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bridges, the Israeli-Palestinian Public Health Magazine, is a unique publication conceived of, written, edited, produced and managed jointly by Palestinian and Israeli academics and health professionals under the sponsorship of the World Health Organization (WHO). The magazine embodies the WHO paradigm of "Health as a Bridge for Peace": the integration of peace-building concerns, strategies and practices with health care. Developed with health care professionals, decision makers and academics in mind, the magazine covers public health topics relevant to both populations and seeks to analyze the impact of the conflict on the health and well-being of both societies. In both structure and content bridges is a cooperative endeavor seeking to build relationships, links and common understanding.

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Cover Photo: **UNDP/PAPP, George Azar**

The Editorial Board invites submissions of letters, comments or articles on public health to **bridges** at:
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The ICF-WHO photos are awarded photographs from the photo contest "Images of Health and Disability 2002 and 2003". The contest has been organized in order to promote the understanding and use of the International Classification of Functioning, Disability and Health (ICF).

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A New Look at Disabilities

by **Hani Abdeen**

The story of Abdullah ibn Maktum in the Qu'ran (Surat Abasa) is an early illustration of the way people with disabilities are related to by our societies. Abdullah ibn Maktoum, a person with a visual disability, is first ignored by the Prophet Muhammad, and then becomes his advisor and eventually is delegated to a position of responsibility in the city of Medina in the Prophet's absence.

Unfortunately, throughout history few people with disabilities have been able to overcome societal barriers both physical and attitudinal and reach ibn Maktum's prominence. Yet the issue of disabilities has generated sufficient worldwide interest at the social, legal and governmental levels only in the past two decades specifically dating back to 1981 when the United Nations declared that year, the International Year of Disabled Persons, and in 1982, when the General Assembly adopted the World Program of Action concerning Disabled Persons.

Our understanding of the issue of disability is being reshaped. This has been achieved by empowering people with disabilities, including children, to change their perspective, so that they perceive themselves and each other as powerful people with the legitimate right to determine how they live their lives and determine the priorities for the provision of disability services, given the scarcity of human and financial resources.

There are two different schools of thought that underpin the disability perspective, namely, the medical model and the social model. The medical model perceives disability to be an individualized problem with undue power given to able-bodied professionals to make decisions on behalf of people with disabilities. This model imposes a presupposition of inferiority, both physical and intellectual, upon people with disabilities. The social model, in contrast, is the antithesis to the medical model. The focus is placed upon the community and society rather than the individual. It maintains that disability has less to do with the body or mental functions, and is more so the consequence of social barriers. Furthermore, under the social model, disability is seen as a human rights issue, which requires the participation of people with disabilities to achieve common mutual goals.

The article in this issue by Harami et al, addresses the way the needs of Palestinian people with disabilities are met through community based rehabilitation (CBR) programs and how Palestinian society is becoming more receptive to including the disabled through change of attitudes and community advocacy. Policy makers and legislators are also important in bringing about desirable change in the disability movement. The article by Feldman depicts the field of policy and legislation as key factors affecting inclusion of people with disabilities. It has become a key priority to pay attention to advocacy and lobbying local and national government authorities to pass laws and policies that will facilitate and improve access to opportunities and resources for people with disabilities in Israeli society. In the "How to –" section, the author has highlighted ways to improve accessibility to a gynecological clinic beyond changes in physical infrastructure.

A new feature in this issue is the "Readers' Forum" section where members of the community pose controversial public health topics or new ideas for discussion. In this edition, the Invitation to a Forum on Developmental Disabilities article by Capelovitch begins a dialogue about current theories and practices for developmental disability disorders. Capelovitch raises many questions that still need clarification through the exchange of viewpoints and experiences. The section aims to generate an interesting discussion in upcoming issues.

Médecin du Monde (MDM) addresses health issues generated by the separation wall such as the difficulties patients and medical staff face in accessing clinical facilities. It highlights the negative impact the separation barrier has on people's lives and the Palestinian health care system.

No doubt, the calamity that has befallen South-East Asian countries as a consequence of the tsunami disaster is heartbreaking and calls for the support of all regions to show support and rally around the people affected. In the news section, WHO has delineated the way needs can be assessed and how healthcare facilities on the local and global levels can mobilize and render assistance to those unfortunate communities affected by this horrific natural disaster.

Through cooperation and building bridges of solidarity and understanding do we achieve our lofty goals in public health. We should be motivated by a Ugandan saying, "It is the teeth that are together that can bite the meat."

A Community-Based Approach to Rehabilitation in Palestine and its Implications for Social Life, Human Rights and Democracy

by **Arne H. Eide**, **Ghada Harami**, **Cindy Greer**

photo: **UNFPA/Steve Sabella**

During its 20-30 year history, community-based rehabilitation (CBR) has evolved into a community development strategy for rehabilitation, equalization of opportunities and the social integration of people with disabilities. (1) Further development of CBR has included human rights, democracy and a gender perspective within the scope of its programs. In this article, data from a previous impact assessment (2) is applied to analyze the role of CBR in creating opportunities for social participation for a segment of the population that previously lacked such opportunities. This is discussed in relation to human rights and democracy within the context of the severe and violent conflict between Israel and Palestine.

While there are many examples of evaluations of CBR around the world, there are few examples in the literature of attempts at measuring its impact on the social integration of individuals with disabilities and their families. (3,4) On the other hand, there is an abundance of literature from all over the world describing the situation for people with disabilities as suppressed and disadvantaged in all respects, and characterized by poverty (5) as well as exclusion from social participation. (6) Internationally, these issues have been given considerable attention, as manifested in the United Nations' Standard Rules (1994) and the World Program of Action (1993). To the extent that CBR is a viable strategy for including and involving disabled individuals into social, economic and political life, it is argued that this strategy is a means of strengthening the very foundation of democracy and human rights in a society.

"...social integration of the most vulnerable into society has tangible effects on the quality of social relations in general."

CBR in Palestine

CBR in Palestine dates back to 1989 and is coordinated by the Central National Committee for Rehabilitation (CNCR). The main implementing partners are 23 non-governmental organizations grouped into five regional committees (Nablus, Jenin, Southern Region, Central Region and Gaza) that coordinate the work. The Norwegian Association of the Disabled (NAD) and the Diakonia Regional Office have been the main supporters of the CBR program since its inception. At the heart of CBR, is a multi-level and multifaceted strategy that comprises a variety of activities initiated nationally, regionally and at the local community level. The predominant conceptualization of CBR from the 1990s primarily represented by the World Health Organization (WHO), has influenced the practical implementation of the program. (7, 8) Following a gradual expansion, the program today covers approximately 50% of the population in the West Bank and 75% in Gaza.

Impact Assessment of CBR

A comprehensive impact assessment of the CBR program was recently carried out[1] (2), comprising multiple methods and data collection:

1. **Baseline Follow Up** – A baseline follow up study was conducted. It comprised of a sample of 1075 or 5.5% of 19840 registered people with disabilities. Community Rehabilitation Workers (CRWs) completed questionnaires about the impact of the CBR Program for each of the people they serve.
2. **Record Audit** – Structured interviews with CRWs about 57 individuals were sampled across regions and according to specific criteria to ensure a broad representation (gender, age, type of disability, level of impact).
3. **Semi-structured Interviews and Focus Group**s - Nineteen semi-structured interviews (individuals and groups) and two focus group discussions were carried out in two regions. Interviewees included service providers, individuals with disabilities and other household members (most often the mother), representatives from different disability groups, a medical relief committee, and a local committee.

Results

The baseline study revealed that community integration was described as the main input for 92% of the individuals in the sample. This comprises a number of activities which aim to improve the social integration of the person with disabilities and his/her household into the local community. In many instances this implies changing the situation from relative isolation to active social participation equal to that of other households and individuals. Of the total number of individuals in the sample, 531 of the 1,075 total individuals showed changes in their situation from isolation towards social participation. This suggests that there is a

השיקום המבוסס בקהילה (CBR) מיושם בכל רחבי העולם, כולל פלשתין, כאסטרטגיה היוצרת הזדמנויות לשילוב החברתי של אנשים עם מוגבלויות בקהילה. הסקירה שלהלן לגבי השפעת ה-CBR על השילוב החברתי בפלשתין, מדגימה כיצד פועל ה-CBR מעבר לאסטרטגיות אחרות של שיקום, ומתפרש גם לתחומי קידום ערכי דמוקרטיה וזכויות האדם. תכנית ה-CBR מעניקה למשפחות ולקהילות מקומיות תקווה לעתיד טוב יותר, וגם ערכים ויכולת שיהיו בעלי חשיבות רבה בשביל פלשתין בשנים הבאות.

لقد طبقت عملية إعادة التأهيل المرتكزة على المجتمع في مختلف أنحاء العالم بما فيها فلسطين كاستراتيجية تهدف إلى خلق فرص للتكامل الاجتماعي بين الأشخاص ذوي الاحتياجات الخاصة وعائلاتهم مع المجتمع. ويوضح التقييم التالي أثر عملية إعادة التأهيل المرتكزة على المجتمع في عملية التكامل الاجتماعي في فلسطين، ويبين التقييم كيف أن عملية إعادة التأهيل قد تجاوزت استراتيجيات إعادة التأهيل لتشمل تعزيز الديمقراطية وحقوق الإنسان.

لا تهدف عملية إعادة التأهيل إلى تزويد العائلات والمجتمع المحلي بالأمل وبمستقبل أفضل فحسب، بل تزودهم بالمعرفة والقيم والقدرة أيضا، والتي ستكون ذات أهمية بالغة للفلسطينيين خلال السنوات القادمة.


photo: **UNFPA/Steve Sabella**

> **"Many mothers shared the isolation of the family member with a disability. This could be due to the stigma attached to having a child with a disability or due to the extra burden involved."**

potential for increased or improved social integration and participation for approximately half of the registered people with disabilities in the area currently covered by CBR.

In the baseline follow up study, the CRWs were asked to describe their main input in each of the sampled individuals. These 18 input items were coded yes (1) or no (0). A model comprising this input index and a number of variables that could be expected to explain variation in community integration (age, duration of CBR contact, region, previous treatment, number of disabilities) revealed that CBR input contributed uniquely ($2 = 41.44$, $p < .01$).

The record audit confirmed the level of impact on social integration indicated in the baseline study. Progress in social integration was measured in 31 of 52 individuals of which more than half had improved substantially. Interviews with the CRWs confirmed the importance of the process of establishing trust and acceptance, changing negative attitudes towards people with disabilities, and focusing on their potential as well as their human and democratic rights. Much of the CRWs' efforts are at the community level including, but not limited to, visiting and talking to families in a certain neighbourhood with a particular problem, conducting public meetings to increase awareness in a local community, as well as meeting with community leaders like teachers and headmasters to promote inclusive education. The CRWs' long term contact with the disabled individuals and their families often instils a sense of security in families that may feel threatened due to cultural beliefs surrounding disability issues, stigma, and general ignorance.

Interviews with the disabled individual and their families (most often the mother) confirmed that the work of CRWs often had a direct impact on their social situation, especially for the mothers. Many mothers shared the isolation of the family member with a disability. This could be due to the stigma attached to having a child with a disability or due to the extra burden involved. The individual's increasing independence relieves pressure on the family, especially the mothers. The CRWs frequently can then include mothers and family members in a process that often leads to increased awareness about the potential and rights of people with disabilities. The next step is encouraging their active involvement in the local community and in many cases activities aimed at bringing about changes in policy and practice to the benefit of people with disabilities.

Through focus group discussions, it became evident that the CBR program had contributed to promoting awareness, positive attitudes and acceptance of people with disabilities in the local communities. These discussions provided further support that the program, by advocating for equal rights and opportunities, promoting involvement of people with disabilities and their families in the local communities, and enabling people with disabilities to obtain their rights to education and participation, had played a significant role in democratization and human rights.

CBR – Promoting Democratic Values

The impact assessment of CBR in Palestine has clearly demonstrated that the efforts by the CRWs and their supervisors have a direct impact on the level of social integration and participation of individuals with disabilities and their households within their local communities. The CBR Program in Palestine is based on a broad definition of disability and rehabilitation which includes the socio-political arena. Recognizing that the foundation of a state is based not only on structures, but on people, values and practices, it has been a deliberate strategy of the CBR Program to combine "traditional" rehabilitation with a process pursuing human rights and democratic ideas and practices. Thus, the CBR Program seeks to invest these important values in the community by promoting equality, tolerance, democratic processes, and respect for human rights. It is argued that social integration of the most vulnerable into society has tangible effects on the quality of social relations in general. Inclusion of this group and consideration of their interests foster a sense of responsibility and maturity in attitudes and in decision making processes that also include social distribution aspects. The social inclusion of people with disabilities and their families also implies that their potential as members of society may be fully utilized not only for their own benefit but also for benefit of the local communities. People with disabilities have a unique experience and thus a special competence that contributes and adds quality to society when given the right opportunities.

