IMPACT OF THE PALESTINIAN NATIONAL CASH TRANSFER PROGRAMME ON PERSONS WITH DISABILITIES' INDEPENDENT

LIVING

Ola Abu Alghaib

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Declaration

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Abstract

This thesis aims to contribute to current policy and academic debates on the impact of cash transfers, as an essential pillar of social protection policy, on persons with disabilities in low-and middle-income countries. It is one of the first studies to specifically explore cash transfer schemes' potential contribution to persons with disabilities' independent living, pursuant to Article 19 of the United Nations Convention on the Rights of Persons with Disabilities. A qualitative country case study approach, with both descriptive and explanatory purposes, was adopted. Multiple lines of evidence were used to examine the Palestinian National Cash Transfer Programme, combining collection and analysis of primary and secondary data through document study, expert interviews, focus group discussions, and in-depth interviews.

This thesis draws on the transformative social protection framework, emphasising the aim of enhancing the rights and social status of the marginalised, thereby reducing their economic and social vulnerability. It argues that social protection for persons with disabilities should adopt a 'transformative' approach to support equity, social justice, and empowerment. The necessary components of an inclusive social protection policy are suggested, transcending the traditional medical or charitable conceptualisations of persons with disabilities.

The thesis highlights the complexity of addressing disability through cash transfer programmes, especially when political, structural, and resource factors are also influential. The main argument is that ad hoc responses to persons with disabilities' needs in cash transfer programmes are insufficient to deliver a sustainable and positive impact on their wellbeing and independent living. The evidence suggests that policy interventions to address persons with disabilities' independent living rights must focus on institutional, social, and political structures, rather than just income. Cash transfers are one policy solution to partially enhance persons with disabilities' autonomy and life choices. However, social protection interventions should extend beyond poverty alleviation social transfers, with broader services than cash. Adopting wide-ranging measures should assure persons with disabilities of equal access to support and mainstream social services, promote their independence, and reduce social exclusion.

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List of abbreviations

AFCS Armed Forces Compensation Scheme

AIDA Association of International Development Agencies

AMG Assistance Médicale Gratuite

ANED Academic Network of European Disability Experts

ANERA American Near East Refugee Aid

ASSIA Applied Social Sciences Index and Abstracts

BRAC Bangladesh Rural Advancement Committee

CAA Constant Attendance Allowance

CBR Community-based rehabilitation

CCT Conditional cash transfer

CRPD United Nations Convention on the Rights of Persons with Disabilities

CSO Civil Society Organisation

CT Cash transfer

CWD Child with disabilities

DALYs Disability-adjusted life years

DFID Department for International Development

DPO Disabled Persons Organisation

DS Disability Survey

ESA Employment and Support Allowance

ESDA Exceptionally Severe Disablement Allowance

EU European Union

FGD Focus group discussion

GDP Gross domestic product

GIZ German Development Agency

Gol Government of Israel

GPC General Personnel Council

GUDP General Union of Disabled People

HDI Human Development Index

HIC High-income country

HMC Higher Medical Committee

IBSS International Bibliography of the Social Sciences

ICF International Classification of Functioning, Disability and Health

ICJ International Court of Justice

ICT Information and communication technology

IDP Internally displaced person

IE Inclusive Education

IIDB Industrial Injuries Disablement Benefit

IL Independent living

ILF Independent Living Fund

ILO International Labour Organization

IMF International Monetary Fund

INGO International non-governmental organisation

LEAP Livelihood Empowerment Against Poverty

LIC Low-income country

LMC Local Medical Committee

LMIC Low- and middle-income country

MDG Millennium Development Goal

M&E Monitoring and evaluation

MENA Middle East and North Africa

MIC Middle-income country

MIS Management Information System

MoEHE Ministry of Education and Higher Education

MoF Ministry of Finance

MoH Ministry of Health

MoL Ministry of Labour

MoSA Ministry of Social Affairs

MoSD Ministry of Social Development

MoT Ministry of Trade

NAF National Aid Fund

NCPA National Centre for Policy Analysis

NGO Non-governmental organisation

NIS New Israeli Shekel

NSDS National Social Development Strategy

ODI Overseas Development Institute

OECD Organisation for Economic Cooperation and Development

OOP Out-of-pocket

OPT Occupied Palestinian Territory

PA Personal assistant

PCBS Palestinian Central Bureau of Statistics

PECS Palestinian Expenditure and Consumption Survey

PICOS Participants, Intervention, Comparator, Outcomes, Study design

PIP Personal Independence Payment

PLC Palestinian Legislative Council

PLO Palestine Liberation Organization

PMT Proxy means testing

PMTF Proxy means-test formula

PNA Palestinian National Authority

PNCTP Palestinian National Cash Transfer Programme

PRISMA Preferred Reporting Items for Systematic Reviews and Meta-Analyses

PWD Person with disabilities

QoL Quality of life

RAMED Regime d'Assistance Medical

SAP Structural adjustment plan

SAP Social Action Plan

SDGs Sustainable Development Goals

SHC Social Hardship Cases

SP Social protection

SRM Social risk management

SSN Social safety net

SSNRP Social Safety Net Reform Programme

TSP Transformative social protection

UAE United Arab Emirates

UC Universal Credit

UN United Nations

UN CRPD United Nations Committee on the Rights of Persons with Disabilities

UN DESA United Nations Department of Economic and Social Affairs

UN ESCWA United Nations Economic and Social Committee for West Asia

UNCTAD United Nations Conference on Trade and Development

UNDP United Nations Development Programme

UNOCHA United Nations Office for the Coordination of Humanitarian Affairs

UNRWA United Nations Relief and Works Agency

UNICEF United Nations International Children's Emergency Fund

UPIAS Union of Physically Impaired Against Segregation

USD Unites States Dollar

VAT Value-added tax

WCA Work Capability Assessment

WHO World Health Organization

WWD Woman with Disabilities

1. Introduction

1.1. Problem statement and rationale

Article 19 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) requires measures that guarantee persons with disabilities (PWDs) the right to live, participate, and enjoy full inclusion in the community. It is complemented by Article 28, CRPD, under which the right to an adequate standard of living and social protection should be guaranteed. This study focuses on the potential impact of cash transfer schemes on PWDs' independent living. Independent living is central to the CRPD's goals, which provide a framework for evaluating PWDs' situation and measuring their progress towards equality with others (Burke, 2009). Yet, even before the CRPD's adoption, countries had formulated numerous policies to improve PWDs' independent living. These included promoting de-institutionalisation and instituting direct payment schemes, both seen as promising for empowering PWDs to choose and manage their own care (Shima and Rodrigues, 2009). The philosophy of independent living posits that all individuals should be able to control their lives and choose their daily actions, including managing their personal lives and participating in a community (Batavia et al., 1991; Martinez, 2003). This requires personal support services and appropriate housing, transport, education, employment, and training. Morris (2004) defines independent living through three main principles: 1) PWDs should have the same choices and control as non-disabled people; 2) independence does not preclude receiving assistance; and 3) the required assistance should be identified and controlled by PWDs themselves.

Over the past 20 years in many high-income countries, such as the UK, cash payments have been recognised as a strategy for tackling inequalities (Zarb and Nadash, 1994). The disability movement has considered them key to achieving full citizen rights. Though disbursing direct payments has diverse implications for different PWD groups, the movement still considers this a progressive measure for achieving full independent living rights (Riddell et al., 2006; Pudney, 2009; Da Roit and Le Bihan, 2010).

Evidence on how the right to independent living (Article 19, CRPD) has been implemented in low- and middle-income countries (LMICs) remains lacking. The literature does not consider whether LMICs have begun to regard direct payments as means of empowering PWDs to choose and control where, how, when, and by whom their support is provided. Without

¹ In high income countries, direct payment schemes grant money directly to PWDs to pay for their own care, rather than the traditional route of a local authority providing care for them.

adequate government policies to finance and support the independent living model, many families have to provide such services themselves, which often results in unhealthy dependency on family members, weakening opportunities for personal growth and independence.

Social protection policies are key to meeting PWDs' specific needs as regards increasing independence, income security, health protection, and social inclusion. However, there are concerns about the effectiveness of social protection policies in addressing PWDs' needs in developing countries (Mitra, 2005; Gooding and Marriot, 2009). Additionally, 'it is not clear to what extent existing programs are (i) reaching the disabled population and (ii) meeting their objectives of reducing poverty and contributing to broader development goals of social and economic inclusion' (Palmer, 2013, p.140).

One key method of social protection provisioning is cash transfers, which have become one of the most widely implemented development policies over recent years (Manley et al., 2011), in the form of non-contributory benefits (ILO, 2014). The provision of cash transfers to cover disability-related costs, together with income from a job, can help PWDs to overcome and avoid poverty traps and facilitate their participation in society (United Nations International Children's Emergency Fund [UNICEF], 2013). However, unlike in developed nations, cash transfers' impact on PWDs has not yet been systematically reviewed in LMICs (Mitra, 2010). Samson (2006) considers this lack of adequate analysis to be the 'biggest gap' in research and information on social protection in LMICs.

Studies have yet to provide conclusive evidence on the effects of cash transfers, as channelled through social protection policies, for PWDs in LMICs. The literature review, presented in Chapter 2, reveals that the debate centres on issues of disability assessment; the impact of cash transfers on access to health, employment, and education; and the design of existing schemes (targeted versus mainstream programmes). However, these studies fail to consider when the grant is accessed and how it may improve PWDs' degree of independent living as a major quality of life (QoL) indicator.

1.2. Research assumptions and objective

The proposed research will bridge this knowledge gap on disability and cash transfer programmes in LMICs, enriching the scant literature on the relationship and interaction between disability and social protection policies. It aims to contribute to the current policy and academic debates on the impact of cash transfers, as an essential pillar of social protection policy, on PWDs in LMICs. The following assumptions drive this research:

- Social protection can address the disability-specific vulnerabilities of PWDs and their households (e.g. social exclusion).
- Cash transfers as part of social protection programmes can present an effective means to support PWDs and their independent living, often being the only cash benefit they can potentially access and utilise in the absence of targeted disability benefits.
- The capacity and effectiveness of cash transfer schemes and related policies to produce the required change in PWDs' lives in LMICs depends very much on the design and implementation mechanisms.

Thus, the overall research objective is to <u>establish whether the Palestinian National Cash</u>

<u>Transfer Programme (PNCTP) supports and fosters greater independent living for PWDs living</u>
in Palestine.

In line with the overall objective, the specific research questions are as follows:

- 1. How do selected components of cash transfer policies for PWDs (i.e. stakeholders, programmes and implementation mechanisms, relevant policies and laws, and available resources) operate in the context of Palestine?
- 2. How and to what extent do existing cash transfer schemes affect PWDs' independent living in Palestine?
- 3. What critical factors in the existing PNCTP promote or prevent PWDs from gaining greater independent living?

To pursue the research objective and address these questions, a qualitative country case study with a descriptive and explanatory purpose is adopted. Multiple lines of evidence are used, combining the collection and analysis of primary and secondary data: document study, expert interviews, focus group discussions (FGDs), and in-depth interviews. The collected qualitative information is contextual and enables understanding of the connections and processes shaped by social actors' perceptions and beliefs: such variables, which are not easily quantifiable, are core to this research. The research's descriptive aim is to accurately depict the conditions under study (policy dimensions and impact at the individual level).

The initial literature review explores numerous relevant national reports on the situation of PWDs. It also examines relevant policies, focusing especially on social protection, strategy documents, and legislation on PWDs and the different services and support mechanisms they are entitled to access to support fulfilment of their rights. Findings from the literature review have informed the design of the qualitative research instruments and been utilised in data analysis: information derived from policy documents has been triangulated with key informant interviews to better understand the barriers hindering the PNCTP's adequate implementation.

The review has also examined relevant regional and international research on the design and impact of cash transfers on PWDs' independent living in LMICs, aiming to understand this study's potential to fill the gap in the literature on this topic.

The study's primary target population is working-age PWDs who are PNTCP recipients. Indepth interviews with PWDs is a key component of this research, aimed at capturing PWDs' voices directly and allowing them to discuss their experiences of accessing the PNCTP and the programme's impact on their independent living opportunities. A diverse purposive sample of PWDs were interviewed, including males and females of different background and demographic characteristics (place of residence, age (18-50), educational status, and refugee status), as well as persons with diverse disability types (visual, hearing, speaking, and physical) and causes (congenital, medical diseases, injury, and conflict-related). This has allowed the capture of diverse perspectives from PWDs living in both the West Bank and Gaza.

1.3. Thesis outline

This thesis is organised in seven chapters. Chapter 1 provides the introduction to this research. Chapter 2 examines the relevant literature to exemplify this thesis's conceptual foundations, such as disability, poverty, and vulnerability. It also reviews the main conceptual frameworks linking social protection, cash transfers, independent living, and social justice, focusing especially on the transformative framework. The chapter finishes by examining global practices in high-income countries (HICs) and LMICs regarding cash transfers and disability, in terms of policy design, implementation, and impact.

Chapter 3 presents the research's methodological foundations, including the research strategy, epistemology, and research paradigm. Positionality is explicitly discussed, and underlying assumptions explored. Importantly, the rationale for choosing qualitative research is explained: in addition to focusing equally on the outcome and process, it allows deep consideration of the perceptions and understandings of the people involved. Finally, limitations related to the political context and restricted physical accessibility are presented.

Chapter 4 reviews the intersection between disability and social protection policy and programming in the Middle East and North Africa (MENA), exploring the region's political and socioeconomic context, the various legal and institutional frameworks which underpin social protection policy, and the related programming landscape. It also considers the situation and needs of PWDs living in the region, and the social protection measures which target them.

Chapter 5 examines the current context in Palestine, explaining the causes of vulnerability for Palestinians in general. In line with this thesis's radical approach to social justice, it focuses especially on the structural impediments to Palestinians accessing social policies in the West Bank and Gaza.

Chapter 6 presents and analyses the research's findings on social protection and disability in Palestine, including how disability is defined and quantified; how social protection is framed, resourced, and delivered; and the ways it is assessed at policy level. It also discusses social protection policy in Palestine, particularly how disability is addressed within the PNCTP, and the programme's impact on PWDs, particularly relating to their independent living.

Chapter 7 discusses the findings presented in Chapter 6 in relation to existing evidence. It also draws general conclusions and derives implications for policy and future research.

2. Literature Review

Chapter 2 analyses the relevant literature with regard to this thesis's conceptual foundations, such as disability, poverty, and vulnerability. It also presents the main conceptual frameworks linking social protection, cash transfers, and independent living, focusing especially on the transformative framework. The chapter ends by examining global practices in HICs and LMICs regarding cash transfers and disability, in terms of policy design, implementation, and impact.

2.1. Disability and vulnerability: clarification of underlying definitions, concepts, and terminology

2.1.1. Introduction

Estimated to number 1 billion, PWDs are the world's largest minority group (World Health Organization [WHO] and World Bank, 2011; United Nations [UN], 2015a). According to the World Bank (2016b, p.1) '[PWDs] are more likely to experience adverse socioeconomic outcomes than persons without disabilities'; moreover, the 2002-2004 World Health Survey² found that, across all countries, vulnerable groups – such as those in the poorest wealth quintile, women, and older people – had a higher prevalence of disability. For all of these groups, the rate was considerably higher in LMICs.

Indeed, it is increasingly reported that PWDs face multiple and overlapping forms of disadvantage due to their disabilities, particularly in LMICs, where social, political, and economic conditions are an inherently major concern for the population at large. PWDs may be systematically marginalised by laws, norms, and practices (Jones and Shahrokh, 2013), and/or face increased vulnerability to external factors compared to the general population (UN, 2015a). This section of the literature review draws on growing, if fragmented, global evidence to explore the complex interactions between disability, poverty, and additional vulnerabilities caused by social exclusion and inequitable access to basic services.

This thesis understands 'disability' from a human rights-based perspective, as a result of 'the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others' (UN, 2006, p.2; Degener, 2016). Implicit in this definition is the understanding that social dimensions of

² Survey materials and data are available through the WHO World Health Survey Data Archive: see http://www.who.int/healthinfo/sage/articles whs/en/

vulnerability, including (alongside disability) gender, ethnicity, and geographic location, deeply influence people's exposure to risk and their resilience (UNICEF, 2015).

This thesis uses a multidimensional definition of poverty that accounts for the multiple disadvantages people suffer, considering both income (consumption, expenditure) and non-income (education, employment) aspects of poverty. Multidimensional measures reveal not only who is poor but how they are poor, i.e. the range of different disadvantages they experience (Mitra et al., 2013; Oxford Poverty & Human Development Initiative [OPHI], 2016).

It also adopts the definition of vulnerability articulated by the transformative social protection school (Sabates-Wheeler and Devereux, 2008): vulnerability extends beyond financial limitations and is conceptualised as being embedded in the sociopolitical context and emerging therefrom, rather than as an exogenous risk factor requiring management. For vulnerable groups at risk in a given context, this model's corollary comprises policies and programmes seeking to transform the context itself, aiming to minimise the risks they face (Sabates-Wheeler and Devereux, 2008). Transformative policies and programmes 'relate to power imbalances in society that encourage, create and sustain vulnerabilities', aiming to tackle the deeper structural causes of vulnerability (Devereux and Sabates-Wheeler, 2004, p.9).

The chapter begins by setting out the various predominant definitions of disability, paying particular attention to the medical, social, ICF, and capability models, as well as the theorists Wasserman and Grönvik. It then turns to approaches to measuring disability prevalence, to disability assessment practices, and to related issues of heterogeneity and intersectionality. The second half of the chapter presents existing evidence on the relationship between poverty and disability, PWDs' access to basic services, and the risks they face in terms of violence and abuse.

2.1.2. Defining disability

Disability is a broad classification, covering a diverse range of people, conditions, and impairments. Within this range, many people experience different challenges in society and everyday life. In addition, some people who may not consider themselves disabled would be classified as such by some definitions. Thus, the employed definition of disability affects the number of people classified as disabled. This has significant implications for resource

allocation, the reach of public policy, and the effects of such policy as experienced by PWDs. The chosen definition or model of disability also significantly influences public policy outputs, by providing the foundation on which governments, agencies, and societies build strategies to meet PWDs' needs. Therefore, the disability definition or model significantly impacts what strategies ultimately reach PWDs, as different models favour different responses to disability.

The precise definition of disability is highly contentious. Until 2006, the Oxford English Dictionary recognised only two meanings of disability: as a synonym of 'inability', or referring to 'legally imposed limitations on rights and powers' (Wasserman et al., 2015, p.2). If disability is defined only by stigmatisation and exclusion, it is not distinguished from race or sex. It is, thus, important not to promote a reductive or simplistic view of disability when defining the term.

Disability concerns the 'classification of people on the basis of observed or inferred characteristics' (Wasserman et al., 2015, p.1). It is as much a philosophical topic as sex or race. Debate continues over whether classifications are biology-based or socially constructed. Some believe that disability reduces wellbeing because of the 'stigma and discrimination it evokes' (Wasserman et al., 2015, p.2). This approach philosophically equates disability to sex or race. For others, disability differs fundamentally from race and sex: in a world free from discrimination, persons with impairments would still have lower quality of life than their ablebodied counterparts.

There is also debate around the characteristics of impairments (physical or mental) and their associated limitations (personal or social). Several scholars challenge the populist view that impairment is objective and biologically grounded (Wasserman et al., 2015). Consensus is lacking on the need to categorise limitations as personal activities or social or political participation. On one side of the debate, disability definitions imply that 'biological impairments are the sole causes of limitation' (Wasserman et al., 2015, p.3). On the other side, the limitations that PWDs face are solely attributed to 'contemporary social organisation'; persons with impairments are 'subject to exclusion and oppression' (Wasserman et al., 2015, p.3). However, this view ignores disadvantages that cannot be attributed to social attitudes. Between these two ends of the spectrum are definitions that combine biological impairments and social responses as joint causes of limitations.

These different definitions have profound implications for the nature of social protection provision for PWDs. The definitions of and assessment mechanisms for disability adopted in each country largely determine PWDs' equal opportunities to access programmes/services, with narrow medical definitions risking greater exclusion. Regarding social protection, for

example, disability definitions determine whether and how an individual is classified as being a PWD, perceptions of the severity of the disability and related support needs, and, ultimately, whether and how they are included in programming. In disability-specific social protection programmes, disability classification shapes whether programmes are universal (i.e. for all PWDs) or targeted (e.g. for only the poorest PWDs or those with high or specific support needs). In mainstream social protection programmes, it determines whether and how adaptations might be made (e.g. removing conditionality from cash transfers).

This section sets out the most prominent approaches to defining disability, outlining the key features, limitations, and applicability to social protection of each approach. It begins by overviewing different types of definitions, as summarised by Grönvik.

Grönvik's five definitions of disability

According to Grönvik (2007), there are five main definitions of disability, as outlined in Table 2.1. The functional definition 'focuses on a person's functional limitation' (p.11) and is largely unconnected to the social environment. This is the medical model, as described above. The relative (or environmental) definition takes account of the individual's surroundings and experiences, in that 'a person with an impairment only finds him-/herself in a disabling situation when the surroundings are inaccessible' (p.11). Grönvik defines the social model of disability as 'barriers in society that keep people with impairments from fully participating in society' (p.12). Under the administrative definition, a PWD is an individual who has been classified by the welfare state as disabled and eligible to receive aid given to PWDs. Finally, under the subjective definition, a person's disability 'makes them the object of different treatments' (p.12), but importance is placed on how the person defines and views themselves.

Table 2.1 Grönvik's (2007) five definitions of disability

Definition Type	Criteria	Purpose (examples)	Agents (examples)
Functional Definition	Disability as a lack of or	'Head-counting' in	Statistical bureaus,
	restrictions of bodily	surveys and censuses to	medical professions
	functions.	assess need for	
		rehabilitation, training,	
		equipment, etc.	
Relative Definition	Disability appears in the	Shift from solely	Disability movement,
	relation between a	depicting individuals as	policymakers
	person with	disabled to focusing on	
	impairment(s) and	the relationship	
	inaccessible	between individuals	
	surroundings.	and surroundings.	

Social Model of	Disability is the	Shift focus from	Disability movement
Disability	oppression of and a	individuals to barriers	
	barrier against people	and oppressive	
	with impairments.	processes within	
		society.	
Administrative	Disabled people are	Delimit categories of	Welfare authorities
Definition	those categorised by	people eligible for	
	the welfare state as	certain benefits and	
	needing/or eligible for	supports.	
	certain support		
	systems.		
Subjective Definition	People perceiving	Identity construction;	Disability movement
	themselves as disabled,	filter questions in	
	irrespective of such	censuses and surveys.	
	perceptions' basis.		

Source: Grönvik (2007).

According to Grönvik (2007), 'different definitions have been devised to suit different purposes' (p.15). A definition may, thus, represent the rejection of a previous definition, or be chosen for a practical purpose, such as conducting a national census. For example, using the functional definition of disability may be particularly useful for rehabilitation, when designing strategies to restore functions is the focus. Being able to define disability is pivotal to governments' ability to implement policies: 'defining some people as disabled and some as not allows authorities to distribute support to some people, but at the same time provides arguments for not giving support to others' (2007, p.15). While, ideally, every person would receive any support they desire, this is not practically possible. Grönvik argues against standardising disability definitions, explaining that different purposes require different conceptualisations and should be approached with clear realization of the possible consequences of operationalising a particular disability definition. Different definitions of disability would lead to 'great differences' in outcomes (2007, p.32). There is also a danger that 'narrow definitions lead to exclusive measures that give rise to underestimates of disability in populations' (Schneider, 2009, p.43).

The medical model

Globally, several definitions and models of disability are employed in policy planning and monitoring. At the two ends of the spectrum for conceptualising disability are the medical and the social models (Trani et al., 2011).

The medical, or individual, model is narrow in scope, with disability 'perceived to be caused by physical impairments resulting from disease, injury or health conditions' (Palmer and Harley, 2012, p.358). In this model, impairment leads directly to the 'loss of bodily and social functioning' (p.358). The medical model is, thus, based on viewing disability as divergence from normal capacity to conduct daily activities. According to this definition, disability is a biological condition inherent to the individual, which reduces her/his quality of life and participation in society in comparison to 'normal' human functioning (Trani et al., 2011).

In this model, prevalence is measured by evaluating the number of persons within a series of impairment categories, each concerning one or more limitations across a range of basic functions and structures of the body. PWDs fall neatly into certain predefined and clearly bounded categories – the deaf, the blind, etc. – and are considered to deviate from the norm. However, it is important to note that prevalence estimates thus defined are biased: any census or survey based on self-reporting, especially with questions that may be considered stigmatising in a given cultural context, may provoke reluctance to answer and, therefore, underreporting. Research adopting this perspective of disability focuses on the disadvantages considered to result from an individual's impairment, while resulting policies aim to compensate for restrictions in some of their activities, rather than addressing barriers to PWDs' full participation in society (Trani et al., 2011).

The social model

The social model is broader and based on a notably distinct paradigm, framing disability as a social construct. Social change, rather than addressing the impairment itself, is the appropriate response. By de-individualising disability, the social model constitutes an important political tool for empowering PWDs. It has been described as 'the central tenet of the self-organised disability movement' (p.358), and has influenced national legislation.

The social model does not absolutely reject the idea of health limitation, which it considers as the impairment, but regards a person as 'differently abled' (Trani et al., 2011). This view, advanced by the disabled people's movement, tends to consider the existing barriers within the social context that prevent a person from achieving the same level of functioning as a non-disabled person. This perspective contends that society should adapt to include PWDs (Oliver, 1996). Advocates of the social model consider that physical limitations become a disability because society does not accommodate differences in human functioning. Mainstreaming disability concerns is a progressive and sustainable way of redesigning society to include all disabled people. However, the social model has implications for measuring prevalence,

conducting research, and defining policies. Questions based on this model not only focus on impairment but also seek to identify the barriers within the social environment that create the disabling situation. This perspective requires policymakers to address restrictions caused by social organisation, promote adaptation through the law, further participation by mainstreaming disability concerns, and ensure equal rights and opportunities (Trani et al., 2011).

Critiques of the social model highlight that it fails to address impairment, which cannot be separated from the experience of disability. To fully account for PWDs' lived experiences, all aspects of disability need to be included. Disregard of impairment has likely 'contributed to limited research into the lives of PWDs and [...] has limited the development of disability-specific policy' (Palmer and Harley, 2012, p.358). Lack of disability-specific policy serves to further exclude PWDs from society. Theorists including Palmer and Harley reject this critique, viewing inequalities between persons with and without disabilities as the result of oppression and discrimination, rather than impairment. The social-relational model has been developed to fuse the individual and society. It acknowledges the personal and social effects of disability, which is asserted to be 'contingent upon social conditions' (Palmer and Harley, 2012, p.358); it also emphasises reducing barriers in society for PWDs.

The ICF model

In both the models presented above, disability is understood as distinct from a 'normal' state of health. However, a third approach regards this normal or 'perfect' health situation as an ideal that few people experience; instead, on a continuum of health status, each individual presents some types of deficiency in certain dimensions of functioning. The ICF model, approved by the WHO, recognises that disability has several dimensions or levels, and is composed of various domains of activities and participation corresponding to the body, the person, and the person-in-society. It regards disability as a combination of different factors that influence the environment in which PWDs evolve. The ICF system calls for assessment of two kinds of factors: environmental (including the physical and social environments, and impact of attitudes) and personal. This view assumes that functioning encompasses all bodily functions, activities, and participation. Accordingly, disability encompasses impairment, activity limitations, and restrictions in participation. From this perspective, disability is considered as absence of functioning or dysfunction: in other words, as a lack of functionings (Trani et al., 2011).

The ICF model thus seeks to create a classification system that integrates the social and medical models of disability. This classification has created a scientific approach to form a mutual global language to describe health-related issues between medical professionals and PWDs. It also aims to facilitate data comparison across different countries. The ICF's contents have been used in statistical analysis, research, clinical practice, social policy, and education (Lundälv et al., 2015).

However, this definition and listing of disabilities present certain limitations. In focusing on the body, individual limitations, and participation, and the ICF's disability definition neglects the interaction between individual and society, thus offering an insufficiently broad perspective for defining policies (Bakhshi and Trani, 2006). Despite the ICF now being widely accepted, the idea persists of a definitive list of limitations classified as a disability. There is a need, however, to view the entire scale, the degrees of functioning, which are more gradual, in relation to specific cultural contexts. It is social parameters – including social structures and access to health and education – that determine when and if a given functional limitation constitutes a disability. Whether and under what circumstances a given impairment becomes a disability are very closely related to the social and political context. Any attempt to standardise a 'list' of disabilities is bound to be limited and insufficiently sensitive to social and cultural variations (Bakhshi and Trani, 2006).

Further, practitioners have expressed concern that the ICF model may hinder PWDs' empowerment in favour of professionals' authority over them and their lives: that is, the ICF's categorisation of PWDs could be misused by medical and social professionals, politicians, authorities, and scientists, resulting in PWDs' marginalization (Lundälv et al., 2015). Some practitioners have indicated that the ICF objectifies people, and that authorities' and health organisations' processes of gathering information according to the ICF could be offensive to users. In addition, when following that classification system, professionals' focus could be misdirected away from their patients' individual needs by standardised implementation practices (Lundälv et al., 2015).

As a supposed classificatory instrument, the ICF does not provide all the information needed for policymaking. First, in defining health as a general state of well-being and not simply the absence of disease, it overlooks the potential conflict between health and other wellbeing dimensions. Second, the ICF is based on a scale of reference: its domain codes require the use of qualifiers, which identify the presence and record the severity of the functioning problem on a five-point scale. Tomake best use of this coding requires the collection of extensive information, yet the ICF does not distinguish between 'functionings' and 'capabilities'. This has important policy implications: policymakers can take decisions to enlarge individuals' capability

sets by providing new opportunities, but simply describing activities that individuals can or cannot do provides only limited information of relevance to policymaking, e.g. on the priorities for public action. Third, the ICF defines disability in terms of limitations (impairment, activity limitations, and participation restrictions), failing to consider other, more positive dimensions, such as the possibility provided by the environment to engage in a specific activity, the positive right to do so, or acquiring the required capacity over time. The ICF also fails to recognise – beyond the function and structure of the body, on one hand, and activities and participation, on the other – the importance of individual identity grounded in one's beliefs, values and preferences; instead, it merely considers the environment as a mechanical facilitator or barrier (Trani et al., 2011).

The capability approach

Martha Nussbaum and Amartya Sen are the two original architects of the capability approach, developed as a framework to analyse different concepts in welfare economics, including standard of living, wellbeing, and poverty. As regards standard of living, Sen argues that its traditional measurement through the ability to buy commodities is inadequate. Under the capability approach, Sen focuses on the type of life people are able to live, i.e. on their practical opportunities ('capabilities') and achievements ('functionings') (Mitra, 2018).

Literature on disability and the capability approach has grown rapidly over the past decade, beginning with its use by Nussbaum (2006) and Sen (2009) to address different disability-related issues. It has been used by other scholars in relation to various issues, including the philosophical grounding of human rights in relation to disability (Venkatapuram, 2014), the evaluation of disability-related policies (e.g. Díaz Ruiz et al., 2015), the challenges to address for education to be disability-inclusive (Mutanga and Walker, 2015), and comparative assessments of wellbeing across disability status (Mitra et al., 2013; Trani and Cunning, 2013; Trani et al., 2015; 2016).

Several scholars argue that Sen's capability approach can be used to define disability as capability or functioning deprivation in general (Burchardt, 2004; Mitra, 2006; Terzi, 2009; Wolff, 2009) or in the context of education (Terzi, 2005), public policy (Trani et al., 2011), or recovery from psychiatric disorder (Hopper, 2007; Wallcraft and Hopper, 2015). With respect to defining disability under the capability approach, there is no consensus on a single interpretation. A central idea in the literature is that classifying an individual with an impairment as a PWD depends on whether his/her functionings or capabilities are restricted. An impairment is an individual feature that may or may not become a disability. Another idea

is that the deprivations, in terms of capabilities or functionings, derive from interactions among various factors (personal, environmental, and the impairment), and that the ability to convert resources into capabilities and functionings (conversion factors) is particularly relevant and should not be ignored (Mitra, 2018). Functionings and capabilities are the main concepts of the capability approach in general and on disability in particular: 'functionings' refers to achievements, while 'capabilities' refers to 'practical opportunities', rather than the everyday sense of 'abilities' (Mitra, 2018).

The capability to be free of health conditions or impairments is an important notion. According to WHO, an impairment is a 'problem in bodily function or structure as a significant deviation or loss': for example, a significant deviation in terms of vision. A health condition is similarly broadly defined by the WHO (2011): it may refer to a disease, disorder, symptom, or injury. Using the capability approach's definition of functioning, health conditions and impairments can be conceived as health functioning deprivations, conveniently shortened to 'health deprivations' (Mitra, 2017).

Disability is defined as deprivation in terms of functionings and/or capabilities among persons with health impairments. It results from the interaction between resources, personal and structural factors, and health deprivations. Disability thus identifies a specific type of deprivation or disadvantage that might be targeted by policies (Mitra, 2018).

Other key concepts of the capability approach applicable to disability include:

- Resources, referring to goods, services, and information owned by, or available to, the individual (Mitra, 2018).
- Structural constraints in the environment, including the physical environment (e.g. terrain, climate, architecture); the economic environment (e.g. markets); social attitudes; laws and institutions (e.g. home, school and work); services, systems, and policies (e.g. transportation, health, and social services); culture; products; and technology (Mitra, 2018).
- Personal factors (e.g. age and sex), which may interact with health deprivations in the
 conversion of resources into wellbeing. For instance, in an environment where women's
 movements are constrained outside their homes, a wheelchair will not bring mobility for
 women with spinal cord injury (Mitra, 2018).
- Conversion functions, referring to people's different abilities to convert resources (goods and services) into capabilities and functionings. They are particularly relevant for disability.
 For example, in an environment where individuals bear medical and rehabilitative care expenses, the same income may lead to very different capability sets for a person with and one without any health deprivation. The affected individual must spend a significant

amount of their income on out-of-pocket health expenditures, while the unaffected individual does not. Conversion could also be very different for two individuals with the same impairment in two disparate environments. For instance, a wheelchair offers little mobility in a village with dirt roads and no public transportation, compared to a town where sidewalks are paved and have dropped kerbs and buses are wheelchair accessible (Mitra, 2018).

Although Sen's capability approach has recently been extensively employed in disability studies, there is little research into how it applies to disability and its consequences in terms of public policy, i.e. in improving the circumstances and inclusion of PWDs (Trani et al., 2011). As Sen states, PWDs may need different types and varying amounts of capability inputs (policies, resources, social norm changes, infrastructures, etc.) to reach the same wellbeing level as the non-disabled (Trani et al., 2011). However, the capability approach seems limited when considering the specific condition of extremely vulnerable groups such as PWDs, particularly individuals with mental illness and intellectual impairments (Trani et al., 2011).

Trani et al. (2011) frame the limitation of applying the capability approach to disability as follows: 'the "space of capabilities" is abstracted from the "space of commodities" and the "space of functionings" in ways that necessarily constrain the critical purchase of the concept...The priority is individual liberty, not social solidarity; the freedom to choose, not the need to belong' (p.154). In the space of capabilities, the individual is one step removed; objectively distanced from the power relations within which his/her identity and life chances are constituted. Within this space, there are three major issues which the individual cannot readily see and which are seldom clearly discussed. First, humans cannot be free from their dependency on one another. Second and third, under capitalist social relations of production, individuals can be free from neither hegemonic controls over their participation in the public realm nor the direct or indirect consequences of the exploitation of human labour. A similar reservation has been expressed by Deneulin and Stewart (2000): they contend that social structures (or 'structures of living together') matter because they not only enable or constrain our capabilities but are also constitutive of our individual identities and the frameworks of meaning by which we value various functionings.

A transformative approach to disability and social protection

The conceptual framework underlying the identification of what disability entails has important implications, for instance, in estimating prevalence and in policymaking. Yet most of

the disability models set out above are insufficient to inform policymakers, including on social protection policy and programming. The individual (or medical) model, the social model, and the ICF-based biopsychosocial model lead to different and sometimes contradicting policy implications.

The capability approach, which encompasses all dimensions of individual wellbeing and is not limited to the impairment or disabling condition, appears more in line with policymaking requirements. However, even the capability approach distances PWDs from the power relations within which their identity and life chances are constituted. Although both the ICF model and the capability approach explore the interaction between personal, structural, and other factors, they still do not place rights at the centre of the discussion as the CRPD requires. The capability approach is, thus, adopted by this chapter as a secondary or subsidiary framework.

As Hartley (2009) observe, the discourse of rights:

provides a more immediate strategic terrain for a politics of need than a discourse of capabilities, particularly if capabilities are to be construed at one stage removed from the context in which our rights have been settled or through which they can be disputed and extended ... a politics of need should be about ... the struggle for the recognition of unspoken needs; the struggle for more direct forms of political participation; the struggle against exploitation. (p.11).

A transformative approach to social protection, to be discussed in detail in section 2.2.4, is the most directly aligned with rights-based approaches and can, thus, better inform social protection policies to be more inclusive and supportive of PWDs' independent living rights. This chapter, therefore, adopts the definition of vulnerability articulated by the transformative social protection school (Sabates-Wheeler and Devereux, 2008): vulnerability extends beyond financial limitations and is conceptualised as being embedded in and emerging from the sociopolitical context, rather than as an exogenous risk factor requiring management. For vulnerable groups at risk in a given context, this model's corollary comprises policies and programmes seeking to transform the context itself, aiming to minimise the risks they face (Sabates-Wheeler and Devereux, 2008). Transformative policies and programmes 'relate to power imbalances in society that encourage, create and sustain vulnerabilities', aiming to tackle the deeper structural causes of vulnerability (Devereux and Sabates-Wheeler, 2004, p.9). We argue that the transformative approach transcends the traditional medical model of disability, as well as the more progressive social model, by emphasising the importance of establishing policy and legal frameworks that are anti-discriminatory and supportive of PWDs'

rights to equally access and benefit from cash transfer programmes. Even the capability approach — which this thesis adopts as a secondary or subsidiary framework — does not place rights at the centre of the discussion in line with the CRPD.

2.1.3. Determining disability prevalence

Measuring and defining disability are inextricably linked: there is growing consensus against pursuing a single definition, with purpose-specific definitions contended to be more useful. Broad definitions 'emphasise the importance of the environment in disability', whereas narrow definitions focus on the impairment in a 'medical sense', or are used pragmatically for such purposes as disability benefit eligibility (Schneider, 2009, p.43). Narrow disability definitions, as adopted in Palestine, tend to generate conservative estimates of disability prevalence, which are more manageable for government interventions. This approach excludes many people who face difficulties but may not self-identify as disabled. It leads to exclusionary interventions, depriving many individuals of the support they need, thereby further excluding them from society.

The WHO's ICF implements a broad disability definition, promoting the notion that 'disability is a universal experience' (Schneider, 2009, p.43) and not confined to a marginalised group. Using a broad definition includes people who experience difficulties ranging between mild and extreme. Some of these people may not experience marginalisation but still have needs to be addressed through policy. There is a widely acknowledged dearth of data on disability. This can be attributed partly to the lack of any single definition: 'measurement of disability is integrally linked to defining disability' (Schneider, 2009, p.42). There are now several internationally comparable measures of disability: e.g. the Washington Group Short Set of Questions on Disability (hereafter 'WG Short Set'); the UNICEF child disability questions; and the WHO Model Disability Survey. As disability and inclusion are reflected in the UN's Sustainable Development Goals (SDGs), 'monitoring and evaluation of accessibility will, therefore, be needed to implement the 2030 Agenda' (Secretariat for the CRPD, 2015, p.1). However, there remain numerous challenges to making the implementation and monitoring of the 2030 Agenda disability inclusive. The Secretariat for the CRPD (2015) identifies nine challenges to enhancing the monitoring and evaluation (M&E) of disability inclusion in the 2030 Agenda:

- insufficient international guidelines for disability data collection and insufficient internationally comparable disability data;
- lack of intra-national data comparability;

- lack of accessibility standards, measures, and assessments;
- data do not reach policymakers;
- lack of indicator framework to monitor disability inclusion, in line with the SDGs;
- perception that disability data collection is too costly;
- lack of an international repository of disability data for M&E;
- lack of impact evaluation studies;
- PWDs not sufficiently involved in M&E of disability inclusion.

In the ongoing absence of international guidelines, different countries develop different methodologies, meaning that data are not internationally comparable. To effectively monitor the impact of existing cash transfer programmes on PWDs at the global and regional levels, data comparability is paramount. Often, several different agencies within the same country collect disability data in different ways, thus producing incomparable datasets at the national level. When disability datasets are available, their effectiveness and utility rely on political linkage and impact-evaluation studies to inform decisionmaking and political agendas.

A lack of robust disability data has implications for not only policymakers but also PWDs themselves. Governments cannot be held responsible for decisions on budget allocation if they do not have disability data available to them. Moreover, PWDs and institutions working in the disability sector have 'no benchmarks or mechanisms by which to hold their governments to account for disability rights commitments, even if these governments have signed and ratified the CRPD' (Lang et al., 2011, p.214). Wider availability of disability statistics would also escalate disability as a development agenda, as 'bilateral and multilateral donor agencies still need to be convinced of the economic case for including disability within their core activities' (Lang et al., 2011, p.215).

Disability data show differences in reported disability prevalence in LMICs and HICs, their respective averages being 2.9% and 15.5% (WHO and World Bank, 2011). However, LMICs are actually more likely to have high prevalence rates due to disease, accidents, poverty, and low use of formal healthcare (Palmer and Harley, 2012). The difference in reported rates can be attributed to use of different types of disability measures, with variations in impairment or functioning screens.

A general consensus has been reached that 'more inclusive definitions and measures should be used for disability prevalence estimates' (Schneider, 2009, p.43). The effects of question wording and the number of response options still require further research. Between 1995 and 2004, LICs used the term 'disability' in their census questions, whereas HICs tended to use the

term 'difficulty', rather than disability. This affects responses, as many individuals who experience a 'difficulty' would not identify as having a 'disability'. Additionally, in many countries, the term 'disability' has many associated stigmas, so respondents may be reluctant to label themselves as such, producing inaccurate disability prevalence estimates. Aiming to provide an internationally comparable disability measure, the WG created its Short Set for use in censuses. Its approach is broader than simply asking, 'Are you disabled?', and captures different 'disabled' populations. The generated data can be analysed by multiple methods, with different thresholds for difficulty severity being used, depending on the purpose. The WG Short Set is more inclusive: in using the term 'difficulty', it captures those who may not identify with 'disability', e.g. the elderly or those with HIV/AIDs. These people's needs can then inform policy. The wider inclusiveness of the term 'difficulty' has particular advantage in teasing out the associations between functional impairment and social inclusion. It allows for further analyses to determine the effect of different degrees of difficulty on employment, education, access to services, social participation, and other factors (Schneider, 2009, p.9).

The WG Short Set is limited to the 'most basic level of functioning' in order to limit 'cultural and socioeconomic influences across countries' (Palmer and Harley, 2012, p.360). Available responses to each question comprise a scale of difficulty, and different countries can 'select different cut-off severity thresholds for political, social and economic reasons' (Palmer and Harley, 2012, p.361). Participants in Schneider's (2009) study found these questions 'easier to answer' and 'not too long to remember' in comparison to the previously used census questions. Critiques of the Short Set suggest that it likely causes certain sub-populations to be under-recorded, such as those with psychiatric or cognitive impairments. Furthermore, the questions do not consider participation or social barriers. However, there is some scope during the analysis stage to correlate functional difficulties with social outcomes (Palmer and Harley, 2012).

According to Palmer and Harley (2012), the different purposes of measuring disability necessitate multiple measures. Implementing only one measure cannot consistently identify disabled people in need of health and social services. The definition used has direct implications for disability policy. This is extremely important for countries with limited resources: they need to be able to target their resources to achieve the best possible outcomes for PWDs.

2.1.4. Assessing Disability

Approaches to disability classification can vary between disability-specific and mainstream social protection programmes, whilst disability classifications within programmes are often based on national definitions, found either in national legislation – specific laws on disability and more greneral laws, e.g. on employment or access to health – or policies. Classifications differ in the extent of their harmonisation across sectors or alignment with international best practice based on the CRPD and ICF (see section 7 for further discussion and linkages to research findings).

The WHO developed the ICF in 2001 as a conceptual framework for organising information on disability and functioning, incorporating different models of disability; it is a 'synthesis of the social and medical disability models' (Palmer and Harley, 2012, p.358). The ICF recognises the 'role of both individual and environmental factors in creating the experience of disability' and 'promotes the notion that disability is a universal experience and not that of a marginalised group' (Schneider, 2009, p.43). This framework is more inclusive and leads to higher estimates of disability prevalence. Assessments that use the ICF ask people about 'difficulties' they have in carrying out activities, rather than using the word 'disabled' or 'disability' (Schneider, 2009). Within the ICF, measurement is 'tied to activities and roles that are statistically normal in the relevant cultural context' (Palmer and Harley, 2012, p.359), framing disability as a dynamic interaction between a health condition and environmental factors. Although the ICF incorporates both medical and social concepts of disability, there has been some critique of the framework from a social perspective, specifically regarding the 'biological conception of impairment', defined as 'a loss or abnormality in body structure or physiological function' (Palmer and Harley, 2012, p.359). If PWDs are intrinsically impaired, due to their physiology, then policies aiming to eliminate discrimination will never be successful.

Given the ICF framework's limitations, high-order functioning screens have been developed. These are useful for assessing severe disability and determining required support, such as health services or social security. The Index of Activities of Daily Living (ADLs), designed by Sidney Katz, is 'one of the few evidence-based functioning screens' (Palmer and Harley, 2012, p.361). It identifies persons who 'experience restrictions in performing complex activities or participating socially' (2012, p.361). The ADLs index measures a person's independence in performing numerous core activities, such as bathing and dressing. This has been extended to instrumental activities of daily living (IADLs), which includes higher-level participation activities, such as shopping and cooking. When using the ADLs index, the research purpose

determines which scaling method to use: e.g. whether a measure of the level of difficulty or of human assistance required is more relevant.

The social model has influenced the assessment of disability, no longer perceived as a purely medical issue. General censuses and surveys cannot collect information on all aspects of disability. Instead, it is more helpful to use 'multiple screens that fit different policy purposes' (Palmer and Harley, 2012, p.362). This is vital in monitoring the level of functioning in a population and assessing PWDs' access to equal opportunities in disability-inclusive policies. In addition, measures for severe disability are required to include related issues in the design and evaluation of policies. Palmer (2012) recommends the WG Short Set and the Katz Index of ADLs as 'valid measures of function consistent with the ICF conceptual framework' (p.363).

The conceptualisation of disability is extremely important as it guides disability-inclusive policy development. This is particularly relevant for developing countries, as their limited resources need to be targeted efficiently. Furthermore, 80% of the world's PWDs live in developing countries (WHO and World Bank, 2011). If disability is viewed as the outcome of social barriers, then policies will focus on addressing these; conversely, if viewed as the outcome of impairment, then policies will focus on responses such as treatment, equipment, and benefits. Ideally, policies should use both approaches or the one most relevant to the desired outcome, adopting social or medical-biological terms as appropriate (Symeonidou, 2014). Further challenges arise in operationalising the ICF, as this can lead to a fluid or enlarged group of PWDs, impacting disability pensions and allowances (Symeonidou, 2014). To shape policy on disability allowances, 'the impairment-disability distinction needs to be clear so that what is meant by "disabled people" is clearly identified' (Symeonidou, 2014, p.1271). Symeonidou argues that the ICF 'cannot form the basis for social policy development' (2014, p.1272): developed by the WHO to classify impairments, it is better suited to rehabilitation contexts. Often, non-disabled policymakers do not consult PWDs; there is disparity between nondisabled people's conception of the experience of disability and what PWDs actually experience. 'Involving PWDs in all data activities can assist building awareness and bringing a disability perspective to data activities' (Secretariat for the CRPD, 2015, p.2). Monitoring can also be improved by 'mainstreaming disability in existing regular data collections' (2015, p.9).

2.1.5. Heterogeneity and intersectionality

The heterogeneous nature of disability increases complexity, with status, needs, and vulnerability varying considerably among PWDs, not only in the type and severity of their impairment but also a wide range of personal and social characteristics. As the WHO and World Bank's (2011) World Development Report on Disability notes, 'while disability correlates with disadvantage, not all people with disabilities are equally disadvantaged'. For example, in Nepal, poverty headcount, incidence, and severity were found to be higher among PWDs than their counterparts without disabilities, but PWDs with at least ten years' schooling were generally not poor. Regardless of disability status, rural dwellers, characterised by lower education levels, less land, and limited access to various facilities, were found to be poorer (Lamichhane et al., 2014).

People with mental health conditions or intellectual impairments seem, in many settings, to be more disadvantaged than those with physical or sensory impairments (WHO and World Bank, 2011). People with more severe impairments or other invisible disabilities, such as debilitating pain or fatigue, often experience greater disadvantage via both their impairments and significant discrimination (Yeo and Moore, 2003; WHO and World Bank, 2011). Conversely, in some countries, people whose disability arose through conflict have higher status in society than those whose disabilities have other causes (Mitchell and Karr, 2014). Two people with the same impairment (e.g. total vision loss) may lead completely different lives depending on where they live, their access to services, and how their communities perceive them.

Discrimination on multiple and intersectional levels is gradually being recognised as a social barrier for PWDs (Schulze, 2010, p.30). Certain segments of the overall PWD population are more vulnerable to falling into poverty and experiencing discrimination, particularly women, the elderly, minority ethnic groups, and people living in rural and remote areas; the risk of poverty or exclusion is higher where two or more of these identifiers are combined (Pinilla-Roncacio, 2015, p.118). Conversely, wealth and status can help overcome barriers to voice and participation (WHO and World Bank, 2011).

The rights and opportunities afforded to PWDs are stratified by gender, with disabled women and girls facing double discrimination and oppression (Morgan and Yablonski, 2011; UN Department of Economic and Social Affairs [UN DESA], 2011; Human Rights Watch, 2012). Yet little is known about the factors that produce the specific disabilities of women and girls (Enarson, 2009). Women tend to have lower opportunity levels for education and employment and may, in some countries, be more likely to be denied rights to voice and participation, as

well as access to social institutions, such as marriage or having a family. In general, women with disabilities (WWDs) also experience higher levels of physical and sexual violence (Enarson, 2009; Pinilla-Roncacio, 2015, p.118). Their vulnerability is compounded by 'gender neutral' approaches to service provision (Enarson, 2009); WWDs' needs remain on the margins of the women's and disability rights movements, as well as of the civil rights movement, leading to disabled women and girls of all backgrounds being 'essentially invisible' (Rousso, 2001). Women from minority or other marginalised groups who have disabilities face additional disadvantages (Ortoleva and Lewis, 2012; Moodley and Graham, 2015). In a national study on poverty and disability in South Africa, disability was found to intersect with gender, age, and race to produce negative outcomes in education, employment, and income for all PWDs, but particularly black WWDs (Moodley and Graham, 2015).

Age may also determine disadvantage: due to entrenched social and structural discrimination, children with disabilities (CWDs) are especially vulnerable and are among the most marginalised globally (Hi and Stc, 2011; Trani et al., 2012; UNICEF, 2013). There is a lack of information on young PWDs, who are often overlooked by programming (Groce and Kett, 2014; Meyers et al., 2014). Furthermore, older PWDs are disproportionately poor (Masset and White, 2004).

2.1.6. Poverty and disability

That disability and poverty are closely related is widely accepted as axiomatic. As Coleridge wrote in his seminal book, *Disability, Liberation and Development* (1993, p.64):

[D]isability creates and exacerbates poverty by increasing isolation and economic strain, not just for the individual but for the family: there is little doubt that disabled people are among the poorest in poor countries.

A World Bank literature review (Elwan, 1999) claims that approximately 15-20% of populations experiencing poverty in developing countries are PWDs, and that households with a PWD member are at greater risk of poverty. Indeed, much of the literature asserts that disability is both a cause and consequence of poverty (Zimmer, 2008; Groce, Kembhavi et al., 2011; Banks et al., 2017), with Yeo and Moore (2003, p.572) describing this relationship as a 'vicious circle'.

On the one hand, poor nutrition and sanitation, limited access to preventive healthcare, and violence are considered to increase the risk of becoming chronically ill or impaired for poor populations (Gladstone et al, 2014; Gottlieb et al, 2009). Low access to preventive healthcare, high levels of undernutrition, and an increased likelihood of working in unsafe environments

increase not only the risk of illness and injury but also of either becoming a permanent disability (Pinilla-Roncacio, 2015). Disabilities in developing countries are mostly caused by preventable impairments associated with communicable maternal and perinatal disease, and by injuries (Elwan 1999). Additionally, violence and conflict could be factors affecting disability and poverty (Mitra, 2018).

The type and quality of information accessible to poor individuals can be negatively affected by low education levels, increasing the risk of a preventable disease becoming a chronic condition or impairment (Pinilla-Roncacio, 2015). Figure 2.1 explores the various causal pathways from poverty to disability.

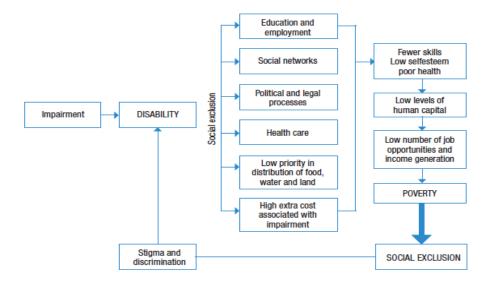
Education and employment Shelter Dangerous working conditions Unhygenic living conditions Lack of voice Malnutrition Sanitation Poor health Limit access to Social Poverty exclusion Political and legal systems High risk of Illness, Health Care accident and impairment Food and nutrients Discrimination and Disability social exclusion

Figure 2.1 Causal pathways from poverty to disability

Source: Pinilla-Roncacio (2015).

On the other hand, disability may lead to poverty through adverse impacts on education, employment, and earnings, as well as increased expenditures related to disability. In the context of limited social protection services, the indirect, direct, and opportunity costs of disability are usually borne by the family, reducing their disposable income and creating poverty traps, and thereby reducing their human capital and increasing their risk of becoming chronically poor and socially excluded (Groce, Kett et al., 2011; Pinilla-Roncacio, 2015; Brucker et al 2015). This is shown in Figure 2.2.

Figure 2.2 Causal pathways from disability to poverty



Source: Pinilla-Roncacio (2015).

Researchers have recently adopted Amartya Sen's (1999) capability approach – defining poverty as a lack of wellbeing – as a lens through which to understand disability (Mitra, 2006; Braithwaite and Mont, 2008; Dubois and Trani, 2009; Groce, Kett et al., 2011). In this approach's language, 'functionings' are activities in which people engage, as well as anticipated states of being, including health and wellbeing; 'capabilities' are opportunities to participate in activities or achieve these anticipated states (Mitra, 2006). These capabilities depend on the individual's available assets (human, social, and financial) and the sociopolitical landscape that enhances or constrains them. Poverty status cannot be established by reference to income alone, since capabilities at both the individual (age, health status, or gender) and social (access to education, gender roles, and expectations) level affect whether income can be converted into functionings, i.e. participation and wellbeing (Groce, Kett et al., 2011).

The capability approach suggests that poverty and disability are mutually reinforcing, as they compound one another to limit PWDs' available capabilities (opportunities) and their ability to convert these into functionings (activities or wellbeing) (Groce, Kett et al., 2011; Graham et al., 2012; Moodley and Graham, 2015). A PWD is less likely to be able to not only earn, due to their impairment or social stigma ('actual disability') but also use their income to secure wellbeing, whether physically constrained by inaccessible environments or lacking the additional finances necessary to overcome their higher cost of living ('potential disability'). PWDs also face a 'conversion handicap': the higher cost of converting income into a good living due, both directly and indirectly, to their impairments (Yeo and Moore, 2003). The need, for

example, to pay for healthcare costs and technical aids, hire a personal assistant or sign language interpreter, or cover additional transport costs means that PWDs require a higher income level to achieve the same living standards as non-disabled people.

However, the evidence is often less consistent or robust than tends to be claimed. Indeed, the complex, causal relationships between poverty and disability remain ill-defined and underresearched (Braithwaite and Mont, 2008; Groce, Kett et al., 2011). In a recent study of the peer-reviewed literature on disability and poverty, only 27 of the 293 articles were evidence-based rather than anecdotal (Groce, Kett et al., 2011). Existing evidence on the relationship between disability and poverty often fails to recognise the disability-linked challenges in the context of wider developments, with most empirical work addressing poverty through an economic resources lens in HICs (Seddon et al., 2001; Palmer, 2014). A lack of comparative (i.e. using the same measures of disability) and longitudinal data has particularly inhibited analysis of the changing economic conditions and statuses of individuals and households, both across countries and over time (Mitra et al., 2013; Pinilla-Roncacio, 2015). Nevertheless, in recent years, a small but growing body of research has begun examining these linkages' specificities (Braithwaite and Mont, 2009; Dubois and Trani, 2009; Graham, Moodley, and Selipsky, 2012; Mitra, Posarac, and Vick 2013).

New data are beginning to show that, in LMICs, individual PWDs tend to experience worse social and economic outcomes than those without disabilities. It should be noted, however, that these studies tend to provide evidence on the association between disability and poverty, rather than causal links between the two. In developed countries, the evidence indicates that, compared to their non-disabled peers, PWDs have lower educational achievement, experience lower employment rates, are paid less when employed, and have a higher chance of being income poor. In LMICs, the growing, albeit still relatively small, peer-reviewed literature has found less likelihood of employment (Hoogeveen et al., 2005; Mitra, 2008; Trani and Loeb., 2010), and lower educational attainment among PWDs (Hoogeveen et al., 2005; Loeb et al., 2008; Trani and Loeb., 2010; Mont and Cuong, 2011).

Using internationally comparable data, Mitra et al. (2013) studied the economic wellbeing and poverty situation of working-age PWDs across 15 developing countries. In almost all of these countries, they found a higher chance of PWDs experiencing multiple economic deficits compared to non-disabled persons. In addition, some studies suggest that poverty associated with living in a PWD-headed household is transferred inter-generationally, with children living in such households likely to be less well educated (Hoogeveen et al., 2005).

At the household level, the evidence is more mixed: whilst two studies have shown that households with disabilities possess fewer assets than other households (Palmer et al., 2010; Mitra et al., 2013), one found no significant difference (Trani and Loeb., 2010). When household wellbeing is measured by expenditures, some have found households with disabilities to have lower spending levels than those without (Hoogeveen et al., 2005; Mont and Cuong, 2011); though Mitra et al. (2013) found households with disabilities more likely to be disadvantaged in 12 of 15 countries, this difference was only statistically significant in four countries.

The interaction between disability and poverty is contingent on the type and severity of disability, sociodemographic characteristics, and environment. Indeed, age, gender, impairment (type and severity), and residence location directly influence whether and how the risk of poverty and disability increases. Additionally, a country's level of human, social, and economic development affects the type and quality of opportunities and services available for all citizens, including PWDs (Pinilla-Roncacio, 2015). In Mitra et al.'s (2013) study, not one dimension of economic wellbeing was systematically associated with deprivation across the 15 countries, with the types of economic deprivations PWDs face varying significantly. Gaps in economic wellbeing and poverty were often more significant in middle-income, compared to low-income, countries. Furthermore, PWDs aged 40 and above and those with multiple disabilities were more likely to be poor on a multi-dimensional level.

These studies demonstrate improvement in the quality and breadth of research on poverty among PWDs in LMICS, and that structural barriers beyond the individual and community level (i.e. social exclusion and higher living costs for PWDs) are being addressed. One key issue demanding further exploration is how to resolve the inherent tension between disability policy's two main goals: (i) providing income security through cash transfer programmes and in-kind benefits; and (ii) supporting PWDs to achieve full inclusion into social and economic life (Mont, 2004). Further research is, thus, needed to underpin a twin-track approach to disability policy, combining allocation of targeted financial benefits to meet additional needs and costs with ensuring equal opportunity and access to mainstream policies and services.

2.1.7. Access to basic services

PWDs' access to basic services and opportunities can be limited by attitudinal, physical, and informational barriers, which directly impact levels of education, health, and employment. With limited evidence to inform efforts to address these obstacles, the challenges they pose are compounded. A comparison of household survey data from Afghanistan and Zambia found

evidence of lower access to education, healthcare, and the labour market for PWDs (Trani et al., 2012). In a study of resource-poor areas in South Africa, households in receipt of disability grants had poorer education and employment outcomes than households without PWD members, despite their better financial situation (Loeb et al., 2008). Conversely, Mont and Nguyen (2013) found that, in Vietnam, the correlation between disability and poverty is weaker in districts with good service provision, i.e. better healthcare and transport infrastructure.

Unmet support needs may relate to everyday activities, such as participation in education, personal care, employment and social activities, access to aids and equipment, and modifications to the workplace or home. Surveys on unmet needs have been conducted in several developing countries. In Africa, national studies of PWDs' living conditions were conducted between 2001 and 2006 in Malawi, Namibia, Zambia, and Zimbabwe. Across the four countries, only the healthcare sector met more than 50% of PWDs' reported needs. Gaps in service provision were particularly high for welfare, assistive devices, education, vocational training, and counselling services (WHO and World Bank, 2011). In a 2006 disability study conducted nationally in Morocco, PWDs expressed their need for better access to healthcare services (55.3%), financial help for basic needs (52.5%), medications (21.3%) and technical devices (17.5%) (WHO and World Bank, 2011).

One of the greatest obstacles to PWDs achieving equality of opportunity and social integration across all domains are attitudinal barriers, which result in stigmatisation and discrimination, in turn denying PWDs their dignity and potential (Wapling and Downie, 2012). PWDs often encounter negative attitudes from community members, government officials, policymakers, and even family members (Burns and Oswald, 2014; Groce and Kett, 2014). Such attitudes might be manifested through inability to see beyond the impairment, discrimination, or bullying (Department for International Development [DFID], 2000; UNICEF, 2013). Discrimination by association can also be experienced by family members (Center for Election Access of Citizens with Disabilities, 2013). Often, attitudes towards PWDs in LMICs are more extreme, and the stigma and shame associated with having a disability are higher than in HICs (Mont, 2014).

Historically, institutions that segregate, such as residential institutions and special schools, have been provided for PWDs (Schulze, 2010; WHO and World Bank, 2011), who have generally been considered deserving of help but excluded from active membership of society (Pinilla-Roncacio, 2015). As well as being overlooked in mainstream development narratives, PWDs' needs are usually invisible in social policies aiming to reduce poverty and increase

access to basic services and the labour market (Bruijn et al., 2012; Al Ju'beh, 2015). This has created the false impression that PWDs are a 'very small group, reserved for the specialist attention of health or rehabilitation professionals and beyond the scope of development studies' (Mitra et al., 2013, p.1).

Physical and information environments

Levels of access to buildings, roads, transportation, information, and communication can either inhibit PWDs or promote their involvement and inclusion. Transportation and access to public facilities are not only essential for education, healthcare, and access to the labour market but also beneficial for participation in civic life. Lack of accessible communication and information puts PWDs at a significant social disadvantage, particularly in sectors where effective communication is critical (e.g. healthcare, education, local government, and justice) (WHO and World Bank, 2011; Mont, 2014).

In a 2005 UN survey of 114 countries, 54% had no standards for accessibility or outdoor environments and streets, 43% had none for civic buildings, and 44% had no standards for schools, health facilities, and other public service buildings. Reports from countries with accessibility legislation suggest low compliance levels, resulting in moderate to severe mobility restrictions for PWDs and inaccessible or separate – and generally inequitable – services (United Nations Special Rapporteur on Disabilities, 2006). Barriers to the provision of both accessible transport and public accommodations include inadequate: resources; planning and design capacity; disability-awareness in relevant professions' training; cooperation between institutions; and enforcement mechanisms (WHO and World Bank, 2011; UN DESA, 2013). Retrofitting public buildings for accessibility is up to 20% more expensive than integrating accessibility into new buildings (UNICEF, 2013). Particularly problematic for accessible transport is the absence of ramps at sidewalks and roads, which further limits PWDs' free mobility and independence (WHO and World Bank, 2011).

PWDs also have inequitable access to everyday telecommunications and, in turn, to information about rights and services. As well as regulatory deficiencies, exorbitant costs, and the fast pace of the technological revolution, the incompatibility of mainstream ICT devices with assistive devices poses a huge barrier to access for PWDs (WHO and World Bank, 2011).

Assistance and support

For many PWDs, assistance and support are prerequisites for good QoL and being able to equally participate in society. This includes assistive devices; support for independent living (self-care, household care, mobility); residential support (independent housing); support in the workplace; and community access (including daycare centres). The overarching principle promoted by the CRPD is that services should be provided in the community, rather than in segregated settings, and be person-centred, involving individuals in decisions about the support they receive (Quinn and Doyle, 2012).

The availability of appropriate assistive devices, family members' presence and willingness to provide support, and the degree to which the environment enables PWDs' participation are all significant factors in determining the need for support services. Moreover, assistance and support needs change across each life stage: formal support in childhood may include respite care and special needs assistance in education; in adulthood, it may include advocacy services, residential support, or assistance in the workplace; and in old age, it might involve home-help services, assisted living arrangements, or palliative care (WHO and World Bank, 2011; Parker and Clements, 2008).

In practice, family members or social networks provide the majority of assistance and support. State supply of support services is generally underdeveloped, while not-for-profit organisations have limited coverage, and private markets rarely offer sufficient affordable support to meet PWDs' needs. Particular gaps in service provision occur at transitions between life stages, e.g. childhood and adulthood (WHO and World Bank, 2011).

There are several key barriers to assistance and support. The first is a lack of funding: in developing countries, a significant share of safety-net resources are allocated to cash programmes for poor households, with only a fraction made available for social welfare services for vulnerable groups, including PWDs. Second, policies or institutional frameworks may be inappropriate, with a shift towards policies enabling community living and social inclusion rather than ongoing segregation. Third, services may be inadequate or unresponsive: in some countries, support services are not available to those living independently. Finally, there may be poor service coordination between the state and voluntary and/or private suppliers (WHO and World Bank, 2011).

