal and lead ministry on inclusive education.

Availability

The Framework for Actions evaluation³⁰ showed increasing school enrollment of children and youth with disabilities. However, the lack of a clear national regulatory framework, including a needs-driven and integrated policy, resulted in the inequitable access to education opportunities in general and inclusive education in particular for children and youth with

²⁹ Ministry of Education and Higher Education. 2014. *The National Assessment for Education for All*. <http://unesdoc.unesco.org/images/0023/002326/232625e.pdf>.

³⁰ Ministry of Education and Higher Education. 2004. *Education for All, Framework for Action 2005–2015*.

disabilities. It also led to a fragmentation of education services and actors and prevented a well-coordinated and comprehensive approach between all stakeholders (see table 4).

Table 4. Range of Available Education Services According to Type and Implementer, 2015

Type of service	MOEHE	MOSA	NGOs	INGOs	UNRWA	MOH	UN Agencies
Mainstream schools	<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		
Special education services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>				
Early detection and prevention programs	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Vocational training	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>				
Accessible learning materials and equipment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>

Source: MOEHE. 2004. *Education for All, Framework for Action 2005–2015*.

Education services, especially in the NGO sector, do not share common quality standards and a unified curriculum. The assessment identified 21 NGO-run schools in Gaza and 115 in the West Bank in different cities, which provide a wide range of education services, but many of them had limited resources and served only a small number of CWD.

Most government, UNRWA, and private/NGO schools lack resources to include children and youth with disabilities. These include capacities on inclusive teaching practices to enable all students to access the curriculum, qualified professionals in the field of disability and inclusive education who provide technical support/training or work with children and youth with disabilities, adequate teaching materials, financial resources, alternative or adjusted curricula, and supportive devices. Likewise, the resource rooms and resource centers of the MOEHE that provide vital support for public schools to include children and youth with disabilities are insufficient in number and coverage.

(Special) educational programs are not available for all types of disabilities for secondary education, for example, for severe mental disability. Mainstream schools primarily focus on accommodating students with mild and moderate physical disabilities and only scarcely address mental and other disabilities. Children with visual impairments in Gaza, for example, receive primary education (grades 1–6) in special schools run by NGOs, then continue their secondary education in the only specialized governmental school for persons with hearing impairments, and may move to a mainstream governmental school to continue the 12th grade.

Affordability

In contrast to public education services, NGO-run schools require a fee that ranges from US\$25–US\$50 per month. Some of these centers may be located far from the student’s place of residence, which may require additional costs for transportation. Such financial burden may be too much for families to afford, especially if there is more than one family member with disability.

Disability-related extra costs like means of transportation, especially in remote areas, are often high. The Palestinian government did not establish a system to reduce or address the financial costs incurred by PWD (for example, transport and technical aids) in the education system. Support to families to cover such costs remains based on the scattered and intermittent aid from donors and civil society institutions.

Accessibility

The MOEHE undertakes efforts to facilitate access to support and assistive tools and devices for students with disabilities (for example, hearing aids, wheel chairs, Perkins machine, and Braille books) through referral. However, such support does not seem to be the rule. According to the Study Analysis 2011,³¹ students with impaired vision in regular schools have so far not received basic assistive devices such as magnifiers, large printed books, and Braille reading textbooks. Given the lack of trained teachers and adequate equipment in both regular and special schools, key elements of the curriculum are not accessible to many students with disabilities. Particularly, the needs of students with less visible disabilities in this regard are often overlooked. The absence of or inappropriate assessment and evaluation tools used by teachers and the limited coverage of the resource centers that offer in-depth assessment significantly contribute to this problem.

While the EFA Package claims to have rehabilitated 523 general schools, a large percentage of the existing education infrastructure and environment is still inaccessible, particularly in Gaza. The Education for All Framework for Action 2005–2015 states that, by 2005, the MOEHE rehabilitated 523 general schools to accommodate children and youth with disabilities. However, to date, physical accessibility features are often only reduced to ramps and overlook, for example, the needs of students with visual impairments.

Accessible transportation is most frequently cited as a key facilitator for children and youth with disabilities to access and remain engaged in education. Yet, the absence of and related extra costs for (*see above in Affordability section*) means of transportation that fit the needs of students with disabilities, especially in remote areas, still prevent them from accessing education.

While students may ask for supportive measures to access the final exams, there are no accommodations or exceptions for students with disabilities for secondary stage tests and for the evaluation. Some groups may face, for example, challenges in writing and listening comprehension (that is, deaf students), and an alternate mechanism is lacking. With a few exceptions (Braille books for grades 1–3 in mathematics), the curriculum is not adjusted to the needs and capacities of students with various disabilities. To address the problem, the MOEHE has created a committee that adapted some textbooks to be available in the near future.

³¹ Study Analysis: Needs of Students with Visual Disabilities, West Bank, 2011.

2. Health and Rehab Services

Health Facts and Figures

The data on the health situation of the disabled was not gathered as part of the PCBS 2011 survey. The best indicators of health deprivation are reflected in the health needs expressed by the PWD.

Box 1. Health Deprivation as Reflected in Unmet Needs of PWD

The 2011 Disability Survey¹ by the MOSA and the PCBS found a high level of unmet needs among PWD, especially for hearing aids, mobility devices, functional therapies, and mental health services. Among persons with physical impairments the rate of unmet medical needs rose to 79 percent and among those with hearing impairments, it was as high as 65 percent.

- **Visual disabilities:** 18.2 percent of persons with visual disabilities are in need of magnifiers compared to 13.7 percent who need a personal assistant/companion, 10.9 percent need a screen reader, and 10.1 percent are in need of a guidance cane.
- **Hearing disabilities:** 46.5 percent of persons with hearing disabilities are in need of hearing aids without T-Switch compared to 44.4 percent with T-Switch, 16.1 percent require an amplifier compared to 14.3 percent who require cochlear implants, and 12.5 percent visual or vibrating alerts or alarms.
- **Mobility disabilities:** 37.1 percent of persons with mobility disabilities are in need of physiotherapy while 24.0 percent require bathing aids, 23.5 percent an electric wheel chair, 22.7 percent require occupational therapy, and 21.0 percent require walking aids.
- **Communication disabilities:** 38.8 percent of persons with communication disabilities require speech and language therapy, 20.5 percent require computers, 13.7 percent require communication boards, and 12.5 percent require sign language translators.
- **Remembering and Concentrating Disabilities:** 32.5 percent of persons with remembering and concentrating disabilities require medications, 20.4 percent require automated reminders, and 15.4 percent require communication aids such as an identification card.
- **Learning disabilities:** 39.9 percent of persons with learning disability require psychological support, 37.0 percent a specialized education program, 35.8 percent require occupational therapy, and 31.1 percent require speech therapy and 28.5 percent physiotherapy.
- **Mental health disabilities:** 38.2 percent of persons with mental disabilities require services of psychiatrist, 34.7 percent support from specialized centers, 30.3 percent are in need of medication, 30.0 percent require medical services, and 27.5 percent need social services.

Health Service Providers

There are four health care providers in Palestine.

- (a) The MOH provides primary, secondary, and tertiary care and purchases unavailable health care domestically (*from the private sector and NGOs, specifically East Jerusalem Hospitals*) and from providers abroad.
- (b) Local NGOs provide primary, secondary, and some tertiary services. A Bank survey found that 13.3 percent of households in the West Bank, compared to 8.1 percent in Gaza, used NGOs frequently, especially for mental health counseling, physical therapy and rehabilitation, and medical training, although a visit to an NGO primary health clinic costs twice as much as a government clinic.

- (c) The UNRWA provides health services for refugees through primary health centers and facilitates access to secondary and tertiary care through a network of contracted hospitals in addition to the UNRWA hospital in Qalqilya.
- (d) The private sector (including INGOs) has grown in recent years with private hospitals, pharmacies, and rehabilitation centers.

Ministry of Health (Key Provider)

- **National Health Insurance. There are two avenues for PWD to access free health insurance:** one under the Palestinian CTP and one for PWD with a disability level of more than 60 percent, for which a disability certificate from the Medical Committee is required. The Disability Law of 1999 provides coverage of health services for PWD and their families and allocation of assistive devices (with co-payment of a maximum of 25 percent of the cost). However, a 2006 regulation of the health insurance system challenged this provision by excluding auxiliary medical, assistive, and learning aids, devices, and supplies from the list of products supplied by the health system. It also does not cover advanced lab tests and relevant medications such as those used for reducing spasticity and epilepsy.³² Additionally, most of the hospitals in the West Bank and Gaza do not have the technical capacity to perform advanced medical procedures such as cochlear implants and sore management. More than 93 percent of the rehabilitation services are offered outside of the MOH through an outsourcing system: MOH has long-term contracts with different NGO-run rehabilitation institutions like the Abu Raya Center, Princess Basma Center, and The Arab Association in BeitJala. The MOH in Gaza provides technical aids through a leasing system. It also coordinates with the NGOs and MOSA to secure necessary assistive devices, but this is subject to available funding.
- **Referral system to provide services not available within the MOH.** Since specialized rehabilitation services such as acute care and trauma units and more advanced assistive devices are not available within the MOH, external referral either to subcontract NGOs inside Palestine or providers outside is available for complex and serious cases. However, the lack of transparency and accessibility render this process highly difficult (see section on gatekeeping mechanism). Such referral only applies to those that are covered under the national health insurance scheme and to date, the referral system hardly covers the actual needs, in terms of accessibility but also scope, especially in relation to technical aids and assistive devices. Patient registers are poorly developed.

Other Ministries

- **Support from the president's office.** The president's office responds in some cases to requests from PWD asking for medical or rehabilitation services or assistive devices. Some of these services are then provided or distributed through governors. The selection process for this kind of support does not involve transparent selection criteria. The Higher

³² The Palestinian Independent Commission for Human Rights, the rights of persons with disabilities in Palestinian society. 2006.

Council of Disability sees the importance of the coordination between the different stakeholders to guarantee equal access to these services.

- **Services provided by the MOSA.** The Emergency Aid is a program run by the MOSA and offers one-time emergency aid to persons in need. It is not a disability-specific scheme. The MOSA staff receive requests usually through local councils or NGOs and conduct visits to assess the need. The MOSA also facilitates access to free public health insurance for poor households under the CTP.

UNRWA

The UNRWA provides health care services to Palestinian refugees, including medical rehabilitation services to PWD. The UNRWA runs a disability program, which is implemented through Community Based Rehabilitation Centers (CBRCs) and outreach activities, offering rehabilitation services, assistive devices, and home modifications, and supporting community and home-based care. The UNRWA facilitates access to these services mainly through subcontracting relevant NGOs. They usually have waiting lists and are not always able to cover the full cost, especially for technical aids and assistive devices. In the West Bank they provide prevention/early detection; physiotherapy (6 clinics and 5 stations on the emergency program working in different camps in the West Bank); and assistive devices like crutches.

Services provided by NGOs

Almost all specialized rehabilitation services are provided by NGOs. The mapping identified 55 NGOs in the West Bank and 33 NGOs in Gaza that provide health-related rehabilitation services. The majority of these are small local NGOs providing a variety of services to a small number of people. However, there are some 7–8 main rehabilitation centers in the West Bank and Gaza that are operated by NGOs and provide a wide range of specialized services including , Bethlehem Arab Society for Rehabilitation, West Bank; Abu Rayya Rehabilitation Center, West Bank; Princess Basmah Rehabilitation Center, Jerusalem; the Palestinian Red Crescent Society (PRCS), West Bank; Al-Wafa Medical Rehabilitation Center, Gaza; Al-Amal Center, Gaza; and Artificial Limbs and Polio Center, Gaza. The MOH has subcontracting agreements with most of them to serve PWD who have medical insurance and are able to obtain a referral.

Analysis of Health Services

Given the limited capacities of the MOH, almost all medical rehabilitation services for PWD in the West Bank and Gaza are implemented by NGOs which are subcontracted by the MOH through a unit called External referral unit. However, the fragile financial situation of the PA causes frequent delays of the payments by the Palestinian government, which seriously affects these providers and the quality of their services.

While the MOH buys relevant rehabilitation services, it does not have standards for the quality of these services. So far, the MOH has not taken up more service provision or a lead regulatory role in this area. In the absence of a coordinating body and limited coordination between the different NGOs and with relevant authorities and policy and decision makers, it remains unclear who oversees service providers and defines and monitors standards and processes of service delivery. As a consequence, high variations and discrepancies between the different rehabilitation centers can be observed³³ as well as a fragmentation which prevents a comprehensive approach to the complexity of needs of PWD.

Availability

The majority of services target the needs of persons with physical disabilities whereas health and rehabilitation services for other types of disabilities, especially mental and intellectual disabilities, are comparatively scarce (for example, speech or occupational therapy and cochlear implants). While rehabilitation professionals are sufficient in numbers for some disciplines (physiotherapy, occupational therapy, nursing), other fields lack professionals (rehabilitation doctors, prosthetics, and orthotics). Assistive devices; prosthetics; and orthotics services (measurement, manufacturing and maintenance) are a huge gap in terms of availability, technical capacity to assess, and quality. Leasing system for ADs (Assistive Devices) is almost absent or unaffordable

Historically, most of these services are provided by NGOs, which, however, have limited capacities. In view of the high demand for rehabilitation services offered by NGOs, there are waiting lists and delays in receiving the required support/service. Most of the NGOs depend entirely on donor funds, which make them additionally susceptible to variations and nonsustainability.

Table 5. Range of Available Health and Medical Rehabilitation Services

Type of Service	MOH	MOSA	NGOs	INGOs	UNRWA	UN Agencies
Primary, secondary, and tertiary care	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
Specialized rehabilitation centers			<input checked="" type="checkbox"/>			
Early detection and early intervention programs	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
Outpatient rehabilitation	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
Outreach service			<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
Hearing tests	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
Information and referral services	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
Assistive devices (mobility)	<input checked="" type="checkbox"/>					

³³ The package of services varies from one center to another; some centers provide only free-of-charge services while others charge their patients.