The impact assessment has shown how working with CBR promotes important values in the community that are essential in strengthening the base for a future, democratic state. The CBR Program in Palestine makes its contribution in this regard. Through the CBR program, many individuals, families and local communities are equipped not only with hope for a better future but also with knowledge, values and ability that will be of great importance for Palestine in years to come.

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Footnotes

1. The full report of the CBR impact assessment is available from any of the authors of this article.
2. Editorial note: Given that the worldwide accepted estimate of people with disabilities in the population is 10%, it is likely that this figure is an underestimate of the true number of people with disabilities in Palestine.

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Status of Disability in Palestine

Rehabilitation and disability-related services and programs in Palestine date back to the 1940s. They have primarily been carried out by local and international NGOs. Until the 1970s, disability programs were limited mostly to blindness and deafness. In the 1980s and during the Intifada, many NGOs started special programs for disabilities and community-based rehabilitation (CBR). When the Palestinian National Authority (PNA) took full responsibility for the health sector, rehabilitation and disabilities were given special support, especially in terms of institutional capacity building and staff development.

The data show that approximately 46,063 (1) people with disabilities live in Palestine, constituting 1.8% of the total population[2]. In the West Bank, the governorates reporting the highest rate of disabilities are Qalqiliya and Tulkarm at 2.3%, followed by Tubas at 2.1%. Jerusalem, Ramallah, Al-Bireh, Jericho and Al Khalil have the same rate at 1.7% of the total population. In the Gaza Strip, the highest rate of disabilities was reported in the Gaza governorate at 1.7% followed by North Gaza at 1.6%.

Since the beginning of the current conflict in September 2000, 52,927 Palestinians have been injured. The Palestinian Ministry of Health (MOH) estimates that 10% of the injured people will have at least one permanent disability, which means that an additional 5,000 Palestinians should be added to the number of people with disabilities.

Gender Distribution

The prevalence of disability among men and boys is higher than in women and girls. Palestinian males are at higher risk for injury due to higher rates of male youth participation in the Palestinian Intifada.

Distribution of type of disability among people with disabilities in Palestine, 1997

Type of Disability	Percentage
Movement	29.7
Vision	19.6
Other	16.6
Psychological	14.1
Speech	10.7
Hearing	9.3
Total	100.0*

*Data from the Palestinian Central Bureau of Statistics (PCBS), 1997

- **Physical Disabilities** The main causes of physical disabilities are cerebral palsy (24%) and poliomyelitis (21%)
- **Hearing Disabilities** The main causes of hearing disabilities are otitis media and fever due to meningitis.
- **Psychological Disabilities** The main psychological disorders in Palestine are stress related disorders (28.7%), post traumatic stress disorders (19.5%), depression (17.5%), anxiety (13.2%), co-morbid psychiatric disorders (15.7%) and somato-form disorders (5.3%).
- **Speech Disabilities** The percentage of people with speech disabilities in Palestine is about 10.7% of total disabilities.

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Shaping Vision into Policy and its Implementation - People with Disabilities in Israel

by **Dina Feldman**

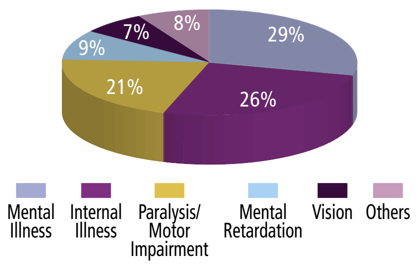
המאמר עוסק בתיאור מצבם של אנשים עם מוגבלות בישראל והרוח החדשה שנוצרה לקראת ובעקבות חקיקתו של חוק השוויון לאנשים עם מוגבלות, התשנ"ח - 1998. חוק זה מקדם את מסורת הטיפול והשיקום של אנשים עם מוגבלות בישראל אל השלב הבא של השתלבות מלאה בחברה על בסיס של זכויות אדם, אזרחות מלאה ותורמת, שותפות ומעורבות בתהליכי קבלת החלטות וניהול חיים עצמאיים בקהילה. העבודה מתארת את המציאות הנוכחית, את האתגרים וכן את הפעולות הנעשות לשם יישום עקרונות חוק השוויון הלכה למעשה.

تصف المقالة وضع الأشخاص ذوي الاحتياجات الخاصة في إسرائيل، والسياسة الجديدة التي تم تطويرها والتي تتعلق بقانون الحقوق المتساوية لذوي الاحتياجات الخاصة الذي سن عام ١٩٩٨ . وقد ساهم هذا القانون في تطوير الثقافة الإسرائيلية العلاجية، وإعادة تأهيل ذوي الاحتياجات الخاصة، ونقلهما إلى مرحلة جديدة في عملية تكامل تامة مع المجتمع؛ انطلاقا من مبدأ حقوق الإنسان، مواطنة كاملة وفاعلة، والمشاركة في عملية اتخاذ القرارات والحصول على استقلالية في المجتمع.

كما تعكس المقالة الحقيقة على أرض الواقع، والتحديات التي تفرضها، وتضع مبادئ قانون المساواة في الحقوق قيد الممارسة.

According to the globally accepted estimate, people with disabilities make up more than 10 percent of the population. To date, the data which exists identifies the number of people with disabilities living in Israel as approximately 13 percent of the population*.

Distribution of Recipients of Disability Benefits, (with Over 40% Disability) by Primary Disability Group



Source: Myers-JDC Brookdale

Traditional Policy and Services

Since the establishment of the State of Israel, its policy towards people with disabilities has been characterized by assurance of their social security and delivery of personal, medical, and rehabilitative assistance.

These policies were aimed to ensure all persons with disabilities with basic living conditions and to enable them to acquire, or reacquire, skills that assist them to function in all aspects of life. The policy manifested in the following services (1):

School System:

- special education, small classes, extra teaching hours, adaptation of suitable teaching methods, technologies and materials, provision of supplemental paramedical care, assurance of safe transport, day care centers, and more.

Approximately one third of people with disabilities are in special education and two thirds are included in the mainstream education system. New legislation is being implemented which emphasizes the importance of inclusion.

Medical System:

- eligibility for medical and paramedical services, public, mental health and psychosocial rehabilitation, assistant technology and equipment.

Transportation:

- eligibility for vehicles and expenses for their upkeep as well as discounts or exemptions from public-transportation fares, allocation of reserved seats in public-transportation vehicles, special parking permits and accessibility in public transportation.

Housing:

- eligibility for accessible public housing.

Social Security and Rehabilitation:

photo: DZICEK/ICF- WHO

- eligibility for disability benefits, personal assistance, vocational training and placement, as well as sheltered housing and leisure activities.

Current Status

The broad array of services described above was intended to shape a social situation in which people with disabilities could integrate fully into society. But reality proved that despite these measures, the degree of such integration was much less than had been expected. A different strategy was needed to be employed in order to create the suitable infrastructure for the full integration of people with disabilities into society and the labor market. (2, 3)

It was determined that the desired reform required a transition from an outlook aspiring to remedy the individual's disabilities and offer total protection out of grace and compassion to a more complementary outlook, which views all of society as responsible for integrating people with disabilities into its ranks. The alternative outlook is based on human rights, equal opportunity and accessibility, so that the individual with disabilities might feel and become an integral part of this society, regardless of the type or severity of his disability.

The New Approach

The Equal Rights Law for Persons with Disabilities (1998) rejected the widespread claim that the inability to fully integrate into Israeli society stems from the weakness or the incapability of the people with disabilities, and instead put the responsibility for this state of affairs on the physical, technological and psycho-social inaccessibility of society. The new law challenged Israeli society to view persons with disabilities as endowed with both the capability and the right to dignified life, liberty and honest labor, based on independence and human rights rather than favors, compassion and charity. (4) This amounted to a declaration of the need for investment of public resources in decreasing stigma, assuring accessibility of the living environment and encouragement of employment in the open market, at the expense of long-term sheltered facilities as implemented, for example, by the United States federal

"The Equal Rights Law for Persons with Disabilities (1998) rejected the widespread claim that the inability to fully integrate into Israeli society stems from the weakness or the incapability of the people with disabilities. Instead it put the responsibility for this state of affairs on the physical, technological and psychosocial inaccessibility of society."

administration. (5)

This breakthrough in the legal situation was scored by the ruling handed down in 1996 by the High Court of Justice in the suit brought by Shahar Botzer against the municipality of Maccabim-Re'ut, which concerned the inaccessibility of dual-purpose structures (for schools and shelters) in a new town. In this ruling, Supreme Court Judge Barak, addressed, for the first time, the realities of life for persons with disabilities as a human rights issue and ruled that there must be a shift from benevolence toward people with disabilities in isolation to an approach which integrates them into society and assures them of equal opportunities based on human rights.

Gaining momentum, social organizations led by people with disabilities led two long strikes held opposite the Ministry of Finance in 1999 and 2002, with the participation of hundreds of persons with disabilities and their family members, to demand that they be provided basic conditions for a dignified life, with an emphasis on social security and mobility. Beyond the material achievements, these strikes enhanced awareness that people with disabilities must be part of the society and participate in any forum discussing their affairs, as declared by the universal slogan "nothing about us without us".

The Equal Rights Law

The new Law views persons with disabilities, of any kind and severity, as citizens equal to any others, who are entitled to fulfill all their rights and to receive services provided to all citizens.

Furthermore, the Equal Rights Law set a goal for Israel to "protect the dignity and liberty of persons with disabilities and anchor their right to equal and active participation in society in all fields of life, as well as properly provide for their special needs in a manner enabling them to spend their lives in maximum independence, privacy and dignity, while making the most of their capabilities".

The new Law considers affirmative action a legitimate means for promoting equal rights principles. This mechanism, which is cited in the preamble to the law, refers to all fields of life[1], but of the full draft of the Law, only four sections have so far been enacted[2]. These sections deal with the principles of equality, the continuity of employment, accessibility of public transportation and the establishment of the Equal Rights' Commissioner's Office and its Advisory Committee. The range of this mechanism's applicability is currently limited, and is relevant mainly to the field of employment in the open market. It should be noted that in many foreign countries, affirmative action also applies to higher education.

Employment Status of People with General Disabilities (6)

Unemployed:

- 85% of recipients of general disability benefits from the NII are not working.
- Among recipients, only 19% report that they would like to work.
- 34% report that they are unable to work due to the state of their health.
- 2% do not wish to work at all.
- 30% are people over 55 years old who do not believe that they can find their place in the workforce because of their age.

Employed:

- Among those who are working, only 15% have any form of employment:
  - 9% are working in the free market (usually part-time)
  - 6% are engaged in protected employment provided by the Ministry of Welfare and Health which are often segregated from the population.

Employment

Employment is a central area of human life that ensures dignified livelihood. In order to enable persons with disabilities to become inclusive in the working world, proper physical, sensory, mental and psychosocial accommodations and affirmative action must be assured, and indeed these matters occupy a central part of the Equal Rights Law.

The Equal Rights Law refers explicitly to accommodations and to affirmative action and states that "actions by the employer, according to this section, may be carried out as a plan including provisions for preferential employment, or promotion, of persons with disabilities who are qualified for the role or the position, and whose qualifications are similar to those of other candidates for the role or position." That is, in order to enjoy affirmative action, candidates with disabilities must first be qualified for the post. This does not mean lowering requirements or bending criteria, but rather activation of a system of adjustments to permit a candidate to manifest the capabilities relevant for carrying out the job. In the matter of affirmative action, a consensus has been forged that the focus must be on persons with severe disabilities, while relying on as clear and applicable definition as possible.

According to the definition of the Equal Rights Law, a person with disabilities is "a person with a physical, mental, or intellectual (including cognitive) impairment, whether permanent or temporary, which substantively limits the person's functioning in one or more central areas of life." A special, quantitative formula has been developed by professionals and civil societies to define severity, based on evidence, existent tools and structures for assessment.

The generic approach toward persons with disabilities requires enlarging the investment to change the attitudes of employers and employees about the capability and motivation of people with disabilities to work and improve dramatically the vocational, technical and academic training. However, this task poses additional, challenges both for the universities and school system, particularly the special-education system, and for the vocational rehabilitation system, which at present are not designed enough to prepare a reservoir of employees with disabilities for the open, modern market. (3)

Accessibility

Accessibility is the main mechanism of implementing equality. It is what opens the material and psychological gates for people with all kinds of disabilities to society by enabling them to enter and move freely in buildings and in open spaces and to get accommodating services free of social stigma and barriers.

The third section of the Equal Rights Law states that persons with all types of disabilities shall be entitled to accessible and suitable public-transportation services at a reasonable frequency, including access to stations and ports where public-transport services operate. In this section, public-transportation services include urban bus lines, trains, air transport and ships intended for the general public.

General accessibility is the next section of legislation which is close to pass in the coming months. It is intended to enhance the reasonable accessibility of governmental, public, municipal and private sites which serve the public in all areas of life (Proposed Law #2951, 2000).