Access to healthcare and rehabilitation

PWDs have less access to healthcare services and more-often unmet healthcare needs compared with the general population, especially in low-income countries (LICs). Of course, having a disability is not synonymous with having a health problem; many PWDs live healthy lives. Nevertheless, PWDs collectively experience poorer health levels: indeed, they are often described as having a 'narrower' or 'thinner' margin of health, with disability associated with a diverse range of primary health conditions, higher risk of developing secondary conditions, and chronic or age-related conditions (WHO and World Bank, 2011; Banks and Polack, 2014). In countries where under-five mortality has decreased to below 20%, mortality rates for CWDs are still estimated to be as high as 80% (Inclusion International, 2006).

PWDs face inequities in access to and the quality and delivery of care across the spectrum of mainstream health services (promotion, prevention, and treatment), resulting in poorer overall treatment outcomes (Banks and Polack, 2014). Often, health facilities are inaccessible; information not communicated appropriately; and transport and health services inaccessible or unaffordable. Misconceptions around disability may discourage families from seeking healthcare, whilst the provision of appropriate services may be limited by providers' discrimination (Fembek et al., 2013; Burns and Oswald, 2014). In particular, PWDs often lack sexual and reproductive healthcare due to the common misconception that PWDs are sexually inactive (Frohmader and Ortoleva, 2013). Research in India's Uttar Pradesh and Tamil Nadu states found that cost (70.5%), lack of services in the area (52.3%), and transportation (20.5%) were the top three barriers to using health facilities (WHO and World Bank, 2011). Meanwhile, a study in Vietnam found that, for the majority of PWDs, healthcare costs represent no less than 40% of non-food expenditure, and that the economic burden of healthcare, particularly related to medication and transport costs, was greatest for PWDs (Palmer, 2014).

Unmet rehabilitation needs can delay discharge, limit activities, restrict participation, cause deterioration in health, increase dependency on others for assistance, and decrease overall QoL; these negative outcomes have broad social and financial implications for PWDs and their families. Obstacles include a lack of strategic planning, resources, and health infrastructure; a lack of agency responsibility for administering and coordinating rehabilitation services; inadequate information systems; complex referral systems that limit access; and a lack of engagement with disabled persons organisations (DPOs) (WHO and World Bank, 2011).

Access to education

CWDs have historically been excluded from mainstream education. They are less likely to enrol in and have lower rates of staying in and progressing through school (UNICEF, 2013; Education for All [EFA], 2015). The gap in attendance rates between CWDs and their non-disabled peers ranges dramatically, from 10% in India to 60% in Indonesia for primary school, and from 15% in Cambodia to 58% in Indonesia for secondary education (WHO and World Bank, 2011).

Enrolment rates differ by impairment type, with access for children with physical impairments generally better than for those with intellectual or sensory impairments. In Burkina Faso in 2006, only 10% of deaf 7-12-year-olds were in school, compared to 40% of children with a physical impairment (only slightly lower than the attendance rate of non-disabled children) (Trani et al., 2012). Among CWDs, boys are more likely to receive an education than girls (Trani et al., 2012; EFA, 2015).

The Education For All movement seeks to provide meaningful learning opportunities for all students within the regular school system (UNICEF, 2013). This complements the CRPD, which stipulates the right of all CWDs to not only be included in general education systems but also receive the individual support they need (i.e. reasonable accommodation and support services). Education contributes to the formation of human capital, and is a key determinant of personal wellbeing and welfare (Trani et al., 2011; Banks and Polack, 2014). Although adults with disabilities are generally poorer than those without, education weakens this connection (WHO and World Bank, 2011).

Barriers to education may be systemic or school-based. The former includes divided ministerial responsibility, lack of relevant legislation and policies, and entrenched beliefs that CWDs need welfare, rather than equality of opportunity. The latter include inadequate teacher training and support, rigid curricula not delivered in accessible formats, physical barriers such as inadequate transport infrastructure and inaccessible school buildings, limited communication models, and low expectations of CWDs (Trani et al., 2011; Bruijn et al., 2012; Srivastava et al., 2015).

Of course, the quality of educational provision also matters; mere attendance is insufficient, with many programmes achieving only minimum standards due to 'lack of resources, teacher training and expectations, and expertise, as well as the persistence of negative social attitudes, leading to discrimination and exclusion' (Bakhshi et al., 2013, p.7).

There is debate over the type of education most appropriate for children with certain disability types. Particularly for deaf students and those with intellectual impairments, some argue that special schools offer more positive experiences than mainstreaming, through high quality, specialised learning environments (WHO and World Bank, 2011).

Access to work, employment, and social protection

A large proportion of PWDs are either unemployed, under-employed, or earn less than their non- disabled peers (Heymann et al., 2014). In a study of 15 developing countries, the relationship between disability and lower employment rates was statistically significant in nine of them (Mizunoya and Mitra, 2013). Mont's (2014) survey of 51 countries found employment rate disparities for PWDs in both gender groups: for men, the rate was 52.8% for those with disabilities and 64.9% for those without; for women, the equivalent values were 19.6% and 29.9%, respectively. In many LMICs, a significant proportion of people, especially among the poor, work in the informal economy and so do not appear in all labour market statistics, with self-employment associated with job insecurity and a lack of welfare benefits (Leymat, 2012). People with intellectual disabilities, mental illnesses, or multiple disabilities are less likely than those with other disabilities to access the labour market (Banks and Polack, 2014).

Numerous factors impact labour market outcomes for PWDs. On the supply side, these include lack of access to formal education or other opportunities to develop their skills; disincentives created by disability benefit systems; and the higher cost of working experienced by PWDs, owing to the potentially greater effort required to reach the workplace and perform work. Indeed, Barnes and Mercer (2005) advocate redefining the meaning of 'work' for PWDs, to reflect that living with impairment in a society organised around non-disabled lifestyles necessitates additional time and effort, together with specialised skills. On the demand side, productivity differentials usually result in lower market wages for PWDs, who may also face discrimination and prejudice in the workplace (WHO and World Bank, 2011; Heymann et al., 2014). Countermeasures include enforcing antidiscrimination laws to improve access to the formal economy – with specific measures including quotas, which aim to increase PWDs' employment opportunities – and vocational services to develop PWDs' capabilities to compete in the labour market. However, evidence on these approaches' effectiveness is limited and, particularly for the former, mixed (WHO and World Bank, 2011).

In a growing number of countries, social protection policies include PWDs in mainstream programmes or target them specifically. These represent an important source of income, and include cash transfers specifically for PWDs. The level of allowance varies significantly, with

eligibility often related to disability severity (WHO and World Bank, 2011). There is insufficient evidence to determine the extent of PWDs' use of mainstream cash transfer programmes (Groce, Kett et al., 2011). Statistical and anecdotal evidence suggest that many PWDs are not reached by social protection programmes, for reasons including low funding levels, complex and unaccountable administrative systems, unavailability or physical inaccessibility of services, and limited awareness of schemes among PWDs (Marriott and Gooding, 2007; Rohwerder, 2014).

2.1.8. Risk of violence and abuse

PWDs are at increased risk of interpersonal violence owing to 'exclusion from education and employment, the need for personal assistance with daily living, reduced physical and emotional defences, communication barriers that hamper the reporting of violence, societal stigma, and discrimination' (Hughes et al., 2012, p.1621). This includes hate crimes against PWDs, as well as physical violence and sexual abuse in homes, institutions, communities, and other settings (Hughes et al., 2012). Failure to believe complaints or take them seriously can be attributed to stigma and stereotyping, while the justice system is often inaccessible to PWDs (Ortoleva and Lewis, 2012). Risks of abuse are exacerbated by various factors, including: public aggression or apathy towards people who are visibly distinctive; exposure to multiple carers for those receiving regular personal assistance and care; people with complex needs or challenging behaviours being attended by poorly trained staff; and a lack of regulation or ministerial accountability (Brown, 2003).

Those with mental illnesses may face even higher risk (Hughes et al., 2012; Mikton and Shakespeare, 2014). Both CWDs and young PWDs are 'especially vulnerable as a result of entrenched social and structural discrimination against them' (Save the Children UK and Handicap International, 2011). Likewise, WWDs are at least 'twice as likely to experience domestic violence and other forms of gender-based and sexual violence as non-disabled women, and are likely to experience abuse over a longer period of time and to suffer more severe injuries as a result of the violence' (Ortoleva and Lewis, 2012, p.16; see also Astbury and Walji, 2013). In addition, there have been many cases of forced and non-consensual sterilisation of women and girls with disabilities (Ortoleva and Lewis, 2012; Fembek et al., 2013).

2.1.9. Conclusion

This section has explored the nature and underlying causes of PWDs' additional vulnerabilities, and argued that the way disability is defined, assessed and counted could have huge implications on approaches used to respond to PWDs' diverse needs.

The relationship between disability and poverty is multidimensional: in LMICs, PWDs and their families experience worse social and economic outcomes than those without disabilities, whilst poor individuals generally face higher risks of becoming chronically ill or impaired. Recognising that evidence has historically failed to situate disability-specific challenges within the context of wider human development, researchers have begun using the lens of Sen's capability approach to understand disability. Poverty and disability are mutually reinforcing, compounding one another to limit PWDs' capabilities (available opportunities) and their ability to convert these into functionings (activities or wellbeing); the cost of converting limited income into a good living is particularly high for PWDs, who tend to have higher living costs. Nevertheless, further research is needed to underpin a twin-track approach to disability policy, combining the allocation of targeted financial benefits (to meet additional needs and costs) with ensuring equal opportunity and access to mainstream policies and services.

Earlier medical, charity, and welfare models treated PWDs as habitual patients needing constant state care, rather than as productive members of society. In sharp contrast, this human rights approach to disability views PWDs as equal citizens with equal rights, resulting in programmes with more relevant goals, such as achieving independent living.

Nevertheless, PWDs continue to face overlapping and multiple forms of disadvantage. Social exclusion contributes to the creation and perpetuation of a vicious circle between disability and poverty; indeed, PWDs' access to basic services and opportunities is usually limited by attitudinal, physical, and informational barriers that directly impact levels of education, health, and employment. Attitudinal barriers that result in stigmatisation and discrimination – thereby denying PWDs their dignity and potential – are among the biggest obstacles to achieving equality of opportunity across all sectors. It is important to recognize the heterogeneity of status, needs, and vulnerability among PWDs; while disability does correlate with disadvantage, not every PWD is equally disadvantaged. Discrimination is intersectional, with the rights and opportunities afforded to PWDs stratified, for example, by wealth, gender, age, and geographical location.

2.2. Framing the debate: social protection and social justice for PWDs in **LMICs**

2.2.1. Introduction

This section will explore the concepts of social protection, cash transfers, social justice, and independent living, arguing they are profoundly interlinked and essential aspects of the theoretical, conceptual, and normative backgrounds for testing the research hypotheses. The first part traces the emergence of social protection as a paradigm in the contemporary literature on development. It also presents the distinguishing features of cash transfer (CT) programmes compared to alternative policy options in social protection frameworks, briefly examining debates around their value compared to in-kind transfers.

Social protection generally constitutes public responses to vulnerability, and is, therefore, highly relevant to PWDs in developing countries. However, it is a highly contested concept. How far social protection programmes, such as CTs, contribute to just outcomes for PWDs and other vulnerable groups needs to be examined.

The section will advocate Sabates-Wheeler and Devereux's approach, which 'weaves together the concepts of rights, needs and empowerment to produce an all-encompassing policy framework of "transformative social protection" (TSP) (Barrientos and Hulme, 2008, p.5). The TSP framework allows us to contextualise social protection within a broader project of social justice, itself a 'contested theoretical concept in social and political theory, and a powerful but elusive term in social policy' (Venieris, 2013, p.iii). For the purposes of this thesis, it will, therefore, be essential to explore social justice theories in relation to social protection for PWDs.

It will also explore competing theories of social justice and their application to PWDs. The conservative/neoliberal traditions will be briefly reviewed through John Rawls' theory of justice (1971). The capability approach of Amartya Sen and Martha Nussbaum will also be assessed.

This section will conclude that the social justice project should identify power relations as key drivers of injustice. Therefore, in the tradition of Iris Marion Young and Nancy Fraser, it will support a radical project of social justice. This is consistent with the TSP framework, which seeks to correct injustice through addressing societal power imbalances that create and sustain vulnerabilities (Devereux and Sabates-Wheeler, 2004). According to this theory, social justice aims to empower groups and individuals; therefore, it supports the key elements for PWDs' independent living, empowerment, and autonomy.

The section, thus, establishes the normative and conceptual framework for analysing social protection policy in Palestine, focusing particularly on programmes targeting PWDs. The PNCTP will be assessed by the extent to which it satisfies TSP objectives and its potential role in social justice. Having discussed the conceptual framework, this research will have identified the analytical tools to assess CTs through the case of Palestine; adopting a TSP conceptual framework for social protection and a radical approach to social justice, the study considers power relations and politics as root elements of vulnerability.

2.2.2. Social protection

Social protection commonly refers to 'public actions taken in response to levels of vulnerability, risk, and deprivation, which are deemed socially unacceptable within a given polity or society' (Conway et al., 2000, p.7). The last few years have brought more attention to addressing disability in social protection programmes, mainly via CT schemes for the poor (Schneider, Waliuya, Barrett et al., 2011). It is, therefore, essential to assess and critically evaluate social protection policies and programmes – primarily CTs – and evaluate the extent to which these provide just and effective remedies, particularly to PWDs. Moreover, given that the most-vulnerable PWDs are among the poorest of the poor in developing countries, it is imperative to assess the social protection agendas, policies, and programmes of international aid and development.

Prior to examining whether the PNCTP can support and foster greater independent living of PWDs in Palestine, the discussion needs placing within the wider social protection debate, particularly in developing countries. There is no universal consensus on the definition and objectives of social protection; it is thus important to understand the emergence of the social protection paradigm, as well as the conceptual frameworks and their philosophical underpinnings since these have implications for assessing social protection programmes.

Social protection: a contested concept

The term 'social protection' has evolved over recent decades and become increasingly popular. Due to its ambiguity, the term remains 'confusing' (Sabates-Wheeler, 2003, p.5); there is, thus, a danger that it is used with different definitions in mind. As Norton et al. (2001) explain, understandings of the term vary 'between definitions which focus on the nature of the deprivations and problems addressed, and those which focus on the policy instruments used to address them; and between those which take a conceptual as opposed to a pragmatic approach to the task' (p.21).

Norton et al. (2001) explain that social protection addresses the vulnerabilities and deprivation of the poorest, additional to providing security to the non-poor to protect them from future potential shocks; it may encompass governmental or non-governmental action. The authors elucidate the various rationales for developing social protection as a policy field, including the enjoyment of social justice and equity and protection from risks.

Two of the major agenda shapers for international policy on social protection are the International Labour Organization (ILO) and the World Bank, whose social protection definitions are distinct. The ILO defines it as the 'provision of benefits to households and individuals through public or collective arrangements to protect against low or declining living standards' (Sabates-Wheeler and Waite, 2003, p.5). As Barrientos (2014) explains, this encapsulates the conception of social protection generally held in developed countries: social insurance, i.e. 'contributory programs covering life-course and work-related contingencies'; and social assistance, 'consisting of tax-financed programmes addressing poverty and vulnerability' (pp.2-3). The World Bank defines social protection as 'public measures intended to assist individuals, households and communities in managing income risks in order to reduce vulnerability and downward fluctuations in incomes, improve consumption smoothing and enhancing equity' (Sabates-Wheeler and Waite, 2003, p.5).

Critics such as Standing (2007) argue that social protection terminology has advanced in response to globalisation and the restructuring of the labour market. Meanwhile, De Haan (2014) warns of the aid industry becoming marked by fads, somewhat controlled by political changes in donor countries and changes in Europe in the early 2010s. Nonetheless, De Haan maintains that social protection itself is no fad but an integral aspect of sustainable development, a position endorsed in this section.

Therefore, while recognising the concept's dilution, it is useful to briefly explore the evolution of social protection in development policy, before exploring the contemporary debate on the conceptual frameworks that shape related thinking.

Social protection as a development policy: a brief overview

As Barrientos and Hulme (2008) observe, there is an evolving agreement that social protection delivers an efficient response to poverty and vulnerability in LMICs. This is demonstrated by growing numbers of national governments adopting social protection strategies; support from major international institutions and donors; and increasing focus on social protection in

academic literature, as 'the emerging paradigm for social policy in developing countries' (Barrientos and Hulme, 2008, p.8).

Merrien (2013) traces the emergence of social protection as a development policy back to the post-World War II era. The ILO's 1952 Convention introduced the 'Social Security (Minimum Standards)' to protect workers and their families from social risks, and provided them with minimum benefits (ILO, 1952).

At this stage, social protection was understood to be restricted to workers in the formal sector. The notion of social protection without financial contribution was 'practically a taboo' (Merrien, 2013). However, during the 1980s, the system collapsed under the weight of structural adjustment plans (SAPs), economic instability, and neoliberal policies; financial institutions were subsequently compelled to compensate for SAPs' social consequences by introducing 'short-term safety net programmes' (Merrien, 2013). Social protection policies were, thus, deemed a way to mitigate the negative side-effects of economic development (Mkandawire, 2001). The World Bank's 1990 World Development Report legitimised social safety-net programmes, stating that the existing basic strategies for poverty reduction needed to be complemented by well-targeted CTs and safety nets, thereby ensuring a more comprehensive approach to social protection.

The 'post-Washington Consensus'

In the latter half of the 1990s, disenchantment with SAPs, the 1997 Asian financial crisis,³ and heightened awareness of the negative impact of global poverty set in motion a fundamental paradigm shift. The fragmented safety-net approach has been increasingly replaced by more holistic strategies, in which social protection is deemed an integral aspect of sustainable development (Browne, 2015).

In the ILO's Decent Work Agenda, social protection is viewed as an essential tool in fighting poverty (García and Gruat, 2003). However, it was the Millennium Development Goals (MDGs), launched in 2000, that truly placed social protection at the centre of the development

the UN's Social Protection Toolbox, http://www.socialprotection-toolbox.org/

The assumption that GDP growth would reduce poverty was seen as a key element in the Asian financial crisis, as only 10% of the population was covered under formal social protection schemes. See

agenda.⁴ By the UN's own admission, though, profound structural disparities actually increased during the latest phase of globalisation, impacting progress towards realising the MDGs by 2015 (ILO and WHO, 2009).

With the 2008 economic crisis, social protection moved nearer the top of the UN's policy agenda through the Social Protection Floor Initiative (SPF-I) (ILO and WHO, 2009), aimed at supporting people dealing with the crisis fallout (ILO and WHO, 2009). 'Social protection floor' is defined as 'a basic set of rights and transfers that enables and empowers all members of a society to access a minimum of goods and services' (ILO and WHO, 2009, p.9), referring to programmes such as 'health insurance, public works programs, or guaranteed employment schemes or cash transfers targeting vulnerable or disadvantaged groups (ILO and WHO, 2009).

Merrien (2013) argues that this 'post-Washington Consensus' led to different opinions on what social protection would mean in practice. The number of contributors to the conceptualisation of social protection grew in this period; agencies including the World Bank, DFID, ILO, UNICEF, United Nations Development Programme (UNDP), Organisation for Economic Co-operation and Development (OECD), and International Social Security Association (Alawni et al., 2012) were joined by a growing number of civil society organisations (CSOs), such as Oxfam, HelpAge International, and the German Development Agency (GIZ) (Merrien, 2013).

The rise of large-scale social protection programmes in the South

At the same time, innovative social programmes arose within the development community, notably 'large-scale programmes [...] such as conditional cash transfers [CCTs] and social pensions' (Merrien, 2013). Most of these new schemes focused on mothers or adult men needing work (both with conditionalities) or older people, people with HIV (without conditionality), and, less specifically, on PWDs (although some overlap with older people). Barrientos (2014) cites examples in China, India, and Brazil. In India, the *National Employment Guarantee Scheme* guarantees 100 days of employment to 58 million poor households in rural areas. Meanwhile, Brazil has implemented a controversial CCT programme called *Bolsa Familia*, which provides transfers to around 40 million households on condition that their children attend school and are vaccinated. Barrientos (2014) claims these examples are the most visible sign of change in developing countries' social protection paradigm. CCTs are

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⁴ See, e.g., UNICEF (2010), which states that 'there is strong evidence that social protection contributes to MDGs 1, 2, 3, 4, 5 and 6 - with stronger impacts for the disadvantaged'.

particularly innovative, as assistance depends on the recipients participating in 'human capital strengthening programmes', which aim to break the 'intergenerational cycle of poverty'; this marks a stark departure from the safety-net model, which imposed few, if any, conditions (Merrien, 2013).

Though later chapters focus on policy analysis and CTs, it is useful here to note the reasons for this change posited by Barrientos: democratisation; sustained growth, generating fiscal space for governments to address demands; and the accumulation of exclusion, which has, together with democratisation, become key for government. This, in turn, has several implications, primarily that governments recognise and act upon their responsibility for tackling poverty, and that social protection is seen as crucial for effective development strategies (Barrientos, 2014). How this obligation is met through social protection programmes is a key challenge for the future. This research aims to contribute to this debate, especially as regards PWDs.

Social protection policy conceptual frameworks

As Barrientos (2014) argues, a 'proper understanding of social protection needs to go beyond an institutional approach and consider underlying development foundations' (p.9). However, the underlying theoretical basis for social protection is rarely discussed in the literature (Barrientos and Hulme, 2008). To provide a sound basis for analysis in this research, it is contended that policy frameworks and their related programmes (including CTs) 'need to be grounded in theories of economic and social development' (Barrientos and Hulme, 2008, p.18). To this end, Munro (2008) identifies three traditional sources for justifications for social protection: human rights principles (mainly economic and social rights); market failure and unexpected risks; and needs-based principles. The risks, rights, and needs schools are discussed below.

Risks

The 'risk school' is derived from the neo-classical economics tradition, which concedes that real-world markets are not perfectly competitive and, consequently, suffer frequent market failure, thus providing 'only a residual welfare state' (Munro, 2008). Social protection measures are consequently justified 'on the basis of real or potential welfare losses arising from market failures and the ability of public action to prevent or compensate for these losses' (Munro, 2008, pp.29-30). According to this philosophy, designing social protection policies is a rational practice that relies mainly on balancing the costs and benefits of different government interventions against the costs of leaving the problem to the market (Munro, 2008).

Rights, as entitlements, are not central to this vision. For the risk school, the defining feature of social protection is 'lifting the constraints to human and economic development' (Barrientos, 2014, p.10). In the late 1990s, the World Bank developed a Social Risk Management (SRM) approach to support people to cope with and manage income risks (Holzmann and Jorgensen, 1999). From this perspective, social protection is 'the best answer to increasingly unstable scenarios when it comes to poverty alleviation'; it allows the vulnerable to escape poverty by investing and accumulating assets (Brunori and O'Reilly, 2010, p.3). This approach identifies safety nets as a means of reducing 'poverty persistence' (Barrientos, 2014, p.10). Arguably, the SRM framework does not consider disability-specific vulnerabilities because it focuses mostly on income variability and, therefore, has limited scope to respond to disability.

Rights

'Rights-based schools' for social protection are derived from the Universal Declaration of Human Rights (UN, 1948) and the International Covenant on Economic, Social and Cultural Rights (UN, 1967), among other sources of international law. Other human rights instruments recognise 'the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability' (Article 28, CRPD). This approach considers citizens as 'rights-holders' and states as 'duty-bearers'; in this context, social protection can be deemed a development of social rights such as equality, inclusion, and non-discrimination (Brunori and O'Reilly, 2010).

The ILO conceives social protection as arising from this version of the human rights philosophy. As aforementioned, the ILO was a pioneer of social protection, which it defined in 1942 as a 'form of social security which provides assistance to persons of small earnings granted as *a right* sufficient to meet a minimum standard of *need'* (ILO, 1942, cited in Munro, 2008, p.32). Since 2011, the ILO has expanded on this, revising its strategy to include a 'two-dimensional approach' intended to achieve the instant implementation of national social protection floors (ILO Recommendation No. 202 [2012]). This approach encompasses basic social security guarantees that ensure a national minimum wage and universal access to essential healthcare (ILO, 2015).

This approach has been growing in popularity since the UN General Assembly's adoption of the SPF-I during the 2010 MDG summit. It maintains that 'pro-poor growth' can only be realised through a harmonised mixture of economic and social policies aiming to empower all citizens and support them to develop their economies, thus contributing to their country's development and poverty reduction strategies (Sabates-Wheeler and Haddad, 2005). A rights-

based approach to development is now official policy in many development organisations, including Save the Children, Oxfam, and World Vision.

Needs

The third conceptual framework places social protection within setups guaranteeing the satisfaction of basic needs (Barrientos, 2014), which is problematic for disability and independent living given its limited focus on basic needs. Munro (2008) traces the origin of this line of thinking to Hobbesian thought (1651) and poverty studies in the nineteenth and twentieth centuries. As Munro explains, these describe 'such things as a basic diet, adequate shelter, sanitary living conditions and simple clothing' as 'necessities' (p.34), and the 'poverty line' is drawn where these needs remain unmet. Under this approach, the state must only intervene where the market, the individual, or the community cannot satisfy these basic needs; it, therefore, has a strong residualist tendency which, like the risk-based school, is closely tied to economic thinking (Munro, 2008). This school has been criticised by rights-based thinkers for being paternalistic and neglecting matters related to agency and participation (Munro, 2008). In fact, Munro argues that the school of basic human needs had lost its effectiveness by the late 1970s, with almost no input until the UNDP launched its human development index (HDI). It should be noted, however, that it does underpin the MDGs.

As a fitting conclusion to this section, Barrientos (2014) affirms that:

[I]n international policy debates across the UN agencies, these three perspectives risk solidifying into competing approaches [...] but it should not be difficult to spot the common ground in the three approaches. To an important extent they point to three different dimensions of the same development challenge (p.11).

Transformative social protection and social justice

This section argues, in line with Sabates-Wheeler and Devereux, that the safety-net conception of social protection continues to prevail among development agencies and other stakeholders, thus representing economic, rather than social, protection (2008). Indeed, social protection 'remains firmly rooted in its origins [...] where assistance was provided on a "discretionary" rather than an "entitlement" basis, usually for a limited time period, often in the form of food, and recipients were pejoratively labelled as "aid beneficiaries" (Institute of Development Studies, 2011, p.1).

Instead, Sabates-Wheeler and Devereux's understanding of social protection is grounded in a vision of: policy provisions designed to target pro-poor growth; governance structures accountable and receptive to all citizens, rich and poor; and an approach to development

based on social justice principles (2008). Emerging from a broader conceptualisation of vulnerability, which takes into consideration structural inequalities, this constitutes the TSP approach.

Vulnerability and social injustice

The TSP school highlights the absence of 'social risks' – important contributors to poverty and vulnerability – from the SRM framework espoused by the World Bank. Sabates-Wheeler and Devereux (2008) distinguish between 'structural' and 'contingent': the former refers to groups and individuals subject to discrimination and marginalisation, leading to long-term poverty and vulnerability, while the latter is a function of various factors, e.g. environmental or economic. They also argue that the SRM focuses largely on 'income variability', thus overlooking other dimensions of vulnerability.

Advocating the TSP over other frameworks, Sabates-Wheeler and Devereux (2008) suggest:

[I]f, rather than focusing on risk as an exogenously given factor to be managed, vulnerability is conceptualized as emerging from and embedded in the socio-political context, then our attention would no longer be focused on how to design a policy so that various groups face less risk in a given context, but on how to transform this context to minimize risk for a range of vulnerable groups. (p.68)

Another TSP-based criticism of the SRM framework pertains to the strategies employed by SRM policies, which mostly concern public and market-based actors, therefore neglecting the larger role of civil society in both perpetuating vulnerability and, consequently, reducing it. Devereux and Sabates-Wheeler (2004) argue that, given the presently limited range of available social protection services in poor countries, non-formal systems, such as those relying on kinship and conventional organisations of reciprocity and dependency, should be seriously considered.

Following the global economic recession, the primary goal of most social protection interventions has been to guarantee minimum survival in low-income households (Devereux, 2011). They recognise social transfers' crucial role in supporting affected people to endure income shocks and keep their assets. However, this has only renewed calls for social protection to extend beyond helping poor and vulnerable people to manage short-term risks: it should also tackle the fundamental causes of their vulnerability (Devereux, 2011). In essence, the TSP school contends that the SRM and growth-focused approaches, and, to a lesser extent,

the human rights schools, do not propose solutions to redress structural imbalances, thus failing to perceive or address the root causes of injustice.

The TSP school thus contextualises the debate on social protection within the larger debate around social justice. For this research, the TSP framework and conceptualisation of vulnerability is particularly relevant to literature on disability and social exclusion. This line of thinking has strong similarities to Minow's 'dilemma of difference', which enquires into the 'law's dilemma about how to ameliorate unfair consequences to the powerless without further reducing their power' (McMullen, 1991, p.253). In relation to PWDs, Minow recognises that one is disabled by 'function of relationships' (Minow, 1990, p.80), 'rather than as traits intrinsic to a particular individual, and that acknowledging this is one way out of the difference dilemma' (McMullen, 1991, p.254). In fact, the social model sees the 'problem' of disability as one of society, not the impaired individual, as opposed to the medical model's view of disability as an affliction to be cured (Coleridge et al., 2010). The human rights approach to disability, central to this thesis, is closely linked to that of social development, i.e. the perception that development interventions should benefit all people, especially the poor, among whom PWDs tend to be the poorest. However, it also acknowledges that the ways individuals interact in groups and society is influenced by the beliefs that shape such interaction in development processes (Bunning et. al., 2017).

As social injustice arises 'from structural inequalities and abuses of power', social justice seeks to address vulnerability and is measured in terms of 'empowerment, equity and the realisation of economic, social and cultural rights' (Nussbaum, cited in Jones and Shahrokh, 2013, p.1). Social justice and disability will be further discussed in later sections. However, it is important to first highlight the 'growing consensus that social protection must address not just income deficits but also structural vulnerabilities and power hierarchies at all levels of society if it is to be an effective means of tackling social exclusion and marginalisation' (Jones and Shahrokh, 2013, p.1).

The transformative element

In contrast to the narrow safety-net conception of social protection, the TSP promotes interventions much wider in scope than CTs, although it acknowledges the latter's importance for vulnerable groups (Devereux and Sabates-Wheeler, 2004). While targeted income transfers provide economic protection in response to economic risks and livelihood vulnerability, the other forms of social protection proposed by the TSP tackle the evident problems of social vulnerability by providing social services and setting up the required actions to adjust or

regulate behaviour with regard to socially vulnerable individuals (Devereux and Sabates-Wheeler, 2004).

In an effort to tackle the deeper structural causes of vulnerability, the TSP school advocates a 'transformative element', i.e. 'policies that relate to power imbalances in society that encourage, create and sustain vulnerabilities' (Devereux and Sabates-Wheeler, 2004, p.9). This explains why Sabates-Wheeler and Devereux refer to social protection as the 'currency of social justice' (2008, p.64), defining it as 'initiatives that transfer income or assets to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalised' (2007, p.5). Sabates-Wheeler and Hulme thereby weave together the concepts of rights, needs, and empowerment to 'produce an all-encompassing policy framework' (Barrientos and Hulme, 2008, p.8).

The TSP framework

To operationalise this definition, four categories of instruments are suggested as fundamental for analysis in this thesis. They will also be essential for categorising social protection policies for PWDs in Palestine, and evaluating their success in promoting greater independent living. The four categories are: 'provision measures, which provide relief from deprivation; preventive measures, which attempt to prevent deprivation; promotive measures, which aim to enhance incomes and capabilities; and transformative measures, which seek to address concerns of social justice and exclusion' (Barrientos, and Hulme, 2016, p.70). Provision, or protective, measures are comparable to mainstream welfare programmes, and include social assistance for the 'chronically poor' and those unable to work (Devereux and Sabates-Wheeler, 2004, p.10). A typical example is social assistance, including targeted CTs, such as disability benefits. The direct CTs for PWDs on which this research focuses would largely fall under this umbrella.

Preventive measures are similar to 'social safety nets' for economically vulnerable groups, and typically include social insurance, such as formalised systems of pensions, health insurance and unemployment benefits. In the TSP categorisation, these measures include informal mechanisms, such as saving clubs and funeral societies, as well as risk mitigation strategies, such as crop diversification (Devereux and Sabates-Wheeler, 2004). *Promotive measures* aim to enhance real incomes and capabilities through 'a range of livelihood-enhancing programmes targeted at households and individuals, such as microfinance and school feeding' (Devereux and Sabates-Wheeler, 2004, p.10). To avoid conflation with other development assistance initiatives, Devereux and Sabates-Wheeler (2004) argue that promotive measures

should have income stabilisation as one of their objectives. (See Chapter 7 for a proposed conceptual framework for a TSP policy supporting PWDs' independent living.)

Examples of transformative measures are those addressing social justice and exclusion, such as changes to the regulatory framework to protect socially vulnerable groups; collective action against worker exploitation; and awareness campaigns and advocacy to enhance social equity. Importantly for this research, they concern vulnerable groups such as PWDs, focused on delivering social protection in ways that empower recipients to be active citizens, rather than passive beneficiaries. If vulnerability is determined by a set of social and economic relations and structures that are not immutable, then these can change through collective action, economic changes, or state intervention (Morgan and Yablonski, 2011).

Figure 2.3, below, depicts the original conceptual framework presented by Sabates-Wheeler and Devereux (2004), which depicts a relationship such as that which may occur between preventive and transformative mechanisms, that is neither strong nor inevitable (Devereux, 2011). Examples given for this relationship are minimum wage legislation or microfinance schemes, which can have both preventive and transformative effects (Devereux, 2011). The figure shows a weak interlink between the protective and promotive features of social protection. This emphasises the likelihood that, in certain situations, safety nets could support people to take actions they might otherwise have avoided to improve their economic opportunities, as in the example of school feeding schemes (Devereux, 2011). Finally, and perhaps most importantly, the TSP approach is deeply aware of the undesirable effects of many protective measures in exacerbating power imbalances, social exclusion, and existing vulnerabilities. Devereux (2011) cites this as an important reason to advance beyond the safety-net conception of social protection.

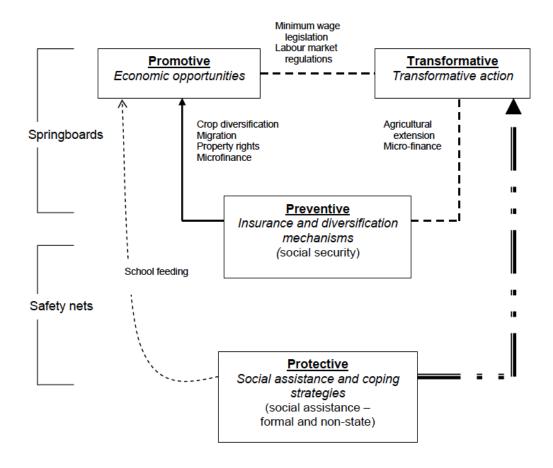


Figure 2.3 A conceptual framework for social protection

Source: Sabates-Wheeler and Devereux (2004, p.11).

Devereux and the TSP school present the vulnerability categories covered by the framework: the 'chronically poor', 'economically vulnerable' or 'at risk', and the 'socially vulnerable' or 'socially marginalised'. They specify that socially marginalised groups, including PWDs, are often also economically vulnerable, being unable to work or confined to low-income, low-status activities. They also identify that sources of economic and social vulnerability interact with and reinforce each other (Devereux, 2011).

The TSP school identifies four intervention types required to effectively address these groups' social protection needs, which are captured in Figure 2.4 below. The main argument of TSP thinking is that policy interventions must be institutionally focused to address poverty, social, and political structures, rather than just income. If poverty is correlated with social exclusion, measures to promote social inclusion and empowerment are more likely to be effective in addressing poverty than indefinitely paying social grants to people only impoverished by this systematic exclusion.

Figure 2.4 A framework for social protection programmes

Vulnerability categories	Examples of affected groups		Category of interventions	Types of programmes
Chronically Poor	Severely disabled		Social Assistance	Disability benefit
	Terminally ill			Single-parent allowances
	Ethnic minorities			Social pensions
	Urban unemployed			Food aid
	Pastoralists			Food-for-work
	Subsistence smallholders		Social insurance	Formalised pensions
Economically at risk	Cash crop farmers			Unemployment benefits
	Internally Displaced Persons			Health insurance
	Orphans			Maternity benefits
	Informal sector workers			Burial societies
	Widows		Transformative action	Changes to regulatory framework to protect
	The elderly			vulnerable groups
Socially vulnerable	Ethnic minorities			Operationalising economic,
	Abducted children			social and cultural rights
	People living with AIDS			Sensitisation campaigns
	Victims of domestic abuse		Social services	Community based care
	People with disabilities			Orphanages
	Street children			Refugee/IDP camps
	Female-headed households			Crèches/pre-schools

Source: Sabates-Wheeler and Devereux (2004, p.13).

Conclusion and points for further debate

This section has presented a case for conceptualising social protection along the lines of the TSP, which identifies equity and social justice as social protection's ultimate goals. The next section will focus on identifying the concept of social justice and what it may look like for PWDs. Crucially, Sabates-Wheeler and Devereux (2008) recognise that a transformative approach cannot achieve the anticipated changes unless able to influence the power relations among different actors, including governments, development agencies, and household members. Therefore, it is questionable to what extent the TSP supports affected people to

define their priorities and demand real and transparent accountability from the different provisioning stakeholders.

However, as Morgan and Yablonski (2011) note, despite 'the conceptual influence' of the TSP approach, social protection policy and practice still:

- 'remains largely "economic protection", focusing on economic shocks, risks and/or material poverty [...] Even where there has been an emphasis on social vulnerability, there has been limited policy or programming to address the overlapping and reinforcing nature of the two';
- 2) 'has focused on manifestations of vulnerability, rather than sources in socio-economic structures and relations. To date, the underlying and structural causes of vulnerability are rarely taken into account' (p.3).

These issues will be further explored in relation to PWDs' social protection in Palestine, aiming to determine best practices and identify lessons learned. The structural causes of PWDs' vulnerability in Palestine will be considered as issues to be addressed by social protection.

2.2.3. Cash transfers

CTs are defined as 'the provision of assistance in the form of cash to the poor or to those who face a probable risk, in the absence of the transfer, of falling into poverty' (Tabor, 2002, p.4). CTs are a major source of support for vulnerable groups, such PWDs, orphans, and underprivileged children (Arnold et al., 2011). CTs are provided either by governments, in the form of social protection schemes, or by the private sector, through private transfers (Tabor, 2002). CTs can be part of a long-term social protection policy or a short-term transitional action (Slater, 2011). When analysing alternative CT mechanisms, the key parameters to consider are transfer design, amount, modality and timing of payment, and the financing mechanisms involved.

In 2000, the ILO reported that 80% of the population in HICs receive one or more forms of CT benefits, whereas less than 10% of the labour force in LMICs is covered under such schemes (Tabor, 2002; ILO, 2014). Since then, LMIC governments have increasingly invested in large-scale CT programmes. Coverage is estimated to range between 0.75 and 1 billion people (Arnold et al., 2011). CTs are increasingly considered to support people to escape poverty, be more effective than emergency food aid programmes, and be strongly linked with improving access to education, health services, or sustainable livelihoods (Arnold et al., 2011; ILO, 2014).

Types of CT programmes

The two main distinguishing CT schemes are contributory transfers (i.e. social insurance) and non-contributory transfers (i.e. social assistance).

Contributory CTs, which are employment-related, are inherently limited to those who make contributions and their dependents, although this principle is often violated by contorting rules to suit different situations. Such programmes are funded through contributions and usually target employees and their families, protecting them against loss of income through retirement, illness, accident, etc. Yet they can also be designed to reach those who have contributed little or nothing (De Neubourg, 2007). The amount and duration for which the latter can derive the cash benefit are determined by their rank and extent of employment prior to the point their earnings stopped. These funds are usually financed through obligatory contributions by employers and employees, with the government being either the guarantor or residual sponsor of the system (Tabor, 2002).

Non-contributory CTs cover a wide range of arrangements, such as universal child benefits and social pensions, of which social assistance is only one (De Neubourg, 2007). These are mainly tax-financed and may involve a means test to determine eligibility (Leisering, 2009). Noncontributory CTs can be completely universal or targeted at certain categories of people (e.g. those aged 60 and above, mothers with young children, or people with officially recognised disabilities). Universal non-contributory transfers aim to reach the entire population or a large segment, and provide flat-rate cash benefits to all, regardless of income, employment, or means (Slater, 2011). These can take the form of social pensions for the elderly, PWDs, orphans, and widows (Tabor, 2002; Leisering, 2009). The cash benefits under such schemes usually take the form of monthly cash payments, administered by governmental authorities, banks, post offices, or private agencies, involving cooperation between public, private, and non-profit organisations (Barrientos et al., 2005, p.22; see also Tabor, 2002). By contrast, targeted programmes are designed to reach a particular group, usually characterised by a vulnerable situation: mostly the elderly, disabled, or young children. Eligibility for such schemes' benefits depends on belonging to the target group. They are normally sponsored by the government (Tabor, 2002; Slater, 2011). Farrington et al. (2007) delineate three targeting phases: (1) policy decisions on who is entitled to access the programme; (2) the processes of reaching out to those people; and (3) the design and implementation of measures to guarantee payments reach the beneficiaries with the least margin of errors in inclusion and exclusion.

Whether CTs can be described as truly universal or categorically targeted is largely a semantic debate. If these categories include low socioeconomic status, then some form of means testing will be required. For means-tested schemes, eligibility is determined by the potential beneficiary's 'means' (i.e. income, consumption, assets, etc.) falling below a certain threshold. Hence, such benefits are usually limited to poor or deprived individuals or households. Means testing can be performed using various methods, such as conducting individual/household assessments or using proxy means testing (PMT) (Farrington et al., 2007), with different indicators ascribed to means, income, and family savings. (See Chapters 6 and 7 for the implications of PMT for PWDs' access to the PNCTP in Palestine.)

Non-contributory transfers, mainly categorical/targeted, may be combined with a set of conditionalities, and are then known as conditional CTs, implying that eligibility depends on the beneficiary's compliance with predefined behaviour, such as their children compulsorily attending school. Cash-for-work payments are another form of conditional CT offered to poor households, taking the form of employment schemes structured as short-term projects, designed mainly for crisis relief purposes (Leisering, 2009; Slater, 2011). Categorical/targeted transfers can also be unconditional when transfers are not linked to co-responsibilities, e.g. targeted schemes for the elderly, women, and PWDs (Farrington and Slater, 2006).

The above characteristics are not necessarily mutually exclusive. A CT scheme for PWDs, for example, may be both targeted (aimed at a specific vulnerable group) and means-tested (aimed at those with income below a certain threshold). Furthermore, such characteristics may vary by degrees. For example, a universal programme aims, by definition, to reach an entire population, yet a policy may be selective and universal insofar as it targets a broad segment of the population, as opposed to only population subgroups.

Cash transfers versus in-kind transfers

With international development agencies increasingly emphasising CTs as a strategy for LMIC poverty reduction, this approach has been challenged. Some criticise CTs for potentially providing a false sense of human well-being, which could mislead policy priorities (Lloyd-Sherlock et al., 2012). One key argument is the complexity of the relationship between income and subjective well-being, especially given the changes in an individual's needs throughout their life (Easterlin, 2010). In contrast, Guy Standing (2008) argues in favour of CTs, mainly the universal, unconditional schemes. He considers this policy to be socially just, as it is usually granted as a right and reinforces social cohesion; moreover, it directs money to citizens who, in most cases, spend it on local products and services, thereby also enhancing the local

economy. From an administrative and economic perspective, he indicates that such schemes are low-cost and easy to manage.

Jayati Ghosh (2011) draws attention to arguments challenging CTs' perceived status as the best government strategy for poverty alleviation. First, she argues that CT schemes are not, in fact, 'an elegant southern alternative' created by development agencies and donors to empower people to choose, independently, how the money should be spent. This approach has a long history in many cultures, often related to religion, such as the Indian system of taxing the rich to pay the poor (Sen and Basu, 2006), and the Islamic Zakat, wherein state revenues are used to provide incomes for the poor and other marginalised community members (Hamid, 2003). Second, CTs cannot alleviate poverty and reduce inequality in isolation; other government policies play an equally important role. Ghosh does not oppose CTs as a policy option; rather, she questions the level of importance they have been accorded compared to other poverty reduction strategies.

Farrington and Slater (2006) elaborate on two key assumptions of CTs within LMICs. First, CTs could discourage people from working. They argue that despite this view's prevalence, it is not yet universal; arguments supporting this assumption are mainly made in countries with hardly any unemployment benefits and very low support levels. The second assumption is that making cash payments has mainly led to consumption tendencies, which can be considered 'money down the drain'. They contend that, with increasing evidence of the positive impact on production achievable through CTs (Johnstone, 2004), debates around CTs are wasteful and unconvincing.

Tabor (2002) advocates for CTs over in-kind transfers, arguing that they provide more choice to recipients, have fewer administrative requirements, and do not incur huge sums to offer protection. He presents three main aspects affecting LMIC government choices regarding cash and in-kind transfers. From an economic perspective, CTs are usually preferred, as they do not directly impact market prices and offer recipients freedom of choice. Both CTs and in-kind transfers provide recipients with an increased level of security, regardless of their income. However, in-kind payments are usually seen as a mechanism to control and influence recipients' behaviour. From an administrative perspective, CTs entail more complicated procedures during the design phase than in-kind payments. Yet once the administrative system is in place, the costs of operating a CT system are probably less than for an equivalent in-kind transfer system (Grosh, 1994). The final aspect is the political perspective: despite the positive economic and administrative aspects of CT programmes, it is often hard to generate positive, sustained political support for them. One reason is government concern that recipients may buy goods and services that would never be directly financed, such as alcohol, cigarettes, and

gambling. Furthermore, through in-kind transfers, politicians can more visibly demonstrate that the poor's basic needs are provided for.

In sum, the reviewed literature indicates general agreement on the benefits of CT schemes for poverty reduction efforts, particularly in comparison to in-kind transfers. However, there is also clear recognition of their limitations, particularly if implemented in isolation.

Cash transfers and disability

CTs in LMICs are receiving increasing research focus regarding the extent of outreach programmes' impact on the poor (Ellis et al., 2009). However, little is known about CTs' impact on PWDs, despite the enhanced attention and allocation of resources to relevant programmes in many middle-income countries (MICs) (Mitra, 2010). From a rights-based perspective, CTs are an instrument to support the recipient to become more independent (Künnemann and Leonhard, 2008). From an economic viewpoint, direct payments can help PWDs cover additional disability-related costs and facilitate their access to other social services and livelihood opportunities, termed 'empowerment through meeting costs' (Marriott and Gooding, 2007, p.15). Therefore, social protection through CTs is considered crucial to achieving PWDs' social inclusion. (See section 2.3 for further discussion.)

2.2.4. Social justice theories, disability, and social protection: a case for the radical project of social justice

Hickey (2014) argues that 'the theory and practice of social protection should be located within a project of social justice' (p.322). This is also the key tenet of the TSP school. However, there are competing theories of social justice across the ideological spectrum, resulting in different implementations of social protection. As Hickey (2014) explains, the philosophical beliefs that support conditional CTs are completely different from those underlying the design of other social protection instruments; hence, adopted social protection instruments are highly influenced by which version of social justice theory is being followed.

It is beyond the scope of this section to review all social justice theories; however, some of the most influential as regards disability will be briefly introduced, including Rawls' social contract in *A Theory of Justice*, Sen and Nussbaum's capability approach, and Young's account of disability as structural inequality.

Social liberalism: Rawls' theory of justice

In *A Theory of Justice*, Rawls (1971) envisions injustice as rooted in 'the nature of institutional arrangements that order life in any society' (Hickey, 2014, p.326). As summarised by Freeman (2014), this position is a central feature of Rawls' social contract account of justice as 'fairness': in this line of thinking, all are 'free and equal persons who jointly agree upon and commit themselves to principles of social and political justice' (p.1).

According to Rawls, this would occur under two basic principles of justice: first, that everyone in society is entitled to basic freedoms; and, second, that individuals act under the 'difference principle', whereby any difference in securing institutional arrangements and distribution would be justified only if it benefited the most disadvantaged in society (Hickey, 2014). Hickey explains that 'reasonable individuals would be keen to ensure that a basic standard of living for all is secured given the risk that they may end up needing such support' (2014, p.325).

As Young (2008) notes, however, 'most social justice theories either do not notice disability at all or bring it up in order to assert that disability is an outlier category (p.81). Rawls is no exception'. From the outset, he overtly excludes PWDs from his contractarian theory of justice. Only fully competent members of society would be allowed to participate in the exercise of choosing the distribution of primary goods: in his words, 'I leave aside permanent physical disabilities or mental disorders so severe as to prevent persons from being normal and fully cooperating members of society in the usual sense' (Rawls, 1985, p.234). Aside from the normative challenge this poses to Rawls' theory (further discussed below), Ansorge (2014) recognises this as a serious issue for justice worldwide, as it excludes an estimated 430 million people.

Critical liberalism: Sen and Nussbaum's capability approach

Human diversity is recognised as a key central concept underpinning the capability approach (Wells, 2015). Amartya Sen belongs to the critical liberalism tradition. In *The Idea of Justice*, he provides a strong critique of numerous points in Rawls' theory, including its contractarian nature, framing justice as the outcome of an agreement between members of a clearly defined society (Brown, 2010).

Sen examines 'The Materials of Justice', specifically expounding the human capability approach (Brown, 2010). Sen reasons that "what happens to people" must be the central concern for a theory of justice and that the primary goods approach of Rawls must be substituted by an approach in terms of capabilities' (Maffettone, 2011, p.119). The capability approach departs

from other distributive theories in that people's assets and wealth or their utility should not be the centre of attention, since they only partially or indirectly reflect how well their life is going (Wells, 2015). Sen's focus is the QoL that individuals are capable of achieving, analysed in terms of the core concepts of 'functionings' and 'capability'. Wells (2015) summarises Sen's explanation of each term as follows:

- *'Functionings* are states of "being and doing" such as being well nourished, having shelter. They should be distinguished from the commodities employed to achieve them (as "bicycling" is distinguishable from "possessing a bike").
- 'Capability refers to the set of valuable functionings that a person has effective access to. Thus, a person's capability represents the effective freedom of an individual to choose between different functioning combinations between different kinds of life that she has reason to value' (p.3).

The capability approach is groundbreaking in considering the impact of social arrangements on the freedom of the individual; it is also relevant to this research in its understanding of 'poverty' as 'deprivation in the capability to live a good life', and 'development' as capability expansion (Wells, 2015). Another relevant aspect of Sen's capability approach is its concept of the 'conversion handicap', which is the cost of converting income into a good living (Sen, 1999).

A PWD faces not only additional barriers in earning a living but also higher living costs. This arises, for example, due to the need to pay for technical aids, hire an assistant, or cover additional transport costs. Therefore, to have the same living standards as their non-disabled peers, PWDs must either have a higher income or live a far more limited lifestyle. This has two key implications for policies targeting PWDs: first, it provides a clear justification for targeted disability benefits; and, second, social protection schemes must consider not only income but also additional potential causes of poverty or vulnerability for PWDs and their families. Sen and the capability approach have, thus, provided the philosophical basis for enabling the individual through a universal social minimum.

Martha Nussbaum should also be mentioned here, having provided the most significant description of a capability theory of justice: drawing on the prerequisites of human dignity, she proposed a list of central capabilities to be integrated into national constitutions and secured for all up to a certain threshold (Wells, 2015). Nussbaum attacks Rawls' exclusion of PWDs and

other individuals who are not able-bodied or of sound mind. In contrast, Nussbaum (2006) insists that the marginalised should, in fact, be central to a theory of justice:

... care for children, elderly people, and people with mental and physical disabilities is a major part of the work that needs to be done in any society, and in most societies it is a source of great injustice. Any theory of justice needs to think about the problem from the beginning, in the design of the basic institutional structure, and particularly in its theory of the primary goods. (p.127).

In her critique of Sen's capability approach, Nussbaum strongly advocates listing the most central capabilities as a basic entitlement. Her aim is to ensure more effective use of the capability approach to achieve social justice (Nussbaum, 2003). She later proposed her list of ten key capabilities essential to human dignity: life; bodily health; bodily integrity; senses, imagination, and thought; emotions; practical reason; affiliation; other species; play; and control over one's environment (Nussbaum, 2006).

Hickey (2014) praises this critique for its 'veracity' and 'relevance' to social protection; however, he contends that 'the alternative offered by capability theories as the main procedure through which entitlements are to be agreed on and distributed' remains problematic (p.328). Capability theorists, in fact, leave reducing injustice to the exercise of public reason, even if 'that reasoning will give no final result' (Gray, 2009, cited in Hickey, 2014, p.328). Hickey (2014) comments that, within the liberal approaches, there is a bias 'towards relatively thin forms of proceduralism as the basis for resolving problems of injustice, which obscures the highly contested character of the political decision-making process around social protection' (p.328).

Using a distinction originally drawn by Wolff, Hickey (2014) recognises that the social liberalism of Rawls and the radical liberalism of capability approaches, unlike (e.g.) the conservative and neoliberal traditions,⁵ could provide support for three types of social policy responses: those that are *internal* to people, such as health and education; support through *external* forms of resources, including CTs and welfare benefits; and efforts to change social and material *structures*, such as legal reforms or the 'reconfiguration of the public space' (p.329).

However, Hickey (2014) argues that Rawls, Sen, and Nussbaum do not provide solid grounds to ensure the achievement of the third element, which corresponds to the TSP school's

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⁵ See Hickey's (2014) accounts of Dworkin's and Nozick's conservative/neoliberal dimension.

transformative element. He reasons, for example, that the capability approach is difficult to operationalise as a guide to transformative action, and that it cannot effectively conceptualise, and hence prioritise, the need for structural-level societal change.

Conversely, Hickey (2014) argues that the Rawlsian approach 'is constrained by its undermining of the principle of difference behind his principle of liberty, which could potentially reduce the attention to existing shapes of institutional bias to better-off groups' (2014). Therefore, he identifies both approaches as more clearly endorsing social protection as part of broader social policy, rather than aligning with the transformative project of social protection (Hickey, 2014).

Finally, this subsection supports Hickey's argument that none of the liberal approaches provide strong support for a more transformative approach to social protection. This is partly due to the methodological individualism underlying much liberal thinking, which tends to avoid interacting with the more structural causes of poverty and exclusion (Hickey, 2014). There is a need, therefore to relocate social protection within a radical project of social justice. As Forst (2001) argues, this prioritises power imbalance as 'the first question of justice', and calls for 'a theory that does not just focus on the justice of the distribution of goods, but on the justice of the "basic structure" of relations of political and economic power, that is, relations of government, of production, and of distribution' (Forst, 2001 p.167-168).

The radical project of social justice: the relational approach

Radical theorist Iris Marion Young takes justice to 'consist of the social and institutional conditions necessary for achieving non-domination and non-oppression, where the latter means the achievement of human flourishing, for all members of society' (Allen, 2011, p.ix). Young critiques the distributive justice paradigm, which concentrates on the allocation of primary goods (Allen, 2011). For her, injustice refers to two types of disabling restrictions: oppression and domination; she stresses that while these constraints include distributive patterns, they also involve decisionmaking processes, divisions of labour and culture (Young, 2011).

Young's conception of oppression is very closely related to the disabled people's and independent living movements in the 1960s. She explicitly refers to how these movements shifted the meaning of oppression to its new usage: suffering not by the hands of a coercive, tyrannical power but, rather, by the structural norms and misguided good intentions of everyday liberal society (Young, 2011).

Young's work is highly relevant to this research, as she directly addresses disability, claiming that '[w]e can learn so much about social justice generally as a concerning issue of structural inequality, normalisation and stigmatisation, if we decide to make disability paradigmatic of structural injustice, instead of considering it exceptional' (Young, 2008, p.82). She also highlights how the disability rights movement challenged the 'common sense' belief of disability as missing the functionings that support normal people to live independently and compete in job markets (Young, 2008). She also champions the movement's argument that the true problem is the mismatch between an individual's characteristics and the overarching societal structures, beliefs, and practices (Young, 2008).

Faced with this 'structural injustice', the only way to achieve equal opportunities for PWDs is to implement the right affirmative measures to support them to function at their best and with dignity (Young, 2008).

The TSP and radical social justice

It is clear from the above that the radical – or relational – approach to social justice is best suited to explaining injustice for PWDs among other groups and individuals, as well as identifying solutions.

Linking back to the start of this subsection, Hickey (2014) explicates the link between radical philosophy and the policy and practice of social protection, echoing the words of Nancy Fraser. She supports transformative approaches to social protection, espousing 'universalist social-welfare programmes, steeply progressive taxation, macroeconomic policies aimed at creating full employment, a large non-market public sector, significant public and/or collective ownership, and democratic decision-making over basic socioeconomic priorities' (Fraser, 1995, p.85).

This philosophy tends to favour a 'universal' and/or 'parametric' approach, instead of targeting resources at specific groups, as this may worsen pre-existing injustice and inequalities (Hickey, 2014). Finally, Hickey explains how this 'clearly aligns radical theories of justice' with the TSP school's advocated shift from 'conservative versions of social protection such as SRM, towards a fuller, transformative notion of social protection' (2014 p.333).

2.2.5. Social justice and independent living for PWDs

In line with the TSP school of thought, this research argues that 'strategies to deal with problems of social vulnerability' – including those of PWDs – 'require a transformative

element, where "transformative" refers to the need to pursue policies that integrate individuals equally into society, allowing everyone to take advantage of the benefits of growth and enabling excluded or marginalised groups to claim their rights' (Sabates-Wheeler and Devereux, 2008, p.70).

As highlighted by Wasserman et al. (2015), justice has received the 'lion's share of attention' in discussions related to philosophy and disability. This section further explores the meaning of social justice for PWDs. It will explore its importance to PWDs from a normative standpoint, considering links between social justice, social protection, and the disability and independent living movements. To lay the foundations for the rest of this research, this subsection will briefly review what the disability rights and independent living movements mean by social justice for disability. The concept, as well as the institutionalised right to independent living, as enshrined in the CRPD, will be introduced as a key tenet of the disability movement for social justice. It will also review the legal rights and programmes intended to achieve independent living for PWDs.

Linking back to the previous section's endorsement of the TSP school, it will be argued that the efficacy of social protection depends on its ability to transform the relationships sustaining poverty and lack of well-being; moreover, for social protection to truly advance as a means of eliminating impoverishment, it should adopt a relational, rather than individualistic, perspective (Devereux and McGregor, 2014). The radical project of social justice will be defended as the best way to now address the injustices PWDs face, and most aligned with the disability movement's calls for empowerment and independent living.

Social justice: the disability rights and independent living movements

As noted in previous subsections, the CRPD's adoption followed years of lobbying and campaigning for social justice and equity by the disability rights movement.

In 1975, a group of UK activists, known as the Union of Physically Impaired Against Segregation (UPIAS), introduced a definition of disability aligned with social justice as a way to tackle prejudices and misconceptions (Loewen and Pollard, 2010). The UPIAS believed that disability was caused by social institutions, societal opinions, and the adoption of the medical model of disability (UPIAS, 1976).

In *The Politics of Disablement*, Oliver (1990) explains the philosophy behind this movement:

If disability is defined as social oppression, then disabled people will be seen as the collective victims of an uncaring or unknowing society rather than as individual victims of circumstance. Such a view will be translated into social policies geared towards alleviating oppression rather than compensating individuals. (p.3)

The disabled people's movement's main policy demands are summarised by Priestley (2012) through four underlying principles. The first is the slogan 'nothing about us without us' (Charlton, 1998), a demand to have a voice in matters of importance to PWDs. Second is demands for investment in enhancing the accessibility of infrastructure, public transport, and information technology (Priestley, 2012). Third is advocating for non-discrimination laws based on equality and human rights (Priestley, 2012). The final principle is PWDs' greater involvement in producing their own welfare solutions, resulting in policy changes towards greater choice and control in everyday life (Priestley, 2012).

Of particular interest to this research, the fourth demand invokes the concept of independent living, a prominent theme in disabled policy claims (Priestley, 2012), while the third is relevant as independent living has been formalised into an international human right under the CRPD.

Independent living to achieve social justice for PWDs

As noted earlier, PWDs were, until recently, considered only within the medical and charity (or welfare) discourses; thus, governments treated them as patients needing constant federal care, rather than as potentially productive society members. International development projects mirrored these models (UN DESA, 2012). The medical model defined PWDs as 'sick' and, therefore, in need of a 'cure' or 'rehabilitation' (Coleridge et al., 2010, p.29), while the charity model defined them as 'unable to take care of themselves, live independently, or earn a living'; PWDs were, thus, considered to be 'objects who only receive and who do not participate in the processes which shape their lives' (Coleridge, 1993, p.47).

These models have been challenged in the past three decades by the human rights approach, which 'provides a clearer understanding of the constraints faced by [PWDs] that reflect social, cultural and economic barriers, and are not inherently part of living with a disability' (UN DESA, 2012). This view was strengthened by the 2006 adoption of the CRPD.

The philosophy of independent living

Enshrined as an institutionalised right in the CRPD, the concept of independent living is a key tenet of the disability movement for social justice. The concepts of autonomy, self-determination, and inclusion are central to the CRPD, providing a framework to evaluate PWDs' situation and measure their progress towards living independently on an equal basis with others (Burke, 2009). Yet the CRPD followed numerous policies implemented in Europe that aimed to improve PWDs' independent living. These included promoting deinstitutionalisation and direct payment schemes, both seen as promising developments toward empowering PWDs to choose and manage their own care (Shima and Rodrigues, 2009).

The philosophy of independent living is that all individuals should be able to control their lives and choose their daily actions, including managing their personal lives and participating in a community (Batavia et al., 1991; Martinez, 2003). This involves access to the right housing, transport, education, employment, training, and personal support services. As introduced earlier, Morris (2004) defines independent living through three main principles: PWDs should have the same choices and control as non-disabled people; independence does not preclude receiving assistance; and the required assistance should be identified and controlled by PWDs themselves.

In the US, the UK, and Nordic countries, independent living first emerged as a concept in the 1960s, with the formation of self-help networks between persons with severe disabilities trying to live in the community (Zola, 1983; Batavia et al., 1991). In the late 1980s, PWDs in the UK started campaigning for their right to independent living and demanded cash payments to cover their own support (Evans, 2003). This confirms PWDs' realisation that cash payments are key to achieving independent living. In 1987, the UK government instituted the Independent Living Fund to provide financial support for PWDs. A second landmark in developing the independent living policy was the Disability Living Allowance, introduced in the UK in 1992. This offered a new form of benefit to address PWDs' care or mobility needs (Hurstfield et al., 2007). The Community Care (Direct Payments) Act 1996 further established British PWDs' right to receive direct payments for personal assistance, allowing them to arrange their own services, choose the type of support they wanted, and decide how it should be delivered (Leece, 2004). Since then, direct payments – and, more recently, personal budgets – have been promoted to provide choice and control for PWDs.

Article 19, CRPD states as follows:

States Parties to this Convention recognise the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

- a. Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
- Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
- c. Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

This pivotal article enshrines the right to independent living, community support, and personal assistance. Under this article, member states are 'required not only to take action to ensure that [PWDs] can live in the community, but also to provide the support and structures that enable people with disabilities to engage in community life' (Open Society Foundation, 2011, p.2). In recognising the structural barriers PWDs face in everyday society, this is an essential and groundbreaking paradigm shift.

Drawing a comparison between disability rights and the civil rights movement led by African-Americans in the 1950s and 1960s, Shreve (1982) writes:

Like Rosa Parks, [PWDs] want and need to be able to ride the bus. The only difference is that Rosa Parks as an African-American woman was not permitted to sit in the front of the bus while [PWDs] just want to get on the bus. (p.4).

The concept of independent living can be said to have emerged from the paradigm shift constituted by the social model of disability; it 'requires a number of societal practices to be put in place which do not discriminate the life chances of an individual purely because they have an impairment (or multiple impairments)' (Jolly, 2009, p.3).

At a policy level, and as first developed by the Derbyshire Coalition of Disabled People in England, Jolly (2009) lists the following primary aims for independent living policy: accessible information; peer support; accessible housing; access to technical aids and equipment; the right to personal assistance; accessible transport; and accessible environments. Education and employment were later added to the list (Jolly, 2009, p.6).

By 2010, the above needs had evolved into the following twelve legal rights in England, or thirteen in Scotland: full access to the environment; adequate provision of technical aids and equipment; availability of accessible and adapted housing; appropriate and accessible information; availability of peer counselling; adequate provision of personal assistance; a fully accessible transport system; equal opportunities for employment; an adequate income; availability of independent advocacy and self-advocacy; availability of inclusive education and training; appropriate and accessible health and social care provision; and (in Scotland only) communication support (Self Directed Support Scotland, 2015).

The key aim of the independent living movement has been to give more resources directly to PWDs' to organise and purchase their own support for daily living, rather than relying on predefined 'services'. The success of early schemes, particularly in Britain, triggered the emergence of new policies for 'direct payments' and 'personal budgets'. As Ratzka (2013) explains:

Government sends monthly amounts directly to the individual and not the service provider. In such a solution, users are free to buy services in the market, from the providers of their choice or they employ their assistants themselves. In this way they can custom-design their personal assistance according to their individual needs and preferences. [...] Direct payments enable [PWDs] to live and work anywhere in the country, to live on our own, in apartments or single-family homes, together with friends, and to start families of our own. (p.2)

There are numerous obstacles to implementing the right to independent living. As well as being a civil or political right, it is also a socioeconomic right. However, at the time of writing, western countries continue to implement extensive austerity cuts in response to the financial recession, thereby majorly impacting social protection policies. On 6 March 2014, the UK government's Minister of State for Disabled People announced that, as of June 2015, 'the

Independent Living Fund (ILF)⁶ will close [...] and funding will be transferred to local authorities and the devolved administrations. Current users of the fund [...] will then receive support through the mainstream adult social care system.' Perhaps most relevant for this research, the press release reassures PWDs that '[a]ll disabled people, including those transferring from the ILF, will continue to be protected by a safety net that guarantees disabled people get the support they need'. This language implies returning to a safety-net model, in contrast to the more progressive transformative programmes.