Type of Service	MOH	MOSA	NGOs	INGOs	UNRWA	UN Agencies
Assistive devices (hearing aids)	<input checked="" type="checkbox"/>					
Assistive devices (visual aids - screen readers and white canes)			<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
Sign language interpreters			<input checked="" type="checkbox"/>			
Personal assistants						
Home adaptation			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Technical aids maintenance			<input checked="" type="checkbox"/>			
Adapted accessible transport			<input checked="" type="checkbox"/>			
Speech therapy			<input checked="" type="checkbox"/>			
Outpatient clinics	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
Orthotics and prosthetic devices			<input checked="" type="checkbox"/>			
CBR services supporting inclusion in labor market			<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
Support for cognitive/communication impairment			<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
Sheltered institutions		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			
Specialized vacation training centers			<input checked="" type="checkbox"/>			

Most of the specialized rehabilitation centers are located in main cities. This leaves rural areas underserved as they require accessible transport and maybe passage of checkpoints and results in extra costs. Services in the Gaza Strip are mainly available in Gaza City.

Outreach services are mainly targeted at persons with physical disabilities. While CBR programs are present in many local areas, they do not have the capacity to deliver such specialized rehabilitation services.

Affordability

Unless the services are covered under the health insurance scheme or provided through a referral, PWD will have to afford considerable out-of-pocket payments to access relevant rehabilitation with NGOs. Given the absence of a transparent and accessible referral system and the fact that there are still a considerable number of PWD without health insurance, affordability becomes a critical barrier for PWD—severely restricting equal access to medical rehabilitation services. In addition, the services covered under the existing national health insurance scheme is limited, which forces PWD who are in need of complex or more advanced services to seek the required support at their own expense.

In-patient rehabilitation services are not affordable for users and their families. Given the centralization of specialized rehabilitation services in urban locations, PWD frequently face high transportation costs.

Accessibility

Since most services are located in urban locations, the lack of accessible transportation, difficulties to use public transportation and related extra costs (see above) were frequently cited as key barriers for PWD to access health and medical rehabilitation services, especially when living in rural and remote areas. Most of the rehabilitation service providers made accessibility provisions for persons with physical impairment (such as ramps and toilets); yet

many do not consider accessibility for users with other impairments such as visual or hearing (for example, sign language interpreters and Braille signs).

Besides physical barriers, access is also restricted by the absence of accessible information on available services that considers and responds to the various communication needs of the different types of disabilities. Most of the MOH hospitals are adapted for PWD while not all the clinics are. The adaptation of these clinics is very essential for PWD, which hinders equal access to get the required medical services.

3. Access to Livelihoods, Jobs, and Income Security

Facts and Figures

The 2011 Disability Survey³⁴ by the MOSA and the PCBS found that the vast majority of PWD do not work (85.6 percent in the West Bank and 90.9 percent in the Gaza Strip). According to a more recent disability census in Gaza, only 10.5 percent of these are self-employed.

Table 6. Employment Status of Employed PWD Aged 18 Years and Older (Percentage Distribution)

Employment status	Number	%
Employer	117	7.5
Self employed	163	10.5
Waged employee	1,242	79.7
Unpaid family member	36	2.3
Total	1,558	100

Source: Palestinian Central Bureau of Statistics. 2013. *Disabled Individuals Census, Gaza Strip, 2012, Main Findings Report*. Ramallah, Palestine.

The unemployed PWD indicated that their employment is generally hampered by insufficient adaptations to workplaces. The major adaptations required are captured in table 6.

Table 7. Adaptations Required for Employment Accessibility

Variable	Visual	Hearing	Communication	Mobility	Remembering and Concentrating	Learning	Mental Health
Accessible transport	20.0	0.0	0.0	34.7	12.5	17.6	31.7
Car parking	6.7	0.0	0.0	24.7	0.0	5.9	17.5
Ramps	0.0	0.0	0.0	27.8	0.0	0.0	9.7
Lift	0.0	0.0	9.1	41.7	0.0	8.8	17.7
Adapted bathrooms	6.7	0.0	9.1	26.4	0.0	5.9	16.1
Human support	6.9	0.0	0.0	4.2	50.0	44.1	20.6
Technical aids	0.0	0.0	0.0	1.4	44.4	26.5	22.6
Communication aids	0.0	0.0	0.0	0.0	12.5	5.9	31.7
Modified work hours	13.3	40	9.1	37.5	22.2	26.5	42.9
Modified workplace	16.7	36.4	0.0	28.8	0.0	20.6	25.8
Modified work tasks	16.7	27.3	0.0	51.4	37.5	35.3	33.3

³⁴ Palestinian Central Bureau of Statistics and Ministry of Social Affairs. 2011. *Disability Survey*. Ramallah, Palestine.

Reaching the place of work is reportedly most difficult for persons with visual disabilities (13.0 percent) followed by persons with hearing disabilities (9.7 percent).

Employment Services

According to the civil service law, 5 percent quota is reserved for PWD; however, due to classification issues and contradictions within the law, legal validation law and the implementation both need to be reconsidered. The 1999 Law No. 4 Concerning the Rights of the Disabled, the Civil Service Law 4/2005, the Labor Law 7/2000, and related bylaws require that the government and NGOs should accommodate the number of PWD at minimum 5 percent of the total employees and adapt the workplace accordingly. The General Personnel Council (GPC) has to retain 5 percent of openings that are announced to be filled by PWD. A conflict is noted between the Civil Service Law and the bylaws regarding the employment of PWD in government institutions: the Civil Service Law states that absence of disease, physical and mental, is required for employment, while the bylaw merely mentions medical fitness. The outdated regulation effectively prevents many PWD from enjoying their right to work.

The recruitment under the 5 percent quota for the public sector is led primarily by the GPC and MOSA in partnership with other two ministries. Since 2012, commitment toward the implementation of the 5 percent quota within the GPC has increased significantly. However, statistics show that to date the majority of employed persons under this scheme are persons with physical disabilities.

Table 8. Distribution of Recruitments by the GPC for the Years 2011/13 According to Type of Disability

Physical	Visual	Hearing	Intellectual	Physical and hearing
106	28	8	0	8

The majority of PWD under this scheme are not recruited in leadership posts. Reportedly, reasonable accommodation in the workplace to meet the needs of the disabled employee is poorly implemented. The general understanding is that the 5 percent of PWD recruitment is the maximum, while it actually presents the minimum. The lack of enforcement powers to apply the 5 percent employment quota is compounded by poor awareness of legal employment rights of PWD among employers.

MOL and General Personnel Council

The MOL has 16 employment offices in the West Bank and 5 in the Gaza Strip, which provide services to jobseekers and employers. However, these remain inaccessible to PWD. The MOL recently conducted a study on ‘Mainstreaming Disability in Policies and Programs - Employment Services in the Occupied Palestinian Territories’,³⁵ highlighting inaccessible buildings with no sign language or specially equipped tools to facilitate PWD access to services. The outreach of employment offices to PWD is generally inadequate and awareness among PWD of the employment services is very limited. The percentage of PWD in the Labour Market Information System is less than 1 percent. Furthermore, human resource and service constraints

³⁵ MOL. 2015. *Mainstreaming Disability in Policies and Programs - Employment Services in the Occupied Palestinian Territories*.

prevent the offices from addressing the needs and rights of PWD more effectively. Staff numbers are insufficient and team members have little awareness on disability rights and capacities of PWD. The level of coordination with the MOSA as an important line ministry for disability is poor. The offices have no programs that provide direct services to the public and limited coordination with local employment programs.

The Palestinian Fund for Employment and Social Protection (PFESP) is a semi-independent, autonomous body originally intended to be operational for 2003 (Sartawi 2011). It is supervised by a board of directors representing the state, employers, and unions (tripartite) and headed by the minister of Labor. Its mandate is to provide services and implement the MOL policies, yet it is not involved in policymaking. The PFESP has implemented self-employment and cooperative projects targeting PWD.³⁶

The MOL has 13 vocational training centers in the West Bank, which accept persons with mild/moderate disabilities, who often do not even disclose their disability when signing up. The MOL signed an agreement with the local disability organization Bethlehem Arab Society in Beit Jala to make four of their vocational centers accessible for PWD. The MOL is also currently conducting a capacity-building program for 25 staff (inspectors) who will be conducting monitoring visits to employers, focusing on disability in the labor market. In January 2015, the MOL started a pilot with the Arabic Association in Beit Jala to provide PWD with vocational training and support to facilitate starting their own business.

In Gaza, the MOL provides short-term employment programs, which recently started to include PWD who are 18 years or older and married. Otherwise, the MOL provides very limited temporary work programs (3 to 6 months) which aim at contributing to the creation of employment opportunities for PWD. In cooperation with the International Labour Organization, the MOL honors employers who provide good practice with regard to the employment of PWD and highlights success stories of PWD in the working environment.

Ministry of Social Affairs

The Economic Empowerment Fund/Fund for the Rehabilitation of PWD managed by the MOSA is funded by the Emirati Red Crescent and was started in 2008. It aims at the rehabilitation and economic empowerment of PWD through income-generation businesses. Till the end of 2014, about 550 zero-interest loans were provided ranging from US\$2,000 to US\$10,000. Albeit open for persons with different types of disabilities, there seems to be a bias toward applicants with mild or moderate disabilities and those with physical disabilities. In addition, the lack of resources at the local MOSA offices to coach and support approved projects may also promote the selection of projects that are most likely to succeed.

The MOSA also runs two vocational centers for PWD, including the Sheikh Khaleifa Vocational Center for PWD and Sheikha Fatima Rehabilitation Center. Both target male and female PWD aged 15 to 35 years and offer assessment, career guidance, and formal and vocational training both in accelerated training workshops in the center or on-the-job training,

³⁶ ETF. 2014. *Labour Market and Employment Policies in Palestine*. Available at: [http://www.etf.europa.eu/webatt.nsf/0/49583C88B3C1AD0DC1257CD1003DA5FC/\\$file/Employment%20policies_Palestine.pdf](http://www.etf.europa.eu/webatt.nsf/0/49583C88B3C1AD0DC1257CD1003DA5FC/$file/Employment%20policies_Palestine.pdf)

various vocational rehabilitation services in the local communities, and loan fund and employment of PWD. Training periods are from 6 to 24 months and cover woodworking, aluminum fabrication, carpentry, hair dressing and beauty treatment, computer operations, sewing, maintenance of electronics and cellular devices, and curtain making and embroidery. The centers are located in the north and the south and serve less than 100 clients per year, who are mainly males with physical disabilities. The training does not reflect current and future labor market needs.

The MOSA runs two other vocational training centers for PWD in Gaza. One of them currently serves 45 PWD (2-year program), who are supported by transportation services while the second center was closed due to the limited resources, drawing attention to the MOL's 4 mainstream vocational training centers in Gaza City, where applicants, however, must pass an assessment of their vocational capacities.

UNRWA

The UNRWA implements the Job Creation Program (JCP) in both the West Bank and Gaza - a yearly Cash-for-Work Project (CaWP) targeting the most vulnerable Palestinian refugees, including PWD, as part of its emergency support work in the West Bank. The CaWP provides an income and basic security to help refugees cope with conflict-related economic hardship, such as land confiscation, destruction of homes and shops, and loss of employment in Israel.

The UNRWA developed a database (Project Daa'm) which measures the socioeconomic vulnerability of each household in detail. As part of its job creation activities, the CaWP will target the most vulnerable families identified by Project Daa'm. JCP laborers work for periods of one to three months in villages and refugee camps or, for those whose movement is restricted (such as herders), in their immediate surroundings. They do a variety of jobs ranging from cleaning, rehabilitation, and construction to farming, sewing, teaching, and assisting in offices and educational facilities. The number of beneficiaries with disabilities is low—from 0.5 percent (400 people) in 2009 to 2 percent (520 persons) in 2012.

Services provided by NGOs, INGOs and UN Agencies

There are several programs by local and INGOs, ranging from providing vocational training to job placement. The main focus is on economic empowerment projects, including (a) support to short-term employment opportunities (3–6 months) and (b) provision of small loans or grants to support PWD start their own business. However, these projects depend on funding availability, so they do not provide sustainable opportunities.

Analysis of Employment Services

Movement restrictions due to the Israeli occupation, the underdeveloped labor market with an overall high unemployment rate, and the geographic and political segmentation resulting in incoherent and incompatible labor market policies generally limit the employment and economic opportunities for PWD. Their economic opportunities are further restricted by the absence of supporting policies and strategies on the inclusion of PWD into the labor market, the frequent fluctuation of human resources within relevant ministries, poor

coordination between the different actors as well as limited financial and human resources, all of which affect the related service delivery. However, besides these structural and institutional limitations, another fundamental challenge in access by PWD to work lies in the trends and negative attitudes and stereotypes of the community, including employers, and considering PWD as generally not suitable to participate in the process of working life on an equal basis with others.³⁷

Availability

Vocational training and economic (re)integration projects remain limited in numbers and scope. The number of PWD benefitting from such opportunities is very small compared to the overall number of PWD who are of working age and unemployed. The current programs (both governmental and NGO led) and graduates do not match current and future labor market demands. Islamic Relief Palestine and the Swiss Agency for Development and Cooperation are currently reforming the MOL TVET curriculum to adapt it to current needs in Gaza. However, there is no indication that this process is disability inclusive.

There are no programs and services available that are tailored to the needs and requirements of WWD (for example, types of skills and also the fact that many require that the person is to stay in the center during the training period). The MOL employment offices as well as vocational training centers of both the government and NGOs are mainly available in main cities. The mapping of available NGOs providing services indicated for example that there are 8 NGOs in Gaza mainly located in Gaza City and 8 in the West Bank mainly located in the southern region of Bethlehem and Hebron. Supported employment is not available within the MOSA or MOL services.