Establishment of the Equal Rights Commission and its Advisory Committee

In the summer of 2000, the Equal Rights Commission for Persons with Disabilities was established in the Ministry of Justice, signifying additional steps in a process towards social reform. The Equal Rights Commission is responsible for the promo-

An Institutional Example

On November 30, 2003, the cabinet adopted Resolution #1073, which pertains to the promotion of the human rights of persons with disabilities. Section 3 of this resolution refers to affirmative action for persons with severe disabilities in hiring and promotion by the Civil Service, as follows:

a) In accordance with the provisions of section 15 a (b) (3) of the Appointments Law, [it is resolved] to require every ministry and budgetary unit to grant priority in hiring and promotion of employees to candidates with severe disabilities, provided that these candidates are qualified for the positions in question and that their qualifications are similar to those of other candidates for said positions.

b) The requirement stated in paragraph a) shall apply to all procedures of training, hiring and promotion of workers in the Civil Service.

The Civil Service Commissioner is required, in consultation with the Commissioner for Equality of Persons with Disabilities and with the Minister of Welfare, to promulgate instructions in all that concerns the application of paragraphs a) and b) above, including the setting of tests to determine severe disability and methods of diagnosing such disability, all according to the recommendations of the inter-ministerial team (Civil Service-Ministry of Justice-Ministry of Industry and Trade) which will be joined by a representative of the Minister of Welfare, for the application of the requirement of proper advocacy for persons with disabilities in the Civil Service.

tion and the implementation of the Equal Rights Law's basic principles, the prevention of discrimination against persons with disabilities, the removal of obstacles they face, the formulation of a comprehensive social policy for the encouragement of the integration and full participation of persons with disabilities in society and more. The office now includes the Commissioner, a legal counseling unit, a unit for the promotion of accessibility, an Internet information center (www.mugbaluyot.justice.gov.il), a unit for public applications, public relations and a training unit. A senior division for inclusion into society is now in the process of being staffed.

> "The alternative outlook is based on human rights, equal opportunity and accessibility, so that the individual with disabilities might feel and become an integral part of this society."

Advisory Committee

The Law for Equal Rights of Persons with Disabilities mandated the creation of an Advisory Committee to the Commission, with the purpose of advising the office on matters concerning its missions, the promotion of the law's principles, equality and prevention of discrimination, and the encouragement of active integration in society by persons with disabilities. Most of the committee's members are required to be persons with disabilities, and that is indeed the case. Fifteen of the 25 members of the Advisory Committee are persons with disabilities, including the chairman and deputy chairman. They include persons with disabilities on behalf of the representative organizations of persons with disabilities and represent people with physical, sensory, mental, intellectual, and cognitive disabilities as well as representatives of the public and families.

The members of the Advisory Committee represent the perspective of people with disabilities and participate in official international activities like the formulation of the convention for protection and promotion of the rights of persons with disabilities currently underway in the United Nations. (7)

Summary

After many years of broad investment in the medical system, social security and rehabilitation, Israel is moving forward to promote the full inclusion of people with disabilities within the society on the basis of human rights and full eligibility to contribute and express their talents in practice. This new approach is only in its initial stages and requires a change in attitudes and priorities among policy makers, professionals, people with disabilities and the general public, so that the stigma can be alleviated and society will become fully accessible in every respect. Progress in the enactment of the Law for Equal Rights of Persons with Disabilities, the framing of the United Nations Convention, the enlistment of activists and practitioners and the increase in budgetary allocations in this area, are greatly bolstering hopes that in the foreseeable future, Israeli society will enable more and more people with disabilities to become an integral and contributing part of society.

Dina Feldman is the Commissioner for Equal Rights of Persons with Disabilities in the Ministry of Justice. She is a clinical and medical psychologist with a PhD in social work.

Footnotes:

1. At this stage, only the initial parts of the law have been passed and the bill now being deliberated in the Knesset includes additional parts.
2. The remaining sections deal with accessibility, housing in the community and personal assistance, culture, leisure and sports, education and schooling, the judiciary system, special needs and information (Equality Law proposal, 2000.)

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7. U.N. (2004). Draft comprehensive and integral international convention on protection and promotion of the rights and dignity of persons with disabilities. Final text complied as adopted (CRP.4, plus CRP.4/Add.1, Add. 4 and Add. 5)

*__Electronic Resources:__

Myers – JDC – Brookdale Institute Website
http://brookdale-en.pionet.com/default.asp
National Insurance Institute of Israel Website
www.btl.gov.il/English/eng_index.asp

From Palestine to New York

A Learning Journey

Suha talks about what she learned from her medical training in New York both in and out of the classroom

by **Suha Tazami**

photo: **UNDP/ Steve Sabella**

Overwhelming. That is how I would describe my first day at the New York-Presbyterian Hospital. The massive size of the place and the very large and busy staff presented a whole new system to adapt to. I just hoped it wouldn't take a long time. After all, I had worked really hard over the past nine months to make my personal project happen.

When I finally arrived in New York City, I felt ready for my six week elective medical training in rheumatology and pediatric neurology at one of the largest health institutions in the United States.

It was a very big transition for me after six years at Al-Quds University Medical School, the only medical school in Palestine. The question that kept running through my mind was – will I survive here? But my fears didn't get me down. On the contrary, they motivated me to get the best I can from such an opportunity.

To my surprise, there was a Jewish Israeli medical student who was also studying with me on the same team. That was quite a coincidence. Coming out of the conflict, the last thing I wanted was for a member from the "other side" to be there.

Initially, I didn't have a problem with it. I didn't even give it much thought. But unfortunately, the Israeli student had a problem with me. I sensed it from the first moment we were introduced, especially when he assumed I am an Israeli when I said I was from Jerusalem. When I corrected him, I saw the disappointment in his eyes. He didn't like it when I talked to others about Palestine and our living conditions and one time we had an argument about it. However, we saw patients together and on a professional level we were civil.

Although there wasn't much time to socialize, I met some other American Jews at the hospital who were very friendly and interested to hear about the current situation at home, my life and my school. Many were eager to understand and help.

What struck me most was the ignorance I had to face about the situation in our part of the world. I don't blame people for it, but it disappointed me, especially those who don't know about the Palestinian story.

One day in the clinic, I introduced myself to one of the attendees as a Palestinian from Jerusalem.

"So are you done serving in the army?" she asked.

Puzzled, I tried to clarify, "Which army do you mean?"

"The Israeli army," she replied.

I never expected to be asked this question and I ended up explaining to her about my status in Israel.

Besides these types of emotional upsets that I went through, the experience was interesting and enlightening. I was impressed with the organizational structure of the American medical system, something which our institutions unfortunately lack. The staff was always busy, but organized and there was always something to do. People spent their time efficiently and were aware of their responsibilities. I believe that this is the basis for a successful institution.

> "Coming out of the conflict, the last thing I wanted was for a member from the 'other side' to be there."

I envied the students for having such a well organized annual schedule, which they knew well in advance and could therefore make their plans accordingly. For us, we can barely make plans for the next day as we live in the land of the unexpected! Our future is always threatened by our present situation. Yet we persevere, we survive, and come to life again.

On the whole, my experience in New York gave me the opportunity to explore another healthcare system. I was empowered to adhere to my humanistic values and my devotion to become a good physician so I can serve my community which is in great need.

In addition, it gave me the opportunity to represent the only Palestinian medical school to people on another continent and show that we exist.

Suha Tazami is a senior medical student at the Al-Quds University School of Medicine in Palestine.

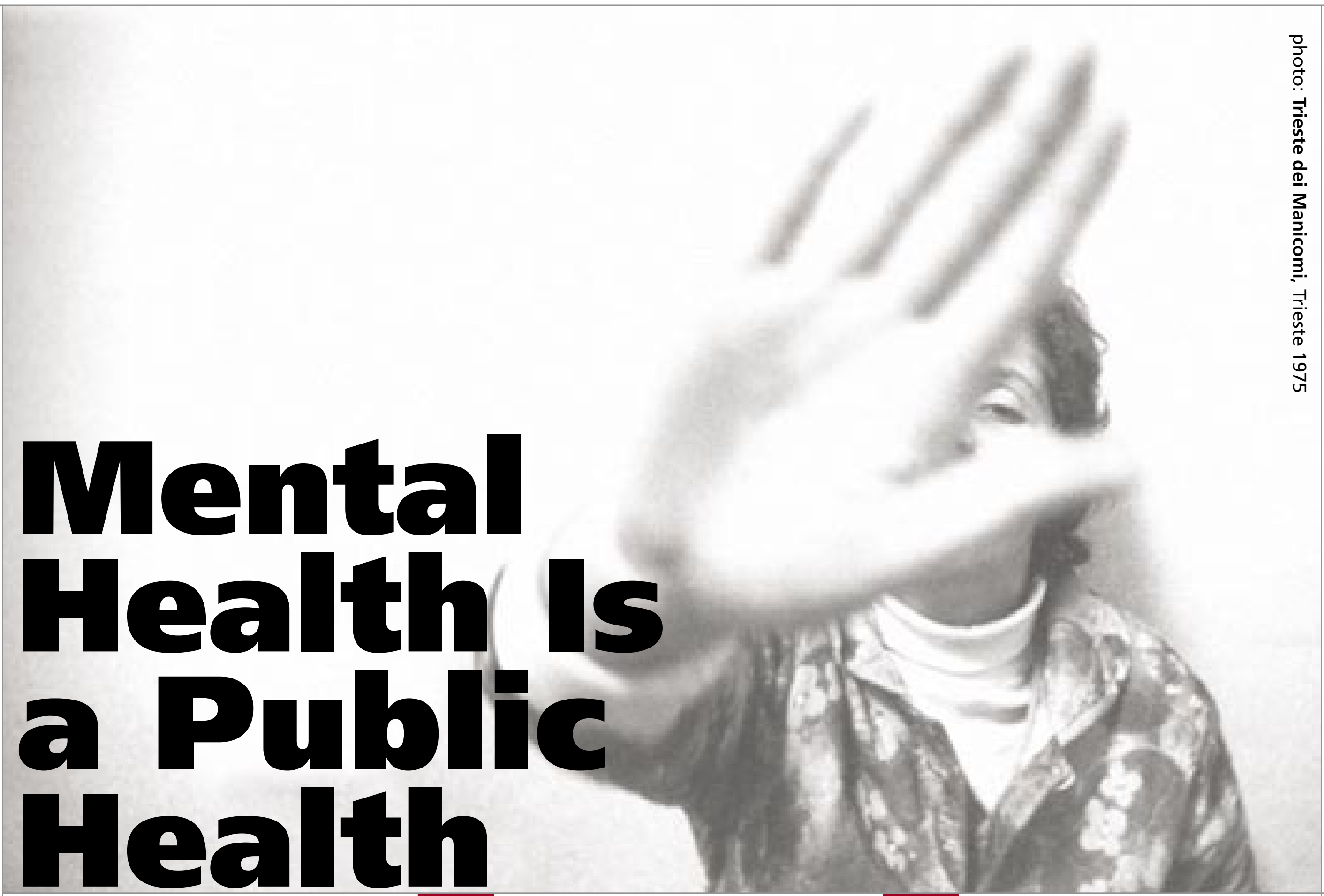


photo: **Trieste dei Manicomi**, Trieste 1975

Mental Health Is a Public Health Priority

An Interview with Dr. Benedetto Saraceno, Director of the Mental Health and Substance Abuse Department, WHO

by **Oriella Ben-Zvi**

From your perspective, what are the main challenges in the area of mental health today? Is mental illness, as a disability, an increasing priority in public health?

Mental health is an increasing priority in public health for several reasons. The way in which mental health is perceived has changed. The World Health Organization and the World Bank measure public health priorities by "adjusted life years" which combines mortality and morbidity. When examining mental illness from a perspective of "adjusted life years" rather than simply by mortality outcome, mental illness becomes much more relevant than before.

The suffering surrounding mental illness by the individual and by the family is enormous. Depression, alcohol abuse and suicide are diseases that disable people for years and years. People may not know that there are 450 million people suffering from mental or neurological illness around the world; 150 million from depression; 76 million from alcohol disorders; 25 million from schizophrenia; and one million people commit suicide every year. That means every second, a life is taken. This clearly demands that mental illness be given significant priority on the public health agenda especially when the burden of disease is measured by human suffering and the near total loss of productivity of patients and caregivers.

Health care systems plays a significant role. They give low financial attention to disabilities. Ministries of Health usually spend less than 2% of the health budget on disabilities. This directly increases the gap between treated and untreated people with disabilities. Moreover, many health professionals don't have the skills and resources needed to treat people with disabilities who often receive un-therapeutic treatment in large institutions which are isolated and not up to medical standards.

What are the priority areas in the coming years in terms of mental health?

