

Caring for the Disabled in the West Bank and Gaza

An Overview

Services for the disabled population in the West Bank and Gaza are provided through governmental organizations, NGOs, and United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA). The Ministry of Health (MOH) provides physical and mental health services in hospital and primary care facilities and through community and home-based care. Through the Ministry of Education (MOED), 400 school counselors provide counseling, early intervention, and referral services for students in its educational system. Ministry of Social Affairs (MOSA) refers individuals designated as social welfare cases within the disability category for rehabilitation services to the MOH.

There are three main levels of rehabilitation services in the West Bank and Gaza: national, intermediate, and community. A description of these levels of care follows:

1. The National Level. In general, the services provided at this level are both long-term and costly. The institutions that provide physical or mental health rehabilitation services are either acute care or specialty rehabilitation hospitals; they are characterized by:

- an ability to provide emergency and tertiary care services;
- having highly qualified staff and specialized teams of providers (e.g., psychiatrists and psychologists, orthopedic surgeons and physiotherapists);
- having a range of specialized medical services that might include physiotherapy, occupational therapy, laboratory services, medicines, nursing, and psychological and social care; and
- utilizing sophisticated equipment and having available appropriate apparatuses that meet international standards.

With respect to physical rehabilitation specifically, there is a generally accepted referral system among the institutions that provide such national level services. These institutions are:

- Bethlehem Arab Society for Rehabilitation (BASR) – Bethlehem; West Bank
- Abu Rayya Rehabilitation Center – Ramallah; West Bank
- Princess Basmah Rehabilitation Center – Jerusalem
- Al-Wafa Medical Rehabilitation Center – Gaza
- Al-Amal Center – Gaza

In 1994, the three centers in the West Bank signed an agreement with the MOH to coordinate the services provided to the disabled, assigning responsibility for categories of services to the institutions based on their particular strengths and capacities. Specifically according to this agreement, the areas of responsibility are:

- BASR --national referral center for children and adults with head injuries, and CVA patients,
- Abu Rayya Center --national center for spinal cord injury for adults and children,
- Princess Basmah Center – national referral center for children with cerebral palsy, psychomotor retardation, and other childhood pathologies from the northern part of the country except spina bifida, spinal cord injury and head injury patients.

This arrangement has helped to avoid duplication of services and enhance the ability of the institutions and their staff to provide high quality specialized comprehensive rehabilitation services. This national coordination has resulted in:

1. an effective referral system for this level of care – care providers know where to send patients, patients know which facilities are more appropriate for their needs, and follow up is more easily maintained;
2. the centers increasingly being recognized for their specific areas of specialty;
3. an improved ability to focus on and improve specialized rehabilitation services;
4. strengthened capacity for these centers to co-locate comprehensive services within or through one facility;
5. strengthened and more highly qualified individual providers and multi disciplinary teams, in part because of the institutions serve as professional resource centers for continuing education and expertise;
6. improved coordination between and among these centers and with other levels of service delivery, most importantly at the community level.

The drawbacks of these arrangements are:

1. insufficient number of specialized professional staff;
2. lack of clearly defined professional standards of care and administrative policies across the institutions;
3. lack of provider experience in certain rehabilitation specialties, including for example, spinal deformities.
4. inadequate complimentary services such as surgical procedures to improve functional capacity for those with certain handicaps; and
5. inconsistent application of quality control management across the centers.

There is no comparable contractual arrangements and referral system for mental health services. The only “national level” (inpatient) hospitals are the psychiatric hospital (in Bethlehem) and psychiatric ward (in Gaza City).

2. The Intermediate Level. These services include diagnosis and treatment, and provision of or referral for social, educational, vocational, and other services. This level of care is provided primarily through NGOs and UNRWA, although the MOH and MOED also provide intermediate level services, for example through primary care centers and schools. For the most part, the NGO services are provided through institutions that offer specialized care (e.g., for mental health, the hearing or sight impaired, for those with motor impairments --physiotherapy and artificial limbs). Table

1 presents estimates of coverage of services, for physical rehabilitation only, at the intermediate level.

