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Study 2025

Barrier Study on Inclusion Standards in the Humanitarian Response in the oPt

Leave No One Behind: Identifying and addressing the barriers faced by persons with disabilities in the humanitarian response.

Acknowledgement

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Contents

List of Acronyms and Abbreviations

Acronym	Full Form
ASD	Autism Spectrum Disorder
CHW	Community Health Worker
CRPD	Convention on the Rights of Persons with Disabilities
DWG	Disability Working Group
FGD	Focus Group Discussion
GBV	Gender-Based Violence
GDPR	General Data Protection Regulation
HI	Humanity & Inclusion
IASC	Inter-Agency Standing Committee
IEC	Inclusive Education Centre
IEP	Individualized Education Plan
INGO	International Non-Governmental Organization
KII	Key Informant Interview
LTP	Long-Term Plan
MHPSS	Mental Health and Psychosocial Support
MoE	Ministry of Education
MoH	Ministry of Health
MoSD	Ministry of Social Development
NGO	Non-Governmental Organization
OHCHR	Office of the United Nations High Commissioner for Human Rights
OPD	Organization of Persons with Disabilities
oPt	Occupied Palestinian Territory
PSS	Psychosocial Support
SEL	Social and Emotional Learning
SOP	Standard Operating Procedure
TLS	Temporary Learning Space
UN	United Nations
WASH	Water, Sanitation and Hygiene
WGQ	Washington Group Questions
WHO	World Health Organization

1. Executive Summary

The humanitarian situation in the occupied Palestinian territory (oPt) has escalated into an unprecedented crisis following the events of October 2023. Nearly 90% of Gaza's population (approximately 1.9 million people) are internally displaced due to ongoing hostilities. It is estimated that at least 25% of people injured in the Gaza Strip have disabilities that require long-term, specialized rehabilitation services, driving the estimated number of persons with disabilities to over 80,000. Meanwhile, the West Bank continues to face systemic movement restrictions, settler violence, and rising instability, with marginalized populations, particularly persons with disabilities, bearing the brunt of exclusion and vulnerability. This period has also been marked by increasing restrictions on humanitarian access as well as the militarisation and weaponisation of aid, at a time when civilian suffering and needs are critical.

2. Objectives

This study, commissioned by Humanity & Inclusion (HI) and implemented by RoadWise Consulting, examines the extent to which persons with disabilities are included in humanitarian service delivery across three key sectors: education, protection, and health. It also explores specific barriers faced in other sectors such as WASH, shelter, food security, and social protection that impact access to inclusive service.

The study aimed to:

- Assess the main barriers to inclusive access for women, men, girls and boys with disabilities.
- Identify enabling factors and existing good practices on disability-inclusive humanitarian action.
- Provide recommendations to stakeholders, governmental authorities, donors, humanitarian clusters, service providers, and communities on inclusive standards and localized responses for persons with disabilities.

3. Methodology

The study adopts a dual methodology: primary data collection in the West Bank through surveys, interviews, and focus group discussions (FGDs), and a literature-based desk review for Gaza. Primary data collection comprised 27 survey respondents from INGOs, NGOs, and service providers: 19 in-depth interviews and 6 FGDs with OPDs, caregivers, and sectoral actors. The literature review component consisted of a rapid review of 15

reports and secondary data analysis, with a specific focus on Gaza. While the study incorporates quantitative and qualitative data sources, the methodology is not statistically representative. Findings reflect patterns that are triangulated across data sets for analytical value rather than generalization.

Major Findings

Education: Children with disabilities face significant exclusion from formal and emergency education services. Inaccessible facilities, lack of teacher training, and the absence of inclusive learning modalities during emergencies compound educational marginalization. In Gaza, schooling has collapsed, while in the West Bank, inclusive models exist but are sporadic and donor dependent. Findings from the interview with the Ministry of Education highlight that while inclusive education is formally acknowledged, there is no institutionalized system to ensure its systematic implementation and monitoring during emergencies. Teachers, as reflected in the educators' FGD, reported the absence of clear standards or structured guidance on how to provide inclusive support in emergencies, often relying on individual efforts rather than institutional mechanisms. Parents of children with disabilities across multiple governorates described substantial challenges in accessing appropriate educational services for their children during crises. These included the refusal of schools to admit children with certain types of disabilities (especially Autism Spectrum Disorder – ASD), lack of transportation, and high costs of specialized private services, particularly in areas such as Jenin and Tulkarem.

Protection: In Palestine, the Ministry of Social Development (MoSD) leads social protection through the Cash Transfer Programme (CTP), but this program is not tailored to persons with disabilities, and it lacks targeted support for children or adults with disabilities. Feedback from municipal representatives in Jenin, Tubas, and Tulkarem revealed weak coordination between local authorities and MoSD, with no clear referral mechanisms in place. FGDs in Nablus and Tubas further underscored that access to social protection is inconsistent and often dependent on personal networks or NGO support. Despite legal commitments like the UN Convention on the Rights of Persons with Disabilities (UN CRPD) and Law No. 4 of 1999, implementation remains limited, especially during emergencies, where disability-specific protection needs are often overlooked.

"The laws exist, but the problem lies in implementation. We need to activate the Palestinian Law for Persons with Disabilities and link it to clear executable budgets."
Key informant interview with representative from a Palestinian OPD

Health: Emergency healthcare systems do not systematically accommodate persons with disabilities. The World Health Organization (WHO) reports that 94% of health centers in the Gaza Strip have been damaged, while half of the hospitals are no longer operating.[1] Children with disabilities in the West Bank face systemic barriers to accessing quality health services, including limited geographic availability of specialized care, high out-of-pocket costs for therapy and medication, and a lack of disability-sensitive training among healthcare providers. Families in areas such as Jenin, Tubas, and Tulkarem reported traveling long distances for basic services, while many falls outside MoSD eligibility, exacerbating exclusion. Attitudinal stigma, poor coordination between ministries, and the absence of a unified referral system further weaken service delivery.

Cross-Cutting Barriers: The study identified a range of environmental, institutional and attitudinal barriers that impact multiple sectors:

- Absence of **unified inclusion frameworks** and limited integration of global standards: There is no national or collective system in place that ensures all stakeholders are using the same principles, definitions, tools, and standards (e.g., IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action). As a result, responses are often ad hoc, vary by location and actor, and fail to ensure consistent inclusion of persons with disabilities. Despite promising municipal-level initiatives, such as Ramallah Municipality's requirement to integrate environmental accessibility for persons with disabilities into the architectural designs of all new buildings, and Tulkarem Municipality's early implementation of accessibility standards, **physical accessibility** remains a pervasive barrier across the oPt. These initiatives, while commendable, are still limited in scale and not systematically adopted nationwide. As noted during a key informant interview by a representative of Tulkarem Municipality in the coordination committee for organizations working with persons with disabilities: "*The Municipality of Tulkarem has started applying accessibility standards in a limited manner as an initial step, with a view to expanding them gradually.*"

[1] World Health Organization. (2025, May 22). *Health system at breaking point as hostilities further intensify in Gaza, WHO warns*. WHO. Retrieved from

- Lack of **disability-disaggregated data** and individualized needs assessments beyond initial screening tools such as the Washington Group Questions (WGQs).
- Weak participation of OPDs in **humanitarian coordination mechanisms and humanitarian response**. As noted by a representative of an OPD in Tulkarem, "*So far, our association has not been included in any official emergency coordination or planning committee, despite our field expertise. Representation of persons with visual disabilities in humanitarian decision-making processes is virtually nonexistent, depriving them of the chance to help design services meant to address their needs.*"
- Caregivers, particularly women supporting children with disabilities, highlighted the impact of social stigma, limited family support, and the need for greater resources. When combined with insufficient access to tailored services and financial assistance, these challenges can affect the continuity of care and support.

Enabling Factors and Best Practices

Despite the gaps identified in the study, several examples of best practices on the inclusion of persons with disabilities were documented:

- Schools in Jenin that provide more personalized support for children with disabilities as specialized teachers' assistants or dedicated resource rooms in Hebron with trained staff.
- Municipality-led accessibility pilots such as Jenin Municipality pioneering steps to promote accessibility, including establishing the West Bank's only sensory park dedicated to persons with visual impairments**.** A municipal representative shared: "*There are general strategic plans in place. However, security conditions imposed by the occupation have limited systematic implementation. As a result, we adopt rapid, needs-based emergency responses. While no detailed emergency plan exists for marginalized groups, immediate support is provided based on urgent needs and available capacities.*"
- Use of WhatsApp by service providers in Gaza to track cases and communicate urgent updates with families and caregivers of persons with disabilities, including changes to service locations, emergency distributions, and referral status during escalations.
- Home-based rehabilitation by community health workers in the northern West Bank.
- Community-Based Monitoring and accessible feedback mechanisms. A representative from a Palestinian NGO implementing physiotherapy and rehabilitation services, emphasized the role of localized adaptations in improving responsiveness during crises. The key informant highlighted that in Tulkarem, a network of local volunteers was activated to monitor urgent cases involving persons with disabilities during lockdowns. Using community-sourced data, the association prioritized interventions in underserved areas like Burqin and Arraba in the northern West Bank, where official maps and government data were lacking. These efforts, along with the establishment of accessible

feedback mechanisms, contributed to more inclusive and responsive emergency response systems.

Recommendations

1. For Governmental Authorities (MoSD, MoH, MoE, Local Government)

- Develop and implement a national disability-inclusive action plan that aligns with the UN CRPD and integrates inclusive education, health, and protection services within existing sectoral strategies.
- Designate and train disability focal points at municipal and ministry levels to coordinate inclusive service provision and monitor accessibility in crisis and non-crisis settings.
- Enforce the use of disability-disaggregated data and functional screening tools across social protection and education databases to support evidence-based planning.

