FACTSHEET – occupied Palestinian territory

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Physical and Functional Rehabilitation in the occupied Palestinian territory (West Bank and Gaza)

"***Being able to buy cookies for my daughter and seeing her smile equals the world! Thanks to the rehabilitation team who supported me to overcome my difficulties.***"
– Ihab, A man, was injured due to the Great March of Return demonstrations in Gaza and received rehabilitation sessions at PACF- HI partner, Gaza, oPt.

What is rehabilitation?

The World Health Organization (WHO) defines Rehabilitation as "a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment." In simple words, rehabilitation helps children, adults, and the elderly with health conditions to be as independent as possible in their daily life activities. It does so through different interventions, including the provision of assistive technologies.

Rehabilitation is commonly used to indicate health services that aim to rehabilitate and habilitate. Habilitation, a word used in the 26th article of the Convention for the Rights of People with Disabilities[1], refers to a process aimed at helping people gain specific new skills, abilities, and knowledge. On the other hand, rehabilitation refers to regaining skills, abilities, or knowledge that may have been lost or compromised as a result of acquiring a disability or due to a change in one's disability or circumstances.

Rehabilitation is for all. Rehabilitation is often seen as a specialized health intervention needed by only a few people, especially those having disabilities. A recent study[2] shows that 2.42 billion people have, or had in their life cycle, conditions that benefitted from rehabilitation interventions. This number suggests that rehabilitation should be a priority health care service contrary to the standard view.

Situation in oPt

How many people need rehabilitation in oPt?

According to the 2017 national census from the Palestinian Central Bureau of Statistics (PCBS), oPt counts a total population of 4,780,978 people between West Bank (2,881,687) and the Gaza Strip (1,899,291). The WHO Rehabilitation Need Estimator reports that around 1.4 million -approximately 1 out of 4 – experienced or are experiencing conditions that could benefit from rehabilitation[3].

According to the last **Multisectoral Needs Assessment** (MSNA, 2021), **14%** of all surveyed households reported having at least one household member with a physical and cognitive difficulty. Almost half of these people report difficulties in walking[4]. This data collides with the last **PCBS** report, which counts 92,710 persons with disabilities in the West Bank and Gaza[4], representing only **2.1%** of the entire oPt population.

The previous World Report on Disability (2011) estimates that 15% of the global population lives with some form of disability; the percentage might be higher in low- and middle-Income countries, such as in oPt[5]. The discrepancy between the PCBs calculation, the MSNA, and the WHO estimator can be explained by two different ways of identifying the disability, the old classifications based on diagnosis (PCBS) versus new classifications based on functioning (MSNA).

Figure 1 : The picture depicts a child trained on using walking aid by an occupational therapist with the participation of his father as part of family education on basic rehabilitation exercises to be followed at home. Gaza Palestine

[1] United Nation; Department of Economic and Social Affairs Disability: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html

[2] A. Cieza et all. (2020). Global estimates of the need for rehabilitation based on the Global Burden of Disease study 2019: a systematic analysis for the Global Burden of Disease Study 2019. Lancet https://doi.org/10.1016/S0140-6736(20)32340-0.

[3] WHO Rehabilitation Need Estimator: https://vizhub.healthdata.org/rehabilitation/

[4] OCHA (2021), Multisectorial Needs Assessment: https://www.ochaopt.org/data/2021/msna

[5] WHO (2011). World Report on Disability.

Within the context of occupation, Palestinians are constantly exposed to violence, which results in new injuries, disabilities, and mental health disorders related to trauma. Since 2018, more than 299 Palestinians have been killed and 29 878 injured with live ammunition. Since the Great March of Return demonstrations, 6239 individuals have been injured. In Gaza, 87% of live ammunition injuries were to the limbs; 24% of the injured were below 18. At the same time, 113 amputations took place, and 21 individuals remained paralyzed due to spinal cord injuries. In the West Bank, 58% of the injuries also occurred in the context of demonstrations, with 16% of them arising during search and arrest operations and 10% the result of settler-related violence. During May 2021 escalation in Gaza, according to the Office of the High Commissioner for Human Rights (OHCHR), 261 Palestinians were killed, of those 130 were determined civilians. Over 2,200 Palestinians were injured, including 685 children and 480 women. On top of the physical trauma, about 54% and 47% of Palestinian boys and girls aged six to 12 years reportedly have emotional and/or behavioral disorders across oPt. The overall disease burden for mental illness is estimated to account for about 3% of disability-adjusted life years[6].

How many people in need actually access rehabilitation services?

According to the last MSNA (2021), among the 14% of households that reported having one member with a physical and/or cognitive difficulty, 33% of them cannot access at least one basic service due to this physical and/or cognitive difficulty. The same assessment shows that 68% of surveyed households reported that at least of members needed to access (generic) health services three months before data collection, but one-third faced access barriers[6]. In a recent sectorial need assessment conducted in Gaza by HI (December 2021), 91.64% of persons with disabilities reported that they need at least one rehabilitation service, including assistive products, but only 17% of them can access it due to attitudinal, physical, communication, and organizational barriers in the community. 71.7 % of the respondents said that rehabilitation services are inaccessible; while 79% also flagged that the rehabilitation services are not affordable.

What barriers restrict the access to rehabilitation services in oPt[7]?