Table 9. Overview of Services on Employment and Economic Empowerment

Type of Service	MOL	MOSA	NGOs	INGOs	UNRWA	UN Agencies
Vocational training and rehabilitation	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>			
Assessment of vocational capacities for PWD		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			
Employment (full time)	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Employment (part time, internship)	<input checked="" type="checkbox"/>					
Microfinance/grants		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Services enhancing the access to employment and livelihood)	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>			
Cash for work program	<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>	
Adapted accessible transport	–	–	–	–	–	
Sign language interpreters			<input checked="" type="checkbox"/>			
Personal assistant	–	–	–	–	–	–
Supported employment			<input checked="" type="checkbox"/>			
Sheltered workshops			<input checked="" type="checkbox"/>			
Specialized vacation training centers			<input checked="" type="checkbox"/>			
CBR services supporting inclusion in labor market			<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	

³⁷ ICHR. National Private Investigation Right of persons with Disabilities in the Decent Work 2013–2011

Affordability

PWD may face considerable costs for accessible transport and other relevant support to reach their workplace or training center. While vocational training provided by the MOL or MOSA is supposed to be free of charge for PWD, some may pay for vocational training opportunities through the private sector or NGO services to increase their chances of finding a job. Grants and loans that are provided to PWD to start their own business do not consider the additional disability-related costs such as adaptation of workplace and personal assistance.

Accessibility

The majority of available training and economic (re)integration opportunities reach males with physical disabilities. Persons with intellectual disabilities and hearing impairments are the least likely to access available opportunities. Existing work-related gender bias against females in Palestine affects WWD disproportionately and severely restricts their access to available opportunities and services. The provision of reasonable accommodation in the workplace and relevant support (for example, personal assistant, sign language interpreter) for employees with disabilities is still inadequate. Most of the information as well as the actual facilities of the employment offices and the mainstream vocational training centers of the MOL and MOSA are not accessible—at times, PWD need to wait in the street to meet their staff.

F. Assessing the Demand of Services

The analysis in the previous section finds that there are numerous programs but they are not contributing positively and significantly to development of PWD. This section examines the same services from the perspective of the PWD and priorities as identified by the people themselves.

The feedback from the FGD participants confirms the findings of the 2011 Disability Survey concerning the huge gaps in the availability, affordability, and accessibility of most services for PWD in the fields of education, employment/economic independence, and health/medical rehabilitation. Access to relevant health/rehabilitation services may involve considerable financial expenses, which places a significant, often unacceptable, financial burden on the individual and their families. WWD and persons with hearing and intellectual disabilities face specific barriers to access available services. The findings also emphasize that the widespread absence or inaccessibility of support services and economic independence excludes PWD from society. Despite the fact that 77 percent of the participants in the focus groups indicated that they are medically insured by the national health insurance, they still have to pay for many of the medical/rehabilitation services themselves.

Participants confirmed that specialized rehabilitation services are mainly led by NGOs while complicated referral procedures from the MOH restrict their access. NGOs' services do not fully cover the gaps of needed services. That is why many have indicated that they had to buy services from the private sector. Participants justify this by the fact that certain services are not provided by NGOs or the quality provided was not satisfactory. Almost all participants indicated that they cannot afford most of the services if they have to pay for them themselves, especially if there is more than one family member with a disability in the family.

The interesting finding was related to CTP benefits, whereby the majority of participants expressed keen hope for the CTP benefit to be increased to accommodate disability-related extra costs. However, all the studies analyzing the impact of increased benefits on development of PWD will have very marginal impact for PWD and rather significant negative impact on the rest of the poor.

1. Priorities Identified

Education

Key education priorities were identified as:

- (a) special education for children with learning difficulties and children with intellectual disabilities;
- (b) sign language services in schools; and
- (c) equal access to education in public schools.

The majority of participants in the FGDs agreed that accessibility to schools in general and classrooms in particular remains a key issue for the full participation and benefit of CWD. Relevant adaptation of infrastructure and environment at the schools is a dire need expressed by all. Another priority was the availability of teachers who have ability and the resources to teach children with different types of disabilities as well as the need for more rooms with relevant equipment and resources was highlighted. Lastly, the importance of curriculum development was highlighted to enable CWD to access the curriculum.

Health and Rehabilitation

Key health priorities were identified as:

- (a) sustainable and close-by hospital care and primary health care; and
- (b) access to specialized rehabilitation services, mainly physical rehabilitation.

Participants highlighted the importance of accessible health centers or mobile clinics both in terms of physical and geographical accessibility. Transportation is a burden, especially if the PWD are from remote and isolated localities and need to pay a fortune to reach these centers. There is a great need for physiotherapy and occupational therapy which is not met at the health centers—a concern especially for those with physical disabilities who may need them on a weekly or daily basis. Participants stressed the importance of medical insurance for all types of disabilities and free medication, especially for those below the poverty line.

Economic Empowerment

Key priorities with regard to economic integration were identified as:

- (a) access to loans/grants to start small business;
- (b) access to services enhancing access to employment and livelihood;
- (c) specialized vocational training services; and
- (d) equal access to full time employment opportunities.

Participants who have the ability to start their own projects and can work for some hours on a daily basis highlighted the importance of access to microfinance and grants to start their own sustainable livelihood. They prioritized grants over loans, expressing insecurity in their ability to repay the loans, and the emotional burden and worry a loan and interest rates may place on them. They may need some training and orientation on how to start a business (for

example, development of business plans and basic skills in financial management) to ensure profits. They highlighted the benefits of cash for work and other short-term job programs, if available.

Those who are employed reported difficulties at their workplaces to obtain relevant adaptation to workplace. Participants with learning disabilities stressed the challenges they face in becoming economically independent.

2. Perceived Availability of Services

Economic and vocational opportunities were identified as the most unavailable services among the participants, with other basic services being partially available. Participants stressed the inadequate availability of basic social services, which prevents them from taking advantage of equal development opportunities. Table 10 summarizes the responses of participants on the availability of various services.³⁸

Table 10. Summary of Participants' Response Regarding Availability of Various Services

Services	Fully Available ³⁹	Partially Available ⁴⁰	Hardly available or not available
Primary health care	×		
Hospital care		×	
Outpatient rehabilitation services	×		
In patient specialized rehabilitation services		×	
CBR services and outreach		×	
Mainstream education in public schools		×	
Diagnosis tests (hearing and visual)		×	
Full time and part time employment opportunities		×	
Service enhancing access to employment			×
Loans/grants to start small business		×	
Assessment of vocational capacities			×
Cash for work program		×	
Elementary and preparatory education services provided by NGOs		×	

With regard to specialized services, the results were disappointing. Participants agreed that most of the specialized services are either available at a very minimal level and they do not know where and how to access them or they are not available at all. Table 11 summarizes the responses of participants on the availability of various specialized services:

Table 11. Responses of Participants on the Availability of Various Specialized Services

Services	Fully Available ⁴¹	Partially Available ⁴²	Hardly available or not available
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³⁸ Judgment is made according to feedback from the majority of the participants.

³⁹ Based on responses from the majority of participants: the services are available at locations near them and most of them are able to access them.

⁴⁰ Based on responses from a very small number of participants: the services are available but in major cities and are not accessible to all the people who need it.

			available
Speech therapy			×
Special education			×
Support for cognitive impairment			×
Supported employment			×
Specialized vocational training centers			×

Another disappointing finding was the significant gap in provision of assistive devices, which is the single most critical factor in PWD attaining autonomy, independence, and access to services. Support services were identified as the backbone for PWD to promote their autonomy and independence, yet most of the needed services are either partially available or not existing at all. Overall, participants feel that most of the relevant services in the fields of education, health/rehabilitation, and employment/economic empowerment are not fully available for them.

Despite the fact that many of the participants confirmed that most of the mainstream services are provided by the government and UNRWA (in the case of refugees), there was still clear indication that some services are still either mainly run by NGOs (like inpatient specialized rehabilitation services, CBR, and outreach) or equally provided by NGOs and government like diagnosis tests (hearing and visual), services enhancing access to employment, and assessment of vocational capacities. This could have great implications on access and availability.

Table 12 summarizes the responses of participants as regards the availability of various support services:

Table 12. Responses of Participants on the Availability of Various Support Services

Services	Fully Available	Partially Available	Hardly available or not available
Mobility assistive devices		×	
Visual aid and hearing assistive devices		×	
Maintenance services for assistive devices			×
Orthotics and prosthetic devices		×	
Rent of assistive devices			×
Home adaptation		×	
Personal assistance			×
Sign language interpreter			×
Adapted accessible transportation			×

As indicated by the participants, most of the specialized services are run by NGOs and the private sector, with complex and unclear eligibility criteria and high cost. This was indicated as a major limiting factor for PWD to access such services.

⁴¹ Based on response from the majority of participants: the services are available at locations near them and most of them are able to access them.

⁴² Based on responses from a very small number of participants: the services are available but in major cities and are not accessible to all the people who need it.

Table 13. xxx distribution of available services according to the type of provider

Specialized Service Provider	Government and UNRWA (%)	NGOs (%)	Private sector (%)	INGOs (%)
Speech therapy	29*	38	24	10
Special education	15	8	77	0
Support for cognitive impairment	0	75	25	0
Supported employment	30	70	0	0
Specialized vocational training centers	14	57	0	29

Note: *Mainly by the UNRWA.

Most of the support services are either provided by the NGOs or the private sector, which has huge implications on opportunities to access the services.

Table 14. Support Service Providers

Services	Government and UNRWA (%)	NGOs (%)	Private sector (%)	INGOs (%)
Mobility assistive devices	29*	35	32	3
Visual aid and hearing assistive devices	6	17	78	0
Maintenance services for assistive devices	11	33	56	0
Orthotics and prosthetic devices	14	64	18	0
Rent of assistive devices	0	67	22	11
Home adaptation	33*	17	33**	17
Personal assistance	0	10	90	0
Sign language interpreter	0	100	0	0
Adapted accessible transportation	23*	67	10	

Note: *Mainly by the UNRWA.

** They have to contract the private sector individually to do it.

In conclusion, it is clear that a big proportion of the services are provided by NGOs and the private sector and this has huge implications for equalizing access to basic services.

3. Perceived Affordability of Services

With regard to affordability, it is clear that specialized services are mainly to be purchased through the private sector, which is expensive and unaffordable, especially because most of the disabled population is either poor and/or aging.

Table 15. Perceptions of FGD Participants on the Financial Coverage of Various Services (%)

Services	Free of charge	Medical insurance/UNRWA	Own expense
Hospital care	7	58	35
Primary health care	9	44	47
Outpatient rehabilitation services	29	16	55
In patient specialized rehabilitation services	12	67	21
CBR services and outreach	100	0	0
Diagnosis tests (hearing and visual)	23	23	53
Service enhancing access to employment	100	0	0
Assessment of vocational capacities	50	33	17
Basic elementary and preparatory education services	45	0	55
Speech therapy	19	19	62
Special education	31	0	69
Support for cognitive impairment	33	0	67
Specialized vocational training centers	70	0	30

Table 16. Perceptions of FGD Participants on the Financial Coverage for Support Services (%)

Services	Free of charge	Medical insurance/UNRWA	Own expense
Mobility assistive devices	53	9	38
Visual aid and hearing assistive devices	24	6	71
Maintenance services for assistive devices	16	5	79
Orthotics and prosthetic devices	29	14	57
Rent of assistive devices	44	67	56
Home adaptation	50	0	50
Personal assistance	12*	0	88
Sign language interpreter	13*	0	88
Adapted accessible transportation	4	0	96

Note: *Mainly NGOs.

4. Perceived Accessibility of Services

With regard to accessibility factor, the general consensus is that accessibility remains a serious concern. About 71 percent of respondents felt that their own house meets their accessibility needs, but only 18 percent felt that their workplace is accessible. Around 43 percent of respondents stated that the schools in their area are physically accessible. Most of the participants indicated that health and rehabilitation centers in their area are fully accessible and almost all hospitals do not provide sign language interpreters for persons with hearing impairments who seek emergency support. Most participants do not use public transportation due to the absence of necessary accessibility features. They feel that this affects their access to services. Participants complained about the lack of provision of accessible books and learning materials in schools for children with visual impairments, which prevents them from accessing the curriculum.

G. Disability Expenditures

1. Public Spending on Disability Services

Overall Spending Status

While there is no disaggregated information available on disability spending as a share of overall public expenditure, the sporadic data indicate that public allocation for disability is almost negligible. In general, the support to education, health, social care, and public utility services for the Palestinian population through the PA is financed by tax revenues and bilateral funding through the Multi-Donor Trust Fund (MDTF), which provided key financing for the PA social sector emergency program. It is financed by the European Commission and ten individual countries (Australia, Austria, Belgium, France, Italy, Norway, Spain, Sweden, Switzerland, and the United Kingdom).⁴³ The largest share of the aid comes from the European Union and the United States.

The Arab League states have also been substantial donors, notably through budgetary support to the PA. According to estimates by the World Bank, the PA received US\$525 million of international aid in the first half of 2010, US\$1.4 billion in 2009, and US\$1.8 billion in 2008.⁴⁴ Foreign aid is the 'main driver' of economic growth in Palestine. The European Union has released the first tranche of its 2015 financial support to the PA and to the UNRWA, totaling €212 million. This new funding will help provide vital basic services such as education, health care, and social services.⁴⁵

The lack of disability budget data across relevant ministries was further confirmed in a recent study by Save the Children,⁴⁶ with the exception of the MOSA who recently shared the cost allocations in the 2013 budget for health rehabilitation services. It revealed the urgent support program budget of NIS 58 million, part of which covers the exemption of medical insurance fees for PWD who show proof of permanent impairment above 60 percent. The report mentioned coverage of rehabilitation through sheltered accommodation and day care centers mainly for children with intellectual disabilities. The total number of children supported was 464, with a monthly range of NIS 350–700 per child. Other cost estimates of services or equipment are listed in the report as follows.

