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Research article

Social support among Disabled Palestinian Children in the Gaza Strip

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Abstract

Aim: This study aimed to determine the social support levels perceived by Palestinian disabled child and to compare the data with sociodemographic variables. **Method:** The sample consisted of 391 disable Palestinian children in the Gaza Strip which was selected randomly from the data base of two NGOs working with such group of children. The age of children ranged from 6-18 years with mean age 11.73. **Instruments:** The children and adolescent's demographic data was collected by questionnaire include sex, age, class, and place of residence, and Social Function Scale. **Results:** The results showed that mean social adaptation was 18.38, life status mean was 14.71, social role mean was 20.34, self-esteem mean was 17.86, and social concept mean was 18.92. The results indicated that the highest relative value for the dimension of life status was 68.35%, followed by self-concept with 63.7%, social role with 62.2%, social adaptation with 61.7%, however, the least relative value was for the dimension of self-esteem of 49.2%. Male children have more self-esteem than female children. The results showed that there were statistically significant differences in social role toward younger age children (less than 10 years) and self-esteem toward children above 14 years. Result showed that there was significant correlation between total social adaptation and life status, social role, self-esteem, and social concept. **Conclusion and recommendation:** Our study showed that Palestinian disabled children need security and they think that parents do sufficient efforts to take care of them, and they have a desire to continue their education. Such findings highlight the needs for formulating comprehensive policies that address all disable children needs, providing assistance to voluntary organizations for provision of the aids and appliances at minimal cost; facilitating appropriate rehabilitation of disabled children by establishment of special schools; advocating the practice of integrated education for such children.

Key words: disabled children, social function, gaza strip

Introduction

Globally, more than one billion people (or about 15% of the world's population) have been estimated to have some form of disability as reported in the first ever World Report on Disability, [1] which clearly indicates that the prevalence of disability has risen since the 1970 estimate [2]. In Japan, the number of children with disabilities is gradually increasing in Japan. In 2011, there were 225,000 children with physical disability who received

“Physical Disability Certificate (Shintai Syougaisya Tecyou)” or intellectual disabilities who received “Mental Disability Certificate (Ryouiku Tecyou)” living at home in Japan, accounting for 1.1% of the total population of persons under 18 years of age. An investigation performed in 2002 in Turkey by the cooperation between the Prime Ministry State Institute of Statistics Administration and Prime Ministry Administration for Disabled

People showed that the prevalence of disability was 12.3%. The prevalence of orthopedic disabilities in the 0–19 age group was 1.41%. According to the legislation established in 2005, it is provided that the charges for training of disabled children in special education and rehabilitation centers will be taken care of by the state, as such schools for disabled children founded by the Ministry of National Education are very few in number. Furthermore, the state pays these institutes monthly for every child, an amount between 180–360 EUR [3].

Furthermore, in China has more than 5 million children aged 0 to 17 years old with disabilities. These children comprise more than 6% of all people with disabilities in China and 1.7% of children in China [4].

In Palestine, the prevalence of disability among children was 1.5%: 1.8% of males and 1.3% of females. Mobility is the most prevalent disability and affects 48.4% of disabled individuals in Palestine: 49.5% in the West Bank compared with 47.2% in the Gaza Strip. Learning disability is the second most prevalent with 24.7%: 23.6% in the West Bank and 26.7% in the Gaza Strip. The main cause of all disabilities covered in the survey was illness, according to 2011 data. Illness was the main cause of 43.7% of visual disabilities; 29.1% of hearing disabilities; 42.9% of mobility disabilities; 28.7% of disabilities related to memory and concentration; 27.6% of learning disabilities; and 27.2% of mental disabilities. Congenital problems were the main cause of communication disabilities 33.6% [5]. Rehabilitation and Palestinian Medical Relief Society in Gaza Strip, showed that 35,866 persons were identified with one disability at least according to WHO criteria; that represents 2.5% of total population of the Gaza Strip. The most common type of disability was vision 33.24 %, physical disability 31.78 %, speech impairment 4.69%, learning impairment 5.48 %, mental problems 2.36 %, hearing disability 7.78%, multiple disabilities 14.23%, and other disabilities 0.44%.