The first barrier in accessing rehabilitation services is the **identification** of **rehabilitation needs**. Primary health centers workers, who have access to the vast majority of the population, lack knowledge on which conditions benefit from rehabilitation interventions and therefore fail to identify and refer people in need to rehabilitation services.

Those who are eventually referred to rehabilitation have to deal with the scarce **availability of rehabilitation services.** Rehabilitation services in oPt are few and unevenly distributed around the territory. Services are mainly in cities and very low in the rural area in West Bank. Especially in Area C, a system of barriers hinders access to services, by-pass roads, checkpoints, and movements limitation, which rends almost impossible the access to qualified and continuum of services, often resulting in secondary complications. In addition, only a few assistive products are available free of charge, and their availability usually links to the availability of external funds to support the service provision. In Gaza, where the demand for assistive products increases during emergencies as new injuries arise, many devices are destroyed or left behind when persons with disabilities have to flee to safer shelters. The lack of maintenance shops for assistive products is another challenge.

Whenever interventions are available, the **quality of the service** is often questionable. oPt rehabilitation

Physical and Functional Rehabilitation policies

As a signatory to the **UN Convention on the Rights of Persons with Disabilities (CRPD)**, oPt commits to promoting Habilitation and Rehabilitation (Article 26) for all. The commitment of oPT towards rehabilitation lead the Ministry of Health to include a rehabilitation specific objective, # 5, into the **Health Sector Strategic Plan for Southern Governorate 2021-2025.** This include:

1. *Enhancing palliative care services*
2. *Upgrading rehabilitation services for the injured*
3. *Strengthening health services and rehabilitation for people with disabilities.*

*More on the global sphere, the Sustainable Development Goal (SDG), target 3.8 - Achieve universal health coverage (**UHC**), including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all* - sets to achieve universal health coverage by 2030. Which, the **UN Political Declaration** echoes by stating that rehabilitation is part of the universal health coverage. The **Declaration of Astana** also indicates that rehabilitation is part of primary health care (**PHC**).

6 WHO, 1 May 2019 "Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan"- Report by the Director-General

[7]Information here were taken from a multitude of sources as part of an internal desk review process from the current rehabilitation project of HI in oPt.

staff still approach assessment and treatment delivery using a purely medical model with low consideration to the beneficiary's functional abilities. The rehabilitation results are often ineffective with the additional barriers of obsolete equipment and outdated treatment methodology, the lack of standards rehabilitation guidance to unify the rehabilitation intervention within emergency and development situations, and duplication of service provision, especially in an emergency that might cause harm for beneficiaries.

Service affordability is an additional barrier. The Ministry of Social Development (MoSD) provides health insurance for people diagnosed by the Ministry of Health (MoH)'s disability committee with a 60% disability. However, it does not give any rehabilitation services. The health insurance coverage is limited to primary and secondary health services -diagnostic and therapeutic, including surgical intervention and medication within MoH stocks. Still, it helps connect people to services offered by NGOs, which provide project-based free services or paid services with symbolic or total fees. This prevents persons with disabilities from affording rehabilitation services, including the transportation fees to reach the rehabilitation centers.

Similarly, the government health insurance - for all the population - covers tertiary care services needed but not available in MoH facilities, provided by non-MoH facilities within and outside the oPt, and covering medical rehabilitation services. Patients are usually discharged after three weeks of stay and continue the rehabilitation in the primary health care clinics. They receive a limited number of rehabilitation sessions to respond to the significant number of people in need of rehabilitation in the community. This results in an ongoing need for rehabilitation services as the intervention does not positively change the functional independence of persons with disabilities.

The barriers in service delivery reflect different limitations at the system level. Central authorities **lack a realistic understanding of the population's real rehabilitation needs and the system's capacity to answer** such conditions. This lack of information is related to the **absence of systematic data collection** on rehabilitation and its **centralized reporting and analysis.** This lack of reliable central information results in the de-prioritization of rehabilitation efforts and resources compared to other health interventions.

Recommendations

Building on the barrier analysis before summarized, HI calls on financial and technical partners to prioritize rehabilitation at different levels of intervention:

Policy level:

- Enhance the MoH capacity to answer rehabilitation needs by conducting a Systematic National Rehabilitation Situation Assessment and developing a centralized rehabilitation data collection system.
- Integrate emergency rehabilitation within the MoH rehabilitation policies and strategies to respond to the needs of trauma patients and people with disabilities during conflicts escalations.

Service level:

- Systematically include within the humanitarian response rehabilitation services in post-trauma cases to avoid secondary complications.
- Systematically accompany the humanitarian response in providing psychological support in the events of physical trauma.
- Improve the capacity of health services to identify rehabilitation needs and enhance the quality of rehabilitation services. This can be achieved by: including rehabilitation needs identification modules in the basic training of primary health centers staff, providing systematic activities to service staff on right-based and used-based approaches, and creating or strengthening referral systems among all levels of care.
- Develop comprehensive referrals pathways in Area C.
- Support the MoH to develop standards rehabilitation guidance to harmonize the rehabilitation services provision and train the rehabilitation professionals on this guidance.
- Develop emergency trauma response plan to be deployed in hard-to-reach locations in the oPt.

Family & community level:

- Raise awareness about rehabilitation as an essential health service that contributes to fulfill the right to health for all.
- Enhance community information on the benefits of rehabilitation and available rehabilitation services.
- Train local community members to support the preparedness plan deployment within emergency events (conflicts, protracted clashes, besieged areas).