Human rights, I believe, is a main concern. This is a prism through which mental health must be viewed. Electro-shock treatment still exists without consent and often without anesthesia. People with mental illness are locked up within institutions for long periods of time. Mental illness also exposes a family to stigma, physical restraint and violence. These are perhaps the most evident issues related to human rights and mental health. But there are other issues including the quality of services which are simply not acceptable in most countries – even in developed ones. I think it is important to note that human rights violations are not only specific to poor countries but rich ones, too.


photo: **ICF-WHO**

A second priority area is suicide. The numbers are alarming. There are countries where this is particularly evident. The countries with the highest suicide rates are all post-Soviet countries. They need urgent intervention. This is also true for China where significantly more women than men commit suicide.

Alcohol abuse is another area not only because 90 million people suffer from this disease, but because this problem has other health and social consequences – domestic violence, traffic collisions and violence against children which pose an immense negative impact on communities.

The fourth important priority is assisting countries to improve the organization of their mental health services. We still see very traditional models; hospital based models are the norm and the rule. We need to decentralize to reach out to communities and decrease the hegemony of large institutions. We need to amplify the voice of mentally ill patients so they are not simply objects of intervention. This requires a remodeling of the relationship between provider and patient. In fact, a peaceful revolution is needed where mental health becomes the business of every one and not just a few psychiatrists.

Conflicts pose health threats of different sorts. What are the main challenges in supporting local systems to protect the mental health of the population?

This is a hard question. In a conflict situation – as opposed to a natural disaster which has a peak and then is over – populations are exposed to chronic trauma. In a conflict, children and vulnerable populations are exposed to daily threats to their lives resulting in long-term trauma. Learning to cope with everyday insecurity is a huge challenge.

This can't be reduced to individual intervention. This is about looking at a community and how they can protect and defend themselves from mental illness. There is great risk of transforming a collective experience to an individual problem; one needs a public health approach rather than an individual, clinical approach.

What is needed is a strong education system which is able to provide an environment that, in spite of the conflict, gives a solid framework for children and adolescents. Strong family support to cope with day to day suffering is also crucial. And you need a strong health system that can respond to citizens' needs.

In the specific context of the Israeli-Palestinian conflict, how do you see the role of WHO in assisting the Palestinian population and supporting their mental health system?

The WHO has been assisting the Palestinian health authorities to strengthen and improve their mental health systems for quite some time. They've assisted in conceiving a strategic action plan for the West Bank and Gaza to shift from a hospital based model to more community oriented care with a capacity for real outreach and mental health teams that are integrated at the primary care level. This requires an immense shift in mentality on the part of psychiatrists and social workers who must learn to see themselves more as community leaders than as providers working from large hospitals. This requires modernization of thinking around mental health; it requires training and the development of models of care around community centers. This may meet resistance in the most traditional components of the medical sector, but we need to push them to be leaders of innovation.

What are your thoughts on health as a bridge for peace?

Tolerance, respect, compassion, not discriminating based on the color of a person's skin, religion or ethnic background, these are all characteristic of quality health care. Health care is based on a philosophy of human rights, solidarity, and compassion. These characteristics make health and medicine a privileged and unique sector to build bridges for peace.

Dr. Saraceno's career is marked by extensive clinical work, research and the publication of over 100 scientificarticles. He has also co-authored and edited a number of books. He was a lecturer at Harvard University, Invited Professor of Psychiatry at the University of Geneva and senior scientist and adviser in a dozen international research projects. For ten years he served as Head of the Laboratory of Epidemiology and Social Psychiatry and as Director of the WHO Collaborating Centre for Research in Mental Health at the "Mario Negri" Institute in Milan.

Protecting Health Following the Asian Tsunami

WHO Health Action in Crisis Department
Report January 6, 2005

The earthquakes and tsunamis that struck twelve countries on December 26, 2004, from South-East Asia to the Horn of Africa, caused one of the worst natural disasters in modern history and directly caused over 150,000[1] deaths, leaving at least half a million people injured and five million people homeless or without adequate access to safe drinking water, food or health services.

A Focus on Life

The response to any disaster has one primary focus – enabling those who are affected to live, to sustain their lives and to enrich their livelihoods.

The health sector is called upon as an integral part of the initial response because:

- Much suffering and death can be averted if health issues are addressed in the earliest stages of the response.
- Health indicators including information about disease incidence serve as a barometer of the response. They are an early and sensitive measure of the effectiveness of the humanitarian action.
- Functioning, dependable, accessible health services that respond to the needs of all affected people are a critical sign that recovery is underway.

Health indicators provide highly sensitive measures of the effectiveness of the response and rehabilitation. If the recovery of local health services is delayed or ineffective, infectious diseases such as cholera, diarrhea, hepatitis and pneumonia can add to the heavy toll of the disaster. The risks are especially severe for the very young and the elderly. Displacement and overcrowded conditions may also lead to an increased risk of measles, influenza, meningitis, respiratory infections and tuberculosis. Pre-existing chronic diseases and events such as childbirth can become life-threatening if left unattended. Vector-transmitted diseases such as malaria and dengue are likely to pose significant threats for weeks and months following such a disaster, particularly if environmental needs are not addressed.

Local and national systems showed remarkable coping capacities, ensuring rescue, assessments and vital relief in the first week. Before this catastrophe, health systems in the affected countries had many strengths and contributed to achievements towards the Millennium Development Goals (MDGs). Supported by strong institutions, civil society and NGOs, they have been active in coordinating health activity since the first hours of relief. It is right that they will take the lead in relief and rehabilitation.

Health Action in Crisis

During the period immediately following the tsunami, local and national health services took the lead in responding to people's distress. They were supported by an extraordinary mobilization of neighborhoods, civil society groups and nongovernmental organizations from the affected communities. These same groups are taking the lead in repairing damaged water, sanitation and health systems. They are the heroes of the hour and they will be the drivers of rehabilitation.

The most pressing needs are safe food and drinking water, sanitation and hygiene, shelter for those who are displaced, protection from vectors of disease and basic essentials like soap and the means to cook. Wherever possible, WHO has sought to guide this assistance, whether from governments, private actors, NGOs or UN partners.

WHO has concentrated on five key

areas of assistance:

- Surveillance of disease: Teams of experts have been deployed in countries through the WHO Global Outbreak Alert and Response Network (GOARN), producing daily epidemiological updates to ensure that national authorities are able to provide early warning of potential health threats as they emerge, verify them and trigger a prompt and correct response.
- Access to essential health care: Assessment and response to need is accomplished by 1 – collating information from reviews of damage to health service infrastructure; 2 – identifying the health needs of affected populations; 3 – analyzing the results together with health ministries as quickly as possible and; 4 – distributing the information to all who seek to save lives and support recovery.
- Essential public health: WHO provides technical guidance to national authorities, NGOs and all other humanitarian actors, about health policy including the disposal of dead bodies, responses to disease outbreaks, maintaining water quality, dealing with excreta, sewage and chemical threats, managing chronic diseases, vaccination programs and maintaining mental health.
- Strengthening supply systems: The supply of medicines, equipment, transport and other vital assets must be ensured so that all in need can access the services they require. Many of these items are obtained locally, though external donations which are carefully matched to local need can make a vital difference. WHO has focused on enabling the in-country health groups to procure these items on their own.
- Coordination of international health response: The coordination effort must enable an effective health sector response, appropriate use of volunteer health workers and the fullest possible involvement of local communities including women's organizations. WHO helps coordinate, manage assistance and secure the best possible outcomes through donor briefings and technical support including common Logistical Supply Systems used by NGOs and the UN system.


photo: **WHO Archive**

Health Action in Rehabilitation

The continued good health of populations is key to the social and economic fabric of communities. Therefore, successful action to preserve health is a critical starting point to sustainable development. We must never forget that poor people, together with persons suffering from disabilities and chronic disabilities, remain vulnerable even as longer term efforts are started. Therefore, the WHO response in the rehabilitation phase will focus on the following areas:

- Planning of health systems and services: Based on assessments of health needs and capacity of the health care infrastructure, WHO will assist government plans for rehabilitation of health services. In many areas, health care workers have died or have been displaced and human resources needs will also need to be urgently addressed. WHO provides technical support to ministries of health so that interested donors and financial institutions execute plans that reflect the long-term needs of all in line with national goals and MDGs.
- Policy guidance: WHO's extensive health expertise, made available under the guidance of its member states, within UN and other international coordination, is used by affected communities to guide the overall international health assistance. All international agencies are applying the lessons of earlier crises as they support recovery. One critical requirement is that rehabilitation incorporates building local capacity to assess risks, prepare for and respond to any future catastrophes. This includes initiatives to reduce disaster damage in critical health facilities. Such matters were addressed at the UN World Conference on Disaster Reduction in Kobe, Japan, held at the end of January 2005.

Conclusion

The tsunami crisis is a devastating tragedy. It is a major set back to the social, economic and health development gains of recent years within the region. WHO is focused both on the health needs of the survivors and the reconstruction and rehabilitation of health systems. Both must be addressed together with a long-term strategy to reduce the vulnerability to future disasters. It is imperative that international support is adequate, effective and sustained. It must be country-led, country-centered and country-coordinated.

Footnotes

1. Estimates have escalated since the date of the summit where this brief was first presented.

How to...

Making Gynecological Services with Disabilities: Creation of a

by **Hila Ben Shushan**

The specific needs of women with disabilities that arise from the combination of their sex and disability have long been neglected by both disability and women's organizations in Israel, as well as the government and other public bodies. Women with disabilities face multiple challenges in accessing basic rights such as health care, employment and even parenthood. In many cases, the special needs of women with disabilities are misunderstood or overlooked even by well-intentioned policy-makers and service providers, causing unnecessary hardships. Health professionals and policy-makers are often unaware of the special needs and the complexity of treatment of women with disabilities, resulting in the provision of inadequate services.

A Model Accessible Gynecological Clinic

The Forum of Women with Disabilities for Women with Disabilities is engaged in a project which aims to tackle the inadequate provision of appropriate health services for women with disabilities in Israel. The project defines accessibility as a situation that enables people with disabilities to be independent and to have equal and dignified access to services enjoyed by the mainstream population. According to this definition, even one step at a clinic entrance, for example, represents a significant impediment to women who use wheelchairs. The model clinic addresses all types of disabilities to ensure that it is accessible to women with physical, sensory, developmental, and emotional disabilities.

The development of an accessible clinic requires more than just physical renovations. It requires increasing awareness among both consumers and service providers to the special needs of women with different types of disabilities and the development of appropriate and dignified responses to meet these needs. The following are important steps in the process:

1. Engage key players to guide the process including women with disabilities, health professionals, health service organizations, disabled rights activists, and donor organizations.
2. Choose the clinic that serves a large number of women with disabilities and in which there is interest of the service providers and staff in the process.
3. Assess the accessibility needs and determine appropriate responses.
4. Develop a training program for clinic staff (medical, administrative and ancillary).

Accessible to Women Model Clinic

How to Develop an Accessible Clinic

Ensuring that a clinic is accessible to women with disabilities necessitates dealing with three elements:

- The medical staff's professional knowledge and attitude towards patients.
- The accessibility of the building where the clinic is located
- The provision of appropriate equipment, medical and non-medical

Staff Training

The service provider's attitude towards the patient is the most important factor in making health services accessible. The goal of an effective training program is to provide the clinic staff (medical, administrative and ancillary) with tools to enable them to relate and provide appropriate services to women across the range of disabilities. Specific areas to be covered are:

- medical information about the treatment of women with disabilities
- technical advice on how to make treatment accessible
- sensitization to needs of women with disabilities

An Accessible Building

The adaptations required to create an environment accessible to women with mobility impairment are more expensive and invasive than those required for other types of disabilities. Therefore it is important to consider a priori the physical aspects of the building where the clinic will be housed. Following are recommended criteria for physical accessibility:

- Doors and corridors should be wide enough to enable maneuvering of a wheelchair.
- At least one toilet should be accessible to people with mobility impairment
- Waiting spaces and examination rooms must be spacious.
- Elevators should be installed if there is more than one floor.
- Parking must be built with a ramp that enables a person with a wheelchair to reach the pavement.

Non-Medical Equipment

Small and relatively inexpensive design elements will ensure a welcoming environment and dignified visit for all women with disabilities.

- a low reception desk
- alternative communication system for women with sensory impairment
- clear signs for women with sensory impairment
- a low water fountain
- a low public phone

Medical Equipment

The following items contribute to accessible and dignified service provision:

- height-adjustable gynecological examination chairs
- a sliding board to enable transfer from a wheelchair to an examination chair
- a hydraulic lift for moving immobile patient from a wheelchair to an examination chair
- an ultrasound machine with an extended arm and option to enlarge picture on screen (for women with a visual impairment).
- an external fetal monitor
- a sterilization machine, special speculum and other equipment as necessary

Different Disabilities, Different Needs

For a clinic to be fully accessible it must take into account the specific accessibility needs for women with different disabilities. The following table outlines ideas for meeting these needs:

Impairment	Accessibility Intervention
Physical Impairment	• A hydraulic gynecologic table that can be lowered so the women can transfer herself and not have to be lifted on to the table.
Developmental Disabilities	• Staff should use simple language and make sure they are understood. • Use concrete aids, such as pictures or dolls, to facilitate explanations. • Staff should take measures to decrease fears and anxieties.
Emotional Disabilities	• Allow more time for the examination. • Understand how psychiatric medications affect women's health.
Visual Impairment	• Use verbal explanations and instructions.
Hearing Impairment	• Use written explanations and instructions. • Adopt alternative communication systems such as digital signs in waiting rooms with numbers showing whose turn it is.

