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ASSESSMENT OF REHABILITATION SERVICES IN THE NORTH DISTRICTS OF WEST BANK IN PALESTINE

By

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ASSESSMENT OF REHABILITATION SERVICES IN THE NORTH DISTRICTS OF WEST BANK IN PALESTINE

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DECLARATION

No portion of the work referred to in this thesis has been submitted as an application for another degree or qualification of this or any other university or institute of learning.

NASSER ABU KHADER,

2002

ABSTRACT

Assessment of Rehabilitation Services in the north districts of Palestine

N. Abu Khader

The purpose of this study was to assess the rehabilitation services in the North districts (Nablus, Salfit, Tulkarm, Qalqiliya, Tubas, and Jenin) of the West Bank in Palestine.

The study population consisted of (43) providers who represented the institutions providing rehabilitation services. Exploratory descriptive design utilizing a structured questionnaire designed by the researcher and reviewed by 4 advisors with a research background was utilized. The questionnaire consisted of (13) sections: The first section was related to socio demographic variables (age, gender, education and experience.) Sections two to section eight covered types of rehabilitation, quality and quantity, size of rehabilitation services, financial matters, human resources, relation with administrative system, patient referring system, cooperation and coordination, national policies and rehabilitation policies. Section nine covered priority rehabilitation needs. Section ten covered the most serious problems that restrict development of services. Section eleven and twelve covered suggestions to develop rehabilitation policies, while section thirteen covered measures to improve quality of rehabilitation services.

Data were collected through face-to-face interviews. The analysis of the data revealed that the majority of providers of

rehabilitation services were young less than 35 years (58.1%). the majority (62.8%) had aBachelor degree; with more than 10 years of experience (53.3%).

- Physiotherapy is the most rehabilitation service provided in the north districts (86%).
- There is duplication in providing services by different institutions, while some services are nonexistent such as Occupational therapy.
- About90.6% of providers indicated needed to develop their work force.
- Results indicated weak administrative measures and lack of laws. This restricts development of rehabilitation services.
- In general the majority of providers suggested that the rehabilitation policy and services should be comprehensive and nation wide. There should be social assimilation of the disabled in their society and, studying of the factors that affect policy-making in the field of rehabilitation and to support rehabilitation institutions. Accordingly, an accepted policy and protocols by different settings: UNRWA, NGO's, government, and private sectors should be targeted in order to improve the quality of rehabilitation services and to ensure a better rehabilitation and well being of the Palestinians with special needs.

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Finally, to my wife and family, I owe a special debt of gratitude for their constant encouragement and support.

I sincerely hope that this study will be beneficial to the policy makers, planners, providers of rehabilitation services and to the disabled in Palestine.

DEDICATION

" Dedicated, with love,

To my wife,

My children

And my friends."

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ABBREVIATIONS

*BA	Bachelor of Arts.
*CBR	Community Based Rehabilitation
*CNCFR	Central National Committee for Rehabilitation.
*CRCR	Central Regional Committee for Rehabilitation.
*CSPD	Comprehensive System of Personnel Development.
*FAFO	Norwegian Institute for Applied social science.
*ILO	International labor organization.
*JEPPA	Jerusalem Family Planning and Protection Association.
*MRC	Medical Relief Committee.
*NGO	Non-Government Sector.
*NIDRR	National Institute on Disability and Rehabilitation Research.
* OT	Occupational Therapy.
*PCBS	Palestine Central Bureau Statistics.
*PCV	Person Centered Values.
*PNHP	Palestinian National Health Plan.
*PSPH	Palestinian Strategic Planning Health
* PT	Physiotherapy.
*RSA	Rehabilitation Service Administration
*SPSS	Statistical Packages of Social Science.
*SRCR	Southern Regional Committee for Rehabilitation.
*UNDP	United Nations Development Program.
*UNICEF	United Nations Children's Fund.
* UNRWA	United Nations Relief and Works Agency.
*VR	Vocational Rehabilitation.
*WHO	World Health Organization.

CHAPTER 1

INTRODUCTION

This study focuses on a sector long neglected by the Palestinian society "the disabled" or as more recently called persons with special needs. During the first two years of the first Palestinian people's uprising, "Intifada" (1987-1989), at least 40,000 people, mostly young adults and children, were injured by the Israeli army's violence (Giacaman, 1989). In addition, during the second uprising, "Intifadat-al-Aqsa", which erupted in September 2000 and is continuing to date, more than 27,000 persons have been injured by the army's violence. Such devastating events caught the public eye, both at the Palestinian and at the international level. These injuries have left many with permanent disabilities. The number of people with disabilities in Palestine in 1997 was (46,063) and in the north district (14,459), (Palestine Central Bureau of Statistics (PCBS), 1997).

Socially, and in the light of the political context in Palestine, the communities' perception of disability has been transformed from a problem bringing shame to individuals and families to a condition that is brought about by political heroism, and, therefore, essentially honorable in nature. Some seized the opportunity and began to pose questions that were more general in nature concerning the disabled in the society as a whole: Who are the disabled in the Palestinian society? Where are they? How many? Are their needs being met? And what is the quality of their lives? The large numbers of people with disabilities means larger visibility. Disabilities are no more a remote

"thing" but rather something that touches many families. Consequently, the large number of disabilities among the Palestinians due to the "Intifadas" has triggered the societies, attention and concern with regards to the disabled. This solidarity with Intifada related disabled has invariably also brought attention to these non-intifada related disabled.

A. Statement of the problem:

Many studies suggested that adequate utilization of rehabilitation services affects the health status of the disabled. The utilization of these services can be affected by several factors. Although there are several studies focusing on disabilities and rehabilitation worldwide, yet relatively very few were conducted in Palestine. This study is a step forward in that respect and is essential for developing rehabilitation services in Palestine.

B. Significance of the study:

This study aims at collecting and describing basic information regarding rehabilitation services for the disabled in the northern districts of Palestine. The importance of this work stems from the fact that it considers the principles of providing a comprehensive rehabilitation service as a basic human right for all citizens. Results of this study will help policy makers as well as rehabilitation care providers to improve the quantity and quality of care given to the disabled in order to meet their needs and to promote cooperation and coordination among the various institutions dealing with the disabled without undue cost to society. Such cooperation involves a division of

labor based on experience in the field, technical expertise and ability to reach and involve communities in planned action.

The importance of conducting this study also lies in the fact that comprehensive rehabilitation must be based on realistic approaches rooted in low cost and appropriate services to the community. In addition, it is hoped that identifying and describing rehabilitation services will enrich information about rehabilitation, encourage planners and health care providers to find measures for filling the gaps, and most importantly, will, in the long term, improve the situation of the disabled, promoting a satisfaction which at this time is questionable. As a result, the rehabilitation status of the disabled will improve, as an outcome of an effective and efficient rehabilitation care services. The most important challenge is to understand the future, to plan for it, and to act to make the future what we want it to be. This research will contribute to the modification of the national rehabilitation policy and to suggest services in a system characterized by cooperation and coordination.

This study may also help in coordinating capabilities of a body of people representing institutions working in the field of rehabilitation to guide research activities, collectively formulating strategy, planning for implementation and evaluation of rehabilitation projects at the country level.

The process of linking all the institutions of the area into a net-work of cooperation, coordination, perhaps beginning with this study results and later in workshop discussions, may lead to identification of problem areas and further needs, and will attempt to upgrade the level

and quality of existing services, and will eventually leading to the amelioration of disability service problems.

C. Purpose and Objectives.

The general purpose of this study was to assess and describe the rehabilitation services in the northern districts of Palestine.

The objectives include:

-Reviewing operational rehabilitation services at the different settings.

- Assessing human resources in rehabilitation settings.
- Suggesting issues for consideration by policy makers in rehabilitation services in Palestine.
- Suggesting training in rehabilitation related areas.
- Describing rehabilitation services in the northern districts.
- Raising the profile of disability issues in Palestine.
- Contributing and promoting policy formulation in the rehabilitation fields.
- Promoting the development of comprehensive rehabilitation strategies and identifying models for implementation.
- Providing base line information for health care providers, policy makers and researcher.
- Providing a critical link between agencies active in the disability issues and rehabilitation.
- Encouraging debate and discussion on social support and health care strategies as part of the rehabilitation continuum.
- Providing more effective, equitable and accessible programs for persons with disabilities.

D. Research Questions:

The following were the guiding questions for this study.

1-What types of rehabilitation services are available?

2-Who is providing rehabilitation?

3-How can quality and quantity of rehabilitation services be improved?

4-What is the size of rehabilitation services?

5-What is the condition of rehabilitation facilities?

6-What are the financial matters in the institutions of rehabilitation Services?

7-What human resources are available for such services?

8-How is the administrative system in these rehabilitation services?

9-What is the condition of the patient-referring system, and coordination and cooperation between the sectors of rehabilitation?

10-What are the top service priorities in the field of rehabilitation?

11-What problems are limiting the development of rehabilitation services?

12-How should rehabilitation policies in Palestine be developed?

13-What can be done in order to improve rehabilitation services?

E. Assumptions

This study was based on the following assumptions:

1- Rehabilitation settings will participate in this study.

2-Administrators targeted to respond to the study questionnaire will respond and freely express their opinion.

3-Administrstors will help and allow the researcher to conduct the

study in their facilities.

F. Limitations of the Study:

The following were the presumed limitations of the study:

1-There are limited resources in the field of rehabilitation research in Palestine.

2-Lack of co-operations by some of the services administrators.

3-Political daily instability in the country.

G. Major Research Concepts and Variables:

1-Rehabilitation care provider's variables.

2-Rehabilitation care services variables.

3-Quality and quantity of the rehabilitation service's variables.

4-Size of the rehabilitation service's variables.

5-Financial variables.

6-Human resource's variables.

7-Administrative system variables.

8-Patient-referring system, coordination and cooperation variables.

9-Rehabilitation policy variables.

10-Rehabilitation priority variables.

H. Definition of Research Terms and Variables:

The following definitions aim at giving the reader an understanding of the terms used in the study as part of the rehabilitation continuum.

- Rehabilitation is defined as putting back the person into function. It also involves obtaining for the disabled as much independence as possible to conduct their daily life.

- Community Based Rehabilitation (CBR) is a system, which envisages using existing resources of manpower and material within the community to promote integration of disabled in all spheres of life and activities.
- Vocational Rehabilitation is a system that assists persons with disabilities to integrate into social and economic life.
- Occupational therapy is the art and science of directing human's participation in selected tasks to restore, reinforce, and enhance performance, facilitate learning of those skills and functions essential for adaptation and productivity, and to promote and maintain health.
- Speech therapy is the art and science of directing human's participation in selected tasks to helps the patient correct speech disorders or restores speech.
- Physiotherapy is defined as the correction and alleviation of movement disorders that cause pain or hinder movement effectiveness, the maintenance of improved levels of movement, the determination of a persons potential capacity for effective body movement, the prevention of potential movement problems, and the prevention of unnecessary deterioration of movement or loss of function.
- Prosthetics is the art and science of helping the patients in daily life activity.

I. Methodology:

The researcher utilized a descriptive quantitative design utilizing a structured questionnaire in a face to face interviewing to

describe the rehabilitation services in the northern districts. The face-to-face technique was most appropriate in order to include all providers of services with different service levels and to achieve high response rate. The study covered all operating rehabilitation centers at the primary, secondary, and tertiary levels.

The targeted population included all the providers of rehabilitation services in the northern districts of Palestine. Responses were provided by the manager of each the 43 centers contacted.

Table (1): Types of Rehabilitation Centers in the North Districts In Palestine.

Centers	Numbers
Physical Therapy	37
Speech Therapy	2
Vocational Therapy	1
C.B.R	2
Prosthesis	1
Total	43

Reference: Personal compilation.

The researcher wished to include occupational therapy as part of rehabilitation services. It was however excluded due to its non-existence in the northern districts.

j. Time Frame:

Table (2): The Time Frame for Completion of the Study

Time Frame	Activities
15-30thMay/2001	Introduction and finalization of study proposal
2-16thJune/2001	Study Setting
18thJune-18thJuly/2001	Literature Review
19thJuly-6thAugust/2001	Frame of Reference
8-30th August/2001	Methodology
1-30thSeptember/2001	Data Collection
1-31st November/2001	Data presentation and Analysis
1-31stDec/2001	Report writing

K. Summary:

This descriptive study was conducted to provide basic information about rehabilitation services in the northern districts of Palestine focusing on different aspect of rehabilitation services including models, administration, facilities, rehabilitation policy, development of services, funds etc of different centers belonging to the Private, NGOs, Government, and UNRWA. It aims at helping the planners, decision makers and rehabilitation providers to better meet the rehabilitation needs, to improve the quality of care, and to better formulate rehabilitation policy.

CHAPTER II

Study Setting

This part of the study is designed to shed light on the West Bank in general and the northern Palestinian districts, the targeted study area, in particular.

A. Geography and Demography of the West Bank:

The area of the West Bank is about 5,800 square km. It is a hilly region composed of four regions: the Jerusalem mountains in the center, the Hebron mountains in the south, the Nablus mountain in the north and the Jordan valley comprising part of the Syrian- African rift and stretching north and south along the Jordan river. The West Bank ranges fall between the coastal plain in the west and the Jordan Valley in the east with a width of 40-65 km, and an average height of 2,400 feet. The West Bank is divided into eleven districts: Nablus, Salfit, Tulkarm, Qalqelia, Tubas, and Jenin districts in the north, and Bethlehem, and Hebron districts in the south, and Ramallah, Jericho and Jerusalem districts in the center (Barghouti and Daibes, 1993,NHP, 1994).

According to Palestine National Health Plan (PNHP, 1997) the total population of the West Bank during (2000) was estimated at 2,011,930. Around 43% of the population resided in the northern districts, 29% in the central districts and 28% in the southern districts of the West Bank. In November 1997, the Palestinian Central Bureau of Statistics (PCBS) released the official results of its population census, housing and establishments. Population estimate in the

Palestinian territories West Bank and Gaza Strip were approximately (3,150,056).

Table (3): Palestinian population Estimates for Selected Years (PCBS) 2000.

Govern orate	2000	2001	2002	2003	2004	2005
Jenin	216126	225711	236428	247305	258321	269464
Tubas	39239	41067	43110	45187	47298	49441
Talkarm	142865	149188	156242	163397	170621	177940
Qalqiliya	78029	81942	86290	90729	95250	99860
Salfit	52137	54595	57339	60130	62968	65851
Nablus	278317	290621	304347	318240	332299	346476
Ram Allah &Al-Bireh	231690	243432	256483	269827	283446	297330
Jerusalem	354417	3670032	380422	394105	408042	422222
Jericho	35352	37066	38968	40894	42839	44803
Bethlehem	147121	153954	161579	169317	177170	185128
Hebron	436637	457781	481433	505694	530541	555965
West Bank	2011930	2102360	2202641	2304825	2408795	2514480
Gaza Strip	1138126	1196591	1261909	1329670	1399796	1472333
Palestinian Territory	3150056	3298951	3464550	3634495	3808591	3986813

*Mid Year- Population Projections.

Age Structure:

The age structure of the population in Palestine is not particularly different from the age structure in any other Middle East country.

Table (4): Percentage Distribution of Palestinians by Selected Age Groups (PCBS) 1997

Age Group	Percentage
O-14	47.1%
15-64	49.4%
65+	3.5%

The population of Palestine according to PNHP (1994) is expected to increase by approximately 45% from 1992-2002. Life expectancy at birth according to estimates provided by UNICEF, JEPPA (Abulibdh, Smith, Nabris and Shahin, 1992) and FAFO (1993) is approximately 66 years and projected life expectancy made by PCBS (1995) indicates continuous increase during the period 1992-2012. For the Palestinian population in the West Bank, it would mean an increase from 66.8 years to 72.8 years.

Table (5): **Percentage Distribution of Disability in the Palestinian Population by Governorate (PCBS, 1997)**

Govern orate	Jenin	Tubas	Tulkarm	Qalqiliya	Salfit	Nablus	West Bank	Gaza Strip	Palestinian Territory
Number	3697	742	2993	1617	935	4575	29849	16214	46063

The number of disabilities post Al-Qasa intifadah, covering the first year of the Palestinian people uprising, is 2832, (Gaza Center for Law and Rights Al-Quds Newspaper, 2001).