2. For Humanitarian Clusters

- Promote the meaningful participation of OPDs in humanitarian coordination mechanisms (especially Protection, Education, Health, Shelter and WASH clusters) to co-design, monitor and evaluate inclusive humanitarian interventions.
- Design and implement evidence-based inclusive humanitarian action across sectors through the systematic collection and analysis of sex, age and disability disaggregated data to support the adaptation of assistance, information and protection.
- Integrate inclusive indicators and accountability frameworks into cluster strategies and monitoring systems to promote disability inclusion in humanitarian response.
- Ensure that inclusive design standards are embedded in cluster guidance and response plans, including minimum accessibility requirements for WASH facilities, shelter units, distribution points, and other essential services.
- Strengthen the mapping of services and referral pathways for persons with disabilities across all sectors to enhance access to both mainstream and specialised services, with a particular emphasis on inter-partner coordination to avoid service duplication and on improved access for women and girls with disabilities who may face additional barriers.

3. For Service Providers

- Ensure facilities and services meet minimum accessibility standards, such as ramps, signage, caregiver spaces, and adapted infrastructure, enabling persons with disabilities to safely reach, enter, circulate within, and utilize services.
- Deliver inclusive and accessible information, education, and communication (IEC) materials for crisis-affected populations, using a variety of formats (e.g., braille, sign language, audio description) tailored to persons with sensory and intellectual disabilities.

- Invest in staff training and inclusive service design to address the specific needs of persons with different types of disabilities.
- Strengthen community outreach and feedback to ensure persons with disabilities are aware of and can safely access services, provide feedback, and raise concerns without barriers.
- Ensure the diverse needs and barriers of persons with different types of or multiple disabilities – including physical, sensory, intellectual and mental health – are systematically identified and effectively inform project design, implementation, monitoring and evaluation.

4. For Donors and International Actors[2]

- Provide multi-year, flexible funding to support the development of sustainable and locally owned inclusive service models, especially in rural and high-risk areas.
- Fund scale-up of good practices, such as inclusive school pilots, disability-inclusive rehabilitation networks, and mobile outreach services for hard-to-reach populations.
- Strengthen compliance mechanisms to ensure that disability inclusion is not only prioritised in policy but also enforced in practice, requiring partners to demonstrate how the inclusion of women, men, girls and boys with disabilities is integrated into program design, implementation, monitoring and reporting.
- Require disability inclusion indicators in all funded projects, including targets for accessibility and the meaningful participation of persons with disabilities or their representative organizations (e.g. OPDs).

5. For Communities and Civil Society

- Support community-based disability committees to identify local needs, facilitate referrals, and monitor accessibility of services in real-time.
- Promote inclusive awareness campaigns to reduce stigma, increase knowledge on rights, and encourage early identification and support for children with disabilities.
- Strengthen caregiver support groups, especially for women, to address isolation and burnout, and link them to local service networks.

[2] This includes agencies and entities such as UNICEF, WHO, UNRWA, OCHA, ECHO, the Norwegian Refugee Council, and the governments of Belgium and Switzerland, who have supported inclusive education and disability-responsive services across the oPt.

Conclusion

This study underscores the critical need to more systematically embed disability inclusion as a standard within the humanitarian response in the oPt, in line with the Inter-Agency Standing Committee (IASC) Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action and other sector-specific minimum standards. With over 80,000 persons with disabilities estimated in Gaza alone[3] and heightened vulnerability across the West Bank, the humanitarian sector must act decisively to uphold the dignity, rights, and visibility of all persons, especially those most at risk of being left behind.

Introduction and Background

The humanitarian situation in the occupied Palestinian territory (oPt) has reached an unprecedented level of devastation and urgency following the events of October, 2023. In the Gaza Strip, over 1.9 million people nearly 90% of the population have been displaced amid widespread destruction of homes, schools, hospitals, and basic infrastructure.[4] According to recent estimates, more than 350,000 housing units have been damaged or destroyed, while healthcare, education, and protection systems have nearly collapsed under the weight of continuous bombardment and blockade-related constraints.[5] This represents one of the largest protection and displacement crises in recent history in the region, with disproportionate and often invisible impacts on persons with disabilities, particularly boys and girls with disabilities. The humanitarian crisis in the oPt has shifted the operational landscape from long-term development efforts to an urgent humanitarian response. Marginalized populations, particularly women, men, girls and boys with disabilities, face systemic barriers that have been exacerbated by repeated emergencies and the ongoing deterioration of social and public infrastructures. These barriers manifest in restricted access to basic and essential services, displacement-related challenges, and a

[3] World Health Organization / OCHA. (2025, April). *Humanitarian Situation Update #286: Gaza Strip* [Data summary of persons with disabilities]. United Nations Office for the Coordination of Humanitarian Affairs. Retrieved from reliefweb.int

[4] United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA). (2025, April). *Situation report #168 on the humanitarian crisis in the Gaza Strip and the West Bank, including East Jerusalem.*

[5] OCHA. (2025). *Situation Update #286 on the Humanitarian Conditions in Gaza*. United Nations Office for the Coordination of Humanitarian Affairs.

lack of inclusive mechanisms in emergency preparedness, response and protection systems.

In the West Bank, intensified movement restrictions, military incursions, and structural discrimination are heightening the vulnerability of and risks faced by persons with disabilities. The absence of accessible emergency response structures—such as inclusive early warning systems, contingency plans, and community protection mechanisms—further compounds their exclusion and isolation during crises. In northern West Bank areas such as Jenin, Nablus, Tubas, and Tulkarem, the situation is particularly severe for girls and boys with disabilities who are disproportionately at risk of being left behind during emergencies. Many are unable to access education and protection services due to diverse environmental, communication institutional and attitudinal barriers.

In the Gaza Strip, the collapse of basic services following the destruction of infrastructure has pushed more than 1.9 million people into a chronic emergency state. As of April 2025, over 80,000 persons in Gaza are estimated to be living with disabilities—an increase of nearly 40% from pre-October 2023 levels—driven by war-related injuries including amputations and spinal trauma.[6] A study by Atfaluna Society for Deaf Children, Gaza, revealed that more than 83% of persons with disabilities reported having lost access to essential assistive devices. Formal education for children with disabilities has been suspended or severely disrupted due to school closures, displacement, and the repurposing of facilities as emergency shelters[7].

Against this backdrop, Humanity & Inclusion (HI) contracted Roadwise Consulting to conduct a study that aims to assess the barriers to inclusive access to humanitarian services, and namely the emergency response, for persons with disabilities, with a specific focus on education, protection, and health. One key rationale for the study is the rapidly shifting context in the oPt, particularly in the Gaza Strip, where the situation has transitioned from protracted vulnerability to full-scale crisis. This shift necessitates a re-examination of disability inclusion strategies under emergency conditions and highlights the urgency of adapting humanitarian response mechanisms accordingly. The study responds to a critical gap in the humanitarian response; namely, the lack of qualitative and field-based perceptions around the barriers that prevent women, men, girls, and boys with disabilities from accessing assistance and services. The study adopts a dual

[6] OCHA. IBID
[7] ACAPS. (2024). *Gaza Strip: Impact of Conflict on Persons with Disabilities*.

methodology: (i) field-based primary data collection in the West Bank, and (ii) a desk-based literature review for Gaza.[8] The study seeks to inform humanitarian planning and foster a more inclusive, equitable humanitarian response across the oPt, by identifying systematic barriers and highlighting best practices.

This study is grounded in a rights-based approach to disability inclusion, aligned with the principles of the UN CRPD, which Palestine ratified in 2014. The CRPD affirms the rights of persons with disabilities to full and effective participation in all aspects of life, including during emergencies. Additionally, the study is aligned with the Inter-Agency Standing Committee (IASC) Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action,[9] which provide a global framework for ensuring that humanitarian responses are inclusive, accessible, and uphold the dignity and rights of all.

The study's findings aim to contribute directly to the strategic planning and interventions of the humanitarian coordination architecture, including cluster mechanisms, the Gaza Disability Working Group (DWG), and inter-agency planning bodies, as well as to support local and international humanitarian actors in the implementation of a more inclusive and accessible humanitarian response. By aligning with existing disability inclusion standards—such as the IASC Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action—and contextualizing them to the Palestinian setting, the study offers practical and contextualized findings and recommendations for international and local actors.

Study Objectives

This study aims to identify and assess the main barriers to inclusive access to humanitarian services for persons with disabilities in the oPt, with a particular focus on the education, protection, and health sectors. The study uses a dual approach to reflect the differentiated realities in the West Bank and Gaza Strip, while also addressing the shared structural challenges faced by persons with disabilities in both areas.

In the West Bank, the study centers on identifying the environmental, communication, institutional, and attitudinal barriers that prevent or hinder girls and boys with disabilities—especially those living in conflict-affected areas such as Jenin, Tulkarem, Tubas, and Nablus—from safely and equitably accessing education and protection

[8] Primary data collection in Gaza was not possible due to movement restrictions, security concerns, and access limitations imposed on both researchers and participants during the crisis.
[9] Inter-agency standing committee (IASC) Guidelines on the Inclusion of Persons with Disabilities (2019).

mechanisms during emergencies. The study also seeks to highlight enabling factors and local innovations that have emerged in response to systemic gaps, with the goal of strengthening inclusive emergency preparedness and response frameworks. The findings will inform humanitarian actors and public institutions on how to design and scale more inclusive practices that align with both humanitarian standards and national education and protection policies.

In the Gaza Strip, the objective is to analyze the compounded challenges that persons with disabilities face in accessing basic services—particularly health, education, and protection—within a collapsed emergency setting. Due to fieldwork constraints, the study draws primarily on literature reviews, national-level interviews, and secondary data. The focus is on identifying patterns of exclusion, protection risks, and service barriers resulting from widespread displacement, destruction of infrastructure, and the lack of inclusive systems. The study aims to inform the design of short- and long-term interventions that address the urgent needs of persons with disabilities, while promoting the inclusion of disability-sensitive approaches in humanitarian coordination mechanisms and emergency response planning.