Table 17. Cost of Service Provision in the Disability Sector

Service	Cost (NIS)
Physiotherapy and occupational therapy sessions as outpatients	15–200 per session depending on location and provider
Inpatient rehabilitation accommodation fees at specialized rehabilitation center	450 without other related cost such as medication and therapy

⁴³ <http://www.worldbank.org/en/results/2013/05/21/support-to-education-health-social-care-and-public-utility-services-for-the-palestinian-population>

⁴⁴ David Wainer [1] "Palestinians Lure Banks With First Sukuk Bills: Islamic Finance," December 08, 2010, Bloomberg/Business Week.

⁴⁵ http://ec.europa.eu/commission/2014-2019/hahn/announcements/eu-releases-eu212-million-support-palestinian-people_en

⁴⁶ Save the Children. 2014. *Cost of service provision in the disability sector. Initial Study*. MOSA, Palestine.

Service	Cost (NIS)
Prosthetics and orthotics	6,000–19,000
Wheelchairs (manual)	1,000–7000
Hearing aids	1,500–3000
Wheelchair (electric)	9,000–25,000
Other assistive devices and technical aids (shower chairs, walkers, and crutches)	100–3,000

Source: Save the Children. 2014. *Cost of service provision in the disability sector. Initial Study*. MOSA, Palestine.

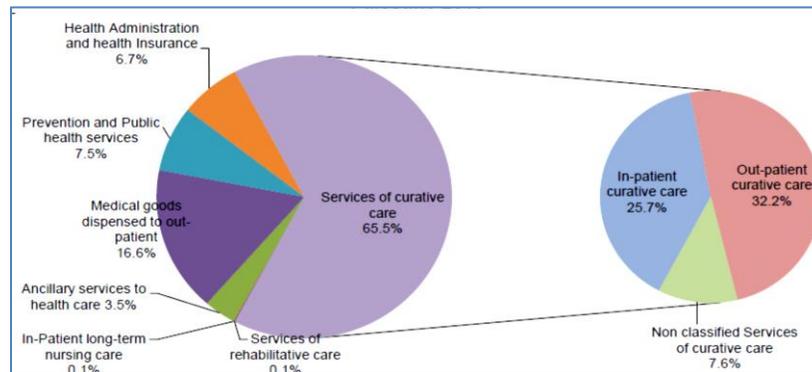
The MOH basically covers disability through referrals to rehabilitation centers run by NGOs. There are no clear financing strategies and budget allocations within the MOH to cover rehabilitation services for PWD. Most of existing financial coverage is channeled through the external referral mechanism managed by the MOH (covering part or full expenses at rehabilitation centers run by NGOs), which does not necessarily ensure access to the required rehabilitation needs of PWD.

To increase the financial coverage for disability, the PA has tried adopting a variety of service delivery mechanisms that can be subsumed within the overall envelope of education, health, and social care. In the early 1990s, the PA’s strategy in ensuring access to basic services for PWD was mainly through contracting services out—mainly to national key NGOs in the field of disability. In the past 5–7 years, this strategy has shifted with the PA taking on more responsibility for the provision of some services either directly or through transferring responsibility (for financing, provision, and regulation) to the lower tiers of the government.

Health Spending

The PCBS Statistical Report, *Palestinian Health Accounts 2013*,⁴⁷ reveals an increase by 6.8 percent in the total expenditure on health in all economic sectors. In 2012, health expenditure totaled US\$1,262 million compared to US\$1,347 million in 2013. Yet, when analyzing the expenditure by function of care as in the two charts below, the indication of expenses related to health rehabilitation is estimated to be only 0.1 percent for services of rehabilitation care.

Figure 7. Percentage Distribution of Total Expenditure on Health by Function of Care in Palestine



⁴⁷ Palestinian Central Bureau of Statistics, Ministry of Health. 2015. *Palestinian Health Accounts 2013*: Ramallah, Palestine.

Source: PCPS 2013.

Although sporadic, spending on disability is best captured by disability referrals offered under the Government Health Insurance (GHI) program. In 2009, the GHI covered 60.4 percent of the Palestinian population and 29.9 percent paid premiums,⁴⁸ while the rest received health services free of charge. Compared to 2000, there has been a decrease in private contributions from workers in Israel, individuals, companies, and private institutions, while MOSA contributions to cover health care for the poor and needy groups has almost doubled in 2006. However, many families do not use health insurance services, which could indicate a lack of confidence or dissatisfaction in the services covered by the GHI, or difficulty in accessing listed service providers. According to the 2007 Health Sector Review, “patient satisfaction with Palestinian health care system is low. Patients generally regard health care services in Palestine as inferior and seek care in Jordan, Israel, and elsewhere.”

Law Number 4 for the Year 1999 Concerning the Rights of the Disabled Chapter 2/Article 10 requires the government to “guarantee health services that are included in the government health insurance free of charge both to the disabled individual and to his/her family.” According to the GHI policy, the MOH should cover all medical and rehabilitation services costs for PWD and authorize public sector referrals for specialized care services. However, in practice, this is not the case. A major part of the above regulatory framework is the referral of PWD to rehabilitation services and assistive devices outside the public system (that is, to a service provider in Palestine but outside the public system or a service provider outside of Palestine) when these services are not available within the government system. This applies if they hold a valid health insurance and a report from a government hospital that indicates that relevant treatment/rehabilitation or assistive devices cannot be provided by a government hospital and referral is required.

An assessment of health services capacity was undertaken in the West Bank⁴⁹ in 2014 that focuses on cost of referrals. It mainly included (a) cost and number of referrals being made from secondary to tertiary care across West Bank and Gaza; (b) distortions in referrals that result in higher costs for referrals to Israeli hospitals; and (c) capacity of referral hospitals in the West Bank and Gaza to treat cases that are currently referred to Israeli hospitals.

The report indicated that the number of referrals has increased eightfold in the last 13 years. As the number of referrals has increased, so has the cost. The consistent upward trend is particularly concerning in a health system where referrals represent 40 percent of the MOH budget. Referrals for specialized care from the MOH have increased steadily from 8,000 cases in 2000 to almost 62,000 in 2013, costing NIS 578.2 million. Figure 8 shows the facilities in the West Bank and East Jerusalem that took referrals. Out of these, only six are rehabilitation centers that provide services for PWD. When adding up the referrals that those centers have received in 2013, only 2,902 referrals out of the 62,000 were for rehabilitation services, and the majority of them covered inpatient and outpatient physical rehabilitation services (occupational therapy, physiotherapy, and nursing).

⁴⁸ MOH. 2010. *National Strategic Health Plan 2011-2013*.

⁴⁹ USAID. 2014. *Rapid Assessment Of Health Services Capacity In The West Bank Palestinian Health Capacity Project*.

The main share of the MOEHE's allocation and expenditure targeting these groups is provided as salary payments for special resource teachers and counsellors. In addition, Braille textbooks at all levels of the system are financed from the MOEHE's budget. Resource teachers for basic education schools have a specific role in supporting children with mild disability under the inclusive education policy. In addition, resource rooms are attached to basic mainstream education schools though these are not yet provided through the regular budget but either through NGOs or community efforts. However, resource rooms are now mandatory in the design of all new schools. Other current allocations of costs include the following:

- For student with visual impairments: The ministry has its own centralized Braille printer and prints all books for students who are enrolled at the government schools. The cost of each book is around US\$1,500 and the student has only to pay US\$10 per book. Additionally, they cover expenses related to books with enlarged font when needed.
- If available through project-based funding, the ministry covers expenses of hearing aids but this is subject to donor budget allocations.
- In the past 10 years, the ministry has managed to create resource rooms in 81 schools out of 2,000 schools at a cost of US\$5,000–7,000 each.
- The ministry finances salaries of around 160 teachers to teach in NGOs providing education to children with hearing impairments or learning difficulties.

Apart from the above, the MOEHE has no budget lines allocated to inclusive education and no policy of subcontracting to ensure provision of services to students with disabilities who cannot be included in the public school system. Most families of CWD (mainly those with hearing and intellectual disabilities) end up having to pay for education services by NGOs or the private sector.

Economic Empowerment Spending

Since most economic empowerment programs are run by NGOs, the data on public spending was not available, with the exception of the MOSA. The MOL is the key agency for supporting employment and economic empowerment services for PWD but no information was available on their programs. Thus, an attempt was made to identify MOSA expenditures for the following programs:

- **The economic empowerment program.** The total budget allocated is NIS 12 million and is provided to PWD in the form of no-interest grants. Since it was established in 2009, the program has serviced 556 loans to persons between 18 and 60 years of age.
- **Specialized vocational rehabilitation programs.** The MOSA runs three centers—one in the south, one in the center, and one in the north of the West Bank. There was no clear budget allocation yet and the ministry sponsors staff and running expenses. The

establishment of the center in the middle region along with one-year support cost was estimated to be US\$580,000.⁵⁰

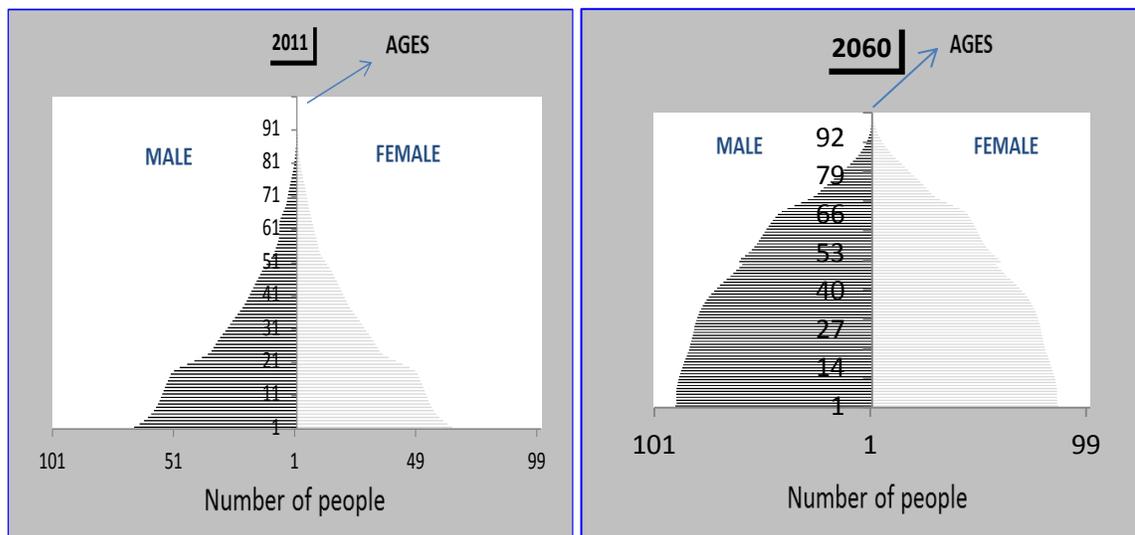
Noncontributory and Contributory Benefits Program

To establish the total costs of the disability benefits is quite a complex task given the different factors involved. A proper analysis should aim to include the current and projected costs and benefits of the monetary compensation for PWD, as well as the costs of in-kind benefits and services in general, taking into consideration all the associated costs of disability such as personal assistance or extra transport costs. This should also include the consideration for rehabilitation and support services (including assisting devices), costs, and benefits. Given the limited time and budget for this exercise now, this section presents some guidance on how best to analyze the benefits for disabled beneficiaries both in the contributory and noncontributory context. It follows some guidelines for effective financial governance.

Contributory programs—Unsustainable and Inaccessible for PWD

While the population in the West Bank and Gaza is one of the youngest in the Middle East and North Africa region, the population is also aging and elderly are generally more vulnerable, with disability prevalence highest among older age cohorts. The total population in the West Bank and Gaza is today around 4.1 million, with 4 percent aged 60 years or older. There are basically less than 185,000 people aged 60 years or older. However, by 2020 the population of elderly will already be more than 240,000, representing more than 5 percent of the population. By the year 2030, they will represent 7 percent, and by 2060, they will be 15 percent of the total population.

Figure 9. Population Pyramids, West Bank and Gaza, 2014–2060



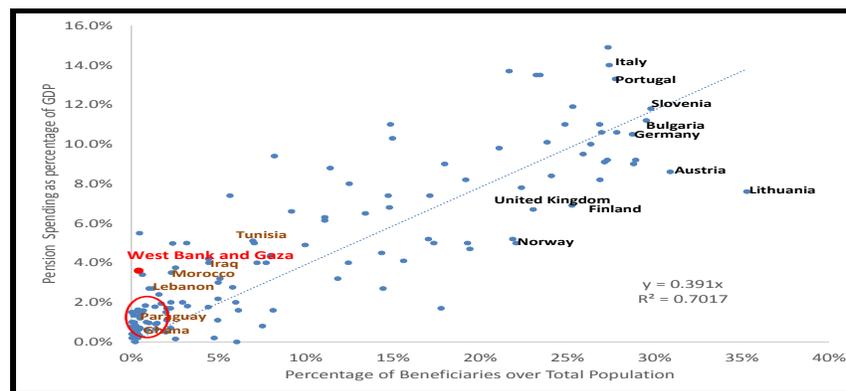
Source: PROST

⁵⁰ Save the Children 2014.