Organisations such as Disability Rights UK opposed the ILF's closure. It requested an immediate alternative ensuring the promotion of independent living of people with high support needs (2014), having earlier called for disability policy reforms to be assessed based on capacity to support independent living in practice (Department for Work and Pensions [DWP], 2014). The struggle for independent living is clearly far from over; debates over funding, the concept, the rights it entails, and the social protection programmes it requires continue to be highly relevant to discussions of social justice for PWDs.

In sum, the independent living movement has pursued breaking the culture of dependency, viewing PWDs as citizens not patients, de-institutionalising services and care, cash payments over services in kind, demand-driven over supply-driven services, and enabling PWDs to participate democratically to overcome oppression (Ratzka, 2013). Therefore, enshrining a formal right to independent living in legislation is insufficient to achieve social justice; as Stein and Ashely (2007) argue, 'legislation needs to transform society's institutional structures and attitudes towards marginalised individuals if they are to be treated equally' (p.1204).

Unfortunately, while Article 19, CRPD stipulates PWDs' right to independent living, evidence on how this right has been implemented in LMICs remains lacking. The literature is yet to explore whether LMICs have recognised direct payments as an empowering mechanism, enhancing PWDs' choice and control over where, how, when, and by whom their support is provided. Without adequate government policies to finance and support the independent living model, many families have no choice but to provide such services themselves, which often results in unhealthy dependency on family members, weakening opportunities for personal growth and independence.

live in their communities rather than in residential care' DWP (2014).

⁶ The Independent Living Fund (ILF) was established in 1988 as an executive non-departmental public body, sponsored by the DWP. It delivered financial support to over 46,000 PWDs, so 'they can choose to

The next section examines the importance of social justice for disability from the political philosophy standpoint, seeking to understand how particular conceptions of social justice shape social protection policies and programmes.

2.2.6. Conclusion

This section has reviewed the concepts and normative frameworks relevant to exploring whether CT schemes support and foster greater independent living of PWDs. After a brief historical overview of how the social protection paradigm became a development policy, it then discussed the social protection concept and its related policies and programmes. The section reviewed the different philosophical groundings associated with social protection, namely risks, rights, and needs. Having discussed the dominance of the SRM paradigm, as championed by the World Bank, it endorsed the TSP school, which combines the three bases for social protection and refocuses its ultimate goal on social justice. A transformative element is necessary to address injustices caused by vulnerability inherent in our sociopolitical structures (Devereux and Sabates-Wheeler, 2007).

Having advocated the TSP approach, the third part of this conceptual framework considered the concept of social justice as related to social protection and PWDs. The section has also introduced the concept of independent living as a possible interpretation of social justice for PWDs. This involves numerous policies and programmes, including direct payments, to allow PWDs greater autonomy.

In conclusion, the above discussion has begun to shape a normative answer to the questions this study poses. Direct payments or CTs are one policy solution that may, to some extent, enhance PWDs' autonomy and available choices. However, the whole concept of independent living – which sees disability not as a medical issue but, rather, as social, political, and personal – necessitates considering social protection policies from a transformative perspective. In isolation, CTs are inadequate to address the relational basis of injustice for PWDs and other vulnerable groups and individuals. Thus, the conceptual framework presented here has laid the foundations for further investigation into social protection policies for PWDs in Palestine.

2.3. Cash transfer programmes, disability, and independent living

2.3.1. Introduction

The section will explore existing cash transfer programmes and practices in HICs and LMICs promoting PWDs' independent living. In line with the TSP approach, it will be argued that cash transfers and other social assistance measures can – if deemed appropriate in a given sociopolitical context – contribute to the short-term economic protection of vulnerable groups, such as PWDs. However, as will be further argued, even where such measures are evaluated as appropriate, they are not inherently conducive to social justice and independent living for PWDs. If intended to empower people, social protection should generally be delivered based on the demands of citizens with entitlements, rather than as charitable 'handouts' to beneficiaries (Devereux and Sabates-Wheeler, 2004).

The section starts by presenting the different modalities of disability benefits in Europe and various LMICs, and advocates more closely linking the European model to the transformative approach of social protection, presumed to enhance PWDs' rights to autonomy and independent living. There are several debates about the pros and cons of the different CT modalities, including their equity and cost-effectiveness. Whether these pros and cons have particular saliency for disabled people and disability benefits will be among this research's considerations. The section will also summarise the findings of the systematic review, which examines cash transfers' impact on PWDs' independent living in LMICs.

Prior to the CRPD's adoption, the disability movement was hesitant to strongly advocate social protection, fearing that protection programmes targeting PWDs would generate work disincentives, undermining their capacity to achieve economic independence and have an equal share in the labour market. However, the movement's views on social protection have significantly changed over the past decade, as evidenced by its strong endorsement of the International Disability Alliance (Swedish International Development Cooperation Agency [Sida], 2014) in the report issued by the UN Special Rapporteur on Social Protection and Disability in 2015. The research argues that well-designed social protection programmes are crucial means of combatting poverty and promoting PWDs' independence, inclusion, and participation in a sustainable manner (UN, 2015b). In various respects, this has helped to shift perceptions on the potential of social protection programmes, now recognised as a means to support PWDs to become active participants in society and the economy.

2.3.2. Disability-specific cash transfer programme practices

In this thesis, social protection (specifically CTs) is advanced as a potential policy framework to promote PWDs' independent living rights in LMICs for two main reasons: its effectiveness in addressing vulnerability and social exclusion, and its relevance to human rights. Global social protection initiatives have typically targeted societies' impoverished and marginalised groups, but whether they have equally addressed PWDs is largely unknown. Since data are rarely collected on disability status in social protection programmes, it is difficult to compare these programmes' reach as regards PWDs and non-disabled people in similar economic conditions. Social protection is an important mechanism for guaranteeing equal access to basic services, such as healthcare, education, and nutrition (Marcus et al., 2004). It is increasingly perceived as a fundamental development policy to promote broader social inclusion and social justice rights, in addition to tackling risk and vulnerability (Bonilla Garcia and Gruat, 2003). As stated earlier, it is increasingly recognised that social protection must look beyond income deficits, considering structural vulnerabilities and power hierarchies at all societal levels to effectively reduce social exclusion and marginalisation (Jones and Shahrokh, 2013).

The disproportionately higher poverty rates among PWDs (Mitra et al., 2011; Mont and Cuong, 2011; Palmer, 2011) have obliged countries to provide social protection to poor PWDs and their households (WHO and World Bank, 2011, p.11). Article 28, CRPD clearly mandates the provision of social protection and CTs to ensure PWDs receive the basic support they need to meet at least the lowest acceptable standard of living. State parties have been asked to commit to social protection for PWDs, rather than it simply being a 'policy option' (Barrientos and Hulme, 2009).

To date, LMICs' social protection programmes for PWDs have largely been designed to respond to severe income poverty; however, their potential to empower PWDs and support their autonomy and independent living in LMICs is starting to receive increasing attention (UN, 2015b).

The main design concerns for CTs include the systems for selecting recipients, payment modalities, and implementing bodies. Additional challenges include assuring allocation of the right benefit levels and establishing suitable targeting mechanisms (World Food Programme [WFP], 2011). When reviewing current social protection (mainly CT) schemes as regards disability, five separate issues must be considered in relation to their design and implementation levels.

 Table 2.2
 Policy considerations related to CT programme design and disability

Issues	Considerations and challenges
Targeting and eligibility in mainstream and disability-specific schemes	 Social protection programmes for PWDs rely mainly on national definitions of disability, based mostly on impairment from a medical perspective. PWDs are not a homogenous group: they differ in disability types and the levels and nature of their needs; this makes targeting remarkably challenging in design and implementation. In most LMICs, PWDs' access to CTs is restricted to those who meet the poverty criteria. The means-tested tools designed to determine household income levels tend to either overlook the extra cost of disability or only cursorily assess a PWD's personal and environmental factors influencing that cost. Eligibility for covering expenses related to rehabilitation or assistive devices, often cited as the greatest need in this area, may also be subject to means testing, which deprives many PWDs and increases their risk of falling into poverty through having to bear those costs. Conditional CTs linked to children's school attendance are not always accessible for families of CWDs, as such children have limited access to education due to their disability.
Disability assessment	 In addition to the means-testing assessment, PWDs must prove their disability to be eligible for benefits. Many countries rely mainly on a medical assessment performed by doctors, with no consideration of the person's functioning. PWDs are considered eligible if diagnosed with a qualifying medical condition or if their determined percentage of disability meets a predetermined threshold. Limited administrative and technical capacities and corruption in this process may often lead to targeting errors and high exclusion rates among applicants with disabilities.
Accessibility	 PWDs' access to social protection programmes is highly influenced by the surrounding physical environment (public buildings, transport, etc.), in addition to available, accessible means of communication and information. Likewise, given that CTs are usually disbursed by bank transfers, the accessibility of cash machines in many LMIC banks is very limited.
Adequacy of benefit levels	 The question of whether the allocated cash amounts are sufficiently large to meaningfully contribute to people's lives remains unresolved. Yet this question has specific relevance for PWDs, given their additional disability-related costs. In general, existing schemes for disability benefits are mainly directed towards securing minimum living standards, without consideration of the individual's current and future socioeconomic development and independence. Disability benefits are usually designed based on a flat rate for all, with no consideration of specific needs, such as the impairment level and disability type, of the eligible recipients with disabilities.
Promotion of work opportunities	The design of many existing CT schemes limits PWDs' chances to access the labour market, since 'inability to work' is a precondition for eligibility. This criterion generates disincentives to improve a person's economic well-being, as benefits may be lost if an individual seeks employment or engages in any other livelihood initiative. 3): Marriott and Gooding (2007): Braithwaite and Mont (2008): Palmer 2011: WHO

Sources: OECD (2003); Marriott and Gooding (2007); Braithwaite and Mont (2008); Palmer, 2011; WHO and World Bank (2011); UN (2015b).

As evident in Table 2.2, the main potential barriers to PWDs accessing CT programmes are: inaccessibility (of the environment and systems); negative attitudes; the absence of protective legal frameworks; preconditions for receiving benefits, such as school attendance; and limited access to information about the availability of and eligibility for the programme (Gooding and Marriot, 2009). Additionally, applying a traditional means-testing assessment, with an incomebased poverty line for eligibility, and allocating fixed benefits to all beneficiaries may not reflect the real levels of PWDs' needs, particularly since most PWDs face additional disability-related costs (Palmer et al., 2015).

Hence, for social protection to be more inclusive and improve the lives of PWDs, the existing eligibility criteria and assessment mechanisms need to be revised (Gooding and Marriot, 2009). A one-size-fits-all assessment and eligibility process may cause injustice by only including some PWDs. Moreover, determining eligibility for and the adequacy of cash benefits without considering the extra disability-related costs, either in the means tests or the awarded benefit amounts, could create disparities in the level of impact for recipients with and without disabilities (Palmer, 2011). What may be adequate for non-disabled persons will probably not be adequate for PWDs.

Approaches to disability benefits in OECD countries

Almost all European countries provide a range of benefits to PWDs. The existing schemes' two main objectives are to: (a) ensure social inclusion and promote the economic prospects of PWDs; and/or (b) compensate for the additional impairment-related costs/needs (Shima and Rodrigues, 2009). Some benefits are contributory, linked to the country's national social security system. Yet several other benefits are non-contributory and do not require an employment record. Many European countries offer benefits such as social security disability pensions and social assistance disability allowances. Each scheme has its own eligibility and assessment system, based on each country's policy frameworks and regulations (Council of Europe, 2003).

Among the types of benefits, 'general income replacement benefits' or 'targeted benefits' supporting the costs of personal care and assistive devices are mainly paid in cash. Other benefits are provided in kind, such as covering personal assistant service hours at home or in the workplace. The final type is benefits that could provide a 'gateway' to other benefits, such as receiving reduced rates for specific services (e.g. transportation), free access to certain public places (e.g. museums), and free parking (Shima and Rodrigues, 2009).

In the UK, for example, the government has been engaged in a widespread programme of 'welfare reform' since 2010, aiming for 'greater fairness to the welfare and pensions systems by making work pay and reinvigorating incentives to save for retirement ... while protecting the most vulnerable – disabled people and pensioners' (DWP, 2013, p.13). The ongoing reform of disability benefits aims to reduce the system's complications. In addition to substituting the Disability Living Allowance with Personal Independence Payments (PIPs), many of the workingage allowances are being combined into one payment, termed Universal Credit, which began its staged implementation in 2016.

Burchardt (1999) classifies the UK's disability benefits into four categories: (1) compensatory benefits, such as industrial injury or war disablement benefits; (2) earnings replacement benefits, providing financial benefits to individuals unable to work due to disability, such as the Employment and Support Allowance (ESA) (Kuper et al., 2016); (3) extra costs benefits to support disability-related costs; and (4) income to top up the means-tested mainstream benefits, such as Income Support and Housing or Council Tax Benefits to PWDs.

The box below summarises the main disability-specific benefits available for adults with disabilities and/or their families in the UK.⁷

Box 2.1 Main disability-specific benefits supporting PWDs' independent living in the UK

Employment and Support Allowance (Kuper et al., 2016): There are two types: (1) the contributory scheme, directed towards applicants who meet the National Insurance conditions;⁸ and (2) the incomerelated scheme, available for applicants who fail to meet the contribution criteria but pass the means test.⁹ Applicants must undergo a work capacity assessment to determine eligibility.

Personal Independence Payment (PIP): This is a non-means-tested, non-contributory, and non-taxable benefit to support individuals aged 16 to 64 to bear the extra costs related to disability or health conditions. PIP is split into two schemes, one for daily life and the other for mobility. Applicants may be able to access one or both types. An applicant may be eligible for the daily life component if they need help with daily activities, such as eating, dressing, etc.; housekeeping; interaction and communication

⁹ The applicant's needs (and those of their partner, if they have one) are compared with their available money (e.g. income and savings) to determine the income-related ESA rate. It can be paid on its own (if the claimant is not entitled to contributory ESA) or as a top-up to contributory ESA (if they are). Income-related ESA can include amounts to help towards mortgage interest payments and other housing costs.

⁷ The main source of information is the homepage of the DWP, https://www.gov.uk/browse/benefits/disability, and Disability Rights UK factsheets published in 2014.

⁸ To be eligible for contributory ESA, the applicant must have paid enough National Insurance contributions in specific tax years.

with others; and making financial decisions. Claimants can also benefit from the mobility scheme if they need help with travelling or moving around. Each scheme is disbursed at two different rates – the standard rate and an enhanced rate – depending on the applicant's ability to perform activities of daily life and/or their mobility level. Eligible applicants are classified as having 'limited' or 'severely limited' abilities, assessed by the person's ability to perform 12 key activities related to daily life and/or their mobility needs during the day and at night. The accumulated score will verify access to either scheme and the prescribed rate. If accepted, beneficiaries are not obliged to reveal how they spend the money; however, approved applicants will be regularly reassessed (DWP, 2014).

Universal Credit (UNISON, 2013): This is a new means-tested welfare benefit that the UK government introduced in 2013, aimed at gradually replacing the following means-tested benefits and tax credits: child tax credit; housing benefit; income-related ESA; income-based jobseeker's allowance; income support; parts of social funding; and working tax credit. Applicants will be evaluated according to the Work Capability Assessment (WCA) to decide whether they are fit to work or have limited capacity to work. Based on this assessment, applicants are informed about the preconditions they must meet to receive Universal Credit (UC).

Personal budgets: These are means-tested direct payments, considered to be a central component of the UK's 'personalisation' agenda. The scheme is designed to give the beneficiary choice and control over the care services they need by directly managing their own support.

Another example of self-directed support available for PWDs is the **Access to Work** scheme, which is a cash benefit designed to cover the additional impairment-related costs encountered by PWDs in employment, such as adaptations in the workplace, having a support worker, and in travelling to work.

The variety of schemes provided for PWDs in the UK could serve their independent living needs, in addition to securing a minimum income when they are unable to work. Eligibility for the non-means-tested PIP is not preconditioned on inability to work, unlike many cash transfer schemes in LMICs, which will be discussed in the next section.

The Academic Network of European Disability Experts' (ANED) 2009 report presented evidence on the policy design modalities of 21 European Union (EU) countries' national protection strategies, developed between 2006 and 2008 (Shima and Rodrigues, 2009). Its findings confirm that many European countries follow a twin-track approach to designing social protection policy, aiming to address the continuing risks of poverty and social exclusion for PWDs.

The first track aims to ensure that PWDs are equally addressed in mainstream programmes geared towards the entire population, such as contributory social pensions and means-tested social assistance programmes. The second track comprises disability-specific benefits and

services, aiming for PWDs' empowerment and independent living through, for example, disability-related income support, deinstitutionalisation, and direct payment schemes.

The report indicates that many countries continue to focus mainly on poverty-related schemes, such as income support, with fewer programmes aiming for social inclusion and participation. However, some countries have achieved progress in enhancing PWDs' independent living and shifting from the medical model to the social model in disability assessment systems, thereby paying more attention to functioning and work abilities than to physical limitations (Shima and Rodrigues, 2009). In terms of supporting legislative frameworks, a significant number of anti-discrimination laws have been adopted in many European countries, with the intention of increasing PWDs' social inclusion and supporting their equal access to care, education, employment, and financial support (Waddington and Lawson, 2009).

ANED's report indicates that, despite the evident progress in focusing on disability in social protection policies, the specific needs of PWDs received most emphasis, rather than mainstreaming disability across all social protection programmes and interventions. It also concludes that, despite all the implemented measures, many PWDs still suffer poverty and inability to access needed services, due to lack of affordability, accessibility, and availability of supportive administrative and legal frameworks. Therefore, many PWDs in Europe continue to encounter a higher risk of exclusion and dependence than non-disabled community members (Shima and Rodrigues, 2009).

Approaches to disability benefits/transfers in LMICs

Disability grants are a form of targeted CTs in some LMICs. They are usually means-tested, non-contributory CTs provided for people of working-age who are unable to work due to physical or mental disabilities (Standing, 2008). They are granted on a long-term or short-term basis, depending on the eligibility criteria specified in each country.

The structure of disability benefits in LMICs differs from that in HICs, such as those in Europe. For example, while European countries typically combine contributory social protection schemes with complementary means-tested schemes for low-income persons, only a few LMICs have contributory systems, and the operating structures of such systems have limited coverage, usually restricted to government employees and, more rarely, the private sector (Bastagli, 2013). Contributory schemes are frequently inaccessible to PWDs in LMICs as a high percentage are likely to be either unemployed or self-employed (WHO and World Bank, 2011).

As indicated earlier, the available disability benefits are mainly directed towards poverty alleviation and are mostly restricted to PWDs assessed as unable to work. There are, however, some examples of benefits being directed to cover PWDs' additional costs, such as rehabilitation, assistive devices, transportation, and personal caregiving. Linking such benefits to inability to work or poverty status varies between countries, but requiring a medical-based disability assessment is a predominant condition in most countries (Mitra et al., 2013).

Most of the selected studies of the systematic review (*presented in full in Appendix 2*) focus on non-contributory cash transfer schemes/policies, intended to advance PWDs' living standards. Although few studies consider the programmes' different implications according to PWDs' impairment type, eight of the 20 papers focus particularly on people with HIV/AIDS. In the design of cash transfer programmes in LMICs, considerable differences between targeted and mainstream programmes were identified.

The targeted programmes mainly employ means-tested eligibility criteria. Most of the papers address targeted programmes that focus on disability. Such programmes are mostly limited to PWDs unable to work because they are poor or living with severe impairment. The programmes provide monthly payments, with significant size variation identified between countries: for example, at the time of the respective studies, the transfers provided by Nepal were USD 1.20 per month, while those in South Africa and Brazil ranged from USD 112 to 154 per month.

In Brazil, the Continuous Cash Benefit Programme, which began in 1996, is the country's second largest non-contributory cash benefit programme. It targets people aged 65 and over who are not working or PWDs incapable of both working and living an independent life. Proof of family per capita income being less than 25% of the minimum wage (below USD 1 per day in December 2005) is also required. In 2005, around 2.1 million people were receiving benefits under this programme, divided equally between PWDs and the elderly (Medeiros et al., 2008).

In Zambia, the District Cash Transfer Scheme, a mainstream programme initiated by the government in 2003, includes disabled people. Its main goal is to decrease poverty levels in the poorest households. The scheme has adopted a unique participatory targeting system, applying three eligibility criteria to select recipients: being extremely needy, being incapacitated, and having no valuable assets (Schneider, Waliuya, Munsanje et al., 2011). The papers referred to other examples of mainstream schemes in Ecuador, Bangladesh, and Jamaica, but the available data could not explain how such targeting is achieved (Mitra, 2005; Mont, 2006).

Mainstream programmes, by contrast, target broader groups generally at risk of poverty. Some of the identified programmes explicitly include PWDs among their targeted beneficiaries. However, there were fewer mainstream programmes than targeted within the identified studies.

From the existing data, there is weak evidence that mainstream programmes systematically include PWDs among their targeted beneficiaries. This reinforces the reasons advanced by Marriott and Gooding (2007) to explain PWDs suffering access limitations:

I) low awareness and limited public information, physical inaccessibility and bureaucracy. II) Means tests may unfairly exclude disabled people who face high costs associated with disability. III) Conditions attached to transfers, such as school or health clinic attendance, may exclude disabled people if these services are not accessible. IV) Public works schemes are likely to exclude disabled people unless special provisions are made. (p.29)

In 2015, the ILO investigated existing practices in relation to non-contributory CT schemes in six LMICs: Argentina, Ethiopia, Ghana, Indonesia, Kyrgyzstan, and South Africa (Abu Alghaib, 2016). 'Inability to work' was found to be the predominant eligibility criterion in Kyrgyzstan, South Africa, and Indonesia. Most of the existing schemes are means tested and involve some form of disability certificate and related assessment procedures. Available data indicate that the related complexity, or corruption, involved in such processes can limit PWDs' access. Overall, the study shows that access to and the coverage of existing schemes remains a big concern for PWDs, especially in remote areas. In relation to schemes targeting households rather than the individuals, such as the Livelihood Empowerment Against Poverty (LEAP) programme in Ghana, additional questions arise, including whether individuals with disabilities will 'sufficiently' benefit from this support, how households with more than one disabled family member are treated, and the potential negative impact on PWDs' participation, autonomy, and choice (Abu Alghaib, 2016).

2.3.3. Impact of cash transfer schemes on PWDs' independent living in LMICs

This subsection summarises the systematic review that guided this thesis (see Appendix 2 for the full systematic review and Chapter 6 for a specific discussion of policy design).

As discussed earlier, cash transfers' impact on PWDs in LMICs has not previously been systematically reviewed (Mitra, 2010), despite Article 28, CRPD confirming that PWDs in all countries have an equal right to social protection (Rohwerder, 2014).

Hence, the review's main objective was to assess evidence on how existing social protection programmes influence PWDs' access to services, empowerment, and independence in LMICs, especially in the MENA region.

The review found moderate evidence that cash transfer programmes in LMICs can improve PWDs' opportunities to access basic services, notably in healthcare. However, evidence on the impact of cash transfers on PWDs' education and employment opportunities is relatively weak. Additionally, coverage and benefit levels remain low, as most existing schemes are limited in resources and impact. Furthermore, none of the identified studies presents evidence on the impact of cash transfers on PWDs' independent living.

Unfortunately, none of the identified studies examined practices or impact within the MENA region. However, I was able to find some relevant grey literature outside the systematic review; I will draw on this in later chapters concerning MENA countries.

The factors identified as influencing impact can be summarised thus:

- Most of the identified studies focus on targeted programmes, where eligibility is limited to people with severe impairment who are unable to work or are living below a specified poverty threshold.
- The main indicated causes of limited coverage in existing schemes are limited funding,
 lack of awareness, failure to consider physical access, and bad administrative practices.
- In existing schemes, the complexity of disability assessment and basing it mainly on medical diagnosis creates an additional barrier to equal access for PWDs. There was hardly any evidence of the adoption of homogeneous assessment criteria, which should consider the social context and properly balance the medical and social aspects affecting PWDs.
- In addition to disability assessment, means-tested entry requirements are seen by researchers as an exclusion factor, since they mainly consider the potential recipient's income, rather than their expenditure.

In summary, although cash transfers play an important role in supporting PWDs, the majority of studies examined here suggest that, in isolation they are not expected to solve the poverty

problem for this group of the population. PWDs' welfare is equally affected by other disability-related policies and development interventions.

2.3.4. Conclusion

This section has examined the need to consider specific issues of social protection policies when addressing disability, focusing primarily on CTs. It discussed: (1) the need to recognise extra disability-related costs when determining payment amounts; (2) adopting a more comprehensive assessment approach; (3) not restricting aid to PWDs based on medical assessments focusing on limitations, rather than functioning; and (4) the need to recognise the heterogenic nature of disability, allowing for flexibility in determining benefits and services based on a scale of options, rather than fixed amounts for all, with no consideration of each applicant's specific situation.

The evidence presented in this section indicates that social protection strategies for PWDs are closer to the TSP approach in HICs than in LMICs. For instance, the UK schemes neatly illustrate the range of benefits and services provided to PWDs within a twin-track social protection framework, offering 'economic protection' and addressing 'social vulnerability'. Some schemes are responsive to economic risks and vulnerabilities, and are either contributory or non-contributory but means-tested, such as the ESA (Kuper et al., 2016). Meanwhile, many others address other forms of disability-specific vulnerabilities – 'social vulnerability' under the TSP approach – including payments to cover disability-related services and additional costs, such as the PIP and the personal budgets schemes.

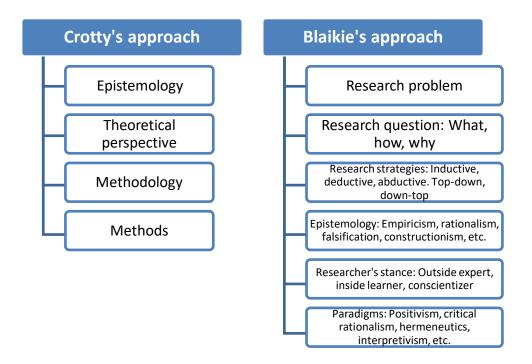
Personal budget schemes recognise the essential need for complementing local-level services and PIP cash payments by supporting disability-related additional costs (Disability Rights UK, 2015). This is considered the route to achieving independent living based on the social model of disability. It assists PWDs to live an active life and participate in society; it enables them to achieve their objectives by personalising their care and providing support planning. Via the personal budget, PWDs are empowered to live the life they choose, and the whole process is centred on their personal aspirations and preferences.

On the contrary, many LMICs retain the narrow safety-net conception of social protection for addressing disability. Though a few countries are moving towards a more comprehensive approach that looks beyond poverty alleviation, disability benefits are mostly still restricted to PWDs assessed as being unable to work.

3. Methodology

This section is written in the first person because it relates directly to the researcher's perception of and relationship with the broader disability and social protection discourse and the research context. Blaikie's (2007) approach was chosen to explain the methodological decisions because it clearly outlines the steps and lists key areas that Crotty's (1998) model fails to address. More importantly, however, it brings special attention to the researcher's stance: the importance of exploring positionality has been widely recognised in qualitative research (Finlay and Gough, 2003), and is vital to developing this research mainly because I am Palestinian and face disability myself. Crotty and Blaikie's approaches are visually represented in Figure 3.1 below.

Figure 3.1 Research sequence adapted from Crotty (1998, p.4) and Blaikie (2007, p.27).



3.1. Positionality and philosophy

Blaikie (2007) refers to positionality as the 'researcher's stance'. According to him, researchers must make choices regarding 'the kind of relationship they wish to have with the people they are researching (insider versus outsider) and the kind of role they will take (learner versus expert)' (p.11). A significant aspect of this research was realising my positionality and its influence on my reactions and interpretations in different interaction spaces. Fook (2012) defines positionality as the researcher's ability to recognise their social position and its influence on the research. He advises researchers to be aware of the situation and to act in

ways that take this into account. My position is that research can be best explained from the mixed perspective of both insider and outsider. In this section, I will explore my complex relationship with the research topic, and the ways in which my lived experience of disability and struggle to participate equally as a full citizen have influenced my thinking.

My route to achieving independent living and the struggle I endured to achieve greater choice and control over my life taught me much about the price PWDs must pay for autonomy, especially in countries lacking systems to support independent living rights. I was only 14 when I lost my ability to walk and became trapped on the third floor of an inaccessible house, with no school and no ability to choose any of my daily activities. With the support of an international organisation, I chose to move out of our family home to pursue my education and dreams, at which time my family and I were pressured socially by our extended family and the community. They assumed that, as a female with a disability, I was vulnerable and unable to make sound choices. An additional challenge for me, to date, has been the lack of understanding and support systems for independent living (IL) rights: for example, seeking personal assistance services is very problematic in Palestine. Even if able to afford it, which is rare, one cannot find a trained person to provide adequate support. I could only ever hire nurses, who tended to act more as controllers than supporters. The second challenge is the absence of any benefit or allowance to support IL needs. Since people with severe disabilities who need this support are mostly not working and, thus, do not have the financial means to afford this service, they rely on their family members' availability and willingness.

In addition to my life experience, I chose this topic based on my previous experience supporting disability rights and independent living as the founder of a DPO for WWDs and a senior staff member in an international disability organisation. I was aware from the start of this research that my positionality as a researcher in my 'home' country may be considered problematic, but I also had the comfort of familiarity, access, and connections. For example, the PWDs I met during the interview phase were very keen to participate in this research, as they believed in what I was doing and trusted me, often sharing personal information to illustrate their struggle with social protection systems. At first, I was concerned regarding my position, sharing similar feelings to those voiced by Pierce, an ethnographer who investigated gender dynamics: '[I] was acutely sensitive to the power I held over those I studied. It was clear to me what I would get out of the research ... but what would they get out of it? Every early personal confidence drove me wild with anxiety ... People trusted me. What was I doing with their trust?' (Pierce, 1966, p.208) However, I learned to treasure this trust throughout the research process and considered myself privileged to be able to reflect on what I was doing and why.

My personal account influenced my approach and research practice; yet I believe that the validity of my findings and the differentiation between my own 'interpretation' of reality and the 'truth' (Heshusius, 1994, p.18) are assured by the rigorous methodological approach I followed, as well as other elements. These include my frequent dialogue with previous colleagues; opportunities to present my research in seminars and meetings at the university and back home; and being part of an informal network of researchers, international NGOs (INGOs), and UN agencies exploring different aspects of social protection and disability globally. All of these activities supported me in developing and deepening my thinking.

I adopted an interpretivist/constructivist approach to underpin this study (Lincoln and Guba, 1985; Bryman, 1988; Crotty, 1998; Blaikie, 2007). The interpretive researcher's activities are usually framed by a constructivist perspective on knowledge: that is, as an interpretive researcher, I build my own understanding and knowledge by making sense of the different experiences to which I am introduced in the field. Though it is also recognised that observations are entrenched in theory, as they are reconciled by ideas and assumptions, the process of research is generally considered to be mostly inductive, in the same way that interpretation is grounded in the data (Ormston et al., 2013, p.13).

The interpretivist paradigm leads to a theory for understanding, though this may not have strong predictive power and has limited generalisability. This paradigm, however, fits very well with the selected approach of a country case study, and aligns with the research objective to provide in-depth understanding of the linkages between social protection measures – particularly the non-contributory PNCTP – and the level of independent living for Palestine's PWDs, rather than seeking global understanding of the impact of social protection on PWDs in general. In contrast:

the methods used in the natural sciences are not appropriate for studying the social world because the social world is not governed by law-like regularities; rather, it is mediated through meaning and human agency. Social reality cannot be captured or portrayed "accurately" because there are different (and possibly competing) perceptions and understandings, though some researchers still aim to "represent" participants' meanings as faithfully as possible. (Ormston et al., 2013, p.12).

Within the interpretivist paradigm, the researcher strives to understand the context of participants. Guba and Lincoln (1994) regard the researcher as being a 'passionate participant'

(p.112). Researchers' interpretation of what they find is shaped by their own experiences and backgrounds (Creswell, 2003). This research aims to explore the perspectives of PWD cash-benefit recipients on how those benefits impact their daily life choices and autonomy. Entering their world and exploring their perspectives yield deeper understanding of *what* their current experiences are with the programme, *why* it is like that, and *how* it can *potentially* be changed. In sum, both the nature of the research objective and questions and my positionality, as outlined above, led me to choose the interpretivist/constructivist approach as a theoretical framework for this research.

3.2. Research strategy and design

In line with the philosophical framework, I adopted a qualitative approach with a descriptive and explanatory purpose. Data collection methods are 'contextual', depending on whether they 'attempt to understand human behaviour within the social, cultural, economic and political environment of a locality' (Hentschel, 1999, p.66). The number of PWDs that benefit from cash transfers does not provide the desired insight into how they affect the PWDs' IL rights. In addition, a quantitative component as part of a mixed-methods study was not feasible, given the absence of up-to-date comprehensive datasets and the lack of relevant resources for new primary data collection. A qualitative approach helped to address research questions that cannot easily be answered with data collected using non-contextual, quantitative tools. Qualitative data collection typically yields information that is contextual and enables understanding the connections and processes shaped by social actors' perceptions and beliefs; such variables, which are not easily quantifiable, are core to this research. The research's descriptive aim is to accurately depict the variables under study (policy dimensions and impact at the individual level). Its explanatory aim is to then provide an interpretation of the findings. This aspect also explores the causal connections between different identified factors, at both the policy and the individual level, considering why certain factors are (or are not) relevant and how they influence Palestinian PWDs' autonomy and independent living, as well as the effectiveness of cash transfer schemes in this regard.

A single case study design has been chosen for the research. According to Matthews and Ross (2014):

a case study is not simply an in-depth study of community, organization or group. The case itself must be pertinent to the research topic. The selection of the case is significant, in terms of its potential to produce data that will enable you to address your research question. (p.128)

Yin (2003) describes five types of case studies. The *critical case* is chosen to test a predefined theory or hypothesis. In the *extreme or unique case*, a situation or group is considered to be unique and different, whereas, in the *representative or typical case*, the situation is seen as representing similar cases. In the *revelatory case*, the researcher has access to a situation that has been hidden; thus, the research would have the potential to elucidate the research topic. Finally, the *longitudinal case* potentially involves repeated observations of the same variables over long periods of time.

My research is a combination of the *unique* and the *representative/typical* type. While primarily addressing knowledge gaps on the impact of cash transfers on PWDs' autonomy in a fragile country, it will likely identify common features and lessons learned that can apply to other schemes in other LMICs, and that may be useful in other parts of the world. The case-oriented approach allows the research to unfold in the complex and specific context of the selected country. It avoids operationalising concepts uniformly and reflects my emphasis on interpretative and causal analysis regarding what factors apply and how they affect the extent to which cash transfers support and foster greater independent living for PWDs.

A critical aspect was the selection of the study country: it had to be relevant to the phenomenon (availability of cash transfer schemes for PWDs) and manifest both shared and non-shared attributes if compared to other countries in the region. Palestine was selected for the following reasons:

- It is within the MENA region, on which there is hardly any evidence on cash transfer and disability. This lack of evidence was confirmed by the preparatory literature review.
- There is evidence of emerging political commitment to disability rights, as reflected in policies related to disability and the existence of cash transfer programmes for PWDs.
- Palestine differs significantly from other countries in the region in terms of particular variables and their effects, providing contrasts and unique situations that this research aims

to examine (e.g. resources, programmes, and broader contextual forces of politics, society, and security).

- Before 2010, the Ministry of Social Affairs (MoSA) had two major cash transfer programmes: (1) the Social Hardship Case (SHC) programme, funded by the EU and targeting vulnerable individuals, including PWDs; and (2) the Social Safety Net Reform Programme (SSNRP), a household-based, means-tested scheme supported by the World Bank. In 2010, the MoSA merged both programmes into the PNCTP and targeted households below the poverty line. This reform is unique and relevant to the research objective, as it allows specific analysis/comparison of PWDs' perceptions of both schemes in terms of design, enrolment, and impact.
- My Palestinian origin was a vital advantage. Besides familiarity with the situation, I have language skills, contacts, and work experience in the country and the MENA region, which prepared me well to grasp the context-specific meanings attached to the observed phenomena.

3.3. Data collection methods

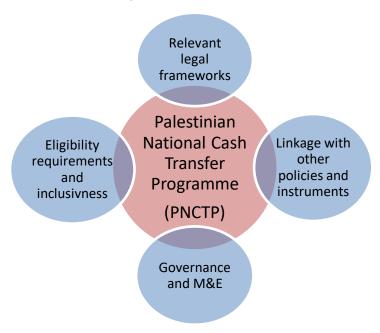
The choice of the level of analysis determines which units of analysis will be targeted, thus guiding the selection of data collection methods. In line with Landman (2008), this research distinguishes between policy and impact levels, and targets both. At the policy level, the programme design, related national implementation, and M&E frameworks were studied, in addition to the local programme-related processes. At the impact level, the study examined the effects of the PNCTP and local implementation processes on the lives of disabled recipients. The link between the two levels is discussed through causal analysis, and an interpretation of the findings and causal connections between identified factors is provided at both macro and micro levels. Data collection involved the analysis of secondary data, as well as conducting new empirical work. The methods used for each level of analysis are detailed below:

- As a preparatory stage, a systematic literature review was conducted to identify existing evidence on the design, implementation, and impact of cash transfer programmes in LMICs.
 The findings of this step helped to refine the focus of the fieldwork.
- 2) The **policy level** analysis focused on:
 - o Relevant legal frameworks, regulations, and policies;
 - Eligibility requirements and related access and assessment mechanisms;

- Coordination with other policies and instruments;
- M&E processes;
- Financing, governance, and administration;
- Efficiency of outreach and response to PWDs' needs.

The study focused on the PNCTP and considered interactions with other schemes relevant to PWDs. Figure 3.2 depicts the pillars of analysis.

Figure 3.2 Pillars of analysis used to examine the PNCTP



Four methods were applied for the **policy level analysis** to obtain the relevant information.

<u>Document study:</u> This involved analysing legislation and official documents that regulate programme design, processes, and administration, providing insight into the programme and the intended chain of implementation, including the actors involved and their interactions. It also included relevant policies, bylaws, and regulations concerning related committees, in addition to assessment processes and reports, surveys, and research on the different programmes and services for PWDs across all sectors (e.g. employment, education, and medical rehabilitation). Secondary data were gathered from several sources, especially the MoSA General Directorate in Ramallah, which provided data about beneficiaries, internal evaluation reports, and monthly monitoring data.

Expert (key informant) interviews: Interviews were conducted with 31 informants with first-hand knowledge of the decisionmaking processes, implementation, and administration of the

PNCTP. These included the Technical Advisor of the PNCTP, the programme's General Manager at the MoSA, and the directors of governorate offices. They helped to reveal the intentions behind the programme's design and goals, and provided information about related processes, implementers (including decisionmakers and programme staff), key bilateral donors, and the target population. Additionally, interviews were conducted with representatives of other ministries that provide key social services for PWDs, such as the Ministry of Labour (MoL), Ministry of Health (MoH), and Ministry of Education (MoE). The intention was to consider their complementarity and links with the social protection services provided by the MoSA. (See Appendix 1 for further details on all research participants)

Interviewing experts is a recognised and widely applied method in social science research. The interviews were semi-structured, which enables covering various topics in one interview while, simultaneously, extracting very specific information (Gläser and Laudel, 2006). The information needs were extrapolated from the research objective, and preliminary theoretical considerations were translated into themes for the interview guide. Interview guides were tailored for different informants to obtain each interviewee's specific experiences and knowledge. The guides were revisited after each interview to add themes relevant to the study that arose in previous interviews. All interviews were conducted face to face and, when physical accessibility allowed, on the premises of the interviewees' respective ministries and organisations. I discursively validated the information after each main section of the interview. Most interviewees were cooperative and interested in offering feedback on the questions.

Because I use a wheelchair, it was quite challenging to reach many of the government offices, which were not physically accessible. I, thus, had to relocate some meetings. The lack of accessible venues in Gaza required meetings to be relocated, as most public buildings were not accessible for wheelchair users. Therefore, most of the interviews in Gaza were conducted in the hotel where I stayed.

Focus group discussions (FGDs): The FGDs targeted local implementers of the PNCTP. These included governorate-level MoSA administrators, social protection coordinators, and social workers familiar with cash transfer schemes, particularly the PNCTP. Lipsky (1980) underscores the relevance of this approach: 'Public policy is not best understood as made in legislatures or top-floor suites of high-ranking administrators, because, in important ways, it is actually made in the crowded offices and daily encounters of street-level workers' (p.xi). Similarly, Lewis and Glennerster (1996) show why policy studies should be sensitive to 'the ways in which local actors constructively adapt the original policy guidelines to local circumstances' (p.xx). The FGDs' first objective was to reveal the political-institutional dimension underlying actual implementation processes in comparison with regulation and the justification of the

programme's policy elements concerning targeting, assessment and transfer design, and M&E mechanisms. The second objective was to explore the daily administration of the programme at local level, and to reveal how disability is assessed and addressed by the programme from the implementers' perspective. Four FGDs were conducted (two in the West Bank and two in Gaza), with a total of 32 participants.

Observation: A disability assessment day at the MoH was observed, with the aim of capturing the interactions, attitudes, and culture of the processes.

3) The **impact level analysis**, concerning the PNCTP's effects on individuals and their environment, was focused on primary data collection:

<u>Focus group discussions (FGDs)</u>: The FGDs targeted PWDs that participate in the PNCTP, and aimed to explore the perceptions, knowledge, and experiences of PWDs in relation to the PNCTP, together with its impact on them:

- Programme design, regarding accessibility, availability, assessment mechanisms, the schemes' adequacy to meet disability-related costs, links to other social services, objectives (poverty alleviation versus support for independent living).
- Utilisation of and the need for grants, regarding control over choices of where and by
 whom the money should be spent; being able to cover additional disability-related costs
 and to access needed social services; the impact of suspending grants at the personal level.
- Impact of grants on autonomy and independent living, regarding choice and control in relation to employment, personal spending, health, place of living, family life, opportunities for learning, relationships and social life, living with independence, and personal care.

Eight FGDs were conducted with a total of 56 participants, mostly held at DPO premises where accessibility for all types of disabilities is ensured.

FGDs involving persons with different disabilities have always been interesting experiences for me. Despite the topic being somewhat complicated, in addressing policy implications at the personal level, I believe that I managed to evoke equal input from all participants. While preparing the questions and tools, I considered the best communication strategies for persons with physical, hearing, and visual impairments, and ways to support persons with severe disabilities to contribute to activities conducted in the FGDs. Simplifying my language and remembering to read written content aloud for persons with visual impairments and those who could not read proved essential.

The interaction level in almost every group was very high. Participants were very keen to discuss their experiences and share their opinions, specifically regarding needs versus available

resources. One participant, a female in her mid-20s from the northern West Bank, approached me at the end of the session and said: 'Thank you very much for inviting me! This is the first time in my whole life that I got the chance to talk freely about my views. Today's discussions were so informative and will probably change the way I feel about many things in my life.' A key challenge was some PWDs' expectation that our discussion could lead to immediate changes in the PNCTP's design and management. I had to explain repeatedly that my project was academic research, whose results the government might or might not consider but that it would provide good evidence for presenting people's real situations.

In-depth interviews: Eight in-depth interviews were conducted with PNCTP recipients that participated in the above FGDs. Each interview was carried out over two visits, with a total duration of four hours. I used a life-history approach, which emphasises the value of presenting individuals' subjective evaluations of their experience (Bakar and Abdullah, 2008). This allowed me to explore the participants' 'micro-historical [individual] experiences within a macro-historical framework' (Hagemaster, 1992, p.1122). The information helped me to explore, in detail, the individuals' experiences of vulnerability and exclusion, and provided insight into the importance of cash benefits in PWDs' lives. The interviews focused on a specific theme and period of participants' lives and generated deep insight into the challenges and vulnerabilities they face, their coping mechanisms, how the cash transfer has influenced their lives, and their plans for the future.

Most of the in-depth interviews with PWDs were conducted at their homes, based on their preference. However, this resulted in many interruptions by other family members wanting to contribute to the discussion. Therefore, much time had to be devoted to explaining and justifying the importance of hearing directly from the PWDs.

3.4. Sampling

I chose the purposive sampling strategy, in which subjects are selected based on certain characteristics (Patton, 1990). It ensures diverse and information-rich participants, which allows for triangulation of data through diverse perspectives on the research question (Gläser and Laudel, 2006).

1) Sampling for the policy analysis:

For the expert interviews, I had to determine who could be considered an expert regarding the research scope and question. The term 'expert' applies to persons with specific practical

knowledge of a particular issue, such that their interpretations in the field of action are meaningful (Bogner et al., 2005). Thus, the following experts were included in this study:

- (1) PWDs who advocate for PWDs' inclusion in social protection policies and cash benefits.
- (2) Persons working in government, non-government services, and other organisations involved in the design and implementation of social protection policies and, particularly, cash transfer schemes.
- (3) Persons working with donors and INGOs who support existing cash transfer schemes.

In the research literature, expert knowledge usually encompasses three components: (1) formal knowledge, (2) practical knowledge, and (3) self-regulative knowledge (Eraut, 1994). Given the socioeconomic environment of this study, expert knowledge was defined with less focus on the first and more on the second and third knowledge types. Hence, expert knowledge was defined as follows: (1) knowledge gained from professional practice or first-hand experience in the field of disability and social protection; and (2) knowledge of organisational, structural, and decisionmaking structures in social protection and disability.

Based on these criteria, 31 key informants were selected for the expert interviews:

- Eight representatives from DPOs;
- 11 representatives from donors, UN agencies, and INGOs that support existing cash transfer schemes (World Bank, European Commission (EC), Diakonia, ILO, WHO, etc.);
- Eight representatives from government authorities directly involved in the design and management of the PNCTP and disability policies within the MoSA;
- Four representatives of the four other relevant ministries (Ministry of Labour [MoL], Ministry of Finance [MoF], Ministry of Education and Higher Education [MoEHE], and Ministry of Health [MoH]).

Most interviews were conducted in the West Bank, mainly in Ramallah, where key ministries, INGOs, and UN agencies are based. Three interviews were conducted in Gaza, mainly with DPO representatives, to understand the difference in implementation between the two regions.

The selection of FGD participants was based on:

- (1) geographical location (working in the same governorate where FGDs with PWDs were carried out);
- (2) gender balance;
- (3) mix of professions/roles (e.g. social workers, local coordinators, managers of governorate offices, etc.).

Based on these criteria, 32 participants were selected for the FGDs:

- 11 local coordinators at the MoSA;
- 7 social workers;
- 5 medical doctors from the MoSA;
- 9 managers of MoSA governorate offices.

2) Sampling for the impact analysis:

For the FGDs with PNCTP recipients with disabilities, eight to ten participants were selected for each FGD, according to the following criteria:

- (1) above 18 years of age;
- (2) gender balance;
- (3) geographical location;
- (4) cross-disability approach;
- (5) PNCTP recipients.

For persons with intellectual or mental disabilities, their caregivers or family members were also invited. FGD participant selection took into consideration that PWDs are not a homogenous population: even two people with the same impairment might have completely different disabilities, depending on where they live, their access to services, and how their communities perceive them. Because some informants had been beneficiaries of the prior schemes, this allowed for deeper analysis through comparing the impact of both models on the same person. Many of these individuals were selected for the subsequent in-depth interviews (see below).

Selection of informants with disabilities considered disability and poverty levels. In the West Bank, the Jenin and Hebron governorates were selected. Jenin, located in the north of the West Bank, has the highest disability prevalence rate (Palestinian Central Bureau of Statistics [PCBS], 2011), at 4.1%, while the rate in Hebron, in the southern West Bank, is 3.8%. In the Gaza Strip, the Gaza and Rafah governorates were chosen: the northern Gaza governorate has a disability prevalence rate of 2.5%, while the rate in the southern Rafah governorate is 2.4%. In addition to high disability prevalence, the four selected governorates are among the poorest and most vulnerable locations in Palestine (PCBS, 2012).

Based on above criteria, 56 participants were selected for a total of eight FGDs: four in the West Bank, with a total of 30 participants, and four in Gaza, with a total of 26 participants. The disability type distribution was as follows: physical: 23; visual: 15; hearing: 10; intellectual: 2; and multiple disabilities: 6. Regarding residence, 26 were from urban areas, 18 from rural areas, and 12 from refugee camps. The age range was from 18 to 51 years. Two of the eight

FGDs were held with WWDs only, freeing them from any cultural concerns that may inhibit their engagement in such a critical discussion. Of the 56 FGD participants, 21 were WWDs.

Participants for the FGDs and in-depth interviews were selected from the MoSA database of 59,445 PWDs who are members of households receiving cash benefits. The database stores the name, address, contact details, role in the family, type of disabilities, and poverty level for those either: (1) below the poverty line, wherein households receive a means-tested national cash transfer benefit; or (2) above the poverty line, wherein households receive a national cash transfer benefit because one family member was a beneficiary of the SHC programme before the 2010 reform. The criteria for selecting participants through the random sample, based on the above criteria, were as follows:

- 50% Gaza (four FGDs);
- 50% West Bank (four FGDs);
- 50% rural, 50% urban;
- 50% male, 50% female;
- Age range (15 46);¹⁰
- 20% persons with visual impairment;
- 20% persons with hearing impairment;
- 40% persons with physical impairment;
- 20% persons with other types of impairment;
- 50% as the only family member with a disability; 50% as part of a family with two or more members with disabilities.

Though the MoSA has a well-developed management information system (MIS), gaining access to the needed data was very difficult. Following a long bureaucratic process of approvals, I was granted access to the system, which I used as the basis for selecting and sampling FGD participants from among PWD beneficiaries of the PNCTP. Nonetheless, almost 25% of the data provided on PWDs benefiting from the PNCTP is either incomplete, false, or outdated. This situation caused massive delays, through having to revert to the original data to generate new lists.

Initial filtering was based on address, poverty level, and age. The shortlists were then re-sorted based on disability type, gender, and family membership. Names with no address or contact

http://data.worldbank.org/indicator/SP.POP.DPND

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¹⁰ This is the World Bank's working-age population range: see

details were excluded, and then every third name was selected randomly. The random selection was performed repeatedly because many of the listed contact details were wrong.

Informants for the follow-up in-depth interviews with PWDs were selected according to the following criteria:

- participation in one of the FGDs;
- gender and disability type;
- recognised in the FGDs as being open and presenting analysis and diverse types of examples, suggesting that deeper analysis might bring added value to the collected data;
- geographical locations (rural/urban).

Eight interviews were conducted (five in the West Bank and three in Gaza). Six of the eight interviewees were PWDs who previously accessed the SHC programme and had been transferred to the PNCTP. Five had physical disabilities and three had visual impairment. Four were females, and four males.

3.5. Data analysis

To analyse the interviews and FGDs, I chose qualitative content analysis. This approach is derived from classical content analysis, an essentially quantitative method premised on a system of categorisation, which aims to quantify each category through a frequency survey (Kohlbacher, 2006). However, in the 1950s, research strategies in content analysis faced criticism for neglecting latent contents and contexts, as well as distinctive individual cases. This critique led to the development of qualitative approaches to content analysis, combining openness and theory-guided investigation as two methodological principles (Gläser and Laudel, 2006). This method applies a systematic classification process to facilitate identifying the contextual meaning through the development of emergent themes in the text (Woods et al., 2002a; 2002b). Data analysis in this study followed the approach proposed by Gläser and Laudel (2006), which is itself based on Mayring's (2000)¹¹ method. The main steps of the analysis were performed manually:

¹¹ Various qualitative approaches to content analysis have been developed, including that of Philipp Mayring in the early 1980s. Mayring proposes developing the category system ex ante, to be potentially adapted to the empirical material in a feedback loop. Gläser and Laudel (2006) modify this approach by proposing a more flexible and open category system, which can be modified throughout the whole

- 1) Arranging data: All interviews and FGDs were transcribed to ensure that each interview's full meaning was represented. The transcription was conducted in Arabic. I decided to use themes/categories as the unit of analysis.
- 2) Development of a category system: Based on the theoretical background and research questions, an initial set of categories was generated (deductive reasoning). This category system was handled openly and adapted, during the extraction process, whenever relevant information found in the text would not fit the existing categories (inductive reasoning).
- 3) Extraction: By means of the category system, relevant information was extracted from the text and systematically reduced; hence, a new basis of information was formed.¹² The extraction process involved methodologically controlled decisions on which information in the original text was relevant for the research objective, and assigning it to the appropriate category, requiring continuous reconsideration of the category system.
- 4) Analysis: This process involved reconstructing meanings and detecting causal connections and mechanisms relevant to the research questions. Owing to the limited number of cases, a comparative analysis of causal mechanisms was performed (Gläser and Laudel, 2006).

Practical steps for managing and sorting data

Data obtained from the research methods were highly diverse and contained many details about different events and facts. Following initial arrangement of the obtained information, the next stage was generating a set of categories based on the theoretical background and research questions (deductive reasoning).

In the analysis phase, I employed a first-person perspective during the initial reading and throughout the categorisation process, then a third-person perspective at the discussion stage and partly when choosing the extracts from the interviews and FGDs to use at the findings stage. Watts (2014) defines first-person perspective as the ability to replace the researcher's own perspectives with those of the participant. In addition, he defines third-person perspective as removing oneself from the data and being informed by exhaustive knowledge of the relevant theoretical literature, rather than one's own opinions or inclinations.

extraction process, with new categories added and existing ones adapted. As this obviates the need for a trial run, analysis efficiency is, thereby, increased.

¹² Extraction is understood here as distinct from coding, which indexes the text for analysis and, therefore, fuses the text and index with the joint subject of analysis (Gläser & Laudel 2006).

To help to establish the first-person perspective, I read the data transcripts at least three times before commencing categorisation. While reading, I started taking notes and highlighting what seemed to be interesting common themes. In the second phase, I started the categorisation process to thoroughly and systematically identify key themes and meanings. I used the left hand-side of the transcript for descriptive themes and the right-hand side for interpretive. Focusing first on the descriptive aspect, I asked 'what' the participant was talking about, writing, on the left, a potential representative theme. I then posed the question 'how', referring to the participant's construction and presentation of the theme to define the descriptive category, which I wrote on the right. While reading the transcripts, I was mindful of whether the same theme appeared repeatedly as a common emerging category.

By way of example, 'decisionmaking' emerged as one of the 'what' themes, while a common descriptive category was 'inability'; thus, in combination, it became clear that many participants constructed decisionmaking as a struggle because they lack the ability to decide on their own daily matters. Other answers, however, revealed that many participants constructed decisionmaking as 'power' and linked it to financial autonomy.

This process supported the identification of relevant subthemes, helping to structure the analysis based on emerging themes and sub-themes. It also helped to create a new structure for summarising and organising the data in a manner conducive to answering the research questions. Common themes were grouped around related concepts, and were arranged in a table listing themes and sub-themes. In the last phase, the whole list was cross-examined to develop the final common themes, a procedure that facilitated the analysis. Extracts were selected using a first-person and then a third-person perspective, but with purposive sampling linked to the identified themes.

3.6. Limitations of the study

Several limitations need to be acknowledged:

- The research and analysis were conducted by only one researcher. Therefore, reliability
 could not be enhanced through investigator triangulation to generate different
 explanations (Golafshani, 2003). Furthermore, the decisions concerning individual
 categories and the circumstances in which a text passage could be assigned to a category
 were not peer-reviewed.
- The study's geographic focus covered PWDs in two cities in the West Bank and two in Gaza.
 This caused many delays in collecting data due to mobility challenges faced by the research

population. Choosing a narrower geographical focus, such as one city, could have allowed more time to be spent with participants, enabling deeper and broader analysis of the relationships between specific variables.

- Data collection in the Gaza Strip was restricted by a tight timeframe, owing to Israeli
 restrictions on the duration of permitted access. This limited opportunities for an evolving
 process and amendments to the schedule to address challenges in accessing relevant
 information or informants.
- The political context in the West Bank and Gaza, and the positioning of military checkpoints between cities and villages, obliged me to organise FGDs in places that are safe for people to reach. This entailed renting hotel venues, at great expense to the researcher, when disability organisation premises were unavailable or impractical.
- Given the sensitive nature of personal needs and prevailing cultural/social norms, some
 experiences, concerns, and priorities may not have been shared or vocalised adequately by
 PWDs during the interviews and FGDs. In particular, this might apply to WWDs' experiences
 of subjection to family members' control over resources and choices.
- It was evident that participants with visual impairments and women were more vocal and able to express their realities more vividly, whereas participants with hearing impairment were less interactive and mainly provided short confirmatory statements in response to points raised by other participants.
- Because of the study's exploratory nature and the very limited sample size, the qualitative data collected were not intended to produce results that represent the whole population of PWDs in Palestine.

3.7. Ethical considerations

The study followed the ethical protocol of the Research Ethics Committee at the Faculty of Medicine and Health Sciences: to ensure confidentiality, all transcripts were anonymised before analysis, and all materials kept in a locked filing cabinet and on a password-protected computer. Recordings and paper copies will be destroyed after checking, and kept as digital computer files only. All transcripts will be destroyed after 10 years from completing this research. Following the UK's Mental Capacity Act 2005, no participants incapable of giving informed consent were included. Accessible versions of the study information sheet and consent form were developed (with braille, large font, etc.) and back-translated from Arabic.

The information sheet was read aloud to the study participants, and the research was discussed, informing participants that they did not have to participate and could withdraw at

any stage. To check their comprehension, participants were then asked to paraphrase the information. Next, they each signed an informed consent form before data collection began. Caregivers, family members, and support workers were not present for interviews or FGDs unless requested by the participant. Particularly in the FGDs, participants were reminded to respect fellow participants' privacy, and not to repeat information disclosed during FGDs to others outside the study. Recognised procedures were followed to protect the researcher's safety; because she is a resident of the territory, no added precautions were required.

3.8. Conclusion

This chapter has explored the methodological approach for the research in this thesis. The following two chapters will further frame the research background by exploring the contextual factors, specific to the MENA region in general and Palestine specifically, that form and perpetuate vulnerability and influence the shaping of existing cash transfer schemes for PWDs.

4. Social protection and disability in the MENA region

4.1. Introduction

This section discusses disability and social protection in the MENA region, reviewing existing social protection policies and programmes for PWDs, and identifying gaps and challenges. As already established, evidence on disability and CTs is very limited. However, its analysis will help situate the case study of Palestine within its regional context, thereby establishing points for comparison with Palestine in terms of the sociopolitical context and government approaches to CT programmes for PWDs.

It examines the intersect between two vitally important social development issues in the MENA region. The first is disability. For PWDs, full participation in social and economic activities and access to services not only helps to fulfil their rights but also benefits their families, communities, and society. Gender issues among PWDs require particular attention (World Bank, 2005, p.i). The second issue is social protection policies and programming, which are both under-researched and under-examined compared to those of other regions. At present, MENA countries operate a variety of social welfare and protection policies that tend to address the symptoms of poverty, inequality and exclusion, rather than their causes (Chatham House, 2014, p.3).

The section begins by introducing the political and socioeconomic context in the MENA region, followed by existing evidence on the legal and institutional frameworks underpinning social protection policy, and the related programming landscape. It then turns to PWDs living in the region and the existing social protection measures that target them. It concludes by drawing a series of comparisons in terms of social protection and disability provisions.

4.2. Political and socioeconomic context in the MENA region

Many MENA countries are undergoing political transition or experiencing civil unrest, which has created the largest number of refugees and internally displaced persons (IDPs) globally. Beginning in December 2010, the Arab Spring brought the overthrow of governments in Egypt, Libya, Tunisia and Yemen, with political instability and social unrest ongoing in each case. It also triggered protests in Jordan, Palestine, Iraq, and Sudan, with the latter three experiencing continuing violence and insecurity (Devereux, 2015, p.22). The protracted crisis in Syria has fostered widespread instability across the region, with fighting spilling over into neighbouring territories and Lebanon hosting more than one million refugees.

MENA's average economic growth continues to be the lowest of any world region, remaining at around 2% per annum since 1990. The regional unemployment rate is 15%: the highest in the world. Labour force participation is also the lowest globally, at 54%, primarily because female participation in the formal sector is very low (Jawad, 2014, p.26). Demographic strains and the consequential 'youth bulge' are limiting young people's work opportunities, with serious social and economic consequences (Devereux, 2015, p.25). This has big implications for relative deprivation of PWDs versus the rest of the population, many of whom are also doing badly.

Yet poverty rates across the overall MENA region are relatively low, averaging 22%. Indeed 'poverty levels have remained unchanged since 1990 and are equivalent to those of Europe and Central Asia' (Jawad, 2014, p.26). In Jordan, the absolute poverty rate in 2010 was 14.4%. However, poverty rates vary considerably at the country level: 54% of Yemen's population live in poverty, and the country was ranked 160th of 187 countries in the Human Development Index for 2014 (Devereux, 2015, p.25).

An estimated 15-17% of the populations of Egypt, Iraq, and Yemen 'have consumption levels that are no more than USD 0.50 per day above the USD 2 per day poverty line', whilst '55 per cent of Egyptians fell temporarily into poverty or near-poverty at least once between 2005 and 2008' (Silva et al., 2012, p.14). Shocks may be idiosyncratic (e.g. illness-related) or covariate (e.g. related to food price spikes). MENA is the world's most food import-dependent region, importing 50% of food consumed; it also has the world's worst water scarcity, and is vulnerable to humanitarian crises arising from multiple conflicts, placing its population at risk of severe and recurring shocks (Pereznieto et al., 2011, p.1). This shows there is an extreme need for social protection for large swathes of their populations, disabled or otherwise.

To date, inequality continues to impede human development in the region. Although the Arab States have seen vast improvements in their human development indicators over the past 25 years, the pace of improvements has slowed considerably since 2010. In addition, MENA countries lose a quarter of their overall HDI value, when adjusted for gender inequalities in education, health, and income. Education is the main driver of inequality, with a 38.9% rate of a HDI compared to the global average of 26.8% (UNDP, 2015a). The Arab States rank second lowest (after South Asia) in the Gender Development Index, which takes into account discrepancies between men and women's HDI levels (Abu Alghaib et al., 2013).

4.3. Policy and institutional frameworks for social protection

Social protection policy and strategy

Although comprehensive social protection policies are lacking across the region, all countries operate public systems that pool labour market, social insurance, and social assistance programmes. State benefits tend to be universal (e.g. family allowances or food and fuel subsidies) or contribution-based (employment social security) social assistance schemes. NGO services usually take the form of means-tested or categorical cash and in-kind assistance (Jawad, 2014, p.28). Additional to universal food and fuel subsidies, the region's formal welfare systems have traditionally either been employment-based social security, favouring male and civic workers, or a mixture of in-kind and cash-based social assistance for vulnerable social groups, mostly comprising female-headed households and orphans. Consequently, two-thirds of MENA populations have no formal social security (Institute for Policy Research, 2013).

There is no coincidence in the vast upscaling of social protection schemes in the region after the 2011 Arab Spring, nor in many MENA countries recent efforts to reform subsidies. Large-scale subsidies serve clear sociopolitical purposes: they are a common government strategy to defuse pressure for reform or regime change. With food access highly market-dependent, MENA governments have historically preferred consumer subsidies as a means to decrease household food insecurity, spending an average of 5.7% of GDP on subsidies (Devereux, 2015, pp.14-15). The focus of policy in the region on cheap food and fuel can be considered less relevant to PWDs than to other social groups. While food and fuel are as important for PWDs as for other household members, PWDs' priority is to gain equal access to central services such as health and rehabilitation, to ensure better functioning and participation.

By contrast, social assistance programmes generally receive a smaller proportion of social protection budgets: for every USD 1 distributed as social assistance to a MENA resident below the poverty line in 2011, USD 158 was spent on subsidies in Yemen and USD 194 on ration cards in Egypt (Silva et al., 2012, p.19). Political short-termism undermines governments' willingness and capacity to develop more comprehensive and sustainable social protection frameworks (Chatham House, 2014).

Institutional framework for social protection

In MENA, the configuration of institutions which underpin the provision of social protection services is shaped by historical developments, together with the political landscape and socioeconomic makeup of each country. Accordingly, service delivery may reflect, as in

Lebanon, weak state institutions and a well-developed tradition of free market enterprise or, as in Egypt, strong state institutions and weaker civil society. Commonalities are, nevertheless, discernible. As well as subsidy programmes, state institutions tend to oversee social insurance systems related to formal employment, especially for public sector workers, and provide public health and education systems. In healthcare, social insurance systems often rely on partnerships with private sector providers (Jawad, 2014, pp.25-28). Social protection is largely domestically financed and state-provided in most MICs, whilst donors' role is significant in lower-middle and low-income countries, and in those affected by conflict (Marcus et al., 2011, p.2).

As outlined above, most MENA governments favour policies for developing economic and human capacities through investment in the private sector; consequently, rather than focusing on causes of poverty, social welfare considerations mainly target symptom alleviation (Institute for Policy Research, 2013). With social policy focused on safety nets and unconditional CTs for the poor, measures to stimulate social cohesion or social rights receive very little attention. In these circumstances, a key role is played by kinship ties, community, and religious organisations in providing emergency social assistance, as well as in constructing a more thorough and integrated social policy agenda (Institute for Policy Research, 2013).

As such, the social functions of social protection are often delegated to traditional and informal sources of support. Historically, nuclear and extended families have played a vital role in social support, through the care of dependents, including young children and PWDs, and financial assistance. It should be noted, however, that over the past decade, the prevalence of poverty and the breakdown of social bonds have rendered families less reliable sources of support (Jawad, 2014, p.25).

Religious welfare organisations operate zakat¹³ and waqf¹⁴ systems, representing by far the most important source of social protection for at-risk populations, particularly informal sector workers.

Jawad and Yakut-Dakar's (2010) typology of religious welfare explores five different types of welfare providers, comprising Islamic actors and institutions. Large welfare organisations may have budgets in the tens of millions (USD) and beneficiaries in the tens of thousands, as well as strong networks throughout service delivery infrastructures (e.g. schools and hospitals). As suggested above, however, levels and usage of social spending in MENA are explained

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¹³ A 2.5% tax on assets to fund welfare provisions.