Table 1: Needs of Intermediate Level Services for Physical Rehabilitation

TYPE	% of Needs Met
A. Diagnostic:	
- General	N/A
- Hearing Tests	100%
- Optical Tests	N/A
B. Treatment	
- Physiotherapy	100%
- Occupational Therapy	40%
- Speech Therapy	42%
- Medical	N/A
C. Technical Aids	
- Hearing Aids	81%
- Wheelchairs	100%
- Artificial Limbs	30%
- Walkers and Crutches	N/A
- Eye Glasses	N/A
- Other Aids (Boots, Belts, Splints, Seats)	50%
D. Special Education	
- Slow Learners Education	20%
- Sign Language	40%
- Braille	88%
- Day-care Centers	50%
E. Vocational Rehabilitation	
- Counseling	3%
- Sheltered Workshop	20%
- Integrated Training	N/A
- Job Replacement	25%

3. Community Level - Community Base Rehabilitation Programs (CBR Programs).

Since the late 1980's, a focus on community-based rehabilitation services has been a hallmark of Palestinian planning and programming. Community-based programs address basic physical and mental health intervention needs (e.g., home-based physical therapy, early childhood education for disabled youth, and crisis intervention counseling for families of those killed in the conflict). Palestinian CBR programs usually include 1) individual case planning with the individual and prostheses, his/her family members, and community volunteers; 2) provision of or referral for technical aids; 3) raising community awareness regarding disabilities and the needs of the disabled population; and 4) prevention activities to lessen the incidence of disabilities. These services are provided by NGO's, which tend to specialize in one or a number of disabilities (e.g. for the hearing or site impaired).

In addition, Palestinian organizations have been actively involved in establishing societies and unions for the disabled persons, improving coordination between the government and NGOs to enhance the services provided to the disabled, and collecting

data and information urgently needed to plan for services. One of the CBR institutions has conducted house to house surveys covering all of the Gaza Strip and approximately half of the West Bank population, to identify needs for rehabilitation services and devise referral systems focusing on community-based services most readily available to those in need.

For more than a decade, the Palestinian rehabilitation community – service providers, planners, and consumers – have worked toward a national system of rehabilitation, encompassing both physical and mental health service needs and with a strong focus on community-based care. These endeavors have included for example: development of a National Rehabilitation Plan in 1989; several Impact Missions sponsored and coordinated by the World Health Organization (WHO), including two generally related to disabilities and a more recent mission, in 2001, focusing on mental health services; on-going coordination among rehabilitation services NGOs through committees based in the West Bank and Gaza; and more recent coordination and policy planning meetings held since the autumn of 2000.

In addition, and given the even more urgent needs to identify priority needs, coordinate services within and between physical and mental health rehabilitation service providers, and to help ensure a comprehensive system that addresses broad socioeconomic needs of the disabled, the MOH and UNRWA, with support from the World Bank, conducted two policy forums in the West Bank and Gaza in August, 2001. The goal of the forums was **to explore ways to strengthen the existing physical and mental health rehabilitation system, linking health and social services with physical and mental health needs.**

Obstacles to Effective Rehabilitation Care for Palestinians

Participants in both meetings identified two categories of obstacles to effective delivery of physical and mental health rehabilitation services. These were: 1) general socioeconomic and policy-related factors, and 2) those specifically related to the systems of care. These obstacles are listed below.

General socioeconomic and policy-related obstacles

1. The current harsh socioeconomic conditions, which may have particular impact on the disabled and on the ability of the public and private sectors to meet their needs. Although no specific studies have been conducted, data suggest that the disabled are disproportionately represented among those who live below the poverty line and/or who are unemployed. Although legally 5% of employment opportunities should be allocated to disabled persons, even in the best of economic times, and certainly under the current economic circumstances, this is difficult to put into practice.
2. The closures and checkpoints (**As of August 2003, there are 120 Israeli checkpoints in WBG. These and road blocks divide West Bank into 300 separate clusters and the Gaza Strip into 3 separate clusters**) place extreme

- barriers to services, both in terms of access by the disabled and by service providers traveling to health care facilities.
3. There is a shortage of adequate educational facilities and programs for disabled children (e.g., kindergarten) and for university students.
 4. The 1999 Disability Law has yet to be implemented or to have related regulations finalized and put into practice.
 5. There is inadequate physical accessibility, for example with respect to public buildings, streets and sidewalks, and recreation and sport facilities.
 6. There is no consensus-based, comprehensive, national strategy with specific implementation plan and related priority programs to address physical and mental health rehabilitation needs.
 7. There are inadequate financial resources to meet the needs of physically and/or mentally disabled populations and to provide adequate prevention and early intervention services, and the high cost of and low revenues for such services.
 8. There is a paucity of public financial resources allocated for psychosocial services at all levels of care.
 9. Both the public and private sectors are dependent on foreign financial support, which encourages donor-driven planning and programming as well as competition among the providers, and severely inhibits sustainability and coordination.