Overall, the study's objectives are:

1. To identify environmental, communication, institutional, and attitudinal barriers that prevent women, men, girls and boys with disabilities from accessing inclusive education, protection, and health services during emergencies.
2. To document lived experiences and service provider perspectives that illustrate the practical impact of these barriers, particularly in times of displacement and conflict.
3. To assess the extent to which disability inclusion standards are reflected in humanitarian response frameworks, including policy design, service delivery, and coordination mechanisms.
4. To provide actionable recommendations for humanitarian clusters, service providers, donors, and public institutions to strengthen inclusive emergency service delivery, with a specific emphasis on practical solutions for both immediate and future interventions.

4. Methodology

This study employed a mixed-methods approach to assess the barriers faced by persons with disabilities in accessing emergency humanitarian services in the oPt, with specific attention to education, protection, and health. The methodology was designed to reflect contextual operational priorities and gaps in the West Bank and the Gaza Strip, and to overcome the limitations imposed by the ongoing humanitarian crisis, especially in the Gaza Strip, where fieldwork was not feasible due to safety and access constraints.

4.1 Geographic Coverage

West Bank: The study focused on four governorates—Jenin, Tulkarem, Tubas, and Nablus—where conflict intensity and displacement risks for children with disabilities have been particularly acute. These areas were selected based on operational access, the presence of ongoing humanitarian interventions—including those under the HI DGD-funded project[10]—and to ensure geographic and service diversity. Selection also aimed to include locations with varying degrees of vulnerability, such as displacement risk, poverty levels, or gaps in disability services, to capture a broad picture of barriers and practices across the West Bank.

Gaza Strip: Due to severe access and security constraints post-October 2023, primary field data collection was not possible. Instead, the Gaza component relied on in-person and online key informant interviews with national actors and stakeholders, and a review of secondary literature and needs assessments from humanitarian agencies and OPDs.

4.2 Sampling Strategy:

A purposive sampling approach was adopted to ensure diverse representation across sectors, geographic areas, and stakeholder categories. The selection process involved the following steps:

1. **Identification of Organizations**: Key organizations and institutions were identified based on their active involvement in disability-related service provision, humanitarian programming, or community-based interventions. This included governmental entities, national NGOs, international NGOs, UN agencies, and OPDs.
2. **Selection of Focus Group Participants**: FGD participants were selected in collaboration with local service providers and community-based actors, prioritizing individuals with lived experience (e.g., caregivers of children with disabilities) and ensuring variation in gender, geographic location (urban, rural, and camp settings), and disability type. Inclusion criteria emphasized individuals' willingness and ability to participate meaningfully and safely.
3. **Survey Respondents**: The online survey targeted service providers working across health, education, and protection sectors. Invitations were distributed through relevant

[10] This barrier study was conducted under the Belgium Directorate-general for Development Cooperation and Humanitarian Aid (DGD) project "Prevention of multiple risks and violations incurred by vulnerable populations and multisectoral response to protection and assistance in the face of shocks: Phase 2", implemented by HI Palestine in the Gaza Strip and West Bank since November 2023.

coordination bodies and sectoral networks to ensure representation from actors engaged in both humanitarian and development programming. Survey respondents represented a range of service providers, including NGOs, international agencies and public institutions

This multi-pronged sampling strategy was designed to triangulate perspectives and ensure that findings reflect both institutional realities and the lived experiences of affected families. While the sampling was non-random and therefore not statistically generalizable, it allowed for a rich qualitative analysis of cross-cutting barriers and promising practices in disability inclusion.

4.3 Sampling Approach

- **Key Informant Interviews (KIIs)**: A total of 19 KIIs were conducted—15 in the West Bank and 4 at the national level—targeting representatives of ministries (MoSD, MoE, MoH), NGOs, UN coordination actors, OPDs, and other service providers. Participants were selected based on their institutional roles and technical knowledge and selection was informed by existing coordination structures and stakeholder mappings under the DGD-funded project.
- **Focus Group Discussions (FGDs)**: 6 FGDs were completed with parents, educators, and frontline service actors in West Bank. Participants were grouped by shared profiles to ensure open and relevant discussions. These included three FGDs with caregivers of children with disabilities (Jenin, Nablus, Tubas), two FGDs with service providers (Hebron, Ramallah), and one FGD with educators. Participants were identified through community-based organizations and service partners, with diversity in gender, geographic location, and disability type considered.
- **Survey of Service Providers:** A structured survey targeting humanitarian organizations yielded 27 valid responses (across INGOs, national NGOs, UN agencies), covering both West Bank and the Gaza Strip, including INGOs, NGOs, UN agencies, and coordination bodies. Survey respondents were selected based on operational presence and engagement in inclusive programming, with outreach coordinated through humanitarian contact lists.

4.4 Data Collection Tools

The following tools were used after validation by HI and piloting:

Semi-Structured Interview Guides: Developed for KIIs and FGDs to explore thematic issues around disability inclusion, accessibility, service delivery, and coordination mechanisms.

- **Survey Questionnaire**: The survey tool was designed based on a structured set of closed and semi-closed questions organised thematically around key sectors: Education, Health,

Protection, Water Sanitation and Hygiene (WASH), Shelter, Food security and livelihoods, and cross-sectoral topics. The tool was administered using SurveyCTO and distributed through humanitarian coordination platforms. It captured institutional perspectives on inclusive service delivery, challenges, and practices across different sectors.

- **Literature Review Coding Framework**: A structured coding matrix was used to extract and synthesize relevant insights from over 15 documents (situation updates, cluster reports, academic papers) with a specific focus on Gaza.

4.5 Data Analysis

- **Qualitative Analysis**: Thematic analysis was conducted on interview and FGD transcripts, identifying recurring patterns and disaggregated insights across education, protection, and health. A matrix coding system was used to triangulate findings across locations and respondent types.
- **Quantitative Analysis**: Survey data were analyzed using descriptive statistics to highlight inclusion trends, institutional practices, and gaps across service sectors. Data were disaggregated by geographical location and organizational type.
- **Literature Review Analysis**: The Gaza-focused desk review triangulated findings from recent assessments with field insights from the West Bank to ensure balanced, evidence-based conclusions.

4.6 Ethical Considerations and Limitations

The study adhered to strict ethical protocols, including:

- **Informed Consent**: Informed consent was obtained at the start of each interview and FGD. All participants were briefed on the study objectives, the voluntary nature of their participation and the confidentiality of their responses.
- **Do-No-Harm Principles**: To uphold Do-No-Harm principles, the research team implemented several safeguards during data collection. FGDs and KIIs were conducted in safe, familiar environments, and facilitators were trained to recognize signs of distress and adjust the conversation accordingly. Questions were framed in a non-intrusive manner to avoid re-traumatization, especially when speaking with caregivers of children with disabilities. Participation was entirely voluntary, and no personal or identifying information was recorded.
- **Data Confidentiality**: To ensure data confidentiality, no names or identifying information were recorded during KIIs or FGDs. All responses were anonymized at the point of transcription. These measures were implemented in line with international data protection standards, including GDPR principles of data minimization, integrity, and restricted access.

4.7 Study limitations:

- **Inability to conduct fieldwork in Gaza**. Due to security and access constraints, the research team was unable to carry out in-person interviews or FGDs in the Gaza Strip. As a result, insights related to Gaza were drawn from a desk-based literature review and interviews with national-level actors working across both the West Bank and the Gaza Strip.
- **Interrupted data collection schedules**: Political instability and security incidents disrupted data collection timelines in locations such as Jenin and Hebron. In some cases, interviews had to be rescheduled or adapted to remote modalities, which may have limited the richness of responses.
- **Limited availability of disaggregated disability data**, particularly for Gaza: The absence of consistent disability-disaggregated data—particularly in Gaza—hindered the ability to quantify needs and service gaps. Most available data lacked breakdowns by type of disability, age or gender, reducing the capacity for detailed analysis.
- **Sampling bias**: As the study employed purposive sampling, participants were primarily drawn from known networks and partners. While this enabled access to experienced actors, it may have excluded underrepresented perspectives, particularly in marginalized communities.
- **Survey constraints**: The service provider survey relied on self-administered responses from organizations across the oPt. While useful for identifying general trends, the sample size (27 respondents) limits the ability to generalize findings.

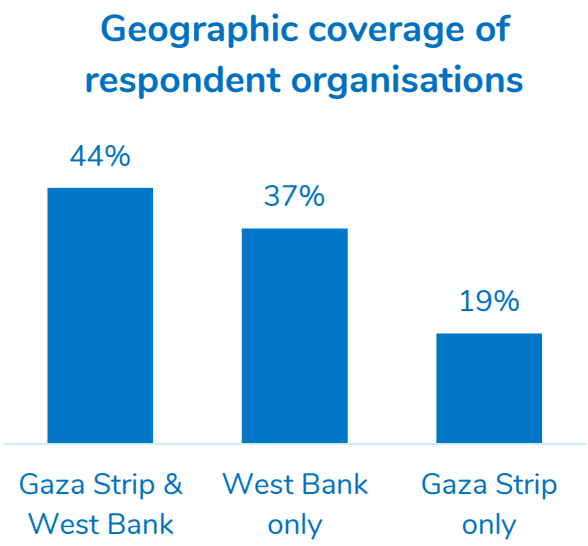
  Despite these limitations, the mixed methodology approach, combining literature review, KIIs, FGDs, and surveys—provide a comprehensive understanding of barriers to disability inclusion. To further mitigate these limitations, the research team conducted targeted follow-ups and validation of findings with national stakeholders.