¹⁴ Religious endowments used for public benefit, including service provision to poor and vulnerable groups.

primarily by a combination of economic and government capacity, rather than any coherent 'Islamic social doctrine' directing social policy; indeed, the influence of Islam is often indirect.

4.4. Social protection programming landscape

There are two broad categories of social protection programmes in MENA, each considered below: (1) statutory provision of social insurance; and (2) non-contributory social protection initiatives, including social assistance, social safety nets, and fiscal subsidies.

Income support / social insurance

Key regional trends include a shift toward contribution-based social insurance systems, with formal sector employees — most often working-age males — the primary beneficiaries. However, this trend has come later and more slowly than in other regions (Turner and Lichtenstein, 2008). Social security coverage varies widely across the region, from 87% in Libya to 8% in Yemen, with the World Bank estimating that formal social protection systems cover only 30-40% of Arab populations (Silva et al., 2012). With their focus on public sector employees, such schemes are not generally pro-poor: excluded populations include agricultural workers, the self-employed, informal sector workers, refugees, and migrant workers (Devereux, 2015). Despite relatively high employment in the region (at almost 85%), social insurance only reaches a minority (Jawad, 2014, p.28).

Social insurance benefits are fragmented, with national resources spread inefficiently across parallel, uncoordinated schemes. Key health insurance benefits are skewed toward the military and political elite, and unavailable to those not in formal, full-time employment (Jawad, 2014, pp.7-8). In the absence of universal comprehensive healthcare provision, out-of-pocket (OOP) health spending is very high, accounting for over 50% of household spending.

Elgazzar et al. (2010) examine the range of OOP expenditures and their implications on policy reforms and living standards in six MENA countries: Yemen, the West Bank and Gaza, Egypt, Iran, Tunisia, and Lebanon. They show that OOP payments account for a relatively high share of total national healthcare financing, averaging 49% and ranging from 4% in Saudi Arabia to 59% in Egypt in 2006. There is greater financial risk for lower income and rural households and families of PWDs. OOP payments are particularly high among 7-13% of households, which might also face devastating outgoings, equal to at least 10% of household spending. After accounting for healthcare payments, poverty rates tend to rise by up to 20%.

OOP spending on healthcare – particularly for PWDs, likely to face significant additional health and rehabilitation expenses— is a policy concern for three reasons. First, by having to pay directly for health services, households may be pushed into or deeper into poverty. Second, those households may spend less on other essential items or resort to negative coping mechanisms. Third, households may decide not to spend money on necessary healthcare to avoid the high costs. This reinforces a vicious cycle of illness, disability, and poverty (Elgazzar et al., 2010).

Social assistance / non-contributory social protection

Rather than introducing pro-poor insurance systems connected to the ever-changing requirements of the employment market, public money has increasingly been channelled into poverty alleviation schemes, through disconnected institutional frameworks, and disbursed by faith and community-based CSOs (Alami and Kashenas, 2012). Those outside the formal sector in MICs (approximately 60%), are able to access different safety nets of varying effectiveness, from general food and energy subsidies and asset transfer initiatives to targeted CT programmes (Pereznieto et al., 2011, p.2).

Table 4.1 Overview of social assistance programmes in study countries¹⁵

Country	Programme	Targeting method	No. of service users
Egypt	Fuel and baladi bread subsidy; cooking oil, rice and sugar ration card — price subsidies and ration cards	Universal	All Egyptians (80.72 million)
Jordan	National Aid Fund — cash transfer to low-income groups	Categorical	206,000
Jordan and Lebanon	Social safety-net programme for Palestinian Refugees — social assistance to poor and vulnerable Palestinian refugees	Categorical/Means-tested	300,000
Yemen	Social Welfare Fund — cash transfer to low-income groups	Categorical	1,000,000

Source: Jawad (2014).

A World Bank review concluded that social safety nets (SSNs) across MENA have had relatively small impacts on poverty and inequality owing to low coverage, poor targeting, and insufficiently generous benefits (Silva et al., 2012). Payment levels under social CT programmes are generally very low, constituting 12% of the expenditure of the poorest quintile, compared

¹⁵ There was no evidence of whether disability is considered in the presented programmes.

to a global average of 20%. The same study found that 23% of (SSN) budgets (excluding subsidies) reach the bottom income quintile in MENA countries; this is far lower than in other regions, including Latin America, Central Asia, and Eastern Europe, where the figure exceeds 50% (Silva et al., 2012, p.25). Jordan's National Aid Fund (NAF) is a regional leader in benefit generosity (Jawad, 2014, p.7); however, there is significant leakage of programme resources to the non-poor, with more than one third of NAF funding benefitting recipients already above the poverty line (Devereux, 2015, p.44). Moreover, in 2006, social assistance in Egypt only reached 12% of the country's poor, with 70% of spending leaking to the non-poor (Devereux, 2015, p.42). This raises questions about the capacity of MENA states to implement effective targeting, including schemes related to disability. This issue will be revisited when discussing the Palestinian context.

Efforts have been made to improve SSN targeting, particularly in Jordan and Yemen. For example, in 2012, Jordan announced new targeting and eligibility criteria for NAF beneficiaries, with 13,000 households removed from coverage following a review of the database (Devereux, 2015, p.44). Similar efforts in Yemen have been thwarted by suspension of the country's largest welfare funds owing to the heightened conflict. Nevertheless, improvements to SSN programming across the region remain much needed.

This emphasis on targeted measures (categorical, means-testing), combined with limited interest in universal social protection schemes (e.g. insurance), also suggests focus on short-term poverty alleviation, at the expense of long-term socioeconomic investment (Jawad, 2014, p.34).

The widespread, but ineffective and inefficient, short-term food and fuel subsidies represent exceptions to a general lack of appetite for universal measures, despite average social spending of 7-10% of GDP suggesting that fiscal space is not as challenging in MENA as in other regions (Silva et al., 2012). Such subsidies inflate SSN spending in the region by 10% of GDP; without them, average spending on non-subsidy social assistance programmes would account for only 0.74% of GDP: below the 0.8% world average (Silva et al., 2012).

Consequently, large social assistance spending fails to produce a commensurate impact on poverty reduction and human development. However, the institutionalised nature of the subsidies is now extremely difficult to reform: to downscale or remove the subsidies would be difficult precisely because they are enjoyed by the politically influential middle classes. The World Bank and the IMF have strongly advocated the reform of subsidy systems in MENA (Devereux, 2015).

Yet experiences of subsidy reform have been mixed. Yemen, for example, has introduced an SSN with the objective of replacing general price subsidies on flour, wheat, and oil with less expensive social assistance initiatives targeting the poor (Devereux, 2015).

4.5. Disability in the MENA region

4.5.1. Situation and needs

There are no reliable, up-to-date statistics on the prevalence of disability across MENA. According to available data, it ranges between 0.4% in Qatar and 4.9% in Sudan. In each of the 18 countries for which data are available, prevalence is reported as 3% or below, which differs dramatically from the 15% global average estimated by the WHO and World Bank (2011). Based on the available data, disability prevalence across MENA appears staggeringly low, given the widespread nature of risk factors for and causes of disability in the region, including communicable and chronic diseases, road traffic accidents, and armed conflict. As censuses are widely used to measure disability, social stigma, which may discourage people from reporting disabilities, may partly explain these low levels. In addition, the use of narrow, medical definitions of disability limit both comparability and reliability. These methodological variations and shortcomings may also partly explain prevalence variations between countries (United Nations Economic and Social Commission for Western Asia [UN ESCWA] and League of Arab States, 2014, pp.9-12).

According to the World Bank (2005), the main challenges relating to disability in the MENA region are: variation in disability definitions between countries; lack of reliable data on disability; the often-prevailing medical model of disability; discrepancies between political commitments, and the absence or weakness of corresponding action plans; fragmentation of existing efforts and ineffective coordination mechanisms; weak mechanisms for prevention and early detection; and significant gaps in essential care and service provision for PWDs.

PWDs face multiple and severe forms of vulnerabilities in the region. In Egypt, for example, PWDs are often stigmatised, secluded by their families, and denied access to work opportunities and appropriate services (Elshami, 2012). PWDs in Lebanon experience discrimination when accessing public buildings, transport, and health services, and applying for bank loans and jobs. As most mainstream schools do not accommodate CWDs, they are often forced to attend residential institutions or forego their right to education altogether (Sida, 2014). Regional evidence on the specific vulnerabilities according to disability type is lacking.

It is estimated that 95% of CWDs in the MENA region are excluded from school at the primary level (Peters, 2009), whilst adults with disabilities — especially women — have fewer opportunities to access employment (UN ESCWA and League of Arab States, 2014). For those countries where comparable data on educational attainment are available, the proportion of persons considered illiterate is substantially higher for PWDs: for example, in Jordan, literacy rates are 61.3% for the population as a whole and 29.6% for PWDs (UN ESCWA and League of Arab States, 2014, p.19). Similarly, there are excessive disparities in economic activity and employment rates: in Egypt, for example, 40% of the total population is employed, compared to 21.2% of PWDs (UN ESCWA and League of Arab States, 2014, p.15). Gender gaps in employment rates exist both for PWDs and total populations: in Egypt, employment rates are 66.11% for men and 12.9% for women in general, compared to 28.4% and 7.5% for male and female PWDs, respectively (UN ESCWA and League of Arab States, 2014, p.19).

Gender and disability norms interact to marginalise women and girls with disabilities. The severity of an impairment tends to pale in comparison with the social consequences of disability. For example, in many Muslim households, a girl with a slight disfigurement may function fully but be considered unfit for marriage, rendering her education unnecessary in her family's eyes; by contrast, a boy with a more severe impairment might be sent to school and given supports that mitigate its effects. PWDs face greater challenges from society's responses to disability than are posed by their specific impairment (Peters, 2009, p.10).

4.5.2. Existing legal and policy frameworks supporting disability

Overarching institutional and legislative frameworks on disability have expanded considerably across MENA in recent years. Of the region's 20 countries, 14 have signed the CRPD and 17 have ratified or acceded to it. Meanwhile, seven have signed and eight have ratified or acceded to the Optional Protocol, which enables the submission of complaints regarding breaches of CRPD provisions by state parties (UN ESCWA and League of Arab States, 2014, p.13) However, up to June 2014, only six have submitted their initial reports to the UN Committee on the Rights of Persons with Disabilities (UN CRPD).

The majority of MENA countries have included disability in their constitutions, though to varying degrees. Almost all countries have adopted laws specifically relating to PWD rights, albeit differing in the extent to which they address social protection. The United Arab Emirate's Federal Law 29/2006 expressly:

aims to guarantee the rights of the person with special needs and to provide all the services within the bounds of his abilities and capacities. The special needs may not be a reason to hinder the person with special needs from obtaining such rights and services especially in the field of welfare and social, economic, health, educational, professional, cultural and promotional services.

Algeria's Law 02-09 on the Protection and Promotion of People with Disabilities (in force from May 2002) stipulates that 'persons with disabilities without income receive social assistance, which takes the form of support or a financial allocation'. Certain MENA countries have developed a platform for equitable opportunities for PWDs through rehabilitation services legislation: in Jordan, for example, the Law for the Welfare of Disabled Persons ensures the integration of PWDs' rehabilitation rights (education, employment, sports and recreation) into the general life of society. Palestinian law provides for free health insurance and education for PWDs, as well as exemption from customs and taxes on private transportation (World Bank, 2016a). Legal provisions concerning employment for PWDs are prevalent, with several countries – including Egypt, Lebanon, and Tunisia – instituting employment quotas, primarily in the public sector, but also increasingly in the private sector (UN ESCWA and League of Arab States, 2014).

However, despite international commitments, the definitions of disability in domestic legal frameworks do not reflect the CRPD-advocated rights-based approach. The CRPD recognises disability as the outcome of the interplay between physical and mental impairments, and social conditions inhibiting inclusion. It, thereby, obliges societies to reform to enable PWDs' full participation. By contrast, in most domestic legislation across the region, disability is articulated primarily as a medical condition, with little or no reference to the role of social and physical environments (Abu Alghaib et al., 2013, p.25). For example, Yemen's Law 61/1999 for the Welfare and Rehabilitation of the Disabled defines as disabled 'any person, male or female, proven by medical examination to be in a permanent or total disability, caused by an injury or illness, and leading to his/her inability to learn or engage in any activity, in whole or in part' (Abu Alghaib et al., 2013, p.25).

In most countries, the ministry responsible for social affairs is responsible for coordinating the provision of social protection, including for PWDs. This mandate sometimes derives directly from the legal framework relating to PWDs' rights. A growing number of MENA countries have also established disability councils, tasked with coordinating matters related to PWDs' rights. However, in some countries that have mandated such bodies' creation, their establishment

has been delayed: for example, Palestine's Higher Council on Disability, created through presidential decree in 2004, 'was only really activated in 2012'. Likewise, Algeria's *Conseil National des Personnes Handicapées* was established by executive decree in 2006 but not 'effectively installed' until 2014 (UN ESCWA, 2017).

4.6. Social protection programming for PWDs

The ILO recommends that social protection floors should comprise, at a minimum, guaranteed access to essential healthcare and basic income security. The two main forms of social protection which uphold the right to income security are social insurance and social assistance: the former is contribution-based and mostly limited to workers in the public and formal private sectors, while the latter is funded by general government revenue and distributed to those judged in need (UN ESCWA, 2017). In the MENA region, wide-scale social protection efforts for PWDs include (World Bank, 2016a):

- a. **Income support** social insurance programmes provide income support to insured workers who become disabled. Some programmes also provide rehabilitation and, possibly, reinsertion support in the labour market.
- b. **Social assistance** social safety-net programmes often include categorical targeting for PWDs, with objectives mostly focused on income support.
- c. **Medical treatments and rehabilitation** usually part of health insurance and public health programmes, but sometimes also within social insurance benefit packages.
- d. **Inclusive education** education programmes promote the inclusion of children and youths with disabilities.
- e. Several other programmes address cross-cutting issues, such as infrastructure and transportation.

Social insurance

Public sector workers tend to be automatically enrolled in social insurance schemes, including disability pensions. To access disability pensions, insured workers must have been declared as having a specific degree of disability. They must also have been enrolled in the social insurance system for a certain period and/or made a certain number of contributions within a specific period. The formula for calculating basic disability benefits usually incorporates the beneficiary's length of contribution and earnings level, applying any applicable minimum and/or maximum thresholds. The size of the benefit is often contingent upon disability severity. In Algeria, full- and partial-disability benefits amount, respectively, to 80% and 60% of the insured's salary. Most social insurance schemes give some type of supplement to those whose disability means they need special support.

Some social insurance schemes include special provisions for PWDs within the insured's household. In Jordan, old-age pensioners with a PWD in their family may be eligible for a 'dependent's supplement' amounting to 12% of the pension (UN ESCWA, 2017).

However, the typical underrepresentation of PWDs in the labour force limits their access to social insurance. Even when PWDs work, its basis is often informal. PWDs who work are less likely than average workers to be permanently employed in the public or private sectors: the forms of employment that tend to offer social insurance coverage. Meanwhile, they are overrepresented among the self-employed, who are not generally covered by social insurance (UN ESCWA, 2017).

Social assistance

Historically, mainstream social assistance schemes in the Arab region have largely comprised universal energy and food subsidies. Recently, however, governments have decisively undertaken to replace these with other schemes deemed more effective and efficient, most notably CT programmes. These are usually defined categorically – i.e. aimed at poorer families with at least one PWD – and, in most cases, are delivered by public agencies, the government, and CSOs.

Algeria's *Pension Handicapé* grants persons with a full disability a monthly CT of USD 36. Some social assistance schemes support the carers of PWDs. Both Iraq and Jordan provide monthly financial assistance to the families of those with disabilities that render them dependent on others' care, as a means of improving living conditions. This is complemented, in many contexts, by charity-run support programmes that provide financial aid and/or free housing

(UN CRPD, 2012; 2013a). In Egypt, the government's World Bank-supported *Karma* ('dignity') and *Takaful* ('mutual support or welfare') programmes provide, respectively, individual pensions to poor PWDs/CWDs (with female caregivers the recipient in cases of severely disabled children) and quarterly cash injections to families whose breadwinner is unable to work due to disability. Mauritania has a CT programme for families of children with multiple disabilities. A few social assistance incentives channelling in-kind support specifically to PWDs can also be found: e.g. in Morocco, food aid is provided to PWDs (UN ESCWA, 2017). Similar programmes, though with different levels of outreach and targeting, exist in most MENA countries.

In MENA's HICs, equivalent programmes tend to offer higher support levels — with gradation according to disability level — and afford PWDs greater decisionmaking power. In Kuwait, monthly allowances of up to USD 923 are provided to children and young PWDs up to the age of 26, should they choose to pursue higher education (compared to USD 129 per month in Iraq). Kuwait also provides to PWDs unable to work a monthly allowance of USD 1962 (UN CRPD, 2015b). In HICs, poverty alleviation measures are more frequently complemented by activities to support social inclusion, such as day-care centres and sporting activities (UN CRPD, 2016a); family education programmes; and specialised counselling (UN CRPD, 2013b). PWDs may also be assisted to access social institutions, for example, through marriage grants (UN CRPD, 2013b) or paid maternity leave (UN CRPD, 2013a). Yet strong linkages with access to long-term employment opportunities were hardly evident in the reviewed CRPD country reports.

Social assistance for PWDs faces important challenges in terms of organisational capacity, financing, and sustainability. Because programmes rely on budgetary distributions and partnerships with CSOs, their sustainability is challenged by limited resources. Information about their reach and even their institutional setup is very limited (World Bank, 2016a).

Another type of social assistance is the so-called public works programmes, under which paid work opportunities, usually short-term, are created for the poor. Mauritania runs a form of public works scheme specifically targeting PWDs: its 'income generating activities' primarily comprise selling telephone cards or foodstuffs. Most countries also have numerous subsidies and tax exemptions for PWDs. In Algeria and Egypt, for example, PWDs are entitled to cheaper or free use of various types of public transport. Tax reductions or exemptions applying to the manufacture, import, and/or purchase of equipment specially fitted for PWDs, notably vehicles, are also very common in the region (UN ESCWA, 2017).

4.6.1. Eligibility and targeting

Statistics are sometimes available on the number of PWDs benefiting from particular social assistance schemes. In 2015, 12,000 PWDs benefited from assistance under Jordan's NAF, constituting approximately 12% of all NAF beneficiaries (UN CRPD, 2012). As of mid-2017, 8,295 CWDs in Morocco lived in households benefiting from the country's CT programme targeting widows. However, it is difficult to draw conclusions about the total number of PWDs covered by social assistance, as most countries have more than one programme and incomplete data (UN ESCWA, 2017).

Further, disability definitions often vary between and within countries, with important implications for eligibility and coverage. The legislative frameworks of Arab countries are increasingly incorporating definitions nearing alignment with the CRPD's and ICF's approach, rather than the medical model

Accordingly, whilst certain countries include both medical and social criteria in determining eligibility for social protection programmes targeting PWDs (e.g. Iraq), many continue to assess eligibility according to narrow, medical disability definitions (e.g. Kuwait and Morocco). Disability assessment is, therefore, another area in which important progress is needed. Differing approaches to disability evaluation and certification are adopted in MENA countries. As summarised in Table 4.2, although many MENA countries depend on professional assessments, the level of autonomy and accountability mechanisms varies.

Table 4.2 Overview of assessment institutions in MENA countries

Country	Assessment institution		
Bahrain	Medical Committee		
Jordan	The Central Medical Committee, Appeal Medical Committee		
Saudi Arabia	The General Organization for Social Insurance's medical board		
Tunisia	Medical Commission (central)		
Qatar	High Medical Commission		
Palestine	Medical Committees (different for West Bank and Gaza)		
Egypt	Medical Commissions		

Source: World Bank (2016b).

High levels of caution are exercised around disability assessment in MENA countries as they lack clear standards and transparent processes. Consequently, disability benefits cover a very small proportion of the population, and inclusion and exclusion errors are often high among those covered. As disability is associated with health impairment in most MENA countries, the approach to assessment is often medicalised. Even in developed countries, the most

prominent drivers of eligibility for disability benefits are medical criteria, overlooking the need to consider non-medical, social causes, such as education level and occupational factors, in assessments and rehabilitation programmes (World Bank, 2016a).

In Egypt, for example, the definition of disability is especially medicalised. Consequently, government policies are based on individualisation and medicalisation of disability, rather than relevant social and economic aspects. Disability is still perceived as shameful by families, who consequently become socially stigmatised and economically vulnerable. In Qatar, the High Medical Commission considers more than just the medical condition when assessing disability, but its exact criteria are not documented, with final decisions only issued as summaries (World Bank, 2016a).

4.6.2. Beyond income support – facilitating independent living

The value of assistance provided to PWDs tends to be insufficient to ensure an adequate standard of living, even in HICs and MICs, such as the United Arab Emirates (UAE) (UN CRPD, 2013c). In isolation, income support – whether through disability pensions or CTs – cannot adequately meet this objective and, therefore, cannot fully meet the needs of PWDs.

Legal and policy frameworks in MENA countries acknowledge PWDs' equal rights to access social protection (Article 28, CRPD) and live independent lives (Article 19, CRPD). Measures to support both have been documented in initial state reports to the UN CRPD. In Jordan, for example, the right of individuals to live independently is stipulated in the constitution and embedded in national legislation, whilst the National Strategy for Persons with Disabilities incorporates family empowerment and social protection, whose aims include improving services to support PWDs to achieve integration and independence; meanwhile, the National Poverty Reduction Strategy acknowledges a link between poverty and disability (UN CRPD, 2012, p.40). These strategies tend to be more coherently articulated in middle- and high-income contexts in the region. Tunisia, for example, advocates a 'two-pronged approach, of which the first... is designed to achieve [economic] growth that will encourage the mainstreaming' of vulnerable groups, including PWDs, whilst the second 'guarantees social and health protection and special assistance for those groups' (UN CRPD, 2011b).

Access to healthcare and rehabilitation services

Health insurance is, like social insurance, often provided on a contributory basis, and thus limited to formal sector workers. However, it may also be extended to specific sections of the population free of charge. Such provisions exist for PWDs in Algeria, Sudan, and Jordan, and for CWDs in Egypt. Free enrolment is sometimes also extended to all beneficiaries of certain social assistance programmes, as in Palestine, Sudan, and Jordan. Alternatively, non-contributory health insurance may be granted through separate schemes established specifically for this purpose. Both Morocco's *Regime d'Assistance Medical* (RAMED) and Tunisia's *Assistance Médicale Gratuite* (AMG) provide insurance entirely free to those deemed most in need and based on a small contribution for those considered vulnerable but not among the poorest. Such healthcare and rehabilitative services are most often provided in the home, particularly for those with severe or multiple disabilities. Tax exemptions for equipment and machinery — including assistive devices, transport, and educational materials — are available in countries across the full spectrum of wealth (from Sudan to Jordan and Saudi Arabia).

It should be noted, however, that well-considered plans for the procurement and delivery of these services are most commonly found in HICs and MICs (such as Tunisia and Saudi Arabia). Health and rehabilitative care, even when available and accessible, is often of inadequate quality or does not otherwise meet PWDs' needs. In a variety of MENA countries, PWDs have raised the issue of prostheses and other forms of equipment being very expensive, of poor quality, or totally unavailable through the healthcare system. Consequently, PWDs often expend large sums on care and equipment, or do not access either, despite insurance provisions (UN ESCWA, 2017). In practice, access is often jeopardised, with many PWDs facing added costs for health and rehabilitation, compounded by a lack of opportunities to work and secure adequate income. Many women are also denied suitable health and rehabilitative care, owing to not only financial constraints but also lack of knowledge about the intersections of disability and health among healthcare professionals (Abu Alghaib et al., 2013, p.47).

Access to assistive devices services

The provision of assistive equipment and adaptations for PWDs is often embedded in national legal codes (as in Yemen), including wheelchairs, prosthetics, and electronic devices (UN CRPD, 2012, pp.27-28).

Whilst comprehensive assistive devices are more likely to be provided free-of-charge in HICs, the importance of support for maintenance costs is often overlooked throughout the region, particularly in LICs. This severely undermines the usefulness of such devices, or even renders them redundant. Accessibility requirements tend to be legally mandated for care and rehabilitation centres and a range of public institutions, including schools, but enforcement is often limited. The state may provide accessible transportation (as in Saudi Arabia) or subsidise or exempt PWDs from fees for public transport (as in Morocco and the UAE, respectively). In middle- and high-income countries (e.g. the UAE), other public services, such as telecommunications, may also be subsidised, and PWDs may receive grants to hire carers, assistants, or drivers: in Kuwait, for example, the monthly value of these grants is USD 333 for those with moderate disabilities and USD 500 for those with severe disabilities.

In Egypt, PWDs have free access to government-owned mass transit buses, in addition to subsidies to buy products for the home, wheelchairs, and prosthetic devices. They are also eligible for reductions on customs taxes for specially equipped private vehicles, as well as prompt approval for installing new telephone lines. However, these measures only reach a small proportion of PWDs, of which most cannot use the non-disability-friendly public transportation and cannot afford to buy the subsidised vehicles (World Bank, 2016a).

Access to appropriate housing options

PWDs' rights to appropriate housing options are often embedded in law and may be provided for under public programmes or targeted efforts. In Jordan, for example, 5% of housing units in the General Organisation for Housing and Urban Development projects are reserved for PWDs and adapted according to their needs. Likewise, in Morocco, PWDs benefit from existing mechanisms supporting decent housing options, while students have the right to appropriate residential accommodation in universities and reduced fees (UN CRPD, 2011c; 2012). In middle- and high-income countries, (e.g. Kuwait), PWDs may be given the option to live in a government-constructed home or receive loans or grants for use in the private market. Targeted measures include state and privately run residential institutions, which offer shared living environments – such as model homes for young people with mental disabilities in Jordan – but are increasingly geared towards supporting independent living. In Sudan, PWDs are

granted land to enable them to construct a suitable home for themselves and their families (UN CRPD, 2015a). However, only HICs prescribe detailed mechanisms and partner responsibilities for implementation and reporting on the numbers of PWDs accessing appropriate housing. In Iran, for example, the banking system is required to fund subsidised credit facilities; the National Organization of Land and Housing is obliged to make the necessary land available, at a reasonable, verified price; and PWDs are exempt from paying various charges (UN CRPD, 2013b).

Access to employment opportunities

The availability of programmes enhancing PWDs' access to employment opportunities varied among the reviewed countries. In Jordan, for example, 'employment opportunities have been provided in businesses and professions appropriate to [PWDs'] experience in their local communities' (UN CRPD, 2012). Morocco supports income-generation projects, whilst Saudi Arabia provides vocational training services. However, details on types of occupation and pay levels tend to be conspicuously absent. Quota systems are frequently used to tackle discrimination and promote access to employment for PWDs; in Egypt and Palestine, these quotas apply in the public and private sectors, whereas in Sudan and Yemen they only apply in the public sector. However, enforcement of these regulations tends to be weak, with WWDs, in particular, continuing to suffer multiple layers of discrimination. Interventions fail to tackle system-wide factors, such as market regulation, supported employment, and school-to-work transitions (Abu Alghaib et al., 2013, p.29). In HICs, PWDs may have the right to retirement pensions, sometimes with a lower age threshold or on par with public sector employees, as in Kuwait and Saudi Arabia, respectively (UN CRPD, 2013c; 2015b).

4.6.3. Barriers to implementing social protection policies supporting PWDs' independent living in the region

Gaps between policy and implementation remain considerable. Chapters 6 and 7 will assess which of these issues are present in Palestine and explore them in greater depth. In their initial reports after ratifying the CRPD, both Jordan and Iran refer to the assumption that PWDs usually live within a supportive family environment. They acknowledge that this assumption has contributed to the limited actions and measures taken to plan for independent living in practice, despite enabling legislative frameworks, thus constraining PWDs' potential to exert choice and control over their lives (Abu Alghaib et al., 2013). Through insufficient public funding and lack of concrete mechanisms to translate protection rights into practice, PWDs

across the region continue to face lives of poverty, dependence, and marginalisation (Abu Alghaib et al., 2013, p.47).

Shortcomings include limited coordination mechanisms. Most MENA countries lack integrated national disability policies; although some public agencies have a mandate to coordinate different programmes, effectiveness is undermined by huge data gaps and fragmented programming with different objectives, run by a mix of public, private, and international agencies (World Bank, 2016a). Many countries, such as Jordan, do not systematically collect data on PWDs receiving funding for housing and adaptation, nor on the poverty rate of PWDs, which would otherwise inform policy development and implementation (UN CRPD, 2012). Moreover, the use of systematic tools to collect and process information about the programmes is very limited (World Bank, 2016a).

Even when social protection is available, there are numerous obstacles that frequently render it inaccessible for PWDs. The support locations are often geographically distant or physically inaccessible. This obstacle may be aggravated by bureaucratic, time-consuming, and expensive application procedures, which frequently require numerous visits to several government offices. Among PWDs in Morocco who do not benefit from RAMED, 49% cite 'administrative difficulties' as their reason for this. In Iraq, similar difficulties have especially affected WWDs, facing obstacles in the form of sexual harassment and social and culturally imposed mobility restrictions, making the lengthy application process especially challenging (UN ESCWA, 2017).

Another major obstacle is the lack of information about available social protection measures. In Morocco, 13% of PWDs not enrolled in RAMED report having no knowledge of the scheme. In Egypt and Tunisia, there is reportedly confusion among PWDs regarding where and how to access social protection services. Governments have taken various measures to alleviate these problems, as in Algeria and Tunisia, where PWDs have been granted priority access to public buildings. In the UAE, applications for disability cards and other forms of social protection, such as CTs, are submitted online, thus reducing the need for PWDs to visit potentially inaccessible government offices (UN ESCWA, 2017).

4.7. Conclusion

Numerous challenges confront countries across the Arab world, including continuing civil discontent; stagnant economic progression; food insecurity and malnutrition; natural disasters; and import dependence. PWDs face specific, but no less significant, challenges, suffering discrimination and exclusion, as well as inadequate access to care, basic services, and employment opportunities.

MENA countries' safety nets and broader social protection programmes offer only partial solutions to some of these challenges. Publicly provided social protection is neither rights-based nor comprehensive. Overarching challenges associated with social protection programming – both in general and for PWDs – can be summarised as follows:

- Low and uneven coverage of social protection measures. Even where contributory social insurance schemes are well-established, large portions of the workforce are excluded; of the self-employed, informal workers, and unemployed, many are PWDs. Many safety nets are time-bound projects with limited funding, while informal social protection cannot provide adequate protection against major shocks (Devereux, 2015). There are also many targeting problems causing inclusion and exclusion errors in the MENA region, which Chapters 5 and 6 will consider in more depth with reference to Palestine.
- Inadequate resource distribution, with the corollary concern that a high proportion of resources are wasted due to poor, or entirely absent, targeting practices. The benefits of general price subsidies are disproportionately captured by the non-poor. Whilst SSNs significantly impact the welfare of the poorest quintile in Jordan, other MENA countries lag far behind. In several, national food transfer programmes have had negligible positive impact on consumption or poverty levels among the poorest, owing to ineffective targeting. Egypt's Monthly Social Pension reached only 8% of the bottom quintile, while Jordan's NAF reached 16.5% (Jawad, 2014).
- Even when monetary benefits are available and accessible, their small size means that they frequently fail to cover even the added costs of disability. Social assistance grants within the framework of mainstream programmes are often of fixed size; despite the higher living costs they typically face, PWDs receive the same sum as other beneficiaries. Therefore, existing schemes are insufficient to allow for extra disability-related costs (UN ESCWA, 2017).
- Considerable gaps in de facto social protection practice. Both public funding and concrete mechanisms to translate protection rights into practice remain insufficient. States tend to be complacent, owing to large numbers of PWDs living in supportive family environments, and the use of narrow medical definitions to determine eligibility, thereby restricting access. For example, inability to work a connotation of the medical approach to disability classifying all PWDs as sick and dependent is usually a precondition of cash assistance. With the notable

- exception of Egypt, CT recipients are either not explicitly prescribed or tend to be family members, inhibiting PWDs' independence and decisionmaking power.
- Inadequate efficiency and coordination of implementation, causing failure to address needs, e.g. in existing support for rehabilitation and employment. Poor coordination might be addressed through developing single national registers for vulnerable groups including PWDs to establish need levels, avoid duplicating benefits, and monitor beneficiaries' progress. The implications of these problems for the PNCTP's effectiveness will be discussed in Chapters 6 and 7.
- Inadequacy in capacity to manage information and in M&E systems, inhibiting transparency, efficiency, and accountability of protection services. The lack of updated and reliable data on both poverty and disability is a key challenge. In Lebanon, the last national household survey was conducted in 2004; despite subsequent significant changes to context, these data are still used for programming. Programs also lack effective management information systems to enable lesson-learning on how to improve their design and implementation (Devereux, 2015, p.68).

To include PWDs in mainstream social protection policies in the region, certain policy features must be supplied to allow greater opportunities to access education, jobs, and social activities in general. In isolation, income support is insufficient to achieve this objective. However, as Jawad (2014) argues, reorienting official social protection policies towards social functions is particularly challenging in the MENA context, as it would require establishing a 'social contract' between states and citizens — which tends to be associated with bestowing citizenship rights — in a region where economic, social, and cultural rights are often absent or not yet deeply embedded. For this reason, until extensive political and institutional reforms are undertaken to produce very different governance structures, a holistic, rights-based approach to social protection is unlikely to appear in most Arab countries. Disabled Palestinians face similar forms of exclusion to other disabled people including negative social attitudes towards disability, marginalisation, poverty, prejudice and discrimination. [...] Additionally, disabled Palestinians face a common difficulty to other Palestinians living within a conflict setting under Israeli occupation, which all Palestinians continue to resist. (Burton et al., 2013, p.814)

5. Contextual factors driving vulnerability in Palestine

This chapter pinpoints the contextual background and challenges specific to Palestine that form and perpetuate vulnerability. It explores the historical and current political conditions, the impact of the occupation, the economic situation, and the influence of international aid. The Palestinian context is unlike that of its Arab neighbours due to the Israeli occupation (UNDP, 2015a). Despite Palestine being classified as 'medium' in terms of human development, with a HDI score for 2014 of 0.677, such advancement is largely determined by external factors, such as international aid and changes in imposed restrictions; therefore, it cannot necessarily be seen as an indicator of sustainable development (UNDP, 2015a).

According to a sociopolitical conceptualisation of vulnerability, 'space, context and time are no longer blind' (Sabates-Wheeler and Waite, 2003, p.7). Therefore, the question for social policy is no longer how to reduce different groups' risk in a given space but, rather, how the space was created and in whose interests (Sabates-Wheeler and Waite, 2003). The effectiveness of social protection programmes in addressing vulnerabilities cannot be assessed without considering the contextual factors. For Palestine, their relevance has an additional dimension: 'as a nation-state still in the making, Palestine represents definitional problems, but also offers an opportunity to examine social policies emerging in the course of an uneven democratic transition marked by conflict in a highly globalized context' (Johnson, 2006, p.968).

In exploring the specific Palestinian context, this chapter presents the central contributing factors relevant to how social protection measures, especially cash transfers, reduce vulnerabilities and poverty for PWDs. In line with Stockmarr's (2013) critique, this chapter's overall stance attributes Palestine's fragility to both the inability of the Palestinian National Authority (PNA) to deliver basic services and the country's inherited political and structural realities. The challenge then is to explore the ways in which social protection in occupied Palestine can work to empower Palestinians, rather than serving to keep the status quo.

5.1. The Israeli-Palestinian conflict

Both during and after World War II, Jewish immigration to Palestine increased and conflict grew. In response, UN Resolution 181 (1947) – the 'Partition Plan' – established one Jewish and one Arab state. The plan's approval led to the 1947-48 Arab-Israeli conflict and, in 1948, the end of British control over Palestine. This triggered war between Israel and the Arab countries, through which Israel seized land from a proposed Palestinian Arab state. Following the war, around 700,000 Palestinians were forced to leave their homes in the area where

Israel had established its own state, thus becoming refugees¹⁶ (Di Bartolomeo et al., 2011). In 1967, Israel occupied the West Bank and East Jerusalem during the Six-Day War. Consequently, Palestinians came to be managed by a subordinate of the Israeli Ministry of Defence, the 'Civil Administration', functioning in close collaboration with the Israeli Military. Numerous aspects of daily life for Palestinians, such as mobility, employment, and business were determined by the Israeli Army and the Civil Administration, 'frequently resulting in intermittent rounds of politically driven confrontations and unarmed civil resistance to the use of lethal force' (World Bank, 2011b, p.1). In mid-2014, there were nearly 750,000 registered refugees in the West Bank, around a quarter of whom live in 19 camps, while the majority live in towns and villages (United Nations Relief and Works Agency for Palestine Refugees in the Near East [UNRWA], 2015). After the 1967 war, the Palestinian Arab community ceased acting as a unified social and political body (Albright, 2015). The desire of these refugees and their descendants to return to their original homes remains among the most challenging debates of the dispute with Israel.

The first Palestinian Intifada (uprising) in 1987 snowballed into a sweeping popular uprising, ended by the Madrid Peace Conference in 1991. In 1993, talks between the Palestinian Liberation Organisation (PLO) and the Government of Israel (GoI) produced the Oslo Accords. Negotiations under the 'Oslo Process' led, in 1995, to 'the establishment – albeit with limited jurisdiction – of a unicameral Palestinian parliament, known as the Palestinian Legislative Council and of a Palestinian government known as the Palestinian National Authority' (Albright, 2015, p.3). As part of the interim agreement, the West Bank and Gaza were divided into three areas: Area A, Area B, and Area C (Figure 5.1). The PNA was given full control in Area A, while it shares control of security with the GoI in Area B (World Bank, 2011b, p.2).

¹⁶ The UNRWA defines Palestine refugees as 'persons whose normal place of residence was Palestine during the period 1 June 1946 to 15 May 1948, and who lost both home and means of livelihood as a result of the 1948 conflict'. See: http://www.unrwa.org/palestine-refugees

Figure 5.1 Division of the Palestinian territories into three areas of control under the Oslo Accords



Source: B'Tselem (2014).

The GoI retained complete security control over Area C. In Gaza, some areas fell under PNA control and others under Israeli control. Hebron and Jerusalem were excluded from the three areas. East Jerusalem was allocated to the West Bank and West Jerusalem to Israel. However, to date, Jerusalem remains under de facto Israeli control. In 2000, a visit of the then-representative of the Israeli opposition, Ariel Sharon, to the Al-Aqsa Mosque sparked the second Palestinian Intifada. In response, the GoI further reduced the PNA's autonomy in Areas A and B, imposing curfews and, more significantly, the system of closures that limit internal movement of people and goods within the West Bank and Gaza, and prevent movement between them. Palestinian unemployment during this period grew, particularly in the West Bank, where a greater proportion of the labour force worked for Israeli employers (World Bank, 2011b).

In 2002, Israel began constructing a wall between the West Bank and Israel (UN Office for the Coordination of Humanitarian Affairs [OCHA], 2015a), despite the recommendations of the International Court of Justice (ICJ) not to proceed. In 2013, after an 'umpteenth' attempt to reestablish peace talks via US intervention, relations between Israel and Palestine worsened (Page, 2015, p.6). Israel declared it would expand the number of settlements, suspend customs

refunds due to the PNA, and withdraw its cooperation from the UN Human Rights Council (UNHRC) (Stockmarr, 2013; UNHRC, 2013). The UN OCHA's humanitarian overview for 2015 reports that 'Palestinians in the oPt face a range of serious protection threats related to these factors including threats to life, liberty and security, destruction or damage to homes and other property, forced displacement, restrictions on freedom of movement and on access to livelihoods, and lack of accountability and effective remedy' (2015c, p.1). A final political agreement over the permanent status of the territories remains elusive, exacerbating these threats.

The 2014 Palestine Human Development Report (UNDP, 2015a) argues that the Palestinian context differs from that of most states, in that the Israeli occupation renders the task of empowerment 'virtually impossible'. The occupation 'inherently presents itself as a source for disempowerment', both directly, through the many policies, and indirectly, 'by retarding and vastly complicating any national effort aimed at attaining, however modest, a degree of empowerment' (p.15).

5.2. Political fragmentation of the PNA

Political fragmentation within the two major Palestinian parties, Hamas and Fatah, further contributed to the vulnerability of Palestinians. After the death of Fatah and PLO leader Yasser Arafat in November 2005, Mahmoud Abbas was elected president of the PNA. Around the same time, the Israeli army assassinated Hamas leader (and co-founder) Ahmad Yassin, and then his successor (and fellow co-founder) Abed Al-Aziz al-Rantisi. In January 2006, Hamas gained the majority of seats in the Palestinian legislative elections. Fatah declined to join their administration and Hamas took full charge (Al Jazeera, 2011). The international community imposed an embargo on the PNA and cut off aid for emergency and development projects (Amnesty International 2010; Al Jazeera, 2011). Attempts at forming a unified government failed. In June there was widespread violence in Gaza. The fighting concluded with Hamas taking control in Gaza, upon which Abbas dismissed the Palestinian government and declared a state of emergency (Al Jazeera, 2011).

The Israelis responded by commencing an ongoing blockade, restricting the entry of basic goods into Gaza and the movement of medical cases, while Egypt closed its borders with Gaza. Most of the population became completely reliant on international aid (Amnesty International, 2010), and Gaza plunged into an ever-deepening humanitarian crisis. By the end of 2007, two governments existed: one in West Bank and one in Gaza, and both acted as if it had sole

legitimacy. This had huge implications for governance, flow of funding, service delivery, and social assistance operations (World Bank, 2011b). These implications on PWDs will be discussed further in section 6.

In 2014, Fatah and Hamas signed a reconciliation agreement, forming an interim unity government in May with jurisdiction over both the West Bank and Gaza. The resulting technocratic government committed to politically recognise Israel and respect all signed agreements, rejecting any form of violence (Page, 2015). However, the de facto division, with the West Bank controlled by Fatah and Gaza controlled by Hamas, has continued.

5.3. Impact of occupation on economy and poverty in Palestine

Though the Palestinian economy has recently been considered to be developing, its GDP is still declining and its unemployment increasing (Kock, 2014). World Bank data present an inconsistent shift in Palestinian GDP growth since 2005, with fluctuating annual growth ranging from -8.6% (2008) to 20.9% (2009) (World Bank, 2015b).

Palestine's HDI value (Hackstein et al., 2013) in 2014 was 0.677, ranked 113th of 188 countries and below the 0.686 average for Arab states (UNDP, 2015b, p.2). From 1980, Palestine's HDI increased by an average of 0.32% annually. Table 5.1 presents Palestine's changing HDI value and indicators between 1980-2014.

Table 5.1 Palestine's changing HDI value and indicators (1980-2014)

	Life expectancy at birth	Expected years of schooling	Mean years of schooling	GNI per capita (2011 PPP\$)	HDI value
1980	62.8			2,781	
1985	65.9			2,466	
1990	68.1			2,896	
1995	69.6	10.4		3,156	
2000	70.8	11.5		4,710	
2005	71.5	12.9	7.6	4,831	0.658
2010	72.2	13.4	8.4	4,439	0.670
2011	72.4	13.3	8.6	4,671	0.675
2012	72.6	13.2	8.9	5,219	0.685
2013	72.7	13.0	8.9	4,914	0.679
2014	72.9	13.0	8.9	4,699	0.677

Source: UNDP (2015b).

However, poverty rates have been increasing steadily in Palestine since 2012 (World Bank, 2015a). The overall poverty rate of 25% in 2014 masks wide regional divergence. Poverty in Gaza was at 39%, almost 2.5 times higher than in the West Bank, at 16% (World Bank, 2015a). The National Commission for Poverty Alleviation (NCPA) first established a national poverty line in 1998, which has been adapted over time. The latest adjustment, in 2011, set the line at

NIS (New Israeli Shekel) 2,293 (USD 637) per month for a two adult and three children family (UNDP, 2015a). Further research is needed to understand how different vulnerabilities may interact and negatively reinforce one another, and to identify exactly who are 'the poor' in Palestine. For example, there are no official data on disability and poverty, but informal interviews with PNA officials revealed that 55,000 households estimated to be below the poverty line included at least one PWD.¹⁷

There is strong consensus in the literature about the causes of Palestine's economic problems, largely stemming from aspects related to the occupation, ¹⁸ with constant eruptions of violence; accumulated government debt (UNDP, 2015a); discouragement of long-term business investments (World Bank, 2012a); limited access to natural resources; dependency on external aid (World Bank, 2008b); and disconnection from external markets.

Palestine's economic problems continue to affect poverty levels, living standards, and the unemployment rate. With no end to the occupation in contemplation and a lack of structural reforms, projections on poverty reduction in Palestine are unclear. Further analytical work is needed to support, particularly, the formulation of economic policies to reduce poverty.

In a 2011 study of the Palestinian economy and poverty rates since 2000, the World Bank argues that the 'nature of poverty in the West Bank and Gaza is intrinsically tied to and must be understood within the historical and political context of this region' (2011b, p.1). This thesis argues that, while poverty in Palestine (and globally) is, indeed, tied to the historical and political context, social relations and how they contribute to or create vulnerabilities are potentially equally important. Hence, while the World Bank's analysis is of seminal importance, having filled a gap in knowledge through its collaborative reports with the Palestinian Central Bureau of Statistics (PCBS) and other PNA authorities, viewing poverty mainly as household income poverty overlooks the structural components to which social protection programmes are expected to respond (Devereux and McGregor, 2014).

Abdel-Shafi (2015) argues that, over the last twenty years, the peace process has failed to improve the economy and reduce poverty rates. Instead of halting or mitigating dedevelopment, the Oslo Accords 'accelerated the process by introducing into the Palestinian economy new dynamics that have further attenuated an already diminished socioeconomic base' (Roy, 1999, p.64). During the 'Oslo' period following the second Intifada, the PNA was unable to govern while Israel held power over the Palestinian economy, with full control over

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¹⁷ Source: interview conducted with the Director of the PNCTP at MoSA in July 2015.

¹⁸ UNCTAD (2015) estimated the economic cost of occupation in Palestine to be around USD 6.9 billion in 2010.

the majority of natural resources, water, and land, as well as external and internal borders (Roy, 2001). Roy concludes that during Oslo 'the economic fundamentals of occupation remained unchanged' (2001, p.10).

Post-Oslo, one of the most damaging factors for the Palestinian economy was the 'closures', ¹⁹ whose effect on Palestinian trade and labour has been harmful or even devastating (Roy, 2001). Turner (2016) explains that closure policies of 'skewed integration were enshrined in the Paris Economic Protocol', which can be dubbed, in effect, the 'economic counterpart to the Oslo Peace Accord' (p.64).

The Guardian's Mona Chalabi neatly encapsulates the dilemma of Palestine's economy, observing that the country depends completely on external players and factors, its legal status is questioned, its land is divided, and the emigration of its young, educated generation increases annually. Such a reality raises major doubts about Palestine's economic functioning and stability (Chalabi, 2013).

5.4. Influence of and dependency on international aid

The role of external aid to support 'state-building' and empowerment is increasingly questioned. Moss et al. (2006) argue that states reliant on international aid for a substantial percentage of their revenue suffer damaging effects on institutional development (p.1). Views vary on the reasonable ratio of aid that could positively impact state-building: Berg (2000) suggests 5% of GDP, on which basis most state recipients of external aid are at risk of aid dependency. By contrast, Clemens and Radelet (2003) suggest 15-45% of GDP, which would place Palestine at the highest margin of risk, given that its external aid reached almost 50% of GDP in 2009.

The implications of aid dependency on state-building and economic growth and stability in Palestine require further analysis. In 2009, it was estimated that per capita financial support for Palestinians was among the highest globally (Portland Trust, 2011). The amounts of aid are also substantial in relation to the annual size of the economy. Figure 5.2 presents the gradual increase in external aid for Palestine from 1995 to 2009.

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¹⁹ This refers to Israel freezing the issue to West Bank Palestinians of travel permits allowing access into Israel for work, trade, or medical treatment (see B'Tselem, 2014).

US\$m USS per capita Total ODA ODA per capita

Figure 5.2 Official development assistance to Palestine

Source: Portland Trust (2011, p.2).

In 2012, external aid – sourced mainly from the EU and the US – comprised 38% of the PNA's budget.²⁰ There are an additional 40 donors, both large and small scale, supporting the government's actions (Portland Trust, 2011).

Around 2,000 NGOs receive external funding to support humanitarian and development work. In 2008, it was estimated that funding streams to national and local NGOs reached USD 250 million. This creates major challenges for the PNA to manage and coordinate (Portland Trust, 2011). The fieldwork for this study highlighted this as a major cause of unequal access to services for PWDs, as there is hardly any coordination between, or government monitoring of, the large numbers of NGOs providing disability services. Instead, they are fully directed by funding agencies' priorities and strategies on where and how to work.

Despite the increase in aid, the PNA repeatedly faces a financial deficit, mainly as it cannot predict how much aid it will receive and when. Based on the political situation, there are always major differences between the initial commitment and actual disbursements (Devoir and Tartir, 2009) – see Figure 5.3.

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²⁰ Source: Ministry of Finance website, available at http://www.pmof.ps/43 [Accessed 23 May 2015].

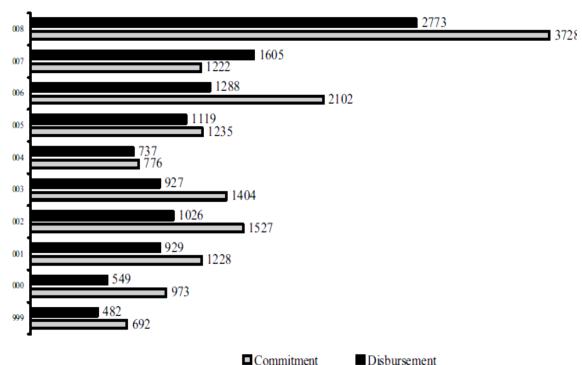


Figure 5.3 Commitments vs. disbursements of external aid (1998-2008)

Source: Devoir and Tartir (2009, p.24).

Consequently, the PNA often has to borrow from local banks, which has enlarged the 'domestic' public debt, reaching USD 736 million in 2012. ²¹ This situation confirms that Palestine's economic growth is largely aid-dependent and unstable (World Bank, 2011c).

Despite the IMF's (2011) recognition that the PNA has created an institutional framework and recruited the required expertise to establish sound economic policies, the PNA remains aid-dependent. Multilateral and bilateral donors have failed to promote real development and growth in the economy (Abdel-Shafi, 2015). For example, the EU, as one of the major donors, committed to provide 53% of the approved funds at the Paris Pledging Conference in 2007 (World Bank, 2008a). Its commitment to the PNA between 2000 and 2013 is estimated to have been EUR 5.22 billion. Yet, as Figure 5.4 illustrates, the majority of funds were dedicated to humanitarian and refugee support, while only 25% were dedicated to development interventions (Abdel-Shafi, 2015).

²¹ Source: Ministry of Finance website, available at http://www.pmof.ps/43 [Accessed 18 April 2015].

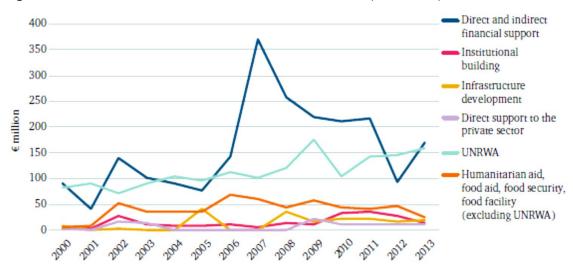


Figure 5.4 Main EU financial commitments to Palestine (2000-2013)

Source: Abdel-Shafi (2015).

The extent of assistance and the way it has been almost imposed by funding agencies have impacted the PNA's cultural function. A top-down, donor-centred aid framework has dominated most processes of coordination, policy discussion, agenda setting, and information sharing. Le More (2004) argues that 'unlike the overwhelming majority of sovereign countries around the world which receive foreign aid, the PNA has had neither legal nor functional autonomy' (p.217). Le More adds that this has resulted in a tendency to marginalise and bypass the PNA in aid-related decisionmaking and coordination. The preconditioned support led to the adoption of a foreign cultural system as the main reference for Palestinians, rather than supporting programmes and policies proposed by the PNA (Lasensky, 2004).

In addition, aid from the international community is insufficient to provide comprehensive essential services to Palestinians, especially in Gaza, where the casualties of conflict often do not receive appropriate care and lack access to specialised services (AI Mezan Center for Human Rights, 2015). According to an Association of International Development Agencies (AIDA) study, 'access and movement restrictions for INGOs are serious, widespread, costly and difficult to overcome. As a result, vulnerable communities are not being reached, the quality of programming is being compromised and the impact of humanitarian and development interventions is being reduced' (AIDA, 2015, p.6). AIDA's report stresses the significance of the constraints imposed by Israel, which restrict development agencies' movement and capacity to reach the neediest communities, and their ability to provide sustainable quality services. Of the AIDA members interviewed for this study, 60% stated that their choice of beneficiaries and locations often depended on access criteria, rather than prioritising the most vulnerable and

needy communities; 75% stated that their quality of service was affected by mobility restrictions (AIDA, 2015).

A paradox is raised here: aid is essential—according to the UNRWA (2011), almost 80% of Gaza's population is currently aid dependent and, therefore, in a constant spiral of fragility when aid falls short. Does aid, nonetheless, help to overcome the real issues that create vulnerability in the first place? Opening up markets and implementing neoliberal policies, as advocated by Western governments, can have positive impacts on the Palestinian economy. However, the economy continues to be dependent on Israel. Not tackling these dependencies leaves Palestine, and therefore its citizens, vulnerable. Stockmarr (2013) has provided relevant analysis by locating the 'fragility of Palestine' not primarily in the PNA's inability to deliver basic services. Instead, he considers its roots to be 'inherently political and structural' and grounded in the absence of political and economic stability (often framed as denial of the right to self-determination); an asymmetric framework for cooperation with Israel; its associated structural dependency on international aid; and, consequently, a growing split between the endeavours of state-building and peace building.

Roy (2001) argues that, since Oslo, donors' strategies in Palestine have failed to support longterm developmental change at the level of formed, sustained, and inclusive social policies. How this reality has been shaping social protection policies will be discussed deeply in Chapter six.

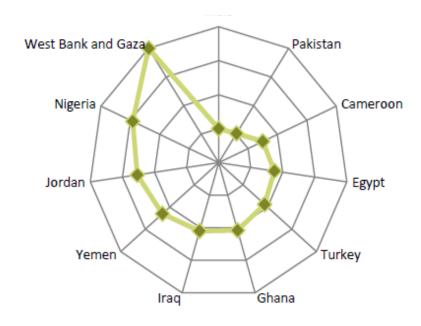
5.5. Compounding vulnerability: implications of conflict, aid dependency, and political fragmentation for Palestinians

With ongoing conflict, extreme aid dependency, restricted movement, and unstable, fragmented social and economic policies, Palestine's current situation is distinctive. These aspects leave Palestinians facing multi-dimensional vulnerabilities and a variety of risks and challenges at economic, social, health, and education levels.

5.5.1. Access to employment and livelihood opportunities

Evidence from the World Bank attributes poverty in Palestine mostly to labour market outcomes, rather than human capital deprivations, as in countries like Yemen. This is confirmed by the fact that its unemployment rate is higher than most countries with similar per capita income (World Bank, 2011b). This is demonstrated in Figure 5.5. below.

Figure 5.5 Unemployment in the West Bank and Gaza compared to selected countries

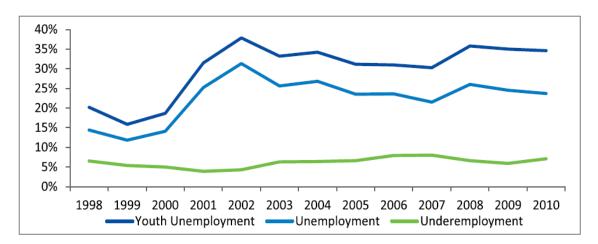


——Unemployment (% of labor force)

Source: World Bank (2011b, p.11).

Unemployment in Palestine has been steadily increasing over recent years, reaching 23.3% in 2014, compared to the 11.8% average across other Arab States (UNDP, 2015b). Of particular concern is the high youth unemployment rate (aged 20-24), reaching 41% of the overall unemployment rate, compared to the 29% average across other Arab states (UNDP, 2015b). Per the ILO, it is vital for the PNA and NGOs to design and implement youth-targeted policies and programmes that respond to current needs and generate more sustainable future employment opportunities. These must take into consideration Palestine's youth bulge, which will peak by 2050, with nearly 65.6% of Palestinians being of working age (UNDP, 2015a). The changing rates of unemployment and underemployment in the West Bank and Gaza are demonstrated in Figure 5.6 below.

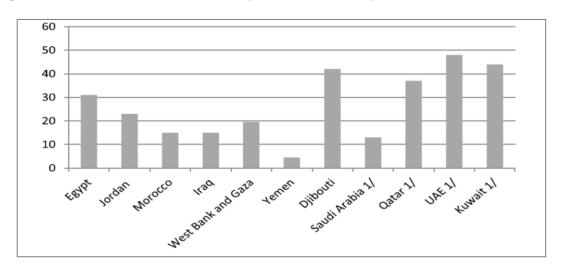
Figure 5.6 Unemployment and underemployment²² in the West Bank and Gaza (1998-2010)



Source: World Bank (2012a, p.24).

There is also a significant gender gap. The female labour force participation rate has been below 16% throughout the last decade (World Bank, 2012a, p.139), much lower than in most other MENA countries, as demonstrated in Figure 5.7.

Figure 5.7 Female Labour Force Participation Rates (15-64 years old), 2009



Source: World Bank (2012a, p.125).

Palestinian women face similar barriers to equal labour market opportunities as women in neighbouring MENA countries (World Bank, 2012a). These are known to include employers' perceptions that women are less productive than men and the societal stereotype restricting female work outside the home (World Bank, 2011b). However, additional causes related to the

²² An employed person is defined as under-employed if their reported hours worked per week are below 35. Underemployment is expressed as a percentage of those currently employed.

Palestinian context further limit women's participation. Most concern protection from abuse by Israeli soldiers at check points: as their mobility is thereby hindered, it is more challenging for women to equally engage in the labour force (World Bank, 2010).

Chapter 6 will discuss PWDs' access to livelihood and employment opportunities, focusing especially on the additional barriers they face.

The United Nations Conference on Trade and Development (UNCTAD) reports that, while the unemployment rate in both Gaza and the West Bank has recently been declining, a rate of nearly 25% is still alarming (2015). During the 2014 conflict in Gaza, the World Bank calculated that the unemployment rate 'skyrocketed' to more than 47% (2015a, p.4). To cover basic daily needs, Palestinians are highly dependent on aid (when available), rely on support from extended family and friends, and (in some cases) permit female household members to pursue public sector employment (UNDP, 2015a).

As shown in Figure 5.8, the proportion of employment in the public sector ²³ increased from 17% (1999) to 26% (2009), with the government absorbing a substantial proportion of the labour force. Private sector employment dropped from 47% to 38% during the same period (World Bank, 2011a).

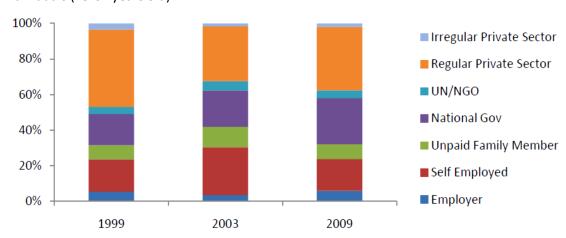


Figure 5.8 Employment by sector in the West Bank and Gaza of all working-age individuals (15-64 years old)

Source: World Bank (2011a).

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²³ The Palestine Labor Force Survey classifies employees as being either in the public sector, e.g. UN/NGO or government, or private sector (including both the regular and irregular private sector). Besides employees, the categories for employed persons are unpaid family member, self-employed, and employer.

Employment rates in Palestine are deeply affected by the occupation (World Bank, 2011a), especially the Gol's closure policy, extensive reliance on the Israeli labour market, and the absence of viable employment opportunities (UNCTAD, 2012). The humanitarian overview report for 2014 confirmed that 'Palestinian movement throughout the West Bank, including into East Jerusalem, remains restricted by a complex system of physical and administrative measures – the barriers, checkpoints, roadblocks, and a permit system – undermining livelihoods and access to basic services' (UN OCHA, 2015b, p.13). Gaza continues to be locked in, with no control over its borders with Israel and the West Bank via the two main controlled crossing points, and with Egypt through Rafah. This has led to limited investment opportunities, and contributed to high unemployment levels (UN OCHA, 2015a).

5.5.2 Access to social protection

Like many MENA countries, Palestine's history of social protection stems from Islamic charitable initiatives and informal in-kind forms of social protection. Over the past 10 years, social protection has become an important part of approaches to poverty reduction in many MENA states (ILO, 2017). However, most of this programming has focused on safety-net approaches, which aim to help households to manage short-term financial issues. Limited attention is given to the social inequalities that perpetuate poverty – including disability – and social protection's potential role in addressing related vulnerabilities (Jones and Shaheen, 2012).

Until 1993, the Palestinian social welfare system was managed by shifting authorities that ruled this area over several decades (Jones and Shaheen, 2012). For example, from 1948 to 1967, the West Bank was under Jordanian rule, whereas Gaza was under Egyptian rule, and each ruler administered different social assistance programmes. Furthermore, different legal frameworks have shaped the social assistance programmes in Palestine: in the West Bank, for example, these programmes were developed according to the Assistance and Rehabilitation Law (1963) and the Law of the Ministry of Social Affairs of the Hashemite Kingdom of Jordan (1959) (Safadi and Easton, 2014). Accordingly, the Jordanian Ministry of Social Affairs offered cash and in-kind assistance only to clearly defined groups, including PWDs, but this assistance was limited to relief, rather than attempting to foster Palestinians' overall welfare (Safadi and Easton, 2014, p.54). Similarly, Gaza followed social protection strategies administered by the Egyptian government, similar in approach to the Jordanian systems. From 1967 to 1994, the Palestinian territories were controlled by the Israelis, under whose direction and influence the

welfare system remained inadequate to meet the basic needs of deprived Palestinians (Safadi and Easton, 2014) including PWDs.

Before the PNA's establishment in 1993, social protection was mainly based on the charity approach and governed by CSOs, political parties, and extended families, without institutionalisation (Safadi and Easton, 2014). Such networks continued to operate after the MoSA's establishment in 1994, since continuing Israeli occupation in much of the country prevented the PNA from gaining full control.

In 1994, the Israeli Civil Administration handed authority over civil affairs in the West Bank and Gaza Strip to the PNA. Having inherited the Israeli Civil Administration's laws and procedures, the PNA decided to reinstate pre-1967 laws and regulations (Shaheen, 2013). Although this was intended as a temporary measure, several internal factors, including the political division between Hamas and Fatah, hindered the evolution of a robust legal framework. The laws remain fragmented, with elements inherited from Ottoman, British, Israeli, Jordanian, and Egyptian rule. Since most pre-date 1967, they do not reflect the many intervening changes at the national and international level. Moreover, the Gaza Strip continues to operate under a different executive branch from the West Bank, while East Jerusalem remains under Israeli control.

Restrictions by the GoI severely impeded the Palestinian Legislative Council (PLC), including frequent movement restrictions that prevented regular council meetings, and the detention of many PLC members. Moreover, the PNA prioritised high-level statebuilding (e.g. establishing branches of government), rather than sector initiatives, such as establishing more long-term social policies.

Since the 2000s, the PNA has implemented a series of reforms of and capacity-building initiatives for its ministerial branches, influenced by the UN and international donors, and with the participation of NGOs and the private sector. Yet, despite recent improvements in national planning, overcomplexity in the design, implementation, and monitoring of social policies persists in Palestine (PNA, 2010).

The current social protection system is criticised for being fragmented and failing to respond to people's needs, mainly due to the influence of donors' different agendas and the lack of a clear political orientation. Policy formulation has been heavily affected by the absence of a stabilised state, Israeli military action, the political fragmentation between Fatah and Hamas, severe dependency on external funding, and the emergence of prominent elites that control the social, political, and economic spheres, undermining the role of the middle class (PNA, 2010).

Until 2006, PWDs had limited access to social protection services; they were only targeted through charity-based in-kind programmes supporting the most vulnerable groups, including those with disabilities, and the emergency social assistance scheme, which provided limited numbers of basic assistive devices, such as walking aids and manual wheelchairs. Disability was not addressed under any mainstream or targeted cash transfer programmes provided by the government or UN agencies. The EU-backed SHC programme, detailed further in section six, was the first and only targeted cash transfer programme supporting the individualised needs of PWDs and vulnerable community members.

5.5.3 Access to education services

Palestine's education system has endured disruption and recurrent crises and emergencies (Al-Ramahi and Davies, 2002). When established in 1994, the MoEHE faced an abandoned and destroyed system, with one of the lowest educational achievement rates globally (Al-Ramahi and Davies, 2002). Internal political divisions, fraud, and incompetence further hampered anticipated educational progress (Nicolai, 2007). Despite massive strategic efforts by the MoEHE, it had to tackle a new wave of crises when the Second Intifada started in 2000 and the occupation re-intensified, leading to a massive loss of school days (Nicolai, 2007).

Nicolai (2007) presents three additional challenges the MoEHE faced when assuming full responsibility for administering education. First, the transition of power from CSOs that had filled the education gap under the Israeli civil administration by establishing 'non-formal education systems'. Second, highly politicised appointments at the ministry, where most of the assigned personnel lacked the required experience and knowledge. Third, the 'fractured geography' of Palestine, with the West Bank and Gaza not geographically connected and being governed by different administrations from 1967 to 1994. Massive efforts were required to harmonise and unify this into one national system (Nicolai, 2007).