Obstacles related to systems of care

1. The current referral systems within and among physical and mental health services and between these services and comprehensive care (e.g., education, vocational training, income support, housing, family services) are inadequate.
2. There is an insufficient number and mal-distribution of trained and experienced professional and other providers.
3. The current facilities are insufficient to meet the demand, particularly given the impediments to travel.
4. There is a shortage of up-to-date and functioning rehabilitation equipment and material in some areas for some specialties (e.g., for visual and hearing impairment).
5. Transportation services (vehicles and escort services) to transport the disabled to rehabilitation and comprehensive services are inadequate and poorly financed.
6. Bureaucratic procedures and high fees at some service provider organizations are barriers to care.
7. There is inadequate follow-up of care by the service providers.
8. There is scant actual integration of community based (CBR) services with primary care and coordination among the CBR providers, although there is much discussion about the need for such integration.
9. Relationships between disabled persons and families of disabled children, and service providers and policy makers must be strengthened.
10. Insufficient basic supplies (e.g. x rays, film paper for EEG machines).

Since the time of the two Policy Forums, nothing much has changed. However; attempts at reactivating the Disability Law have recently started by means of conducting workshops to come out with implementation mechanisms. In addition, in September 2003 the WHO will start the process of drafting the Mental Health Policy for WBG.

Prevalence of Disability in West Bank and Gaza

The most recent prevalence study of disabilities in the West Bank and Gaza, published by the Palestinian Central Bureau of Statistics (PCBS) in 2000, was based on data collected in 1997. For purposes of the survey, PCBS defined a disabled person as one:

“...suffering from a clear and evident weakness in performing certain activities due to continuous difficulties emanating from a physical, mental or health state that lasted for more than six months. Disabilities resulting from a bone break or a disease lasting for less than six months are not considered disabilities.”¹

This definition is comparable to that used by the WHO that implies some level of rehabilitative care (i.e., that approximately 1.5% of any population has a disability requiring some level of rehabilitative care). The findings from this national survey provide the only broad prevalence data available related to disabilities in the WBG, and are therefore invaluable to a discussion of broad-based prevention and intervention strategies. However, it is important to consider that the results are based on self-report and that many conditions that bear a severe social stigma (including some physical disabilities, mental disorders, and alcohol or other drug use) are significantly under-reported in all countries. The PCBS survey thus serves as an invaluable point of departure for further epidemiological assessment of the prevalence of disabilities in the WBG.

In the PCBS survey, the results of which were published in the report “Disabled Persons in the Palestinian Territory,” just over 46,000 Palestinians (or 1.8% of the Palestinian population) were disabled, with a slightly higher rate in the West Bank (1.9%) than in the Gaza Strip (1.6%).² The Qalqiliya and Tulkuram governorates had the highest percentage of disabilities in the West Bank (2.3%). The prevalence in Jerusalem, Ramallah and Albireh, Jericho, and Hebron was the same – 1.7%. In Gaza Strip, the highest prevalence was in the Gaza governorate (1.7%) and North Gaza (1.6%). The remaining governorates were estimated to have a prevalence of 1.5% of the total population. Refugees were more likely to be disabled than non-refugees (1.9% of refugees were estimated to be disabled) and residents of urban areas less likely than other

¹ Palestinian Central Bureau of Statistics, Population, Housing and Establishment Census-1997, Disabled Persons in the Palestinian Territory. June 2000. p. 18

² Palestinian Central Bureau of Statistics, Population, Housing and Establishment Census-1997, Disabled Persons in the Palestinian Territory. June 2000. p. 21.

populations to be disabled (1.7% of urban residents were estimated to have some type of disability).³

The five most prevalent disability categories in the WBG, according to this prevalence study, were: mobility (over 30%), visual impairment (14.6%), mental disabilities (14.5%), and multiple disabilities (7.9%). More than one-third (36.8%) of the disabilities were related to congenital conditions and one-third to diseases (34.1%). Just over ten percent (10.3%) were related to traffic or other non-work injuries. The fourth most common cause of disability among Palestinians was “war” –which was the causal factor in 5.5% of disabilities. Birth-related trauma was the fifth most common cause – related to 3.6% of disabilities.⁴ Work-related injuries account for 3.2% of disabilities –relatively high for a low/medium income country.