Table (6): Percentage distribution of type disability in Palestine by Governorate (PCBS, 2000)

Govern orate	Seeing	Hearing	Speech	Hearing & Speech	Physically	Grasping	Mental	Mental Physical	Multiple	Others	Total	With Disability
Jenin	16.8	4.6	4.5	5.1	33.0	3.5	11.6	3.7	9.3	7.9	100	3697
Tubas	13.6	5.9	3.9	6.2	32.1	5.5	11.9	3.3	9.4	8.2	100	742
Tulkarm	16.5	5.0	3.8	5.7	32.5	3.4	12.6	3.6	8.7	8.2	100	2993
Qalqiliya	15.3	5.2	5.5	6.4	30.8	3.7	13.6	3.6	8.0	7.9	100	1617
Salfit	18.0	4.6	5.8	5.2	25.7	4.1	18.6	3.3	9.0	5.7	100	935
Nablus	14.3	4.7	6.0	6.5	34.0	3.7	13.0	3.8	6.9	7.1	100	4575
Ram Allah & Al-Bireh	16.6	6.1	6.3	6.7	27.8	3.6	13.6	3.8	7.4	8.1	100	3558
Jerusalem	15.6	5.8	5.3	5.2	26.7	3.6	12.2	6.5	8.6	10.5	100	1920
Jericho	11.2	6.3	7.1	6.2	27.7	3.6	21.5	4.4	6.0	6.0	100	520
Bethlehem	16.4	6.7	4.1	5.9	27.2	3.6	18.7	3.7	6.5	7.2	100	2666
Hebron	14.0	5.5	6.0	5.8	29.8	3.5	12.0	5.6	8.7	9.1	100	6626
West bank	15.4	5.4	5.3	5.9	30.4	3.6	13.4	4.3	8.1	8.2	100	29849
Gaza Strip	13.2	4.7	6.2	7.2	29.8	3.2	16.4	5.1	7.6	6.6	100	16214
Palestinian Territory	14.6	5.1	5.6	6.4	30.2	3.5	14.5	4.6	7.9	7.6	100	46063

Results showed that the majority of disabilities in the Palestinian Territory are physically disabled, were the percentages (30.2%).

B. Characteristics of the study area:

Nablus, Salfit, Tulkarm, Qalqiliya, Tubas, and Jenin are the Palestinian districts, which are located in the northern area of the West Bank. Nablus district is the center of the northern area. It lies between two mountains and is famous for its sweets especially Kenafa. It's also famous for Turkish baths. Jenin is famous in agriculture especially olive trees and watermelon from (Marj Bin Amir). Tubas is famous for vegetables. Qalqiliya and Tulkarm are famous in citrus fruits. Salfit is famous for olive trees.

Population and Household: According to PCBS, (1997), the population of the northern districts is estimated at (726,191) people over (123098) households.

Table (7): Palestinian Grand Total of Households, (PCBS, 1997)

Governorate	Jenin	Tubas	Tulkarm	Qalqiliya	Sal fit	Nablus	North Districts	West Bank	Gaza Strip	Palestinian Territory
Total	32863	5792	22314	11413	7830	42886	123098	262195	144381	406576

The northern districts are predominantly Muslim like the rest of the country. However, there are Christian and Jewish communities residing in Nablus and Jenin.

The northern districts especially (Nablus) have long been famous for the presence of the Turkish baths in the old city, natural water at AL-Baidan, and Sabastia tourist sites.

The main findings of the educational statistical yearbook 1997-1998 of the PCBS, show that there are 2,400 schools and kindergartens in the West Bank and Gaza Strip. In the northern districts there are (500) schools, three universities (An-Najah, the Arab American University and Al-Quds Open University), and three

colleges (Al-Rawda, An-Najah, and Al Khodori) in addition to one nursing school.

Table (8): Distribution of Schools per region in Palestine, (PCBS) 1997.

School	Number
North districts	500
West Bank	1814
Gaza Strip	586
Total	2400

Table (9): Distribution of Schools by Supervising Authority, in Palestine, (PCBS) 1997.

School	Number
Government	1175
UNRWA	265
Private	171
Kinder garden	789
Total	2400

Table (10): Percentage of Illiterate Palestinian Population by Age, (PCBS) 1997.

Govern orate	10 Years and Over	15 Years and Over
Jenin	11.7	13.8
Tubas	14.9	17.7
Qalqiliya	12.5	14.9
Sal fit	12.4	14.7
Tulkarm	12.1	14.0
Nablus	10.0	11.7
West Bank	11.8	14.0
Gaza Strip	11.3	13.6
Palestinian Territory	11.6	13.9

The median age at first marriage in the northern districts is 24 for males and 19 for females, (PCBS, 1997). However 39.2% of married disabled persons have physical disability and 20.3% have seeing disability, (PCBS, 1997).

North districts are considered a major center in the West Bank for olive oil and soap industry. People are mainly industrial workers or Laborers. Many of them work in Israel. Unemployment has been on the rise with 297,000 reported unemployed during the first quarter of 2001, (PCBS Press report on labor force survey results, January 2001). The data revealed that the percentage of economically active disabled persons (aged 10 years and over) was 25.6% in the Palestinian Territory (West Bank & Gaza Strip), of which 28.1% resided in the West Bank and 20.1% in the Gaza Strip.

The estimated poverty line for the year 2000 based on (1622) NIS for a household composed of two adults and four children, indicated that (64.2%) of the Palestinian households (2,107,400 individuals) were expected to be living below the poverty line. This figure reached (55.7%) in the West Bank against (81.4%) in Gaza Strip, (PCBS, 2001).

Table (11): Percentage of Households Living Below Poverty Line in the Year 2000 by region, (PCBS, April 2001).

Region	%Below Poverty Line	%Above Poverty Line	Total
West Bank	55.7	44.3	100
Gaza Strip	81.4	18.6	100
Palestinian Territory	64.2	35.8	100

Selected Health Indicators.

Disability Prevalence: It was found that 1.8% of the Palestinians were disabled. The total number of Palestinian population with disability was 46063 (PCBS, 2000). The Population in need of rehabilitation is 2-2.5%. That is. Between 30,000-37,000 persons in the West Bank and Gaza Strip. The large majority of the disabled in the West Bank (almost 80%) were not being reached by the services they need, (Giacaman, 1989).

During the first 2 years of the Palestinian peoples uprising (1987-1989), at least 40,000 persons mostly young adults and children were injured by the Israeli army's violence (Giacaman, 1989). In addition, from the beginning of the second uprising," Intifadat-al-Aqsa, 27th September to 30thJune2001, at least 26738 persons were injured by the army's violence (Gaza Center for Law and Rights, 2001). It is expected that the number is continually on the rise as the Intifada is ongoing.

C. Rehabilitation care facilities:

Different operators provide rehabilitation services in the northern districts. According to PCBS (1997), these providers include:

1- **Government Sectors:**

The Palestinian Ministry of Health, Ministry of Social Affairs, and military medical services operate the public sector. This sector provides free of charge services to Palestinians holding a valid government insurance card, and to all children under 3 years old, at primary and secondary rehabilitation care services.

2- The United Nations Relief and Works Agency (UNRWA):

Provides free of charge services to all registered refugees eligible for rehabilitation services, mostly primary health care as well as secondary health care by supporting hospitalization and other service schemes at subsidized hospitals.

3- Non-Government Sectors:

This sector is operated by the charitable, International and Local societies, which provide primary, secondary and Tertiary rehabilitation services at minimal fees or free of charge to social cases.

4- Private Sector:

Private rehabilitation centers or institutions that provide services at costly prices operate this sector.

Table (12): The size of rehabilitation services in the north districts (personal compilation).

Sectors	Public	Private	NGOS	UNRWA	Total
Numbers	5	19	15	4	43

The level of rehabilitation services include:

A- Rehabilitation services provided at the primary health rehabilitation care level –Community Based Rehabilitation (CBR).

B- Secondary level services include cases where no permanent disability is expected or when the permanent disability is not very serious and where the injured person is in no need to remain in hospital, for extended periods of time.

C- The tertiary level of service includes cases that require institutionalization for extended periods of time -months to about one year and where the injury or disability is serious, such as paraplegia.

Description of the settings:

In this study, the researcher selected all settings as described in table (12). The Major part of the rehabilitation care/services in northern districts is delivered by the NGOS, and the private sector operating for (34) centers and clinics located in the northern districts. Services offered in these centers, include: Physiotherapy, prosthesis, CBR, and especial education. The majority of these centers are located in Nablus district .The Average number of the disabled and patients visiting these centers per day before the second uprising (Intifadat, al-Aqsa) was 15-20.

1-UNRWA Services:

The rehabilitation services are distributed in three refugee camps (Jenin, Balata, Noor Shams) and in Qalqiliya hospital. The centers provide their preventive & curative rehabilitation services to the Palestinian refugees who live in the northern districts. Physiotherapists, and assistants run these clinics and centers. They also screen for disabilities. Physiotherapy services are provided six days per week. Services are provided free of charge for all refugees.

2- ***Public/ Government Services:***

The public /government rehabilitation services are operated by the Palestinian Ministry of Health and the Ministry of Social Affairs.

The center provides its curative rehabilitation services to the insured Palestinians who live in the northern districts.

3-NGOS:

The NGO's rehabilitation services are distributed in all northern districts .The major part of the services is in Nablus district. These centers offer Physiotherapy, Speech therapy, prosthesis and especial education services. Services are provided at minimal cost and free of charge for the social cases. There is only one Vocational Rehabilitation center in Nablus, which provides its services to the Palestinian disabled who live in the north districts and which is also operated by an NGO.

4-Private:

Private rehabilitation services are also available in the northern districts .The major part of the services are also in Nablus district. Most services are located in the center of the cities. Physiotherapy is the major type of the services in this sector.

Chapter III

The Orientation Of Rehabilitation Services and History

A. Introduction:

An important part of this orientation to rehabilitation is the "values-based" system for rehabilitation services, which works to help persons with disabilities succeed in employment, careers and independent living. The ways people act towards people with disabilities begin with what they think about these people. That is why the values and beliefs about disabilities are so important. If you think disabilities are just part of life and any one could have a disability, you will think that someone with disability is just like anyone else. This history will show you some of the things people thought and did about the disabled, and why we do things differently today(Htt://www.coe.missouri.edu/~rcep7/orient/history.htm).The basic principles of the value based system for rehabilitation includes:

1-Person centered values and the medical model:

There is a change going on in the public rehabilitation system as service staff switch to some thing called "person centered values". The way things were done in the past is now called the "medical model". In the medical model, rehabilitation staff dealt with people with disabilities like cases, not as people. They labeled people according to their disability. The person with disability never said any thing about it and sometimes felt like an object rather than a person. Under "person-centered values", the rehabilitation system works more like a typical grocery store. With help of staff, the person with

a disability can decide what he or she needs and then picks the service system to receive.

2-*Focus on the person, not the disability*:

The person with disability is the only one who really knows what effect their disability is having on their life. The person, not the doctor, is the best expert. People with disabilities know their disabilities from the inside out Spend time with them, and they will tell you. Person Centered Values (PCV) is based on a set of ideas about people with disabilities and how we should treat them .It starts with the idea that people with disabilities are people first, not variations on a disability diagnosis.

3-*Focus on support Needs, not on limitations*:

Try to think that someone with a disability is different from you, rather than lives less than you. All of us have basic needs, friends, control of our lives, comfortable places to live in, food, ect. People with disabilities also have different needs. If we start thinking of those needs as limitations, we are defining the disabled's lives as less full than ours. They just have different needs.

***4-Emphasis on community participation*:**

All people live in communities. If people with disabilities can live in the wider community of their neighborhoods and towns, they can participate in the natural give-and-take traditions of their town. Drawing on the various resources of the community helps

rehabilitation service providers offer a great range of support to people with disabilities.

5-Every one is employable:

This is one of the most progressive ideas in person-centered values (pcv). Every person, no matter how severe his/her disability can provide useful services in a job setting. (PCV) says everyone can go out in the community and do something.

6-Expect people to choose their own risks and be responsible for the results:

Adults with disabilities should have the same freedom. If the person who is blind or with quadriplegia wants to go swimming, let them try. The best way to find out what works for someone is to give it a try.

7-Environment can be the source of problems:

The problem is not the person's disability or their behavior, the problem is the environment. Environment can mean many things. People who know an individual well will be able to understand their communication behavior .The best way to treat someone like a person instead of a thing is talking to them, spending time with them, and finding out what they think about things. Experts are only to give advice and information to the person.

During the mid 1960's, radical "de institutionalization revolution" began. It was supposed to end the, often, cruel and inadequate care of institutions. The idea was that individuals would

live in their communities and have a normalized life, Group homes, residential care facilities, and developed houses, where persons with similar disabilities could live together.

During the 1970's people with disabilities and their friends and families started a "Civil Rights Movement for People with Disabilities, also called the disability rights movement. These activists asked for community inclusion and choice for people with the disabilities. They also said the person with a disability (the consumer) should be the person who decides what services he wants to help him become part of that community .The person with the disability should be the decision maker.

The disabilities rights movement in the world changed the system of rehabilitation care. A new type of staff workers, the advocates, appeared to help people with disabilities understand their choices and responsibilities. Disability rights activists created community based " independent living centers in the community where people with disabilities could get help from advocates and peer counselors (other people with disabilities) about how to live on their own. Vocational rehabilitation staff focused more on integrated jobs where someone with disability worked with non-disabled coworkers instead of sheltered workshop situations, where he could earn at least minimum wage. Staff members, advocates, disability right activists, and people with disabilities are all working to remove the physical and attitudinal barriers that stand in the way.

B. History of legislation:

The rehabilitation Act of 1973 corrected some of the problems and started the modern age of vocational rehabilitation. It marked the beginning of person-centered values (PCV) as a major part of U.S law. Vocational rehabilitation counselors created Individualized Written Rehabilitation Programs (IWRPs) for each person .The 1973 Rehabilitation Act used specific definitions of "severe" disabilities, and for the first time, gave people with disabilities the right to appeal decisions about their services (Htt://www.coe.missouri.edu/~rcep7 /orient/history/history.htm).

C. The Rehabilitation System Today:

There are more than fifty million people with disabilities in the United States, making them the largest minority group in the country. To serve this large group of people, each state and territory of the U.S. has its own vocational rehabilitation agency in local government, working in partnership with the Rehabilitation Service Administration (RSA). Instead of supervising and controlling the agencies, RSA advises the state agencies about the national government official policies towards rehabilitation.

The most recent additions to the rehabilitation Act required a "Comprehensive System of Personnel Development" (CSPD) for all staff members to familiarize them with supporting, (PCV), and the new principles of the public rehabilitation system. Unfortunately, there are no accepted standards or content for this personnel development for most staff positions (Htt://www.coe.missouri.edu/~rcep7/orient/ history.htm).

D. History of Rehabilitation in Palestine

A new relationship with international aid institutions has been drawn since the Israeli occupation of the Palestinian territories in1967, and since the Palestinian non-governmental institutions and societies started dealing with the emerging situation under occupation and the societies efforts to bridge the gap formed when a governmental sector was left under Israeli control.

The early 1970s witnessed remarkable growth in the international institutions activities in the Palestinian occupied territories. These institutions started forming relations with local institutions working in various fields such as health, education and social issues.

The Union of Charitable Societies in the Governorates succeeded in unifying all committees under the umbrella of the Central Committee for Rehabilitation of the Disabled, Jerusalem.

In 1980, this committee worked to resist occupation. Early in 1990, the Society Unified with the Central National Committee for Rehabilitation of Disabled, which in 1991 issued a national document on rehabilitation strategies and policies in Palestine.

The outbreak of the Palestinian popular Intifada (uprising) in 1987resulted in increasing the number of the injured and the disabled who greatly needed treatment and rehabilitation. The Intifada created an important element to the institutional infrastructure of the Palestinian society. This infrastructure led to strong Palestinian institutional foundations working in the health sector in particular. The society's attitude towards disability changed due to Intifada-caused

injuries. Support and aid by donors increased especially to the various programs of Palestinian national (non-governmental) organizations and the rehabilitation programs in particular.

In the late 1980s and early 1990s, two centers for rehabilitation of the disabled were opened at Arab Bethlehem Society of Rehabilitation for the Physically Disabled in Beit Jala, and Abu-Raya Center in Ramallah.

In 1987, a physiotherapy program was established at the Women's Community College UNRWA. In 1989, the first university program for teaching physiotherapy started at Bethlehem University. This program graduated 120-130 specialists in this field. Also in 1989, two two-years courses by Doctors Without Borders (Medicines Sans Frontiers) in physiotherapy were held in Nablus and Qaliqlia and were carried out because of the pressing need for rehabilitating the disabled and the injured of the Intifada.

In 1990, the Rehabilitation program at UNRWA was established. This program played a great role in forming local committees concerned with looking after and rehabilitating the disabled in the Palestinian camps. The decade from 1982 to 1992 was considered, internationally, the Decade of the Disabled. It was noticed that the number of the disabled increased with out increase in the number of specialist to take care of this group.

Later, the Palestinian Red Crescent Society held another two-year course in physiotherapy in Hebron Governorate and in the Gaza Strip. With the arrival of and establishing of the Palestinian Authority, interest in this field by universities and educational institutions increased. Various programs in physiotherapy, occupational therapy

and speech therapy at Al-Quds University, Bethlehem University and the Arab-American University were established.

In 1991, the Palestinian General Union for the Disabled emerged to form a historic changing point in the lives of the Palestinian disabled and to proceed (with them) forward to the position of decision-making by activating the legislative council's participation and concern in the issues and rights of the disabled and speeding the approval of draft of the Palestinian law of the Disabled.

In 1994, the first Association for physiotherapists was established in Palestine to organize this profession and promote work force in the field.

In 1998, a national workshop was held to draw policies and strategies for rehabilitation in Palestine. And eventually, Palestinian Authority passed the Palestinian law of the Disabled.