Since 2010, education in Palestine has demonstrated mixed progress (UNDP, 2015a). Remarkable improvements in access and achievements include reaching a literacy rate of 96.3% in 2014: among the highest globally (UNDP, 2015a). The American Near East Refugee Aid (ANERA) reported that Palestine has 38% enrolment in preschool, compared to the 25% average in MENA (Anera, 2014). However, the 2011 PCBS Disability Survey (DS) found that 60% of CWDs are not enrolled in schools and 53.3% of PWDs are illiterate (PCBS and MoSA, 2011).

The MoEHE's third Education Strategy (2014-2019) aims for a more holistic approach to learning, indicating the need to reform the system to meet the country's development needs.

Yet the ministry still faces operational challenges related to Israeli actions. The occupation's negative impact on the education system persists, with inadequate school infrastructure, a shortage of qualified teachers, and limited access to schools in remote areas (UNDP, 2015a).

Save the Children Sweden (2011) has widely documented the impact of checkpoints and movement restrictions on the right to access education for Palestinian children. The continuing blockade on Gaza and ongoing attacks of the Israeli army impacts effectiveness by limiting: service quality; access to teaching materials; the ability to reconstruct demolished schools; and the availability of building materials to maintain or expand existing facilities (UNICEF, 2010). Complex mobility limitations in the West Bank have impacted the ability of thousands of children and teachers to reach schools on a daily basis (Hilal, 2012).

5.5.4 Access to health services

The PNA assumed responsibility for health services through the MoH in 1993. Previously, the Israeli Ministry of Defence had been fully responsible for healthcare services. This caused complete dependency on Israel and weakened the healthcare system (Hamdan and Defever, 2003). The geographic division and movement restrictions resulted in a scattered healthcare system, limiting access and service provision (Qato, 2004). From 1995, Palestinians could no longer access the specialised Israeli medical services. In the absence of alternatives, the PNA had no option but to create a referral system to Israel, from which it purchased medical and physical rehabilitation services.²⁴ From the start of the Second Intifada in 2000, the MoH continued to face major challenges in responding to the many injuries caused by the conflict, with many leading to permanent disabilities.²⁵ The MoH reported that 25,000 Palestinians had been injured during 2001: 61% suffered minor injuries, while 39% sustained severe physical, visual, and/or mental impairments requiring specialised and intensive rehabilitation services (Qato, 2004).

The present health system is considered weak and fragmented (UNDP, 2015a). The WHO (2010) reported that, in relation to traditional health indicators, the health status in Palestine is 'commendably reasonable'. Health services are delivered by four main actors: the MoH, NGOs, the UNRWA (mainly for refugees), and the private sector. The MoH operates 64% of primary healthcare in the country, as indicated in Figure 5.9 (UNDP, 2015a).

²⁴ Interview with the chief of the referral system at the MoH, conducted in August 2015.

²⁵ Interview with the MoH representative in charge of disability affairs in July 2015.

■ MOH ■ NGO ■ UNRWA ■ Palestinian Medical Military Services

Figure 5.9 Primary healthcare centres in Palestine by provider, 2013

Source: UNDP (2015a, p.122).

In terms of rehabilitation services for PWDs, NGOs and the UNRWA play a much greater role, causing unequal access and additional costs for PWDs and their families. The MoH is the health sector's main regulator. The ministry monitors its own systems as well as those provided by NGOs and the private sector, which is problematic regarding accountability (UNDP, 2015a). The 2014 Palestine Human Development Report indicates the need for improved health financing, to guarantee better access to health services for those who cannot afford them, such as the poor and unemployed (UNDP, 2015a).

The findings of a 2010 World Bank study indicate that household spending comprises almost 50% of health financing, which implies that access to health services depends on ability to afford them (Elgazzar et al., 2010). Figure 5.10 presents a comparison between MENA countries (Elgazzar et al., 2010).

Figure 5.10 Health financing scheme coverage rates in MENA, 2008

Country	Est. % of population enrolled in social health insurance	Est. % of population enrolled in private health insurance	Est. % uninsured	Est. % of population entitled to subsidized/free governmental health services or insurance
Yemen	n/a	n/a	n/a	100.0
Libya	n/a	n/a	n/a	100.0
Lebanon	52.0	15.0	>48	23
Iran	69.3	n/a	30.7	67.0
Egypt	45.0	<1	55.0	100.0
West Bank-Gaza	48.5	10.2*	22.4	18.9**
Tunisia	78.0	n/a	14.8	7.2

Sources: Yemen, Ministry of Health, 2007; Libya, Ministry of Health, 2008; Lebanon, Ministry of Finance/Ministry of Health Annual Report; Lebanon, percent receiving Ministry of Health-funded treatment, Ammar, 2003¹²; Iran, Household Expenditure Survey, 2006; Egypt, Ministry of Finance/World Bank, Health Policy Note, Public Expenditure Review 2007; Tunisia, Ministry of Health; West Bank-Gaza, Ministry of Health/World Bank Health Policy Note, 2009. *Includes military, private and Israeli insurance schemes. **Covered by United Nations Relief and Works Agency.

Source: Elgazzar et al. (2010, p.15).

In the MENA region, Palestine has the second-lowest enrolment percentage in social health insurance, but the second highest in private health insurance. This could indicate lack of confidence in public health service quality and/or problems accessing healthcare (Elgazzar et al., 2010, p.15). The 22.4% of the Palestinian population without insurance face struggles in financing their medical needs, exposing them to the risk of falling into poverty.

Within the current medical insurance system, the majority of specialised services are outsourced (UNDP, 2015a). Referrals of patients to national NGOs, the private sector, or external health facilities in other countries, such as Israel, Jordan, and Egypt, are neither systematic nor transparent. Consequently, patients are deprived of equal access to quality services (UNDP, 2015a). In its 2011-2013 national health strategy, the MoH presented future plans for a new national insurance scheme to increase the range of services covered (MoH, 2010). However, feedback gathered from MoH officials during this study's fieldwork indicated no progress to date on this.²⁶

The WHO (2010) has recognised the major negative effects of the occupation on Palestinians' health. Giacaman et al. (2009) suggest that, in addition to causing many deaths, injuries, and disabilities, the occupation poses a further risk to health by restricting access to services. The separation wall, in combination with its controlled gates and permit system to access Jerusalem and Israel, continues to be the main barrier. The WHO has documented the impact of the wall and movement restrictions in severely limiting access to specialised hospitals in East Jerusalem. Additionally, health facilities are a strategic target of the Israeli army.

²⁶ Interview with the Director of the Referral System at the MoH in July 2015 (Ramallah).

According to the WHO, in 2012 alone, 35 health centres and hospitals in Gaza were bombed, with 26 ambulances irreparably damaged (Hagopian et al., 2013). This had an immediate negative impact on peoples' wellbeing, especially combined with limited access to needed medication. Almost half (42.5%) of essential drugs were at zero stock level in May 2012 and 65% of medical disposables were at zero stock in October 2012. These shortages were exacerbated by the hostilities, which generated overwhelming demand for services. 1,399 residents of Gaza were injured, according to the Ministry of Health (Hagopian et al., 2013, p.6).

A 2015 EU report highlighted that the 'latest conflict in Gaza both increased the number of [PWDs] but also led to the destruction of the main centre in Gaza providing services to [PWDs]' (pp.6-7). Additional barriers to PWDs accessing health and rehabilitation services will be addressed in Chapter six.

5.5.5 Food security and food sovereignty

According to the results of a 2013 socioeconomic and food security survey, about 1.6 million Palestinians face food insecurity, across both the West Bank and Gaza (PCBS et al., 2014). The survey also found that most Palestinian families spent more than half of their earnings on food, while one-third of all families were categorised as food insecure. Also in 2013, 57% of Gaza's population were reported food insecure, compared to 19% in the West Bank, reflecting the huge impact of the Israeli closure of Gaza (UNDP, 2015a). In a joint press release concerning their 2013 survey, PCBS et al. (2014) indicated that Palestine cannot recover from its high food insecurity without concrete measures tackling the problem's root causes, chiefly the blockade in Gaza and movement restrictions in the West Bank. The two main bodies providing food aid are the WFP, supporting non-refugee households, and the UNRWA, for Palestinian refugee communities (UNDP, 2015a). The PNA's National Development Plan 2014-2016 considers food security as a priority policy (PNA, 2014).

According to a 2015 MA'AN Development Centre report, Palestinian food insecurity is chiefly caused by the PNA's lack of control over natural resources, in addition to unemployment and poverty. The report argues that Palestine 'lacks this sovereign ability to define its own food policies[:] Palestinians locally produce only 60% of the consumed food items, including rice, flour, bread, meat, and fish, and only 5% of the total cereals and pulses' (MA'AN Development Center, 2015, p.6).

Access to water is crucial, but Israel's control over many natural springs restricts the supply needed for irrigating agricultural land (MA'AN Development Center, 2015). Finally, as food sovereignty entails power over natural resources, Palestine is also constrained in this regard, given its limited control.

5.6. Conclusion

This chapter has sought to identify the key elements generating and perpetuating vulnerabilities, through an approach combining critical theory and the TSP framework, according to which Palestinians' poverty and vulnerabilities cannot be understood in isolation from the historical and current political barriers and power dynamics. It has portrayed a stateless country that, to date, lacks self-determination.

Palestine has endured centuries of colonisation, under different foreign powers, and remains today under occupation by an undeterred Israel. Israeli politics of denial and dispossession, conflict and violence, together with internal political strife, have determined Palestine's dependency on the Israeli economy and on substantial foreign aid, leaving the PNA unable to establish a greatly needed social welfare system. At the same time, an environment of insecurity and violence has exacerbated the sociocultural barriers already operative for the most vulnerable people in a patriarchal, traditional society. Following the Oslo Accords, several factors have hindered the PNA's capacity to provide sustainable and equitable access to social services to all Palestinians, such as inheriting the Israeli administrative systems, donor agendas, and the dominance of civil society in controlling almost all social services. Consequently, the transfer to the PNA of full power to regulate and monitor social services has been very slow, with implications for accountability measures, quality standards, and available services' accessibility and affordability for the poor.

Israeli policies have clear impacts on Palestine's socioeconomic wellbeing, driving unemployment and food insecurity, and restricting movement. Israel 'undermines or weakens the ability' of the Palestinian economy to 'grow and expand by preventing it from accessing and utilising critical inputs needed to promote internal growth beyond a specific structural level' (Roy, 1987, p.56). Although the post-Oslo period promised gradual progress towards Palestinian independence, such aspirations remain unfulfilled; in fact, the Palestinian economy remains heavily reliant on Israel for goods and labour markets.

The Palestinian economy and its population remain heavily dependent on international aid, which has become pivotal since Oslo. This, too, has been volatile and unsustainable, with donors introducing a top-down approach detrimental to Palestinian self-determination.

In addition, the ongoing political fragmentation has brought negative implications for governance systems. Palestinians must comply with two separate governments in one country. This has implications for interpreting, executing, and monitoring national legal frameworks and policies.

In summary, the Palestinian context confirms the existence of additional causes of vulnerability beyond the known socioeconomic and cultural factors also found in neighbouring countries. This adds another layer of complexity for policy design and implementation in all social policy aspects in the country.

The following chapter will detail the research findings, including an analysis of disability policies and laws in Palestine, a review of the PNCTP, and examination of its impact on Palestine's PWDs.

6. Findings

This chapter presents findings on the PNCTP's role in fostering greater independent living for Palestine's PWDs. It seeks to identify the factors influencing the programme's impact on promoting or preventing greater independent living. Section 6.1 analyses the role of the broader policy and governance environment in shaping cash transfer programmes for PWDs. Section 6.2 examines the level of inclusion of disability within the PNCTP. Section 6.3 explores how the programme affects the perceived level of PWDs' independent living. Finally, section 6.4 examines the critical factors influencing PWDs' level of independent living. The findings are described under themes that emerged from the data, collected through document review, observation, key informant interviews, FGDs, and in-depth interviews with PNCTP recipients with disabilities.

6.1. Inclusion of disability in the broader social policy environment in Palestine

Palestine's disability sector is led by the MoSA and based on the 1999 Disability Law, which recognises that PWDs' rights are indistinguishable from those of the able-bodied. However, because the law lacks 'any articles that would provide an incentive for its implementation' (Alawni et al., 2012), and because dedicated financial resources are limited, little progress has been made towards inclusivity within social policy. Indeed, while the government provides care and education to some PWDs (MoSA, 2012a), and ratified the CRPD in 2014, the bulk of services provided are reported to be insufficient by civil society because 'disability-inclusive policies are not priorities for decision makers' (Handicap International, 2013).

In general, provision for PWDs in Palestine remains quite weak and siloed from mainstream services. Medical specialists capable of diagnosis and rehabilitation are rare and often difficult for PWDs to access, given the regular costs of services and transportation that they and their families must bear, in addition to travel restrictions imposed by the occupation (Palestine Note, 2011). Referral mechanisms and coordination are also lacking, and the roles and obligations of relevant ministries are neither well defined nor effectively enforced by key government officials (Pereznieto et al., 2014).

Since 1980, the many young Palestinians suffering permanent impairment through conflict has increased awareness of disability, which has even come to be associated with heroism. However, while people's views of persons with conflict-incurred disabilities remain positive, exclusion of and discrimination against other PWDs are still prevalent (World Bank, 2017a).

6.1.1. Measurement and data on disability

Discrepancies around who is disabled and how disability information is defined and collected greatly impact policymakers' broader understanding of the prevalence of disability. The also influence the effectiveness of determining clear eligibility criteria for the available services. This subsection explores how the broader definition of disability in Palestine impacts how PWDs benefit from the PNCTP.

Almost all participants acknowledged the impact of disability definition on policy formulation and delivery. In this regard, Palestine's current legal and regulatory framework is still based on the medical diagnosis and, thus, oriented towards the degree of capability. The 1999 Disability Law defines a PWD as '[a]ny individual suffering from a permanent partial or total disability whether congenital or not in his/her senses or in his/her physical, psychological, or mental capabilities to the extent that it restricts the fulfilment of his/her normal living requirements in a manner not usually faced by those without disabilities'. In contrast, the CRPD defines PWDs as 'those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society, on an equal basis with others' (Article 1). Musa (2015) contends that Palestine's legal definition of disability should be changed to align with international definitions, as encapsulated in the CRPD. The narrower the disability definition, the lower the likely estimates of disability prevalence, with a tendency to only recognise very severe disabilities and, thus, overlook less severe or invisible impairments (Schneider, 2009). Additionally, Palestine's specific regulations on assessment processes either neglect to define disability for their purposes or follow a medical approach.

Ten key informants from the relevant ministries defended the current articulation of disability in national policies, arguing that the definition adopted in the 1999 Disability Law fully accords with the CRPD's principles. They further contended that no policy reforms around defining disability or collecting related data are needed. Yet three of them challenged that assumption, admitting that the existing definition is problematic and needs reconsideration.

When our President Abu Mazen ratified the Convention on Disability in 2014, we were asked by our minister to review the Disability Law in line with this treaty. I personally read through all relevant documents and did not see any difference. We are using the same language and are very clear who is disabled and who is not. (Head of Disability at MoSA: key informant interview)

When we designed the national disability strategy in 2012, we had major issues agreeing on which disability definition we needed to adopt. We realised that, additional to the definition stipulated in the national disability law, each ministry and sometimes each programme within that ministry has a different definition of disability. (Director of the Economic Empowerment Programme at MoSA: key informant interview)

An MoL participant noted that *the term 'disabled'* in the current national laws is 'very problematic' for them. He explained that, in relation to the right to employment, the 1999 Disability Law requires the public sector to commit to a 5% quota for PWDs, but it does not clearly define disability. As disability is still understood as requiring care and rehabilitation, which can be interpreted as inability to work, PWDs are, thus, automatically excluded from being considered for posts.

The majority of DPO participants (six) regarded the existing definition as an instrument of discrimination, used by the government to deny PWDs access to services.

Our destiny and identify is defined by the type of disability we have and the disability percentage we are given. Free access to health services is preconditional on a certain threshold of disability, and access to employment based on the quota system seems to only be open to persons with physical disabilities. The rest have to manage without. (22-year-old female participant with a visual impairment: focus group discussion)

Two of them raised another problem regarding the disability definition in employment laws. They flagged a huge contradiction between the articles and the bylaws of civil law in relation to disability: the civil law requires government bodies to allocate public sector job placements to freed prisoners and persons whose disabilities resulted from the resistance. However, the bylaw clearly requires all candidates for public employment to be verified as being 'medically fit' and 'clear of illnesses, physical and mental impairments'. The participants argued that this clause immediately puts them 'out of the equation'.

Referring to their continuous support for the government in developing a clear framework for disability definition, applicable across all ministries, participating donors and UN agency representatives agreed that they could not yet achieve this objective. One of the key disability donors commented, 'they can't agree yet on who should benefit from disability services, where, and how many people we are talking about. For us, this is very problematic'. This was reinforced by a UN agency representative: 'We are concerned as the different available data sources allow for different definitions of disability, which leads to different estimates of the prevalence of disability'.

Regarding the implications of the disability definition in guiding policymakers' decisions on the PNCTP, the MoSA uses national survey findings as the basis for understanding the population's situation and designs its policies and resources accordingly. The three main data sources used by the MoSA to inform disability policy are the 2007 Palestinian Expenditure and Consumption Survey (PECS), the 2011 PECS, and the 2011 Disability Survey (DS).

One example of the inconsistency in defining disability is the different phrasing of the question(s) on disability in the different surveys. The 2007 PECS asks whether the person suffers from any of the following disabilities: vision, hearing, mobility, use of fingers, mental, and other specific areas. While both the 2011 PECS and the DS piloted the adoption of the WG Short Set methodology, there was neither consistency nor full compliance with the guiding principles for using those questions.

Another example is the different definitions of disability and the differing profile of PWDs:

- The 2007 PECS definition was based on self-reported disability status: it posed the
 question, 'Does the person suffer from any of the following disabilities?', followed by a
 list of specific disabilities. The PNCTP targeting form still uses the same question to
 ascertain the disability rate.
- 2. Conversely, the 2011 DS²⁷ and 2011 PECS allow for two definitions of disability, based on a functional disability assessment: they pose the question, 'Does [individual's name] have any difficulty in ...?', the possible responses to which are 'no difficulty', 'partial difficulty', 'large difficulty', and 'complete difficulty'. The narrow definition includes individuals who can hardly perform, or cannot perform at all, certain tasks. The wide definition includes all individuals with any difficulty performing certain tasks. Still, there are differences between the DS and 2011 PECS, as the former contains more detailed questions and each use different reference periods. For instance, the DS asks

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²⁷ The Disability Survey was conducted by PCBS, in close coordination with MoSA.

about functional limitations during the prior six months, while the 2011 PECS and the PNCTP targeting form collect data on disabilities at the time of their completion. Table 6.1 presents the available data and questions from each of the three data sources.²⁸

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²⁸ It is obvious that the PNCTP targeting form collects the least amount of data, while the DS collects more detailed data. For example, the 2011 PECS and the targeting form collect information on movement difficulties in general, while the DS collects separate information on difficulties in specific mobility-related activities, such as moving inside the house, moving outside the house, walking for longer than 15 minutes outside the house, and use of hands and fingers.

 Table 6.1
 Various types of disability and their definitions in the principal data sources

	DS, 2011	PECS, 2011	СТРТА, 2012	PNCTP administrative data, April 2015
Visual	Impairments in seeing, with or without wearing glasses	Any difficulty in seeing	Does family the member suffer any difficulties in any of the following (select up to 3)? [vision / vision & hearing]	Does [] suffer from any disability? [visual]
Audio	Impairments in hearing, with or without hearing aids	Any difficulty in hearing	Does the member suffer any difficulties in any of the following (select up to 3)? [hearing / vision & hearing]	Does [] suffer from any disability? [hearing / hearing & speech]
Mobility	Impairments in moving inside and/or outside the house, and/or in walking for 15 minutes outside the house, and/or in using the hands/fingers	Any difficulty in movement	Does the member suffer any difficulties in any of the following (select up to 3)? [mobility]	Does [] suffer from any disability? [kinetics / mental & mobility / use of fingers]
Other disabilities, i	ncluding:			
Speaking	Impairments in speaking	n.a.	n.a.	Does [] suffer from any disability? [speech / hearing & speech]
Memory and concentration	Impairments in memory and concentration: difficulties in remembering to do something important, and/or constantly forgetting where to put things, and/or difficulties in concentrating to do something for ten minutes.	n.a.	n.a.	n.a.

Table 6.1 Various types of disability and their definitions in the principal data sources (cont.)

Learning	Impairments in learning: mental functions associated with brain injury conditions, and/or personal skills as a result of injury, autism, and/or difficulties in learning everyday skills (such as reading, writing, use of simple tools)	n.a.	n.a.	n.a.
Mental health	Mental health impediments (anxiety, doubt, addictions, eating difficulties) affecting his/her daily activity	n.a.	Does the member suffer any difficulties in any of the following (select up to 3)? [mental retardation]	Does [] suffer from any disability? [mental / mental & mobility]
Communication	n.a.	Any difficulty in communication	Does the member suffer any difficulties in any of the following (select up to 3)? [communication]	n.a.
Understanding	n.a.	Any difficulty in understanding	Does the member suffer any difficulties in any of the following (select up to 3)? [understanding]	n.a.
Multiple	n.a.	n.a.	n.a.	Does [] suffer from any disability? [multiple]
Other	n.a.	n.a.	Does the member suffer any difficulties in any of the following (select up to 3)? [other]	n.a.

Note: 'DS' – Disability Survey; 'PECS' – Palestinian Expenditure and Consumption Survey; 'CTPTA' – Cash Transfer Programme Targeting Assessment; 'PNCTP' – Palestinian National Cash Transfer Programme.

Additional to the discussed implications of inconsistent disability definition, there were issues around how disability data are collected, even when there is agreement on the adopted definition. This factor was reported as an additional barrier to understanding the actual prevalence and geographical distribution of disability. Specifically, the DS findings were disputed as failing to reflect the reality on the ground, with the true rates believed to be far higher. A World Bank Study conducted in 2015 reinforced this argument, attributing the problem partly to cultural and sociopolitical justifications, but also flagging shortcomings in data collection methodology and a lack of transparency in the disability assessment and certification process (World Bank, 2017a). The national disability strategy indicated that Palestine's overall disability rate is much higher than 7%. The underreporting could be due to 'families who refrain from registering their disabled boys and girls for social considerations mainly related to stigma and fear of exclusion from community' (World Bank, 2017a). Five of the interviewed key informants recognised that the DS findings are problematic and do not necessarily reflect the actual disability situation in Palestine. They suggested that policymakers attempt to reduce the number of recognised PWDs to justify downsizing the resources and programmes directed to them. They also cited errors during data collection and the cultural stigma around disability.

No one in the country realises the implication of the Minister's decision in 2011 to nationally adopt the narrow definition rather than the wide definition ²⁹ of disability in the national Disability Survey. This decision downsized the number of PWDs who would be entitled to benefits or services from being 6.9% of the population to 2.7%. (Manager of the Disability Unit, MoSA: key informant interview)

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²⁹ Based on response options in the WG Short Set, the 'narrow' definition only includes those answering 'a lot of difficulty' or 'cannot at all', while the 'wide' definition also includes those answering 'some difficulty'.

We were part of the group that trained the field data collectors who were meant to conduct the Disability Survey. For many of them, it was the first time they were introduced to disability. They kept making mistakes of adding more words to the Washington Group questions, which is considered a huge risk, either shifting the answer or preventing the person from declaring their disability. (Advocacy coordinator for the Union for Persons with Physical Disability: key informant interview)

The final problem concerns the availability and accuracy of the information gathered at programme level. Inconsistency in data collection, centralisation, and ministry-level analysis were cited by participants to explain discrepancies in designing informed services and ensuring equal access for all PWDs. Due to inaccuracies in the disability data and the lack of a centralised PWD database, many PWDs are deprived of access to basic services, with service providers unaware of those most in need (MoSA, 2010a, p.13). In terms of education, because actual PWD numbers are unknown, the demand for services and their required scope are also unknown (UNICEF, 2016).

According to a key disability donor supporting the government, it is always difficult to identify disability data to track progress. She indicated that their organization invests significant annual sums to address disability issues in the education and social protection sectors, yet constantly struggles to identify quantitative data to measure the progress achieved: 'the inconsistent figures, which are almost always outdated, are always our biggest challenge'.

This was echoed by a participant from the MoH: he noted there is a good registry system for PWDs receiving medical care in hospitals, but no systematic approach for collecting and updating information on their status once discharged or transferred to rehabilitation centres. He explained that fragmented data are only available from some rehabilitation centres or international organisations working in the disability sector, with nothing at national level. The following example was shared by another ministry representative:

I am the person in charge at the Ministry for Statistics, and I can tell you that none of our records include a section on disability. If you go to our website and read all our annual reports, strategies and future plans, you will not find a substantial mention of disability. Disability for us is the least analysed variable when measuring progress. (Director of Inclusion Unit, MoE: key informant interview)

6.1.2. The legislative and policy context of disability inclusion

The articulation of disability in national legislative and policy frameworks affects how programmes and services are shaped, including those related to social protection cash transfer and in-kind benefits. Having ratified the CRPD in 2014, Palestine is expected to align all related legislation with the CRPD principles, prohibiting all forms of discrimination and embedding equal rights for PWDs. This subsection presents evidence on progress to date on disability exclusion in existing laws and policies. The findings show that neither disability-related nor mainstream laws have been subject to any reform since the CRPD's ratification, yet several strategies have been developed.

Though disability is reasonably well articulated in national laws, translating legislative commitments into clear strategies has been problematic (World Bank, 2017). Musa (2015) argues that addressing disability within national laws is not, in itself, sufficient to protect PWDs' rights. Musa reasons that the absence of complementary legislation, the unstable geopolitical situation, and weak governmental infrastructure all contribute to undermining the law and, thus, continuing to limit PWDs' equal access to services. These observations were reinforced in this research, with most participants reporting that effective fulfilment of PWDs' rights is still frustrated by numerous factors including limited articulation, contradiction between relevant frameworks, and failure to translate commitments into bylaws and plans.

Government representatives agreed that the existing disability law issued in 1999 accords with the CRPD, despite being formulated many years ago. The only challenges acknowledged were the absence of clear bylaws and the translation of legislative commitments into action.

Under Article 2 of the 1999 Disability Law, '[PWDs] have the right to a free and decent life. They are also entitled to access services on an equal basis with others'. Article 3 affirms the State's responsibility for ensuring the protection of PWDs' rights and facilitating their independence. Under Article 5, the State should rehabilitate PWDs based on their needs. PWDs must contribute 25% of their rehabilitation costs, with an exemption for those whose disability was caused by Israeli occupation forces. Article 12 stipulates that the MoSA should, in coordination with relevant ministries, ensure that all commitments stipulated in the law are enforced.

Besides enacting the 1999 Disability Law, the PNA adopted the National Strategic Plan for the Disability Sector in 2012. It was developed by the MoSA, in consultation with service providers and DPOs. It presents disability as a prime development issue, and aims to unify national efforts to avoid duplication or fragmentation. It covers five strategic issues: policy reform, assurance of a rights-based approach in policy processes, capacity development, protection

against discrimination, and equal access (Musa, 2015). While appealing on paper, the absence of major progress towards implementation was recognised by most interviewees.

Despite the ambition, we failed to put it into practice. The immediate change of minister following its adoption, who had a complete difference in view on how disability should be addressed, has resulted in it still being on the shelf with no use at all. (Director of Disability Unit, MoSA: key informant interview)

Despite its comprehensiveness, it did not detail the roles of each ministry within the agreed actions. It failed to make our ministry accountable to this strategy because it is not directly in line with our own plans and language. (Representative of MoH: key informant interview)

Seven DPO representatives, however, considered both the 1999 disability law and related strategy to be outdated. They could not accept Palestine ratifying the CRPD but continuing to follow a law over 15 years old. They stressed the need for the Palestinian legislature to stop treating disability as a social issue to be handled by the MoSA. One DPO participant stated, 'PWDs will continue to be the poor unproductive community members that are to be served by charity organisations until all the related laws and policies are reformed'.

The 2004 Public Health Law stipulates that the MoH must 'provide health insurance for residents within the available capabilities'; yet it does not provide the legal guarantees required by PWDs. Under present law, PWDs are eligible to access free government health insurance through two alternative channels: if he/she is a family member of the household receiving a cash benefit through the PNCTP; or through the right to access health and rehabilitation services in the 1999 Disability Law. Nevertheless, a 2006 health insurance bylaw has since curtailed this right by excluding coverage for several key technical aids (MoSA, 2010a).

Under the MoH's National Health Strategy 2014-2016 (MoH, 2014), policies are centred around delivering a comprehensive network of healthcare services, guaranteeing protected and affordable access to social services, with vulnerable groups – including PWDs – receiving greater attention. The adopted action plan aimed to guarantee the availability of required infrastructure, dedicating a section on obligatory accessibility criteria to ensuring access for

PWDs. Nevertheless, the MoH lacks a comprehensive vision for health-related rehabilitation services for PWDs (MoH, 2014).

Our national laws and policies do not talk to each other, and many times they contradict one another. While the disability law confirms the right to free medical insurance for PWDs, the system of health insurance for 2006 did not point out that health insurance is free of charge for them. (Director of Primary Health Services: key informant interview)

Laws and policies related to employment were the least inclusive of disability in terms of promoting and protecting PWDs' rights to access employment, based on the literature review and interviews. The Basic Law emphasises the right of every citizen to work. However, it does not directly mention disability.

Under Article 13 of the Palestinian Labour Law 7/2000 (hereafter 'the 2000 Labour Law'), '[t]he employer is committed to employing a number of qualified disabled laborers in jobs appropriate to their disablements at a percentage not less than 5% of the establishment's labour size'. Despite the Council of Ministers being empowered to issue bylaws under Article 139 of the 2000 Labour Law, none have been issued to date.

The amended Civil Service Law 4/2005 concerning employment in the government sector affirms, in Article 23, that '[a] portion of jobs is decided by the Cabinet for the freed prisoners, the wounded who were injured in the resistance operations, and those whose states allow them to do those jobs'. The relevant bylaw of the Civil Service Law, Cabinet Decision No. 45 of 2005, confirmed in Article 34 that all government departments must abide by the 5% minimum for the employment of PWDs for new appointments. The General Personnel Council (GPC) must allocate 5% of announced openings to PWDs. A conflict is noted between the Civil Service Law and the bylaws regarding PWDs' employment in government institutions: while the former states that the absence of disease, physical and mental, is required for employment, the latter merely mentions medical fitness.

PWDs are not explicitly mentioned in the MoL's 2014-16 Strategic Plan, the National Strategy for Employment, or the Technical and Vocational Education and Training Strategy.

The limited attention to disability within employment contradicts Article 10 of the Disability Law, requiring 'government and non-government organisations to absorb a number of disabled individuals provided that the number is not less than 5% of the number of staff in

each organization. (...) the workplace shall be suitable for the employment of these individuals' (MoL, 2002). Cabinet Decision No. 40 of 2004 affirms that, under Article 12 of the 1999 Disability Law, 'all government and non-governmental institutions should accommodate PWDs at minimum 5% of the total employees'; however, this bylaw also reiterated that the obligation only applies to structures with more than 20 employees. This is problematic as many NGOs and companies are small in size.

Six DPO participants raised the urgent need for alignment between disability and employment laws to realise more effective measures supporting PWD's equal access to the labour market. One DPO representative, citing the 2011 DS finding that almost 80% of PWDs are unemployed, suggested the situation may now be worse and saw it as 'a matter of national emergency' to make national employment laws and regulations more inclusive of disability.

Moreover, disability receives more attention under social assistance frameworks than in social security strategies and plans. Article 22 of the 2003 Amended Basic Law states that '[s]ocial, health, disability and retirement insurance shall be regulated by law' and '[m]aintaining the welfare of families of martyrs, prisoners of war, the injured and the disabled is a duty that shall be regulated by law. The National Authority shall guarantee these persons' education, health and social insurance'. Article 25 of the Amended Basic Law requires that '[w]ork relations shall be organised in a manner that guarantees justice to all and provides workers with welfare, security, and health and social benefits' (PNA, 2005); yet it does not directly address disability.

In 2015, Palestine was preparing to roll out a comprehensive social insurance scheme: a tripartite National Social Security Committee, supported by the ILO, drafted a law building on the Civil Servant Pension Scheme and the 2000 Labour Law. The first draft, issued in March 2016, ³⁰ was withdrawn following civil society opposition, including from the disability movement, ³¹ as (among other problems) it did not even mention disability. The revised version of the law provides positive discrimination for PWDs on two levels: (1) the right to early retirement after 10 years of public employment, as opposed to 30 years for a non-disabled person; and (2) the retirement pension salary extends beyond the public employee's death to serve the needs of their son or daughter if they have a disability and are unable to work, regardless of their age. Improving social protection is a key pillar of the *Palestinian National Development Plan 2014-2016*, and includes the need to develop a rights-based social protection systems and services for PWDs (ILO, 2013).

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³⁰ Cabinet Decision No. 19 of 2016 regarding Social Security.

³¹ For more information about the campaign, see https://ar-ar.facebook.com/SSC.PAL

MoSA has two main strategies addressing disability: the Cash Transfer Strategy (PNA, 2014), launched in 2010, and the Social Protection Strategy for 2014-2016. The Cash Transfer Strategy explains the regulatory frameworks related to the PNCTP (discussed in detail in the following subsection). One of the main reforms is the 2011 decision to merge the two existing cash schemes (individual and household) into one for administrative purposes. The implications of this for PWDs will be analysed in the following subsections.

The MoSA's Social Protection Strategy 2014-2016 identifies features of the ministry's work based on the Social Protection Floors. The strategy mentions disability several times in its analysis, as well as in the action priorities. The second objective contains an indicator for the proportion of PWDs receiving services, while the third objective contains an indicator for the number of PWDs benefiting from national social security.

Four DPO participants indicated that, to date, there has been no proper social security and protection for PWDs in Palestine. Most of the existing laws and policies support either 'the public sector or poor households'. They argued that the majority of working-age PWDs are unemployed and, thus, dependent on other family members. There is hardly any clear support mechanism to guarantee decent living conditions for them.

6.1.3. Governance, accountability, and resourcing of the disability sector

The successful delivery of cash transfer schemes for PWDs – and the enhancement of their impacts – depends on the availability and affordability of other social services (MoSA, 2010b). This subsection will argue that the existing resource allocation, modalities of implementation, and monitoring mechanisms are both problematic and ineffective in addressing disability within existing policies and services.

Financing disability services

Evidence gathered from all related ministries demonstrates the lack of well-defined financing strategies and budget allocations regarding disability. Resources are both limited and poorly distributed in government budgets, with excessive disbursement in some sectors and finance shortages in others.

As indicated in earlier subsections, foreign aid is the main source of finance for social services in Palestine, supplemented by tax revenues (ILO, 2017). There are no disaggregated data on disability spending in relation to overall public expenditures (World Bank, 2015); however,

current evidence indicates that public allocation for disability is almost negligible (Save the Children, 2014).

The 2013 Health Accounts in the PCBS Statistical Report 2013 (PCBS and MoH, 2015) show an increase of 6.8% in total spending on health. However, when examining spending by care function, as indicated in Figure 6.1 below, rehabilitative care services received only 0.1% of total spending, despite the commitment to pay 75% of all rehabilitation costs.

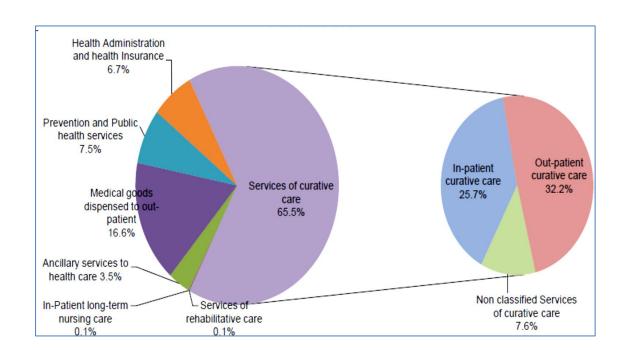


Figure 6.1 Distribution of total expenditure on health by care function in Palestine (2013)

Source: PCBS (2013).32

The MoE's budget provision for disability essentially comprises a limited amount of funding for special resource teachers and counsellors. Limited resources are allocated to producing the curricula in accessible formats for students with visual impairments (PCBS, 2015). The MoL has no budget allocations for disability, relying mainly on donor project-based funding to support small-scale actions. The MoSA has USD 3 million of loan funding from the Gulf countries to support the Economic Empowerment Programme for PWDs; meanwhile, other MoSA programmes constantly struggle with limited resources. (The PNCTP's financing modalities are discussed further below.)

³² The second pie chart is a further breakdown of the services of curative care.

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Representatives of the MoE, MoF, and MoH reported that none of their respective ministries has a systematic budget allocation for both disability-specific and mainstream programmes. They explained that their ministries' existing disability-specific programmes are mainly financed through limited funds from donors. The MoF representative believed that limited political will, poor understanding of how to build disability-sensitive budgets, and donor dependency are the key drivers of the current situation. He was also concerned that the government lacks the 'right figures' on how much it would cost to meet its disability policy obligations. He stated, '[t]he government has no clue how much we need to commit to the obligations around disability'. Donors' influence on financing disability in the country was explained as follows:

Palestine is a donor-dependent country. We are steered according to external agendas and beliefs. On disability specifically, the problem is not that there is no money, but the reality is that almost 70% of the funding goes to NGOs who then control where and on what to spend it. Most of the ministries receive minimal funding translated into small projects. (Director of Inclusion Unit, MoE: key informant interview)

Four participants from a DPO confirmed the government officials' analysis, adding that their attempts to influence national budgeting are very limited as they are never informed by the government about the timing and processes involved. Their biggest concern was the limited financial resources allocated for assistive devices and referrals to specialised rehabilitation services. According to the director of the Deaf Union, financing disability is 'appalling and inequitable to all PWDs in the country'.

Monitoring and evaluation

The absence of effective monitoring mechanisms was the second factor considered by participants to hinder existing policies and services' effective implementation; limitations persist at national, ministry, and civil society levels. Many concerns were raised regarding the Higher Council on Disability's structure, mandate, and performance. It was established in 2004 as an independent entity governed by the MoSA. It was mandated to oversee the implementation and monitoring of disability services nationally. According to existing studies, the council has been poorly resourced since its establishment, and did not become fully active until 2012. The failure of the Higher Council on Disability to effectively monitor disability policies can partly be attributed to its lack of PWD representation (World Bank, 2016).

Additionally, M&E mechanisms are almost non-existent in government-run facilities, or even the most sophisticated centres run by NGOs or private actors (World Bank, 2017a). UNICEF (2016) calls for the implementation of a national mechanism for monitoring the implementation of laws concerning disability in Palestine.

The review of all relevant laws and policies indicated the absence of a clear accountability mechanism, whereby PWDs can file official complaints when facing any form of discrimination in access to services. Additionally, as Palestine has not yet ratified the Optional Protocol to the CRPD, the government has not committed to ensuring PWDs can complain directly to specialised international monitoring committees concerning any existing violations of their rights.

According to three representatives of the ministries, including the council's coordinator, the present weakness in the council's functioning is mainly due to being under the MoSA's full control. According to the council's coordinator, the existing situation can be seen as a 'conflict of interest', as the MoSA is simultaneously one of the main 'arms of implementation' of disability services and the 'guard' responsible for ensuring that all services, including its own, are well implemented. The MoL representative added that there are no ministry-specific monitoring plans related to disability. He stated that 'as it stands, everyone gets away without any punishment or sanction, whether it is a ministry, a school, a hospital or a company. Reporting on disability is only considered if a donor asks for it'.

Four DPO participants believed that the existing national monitoring system is failing to capture the real situation regarding disability, which they mainly attribute to DPOs' inconsistent involvement in existing monitoring structures at national and ministry level. Of the existing 18 members of the higher council, only two are DPOs, representing part of the disability movement in the country. The participants perceived that the government has its own 'preferred DPOs', who are usually invited and consulted regularly, including one that is politically affiliated to the government; the other DPOs (the vast majority) are completely disconnected from any strategic discussion around disability at national level.

Implementation approaches

Finally, participants raised inadequate modalities for implementing disability policies and strategies as problematic for existing policies and services. Since its establishment in 1993, the PNA has chosen to subcontract key disability services, rather than creating its own public services. According to a recent World Bank study, most ministries are slowly assuming more responsibility for leading the delivery of policy commitments related to disability, due to the realisation of existing process constraints (Musa, 2015). The MoSA is designated the key

government body responsible for disability rights and protection under Article 2 of the 1999 Disability Law. Other government ministries are also given key roles in disability-related issues, such as those concerning education, health, local government, and labour (World Bank, 2016). The participants shared the existing modalities of implementation, as summarised in Table 6.2.

Table 6.2 Existing modalities of implementing disability policies and strategies

Service provider	Implementation modalities	
Government	Directly through ministries	
	Subcontracted to NGOs	
INGOs	Directly through their national offices	
	In partnership with NGOs / DPOs	
NGOs	Mainstream services	
	Disability-specific services	
UN agencies	Directly through their national offices	
	In partnership with NGOs	
Private sector	Mainstream services	
	Disability-specific services	

Source: FDG participants.

For almost all participants, this reality is very challenging, as the clear lack of coordination among the above service providers and the government is failing to create a national regulatory framework, with defined roles and assurance of delivering quality services. None of the existing bodies can track the achieved progress and identify gaps, as most providers, such as NGOs and donors, are directly accountable to the relevant ministry.

Seven DPO participants highlighted that NGO service providers have major influence on both the type and quality of services provided. They also have a stronger role in determining the services' beneficiaries, since many of the services they provide are not financially covered by the government.

Let's face it, the government is hardly implementing any of its commitments to disability. It simply gives the money to NGOs and they decide on how and where to deliver. We at the Ministry subcontract rehabilitation services to more than 30 service providers. We do not have the capacity to follow up what they do, we simply trust what they say they did. (MoH representative: key informant interview)

The management of the disability sector by the government is complex due to the engagement of various actors such as NGOs and donors, with lack of clarity on who is leading the sector and who is supporting the process. (Director of Economic Empowerment Programme, MoSA: key informant interviews)

According to a 2016 World Bank study, CSOs tend to be well funded due to the high levels of donor aid flowing into them. This does, however, compound service delivery fragmentation, due to decentralisation and the lack of coordination between CSOs and the government (MoSA, 2010a).

6.1.4. Approaches to disability assessment

In general, disability assessment can be a barrier to accessing disability-specific and mainstream cash schemes. This subsection will explore the adopted approach to assessment and examine the process through which it is conducted in Palestine.

As well as interviews, FGDs, and a literature review, this part of the analysis is also based on observation of a disability assessment day at the MoH. Most DPO participants expressed critical views of the existing disability assessment mechanisms and eligibility criteria for services and benefits, noting that these are heavily influenced by the narrow, medical perspective of disability. Furthermore, they considered the current practices outdated, complex, and opaque as regards equal access to services.

Many laws and bylaws regulate access to the various benefits and schemes for PWDs, as well as the functions of the MoH medical committees, as the key actors in disability assessment in Palestine (e.g. Pension Law 7/2005, 2000 Labour Law, Public Health Law 2/2004, and Civil Service Law 4/2005).

The 1999 Disability Law stipulates, in Article 10, that the MoSA shall be 'in charge of coordination with all relevant and competent bodies to secure the welfare and rehabilitation of the disabled'. Under this provision, the MoSA is required 'to determine the nature of the disability, its degree and the extent to which it affects the family of the disabled, and to provide the appropriate assistance' in the social sphere; 'to diagnose and classify the level of disability' in the health sector; and to 'provide the educational analysis essential for determining the nature of the disability and its extent' in the education sector (World Bank, 2017a). This is specified in more detail in Cabinet Decision No. 40 of 2004. However, this bylaw stipulates that classification and determination of the type and level of disability should be

based on the outdated International Classification of Impairments, Disabilities, and Handicaps (ICDH).³³

The current *National Strategic Plan of the Disability Sector* focuses strongly on developing a professional system to diagnose degrees of disability, stating the objective that 'the diagnostic processes of the disabilities' degree are based on comprehensive and professional standards and bases and are internationally accepted' (MoSA, 1999, p.20). It specifies the following immediate interventions:

- Developing criteria for diagnosing the degree of disability based on the international criteria, premised on the comprehensive, interactive, and human rights-based concept of disability.
- Training and empowering the diagnosis and assessment committees.
- Setting up diagnosis and assessment committees with multiple specialisations.
- Developing diagnosis and assessment procedures that ensure human dignity.
- Declaring and subjecting to accountability and monitoring the diagnosis and assessment procedures, so as to guarantee the integrity of the diagnosis process.
- Ensuring geographical access for all PWDs, even in distant areas (MoSA, 2012a).

Numerous policy papers and strategies further shape the national framework on disability, assessment, and eligibility: for example, the MoSA's (2012a) *Social Policy Paper on the Establishment of a Case Management System for Children with a Disability* requires a medical examination or physical screening and broader assessments of CWDs to determine the type and level of disability.

The organisation, function, and composition of the Medical Committees are governed by a bylaw based on a decision of the National Cabinet in 2006. This bylaw is pursuant to Civil Service Law 4/1998, the reformed Civil Service Law 4/2005, the 1999 Disability Law, and Public Health Law 20/2004.

Pursuant to this regulation, Medical Committees are established at the regional and national level. Medical Committees in the West Bank and Gaza follow the same procedures and regulations, yet they do not have strong coordination mechanisms. According to the regulations, the committees' decisions should be based on consensus.

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³³ This was the precursor to the ICF.

Local Medical Committees (LMCs) at district level should comprise at least three specialists from government hospitals and meet at least once a week. LMCs may refer to other specialists for a further opinion before making a final decision. The Higher Medical Committee (HMC) is chaired by the General Director of Primary Care and Public Health and should comprise at least five government specialists. The HMC should meet at least once a month.

Current practices and procedures

The LMCs are generally composed of specialists in internal medicine, orthopaedics, and general and paediatric surgery, and convene on a weekly basis. The HMC comprises a greater variety of specialist expertise, including a psychiatrist, and meets twice a month. No definite selection criteria for committee members could be identified, besides previous work experience in the MoH, nor any clear mechanism for monitoring and reporting on the committees' practises and outputs.

A prerequisite for initiating assessment by a Medical Committee is the existence of one or more diagnoses that can lead to disability and the individual's application to one of the services or schemes whose eligibility criteria demand assessment by a Medical Committee. In some cases, the access mechanism of a particular scheme requires the re-assessment of PWDs who have already undergone an assessment and obtained a disability certificate. This implies that the procedure starts when the individual is referred for assessment. A referral letter is usually issued by the relevant ministerial authority responsible for the benefit or service for which the applicant applies. In some cases (e.g. the application for free medical insurance for PWDs that do not benefit from the PNCTP), the General Union of Disabled People (GUDP) provides a referral letter if that the applicant is a GUDP member. Otherwise, a fee of reportedly NIS 500 is charged for the assessment.

The main assessment tool of the Medical Committees is a handbook on 'Criteria for Determining Degrees of Disability', published in Israel in 1969 by the Ministry of Defense, Department of Personnel and translated by the Department of Health, Military Headquarters. Article 18 of the bylaw that regulates the Medical Committees states that the MoH should issue an equivalent Palestinian guideline, but this provision has not yet been implemented. The handbook provides a list of conditions and disorders together with the degree or percentage of disability allocated to each. It covers a broad range of conditions including internal disorders, urogenital conditions, neurological syndromes, eye disorders, psychotic and psychoneurotic conditions, conditions related to the ear, nose, mouth and throat, skin disorders, etc. For example, a total paresis on the right side is assigned 80% disability, while a total paresis on the

left side constitutes 70% disability. Assessments sheets are presented for completion during the assessment, although reports suggest they may need to be updated.

The committees base their decision on medical reports from public hospitals, taking into consideration the individual's medical history and performing examinations, if applicable. In case of work injury, the applicant's profession and how the injury will affect his/her work performance are reportedly important factors in determining the disability percentage. Applicants assessed by an LMC may be referred to the HMC if no conclusion can be reached at local level.

The output of the assessment is usually the indication of the condition and a disability percentage, which are a vital criteria for some schemes (e.g. free medical insurance is available for PWDs with at least 60%). A brief recommendation is provided if requested by the referring authority (e.g. for an early retirement application).

Problems identified

One issue observed first-hand relates to the facilities where the assessments take place. In some circumstances, these facilities may not meet the relevant requirements. Some are too small to accommodate the many applicants or to enable their thorough medical examination. They may lack basic furniture for examinations, such as chairs and beds, or to accommodate the needs of applicants with severe physical impairments during the waiting time and the examination. The setup may not facilitate the orientation of applicants, and basic provisions to maintain their dignity and privacy during all stages of the assessment were observed to be lacking.

The high number of applicants assessed during each HMC session may indicate either the high demand for assessments in general or a high number of referrals from the LMCs for further validation. In either case, the situation prevents the thorough examination of applicants and the full review of all records on file. As such, assessments were observed to be rather cursory and often based only on brief questions and the documents on file. The field work observation also revealed that processes to facilitate committee decisionmaking, as stipulated in the regulations, are not in place. In most observed cases, conclusions and recommendations were made only by the examining doctor and countersigned without further discussion of the case.

Besides the above-mentioned handbook for allocating impairment percentages, there is no indication of clear and transparent criteria or indicators for assessment and decisionmaking. As such, each committee's decisions depend largely on the judgment of its individual members, which can create confusion and makes them susceptible to bias and informal influences. This is particularly critical since the committees' decisions are reportedly 'like court orders' for

referring stakeholders or agencies (e.g. the pension agency): they determine the allocation of financial resources and cannot be contested.

As stated in the regulations, these committees do not specialise in disability matters, and their sole tool for assessing PWDs and invalidity is the above-mentioned handbook. Thus, committee members may lack further skills or guidance regarding the broader concept and assessment of disability and PWDs. Consequently, current disability assessment is based on the medical model, and committee members base their disability severity conclusions largely on the condition and/or nature of the impairment, without greater evaluation of the individual's daily activities, participation, and environmental factors. In addition, the composition of the LMCs limits their medical expertise, with vital specialities such as mental health not represented.

The national umbrella organisation, the GUDP, was founded to play a significant role in facilitating PWDs' access to assessment processes, particularly in relation to employment under the 5% quota and to free health insurance. They provide referral letters to the Medical Committees to support PWDs' in obtaining the disability certificate; however, this service only applies to GUDP members, who are mostly based in the main cities. DPOs should play a vital role in the design and monitoring of governmental programmes to promote PWDs' inclusion and in facilitating access to available benefits and services for their constituency. Yet linking such services to membership contravenes the CRPD's principle and objective of equal access and violates DPOs' mandate to advocate the interests of all PWDs. It also raises questions about the transparency and accountability of the whole assessment process.

Finally, the assessment's output is generally limited to the so-called 'disability certificate', which indicates the status of being a PWD, comprising the condition and the disability percentage, together with a recommendation (e.g. fit-to-work assessment) if requested by the referring authority. There is additional evidence for benefit or programme-specific assessments, i.e. assessment criteria set according to specific purposes and for particular schemes and reports.

My own reflections on the process, based on the observation, are as follows:

It was very difficult for me to be present that day as I was aware that I had to maintain my neutrality and focus on observing and documenting what I was seeing. Yet I couldn't stop feeling angry and sad for the hundreds of people piling up in that room, anxiously waiting for hours for a decision that, for many of them, would be life-changing.

The process was appalling for me. I was asked to sit at the side of the big round table where 15 doctors sat behind their piles of files. The big hall was split into two parts with a

wooden divider; one side of the room had all the applicants and the other side contained the doctors. Everyone in the hall can hear everything. They started at 10:30am, calling people in six at a time, and three doctors started to examine each of the summoned applicants. They all spoke loudly, examining people openly, sometimes asking very personal questions and removing parts of the applicants' clothes to examine them.

The decisions were made very quickly, in less than 5 minutes, and very little opportunity was given for applicants to explain anything. The decision was even quicker in some situations, where the applicant was brought in by another doctor without being called; there were four such incidents the day I attended, and I could see that they decided to allocate a high disability percentage without looking deeply into the files or asking any questions. The whole process made me question the transparency and accuracy of the decisions made that day.

There was one moment where I was about to lose patience: one of the applicants started screaming in the hall, 'That is not fair, that is not fair'. They reacted by summoning the security guard, who forcibly pushed him out of the room in his wheelchair. When I asked what was happening, I was told he had been given 40% disability, despite being a wheelchair user and unable to move his arm. His application was for car tax exemption, which requires at least 60% disability.

PWDs in Palestine are entitled to a range of services and benefits based on existing policies and laws. In most cases, the decided severity of disability (the disability percentage) determines an individual's entitlement to benefit from existing schemes.

Figure 6.2 presents all the schemes and programmes identified by the participants as requiring some form of disability assessment to determine eligibility.

Figure 6.2 Overview of identified schemes, programmes, and support services involving a disability assessment



Below are illustrative examples of current practices and procedures for disability assessment for the schemes, programmes, and benefits with potential linkages to the PNCTP.

Assessment processes in the Civil Servant Pension Scheme

For the social protection sector, the first scheme for which the access and assessment procedure is analysed is the *Civil Servant Pension Scheme*. The Palestinian pension system currently comprises one unified public pension scheme, covering civil servants, security forces personnel, employees of local authorities and public institutions, and optional private sector workers. Pension Law 7/2005, last amended in 2007, integrated the two former schemes for civil servants in the West Bank and the Gaza Strip and the pension scheme for security forces personnel.

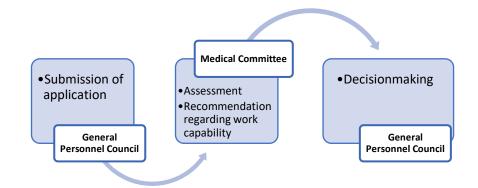
The retirement schemes are regulated by the Pension Law 7/2005 and managed by the Palestinian Pension Authority.

Eligibility criteria:

- Evidence of permanent or temporary disability from a Medical Committee;
- Under 60 years old;
- Number of years served.

Access and assessment process:

Figure 6.3 Access and assessment process for early retirement based on disability



As shown in Figure 6.3, the applicant first submits an early retirement application to the GPC, which refers the applicant to an LMC, requesting a recommendation on whether the applicant's disability affects their work capability to such a degree that it prevents them from working. On receiving the LMC's recommendation, a committee of representatives of the GPC, MoSA, and another two ministries review and decide upon the application, based on the recommendation and other aspects, such as years of employment. Usually, the GPC's decisionmaking process does not involve a personal interview with the applicant. Reportedly, there are very few applications per year.

The key challenges raised by participants mainly concerned the absence of sound criteria, descriptors, and expertise to assess work capability. The Medical Committee's recommendation is largely based on the condition; while they may enquire about the individual's work, the assessment rarely involves a structured assessment of the health condition's effects on a claimant's ability to perform work duties.

Assessment processes in the Fund for the Rehabilitation of PWDs scheme

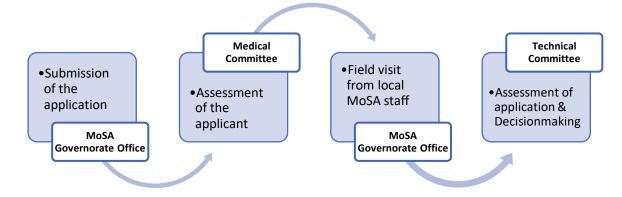
The second scheme analysed within the social protection sector is the *Fund for the Rehabilitation of PWDs*. Launched in 2008, it aims to rehabilitate and economically empower PWDs through income-generating businesses. To date, about 550 loans have been provided, ranging from USD 2,000 to 10,000. The dund's regulations establish its mandate, eligibility criteria, and access mechanism.

Eligibility criteria and required documentation:

- Aged from 18 to 44;
- Completed application form and feasibility study for the proposed project;
- Disability certificate from a Medical Committee;
- No other source of regular income above the extreme poverty rate indicated by the PCBS;
- Report on assessment of applicant's capacities to implement the project;
- For persons with intellectual disabilities, their families can apply on their behalf.

Access and assessment process:

Figure 6.4 Access and assessment process for the Fund for the Rehabilitation of PWDs



As shown in Figure 6.4, PWDs apply through the Inclusion Officer at the relevant MoSA governorate office, and submit the required documents. If a disability certificate is not already available, the social worker will refer them to the Medical Committee for assessment. The purpose of this assessment is to determine eligibility for PWD status and the disability percentage, rather than assessing the applicant's capacities and support needs in relation to

their project. Through assessment of the latter is envisaged in the fund's regulations, it has not yet been implemented.

The main reasons for rejecting an application were reported to be poor feasibility, lack of innovation, suspected fraud, or the presence of a severe disability.

The key challenges addressed by participants mainly concerned the 'severity' of disability, which is considered a main predictor for a project's success. Participants noted that this may lead to bias towards selecting applicants with mild or moderate disabilities and those with physical disabilities, as those deemed most likely to succeed. They also raised concerns around the lack of clear and comprehensive assessment criteria regarding the scheme's purpose; eligibility being based on the applicant's condition, rather than their functional capacity; and the length and complexity of the process. (See section 6 for analysis of the assessment process for the PNCTP.)

Assessment processes in the employment sector

With regard to access and assessment in the employment sector, the policy analysed is the 5% quota in the government sector.

Access and assessment process:

Accessing employment through the 5% quota currently involves only pre-selected job openings specifically for PWDs.³⁴ Applications must be accompanied by a disability certificate from a Medical Committee indicating the condition and severity of the applicant's disability. Thus, an applicant who has not previously been assessed must undergo an assessment by a Medical Committee. The applicant can obtain a referral letter for the Medical Committee from the GUDP, provided they are a member.

A committee comprising representatives of the GPC, the ministry where the post will be filled, the MoSA, and two further ministries review the applications and prepare an initial shortlist. Shortlisted applicants are required to attend a written technical test. The applicants scoring highest on the test are invited for an interview with the above committee, at which the compatibility between the job requirements and the candidate's abilities is assessed. The interview format provides the committee with assessment criteria: academic qualifications,

³⁴ According to a personal discussion with the director of the GPC in January 2015, they recruited about 150 PWDs between 2011 and 2013, and the overall percentage increased from a maximum of 3.1% between 2005 and 2011 to 5.3% in 2013/14.

relevant experience, courses taken, English skills, computer skills, specific position-related questions, general impression, and general knowledge. Reportedly, there are no exclusion criteria regarding the disability type or severity. The need for workplace adjustments — or accommodations — to facilitate a candidate's employment is reportedly assessed during the interview and subsequently met where practicable (e.g. provision of screen readers).

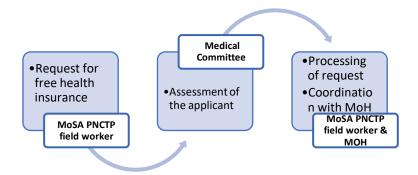
The key shortcomings raised by participants mainly concerned the absence of expertise and systematic assessment to provide recommendations on reasonable accommodations for candidates. This is particularly important, as a recent study on PWD employment in Palestine revealed that the absence of tools/mechanisms for assistance, lack of accommodation for their needs in the workplace, and difficulty in accessing their workplace all remain key barriers to sustainable employment (Musa,2015). The participants generally perceived that people with a physical disability have the best labour market outcomes and represent a disproportionally higher share among PWDs employed in the government sector under the 5% quota policy.³⁵ They explained that this may be due to bias in the assessment towards certain disability types.

Assessment processes for free health insurance

With regards to access and assessment in the health sector, the first scheme analysed is *free medical insurance*. There are two routes for PWDs to access free health insurance: under the PNCTP, which is governed by the programme's regulations, and, for PWDs with a disability level of 60% or more, under Article 2(5), Public Health Law 20/2004 and Article 22, 2003 Amended Basic Law, the latter requiring the PNA to guarantee PWDs' education, health, and social insurance (Al Tamimi, 2014).

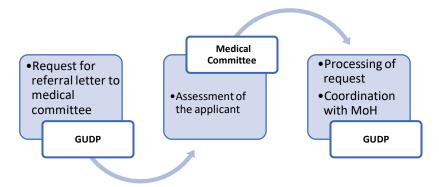
³⁵ According to GPC statistics, of 150 PWDs recruited by the GPC between 2011 and 2013, 108 were persons with physical disabilities.

Figure 6.5 Access and assessment process for free health insurance under the PNCTP



Beneficiaries under the PNCTP are automatically entitled to free health insurance. As shown in Figure 6.5, the MoSA field worker first refers the beneficiary to a Medical Committee. Once the beneficiary has obtained a disability certificate, the social worker processes the request by forwarding the documents to the MoH, which determines whether to issue the insurance certificate. Under this option, there is no minimum disability percentage required for eligibility.

Figure 6.6 Access and assessment process for free health insurance for PWDs with over 60% disability



PWDs with a <u>disability level over 60%</u>, certified by a Medical Committee, can claim free health insurance from the MoH. As shown in Figure 6.6, to access a free assessment by a Medical Committee, PWDs obtain a referral letter from the GUDP. If the assessment certifies at least 60% disability, the GUDP will coordinate with the MoH to obtain health insurance for the applicant.

The main weakness raised by participants was that the GUDP generally only issues Medical Committee referral letters for its members, which prevents equal access to this scheme.

Assessment processes for access to rehabilitation services and assistive devices.

The second scheme analysed within the health sector is the provision of *rehabilitation services* and assistive devices. Article 5 of the 1999 Disability Law stipulates that '[t]he state shall provide the disabled with rehabilitation in all its forms in accordance with the requirements of the nature of the disability. The contribution of the disabled shall not exceed 25% of the expense' (PNA, 2005).

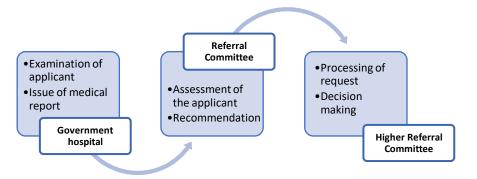
Cabinet Resolution 108/2004 on the Supreme Medical Committee of Referrals regulates referrals to non-governmental centres in-country or abroad and the function of the relevant decisionmaking committee and departments. Based on the Minister of Health's decision No. 12 of 2004 and an order issued by the Council of Ministers on 8 March 2004, the Higher Committee of Medical Referrals was formed. Based in Ramallah, it is supported by two local Referral Committees, one in the south and one in the north; members are specialised doctors from government hospitals. The higher committee's members work in the MoH Unit for Referral. The Higher Committee of Medical Referrals examines all transfers, whether incountry or abroad, and makes decisions regarding access to rehabilitation based on the below criteria.

Eligibility criteria:

- Health insurance;
- Report from a government hospital indicating that relevant treatment/rehabilitation or assistive devices cannot be provided by a government hospital, and referral is required.

Access and assessment process:

Figure 6.7 Access process for rehabilitation referral



As shown in Figure 6.7, applicants first present themselves at a public hospital for examination. If applicable, a medical report will be issued indicating the need for referral to services outside the public sector or outside Palestine. The applicant will be referred to a Local Referral Committee for assessment. The committee reviews the application and sends its recommendation to the higher committee for approval and determination of the percentage contribution by the patient. The higher committee refers their decision back to the local committee, which then informs the patient. Often, patients follow up directly with the higher committee.

The main challenges raised by participants concern variations in assessment results for the same person according to the conducting committee. There is also no clarity on how this percentage is determined and whether the applicant's financial and social situation is assessed; this payment may present a major financial barrier to accessing these services for PWDs and their families. Additional issues included the inaccessibility of the office of the Higher Committee of Medical Referrals in Ramallah; people with a physical disability have to be carried to the second or third floors to be assessed by the committee; and, according to the regulations, prosthetic and assistive devices are excluded from the services provided through this scheme. Participants from the MoH clarified that, in practice, the provision of such devices is approved, but the applicable criteria are unclear, and PWDs face a long wait to get the device they need.

Conclusion

From the above analysis of the influence of current disability assessment mechanisms and their potential impact on access to services, the main problems identified from participants' comments and the literature review include: the systems' lack of transparency, outdated tools, the medical approach, complexity of access, lack of unity/coordination among the different mechanisms, and a disconnect between the assessment and the anticipated benefit or service.

The functions of the current assessment include only determining and certifying a status based on medical criteria and, in some cases (e.g. early retirement), issuing a recommendation. Though some regulations (e.g. concerning the Fund for Rehabilitation of PWDs) acknowledge the need for broader assessments in terms of activities and participation, these have not materialised to date.

Assessment committees still only include medical doctors, excluding from the process psychosocial and other therapeutic professionals who could help to more comprehensively assess an individual. In addition, the variety of specialisms represented in the LMCs is limited by their small membership. Thus, they may not be specialised in assessing the medical criteria

associated with certain morbidity areas (e.g. mental health). In such cases, the applicant will usually be referred to the Ramallah-based HMC, which only meets once per month, partly explaining its long waiting list. Thus, such referrals add to the HMC's workload, prolong the process for the applicant, and potentially present considerable barriers, such as transport and related expenses.

Establishing eligibility in line with the CRPD's human rights-based approach requires special focus on ensuring procedural justice. In some cases, the current disability assessment procedures seemed vague or unregulated by the existing frameworks. Applicants may be left confused over how a decision on the disability percentage was reached and the duration of their eligibility to benefit from a particular scheme. The procedures to be followed by an individual prior to assessment vary for the different benefits and related institutions and are sometimes bureaucratic. Geographical and physical inaccessibility may add to the burden on the individual applicant. The process and setup of the assessment may place them in the position of a passive 'patient'. Assessment and related gatekeeping mechanisms should guarantee equal access to services for all PWDs. In this context, the above analysis critically notes indications of PWDs' exclusion from a service or benefit based on their impairment. For example, beneficiary statistics of the Fund for the Rehabilitation of PWDs indicate that there may be bias favouring persons with mild or physical disabilities. Likewise, the requirement for PWDs to undergo an additional assessment by a Medical Committee when applying for a driving license, where deemed 'necessary', may be discrimination on the grounds of disability.

In Palestine, the current assessment systems are oriented towards restricting access to a given type of service (gatekeeping). Thereby, most access processes or eligibility criteria establish only the existence and percentage of disability. Likewise, the Medical Committees focus on the loss of capabilities, with a view to establishing the status of 'being disabled' and the disability percentage, rather than determining existing abilities or support needs and targeting the best match between needs and services. Thus, the current assessment approach determines labels, instead of focusing on intervention with a concrete orientation to services.