The disabled population in the WBG – as in other countries – is diverse. More than half (55.1%) of younger disabled persons (5-24 years of age) were enrolled in a regular educational program, with nearly 60% in the West Bank involved in an educational program and less than half of those in the Gaza Strip being so involved. Approximately one-fourth of the disabled population was employed – just over 28% in the West Bank and just over 20% in the Gaza.⁵

To this 1997 prevalence study must be added the recent disabilities resulting from the current conflict, which has been ongoing since September 28, 2000. As of 31 July 2003, the total number of casualties is 36,448 according to a report by the International Press Center.

Out of the total number of injured Palestinians, The General Union of Palestinian Disabled estimates that 25,000 suffer from permanent disabilities – out of which 500 are children.⁶

Mental Health Conditions: A Particular Problem

Because there have been no large-scale mental health epidemiological studies in the WBG, it is not possible to identify the most prevalent mental health diagnoses among Palestinians. However, the prevalence of psychological stress-related disorders has been documented since the early 1990's. Indeed, in 1991, according to a study by the Gaza Mental Health Clinic, more than one-third of all patients receiving services had stress-related disorders, while just over one-fourth had organic disorders and less than 10% had

³ Palestinian Central Bureau of Statistics, Population, Housing and Establishment Census-1997, Disabled Persons in the Palestinian Territory. June 2000. p. 21.

⁴ Palestinian Central Bureau of Statistics, Population, Housing and Establishment Census-1997, Disabled Persons in the Palestinian Territory. June 2000. p. 26 and 28

⁵ Palestinian Central Bureau of Statistics, Population, Housing and Establishment Census-1997, Disabled Persons in the Palestinian Territory. June 2000. p. 22.

⁶ The Palestine Monitor, Statistics for the Palestinian Intifada, 28 September 2000 – 8 July 2003

psychoses.⁷ According to the 1997 census (referenced above), 14.5% of the population self-report some type of mental disorders; in fact, it was the third most frequently self-reported disability among Palestinians. This report does not describe special education needs, nor are there any available data for WBG that estimate prevalence of learning disabilities, whether or not related to DSM IV conditions.

In the WBG, in one of the largest studies of mental health conditions related to political violence, Khamis found that 35% of the 900 persons included in the study (selected from 1993 Palestinian Human Right Information Centre to identify Palestinians who had experienced intifada-related trauma) “met full criteria for **Post traumatic Stress Disorder (PTSD)** diagnosis.”⁸ The Gaza Mental Health Center has documented, through a number of research projects, both trauma-related psychological disorders, their consequences and other factors, including for example: prevalence of PTSD in the Gaza Strip,⁹ the psychological impact of trauma on children,¹⁰ and on resiliency among children exposed to violence.¹¹

Recently, the GCMHP¹² published another study of prevalence of PTSD among Palestinian Children which aimed to discover the prevalence of PTSD, and other levels of psychological suffering among Palestinian children living under severe conditions during the last two and half years of the Al-Aqsa Intifada. The sample consisted of 944 children between 10-19 years, randomly selected, with an arithmetic mean of 15.1±1.5, while 49.7% of the sample were boys, 50.3% were girls. Refugees represented 76.8% of the sample, and the rest were citizen residents. The most important findings of the study were:

1. The most frequent types of exposure for children:

- " 94.6% witnessed funerals
- " 83.2% witnessed shooting
- " 66.9% saw injured or dead who were not relatives
- " 61.6% saw family members being injured or killed
- " 36.1% were tear gassed

2. Increase in exposure to traumatic events led to an increase in the rate of identifiable PTSD symptoms:

⁷ El-Sarraj, E, Abu Tawahina, A, and Abu Heine, F. (The Palestinians: An Uprooted People. In: Marsella, AJ, et al. (1994) *Amidst Peril and Pain: The Mental Health and Well-Being of the World's Refugees*. Washington, D.C.: American Psychological Association, p. 150

⁸ Khamis, V. (2000). *Political Violence and the Palestinian Family: Implications for Mental Health and Well-being*. New York: Haworth Maltreatment and Trauma Press, p. 41

⁹ Qouta, S, El-Sarraj, E, and El-Masri, M. (1999) *An Epidemiological Study of the Prevalence of Stress Related Psychiatric Disorders Among Palestinians in the Gaza Strip*.