In 2000, the first Vocational Rehabilitation Center for the Disabled was established in Nablus to serve cases of the northern districts.

E. Rehabilitation in Palestine Today

The rehabilitation services in Palestine have been remarkably developing. The number of institutions and centers dealing with this field and the number of work force have been increasing. The universities and other educational institutions' concern and interest has also been increasing. Nevertheless the rehabilitation services suffer from shortage in the services available especially OT, VR, and Speech therapy.

Chapter IV

Rehabilitation Policies

A. Introduction:

The programs and services concerning rehabilitation and disabilities date back to the1940s. These programs and services were originally provided by local and international non-governmental organizations. The Palestinian Red Crescent Society has been very active in bearing the responsibility preparing and conducting programs targetting the people who need rehabilitation and physiotherapy. But, rehabilitation, until the 1970s had been restricted to hearing and sight disabilities and other problems and non-complicated cases. It had neglected disabilities among the old. In the 1980s, particularly during the Intifada, many nongovernmental organizations started special programs for the disabled.

With the emergence of the new era when the Palestinian National Authority took full responsibility over the health sector, rehabilitation and disabilities have received special attention, particularly, in the field of developing institutional human resources. In February 1996, the Ministry of Health established a new department for medical rehabilitation, and physiotherapy in Nablus and Gaza city. The tasks of this department include services at the level of hospitals and primary health care. The department also participates in planning, organizing and carrying out services in Palestine. It also participates in promoting human resource and training programs aiming at developing and sustaining human

resources and vocational development in the field of rehabilitation and disabilities. Finally, this department makes field visits to rehabilitation and physiotherapy institutions for cooperation and coordination of services at the national level (National Strategic Plan for Health, (NSPH), 1999).

The National Strategic Objectives for Rehabilitation (NSPH, 1999).

- Provide technically, high rehabilitation and physiotherapy services for patients in the hospitals to reduce negative consequences and prospective disabilities.
- Draft especial law to protect the disabled and to provide comprehensive rehabilitation services to about 80% of people by 2003.
- Train two specialists in the field of rehabilitation annually.
- Establish a national and continual system for guidance, enhancement, health education and prevention in the rehabilitation field.
- Firmly-establishing a national ground for active cooperation, coordination and partnership between services providers particularly the Ministry of Health, the Palestinian Red Crescent Society and the other non-governmental organizations taking part in the rehabilitation on the one hand and the disabilities on the other.
- Specify the role of Ministry of Health and other parties providing the rehabilitation services in providing health insurance.

- Employing the functional training while introducing rehabilitation services to the disabled to help them assimilate gradually in the society.
- Plan hospital based program to provide rehabilitation and physiotherapy service in the West Bank similar to the program in Gaza Strip.
- Establish a rehabilitation unit in each hospital at 50-bedcapacity, and in the primary health care centers at levels 3 and 4.
- Prepare unified regulations and protocols for providing and evaluating rehabilitation services.
- Enforce rehabilitation programs based on the society and linking such programs with the primary health care facilities.
- Support non-governmental organizations specialized in rehabilitation.
- Provide services to those who suffer from severe disabilities.
- Providing rehabilitation services to the addicts, (NSPH, 1994).

B. The factors that influence (affect) drawing policies for rehabilitation in Palestine:

Planning at the medium-term level and the long-term level the future of any system of rehabilitation requires dealing with a number of the difficulties whether those connected with curricula or other areas which influence drafting and enforcing rehabilitation policies. These are attributed to

-Difficulty in the process of planning and the changes in the structure of the systems of health care and rehabilitation for the Palestinian society due to the difficulty economic and political situation and the

inherited burden from the government staff during the long years of the occupation. This situation complicates the process of estimating the financial and non-financial resources in anticipation of the rehabilitation requirements and needs.

-Lack of ability in strategic planning, and drawing these policies. This refers to the lack of experience in this sphere and not giving planners the opportunity for planning due to the weakness in the culture of planning at all levels.

-Weakness in the connection between the planning department as a national resource for making policies and the decision–makers in all stages for the improvement of the rehabilitation sector in Palestine.

-Lack of clarity in putting and drawing these policies in a comprehensive national manger with broad based participation.

-Duplication of the main sections in the West Bank and Gaza Strip due to the separation by Israel and the difficult measures which result from this.

-Deficiency of the informative, administrative and rehabilitation system throughout history. The Palestinian health sector has lacked the reliable and valid information in many areas and this influences drawing of policies.

-Lack of researches in the rehabilitation sphere. Research in the health sphere and rehabilitation in Palestine is very limited. The available researches take a descriptive and primitive shape to a large extent and focus on the negative sides of health, disease, the number and type of the handicaps. The available activities of research need support.

-Weakness and limitation in the rehabilitation services themselves.

-International aid decreasing continuously and affecting several NGOs and those providing rehabilitation services.

These obstacles, which affect the drawing of the health policies, are largely attributed to the instability of the political situation and the Israeli restrictions and control. Additionally, they are impacted by the complexity of the international cooperative process, especially the support projects. Other reasons include:

*Absence of cooperation in designing some of the aid projects especially these designed prior to 1994.

*The lack of strategic planning concerning the requirements, the predictions and the Palestinian priorities.

*The donor's interests, which do not necessarily suit the Palestinian priorities.

*The insufficiency and sometimes lack of experience of the rehabilitation staff working in the management of international cooperation projects.

*Insufficient training in this sphere.

*The exaggeration in the budgets of remuneration to the international consultative companies and their advisors (consultants).

*The consultants, inability to use the Arabic language and their in experience in Arab cultures.

*Disconnection between some projects operations and the work of the ministry of health.

The Political Factor:

The present environment in which the Palestinian rehabilitation services operate makes the planning for the health sector

in general and rehabilitation in particular a complex matter. The political environment, negatively affects policy making in Palestine due to the separation between the Gaza Strip and West Bank and continuing conflict due to the Israeli occupation. Furthermore the health situation is connected strongly with the economic and political circumstances.

The following are the main factors, which affect the making and drawing of the rehabilitation policies in Palestine:

- The incomplete control of the Palestinian Authority of the Palestine land. These Israeli restrictions make it impossible for the Palestinians to supervise the environmental affairs or practice real control over the revenues and to set up comprehensive systems, which aim at developing the health and rehabilitation systems.
- The separation between the West Bank and Gaza Strip. This separation negatively influences policymaking and is an obstacle in the way of effective coordination and planning for the rehabilitation services. Because of this separation, the drawing of proper rehabilitation policies and strategies will not be achieved. It will be greatly hampered by the lack of the direct communication between the minister and managers and also between those in charge of the planning and the different providers.
- Poor coordination, as a result from this separation has led to the discrepancies in the number of the health workforce in the West Bank in comparison with Gaza Strip. This separation also affects the work of the non-governmental organizations because their dual offices in the West Bank and in the Gaza Strip and difficult in coordination.

- ***The Economical Effect***

The Israeli policies, which prevent workers from working or restricting their numbers, affect health and policies. The number of people benefiting from health insurance has decreased, as the unemployed people cannot afford the premiums.

The deteriorating economic situation restricts the Palestinian Authority and the non-governmental organizations' abilities to meet the insurance expenses for the needy. Furthermore, the deteriorating economic situation will greatly affect the efficiency of regaining the expenses even in the private sector.

The economic factors play a key role in the strategic planning process. They directly affect the planning that leads to success or failure of any program or project. Therefore, the national income, average income per individual, unemployment levels, energy and raw materials, salaries and wages, savings and consuming attitudes and interest rates should be taken into consideration.

The Insufficiency of the Infrastructure:

The long years of the occupation prevented the rehabilitation sector from development .The rehabilitation services need much development in this sphere which has started by NGOs and is moving under the Palestinian Authority.

Maldistribution of Services:

The bad distribution in rehabilitation services between the different area in the West Bank and Gaza Strip affects passively the

drafting of rehabilitation policies in Palestine. The bad distribution appears in the infrastructure. Also, most of these services are available in the city and in the middle of and around the city.

The problem in the equality between the residents in the ability to reach the rehabilitation services will remain. Furthermore, professionals put these policies without any contribution by the local society. This affects the people's response to these policies.

The Domination of the Medical Model:

Negatively affects drafting of policies, because no attention is given to rehabilitation especially (CBR), which saves much of the health budgets if properly addressed.

The Social Effect:

The absence of the Palestinian community's participation in the process of planning negatively affects the success and the effectiveness of planning and drafting of policies in rehabilitation. Additionally there is no evaluation of the view of the rehabilitation service system, which responds to the requirements of the Palestinian community, and the inflexibility of the system to respond the external factors within its control leads to weakness in drawing policies in the sphere of rehabilitation.

The society's values and attitudes towards the program or project under planning should be researched and integrated in the planning process. The population's age patterns to identify the target group of the project, work force, work value, people's beliefs and attitudes towards the project- whether they support or reject, and

society's attitudes towards industry or health should also be researched thoroughly as all these affect the programs efficiency.

Chapter V

LITERATURE REVIEW

The initial review of literature revealed that there was extensive literature on disabilities attending rehabilitation services, but relatively few studies were conducted to assess/review the rehabilitation services. The effective and appropriate assessment of rehabilitation service must go beyond the usual measure of structure, process and outcome variables, but it should involve the consumer, employers, and administrator of their evaluation and opinion of rehabilitation service. This chapter provides an overview and summarizes relevant literature and research conducted on disabilities with several aspects of rehabilitation services, which include facilities, management, funding, human resources, services, and policies.

A. Review of Relevant Theoretical Literature

Rehabilitation is defined as putting back the person into function. It also involves obtaining for disabled persons as much independence as possible in the conduct of their daily life in several ways.

Rehabilitation has multiple aims. Dalley (1999), defines Rehabilitation as a multi faceted affair involving physical, psychological and social factors. The World Health Organization defines rehabilitation as all measures aimed at reducing the impact of disabling and handicapping conditions and at enabling the disabled and handicapped to achieve social integration (WHO, 1981). This effectively means that rehabilitation includes measures other than

medical/ physical manipulation, entailing extra medical measures such as counseling, social work, job placement and the like.

In 1980, the World Health Organization adopted an international classification of impairments, disabilities and handicaps, which suggested a more precise and at the same time relativistic approach. The International Classification of Impairments, Disabilities, and Handicaps make a clear distinction between impairment, disability, and handicap. It has been extensively used in areas such as rehabilitation, education, statistics, policy, legislation, demography, sociology, economics and anthropology. Some users have expressed concern that the classification, in its definition of the term handicap, may still be considered too medical and too centered on the individual, and may not adequately clarify the interaction between societal conditions or expectations and the abilities of the individual.(Http;//www1.umn.edu/humanrts/intree/disabilitystandards. Htm1).

The International Classification of Impairments, Disabilities and Handicaps were first published by the (WHO) in1980. The revision process has resulted in many changes to the original classification, including a change of the name Disability and rehabilitation to 'International Classification of Functioning and disability'. This new name is accompanied by a change of emphasis from negative description of impairments, disabilities and handicaps to neutral descriptions of body structure and function, activities and

participation.(http:/www.who.int/icidh/intro.htm medical and social models).

1. Community Based Rehabilitation (CBR).

CBR is defined as " a system, which envisages using existing resources of manpower and material within the community to promote integration of disabled in all spheres of life and activities" (Thomas, 1990, p3)."The Community Based Rehabilitation strategy is an effort to design a system for change for improving service delivery in order to reach all in need, for providing more equal opportunities and for promoting and protecting the human rights of disabled people"(Helander, 1993, page 5).

People with disabilities are estimated at 7-10% of the population in any country, and around 2% would need some form of rehabilitation services. Yet only.01% to 0.02% of the population in developing countries actually gets such services. There are presently about 200 million moderately and severely disabled people in developing countries, where disabilities are mostly poverty related. The incidence of disability has always been on the increasing trend, and about 60% of disabilities could have been prevented (WHO Expert Committee, 1981, Murthy, 1992).

In bringing about positive impact on the situation of people with disabilities, at least three approaches have been practical, namely: Institutional Based Rehabilitation, community based rehabilitation (CBR), and extension of institutional based rehabilitation. CBR is

considered one of the most practical and efficient rehabilitation approaches (Handojo, 1991; Helander, 1988).

In 1976, member countries of the (WHO) decided to include rehabilitation in the goal "Health for all by the year 2000" (Helander, 1980). Recognizing that people with disabilities in developing countries have a large need for rehabilitation and have very limited access to rehabilitation facilities, WHO has developed community based rehabilitation program designed to integrate with programs for primary health Care.

In1979, a manual published by WHO proposed a simple demystified set of technologies for the community and family levels (Helander, 1980). In 1989, a revised version of the manual entitled Training in the community for people with disabilities" appeared. People with disabilities, and their families, and their communities have benefited from CBR. (Helender, 1989).

In 1992, the United Nations Development Program in Geneva hosted a discussion forum. Helander presented his latest definition of CBR at Geneva forum. "Community Based Rehabilitation is a strategy for improving service delivery, for providing more equitable opportunities and for promoting and protecting the human rights of disabled people" (UNDP, Helender, 1993). It calls for the full and coordinated involvement of all levels of society.

According to WHO (1981), evaluation is a systematic way of learning from experience and using the lessons learnt to improve current activities and promote better planning by careful selection of alternatives for future action. This involves an analysis of different phases of a program, its relevance, its formulation, its efficiency, effectiveness and its acceptance by all parties concerned. A working definition of evaluation from Krefting (1994): is systematic collection, analysis, and interpretation of information about the activities and outcomes of Rehabilitation programs in order for interested people to make judgments about what the program is doing and how it can be improved. In fact, evaluation is one of the most important kinds of research in social change programs.

CBR for and with people with disabilities by ILO, UNESCO and WHO (ILO et al, 1994, page3), attempts to clarify the objective of CBR and the methods for implementation. Aimed at policy makers and programmer managers, it addresses the issues of sustainability, disability policies and integration into the community. The process used and service components of each Center vary slightly but are generally described in the Rehabilitation Act (1992) as skills training, peer counseling, and both individual and systems advocacy.

Mittler, (1984) does not attempt to define quality of life, but states that one major component must concern the opportunities to make choices between perceived alternatives. He develops this theme of informed choice making for professionals, consumers, advocacy groups and policy makers, stressing that all should work together to

provide better coordinated services, so people with developmental disabilities do indeed have access to those things that the rest of the community can access and have support services to allow them to reap full advantage from these opportunities.

Ferguson's, (1988) environmental design can have a significant impact on the quality of life of a person with a disability. An environment designed to be adaptive and barrier-free can enhance the self- concept, independence and social interactions of people with disabilities.

Kwok, (1991) reported "An Evaluative Research Design for Urban Community Based Rehabilitation Programmed- a care study from Hong Kong, in 1991. The paper presented a quasi-experimental evaluative research design in assessing the impact of CBR in Hong Kong.

2. Vocational Rehabilitation (VR).

Apart from prescription to communities to find jobs for the disabled, there have been other, perhaps more comprehensive, efforts to provide work for disabled persons in the open labor market. These, however, have been mostly limited to developed countries. Measures on behalf of the disabled depend upon their condition, but with two distinct, though not always separate, emphases. The measures may, on the one hand, be directed at alleviating the inevitable disadvantages and often considerable suffering that person is subjected to on becoming physically or mentally disabled. On the other hand, these

measures may be initiated from the standpoint of dealing with society's problems.

In most developing countries, the problems of unemployment and under-employment are such a magnitude that they call for very different strategies with respect to facilitating jobs for the disabled. In most European countries, vocational rehabilitation is generally the responsibility of ministries or departments of employment or labor.

We all know that people with disabilities have the same rights, hopes and aspirations as everyone else. This fundamental principle, however, is not yet appreciated universally as evidenced by the fact that no country in the world has yet solved the problem of integrating all its disabled citizens into active social and economic life. Economic and social problems have seriously limited the employment opportunities for disabled people. Even if jobs are available, many disabled people are working below the level of their potential. In many developing countries the situation is even worse and job prospects for them in the open labor market are minimal or non existent, (Zhoa, and Kwok, 1997).

The International Labor Organization's (ILO, 1983) convention stressed that the government policy should aim at ensuring employment appropriate to all categories of the disabled, and at promoting employment opportunities for the disabled in the open labor market. The ILO Recommended that the disabled persons should enjoy equal opportunity and treatment in respect of access to, retention

advancement in employment which, wherever possible, corresponds to their own choice and take account of their individual suitability for such employment.

In China, (1997) more than 70 percent of the disabled persons with working abilities are employed in large and medium sized cities and the average employment rate of the disabled in the urban areas is about 60 percent. The reason for this rapid development is due to the preferential policy of the government.

The State VR agencies in the USA assist persons with disabilities to locate employment by developing and maintaining close relationships with local businesses. The VR program provides a wide range of services and job training to people with disabilities who want to work. At present, the VR system has more 1.2 million eligible individuals, over 80% of who have significant disabilities. Htt://www.ed.gov/offices/OSERS/RSA/PGMS/bvrs.htm1Basic Vocational Rehabilitation Services.