Socio-Demographic Profile

This section presents the socio-demographic characteristics of the populations reached through the quantitative and qualitative components of the study. It provides a snapshot of respondent profiles and the intersectional factors that influence the access of persons with disabilities to humanitarian assistance and emergency services in the oPt, including gender, age, type of disability (physical, sensory, intellectual), geographic location (urban vs. rural), displacement status, and caregiver role. These factors were particularly relevant in shaping barriers and experiences the education, protection, and health sector services.

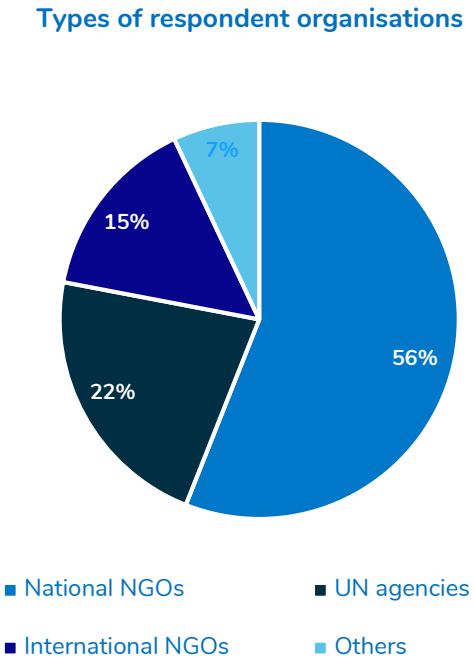
5.1 Survey Respondent Profile

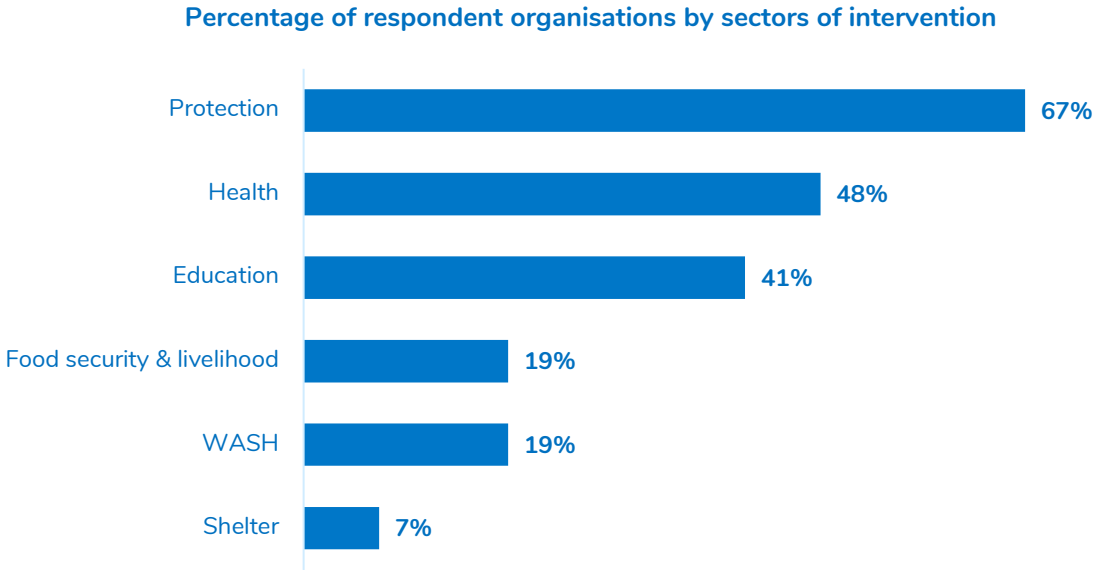
A total of 27 service providers participated in the structured survey. These included national NGOs (56%), international NGOs (15%), UN agencies (22%), and coordination bodies or networks (7%). Organizations operated across multiple governorates in both the West Bank and Gaza Strip, with 44% covering both regions, 37% based only in the West Bank, and 19% operating exclusively in the Gaza Strip. Respondents held senior or mid-level.



I positions, such as program managers, technical leads, and M&E officers, ensuring that insights reflected both strategic and operational perspectives. The majority of organizations (85%) had over seven years of experience working in the humanitarian field, lending institutional depth to the findings. Other organizations indicated either 1-3 years of experience (7%) or less than one year (7%).

The 27 Respondent organizations reported involvement across a variety of humanitarian sectors. The most commonly reported sector of intervention was Protection for 18 of surveyed organizations. Health services were reported by 13 organizations and Education programmes were provided by 11 organizations. Other sectors of intervention included Water, Sanitation and Hygiene (WASH) and food security and livelihood for 5 organizations each, and shelter activities for 2 organizations. Over three-quarters of the organizations (79%) explicitly target persons with disabilities in their programming, while the remaining 21% did not implement disability-focused interventions.

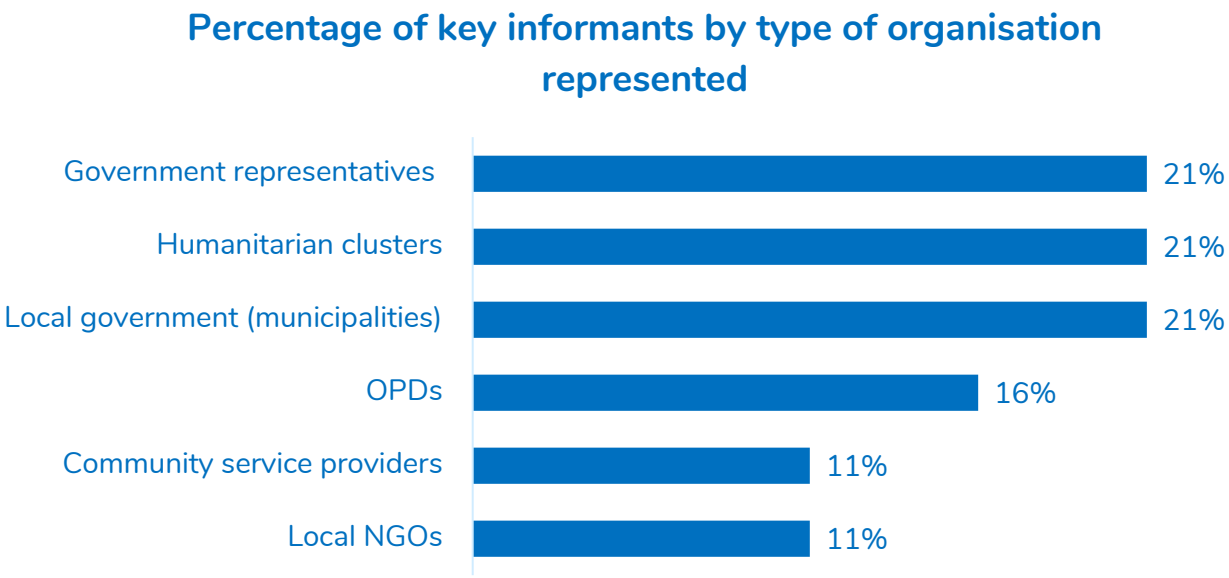




5.2 Qualitative Respondents

The qualitative component included:

- **19 KIIs** with stakeholders from Ministries (Ministry of Health, Ministry of Education, and Ministry of Social Development), OPDs, humanitarian clusters (Protection, Shelter, Education), local governments (municipalities), community service providers, and local NGOs.



- **Six Focus Group Discussions (FGDs)** with parents of children with disabilities, educators, and community-based service providers, primarily in Jenin, Tulkarem, Tubas, and Nablus, covering a total of 52 participants. Participants were selected to ensure diverse representation in terms of gender, disability type, and community role. Caregivers included mothers and fathers of children with a range of disabilities—physical, sensory (hearing

and vision), and intellectual—spanning from early childhood to adolescence (2-18 years old). Educators included public school teachers and specialized teachers. Community-based participants included social workers and staff from local disability organizations. Participants represented a broad range of lived experiences, including caregivers of children with physical, sensory, and intellectual disabilities. Specific efforts were made to include both female and male voices, with emphasis on the unique challenges faced by girls and women with disabilities in displacement and humanitarian contexts.

5.3 Functional Limitations

The study adopted the conceptual framework of the Washington Group Questions (WGQs) (short set) alongside additional adapted criteria to analyze functional limitations among the populations discussed. While the quantitative survey did not directly target individuals with disabilities, the literature review and qualitative interviews highlighted a range of functional difficulties reported across both regions. These functional difficulties related to mobility, hearing, vision, communication, and cognition can lead to disability when combined with barriers in the environment and social attitudes.

- **Mobility-related difficulties** were the most frequently referenced, particularly among children who rely on assistive devices such as wheelchairs or walkers. These limitations often result from physical impairments but manifest as disability when public infrastructure is not accessible.
- **Visual and hearing difficulties** were commonly cited in education-related barriers, including lack of adapted learning materials, absence of sign language interpretation, or unavailability of Braille resources.
- **Cognitive and developmental difficulties**, such as those associated with autism spectrum disorder and Down syndrome, were raised repeatedly by caregivers and educators as areas where institutional support is critically lacking—particularly during emergencies.
- **Multiple functional difficulties** were especially noted in the Gaza Strip, where conflict-related injuries have led to an increase in dual or compounded limitations (e.g., amputations combined with cognitive trauma), resulting in complex disability cases.

5.4 Displacement and Household Vulnerability

Displacement status was a critical intersecting factor. In Gaza, over 90% of the population[11] is currently displaced, with many families—including those with members with disabilities—sheltering in overcrowded collective centers or informal tents. In the West Bank, several interviewed stakeholders—especially in Tulkarem and Jenin—highlighted that recent military operations and mobility restrictions have led to new patterns of displacement, directly impacting access to services for families with children with disabilities. These dynamics were especially noted in relation to access to education and health services, where movement restrictions, safety concerns, and transportation barriers were identified as compounding challenges.