¹⁰ Qouta, S, Punamaki, R-L, and El-Sarraj, E. (1995) *The Relationship between Traumatic Experiences, Activity, Cognitive and Emotional Responses Among Palestinian Children*, Intl. J. of Psychology, 30 (3), 289-304

¹¹ Qouta, S., Punamaki, R-L, and El-Saaraj, E. *Resiliency Factors Predicting Psychological Adjustment After Political Violence among Palestinian Children*. Accepted for publication in the *International Journal of Behavioral Development*, 2000.

¹² Qouta, S (2003). *Prevalence of PTSD among Palestinian Children*, GCMHP.

" 32.7% of the children suffered from acute levels of PTSD symptoms indicating psychological intervention

" 49.2% of the children suffered from moderate levels of PTSD symptoms

" 15.6% of the children suffered from low levels of PTSD symptoms

" 2.5% of the children had no symptoms.

3. The study found significant differences between boys and girls. For acute levels of PTSD, 57.9% of girls developed such symptoms, while among boys it was 42.1% , p-value = .01.

4. Children living in camps suffered more than children living in towns. It was found that 84.1% of camp children developed PTSD, while 15.8% of town children developed PTSD.

5. In a projective research test (where children were presented with a picture of 'Fatma', a 15-year-old Palestinian student. The children were asked by the researchers about what thoughts does Fatma have in her mind). The results indicated that:

a. 66% of children thought that Fatma would like to concentrate her efforts on school issues.

b. 24.7% of children thought that Fatma would like to be a martyr. (Where males represent 67.8% and females represent 32.2% of this percentage)

c. 8.7% of children thought that Fatma would like to encourage the peace process.

d. 0.1% of children thought that Fatma would like to be involved in national struggle.

e. 0.5% of children thought that Fatma would like to concentrate on religious issues.

The GCMHP has done another study¹³ as part of an epidemiological investigation of mental health problems among patients in primary health care clinics in the Gaza Strip. The study aimed at investigating the prevalence and associated socio-demographic variables of Post traumatic Stress Disorder (PTSD) among patients attending Primary health care centers in the Gaza Strip, It was found that the overall prevalence of PTSD symptoms in primary health care patients was 29%, and significantly higher among females than in males (P=0.001). Prevalence of PTSD among those exposed to traumatic events was 36%. Highly educated patients were more often exposed to traumatic events, but the prevalence of PTSD was lower than among less educated patients. Males exposed to traumatic events reported a lower prevalence of PTSD than traumatized females. It is worth mentioning that the number of patients who participated in this study were 661 in 10 primary health care centers.

¹³ Afana, Abdel-Hamid et al (2002). The prevalence and associated socio-demographic variables of Posttraumatic Stress Disorder (PTSD) among patients attending Primary health care centers in the Gaza Strip, GCMHP

Availability Of Rehabilitation Services in the West Bank and Gaza

Prior to the Oslo Accords, virtually all physical rehabilitation services in the West Bank and Gaza were operated either by the non-profit private sector or by UNRWA. In 1989, Giacaman et al identified 57 non-governmental organization (NGO) facilities providing rehabilitation services in the West Bank,¹⁴ most of which provided services on an outpatient basis. Two new inpatient facilities (one in Ramallah and one in Bethlehem) were constructed entirely with donor support. In Gaza, NGOs provided services for disabled children and their mothers (e.g., Society for the Care of Handicapped Children), outpatient physiotherapy and manufacturing of orthopedic devices (e.g., the Benevolent Society in Gaza), and outpatient and preventive services for children with a wide range of disabilities (e.g., the Child Development Center).¹⁵ Several private organizations (Bethlehem Arab Society, Catholic Relief Services, Center for Handicapped Children in Gaza, Diaconia) had initiated programs for at-home care or networks of community-based rehabilitation centers.

Over a several year period, largely in response to the first Intifadah, donors had supplied extensive rehabilitation technology to these NGOs, including up-to-date physical therapy equipment. Hundreds of Palestinians had been trained in the WBG or abroad as physical therapists and community-based “ancillary” service delivery personnel. In one case, for example, the Center for Handicapped Children arranged with U.S. organizations for certified training of allied health personnel to provide speech and hearing services to disabled children.