Engaging in a participatory process rather than just renovating a facility has the added value of:

- raising awareness of women with disabilities' right to health services
- opening channels of communication and developing cooperative relationships with those responsible for providing these services
- development of a training program that can be replicated in medical and health science schools to ensure future generations of service providers is sensitized to the needs of women with disabilities.

Ensuring that women with disabilities have the basic right of access to health care is a worthy goal for health care systems around the world.

Hila Ben Shushan is the coordinator of the Forum of Women with Disabilities for Women with Disabilities in Israel, a partnership of Bizchut and Joint Israel-Disability and Rehabilitation Unit.

The information in this article is based on a project in progress undertaken by the Forum of Women with Disabilities for Women with Disabilities (a partnership of Bizchut, the Israel Human Rights Center for People with Disabilities and the Joint Israel-Disability and Rehabilitation Unit) with the support of the Pfizer pharmaceutical company. The model clinic will open in April/May 2005.
Bizchut website: www.bizchut.org.il

How to... Making Gynecological Services Accessible to

photo: UKHANOW/ICF-WHO

- איזורי ההמתנה וחדרי הבדיקה צריכים להיות מרווחים.
- יש להתקין מעליות אם תהיה במרפאה יותר מקומה אחת.
- יש לבנות משטח חניה עם שיפוע שיאפשר הגעה אל המדרכה בכסא גלגלים.

ציוד שאינו רפואי

מרכיבי עיצוב קטנים וזולים-יחסית יוכלו להבטיח סביבה נעימה וביקור מכובד לכל אשה עם מוגבלות.

- דלפק-קבלה נמוך
- מערכת תקשורת חלופית לנשים לקויות-שמיעה
- שילוט ברור לנשים לקויות שמיעה
- מתקן שתייה נמוך
- טלפון ציבורי נמוך

ציוד רפואי

כדי להבטיח נגישות מרבית, הכרחי להצטייד בפריטים האלה:

- כסאות-בדיקה גינקולוגיים מתכווננים בגובה
- לוח-החלקה שיאפשר מעבר מכסא גלגלים לכסא-בדיקה
- מתקן הרמה הידראולי להעברת חולה עם מוגבלות בניידות מכסא גלגלים לכסא-בדיקה
- מכשיר אולטרא-סאונד עם זרוע מוארכת ואופציה להגדיל את התמונה על הצג (בשביל נשים מוגבלות-חושים)
- מוניטור עוברי חיצוני
- מכשיר חיטוי, ספקולום מיוחד, וציוד נוסף לפי הצורך

צרכים שונים למוגבלויות שונות

כדי שהמרפאה תהיה נגישה לגמרי, עליה להתחשב בצרכי הנגישות הייחודיים של נשים עם מוגבלויות שונות. הטבלה שלהלן מתווה רעיונות למענה על הצרכים הללו:

הליקוי	ההתערבות להבטחת נגישות
ליקוי פיזי	שולחן גינקולוגי הידראולי שניתן להנמיכו כדי שהאישה תוכל לעבור אליו בעצמה ולא יהיה צורך להרים אותה אליו.
ליקויי התפתחות	• על הסגל להשתמש בשפה פשוטה ולהבטיח כי המטופלות מבינות. • יש להשתמש בעזרים מוחשיים, כגון תמונות או בובות, כדי להקל על מתן הסברים. • על הסגל לנקוט באמצעים כדי להפחית פחדים וחרדות.
מוגבלויות נפשיות	• יש להקצות זמן רב יותר לכל בדיקה • יש להבין את השפעתן של תרופות פסיכיאטריות על בריאות האישה.
ליקוי ראיה	יש להשתמש בהסברים והנחיות מילוליים.
ליקוי שמיעה	• יש להשתמש בהסברים והנחיות בכתב. • יש לאמץ מערכות-תקשורת חלופיות כגון שלטים דיגיטליים בחדרי ההמתנה, המראים את מספרה של הבאה בתור.

הכניסה לתהליך של השתתפות בצרכי המטופלות, ולא רק שיפוץ המתקן, יש לה ערך מוסף מכמה היבטים:

- הגברת המודעות לזכותן של נשים עם מוגבלויות לקבלת שירותי בריאות
- פתיחת ערוצי תקשורת ופיתוח יחסי שיתוף-פעולה עם האחראים להגשת השירותים האלה
- פיתוח תכנית הכשרה שניתן לחקותה בבתי הספר לרפואה ולמדעי הבריאות, כדי להבטיח שהדורות הבאים של מגישי השירות יהיו רגישים לצרכיהן של נשים עם מוגבלויות

הבטחת זכות-היסוד של נשים עם מוגבלויות לטיפול רפואי היא מטרה ראויה למערכות הבריאות בעולם כולו.

הילה בן-שושן היא רכזת פורום נשים עם מוגבלויות למען נשים עם מוגבלויות בישראל, שבו שותפים ארגון "בזכות" והיחידה לנכויות ולשיקום של ג'וינט ישראל.

המידע הכלול במאמר זה מבוסס על פרויקט המתבצע מטעם פורום הנשים עם מוגבלויות בישראל (שותפות של ארגון "בזכות," המרכז הישראלי לזכויות אדם של אנשים עם מוגבלויות, והיחידה לנכויות ולשיקום של ג'וינט ישראל) בתמיכתה של חברת התרופות פייזר. המרפאה לדוגמה תיפתח באפריל-מאי 2005.

כיצד להבטיח שירותים גינקולוגיים לנשים עם מוגבלויות?

מאת **הילה בן-שושן**

נשים עם מוגבלויות ניצבות בפני אתגרים מרובים בדרכן למימוש זכויות יסוד כגון טיפול רפואי, תעסוקה, ואפילו הורות. ארגונים למען אנשים עם מוגבלויות וארגוני הנשים בישראל, וכן הממשלה וגופים ציבוריים אחרים, לא השכילו לטפל בסוגיה זו. במקרים רבים, נתקלים הצרכים הייחודיים של נשים עם מוגבלויות בחוסר הבנה או בהתעלמות. לעתים קרובות, בעלי המקצועות הרפואיים וקובעי המדיניות אינם מודעים כלל לצרכים הייחודיים של נשים עם מוגבלויות ולמורכבות הטיפול בהן, והתוצאה היא הגשת שירותים בלתי מספקים.

מרפאה גינקולוגית נגישה לדוגמה

פורום הנשים עם מוגבלויות מפעיל פרויקט שמטרתו לתקן את השירותים הרפואיים הבלתי מספקים המוצעים לנשים עם מוגבלויות בישראל. הפרויקט מגדיר את הנגישות כמצב המאפשר לאנשים עם מוגבלויות לחיות חיים עצמאיים ולקבל גישה שווה ומכובדת לשירותים שמהם נהנית האוכלוסיה הכללית. על-פי הגדרה זו, למשל, אפילו מדרגה אחת בכניסה למרפאה יש בה מכשול משמעותי לנשים המשתמשות בכסא גלגלים. המרפאה לדוגמה מבטיחה נגישות בכל התחומים, כדי שתהיה נגישה לנשים עם מוגבלויות פיזיות, נפשיות, התפתחותיות ורגשיות.

פיתוחה של מרפאה נגישה מחייב לא רק שיפוץ מבני. הוא מחייב מודעות מוגברת הן בקרב המטופלות, הן בקרב מגישי השירות, לצרכים המיוחדים של נשים עם סוגים שונים של מוגבלויות, ופיתוח מענה הולם ומכובד לצרכים האלה. להלן כמה מן השלבים החשובים בתהליך הזה:

1. לערב דמויות-מפתח בהנחיית התהליך, ובהם נשים עם מוגבלויות, בעלי מקצועות רפואיים, ארגונים המגישים שירותי בריאות, פעילים למען זכויות אנשים עם מוגבלויות, וארגונים התורמים תמיכה כספית.
2. לבחור את המרפאה כך שתשרת מספר גדול של נשים עם מוגבלויות, נוסף על האינטרס של מגישי השירות והסגל.
3. לאמוד את הצרכים להבטחת הנגישות ולקבוע את המענה ההולם עליהם.
4. לפתח תכנית הכשרה לסגל המרפאה (הצוות הרפואי והמינהלי וצוות העזר).

המרפאה לדוגמה מבטיחה נגישות בכל התחומים,
כדי שתהיה נגישה לנשים עם מוגבלויות פיזיות, חושיות,
התפתחותיות ורגשיות

כיצד לפתח מרפאה נגישה

הבטחת נגישותה של המרפאה לנשים עם מוגבלויות מצריכה טיפול בשלושה מישורים:

- הידע המקצועי של הסגל הרפואי והיחס שלו כלפי המטופלות.
- נגישות המבנה שבו ממוקמת המרפאה.
- אספקת הציוד ההולם, הרפואי והאחר.

הכשרת הסגל

יחסם של מגישי השירות כלפי המטופלות הוא המרכיב החשוב ביותר בהנגשת שירותי הבריאות. מטרתה של תכנית הכשרה יעילה היא לתת לסגל המרפאה (הצוות הרפואי, המינהלי וצוות העזר) את הכלים שיאפשרו להם להתייחס לנשים עם כל מגוון המוגבלויות ולהגיש להן את השירות ההולם. תחומים ספציפיים שייכללו בתכנית הם:

- מידע רפואי על הטיפול בנשים עם מוגבלויות
- ייעוץ טכני על דרכי הנגשת השירות
- הגברת הרגישות לצרכיהן של נשים עם מוגבלויות

התאמת מבנה נגיש

ההתאמות הדרושות כדי ליצור סביבה נגישה לנשים המוגבלות בניידות הן יקרות ומורכבות יותר מאלו הדרושות לשם מענה על הצרכים הנובעים ממוגבלויות אחרות. לכן חשוב לשקול מלכתחילה את ההיבטים הפיזיים של המבנה שבו תשוכן המרפאה. להלן אמות-מידה המומלצות לנגישות פיזית:

- הפתחים והפרוזדורים צריכים להיות רחבים די הצורך לתמרון בכסא גלגלים
- לפחות חדר שירותים אחד צריך להיות נגיש למוגבלי-תנועה.

للإشراف على هذه العملية كالنساء ذوات الإعاقات، العاملين في مجال الرعاية الصحية، ومنظمات الرعاية الصحية، ونشطاء في الدفاع عن حقوق المعوقين والمؤسسات الممولة.

٢. قم باختيار العيادة التي من شأنها أن تقدم الخدمة لأكبر عدد من النساء من ذوات الإعاقات وتخدم مصالح مقدمي الخدمة وطاقم العمل.

٣. قم بتقييم مدى سهولة الوصول إلى العيادة، وقم باتخاذ الأجرآت المناسبة.

> **على العيادة النموذجية أن توفر كافة المستلزمات التي من شأنها أن تسهل وصول النساء ذوات الاعاقات؛ سواء أكانت جسدية، أم حسية، أم تطورية أم إنفعالية**

٤. قم بتطوير برنامج تدريبي لطاقم العمل (النواحي الطبية والإدارية).

كيفية تطوير عيادة ميسرة الوصول

لضمان أن تكون العيادة ميسرة الوصول للنساء ذوات الإعاقات هناك ثلاثة عناصر يجب توفرها:

- المعرفة المهنية وتوجهات طاقم العمل نحو المرضى.
- اسهولة الوصول إلى البناية التي تحوي العيادة.
- اتوفر المعدات الملائمة؛ سواء أكانت طبية أم غير طبية.

تدريب طاقم العمل

تعتبر توجهات مقدمي الخدمة نحو المرضى من أهم العوامل التي من شأنها أن تيسر وصول الخدمات الطبية. ويكمن الهدف وراء برنامج تدريبي فعال إلى تزويد طاقم العيادة (سواء الطبي أو الإداري) بالأدوات التي تمكنهم من توجيه وتقديم الخدمات المناسبة إلى النساء من ذوات مختلف الإعاقات.

والقضايا المحددة التي يجب تغطيتها في هذا البرنامج تشمل:

- امعلومات طبية حول علاج النساء ذوات الاعاقات.
- انصائح تقنية حول تسهيل الوصول إلى العلاج.
- االشعور والإحساس بحاجات النساء ذوات الاعاقات.

بناية ميسرة الوصول

إجراء التعديلات على البناية لخلق بيئة ملائمة من شأنها أن تيسر وصول النساء اللواتي يعانين من صعوبة في الحركة أكثر كلفة وأكثر ازدحاما من تلك المخصصة لذوات الاعاقات الأخرى. لذا من الضروري الأخذ بعين الاعتبار مسبقا البناية التي ستحوي العيادة.