3. OCCUPATIONAL THERAPY (OT).

Occupational Therapy (OT) may be the best-kept secret in health care. The use of the word "occupational" in describing this health care profession refers to how the patient utilizes his or her time, including self-care, work, and leisure. Occupation as a means of preventing, reducing, or overcoming physical, social, and emotional challenges in people of all ages. Occupational therapists use goal specific activities to help people of all ages prevent, lessen, or

overcome disabilities. Those who work in occupational therapy use their personal and professional skills to help people deal with health problems that interfere with their ability to function in daily life, (Breines, 1995), (Turner, 1992).

Occupational therapists are important members of the health care team, working closely with physicians, psychologists, nurses, and physical, speech, and recreational therapists. Occupational therapy is a varied, interesting, and rewarding career. An occupational therapist works with individuals whose participation in life has been impaired by physical injury/ illness, developmental /learning disabilities psychological/ emotional problems or the aging process. (Hopkins, 1988, Turner, 1992).

Occupational therapy is the art and science of directing man's participation in selected tasks to restore, reinforce, and enhance performance, facilitate learning of those skills and functions essential for adaptation and productivity, and to promote and maintain health. Its fundamental concern is the capacity, throughout the life span, to perform with satisfaction to self and others those tasks and roles essential to productive living and to the mastery of self and the environment, (Pizzi, and Torrance, 1993).

Occupational therapy is the use of activity or interventions designed to achieve functional outcomes which promote health, prevent injury or disability, and which develop, improve, sustain or restore the highest possible level of independence of any individual

who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, or disorder or condition. It includes assessment by means of skilled observation or evaluation through the administration and interpretation of standardized or non-standardized test measurements. (Nelson, 1996).

Occupational therapy helps the patient regain the ability to do normal every day tasks. Restoring old skills or teaching the patient new skills to adjust to disabilities through adaptive equipment, esthetics, and modification of the patient's home environment may achieve this. OT includes learning how to use devices to assist in walking (artificial limbs, canes, crutches, walkers), getting around without walking (wheelchairs), or moving from spot to another boards, lifts, and bars, (Darnell and Heater, 1994).

Occupational therapy is the treatment of physical and psychiatric conditions through specific activities in order to help people reach their maximum level of function and independence in all aspects of daily life, (Turner, Foster, Johnson and Stewart, 1996).

4. Speech Therapy

Speech therapy helps the patient correct speech disorders or restores speech. Speech therapy may be prescribed to rehabilitate a patient after a brain injury, cancer, neuromuscular diseases, stroke, and other injuries/illness being treated and the patient's response to therapy, (Ender by, Pam, 1996).

Human communication is a social interaction among people. Communication is a social event; it is action that often affects other persons. Therefore, communication may be defined as a form of social behavior. Human beings have the most elaborate, sophisticated, versatile, and creative means of communication. The scientific study of human communication is somewhat recent. In fact, the disorders of communication have played a major role in promoting a more intensive study of communicative behaviors, systems, and processes, (Hegde, 1994).

Ancient Egyptian art factual representations of the lungs and trachea are interpreted as representing the connection between continuity of breath on the one hand and life or the soul on the other (Panconcelli-Calzia, 1957b). However, the interpretation of such images may be unclear when it is not supported by a verbal tradition. As in the Biblical references to speech problems, the ancient Chinese textual tradition makes it clear that laryngeal function and voice production were the subject of Chinese medical thought at least two millennia ago and perhaps much earlier. The earliest civilizations to make lasting contributions to the understanding of voice production were those of ancient India and Greece. The Latin word "Vex" from which the English term "voice" is ultimately borrowed, descended from indo-European term indicating the acoustic emission of voice, particularly in religious and legal aspects, (Brown, Partin, and Crary, (1996).

A working definition of aphasia is that it is a disorder of language resulting from brain damage, (or dysphasia, with which it is

taken to be synonymous) like all other open-class words provides a relatively simple semantic framework that can be enriched by inferences based on knowledge,(Cole, and Whurr, 1989).

Martin (1963) noted that speech therapy is "a process occurring in an interpersonal relationship and operating on principles or laws to be discovered, (Lass, 1979).

5. PROSTHETICS

The history of prosthetics and amputation surgery began at the very dawn of human medical thought. It parallels the development of medical science, culture, and civilization itself. Prostheses history begins with humans, spiritual and functional need for wholeness. Prostheses were developed for function, cosmetic appearance, and a psycho-spiritual sense of wholeness but not necessarily in that order. These patient needs have existed from the dawn of time to the present. Early prosthetic principles that were developed have existed to this day and are amazingly efficient in function. In the three great western civilizations of Egypt, Greece, and Rome the first true rehabilitation aids recognized as prostheses were made. (Padula, and Friedman, 1987).

The industrial revolution brought about prosthetic advancement fueled by money available to amputees following the American Civil War, spawning a colorful array of humanitarians, scientists, and charlatans. Finally the modern era of prosthetics arose

with quantum leaps in technology developed in the two world wars. (Wilson, Bennet, 1981).

The earliest anthropological evidence of an amputee is that of human skull in the Smithsonian Institution 45,000 years old that shows teeth shaped and aligned in such away that indicate he was upper extremity amputee (Wilson, and Bennet, 1978). Other evidence is found in cave paintings in Spain and France, about 36,000 years old, which show the negative imprint of a mutilated hand. Later painting like these were also found in New Mexico and suggest the practice of self-mutilation to appease gods in religious Ceremonies, (Friedman, 1978).

The prostheses of ancient cultures began as simple crutches or wooden and leather cups depicted in Moche pottery. This grew into a type of modified crutch or peg to free hand for functioning, (Wilson, and Bennet, 1978). An open socket peg had cloth rags to soften the distal tibia and fibula and allow range of motion. These prostheses were very functional and incorporated many basic prosthetic principles.

The reasons for amputation in ancient times varied. Congenital deformities have always been present, especially in Arabic countries where first cousins were encouraged to marry. War was often the cause of traumatic amputation in battle or when taken prisoner. In the Arabic countries the right hand was used for eating from a common bowel and the left used for toileting. Theft was punishable by the

removal of the right hand, effectively ostracizing the thief from the social group. Religious ceremonies were another cause of amputation. (Padula, and Friedman, 1987).

As the World War 1 (1914-1918) began, American prosthetic's remained a very independent, competitive group, rarely working with surgeons let alone each other. Amputee casualties in the U.S. (4,403) were much fewer than the British (42,000) and European armies (100,000). This resulted in European prosthetics jumping ahead in experimentation of their American counterparts. (Sanders, 1986).

6. PHYSIOTHERAPY (PT):

Physiotherapy (PT) is defined as the correction and alleviation of movement disorders that cause pain or hinder movement effectiveness, the maintenance of improved levels of movement, the determination of a persons potential capacity for effective body movement, the prevention of potential movement problems, and the prevention of unnecessary deterioration of movement or loss of function (Peat, 1981).

Physiotherapy means the examination, treatment, or instruction of human beings to detect, assess, prevent, correct, alleviate or limit physical disability, bodily malfunction or pain. "Physiotherapy" includes the administration and evaluation, of tests and measurements of bodily function and structures, the planning administration, evaluation, the use of physical agents, measures, activities, and

devices and the provision of consultative, educational, and other advisory services (Richardson, 1999).

PT is a direct form of professional patient care and a vital part of total health care for patients who have temporary or permanent disability or pain due to injury, disease, birth defect, or loss of limb. Its emphasis is on the quality of life of the patient, and it focuses particularly, on preventing disability and returning the disabled to a more active productive life. (Thomson, Skinner and Piercy, 1991).

Physiotherapists are now responsible for their own profession, and not subservient to others. In the area of clinical practice, also, developments in technology and attitudes have placed the profession at the front of new "alternative" therapies. Three goals should be set the future: Publicity for the profession, the development of understanding relationships with other medical professions, and research into physiotherapeutic techniques. (David, 1987).

B- Research in West Bank and Gaza Strip:

The number of studies conducted in Palestine on rehabilitation and disabilities, in general and consumer assessment of rehabilitation services, in particular, are very limited.

Another study was conducted by the University of Calgary and Society for the Care of Handicapped Children, (1986), in Gaza Strip, where a house-to-house survey on a sample of the refugee population was conducted. This study yielded the figure of 2.4% for the

prevalence of disability among preschool age and school age children. Of the total disabilities, 4% were for seizure disorders, about 8% related to the sight, 11% related to hearing loss, 5% related to poliomyelitis, 6% hemi and quadriplegias, and the rest a mixture of other types of disabilities. Assuming the total population of the West Bank and Gaza in order of 1.5 million people, the study estimated that about 150,000 persons suffered from disabilities, ranging from very mild to very severe. Also the estimation that between 2-2.5% of the population is in need of rehabilitation in one-way or another.

A retrospective study conducted on the West Bank district, Giacaman, et.al.(1989) With focus on the formulation of a rehabilitation policy for disabilities in the West Bank, found that 57 institutions were actively providing services to the physically and mentally disabled and those suffering from sensory disabilities. 61% were located in the central region of the West Bank (Bethlehem, Jerusalem, Ramallah, and Jericho), 28% in the North (Nablus, Qalqiliya, Jenin, and Tulkarm) and 7%in the South. None of the institutions provided all the services. Obviously, the persons who provided the information did not think of this service as particularly important or as a separate and distinctly important activity. The financial problems were the most commonly listed problems that these institutions faced, followed by dealing with the families of the disabled, dealing with the employees motivation and their level of their awareness, and the problem of isolation of institutions. Many of the institutions, especially those dealing with the mentally handicapped, suffered from inadequate physical conditions and lacked

programmatic action .The personnel involved in caring for the disabled in these centers either lacked adequate training or were not trained at all.

A study was conducted by the Northern regional committee for rehabilitation (1994). The study included 22 Palestinian villages in the Jenin district with special reference to the needs of persons with disabilities. The surveyed communities included 1.9% persons with disability of the total population. The general lack of services and the relative underdevelopment characterizing the region have particularly difficult ramifications for this sector of the population. Apart from a very few secondary or mid level support services (most notably physiotherapy), persons with disabilities in the Jenin district lacked access to the most basic support and rehabilitation services. As in this case of basic service provision to the general population, the nongovernmental sector is responsible for the bulk of what little services are available. Only 57% of those with disabilities have ever sought such services and the majority of these received curative medical services only, to the exclusion of other types of vital services, such as educational, social, and rehabilitation services. Furthermore, 58% of those with disabilities (893) reported that they were without the technical aides they required. The study also researched that; only 8% of all males adult with disabilities are regularly employed. The researchers in this study recommended that rehabilitation projects must include vocational and other training projects towards the employment of persons with disabilities.

A study on 23 Palestinian villages in the central district of the West Bank with special reference to the needs of persons with disabilities conducted by the Central Regional Committee for Rehabilitation CRCR (1995), succeeded in identifying 1,056 disabled people living in these communities. The majority of the disabled were found to suffer from moderate and severe disabilities, with only 4% denoting their disability as of the mild type, and indicating the need for CBR projects in these communities. In total, 25% of the disabilities were related to movement, a high percentage of 44% were related to the sensory system -sight, hearing and speech and 31% were multiple in nature, mental mixed with other types of disabilities. The researchers in this study recommended that the central area CBR program take the shape of not only individual assistance within homes, but also the shape of communal education and action. On the one hand, the disabled of the central area need assistance to solve their physical problems. On the other hand, an attempt to gradually change the negative perceptions of communities towards disability stigma and shame is very much part of disability rehabilitation, in addition to being a fundamental human right. Finally, disability rehabilitation is not merely a program of assistance but also a program that is directed towards guaranteeing the fundamental human rights the of disabled.

A study of 19 Palestinian communities in the South district of the West Bank (Bethlehem and Hebron regions), with the intention of informing the development of CBR programmer, was launched by the Southern Regional Committee for Rehabilitation (SRCR, 1996). The surveyed communities included 2,729 persons with disabilities, or

2.4% of the total population, comparable to disability rates elsewhere in the developing world. The Hebron region recorded the highest rate of disability (2.5%), higher than Bethlehem (2.2%). In the total Southern Region, 2.5 skills per a disabled person need to be learned, with disabled persons in the Hebron region faring well than in Bethlehem, (2.6 versus 2.4 skills per person). These results indicate the need for CBR activities towards assisting the disabled, and their families in coping with daily life activities. However, the results of the study clearly demonstrated the need of CBR activities aimed at assisting the disabled and their families to maintain an optimal level of coping and social integration within communities, rather than continually seeking institutional care that offers the "magic cure" at high costs and in a sporadic fashion. In deed, CBR is the foundation upon which disability rehabilitation should be built, utilizing institutional care for specific purposes and for finite periods. The researchers recommended that CBR be the only way that is able to address needs at a minimal cost and in a humane manner.

Another study which was conducted by PCBS, (1997), indicated that rehabilitation services are at intermediate level in the West Bank and Gaza Strip. The results are based on the assumption that CBR programmers provide 60% - 70% of rehabilitation needs at the community level, while 20%-30% of the rehabilitation needs are provided at the intermediate level and about 10% of these needs are provided at the national level. The results indicated that most of the disabilities need more rehabilitation services; about 85% of the mental disabilities, 77.6% of strange behavior disabilities, 28.6% of hearing

disabilities, and 28.6% of epilepsy need more rehabilitation services. On the other hand, the results showed that the following up of medical treatment and providing medicine is one of the rehabilitation needs for the physically disabled with a range of 47.4% to 75.0% for epilepsy against 29.9% for speech disability and 27.5% for strange behavior disability. Also Vocational training is considered one of the rehabilitation needs for about 7.4%of the physically disabled, 4.0% for hearing disabilities, against 10.2% of seeing disabilities, 12.7%of mental disabilities, 11.3% of rage behavior disabilities. The results of the survey indicated that about 64.5% had physical disabilities, 7.6% hearing disabilities, and 53.6% seeing disabilities did not get services.

The Central National Committee for Rehabilitation (CNCR), (1998), conducted a study in Jerusalem, to ward the rehabilitation policy in Palestine. With the survey of establishments offering rehabilitation services a total of 174 establishments were found working at the middle level (secondary levels). The civil organizations run about 60% of these services while the rest of the services are distributed between the government, public sector and the UNRWA.

Table 13 Distributions of Rehabilitation Institutions CNCFR, 1998)

Distribution	North districts	Middle districts	South districts	Gaza Strip	Total
Number	40	45	37	52	174

The geographical distribution of the services is in congruence with the geographical distribution of the handicaps. For example, In Bethlehem, there are 26 establishments, while there are 11 in Hebron. In 1996, the organization in Bethlehem offered about 93% of the services in the south area although the Bethlehem population served constituted only 30%from the total population handicaps served.

PCBS, (2000) indicated that the percentage of disability prevalence in Palestine was 1.8%, of which 1.9% in the West Bank and 1.6% in Gaza Strip. The highest percentage of the disabilities in the West Bank was Qalqiliya and Tulkarm at 2.3% followed by Tubas district at 2.1% and Jerusalem & Al-Bireh, Jerico, and Hebron were found to have the same percentage of 1.7%.

Physiotherapy services:

Physiotherapy services are available to an extent, which satisfies the requirements in Gaza Strip and in the North of the West Bank. The majority of PT services are distributed in the center of the city, and the most PT services are managed by NGOs and Private sectors.

Occupational therapy:

The occupational therapy (O.T.) in Palestine is in sufficient to meet the needs of the community, especially that there are no OT services in the north districts of the West Bank.

Aide's equipments:

The majority of this service is available in the middle, and south of the West Bank. There is lack of aid's equipment in the north districts, especially the prosthesis equipments.

Speech therapy:

This service is absent in most areas or it covers a small percentage of needs. For Example, the absorbed power of these services in the North area equals 120 cases versus more than 3000 estimated cases. The available services do not cover around 4% of the needs.

Vocational Rehabilitation:

Lack of vocational rehabilitation services in the north districts, and there is only one center in Nablus city.

Human resources and training requirements:

It is clear that there is a general shortage in qualified professionals from those who have certificates to work in different services at middle level.

It was clear from literature that the rehabilitation services do not meet the needs of the disabilities. In addition, there are no comprehensive rehabilitation services in Palestine. The general purpose of studies to meet the needs of the Palestinian community (CNCR, 1998).

Community Based Rehabilitation:

A strategy within the social development. It is not possible to develop the rehabilitation concepts and bases without benefiting from the rich experience of the Palestinian developmental work in general and the primary health care concepts in particular.

The social assimilation concepts and the equal opportunity principles for the disabled have been developed on the ground of human rights concepts founded by resistance, and sacrifice operations carried out mainly by Palestinian national work institution, and the various people's organizations.

This program is currently run in over 70 sites in the West Bank, and Gaza Strip. It covers about 300,000 people in the villages of Ram Allah, Northwest Jerusalem, Gaza, KhanYounis, and many villages around Jenin, Nablus, Tulkarm, Qaliqilia, and in Jericho, and the Jordan valley.

This program has more than 6000 disabled people, dealing with all matters concerning their disabilities. (Medical Relief Committee (MRC), 2000).