There were scant facilities for mental health services in the West Bank and Gaza prior to the PA. The only public facilities (that is, those operated by the Government of Israel Civil Administration--GOI/CA) were: 1) one psychiatric hospital--which also had an outpatient department and which was located in Bethlehem; and 2) five public primary health centers located in the West Bank and two in Gaza that offered minimal outpatient mental health services.¹⁶ There was one privately operated outpatient clinic in the West Bank (the Psychological Counseling Center, located in East Jerusalem), and one in Gaza (the Gaza Community Mental Health Center). Both of these were non-profit centers and supported through donors. Several NGOs offered counseling in their centers on a periodic basis, either by a trained psychologist (there were few in the WBG at that time) or by social workers.

As was the case prior to the Oslo Accords, non-governmental organizations (NGOs) currently provide, by far, the majority of physical and mental health rehabilitation services in the WBG. At least 125 rehabilitation centers in the West Bank and Gaza are

¹⁴ Giacaman, R et al (1989), p. 15

¹⁵ Policy Research Incorporated. (1992) Development Opportunities in the Occupied Territories: Health. Bethesda, MD: PRI, p. 19

¹⁶ Policy Research Incorporated. (1992) Development Opportunities in the Occupied Territories: Health. Bethesda, MD: PRI, p. 19

operated by NGOs, for the most part focusing on one or a limited number of disabilities (e.g., for hearing and speech impairment, visual impairment, spinal cord injuries). The Ministry of Health (MOH) provides immediate post-trauma care through orthopedic and rehabilitation units in its hospitals, and physical therapy in some hospitals and primary care centers, and through contracts with NGOs. UNRWA also provides physical rehabilitation services, for the most part through their primary care centers, but also through contracts with NGOs.

There are scant facilities for either inpatient or outpatient mental health services. The MOH operates two psychiatric hospitals, the Bethlehem Psychiatric Hospital, a 320-bed facility, and the 41-bed Gaza Mental Health Hospital. The Directorate of Primary Health Care also has a system of Community Mental Health Clinics. Of the NGOs providing rehabilitation services, less than one-third provide mental health services. The Gaza Community Mental Health Program (GCMHP), the largest of these, has a network of prevention, detection and screening, and treatment services in Gaza, including four centers specifically targeting women. In the West Bank, the Palestinian Counseling Center has provided prevention and treatment services as well as training in counseling, for nearly 20 years. UNRWA refers clients to GCMHP for psychological counseling, but there is no contractual relationship through which the Program is reimbursed for these services.

For the most part, the rehabilitation centers focus on one or a limited number of disabilities such as hearing, speech and sight impairment, and spinal cord injuries. There are scant facilities for mental health services, which are largely provided by NGOs. In fact, of the 125 NGOs providing rehabilitation services, less than one-third provide mental health services. The Gaza Community Mental Health Program (GCMHP, previously named the Gaza Mental Health Center) has a network of prevention, detection and screening, and treatment services in Gaza, including four centers specifically targeting women. In the West Bank, the Palestinian Counseling Center provides prevention, detection, screening, and treatment services, but is focused primarily on East Jerusalem and environs. This center is severely hampered by the lack of geographic access to other parts of the West Bank, in which mental health services are barely existent.

Notably, women's organizations have played a key role in community-based rehabilitation services in the WBG. Nearly one-half (47%) of the 63 NGOs in the West Bank and 27% of the 40 NGOs in the Gaza Strip that provide disability and rehabilitation services are supervised and or managed by women. The disability and rehabilitation services provided by these organizations vary from mental, physical, hearing impaired, and visually impaired. Almost all of the NGOs provide services for both women and men. Nine of the sixty-three NGOs in the West Bank are women organizations, and seven of these specifically provide services for women.

*Please refer to the list of NGOs providing rehabilitation services in the West Bank and Gaza sent as an attachment to my message.

For more information on the programs and activities of Palestinian NGOs during the Palestinian Uprising “Intifada”, please visit the links below:

www.gcmph.net	Gaza Community Mental Health Program
www.hdip.org	Health, Development, Information and Policy Institute
www.pcc-jer.org	Palestinian Counseling Center
www.upmrc.org	Union of Palestinian Medical Relief Committees
www.palestinemonitor.org	Palestine Monitor
www.palestinercs.org	Palestinian Red Crescent Society
www.wclac.org	Women’s Center for Legal Aid and Counseling
www.moh3.com	Ministry of Health
www.pcbs.org	Palestinian Central Bureau of Statistics