6.2. Inclusion of disability within the Palestinian cash transfer programmes

The successful delivery of cash transfer schemes for PWDs is influenced by policy decisions around disability inclusion in programme design (MoSA, 1999). This section analyses how disability is mainstreamed in the PNCTP.

6.2.1. Evolution of cash transfer programmes in Palestine

From 2006, the MoSA ran two parallel cash transfer schemes: the EU-backed SHC programme and the World Bank-financed SSNRP, launched in 2006 and 2007, respectively. It was very challenging to obtain detailed information about the previous schemes. The MoSA has no comprehensive historical records. Organisational memory is limited to a few donors' reports and a few long-term ministry staff. The information presented is drawn from key informant interviews and evidence collected from donors' reports and evaluation reports.

When launched in 2006, the SHC programme was the largest CT programme in the West Bank and Gaza in terms of funding and coverage. Eligibility was assessed through home visits conducted by one of 350 social workers, using categorical classifications that prioritised vulnerable groups (e.g. women, at-risk children, the elderly, and PWDs) (UN ESCWA, 2009).

The SHC programme provided cash assistance to approximately 48,700 individuals, at a rate of USD 250 per case every three months. Eligibility was determined as follows: evaluation by the social worker through desk and field assessments; categorised classification of beneficiaries; examination of the household's different income sources; and approval from the director of the authorised directorate. The programme was run by the Anti-Poverty Department, and implemented in the field by the Directorate of Social Affairs. While programme-related information was recorded on computers, there was no database system in place, and it was difficult to extract information about beneficiaries, their specifications, and the assistance they received, for use in planning and administrative decisions.

The SSNRP was a smaller programme, targeting poor households using PMT (Jones and Shaheen, 2012). It was established with the aim of reforming the SHC programme and improving its effectiveness and efficiency in targeting the poor, based on equality, justice, and transparency. Instead, however, the SSNRP evolved into a self-contained programme providing periodical cash assistance, operating its own working and targeting mechanisms.

Given that the SHC programme and SSNRP had different targeting criteria, designed based on their respective donors' requirements, decisions for payments and entitlements were reported to be inconsistent and lacking in transparency and accountability. The implementation of these and other government and non-government programmes was highly fragmented. The absence of a unified database, to provide information about the type and quality of assistance received by families, particularly undermined coordination and coherence, notably in relation to targeting, which was generally perceived to be opaque (Jones and Shaheen, 2012). In the late 2000s, it became increasingly clear that substantial efficiencies could be achieved through improved coordination, coverage, and targeting.

In recognition of the fragmented reality of social protection provision, the MoSA was mandated to develop a social protection policy in coordination with the relevant ministries. It was also charged with consolidating cash assistance programmes into a single programme, with unified targeting, mechanisms, regulations, work instructions, and database. This consolidation targeted providing a safe and dignified life for the poor, enabling them to effectively and efficiently participate in the overall development process. The aim was to build a strong central programme, integrated with other relevant programmes and mobilising all available resources under a single umbrella, to provide an effective and high-quality service. This demonstrated political will to provide better protection measures for the most vulnerable groups, including PWDs, as stated in the national Social Protection Strategy in 2010 (Jones and Shaheen, 2012).

Targeting was an area of particular focus in the reforms. The World Bank was especially influential in merging the SHC programme and SSNRP, encouraging the EU to adopt the same targeting mechanism as the SSNRP for determining benefit levels and payment modality. This mechanism was based on a proxy means-testing formula (PMTF), which takes account of demographic, health-related, economic, residential, geographical, and educational variables. This represented a significant shift from the SHC programme approach, which used categorical targeting and provided a standard cash transfer amount to all beneficiaries. The unified targeting system was intended to strengthen coordination among the many actors in Palestine's social protection sector (PNA, 2010). There was no evidence to indicate that disability and PWDs' access to social protection played a role in the reform, or that the objective to reach more vulnerable persons, such as PWDs, was a driver in the reform processes.

Based on the above, the MoSA introduced the Social Protection Strategy in 2010: an ambitious set of reforms aiming to provide a 'decent life for the Palestinian citizens on the path to sustainable human development in the independent Palestinian state', with social protection presented as the PNA's duty or responsibility towards its citizens (World Bank, 2013). Also in 2010, supported by the World Bank, the MoSA initiated in-depth reform of its social safety-net programmes, with a view to introducing transformative measures. The aim was to alleviate the

impact of ongoing social and economic crisis on the most vulnerable, protecting the human capital of poor children; and to strengthen the ministry's institutional capacity to deliver its commitments.

The reform's main objective was to merge the SHC programme and SSNRP into the PNCTP, intended to be a central, transparent, fair, accountable, and relevant programme; it would integrate and guide other national CTs, and mobilise all resources to better address poverty in Palestine (PNA, 2010). Figure 6.8 summarizes the differences between the two old cash schemes (SSNRP and SHC) and the PNCTP in terms of type, eligibility, amount, nature of recipients, etc.

2010 policy reform merging Palestine's two national non-contributory Figure 6.8 schemes into one

Household poverty alleviation scheme, targeting the poorest of the poor. Eligibility was determined by a PMTF equation. Disability was not an inclusion criterion. Decisions were made based on a computerised system, with little influence from field workers.

The benefit was calculated on the basis of the National Assistance Scale. Regardless of its size, each family received a monthly amount of USD 55, plus USD 10 per family member, with the total not exceeding USD 140 per month. There was no increase in the amount for a family with a PWD member. The money was granted to the household

Social Hardship Case (SHC) programme

Individualised 'social case (shc) programme
Individualised 'social case' scheme targeting specific
groups, such as orphans, widows, divorcees and
abandoned women, the elderly, and persons with
chronic illnesses and disabilities. Eligibility was not
based on poverty assessment but, rather, a
situational assessment of the applicant by a social
worker. There was no specific criterion for income.
The decision was made by the director of the
authorised directorate, based on the field worker's
recommendation.

The amount was USD 250 per beneficiary once every three months. It was unclear how the amount was calculated, but the money was transferred directly to

Palestinian National Cash Transfer Programme (PNCTP)

(PNCTP)

Household poverty alleviation scheme targeting the poor. Eligibility is determined by a PMTF equation. Disability is marginally considered, and a disability assessment is required to prove the disability of a family member. Decisions are made using a computerised system, with little influence from field workers.

The amount is USD 195 to USD 468 per quarter, and calculated to bridge 50% of the household poverty gap. This amount takes into account the number of family members, with the additional sum declining after nine members and not increasing beyond Toetermination of the amount does not consider if the family has a PWD member. The money is granted to the household head.

Complementary to the merger of the two programmes, the MoSA aimed to strengthen its partnership with the EU and the World Bank, increase the capacities of MoSA staff around generation of data, analysis and reporting, and invest in developing more robust accountability and monitoring systems. However, MoSA participants indicated that the first objective – restructuring the cash schemes – received major focus, while the rest were of less priority.

6.2.2. The PNCTP: design and implementation features

The PNCTP is now the largest social transfer programme in Palestine, in terms of both coverage and funding, representing around 1% of Palestine's GDP. The PNCTP is a mainstream household scheme that seeks to alleviate poverty in the West Bank and Gaza by providing cash assistance to poor and extremely poor Palestinian families, accompanied by complementary assistance, including in-kind support (Jones and Shaheen, 2012).

Eligibility criteria: Palestine was the first country in the region to target its CT programming according to consumption-based PMT, with social workers estimating the welfare of each applicant's household during regular home visits. The MoSA set the poverty line and extreme poverty line in accordance with PCBS data and has also attempted to standardise methodologies and targeting criteria among the various donors and agencies implementing social assistance programmes.

Value and delivery mechanisms: Under the PNCTP, eligible households receive between NIS 750 and 1,800 (USD 195 and 468) per quarter to bridge 50% of the household poverty gap, i.e. the difference between estimated household consumption (per the PMTF) and the extreme poverty line. The cash transfer amount is also adjusted to account for the number of family members, with the additional sum declining after nine family members and not increasing beyond 17. The average amount given to each family in Gaza, where the average family size exceeds six members, is NIS 1,284; in the West Bank, where the average family size is lower (around four members), the average amount is lower, at NIS 918. The cash transfer recipient is the household head, and the decision is based on the PMTF results, social worker recommendation, or directorate-level social protection network committees (Jones and Shaheen, 2012).

Monitoring and accountability: The existing monitoring system relies on two main mechanisms for monitoring the programme's effectiveness. The first is data analysis using the newly developed MIS, and the second is recipients' feedback to the PNCTP Complaints Unit. Citizens' complaints reach the MoSA through designated boxes located at the directorates in all governorates; other complaints are transferred from the Office of the President, the Office

of the Prime Minister, and governors' offices, or raised by human rights organisations. Under the PNCTP's current monitoring system, households whose cash transfer is reduced or proposed for withdrawal can raise a written or verbal complaint (via social workers or NGOs) to the MoSA. If the MoSA appeal committee at district level also deems that the household should no longer receive assistance, beneficiaries can lodge a final appeal with the MoSA Complaints Unit in Ramallah.

Links to other social protection services: In addition to the transfer, beneficiary households are also entitled to other state-provided assistance, including food support (dry food rations in Gaza and isolated areas of the West Bank, and vouchers in urban areas of the West Bank); school fee waivers; and additional cash grants for one-off emergency needs. Additionally, PNCTP beneficiaries are eligible for free government health insurance, including medicines and operations. The unavailability of certain medicines and the costs of specialised treatment for more complex illnesses, which are not covered by the medical insurance, place a significant economic burden on vulnerable households. Through other funds, the PNCTP assists households to cover some of these expenses, but is frequently insufficient to cover the cost of expensive equipment or necessary medical supplies (Jones and Shaheen, 2012).

Except for MoSA officials and World Bank staff, almost all interviewees expressed serious concerns on the ability of the PNCTP, as presently designed, to address PWDs' needs. The main concerns related to the move from a disability-specific individualised scheme (under the SHC programme) to a mainstream, household poverty alleviation scheme, shifting the focus of benefits from the individual to the household. The implications of this design shift for PWDs' access to services and independent living are discussed in detail in section 6.3.

Stakeholders' reflection on the reform

Seven of the eight interviewed DPO representatives criticised the merger the two previous programmes with regard to the reform's rationale, process, and impact on the most marginalised, primarily PWDs. They explained that they were only partially involved in the processes and were not informed about the reform's potential impact on their members' lives. They believed that the nature of the reform was influenced by donors and international experts and was compounded by the government's ignorance of its implications for their citizens' daily lives. They stated they had been promised by Minister of Social Affairs that the new programme, using proxy means targeting, would specifically address PWDs. They were also told its aims would extend beyond providing a safety net for PWDs — who are

disproportionately likely to be poor – by ensuring their basic needs are met, thus enabling them to live with dignity.

We were only informed about the decision to merge the two schemes at a very late stage in the process. We, along with the other three national DPOs, were invited to the final national workshop where a European expert presented the plan. It was very hard to keep up with the discussion as the presentation was in English and the ministry provided a weak translator. (Director of the Deaf Union: key informant interview)

The only thing I recall very well was the confirmation of an expert, during a meeting at the MoSA, that the new scheme would not harm any of the existing beneficiaries with disabilities. He stated that the only difference would be that the money would now go to the head of the household and not the individual. [...] we were shocked to discover that many PWDs had been informed that they would no longer benefit from the scheme as they did not comply with the new eligibility criteria. (Chairman of Union for Persons with Physical Disability: key informant interview)

We did not know what to do; hundreds of PWDs came to us asking for help as they found themselves suddenly with no financial support. We tried to reach out to the ministry to ask for clarification but failed to make any progress. (Programmes Director of a DPO representing persons with visual impairments: key informant interview)

However, government officials had a different opinion on the reform. In key informant interviews, almost all PNCTP senior management staff strongly defended the existing scheme, arguing that the decision to merge the two old schemes created a more just and effective mechanism, reaching and benefiting the country's most marginalised populations.

A PNCTP senior manager described how, due to poor coverage and weak funding, the old schemes failed in two key respects: (1) contributing to poverty reduction; and (2) enabling vulnerable groups to develop coping mechanisms to mitigate economic, seasonal, and social shocks and risks. According to him, consolidating the two cash assistance programmes into one served to unify targeting, mechanisms, regulations, and work instructions, as well as

combining records in a single database; this provided a 'safe and dignified life for the poor', enabling them to 'participate in the overall development process effectively and efficiently'. Another PNCTP staff member described the old schemes as suffering from non-transparent working mechanisms and having 'unjust and inequitable targeting and benefit'. She explained they had 'no choice' but to prioritise developing a strategy to consolidate cash transfers under one programme framework, which would require 'less cost and effort' and be 'more achievable in the short term'.

However, three of the five interviewed senior staff of the PNCTP admitted that they did not have full control over the merger decision, and that it was highly influenced by donors. They recalled having proposed four options: (1) maintain the two programmes unchanged; (2) implement some improvements to the two programmes; (3) unify the two into one programme; or (4) create a new programme. According to the staff members, however, donors strongly influenced the final decision, as illustrated in the following quotes, which explain their rationale for choosing the third option:

At that moment we had limited options to choose from and the donors insisted that we should move quickly with the reform, otherwise we would be at risk of delayed support for the scheme. (PNCTP manager: key informant interview)

[T]he first option could not have been selected as it would have kept the service fragmented and would not have achieved the desired goal of the cash transfers. The fourth option was supposed to have started from scratch, and this would have meant the allocation of new budgets, which were not available. The second option was our preference, as we believed that both schemes complemented each other and served different purposes, but donors were hesitant to look into it as it meant that they may have had to commit to further budgets. Eventually, we were left with option three, with a strong guarantee from both the EU and the World Bank that we would receive the technical assistance needed to ensure that the new design would be based on transparent, flexible, and equitable eligibility criteria, suitable for the Palestinian environment. (PNCTP technical advisor: key informant interview)

The World Bank and EU representatives fully supported the government officials' argument that the PNCTP was more effective than its predecessors. They indicated that the current PNCTP is aligned with the MoSA's social protection strategic objectives – namely, to develop

systems for social assistance and empowerment of the poor and marginalised – and also advances the development of social services for vulnerable and marginalised groups. They explained that the new design hugely impacted coverage, reaching double the number of households as under the old schemes. They also emphasised that the new arrangement achieves strong collaboration between the World Bank and EU in supporting the MoSA's development needs. However, representatives of both donors could not explain how this reform affected PWDs.

Despite the fact that the EU funds the programme separately from the World Bank, we both continue to coordinate very closely our efforts to provide necessary technical expertise needed to advance the functioning of the programme. The June 2010 merger of cash transfer programmes advanced the level of collaboration between us. (Representative of the Office of the European Union: key informant interview)

[I]n the past, the European Union funded the Special Hardship Case (SHC) programme and the [World] Bank funded the Social Safety Net Reform Project. Now we both collaborate in funding the PNCTP. We believe that it was the right decision to make, and are continuously supporting the ministry to ensure accuracy of targeting and delivery. (Senior World Bank staff member: key informant interview)

6.2.3. How disability is addressed in the PNCTP

The PNCTP features intended to address disability and disabled family members were found to be limited.

Since 2011, in addition to poverty-related variables, the adopted PMTF has assessed eligibility by measuring household consumption, and has also taken account of extenuating circumstances, such as the presence of a person with a disability or chronic illness. Disability is one of the 31 proxy variables considered in calculating a household's welfare. Once the family declares the presence of a disabled family member, the social worker then requires proof of that member's medical certification. Informants reported that, in calculating the household score, the weighting of disability is relatively minor. Additionally, a disability assessment is required for every family member that has a disability. It is critical to note that, through the programme merger and corresponding move towards household-level proxy means testing,

interventions no longer address the specific and wide-ranging vulnerabilities of PWDs. Indeed, because of its reliance on means testing, which targets households as a whole, the PNCTP is effectively blind to PWDs' needs (Pereznieto et al., 2014). (See section 6.4.1 on the influence of PMTF and the required disability certificate on PWDs accessing the PNCTP.)

Though the cash transfer amount is adjusted in accordance with the number of family members, it is unaffected by either the presence of a PWD member or the number of PWDs in a household. Thus, the PNCTP does not account for the additional disability-related costs incurred by PWDs and their families (see section 6.4.4 on the adequacy of PNCTP benefits).

As members of beneficiary households, PWDs are entitled to free access to other state-provided social services, such as fee waivers for children enrolling in Palestinian government schools and local universities (Jones and Shaheen, 2012). In practice, though, such support is not widely available and is provided on an ad hoc, rather than systematic, basis. Further, schools and universities are not equipped to provide inclusive education to students with disabilities (whether hearing, visual, or mental) (Pereznieto et al., 2014). Additionally, enrolment in and free access to the governmental national medical insurance is granted to all members of households benefiting from the PNCTP.

There are, however, limits to the services covered under this medical insurance for PWDs' disability-specific medical and rehabilitation needs, including required rehabilitation services, specific medicines and equipment, and maintenance-related costs (e.g. batteries for hearing aids, wheelchairs, etc.) incurred by PWDs. This places a significant economic burden on PWDs and their families (see section 6.3.3 on the PNCTP's impact on accessing specialised services).

6.3. Impact of the PNCTP on PWDs' perceived independent living

Responses to PWDs' needs have historically been framed in terms of care, with service models treating them as dependents, passive care recipients, and, in turn, a 'burden' on family and society, rather than as active rights-holders (Pereznieto et al., 2014). Supporting PWDs to have the freedom and opportunities to live lives they value requires a paradigm shift from this legacy of paternalism, dependency, and stigma, towards support as a state obligation relating to human rights, equality, and social justice. Support must give 'voice' to PWDs by enabling them to exercise choice and control over their own lives, irrespective of their impairments, rather than having to follow the views of those managing their needs (UNGA, 2015).

Article 19, CRPD requires the establishment of a range of personalised support services to meet the individual's personal circumstances. This represents, per Quinn and Doyle (2012), a 'silent revolution' in traditional understandings of welfare, abandoning gross proxies of need to focus on the person's life plans and ambitions (p.5). Community services must be made fully inclusive of and accessible to PWDs, requiring a diversion of scarce resources from institutions to enabling community living (UNGA, 2017).

The draft General Comment No. 5 (2017) on Article 19, issued by the UN CRPD (2017), states that '[c]ash transfers such as disability allowances represent one of the forms in which States parties provide support for persons with disabilities in line with articles 19 and 28 of the Convention. Such cash transfers often recognise disability-related expenses and facilitate the inclusion of persons with disabilities in the community' (p.12; see also Quinn and Doyle, 2012; UNGA, 2017). The PNCTP's impact on PWDs' independent living is now examined, based on the specific provisions of Article 19 (Table 6.3).

 Table 6.3
 State obligations under Article 19, CRPD

Rights	Obligations
Article 19(a): The right to choose one's place of residence and to decide how, where, and with whom to live.	 Accessible and affordable housing options must be available within all areas of the community, providing accommodation to PWDs who live alone or as a part of a family. Housing must be affordable to PWDs, which often requires individual subsidies, as PWDs tend to have less income than others.
Article 19(b): The right to access individualised support services must be considered a right instead of a form of medical care or charity.	 Availability of support services and service providers according to the person's individual requirements and personal preferences. In addition to personal assistance, these services might include sign language interpreters and technical aids, such as ICT software and equipment, wheelchairs, guide canes, etc.
Article 19(c): The right to access non-disability-specific community services and facilities used by persons in the community who do not have disabilities.	 Applicable to hospitals, schools, transport, shops, markets, museums, and similar facilities and services. Community services must also be available, i.e. within safe physical and geographical reach of all PWDs living in urban or rural areas. They must be affordable, accounting for PWDs often having low income. They must be accessible to PWDs on an equal basis with others. Services must be adaptable and responsive to the requirements of PWDs in a given community. They must also be acceptable, which means being of the same quality as services provided to the general public, and being gender, age, and culturally sensitive.

Source: Summarised from UN CRPD (2017).

6.3.1. Coverage of PWDs under the PNCTP

Since its inception in 2010, the programme has grown rapidly to cover over 115 (of a total of 12,957) households by 2015 (World Bank, 2017b), compared to 55,000 households formerly covered by the SHC programme before the 2010 merger. Evidence on beneficiaries with

disabilities indicates that more than 50% of PNCTP recipient households have a PWD member (UNGA, 2017, p.14). In a randomly generated quantitative survey conducted on behalf of the Overseas Development Institute (ODI) (Pereznieto et al., 2014), around 60% of all beneficiary households had at least one PWD member; further, the 761 households that reported at least one PWD housed a collective total of 1,349 PWDs, meaning that many households had more than one PWD member. A sizeable proportion were CWDs: nearly 32% in Gaza and around 25% in the West Bank. According to data provided by the MoSA for this research, as at May 2015, the total number of household members benefiting from the programme is 662,742, of which 59,284 (8.95%) are PWDs.

The number of PWDs now covered seems to be much higher than under the two prior schemes. Yet there was no evidence on the reform's impact on PWDs previously benefiting from the SHC programme: having lost their direct and individual financial support, they are now, instead, members of a recipient family.

Among the participants, DPO representatives and recipients with disabilities argued that the reform's design has been potentially detrimental to thousands of PWDs, whereas government officials perceived it as being cost-effective, just, and relevant to the country context. Many PWDs have been excluded from the merged scheme, since unable to meet its targeting requirements, or become members of recipient families deriving hardly any benefit from the cash received. In general, the findings indicate that while many more PWDs are now covered by the PNCTP, as members of households benefiting from the scheme, it is not necessarily as valuable for them as the individualised SHC programme.

According to social workers participating in the four FGDs, the reform resulted in two new realities on the ground for PWDs. First, many recipients under the SHC programme were excluded from the new scheme and left without support because their families failed to meet the new criteria. Second, due to the PNCTP's limited consideration of disability, those who continue to be covered as members of households receiving the transfer are hardly benefiting from it. The social workers also confirmed that within, the PNCTP, they do not influence the decision on entitlement, which diminishes their capacity to support community members with disabilities who they know to be at risk of severe medical complications and social exclusion through inability to access required support.

The social cases individualised scheme was supporting PWD needs such as medication, assistive devices, and transport. The amount varied and the decision was mainly based on our assessment [...]. family income did not matter. We had at least 60% influence over the decision around eligibility. Now it is the computer that decides people's destiny [...] we have lost our credibility in the community. (PNCTP field social worker: focus group discussion)

The ministry knew that the new formula would automatically exclude high numbers of PWDs receiving the SHC grants, that's why they made a quick decision to create a transition strategy over a period of three months to shift between the schemes, in order to reduce the attention. To my knowledge, only 10,000 PWDs of the 30,000-people receiving [under] the hardship programme continued receiving support through the PNCTP. (District-level MoSA staff member: focus group discussion)

Overall, the merger's impact on PWDs access to support has been negative. For thousands of PWDs, the discontinuation of targeted programmes following the PNCTP's 2010 launch has deprived them of valuable support, including the ability to purchase equipment (e.g. provision and maintenance of wheelchairs and hearing aids), personal care items (including diapers and sanitary towels), and access to therapeutic services (Hackstein et al., 2013). Moreover, there is no clear mechanism to consider the impact of the presence of a disabled member in a household whose head is able to work, thus excluding the household from the PNCTP.

In the next two subsections (6.3.2 to 6.3.4), 'participant' and 'interviewee' refers only to those with disabilities.

6.3.2. Impact of the PNCTP on PWDs' ability to choose their place of residence

Under Article 19, the availability and affordability of housing options, enabling PWDs to live alone or as part of the family, are essential to provide the individual with options on where, how, and with whom to live, according to their personal preference.

Discussions with FGD participants and interviewees revealed that, for the majority of PWD participants, independent living meant PWDs' ability to control their lives within the larger family home. Except for five young males, who were hoping to get married and start a family,

PWD participants' ambition was to have full freedom to make their own choices within the larger family context. There were mixed views on the reasons behind that preference.

For male participants, availability and affordability were the main barriers to finding a place to live independently. Inability to afford the rent, home adaptation, and their living needs were three fears behind choosing to live within the larger family. For them, it was the only way to secure some of their disability-specific costs and access help when they need it. The disability type and severity seemed to influence people's choices. For instance, 10 of the 15 participants with hearing impairments were keen to live independently from their families, while all participants with a severe physical disability were not keen to consider this as an option.

The shift from the SHC programme to the PNCTP was reported by eight of the 56 participants to have highly impacted their choice on where to live. They agreed that ceasing to directly receive the cash transfer weakened the power and agency of the disabled family member, and reinforced the pre-existing unequal power dynamic between PWDs and the rest of the family. This reduced PWDs' self-confidence and their ability to live independently and actively participate in the public arena. It was argued by participants that with the transfer received by the household head, members with disabilities had no choice but to take the 'safe route' by staying with the family.

I am 40 years old and still depend on my father to cover my expenses. This is very depressing for me as I see no future for myself. I see how my younger brother got married, has four children, and manages his own shop, and wonder why I have not been able to achieve similar results. We achieved the same level of education and grew up in the same family; the only difference is that I have a disability and he doesn't. I keep dreaming about forming my own family and living an independent life in a small house with my wife and children, but every day I face a reality that makes me doubt this will ever happen. (40-year-old male participant with a visual impairment: focus group discussion)

More than half of PWD participants indicated that, every month, they live in hope but can never be guaranteed that their needs will be prioritised over those (often pressing) of other family members.

Seven PWD participants described emerging tensions within their immediate families following the scheme merger, as they suddenly lost the right to make choices in responding to their many personal daily needs. 'Loss of dignity' and 'frustration' were strongly emphasised by participants explaining the constant cycle of negotiating over living arrangements, such as

having to move back into their family home or share a smaller room with other members to free their own bigger room for 'other useful purposes'.

From the FGDs, it emerged that the PNCTP does not have any linkages to other programmes supporting PWDs' independent living. Providing the financial support necessary for them to live independently and/or providing subsidised homes would allow them to choose where to live. Five participants with physical disabilities explained that, especially in rural areas, there are no accessible flats to rent. Therefore, the only option is to rent newly built flats, which are mostly expensive and need many costly changes to accommodate PWDs. They also explained that there are no laws obliging landlords to cover the costs of required adaptations. This greatly limits the available options for PWDs, who rely entirely on the landlord's 'goodwill' to cover the cost of changes.

One participant explained the challenges and frustration he experienced at being deprived of his 'non-negatable' right to live independently and form a family. He is 24 years old, was born with a physical disability, and uses a wheelchair for mobility. Having never experienced walking, he 'could not tell the difference' between his way he moves around and his brother's who has no disability. He could see, however, that his life course had been much more challenging than those of his slightly older brothers. He spoke in detail of his mother's struggle to take him to school every day, sometimes carrying him to the bus because no accessible transport was available in the village. He recounted the long negotiation required to convince his family allow him to enrol in college, as his father could not be convinced that he would be able to find a job and contribute as his brothers did. The first time he felt the real impact of disability on his life was when he reached 22 and started to contemplate the future. His first goal was to leave the family home as his two brothers had done. He initially tried to find accessible flats close to his family, but the small size of the village and the old style of its large houses, both expensive to rent and difficult to adapt, precluded this option. He then expanded his search to the main city of Ramallah after long negotiation with his mother, who believed he would be incapable of living alone due to his disability. After a long search, he found a small first-floor flat costing USD 450 per month. With no job and no direct financial benefit, he asked his father for support, but faced flat rejection: arguing that the PNCTP cash transfer hardly covered the family's basic needs, his father insisted he should stay with the family until he found a job covering his all costs, as no one in the family could provide him with additional support. He tried then to obtain financial support from the MoSA; they immediately informed him that as his family household was a PNCTP recipient, he could not access any other support. The ministry also informed him that there is no such support for enabling PWDs to live independently, so it would be better for him to stay at home. During the in-depth interview, he expressed uncertainty on what to expect from his future and explained that he could not be optimistic about his chance of living in his own space unless the whole system were to change.

For female participants, the PNCTP was reported in FGDs and interviews to have negatively impacted self-reliance and independence. Four of the interviewed WWDs believed they are more vulnerable that than their male counterparts due to pre-existing cultural, religious, and gender norms, combined with the stigma and negative perceptions of their capabilities due to disability. The four participants indicated that unless they get married – which they believed to be unlikely due to the social stigma around WWD's marrying – their families would strongly resist and oppose their wish to live separately, even if they can afford it. They attributed their families' behaviour to overprotection and a lack of confidence in their ability to manage their lives independently.

For a 27-year-old female participant with a visual impairment, the PNCTP does not support her to take control of her life. She explained that she simply wanted to have her own bedroom, cupboard, and a little space in the house where she can place things as she likes and learn how to move around without assistance. She explained that the money she used to receive under the SHC programme strengthened her role in the family; in supporting her independence to a certain extent, it enabled her to maintain her self-respect and confidence. She described the old scheme as the 'little stick that prevented the tree from falling'.

Another female participant, aged 30 and with a physical disability, had asked her father for money to cover the adaptations to the living room bathroom, which would have enabled her to use it without her mother's assistance. She recalled his reply that 'this money comes to us to cover real costs'. The same views were shared by a third participant: a 23-year-old female with a hearing impairment. She explained that, for PWDs in the Palestinian community, women are considered less capable than men to engage in family decisions around finances, since the household head — which is generally the father — believes that men are more capable of making the right choices. She stated, 'my mother is barely able to influence how the money is spent; how do you expect me, the daughter with a disability, to be able to do so?!' She added:

[T]he fact that the amount is very limited and not even regular, because there is no guarantee that I will get it on a monthly basis, makes it really difficult to negotiate and demand a share of the money. We are eight people in the house. I don't even dare to ask for anything for myself as I know that what my father gets every month basically covers bills, or grocery and food requirements, and is spent on the way home once the payment is cashed before even reaching the house because of debts. (27-year-old female participant with visual impairment: in-depth interview)

One interviewee, a 26-year-old woman from Jenin, was living with 10 other family members in Jenin refugee camp. She has a physical disability and has never managed to find a job, despite holding a bachelor's degree in English literature. She is now covered by the PNCTP, through which the family receives NIS 1800 (USD 450) every 3-4 months. She was previously a direct beneficiary under the SHC programme, which enabled her to rent a small bedroom and accompanying bathroom next door to her brother's house, as she was keen to live independently but remain close to her family. She was very excited during that period and felt she was a very important family member, as she was consulted on larger household matters and participated in decisionmaking concerning the overall family. She believed that being able to contribute financially, even with small amounts of money, shifted her role in the family. Now, since the change from an individual to a family grant, she has had to leave her separate room and move back in with the larger family. She described it as being 'back in prison', where everyone is interfering and she has no control anymore.

I used to cook for myself; now I eat what others decide to cook when they feel they want to eat. [...] feeling independent for one year and a half felt great. Right now, I don't really have a say on anything, even my personal matters, and I have lost my ability to meet my own needs and control my own life. We are 11 family members in three rooms. It is a crowded space, and as a female, I don't dare to speak up and ask for money unless it is given to me. (in-depth interview)

The above findings suggest that, as regards advancing PWDs' independent living choices, the PNCTP's contribution has been limited. In the absence of additional government support to cover PWDs' costs of living independently, the amount provided to the family under the PNCTP cannot contribute to PWDs' preferred living arrangement choices. The implications seemed to be greater for participants with physical disabilities. The shift in who receives the cash and the move from an individualised scheme to a 'one-size fits all' approach has not promoted PWDs' independence, instead limiting their capacity to make decisions concerning their own wellbeing.

The PNCTP was also found unresponsive to the intersecting forms of discrimination faced by WWDs, which seriously affect their independence within the larger family setting. WWDs reported additional social and cultural barriers to accessing their desired living arrangements.

6.3.3. Impact of the PNCTP on PWDs' access to individualised support services

Under Article 19, the availability of support services – such as personal assistance, sign language interpreters, and assistive devices – is essential to meet individual requirements and personal preferences.

As discussed in earlier sections, the MoSA still offers some disability-related services, such as the provision of basic assistive devices, but these tend to be severely understaffed and under-resourced relative to need levels. Further, these programmes appear to operate almost independently, with very little coordination and integration with the PNCTP or other complementary services. In interviews conducted for an ODI study (Abu-Hamad et al., 2015), one MoSA official acknowledged that 'there is no clear strategy for disability', and another that 'we used to help the disabled but not anymore'. In the same study, a National Society for Rehabilitation official argued that, whilst PWDs previously received targeted support under the SHC programme – e.g. transportation fees and special assistance – the cash transfer merger left them almost entirely dependent on NGOs and inconsistent donations to cover their access to basic services.

Almost all of the 56 PWD participants reported being unable to afford access to such services, and agreed it was not being supported by the PNCTP. They explained that cash amounts under the PNCTP were insufficient to meet these additional expenses, and the PNCTP has no links to any other programmes that could fill this gap.

PWD participants identified several key barriers limiting their ability to live independently: space control, autonomy in daily living activities, choice of where to go and when, decisions on how to spend available resources, and the ability to access support services. The majority agreed that the PNCTP fails to meet their needs, as it neither provides additional finance to cover their costs nor links them with free or affordable support services.

Table 6.4 presents the main support services reported by FGD participants to be crucial for their independence, and which require additional cost to ensure timely access.

Table 6.4 Types of support services needed by PWDs in Palestine

Type of Support Service	Number of participants reporting service:		
	Needed	Available	Affordable
Assistive devices, such as mobility	56 participants	25	12 (equipment used
and hearing aids, screen readers,			by persons with
white canes, braille materials,			visual impairments)
orthotics and prostatic devices,			
etc.			
Personal assistants	41	7	0
Sign language interpreter	15	4	2
Home adaptations	25	25	0
Accessible transport	25	5	7
Medical and hygiene products,	18	18	5
such as catheters and diapers			
Disability-related medication	25	19	7
needed on a permanent basis			
(supporting incontinence,			
spasticity, chronic pain, etc.)			

In the FGDs, access to assistive devices was reported as needed by every PWD participant, representing various disability types, yet these were available for fewer than half, and fewer than a quarter reported being able to afford the services. The main barriers presented by participants were as follows:

- The majority of assistive devices needed are not covered by medical insurance. The
 only way to obtain financial coverage is through the Office of the President or having
 strong connections with high-level government officials.
- The few assistive devices (such as a walker or crutches) offered by the MoSA only serve persons with minor physical impairments and are of poor quality.
- Wheelchairs, orthotics, and hearing aids are provided by NGOs and private companies
 in the main cities. Participants with physical and hearing impairments indicated that
 these services are very expensive and hard to reach, given their limited availability at
 local level.
- NGOs providing assistive devices have a preference in terms of disability type and geographical coverage, leaving many PWDs no option but to buy from private companies in Palestine or Israel.
- There are no financial schemes supporting the cost of the required equipment, while charity organisations may only cover a very small amount, forcing the PWD or their family to borrow money to cover the rest.

It is my legs. Would someone question your need for your legs? I constantly need to change my wheelchair because our village has very bumpy roads. Getting a new wheelchair is a struggle each time as I have to almost beg for the money from around 10 organisations and borrow the rest until I manage to gather the cost of the new chair [...] I am not a VIP and none of my family members are; that's why I am never able to get financial coverage from the government to cover the cost of my chair. (25-year-old male participant with a physical disability: in-depth interview)

Five participants with hearing impairments explained that only two main service providers offer sign language interpreters, operating in the cities of Ramallah and Gaza. The services are not just limited in availability but also very expensive. For example, one participant had paid NIS 150 (USD 35) for an interpreter to accompany him to a four-hour workshop. All five participants agreed that there is no funding available to cover the cost of such services; consequently, they mainly rely on family members to accompany them wherever they go, as almost all services throughout Palestine have no sign language interpretation available.

I had to leave university because I could no longer pay for someone to support me with sign language interpretation during lectures. In my first year of study for the English Literature bachelor's degree, I used to take my sister with me to do the signing. I had to pay for her transport and it was always a challenge to ensure she was available when I needed her. At the start of the second year, she got married, so I was left alone and started to hire a professional signer, as the university couldn't offer that service to me. Unfortunately, I had to drop out before the end of that semester as my father couldn't financially support me anymore, and I couldn't find any external help. (31-year-old participant with a hearing Impairment: focus group discussion)

In the FGDs, 25 participants with physical and visual impairments confirmed that personal assistants are essential to support their meaningful independence and participation within the family and community. Yet almost all expressed their daily struggle because such services are either absent or not covered by any available system. Reliance on other family members for support seemed to be the norm. However, the implications of such reliance on both the individual PWD and their family seem very negative: in explaining their inability to access the services, PWD participants frequently cited 'dependency' and 'powerlessness'.

'Lack of privacy' was another concern, as demonstrated by the following example:

I can't decide on things on my own. Because my sister is with me all the time for support, she feels she has the right to know everything about me, and in many instances, she even interferes to influence my choices. I don't know what to do to change. I am simply stuck. ... [M]y chances of bathing and eating when I want are dependent on other family members' availability... I feel so humiliated asking my mother every other day to wake up earlier to help me shower. (30-year-old female participant with visual impairment: in-depth interview)

In the FGDs and interviews, 17 participants expressed their concern that having to use a family member as a personal assistant affects the family as a whole, whether through lost working days or, when the assistant is the PWD's mother or sister, lost housework time. They also explained that having a family member as a personal assistant violates one's own personal life and constrains daily choices.

Three male participants in the FGDs shared their daily experience of compromising on personal activities outside the house, which have to be planned according to their assisting family member's availability and willingness to accompany them to medical appointments, job interviews, the shops, etc. One participant, who has severe physical disability and uses an electric wheelchair, explained that he can only leave the house on Saturdays because his older brother, on whom he relies to support his needs, works every other day. He said that his family cannot afford for his brother to work even one fewer day per week. Consequently, he often feels guilty for depriving his brother of his only day of rest, and so has frequently cancelled plans, including even those he considers important.

A female participant shared her experience of using her sister as a personal assistant during an in-depth interview. With four sisters and three brothers, her small house is, for all her family, a 'crowded space with no privacy', but especially challenging for her. She has struggled to have a life of her own, especially as regards personal and emotional matters that are usually preferred to be known by other family members in Palestinian culture, such as going out to meet a person she likes or buying things for herself. Her inability to move around without physical assistance left her with no choice but to involve her sister in such matters. She repeatedly recalled the period when she benefited from the SHC programme, which gave her the privilege of choosing how and from whom to receive support.

All of these 17 participants wanted the option to hire a personal assistant outside their own family, both to reduce their family's financial burden and to grant them a higher level of personal control and power over their daily lives.

Furthermore, 10 participants with physical disabilities explained that they routinely face risks of medical complications: with no provision for their daily requirements of specific medications and medical disposables, such as catheters, diapers, etc., they constantly struggle to meet those costs. As the 10 participants explained, while the free medical insurance they receive under the PNCTP should support them to secure all their medical needs, such items are, in practice, completely absent from the MoH's medical stores and pharmacies. Eight wheelchair-users with physical disabilities also raised the costs associated with home adaptations: even though this is a one-off cost, they have not been able to obtain financial coverage to make their houses fully accessible for them. Consequently, they are unable to move independently within their home environment. Two of them revealed being unable to access parts of their houses due to stairs or narrow doorways.

The final barrier raised during the FGDs by participants with physical impairments, predominantly wheelchair users, was the availability and affordability of accessible transport. According to 13 participants, public transport is inaccessible and private companies see no potential market in providing accessible transportation. The only such services available are the few accessible cars used by NGOs providing rehabilitation services, or the one or two cars operated by private companies in a few main cities. The use of medical ambulances was cited as many people's last resort to move between cities, especially in areas with many Israeli checkpoints. All available services were reported to be very expensive, costing five times the usual standard fare; unsurprisingly, this was not affordable to any of the participants.

When I was part of the old programme, I received NIS 1200 [USD 300] every three months. I was using the money to cover transport and personal support. Since 2011, my life has turned upside down. Not only do I not have the money anymore, I am also now unable to control when I can go out, as it all depends on when my brother is free, and sometimes it requires some negotiation and convincing to make him agree to take me out. This is really humiliating for me. (33-year-old female participant with a physical disability: focus group discussion)

From discussions with FGD participants and interviewees, it became clear that the amount their families receive through the PNCTP cannot contribute to the cost of the above services: the sum is very small, and the household head holds power to decide how it is spent. There

was no indication that any of the provided cash is allocated to the disabled family member's needs.

[M]y needs are not well taken care of, not because of injustice but because of the overwhelming needs of the family members that are not covered by the grant. Every month, I have to ask my mother to try to convince my father to give me some money to cover at least some of my disability needs. As a result, I almost always end up using diapers all the time, as I can't afford both diapers and catheters. This causes me further urinary tract infections and forces me to stay at home out of embarrassment. (25-year-old female participant with a severe physical disability: in-depth interview)

In summary, the above findings indicate that the PNCTP hardly supports PWD recipients to access support services, which are essential for their independence and enabling them to access other services, such as education and employment.

6.3.4. Impact of the PNCTP on PWDs' access to non-disability-specific community services

The third obligation on countries under Article 19, CRPD is to ensure the availability, affordability, adaptability, and acceptability of non-disability-specific community services, such as hospitals, schools, and shops.

Similar to their experiences of access to support services, most FGD participants and interviewees reported hindered ability to access essential mainstream community services due to limited availability and high cost. The main services highlighted as priorities to enable the participants' independent living comprised access to rehabilitation, economic empowerment programmes, and support to access waged employment services. The findings indicate that, in linking PWDs to required services, the PNCTP's role is very limited for the following reasons.

Limited financial coverage of rehabilitation services under the free medical insurance

In addition to the cash transfer, PNCTP beneficiaries are entitled to free medical insurance, covering all required medical services. Aside from those with physical disabilities, all FGD

participants agreed that the provided insurance usefully supports their access to primary and tertiary healthcare services. For 15 of those with physical limitations, access was more challenging due to the limited accessibility of health service infrastructure. Even where services are available within their community, not all of these services are physically accessible for PWDs, as many local clinics have stairs and lack accessible toilets. For example, three female participants with physical disabilities reported that their access to gynaecology clinics is very limited: the only accessible clinics they can reach are in main cities, requiring additional cost and support from the family and resulting in further medical complications due to the delays to reach the right clinic.

In our culture, it is believed that visiting the gynaecologist is only linked with pregnancy, so they never expect someone like me, a female with a disability, to need that service. Two years ago, I suffered from continues bleeding and was advised to see a gynaecologist. I called five clinics in our city and none was accessible because they all had stairs. My mother then decided to support me to attend a private centre in Ramallah to seek support. We had to pay NIS 500 (USD 120) to reach the centre and pay for the doctor. The moment we entered, I realised another problem: the medical bed was really high and not adapted to adjust to my wheelchair level. We struggled to find a nurse willing to help my mother lift me onto the bed to allow the doctor to examine me. (25-year-old female participant with a severe physical disability: in-depth interview)

I can't deny that having free medical insurance is useful for me, allowing me to go to the doctor when I am ill, but the problem is that in our village there are no health centres that are accessible. Each time I need to see the doctor, I have to go to the main hospital in Hebron to get the service I need, and that costs me a lot of money. (25-year-old female participant with a physical disability: focus group discussion)

Another reported challenge regarding medical insurance was the earlier-discussed issue of limited cover for disability-specific medications. With no other means available through the PNCTP to cover such costs, participants reported that they and their families must bear this significant economic burden.

The biggest concern for 20 participants was the ability to afford needed medication. Those with physical disabilities reported that, despite being covered by medical insurance, they can scarcely ever find their prescribed medication in MoH pharmacies. A 27-year-old male with physical impairment (from the southern rural region of Hebron) explained that he spends 'NIS 400 (USD 120) on a monthly basis to cover the medication [he needs] to control [his] muscular spasms'. He described his routine of attending the local MoH clinic every month to obtain the medication; on nine occasions in every ten, he is informed, 'we don't have it in stock, come next month and maybe we will have it by then'; but they never do.

A third reported limitation emerging through the FGDs and interviews is that the medical insurance does not ensure access and coverage for rehabilitation services. Eight interviewees reported a wide range of needed rehabilitation services, which mainly serve persons with physical or hearing impairments, such as physiotherapy, occupational therapy, and speech therapy services.

As these eight interviewees explained, limited access is attributable to almost all of those services provided by either NGOs or private businesses. Securing a referral to cover such services through the medical insurance was reported as a major challenge, particularly when inpatient services are required (see section 6.1.4 for further discussion of limitations in the existing referral process). In the best-case scenario, it was indicated by 11 participants that a small number of referral applications might receive partial coverage for limited services, which has to be renewed in cases of extension of covered treatment.

A 25-year-old female participant with a physical disability shared her experience (two years' earlier) of trying to obtain the MoH's approval to cover her physiotherapy sessions. She needed support in using the new walking assistive device provided by an INGO working in her village.

I cried with joy when I put that new brace on, as I was so excited to be able to walk again after five years of being in a wheelchair. My family could not afford the walking device after I lost my leg as a result of falling from an olive tree while picking olives. The doctor at the society said that I would need physiotherapy sessions to train me on how to use it. It has already been one year, and I am still unable to find the support I need. The brace is still placed at the corner of my room and I am losing hope of being able to walk again. (in-depth interview)

Forty-two FGD participants indicated they have no control over choosing the service they need, such are the limitations on services provided by the government through the medical insurance. Consequently, most reported ultimately using the least-costly services, even when they know such services lack quality. For 13 participants with physical and hearing impairments, the PNCTP's impact on covering their rehabilitation needs is marginal, as they receive insufficient support to cover the required service or the link to free or affordable services.

Last year, I needed speech therapy sessions at al Nahda rehabilitation centre in Ramallah after I got the new hearing aid. Despite many attempts to get the required referral through the medical insurance, I ended up having to pay for the service because I was unable to get the coverage from the ministry. The result was that I could only afford three sessions out of the 15 I needed due to limited financial resources. I couldn't ask my father for more as I know that the monthly amount we get from the MoSA hardly covers other basic family needs. (34-year-old participant with a hearing impairment: focus group discussion)

Poor disability-related linkages between the PNCTP and the Deprived Families Economic Empowerment Programme (DEEP)

Participants in seven of the eight FGDs highlighted that they do not benefit from existing economic empowerment programmes designed for poor families receiving the PNCTP benefit. The main programme discussed was the DEEP, whose objective is to improve the living conditions of deprived Palestinian families, contributing to a revitalised Palestinian economy. The programme supports self-employment and micro-enterprise development as means to reduce unemployment, achieve higher economic growth, and reduce poverty. In particular, it aims to expand opportunities for members of deprived Palestinian families to become entrepreneurs, by providing them with financial and business development services (UNDP, 2008).

In the FGDs and interviews, 20 PWD participants raised the following challenges for benefiting from the DEEP, despite being part of families eligible to participate as PNCTP recipients, which is one of the main criteria for inclusion:

- In its eligibility criteria, the DEEP gives no special consideration to families with PWD members, who may be more vulnerable and at greater risk of remaining in poverty than other PNCTP recipients.
- Available vocational training and financial and non-financial services are not accessible
 to PWDs. Most of the vocational training centres are not physically accessible to
 PWDs, and there is no consideration of other accessibility requirements, such as sign
 language interpretation, in the provided training schemes.
- Preconditions to access microcredit loans are very difficult for PWDs to comply with,
 especially the requirement of two guarantors, as many family members may be less
 keen to support due to false assumptions around PWDs' capabilities to develop their
 own businesses.
- 4. Information about the DEEP is not fully accessible to persons with visual and hearing impairments.
- 5. The DEEP gives no specific attention to the additional barriers to WWDs accessing the provided services, in terms of eligibility, availability, and adaptability of the skills and opportunities provided.

Despite high interest, participants reported that very few PWDs have benefited from the DEEP and other business development schemes. Twenty participants stressed that PWDs are not well targeted within the DEEP, and more attention to the importance of developing strategies that ensure more disability-inclusive targeting is greatly needed.

Five participants explained that the programme's design does not ensure the effective mainstreaming of disability. Their experiences in applying for the existing micro grants or employment programmes indicate that the whole system is insufficiently inclusive of PWDs. One example concerned the lack of understanding of disability among implementing NGO partners, which results in orientation and interview sessions being organized on the second and third floors of buildings with no physical access or the failure to provide sign language interpretation. Another example was the referral to computer training centres that do not provide the software needed by trainees with visual impairments.

A 36-year-old male participant with visual impairment indicated, during an in-depth interview, that he first heard about the programme while attending a workshop organized by the MoSA. He remembered very clearly that the presenter introduced the programme as an innovative initiative supporting the most marginalised Palestinians to become economically empowered:

I was encouraged to hear that day that the programme has already supported more than 25,000 poor families and provided job opportunities for thousands of young Palestinians who are keen to work. I remember very well raising my hand and asking about the number of PWDs supported so far, and I also remember very clearly the standard answer I received. They stated that while they do recognize the importance of disability inclusiveness in the programme, this was still a work in progress, and they were now working on strengthening that element in their targeting.

Ten of the 20 participants who commented on the DEEP indicated that they would not even try to apply for the programme, as they know from others who have done so that their chances of acceptance are very minimal. They also attributed equal responsibility for their exclusion from the programme to the MoSA and the UNDP, the latter being an international body expected to protect their rights.

Absence of linkages between the PNCTP and existing disability-specific self- and waged employment opportunities

In the FGDs and interviews, most participants were keen to gain their own income but expressed that the cash transfer's effect on their access to livelihood opportunities is marginal or even negative. Thirty-five PWD participants reported that the fear of their family losing the PNCTP transfer – receipt being preconditional on all family members' inability to work – prevents them from seeking jobs or applying for available programmes supporting waged or self-employment opportunities.

Regarding limitations of their access to self-employment programmes, 15 participants shared their frustration that they cannot apply for the Fund for the Rehabilitation of PWDs as this could risk their families' eligibility for the PNCTP. As indicated in earlier subsections, the Economic Empowerment Fund is a pool of funding managed by the MoSA to provide PWDs with interest-free loans to develop their own businesses. However, one of its main eligibility criteria is that the applicant is not benefiting from any other in-kind or cash transfer programme provided by the MoSA.

The following experience of one participant, expressed during an in-depth interview, illustrates the PNCTP's failure to support PWDs to benefit from the Fund. He is 38 years old and lives in a village near Jenin. He has had multiple impairments since birth, causing speech and physical limitations. He is married to a woman from the same village with moderate learning difficulties; they have two children born with the same condition as their father and cannot attend school because he cannot cover their transport costs.

I am responsible for the four of us. I have to secure food, clothes, and medicine for all of us. Many days I go to sleep hungry because I know that we don't have enough food for everyone. I get NIS 750 [USD 250] every three months from the ministry. They know that this is not enough for us. I tried many times to explain to them that the four of us need rehabilitation and medication that will cost us more than the amount they give us. Every few months, they agree to give us a box of food, but that is not what I want. I want to work and get more money for the family.

[...]

I used to have a small mobile cart that I sold sweets from to school children in our village. But, last year, the social worker visited me and said that I should not do that, as if the ministry were to find out about it, they would stop the transfer. I also tried to get a small loan from the ministry to open a small shop, but I had to withdraw my application because I was told that they would stop the transfer if I got the loan. I got scared because, for me, at least I know now that we have something coming every three months, even if it is not enough [...] I am very angry that our community perceives us as the disabled, poor family who is helpless and in need of charity support. I want us to be economically independent of external support, but I don't know how to achieve that.

Access to waged employment is generally very limited for Palestine's PWDs, but even harder for PNCTP recipients. According to the *Disabled Individuals Survey 2011: Main Findings Report* (PCBS and MoSA, 2011), both the employment rate and average education status is lower for working-aged PWDs than their non-disabled peers (for instance, 50% of working-age PWDs had either never attended school or attended school only at elementary level, compared to 18% among the working-age non-disabled). Additionally, comparing working-age individuals, a PWD is 33% less likely to be employed than a non-disabled person.

Discussions with participants in FGDs and interviews revealed that the current public-sector quota system for PWD employment has no links with the PNCTP; consequently, PWDs must choose to either be employed through the quota system or benefit from the PNCTP as a recipient family member. The respective regulations of both systems prohibit PWDs from simultaneously participating in both.

Twelve participants in the FGDs and interviews indicated that they 'gave up' applying for government jobs because the quota system is not put into practice and, where they are offered a job, it usually does not match their qualifications and is based in a main city with an income exhausted on job-related accessible transport and/or personal assistant services. Testimonies from 37 participants in five FGDs show that, until they have better chances to access sustainable and economically rewarding employment opportunities, they prefer to remain as members of families benefiting from the PNCTP scheme, which at least guarantees meeting their shelter, food, and other basic needs.

Fear of losing the grant by pursuing an opportunity without guaranteed success was their main concern. Most of their feedback centred around lack of trust in the government's claimed commitments to equal and fair employment opportunities for PWDs. One participant with a visual impairment, who graduated from university with an bachelor honours degree in History, explained that he was strongly encouraged by family and friends to apply for a History teacher position at the MoE. He successfully passed the written test, but after the final interview, his only rival for the position was hired instead, despite his social work degree being poorly matched to the post. He, therefore, concluded that the second candidate was most likely preferred because he had no disability. Participants were also concerned by the cost effectiveness of sacrificing a small but sustained amount of money for a potentially larger but uncertain income opportunity. The other issues they raised concerned equal pay for PWDs compared with others, as the costs of transport to work, hiring support workers, and work adaptations are not considered.

Another participant with visual impairment reported that he was offered an interim three-month job as an administrative assistant at the MoL in Hebron. His first day at work was a very disappointing experience, as his employer did not provide the software program enabling him to perform his job, despite having promised to do so. Consequently, he had to buy the software using his own salary, which cost 50% of his income for the whole three months.

The following experience of a 30-year-old female participant with a visual impairment illustrates another example of the discussed challenges for PWDs to access employment opportunities when enrolled in the PNCTP.

It mainly expresses the additional power dynamic barriers facing WWDs who consider exiting the PNCTP:

I had to give up my job at the municipality when my family applied for the MoSA's financial support. We were told that if the social worker were to see in the application that I am working at all, the application would be rejected. When I sat with my brother and made the calculations, we realised that if we received the maximum amount from the cash programme, the family would get more money than what I was earning, as I spent half of what I got on accessible transport. I am so sad now that I accepted that, as I now have no resources at all, but I had no choice then as my father insisted I should do it. (in-depth interview)

Four participants who formerly benefited from the SHC programme explained that it did not prohibit recipients from working: on the contrary, they were able to cover the additional costs to reach work from the money they received under that programme, enabling them to benefit fully from their salary to cover other additional needs.

The above findings suggest significant limits in the PNCTP's ability to advance PWDs' independent living, as stipulated in Article 19, CRPD. Participants' feedback confirmed that the PNCTP has limited impact in supporting PWDs to choose their preferred living arrangements and access the required support and mainstream community services essential for them to enjoy an independent life.

Additionally, the shift in who receives the cash and the move from an individualised scheme to a 'one-size fits all' approach has not promoted PWDs' independence, instead limiting their capacity to make decisions concerning their own wellbeing. The findings also revealed that the scheme is not responsive to the different needs of PWDs according to their disability type, and does not consider the other intersecting forms of discrimination facing WWDs, which can put them at higher risk of exclusion from the available services.

6.4. Critical factors influencing the PNCTP's impact on PWDs

This section considers the main elements of design and implementation that have influenced the PNCTP's impact on PWDs' independent living.

6.4.1. Access to the PNCTP

In every FGD, PWD participants identified multiple factors affecting their interaction with and access to the PNCTP. The main reported barriers concerned limited access to information, the application process, and the physical accessibility of assessment centres.

Access to information: In six of the eight FGDs and two in-depth interviews, participants agreed that lack of awareness about the programme's eligibility criteria, application procedures, and grievance policy affects their access to the PNCTP. They explained that they did not know where to find information explaining the programme's operation. Participants in the remaining two FGDs reported visits to their district MoSA offices or information broadcasted through the media as the source of their knowledge about the PNCTP. Additionally, PWDs living in remote areas reported being less connected with DPOs, causing their knowledge around disability services, including cash benefits, to be very limited. Most participants with visual or hearing impairments reported that existing communication on the programme is not adapted to their needs. Additionally, WWDs reported further challenges, as they are less likely to engage in family or community discussions due to negative attitudes, social stigma, and overprotection, as illustrated in the next quote:

I hardly watch TV as it is in the living room that has two steps, so I can't always be there unless my older brother is in the house to help me in because of my wheelchair. This is the first time I have heard about the programme. I always wanted to continue my education, but my father kept saying he couldn't afford my transport costs to go to school. Now that I know that we are getting support, I will ask him again. (22-year-old female participant with a visual impairment: focus group discussion)

Both female and male participants highlighted the need for better understanding of eligibility criteria and how the disability assessment is linked to the PNCTP. When asked about these criteria, respondents gave conflicting answers. Some said it is 'money given to my family because I am disabled', while others said, 'we get it because we are poor'. Participants in four

FGDs indicated that they did not know details of who can receive the transfer or how. Their confusion around the assessment process is illustrated in the following quotes:

Waiting for my turn on the day of the assessment, my mother started asking people waiting what is the required percentage to get approved for an MoSA grant. One said it has to be 100%. Then, another lady said that it needs to be above 60% for you to be eligible. (26-year-old female participant with physical impairment: in-depth interview)

The whole disability assessment process took five to seven minutes. I was given a paper indicating that I have 65% disability. After all that suffering, our family application was not accepted, and I always wondered if the percentage provided to me was the reason behind that. (21-year-old male participant with a hearing impairment: focus group discussion)

The process started with a request from the social workers for me to prove my disability. No one guided us on what to do, and our understanding was that we should be eligible because we are in a family that has four members with a disability, and none of us is working except my elder brother, who works as a cleaner in Israel. (36-year-old male participant with visual impairment: in-depth interview)

Application process: In six of the eight FGDs, participants reported that the application process and required administrative procedures were very lengthy and complex. Specific concerns were raised regarding the required disability assessment, which entails additional processes and frequent visits to different departments. According to the majority of beneficiary participants, the application process takes between three months and two years, which was perceived as 'unfair' and 'tiresome'. No financial support is provided to applicants during the application process, and approved grants are not backdated to cover the application period.

A divorced 34-year-old woman with a visual impairment, who has one child, explained that it took two years and several contacts with MoSA social workers before she was approved as eligible for the PNCTP. In two FGDs, participants explained the implications of that delay for their health and wellbeing: in the meantime, they had no access to free medical insurance and their families could not afford to fund all their medical and rehabilitation needs.

For former recipients under the SHC programme (21 participants), frustration was even higher. Because they were very familiar with the simplicity of that scheme's application procedures, 18 of them indicated that the PNCTP procedures are too complex and time consuming for families with PWD members. Their frustration was very evident:

Receiving the disability grant was a life changer for me, but I was informed in 2011 that the system will change and I may not continue receiving the support. We received a letter informing me that the programme had stopped and for me to be considered for future support, my family should apply for the new programme. The letter did not explain anything about the new programme or even provide any guidance on how to apply. We then struggled for months to try to understand the new system and realised that it is no longer only me getting the support and that the whole family needs to be assessed, and that, in any case, I will not be anywhere near where I was before in terms of support. That was a day I will not forget. My family application was rejected, and since then I am struggling to manage my needs. (27-year-old male with a severe physical disability: in-depth interview)

Accessibility of application and assessment centres: Participants in five FGDs agreed that the MoSA's local offices and MoH's disability assessment units are not physically accessible for PWDs. They are usually located on upper floors with no lifts; there are no ramps or accessible toilets; and none of the buildings has any signage to guide people with visual impairments. One participant shared the humiliating and embarrassing experience of having his medical assessment at the inside of main entrance of the MoH's central office in the north, as he could not reach the second-floor room where the meeting was being held. The next quotes illustrate participants' reported experiences with physical access:

If you are a person with a disability and want to visit the MoSA to ask about something, this is a big dilemma because of the MoSA's inaccessible offices. Most [PWDs] need to visit the MoSA office at least once a year to get a support letter to allow them to renew their disability assessment report, which is required for the [PNCTP] and other services. They could be waiting in the street for at least two hours until the social worker finds the time to come to help. (34-year-old male participant with physical impairment: focus group discussion)

I am a wheelchair user and needed to be seen by the Medical Committee. The only way to do that was to be carried up to the third floor via the stairs. I didn't want to do this as I feared falling, but didn't dare tell my father no, all I could do was close my eyes and pray that I will not fall while going up. (26-year-old female participant with physical impairment: in-depth interview)

Similar accounts were echoed by participants with hearing impairments, who reported the absence of sign language support services at every MoSA office.

6.4.2. Payment methods

The findings revealed that PWD recipients, particularly those with visual and mobility impairment, face major difficulties in accessing PNCTP payments. Most of the factors reported as influencing access were disability-specific difficulties, with greater implications for persons with severe physical disabilities due to their high-level accessibility requirements.

Five FGD participants who head households, and so are direct recipients under the PNCTP, indicated that payment procedures i.e. via a bank affect the transfer amount they can use because they cannot access the grant themselves. Two main difficulties were raised. First, banks are generally only located in main cities, requiring applicants to pay extra costs to collect the cash. They have to travel long distances in expensive private transport, due to the absence of accessible public transport and the need to bypass many checkpoints, forcing them to take longer routes. Second, many banks are not accessible to customers with visual impairments; therefore, they advise the recipient to open the account in the name of another, non-disabled family member. Both issues were reported to cause additional expenses and delays in receiving the grant, in addition to the loss of power over who receives the money and decides how it should be spent.

We live in a village near Ramallah. We have to pass through two Israeli checkpoints to reach the main city. One of those checkpoints requires you to be out of your car and pass through a very narrow electric gate to get in. My wheelchair does not fit in, which means I have to either go through a risky and humiliating negotiation with the soldiers to allow me to stay in the car or go around the checkpoint along a very rocky, risky road, which usually costs me twice the money and causes additional delays. (24-year-old male participant with physical impairment: in-depth interview)

[The] bank regulations will not allow me to open an account because I have a visual impairment. Their excuse was that they need the account holder to sign for payment checks along with other documents. I told them I can use the cash machines, but they stated that none of the ones they have provide the voice or braille option. The account ended up in my brother's name and I used to fight with him over each payment, as he used to spend at least a third of the money before he would come home and hand me the remaining amount. (25-year-old female participant with physical impairment: in-depth Interview)

6.4.3. The specific targeting mechanism

Forty-nine PWD participants agreed that the PNCTP's targeting and assessment mechanisms are important factors in determining the inclusion or exclusion of many eligible PWDs. Except for donors and senior PNCTP staff, participants argued that the existing setup of the PMTF and disability assessment urgently need revising to ensure better targeting and inclusion regarding disability.

Among the DPO and human rights organisation representatives and social workers, almost all stressed the importance of reshaping the PMTF questions and weighting in accordance with the 2011 PECS, as it is more accurate concerning disability.

A PCBS representative explained that the PNCTP's targeting mechanism relies on a PMTF, rather than categorical-based targeting, which was the mechanism used before the World Bank became involved in Palestinian social protection in 2004. In line with the PNCTP's aim of assisting extremely poor households, Palestine was the first MENA country to target cash transfer programming according to a consumption-based PMTF that estimates each applicant household's welfare, administered by social workers during regular home visits. The MoSA adopted definitions of the poverty line and extreme poverty line in accordance with PCBS data, and has also attempted to standardise methodologies and targeting criteria across the various donors and agencies implementing social assistance programmes. However, in practice, progress in standardising targeting criteria has been slow due to differing institutional objectives.

Social workers in two of the four FGDs with the PNCTP's staff illustrated how the PMT assessment is performed:

- Households apply for the PNCTP by completing a questionnaire.
- The information provided is entered into the unified database, which calculates a total
 consumption score using a multiple regression analysis, taking into account 31 proxy
 variables measuring different aspects of consumption. The regression model was built
 using indicators from the 2007 PCBS Palestinian Expenditure and Consumption Survey.
- Households deemed eligible based on this score are visited by a social worker to validate the information supplied.
- The PMT calculation is then run a second time, based on this additional information.
 Households again found eligible are approved for enrolment.
- The consumption of each beneficiary household is reassessed after one year through home visits by social workers, and the amount of cash assistance recalculated according to whether the situation has worsened or improved.
- Ideally, in situations of significant improvement, households are phased out of the programme gradually, over a period of up to six months.

The findings highlight the importance of updating the PMTF to better align with the reality in Palestine – reflecting any fundamental changes in expenditure and consumption levels – and be more sensitive to disability, accounting for the relevant determinants. The range of issues raised in relation disability will now be considered in detail.

Based on the 2007 PECS, a set of 34 variables was selected to calculate the welfare indicator in the PMT score. The welfare indicator is the per adult equivalent monthly household consumption expenditure and is similar to the indicator used by the PCBS to produce poverty estimates for Palestine. The consumption aggregate used for the PMTF's purposes includes expenditures on food, alcohol, and tobacco; the imputed value of self-produced non-durables; and the non-adjusted value of assets. However, it excludes the value of imputed rent for households that own their dwelling. By contrast, the 2011 PECS gathered information on the following idiosyncratic and covariate shocks, as well as substantial financial changes: (i) the main breadwinner lost his/ her job; (ii) the family lost its business; (iii) the family lost its property (e.g. house, agricultural land); (iv) the family has difficulties in accessing the workplace, market, or land; (v) the family loses assistance; (vi) the family loses all or part of a salary or experiences a delay in receiving it; (vii) the family experiences a rise in food prices; and (viii) other shocks.