وفيما يلي بعض المعايير التي يوصى بها فيما يتعلق بتيسير الوصول إلى البناية:

- ايجب الأخذ بعين الاعتبار أن تكون الأبواب والممرات واسعة تسمح بدوران الكرسي المتحرك.
- ايجب تخصيص حمام واحد على الأقل لذوات الاعاقة الحركية.
- اغرف الانتظار والفحص يجب أن تكون فسيحة.
- ايجب توفر المصاعد إن كانت البناية مكونة من أكثر من طابق واحد.
- ايجب توفر سطح مائل في موقف السيارات يمكن الشخص الذي يعاني من صعوبة في الحركة من الوصول إلى الرصيف.

التجهيزات غير الطبية:

من شأن بعض عناصر التصميم قليلة التكلفة نسبيا أن توفر جوا مريحا للنساء ذوات الاعاقات:

- أان يكون مكتب الاستقبال منخفضا.
- انظام اتصال بديل للنساء ذوات الاعاقات الحسية.
- الإشارات واضحة للنساء ذوات الاعاقات الحسية.
- احنفية الماء غير مرتفعة.
- اتلفون عمومي غير مرتفع.

التجهيزات الطبية:

لضمان سهولة الحركة يجب توفير الأدوات التالية:

- اكراسي خاص بفحص الأمراض النسائية يمكن تعديل ارتفاعها.
- اتوفير لوح منزلق يساعد النقل من الكرسي المتحرك إلى كرسي الفحص.
- امصعد هيدروليكي لنقل المريض الذي لا يستطيع الحركة من الكرسي المتحرك إلى كرسي الفحص.
- اجهاز فحص الأشعة فوق الصوتية مع ذراع يمكن مده مع خيار تكبير الصورة على الشاشة (للنساء ذوات الاعاقات البصرية)
- اجهاز عرض خارجي للجنين.
- اجهاز تعقيم، جهاز فحص المهبل ومعدات أخرى حسب الحاجة.

إعاقات مختلفة، احتياجات مختلفة

لكي تكون العيادة ميسرة الوصول بصورة كاملة يجب الأخذ بعين الاعتبار الحاجات الخاصة للنساء ذوات الإعاقات المختلفة.

ويبين الجدول التالي بعض الأفكار لتلبية هذه الاحتياجات:

الإعاقة	التدخل في تيسير الوصول
إعاقات جسدية	طاولة هيدروليكية للفحص النسائي يمكن خفضها لتستطيع المرأة نقل نفسها دون الحاجة إلى أن ترفع على الطاولة.
إعاقات تطورية	• اعلى طاقم العمل أن يستخدم لغة بسيطة وأن يتأكد من أنه قد تم فهمه. • أاستخدم وسائل إيضاح ملموسة مثل الصور أو الدمى لتسهيل الشرح. • اعلى طاقم العمل أن يتخذ الإجراءات المناسبة لتخفيف الخوف والتوتر.
إعاقات إنفعالية	• امنح وقتا إضافيا للفحص. • افهم كيف يؤثر دواء العلاج النفسي على صحة المرأة.
إعاقات بصرية	• استخدام اللفظ لإعطاء التعليمات وللشرح.
إعاقات سمعية	• استخدام الكتابة كأداة للشرح وإعطاء التعليمات. • استخدام وسائل اتصال بديلة كالأرقام لتحديد الدور في غرفة الانتظار.

الدخول في عملية تشاركية أكثر من مجرد إعادة ترميم للمرفق له فوائد إضافية:

- ازيادة الوعي حول حقوق النساء ذوات الإعاقات حول الخدمات الطبية.
- اخلق قنوات من الاتصال وتطوير علاقات تعاونية مع مقدمي تلك الخدمة.
- اتطوير برنامج تدريبي يمكن أن يطبق في كليات الطب وجامعات العلوم الطبية لضمان إحساس الجيل القادم من مقدمي الخدمة لحاجة النساء ذوات الاعاقات.

إن ضمان حق النساء ذوات الاعاقات في الوصول إلى الرعاية الطبية هو الهدف الحقيقي لنظام الرعاية الطبية في مختلف أنحاء العالم.

هيلا بن شوشان هي منسقة منتدى النساء ذوات الاعاقات في إسرائيل وهو مشروع شراكة بين ”بزخوت“ ووحدة إعادة التأهيل في اللجنة اليهودية الأمريكية الموحدة للدعم– إسرائيل.

المعلومات في هذا المقال مرتكزة على مشروع منتدى النساء ذوات الاعاقات الذي ما زال قيد التنفيذ وهو (مشروع شراكة بين ”بزخوت“، مركز لحقوق الإنسان للأشخاص ذوات الاعاقات ووحدة إعادة التأهيل وذوات الاعاقات في اللجنة الأمريكية اليهودية الموحدة للدعم) بدعم من شركة بفزر للأدوية. يعمل المنتدى كشبكة دعم وكمركز بحث ومجموعة مناصرة وحشد التأييد لتقوم السلطات بسد حاجات النساء ذوات الإعاقات المختلفة. سيتم فتح العيادة النموذجية في نيسان ٢٠٠٥. العنوان الالكتروني ”بزخوت“ www.bizchut.org.il/eng/upload/.more/women.html

Women with Disabilities: Creation of a Model Clinic

photo: UNFPA/Steve Sabella

كيفية تيسير وصول الخدمات الطبية النسائية للنساء ذوات الاعاقات

هيلا بن شوشان

الاعاقات بالنساء ذوات الاعاقات، والناجمة عن كونهن نساء من ناحية، ولهن احتياجات خاصة تم تجاهلها من قبل المنظمات التي تعنى بالنساء ذوات الاعاقات في إسرائيل، بما فيها الحكومة والمؤسسات العامة، من ناحية أخرى.

تعاني النساء ذوات الاعاقات من تحديات متعددة، خصوصا في الحصول على حقوقهن من ناحية الحصول على الرعاية الطبية، والتوظيف، وحتى تكوين أسرة. وفي كثير من الحالات نجد أنه يساء فهم احتياجاتهن، أو تتم المبالغة في هذه النظرة، وإن كانت بحسن نية من قبل صناع القرار ومقدمي الخدمات. وبالتالي خلق صعوبات لا حاجة لها.

وغالبا لا يدرك العاملون في مجال الرعاية الصحية وصناع القرار مدى تعقيد علاج النساء ذوات الاعاقات؛ الأمر الذي يؤدي إلى تقديم خدمات غير ملائمة.

نموذج لما يجب أن تكون عليه العيادات الطبية النسائية لتيسير وصول النساء ذوات الاعاقات

يعكف منتدى النساء ذوات الاعاقات على تنفيذ مشروع يهدف إلى الوقوف على الخدمات غير المناسبة في المجال الطبي المقدمة للنساء ذوات الاعاقات في إسرائيل. ويعرف المشروع تيسير الوصول، كحالة تمكن ذوات الاعاقات من الحصول على الاستقلالية، والتمتع بحقوق مساوية ومشرفة في الوصول إلى الخدمات التي يتمتع بها عموم الناس.

وبناء على هذا التعريف فإِن درجة واحدة على مدخل العيادة الطبية على سبيل المثال تمثل عائقا للنساء اللواتي يستخدمن الكرسي المتحرك. فالعيادة النموذجية تأخذ بعين الاعتبار كافة جوانب تيسير الحركة؛ لضمان وصول النساء ذوات الإِعاقات الجسدية والحسية والتطورية والإِنفعالية.

إن تطوير العيادة التي يسهل الوصول إليها يتطلب أكثر من مجرد إعادة ترميم للبناء، ليشمل زيادة الوعي بين المرضى ومقدمي الخدمات حول الحاجات الخاصة للنساء ذوات الإِعاقات في المجالات المختلفة، والعمل على تطوير ردود مناسبة ومشرفة لتلبية هذه الاحتياجات.

وفيما يلي بعض الخطوات الهامة في هذا المضمار:

١. حاول أن تشرك أشخاصا رئيسيين

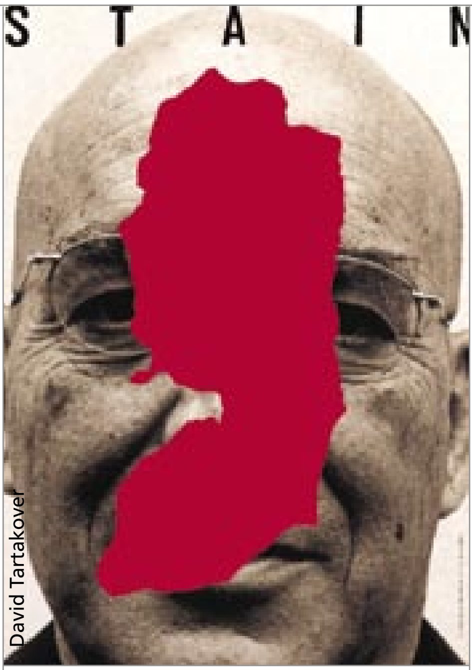
The Separation Barrier to Health Care

by **Medecins du Monde-France**

Médecins du monde (MDM – France), has teamed up with Physicians for Human Rights (PHR) and the Palestinian Red Crescent Society (PRCS) in a joint art campaign appearing both in the Israeli and Palestinian press in an effort to address health issues generated by the separation barrier.

MDM, PHR and PRCS share a common position on the separation barrier (also referred to as the Wall). The Wall appears as the final and most visible part of a network of barriers, both physical and administrative, which restricts Palestinians' right to life and freedom of movement in the Palestinian territories. Since it does not follow the Green Line and encroaches into the West Bank, the tracing of the Wall is both disproportionate, in its health impact, and illegal. It violates both International Human Rights Law and International Humanitarian Law.

In order to address the public at large, MDM will reach out to people through inserts in the press illustrating the work of Israeli and Palestinian artists. These inserts will be enriched with medical messages about the impact of the Wall. The art campaign will be exhibited in six major European cities including Paris and London later this year.



David Tartakover

MDM-France is an international solidarity association. It depends on the volunteer commitment of its members, who are medical professionals, in order to address the health needs of the most vulnerable populations both in France and in 52 countries around the world. Based on 25 years of medical experience, it bears witness to the obstacles in accessing medical care and denounces the violations of human rights.

MDM has been present in the Palestinian territories since 1995. It operates in Gaza, Nablus and some villages affected by the Wall. May, 2004, marked the beginning of the "Wall Response Program". The program's activities include providing technical and financial support for a total of 11 clinics run by Health Work Committees (HWC) in the North Jordan Valley and south of Bethlehem as well as establishing an ambulance station with PRCS in the East Jerusalem town of Aizaria.

From the beginning, MDM decided to take action against the Wall's negative health impact by voicing the patients' and medical staff's daily difficulties in accessing medical facilities due to the Wall. To date, over 80 testimonies have been gathered in the field. These testimonies combined with medical data analysis have been compiled in an MDM report entitled "The Wall – The Ultimate Barrier". The testimonies presented in this report and MDM's medical expertise in the field illustrate the deterioration of the Palestinian health care system due to the ongoing construction of the Wall.

For more information:
www.healthandwall.org

Palestinian Public Perceptions

Highlights of the forthcoming Palestinian Public Perceptions – Report 8 show:

- 44% of Palestinians say that employment is the most important need followed by food with 31% of the population.
- 45% say the most needed community facility is water.
- 51% of Palestinians chose a specific health facility because it is covered by health insurance and 16% because it's the cheapest.
- 40% receive health coverage from the Government, 17% from UNRWA and 26% cover their own medical expenses.

This survey is one of several which analyze the living conditions of Palestinians over the last four years. The surveys rely on polls that measure Palestinian's perceptions about living conditions, their evolution, assistance received and its impact, as well as many other relevant topics for individuals and organizations involved in assistance to Palestinians.

The full report is presented by the Graduate Institute of Development Studies (Geneva University) in collaboration with several Palestinian institutions, the Swiss Agency for Development and Cooperation as well as several UN agencies. The reports are issued twice a year. Reports 1-7 are available at www.dartmonitor.org and Report 8 will be available shortly.

Disabled and Beautiful

by **Gilli Buium**

People with disabilities don't have it easy. In addition to coping with their disability, they also have to face a society which is unaccepting. They confront physical barriers like inaccessible infrastructure as well as social barriers such as lack of acceptance as equal members of society.

This reality motivated a group of young, disabled people, known as Benadam (human-being in Hebrew) to take action. The group was established last year by three disabled people in their 20's who want to revolutionize the way society perceives disabled people. Their main strategy is to put on provocative events with which disabled people aren't usually associated. Their most recent event was a trendy fashion show featuring disabled people as the models. The slogan for the fashion show was "I am disabled and sexy".