Children with disabilities defined as children being described as having impairments, activity limitations and participation restrictions, or disadvantages, as classified under the International Classification of Functioning, Disability and Health (ICF) [6]. Children with disabilities require health and other related services beyond that required by normal children in order for them to be individually planned or coordinated. Social identities can change but, according to Goffman, each individual has just one biography and the stigma cannot be erased [7]. Each person with the stigma of disability uses many identities. Depending on the social situation, people may present themselves as stigmatized when in different situation they present themselves as ‘normal’, in one occasion they do not provide any information about themselves when in other one they may provide some information. Surrounded by family their ‘own’ people such a person can reveal all the truth about themselves Muslims who live in countries suffering from political instability or war, such as Palestine and Syria, have been shown to have significantly higher rates of disability [8].

Historically, the medical model of disability has been accepted as the best way to approach the subject of disability. This model focuses on identifying and treating impairments in individuals with disabilities, with the aim of reducing those impairments and helping individuals adapt to society [9]. Over time, the social model has challenged the dominance of the medical model. The social model of disability suggests that disabilities are caused by the way in which a society is organized, rather than by individual impairments. This model focuses on identifying and removing systemic barriers that restrict the quality of life of individuals with disabilities [10]. Children with disability (CWD) face unrealistic beliefs and social discrimination [1]. Social stigma still prevails in Arab countries societies and has negative effects on CWD and their families [11].

Generally, social support is defined as material aid and spiritual support performed by spouse, friends, and family as well as by some socially, politically, and economically qualified supporters [12]. In particular, in families with disabled children, it is important to obtain support from internal and external sources to not experience trait anxiety, depending on the deadlock conditions they encounter. This study aimed to determine the social support levels perceived by Palestinian disabled child and to compare the data with sociodemographic variables.

Method

Participants

The participants were 391 Palestinian children, 192 were boys (49.1%) and 199 were girls (50.9%). The age ranged from 6–18 years old ($M = 11.73 + 3.52$).

Instruments

Sociodemographic data

The children and adolescent’s demographic data was collected by questionnaire include sex, age, class, and place of residence.

Social support scale

The social support scale was developed and validated in the Gaza Strip, which consists of 46 items with 5 subscales. It measures social adaptation (9 items), life status (9 items), social role (10 items), self-esteem (9 items), and self-concept (9 items). The score ranges from 0 = not true, 1 = sometimes true, and 2 = true. The reliability tests of the subscales were done using Cronbach’s alpha, for social coping $\alpha = .65$, life status $\alpha = .82$, social role $\alpha = .74$, self-esteem $\alpha = 0.79$, and self-concept $\alpha = 0.64$.

Study procedure

The fieldwork was conducted by community health rehabilitation workers who give support for such target group. They were 25 professionals familiar with this target group and had been working with them in the community for long time. They were trained for research and data collection, and they visited the families according to

Table 1. Sociodemographic characteristics of the study sample (N= 381)

	N	
Sex		
Boys	192	49.1
Girls	199	50.9
Age		
	Mean 11.73 (SD =3.5 years)	
6-10 years	158	40.4
11-13 years	108	27.6
14 and above years	125	32.0
Address		
North Gaza	56	14.3
Gaza	108	27.6
Middle area	74	18.9
Khan Younis	54	13.8
Rafah area	99	25.3
Place of residence		
City	171	43.7
Village	170	43.5
Camp	50	12.8
Family monthly income		
No income	117	29.9
Less than \$250	203	51.9
\$251-500	59	15.1
More than \$ 501	12	3.1
Job		
Student	168	48.8
Unemployed	119	34.6
Employee	30	8.7
Merchant	3	0.9
Simple worker	24	7

Table 2. Characteristics of the disable children

	N	%
Type of disability		
Physical	159	40.66
Visual	136	34.78
Multiple	52	13.30
Hearing	18	4.60
Speech	13	3.32
Mental	13	3.32
Cause of disability		
Inherited and congenital	283	72.7
War on Gaza in 2009	35	9
Home accidents	23	5.9
Road Traffic Accidents	15	3.8
Date of disability		
Less than 6 months	76	19.4
One-5 years	54	13.8
More than 5 years	261	66.8
Rehabilitation status		
Active (currently receiving services)	220	56.3
Not active (currently not receiving services)	171	43.7