Thematic Findings

This section presents the key thematic findings from the study, organized by sector, with a focus on education, protection, and health as primary areas of inquiry. Each subsection integrates evidence from qualitative KIIs and FGDs, the quantitative survey, and literature review findings—particularly in the context of the Gaza Strip, where secondary data served as the main source. While each sector is discussed individually, the findings also highlight how personal characteristics—such as disability status, gender, and displacement—interact to create multiple, overlapping vulnerabilities that influence individuals' access to essential services.

6.1 Education

Access to education emerged as one of the most frequently cited challenges for girls and boys with disabilities across both the West Bank and Gaza Strip. Stakeholders consistently emphasized the lack of system-wide preparedness to ensure continuity of learning during emergencies, and the absence of infrastructure, staff capacity to support students with disabilities, and policy enforcement necessary to uphold inclusive education standards.

6.1.1 West Bank

Field data from KIIs, FGDs, and surveys revealed a range of environmental, institutional and social barriers to accessing education:

[11] United Nations Office for the Coordination of Humanitarian Affairs (OCHA). (2025, June). *Humanitarian Situation Update – Gaza Strip*. OCHA oPt.

- **Institutional Gaps:** Despite formal commitments to inclusive education, the Ministry of Education (MoE) lacks a centralized mechanism for implementing and monitoring inclusive emergency education strategies. School directors and cluster representatives acknowledged the absence of clear guidelines, support frameworks, or data systems for inclusion during crisis response. Yet, the Ministry emphasized that inclusive education especially in emergencies is a policy priority. Parents of children with disabilities across multiple governorates described substantial challenges in accessing appropriate educational services for their children during crises. These included the refusal of schools to admit children with certain types of disabilities, lack of transportation, and high costs of specialized private services, particularly in areas such as Jenin and Tulkarem.

"The Ministry's current plan includes an update of the inclusive education policy and the development of a renewed strategic framework. Civil society and persons with disabilities are now being involved in shaping this new policy to ensure it is more representative and inclusive. There is also a move to incorporate an emergency education annex into the inclusion policy, which would address issues such as displacement, loss of documents, psychosocial support, and the provision of alternative education." Key informant interview with representative from the Ministry of Education.

- **Inaccessible Infrastructure:** Parents in Jenin, Tubas, and Tulkarem repeatedly cited gaps in physical accessibility across public schools. In many cases, schools lacked ramps at entrances, accessible toilets, and elevators for multi-level buildings. While the MoE has partnered with HI and Belgian donors to implement accessibility adaptations in 18 schools, these efforts address only a small portion of the national need.[12] Across the FGDs with parents and teachers, there were examples of schools and communities making informal adjustments to ensure at least partial participation of children with disabilities. These include relocating students with physical disabilities to ground-floor classrooms and encouraging peer support to help children navigate inaccessible school environments. In Tulkarem and Tubas, families highlighted the availability of specific schools or centers that cater to children with visual or hearing impairments. For example, several parents mentioned the role of specialized schools such as "Al-Noor School for the Blind" in

[12] Interview with Ms. Nariman Al-Sharawneh, Director General of the Special Education Department at the Ministry of Education

providing Braille materials and trained staff. However, these examples were the exception rather than the rule and were geographically limited in reach.

- **Limited capacity and training:** FGDs with teachers indicated a widespread lack of pre-service or in-service training on inclusive education practices or classroom management during emergencies. Support teachers, assistive technologies, and specialized services were either absent or privately financed by parents, often at great financial strain. While some schools have taken steps to establish internal emergency structures—such as school emergency committees tasked with responding to urgent situations, including those involving students with disabilities—these efforts remain largely ad hoc and inconsistent. Some schools also reported having student parliaments and health committees that play limited roles in supporting inclusion, along with the presence of shadow teachers for students requiring individual assistance.

- **Social and Attitudinal Barriers:** Families reported facing stigma and rejection from school administrations, with some schools denying admission to children with disabilities under claims of "lack of readiness." Peer bullying, emotional neglect, and limited social inclusion were also noted as significant concerns. Parents of children with disabilities in FGDs recounted instances where their children were excluded from classroom activities or faced stigma in public settings, with no effective mechanisms in place to address such incidents or support the children emotionally and socially.

- **Pedagogical Challenges:** Uniform curricula, absence of accessible learning materials (Braille, sign language videos, etc.), and lack of individualized education plans (IEPs) meant that many children were enrolled but not meaningfully participating in learning. On teacher added: "*Unfortunately, the curricula or learning activities were not adapted due to time constraints and the high number of students in classrooms. In addition, teachers lack the necessary learning aids, such as shadow teachers.*"[13]

[13] FGD conducted with teachers on 15 March 2025

Survey responses reinforced these insights:[14]

- In the West Bank, nearly all education sector respondents (13 organizations) identified multiple environmental and institutional barriers that hinder access to education for children, and even more for those with disabilities. There was near-unanimous consensus on four key challenges: delays or inability to reach schools due to travel restrictions; increased transportation costs rendering access unaffordable; safety concerns for children traveling long distances or through restricted areas; and reduced access to specialized or inclusive educational facilities. Only one organization did not report transportation costs or limited access to inclusive schools as barriers
- 10 out of 13 education-focused organizations reported that school infrastructure was not physically accessible.
- 8 organizations confirmed having no adapted educational content or trauma-sensitive learning tools in emergency settings.
- 6 organizations had formal partnerships with caregivers to co-design inclusive learning plans.

6.1.2 Gaza Strip

Due to the total suspension of formal schooling since October 2023 and the collapse of basic infrastructure, inclusive education in Gaza has been impossible to promote:

- Based on the most recent infrastructure damage verification, 95% of schools in Gaza are reported as either partially or completely damaged, with most buildings now serving as temporary shelters and lacking any continuity plans for learning or accessibility accommodations.[15]
- Before the war, 21,200 children with disabilities were enrolled in Gaza schools; as of early 2025, access to learning has been suspended for nearly all of them, with no inclusive informal or remote learning systems available.[16]
- Based on survey responses from nine organizations, there is a strong consensus that the destruction of schools or damage to educational infrastructure is a critical barrier limiting access to education for children with disabilities in Gaza. Eight out of nine organizations also identified the interruption of specialized education services due to displacement of

[14] A total of 13 survey out of 27 respondent organisations reported working in the Education sector.
[15] OCHA. (May 2025). *Verification of damages to schools based on proximity to damaged sites – Update #9*. United Nations Office for the Coordination of Humanitarian Affairs.
[16] ACAPS (2024). *Impact of the conflict on people with disabilities in the Gaza Strip* [Report]. ACAPS. Retrieved from ACAPS website

educators or students as a main barrier. Eight out of nine organizations cited the lack of assistive devices or technologies and overcrowded temporary classrooms or shelters as significant issues.

- Combating the collapse of formal service delivery systems, families of children with disabilities in the Gaza Strip have adopted a range of informal coping strategies to ensure continuity of care, learning, and psychosocial support.[17] These include home-based rehabilitation routines, peer support circles among caregivers, and improvised educational activities led by parents and community members (Atfaluna Society for Deaf Children, 2025). At the institutional level, the Education Cluster implemented a phased emergency education response, establishing 583 temporary learning spaces and delivering recreational, psychosocial, and foundational learning interventions to over 167,000 children, using rotating shifts and a condensed curriculum to maximize reach despite constraints.[18]

6.1.3 Emerging Promising Practices

Despite system-wide challenges, some localized practices indicate potential for scalable solutions:

- In Tubas and Tulkarem, specific schools such as *Al-Noor School for the Blind* were noted for offering Braille learning materials and trained staff.
- Some educators collaborated with NGOs for informal disability-specific orientations.
- Parents, particularly mothers, addressed some institutional gaps by personally accompanying their children to school or organizing informal solidarity networks to support school transport and advocacy efforts (FGD with parents).

However, these efforts remain isolated and unsustainable without institutional investment, systemic coordination, and long-term resource commitments.

6.2 Protection

The findings across all data sources reveal that persons with disabilities, particularly boys and girls with disabilities, are marginalised from formal and informal protection systems during emergencies in both the West Bank and Gaza Strip. This exclusion manifests in the breakdown of referral pathways, lack of inclusive safe spaces, absence of tailored support for caregivers, and inadequate child protection mechanisms. The study also observed a

[17] Atfaluna Society for Deaf Children. *Situation Report for Persons with Disabilities in Gaza 2025*. Gaza: Atfaluna, 2025.
[18] Education Cluster. *Palestine Education Overview 2024*. Palestine Education Cluster, 2024

consistent lack of coordination between protection actors and OPDs, despite the increasing vulnerability of persons with disabilities in crisis settings.

A total of 16 organizations shared insights on the barriers to accessing protection services, with the main barriers reported to be: physical barriers to safe spaces (15), lack of awareness about available protection services (15), lack of transportation options (14), financial barriers to access legal or social services (13) and social stigma or exclusion from community-based protection mechanisms (12). Moreover, organizations reported that barriers to accessing protection services vary significantly by type of disability, highlighting the need for systematic data disaggregation and access monitoring by type of disability in the protection sector.

6.2.1 West Bank

- **Limited Disability Inclusion in Community-Level Protection Structures:** While the Protection Cluster has developed formal service mapping and referral systems at the institutional level, findings from FGDs with parents and KIIs with community service providers revealed that most community-based protection structures—such as school-based emergency committees, informal caregiver networks, and local crisis response groups, often lack systematic and structured inclusion of disability considerations. At this level, referral processes are typically informal and reliant on personal initiative, with limited awareness or access to the Cluster-wide referral pathways among frontline community-based actors.