"I feel as beautiful and attractive as any other person," said Ido Gruengard, one of the organizers of the project and an architecture student at Tel-Aviv University. "Our mission is to show that we are regular people, just like anybody else," he added. Society, according to Gruengard, looks at disabled people as passive and incompetent. The fashion show allowed them to prove otherwise. They presented young, people with disabilities who are active and enjoying a fulfilling personal and professional life.

They came on stage proudly wearing designer clothes made especially for the occasion by the most popular Israeli fashion designers. The show packed the Dome nightclub in Tel Aviv which volunteered its location and the evening was a huge success. In addition, the fashion show received wide coverage in the media, fulfilling the organizers' main goal – to make everyone see them as equal, instead of simply disabled.

Next on Benadam's to-do list is to open up a coffee shop where the waiters are disabled. The underlying idea is to have people who are not disabled served by disabled people – a rare reversal of roles and a creative approach to challenging the way disabled people are perceived.

For more information:
www.benadam.co.il

Patient's Friends Society Sunrise Group – Breaking the Silence

by **Carol El Jabari**

The Sunrise breast cancer support group was established in 2000 under the auspices of Patient's Friends Society-Jerusalem as the first such initiative in the Occupied Palestinian Territories. The women aim to 'break the silence' surrounding cancer diagnosis and increase awareness about prevention, early detection and treatment. They are also committed to improving patient- professional communications to facilitate better treatment for those diagnosed with cancer.

At present, over 50 patients and survivors from Jerusalem and the West Bank are registered with the group which seeks to address the psycho-social aspects of living with cancer. Several women have been trained as Reach to Recovery volunteers visiting patients in their homes and in hospital. In addition, they also volunteer to take calls on the helpline from men and women all over the country. This service is advertised in the local press and on local radio and television. The helpline phone number is 02-6277990.

Many members of the group participate in empowerment activities which include conferences, seminars, language courses (to learn Hebrew in order to better understand the physicians and nurses who treat them in Israeli hospitals) and monthly meetings with Israeli survivors to learn, share and network. In June two members and the group coordinator plan to attend the International Reach to Recovery conference in Athens. This will be an excellent opportunity to meet women from all over the world living with breast cancer- to discuss how they deal with it, be exposed to new scientific and psycho-social matters and have a chance to have fun.

For more information about the Patient's Friends Society:
www.pfsjer.org

photo: UNFPA/Steve Sabella

Project Cope: Coping with Breast Cancer Among Palestinian and Israeli Women

by **Yael Rockoff**

Thirty five Israeli and Palestinian professionals participated in a roundtable discussion about breast reconstruction after breast cancer surgery at the YMCA, Jerusalem, this past January. The event was part of a forum which aims to provide an arena for networking and professional growth for Palestinian and Israeli health professionals.

At the meeting, reconstruction techniques were presented by Dr. Aziz Shoufani, a plastic surgeon and the Medical Director of St. Joseph's Hospital in East Jerusalem, and Dr. Dean Ad El, Director of the Plastic Surgery Burns Unit at Rabin Medical Center in Petah Tikva. Dr. Ilana Kadmon, the Breast Care Nurse at Hadassah Hospital, Ein Karem, spoke about reasons women choose to reconstruct or not, the timing of the surgery and other psychosocial factors. Three breast cancer survivors, one Israeli and two Palestinians, spoke about their personal experiences with reconstruction. Participants included oncologists, surgeons, nurses, general physicians and social workers.

The event was sponsored by Project COPE, a cooperative project initiated in 2000 for health professionals and women living with breast cancer in a joint effort to fight breast cancer, create networks among professionals and women with cancer, as well as expand and develop services to address unmet needs. The COPE partners are Patient's Friends Society—Jerusalem (PFS), the Israel Cancer Association (ICA), JDC-Middle East Program (AJJDC, JDC-Israel, Myers JDC-Brookdale Institute) and Augusta Victoria Hospital, East Jerusalem.

In his concluding remarks at the roundtable discussion, Dr. Omar Abdul Shafi, general surgeon and member of Patient's Friends Society's board of trustees, commented that cooperative projects such as COPE, play an important role in promoting coexistence and improving understanding.

To learn more about Project COPE contact Yael Rockoff, JDC COPE Coordinator, at 972-2-6557272, or by e-mail at yaelr@jdc.org.il

2005 World Health Day

Make every mother and child count

by **Shiri Ourian**

Make every mother and child count. This is the slogan for World Health Day 2005 which will be held on April 7. According to the WHO, this reflects the reality that the health of women and children is not a top priority for many governments and the international community.

Each year more than half a million women die from pregnancy-related causes and 10.6 million children die, 40% of them in the first month of life. Almost all of these deaths are in developing countries and many could be prevented with well-known interventions, if only these interventions were more widely available.

The WHO invites all stakeholders to make a personal commitment to organizing events around World Health Day. “This is an opportunity to raise awareness regarding the health threats to mothers and children that are often overlooked. Appropriate advocacy on this issue could make a significant difference,” reports Dr. Ambrogio Manenti, Head of Office, WHO West Bank and Gaza. The World health report, devoted to maternal and child health, will be launched on World Health Day.

In order to make a coherent, global impact, events can be oriented around the following messages:

1. Too many mothers and children are suffering and dying each year.
2. Healthy mothers and children are the real wealth of societies.
3. Millions of lives could be saved using knowledge we have today. The challenge is to transform this knowledge into action.
4. In order to make a difference, we must all join forces and act. Together we can do it. Each one of us has a role to play.

To support your events, the WHO has developed a variety of resources including:

- design and promotional materials (logos, toolkit, posters, etc.)
- resource documents about maternal and child health
- World Health Day 2005 website which includes a place to register your event

All of these sources are available online at www.who.int/world-health-day/2005/en/

A Day in the Life

A Family's Tragedy

by **Daniel Ben Simon**

It was after midnight and Eliyahu Shrabkovsky, a veteran journalist at the EFE Spanish news agency, was finishing his 24 hour shift. Another day of this bloody Intifada had come to a close.

Just before Eliyahu went to bed, he heard on the radio that there had been a suicide attack at Mike's Place, a famous restaurant on the Tel-Aviv seashore. Another suicide bomber blew himself up causing chaos and panic.

"There were many casualties," the news reporter announced.

Eliyahu jumped from his bed and returned to his desk. Without hesitation, he started to write the story. Over time he had grown accustomed to writing a wide range of stories – most of them tragedies, very few happy stories.

Tonight, once again, he was writing about a tragedy. For a few moments his mind drifted to the victims – the dead, the nearly dead, the seriously injured, the slightly injured and the shock victims. He thought of those who witnessed the horror and the unfortunate who had to collect the body parts.

At times he felt submerged in horrible thoughts. How long will this bloody conflict last? Has God cursed the Holy Land? Will I live to see the day when Israelis and Palestinians live happily as good neighbors?

More than once, despair filled his heart. But that evening he was too busy writing the story. There wasn't enough time to dwell on existential thoughts.

The telephone rang. In the other room, Marta, Eliyahu's wife, picked up the phone.

"Don't worry, everything is ok," the voice on the other end half cried, half whispered.

"Ariel is just injured."

"How bad?" asked Marta, almost unable to speak.

"Not too bad," replied Sarit, Ariel's girlfriend.

Marta felt dizzy. For a few moments she sat idle in her room. She didn't know how to tell her husband that

and Rehabilitation

their son, Ariel, was among those who had been injured at that ill-fated restaurant. Eliyahu knew that his son was a regular guitarist at "Mike's Place", but he was working on his story and Ariel didn't come to his mind. He always wrote about the others. Even in his nightmares, he never imagined that one day, his son would be one of them.

"I was writing the story of the suicide attack," recalled Eliyahu, "The reports were saying 30 victims, maybe 40. Then my wife came close to me and looked at me. I couldn't understand why she was staring at me."

"Ariel is among the injured," Marta told her husband.

"How bad?" he asked, his voice trembling.

"Not too bad," she replied.

Eliyahu and Marta hardly found the time to grasp the tragic news. They drove to the hospital in Tel-Aviv. Though they had toughened since they immigrated to Israel in 1969, nothing prepared them for this painful experience. Two years after the Six Day War, the young couple left their native and beloved Argentina, to start a new life in Israel. They chose to settle in Jerusalem and never thought about moving to another city, more peaceful or less dangerous.

More than 30 years later, they hardly considered themselves entirely Israeli. At times they still feel and act like newcomers in their own country. Nearly all of their friends speak Spanish. Like most of them, they are not at ease with Hebrew and would rather read and write in their native language.

The drive to Tel-Aviv seemed interminable and excruciating. When they arrived at Tel-Hashomer Hospital, they were met by a group of doctors.

"They told us that Ariel was seriously injured," recalls Eliyahu, "that our child suffered from burn injuries and that he will need a long recovery."

"The patient was covered with bandages from head to toe. Only his eyes were uncovered. They looked at him. It was Ariel."

As they spoke to the doctors, Eliyahu and Marta saw nurses pushing a bed down the corridor. The patient was covered with bandages from head to toe. Only his eyes were uncovered. They looked at him. It was Ariel. They could hardly control their emotions. Their 23 year-old son was alive but he looked so helpless.

It took six weeks of painful and daily treatment before Ariel fully regained his consciousness. During that period, Marta stayed at his bedside. Eliyahu returned to his work in Jerusalem after a few days at the hospital.

"I needed a mental break," he said. "Seeing Ariel lying in bed unconscious for so long was unbearable for me. So I went back to work just to get busy and to forget a little bit."

His son's injury provoked troubling thoughts. He always considered himself a pacifist and a peace activist. He attended many peace demonstrations and rallies for co-existence. In his eyes, there was nothing uglier than war, nothing more inhumane than bloodshed.

"For God's sake," he said, sitting in his living room on a rainy and windy evening in Jerusalem, "What on earth drives a young man to kill himself and take so many with him? This is madness. Ariel is a musician and his mission in life is to make people happy. Why would anyone want to kill him? What has he done wrong?"

After his son recovered, his heart went out to the thousands of Palestinians who had been injured during the Intifada. How many of them received the treatment that his son received?

"The Israeli doctors saved his life thanks to their devotion, tireless efforts and love for Ariel," he said. "How many injured Palestinians are as lucky as Ariel? I'm afraid that none. I'm afraid that their hospitals are ill-equipped and many die as a result of a lack of medication, treatment, and highly-trained doctors."

This experience has not shattered Eliyahu and Marta's dream of peace. On the contrary, it has bolstered their quest for a better life for Israelis and Palestinians.

"We always hated war," said Eliyahu. "Now we hate it even more."

Marta nodded, smiling.

Daniel Ben Simon writes for the Israeli newspaper "Haaretz".
Ben Simon's writings focus mainly on issues relating to Israeli society.
In 2004, he received the Sokolov Prize for journalism.

A Day in the Life

Arqam's Lost

by **Abdel-Basit Khalaf**

Dreams

At the age of 23, many young men have started their university education with a career in mind and many are already looking for a partner, perhaps even starting a family and carrying out other dreams of young adulthood.

This is not the case for Arqam Abu Al-Hyjaa'. Arqam was born in the Jenin refugee camp and thus, from birth, his dreams were limited. He was forced to drop out of school before completing high school and began learning how to install water pipes to earn some money and help his family financially.

Life has not smiled upon Arqam. He and his family will never forget the night of January 6, 2002. On that night, on his way home on the Haifa road, Arqam stopped to help a young man who was bleeding on the roadside. Outside of his car, Arqam was shot twice in the neck by an Israeli soldier. Arqam now lives life with 90% disability, paraplegia and lost dreams.

Arqam's Cage

Arqam's room shows reminders of this tragedy – a wheelchair, a specially designed bed and a cupboard full of drugs and medical instruments. In another corner of the room there are two birds in a cage. Arqam refers to them and says "I am in a cage, too."

"When I was shot, I felt as if life had forsaken me. I recited the opening chapter of the Qur'an twice. My head was spinning quickly. I felt intense pressure in my ears and then I felt like I was flying in the sky," Arqam recalls with pain on his face.

This feeling was only the beginning of Arqam's agony which has lasted four years and has become increasingly worse.

The Family Takes on the Disability

Arqam was taken to Sheikh Zayed Hospital in Ramallah where he was in as state of coma for two weeks. Once conscious, he moved from one hospital to another and from one rehabilitation center to the next. He spent an entire year away from home and ended up with a special bed and a wheelchair in his room. His brothers Alaa' and Noor as well as his parents learned about names of drugs and medical equipment such as Lizoral, Linotral, Contlix, suppositories, urine packs, medical pipes, and sterilizers. "My son suffers from a continuous urinary tract infection. He needs to have his blood and urine tested all the time in addition to physical therapy," says Arqam's father covering his face. He adds, "I burst into tears every time I remember the situation of Arqam."

"My brother needs to have his urine pumped out six times a day. He also needs to have physical therapy, in addition to changing his sleeping position all the time," says his brother, Alaa', who was forced to leave school to help his brother.