Table 3. Means, SD, and percentage of social support subscales

	Mean	Std. Deviation	%
Social adaptation	18.38	3.40	61.7
Life status	14.71	4.10	68.35
Social role	20.34	3.93	62.2
Self-esteem	17.86	4.09	49.2
Social concept	18.92	3.37	63.7

Table 4. Percentage of social support subscales in disabled children

Social Adaptation	True	True to some extent	Not true
I feel that I need for security.	77.8	12	10.2
I like to receive my friends	61.4	21.5	17.1
I like to visit my friends	59.9	22.3	17.9
I'm more sensitive to others eye contacts	34.8	36.6	28.6
I feel embarrassed from others	27.1	38.6	34.3
I prefer practicing in-door activities	25.1	25.3	49.6
I began to fear from meeting others	15.4	36.8	47.8
I feel I'm rejected from neighbors.	7.9	21.7	70.3
I feel I'm rejected from family.	7.4	13.6	79
Life status			
I feel that my mother spent sufficient efforts to take care of me	81.6	15.6	2.8
I feel that my father does sufficient efforts to take care of me	74.7	18.7	6.7
I have a desire to continue my education	66	18.9	15.1
I have still concept of success	65	22	13
I have adequate health care	46.6	36.6	16.9
I feel I am reassured	39.6	40.2	20.2
I feel that my social needs are met	35.8	39.1	25.1
I feel that my basic needs are available	35.3	39.9	24.8
I feel I am satisfied about my life level	32.5	44.5	23
Social role			
I can exercise my social activities without help.	43.2	37.6	19.2
I desire to change my expectation of life.	39.6	44.3	16.1
I understand my new personal needs.	39.4	42.7	17.9
I positively response to new situations.	32.2	49.6	18.2
I understand the demands of new life.	31.5	47.6	21
I understand the changing of the social role.	29.7	51.9	18.4
I feel that I don't participate in making my own decisions.	17.9	47.6	34.5
Family began to put new restrictions on my life.	16.4	33.5	50.1
I behave out of my control	15.9	36.3	47.8
My social status in my family is changed.	10.2	23	66.8
Self-Esteem			
I feel I need to belong.	64.2	22.5	13.3
I feel the need of success greater than in the past.	64.2	23.8	12
I feel the need of love and social recognition.	60.1	25.8	14.1
I started to compare myself with other peers	32.5	38.1	29.4
I feel my father become more nervous	26.6	32.2	41.2
I feel I'm hesitate to express my feelings.	19.7	43.7	36.6
I feel my mother become more nerve.	19.4	37.1	43.5
I started to hear non-decent descriptions from family.	15.6	28.1	56.3
I feel there is a change of my brother's feelings to me.	15.1	28.1	56.8
Self-Concept			
I feel that others are better than me	22.5	38.9	38.6
I'm hesitate to express my feelings	15.9	44.5	39.6
I feel more negatively than before	13.6	34.8	51.7
I feel that I'm insignificant	13.3	34.3	52.4
I feel disability is a punishment for me	13	21.7	65.2
I have the ability to take responsibility	24.8	46.8	28.4
I feel I can succeed	51.4	31.2	17.4
I'm proud of my potentials and abilities	46.6	36.8	16.6
I feel confident in front of others	39.6	37.6	22.8

Table 5. Independent t test for differences in sex and social support subscale

	Sex	Mean	Std. Deviation	t	p
Social adaptation	Male	18.41	3.68	.159	.874
	Female	18.36	3.11		
Life status	Male	14.97	4.32	1.271	.204
	Female	14.45	3.86		
Social role	Male	20.64	4.09	1.486	.138
	Female	20.05	3.77		
Self-esteem	Male	18.41	4.23	2.654	.008
	Female	17.32	3.89		
Social concept	Male	19.22	3.55	1.720	.086
	Female	18.63	3.18		

Table 6. Pearson correlation coefficient test between social support subscales

	Social adaptation	Life status	social role	Self-esteem
Social adaptation				
Life status	.14**			
Social role	.24**	.28**		
Self-esteem	.31**	.01	.38**	
Social concept	.26**	.15**	.54**	.54**

prepared lists of number of children selected to the Database of the NSR (National Society for Rehabilitation) & PMER (Palestinian Medical Relief Society) working with such group. The field workers presented an information letter to the parents, and if agreed, they obtained a written permission for their children's participation. Children were interviewed individually at their homes and each an interview lasted approximately 60 minutes. The interviewers informed children that there was no right or wrong answers, provided guidance in filling-up the scales. Children and parents were also informed that they were free to withdraw from the study at any time. The data collection was done between August and September 2009.