Prevalence of disability is expected to increase with an aging population and ongoing conflicts. The latest conflict, which erupted in Gaza in July 2014, has caused a humanitarian crisis affecting most of the 1.8 million people in Gaza, including 110,000 older people. Emergencies pose a wide range of serious threats to security, health, and well-being. The situation of older adults is generally much less known and their needs and potential capabilities are often overlooked in emergency policies and programs. Opportunities to assist older adults are generally missed, leaving many without any protection. When projecting disability costs, it is important to consider these factors.

Only around 1 percent of the total population in the West Bank and Gaza are receiving some type of pension from the contributory system. Thus, the cope of including benefits for disability is difficult to foresee. In 2013, there were only a little more than 40,000 people receiving some type of benefit from the contributory system (almost half of them were receiving survivorship pensions). Comparison with countries with similar percentage of beneficiaries over the total population also confirms **the heavy burden of pension expenditures in the West Bank and Gaza.** Countries with similar percentages of coverage, such as Paraguay, Ghana, or many others, have a lower percentage of pension spending over the gross domestic product (GDP), between 0.1 percent and 2 percent of GDP (see figure 10).

Figure 10. Pension Spending Pattern



Source: HDNSP Pensions Database.

The Palestinian contributory system is mostly financially unsustainable in the current form and urgently requires reform. The fiscal burden of paying for pension is already apparent and projections show rapid worsening. There is a clear danger that the scale of the transfers needed by the pension system, now and in the future, will ‘crowd out’ spending on other vital programs, such as the CTP (and others). The current beneficiaries and costs of the CTPs vs. beneficiaries and costs of the social insurance program in the West Bank and Gaza are presented in table 19.

Total pension spending in 2013 was around NIS 1,089 million,⁵¹ which represents around 3 percent of Palestinian GDP.⁵² As indicated in table 19, CTP represented instead 1.6 percent of

⁵¹ Based on December 2013 data (the amount includes regular and lump-sum payments).

⁵² Estimated GDP in 2013 was NIS 40.72 billion.

GDP. However, the contributory system has only around 50,000 beneficiaries, while the CTP has around 700,000 (the CTP has more than 65,000 while the contributory system only has around 1,000 beneficiaries of disability pension). There is a clear danger that the scale of the transfers needed by the contributory system (unless it is reformed), now and in the future, will ‘crowd out’ spending on other vital programs, such as the CTP.

Table 19. Disability Beneficiaries vs. All Beneficiaries (CTP and Social Insurance Costs)

CASH TRANSFER PROGRAM		Aged Younger than 18	Aged 18 and Older	Total	Annual spending in NIS
NUMBER OF DISABLED					
	Men	30,208	7,615	37,823	35,062,763
	Women	21,954	6,203	28,157	33,424,786
NUMBER OF NON-DISABLED					
	Men	183,463	144,759	328,222	265,019,060
	Women	227,442	139,888	367,330	333,163,200
TOTAL SPENDING					1.6% of GDP (0.2% disability) 666,669,809
<i>Average monthly benefit (NIS)</i>					
AVERAGE BENEFIT FOR DISABLED					
	Men	81	63	-	
	Women	109	62	-	
AVERAGE BENEFIT FOR NON-DISABLED					
	Men	71	62	-	
	Women	79	70	-	
SOCIAL INSURANCE PROGRAM					
NUMBER OF DISABLED BENEFICIARIES		-	-	1,089	
NUMBER OF NON-DISABLED		-	-	45,557	
<i>Average monthly benefit (NIS)</i>					
AVERAGE BENEFIT FOR DISABLED		-	-	1,800	23,522,400
AVERAGE BENEFIT FOR NON-DISABLED		-	-	2,288	1,250,812,992
TOTAL SPENDING					3.1% of GDP (0.1% disability) 1,274,335,392

Sources: MOSA and PPA.

The following are the main characteristics that need to be considered during a cost analysis exercise of disability programs (in both contributory and noncontributory programs). The determinants of such costs are affected by three main elements: (a) probability of becoming disabled; the prevalence of disability is strongly correlated with age—although still very young, the West Bank and Gaza population is also aging; (b) benefit payments; and (c) survival probability for disabled beneficiaries (the life expectancy of PWD).

Noncontributory programs

Ensuring stable financing for social programs, such as CTPs in the West Bank and Gaza, financed by general revenues requires long-term actuarial projections of expenditures and a social budget. Preparing the government’s annual budget is a complex task and usually a difficult exercise in balancing competing demands. A social budget, combined with a Social Protection Expenditure and Performance Review (SPER), allows the government to calculate what percentage of its total budget will be needed, now and in the long term, so that the noncontributory schemes (such as the CTP in the West Bank and Gaza) provide the desired level

and quality of social protection. It is necessary to ensure that sufficient funds are allocated in the government's annual budget to permit the CTP to operate in such a manner that it can meet its objectives. The government should list CTP as a separate budget line and should account for the benefits and the administrative costs separately. Annual reports on the operations of the CTP should be prepared and submitted for approval to the legislature and the board (if there is a board).

The financial sustainability of both services and cash benefits for disabled is a very important element to be considered in the CTPs in the West Bank and Gaza. The earlier review conducted for the regional disability study revealed that these benefits have been designed without a clear vision of the long-term cost implications of the programs. It is important to determine the long-term cost implications and explore options to provide more cost-effective services and cash benefits. It is important to understand the costs—monetary and nonmonetary—related to the various forms of disability.

Guidelines for Effective Financial Governance

The disability pension program assessment and financial governance should focus on (a) administrative procedures; (b) definition of risks covered (partial/total, permanent/temporary); (c) disability assessment criteria; (d) benefit formula (or benefit in general); (e) cost of the program and financing mechanisms; and (f) costs and financing of rehabilitation programs.

Ensuring sound financial governance of the CTP and the department running the program is a key function for the effectiveness of the program. It is necessary to distinguish between governance of benefit expenditures, which are authorized under the legislation establishing the program, and governance of operational expenditures on administration.

Since the amount of benefit expenditures depends on the legislation (or policy decision), it is not subject to the same controls as the amount of administrative expenditures. Consequently, different approaches apply to financial governance of benefit expenditures and financial governance of operational expenditures.

It would be effective for the CTP program to have an accounting framework, which is a reporting system for producing the expenditures, and enabling the budget to be monitored. Management accounts can also be produced to supplement the income (budget allocation for CTP) and expenditure account and support the monitoring and evaluation of the finances of the scheme, and thereby enable a detailed analysis of costs (this would be an equivalent of the annual balance sheets in the contributory schemes).

Annual budget of CTP would have three main purposes:

- (a) Planning - quantification of the cost of actions required to achieve immediate and long-term objectives. This allows donors and other interested parties to see which objectives can be achieved in the coming year and which have to be postponed.
- (b) Authorization - the approved budget creates authority to incur expenditures.

(c) Control - the approved budget for CTP is the basis for monitoring and control of the department's operations

It provides a standard against which performance can be measured.

H. Moving Forward - Learning and Localizing Global Experiences

The country's success in bringing the agenda to the forefront of the national dialogue is apparent in the assessment. It is also apparent that there is no single best way to forecast and provide needs. Moving forward, the objective is to maximize the impact of the existing and planned programs on well-being of PWD. More concretely, the objectives are (a) significant reduction of exclusion among the disabled; (b) increased access to diversified, good quality, community-based and family-oriented social care and rehabilitation services; and (c) increased access for the disabled aimed at social and economic empowerment.

Lack of adequate data and resources have prevented analysis of various program and cost options to propose a strategic and technical work program that will maximize impact for PWD. Even so, the data gathered can contribute to the debate about improving service provision, the assessment finds that a bit more foundational and technical work is required to propose an informed direction to the PA.

The strategy should be embedded in the principles of capturing the 'low-hanging fruit' and paving the pathway toward increased inclusion. The UN CRPD recognized that countries will progressively realize the rights that they commit to by ratifying the Convention.⁵³ Countries must develop and implement laws, policies, and reforms in “a sequence and at a pace that is practically feasible, given the country's resources, political system, and social and cultural context.”⁵⁴ The recommendations below respond to the need for a systematic phased approach for the immediate, medium, and long term.

- **IMMEDIATE** actions that can be taken during the next 12–24 months to lay the foundation for modernizing the institutional support functions and providing direct benefits to PWD.
- **MEDIUM-TERM** actions (2–4 years) are directed at removing basic obstacles in achieving social and economic independence through sector reforms across.
- **LONG-TERM AGENDA** is to promote universal access (accessible public facilities and transport) and inclusion. This is an overarching element with no time constraints. It would seek to involve all stakeholders—the disabled, non-disabled, communities, the public and private sectors—in the design and implementation of accessible infrastructure and facilities. This work also has to be embedded into sector dialogue and operational planning.

This chapter focuses on immediate and medium-term actions under broad two primary areas.

⁵³ http://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf.

⁵⁴ Bickenbach et al. 2015. “Assessing Disability in Working Age Population a Paradigm Shift: from Impairment and Functional Limitation to the Disability Approach.” World Bank. <http://documents.worldbank.org/curated/en/2015/06/24660032/assessing-disability-working-age-population-paradigm-shift-impairment-functional-limitation-disability-approach>

- C. The first area is the **modernization of institutional structures and support services**. Central to this discussion is the disability assessment processes. Subsequently, five building blocks are discussed. The section concludes with gatekeeping procedures.
- D. The second area discussed is **direct support to PWD**, emphasizing specific human development interventions, specifically economic inclusion, health insurance, and educational resources centers.

Both areas of discussion cover an overview of the topics and specific project examples. It should be recognized that country context and disability policy greatly influence both areas of concern.

C. Modernizing Institutional Structure and Support Services

A.1: First Things First—Undertaking Disability Classification/Certification Review and prepare proposal for reforming the outdated system of classification

This is the single most important factor, which hampers PWD from being registered so that they can benefit from government and nongovernment programs. This should be reformed and the disability assessment should be in line with the WHO International Classification of Functioning, Disability, and Health (ICF). Historically, disability assessment has been synonymous with medical assessments of impairment. The understanding of disability has evolved to be broader than individual impairment.

The Assessing Disability in Working Age Population a Paradigm Shift: from Impairment and Functional Limitation to the Disability Approach report describes disability assessment and disability policy:

- Disability assessment is an authoritative administrative process of determining the kind and extent of disability as part of a larger state administrative procedure called disability evaluation or determination.
- Disability assessment is extensively used throughout disability policy as an essential part of the determination of eligibility for services, products, or protections authorized by a state official disability policy.
- Disability assessment is significantly shaped by disability policy. Disability policy, like all forms of social policy, is determined by many factors and designed for many purposes and objectives.

Disability assessment procedures can be judged in terms of validity, reliability, transparency, and standardization; but they will also be judged as fit for the policy for which eligibility is required. Typically, the assessment is used for the determination of employment benefits; however, there are significant implications on educational, health, and transportation benefits as well.

Evaluation and reform of the disability assessment processes could be in line with the WHO ICF. The 2003 ICF Checklist⁵⁵ provides information on the nature of information to be used in clinical settings. Clinical settings are not the only source of information. Physicians and other health professionals, social workers, employment counsels, assessment committees, tribunals, and other legal bodies, and state officers/program administrators often contribute to the process. Given the many sources of information and diversity, initial assessments may be challenged. Evidence documents that a high percentage of appeals are awarded to claimants. Therefore, appeals processes for the determinations are an essential part of the disability assessment process. Appeals allow for a reconsideration of information, correction, or addition to the record and testimony and/or support by PWD advocates.

However, given the complexity of functional approach, there are limitations to the usefulness of the ICF. The functional model introduced disability as a continuum, not a binary condition. Furthermore, clinical settings are not the only source of information for assessments. “The manner in which a health problem or impairment plays out in a person’s life is far more relevant in the determination of the person’s capacity to work than the medical cause or etiology of the problem or impairment.”⁵⁶ Physicians and other health professionals, social workers, employment counsels, assessment committees, tribunals, other legal bodies, and state officers/program administrators often contribute to the process. Since disability is not a black-or-white condition, the possibility of variability is introduced into the determinations process; thus, initial assessments may be challenged. Evidence from the United States suggests that the culture, and to a lesser degree supervisory preferences, influence the assessment process. Furthermore, a high percentage of appeals are awarded to claimants.⁵⁷ Therefore, appeals processes and other feedback mechanisms, such as satisfaction surveys, are an essential component of the disability determination system, to allow for a reconsideration of information, correction, or addition to the record and testimony and/or support by PWD advocates.

A.2 Getting it Right—Consolidating Disability Data and Improving Targeting

Among the benefits of using the ICF as a basis for establishing disability assessment, is that it provides an international platform for assessment and measurement, an optimal data reporting structure, and an accountability framework, which is increasingly being internationally accepted.⁵⁸

At the country level, the ICF can further assist with the consolidation of data, the cooperation across ministries and programs, and better monitoring and evaluation systems. While it should be recognized that different criteria for participation in programs may be necessary, the consistency of data provides an opportunity to base policy decisions on evidence and allow for accommodation or disability-specific factors such as improved targeting and participation by PWD on an equal basis as other persons.

⁵⁵ <http://www.who.int/classifications/icf/icfchecklist.pdf?ua=1>.

⁵⁶ Bickenbach et al. 2015.

⁵⁷ Keiser, L. 2003. The Determinants of Street-Level Bureaucratic Behavior: Gate-keeping in the Social Security Disability Program. National Public Management Research Conference, Georgetown University, Washington DC. <http://pmranet.org/conferences/georgetownpapers/Keiser.pdf>.

⁵⁸ Bickenbach et al. 2015.

The Sri Lanka project,⁵⁹ ‘Diri Sawiya’ Assisting PWD through Cash Transfers and Training (P123632), was designed to provide targeted cash transfers to PWD and to pilot vocational training and skills development for disabled persons.⁶⁰ The pilot demonstrated the need for the government to develop effective electronic management information systems (MIS) that could be used by many ministries of various purposes. It has led to the proposed collaboration on MIS between the Ministry of Housing and Samurdhi (MHS)—which operates an integrated welfare program that provides cash transfers, microfinance, and various community and livelihood development activities—and the Ministry of Social Services, Welfare and Livestock Development (MSSWLD)—which provides social pensions for the elderly and PWD—and the 331 divisional secretaries—which manage social services at the local level.