CHAPTER VI
METHODOLOGY

A. Research Design:

In this study the researcher has utilized a descriptive quantitative design utilizing a structured questionnaire with face-to-face interviewing technique to describe the rehabilitation services in the northern district of Palestine. The face-to-face technique was most appropriate in order to include all providers of services with different service levels and to achieve high response rate.

The study covered all operating rehabilitation centers at the primary, secondary, and tertiary levels at the time of collecting the data.

B. Identification of Population and Sample:

The target population includes all the providers of rehabilitation services in the northern districts of Palestine. Responses were provided by each centers manger or responsible person.

Sampling Methods:

The researcher himself conducted the interview.

C. Setting:

The researcher targeted four sectors, (Government, UNRWA, NGOS, Private) which provided rehabilitation services.

D. Ethical Consideration:

A formal Letter: from the dean of graduate studies- Al Najah University was sent to each center requesting the director, or the chief of rehabilitation department as applicable, to allow the researcher to conduct the study.

Explanatory Form: Every eligible manager or responsible person participating was given a full explanation about the research, including: the purpose, nature of study, importance of participation in addition to assurance of confidentiality of information and voluntary participation and was given total freedom to accept or reject participation in the research as shown in Appendix 2.

E. Instrument:

For the purpose of conducting the face-to-face interview, the researcher designed a semi-structured questionnaire. The Questionnaire aimed at exploring the rehabilitation services. The questionnaire was written in the Arabic language to be easily understood by providers. It was divided into thirteen questions; each question consisted of several items (Appendix3), designed to collect information falling under the following categories: -

Question1: Related to the types of rehabilitation services in the centers.

Question2: Related to the quality and quantity of the rehabilitation services in the centers.

Quation3: Items related to the size of rehabilitation services in the centers.

Question4: Items related to the funding of the rehabilitation Services

in the Centers.

Question5: Items related to the human resources in the rehabilitation centers.

Question6: Items related to the administration systems in the rehabilitation Centers.

Question7: Items related to the referral system and cooperation and coordination Between centers.

Question8: Items related to the general policies of the rehabilitation.

Question9: Items related to the priorities of the rehabilitation.

Question10: Items related to problems that limit the development in the Rehabilitation services.

Question11: Items related to the beliefs, regarding needs to develop the Rehabilitation policies.

Question12: Items related to the opinion to develop the rehabilitation policies.

Question13: Items related to the improvement of the quality of the rehabilitation services.

F. Pilot Testing:

Three advisors who had research background and two qualified rehabilitation professionals evaluated the questionnaire for validity purposes. Pilot testing was conducted before data collection since it was necessary to detect gaps prior to field implementation and to identify the time needed to complete the interview. Six providers not included in the target population of this study participated in the pilot testing.

G. Data Collection:

The researcher had planned to spend five days in the field in each district for interviewing and data collection from the providers. Each provider was first given a complete explanation about the purpose, nature of the study in addition to assuring her/him of anonymity and confidentiality and that provider was free to accept or reject to participate in the study.

At the end of each interview, the researcher scanned the questionnaire to ensure adequate completion of all information. Thus any missing data was obtained before the provider left the interviewee.

H. Methodological Limitation:

Limitation of this study were related to

1-A relatively small size from one district where by the finding can only represent the case itself.

I. Method of Data Analysis:

The data was entered into the computer. While utilizing the statistical program SPSS descriptive statistics such as means, percentages, frequency distributions, and ranks were made available.

J. SUMMARY:

This chapter gave an overview of the methodology that was used to answer the research questions, which included the research design, the target population, sampling, setting, instrument and methods of data collection and analysis.

CHAPTER VII
RESULTS

A. Data Analysis Procedure:

Data collection was carried out in the period between September and November 2001. The population of the study constituted 43 centers. The centers were from governmental centers and clinic, non-government centers, UNRWA centers, and private centers in the northern districts. Face to face interview technique was carried out, 13 questionnaires were completed ensuring 100% response rate as a frame reference. Data was then coded and entered into the computer by the researcher who was helped by a computer technician. The data was double checked through a comparison between the printout and code sheets. No discrepancy was detected.

Descriptive statistics for closed-ended questions was carried out using the (SPSS) program indicating means, frequencies, and percentages.

For data analysis, the researcher used the following percentages:

- (80%) and above was considered very high degree of strong agreement.
- (70-79.9%) was considered high degree of agreement.
- (60-69.9%) was considered moderate degree of agreement.
- (50-59.9%) was considered low degree of agreement. That is disagreement.

- (Less than 50) was considered very low degree of agreement. That is strong disagreement.

B. Presentation of Results:

The presentation of data covered the13 parts of the questionnaire. Part one presents descriptive analysis of the demographic characteristics of subjects. The second part presents descriptive analysis of types of rehabilitation services. The third part presents descriptive analysis of respondents assessment of rehabilitation services in relation to several aspects of quality and quantity of services, size of services, financial and human resources, administrative system, referral system, cooperation and coordination between the institutions, rehabilitation policies, priority of rehabilitation, serious problems facing the development of rehabilitation, development of rehabilitation policies, and suggestions needed to develop rehabilitation policies to improve rehabilitation services quality. The findings are presented in a tabular form.

1. Demographic Variables:

For this part, frequency distributions were developed for each of the descriptive variables of the population.

Table (14): Distribution of the study population by gender group.

Gender	Frequency	Percent
Male	28	65.1
Female	15	34.9
Total	43	100.0

According to gender, table (14), shows that the majority of these providers (directors of institution or deputy) who responded to the questionnaire are males.

Table (15) presents information on age of the rehabilitation providers. There are more respondents below 35 years. The majority of respondents (58.1%) were less than 35 years old.

Table (15): Distribution of the study population by age group.

Age	Frequency	Percent
Less 35	25	58.1
35 and more	18	41.9
Total	43	100.0

Table (16) shows that the majority of the providers were at the BA and diploma level, (62.8%, 23.3%) respectively. On the other hand, only14% of the providers had higher educational level.

Table (16): Distribution of the study population by educational level.

Education level	Frequency	Percent
Diploma	10	23.3
BA	27	62.8
High education	6	14.0
Total	43	100.0

Table (17) shows that the majority of the providers had 10 years experience or more, (53.5%). Only (46.5%) of the providers had less 10 years of experience.

Table (17): Distribution of the study population by experience .

Experience level	Frequency	Percent
Less than 10 year	20	46.5
More than 10 year	23	53.5
Total	43	100.0

Table (18) indicates that (44.2%) of the respondents worked in private centers, while only (11.6) of the respondents worked in government centers.

Table (18): Distribution of rehabilitation center by governing body.

Centers	Frequency	Percent
Government	5	11.6
Non Government	15	34.9
UNRWA	4	9.3
Private	19	44.2
Total	43	100.0

Results related to the first question:

Q1: What are the types of rehabilitation services in the centers, and institutions?

To answer this question frequencies and percentages are used as indicated in table (19). Results show that the most common type of rehabilitation services was Physiotherapy (86%). The level is low on items (2) occupational therapy and item (3) speech therapy where percentage of responses on yes was (9.3%). The level is very low in item (4) vocational rehabilitation where the percentage of response is (4.7%).

Table (19): Frequencies and Percentages of the types of rehabilitation services.

		Yes		No	
N	Types or rehabilitation services	Frequency	Percentage	Frequency	Percentage
1	Physiotherapy	37	86	6	14
2	Occupational Therapy	4	9.3	39	90.7
3	Speech Therapy	4	9.3	39	90.7
4	Vocational Rehabilitation	2	4.7	41	95.3
5	Prosthesis	15	34.9	28	65.1
6	CBR	10	23.3	33	76.7
7	Counseling rehabilitation services	13	30.2	30	69.8
8	Other services	13	30.2	30	69.8

Results related to question 2

Q2: What are the employee's opinion about the quality and quantity of rehabilitation services in the institution?

The results in table (20) show that the degree of employees opinion about quality and quantity are very high more than (80%) on items (3) equipment is sufficient to carry out rehabilitation, item (6) I evaluate rehabilitation services provided at the institution continually, item (8) Service is easily accessible, item (9) the relation with patients or beneficiaries is professional, item (10) Secrecy is observed when services are provided. The degree of responses are high (70.6%-78.2%) on items, (1) I am contented with the level of services provided to the patients, item (4) The time assigned for treatment is sufficient, item (5) The quality of the services provided meets beneficiaries needs, item (11) Privacy is observed when services are provided. The degree is moderate (61.4% and 67%) in items, (2) The

rehabilitation programs provided at the institution is effective and meets needs of society, item (12) Services are continually evaluated by employees at the institution. The degree is very low (48.8%)in items, (7). The beneficiaries evaluate rehabilitation services provided at the institution continually, where the percentages of responses are (48.8%) respectively. For the total Score the degree was high where the means percentage was, (74.8%).

Table (20): Means and Percentages of employee's opinions about equality and quantity of the rehabilitation services.

N	Quality and Quantity of rehabilitation services	Means	Percentages	Degree
1	I am contented with the level of services provided to the patients.	3.53	70.6	High
2	The quality of rehabilitation programs provided at the institution is effective and meets needs of society.	3.07	61.4	Moderate
3	Equipment is sufficient to carry out rehabilitation.	4.37	87.4	Very high
4	The time assigned for treatment is sufficient.	3.60	72	High
5	The quality of the services provided meets beneficiary's needs.	3.91	78.2	High
6	I evaluate rehabilitation services provided at the institution continually.	4.2	84	Very high
7	The beneficiaries evaluate rehabilitation services provided at the institution continually.	2.44	48.8	Very low
8	Service is easily ascendible.	4.05	81	Very high
9	The relation with patients or beneficiaries is professional.	4.37	89.4	Very high
10	Secrecy is observed when services are provided.	4.42	88.4	Very high
11	Privacy is observed when services are provided	3.74	74.8	High
12	Employees at the institution continually evaluate services.	3.35	67	Moderate

* Maximum point of response (5) points.

Results related to Question 3

Q3: What are the provider's opinions about the size of rehabilitation services in the institution?

Table (21) shows that the degree of providers opinion about size of rehabilitation services is very high (86%) on item (5) There is unjustified duplication in providing services by different institutions. The degree of response is high (77.2%) on item (3) Number of employees at the institution is sufficient. The degree is moderate (66-68.4%) on items (1) Size of work/tasks of employees is big, item (2) Area of site suits size of work, and item (4) Size of work matches objectives of institutions.

Table (21) Means and percentages of provider's opinion about the size of Rehabilitation services in the institution.

N	Size of rehabilitation services	Mean	Percent	Degree
1	Size of work/tasks of employees is big	3.42	68.4	Moderate
2	Area of site suits size of work	3.30	66	Moderate
3	Number of employees at the institution is sufficient	3.86	77.2	High
4	Size of work matches objectives of institutions	3.40	68	Moderate
5	There is unjustified duplication in providing services different institutions.	4.30	86	Very High
6	It is necessary to increase the institutions capability to host more beneficiaries	2.86	57.2	Low

* Maximum point of response (5) points.

Results of Question 4

Q4: What is the provider's opinion about the financial matters in the rehabilitation services centers?

Table (22) shows that the degree of employees opinion about financial matters are high (70% to 79.9%) on items (3) Expenses are higher than income (72.6?%) item (4) Budget is managed effectively (78.2%), item (5) Rehabilitation services costs are reasonable (74.8%). The degree is moderate (62.8-68.8%) on items (1) The center covers expenses, item (2) Continuity depends on out side support.

Table (22) Means and Percentages of Provider are Opinions about the Financial matters of the Rehabilitation Services in the Institutions, and Centers.

N	Financial matters	Means	Percent	Degree
1	The center covers expenses.	3.14	62.8	Moderate
2	Continuity depends on outside support.	3.19	63.8	Moderate
3	Expenses are higher than income.	3.63	72.6	High
4	Budget is managed effectively.	3.91	78.2	High
5	Rehabilitation services costs are reasonable.	3.74	74.8	High

*Maximum point of response (5) points.

Results of Question 5

Q5: What is the relationship with manpower in the institution where you work?

The results of table (23) on the degree of relation with human power in the institution are very high (80% and above) on items (2) Work force in the institution should be promoted, item (3) Work

force should be increased, item (5) Training work force is done in accordance with the institutions field of rehabilitation, item (6) The certificates I hold quality me to work in the field of rehabilitation. The degree of responses is high (71.6%) on item (7) Employees at the institution are qualified and have experience in rehabilitation. The degree is moderate (64.6%) on item (8) Regulation in the institution enables employees to involve in progressive education activities. The degree is low (52 and 53%) on items, (4) The institution has a budget for work force promotion, and (1) The institution promotes its work force.

Table (23) Means and percentages of relationship with human Resource in the institutions.

N	Relation ship with manpower	Means	Percent	Degree
1	The institution promotes its work force.	2.65	53	Very low
2	Work force in the institution should be promoted.	4.09	81.8	Very high
3	Work force should be increased.	4.53	90.6	Very high
4	The institution has a budget for work force promotion.	2.60	52	Low
5	Training work force is done in accordance with the institution's field of rehabilitation.	4.56	91.2	Very high
6	The certificates I hold qualify me to work in the field of rehabilitation.	4.60	92	Very high
7	Employees at the institution are qualified and have experience in rehabilitation.	3.58	71.6	High
8	Regulation in the institution enables employees to involve in progressive education activities.	3.23	64.6	Moderate

- Maximum point of response (5) points.

Q6: What is the relation ship with administrative system in the institution where you work?

The results of table (24) show on the administrative system in the institution is very high (80% and above) on item (3) The boss or manager lacks certificates and experience to qualify him to work in rehabilitation. The degree of responses are high (72.6-78.2%) on

items, (2) I have a clear job description, and item (9) All employees know laws and regulation of the institution. The degree of responses is moderate (65.6 and 69.4%) on items, (1) my salary meets my needs, item (4) Relationship between employees and administrations is good, item (6) there is regulation concerning the quality of rehabilitation services provided, and item (8) The system of incentives/ motivation in the institution is applied. The degree of responses is low (58.2 and 59.6%) on items, (5) there is regulation concerning work force promotion, item (7) Administrative regulations and laws are developed and help improve the services provided.

Table (24) Means and Percentages of Administrative System.

N	Administrative system	Means	Percent	Degree
1	My salary meets my needs.	3.35	67	Moderate
2	I have a clear job description.	3.91	78.2	High
3	The boss or manager lacks certificates and experience to Qualify him to work in rehabilitation.	4.47	89.4	Very high
4	Relationship between employees and administrations is good.	3.28	65.6	Moderate
5	There are regulations concerning the quality of Rehabilitation services provided.	2.98	59.6	Low
6	There is regulation concerning work force promotion.	3.47	69.4	Moderate
7	Administrative regulations and laws are developed and help improve the services provided.	2.91	58.2	Low
8	The system of motivation/incentives in the institution is applied.	3.37	67.4	Moderate
9	All employees know laws and regulations of the institution.	3.63	72.6	High

* Maximum point of response (5).

Q7: what is your opinion about the patient-referring system, coordination and cooperation between your institution and other institutions?

The results in table (25) show that on the degree of patient referring system responses with very high satisfaction and agreement (80% and above) are on items (5) Cooperation and coordination between institutions is essential to improve rehabilitation, item (6) there is duplication of activities in the different institutions. The degree of

response were high (76.8%) on item (2) The relationship between the institution and the other institutions is strong. The degree of responses is moderate (60 and 68.8%) on items (1) Patient's-referring system of at the institution is good and on item (3) there is no interaction between the institution and the universities and colleges teaching rehabilitation. The degree is low (52.6 and 53.4%) on items, (4) the relationship between the institution and the universities and colleges teaching rehabilitation is strong, and item (7) Exchanging expertise between institutions is active.

Table (25) Means and Percentages of patient referring system, and cooperation, coordination between institutions.

N	Patient referring system cooperation and coordination	Means	Percent	Level
1	Patient's-referring system of at the institution is good.	3.44	68.8	Moderate
2	The relationship between the institution and the Other institutions are strong.	3.84	76.8	High
3	There is no interaction between the institution and the Universities and colleges teaching rehabilitation.	3	60	Moderate
4	The relationship between the institution and the universities and colleges teaching rehabilitation is strong.	2.67	53.4	Low
5	Cooperation and coordination between institutions is Essential to improve rehabilitation.	4.70	94	Very high
6	There is duplication of activities in the different institutions.	4.67	93.4	Very high
7	Exchanging expertise (between institutions) is active.	2.63	52.6	Low

* Maximum point of response (5).

Results related to question 8

Q8: What is your opinion about the national policies in general, and rehabilitation policies in particular?

The results of table (26) show that the degree of providers opinion towards the national policies, and rehabilitation policies in particular are very high (80% and above) on items (1) The rehabilitation policy should be comprehensive and nation wide, item

(2) There should be a policy for progressive education in the field of rehabilitation, item (3) Planning and a policy-making in the field of rehabilitation in Palestine is weak, item (4) There is a need to involve society and activate its role in rehabilitation, item (6) In application of laws and regulations negatively affects rehabilitation services. The degree of responses is moderate (61 and 64.6%) on items, (8) There is need to develop the patient's-referring system nation wide, and item (9) The quality of services provided by the institution in the field of rehabilitation in general is good. The degree is very low (34.4 and 43.2%) on items, (5) Distribution of rehabilitation centers in Palestine is just and appropriate, and item (7) I am satisfied with the rehabilitation policies in Palestine.