Statistical analysis

The data was analyzed using the statistical package for social sciences (SPSS) program (version 23). Descriptive techniques were used to examine the similarities and differences of variables associated with type of disabilities of children and social support. One Way ANOVA test was performed to test the statistical significance of between more than two group differences for distributions and means. The Pearson correlation was used to examine the relationship between social support subscales. The statistical significance of differences was assessed using two-tailed independent samples t-tests ($p < .05$).

Results

Sociodemographic characteristic of the study

The sample responded to the interview were 391

participants with response rate of 97.7%, it consisted of 192 males (49.1%) and 199 girls (50.9%). The age of children ranged from 6-18 years with mean age of 11.53 years ($SD = 3.5$). According to place residence 14.3% of children were from North Gaza, 27.6% were from Gaza, 18.8% were from Middle area, 13.8% were from Khan Younis, and 25.3% were from Rafah area (south of Gaza). According to type of residence, 43.7% of children live in cities, 43.5% live in villages, and 12.8% live in camps. In looking for the family monthly income, 29.9% had no income, 51.9% of the families' monthly income was less than \$250 per month, 15.1% earned \$251-500, and only 3.1% earned more than \$501.

Characteristics of the disability of the children

The statistical analysis showed that 40.66% of disabled children have physical disability, 34.8% had vision disability 13.3% had multiple disability whereas, 4.6 % had hearing impairment, 3.32% had speech disability, and 3.32% had mental disability. Also, it was noticed from the results that 23.8% of disability was attributed to heredity factors, 48.6% for congenital, 9% for the last war on the Gaza Strip. The majority of children 80.6% reported that their disability is back to several years, 19.4% was before 6 months of the study. Regard rehabilitation status of cases, 56.3% of the disabled children were currently active cases (currently receiving services) with both societies, and 43.7% were inactive (currently not receiving services) and their files were closed.

Measurement of Social support of disabled children

This part of analysis discussed the responses of the disabled children about the social support, which consist 5 subscales based on the variables of measurement of social support.

Mean and Standard deviations of social support subscales

The results showed that mean social adaptation was 18.38 (SD = 3.40), life status mean was 14.71 (SD= 4.10), social role mean was 20.34 (SD=3.93), self-esteem mean was 17.86 (SD=4.09), and social concept mean was 18.92 (SD=3.37). The results indicated that the highest relative value for the dimension of life status was 68.35%, followed by self-concept with 63.7%, social role with 62.2%, social adaptation with 61.7%, however, the least relative value was for the dimension of self-esteem of 49.2%.

Frequency of social support subscales

The results indicated that the highest response of social adaptation by the disabled children was 77.8% had "feeling for the need for security", 61.4% were "wishing to receive their friends", 59.9% were "wishing to visit their friends". For life status, 81.6% of children said that "feel that their mothers are doing the best for their care", 74.7% "feel that fathers are adequately taking care for them", 66% were "wishing to continue their education", and 65% "feel that they can make success.

For social role, 43.2% "feel that they can exercise social activities without help", 39.6% were "wishing to change their life expectations", and 39.6% "understand their new personal life. For self-esteem, 64.2% said "I feel that I need for affiliation", and 64.2% "feel of need for success more than the past". For self-concept of disabled children, 22.5% said "I feel that others are better than me", and 15.9% said "I used to hesitate to express my feelings.

Differences in social support subscales regarding sociodemographic variables

The results indicated that there was a statistically significant difference between males and females regarding to self-esteem of disabled children, male children have more self-esteem than female children ($t(389) = 2.65, p > 0.008$).