The Diri Sawiya project also used the WHO/World Bank Model Disability Survey (MDS) to establish baseline data on the current prevalence of disability with in the country and the individual and household demographics of person with disabilities. The WHO and the Bank collaborated on the development of the MDS. The MDS is a general population survey that provides detailed and nuanced information on the lives of PWD.⁶¹ Responding to the well-documented lack of internationally comparable data, the MDS allows for “direct comparison between groups with differing levels and profiles of disability, including comparison to people without disability. The evidence resulting from the MDS will help policymakers identify which interventions are required to maximize the inclusion and functioning of PWD.”⁶² The MDS has been conducted in Chile⁶³ and the results of both surveys are expected in 2016.⁶⁴

Because the survey addresses not only reliable self-reports of health conditions but also accurate insights about the environmental condition and accommodation such as assistive devices and personal assistance, the results of the MDS helped paint a picture of how PWD experience disability in real life contexts.⁶⁵ As a standardized instrument for data collection on disability, the MDS “provides comprehensive and systematic documentation of all aspects of functioning in a population” to provide the data needed for effective disability public policy and allow for international comparison.”⁶⁶ Furthermore, it may provide the evidence needed to identify interventions that may be needed and contribute to the evaluation of the effectiveness of interventions.⁶⁷

Experience from Sri Lanka demonstrates that consolidation of data could be a critical step towards targeting and effective disability determination system. Building upon the Diri

⁵⁹ Sri Lanka “‘Diri Sawiya’ Assisting PWD through Cash Transfers and Training” project (P123632). <http://www.worldbank.org/projects/P123632/diri-sawiya-assisting-pwd-through-cash-transfers-training?lang=en&tab=overview>.

⁶⁰ Ibid.

⁶¹ http://www.who.int/disabilities/data/mds_v2.pdf?ua=1.

⁶² http://www.who.int/disabilities/data/srilanka_mds/en/.

⁶³ http://www.who.int/disabilities/data/chile_mds/en/.

⁶⁴ The MDS was pilot tested in Cambodia and Pakistan.

⁶⁵ Chatterji. “Designing a Model Disability Survey –A Consistent Conceptual and Measurement Framework for Disability Data.”

http://intresources.worldbank.org/DISABILITY/Resources/280658-1327953883745/MDS_rationale.pdf.

⁶⁶ <http://www.who.int/disabilities/data/mds/en/>.

⁶⁷ Chatterji. Ibid.

Sawiya project, the proposed Sri Lanka Social Safety Nets Project (P156056)⁶⁸ has planned to further enhance the poverty impact of its cash transfer disability benefit by improving their targeting, coverage, and accountability. Targeting of disability benefits is based on income, household, and beneficiary characteristics (including age and severity of disability). The household characteristics used for targeting are a subset of those used under the government's largest social safety net programs. Therefore, part of the reforms includes the development of the MIS, which will provide the ability to share information across ministries, manage payments of benefits electronically, and provide opportunities to document effectiveness of the program. Communications campaigns will be developed to inform beneficiaries of program changes regarding targeting and payment of benefits. Additionally, a process evaluation will be conducted to refine the registration and payment of disabled beneficiaries. The proposed reforms are a part of the overall development of a national social protection strategy.

The Bosnia and Herzegovina Social Safety Nets and Employment Support Project addressed targeting.⁶⁹ There were significant political challenges to the address through both empirical research and communication channels. The political challenges stem from a system that used categorical status of disability as the primary, if not sole requirement for services. The prior benefits system was highly regressive, lacking in equity and efficiency. Simulations with Proxy Means Testing (PMT) suggested that better targeting outcomes for non-insurance transfers would redress the inequity and elevate some of the mounting fiscal pressures. Technical assistance would be provided to support (a) improvements in the survey instrument for a living standards scorecard to determine household and individual eligibility based on the proxy means targeting formula and (b) introduce WHO disability assessment based on functioning. It should be noted that the success of the targeting also required the development of a communication strategy. This component was necessary to explain the reforms, increase the transparency of the program, and address those with the greatest needs, which were not met.

A.3 Unbundling and Clarifying Gatekeeping Procedures

Given that disability certification is necessary to access benefits, gatekeeping procedures are critical to establishing who can become beneficiaries and the type, level, and duration of benefits. While gatekeeping is often seen as a way to restrict access to a specific population for specific services, it has the potential to create transformative opportunities by “aligning services of any type with users who can make best use of them.”^{70,71} There may be different entry

⁶⁸ Sri Lanka “Social Safety Nets Project (P156056)” http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/SAR/2015/10/02/090224b08311cf25/1_0/Rendered

⁶⁹ Bosnia and Herzegovina - Social Safety Nets and Employment Support Project (P116774) http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2010/02/10/000333037_20100210003029/Rend ered/PDF/509170PAD0P1161y100IDA1R20101002611.pdf

⁷⁰ Evans, Peter (May 12–14, 2009) “Improving Gatekeeping Functions of Child Protection Systems” Background paper prepared for 2nd Child Protection Forum for Central Asia on Child Care system reform. Bishkek, Kyrgyzstan

⁷¹ WHO, Regional Office for Europe Office (November 26-27, 2010) “Identifying the Needs of Each Child and Young Person” presented at “Better health, better lives: children and young people with intellectual disabilities and their families” Bucharest, Romania, 26–27 November 2010. http://www.euro.who.int/__data/assets/pdf_file/0009/126567/e94427.pdf

paths to programs, but the policies, procedures, and administration must be consistent across gatekeeping functions at the individual, community, and national levels.⁷²

Gatekeeping functions include (a) allocation of resources; (b) referrals to service agency; (c) case plan implementation and case management; and (d) case progress reporting, monitoring, and periodic assessment.⁷³ A proposal to develop gatekeeping procedures should include licensing and accreditation, quality standards, and monitoring and evaluation of services, as well as the creation of an integrated system of information and feedback.

In 2003, UNICEF and the Bank created a toolkit of Gatekeeping Services for Vulnerable Children and Families and examples of gatekeeping in European and Central Asia countries. The toolkit includes various templates and checklist, which may be adopted for disability contexts.

Inadequate organization of the gatekeeping function was one of the major barriers that the government of Azerbaijan was facing in 2008. Specifically, “the needs of vulnerable children, women, youth, elderly, PWD, and other vulnerable groups are mostly unaddressed, leaving them often marginalized and socially excluded. In response, the project intended to contribute to the restructuring of the National Disability Certification Service (NDCS);⁷⁴ however, the component was dropped due to insufficient knowledge by the ministry and bidders alike.⁷⁵ The ministry remained engaged with the topics and “made important progress in the area by improving governance and business processes in the implementation of disability policy. The ministry has drafted two key documents on the future of disability policy in Azerbaijan - Draft Law on Persons with Disabilities (in line with international standards) and National Action Program on Protection of Rights of Persons with Disabilities.” The lesson learned from the project was that “Institutional development and reform take time and the path to changes can be, and often is, circuitous. The key is to acknowledge this and to remain engaged in the effort. Oftentimes that engagement requires access to high level policy makers.”

With regard to setting up a Case Management and Referral apparatus, there is a lesson to be learned from the Jamaica CCT MIS. The Jamaica CCT Management Information System⁷⁶ project presents an example of case management technology, “which allows social workers to focus and work on specific issues until a resolution is reached,” and encompasses the following functions:

(a) Process Application

⁷² Evans. *ibid.*

⁷³ <http://www.worldbank.org/content/dam/Worldbank/Event/safetynets/1.%20Disability%20and%20SSN%20December%2011%202013.pdf>

⁷⁴ Azerbaijan (2008) Social Protection Development Project P105116
http://imagebank.worldbank.org/servlet/WDSContentServer?IW3P/IB/2008/05/08/000333037_20080508035604/Rendered/PDF/426160PAD0P10517369B01off0use0only1.pdf

⁷⁵ Azerbaijan (2015) Implementation Completion And Results Report: Social Protection Development Project P105116

<http://wbdocs.worldbank.org/wbdocs/viewer/docViewer/index1.jsp?objectId=090224b08110300b&standalone=true&respositoryId=WBDocs>

⁷⁶ Quintero, H. “Jamaica CCT Management Information System: MIS System Requirements.”

<http://siteresources.worldbank.org/EXTSAFETYNETSANDTRANSFERS/Resources/Jamaica-PATH-MIS-System-Requirements.pdf>

- (b) Verify Education Compliance
- (c) Verify Health Compliance
- (d) Process Payments
- (e) Process Recertification
- (f) Process Family Changes
- (g) Process Complaints
- (h) Process Refunds
- (i) Process Appeals
- (j) Refer Case to Other Agencies
- (k) Monitor Payment Collection
- (l) Audit Beneficiary

However, technology alone is not sufficient for case management and referral availability and coordination of services is the key. It is key is to have local staff available who are knowledgeable about available services and creatively address service gaps. As described above, strong affiliations between entities at the local level allow for robust referral.

Case management is the “coordination of services on behalf of a party” and applies to both medical and employment services.⁷⁷ It recognizes that there are many aspects that must be addressed to achieve a desired outcome from a specific intervention and that a failure to address a barrier in one area may create barriers in another and reduce equity across the population.⁷⁸ Time is also an important element to case management. Shaheen⁷⁹ describes the process linearly, addressing five components. The sequential components are (a) identifying potential client base, (b) contacting potential claimants, (c) intervening through either direct provision of services or referral, (d) following up, and (e) monitoring and evaluation. However, the process is rarely so straightforward; rather it is often a reiterative process. Evidence suggests that many PWD, particularly those with mental health and psychosocial issues, may drop in and out of programs many times. The ease with which a claimant can reenter a program should be considered.⁸⁰ The provision of accommodation and coordination with other services by the case manager may be necessary to mitigate external stressors that negatively affect participation.

A.4 Advancing Inter-sectoral Collaboration for Optimizing Resources

Time and again, evidence has shown that lack of coordination among national authorities and between national and international agencies has had costly and adverse outcomes for the eligible and potential beneficiaries. Consistent with the understanding that disability is broader than individual impairment and needs to be reflected in the wide cross-section of sectors that are addressed by the various CRPD articles, collaboration with local government

⁷⁷ Grun, Rebekka. “Facing the client: the role of case management” Activation & Pathways to Self-Sufficiency in ECA: Bridging to New Knowledge Frontiers, Together. World Bank.
http://siteresources.worldbank.org/INTLM/Resources/390041-1141141801867/2275364-1333569565688/2Facing_client.pdf.

⁷⁸ Marquez, Patricio. 2014. “Integrated Community Case Management: How Can We Ensure Its Sustainability?”
<http://blogs.worldbank.org/health/integrated-community-case-management-how-can-we-ensure-its-sustainability>

⁷⁹ Shaheen. 2008. “Prevention and Protection of Working Children,” cited in Grun, *ibid*.

⁸⁰ Willman, Alys, Ann Willhoite, and Natalia Tejada V. 2015. “Fundamentals of Psychosocial Support and Development in World Bank Operations. (link forthcoming).

education/health offices and NGOs will be critical to optimize resources and reach those who truly deserve these services.

The **Disability Action Council of Cambodia** is an example of collaboration to secure prosthetics and orthotics, develop professional rehabilitation training, facilitate local management, and otherwise share information.⁸¹ A second example is the Serbia Delivery of Improved Local Services

(DILS) Project, which “works across the education, health, and social protection sectors, and is closely tied to efforts to strengthen the capacity of local public administration, [to] facilitate an integrated approach to service delivery and allow for the coordination and phasing of sector-specific policy measures and investments. Policies to improve service delivery to households, and to assist vulnerable groups (including the disabled, children, and elderly) in particular, require coordination of health, education, and social assistance measures. A recent World Bank report on social assistance and child welfare in Serbia demonstrated that the greatest need for improved health, education, and social protection is often among households in the same target beneficiary group.”⁸²

In 2013, the Technical Secretariat for the Inclusive Management on Disabilities of the Vice-presidency of the Republic of Ecuador was established to coordinate across sectors, to develop and implement public policy on disabilities. It works on many fronts—universal accessibility, productive and inclusion, disaster risk reduction, and others. Its strategy is to strengthen the territorial networks’ intersectoral coordination at the district level and the creation of local management committees on disability, community action plans, and citizen assemblies, at the parish level in the country. An example of its local action is the implementation of citizen observatories that provide evidence on how well-addressed programs are working in the areas of PWD access to health, work, education, communication, participation, and justice.⁸³

Ecuador’s Disability Action Plan provides another successful intersectoral coordination of services along the one-stop concept. It covers therapeutic assistance, such as aids for daily activities; social protection and ongoing care; preventative measures such as neonatal screening; inclusion programs; and ensuring the ability to exercise civil and political rights. Ecuador’s disability reforms have benefitted significantly by the actions and visibility of former Vice President, Lenin Moreno. As a wheelchair user, his personal experience sheds light on the political and institutional processes that were necessary to move Ecuador in 2008 “from being a state without a policy for PWD and with isolated welfare proposals, to a country that offers a wide range of opportunities so that this priority group can be included in society in the best way possible, by giving this group an active role in the construction of the future,” in 2013.

A.5 Deepen Understanding and Capacity of Decision Makers and Practitioners on Disability Issues and Prejudices

⁸¹ World Report on Disability.

⁸² Serbia Delivery of Improved Local Services (DILS) Project (P096823)
http://imagebank.worldbank.org/servlet/WDSContentServer/IW3P/IB/2008/02/28/000333037_20080228231611/Rendered/PDF/389210PAD0P0961e0only10R20081003211.pdf.