Table (26) Mean and Percentages of National opinion related to Rehabilitation Policies.

N	National Policies	Means	Percent	Degree
1	The rehabilitation policy should be comprehensive and Nation-wide.	4.81	96.2	Very high
2	There should be a policy for progressive education in the Field of rehabilitation.	4.56	91.2	Very high
3	Planning and policy-making in the field of Rehabilitation In Palestine is weak.	4.56	91.2	Very high
4	There is a need to involve society and activate its role In rehabilitation.	4.53	90.6	Very high
5	Distribution of rehabilitation centers in Palestine is just and appropriate.	1.74	34.8	Very low
6	In application of laws and regulations negatively Affects Rehabilitation services.	4.60	92	Very high
7	I am satisfied with the rehabilitation policies in Palestine.	2.16	43.2	Very low
8	There is a need to develop the patients'-referring system Nation-wide.	3.05	61	Moderate
9	The quality of services provided by the institution in the Field of rehabilitation in general is good.	3.23	64.6	Moderate

- Maximum point of response (5) points.

Results related to the question 9

Q9: What is the top priority of the following in the rehabilitation services?

The question asked respondents to respond to different statement giving number one to statement of most priority two, to the one that follows etc... When means of ranking were calculated the mean close to one would indicate the most priority.

The provider's ranked item (1) Social assimilation of the disabled in their society as first priority. Rank (2) to the item (5) Promoting work force in the field of rehabilitation. Rank (3) to the item (4) Coordinating and distributing services and improving patient-referring systems. Rank (4) to the item (2) Improving quality and quantity of rehabilitation services provided. Rank (5) to the item (6) Upgrading education the universities and colleges teaching rehabilitation. Rank (6) to the item (3) Increasing expenditure in the field of services provided to the disabled and rank (7) to the item (7) Keeping up with scientific development and technology in the field of rehabilitation.

Table (27) Means and Ranks of the top priority in the rehabilitation fields?

N	The top priority in the rehabilitation field	Means	Ranks
1	Social assimilation of the disabled in their society.	3.33	1
2	Improving quality and quantity of rehabilitation services provided.	3.77	4
3	Increasing expenditure in the field of services provided to the disabled.	4.72	6
4	Coordinating and distributing services and improving patient-referring systems.	3.72	3
5	Promoting work force in the field of rehabilitation	3.65	2
6	Upgrading education the universities and colleges teaching rehabilitation	4.72	5
7	Keeping up with scientific development and technology in the field of rehabilitation.	4.77	7

Results related to question 10

Q10: What is the most serious problem that restricts the development of services? To analyse this question means and ranks are used in table (28).

The question asked respondents to respond to different statements providing number one to statement of most serious problem facing the development of rehabilitation services, two to the one that follows etc... When means of ranking were calculated the mean closer to one would indicate the most serious problem.

Table (27) shows the most serious problems facing the development of rehabilitation services. On the top of the list of most serious problems is item (1) Isolating, rather than assimilating the disabled in the society. Rank (2) to the item (2) The different economic and political conditions. Rank (3) to the item (3) The restricted number and experience of work force in rehabilitation. Rank (4) to item (6) Maldistribution of rehabilitation services. Rank (5) to item (7) Duplication of work in the rehabilitation institutions. Rank (6) to the item (4) Rehabilitation policies are not crystallized. Rank (7) to the item (5) Law is not applied or inapplicable. Rank (8) to item (8) Poor education programs in universities and colleges teaching rehabilitation.

Table (28) Means and Ranks of serious problems that restrict the development of rehabilitation services.

N	Serious problems	Means	Ranks
1	Isolating, rather than, assimilating the disabled in the society.	1.2	1
2	The difficult economic and political conditions.	2.86	2
3	The restricted number and experience of work force in rehabilitation	3.91	3
4	Rehabilitation policies are not crystallized.	4.72	6
5	Law is not applied or inapplicable.	5.76	7
6	Mal distribution of rehabilitation services.	3.95	4
	Duplication of work in the rehabilitation institutions.	4.07	5
8	Poor educational programs in universities and colleges teaching rehabilitation.	6	8

Results related to the question 11

Q11: Do you believe we should develop rehabilitation policies in Palestine? The results indicated that the majority of providers (90.7%) believe that rehabilitation policies should be developed.

Results related to the question 12

Q12: What is needed to develop rehabilitation policies?

The results in table (29) show that responses of providers for developing rehabilitation policies. The most important need is item (4) studying the factors that affect policy-making in rehabilitation, with (86%), responding with yes. Item (7) follows, Evaluating and studying the law to check its suitability and applicability, where the percentage of yes responses is (83.7%). The lowest need for developing rehabilitation policies is item (2) Involving the Palestinian society in planning and policy-making in the field of rehabilitation, where the percentage of these who responded with yes is, (46.5%), and item (8) Applying law and legislation, where the percentage is, (48.8%).

Table (29) Frequencies and Percentages of responses for developing Rehabilitation policies in Palestine.

Responses		Yes		No	
N	Developing policies	F	%	F	%
1	Study the needs of the Palestinian society.	31	72.1	12	27.9
2	Involving the Palestinian society in planning and policy-making in the field of rehabilitation.	20	46.5	23	53.5
3	Re-evaluating rehabilitation services.	29	67.4	14	32.6
4	Studying the factors that affect policy-making in the rehabilitation.	37	86.0	6	14
	Promoting work force in rehabilitation	27	62.8	16	37.2
6	Developing administrative systems applied.	22	51.2	21	48.8
7	Evaluating and studying the law to check its suitability & applicability.	36	83.7	7	16.3
8	Applying law and legislations.	21	48.8	22	51.2
9	Studying restrictions to planning and policy-making and founding alternatives.	31	72.1	12	27.9

Results related to question 13

Q13: What do you think is appropriate and needed to improve rehabilitation services quality?

The results in table (30) show that the majority of respondents (86%) think that most needed to improve rehabilitation services quality is item (14), Governmentally supported rehabilitation institutions. The lowest need to improve rehabilitation services quality is item (6), Following up and controlling rehabilitation services through competent authorities, where the percentage of Yes responses

is, (51.2%). Generally the majority of respondents think that all items are appropriate and needed to improve rehabilitation services quality.

Table (30) Frequencies and Percentages of responses to improve rehabilitation services quality.

Responses		Yes		No	
N	Improve rehabilitation services quality	F	%	F	%
1	Increasing investment in the field of rehabilitation.	32	74.4	11	25.6
2	Developing patient-referring system.	24	55.8	19	44.6
3	Developing administrative systems.	31	72.1	12	27.9
4	Promoting and increasing work force.	31	72.1	12	27.9
5	Adopting modern technology.	27	62.8	16	37.2
6	Flowing up and controlling rehabilitation services through Competent authorities.	22	51.2	21	48.8
7	Exploiting natural resources in the society.	32	74.4	11	25.6
8	Doing research in the field of rehabilitation.	26	60.5	17	39.5
9	Preventing duplication of activities in the various institutions.	34	79.1	9	20.9
10	Improving employee's conditions and applying the system of motives.	32	74.4	11	25.6
11	Developing educational programs.	31	72.1	12	27.9
12	Involving the society in the rehabilitation process.	30	69.8	13	30.2
13	Distributing rehabilitation services fairly.	32	74.4	11	25.6
14	Governmentally supporting rehabilitation institutions.	37	86	6	14
15	Creating specialties in the field of rehabilitation.	30	69.8	13	30.2
16	Applying laws/ regulations concerning rehabilitation.	31	72.1	12	27.9
17	Planning and making policies for rehabilitation nation-wide.	30	69.8	13	30.2

C. Summary:

This chapter has presented an overview of the results of responses of 43 providers from 43 rehabilitation service institutions and centers. The purpose was to describe rehabilitation services. Data was collected in the period between September and November 2001, and was analyzed using percentages, frequency distributions, and ranks.

Results were presented on the thirteen questionnaire parts: the descriptive responses related to the types of rehabilitation services, quality and quantity of rehabilitation services, size of rehabilitation services, financial matters, human resources, administrative system, patient-referring system, cooperation and coordination between institutions, rehabilitation policies, priority of rehabilitation, serious problems, and suggestions to develop rehabilitation policies. The last part was related to appropriate rehabilitation services and the need to improve their quality.

CHAPTER VIII
DISCUSSION

The results of this descriptive study present information on assessment of rehabilitation services in the northern districts as perceived by the providers.

A. Discussion of the Major Findings:

Analysis of the responses to the questionnaire revealed that the rehabilitation services in the northern districts where offered by different institutions or centers of the rehabilitation affiliated with different rehabilitation provider sectors.

(1): Types of Rehabilitation Services.

The majority of rehabilitation services in the northern districts are concerned with Physical therapy (PT), and form about (86%) of the total services provided. Other services form fewer percentages, for example speech therapy (9.3%), Occupational therapy (9.3%), and Vocational rehabilitation (4.7%). PT activities developed rapidly started in Palestine, in the first intifada (uprising) in 1989, due to the increasing number of injuries. Professionals, and the community started to understand the PT role in rehabilitating the disabled, and four universities, and colleges started teaching PT. On the contrary, other services were neglected for a long time. Occupational therapy, for example was dropped from the syllabus of Bethlehem University may be because the PT services considered the top priority of

rehabilitation services in Palestine and because Palestine lacks professionals who can run OT academic programs and services.

The absence of occupational therapy may also be attributed to lack of knowledge of the providers and community of its importance, lack of finances, and overall shortage of specialized human resources in the northern districts. In addition Human resources consider physiotherapy as the most financially rewarding rehabilitation job in the field.

In the northern districts, there is only one Vocational center in Nablus district to rehabilitate the disabled. Coordination, cooperation, and patient- referring system between institutions should be improved to rehabilitate the disabled and to meet their needs.

As for prosthesis, the results revealed that the percentage of prosthesis services is (34.9%). These services are provided outside the northern districts. Engineers or assistants take the measurements, and design equipment in Jerusalem at princess Basma, and at Bethlehem Arab Society centers, or in private centers.

In the northern districts there is not a single manufacturer for prosthesis. Planners and decision makers should work on establishing one factory in the northern districts to meet the needs of beneficiaries.

With regard to speech therapy, services are localized in Nablus district. Planners, and decision-makers should attempt to better distribute services in the northern districts as needed.

Planners and decision-makers should encourage institutions to provide services and the government should support them. In addition, the numbers of human resource dealing with vocational, and speech therapy should be increased, and services better organized.

The results of this study are consistent with the CNCR conference, 1998 which emphasized that there are no OT services in the north districts.

(2): **Quality and Quantity of Rehabilitation services.**

Results of this study indicated and according to the providers that the beneficiaries do not evaluate rehabilitation services continually. These results may be explained by the fact that the respondents believe that beneficiaries are unable to evaluate the rehabilitation services, poor team work, weakness in the administrative system, and lack of total quality management in the institution.

Evaluation of rehabilitation services is the responsibility of all professionals and beneficiaries in the field to ensure that rehabilitation services are good in quality and quantity. The feedback from the employees and beneficiaries for evaluating rehabilitation services is necessary to improve the quality and quantity of rehabilitation services to meet the needs of the society.

The planners and management should strive towards total quality management, and human resources, by holding continual

works shops and continue education programs on the process of evaluating and upgrading services.

(3): **Size of Rehabilitation services.**

Results of this study indicated that majority of provider's (86%) indicated that there is unjustified duplication in providing services by different institutions, and that the number of employees at the institutions is sufficient, (77.2%).

The unjustified doubleness is due to weakness in planning, cooperation and coordination between institutions, which also restrict the development of rehabilitation services. The responses showed that from the point of view of the provider the number of employees at the institutions is sufficient yet; the researcher believes that there is a need for human resources to work in the rehabilitation field. If there was free of movement in the Palestinian land without restrictions from the Israeli occupation, more clients are expected to be seeking services and the employee's workload would increase.

The political, and socio-economic situation in the Palestinian districts is very bad due to closure imposed by the Israeli military, which certainly affect numbers of beneficiaries.

(4): **Financial Matters.**

Results in this study showed that, the centers claim to cover some of them expenses, but they continually depended on outside

support. Their expenses are higher than their income although they believe that, the budget was managed effectively, (78.2%).

These results may be explained by the fact that these institutions and centers were opened haphazardly. Duplication of activities in different institutions, weakness in the administrative system, mal distribution of rehabilitation services, and the quantity and quality of services are questionable. The political-economical situation is also a complicating matters.

The providers, the planners, and the decision-makers should draw alternative policies to solve the problem since outside financial support may stop. The government should strongly support rehabilitation institutions.

The financial problem was most commonly listed problem that institutions faced. This study is consistent with another study (Giacaman, 1989).

(5): **Human Resources.**

Results of this study showed that providers do not adequately encourage the upgrading and promotion of human resource. These results may explained due to lack of financial resources and that it is not a top priority in the institution and centers.

The percentage of provider's experience levels is (less10 years) was (46.5%), and (higher education) was (14%). The results indicate that rehabilitation is a new field in Palestine. Thus the

planners, and decision-makers should develop human resources in general, and give priority to the lacking fields of rehabilitations.

(6): **Administrative Systems.**

Results showed that the respondents did not agree that administrative regulations and laws are developed which help to improve the services provided, and there are regulations concerning the quality of rehabilitation services provided. These results may reflect a weakness in the administrative system in the institutions.

According to these results, the planners and decision-makers should establish, rehabilitation services administration to develop and implement comprehensive and coordinated programs of rehabilitation and support, and to motivate employees, and control and improve the rehabilitation services.

(7): **Patients Referring System.**

The results of this study showed that the duplication of activities in the different institutions in perceived as very high by the respondents.

These results may reflect a weakness in the patients referring system in the institutions.

The providers, the planners, and the decision-makers should prevent the duplication in the institutions, and build patients referring system nation-wide.

The researcher believes that the duplication in the institution may reflect the absence of applicable law and order, unclearity of

policies, and no control of rehabilitation services through competent authorities.

(8): **National Policies and rehabilitation policies.**

The results showed that the majority of respondents were very keen regarding the national policies of rehabilitation. The rehabilitation policy should be comprehensive and at the national level (96.2%), and there should be a policy for progressive education in the field of rehabilitation (91.2%). In addition, there is a need to involve society and activate its role in rehabilitation, and there is need to develop the patients referring system nation-wide.

This study showed that the respondents also believed that "distribution of rehabilitation centers in Palestine is just and appropriate" was not true. The providers strongly disagreed with the statement, and the percentage was (34.8%). Also, their answers to item "satisfaction with the rehabilitation policies in Palestine", was low where the percentage was (43.2%).

The researcher agrees with the results that there is geographical maldistribution of centers, because most are centered in cities. Absent strategic planning to distribute rehabilitation services in the northern districts leads to this maldistribution.

The researcher generally agrees with the above results, because of many factors including:

- Unclearity of policies .
- Maldistribution of rehabilitation centers in Palestine.
- Weak planning and policy-making in the field of rehabilitation in

Palestine.

- Rehabilitation policies need much work to be drafted.
- Laws are absent.
- There is duplication of work in the rehabilitation institutions.
- The government poorly supports rehabilitation institutions.
- Most of the providers do not participate in drawing policies.
- Isolation, rather than, assimilation of the disabled in the society.

The study results are consistent with other studies such as (Giacaman, 1989, and with the CNCR, study 1998), in that there is no comprehensive rehabilitation in Palestine.

(9): **Priority of Rehabilitation.**

The results of this study revealed that the top priority in rehabilitation as perceived by respondents was social assimilation of the disabled in the society then promoting work force in the field of rehabilitation, coordinating and distributing services and improving patient-referring system, improving quality and quantity of rehabilitation services, upgrading education in the universities and colleges teaching rehabilitation ...etc.

There are considered to be very important for the planners and decision makers to concentrate on these priorities. Many of the studies concentrate on integration of the disabled in the society. This study is consistent with the medical and social model of disability to fully integrate the disabled in the society.

(10): Serious Problem facing the Development of Rehabilitation Services.

The results of this study revealed that the most serious problems facing the development of rehabilitation services were isolating rather than assimilating the disabled in the society, the difficult economic and political situation, the restricted number and experience of work force in rehabilitation, mal distribution of rehabilitation services, duplication of work in rehabilitation institutions, non-crystallization of rehabilitation policies, absent or inapplicability of law, and poor educational programs.

This study is also consistent with another study on 23 Palestinian villages in the central district of West Bank with special reference to the needs of persons with disabilities (CRCR, 1995).

The researcher is in agreement with the providers perception especially that the most serious problem, is isolating the disabled which restricts the development of rehabilitation services.

The integration of the disabled in Palestine is inactive because of many factors:

- Laws are not applied or inapplicable.
- Maldistribution of rehabilitation services.
- Difficult economic and political situations.
- Rehabilitation system is not comprehensive.
- Lack of governmental support for the disabled and the institutions working in the rehabilitation fields.