"The current protection system lacks actual inclusivity, particularly due to the absence of accurate and updated data on persons with disabilities. The concentration of specialized institutions in areas like Bethlehem has also led to poor responsiveness in the northern regions during recent crises, exposing unequal service distribution and limited flexibility in adapting to field changes." Key informant interview with representative from the Protection Cluster, West Bank

- **Invisibility in Emergency Preparedness Plans:** School safety protocols and municipal emergency response strategies rarely account for children with disabilities. While many families—regardless of disability status—faced significant challenges during displacement, parents of children with disabilities reported compounded barriers. These included a lack of accessible transportation, absence of tailored communication about evacuation procedures, and no prioritization for safe shelter or medical needs. In overcrowded shelters or informal encampments, caregivers were left to independently manage their children's complex physical, sensory, or cognitive needs without support.

The absence of inclusive planning and outreach left them more exposed to protection risks, emotional distress, and disruption of essential care routines.

- **Gendered Protection Risks:** Adolescent girls with disabilities were identified as facing multiple, overlapping risks—including harassment, exclusion from community shelters, and denial of basic hygiene and dignity kits. Teachers and mothers expressed concern over the lack of privacy and security for girls with disabilities, especially in crowded displacement settings.
- **Stigma and Social Exclusion:** Families frequently described experiences of discrimination from both neighbours and service actors. Children with disabilities were often excluded from community-based psychosocial activities, child-friendly spaces, or recreational events. Parents also noted that their children's emotional needs were not recognized as part of protection frameworks. Survey results supported this concern: only 7 out of 19 protection-focused organizations reported including children with disabilities in psychosocial support or child protection interventions. This systemic exclusion not only limited access to vital services but also reinforced negative social attitudes and deepened the sense of isolation experienced by both children and their caregivers.

Survey data support these findings:

- 15 of the 27 surveyed organizations identified protection as a core area of work, yet fewer than half reported having disability-specific protocols or staff trained in inclusive protection practices.
- 11 out of 15 organizations reported that most facilities are not designed to accommodate mobility aids. 2 organizations reported having service centers and safe spaces which includes accessible features.
- 13 organizations reported that no services are currently adapted for persons with sensory disabilities, such as the availability of sign language interpretation or Braille materials.
- 6 organizations reported tailored support for women, girls and older persons with disabilities.
- 9 out of 15 organizations delivering psychosocial support (PSS) programmes indicated that caregivers are included but only in limited capacity, while 2 noted that caregivers were not included at all.
- Only 2 out of 13 organizations providing trauma-focused PSS support for persons with disabilities reported the programmes being both *available* and *accessible*.
- 4 organizations indicated having protection-related partnerships with OPDs or caregiver groups.

6.2.2 Gaza Strip

The protection crisis in Gaza is compounded by the total collapse of infrastructure and governance structures, leaving children and adults with disabilities in a state of heightened exposure to harm.

- **Lack of Accessible Shelters:** Literature analysis and national-level interviews confirm that the vast majority of collective shelters are not accessible to persons with disabilities. Inaccessible latrines, overcrowding, lack of mobility support, and poor safety protocols have left many persons with disabilities either confined to unsafe areas or entirely dependent on caregivers.[19]
- **Disruption of Protection Services:** Child protection case management, gender-based violence (GBV) referral pathways, and mental health and psychosocial support (MHPSS) services have been severely disrupted. This has left children with disabilities—especially those with cognitive impairments or mental health conditions—without structured support for trauma recovery or safeguarding.
- **Lack of Inclusive Risk Communication:** Critical protection-related information (e.g., evacuation orders, location of safe spaces) is rarely made available in accessible formats such as sign language, audio messages, or pictorial formats. As a result, children and adults with sensory or intellectual disabilities were often unaware of available services or danger zones.

6.2.3 Local Efforts and Gaps

- **Caregiver-Initiated Protection:** In both Gaza and the West Bank, protection support for children with disabilities is largely informal and caregiver-led. Mothers, in particular, were found to act as the primary risk mitigators, advocating for space, safety, and inclusion where formal systems were absent.
- **Fragmented Service Coordination:** While a few municipalities and NGOs have attempted to include disability markers in protection programming, these efforts are often underfunded, temporary, and poorly coordinated. The absence of shared databases or tracking systems makes it difficult to sustain or scale interventions.

[19] Human Rights Watch. (2024, September 30). *"They Destroyed What Was Inside Us": Children with Disabilities Amid Israel's Attacks on Gaza*.

“Despite good intentions, coordination with ministries remains slow and relies more on personal relationships than on a structured system. There is still no unified national system for sharing data on persons with disabilities, which means the response depends on our internal resources or connections within the local community." Key informant interview with representative from a Palestinian NGO implementing physiotherapy and rehabilitation services

6.2.4. Addressing barriers to accessing protection services

Surveyed organizations proposed a range of solutions and immediate priorities to address the identified barriers for persons with disabilities. A total of 14 organizations emphasised the need to incorporate universal design and accessibility standards into all protection spaces, including shelters and service centers. Moreover, 17 organizations recommended the development of tailored PSS support resources for persons with disabilities. Finally, 16 respondent organizations highlighted the importance of providing disability-specific training to humanitarian staff and caregivers. In the Gaza Strip specifically, six organizations emphasised the need for deployment of mobile protection teams to displacement settings to reach individuals in temporary or hard-to-reach locations. Four organizations stressed the importance of repairing damaged protection service centers to enhance physical accessibility. To address the impact of movement restrictions specifically, three main enablers were proposed, namely: (i) establishment of mobile protection units to reach individuals in restricted or remote areas; (ii) investing in local partnerships to improve service delivery in restricted or remote areas; and (iii) development of accessible digital tools to provide remote protection services. A representative of a national OPD called for **enhancing early warning systems** to ensure they are accessible to persons with disabilities, including formats such as audio alerts, visual signals, and Braille-compatible messages.

6.3 Health

Access to inclusive health services for persons with disabilities during emergencies is severely constrained across the oPt. Survey responses from 9 out of 13 organizations implementing health services highlighted key barriers, including physical inaccessibility of facilities (9), lack of trained personnel in disability-specific needs (9), lack of specialized equipment or services (9), and communication challenges such as absence of sign language interpreters or accessible information formats (9). Financial constraints were also noted by 7 organizations, while 3 cited systemic issues such as fragmented services and delays in referrals for persons with disabilities. Although detailed information on

adaptive measures was limited, several organizations mentioned the use of mobile clinics, plans to enhance infrastructure accessibility, and future staff training initiatives as part of their response.

6.3.1 West Bank

- **Physical Accessibility Gaps:** Parents, caregivers, and local service providers consistently reported that most health centers, including clinics and hospitals, lack ramps, elevators, adapted entrances, or examination rooms suitable for wheelchair users or persons with mobility impairments. Lack of accessible or affordable transportation, especially in remote areas or during military closures, made it nearly impossible for many persons with disabilities to reach health services without external assistance. These barriers significantly delayed or prevented medical attention during emergencies.
- **Lack of Disability-Sensitive Services:** Health personnel, particularly in emergency settings, are generally not trained on disability inclusion. Parents recounted cases where children with cognitive or behavioural disabilities were misdiagnosed or denied treatment due to misunderstanding their communication or behavioural patterns. Survey findings show that 9 out of 13 health organizations identified the absence of trained personnel on disability-specific needs as a major barrier, highlighting systemic gaps in emergency medical preparedness.
- **Emerging National Coordination and Data Systems:** Recent efforts have been made to strengthen cross-sectoral coordination and data-driven planning for disability inclusion during emergencies.

"We have established a national multi-sectoral committee, including health, social development, and unions, to lead the disability file. An electronic application has been developed to register the data and needs of persons with disabilities, which helps in planning and prioritization during emergencies. We also collaborate with the General Union of Persons with Disabilities, the Red Crescent, and partners like Humanity and Inclusion to provide more responsive rehabilitative and health services." Key informant interview with representative from the Ministry of Health

- **Access Disruption Due to Checkpoints and Permits:** In areas like Jenin and Hebron, caregivers highlighted the difficulty in reaching hospitals due to military checkpoints or lack of permits, especially when evacuating during clashes or closures. These delays had severe consequences for children requiring urgent or specialized care. Survey respondents emphasized that military checkpoints, roadblocks, and curfews severely limited access to health services, particularly for individuals with mobility impairments. This was especially acute during escalations in violence.

- **Fragmented Rehabilitation and Assistive Device Services:** The availability of physiotherapy, occupational therapy, and mobility devices was limited and highly localized. Caregivers often depended on personal networks, social media, or NGO contacts to locate crutches, hearing aids, or walkers.

Survey findings showed:

- Only 7 of 27 organizations surveyed provided health-related support directly to persons with disabilities.
- All 7 organizations reported the absence of specialised training among staff on inclusive practices and communication methods, particularly in engaging with individuals with intellectual disabilities, mental health conditions and sensory impairments.
- 5 organizations offered mobile services, but only 2 confirmed that these were fully accessible to persons with disabilities.
- None had trained staff in mental health support specifically for children with disabilities.