Facing the Tragedy

The young boy who once specialized in water pipes and installation is now an expert on the functioning of his cells and spinal cord. His spinal cord was seriously damaged and only about 15% of it is still functioning.

"I was gradually informed by my physicians that the two bullets affected my spinal cord as well as my nerves. I was also informed that I would not able to walk or use my arms," Arqam added.

Now Arqam spends his day either lying in his bed or sitting in his wheelchair which is a great source of discomfort. "I try to forget my pain but I can't succeed. My night is very long, full of nightmares," Arqam said.

Arqam decided to hold on to the water pipe equipment he had once used in the hopes that he will use them again one day. At the same time, he encourages his brother to follow his career track. Sometimes he asks his brothers to show him the tools so he can remember.

The Sorrow Persists

Arqam's mother's eyes seem to be constantly full of sorrow. Her silence indicates the family's shock and continuous suffering. The family cannot afford to send Arqam to Germany for treatment and sometimes, because of their poor financial situation, they are not able to secure medicine for Arqam. Despite his disability, Israeli soldiers forced him and his family outside of their home on two separate occasions into very cold weather so that the house could be searched empty of people.

Arqam's dreams have changed. He no longer thinks of finding a partner or building his own home as he did before. His dreams are now about getting through each day.

He concluded by saying, "I hate to listen to the news which talks about killing, bloodshed and people with disabilities like me."

Abdel-Basit Khalaf is a writer and journalist specializing in women's and children's development as well as environmental issues.

photo: CASTILLO/ICF-WHO

Disability and Rehabilitation

WHO’s View

Disabilities continue to be an increasing problem especially in low-income countries. The availability and quality of rehabilitation for the disabled has a major social, political, and economic impact on society

About 600 million people in the world experience disabilities of various types. Eighty percent of the world’s disabled people live in low-income countries; the majority of them are poor and do not have access to basic services including rehabilitation facilities. Their primary struggle is to survive and meet basic needs such as food and shelter, particularly in case of severe or multiple disabilities.

The global disabled population is increasing. Population growth, medical advances that preserve and prolong life, war injuries, landmines, HIV and AIDS, malnutrition, chronic conditions, substance abuse, accidents and environmental damage, all contribute to this increase.

Social and Economic Factors

Social issues are an intrinsic part of disability issues – human rights, economic conditions, particularly poverty and societal conditions including beliefs, attitudes and practices result in social and environmental barriers for disabled people.

The estimated number of people who require rehabilitation services at any point in time is 1.5% of the global population, i.e. about 90 million people. The number of disabled people continues to be estimated at 7% to 10% of the population, although individual countries have given numbers that vary from approximately 4% to 20%. These estimates reflect many persons whose needs for rehabilitation services, and for equal rights and full participation, have not been met.

Community Participation

Community Based Rehabilitation (CBR) is a strategy to promote the sense of "community ownership" and the full participation of disabled people in all its activities. The major objective of CBR is to enable persons with disabilities to maximize their physical and mental abilities, to access regular services and opportunities and to achieve full social integration within their communities and societies. CBR may also serve as a stimulus for community leaders and social groups to come together. Such a forum enables a variety of concerns to be addressed, in addition to the needs identified by disabled people themselves.

Women and Children with Disabilities

Because women are most often the primary caregivers, particular attention is to be given to the role that they play in their homes and communities. Furthermore, it will be important to consider the needs of girls and women with disabilities, who confront a double disadvantage caused by gender discrimination and limited opportunities for people with disabilities.

According to UNICEF, 10% of children are born or acquire a disability of which no more than 10% receive appropriate rehabilitation. In low-income countries, children's disabilities are usually identified when they are 3 to 4 years old. As a consequence, rehabilitation starts too late, losing the opportunity to provide an early intervention during a period when rehabilitation has a larger impact.

> "The estimated number of people who require rehabilitation services at any point in time is 1.5% of the global population, i.e. about 90 million people."


photo: CALASANS/ICF-WHO

Shift in Professional Attitudes

Education of professionals in the health and social services has traditionally focused on the "medical" aspect of disability whereby the individual was seen as dependent rather than a person with a potential for independent living. This "professional" approach to disability, which is discipline and disease oriented, frequently reinforced the concept that the individual was a "patient" or a "social case" rather than a "person". Rehabilitation professionals have a major role to play in enhancing more positive attitudes towards disability, through a commitment to working in close alliance with persons with disabilities and their families, while promoting the concept of independent living and full participation in the community.

Collaboration

Intersectoral collaboration among health, education, social and labor sectors is needed in order to ensure that persons with disabilities receive all available services to assist them in achieving equal opportunities. The involvement of persons with disabilities is an essential feature of all programs. People with disabilities and the organizations representing their interests play an active role in promoting equal opportunity. As such they have a major economic, social and political impact on society and on the restructuring of health and social programs.

For more information:
www.who.int/ncd/disability/

Invitation to a Forum on Developmental Disabilities

by **Sarah Capelovitch**

The publication of bridges prompted me to reach out to Israeli and Palestinian colleagues working with children with special needs and their families. Paramedical professionals and others are invited to exchange ideas, pose questions and send suggestions or thoughts on how to meet the challenges presented by children with special needs.

I will start the dialogue with some thoughts on current developments in movement science theory and how it is reshaping traditional interventions strategies.

Three of the most currently influential sources reshaping clinicians' thinking are:

1. The World Health Organization (WHO) ICIDH-2: International Classification of Impairments, Activities and Participation 1997, and its latest edition – International Classification of Functioning, Disability and Health[1]
2. The Dynamic Systems Theory – a framework to explain development in general and motor behavior specifically[2]
3. The principles of Family-Centered Care[3]

The core principles of these three sources have led clinicians to rethink and modify intervention strategies used with infants and children. One of the intervention approaches, or rather intervention concepts, undergoing changes is Bobath-Neurodevelopmental Treatment (NDT), widely used and taught by certified instructors the world over. During the 1980s, Dr. and Mrs. Bobath (London, UK) began to question the efficacy of inhibiting pathological patterns of movement and facilitating "righting and equilibrium reactions" as a means to improve function.

Today the Bobaths' thoughts and clinical applications are evolving. The Bobath-NDT concept is incorporating evidence-based research in movement science and adapting intervention strategies accordingly.

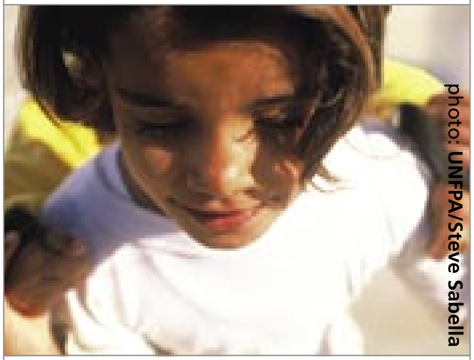


photo: UNFPA/Steve Sabella

Current theories about motor behavior suggest:

1. Treatment strategies should not be directed at the impairment level, as this does not seem to lead to functional gain.
2. Allow the child with cerebral palsy (CP) or other neurological conditions to find his or her best solutions to a motor challenge.
3. Select goals that are related to activity and participation with peer groups, family and society, rather than choosing goals at the level of the impairment (e.g. tone reduction).
4. Motor behavior is influenced by the child's personality and motivation and by the conditions in the environment.
5. Therapists must be able to identify transition periods in the child, when motor behavior is most variable, and try to plan intervention then.
6. Therapists must keep "hands on" at a minimum and encourage the use of adaptive equipment.
7. Do not work for normalization of movement patterns; work for increasing activity and level of participation.
8. Invite parents to be equal and active partners in the intervention team.

There is a great deal more to be said on this subject. Many questions can and should be raised as to how the movement sciences have impacted our clinical work. How does it impact on delivery of Community-Based Rehabilitation (CBR)? Does it affect approaches or relationships within families of children with special needs? Some of the theoretical and clinical suggestions are culturally-influenced. I invite you to share your thoughts on this and ways we can work together.

Bridges invites you to submit ideas for joint Israeli-Palestinian projects, activities and efforts to our Readers' Forum at bridges@who-health.org

Dr. Sarah Capelovitch is a pediatric therapy consultant and Senior Tutor at the European Bobath Tutors Association (EBTA). capes@netvision.net.il

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Letters to the Editor

Best wishes for bridges

Dear Dr Manenti,

I was delighted to find out about and read the launch issue of 'Bridges' - a courageous. well-designed and very readable initiative. Please accept my best wishes for the success of the project. It is heartening to see that all of the members of the Advisory Board are either Israelis or Palestinians. I was particularly glad to see the two articles about ambulance drivers, the interview with Richard Horton and the article by David Nabarro, and the short piece about Physicians for Human Rights - Israel.

With reiterated best wishes.

Sir Iain Chalmers
Editor, James Lind Library
Oxford, UK

Help to Sustain the Initiative

Dear editor

Congratulations for this initiative. It is a good start for real and constructive dialogue and exchange of experience and ideas for the benefit of the health sector in the Palestinian and Israeli communities. The sponsorship of the WHO will strengthen "Bridges" and give it more credibility.

However, I think it is more difficult to advocate this magazine in the Palestinian community than the Israeli community, due to the general problems and obstacles the Palestinian society faces as well as health sector specific problems such as lack of free access to health services for patients and health professional.

I'd like to suggest the following points to guarantee the sustainability of this initiative:

- "Bridges" should touch on the current obstacles related to the conflict on the health stiuation in the oPt. It could be used as a platform to raise awarness in both societies for this issue.
- The articles should be up to date, with recent data and should not generalize data that refers to populations with very specific characteristics that cannot represent the whole population. Also the sources of information should be valid, reliable and not biased.
- Health professionals from both communities should feel the importance of the magazine and see it as a tool with direct impact on their proffesion and their patients. When choosing the articles, the gap between the Palestinian and Israeli health care systems should be considered.

Finally, I wish the magazine all the success.

Yousef Muhaisen, Jerusalem

Why change a successful vaccination policy?

The subject of polio immunization policy is under review in many countries as progress is being made toward global eradication. It is useful to recall the Israeli and Palestinian joint, pioneering work in polio control using a system of combined live oral polio (Sabin) vaccine (OPV) with inactivated injected Salk vaccine (IPV). This combined program led to the successful eradication of poliomyelitis in Gaza, the West Bank in the early 1980s, and later in Israel after 1988.

The "Gaza System" was originally adopted to quell large epidemics of clinical poliomyelitis cases occurring in Gaza and to a lesser extent in the West Bank, during the 1970s and especially in the years 1976 and 1977, despite widespread and intensive use of OPV. In fact, cases included children who had received up to 4 doses of OPV.

The combined OPV/IPV program showed dramatic results almost immediately in eliminating poliomyelitis in Gaza and subsequently in the West Bank. Israel used OPV-only in most of the country except for two districts which used IPV-only from 1980-1988. In 1988, Israel suffered a polio epidemic in one of those districts. This outbreak included 15 cases among young adults and 1 death; one case of polio in the West Bank preceded the outbreak in young adults in the adjacent area of Hadera, Israel. (2) This experience showed that both OPV and IPV alone have important shortcomings and that IPV-only populations were susceptible to and could transmit imported wild poliovirus. (2)

The Ministries of Health of the Palestinian Authority and of Israel have continued to use the combined OPV/IPV program since 1988, and has been adopted by some other states in the Middle East. Despite periodic reports of wild poliovirus in the surveillance of sewage in Gaza, no clinical cases have been discovered in the area since 1988.

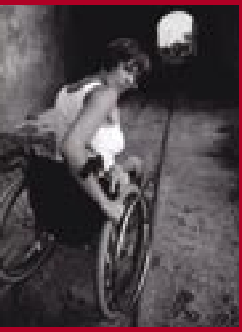
The Israeli Ministry of Health is currently debating polio immunization policy and may consider adoption of an IPV only policy. Such a change is, in my view, unjustified. The combined OPV/IPV strategy has protected the area despite the risk of importation of wild virus as well as from vaccine associated cases. Israeli-Palestinian cooperation in this field has been a great success and should be extended to other fields of public health cooperation.

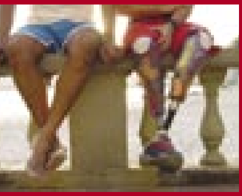
Ted Tulchinsky, MD MPH,
Jerusalem

References
1. Tulchinsky TH, Abed A, Shaheen S, Toubassi N, Sever Y, Schoenbaum M, Handscher R. A ten year experience in control of poliomyelitis through a combination of live and killed vaccines in two developing areas. American Journal of Public Health, 1989;79:1648-55.
2. Slater PE, Orenstein WA, Morag A, Avni A, Handsher R, Green MS, Costin C, Yarrow A, Rishpon S, Havkin O, et al. Poliomyelitis outbreak in Israel in 1988: a report with two commentaries. Lancet. 1990;335:1192-8.

Forthcoming issues will feature:

- Nutrition
- Women's Health
- Mental Health
- Health Promotion





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