Having been developed using the 2007 PECS findings, the weighting of the questions in the current PMTF does not reflect the actual situation on the ground. The following key concerns were identified regarding the PMTF's ability to capture the actual realities of considered households:

- 1. The PMTF does little to identify households facing other shocks (those unrelated to an increase in food prices). One social worker suggested that additional filters should be used in combination with the PMTF to address other shocks. For example, the MOSA could address shocks related to job loss by using the PMTF and community targeting to identify households with at least one employed member.
- Except for enquiring whether the family has refugee status, the questions neither
 consider context nor reflect the additional vulnerabilities facing Palestinians due to the
 occupation. For example, households in villages surrounded by Israeli checkpoints face
 the additional financial burden of circuitous routes to cities.
- 3. The PNTF is not gender-sensitive and does not consider the additional challenges faced by female-headed households. The variables indicating whether the household is headed by a male or a female have large and significant weights in the PMTF but differ little in magnitude: -0.254 if the household head is male and -0.275 if female. Three social workers indicated that the PMTF should be revised to analyse this issue in more depth.
- 4. The West Bank and Gaza differ greatly in many respects, yet that is not reflected in the PMTF's weighting. A World Bank poverty report (2011b) found that many of the factors associated with poverty are more strongly present in Gaza than in the West Bank: for instance, poverty is higher for every household size, and unemployment of the household head has a stronger association with poverty. Furthermore, the returns to education are lower in Gaza than in the West Bank.

The current PMTF accounts for the occurrence of disability by using the existence of at least one disabled member in the household to predict consumption (or, equivalently, to construct the score). The sign of the coefficient is negative (meaning that households with at least one disabled member have lower consumption), but the coefficient itself, -0.059, is small and not significantly different from zero, meaning that it does not significantly affect the decision. The way disability is defined in the 2007 PECS was raised as another justification for revising the PMTF. The question for defining disability in the existing PMTF poverty predictors – based on the 2007 PECS, rather than the 2011 PECS – is problematic. The 2007 PECS asks whether the person suffers from any of the following disabilities: vision, hearing, mobility, use of fingers, mental, and other specific areas; conversely, the 2011 PECS uses the WG Short Set methodology adopted globally, and includes detailed questions on the severity of disability in

vision, hearing, mobility, understanding, and communication. Thus, the more recent survey provides more detail on these disabilities which can inform better understanding and decisionmaking around needs per the type and severity of disability.

The application precondition of acquiring a formal disability certificate for each disabled family member was reported to be an arduous, expensive, and unjust process. The key shortcomings raised by participants related mainly to the complexity of the assessment process, which causes massive delays, and the costs of funding transport to main cities to obtain the certificate, further increasing the vulnerability of families with PWD members.

Another indicated problem is that, in the 2007 PECS, the question related to disability enquires whether there is 'at least one PWD in the household'; by contrast, the 2011 question was altered to enquire about 'the number of disabled individuals in a household'. This has implications for the accuracy of the collected and analysed data, since the 2007 model gives programme staff no information on the number of PWDs in each household'. The 2011 PECS provides deeper insight into the economic status of the family, as expenditure is likely to be higher for households with more than one PWD member.

Although the current PMTF initially performed well, conditions in Palestine have changed since 2010, and the newer versions of the PECS have a larger sample size and a more robust sampling frame compared to the 2007 census. Yet updating the PMTF has still not been considered.

Furthermore, bearing in mind the variations between the definitions of the predictors in the two surveys, Table 6.5 presents a significant increase in the percentage of households with at least one disabled member, from 11% in 2007 to 22% in 2011. It is unclear, however, whether this increase is due to deteriorating health status among Palestinians or the aforementioned change in the definition question. Nonetheless, it indicates that the government needs to reconsider its assumption that the existing scheme is effectively targeting families with PWD members, as it seems many of those families may be outside the current scheme.

Table 6.5 Disability demographics of households in Palestine (2007 and 2011)

		2007 PECS	2011 PECS
		Mean	Mean
Household demographics			
	Number of children under 5	1.12	0.95
	Number of children aged 6 to 11	1.04	0.94
	Number of children aged 12 to 15	0.76	0.62
	Number of children aged 16 to 17	0.33	0.33
	Number of elderly people aged 65 or above	0.23	0.21
	Number of adults aged 18 to 64	2.91	2.92
	Number of unemployed adults aged 18 or above	0.27	0.25
	At least one member with a disability	0.11	0.22

Sources: 2007 and 2011 PECS.

Additional to the discussed challenges concerning the PMTF, all DPO participants agreed that the prerequisite to obtain a disability certificate to prove a family member's disability is a major access barrier, causing families with one or more PWD members to be excluded from the scheme. Families unaware of the insignificant influence of disability on their application's prospects may struggle for weeks to obtain the certificate, hoping it will increase their chances of acceptance under the PNCTP. The amount of effort and money required, combined with the lack of transparency in the process, puts families at risk of delays and exclusion.

DPO participants and social workers confirmed that the disability assessments conducted by the Medical Committees are medical in nature, equating disability with a health condition or impairment. As discussed in section 6.1.4, the whole process is based on medical assessment, unclear, and open to corruption, with many families able to obtain fake certificates to strengthen their chances of being included in the scheme.

Last week, a father of five children with disabilities approached us for support as he could not afford to go through the whole process of applying for a disability certificate for the five children. He is the breadwinner and he can only take one child at a time at least three to four times until he completes the process. He was torn between the need to complete the application and his ability to afford the required process. (Programme coordinator at a DPO supporting persons with physical disabilities: key informant interview)

[We] all know that if you don't have strong connections, you will end up being rated as less disabled than you really are, then the money you are entitled to will be limited. (Advocacy manager at a DPO supporting WWDs: key informant interview)

Conversely, donors defended the PMTF, indicating that it is 'the most accurate in the region'. According to the two interviewed World Bank staff members, the existing PMTF is the most suitable method to have been used in the region; however, they both agreed there may be scope to improve the PMTF to better support vulnerable groups, especially PWDs, though neither could provide further details on when and how this might be considered within the Palestinian context.

[W]e are aware that vulnerable groups are in need of additional or a different kind of support from other recipients of the poverty alleviation schemes. The PMTF can be shaped to identify them under a different cut-off point for eligibility additional to providing them with other interventions [...]. We are in discussion with the ministry about the feasibility of reforming the existing formula, but that will require new costing and modelling. We did discuss, internally, the possibility of considering this during the coming phases of technical assistance. (Senior World Bank staff member: key informant interview]

A government representative shared the donors' view. However, a senior management official at the MoSA defended the decision to continue using the current PMTF, providing the following rationale for not revising: 'Internationally, Palestine is ranked first in the fight against the resulting exclusion errors, and the margin of inequality in using the equation does not exceed 20%'.

Discussions with senior PNCTP staff revealed their awareness of imbalances that can negatively affect the results of applications and hinder the timely receipt of assistance, which can worsen the situation for already struggling poor families with a PWD member. The PNCTP's director indicated that the MoSA is aware the equation does not function for PWDs

and other marginalised groups, because the weight of the disability variable may be very small or even zero. However, she did state that the government (mainly the MoSA) offers other forms of support that contribute to filling this gap, such as interest-free loans for PWDs and supporting access to medical services through the provided medical insurance.

The PNCTP's manager justified the requirement to obtain official certification of disability as fulfilling the need to prove disability status. She indicated that this measure reduces corruption and ensures the accuracy of information provided. She did not anticipate this requirement changing in the future.

Both the PNCTP manager and senior advisor reported constant internal discussions of possibilities to explore PMTF improvements, including whether multiple targeting forms could be used (based on regional differences between the West Bank and Gaza); adopting more cutoff points (also based on regional differences between the West Bank and Gaza); and targeting at the individual, rather than household, level. Additionally, regarding disability, there was a clear recommendation to add new predictors – particularly the costs of disability – for possible incorporation in a future model. They explained that, although many of the discussed recommendations for the PNCTP are very relevant, there has not yet been any agreement on implementing them, with the constant excuse that 'this may complicate matters' and MoSA 'don't have the required resources to make that happen'.

Conversely, social workers were less certain about the PMTF's accuracy and fairness. One key challenge expressed by 20 PNCTP FGD participants was the difficulty in understanding the formula's construction, thus preventing understanding of the reason(s) for excluding families who are poor and have numerous PWD members. They stated that the PMTF system aimed at 'limiting human intervention, since the equation produces results from an automated system'; therefore, they have no capacity to influence the results. Participants in the four FGDs with social workers indicated that, every day, they encounter many PWDs in great need of support but whose family is 'not meeting the criteria'. One social worker stated:

It is a secret ... we are not allowed to know the weight of each question. Our perceived role is mainly to collect data. Often, we don't agree with the results because we think they are unfair to many families with disabled members. We are only asked to tell the family that, according to the equation, they are not entitled to any assistance. It is very depressing for us. (Local social worker: focus group discussion)

Social worker participants also indicated that the PMTF overlooks the heterogeneity across different disability types. Therefore, the PMTF needs updating with regard to both the number

of disabled members in a household and the heterogeneity of disabilities. They also confirmed that the current PMTF does not collect information about the nature of social services, the individual's awareness of the existence of those services, and the individual's desire for social participation. They argued that enquiries should concern not only the opportunities for and barriers to the affected individual's participation in certain activities but also whether the individual would like to participate in them.

6.4.4. Adequacy of benefits

The findings show that the PNCTP cash benefit amount is affecting PWDs' financial status, in turn influencing their behavioural decisions around independent living prerequisites. All PWD participants reported that the amount is inadequate to meet additional disability-related costs, which are crucial for the individual to live independently; it also fails to protect them from falling into deeper poverty due to their disability. This was particularly highlighted by participants with severe physical disabilities, due to their high-level need for support services. The term 'income loss' was repeatedly mentioned as a potential cause for those individuals and their families falling into the poverty trap. As the PNCTP is inadequate to cover relevant support services, the PWD or their family is forced to make 'painful choices' on either spending considerable sums paying for such services (if they even exist) or having a family member provide that support, causing an additional financial burden as this individual cannot work on that day.

The 21 previous SHC programme beneficiaries had mixed views on the PNCTP's adequacy to cover their individual disability costs, but all agreed that the benefit amount was not sensitive to family members with disabilities. They believed that the former scheme was very effective in supporting individual needs but confirmed that the absence of affordable or free medical and support services under that scheme meant the monthly amounts were never enough to cover all their needs. Thus, even under the previous scheme, they had to compromise and prioritise how to spend the money.

The next quotes illustrate the opinions of both former recipients under the SHC programme, who transitioned to the PNCTP:

[I]t wasn't paradise, but at least I had something to work with. (25-year-old female participant with a physical disability, and former SHC-recipient: in-depth interview)

[E]very month, I need NIS 300 [USD 100] to buy catheters, as I am unable to control my bladder, in addition to the medication and diapers I need on a monthly basis. Life was much easier before, as I was able to cover a big part of those expenses from the money I received directly. (19-year-old male participant with a physical disability, and former SHC-recipient: focus group discussion)

The factors influencing the PNCTP's impact on PWD participants' economic independence and independent living are summarised as follows:

- First, neither the 2007 nor the 2011 PECS capture specific expenditures on disability but, rather, the household-level expenditures on various items and groups thereof. The data are divided into 55 detailed consumption and expenditure groups, amounting to 667 food and non-food items. Disability-specific costs may include, for example, expenditures on home care, travel, various other health items, consumables, prescriptions, housing modifications, aids and appliances, and furniture (Pereznieto et al., 2014). However, by recording only household-level expenditures, it is impossible to differentiate between spending on household members with and without a disability. For example, if two households are similar except that one has a disabled member, and that household has higher health expenditures during the past month, this extra spending may not necessarily have been on the disabled individual.
- Second, both the 2007 and 2011 PECS did not capture other equally important quantifiable costs associated with disability, such as the time and income lost by those caring for the disabled family member, as well as the amount of money spent specifically on their needs. Currently, there are no data available in Palestine regarding caregivers for disabled family members. This information is needed to enhance understanding of the costs of disability, so as to inform reforms to increase the programme's inclusivity.
- Third, the value of the transfer does not alter according to whether a household contains a PWD member, or according to the number of PWDs in a household. As discussed in section 6.2.3, the cash transfer amount is only adjusted to reflect the number of family members. This means that the PNCTP does not account for the additional disability-related costs incurred by PWDs and their families.
- Finally, eligibility for the existing scheme is merely linked to the economic situation of the family, and not the PWD. If the family's situation improves, they will then be automatically phased out from the programme, with no consideration of the implications for the family's

PWD member(s). A 19 years old man with physical impairment from Jenin, who lives with eight other family members, received an individual grant of NIS 1,000 (USD 250) from 2005 to 2010. This then changed to NIS 750 (USD 150) as a family grant through the PNCTP. In 2014, the MoSA decided to stop the family grant because one of his elder brothers started working. The family appealed, explaining that they have a PWD member with additional disability-specific expenses, and that the brother currently working would marry. However, their appeal was rejected twice, based on the PMT criteria, which exclude applications if at least one family member is working.

From the above findings, it is evident that the amounts allocated under the existing PNCTP are inadequate to cover the additional disability-related costs. As the transfer's value does not alter according to whether households contain a PWD, the PNCTP does not account for these additional costs incurred by PWDs and their families. The presented barriers to PWDs covering their medical and disability-related functional needs puts them at higher risk of exclusion and becoming trapped in poverty, as their constant striving to cover costs may lead to additional medical and functional limitations. The programme also fails to design strategies to protect PWDs from falling into poverty through inability to afford the required services, which are mainly provided by the private sector and are not covered by the existing medical insurance package. As considered earlier in relation to other issues, WWDs face further implications due to gender- and disability-based inequalities.

6.4.5. Monitoring and evaluation

Participants raised several concerns around the existing accountability mechanisms adopted by the MoSA for the PNCTP, which are affecting the programme's impact on PWDs. These include poor utilisation of the existing programme's MIS, inaccessibility of the complaints procedure, and limited engagement of DPOs in the whole process. The reported concerns raise doubts on the ability of current PNCTP accountability mechanisms to capture inequalities in targeting disability; they also weaken the PNCTP's effectiveness as a mechanism for tackling PWDs' poverty risks and vulnerabilities.

Six DPO interviewees and 23 FGD participants highlighted an absence of systematic attention to PWD representatives' involvement in PNCTP design, monitoring, and evaluation. They contended that DPOs should have a vital role in the design and monitoring of government programmes to promote PWDs' inclusion and in facilitating access to available benefits and services for their constituency. DPOs' absence from the process was causing them to question its transparency and accountability. They also confirmed that the existing complaint

procedures are inaccessible to persons with almost all types of disabilities, as the PNCTP complaints units are mostly placed in urban areas with limited physical accessibility, and written or verbal reporting mechanisms are not adapted for persons with visual or hearing impairments.

We, as DPOs, are never informed about the procedures and standards followed by the ministry to handle and follow up complaints. This is diminishing our capacity to support members in submitting complaints when informed that they are not eligible for assistance [...]. We are also never involved in any process related to evaluating the programme. (Director of the Deaf Union: key informant interview)

I heard about the complaints unit in Ramallah but did not know how to reach it to speak up about my frustration with the way the programme works [....] we complain to God as it seems he is the only one that may listen to us. (35-year-old male participant with physical impairment: focus group discussion)

Additionally, three representatives from human rights organisations and UN agencies raised concerns regarding the accuracy and coverage of the PNCTP's MIS. They questioned the accuracy of data in the current MIS, mainly regarding the extent to which the programme reaches the most marginalised community members, including PWDs. They explained that the newly designed MIS was sponsored by the World Bank as part of its technical assistance programme, aiming to enhance both the extent to which potential beneficiaries are reached (i.e. reducing exclusions) and the collection of information for M&E purposes. They believed that the PNCTP's almost complete dependency on donors gave them extensive control over how the programme is managed and monitored. Furthermore, they drew attention to the lack of connection between the PNCTP's M&E system and the M&E systems for cash scheme services run by other actors, such as INGOs and charity organisations: this disconnect precludes understanding the overall coverage of the existing cash transfer schemes, potentially enabling manipulation by and a double benefit for certain community groups.

[W]hen we conducted a national assessment around the impact of the programme on CWDs, the ministry was very cooperative. They provided us with a sample of contact details for 300 households listed as families with a child with a disability. Our consultant was struck by the fact that at least 30% of the data were inaccurate, as many of those families reported not having any family member with a disability, and others stated that they graduated from the programme many

years ago. We had to reach out to national DPOs and disability NGOs to get further data to enable us to complete the study. (UN official: key informant interview)

We also could not figure out the actual number of those individuals who ended up excluded from the programme after the merger, as the ministry did not have a transparent system to provide that level of information. (Director of the Independent Commission for Human Rights: key informant interview)

Nine social workers in the FGDs identified a disconnect between the beneficiary data in the computerised national MIS, intended to reflect poverty-related information, and the realities on the ground for recipient family members with disabilities. They highlighted apparent limitations in the availability of information on how the programme is responding to the needs of different marginalised groups, especially PWDs.

Furthermore, social workers in the FGDs reported that the use of the PMTF had effectively eroded their professional role: onerous data collection requirements for monitoring household eligibility are accompanied by reduced room for discretion in assessments. They also felt the shift in their role had reduced their credibility in the community's eyes, as they are unable to clearly articulate reasons for programme inclusion or exclusion. Very heavy caseloads also preclude them from providing more tailored support to the most vulnerable households, including those whose members, including PWDs, have specific vulnerabilities. Finally, social workers' relationship with MoSA Ramallah appears to be unidirectional: district social workers who have contact with beneficiary households feed into the national database but are not actively included in programme design decisions or feedback processes.

The present database has hardly any information about the situation of the family member with the disability. All that the computer collects and analyses are the age and type of disability of the person, nothing more. [...] There is no comprehensive unified system telling us the status of the poor disabled community and what their needs are. [...] no one in the ministry now can tell you what we are actually doing to support those members through this programme. (Field social worker: focus group discussion)

Overall, there was agreement on the need for more effective accountability mechanisms, enabling PWD recipients to complain in situations of inequality of access and impact, and allowing their representative organisations to contribute to strengthening PNCTP accountability measures for PWDs.

7. Discussion and general conclusions

As the literature review in Appendix 2 shows, existing studies have failed to consider or provide conclusive evidence on the effects of cash transfers for PWDs in LMICs. This thesis is among the first works to examine the impact of cash transfers on PWDs' independent living and autonomy:

- It synthesises evidence on the PNCTP's impact on PWDs' independent living, based on the obligations under Article 19, CRPD.
- It presents the potential role of the broader policy and governance environment in shaping cash transfer programmes for PWDs.
- It elucidates the role of cash transfer design and implementation features in influencing impact on PWDs' independent living.

In doing so, it contributes to efforts to bridge this knowledge gap on disability and cash transfers in LMICs and enriches the scant literature on the interaction between disability and social protection policies.

To achieve the above, a qualitative country case study approach with descriptive and explanatory purposes was adopted. Multiple lines of evidence have been used, combining the collection and analysis of primary and secondary data: document study, expert interviews, focus group discussions, and in-depth interviews. The descriptive aspect of this research aimed to accurately depict the variables under study (policy dimensions and impact at the individual level).

The following sections discuss the main research findings in the context of relevant concepts, and relate them to regional, national, and global empirical evidence on cash transfers and disability policy design and implementation. This chapter draws policy implications for designing transformative cash transfer programmes that are responsive to and support PWDs' independent living rights and identifies areas for future research.

7.1. Discussion of findings

The PNCTP was designed in 2011, when disability rights started to gain global momentum. At that time, 111 countries had ratified the CRPD, and State Parties needed to review and align their regulatory frameworks and policies with the Convention. However, at the global level, many questions on how to progress towards more disability-inclusive policies and programming were left unanswered partly because an agreement could not be reached. Without global recommendations on how to ensure PWDs are not left behind in social cash

transfer programming, the Palestinian government had little direction on designing the PNCTP to effectively include PWDs.

The decision to merge the two main cash transfer schemes was heavily guided by the World Bank, one of the key sponsors of cash transfer programmes in Palestine. The merger was intended to deliver a unified, cost-effective, and efficient scheme to address poverty alleviation and social justice for the poorest communities. However, with the integration of the SHC programme and the SSNRP, and the replacement of categorical targeting with householdlevel PMT, the specific and wide-ranging vulnerabilities of PWDs are no longer addressed. With the discontinuation of targeted social cash transfers after the launch of the PNCTP in 2010, PWDs have been deprived of individualised support, choice, and control over their way of living. Figure 7.1 summarises the contextual factors influencing the PNCTP's design, with regard to national conditions and the disability policy space, and the detrimental consequences for PWDs. The implications of this merger, implemented without considering the needs of PWDs and the effects it would have on them, is a key lesson from the Palestinian experience, highlighting the need for systematic inclusion of disability when planning and formulating social cash programmes.

Figure 7.1 Context and effects of the PNCTP's design

National context

- Palestine is under occupation, with weak governance and accountability mechanisms, policies and systems, subject to control by donor agendas
- Most social services are provided by NGOs and the private sector
- High unemployment and poverty rates
- Focus on safety-net approaches which aim to help households to manage short-term financial issues, but pay little attention to the social inequalities that perpetuate poverty, including disability

Disability policy context

- Lack of financing strategies and budget allocations
- Absence of effective complaint mechanism for PWDs facing discrimination in accessing services
- Limited coordination among disability service providers and government; no national regulatory framework with defined roles
- Disability assessments limited to medical aspects, with no consideration of activities, participation, and environmental factors
- · Lack of unified disability definition
- Poor harmonisation of national laws and policies → inconsistent and contradictory regulations
- Absence of legal provisions on social protection for PWDs → service delivery inconsistencies in availability and equity
- Limited participation of DPOs in social protection monitoring structures and processes
- Many specialised and support services are provided by NGOs and the private sector, causing high fees for PWDs

Implications on PNCTP design

- Lack of disability indicators within the MIS system
- Limited capacity to capture and respond to disability-related vulnerabilities
- Inaccessibility of application, payment, and complaints procedures
- Limited engagement of DPOs in M&E
- Use of conflicting disability definitions
- Poor responsiveness to different needs of PWDs
- No consideration of disability-related costs in the eligibility determination → exclusion of families with disabled members who would meet the threshold were these costs considered
- Limited protection of families with many disabled members → high disability-related costs burden
- · Complex and unjust assessment
- Poor linkages to essential support and mainstream services
- Ineffective promotive feature, with inability to work an eligibility precondition
- Payment amounts do not reflect disability-related additional costs

Impact on PWDs' independent living

- Higher risk of remaining in or falling into poverty as individuals
- Difficulties in meeting their basic needs
- Higher risk of medical complications due to limited coverage of the medical insurance
- Limited access to essential support services, resulting in limited functionality and increased dependency on other family members
- Less control over life choices, including place of residence
- Financial reliance on other family members
- Restricted access to livelihood and employment opportunities due to inability to work precondition
- Limited availability of support devices most critical for their social and economic independence
- Higher risk of social exclusion and dependency for WWDs and persons with severe physical impairments

7.1.1. Factors that shape the PNCTP's design

To assess the PNCTP's effectiveness in supporting PWDs' independent living, it was vital to gain understanding of any external or contextual factors potentially influencing, either directly or indirectly, the programme's design and administration in relation to disability and PWDs. In this regard, the findings highlighted the political context, understanding of the concept and scope of disability, and the extent of disability inclusion in social policies.

Political context

The effectiveness of social protection programmes – including cash transfers – in addressing vulnerabilities can neither be assessed nor ensured without considering contextual factors. The findings highlighted that Palestine differs significantly from other countries in the region: its historical and current political conditions, the occupation, its economic situation, and the influence of and dependency on foreign aid and agendas all engender additional forms and causes of vulnerability beyond the socioeconomic and cultural factors also found in neighbouring countries. Though Palestine's HDI score of 0.677 for 2014 puts it in the medium human development category, much of its advancement is determined by external factors, such as foreign aid and changes in imposed restrictions; therefore, this indicator does not necessarily reflect sustainable development (UNDP, 2015a).

Yet, these additional dimensions – donor-dependency, the lack of or fluctuation in political power and control, and the influence of inherited frameworks and systems – were also found to significantly challenge the government's commitment to ensuring social protection for PWDs and other vulnerable groups. The results highlighted, in particular, the negative impact of dependency on foreign aid, which Stockmarr (2013) considers one of the main causes of Palestine's fragility, on the design, implementation, and impact of social protection policies, especially the PNCTP. The influence of donors on Palestine's social protection policy, programming, and implementation reflect a longer-term pattern. It was only in 1994 that the PNA gained control over social services, such as education, health, and social welfare systems (UN ESCWA, 2009). Due to political uncertainty and a difficult fiscal situation, the bulk of the national budget – including social assistance – is financed through donor funding, rather than domestic revenues. The PNA contributed around 27.40% of the PNCTP's budget in 2014, whereas the EU and the World Bank funded 68.24% and 4.36% respectively.³⁶ The PNA's contribution is itself heavily dependent on international assistance. Although foreign aid to the PNA has declined in recent years, it still represents a substantial portion of the national

³⁶ Source: MoSA's internal financial records.

budget. As such, donors also played a key role in the 2010 reform of social cash transfer programmes and the PNCTP's development: the World Bank significantly influenced the PNCTP's direction and design, despite only contributing 5% of the budget. This raises questions around ownership and ensuring the relevance of existing schemes to citizens' needs and priorities.

For Shaheen (2013), the only way to transcend Palestine's current traditional social protection approach, and thus reinforce its performance, is to establish a comprehensive, rights-based legal framework in which to ground social protection systems. However, the factors found by Shaheen to hamper implementing the PNCTP – namely the fragmentation of services and limited coordination among the diverse actors, including the government, NGOs, and multilateral entities – present major obstacles to such reform. This reality underpins the wider debate around the impact of fragile environments on social protection (policies), characterised by fragmentation of interventions, poor ownership, and poor planning for sustainability (DiCaprio, 2011).

Understanding of disability

How disability is defined significantly influences who is classified as 'having a disability', the allocation of relevant resources, the reach of disability policy, and the ultimate policy impact or benefit for PWDs. It also guides the policy outputs, as different disability concepts are related to different responses or strategies. Being able to define disability is pivotal for governments when formulating and implementing social policies, providing a basis for distributing support to persons defined as 'disabled' and denying such support to others (Grönvik, 2007). There is no global consensus on how to define disability. Even the CRPD only offers a non-exhaustive definition in the 'purpose' provision of Article 1. This significantly impacts policy design and monitoring: potentially unfamiliar with current discourses on the definition and conceptualisation of disability, policymakers may choose to operationalise a definition for gatekeeping deemed the most economical or beneficial to the government, rather than one that creates the best possible outcomes for PWDs.

Some oppose a single definition, considering purpose-specific definitions to be more useful. Grönvik (2007), for example, argues that different purposes require different conceptualisations of disability, and should be approached with clear realization of the consequences of operationalising a particular disability definition. For example, using the functional definition of disability may be particularly useful for rehabilitation, when designing strategies to restore a person's functions is the focus.

However, this research's findings demonstrate how problematic such an approach can be in practice. Palestine's current legal and policy framework on disability is still based on the medical model. Its 1999 Disability Law provides a narrow, medical definition of disability, which is adopted and modified by the relevant ministries and departments involved in social protection measures, and inconsistently applied. The findings have shown huge discrepancies between and within social protection programmes and the various tools they use for gatekeeping by who is considered 'disabled'. This practice not only limits transparency, an essential component of any rights-based social protection programme, but also greatly impacts the delivery of social protection programmes, particularly the PNCTP. It prevents equal access to all social protection programmes that include disability; even if disability is an eligibility criterion, PWDs may not necessarily fit the chosen definition. It also reduces the efficiency of mechanisms for referring PWDs under the PNCTP to other social protection programmes or services linked thereto.

The definition and measurement of disability are inextricably linked (Schneider, 2009). Thompson (2017) argues that '[t]he definition of disability, the quality and methods of data collection, rigour of sources and varying disclosure rates are factors influencing the prevalence of disability' (p.2). A lack of robust disability data has implications for both policymakers and PWDs: governments cannot be held responsible for budget allocation without disability data to inform them, while PWDs and disability sector institutions have no benchmarks by which to hold their governments accountable for disability rights commitments, such as the CRPD (Lang et al., 2011). Reliable disability statistics also escalate disability as a development agenda, as 'bilateral and multilateral donor agencies still need to be convinced of the economic case for including disability within their core activities' (Lang et al., 2011, p.2015).

The dearth of data on disability in Palestine is widely acknowledged and can be partly attributed to the lack of any single definition. The findings highlighted that using different disability definitions inhibited understanding the actual prevalence of disability and how it affects disability data collection and comparison across different programmes, including the PNCTP. The use of different definitions produced different disability percentages. The 2011 DS findings were disputed as failing to reflect the reality on the ground, with the true rates believed to be far higher. That survey adopted the narrow, rather than the wide, definition of disability, reducing the number of PWDs entitled to benefits or services from 6.9% of the population to 2.7%. Additionally, the identification of PWDs in the PNCTP is based on self-reporting, following the 2007 PECS definition of disability, i.e. whether the person suffers from a physical, vision, or hearing disability. This had implications for understanding the number of PNCTP-eligible households with PWD members.

A general consensus has been reached that more inclusive definitions should be used for disability prevalence estimates (Schneider, 2009). Many individuals who experience a 'difficulty' do not identify as having a 'disability', not least because of the associated stigma in many contexts. A broad definition includes people who may not experience marginalisation but still have needs to be addressed and emphasises the importance of the environment. In contrast, narrow definitions, like the one used in Palestine, focus on impairment in a 'medical sense', and are often used pragmatically for such purposes as benefit eligibility (Schneider, 2009). The findings confirm that use of narrow definitions, as in Palestine, tends to generate conservative estimates of disability prevalence (Thompson, 2017), leading to exclusive measures that deprive many individuals of necessary support, thereby further excluding them from society.

The UNICEF child disability questions, the WHO Model Disability Survey, and the WG Short Set all provide alternatives for identifying PWDs through various means (e.g. census, survey, and project). The WG Short Set, which has already been piloted in the 2011 DS in Palestine, uses the term 'difficulty', which captures those who may not identify with 'disability' and identifies the associations between functional impairment and social inclusion. It permits further analyses to determine the effect of different degrees of difficulty on employment, education, access to services, social participation, and other factors (Schneider, 2009, p.9). Critiques of the WG Short Set suggest that it likely causes certain sub-populations to be under-recorded, such as those with psychiatric or cognitive impairments, and does not consider participation or social barriers (Mont, 2007). However, the reported functional limitations of a PWD can be interlinked with outcomes related to his/her daily life (Palmer and Harley, 2012), for example, through analysing the connection between severe physical disability and access to employment.

Methodologies that produce more robust disability data have become especially important with the inclusion of disability in the SDGs, requiring not only national-level monitoring of PWDs' inclusion and the impact on them of cash transfer programmes but also data comparison at regional and global levels.

These weaknesses (e.g. lack of reliable data on disability; the commonly used medical model, rather than rights-based approaches) are not unique to Palestine: similar problems are found across the MENA region and beyond. Yet, as a country with limited resources, reliable data on disability, impairment, and functioning are extremely important for Palestine to be able to effectively target resources to maximise outcomes for PWDs. For this purpose, it is paramount to develop evidence-based policies and programmes for poverty and inequality reduction, such as the PNCTP, and the assessment of how they address PWDs' needs.

Disability in (mainstream) social policies

The findings showed that the disability narrative in social policies, including social protection, varies significantly: in some policies, laws, and strategies, disability is well articulated; in others, it is hardly mentioned (World Bank, 2017; Musa, 2015). Accordingly, in practice, programmes and social services provide mixed levels of access for PWDs. For example, the MoH's National Health Strategy 2014-2016 commits to guaranteeing protected and affordable access to social services, with vulnerable groups — including PWDs — receiving greater attention, but offers no commitment to supporting PWDs' access to health-related rehabilitation services or assistive devices. None of the analysed policies and strategies showed clear adoption of the twin-track approach, setting the right balance of availability of mainstream and disability-specific services (DFID, 2000).

Regarding cash transfer programmes, there are two types of cash transfers for PWDs: 1) mainstream cash transfer programmes, designed for broader poverty reduction but including provisions for PWDs; and 2) categorical transfers that specifically – and universally – target PWDs (Mitra, 2005; Gooding and Marriott, 2009). Whilst both are becoming more common in the developing world, neither is a panacea. Mainstream programmes may not be sensitive to the higher real and opportunity costs inherent in disability, and have conditions that may exclude PWDs. Conversely, categorical transfers tend to be limited in scope, due to their budgets, and challenged by the nature of the disability assessment on which they rely for targeting (Mitra, 2005; Gooding and Marriot, 2009; Schneider et al., 2011). The negative implications of the merger of the two previous cash transfer programmes, with targeted support for PWDs discontinued, add weight to the literature advocating a twin-track approach in social protection for PWDs, to address the risks of poverty and social exclusion for PWDs and support their independent living (ILO, 2017). Such an approach would involve:

- all social protection programmes being designed, implemented, and monitored to ensure the inclusion of PWDs, emphasising the removal of barriers and avoiding adverse effects;
 and
- developing disability-specific programmes that can offer the support and benefits required by PWDs but not provided through mainstream programming (ILO, 2017).

A study of 21 EU countries' social protection strategies developed between 2006 and 2008 found that many follow the twin-track approach (Shima and Rodrigues, 2009). The UK schemes neatly illustrate the range of benefits and services that can be provided to PWDs within a twin-track social protection framework, combining 'economic protection' with addressing 'social vulnerability'. Some schemes are responsive to economic risks and vulnerabilities, and are either contributory or non-contributory but means-tested (Kuper et al., 2016); others address

disability-specific vulnerabilities under the TSP approach, such as payments supporting the coverage of services, and additional disability-related costs, such as personal budgets schemes.

This is considered the route to achieving independent living for PWDs based on the social model. However, only a few LMICs have begun to embrace a more comprehensive approach that combines access to mainstream schemes with disability-specific provisions. In the MENA region, there are a few countries that provide disability-specific cash transfers, such as Algeria's *Pension Handicapée*. There are also some social assistance schemes catering to PWDs' caregivers: Iraq and Jordan (through its NAF) provide monthly cash transfers to the families of those with disabilities that render them dependent on others' care (UN CRPD, 2012; 2013a). In Egypt, World Bank-supported government programmes provide pensions to poor PWDs/CWDs and quarterly cash injections to families whose breadwinner is unable to work due to disability. In Palestine, the lack of disability mainstreaming effectively reduces access to social protection programmes for PWDs. In many cases, policymakers lack understanding around the types of programmes needed to promote PWDs' independent living. This is well illustrated by the political decision to merge the two cash transfer schemes and discontinue the only scheme

explicitly targeting PWDs, thereby driving Palestine even further from a comprehensive twin-

7.1.2. PNCTP design and implementation elements critical to the participation of and impact on PWDs

This section discusses findings on the role of design and implementation features in the PNCTP's impact on PWDs, and relates them to other evidence and global debates on barriers to PWDs accessing and benefiting from cash transfer schemes (Mont, 2010), identifying possible policy implications.

Assessment and determination of disability

Eligibility processes in Palestine vary according to their purpose, with responsibilities fragmented among different ministerial departments. Each ministry has its own eligibility processes for specific schemes. However, the MoH's Medical Committees hold the key function³⁷ in actually assessing disability and determining the disability degree as the major

track approach.

³⁷ Except for assessments under the MoEHE's inclusive education programme and those of the Referral Committees.

eligibility criterion for most benefits for PWDs, including the PNCTP. Current assessment practices raise numerous problems.

The disability assessments conducted by the Medical Committees are medical in nature, equating disability with a health condition or impairment. The determination of disability and its severity is based solely on medical criteria related to the applicant's health condition or impairment. There is no evidence of sufficient evaluation of or linkage to daily activities, participation, and environmental factors, in line with the CRDP's principles. Yet assessment of only impairments and functional limitations risks uniform allocation when only based on categorisation of the disabled population (Arnould et al., 2013). The Medical Committees use an outdated assessment tool inherited from the Israeli Ministry of Defense, Department of Personnel, which allocates disability percentages for a broad range of conditions³⁸ yet does not reflect advances in classification, e.g. the ICD-10³⁹. A provision of the bylaw regulating the Medical Committees requires the MoH to issue updated Palestinian guidelines, which it has not yet done. The committees base their decision on medical reports from public hospitals, taking into consideration the individual's medical history and performing examinations, if applicable. The assessment's only output is a certificate indicating the individual's condition and disability percentage. A brief recommendation is also provided if requested by the referring authority. The determination of disability and its severity is based on medical criteria, equating disability with a health condition and/or impairment, and without sufficient evaluation of levels of daily activities or participation or of environmental factors. This medical orientation is further underpinned by the absence of an inter-disciplinary approach, i.e. including psychosocial and other therapeutic professionals in the committees.

Current assessments do not respond to differences in purpose or information needs relevant to a specific benefit or service. They focus solely on gatekeeping, rather than determining abilities or needs with a concrete orientation to relevant services.

Generally, disability and eligibility assessments vary according to their purpose, functions, and degree of centralisation, i.e. whether a 'one-stop-shop' or fragmented among different ministerial departments. The Palestinian practise is a combination of both: each ministry has its own eligibility mechanisms, on which bases it provides specific benefits, while the assessment of disability is conducted for almost all schemes by the Medical Committees. One would assume that the purpose of the assessment and related information needs vary for the

³⁸ For example, a total paresis on the right side is assigned 80% disability, while a total paresis on the left side is 70% disability.

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³⁹ International Statistical Classification of Diseases and Related Health Problems 10th Revision.

different schemes. However, there are no regulations to ensure the current assessments consider or respond to these differences in their criteria and outputs. The current assessments only function to certify disability status based on medical criteria and, where applicable (e.g. early retirement), to deliver a recommendation. In some cases, e.g. the Fund for Rehabilitation of PWDs), the regulations acknowledge the need for broader assessments in terms of activities and participation; however, to date, these have not materialised.

The PNCTP requires all family members with disabilities to provide the relevant Medical Committee certificate. Those who do not yet have one or whose certificate is older than one year need to undergo the assessment, reported by participants to be an arduous, expensive, and unjust process. The disability assessment lacks transparency and accountability. The whole process seems to be unregulated at times, and variations between assessment practices and the governing regulations, or between locations, especially the West Bank and Gaza, were detected, reportedly confusing claimants as to how decisions are reached. Besides the complexity of the process, which causes massive delays, the geographical and physical inaccessibility of the assessment locations further compounds inequalities. Furthermore, the lack of a monitoring system for the Medical Committees and transparent complaint and appeal mechanisms add to the perceived lack of transparency.

Reviewed evidence indicated that the approaches and processes of existing medical assessments exclude persons with certain types of disabilities from accessing mainstream and disability-specific programmes (Banks et. al., 2016; Mitra, 2010; Gooding & Marriot, 2009). The findings also confirmed concerns that the ICF negatively impacts PWDs' empowerment by favouring professionals' control over them and their lives: that is, the ICF's categorisation of PWDs could be misused by medical professionals, resulting in PWDs' marginalisation (Lundälv et al., 2015). The ICF further fails to recognise the importance of individual identity grounded in one's beliefs, values, and preferences, and considers the environment as merely a mechanical facilitator or barrier (Trani et al., 2011).

Ensuring equal access requires the revision of disability assessments in accordance with the CRPD. In this regard, the WHO (2011) recommends using the ICF as a framework for developing disability assessment criteria and procedures, focusing on support needs to maintain and improve functioning. Contrary to traditional assessments, basing eligibility on medical criteria, the ICF supports the shift from impairment- to disability-oriented assessments.

The ICF has faced criticism for the challenges that arise in its operationalisation (Symeonidou, 2014) and for positioning disability as the outcome of impairment (Shakespeare, 2006), which has led to policies focusing on limited individualised responses, such as treatment, equipment,

and benefits. Nonetheless, an increasing number of countries have started to use the ICF. Taiwan, Nicaragua, Argentina and Mexico have all introduced ICF-based disability assessment systems (WHO, 2011). Meanwhile, Japan, Italy, Australia, and Portugal have used the ICF/ICF-Children and Youth version (ICF-CY) framework to guide clinical measurements and evaluations of people requiring rehabilitation, home care, special education, and disability support.

In conjunction with other UN agencies, the WHO has attempted to discuss with the MoH the importance of reforming disability assessments in Palestine in alignment with the ICF. However, the MoH strongly resisted, claiming that the existing mechanism serves the government's objectives and that any reform would require investments the government cannot afford. The conceptualisation of disability is extremely important for the assessments. In Palestine, the underlying legal definition of disability and PWDs is still based on the medical model, focusing on loss of capability. As such, the development of a legal framework that defines disability in line with the CRPD and mandates the use of the ICF in disability assessment will be paramount to any reform. Additionally, Palestine needs to move away from linking PWDs' eligibility for social benefits to inability to work, as this reinforces the medical approach to disability and endorses the misperception that PWDs are sick, dependent citizens, incapable of working productively. Eligibility for disability-related social protection benefits should, instead, be based on a functional approach.

Accessibility of the programme and related mechanisms

This research identified numerous factors that affect the interaction of PWDs with and their access to the PNCTP. First, there is limited availability of accessible information about the PNCTP's implementation processes and mechanisms, such as eligibility criteria, application procedures, and the grievance policy. Second, the range of disabilities accepted under the PNCTP is very narrow. Third, the application and administrative procedures are complex. Fourth, the physical accessibility of the application centres is either lacking or poor, especially for persons with severe physical disabilities. Finally, the payment methods are inaccessible for recipients with visual impairments.

These findings confirm the observations of Banks et al. (2016) that access to social protection programmes in LMICs falls far below PWDs' needs. Eight of the reviewed studies in the systematic review relate to barriers faced by PWDs in accessing social protection programmes.

This research highlights that access to information is an important challenge for PWDs as regards social protection. Among the barriers to accessing relevant information, low

awareness of social protection programmes and entitlements is a significant problem (Gooding and Marriot, 2009), a fact emphasized by this study's PNCTP participants with disabilities. People with certain types of impairments – e.g. vision, hearing, or intellectual – require forms of communication that respond to their different accessibility needs. Well-designed and publicly accessible information (systems) would facilitate improved efforts to address PWDs' needs. Yet programmes often fail to invest in communications and are even less likely to adapt these to PWDs' needs. In many countries, social work systems, which should play a key role in raising awareness of programmes' existence, are weak (Kidd et al., 2017b). PNCTP users reported such experiences, with participants indicating that field social workers did not provide braille materials about the PNCTP or facilitate sign language interpretation.

Banks et al. (2016) and Kidd et al. (2017b) confirm that PWDs' exclusion from social cash transfer schemes is often attributable to the application and registration processes. For example, during the PNCTP application process, PWDs are identified based on self-reporting, and the question posed identifies physical, vision, and hearing as the only three relevant disability types. This immediately excludes persons with other types of disabilities. Additionally, PWDs are often unclear about application requirements, lack correct documentation, or encounter difficulties accessing grant offices. In addition to application fees, PWDs may face expenses in seeking social protection which prove prohibitive: e.g. for transport, childcare, or assistance. FGD participants with physical impairments (predominantly wheelchair users) highlighted their problems regarding the availability and affordability of accessible transport to reach PNCTP application offices. The time needed to complete an application may also not be considered when deciding the payment start date for a person's disability benefit (Banks et al., 2016; Kidd et al., 2017b). In South Africa, for example, whereas mainstream benefits are backdated to the first application date, disability grants are only backdated to the application's approval, which may be several months later.

Even when enrolled in programmes, PWDs – particularly those with mobility challenges – can face significant difficulties in accessing payments (Kidd et al., 2017b). Pay points may be located far from their homes, requiring additional transport costs; entering pay points and banks may be difficult in the absence of wheelchair ramps or lifts, and long waiting times may also be challenging for some (Kidd et al., 2017b). Recipients of South Africa's disability grant pay up to 7% of the grant's value to access the payments. Women may face even higher costs: in South Africa: for example, some WWDs pay a male companion to keep them safe when collecting their grant or, alternatively, travel in taxis (Kidd et al., 2017b). Likewise, WWDs in Palestine reported incurring extra transport costs since their families urge them to be

accompanied by a family member when picking up the PNCTP transfer from the bank, for fear of abuse from Israeli soldiers.

Evidence from MENA shows similar trends regarding the accessibility of cash transfer schemes to PWDs. According to a report by the UN ESCWA (2017), lack of information on available measures is a major obstacle to accessing social protection schemes across MENA. In Morocco, 13% of PWDs not enrolled in the RAMED reported having no knowledge of the scheme. In Egypt and Tunisia, there is reportedly confusion among PWDs regarding where and how to access social protection services. The few governments to have implemented measures to address these problems include Algeria and Tunisia, where PWDs are granted priority access to public buildings, and the UAE, where applications for disability cards and other forms of social protection are submitted online, avoiding the need for PWDs to visit potentially inaccessible government offices (UN ESCWA, 2017).

Calculating disability-related expenditure

The economic costs associated with disability include direct and indirect costs. Direct costs may be subdivided into two elements: first, additional expenditures on general items needed by every household, such as healthcare, transportation, or food; and, second, disability-specific costs, such as rehabilitation and assistive devices, personal assistance, and adaptations to housing and vehicles (Tibble, 2005; Palmer et al., 2015). Indirect costs represent foregone benefits or opportunities, such as the lost income of PWDs or their caregivers. The lower earning capacity of PWDs may result from limited work choice, anti-work incentives in government programmes (like the PNCTP), or educational or social barriers to employment. Caretakers may be unable to undertake paid work, or may be restricted in their work type or hours, due to their responsibilities. The full economic costs of caregiving might not be fully realised until the future: For instance, Vietnamese children with disabled adults in their household were found to be significantly less likely to attend school (Palmer et al., 2015). In this research, participants with severe physical disabilities, for example, indicated that due to the absence of personal assistant services, family members had to stop working on a temporary or permanent basis to provide the relevant support.

There are different approaches to measuring disability-related extra costs (Tibble, 2005):

- The subjective approach: PWDs (or experts) are asked to estimate their additional expenditure. However, estimates based on what people spend are likely to underestimate their actual costs.
- 2. The comparative approach: Spending patterns of PWDs are compared with those of 'similar' non-disabled people. Studies ask both populations how much they spend on

individual items, with the differences illustrating where their respective priorities differ.

- 3. The standard of living approach: PWDs are assumed to have a lower standard of living than non-disabled people with the same income, as they divert money to goods and services required due to their disability. Using standard of living indicators, PWDs' and non-disabled people's standards at the same income are compared to identify disability-related extra costs.
- 4. The budget standards approach: PWDs are asked to state their needs, but instead of reporting their expenditure, they collaborate in focus groups to develop a list of items required for a reasonable standard of living. In contrast to the standard of living approach, this method measures disability-related needs, not extra costs, presenting the income needed to achieve a certain standard of living.

Mitra et al. (2018) reviewed the literature on the direct costs of disability. They identified 20 studies from ten countries, predominantly HICs (except Bosnia-Herzegovina, Vietnam, and China). All estimated sizeable extra costs, ranging from USD 1,170 to USD 6,952 per year, depending on severity, lifecycle stage, and household composition. Highest costs were observed among those with severe disabilities and those living alone or in smaller households. The limited evidence from LMICs is from Vietnam, where the extra cost of disability is estimated to account for 8.8% to 9.5% of annual household income. The estimate for additional health costs alone is USD 595 per year (Van Minh et al., 2014). A dynamic of low and unstable income combined with ongoing disability-related (especially healthcare) costs necessitates a range of coping mechanisms: borrowing, reducing expenditures, drawing upon savings, and substituting labour. These help to maintain living standards in the short-term, yet threaten the longer-term welfare of the PWD and their household. Current social protection programmes address some immediate economic costs of disability, but do not entirely cover these additional costs.

That disability-related extra costs are sizeable and heterogeneous makes it critical for variations in needs to be considered in determining poverty thresholds and benefits for the disabled population. Quantifying the extra costs of disability and adjusting poverty rates is necessary for policymakers to allocate sufficient resources to providing disability support services, in accordance with their obligations under international disability law; it also provides a basis for determining eligibility and benefit levels for social protection programming (Mitra et al., 2018).

However, measuring these costs in LMICs is difficult and related studies are scarce. Recent research tends to measure actual spending, rather than what needs to be spent; lower

estimated costs in developing countries may not indicate lower costs of accommodating PWDs' needs; rather, the goods and services they need may simply be unavailable (Mitra et al., 2018). To develop the evidence base, more rigorous, internationally comparable data on disability are needed. Qualitative and participatory research is also needed to investigate unmet needs and the consequences of extra costs (Mitra et al., 2018). Quantifying the additional costs faced by households with disabled members is of direct policy relevance. It is important for not only accurately measuring poverty but also assisting policymakers in designing programmes to support PWDs' independent living rights under Article 19, CRPD. This is especially salient in LICs, where the majority of the world's population with disabilities reside (WHO and World Bank, 2011).

There was no evidence available on the direct and indirect costs of disability of PWDs and their families in Palestine, and the collection of relevant information was beyond the scope of this research. Yet such analysis would be needed to inform the disability-inclusive reforms of PNCTP eligibility and transfer amounts.

Disability inclusion in the PMTF

This research found various challenges in relation to targeting, eligibility assessment, and disability. First, the PNCTP's targeting mechanism relies on proxy means testing, rather than categorical-based targeting, as used prior to the World Bank's involvement from 2004. Second, the weight given to the presence and/or number of family members with disabilities or their disability type(s) is close to zero, thus not accounting for the family's additional financial burden of covering disability-related costs. Third, there is no recognition of the heterogeneity of PWDs in their requirements for different types of services, the costs of which also vary. Fourth, a formal disability certificate must be acquired for each disabled family member as a precondition for the application's consideration. Finally, there is inconsistency in the questions to determine disability and inquiring on the number of household members with disabilities. The findings contribute to global debates on the effectiveness of proxy means testing to capture the extra costs of disability, and whether we should assess the means of the PWD or their family in disability-specific cash transfer programmes that require poverty assessment. They provide a critical counter to prior contentions that the PMTF used in the PNCTP is accurate and among the world's best (International Society for Prosthetics and Orthotics [ISPO] and WHO, 2004; World Bank, 2012b). They also reinforce criticisms from Pereznieto et al. (2014) and Abu-Hamad et al. (2015) of the shift from categorical targeting towards household-level proxy means testing: Both studies claim that, due to reliance on means testing

to determine eligibility, which targets households as a whole, the PNCTP is effectively blind to PWDs' needs.

Determining eligibility raises complex questions for any social protection programme, particularly when it includes disability (ILO, 2017). Globally, PMT has become the predominant methodology for targeting social protection schemes, claimed to provide an objective mechanism, especially given the unreliability of income data (Kidd and Wylde, 2011). Conventional means testing assesses eligibility for social assistance by verifying whether an individual's or household's financial resources fall below a certain threshold. By contrast, PMT predicts a household's welfare level, using statistical analysis (multivariate regression) of national household survey data to correlate certain proxies with poverty and income. It then attempts to estimate household income — or means — by scoring them against this set of proxies: e.g. demography, housing type, and productive assets. This score is used to estimate consumption, itself a proxy for household income (Kidd, 2014; Kidd et al., 2017a).

Recent studies have found PMT to be 'inaccurate and arbitrary', with: a) high in-built design errors; b) additional errors introduced during implementation; c) infrequent surveys preventing responsiveness to the dynamic nature of household incomes; and d) a tendency to generate conflict within communities (Kidd, 2014; Kidd et al., 2017a). In the absence of sufficient resources, alternative-rationing mechanisms should be considered. Indeed, according to a 2016 World Bank study, PMT performs worse than simpler categorical approaches or even basic income schemes (Brown et al., 2016). A 2013 assessment of the PNCTP's targeting found that the large majority of applicants classified as extremely poor by the programme are indeed extremely poor, with more than 80% of beneficiaries in the bottom income quintile (Silva et al., 2013). Still, a substantial number of extremely poor households are not included in the programme (Jones and Shaheen, 2012). This is partly because, in establishing household eligibility, the existing PMTF fails to capture all households needing cash assistance.

Alternatives include: eligibility rationing, wherein eligibility criteria are highly restricted but nevertheless universal; random rationing, wherein beneficiaries are selected by lottery in an arbitrary, but at least transparent, manner; community rationing, wherein communities themselves are asked to ration programme benefits; and auction rationing, wherein potential recipients bid against one another for inclusion (Freeland, 2017). Yet given the World Bank's view that 'the PNCTP's PMTF model targeting accuracy is among the best in the world' (2012, p.6), it will be difficult for the MoSA to consider these or any alternatives.

A limiting factor of PMT as regards disability is that it bases analysis on income, rather than consumption. Braithwaite and Mont (2009) argue that measuring consumption, rather than

income, is a more accurate method for assessing PWDs' poverty. Focusing exclusively on income omits consumption obtained through alternative methods, such as bartering or in-kind transfers. Economics of scale in consumption should be used to adjust for the relative cost of living, or assumed standard of living, of households with PWD members. The number of members affects the per-capita cost of reaching a certain welfare level. Individual differences between household members also affect the measurement of consumption: children, adults, the elderly, and PWDs have varying consumption needs to reach an equal welfare level. Poverty measures that do not account for such differences are inevitably limited.

Despite the PNCTP's poverty assessment considering consumption at the household level, it still falls short of capturing disability-related vulnerabilities. By not collecting information related to the extra costs of disability, the PNCTP fails to capture the actual poverty rates of households that include one or more PWDs. This was reported to have significant implications for the eligibility of families with one or more PWDs, who may be inaccurately evaluated as being above the poverty line because their extra costs spend on disability needs is not captured. This finding related to arguments that poverty assessment must consider the following in order to be sensitive to disability (Braithwaite and Mont, 2009; Mont, 2017); if reformed to consider such aspects, the PNCTP would also more effectively target and respond to disability-specific vulnerabilities:

Extra costs of disability: A given level of consumption is not the same for a disabled and a non-disabled person, making poverty measures for PWDs difficult. According to the capability approach, poverty is not solely a function of material goods but, rather, based on standard of living, described by the capability to engage in various functionings. Hence, poverty should not be measured by material goods without consideration of what those goods are used for and the other resources available to people. If the poverty line is adjusted for disability-related extra costs, the poverty rate of households that include one or more PWDs rises significantly.

Multidimensional nature of poverty: Poverty not only concerns consumption; it also relates to the ability to participate fully in society and build economic security through accumulating assets. A multidimensional measure of poverty that considers access to education, employment, health, etc. yields a stronger correlation between disability and poverty. Standard household-based poverty measures lead to the misleading assumption that if a household has enough income, none of its members are poor, even when those with disabilities face additional disability-related costs and lack access to income or other financial support to cover them.

Equal benefit across the household: If a household's consumption falls below the poverty line, all of its members are classified as poor. The assumption here is that all members benefit

equally (or in a constant proportion, called an equivalence scale) from the household's expenditure or income. However, the consumption needs of PWDs differ from those of non-disabled individuals, and PWDs' needs may not be prioritised within households. Participants reported this as a key barrier to them benefiting from the PNCTP to cover their needs. Braithwaite and Mont (2009) propose a methodology for examining disability and poverty, in line with Sen's capability model and the ICF, which has two main features: a separate (higher) poverty line for households with one or more disabled members; and assessments that combine a consumption-based measure of poverty with a functional measure of disability. Additionally, Zaidi and Burchardt (2003; 2005) suggest that combining equivalence scales with standard consumption measures of poverty enables PWDs' different experiences to be taken into account, while also improving data accuracy. The 'standard of living approach' they propose estimates the additional costs of disability. This allows for the analysis of different conversion factors experienced by PWDs. For this approach to be relevant to developing countries, disability definitions supported by datasets would need to be tested.

Braithwaite and Mont (2009) applied Zaidi and Burchardt's approach to Bosnia and Herzegovina and Vietnam to find the extra costs of disability. In both countries, the poverty line was raised. Similarly, the poverty rate for households with PWDs is higher than for households without in both countries. This increases the overall poverty rate. For policy to enable PWDs to have good QoL, adjusted poverty lines are more effective.

Kidd et al. (2017b) and Braithwaite and Mont (2009) discuss the crucial policy question that emerged from the thesis's findings: whether we should assess the means of the PWD or their family in disability-specific cash transfer programmes that require poverty assessment. As one of the PNCTP's two predecessors, the SHC programme did not use PMT but relied on categorical eligibility criteria, with MoSA field workers assessing the individual's disability and economic status against predefined criteria. Kidd et al. (2017b) support this approach, arguing that 'targeting mechanisms – such as proxy means tests – should not be used for individual entitlement schemes as they are unable to assess the income of individuals' (p.70). The experiences of many participants in this research underpin this point: if a PWD is evaluated against their family's income, they may be defined as ineligible, even with no independent source of income.

Integration into the wider support system for PWDs

The findings highlighted the poor integration of the PNCTP into the wider system of services that should support PWDs' independent living. Key challenges in this regard include:

- Inadequate coordination: The MoSA is under-equipped to drive a cross-ministerial mandate to coordinate disability related services. It also lacks a strong, established system for referrals or coordination between the PNCTP and the ministry's disabilityrelated vertical services.
- Lack of integrated disability policies: The MoSA's mandate to coordinate different programmes is undermined by huge data gaps and fragmented programming with different objectives, run by a mix of public, private, and international agencies.

These findings underpin the call of other studies for stronger integration of and coordination between cash transfers programmes and other social services to ensure a positive impact on PWDs. Schneider et al. (2011), for example, emphasise that in addition to cash transfers, 'almost all [PWDs] require some form of accessible services, support to cover extra costs associated with disability, personal assistant allowance, etc.' (p.43). Of particular importance, therefore, is access to employment opportunities to prevent PWDs becoming or remaining marginalised passive recipients of social assistance (Mont, 2010; Mleinek and Davis, 2012).

So far, efforts in LMICs to link cash transfer schemes targeting PWDs with broader social protection and other social services are mixed. In Schneider et al.'s (2011) study of coping strategies in South African households with one or more chronically ill members, combined access to cash transfers (including but not limited to disability benefits) plus access to free healthcare services provided the best context for household coping. Conversely, those households with only one of these two social protection components struggled and often fell into critical poverty. A review of non-contributory disability benefits, including mainstream schemes with disability components, in Argentina, Ghana, the Kyrgyz Republic, and South Africa revealed similar trends to those found in this thesis (Abu Alghaib and Wilm, 2016). All four countries presented linkages between contributory and non-contributory schemes, and/or to other social or support services, categorical subsidies, and non-cash benefits. Stronger links were evident between non-contributory schemes and access to free medical care, whereas linkages to employment and vocational training programmes were limited by poor availability. However, the combination of non-contributory cash benefits and access to free medical care was insufficient to cover disability-related rehabilitation costs. Furthermore, the benefits of free access to public healthcare were compromised by the extra costs of associated services, such as accessible transport, personal assistance, and technical aids (Abu Alghaib and Wilm, 2016).

Complementary services and programmes seem critical in creating an enabling environment for PWDs to live independently, complemented by direct cash schemes to cover additional disability-specific costs. In this regard, there is scope to improve referral, integration, and coordination in Palestine, especially between non-contributory schemes and employment programmes, to increase the PNCTP's transformative effects.

Monitoring and evaluation

The findings reveal several concerns regarding how the PNCTP is monitored. First, utilisation of the existing MIS is poor in terms of accuracy and coverage, mainly in relation to reaching the most marginalised community members, including PWDs. Second, existing complaint procedures (including the complaint unit) are inaccessible for persons with almost all types of disabilities. Third, there is limited engagement of DPOs in the PNCTP's design, monitoring, and evaluation. Finally, there are no monitoring mechanisms to scrutinise the programme's impact on PWDs' living standards and independent living.

Given the systemic weaknesses, the current PNCTP accountability mechanisms seem incapable of capturing disability-related inequalities. Neither PWDs' access to the scheme nor the barriers they face are regularly monitored. The programme's MIS does not include robust indicators on disability and is not sufficiently disaggregated to monitor the challenges faced by PWDs. This weakens the PNCTP's effectiveness in tackling poverty and vulnerabilities among PWDs.

According to Jones and Shaheen (2012), there is not yet an embedded M&E strategy, nor any plans to implement participatory approaches – e.g. social audits – which would enable communities to provide regular feedback to programme implementers. Community social protection committees have some limited involvement in decisionmaking around targeting, and in debating inclusion and exclusion errors, but are not mandated to conduct wider programme M&E. Further, it is not clear that groups with specific vulnerabilities, including PWDs, are actively engaged in the process (Jones and Shaheen, 2012).

The situation across the MENA region differs little from that in Palestine. Devereux (2015) argues that many countries across the region lack sufficient capacity to manage information and M&E systems, as required to support more transparent, efficient, and accountable protection services. The lack of recent and reliable data on both poverty and disability is challenging. In Lebanon, for example, the last national household survey was conducted in 2004, yet these data are still used for programming. Programmes also lack effective MISs to enable lesson-learning on how to improve their design and implementation (Devereux, 2015).

The thesis's findings support Gooding and Marriot's (2009) argument that the need to monitor PWDs' inclusion in social cash transfer programmes is not widely recognised in the literature. There is little evidence of programmes in developing countries that regularly monitor disability

inclusion or access barriers for PWDs. Few, if any, MISs include disability indicators. Some inquire about disability, usually based on self-reporting. Disability data are not disaggregated by type or severity. There have been very few evaluations of disability-specific schemes, and almost no disability-inclusive evaluations of mainstream programmes (Kidd et al., 2017b).

Regarding complaints mechanisms, administration systems are often complex and unaccountable (Gooding and Marriot, 2009). There is little evidence that social transfers have increased empowerment or changed structural inequalities. Among societies' poorest and most-excluded members, beneficiaries are unlikely to possess the resources to protect their rights and provide the feedback needed by implementers to improve programmes (Browne, 2014). There are few examples of good complaints mechanisms, and even fewer that are adapted for PWDs. In South Africa, a rare example of a country with a developed complaints mechanism, around 95% of appeals are related to the Disability Grant, usually concerning the disability assessment (Kidd et al., 2017b).

Since the PNCTP's M&E system fails to capture disability, Palestine is not meeting its obligations as a CRPD state party: Article 33(3) requires that '[c]ivil society, in particular [PWDs] and their representative organizations, shall be involved and participate fully in the monitoring process'. Yet Palestine's national monitoring processes have only limited DPO engagement and lack informed citizen participation and opportunities for providers and beneficiaries to interact, thus neglecting key features of a well-rounded social protection approach (Pereznieto et al., 2014).

7.1.3. Impact of the PNCTP on PWDs' independent living

The research found the PNCTP's impact on PWDs' independent living to be fairly negligible. The experiences of participants with disabilities highlighted two gaps in this regard: the PNCTP's poor linkages with support and mainstream services; and the limited protection or cure from poverty that the PNCTP offers PWDs.

Progress towards realising independent living

Independent living, as enshrined in Article 19, CRPD, is constituted by three major elements: the right to choose where to live, access to mainstream services, and access to disability-specific support services. In practice, however, progress in implementing these rights varies greatly between different contexts. In Europe, where there have been active independent living movements since the 1960s, the extent and quality of personal assistance policy and

implementation remains mixed. In many EU countries, PWDs are unable to obtain government-funded personal assistance, or funding is restricted to those with physical and sensory impairments (Jolly, 2009). Townsley and Ward (2010) mapped the living situations of PWDs across Europe: only three countries (Denmark, Norway, and Sweden) had no evidence of large-scale institutional living. In four countries with a deinstitutionalisation policy (Poland, Latvia, Bulgaria, and Romania), PWDs nonetheless have few options for community-based living, forcing many PWDs to 'choose' residential care, in the absence of other options. Evidence of the implementation of independent living policies in LMICs is very weak. Among the few examples is Fisher and Jing's (2008) analysis of China, which found that responsibility for independent living rests primarily with PWDs themselves and their families, with the state's support being limited to institutional care.

In Palestine, independent living has not been taken up as a philosophy or movement but is, rather, a personal aspiration of PWDs. While participants' understanding of independent living varied greatly, the discussions showed that all three aspects (right to choose where to live, access to mainstream services, and access to support services) were highly relevant to them. Notably, Palestine does not follow an institutional approach: there are no residential institutions for PWDs since, culturally, it is the family's responsibility to provide accommodation and support to members with disabilities. However, even in the absence of an institutional approach, participants reported strong limitations of their right to choose where to live. The stories they shared reflected their daily struggles to access any of the three aspects of independent living. WWDs reported additional social and cultural barriers to accessing their desired living arrangements. They indicated that their families would strongly resist and oppose their wish to live separately, even if they could afford it, attributing their families' behaviour to overprotection and a lack of confidence in their ability to manage their lives independently.

There is no available evidence on CT's impact on PWDs' independent living; however, CTs have been shown to potentially empower PWDs in LMICs to make life-improving decisions. In Zambia, for example, one of the primary benefits reported by recipients is an increased sense of worth and control over their own lives. Examples include being able to attend church (being able to pay their dues), becoming members of cooperatives, and participating in voting for committees. In Mozambique, PWDs reported that CTs' predictability allowed them to plan their expenses, and that transfers afforded them greater dignity in the eyes of their family and wider community.⁴⁰ PWDs in Bangladesh reported that CTs 'definitely contribute to some self-

⁴⁰ Systematic review findings.

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esteem and respect earned within the family[, whereas previously] they were considered a burden and a liability' (Palmer, 2013, p.150).

The PNCTP's positive impact on PWDs' independent living was minimal. While it has achieved demonstrable impact at household level, the findings suggest the need for greater focus on addressing the multiple and unique vulnerabilities that can accompany disability and prevent independent living. This evidence confirms the disability-related results of four recent impact-evaluations of the PNCTP (Abu-Hamad and Pavanello, 2012; Hackstein et al., 2013; Pereznieto et al., 2014; Abu-Hamad et al., 2015), as summarised in Box 7.1:

Box 7.1 Summary of the disability-related findings of prior impact studies

- Despite PWDs being eligible for free government health insurance as CT beneficiaries, there are limits to the available medicines and coverage of rehabilitation and assistive device services. PWDs are, therefore, required to cover such costs, placing a significant economic burden on vulnerable households.
- The merger of the two prior schemes negatively impacted PWDs. The discontinuation
 of the targeted programme for PWDs following the PNCTP's 2010 launch deprived
 some families of valuable support to access services, including equipment, or personal
 care items, and access to therapeutic services.
- 3. The impacts of the CT on PWDs are limited, but include caregivers experiencing a high workload, exhaustion, and social isolation when caring for disabled and the elderly.
- 4. The programme's poverty-targeting approach is too narrow, limiting its capacity to respond to the complex and interlinked vulnerabilities facing PWDs.