6.3.2 Gaza Strip

In the Gaza Strip, the destruction of healthcare infrastructure has made access to health services for persons with disabilities virtually impossible:

- **Collapse of Rehabilitation Services:** According to HI, Gaza's only two prosthetics and orthotics workshops have been destroyed, and the limb reconstruction and rehabilitation center became non-operational in December 2023.[20] In addition, 39 physiotherapists have been killed, and key rehabilitation centers such as the one at Nasser Medical Complex are currently non-functional, as reported by WHO. As a result, essential services such as prosthetics fitting, physiotherapy, and assistive device support have been effectively suspended in most areas.[21]
- **Lack of Assistive Devices and Maintenance Services:** An assessment by Atfaluna Society for Deaf Children (2025) found that over 83% of children and adults with disabilities in Gaza reported having lost access to assistive devices such as wheelchairs, hearing aids,

[20] Humanity & Inclusion, "Attacks on Healthcare and Impacts on Physical Rehabilitation and Mental Health Services in the
Gaza Strip," Humanity & Inclusion, November 2023,
https://www.hi.org/sn_uploads/document/112023-Issue-Brief-Gaza-Health-Rehab-EN.pdf, p.3 (accessed June 26, 2025).
[21] *WHO analysis highlights vast unmet rehabilitation needs in Gaza*", published 12 September 2024. Source:

and mobility frames. With borders closed and imports restricted, repairs or replacements are unfeasible.[22]

- **Critical Shortages of Medication and Specialized Care:** Persons with epilepsy, cerebral palsy, or other chronic conditions reported being unable to access vital medications due to stock shortages and supply chain breakdowns. Specialized care such as pediatric neurology or orthopedics was described as "non-existent" by FGD participants. Surveyed organizations with active health operations in Gaza reported an acute shortage of trained personnel and essential supplies, as well as an overwhelming burden on remaining medical staff, compromising the quality and continuity of care.
- **Mental Health and Psychosocial Support (MHPSS):** The conflict has significantly exacerbated trauma and psychosocial distress. However, no inclusive MHPSS systems exist to cater specifically to children with disabilities. Accessible helplines, disability-trained counselors, and safe spaces for therapy are almost entirely absent.

6.3.3 Positive Community Practices and Gaps

The following community practices and gaps were cited from parents, teachers, and other respondents based on the KIIs, FGDs, and survey conducted.

- In Hebron, a local NGO-run clinic adapted its examination rooms and trained two nurses in basic sign language in coordination with an OPD. This was cited by several caregivers as an example of inclusive practice worth replicating.
- In Gaza, community health volunteers have informally stepped in to provide home-based support to persons with disabilities, but these efforts remain fragmented and heavily reliant on donor-funded humanitarian projects.
- The absence of a unified health information system tracking persons with disabilities across the oPt was a critical gap identified by service providers and UN agencies alike.

6.3.4. Addressing barriers to accessing health services

Of the 10 surveyed organizations that shared recommendations to improve disability-inclusive health services, there was a consensus on the need for four key practices: improving the accessibility of health facilities (for example through adding ramps and visual aids), developing community outreach programmes to raise awareness of available services, strengthening partnerships between healthcare providers and disability-focused organizations, including OPDs, and implementing regular feedback mechanisms to

[22] Atfaluna Society for Deaf Children. (2025, April). *Situation Report: Persons with Disabilities in Gaza Post-October 2023 War*. Gaza: Atfaluna Society for Deaf Children.

enhance responsiveness of health services to the needs of persons with disabilities. Organizations proposed to enhance collaboration with OPDs through the establishment of joint training sessions, joint funding proposals, developing shared guidelines for inclusive healthcare delivery, and creating regular platforms for communication and coordination. In KIIs, healthcare actors acknowledged systemic gaps in rehabilitation access. A representative from the Ministry of Health noted: "*The health system can only partially meet the needs of marginalized groups, as access often depends on referrals, which creates gaps—especially under growing pressure on rehabilitation institutions. There is a shortage of public rehabilitation centers. To address this, we have begun establishing rehabilitation facilities at Palestine Medical Complex and in Qabatiya, and we are working to launch a prosthetics laboratory. All members of the Disabled Persons Union are covered under public insurance, which guarantees treatment prior to completing administrative formalities.*"

6.4 Other Sectors and Cross-Cutting Barriers

While this study centers on education, protection, and health, the analysis also assessed the critical barriers to accessing other essential humanitarian sectors—specifically WASH, Shelter, Food Security, and Social Protection – given their linkages and interaction with other sectors in terms of holistically addressing the needs of persons with disabilities.

6.4.1 WASH

Access to WASH services and facilities directly affects the health, dignity and protection of persons with disabilities:

- The FGDs with parents in the West Bank demonstrated that most public WASH facilities lack ramps, wide doors, handrails, or seated latrines—rendering them unusable for many persons with disabilities.
- In the Gaza Strip, KII respondents and the literature review reveal that bathing and using latrines without support exposes persons with disabilities to dignity violations, health risks, and physical injuries. Surveyed organizations also reported damage to WASH networks and overcrowded shelters lacking adequate and accessible WASH facilities as critical barriers for persons with disabilities in Gaza.
- Four surveyed organizations with WASH programmes identified three main barriers for persons with disabilities in accessing WASH services: (i) physical obstacles to reaching water points or toilets; (ii) lack of accessibility features such as ramps or tactile signage, and (iii) financial constraints limiting the ability to purchase required hygiene materials.

These WASH gaps are not only a health risk but also a deterrent to accessing education or protection services, particularly for adolescent girls with disabilities during menstruation. Moreover, lack of accessible WASH was identified as having detrimental impacts on the privacy, safety and dignity of persons with disabilities.

Survey results highlighted the urgent need for universal design and innovative solutions to ensure accessible for persons with disabilities. Organizations emphasised the importance of inclusive community engagement in the design and maintenance of WASH facilities, ensuring regular consultations on WASH planning, providing awareness and capacity building for community members and encouraging local advocacy groups to participate in WASH decision-making processes.

6.4.2 Shelter

Shelter settings reflect one of the starkest indicators of exclusion:

- In the West Bank, many families with persons with disabilities avoid official emergency shelters due to inaccessible infrastructure, fear of discrimination, or lack of privacy.
- In the Gaza Strip, destroyed homes and inaccessible collective centers result in many persons with disabilities remaining in hazardous locations or informal shelters without access to services.
- Evacuation procedures and temporary shelter design rarely consider the needs of persons with disabilities, particularly persons with visual, cognitive, or physical impairments. This further restricts access to protection and health services, and leaves persons with disabilities vulnerable to violence, neglect, and secondary trauma.

Despite these barriers, policy efforts to mainstream disability in cluster-level guidance and standards were reported by the Shelter Cluster:

"We rely on the Global Shelter Cluster's humanitarian framework and are adapting it to the Palestinian context. In the West Bank, we developed detailed implementation guides in collaboration with UN-Habitat and NRC for designing temporary and 'transitional' shelters that incorporate the specific needs of persons with disabilities and the elderly. We also issued templates to evaluate shelter accessibility during intervention planning." Key informant interview with representative from the Shelter Cluster, West Bank

6.4.3 Food Security

Food distribution systems are often inaccessible by design:

- Long queues, distant distribution points, and lack of home delivery options exclude persons with disabilities, particularly those without caregivers.
- No dietary accommodations are made for children with disabilities with specific health or sensory needs (e.g., epilepsy, autism-related sensitivities).
- Interviewees from local government units in the West Bank described persons with disabilities being "*the last to be remembered and the first to be forgotten*" during aid distributions.
- In West Bank, food distribution programmes were reported to be negatively impacted by physical access barriers, such as road closures, checkpoints and permits, while in Gaza the destruction of physical infrastructure was a significant obstacle.

Surveyed organizations reported implementing diverse enablers to address these barriers, including the introduction of priority lines or disability-inclusive points at food distribution centers, however these were found to be inconsistently implemented. Key recommendations for more inclusive service delivery covered: deploying mobile units to support food distribution in restricted areas, stronger partnerships with local OPDs, and consulting with persons with disabilities directly to enhance the accessibility of distributions.

6.4.4 Social Protection

Inadequate social protection is a root cause of systematic exclusion across all sectors:

- Emergency cash transfers and disability allowances are underfunded, inconsistently delivered, and exclude many displaced or undocumented persons with disabilities.
- Systems rely on outdated registries that omit children or those newly disabled as a result of war-related injuries—especially in the Gaza Strip.
- Without flexible and inclusive targeting systems, many persons with disabilities are either excluded from humanitarian cash assistance altogether or receive amounts that are insufficient to cover their specific needs. This includes the inability to afford transportation to service points, purchase essential assistive devices, or access necessary medications. Several KII respondents emphasized that most cash programmes are not designed with disability-related costs in mind, and that targeting criteria rarely prioritize or adapt to the compounded vulnerabilities faced by persons with disabilities. The absence of cash or service entitlements prevents engagement in other sectors such as education and health and reinforces cycles of invisibility and exclusion.

6.4.5 Structural and Community Barriers Reinforcing Exclusion

The sector-specific challenges outlined above are symptoms of deeper systemic barriers, including:

- **Limited Application of Inclusion Standards**: While global frameworks such as the *IASC Guidelines* provide critical guidance on the inclusion of persons with disabilities in humanitarian action, these are not fully translated into actionable and localized standards within the Gaza Strip and West Bank coordination systems. According to a key informant from the Protection Cluster, the cluster refers to policies developed by the Inter-Agency Task Force and draws on practical guidance materials from organizations such as HI and UNHCR. These resources offer frameworks for inclusive planning and implementation. However, implementation remains uneven, as the effectiveness of these standards depends heavily on the ability and commitment of local partners to apply them in practice.
- **Disability Data Gaps**: The majority of humanitarian agencies still do not collect or use disability-disaggregated data, which results in persons with disabilities being excluded from services, beneficiary lists or targeting criteria. As a result, they are often overlooked in the provision of food, shelter, and cash assistance, making it harder for them to access essential aid.
- **Stigma and Caregiver Burnout**: The over-reliance on caregivers and persistent social stigma reduce service uptake and result in further marginalization of persons with disabilities.

  Short-Term Funding Models: Project-based inclusion pilots are not scaled or sustained, particularly in WASH and shelter. This is largely due to short-term funding cycles that prioritize immediate outputs over long-term systemic change. As a result, initiatives that demonstrate good practice in disability inclusion often end when project funding ends, leaving persons with disabilities without continuity of care or necessary adaptations.