⁸³ <http://www.worldbank.org/en/news/feature/2012/01/23/ecuador-people-with-disabilities-fight-for-real-inclusion.print>.

The understanding of disability has been undergoing an evolution at international levels. Understanding disability through the bio-psychosocial model creates opportunities for a wide range of stakeholders to contribute to formulation and implementation of disability policy and programs to enable PWD to participate in the economic and social society. However, a shared understanding is insufficient. Capacity building at all levels is needed to achieve an inclusive society. One must be able to identify barriers to full and equal participation as well as have the tools to remove obstacles. Soliciting input directly from PWD facilitates the identification and removal of barriers and development of accommodations. Sustained positive interaction with PWD may also serve to lessen stigmatization of PWD. Conversely, a lack of understanding of the experiences of PWD may foster prejudice and lack of action.

WHO elaborates three domains for capacity building.⁸⁴

1. Human resources: people and the knowledge and skills they require.
2. Institutional and infrastructural capacity: the systems and structures necessary to allow the people referred to above to be effective.
3. Networks and partnerships: a means by which capacities can be strengthened within and across settings and important for using resources effectively and priority setting.

The capacity-building approach was uniquely framed within a systems approach in Malawi to develop an understanding of the educational situation of CWD. A Situational Analysis was commissioned for the Malawi Inclusive Education for Disabled Children Project (P126025) to improve implementation progress. The analysis took seven months to complete, at a cost of US\$140,000. The terms of reference for the Situation Analysis included a comprehensive institutional review of the roles, responsibilities, and capacity of all parties, including the government, CSOs/NGOs, donors, and parent groups. Both qualitative and quantitative methods were used. The findings included the strengths, weaknesses, opportunities, and threats to the capacity of the government stakeholders. The recommendations were at the local school, community level, and national policy and institutional levels, in addition to project-specific resource and management recommendations. The analysis proposed three actions. The first critical step was to establish a shared understanding across the levels about disability and the objectives of disability policy as it pertained the various roles. Additional steps included the mapping of community resources, and linking with relevant networks such as existing NGOs, local health services, and parent groups is to be a part of the plan too.

As a result of the Situation Analysis, both the project design and implementation of the project was restructured. These changes included reframing local interventions as pilot projects, significantly reducing the number of schools receiving grants and revising the number of teachers trained. In addition to direct support of local schools, the Situational Analysis highlighted major gaps in the knowledge of, experience with, and capacity to implement inclusive educational policies. The project fostered the emerging National Education Sector

⁸⁴ WHO. 2009. Strategic plan for capacity building 2009–2013.
http://www.who.int/violence_injury_prevention/capacitybuilding/strategic_plan/Strategic_plan.pdf?ua=1

Policy (NESPo), in the Ministry of Education Science and Technology (MoEST) strategies, and across all mainstream departments and education institutions.

D. Planning and Providing Direct Support to PWD—Aligning with Priorities identified

Direct support to PWD and their households can come in many forms. Income support for those unable to work is typically the most common form of support; however, those forms of support also contribute to the integration of PWD into social and economic participation. In some instances, “transfers and other services to target households is even more important for vulnerable groups than for other recipients of social assistance.”⁸⁵ This report recommends three areas for consideration that will, if provided in concert, deliver the direct benefits to PWD. These three areas are (a) economic support of PWD, addressing both inclusion and accommodation of programs; (b) improved health insurance and provision; and (c) inclusive education at the primary and secondary levels. Case studies of each area are provided below as examples of the types of actions that can be taken to lay the foundation for support of PWD.

The results of a study of economic and poverty situation of working-age PWD and their households in 15 developing countries provide empirical evidence that “policies and programs to improve socioeconomic status of PWD and their families need to be adapted to country-specific contexts.”⁸⁶ Notably, the authors argue that “comprehensive poverty profiles of persons and households with disabilities are needed for disability policies to be efficient and effective.” Furthermore, “research is needed to evaluate interventions such as income support and programs to economically empower PWD in developing countries. Some interventions, such as CBR, have long been in the field, but little is known on what works.” Both longitudinal and cross-sectional data is needed to fill the knowledge gaps.

The functional approach to disability assessment that the ICF supports is complex because disability is not experienced in a vacuum. Similarly, the processes, criteria, and benefits ascribed to disability assessment do not operate in isolation. Rather, disability assessment is greatly influenced by a disability policy, institutions, definitions of disability, institutional incentives, and broader social and economic objectives.⁸⁷ As Grosh et al. state:

“A perennial question regarding vulnerable groups and safety nets is whether they are better served through special programs or within the social assistance programs designed for the wider population. In general, the preference is to serve vulnerable groups through a single, well-run social assistance program on grounds of equitable inclusion and efficiency of operations, but this may not always be feasible. The decision will depend in part on technical criteria, such as the caliber of alternative general social assistance programs, the accuracy of categorical targeting by vulnerability versus poverty in a specific setting, and the scope for reducing administrative costs

⁸⁵ Grosh, M., C. del Ninno, E. Tesliuc, and A. Ouerghi. 2008. “For Protection and Promotion: The Design and Implementation of Effective Safety Nets.” World Bank, Washington, DC.
<https://openknowledge.worldbank.org/bitstream/handle/10986/6582/45496.pdf?sequence=1>

⁸⁶ Mitra, Sophie, Posarac Aleksandra, and Vick Brandon. 2011. “Disability and Poverty in Developing Countries: A Snapshot from the World Health Survey.” SP Discussion Paper 1109, World Bank, Washington, DC.

⁸⁷ Bickenbach et al. 2015.

by combining programs. More qualitative factors such as whether political support for the vulnerable groups differs, whether earmarked transfers will empower members of vulnerable groups within their households, and whether special programs would be more or less stigmatizing than general social assistance are also significant factors in the decision.”⁸⁸

B.1 Promote Economic Inclusion of PWD

Building on the MOSA’s plans, an attempt will be made to lessen the tension among CTP beneficiaries by boosting the support to beneficiaries through an integrated package of services for PWD.

The Bosnia and Herzegovina Social Safety Nets and Employment Support Project⁸⁹ offers two innovative features to support PWD. Component One provides technical assistance to develop, pilot, and introduce improved eligibility processes for non-insurance cash transfers. The innovation in this component pertains to the way the project rolled out to beneficiaries. Typically, a program would be offered to the general population first. This project phased the implementation by rolling it out to recipients of disability benefits and then extending to the general population. Selection of disability benefits first was a pragmatic step as a defined subset of the population for the implementation of CTP, to test the implementation arrangements before rolling out the program to all beneficiaries.

Contending that “Almost all jobs can be performed by someone with a disability, and given the right environment, most PWD can be productive,” the World Report on Disabilities employment chapter lays out the barriers to entering the labor market and how to address those barriers. Such barriers include lack of education and vocational rehabilitation and training, lack of access to financial resources, disincentives created by disability benefits, the inaccessibility of the workplace, and negative perceptions of disability and disabled people. It offers specific recommendations for action by governments, employers, and other organizations such as microfinance institutions and trade unions. The remedies to overcome the barriers faced by PWD seeking employment include addressing laws and regulations, which may include antidiscrimination and affirmative action regulations, incentives to employers, vocational rehabilitation, and training; self-employment and microfinance; working to change attitudes; and vocational case management.

In cases where either persons are unable to work or that suitable employment cannot be secured, alternative forms of income support may be implemented. Income support can come in the form of contributory pensions for workers who become disabled, or noncontributory CTPs. In the case of conditional cash transfers, accommodations might need to be made to the conditions to allow PWD to participate. In noncontributory schemes, care should be taken to minimize disincentives to those who might otherwise be economically able to exit from such programs.

⁸⁸ Grosh et al. 2008.

⁸⁹ Bosnia and Herzegovina - Social Safety Nets and Employment Support Project (P116774) http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2010/02/10/000333037_20100210003029/Rendred/PDF/509170PAD0P1161y100IDA1R20101002611.pdf.

Attention should be given to transitional programs that feature transitional services, “so that people feel an incentive to work, while at the same time being secure in the knowledge that a benefit is still available.”⁹⁰ In addition to the non-insurance unconditional cash transfer, the **Bosnia and Herzegovina Social Safety Nets and Employment Support Project**⁹¹ supported “job brokerage services for those active job seekers who become ineligible to receive cash transfers or who are vulnerable.” It specifically targeted PWD who are able to work. The component helped improve the political acceptability of targeting and other safety net reforms by providing transitional support to those who would lose benefits as a result of these reforms and an activation role to help vulnerable jobseekers access job opportunities. The specific activities that the project supported included on-the-job-training apprenticeships; self-employment; workfare; job counseling services; public and private partnerships for job brokerage and capacity strengthening of employment services to focus on job brokerage services. As a result, 10,833 hard-to-employ jobseekers received services.⁹²

Encouraging entrepreneurship is another path to empowering PWD economically. One example of a successful program is the Technical Secretariat for Disabilities of the Vice-presidency of the Republic of Ecuador provision of “financial capacity building and training in support of enterprises run by persons with disabilities” As a result, the Technical Secretariat has supported 257 enterprises and has committed to supporting an additional 250 through the end of 2015. It recognizes that assessment of the program is essential, and therefore, it is collaborating to identify, assess, and implement a set of measurement indicators, including indicators to assess poverty levels.⁹³

B.2 Extend Health Insurance Coverage to PWD

The review of the existing MOH health insurance package will be a critical first step toward addressing the issues of limitations for PWD on their coverage. Priority should be given to provide assistive **devices (prosthetics and orthotics) to 75 percent of PWD** as part of critical service package to prevent the existing mobility, hearing, and vision capacity from deteriorating further. An example of a reform package is the provision of the Basic Package of Health Services (BPHS) by the government of Afghanistan.⁹⁴ The Ministry of Public Health (MOPH) explicitly expanded coverage to include both mental health services, specifically, (a) community management of mental problems and (b) health facility based treatment of outpatients and inpatients and physical disability services, such as (i) physiotherapy integrated into primary health care services and (ii) orthopedic services expanded to hospital level. The reform took place over 10 years ago. The Bank contributed to this reform, which “expand[ed] the scope, quality and coverage of health services provided to the population, particularly to the

⁹⁰ Mont D. 2004. “Disability employment policy.” SP Discussion Paper 0413, World Bank, Washington DC.

⁹¹ Bosnia and Herzegovina - Social Safety Nets and Employment Support Project (P116774). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2010/02/10/000333037_20100210003029/Rend ered/PDF/509170PAD0P1161y100IDA1R20101002611.pdf.

⁹² Bosnia and Herzegovina - Social Safety Nets and Employment Support Project (P116774). Implementation Status and Results Report Seq. No. 11. http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/ECA/2015/05/26/090224b082ec52fe/1_0/Rendered /PDF/Bosnia0and0Her0Report000Sequence011.pdf.

⁹³ <http://microcreditsummit.org/news/80/the-government-of-ecuador-announces.html#sthash.HkKfdi69.dpuf>.

⁹⁴ Transitional Islamic Government of Afghanistan. 2003. “A Basic Package of Health Services for Afghanistan” <http://unpan1.un.org/intradoc/groups/public/documents/APCITY/UNPAN018852.pdf>.

poor, in the project areas, and to enhance the stewardship functions of the Ministry of Public Health (MOPH).” through a Results Based Financing Scheme in the amount of US\$100 Million.⁹⁵

B.3 Extending Education Coverage to PWD—Developing Resource Centers for Inclusive Education

The evidence from the existing resource centers indicates that these resources centers, though limited in number, are having a significant impact in terms increased enrollment among CWD.

Moldova took small but significant steps to turn around the education structure to integrate PWD. Historically, the government of Moldova maintained residential institutions, which served to isolate and stigmatize PWD. Over the past decade, the Ministry of Labor, Social Protection, and Family (MLSPF) has moved many PWD out of central residential institutions and into private homes or into small group homes through the creation of social care service centers, foster care, and small-scale group homes. The transition to a local care model has enabled better integration of PWD within local economic and social society. At the inception of the project, the Ministry of Education operated 52 residential institutions, including schools for children with learning disabilities and schools for children with physical and sensory impairments. The institutions often do not have the facilities and equipment to meet the needs of the children, are at a great distance from family, and are relatively expensive. The government has approved a Program for Development of Inclusive Education for 2011–2020 with the intent to mainstream CWD.

The Moldova Integration of Children with Disabilities into Mainstream Schools project contributes to this objective to mainstream CWD. It finances a pilot that “local governments can successfully apply national policies that promote integration of CWD into the mainstream education system” by improving access to existing schools and the creation of ‘hubs’. The project finances 20 demonstration projects. The project engages in (a) data collection and services delivery to PWD; (b) policy development and implementation through capacity development and integration between local governments and schools, ministries (Ministry of Labor, Social Protection and Family and the Ministry of Education), and donors (Japan, UNICEF Moldova, World Bank); and (c) activities in a variety of interrelated areas, specifically planning, construction, training, and community engagement, to cover the interrelated aspects of meeting the needs of students with disabilities⁹⁶.

Similarly, the objective of the Republic of Malawi’s Inclusive Education for Disabled Children Project is to “test innovative methods to promote the enrolment of CWD currently excluded from mainstream schools and influence the development of an inclusive education policy.” The components of the project include (a) direct support to local schools, (b)

⁹⁵ Afghanistan: System Enhancement for Health Action in Transition Project (P129663). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/02/21/000442464_20130221131427/Rend ered/PDF/736450PJPR0P120Official0Use0Only090.pdf.

⁹⁶ www.worldbank.org/projects/P144618/integration-children-disabilities-mainstream-schools?lang=en

campaign to promote inclusive education, (c) capacity building of implementing agency, (d) policy dialogue, and (e) monitoring and evaluation. The combination of all components was necessary to demonstrate inclusive educational practice, measure progress, and create sustainability of the reforms. Some schools provide resource centers for students with disabilities. Such schools are concentrated in the most urban districts.