The researcher believes these issues should to be the responsibility of the health planners as well as the rehabilitation services providers.

(11): **Development of Rehabilitation Policies.**

The results of this study revealed, that most of the providers believe that the rehabilitation policies should be developed, (90.7%).

This result is consistent with (Giacaman, 1989, and CNCR, 1998). Developing rehabilitation policies will be reflected positively on the rehabilitation services such as organizing, coordinating, controlling rehabilitation services, in general.

It is very important for planners to evaluate and review rehabilitation to develop the policies that are appropriate, suitable and easy for implementation in Palestine.

(12): **The suggestions needed to develop rehabilitation policy.**

The results of this study showed, that the majority of providers, (86%) positively views studying the factors that affect policy-making in the field of rehabilitation. On assessing whether the law is suitable and applicable, the majority (83.7%) believe it is. Also the result of this study revealed that studying the needs of the Palestinian society and studying restrictions to planning and policy-making and finding alternatives were perceived necessary to develop rehabilitation policy (72%).

The results showed that responses to statements indicating applying law and legislation, developing the administrative system, and involving the Palestinian society in planning and policy-making in the field of rehabilitation were negative and they believed they did not extensively exist.

The providers, the planners, and the decision-makers should be developed law and legislation, administration system, and involving the Palestinian society in planning and policy-making in the field of rehabilitation.

(13): **Appropriate Rehabilitation Services and the need to improve Quality.**

The results of this study revealed that governmental support towards rehabilitation institutions was the most needed and appropriate to improve rehabilitation service's quality. There is a call for preventing duplication of activities in the various institutions, and fair distribution of rehabilitation services, improving employee's conditions and applying the system of motives, developing educational programs, and increasing investment in the rehabilitation field. This study results are consistent with the national strategy for health in Palestine, (1999).

The provider's responded with low satisfaction on follow up and control of rehabilitation services through competent authorities and developing patients-referring system.

The researcher believes these issues are necessary to improve quality of rehabilitation services, and for future studies.

B. Conclusion.

This study aimed at describing the rehabilitation services in the northern districts in the West Bank in Palestine. Information in this regard was collected, and pointed out important aspects that need to be considered by various rehabilitation care providers in the northern districts and can be summarized as follows:

1. The majority of rehabilitation services are conducted by the private and NGOs sectors. The government should increase the rehabilitation services especially OT, VR, and Speech therapy.
2. It is important to work on improving the quality and quantity of rehabilitation services. Also the feedback from the employees and beneficiaries on evaluating rehabilitation services is very necessary to improve the quality and quantity of these rehabilitation services.
3. Unjustified duplication in providing services by different institutions should be minimized.
4. Collaboration between institutions is necessary to improve rehabilitation services by exchanging the expertise and preventing duplication.
5. Administrative systems need to be developed, and updated.
6. Patients-referring system and cooperation and coordination need to be improved.
7. There is needed for nation-wide policies on rehabilitation.
8. Social assimilation of the disabled in society was the top priority and the most serious problem that restricted the development of rehabilitation services.
9. The results of this study revealed, that the majority of providers believe that rehabilitation policies should be developed, and the

percentage was (90.7%) and the providers, responses on studying the factors that affect policy-making in the field of rehabilitation, scored the percentage of (86%).

C. Over all Recommendation:

1. Recommendation for types of rehabilitation services.

- The planner and decision maker should be encourage the institution to have new services needed such as (OT, VR, Speech therapy).

2. Recommendation for improving quality and quantity of rehabilitation services.

- The planner and decision maker should be participate the beneficiaries in evaluating of rehabilitation services provided at the institution continually.

3. Recommendation improving the size of rehabilitation services.

- The planner and decision maker should be preventing the unjustified duplication in providing services by different institutions.
- The quality of rehabilitation programs should be effective and meet need of society.
- The employees should be evaluating rehabilitation services continually.

4. ***Recommendation for improving the financial matters in the institution.***

- There should be marketing of rehabilitation services.
- The budget should be managed effectively.

5. ***Recommendation for developing and improving the human resource in the institutions.***

- The planner and decision maker should be putting a budget for Continuing education.
- The institutions should upgrade their work force.
- Regulations in the institution should be enabling employees to involve in progressive education activities.

6. ***Recommendation for administrative system of rehabilitation services.***

- Administrative regulations and laws should be developed to help to improve of rehabilitation services.
- The system of motivation/incentives in the institution should be applied.
- Job description in the institutions should be clear to the employees.
- The decision-makers should develop the Rehabilitation Services Administration nation-wide.

7. ***Recommendation for patient-referring system, cooperation and coordination between institutions.***

- Cooperation and coordination between institutions is essential to

improve rehabilitation services especially the exchange expertise.

- The planner and decision maker should be preventing the duplication of activities in the deferent institution.
- The planners and decision-makers should develop the patient-referring system nation-wide.

8. ***Recommendation for nation's policies in general and rehabilitation policies in particular.***

- The rehabilitation policy should be comprehensive and nation-wide.
- There should be a policy for progressive education in the field of rehabilitation.
- The patient's-referring system should be developing nation-wide.
- Laws and regulation should be applied to improve of rehabilitation services.
- Distribution of rehabilitation services in Palestine should be just and appropriate.
- Planning and drawing policies in the field of rehabilitation in Palestine should be appropriate and effective.

9. ***Recommendation for top priority of rehabilitation.***

- There should be social assimilation of the disabled in Palestinian society.
- The planner, decision maker should be promoting work force in the field of rehabilitation.

- Planner and decision makers should be cooperating, distributing services, and improving patient's-referring systems in Palestine.
- The planner, decision maker, and providers should be improving quality and quantity of rehabilitation services provided.

10. ***Recommendation for preventing the most serious problem that restrict the development of rehabilitation services.***

- There should be social integration for the disabled in the Palestinian society.
- The planners, decision makers, and providers should be drawing alternative policies to meets the difficult economic and political conditions in Palestine.
- The planner and decision makers should be increasing and improving the number and experience of work force in rehabilitation.
- Planner and decision makers should be distributing rehabilitation services congruent with needs in the Palestinian society.

11.Recommendation for developing rehabilitation policies in Palestine.

- The planners and decision makers should be studying the factors that affect policy-making in the rehabilitation.
- The planners and decision makers should be evaluating and studying the law to check its suitability and applicability in Palestine.
- The planners and decision makers should be studying the needs of

the Palestinian society.

- The planner and decision maker should be re-evaluating rehabilitation services.
- The planners and decision makers should be promoting work force in rehabilitation.

12.***Recommendation for improving the quality of rehabilitation services.***

- Government should support rehabilitation institutions in Palestine.
- The planner and decision maker should be distributing rehabilitation services fairly in Palestine.
- The decision makers should be improving employees conditions and applying the system of motivation.
- The planner and decision maker should be increasing investment in the field of rehabilitation.
- The planners and decision makers should be preventing duplication activities in the various institutions.
- The planners and decision makers should be developing rehabilitation services administration.

D. Recommendations for Further Research.

This study was descriptive in nature to collect information regarding the characteristics of rehabilitation services in the north districts. It serves as base line data for further studies related to rehabilitation services. Based on this study, it is recommended that the future studies in this area use other variables in addition to those in this study, which would be of great advantage to rehabilitation planning programmers. The population size can be increased in order to cover all West's Bank as well as Palestine as a whole, to allow for the generalizability of the findings. Furthermore, qualitative exploration of rehabilitation services has not been widely founded in the rehabilitation literature and so it is highly recommended to hold qualitative research to provide a richer view of the Palestinian rehabilitation services.

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Appendix 1

An-Najah
National University
Deanship of Graduate Studies

جامعة
النجاح الوطنية
عمادة كلية الدراسات العليا

التاريخ : ٢٠٠١/٧/٧

السادة / ..... المحترمون

تحية طيبة وبعد ،،

الموضوع : تسهيل مهمة الطالب نصر خليل ابراهيم ابو خضر رقم التسجيل (٩٩٥٠٤٠٢)

يرجى من حضرتكم تسهيل مهمة الطالب / نصر خليل ابراهيم ابو خضر من طلبة الماجستير تخصص الصحة العامة في كلية الدراسات العليا لاجراء دراسته. وهو الآن بصدد إجراء دراسة بعنوان :

(تقييم خدمات التأهيل في شمال الضفة الغربية)

لذا يرجى التكرم تسهيل مهمته وعمل مقابلات شخصية مع مدراء المؤسسات والموظفين لدى مؤسستكم.

شاكرين لكم حسن تعاونكم.

وتفضلوا بقبول الاحترام ...

عميد كلية الدراسات العليا

د. محمد العملة

جامعة النجاح الوطنية
كلية الدراسات العليا
نابلس - فلسطين

نسخة : الملف

نابلس – ص.ب ٧ هاتف: ٢٣٨١١١٣/٧، ٢٣٨٦٥٨٤، ٢٣٧٠٠٤٢ (٠٩) (٩٧٢) فاكسيل: ٢٣٨٧٩٨٢ (٠٩) (٩٧٢)
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Appendix 2

دراسة لتقييم خدمات التأهيل
في شمال الضفة الغربية
فلسطين

الاخوة/ الأخوات الأفاضل:

أعلمكم بأنني أ قوم بدراسة ميدانية لتقييم خدمات التأهيل في شمال الضفة الغربية في كل من محافظة (جنين ، طولكرم ، قلقيلية ، نابلس ،طوباس و،سلفيت). كجزء من متطلب برنامج الماجستير في الصحة العامة في جامعة النجاح الوطنية .

إن الهدف من الدراسة هو تحسين نوعية خدمات التأهيل في شمال الضفة الغربية لتلبي احتياجات المنتفعين.وان لمشاركتكم أهمية كبرى لتحقيق هذا الهدف الذي نسعى جميعا لاجله.

وقد تم إختياركم للمشاركة في هذا البحث بناءا على خبراتكم ودوركم المتميز في مجال التأهيل. أود أن أشير المعلومات التي سوف يتم الحصول عليها سوف تعامل بسرية تامة ولن يتم ذكر أسماء الأفراد المشاركين وخصوصياتهم وسوف نترك لك الاختيار في الإجابة أو الرفض .

إن الباحث يدعوكم للمشاركة في هذا البحث راجيا منكم أن تسعوا قدر الإمكان لإعطاء أدق المعلومات وأكثرها صحة حسب رأيكم حتى تتوفر المعرفة الأفضل حول هذا الموضوع.

وأؤكد ثانية بأنة ليس هنالك أي هدف من الحصول على هذه المعلومات إلا لاستخدامها في مجال البحث العلمي ومن اجل الرقي بخدمات التأهيل علما بأن تجاوبك هو اختياري

إن موافقتك على المشاركة في هذا البحث مهمة جدا ونحن نقدرها ونثمنها بدرجة عالية.

مع الاحترام
نصر خليل آبو خضر

Translation From Arabic Language

Appendix 3

Assessment of Rehabilitation Services in the North Districts of West Bank in Palestine

Date of Interview: ----------

Serial Number: ----------

Age: -----*Sex*: -----*Scientific Degree*: ----------*Experience*: --------

Institution/ Center: (1) *Government* (2) *Non Government* (3) *UNRWA* (4) *Private*

Please answer these questions by putting mark (*) to ward your felling:

1- *Strong Agreement* 2- *Agreement* 3- *Moderate Agreement* 4- *Disagreement* 5- *Strong Disagreement.*

Q1

What are the types of rehabilitation services in the centers, and institutions?

1. Physiotherapy
2. Occupational Therapy
3. Speech Therapy
4. Vocational Rehabilitation
5. Prosthesis
6. CBR
7. Counseling rehabilitation

Other Services.....

Q2

To what extent do you agree with these statements concerning quality and quantity of rehabilitation services in the institution where you work?

N	Quality and Quantity of rehabilitation services	Strong Agree	Agree	Moderate Agreement	Disagree	Strong Disagree
1	I am contented with the level of services provided to the patients.					
2	The quality of rehabilitation programs provided at the institution is effective and meets needs of society.					
3	Equipment is sufficient to carry out rehabilitation.					
4	The time assigned for treatment is sufficient.					
5	The quality of the services provided meets beneficiary's needs.					
6	I evaluate rehabilitation services provided at the Institution continually.					
7	The beneficiaries evaluate rehabilitation services provided at the institution continually.					
8	Service is easily ascendible.					
9	The relation with patients or beneficiaries is professional.					
10	Secrecy is observed when services are provided.					
11	Privacy is observed when services are provided					
12	Employees at the institution continually evaluate services.					

* Maximum point of response (5) points.

Q3

To what extent do you agree with these statements concerning the size of rehabilitation services in the institution where you work?

N	Size of rehabilitation services	Strong Agree	Agree	Moderate Agree	Disagree	Strong Disagree
1	Size of work/tasks of employees is big					
2	Area of site suits size of work					
3	Number of employees at the institution is sufficient					
4	Size of work matches objectives of institutions					
5	There is unjustified duplication in providing services different institutions.					
6	It is necessary to increase the institutions capability to host more beneficiaries					

* Maximum point of response (5) points.

Q4

To what extent do you agree with these statements concerning financial matters in the institution where you work?

N	Financial matters	Strong Agree	Agree	Moderate Agree	Disagree	Strong Disagree
1	The center covers expenses.					
2	Continuity depends on outside support.					
3	Expenses are higher than income.					
4	Budget is managed effectively.					
5	Rehabilitation services costs are reasonable.					

*Maximum point of response (5) points.

Q5

To w extent do you agree with these statements concerning relationship with human resource in the institution where you?

N	Relation ship with manpower	Strong Agree	Agree	Moderate Agree	Disagree	Strong Disagree
1	The institution promotes its work force.					
2	Work force in the institution should be promoted.					
3	Work force should be increased.					
4	The institution has a budget for work force promotion.					
5	Training work force is done in accordance with the institution's field of rehabilitation.					
6	The certificates I hold qualify me to work in the field of rehabilitation.					
7	Employees at the institution are qualified and have experience in rehabilitation.					
8	Regulation in the institution enables employees to involve in progressive education activities.					

- Maximum point of response (5) points.

Q6

To what extent do you agree with these statements concerning relationship with administrative system in the institution where you work?

N	Administrative system	Strong Agree	Agree	Moderate Agree	Disagree	Strong Disagree
1	My salary meets my needs.					
2	I have a clear job description.					
3	The boss or manager lacks certificates and experience to Qualify him to work in rehabilitation.					
4	Relationship between employees and administrations is good.					
5	There are regulations concerning the quality of Rehabilitation services provided.					
6	There is regulation concerning work force promotion.					
7	Administrative regulations and laws are developed and help improve the services provided.					
8	The system of motivation/incentives in the institution is Applied.					
9	All employees know laws and regulations of the institution.					

- Maximum point of response (5).

Q7

To what extent do you agree with these statement concerning patient-referring system, coordination and cooperation between your institution and other institutions?

N	Patient referring system cooperation and coordination	Strong Agree	Agree	Moderate Agree	Disagree	Strong Disagree
1	Patient's-referring system of at the institution is good.					
2	The relationship between the institution and the Other institutions are strong.					
3	There is no interaction between the institution and the Universities and colleges teaching rehabilitation.					
4	The relationship between the institution and the universities and colleges teaching rehabilitation is strong.					
5	Cooperation and coordination between institutions is Essential to improve rehabilitation.					
6	There is duplication of activities in the different institutions.					
7	Exchanging expertise (between institutions) is active.					

* Maximum point of response (5).

Q8

To what extent do you agree with the following statements concerning National policies in general, and rehabilitation policies in particular?

N	National Policies	Strong Agree	Agree	Moderate Agree	Disagree	Strong Disagree
1	The rehabilitation policy should be comprehensive and Nation-wide.					
2	There should be a policy for progressive education in the Field of rehabilitation.					
3	Planning and policy-making in the field of Rehabilitation In Palestine is weak.					
4	There is a need to involve society and activities role In rehabilitation.					
5	Distribution of rehabilitation centers in Palestine is just and appropriate.					
6	In application of laws and regulations negatively affects rehabilitation services.					
7	I am satisfied with the rehabilitation policies in Palestine					
8	There is a need to develop the patients'-referring system Nation-wide.					
9	The quality of services provided by the institution in the Field of rehabilitation in general is good.					

- Maximum point of response (5) points.

Q9

List the following items concerning rehabilitation giving number (1) to the top priority, number (2) to the less priority...etc.

1-Social assimilation of the disabled in their society.

2-Improving quality and quantity of rehabilitation services provided.

3-Increasing expenditure in the field of services provided to the disabled.

4-Coordinating and distributing services and improving patient-referring systems.

5-Promoting work force in the field of rehabilitation.

6-Upgrading education the universities and colleges teaching rehabilitation.

7-Keeping up with scientific development and technology in the field of rehabilitation.

Q10

List the most serious problems facing the development of rehabilitation services. Give number (1) to the most important problem, number (2) to less important and so on.

1-Isolating, rather than, assimilating the disabled in the society.

2-The difficult economic and political conditions.