Recommendations

Drawing from the findings across education, protection, health, and related sectors, this section outlines actionable recommendations to promote inclusive humanitarian service delivery and emergency response for persons with disabilities in the oPt. The recommendations target humanitarian actors, local authorities, and donors to support systemic improvements in design, coordination, and implementation.

7.1 Strengthen Inclusive Sectoral Service Delivery

- **Education:**

-Promote the integration of inclusive measures and indicators into education sector emergency preparedness and response plans. This includes advocating with donors for increased emergency funding to support critical areas such as teacher training on inclusive practices, accessibility audits of school infrastructure, provision of assistive technologies, and inclusive learning materials.
-Raise awareness and strengthen the capacity of teachers and education personnel to identify and respond to the diverse needs of learners with disabilities in both formal and non-formal education settings. This should include training on inclusive pedagogy, classroom accommodations, and early identification of disabilities.
-Ensure that learners with disabilities are fully included in remote and blended learning modalities through the use of accessible digital platforms. This includes the provision of audio-visual aids, captioning, sign language interpretation, screen readers, and other assistive technologies as needed.
-Ensure that community learning centers and Temporary Learning Spaces (TLSs), particularly in displacement and crisis-affected areas, are physically accessible and inclusive for children and youth with disabilities. This includes infrastructure adaptations (e.g., ramps, signage), accessible WASH facilities, and appropriate seating.
-Adapt emergency and hygiene kits to include items that address the specific needs of learners with disabilities (e.g., adaptive hygiene products, sensory-friendly materials).
Strengthen multi-sectoral referral mechanisms between education, health, and protection sectors by integrating rehabilitation services and MHPSS, ensuring a coordinated and inclusive response during emergencies.

- **Protection:**

-Establish child-friendly, disability-accessible safe spaces in shelters and public areas.
-Improve the physical accessibility of protection services and facilities by conducting participative accessibility audits and allocating budget to make adaptations, in line with global and national standards.
-More systematic disaggregation of data and monitoring of access by type of disability, alongside age and gender, to identify specific needs and access barriers according for persons with different disabilities.
-Conduct regular analysis of protection monitoring data to identify the key risks and specific needs of women, men, girls and boys with different disabilities.

- Strengthen case management systems to include functional assessments and referral pathways specific to children and women with disabilities.
- Train frontline protection staff on disability-inclusive service delivery, with a specific focus on identifying and interacting with persons with disabilities, particularly persons with intellectual disabilities and mental health conditions.
- Develop tailored PSS guidance and materials for supporting persons with disabilities, and institutionalize the role of caregivers more robustly within PSS interventions.
- Ensure outreach modalities – including mobile protection units and home-based models – are accessible for persons with disabilities, particularly persons with limited mobility or who are housebound, and develop accessible digital tools to provide remote protection services.

- Enhance local partnership to improve protection service delivery in restricted or remote areas.
- Conduct awareness-raising in affected communities to sensitize community leaders and members about disability rights, barriers faced by persons with disabilities, equitable access to humanitarian services, and to promote meaningful participation of persons with disabilities in community-based protection structures.

- **Health:**

- Restore and scale up rehabilitation and psychosocial services with mobile outreach units, accessible digital consultations and community-based rehabilitation programs, especially in Gaza.
- Ensure inclusive triage and prioritization of persons with disabilities in mobile clinics and emergency medical units by training staff to recognize disability-related vulnerabilities, ensuring effective communication methods (e.g., sign language or visual aids), and adapting spaces for accessibility, while still adhering to medical urgency protocols.
- Train frontline healthcare staff on inclusive service delivery and communicating with persons with different disabilities.
- Enhance collaboration between health service providers and OPDs, for example through joint training sessions, joint funding proposals, developing shared guidelines for inclusive healthcare delivery and creating regular platforms for communication and collaboration.
- Monitor the inclusion of persons with different types of disabilities in health programs to inform actions to enhance the inclusiveness and accessibility of health services for persons with different disabilities.

7.2 Mainstream Inclusion Standards in Other Specific Humanitarian Sectors

The following key recommendations were identified for other humanitarian sectors explored in the report, linked to the primary sectors of analysis:

- **WASH:** Design latrines, bathing units, and water points based on universal design principles. Include hygiene kits adapted for persons with incontinence or limited mobility.
- **Shelter:** Ensure that shelter vulnerability and targeting criteria explicitly include persons with disabilities and families with accessibility needs. Where feasible, prioritize accessible shelter allocation and incorporate basic adaptations (e.g., ramps, privacy screens) in the design of transitional or upgraded shelters.
- **Food Security:** Incorporate home delivery options and disability-specific dietary considerations in food aid planning. Involve community committees that include persons with disabilities and OPD representatives in the design and targeting of food assistance to ensure it reflects accessibility and inclusion needs.
- **Social Protection:** Introduce flexible, rapid disability verification for emergency cash support. Expand the coverage of existing disability-targeted cash transfer programs to reach a greater number of eligible individuals, particularly those affected by conflict or displacement. Harmonize eligibility criteria, benefit levels, and payment mechanisms between the West Bank and Gaza Strip to ensure equitable and consistent support.

7.3 Institutionalize Disability-Inclusive Coordination and Disaggregated Data

- **Establish Disability Focal Points** within clusters and local municipalities to coordinate inclusive planning, monitoring, and advocacy.
- **Engage OPDs and persons with disabilities** systematically in planning processes across different sectors, particularly during rapid assessments and targeting exercises.
- **Mandate disability disaggregation** in all humanitarian data systems using Washington Group Questions or equivalent tools to monitor inclusion and access to services. Ensure that sectoral data can be disaggregated by age, gender and disability at minimum.
- **Barrier identification and removal:** systematically identify barriers to services for women, men, girls and boys with disabilities in humanitarian services throughout the project cycle, and implement actions to remove or mitigate the barriers.

7.4 Invest in Localized Capacity and Sustainability

- **Fund multi-year programs that embed inclusion** within government and NGO services (e.g., inclusive education programs in the Ministry of Education, inclusive protection services via the Ministry of Social Development).

- **Support OPDs and local disability-focused organizations** with institutional strengthening, resource mobilization, capacity building and tools to meaningfully engage in humanitarian coordination mechanisms.
- **For Ministries and Humanitarian Clusters:** Scale up successful pilot interventions—such as municipality-led infrastructure accessibility upgrades and digital case tracking systems used by service providers—and institutionalize them by embedding these practices into national policies, municipal planning, and cluster-level standard operating procedures (SOPs).

Case Studies: Highlighting Innovative Models and Best Practices

Despite significant structural and systemic barriers to inclusive services, protection and assistance for persons with disabilities, several promising practices and innovative models across the West Bank and Gaza Strip have demonstrated the potential for an inclusive humanitarian response. This section outlines six case studies that highlight successful initiatives across education, protection and health sectors, with a particular focus on accessibility and digital inclusion.

Each case study is grounded in field-based inputs—KIIs with OPDs, service providers, or humanitarian cluster actors (March–May 2024)—and is followed by several recommendations for scale or replication.

8.1 Continuity of Learning for Children with Disabilities – Inclusive Schools in Hebron and Jenin, West Bank

In the West Bank, two inclusive schools in Hebron and Jenin were able to maintain education access during periods of military incursions and movement restrictions by:

- Transferring lessons to temporary learning spaces (TLS) equipped with basic accessibility features (e.g., ramps, low-vision materials).
- Continuing social-emotional learning (SEL) activities adapted for children with different functional limitations.
- Maintaining contact with families via teacher-led WhatsApp groups to support learning at home.

Recommendation: Institutionalize the use of SEL tools and accessible TLS designs in emergency education protocols; require that disaggregated disability data be collected in education assessments.

8.2 Municipality-Led Accessibility Pilots (Nablus and Hebron, West Bank)

In the West Bank, Nablus and Hebron municipalities led local infrastructure upgrades in partnership with OPDs. Interventions included:

- Conducting accessibility audits with OPDs to guide priorities.
- Installation of ramps, handrails, and signage in municipal service buildings.
- Use of local contractors, making it cost-effective and feasible even during budget constraints.

Recommendation: Nationalize an "accessibility minimum package" for municipal spaces and make OPD consultation mandatory in all infrastructure tendering processes.

8.3 WhatsApp-Based Case Tracking and Information Sharing (Gaza Strip)

Following October 2023, a coalition of 5 local NGOs in Gaza used encrypted WhatsApp groups to:

- Track the urgent needs of persons with disabilities (e.g., injury, shelter status, assistive devices).
- Refer cases to existing service providers for urgent care.
- Share real-time updates on shelter relocations and food delivery routes.

Recommendation: Expand the use of accessible digital communication platforms in emergencies; ensure OPDs and caregivers are included in cluster-level information sharing systems.

8.4 Home-Based Rehabilitation via Community Health Workers – Northern West Bank

In Qalqilya and Tubas, local health NGOs trained Community Health Workers in basic rehabilitation service delivery. Services included:

- Physical therapy for children with cerebral palsy or war-related injuries.
- Basic psychosocial support and referrals to mobile clinics.
- Service to households facing stigma or mobility restrictions.

Recommendation: Mainstream a similar home-based rehabilitation model into primary healthcare packages, especially for displaced families, and fund Community Health Worker inclusion under Health Cluster action plans.

8.5 Inclusive Emergency Kit Distribution – Tulkarem, West Bank

A grassroots OPD in Tulkarem partnered with an INGO to design and distribute disability-tailored kits that included:

- Noise-cancelling headphones for sensory-sensitive children.
- Incontinence supplies for adults with mobility limitations.
- Communication boards for non-verbal children.

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Don du Gouvernement Belge

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