The objective of the resource centers is to prepare learners for inclusion in mainstream classes although some children may be educated exclusively within the resource centers in grades 1 and 2. The centers are staffed by teachers trained at Montfort SNE College and work collaboratively with parent support groups, school management committees, and mainstream classroom teachers. Schools without resource centers may employ special educational needs itinerant teachers; however, not all schools can provide these services. The policy and practices of the centers are not without controversy; some parents relocate their families to enable their children to participate in the resource centers. Conversely, some parents and student with disabilities report they would rather be educated in segregated school, in response to high levels of stigmatization in mainstream school. Public link: http://www.worldbank.org/projects/P144618/integration-children-disabilities-mainstream-schools?lang=en_

The UNESCO 2010 Global Monitoring Report⁹⁷ presents four examples of support to CWD in schools.

- “The Lao People’s Democratic Republic has a network of 539 schools - three for each district in every municipality and province - that teach children with disabilities alongside their peers and provide specialized support. The schools give children with special needs opportunities to learn in an inclusive environment, partly through investment in specialized teacher training. The experience accumulated through the program is informing wider school reforms (Grimes 2009).”

http://www.eenet.org.uk/resources/docs/A_Quality_Education_For_All_LaoPDR.pdf

- “In South Africa, the focus has shifted from special schools to inclusive education in mainstream schools. Authorities have to identify the level of support required by individual learners with disabilities (South Africa Department of Education 2005; Stofile 2008)”⁹⁸ “Research in Eastern Cape, one of the poorest provinces, found that inclusive education produced significant gains, ranging from improved physical access to support for specialized teaching practices and increased admission of learners with disabilities (Stofile 2008). Non-government organizations have played an important part and in many poor countries are the primary source of education for children with disabilities. Through

⁹⁷ UNESCO. 2010. “EFA Global Monitoring Report: Reaching the Marginalized.” <http://unesdoc.unesco.org/images/0018/001866/186606E.pdf>

⁹⁸

- [http://etd.uwc.ac.za/xmlui/bitstream/handle/11394/2827/Stofile PHD 2008.pdf?sequence=1](http://etd.uwc.ac.za/xmlui/bitstream/handle/11394/2827/Stofile_PHD_2008.pdf?sequence=1).

active engagement with children with disabilities, their parents and education authorities, such groups are producing results that demonstrate what is possible.”

- In 2003, a Bangladeshi NGO, BRAC, established a preschool and primary education program aimed at increasing participation by children with mild special needs. By training teachers, providing equipment, adapting the curriculum, and improving physical access, it had reached about 25,000 children by 2006 (Ryan et al. 2007; UNESCO 2010, 202)⁹⁹.

⁹⁹ www.niaslinc.dk/gateway_to_asia/nordic_webpublications/x506033235.pdf

SUMMARY

The country's success in bringing the agenda to the forefront of the national dialogue is apparent in the assessment. Going forward, the government must develop and implement laws, policies, and reforms in a sequence and at a feasible pace. Visibility from high-level leaders can quicken the pace by facilitating the deep and broad integration across all sectors. There are actions that can be undertaken in the immediate and medium terms, as well as long-term and ongoing actions. The proposed actions focus on two primary areas: **modernization of institutional structures and support services**, and **direct support to PWD**. Interventions in these areas should be informed by the four guiding framework principles: **Availability, Accessibility, Affordability, and Accountability** of policies and services to meet the needs that are common to persons with and without disabilities as well as provide specific services **to equalize opportunities and ensure inclusion of PWD**.

Following the above priorities, the ongoing work needs to be well documented and rigorously evaluated. Data collection, development of MIS, and tracking well-developed indicators must be implemented. The evaluation of the completed and ongoing programs should be conducted and utilized

to further inform and **refine** policy decisions and to inform regulatory mechanisms for improving the service delivery into normative, corrective, and continuous promotion actions. In addition, it would be critical to support strong grievance and complain mechanisms and comprehensive communication strategies to advance the effective implementation of services. Local and national agents, service providers, and PWD and their representatives and households should form a foundation for promoting and ensuring access to services for PWD

ANNEX 1: Strategies, Plans, and Policies on Education for Persons with Disabilities

MOEHE: EDSP 2014–2019 - A Learning Nation

The 2014–2019 Strategy¹⁰⁰ of the MOEHE dedicates a full chapter to students with special needs and sets forth the following strategic options and anticipated results for the period 2014 to 2019.

- (a) A national policy for inclusive education and national database for all school-aged CWD
- (b) An integrated diagnostic center that relates to all relevant public institutions
- (c) Trained Human Resources personnel employed in the field of special education and more experts on all types of disabilities
- (d) Amended legislation to specify rights and implementation modalities
- (e) Expanded services in psychosocial, educational, and social support to increase the percentage of students with disabilities and special needs integrated in public schools
- (f) Diploma program in special education and expanded professional licensing to include relevant professions
- (g) Improved school environment and means and facilities necessary for the process of education
- (h) Clear mechanisms for complementing the role of schools and parents in the education of CWD

National Plan for the Educational Inclusion of Students with Impaired Vision (2014–2019)

The national plan for the educational inclusion of people with impaired vision is a joint initiative of the MOEHE, CBM, and the International Council for Education of People with Visual Impairment. It supports the National Program on Inclusive Education for Children with Impaired Vision and has four objectives: (a) granting quality education in inclusive environments; (b) community empowerment through awareness and advocacy programs; (c) improving responsiveness toward access for blind and visually impaired; and (d) enhancing the quality of services through strong partnerships.

Key interventions in the plan include the following:

- Services for PWD: Assessment of Supply and Demand Side in the West Bank and Gaza
- Establishment of resource center pilot
- Preparation of regular schools, students with impaired vision, and their parents for educational mainstreaming
- Braille training made available for adults who have not learned as children or acquired disability later
- Development of referral system to support students in accessing further education
- Availability of comprehensive mobility and orientation courses and instructors

¹⁰⁰ MOEHE. 2014. *Education Development Strategic Plan (EDSP) 2014-2019 - A Learning Nation*. Available at http://planipolis.iiep.unesco.org/upload/Palestine/Palestine_Education_development_strategic_plan_2014_2019.pdf

- Capacity enhancement of public school teachers, school inclusion supervisors, and assistant teachers on specific techniques required to teach students with impaired vision
- Availability of textbooks in accessible formats or accompanied by adequate resources that can facilitate learning

MOEHE: Draft Palestinian Inclusive Education Policy

Based on Law No. 4 Concerning the Rights of the Disabled, the MOEHE started its Inclusive Education Programme in 1997, which embraced a policy of including students with disabilities in mainstream public schools. However, it lacked mechanisms to oversee accountability and ensure its full implementation. To address the absence of a coherent policy, the MOEHE drafted a formal Inclusive Education Policy for Palestine, with the financial support of the Diakonia/Norwegian Association of Disabled and Save the Children.

Key commitments of the policy include¹⁰¹ the implementation of relevant international and national commitments such as Education for All, Convention on the Rights of the Child, CRPD, and the promotion of attitude change and understanding of the importance of nondiscrimination and diversity in education. It aims at eliminating environmental, attitudinal, and resource barriers to access to education for all and promotes child-centered approaches and a twin-track approach that combines systemic changes with individualized support. Further focus is on the development of inclusion-oriented human resources, the participatory development of sustainable inclusive education settings as well as inclusive life-long learning from early childhood to vocational, nonformal, and adult education.

MOEHE: Policy for Safe and Equitable Access to Quality Education

This policy was adopted in 2012 and built upon the PA Report on the Implementation of the Convention on the Rights of the Child, which identified main policy gaps and recommendations on how to resolve them.¹⁰² It targets all levels (child, family, community, institutions, and government). Disability-relevant strategic objectives of this policy include the following:

- Awareness raising in marginalized areas on the importance of education and children's right to education, especially for CWD and girls.
- Provision of paid transport in marginalized areas that are accessible for PWD.
- Establishment of libraries and library corners, for persons with visual disabilities.
- Analysis of all school-aged CWD, and *gradual integration of these students into the education system and prevention of dropout and/or seek alternative forms of education that could be provided by the family and/or community.*¹⁰³ The policy envisages a 5 percent increase in the number of children with disability enrolled in schools over the next five years.
- Detection of students with learning difficulties should be enhanced to intervene at an early age.

¹⁰¹ Palestine Inclusive Education Policy, Ministry of Education and Higher Education, 2015.

¹⁰² MOEHE. 2012. *Palestinian Policy for Safe and Equitable Access to Quality Education—Targeting Marginalized Areas and Groups- Palestine*. Available at http://www.lacs.ps/documentsShow.aspx?ATT_ID=7383.

¹⁰³ Ibid.

ANNEX 2: Strategies, Plans, and Policies on Health and Rehabilitation for Persons with Disabilities

Ministry of Health: National Health Strategy 2014–2016

The current strategy¹⁰⁴ of the MOH has five strategic objectives:

- (a) Ensure rights-based comprehensive and integrated health services to all, taking into consideration disability, gender, and other characteristics.
- (b) Promote preventive health care and management of noncommunicable diseases.
- (c) Establish an effective, comprehensive, and sustainable system of quality and patient safety that encompasses all aspects of health service delivery.
- (d) Ensure the availability of a qualified health workforce capable of delivering quality health services.
- (e) Enhance institutional development and health governance.

The first objective focuses explicitly on the most vulnerable groups, including PWD. The strategy indicates that the policies will be focused toward providing a comprehensive network of health care services that ensures safe and affordable access to different services across the various Palestinian governorates, with a focus on the vulnerable. This will be achieved through the development of a National Health Service coverage plan, which will consider the different groups within the Palestinian community, focusing on the most vulnerable, including those with disabilities. The service coverage plan will also focus on the availability of appropriate infrastructure and the strategy highlights the criteria of accessibility to ensure access for PWD.

While the MOH does not have a holistic approach for health and rehabilitation services for PWD, the strategy singles out the following interventions related to disability.¹⁰⁵

- **Screening and Early detection**

Develop early detection programs for disabilities among children, including learning disabilities, and develop appropriate protocols and diagnostic and therapeutic tools for these disabilities.

- **Primary Community Mental Health Care**

Develop community mental health services and integrate these services into primary health care services, facilitate the provision of specialized and trained staff, implement various mental health protocols, and raise community awareness about the importance of these services and the importance of mental health in the community.

¹⁰⁴ MOH. 2014. *National Health Strategy 2014–2016*. <http://www.moh.ps/attach/617.pdf>.

¹⁰⁵ Ibid.

ANNEX 3: Strategies, Plans, and Policies on Access to Livelihoods, Jobs, and Basic Services Insuring Basic Income Security

The Palestinian labor market operates under unstable or difficult political conditions and the geopolitical situation restricts further policy development and the role of the PA as a policymaker and regulator. The provision of employment services is very fragmented in Palestine and the role of the public sector has historically not been dominant. Employment policies and services are characterized by the active involvement of donors and NGOs and the weak role of public and private agencies. In this context, PWD are not a priority. The employment of PWD is reportedly generally based on personal efforts and relations, which reflects the current absence of clear policies, strategies, or programs for the economic empowerment and inclusion of PWD into the labor market, indicating that there are no collective solutions.¹⁰⁶ The governmental and nongovernmental institutions still turn a blind eye to the provisions of the 1999 Law No. 4 Concerning the Rights of the Disabled, the Civil Service Law 4/2005, the Labor Law 7/2000, and related bylaws which require the government and NGOs to employ at least 5 percent of their staff from among the PWD and adapt the workplace accordingly.

As far as the MOL is concerned, neither its current strategic plan (2014–2016) nor its National Strategy for Employment¹⁰⁷ or the TVET strategy,¹⁰⁸ make an explicit reference to PWD. The MOL does not have very accurate statistics about the number of disabled people in the labor market.

Supreme Council of the Affairs of Persons with Disabilities - National Strategic Plan of the Disability Sector in the Occupied Palestinian Territories

The strategic framework for the disability sector aims to serve as a reference for all related parties, clarifying the vision, policies, and objectives related to disability and PWD. With regard to access to employment and related services, the Intervention Policy Direction 3 focuses on “expanding the potential of having access to jobs as a main key to improve economic security and welfare of PWD and their families.” The aim is for PWD to enjoy economic security that is above the national poverty line.

The strategy provides a set of success indicators:

- The decline of cases violating the quota in private and public organizations
- Committees set up from the human rights organizations to monitor the process of employing PWD
- Issues and indicators associated with disabilities to be included in the models used by the Directorate of Inspection in the MOL

¹⁰⁶ Independent Commission for Human Rights. 2014. *The Right of Persons With Disability To Decent Work In Palestine*.

¹⁰⁷ http://tvvet-pal.org/sites/default/files/10-09-18_ES_AR_final.pdf

¹⁰⁸ file:///C:/Users/user/Desktop/Scope%20of%20work/Employment/11-02-09_revised%20TVET_strategy-final_Signed-version_EN_0.pdf

- An alternative regulation about the health fitness based on a comprehensive and rights perspective
- The effectiveness of the joint database of the sectors
- Number of analytical studies (assessment) of the integration process
- The number of successful projects carried out and managed by groups of PWD
- Number of feasibility studies which are ready and favoring PWD
- Number of PWD who have professional skills in areas which meet the market demands

The strategy also sets forth a number of future interventions, relevant to achieve the above objective:

- Adjustment of the mainstream rehabilitation and vocational training centers and programs
- Expansion and variation in the specialized rehabilitation and vocational training programs to meet the requirements of the job market
- Provision of the required capital to carry out income-generating projects for PWD (such as incubator/cooperatives)