3-The restricted number and experience of work force in rehabilitation Rehabilitation policies are not crystallized.

4-Law is not applied or inapplicable.

5-Mal distribution of rehabilitation services.

6-Duplication of work in the rehabilitation institutions.

7-Poor educational programs in universities and colleges teaching rehabilitation.

Q11

Do you believe we should develop rehabilitation policies in Palestine?

(1) Yes (2) No (3) I don't Know

Q12

If your answer is yes, circle the most appropriate suggestions needed to develop rehabilitation policies. You can choose more than one.

1-Study the needs of the Palestinian society.

2-Involving the Palestinian society in planning and policy-making in the field of rehabilitation.

3-Re-evaluating rehabilitation services.

4-Studying the factors that affect policy-making in the rehabilitation.

5-Promoting work force in rehabilitation.

6-Developing administrative systems applied.

7-Evaluating and studying the law to check its suitability & applicability.

8-Applying law and legislations.

9-Studying restrictions to planning and policy-making and founding alternatives

Others.....

Q13

Circle what you think appropriate and needed to improve rehabilitation services quality?

1-Increasing investment in the field of rehabilitation.

2-Developing patient-referring system.

3-Developing administrative systems.

4-Promoting and increasing work force.

5-Adopting modern technology.

6-Flowing up and controlling rehabilitation services through Competent authorities.

7-Exploiting natural resources in the society.

8-Doing research in the field of rehabilitation.

9-Preventing duplication of activities in the various institutions.

10-Improving employee's conditions and applying the system of motives.

11-Developing educational programs.

12-Involving the society in the rehabilitation process.

13-Distributing rehabilitation services fairly.

14-Governmentally supporting rehabilitation institutions.

15-Creating specialties in the field of rehabilitation.

16-Applying laws/ regulations concerning rehabilitation.

17-Planning and making policies for rehabilitation nation-wide.

Others.....

Appendix 3

أسئلة الاستبيان

دراسة لتقييم خدمات التأهيل في شمال الضفة الغربية

تاريخ المقابلة...../...../.....

الرقم المتسلسل.....

العمر.....الجنس.....الدرجه العلميه.....سنوات الخبرة.....

طبيعة المركز/المؤسسة: ٠١ قطاع حكومة ٠٢ قطاع غير حكومي٠٣ وكالة الغوث ٠٤ قطاع خاص

أرجو الإجابة بوضع اشارة( ) على كل من الأسئلة التالية بالطريقة التي تعبر عن شعوركم اتجاه الأسئلة أو العبارات المدرجة في الجداول التالية على أساس.

١- أوافق بشده ٢- أوافق ٣- حيادي-لا اعلم ٤- أعارض ٥- أعارض بشده

س١

ضع دائرة حول أنواع الخدمات المقدمة في المركز أو المؤسسة التي تعمل بها.

١- علاج طبيعي

٢- علاج وظيفي

٣- علاج النطق

٤- تأهيل مهني

٥- أطراف صناعية وأجهزة مساعدة .

٦- برنامج التأهيل المبني على المجتمع .

٧- خدمات تأهيلية إرشادية .

٨ - خدمات اخرى حدد/ حددي ذلك.

س٢

إلى أي مدى توافق مع هذه العبارات ذات العلاقة بنوعية وكمية خدمات المؤسسة التي تعمل بها.

الرقم	السؤال	أوافق بشدة	أوافق	حيادي	أعارض	أعارض بشدة
٠١	أنا راضي عن مستوى الخدمات المقدمة للمرضى					
٠٢	نوعية برامج التأهيل المقدمة في المؤسسة فعالة وتناسب لحتياجات المجتمع					
٠٣	الأجهزة والمعدات كافية للقيام بالتأهيل					
٠٤	الوقت الذي يعطى لعلاج المنتفعين كافي					
٠٥	نوعية الخدمات المقدمة تلبي لحتياجات المنتفعين					
٠٦	أقوم بتقييم خدمات التأهيل المقدمة في المؤسسة باستمرار					
٠٧	يقوم المنتفعين بتقييم خدمات التأهيل المقدمة في المؤسسة باستمرار					
٠٨	مكان العمل سهل الوصول إليه لتلقي الخدمة					
٠٩	علاقتنا مع المرضى أو المنتفعين علاقة مهنية					
١٠	تراعى السرية في تقديم الخدمات في المؤسسة					
٠١١	تراعى الخصوصية في تقديم الخدمات في المؤسسة					
٠١٢	يتم تقيم الخدمات باستمرار من قبل العاملين في المؤسسة					

س٣

إلى أي مدى توافق مع العبارات ذات العلاقة بحجم خدمات المؤسسة التي تعمل بها.

الرقم	السؤال	أوافق بشدة	أوافق	حيادي	أعارض	أعارض بشدة
٠١٣	حجم العمل لدى الموظفين كبير					
٠١٤	مساحة المكان تتناسب مع حجم العمل					
٠١٥	عد د العاملين في المؤسسة كافي					
٠١٦	حجم العمل في المؤسسة يتطابق مع أهداف المؤسسة					
٠١٧	هنالك ازدواجية غير مبرره في تقديم الخدمات مع مؤسسات أخرى					
٠١٨	هنالك ضرورة لزيادة قدرة المؤسسة لاستيعاب اكبر عد د من المنتفعين					

س٤

إلى أي مدى توافق مع هذه العبارات ذات العلاقة بالأمور المادية في المؤسسة التي تعمل بها.

الرقم	السؤال	أوافق بشده	أوافق	لا اعلم	أعارض	أعارض بشده
٠١٩	المركز يغطي نفقاته					
٠٢٠	استمرارية المؤسسة لو المركز مرتكز على الدعم الخارجي					
٠٢١	مصاريف المركز عالية مقارنة مع الدخل					
٠٢٢	يتم توزيع وصرف الميزانية في المؤسسة بطريقة جيده					
٠٢٣	أسعار خدمات التأهيل مناسبة					

س٥

إلـــى أي مـــدى توافـــق مـــع هـــذه العبارات ذات العلاقة بالقوة البشرية في المؤسسة التي تعمل بها.

الرقم	السؤال	أوافق بشدة	أوافق	حيادي	أعارض	أعارض بشدة
.٢٤	المؤسسة تعمل على تنمية القوة البشرية العاملة فيها					
.٢٥	يجب تنمية القوة البشرية في المؤسسة					
.٢٦	هنالك ضرورة لزيادة عدد القوة البشرية					
.٢٧	توجد ميزانية مخصصة لتنمية القوة البشرية في المؤسسة					
.٢٨	تدريب القوة البشرية يتم بناءا على احتياجات المؤسسة					
.٢٩	الشهادات التي أحملها تؤهلني للعمل في مجال التأهيل					
.٣٠	العاملين في المؤسسة مؤهلين ولديهم خبرات في التأهيل					
.٣١	أنظمة المؤسسة تفسح المجال للعاملين بالانخراط في نشاطات التعليم المستمر					

س٦

إلـــى أي مـــدى توافـــق علـــى هذه العبارات ذات العلاقة بالنظام الإداري في المؤسسة التي تعمل بها.

الرقم	السؤال	أوافق بشده	أوافق	حيادي	أعارض	أعارض بشده
٣٢.	راتبي يكفيني					
٣٣.	يوجد عندي وصف وظيفي واضح					
٣٤.	المسؤول أو المدير بحاجة إلى شهادات وخبرات تؤهله للعمل في مجال التأهيل					
٣٥.	العلاقة بين الموظفين والإدارة جيدة					
٣٦.	هنالك أنظمة ذات علاقة بنوعية خدمات التأهيل المقدمة					
٣٧.	هنالك أنظمة ذات علاقة بتطوير القوى البشرية					
٣٨	الأنظمة والقوانين الإدارية متطورة بحيث تسمح بتحسين الخدمات المقدمة في المؤسسة					
٣٩.	يطبق نظام الحوافز في المؤسسة					
٤٠.	الأنظمة والقوانين في المؤسسة معروفة لجميع العاملين					

س٧

إلـــى أي مـــدى توافـــق مع العبارات ذات العلاقة بنظام التحويل والتنسيق والتعاون ما بين المؤسسة التي تعمل والمؤسسات الأخرى.

الرقم	السؤال	أوافق بشدة	أوافق	لا اعلم	أعارض	أعارض بشدة
٠٤١	نظام التحويل في المؤسسة جيد					
٠٤٢	العلاقة ما بين المؤسسة والمؤسسات الأخرى قوية					
٠٤٣	لا يوجد تفاعل ما بين المؤسسة والمجتمع					
٠٤٤	علاقـــة المؤسسة مع الجامعات والمعاهد التي تدرس التأهيل قوية					
٠٤٥	التنســـيق والتعاون ضروري ما بين المؤسسات لرفع مستوى التأهيل					
٠٤٦	هنالك ازدواجية بالعمل مع المؤسسات الأخرى					
٠٤٧	تـــبادل الخـــبرات مـــا بيـــن المؤسسة والمؤسسات الأخرى قوية.					

س٨

إلـــى أي مـــدى توافـــق مـــع هـــذه العـــبارات ذات العلاقة بالسياسات عامة وذات العلاقة بالتأهيل.

الرقم	السؤال	أوافق بشده	أوافق	حيادي	أعارض	أعارض بشدة
٠٤٨	سياسة التأهيل يجب أن تكون شاملة وعلى مستوى الوطن					
٠٤٩	يجب أن يكون هنالك سياسة للتعليم المستمر في مجال التأهيل					
٠٥٠	هـــنالك ضعف في التخطيط ورسم السياسات في مجال التأهيل في فلسطين					
٠٥١	هنالك ضرورة لإشراك المجتمع وتفعيل دوره في مجال التأهيل					
٠٥٢	عملـــية توزيـــع المراكـــز والمؤسسات التأهيلية عادلة ومناسبة في فلسطين					
٠٥٣	عدم تطبيق القوانين والتشريعات يؤثر سلبيا على خدمات التأهيل					
٠٥٤	أنا راضي عن سياسات التأهيل في فلسطين					
٠٥٥	هنالك ضرورة وحاجة ماسة لتطوير نظام التحويل على صعيد وطني					
٠٥٦	نوعية الخدمات التي تقدمها المؤسسات عامة في مجال التأهيل جيدة.					

أرجو الإجابة على هذه الأسئلة بوضع دائرة حول الأجوبة التي يتم اختيارها.

س٩

عـــدد الأولويـــات في مجال التأهيل كما ترونها مناسبة مع إعطاء رقم(١) للأولوية القصوى ورقم (٢) للأولوية التي تليها وهكذا.

( )- الدمج الاجتماعي للأشخاص المعاقين في إطار مجتمعهم.
( )- تحسين نوعية وكمية خدمات التأهيل المقدمة.
( )- زيادة النفقة في مجال الخدمات المقدمة للأشخاص المعاقين
( )- تنسيق وتوزيع الخدمات وتطوير أنظمة التحويل.
( )- تنمية القوة البشرية في مجال التأهيل.
( )- رفع مستوى التعليم في الجامعات والمعاهد التي تدرس التأهيل.
( )- مواكبة التطور العلمي والتكنولوجيا في مجال التأهيل.

س١٠

عدد أهم مشاكل تحد من تطور خدمات التأهيل. أعطى رقم (١) لأهم مشكلة ورقم (٢) للمشكلة التي تليها وهكذا.

( )- ١العزل وعدم دمج المعاقين في المجتمع.
( )-الظروف الاقتصادية والسياسية الصعبة.
( )- عد د وخبرات القوة البشرية في مجال التأهيل محدودة.
( )-سياسات التأهيل غير مبلورة
( )-القانون لا يجري تطبيقه أو غير مطبق.
( )-سوء توزيع خدمات التأهيل.
( )-لازدواجية العمل في المؤسسات التي يعمل في مجال التأهيل.
( )-ضعف البرامج التعليمية في الجامعات والمعاهد التي تدرس التأهيل.

س١١

هل تعتقد أننا بحاجة إلى تطوير سياسات التأهيل في فلسطين ؟

(١) نعم (٢) لا (٣) لا اعرف

س١٢

إذا كانـــت الإجابـــة نعم . ضع دائرة حول الاقتراحات التي تراها مناسبة وضرورية لتطوير سياسات التأهيل، يمكن اختيار اكثر من اجابة.

١- دراسة احتياجات المجتمع الفلسطيني.
٢- إشراك المجتمع الفلسطيني في التخطيط ورسم السياسات في مجال التأهيل.
٣- إعادة تقييم خدمات التأهيل.
٤- دراسة العوامل التي تؤثر على رسم السياسات في مجال التأهيل.
٥- تنمية القوة البشرية في مجال التأهيل.
٦- تطوير النظم الإدارية المعمول بها.
٧- تقييم ودراسة القانون لمعرفة مدى ملاءمته وسهولة تطبيقه.
٨- تطبيق القانون والتشريعات
٩- دراسة المعيقات التي تحد من التخطيط ورسم السياسات وخلق البدائل
- غير ذلك حدد/ي:----------

س١٣

ضع دائرة حول ما تراه مناسبا وضروريا لتحسين نوعية خدمات التأهيل:

١- زيادة الاستثمار في مجال التأهيل.
٢- تطوير نظام التحويل في مجال التأهيل.
٣- تطوير النظم الإدارية في مجال التأهيل.
٤- تنمية القوة البشرية وزيادة عد دها.
٥- إدخال التكنولوجيا الحديثة في مجال التأهيل.
٦- متابعة ومراقبة خدمات التأهيل من قبل الجهات المسؤولة.
٧- استغلال الموارد الطبيعية في المجتمع.
٨- عمل دراسات وأبحاث في مجال التأهيل.
٩- منع ازدواجية العمل في المؤسسات.
١٠- تحسين وضع الموظفين وتطبيق نظام الحوافز.
١١- تطوير البرامج التعليمية
١٢- إشراك المجتمع في عملية التأهيل.
١٣- توزيع خدمات التأهيل بشكل عادل.
١٤- دعم الحكومة للمؤسسات العاملة في مجال التأهيل.
١٥- خلق تخصصات في مجال التأهيل.
١٦- تطبيق القوانين المتعلقة بالتأهيل.
١٧- تخطيط ورسم سياسات التأهيل على المستوى الوطني
- غير ذلك حدد/ي:----------

ملخص

تقييم خدمات التأهيل في شمال محافظات الضفة الغربية في فلسطين

نسر أبو خضر

إن الهدف من الدراسة هو تقييم خدمات التأهيل في محافظات شمال الضفة الغربية (نابلس ، سلفيت، طولكرم، قلقيلية، طوباس، جنين). الدراسة اشتملت مشاركة كل المؤسسات المقدمة لخدمات التأهيل في شمال الضفة الغربية والبالغ عددها (٤٣) مؤسسة ومركز.

طريقة الدراسة ارتكزت على أسلوب البحث العلمي الوصفي. احتوت الدراسة على (١٣) جزء تتعلق بأنواع خدمات التأهيل، نوعية وكمية خدمات التأهيل، حجم خدمات التأهيل، الأمور المادية، النظام الإداري، نظام التحويل والتنسيق والتعاون ما بين المؤسسات، السياسات العامة وذات العلاقة بالتأهيل، الأولويات في مجال التأهيل، أهم المشاكل التي تحد من تطور خدمات التأهيل، مدى الحاجة إلى تطوير سياسات التأهيل، الاقتراحات الضرورية لتطوير سياسات التأهيل، الاقتراحات المناسبة والضرورية لتحسين خدمات التأهيل.

تم عمل تحكيم للاستمارات من قبل ذوي الاختصاص في مجالات التأهيل وغيرهم. البيانات جمعت من خلال المقابلة المباشرة مع الباحث (وجها لوجه).

أظهرت النتائج ما يلي:

- إن الغالبية من الذين تمت مشاركتهم ومقابلتهم أعمارهم اقل من ٣٥ كانت نسبتهم (٥٨,١%) بالإضافة أن نسبة حاملو الشهادة الجامعية كانت نسبتهم (٦٢,٨%) وكما أن الذين تزيد خبراتهم عن ١٠سنوات كانت نسبتهم (٥٣,٣ %).
- الغالبية العظمى من خدمات التأهيل كانت العلاج الطبيعي في محافظات شمال الضفة الغربية وكانت النسبة هي (٨٦%) من الخدمات.

- هنالك ازدواجية غير مبرره في تقديم الخدمات مع مؤسسات أخرى، وكانت النتيجة (٨٦%).
- الغالبـــية العظمـــى مـــن الذين تمت مقابلتهم كانت استجابتهم عالية لزيادة العمل في الموئسات، وكانت النتيجة (٩٠,٦%).
- النتائج أوضحت إن هنالك ضعف في التخطيط والتعامل ألا داري السليم والقوانين التي تحد من تطور خدمات التأهيل.

كان رأي واقتراحات الغالبية العظمى إن سياسات التأهيل يجب إن تكون شاملة وعلى صعيد وطني، دمج المعاقين في المجتمع، دراسة العوامل التي تؤثر على رسم السياسات في مجال التأهيل، ودعم الحكومة للمؤسسات العاملة في مجال التأهيل.