Sources: Abu-Hamad and Pavanello (2012); Hackstein et al. (2013); Pereznieto et al. (2014); Abu-Hamad et al. (2015).

However, these studies seemingly fail to consider these disability-specific vulnerabilities and challenges when assessing the PNCTP's overall effectiveness, as summarised in Box 7.2.

Box 7.2 Summary of the general findings of prior impact studies

- The general wellbeing and QoL of all household members have improved since the PNCTP's introduction, as reflected in, e.g., improved nutrition and food security, better living environments, and access to health and education services.
- The PNCTP is reported to have increased people's sense of self-esteem, dignity, and
 assertiveness, with the CT giving them greater security and control over their lives and
 contributing towards greater financial independence.
- 3. In male-headed households, women reported benefiting from an enhanced role in household decisionmaking.

Sources: Abu-Hamad and Pavanello (2012); Hackstein et al. (2013); Pereznieto et al. (2014); Abu-Hamad et al. (2015).

Barriers to PWDs' independent living are found in both the content and implementation of law, policy, and programming. In Slovenia, for example, though domestic laws support some forms of deinstitutionalisation, there is no specific law to support independent living in the community (Zavirsek and Gorenc, 2009). By contrast, in the UK, the legal and policy frameworks provide for personal assistance, but local authorities responsible for administering the relevant payments increase access restrictions: over 70% of authorities limit payments to those considered most severely disabled (Jolly, 2009). Further obstacles to the implementation of Article 19, CRPD include:

- Misunderstanding or misuse of the key terms: a) choice and control; and b) access to support in the community and to mainstream services;
- Negative attitudes and stigma, hindering the development and implementation of inclusive policies, even with political will for reforms;
- Lack of or inadequate or inaccessible community support services, which reduce
 PWDs' ability to make choices about their lives;
- Inaccessibility of mainstream community services and facilities (e.g. lack of accessible transportation);
- Barriers relating to other CRPD provisions with implications for Article 19, for example, in relation to social protection, education, or employment (European Network on Independent Living [ENIL], 2017).

Many of the above aspects that prevent or hamper PWDs' choice and independence were also raised in discussions with PNCTP participants with disabilities. However, the most prominent concern, which will be discussed in more detail below, is poor access to services.

Protection from or alleviating poverty

Poverty reduction or alleviation is crucial for PWDs' independent living because it is a prerequisite for overcoming their exclusion across different levels and areas of life. The findings suggest that the PNCTP does not offer PWDs the same protection against or alleviation from poverty as non-disabled Palestinians.

If designed as a personal grant directed towards PWDs, cash transfers have proven to effectively reduce poverty levels for PWDs and their families. In South Africa, national data suggest that 77% of disability grant recipients spend this money mainly on food and electricity. In the Western Cape and Eastern Cape provinces, disability grant recipients use the cash to pay for groceries, medicines, their education, or accommodation. Likewise, in Namibia, 90% of disability grants were found to be spent on necessities, particularly food (Elgazzar et al., 2010). In Botswana and South Africa, research has shown that when income is lost due to illness, grants are crucial to help meet basic needs such as food. Also in South Africa, cash benefits are credited with equalising income between households with and without disabled members (Loeb et al., 2008).

However, whilst cash transfers to households improve their economic status, it is unclear how they affect the economic situation of PWDs themselves. An analysis of Namibian national survey data found participation in various social protection programmes to significantly reduce a PWD's probability of living in a poor household (Banks et al.,2016). Yet there is evidence that benefits distributed at household level may not always be spent on disabled members (Palmer, 2013). In South Africa, for example, PWDs expressed concern that they lacked control over grants, and that the needs of the wider household were prioritised over their own. Likewise, in Palestine, the shift from individual to household poverty alleviation shifted control over the payment, significantly undermining PWDs' financial status and, thus, their independent living choices.

In their systematic review, Banks et al. (2016) found that not all disability grants directed to PWDs were sufficient to protect or promote minimum living standards, let alone independent living. In Vietnam, for example, the cash transfers are insufficient to even cover PWDs' minimum daily food intakes. Such evidence raises questions regarding the adequacy of social cash transfer amounts, whether household or targeted. Banks et al. (2016) highlight that social

⁴¹ Systematic review findings.

⁴² Systematic review findings.

protection schemes often fail to cover the additional disability-related expenses – such as assistive devices, and medical and transport costs – which often impose a significant financial burden on households: Disability-associated costs can account for as much as 18% to 31% of total household income. The failure of social cash transfer programmes to compensate for these extra costs can propagate economic inequalities between recipients with and without disabilities. In Vietnam, for example, although health insurance protected PWDs against catastrophic health expenses, they were at increased risk of poverty compared to other community members, due to continual OOP expenditures for items not covered by their plans (Banks et al., 2016).

The Palestinian experience supports these challenges: recipients with disabilities unanimously found PNCTP transfers inadequate to meet additional disability-related costs. A World Bank study (2017) confirmed the insufficiency of PNCTP payments to address the special needs of households with disabled members. Most of the support services for Palestine's PWDs are provided by NGOs and the private sector, for which the fees and costs that must be met by the PWD or their family may be high. Disability-related extra costs, such as transport, are often considerable in Palestine, and there is no system to address these expenses (World Bank, 2017). The economic barriers for PWDs to meet their disability-related needs puts them at higher risk of becoming trapped in poverty: They constantly need to prioritise their limited financial resources for these purposes, and they and their families are forced to make 'painful choices': to spend considerable sums paying for such services (if they even exist), or have a family member provide support, causing an additional financial burden as this individual cannot simultaneously work.

The findings reinforce the global argument that PWDs and their families are more likely to become poor if such costs are not considered in social protection policies; they also underpin the literature indicating the absence of a universally agreed approach to measuring disability-related costs. While the PNCTP addresses some immediate financial costs of disability, it does not meet the continuous additional costs. The transfer amounts are low by income-replacement standards, while insurance does not offer financial protection against all healthcare costs, and assistive technology is omitted from insurance entitlements altogether. Where assistance, such as rehabilitation services, are claimable under the insurance, accessibility remains low due to supply-side barriers, resulting in additional direct and indirect costs (Palmer et al., 2015). As such, the findings also highlight the failure of the Palestinian health insurance system to reduce OOP healthcare payments, which is affecting households' living standards, especially for those with disabilities (Abu-Hamad and Pavanello, 2012; Hackstein et al., 2013; Pereznieto et al., 2014; Abu-Hamad et al., 2015).

For those who previously received cash transfers under the SHC programme but were excluded from the PNCTP by the revised eligibility criteria, the scheme has negatively impacted their poverty status. The reform deprived these PWDs of valuable support services, and the term 'income loss' was repeatedly mentioned by participants as a potential cause of those individuals and their families falling into poverty. In addition, the number of households enrolled in the PNCTP is rationed according to funding constraints, resulting in a waiting list, even among eligible households. In the absence of cash benefits that categorically target PWDs, such delays may expose this group to a particular risk of falling into or being trapped in poverty.

Household transfers, such as those under the PNCTP, cannot cover all disability-related costs as a stand-alone measure. It is the absence of other targeted disability benefits in Palestine that highlights the PNCTP's failure to account for disability or, rather, the need for it to respond to at least some disability-related costs and lower standards of living by including disability more prominently in its design.

Access to mainstream and support services

Cash transfers form an important part of social protection programming for PWDs. In HICs, direct cash transfers to PWDs impact significantly on their independent living. In the last two decades, advanced welfare states have introduced 'cash-for-care' schemes, whereby individuals receive money or vouchers to purchase care (Arksey and Baxter, 2012). These have been heralded by the disability movement as an important means to achieving independent living and, hence, greater social justice, through enhanced recognition and financial redistribution (Riddell et al., 2005). In Scotland, Witcher et al. (2000) found that:

- Direct payments can dramatically increase recipients' choice and control over their lives,
 particularly when contrasted with limitations imposed by authority-provided services.
- Direct payments allow recipients to choose by whom, when, and how assistance is provided, improving significantly the quality of and their control over support (arrangements).
- Direct payments could promote social inclusion, enabling recipients to participate in social and political activities.

In Arksey and Baxter's (2012) longitudinal study, one of the strongest themes to emerge concerned direct payments' impact on families and carers. Interviewees identified reduced pressure on family members as among the most important benefits of using direct payments for a personal assistant (Arksey and Baxter, 2012).

However, it became clear in this research that cash transfers (even targeted disability grants) are insufficient as a single measure. Social protections can only effectively support PWDs'

independent living when strongly linked with access to necessary mainstream and support services.

Globally, there is moderate evidence that social cash transfers can improve PWDs' access to basic services, most notably to healthcare, whereas evidence on the effects on access to education and employment is relatively weak. The effects of targeted disability benefits on access to health services are mixed, partly due to benefit-level differentials between countries. In Brazil, transfers have enabled PWDs to afford private and better quality medical services, but the disability pension in India was found insufficient to pay for one week's medicine for people with severe impairments (Gooding and Marriot, 2009). Although health insurance in Vietnam significantly increased PWD recipients' use of health services, some issues around the sufficiency of coverage were found, particularly in comparison with recipients without disabilities (Banks et al., 2016).

Evidence on the impact of CTs on livelihoods and labour market participation is mixed. A study in two South African provinces showed that the grant's provision improved access to job-seeking opportunities. However, a second reported that the disability benefit prevented recipients from entering into and remaining in employment, while a third reported that the grant might have encouraged men to drop out of the workforce. Indeed, Banks et al.'s (2016) systematic review results indicated a 10% increase in coverage of the grant to be associated with a 15% drop in employment rates among PWDs. Nevertheless, in contexts of high unemployment and poor working conditions, reliable grants can offer a more secure and dignified livelihood. For many PWDs, even insecure employment is unlikely, whether due to impairment or social and environmental barriers. In these situations, it is not grants that prevent or stop PWDs from working but, rather, the absence of viable employment options (Palmer, 2013).

The Palestinian experience differs little. Regarding disability, the first strategic objective of the MoSA's Social Protection Strategy confirms the government's commitment to developing social assistance and empowerment systems for poor and marginalised groups and calls for the development of social services for them. To fulfil this objective, the strategy highlights the need to develop a system of regular and emergency cash and in-kind social assistance that is both interconnected and harmonised with the social services system. However, the design and implementation of the PNCTP was not found to support this objective, in terms of both accessibility and availability.

⁴³ Systematic review findings.

The findings highlighted the PNCTP's poor capacity to link recipients with disabilities to essential services that would support their independent living. Given the poor integration of the PNCTP with the wider support system for Palestine's PWDs, their access to support and mainstream services through the programme is limited. This includes programmes under the MoSA (e.g. the VAT exemption scheme for vehicle purchases or the Fund for the Rehabilitation of PWDs) but also other ministries (e.g. the provision of rehabilitation and assistive devices under the MoH). The consequences may be further medical and functional complications, and (continuing) economic and practical dependency of PWDs, rather than empowerment and independent living. The PNCTP even explicitly prevents beneficiaries with disabilities from accessing some social protection programmes: For example, making eligibility contingent on all family members being unable to work prevents some PWDs applying for support from the Fund for the Rehabilitation of PWDs, to avoid endangering their families' eligibility. The same restriction applies to the 5% employment quota for PWDs in the government sector.

In addition, the shift from individual to household poverty alleviation with the PNCTP, and thus the change in control over the payment, further limits PWDs' access to necessary mainstream and support services. Yet the findings also revealed problems with both the accessibility and availability of services in Palestine, especially for support services such as personal assistants and sign language services. A clear disassociation between PWDs' needs and the services available to them was identified. The disability-related vertical services offered by the MoSA tend to be severely understaffed and under-resourced relative to the levels needed to effectively support PWDs' independent living within the community. The health insurance, for example, has limited cover for disability-specific medications, and does not ensure access to and coverage for rehabilitation services and assistive devices. This supports Banks et al.'s (2016) argument that health insurance is insufficient to cover more complex healthcare needs, which PWDs are more likely to have. They found PWDs' self-reported healthcare spending to be four times greater than that of persons without disabilities. Furthermore, other schemes such as subsidised housing, personal assistance, or sign language interpretation are completely lacking.

Transformative social cash transfers

The research results highlight that disability-specific vulnerabilities must be understood to extend beyond financial limitations, emerging from PWDs' interactions with their sociopolitical context. In this regard, the findings revealed the PNCTP's limited capacity to respond to the multiple forms of stigma and discrimination at the intersection between gender, disability, and poverty (WHO and World Bank, 2011). In failing to remove the socioeconomic barriers that

restrict PWDs' decisionmaking and to address the social and structural inequalities that PWDs face, the PNCTP only has limited impact on PWD's autonomy and capacity to live independently.

Accordingly, policies and programmes should not seek to merely reduce the risks faced by PWDs in a given context. Rather, for them to support PWDs' independent living, they need to transform the context itself by redressing the power imbalances that create those risks. Social protection for PWDs requires such a 'transformative' approach, aiming to support equity, social justice, and empowerment. As such, the results underpin the argument of Sabates-Wheeler and Devereux (2008) that social protection should transcend providing 'economic support and seek to tackle "non-economic" or "social vulnerabilities" produced by structural inequalities and inadequate rights' (Babken Babajanian, 2013, pp.4-5). Although the PNCTP is considered exceptional in the MENA region, it does not yet realise its transformative potential for promoting social and economic inclusion as key to independent living. Indeed, by relying strictly on means-testing and abolishing many of the categorical supports for which PWDs were eligible under earlier schemes, the PNCTP has effectively 'relegated Palestinians with disabilities to the shadows' (Hamad et al., 2015, p.20; see also World Bank, 2012b, p.12).

Ironically, prior to the 2010 merger of its two cash transfer schemes, Palestine was closer to what could be considered a transformative approach, promoting the independent living of Palestine's PWDs. That model could have been enhanced through greater linkages between the two schemes; effective linkages with available services; reforms of the mainstream scheme towards disability inclusion; and increasing efficiency and PWDs' participation in M&E and accountability measures. However, by merging the two schemes, Palestine moved further away from fulfilling PWDs' independent living rights pursuant to Article 19, CRPD. Therefore, Palestine's experience provides valuable policy directions for countries considering cash transfer scheme reforms pursuant to the CRPD.

7.2. Transformative cash transfer programmes: fostering independent living for PWDs

In examining the role of LMIC cash transfer programmes in supporting PWDs' independent living rights, it became clear from the findings that, at policy level, addressing disability through cash transfers is complex, especially if combined with political, structural, and resource factors. The CRPD's states parties need to better understand what drives the greater impact of cash transfer programmes on PWDs. The thesis attempts to identify the necessary

components of an inclusive social protection policy that transcends the traditional medical or charitable conceptualisations of PWDs. The main argument is that ad hoc responses to PWDs' needs in cash transfer programmes are insufficient to deliver a sustainable and positive impact on their wellbeing and independent living. The evidence shows that, for disability and cash transfers, a 'one size fits all' approach is ineffective. Political will, resources, and broader consideration of disability across all social policies, core design features, and implementation approach all contribute to determining a cash transfer programme's potential impact on PWDs.

Policy interventions to address PWDs' independent living rights must focus on institutional, social, and political structures, rather than just income (Devereux and Sabates-Wheeler, 2004; Jones and Shahrokh, 2013). Direct payments or cash transfers are one policy solution that may, to some extent, enhance PWDs' autonomy and choices. However, the range of social protection interventions should extend well beyond social transfers, with wide ranging measures to ensure access to social services, thus promoting empowerment and reducing dependency (Devereux and Sabates-Wheeler, 2004; Jones and Shahrokh, 2013; Palmer, 2013). The concept of independent living necessitates considering social protection policies from a transformative perspective, addressing the relational basis of injustice for PWDs and other vulnerable groups and individuals.

As Jolly (2009) explains, the concept of independent living 'requires a number of societal practices to be put in place which do not discriminate the life chances of an individual purely because they have an impairment (or multiple impairments)' (p.3). This involves access to cash payments or personal support services but also appropriate housing, transport, education, employment, and training.

7.3. Suggested policy framework

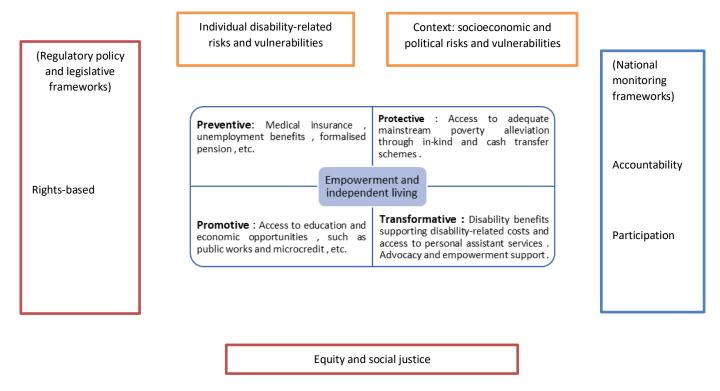
Based on the findings of this research, the following key aspects for governments and policymakers are proposed for ensuring that cash transfer programmes in LMICs foster PWDs' independent living and address their social exclusion:

- Ensuring explicit obligations in terms of independent living and social protection for PWDs in national legislative and regulatory frameworks.
- 2. Combining effective access to mainstream schemes with disability-specific provisions that are sensitive to the various types and levels of disability.
- Linking the PNCTP and any new disability-specific cash transfer programmes to
 mainstream and support services, with coordinated referral mechanisms guaranteeing
 equal access.

4. Establishing a well-coordinated national monitoring and evaluation system that is inclusive and participatory.

Figure 7.2 presents a conceptual framework for designing a transformative social protection policy supporting PWDs' independent living.

Figure 7.2 Conceptual framework for a transformative social protection policy supporting PWDs' independent living



Any social protection system should follow and be assessed against the principles of the CRPD, particularly with regard to non-discrimination, participation, inclusion, equal opportunities, accessibility, etc. Each policy intervention needs to operate in close coordination with other policies and services to reduce vulnerability and poverty, and increase independence. Implementing an inclusive, mainstream social protection system will simultaneously guarantee for PWDs both the protective aim of social protection and access to mainstream services through promotive interventions. Additionally, preventive policy interventions should aim to reduce PWDs' potential medical and functional risks from limited access to medical and rehabilitation services. Moreover, the availability of disability-specific cash schemes will ensure access to required support services, which are essential for PWDs' autonomy and independence. With this policy in place, PWDs will have autonomous capability to steer their life through self-determination, and full control of their own decisions.

1) Ensuring explicit obligations in terms of independent living and social protection for PWDs in national legislative and regulatory frameworks.

This can be achieved in Palestine through:

Legislative frameworks: Alignment of the national disability definition in the 1999 Disability Law and other related laws and regulations with the CRPD; harmonisation of legislative texts regarding access to a wide range of services at local level, avoiding contradictory entitlements that often become disincentives for inclusion and participation; and determination of clear eligibility criteria across the different programmes (including the PNCTP) based on the aforementioned definition, ensuring transparency on who is considered disabled and reducing inclusion and exclusion errors.

Accessibility: Information regarding existing services, entitlements, and more general social rights must be accessible for all PWDs, in terms of both dissemination and communication methods (e.g. braille, easy-to-read). This aspect is particularly important for people living in isolated or rural areas, for whom it is usually very difficult to travel to municipal agencies for information or evaluation. Likewise, access to infrastructure and transport needs to be ensured, and reasonable accommodations made, where needed.

Disability assessment: Disability assessments must move beyond gatekeeping and a medical approach to a more comprehensive assessment, such as the ICF. This may include reconsidering which services necessitate a disability assessment. Yet it also involves reviewing the objectives/purposes of disability assessments for the different programmes: it is often unclear why disability is assessed and what information is needed from an assessment. Agreement on the purpose of disability assessments for the various services will clarify when an assessment is required, and which criteria and processes need to be developed or applied, thereby abandoning the current 'one size fits all' approach.

Twin-Track Approach: Access to social services and programmes, including cash transfer programmes, needs to follow the twin track approach. The first track aims to ensure that PWDs are equally addressed in mainstream services and programmes geared towards the entire population, such as access to health services and the PNCTP. The second track comprises disability-specific benefits and services, aiming for

PWDs' empowerment and independent living, such as the old SHC cash scheme supporting disability-specific costs and the Fund for the Rehabilitation of PWDs.

2) Combining effective access to mainstream schemes with disability-specific provisions that are sensitive to the various types and levels of disability

As discussed earlier, a twin-track approach to inclusive social protection is needed. Countries should first make mainstream social protection schemes as inclusive as possible. Notwithstanding the importance of doing so, this needs to be complemented by disability-specific programmes to meet PWDs' specific needs.

a) Reforming the PNCTP to be more disability-inclusive:

Improving disability inclusion in mainstream cash transfer schemes aiming for poverty alleviation, such as the PNCTP, is key to achieving fairer and more equitable distributions to PWDs and their families. This can be accomplished through:

Transfer value: Adjustment of the benefit payment amounts for disability-related extra costs for households with one or more PWD member, accounting for the number of PWDs in the household and their degree of disability.

Targeting mechanisms: Adjusting the existing PMTF to account for disability-related extra costs. Guaranteeing equality of impact for PWDs requires either a separate (higher) poverty line for households with one or more PWD member, or an alternative targeting mechanism that combines a consumption-based poverty measure with a functional disability measure to estimate the additional costs. Additionally, using the WG Short Set for PNCTP data collection will ensure consistency with other national approaches to collecting data on disability.

Conditionalities: Removal of inability to work as an eligibility criterion for disabled household members. This will support PWDs in covering additional disability-related costs, which could otherwise expose them and their families to a higher risk of remaining in or falling deeper into poverty.

b) Consider designing a disability-specific cash scheme:

The findings indicated the need to consider creating a parallel disability-specific cash scheme operated by the MoSA, based on its experience of the previous SHC programme. Such a scheme is key to facilitating access to support services, such as personal assistance or sign language interpretation, and/or securing a minimum income for people with no earnings from labour due to disability. In Palestine, such individualised support is essential for promoting higher levels of independent living, as cash gives recipients the flexibility and power to make their own choices; PWDs, in particular, require multiple types of support to live independently.

Additional design features to consider:

Transfer value: Adapting payment amounts to the level or degree of disability. The payments should enable PWDs to cover any disability-related extra costs, such as goods and services, as necessary to promote their equal participation and independent living. The research showed that determining the amount through a 'one size fits all' model does not adequately address the range of additional financial needs of PWDs.

Means-testing: Disability benefits should not be subject to means testing, since selfemployed PWDs still incur disability-related expenditures, such as the costs of a support worker or accessible transport. If such costs are not covered, many PWDs who seem to be above the poverty line may, in reality, fall below it.

Payment method: Payments need to directed to PWDs, and payment methods and procedures, e.g. payment via a bank, need to be fully accessible to all types of disabilities and available at community level. This would reduce PWDs' exposure to additional expenses and delays in receiving the payment, in addition to restoring their power over how it should be spent.

 Linking the PNCTP and any new disability-specific cash transfer programmes to mainstream and support services, with coordinated referral mechanisms guaranteeing equal access.

Cash transfers alone are insufficient to cover all of a PWD's independent living needs. The availability, accessibility, and affordability of various mainstream and support services are equally vital to increasing the impact of cash transfer schemes on PWDs.

Suggested amendments to ensure the above are:

- Referral: Reform of the existing referral procedures, moving from a bureaucratic inventory of impairments towards an accessible service that provides comprehensive assessment and advice, in an inclusive approach which is responsive, useful, and respectful to users. The evaluation of needs should become person-centred and adapted to the particular situation and abilities of each individual. Their personal choices should be considered and included in the personal plan of services or in the recommendations for intervention. The concept of a 'one stop shop' should be introduced to simplify the referral procedure and render it more effective.
- Availability: Widening the spectrum of social services at community level is an
 acknowledged priority that needs adequate resources, commitment, good planning,
 and follow-up mechanisms. This process will contribute to the necessary transition
 towards decentralisation of services and support for PWDs' community living. This
 requires promoting the development of relevant community-based services in
 governmental agendas, if they do not already exist.
- Health & rehabilitation: Developing stronger linkages between cash transfer
 programmes and both habilitation and rehabilitation services as key areas to promote
 access for PWDs. Most fundamentally, this would require the expansion of existing
 medical insurance schemes to cover relevant services and goods (e.g. assistive devices
 and medical rehabilitation services).
- Economic empowerment: Establishing closer linkages to economic empowerment services, such as DEEP and the MoSA's Economic Empowerment programme for PWDs, in addition to other skills development, vocational training, and small business loan schemes run by various ministries, NGOs, and the UNRWA. This would increase the transformativeness of grants.
- Support services: Several types of services need to emerge (or develop) more rapidly and more systematically, due to their crucial importance in the lives of PWDs, such as sign language interpretation, personal assistant services. Accessible transport services, either through public transportation or private taxi companies regulated by the Ministry of Transportation, need to be available and affordable to PWDs. This is a key priority as it affects access to other social services.

4) Establishing a well-coordinated national monitoring and evaluation system that is inclusive and participatory.

Understanding the implications of national social policies, including cash transfer schemes, for PWDs' living standards and independent living requires the following:

Data: Collecting up-to-date disaggregated information (by age, gender, disability type, location) within existing M&E systems, including the PNCTP's MIS, to track the national response to PWDs' needs and measure its effects on PWDs' access to services and programmes. This will involve developing relevant capacities among staff, suitable tools, and consistency between the different data collection measures.

Participation: Involving and consulting PWDs – via their representative organisations (DPOs) – in the M&E processes of national policies and programmes, including the PNCTP's M&E system and the Higher Council on Disability, which is mandated to monitor PWDs' access to social services. PWDs are the most relevant contributors to in-depth understanding of the access barriers they face and the specific needs and vulnerabilities of PWDs with different types of disabilities.

Accountability: Ensuring that existing complaint mechanisms are accessible and adaptable for PWDs with different types of disability. They should also consider gender-related barriers that could inhibit women with disabilities voicing their complaints. Adequate resources are required to ensure the provision of tools and measures for collecting and processing complaints, offering simplicity, effectiveness, and accessibility to PWDs.

Capacity building: supporting DPOs to develop collective action for disability rights, advocating regulatory changes to protect PWDs against inequality and abuse and to enhance social equity. For PWDs to have the freedom and opportunities to lead lives they value, the paradigm must shift from the legacy of paternalism, dependency, and stigma towards support as a state obligation, premised on human rights, equality, and social justice. Support must give 'voice' to PWDs by enabling them to exercise choice and control over their own lives, irrespective of their impairments, rather than having to obey those managing their needs.

7.4. Limitations and future research

7.4.1. Research limitations

Several limitations should be considered when interpreting the findings of this thesis. First, available information on social protection and disability in Palestine was extremely limited, as very little has been published on this topic. Second, the small number of participants and the qualitative nature of the research may have created biases which could limit the validity of the generated evidence. Third, because the SHC programme was no longer operating during the research period, it was not possible to deeply capture the differentiation in policy design, governance, and implementation between the mainstream and disability-specific schemes in Palestine. This may have excluded other relevant policy dimensions requiring investigation.

Finally, while this research considered regional and global practices around cash transfer programmes and disability in LMICs, it focuses primarily on Palestine as a case study. Given the influence of occupation-related socioeconomic and political factors in shaping the design of social protection programmes, the findings for Palestine may not be generalisable to the situations in other LMICs. Similar research is required in other countries to allow comparisons across different contexts, thereby increasing the ability to guide policy decisions.

7.4.2. Future research

The research process and findings highlighted the need for more evidence on how social cash transfers in LMICs can become more inclusive of PWDs, including the identification of good practice in existing programmes, and the piloting of new interventions to test disability-inclusive approaches. In this regard, the following areas for further research can be prioritised:

Calculating the extra cost of disability: More research is needed to understand how these costs differ by disability type, and to determine how they are best calculated. This information will help to determine the additional income needed by PWDs or a household with a disabled member, and to consider this in setting transfer values.

Social protection data on disability: There is a need to identify means to use and make available (disaggregated) data on disability for the design and implementation of both mainstream and disability-specific social cash transfer programmes, to ensure that these interventions effectively address PWDs' needs and vulnerabilities.

Financing disability-specific cash transfers: Further research is required to analyse and understand the different sources financing disability-specific schemes in LMICs. This would enhance our understanding of feasible costing methodologies, and promote the identification and replication of sustainably financed social protection benefits for PWDs in countries with limited resources.

Impact of cash transfer schemes on PWDs in LMICs: There are few studies on the impact of cash transfers on PWDs' access to social services and independent living. Future research should address these evidence gaps, generating evidence on what has and has not worked. Of particular interest are the disability-inclusive cash transfer programmes adopted pursuant to the CRPD; the impact on PWDs subject to further exclusion, such as WWDs and persons with severe and/or intellectual disabilities; and analysis of the effects of schemes targeting households on family members with disabilities.

Disability assessment: There is no evidence on the extent to which different approaches to disability assessment produce different results, in terms of access to social protection schemes in LMICs. Such contexts' disability assessment methodologies need to be further analysed and compared to determine elements of feasibility and cost-effectiveness, as well as their role in facilitating access to social protection for PWDs.

Cash transfers for PWDs in conflict-affected or fragile countries: The findings emphasized that a context as volatile and fragile as Palestine generates additional barriers to PWDs accessing and benefiting from social cash transfers. Further research is needed to understand the elements of social protection policy and implementation required to reduce inequalities for PWDs in such situations. Understanding how access and impact are informed by compounding factors, such as conflict, gender, and disability types, would be valuable for deeper understanding of how their influences can promote or hinder PWDs' independent living.

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Appendices

Appendix 1: Research participants

 Table A1.1
 Details of research participants

Method	Participants details	Total number of participants
Key informant interviews	 8 DPO Representatives. (5 in West Bank; 3 in Gaza) 11 representatives of donors, UN agencies, and INGOs (West Bank) 8 MoSA representatives (8 in West Bank; 4 in Gaza) 4 ministry representatives: 1 from each of the MoL, MoF, MoE, and MoH (West Bank) 	31
4 FGDs with PNCTP local staff	 11 local coordinators 9 managers of governorate offices 7 field social workers 5 medical doctors from the MoH (2 FGDs in the West Bank; 2 in Gaza)	32
8 FGDs with PWDs	 23 participants with physical disabilities 15 with visual impairments 10 with hearing Impairments 2 with intellectual disabilities. 6 with multiple disabilities (4 FGDs in the West Bank, totalling 30 participants; 4 in Gaza, totalling 26 participants) 	56 (21 females; 35 males ⁴⁴)
8 in-depth interviews ⁴⁵	 3 participants with visual impairments (1 male; 2 females) 5 participants with physical disabilities (2 females; 3 males) (5 in the West Bank; 3 in Gaza) 	8

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 $^{^{\}rm 44}$ Regarding residence, 26 were from urban areas, 18 from rural areas, and 12 from refugee camps. The age range was from 18 to 51 years. Two of the eight FGDs were held with WWDs.

⁴⁵ Six of the eight interviewees were PWDs who previously accessed the SHC programme and had been transferred to the PNCTP. Among the 56 FGD participants with disabilities, 21 were former recipients under the SHC programme.

Appendix 2: Systematic review of the impact of cash transfers on PWDs in LMICs

A2.1. Abstract

Context: In LMICs, cash transfers for PWDs aim to support access to basic social services in order to reduce poverty. Several LMICs have introduced cash transfers as the main policy framework to support PWDs who are poor or unable to work. However, these programmes' impacts on PWDs in different contexts has not yet been systematically reviewed.

Objective: To assess current evidence on how existing social protection programmes influence PWDs' access to services, empowerment, and independence in LMICs.

Data Sources: Studies were identified by searching a number of electronic databases (e.g. Applied Social Sciences Index and Abstracts [ASSIA], Web of Knowledge, and PubMed), scanning reference lists of papers, and consulting with experts in the field. The last search was run on 15 March 2014. Data extraction was based on existing information related to papers' adopted methods and research outcomes. The quality of identified studies was assessed in terms of relevancy, data sources, and depth of analysis.

Study Selection: The inclusion criteria for papers were as follows: written in English; use a quantitative or qualitative methodology (or both); mainly examine the relation between cash transfers and disability; published in a peer-reviewed journal or in the grey literature; focus only on LMICs, as classified by the World Bank. Of 7,506 identified papers, 59 were relevant for assessment, and 20 were included in this review.

Results: There is moderate evidence that cash transfer programmes in LMICs can improve PWDs' opportunities to access basic services, notably healthcare services. However, evidence on the impact of cash transfers on PWDs' education and employment opportunities is relatively weak, and none of the identified studies presents evidence on the impact of overall QoL, social inclusion, and independence.

Conclusions: The literature relating to disability and cash transfers in LMICs is extremely heterogeneous, with a wide range of studies — mainly situated in South Africa — using different instruments. Most studies use qualitative methods, with little or no quantitative information, and report national data from a single country. Data are particularly lacking in MENA countries. Further research is, thus, needed to explore the effectiveness of cash transfer programmes in promoting better living standards for PWDs in LMICs. In particular, scholars should aim to

define those schemes that are crucial in LMIC settings, where resources are limited and PWDs' rights mostly unrecognised.

A2.2 Study rationale

In recent years, cash transfers, especially those paid to PWDs, have become one of the most widely implemented development policies in emerging economies (Manley et al., 2011). For instance, there are different types of disability grants among LMICs, such as South Africa, Brazil, and Thailand (Durán-Valverde and Pacheco, 2012). Similarly, Gooding and Marriot's (2009) literature review on the inclusion of PWDs in cash transfers presents various models of LMIC programmes targeting PWDs, detailing who is eligible, how much is transferred, and for how many individuals. Nevertheless, the impact of cash transfers for PWDs in LMICs has not previously been systematically reviewed (see Mitra, (2010b), despite the provisions in Article 28, CRPD confirming that PWDs in all countries have an equal right to social protection (Rohwerder, 2014).

A2.3 Study objective

PWDs face a high risk of poverty and are often at risk of social exclusion (Yeo and Moore, 2003). Hence, this systematic review examines evidence on the relationship in practice between cash transfers – a key social protection policy intervention – and disability. In particular, it pinpoints studies exploring the impact of programmes that encourage greater access to services, empowerment, and independence for PWDs; it also discusses gaps in current debates and information, and proposes potential directions for future research. The main objective is to assess current evidence on how existing social protection programmes influence PWDs' access to services, empowerment, and independence in LMICs.

The key sub-objectives of the presented analysis are as follows:

- identify the strategies and schemes within cash transfer programmes that address disability;
- explore and analyse existing evidence of the impact of cash transfers on PWDs (mainly
 in creating equal access to services and improving their ability to live independently);
- identify the methods used to evaluate this impact;
- synthesise the findings and draw conclusions on the strengths and implications of these programmes;
- identify gaps in the literature for future research to investigate.

A2.4. Methods

Inclusion and exclusion criteria

Inclusion and exclusion criteria were set prior to search term development, both to guide the search and for reference during article screening. The PICOS framework was used to define the scope (Petticrew and Roberts, 2008):

- Participants: PWDs in LMICs that receive cash transfers;
- Intervention: Qualitative, quantitative, and mixed methods; intervention and
 descriptive, research and development studies that examine cash transfers and
 disability. Types of documents to be included are primary and secondary (review)
 studies (including the grey literature);
- Comparator: There is no comparator restriction;
- Outcomes: Studies that demonstrate how cash transfers influence access to services and independent living;
- Study design: Quantitative, qualitative, and mixed method studies.

Types of studies

The following types of studies were eligible for inclusion:

- papers published in English with no date limitation;
- papers addressing programmes implemented in LMICs, as defined by the World Bank;
- papers that address disability within the scope of analysis.

Papers describing programmes and those addressing in-kind benefits (e.g. vouchers, food for work, and school meals) or insurance schemes (e.g. self-financed health insurance) were excluded.

Data sources

Studies were found by searching electronic databases, scanning reference lists of papers, and consulting with experts in the field. In particular, searches were run on the following databases: ASSIA, Web of Knowledge, WHOLIS, Cochrane Library, EconLit (EBSCO), Midline Ovid, PubMed, JSTOR, Scopus, Eldis, The Journal of Development Studies, Wiley Online Library, CINAHL Plus, POPLINE, International Bibliography of the Social Sciences, Google Scholar, and Google Search. The last search was run on 15 March 2014.

Search strategy

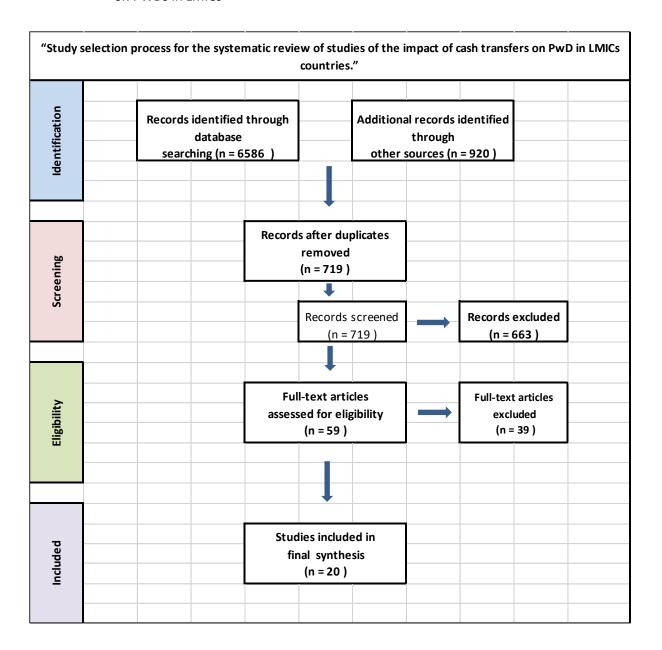
The search strategy employed a combination of free-text terms, using three sets of search filters for the themes of 'disability', 'cash transfers', and 'low- and middle-income countries'. The search terms used were as follows: (disab* OR Impairment) AND (developing countr* OR low income countr* and middle income countr* or a detailed search for each LMI country name) AND (cash transfer* OR social assist*) OR (social protect*). The 'advanced search option' was used when available. The search fields were either 'Abstract + title' or 'Abstract, topic, or keywords', depending on the database setup. PRISMA guidelines were adhered to throughout the review (Moher et al., 2009).

A2.5 Results

Study selection

In total, 7,506 articles were identified from the databases, of which 719 remained after excluding duplicates. Through the abstract screening, 59 articles were selected for a full-text review. Of those, 20 were chosen for a second round of full-text review. This included articles found by screening reference lists in retrieved papers, snowballing, and the additional screening of organisational websites (see Figure A2.1).

Figure A2.1 Selection process for systematic review of studies of the impact of cash transfers on PWDs in LMICs



Limitations of methods used in included studies

The inclusion criteria were met by 20 studies, published between 2004 and 2013. Most of these focused on only one country. Fifteen studies addressed African countries (13 on South Africa), while two focused on Asia, four on Latin America, and one on Europe. Seventeen studies used qualitative methods, two used quantitative methods, and one employed a mixed approach. Unreliable data were identified in some studies; indeed, the wide range of methods used to analyse interventions and convey the results prevented comparisons between papers. Interviews, focus group discussions (FGDs), and literature reviews were more commonly used than questionnaires and other quantitative data sources.

A2.6. Data extraction and quality assessment

A data extraction sheet was formulated by modifying the Cochrane Consumers and Communication Review Group's (2014) data extraction template. The initial sheet was pilottested on five randomly selected studies, and refined accordingly. In addition to the key PICOS framework information, the authors' names, publication date, research question, and geographical location of the study were also extracted.

It was vital, but not easy, to identify a validated tool for assessing the quality of mixed study designs, presenting diverse types of evidence. The standard quality assessment tool, QualSyst, was thus used (Kmet et al., 2004), as it is designed to evaluate the quality of quantitative and qualitative studies. The tool provides two parallel scoring systems, based on applications developed by Cho and Bero (1994) and Timmer, Sutherland, and Hilsden (2003) for quantitative studies, and by Mays and Pope (2008) and Popay, Rogers, and Williams (1998) for qualitative studies. The QualSyst tool integrates both systems and ensures that the chosen studies meet a minimum quality standard. All papers were reviewed by a second reviewer experienced in studying disability and social policy in LMICs.

The three primarily quantitative papers were assessed on the level to which the criteria presented in Table A2.1 were met ('fully' = 2, 'partially' = 1, 'not at all' = 0). Elements not relevant to any of the specific study designs were excluded and ranked as 'n/a'.

 Table A2.1
 Quality assessment sheet for quantitative studies

Criteria
Question/objective sufficiently described?
Study design evident and appropriate?
Method of subject/comparison group selection or source of information/input variables described and
appropriate?
Subject (and comparison group, if applicable) characteristics sufficiently described?
If interventional and random allocation was possible, was it described?
If interventional and blinding of investigators was possible, was it reported?
If interventional and blinding of subjects was possible, was it reported?
Outcome and (if applicable) exposure measure(s) well defined and robust to
measurement/misclassification bias? Means of assessment reported?
Sample size appropriate?
Analytic methods described/justified and appropriate?
Estimate of variance reported for the main results?
Controlled for confounding?
Results reported in sufficient detail?
Conclusions supported by the results?

Source: QualSyst (Kmet et al., 2004).

For the quantitative studies that were selected (see Table A2.3 for details on all selected quantitative studies), scores were calculated by summing up the points for relevant criteria and dividing by the total potential score (i.e. $28 - (number of 'n/a' \times 2))$. A similar calculation and scoring method were used for the qualitative studies, assessed against the 9 criteria presented in Table A2.2. Again, the score for each study was calculated by dividing the actual total score by the total potential score (accounting for 'n/a' responses).

Table A2.2 Quality assessment sheet for qualitative studies

Criteria
Question/objective sufficiently described?
Study design evident and appropriate?
Context for the study clear?
Connection to a theoretical framework/wider body of knowledge?
Sampling strategy described, relevant, and justified?
Data collection methods clearly described and systematic?
Data analysis clearly described and systematic?
Use of verification procedure(s) to establish credibility?
Conclusions supported by the results?

Source: QualSyst (Kmet et al., 2004).

The compiled scores of all the studies (see Table A2.4 for details on all selected qualitative studies) ranged from 0.54 to 0.88 (mean = 0.66). Discrepancies in the overall scores between both reviewers ranged from 0.02 to 0.12. Variations between the two sets of scores were mainly due to the applicability of specific study-design elements and on the scores of 'fully' versus 'partially' items to fulfil specific criteria. In situations where the scores of certain items did not match, the reviewers finalised the most appropriate score after discussion.

Table A2.3 Data extraction and quality assessment sheet for quantitative studies (in descending order of quality)

Authors , year, and total quality score	Study aim	Coun try	Study design and methods used	Sample size, data source, pilot or national	Types of participants	Types of interven tions
Mitra (2010) 88%	To assess the disability grant programme's targeting effectiveness and effects on labour supply	South Africa	Mixed (self- reports and standard measures of economic wellbeing)	Two reports of the Labour Force Survey, a nationally representative household survey	Working-age PWDs (unemployed due to disability)	Disability grant
Mitra (2009) 66%	To examine the effect of South Africa's disability grant programme on labour supply in the context of a policy change in disability screening	South Africa	Quantitative (difference-in- difference estimator)	Pooled cross-sections of data (Labour Force Survey from March 2000 and September 2001)	Working-age PWDs	Disability grant
Phaswan a- Mafuya et al. (2009) 45%	To assess the need for disability grants for people with HIV/AIDS and provide recommendations for administering the grants	South Africa	Mixed (interviews and questionnaires)	The qualitative component involved 38 interviews with HIV/AIDS stakeholders; the quantitative component comprised 607 questionnaires.	People with HIV/AIDS	Disability grant

Table A2.4 Data extraction and quality assessment sheet for qualitative studies (in descending order of quality)

Authors, year, and total quality score	Study aim	Country	Study design and methods used	Sample size, data source, pilot or national	Types of participants	Types of interventions
Selvester et al. (2012) 80%	To focus on beneficiary and community perceptions of the cash transfer programme	Mozambique	Qualitative (interviews, FGDs, case studies, and life histories)	Approximately 300,000 households representing a range of organisations, as well as beneficiaries and nonbeneficiaries in the two study sites	PWDs who receive a cash transfer	Cash transfer programme
Whitworth et al. (2007) 75%	To review the range of benefits and nature of social security coverage for long-term sick	South Africa, Canada, India, Mexico, Netherlands, Sweden, UK,	Qualitative (case studies)	Review of seven international case studies of state income maintenance	Long-term sick and PWDs	Income maintenance policies
Peltzer (2012) 75%	and PWDs To assess the predictors of disability grant status and the impact of the grant on the health outcomes of HIV patients and on antiretroviral therapy (ART)	and the US South Africa	Qualitative (longitudinal study over 20 months using an empirical survey, semi- structured interviews, and patient file reviews)	policies A total of 735 patients receiving HIV ART treatment over 20 months at three public hospitals, from October 2007 to February 2009	People with AIDS	Disability grant

Table A2.4 Data extraction and quality assessment sheet for qualitative studies (in descending order of quality) *(cont.)*

Johannsmeier (2007) 70%	To explore the effects of disability grants on recipients in relation to the labour market	South Africa	Qualitative (non- probability quota sampling, FGDs, the researcher's reflections, and interviews)	Study of eight urban and rural areas of KwaZulu Natal Province, and FGDs with 46 participants	People with physical, visual, and hearing disabilities who are receiving disability benefits (grants)	Disability grant
Goldblatt (2009) 65%	To examine existing concerns with the disability grant programmes, especially the obstacles for women	South Africa	Qualitative (fieldwork interviews, observations, and FGDs)	Observed two assessment panels and interviewed 93 officials, applicants, and beneficiaries in two rural areas	People who had been refused grants or had them stopped	Disability grant
Knight et al. (2013) 65%	To investigate the impact of disability grants on poor households affected by HIV	South Africa	Qualitative (semi- structured interviews and non- participant observations over a six- month period from January 2008)	In-depth case studies of 10 households with a member receiving a disability grant	Poor households affected by HIV	Disability grant
Leclerc- Madlala (2006) 55%	To explore how AIDS treatment policies, practices, and grants for sufferers are negotiated by people caught in the double-bind of managing their own health and income	South Africa	Qualitative (participant observations and discussions with support group members)	Assessment of the experiences of counsellors and clients in support groups for HIV-positive people; four support groups led by four counsellors, including 33 clients, which met 10 times over five months	AIDS- affected individuals and counsellor members of the hospital's community advisory board	Disability grant

Table A2.4 Data extraction and quality assessment sheet for qualitative studies (in descending order of quality) *(cont.)*

Haven (2013) 55%	To examine the effects of safeguard policies on households with PWDs	Philippines	Qualitative (document reviews, two interviews, and two FGDs)	The informants were the person in charge of the project and the Social Development Specialist from the World Bank in the Philippines. FGDs were conducted with two parents with disabilities and four parents of CWDs.	Households with PWD members	Conditional cash transfer programme
Medeiros et al. (2006) 50%	To analyse the design and execution of the Continuous Cash Benefit Programme to make suggestions for improvement	Brazil	Qualitative (questionnaires, interviews, and a review of studies of the Cash Benefit Program)	Questionnaires to medical experts, interviews with programme managers, and a review of relevant studies	Elderly or extremely poor PWDs	Continuous Cash Benefit Programme
Shopov (2004) 45%	To outline the strengths, weaknesses, opportunities, and threats of existing social protection policies for PWDs	Bulgaria	Qualitative (empirical analysis)	Related ministry resources, Ministry of Health data, The Ministry of Labour and Social Policy data, and national household data	PWDs	Disability social protection programmes
Mitra (2005) 40%	To assess how social protection programmes can be designed, implemented, and evaluated to ensure equal access for poor PWDs	Brazil, Costa Rica, Chile, India, Korea, Pakistan, and South Africa	Qualitative (empirical analysis)	National Census and disability surveys in LMICs	PWDs receiving social assistance	Targeted and mainstream safety nets for PWD
Simchowitz (2004) 40%	To outline the shortfalls in the current social safety net, particularly for people suffering from HIV and AIDS	South Africa	Qualitative (interviews and observations)	2003 survey of nine provinces, and data from the Department of Social Services in the Western Cape	People both living with AIDS and receiving disability grants; staff of the Department of Social Services	Disability grant

Table A2.4 Data extraction and quality assessment sheet for qualitative studies (in descending order of quality) *(cont.)*

Mont (2006) 40%	To examine whether CCT programmes adequately meet PWDs' needs	Central and South America	Qualitative (analysis and discussion of how CCT programmes address disability)	Studies in different parts of Central and South America; overview of the programmes existing in different countries	PWDs eligible for CCT	Conditional cash transfer
Hardy and Richter (2006) 40%	To investigate the connection between social security and access to ART	South Africa	Qualitative (interviews and collection of government documentation)	Thirteen interviews with potential benefit recipients and community workers	Representatives of the social department, legal advice offices and NGOs; community workers; current and potential grant recipients	Disability grant
Veenstra (2006) 40%	To examine social protection policies in relation to HIV/AIDS and investigate evident change in practice	South Africa	Qualitative (analysis of household studies)	Numerous household studies in 2000– 2004	Households with an AIDS- sick person or a recent AIDS- related death	Social protection programmes, mainly social assistance
Schneider, Waliuya, Munsanje et al. (2011) 40%	To reflect on disability in social protection, specifically in social assistance programmes	Uganda, Zambia, and South Africa	Qualitative (literature review and interviews)	Drawing on work undertaken in three countries that addresses disability within specific social assistance programmes	PWDs and their households	Social assistance programmes
Nattrass (2006) 25%	To explore the potential of existing disability grants to encourage people to become and/or remain ill	South Africa	Qualitative (interviews and other data collection methods)	Research findings of the Community Agency for Social Enquiry in 2004 and national Labour Force Surveys	Working-age PWDs	Disability grants

A2.7. Analysis of review findings

A2.7.1. Evidence of programme designs and implementation choices

Types of programmes

The interventions in most of the selected studies were non-contributory cash transfer schemes/policies, intended to advance PWDs' living standards. Although few studies considered the programmes' different implications according to PWDs' impairment type, additional focus was placed on people with HIV/AIDS (eight papers). In the design of cash transfer programmes in LMICs, there were considerable differences between targeted and mainstream programmes.

The targeted programs where mainly assessed through means-tested eligibility criteria. Most papers addressed targeted programmes that focus on disability. Such programmes are mostly limited to PWDs unable to work because they are poor or living with severe impairment. The programmes provide monthly payments, with significant size variation identified between countries: for example, the transfers provided by Nepal were USD 1.20 per month, while those in South Africa and Brazil ranged from USD 112 to 154 per month.

In Brazil, the Continuous Cash Benefit Programme, which began in 1996, is the country's second largest non-contributory cash benefit programme. It targets people aged 65 and over who are not working or PWDs incapable of both working and living an independent life. Proof of family per capita income being less than 25% of the minimum wage (below USD 1 per day in December 2005) is also required. In 2005, around 2.1 million people were receiving benefits under this programme, divided equally between PWDs and the elderly (Medeiros et al., 2008).

South Africa's social welfare policy is unique among LMICs, offering a substantial amount of money through non-contributory disability grants for working-age PWDs unable to access employment opportunities. In 2004, 1.3 million of 10 million social grants paid per month were dedicated to PWDs (principally for people carrying HIV/AIDS). Additionally, through reforms to the disability grant system, policymakers were able to respond to community members' growing demands to use the grant strategically to mitigate poverty (Mitra, 2005; Nattrass, 2006; Whitworth et al., 2007; Schneider, 2011).

Mainstream programmes, by contrast, target broader groups generally at risk of poverty. Some of the identified programmes explicitly include PWDs among their targeted beneficiaries. Though there were fewer mainstream programmes than targeted ones that looked into disability.

From the existing data, there is weak evidence that mainstream programmes systematically include PWDs among their targeted beneficiaries. This reinforces the reasons advanced by Marriott and Gooding (2007) to explain PWDs suffering access limitations:

I) low awareness and limited public information, physical inaccessibility and bureaucracy. II) Means tests may unfairly exclude disabled people who face high costs associated with disability. III) Conditions attached to transfers, such as school or health clinic attendance, may exclude disabled people if these services are not accessible. IV) Public works schemes are likely to exclude disabled people unless special provisions are made. (p.29)

In Zambia, the District Cash Transfer Scheme, a mainstream programme initiated by the government in 2003, includes disabled people. Its main goal is to decrease poverty levels in the poorest households. The scheme has adopted a unique participatory targeting system, applying three eligibility criteria to select recipients: being extremely needy, being incapacitated, and having no valuable assets (Schneider, Waliuya, Munsanje et al., 2011). The papers referred to other examples of mainstream schemes in Ecuador, Bangladesh, and Jamaica, but the available data could not explain how such targeting is achieved (Mitra, 2005; Mont, 2006).

Coverage of existing schemes

On the coverage levels of targeted and mainstream programmes, most papers found numerous operational and attitudinal barriers hampering PWDs' access to existing schemes, leading to limited coverage in most countries. The main barriers identified were physical accessibility, poorly coordinated administrative systems, attitudinal and communication barriers, and a lack of awareness (Marriott and Gooding, 2007; Goldblatt, 2009; Gooding and Marriot, 2009; Mitra, 2010; Haven, 2013). In India, eligibility criteria explicitly exclude certain impairments, such as persons with autism and various other disorders (Whitworth et al., 2007). In **Brazil**, coverage differs by geographical location and type of disability, with an apparent bias towards assistance in urban areas (Medeiros et al., 2008).

Disability assessment as a qualifying measure

In addition to the problems PWDs face when means testing is a key eligibility criterion, eight of the selected papers addressed disability assessment as a key constraint on PWDs' being able to benefit from such schemes. Most of the programmes reportedly use medical assessments of health conditions and impairments by doctors as the only bases for determining eligibility;

especially concerning is that the implementation of such disability tests is reported as being difficult and subjective. The programmes little consider other factors related to the person's functioning (e.g. bodily functions and participation in activities) or environmental factors, as defined in the International Classification of Function.⁴⁶ Some of the approaches to disability assessment and their implications are presented in Table A2.5.

Table A2.5 Key disability assessment models and their implications

Author	Country	Assessment mechanism	Consequences
Marriott and Gooding (2007); Whitworth et al. (2007)	India	To be certified as disabled, individuals must receive a medical report from a doctor. Following the medical check, the doctor must indicate the disability percentage for persons with visual impairment, hearing impairment, cerebral palsy, leprosy, mental retardation, or mental illness. The predefined threshold of disability percentage to be eligible is 40% and above.	Some key disabilities are excluded, such as autism and other spectrum disorders, haemophilia, thalassemia, and milder disabilities. The application of this disability measurement process is complicated and subjective. Evidence suggests that bribes are frequently offered to strengthen the applicant's chances of receiving a disability certificate.
Schneider (2011)	South Africa	Assessment and targeting for the disability benefit are based on a medical report issued by a doctor.	Some people believe they are entitled to the disability allowance as they suffer from a chronic disease, such as diabetes, hypertension, or HIV/AIDS, despite not suffering from any functional limitations. Consequently, there was a significant unexpected rise in the applications for disability grants in 2002–2004.
Hardy and Richter (2006); Leclerc- Madlala (2006)	South Africa	For eligibility, people with AIDS should be considered sick enough to not work. A general rule that applies in most hospitals and clinics is that an individual with a CD4 cell count of ≤200, roughly associated with clinical Stage 4 of AIDS, meets the medical criteria for accessing a disability grant.	Many PWDs are caught between choosing to benefit from the disability grant and commitment to lifesaving medication. This has complicated their situation, leaving many with no option other than to drop their medication to continue to qualify for the grant.

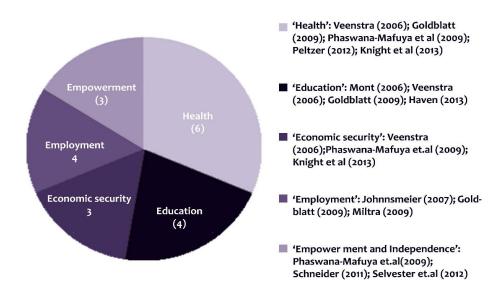
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⁴⁶ The International Classification of Function is the WHO's (2002) framework for health and disability. It is a conceptual basis for the definition and measurement of health and disability in health-related sectors.

A2.7.2. Impact of programmes on PWDs' access to services, empowerment, and independence

The reviewed literature indicated that, to ensure PWDs can access services, conditional cash transfer programmes must be effective, integrated, and mainstream. Most of the studied mainstream programmes exclude PWDs due to their inability to meet eligibility criteria. As shown in Figure A2.2 below, 11 papers of the 20 addressed the impact of cash transfers on PWDs. Furthermore, seven of the identified papers examined the impact of cash transfers on persons with HIV/AIDS; four examined the impact on health; four on education; three on economic security; and one on empowerment. However, the depth of information and analysis varied, and these studies were mainly based on feedback from a limited number of actors, rather than sound statistical evidence. Further, although cash transfers can improve access to healthcare services, the impact on access to education is mainly negative. Additionally, while cash transfers seem to improve households' economic status, it was unclear whether such transfers affected PWDs' economic situation, specially their access to employment opportunities. These points are discussed in more detail below.

Figure A2.2 Number of papers addressing each type of impact



The impact of cash transfers on health

The papers presented a relatively consistent view on the impact of cash transfers on PWDs' health outcomes. The six identified studies (one quantitative and five qualitative) scored from 80% to 40% (mean = 54%) in the quality assessment. It was not possible to determine the overall impact on health status. However, most of the analysed evidence shows that cash transfers have promoted better access to healthcare services for PWDs in LMICs, as well as impacting positively on their health status. In a cross-sectional mixed method study in South Africa, 88% of participants indicated that the disability grant has positively influenced treatment adherence and attitudes toward treatment (Phaswana-Mafuya et al., 2009). Additionally, based on an analysis of South African households in 2000–2004, social grants are used to improve the health of HIV/AIDS sufferers, who are categorised as PWDs, by assisting with treatment costs or indirectly contributing to better health outcomes (Veenstra, 2006).

The impact of cash transfers on education

The four identified studies (all qualitative) scored from 65% to 40% (mean = 50%) in the quality assessment. There was consistent evidence of schemes failing to deliver significant improvements in access to education services. Moreover, when a positive impact was reported, it was unclear whether this translated into improved education status for children. In

a review of the conditional cash transfer programme in the Philippines, 42% of the households with CWDs reported their inability to attend school, while more than 33% experienced difficulty travelling to school (Haven, 2013). Similarly, in a study of HIV/AIDS households in the Eastern Cape Province's Mount Frere region, transfers targeted at children were found to not necessarily improve their access to education. Since the caregiver controls the grant, this funding is usually allocated to addressing the whole family's immediate consumption needs (Veenstra, 2006).

The impact of cash transfers on economic security

The three identified studies (one quantitative and two qualitative) scored from 65% to 40% (mean = 50%) in the quality assessment. They provide strong evidence that cash transfers have lessened the depth or severity of poverty for targeted PWDs and their families. In South Africa, 77% of disability grant recipients nationwide reported spending this money mainly on the priorities of food and electricity. Findings were similar in the Western Cape and Eastern Cape provinces, where disability grant recipients reported paying for groceries, supporting elderly parents, and paying for medicines, in addition to furthering their own education, renting a flat, or assisting with family members' education (Johannsmeier, 2007). In KwaZulu-Natal (South Africa), households with members receiving the disability grant reported significantly fewer shortages of food than HIV-affected households without the grant (Knight et al., 2013). In Botswana and South Africa, the research showed that when income is lost through illness, social grants are crucial for supporting basic needs, such as food (Knight et al., 2013).

The impact of cash transfers on employment

The three identified studies (all qualitative) scored from 70% to 66% (mean = 67%) in the quality assessment. The findings on employment outcomes were more limited and mixed. A study of the disability grant system in two South African provinces showed that the grant's provision improves access to job-seeking opportunities (Goldblatt, 2009). However, according to a discussion document published in 2006, disability prevents recipients entering into and remaining in employment in South Africa (Johannsmeier, 2007). Additionally, South Africa's Labour Force Survey indicates that the disability grant might have encouraged men to drop out of the workforce (Mitra, 2010). Mitra (2009b) calls for further research to understand the effects on labour supply of disability programmes, in the context of the high unemployment and poverty in LMICs.

The impact of cash transfers on empowerment and independence

The three identified studies (one quantitative and two qualitative) scored from 80% to 40% (mean = 55%) in the quality assessment. For each LMIC considered, the papers explicitly indicate cash transfers' potential to empower PWDs to make their own life-improving decisions. In Mozambique, PWDs receiving the grant identified its two key impacts on their lives: (i) its predictability allowed them to plan their expenses; and (ii) it afforded them greater dignity in their community, particularly among family and friends (Selvester et al., 2012). In Zambia, one of the primary benefits reported is the recipient's increased control and sense of worth, including being able to attend church, become community active members, and participate in voting for committees (Schneider, 2011).

A2.8. Discussion

This is the first systematic review to examine how cash transfers affect PWDs in LMICs. It points to an incomplete evidence base on this topic. Despite increasing scholarly attention, especially in recent years, the generated evidence remains vague and of inconsistent quality. Nevertheless, the available evidence tentatively demonstrates the positive links between cash transfers and the QoL and wellbeing of PWDs (Gooding and Marriot, 2009; Palmer, 2011). Indeed, the evidence shows that both targeted and mainstream cash transfer programmes contribute to improved health, economic, social, and educational outcomes. However, coverage and benefit levels remain low, as most existing schemes are limited in resources and impact.

The results confirm that research on the impact of cash transfers and disability in LMICs is limited, with only a small number of highly heterogeneous studies. None of the identified studies examined practices or impact within the MENA region. Of the 20 identified papers, the majority are literature reviews, with some works using interviews and questionnaires to collect primary data. Although useful for providing qualitative information, such studies can only offer weak and limited interpretations of these data. Furthermore, the use of a large number of different instruments complicates comparing results across studies, as each instrument has its own strengths and weaknesses. Similarly, most of the identified studies derived their information from small samples, thus inhibiting generalisation to larger populations. Moreover, only two studies used mixed methods (Phaswana-Mafuya and Peltzer, 2009; Mitra, 2010), and their weak attempts to link the qualitative and quantitative aspects further hindered generalisation from small, single-country groups to broader populations.

Regarding cash transfers, the wide diversity of design options, multiple objectives, and range of potential impacts poses significant challenges in reviewing the available evidence. Unexpected benefits and impacts that extend beyond the direct recipient to their wider family and community may also exist (e.g. where disability grant recipients use their money to meet basic household needs, such as food).

Despite differences in their methods, most of the reviewed studies found a problematic lack of attention to what constitutes a disability in the design phase of cash transfer programmes. Most papers flagged numerous operational and attitudinal barriers preventing PWDs from accessing existing schemes, leading to limited coverage in many countries; other problems relate to the failure to consider extra disability-related costs and the disability assessment. Moreover, only four of the 20 papers discussed the relationship between poverty and the extra cost of disability (Mitra, 2005; Medeiros et al., 2008; Gooding and Marriot, 2009; Schneider, Waliuya, Munsanje et al., 2011). Those costs were classified into two types: (i) additional expenditure on items that non-disabled people also purchase (e.g. transportation, food, healthcare); and (ii) expenditure on items specifically related to disability (e.g. communication aids, modification of home or vehicle) (Mitra, 2005, p.27).

The additional key review findings are summarised as follows:

- Except for South Africa, which nevertheless has its own concerns about programme applicability, no available data support best practices in the design and delivery of cash transfer programmes for PWDs in LMICs.
- There is little published information on the relationship between cash transfers, independent living, and social inclusion. While existing studies have focused on how cash transfers influence self-esteem and control over received funds, analysis of how they affect PWDs' autonomy, independence, and social inclusion is missing.
- Most of the identified studies focus on targeted programmes, where eligibility is limited to people with severe impairment who are unable to work or are living below a specified poverty threshold.
- Most existing evidence is from South Africa, with various studies in this context addressing the relationship between HIV/AIDS and the disability grant system.
- The main indicated causes of limited coverage in existing schemes are limited funding, lack of awareness, failure to consider physical access, and bad administrative practices.
- In existing schemes, the complexity of disability assessment and basing it mainly on medical diagnosis creates an additional barrier to equal access for PWDs. There was

hardly any evidence of the adoption of homogeneous assessment criteria, which should consider the social context and properly balance the medical and social aspects affecting PWDs.

- In addition to disability assessment, means-tested entry requirements are seen by researchers as an exclusion factor, since they mainly consider the potential recipient's income, rather than their expenditure.
- Some evidence of cash transfers' positive impact on access to healthcare was identified for PWDs; however, the evidence on access to education and employment were mixed.

In summary, although cash transfers play an important role in supporting PWDs, most of the studies examined here suggest they are not expected to solve the poverty problem for this group of the population. PWDs' welfare is equally affected by other disability-related policies and development interventions.

Strengths and limitations of the systematic review

The strengths of the presented review include the search strategies' inclusiveness, the tools and rigorous analysis methods used, and considering both qualitative and quantitative evidence. However, the relatively small number of quantitative studies is a limitation, while the search strategies excluded non-English language studies. In addition, as with any systematic review, full identification of relevant studies cannot be assured. Furthermore, the large variety of study designs and methods for assessing cash transfers' impacts on PWDs complicated our review. While the QualSyst tool was useful for arbitrarily defining the strength of each study, the use of other quality assessment tools could have produced different review outcomes.

A2.9. Conclusion

Cash transfers are a key social protection policy for PWDs who are poor and/or unable to work. However, few studies have yet examined how targeted or mainstream disability programmes are implemented, or how they have expanded their reach to beneficiaries. This systematic review, thus, evaluated aspects of the design, operation, and influence of the identified schemes in LMICs.

The main findings point to the need for further research into the issues raised herein: eligibility criteria, coverage, and impact. The review also confirmed the complete absence of evidence

on CTs impact on PWDs in the MENA region. As regards methods, the reviewed studies' limitations confirm the need to tailor evaluation strategies to be more responsive to disability-related contexts. Additionally, the reviewed studies on LMICs neglected many other questions relevant to cash transfers' impacts on PWDs, including their capability to promote PWDs' social and economic rights, and contribute to their full social inclusion, access to services, and independence.