Post hoc test using Tukey test showed that there were statistically significant differences in social role toward younger age children (less than 10 years) ($F(2, 290) = 7.72, p = 0.001, \eta^2 = 0.06$) and self-esteem toward children above 14 years ($F(2/290) = 7.72, p = 0.03, \eta^2 = 0.07$).

Relationships between social support subscales

In order to find the relationship between social support subscales, Pearson correlation coefficient test was performed. Result showed that there was significant correlation between total social adaptation and life status ($r = 0.14, p = 0.001$), social role ($r = 0.24, p = 0.001$), self-esteem ($r = 0.31, p = 0.001$), and social concept ($r =$

$0.26, p = 0.001$).

Discussion

This study investigated social support including social adaptation, life status, social role, self-esteem, and self-concept of the children with disability in the Gaza Strip. Our study showed that 72.7% of disability in children was attributed to heredity and congenital causes. Similarly, [13] reported that genetic diseases may be responsible for two-thirds of childhood blindness in Arab societies, ranging from 47 percent in Tunisia to 86 percent in Kuwait. While, internationally genetic factors were the cause of 50% of hearing impairment in infants. The other factors cause disability are referred to 9 % for war, 5.9% for home accidents, and 3.8% for road traffic accidents; Hakim & Jaganjac (2005), suggested a high rate of accident-related disability in Arab countries. According to the report of the World Health Organization [1], the number of people with "moderate or severe disability" in the 0–14 age group was 93 million (5.1%), and the number of people experiencing serious difficulties was 13 million (0.7%) [14]. In the 2008 report of the United Nations Children's Fund (UNICEF), it was not possible to reach a certain number, and the results were ambiguous or exaggerated [14].

Social adaptation for children with disabilities showed that 77.8% in "need for security"; Although there are good signs of social mainstreaming; including summer camps, recreational activities, and sharing in anniversaries, but there still much for work.

It is likely that the last Israeli aggression still impact on children's feeling and thinking. At the beginning of the 21st century, armed conflict, terrorism, and aggressions have cast a long shadow over Iraq, Sudan, the Palestinian territories, Lebanon, Somalia, Morocco-Western Sahara, Algeria, and sporadic terrorist mass killing in Syria, Jordan, Saudi Arabia, and Egypt [8]. Others, Milner and Kelly [12] identified attributes of place that provide potential participants an anticipation of being welcome. Individuals with disabilities gravitated toward places where they felt known, where they experienced reciprocity, where their participation was expected, and where they felt psychologically safe.

The study suggests that feeling of stigma is remarkable. Intellectual disabilities, mental illnesses are more stigmatizing than physical/sensory disabilities; 34.8% expressed more sensitive to others' eye contacts, 27.1% expressed feeling of embarrassment from others, and 25.1% prefer in-door activities. Nevertheless, there seems to be deep-seated preju-

dice against people with congenital and hereditary disabilities compared to disability of old age. Psychosocial disorder is a result of an interaction between the child's personality, experience, and environment (family, peers or school). Aggressive or antisocial behaviour is much common in boys than girls; however, antisocial behaviour brings a teenager in conflict with the law but implies serious personality difficulties for girls than for boys.

Nevertheless, the treatment approach is a choice for intervention based on kind of intervention strategy; for example, Community Based Rehabilitation (CBR) inclined to use family therapy. In general, women are more likely than men to become depressed, and women with child with disability, in particular. Needless to say that certain factors increase susceptibility e. g. poverty, health status, life stresses such as early loss of own parent, unemployment, death of relatives, etc.

Gender reflects another shade of stigma, with females being at a distinct disadvantage; once for being a woman and the other for being with a disability; for example, male-children with disability have self-esteem more than female-children with disability. From a gender perspective, development can absolutely has a beneficial outcome for women only when the working culture, structure, systems and procedures, and underlying values of the institutions, which shape women's lives themselves, reflect a concern for gender equity. Gender identity is determined by social factors; how to behave appropriately, attitudes, roles and activities are for female or male, and how they should relate to other people, [15]. Others, Ozyazicio et al. [16] in study of Turkish children showed that was no significant difference between the gender of the child and parents' social support and anxiety scores.

Though there have been good indicators for involvement of fathers in sharing mothers in social role but still the gender gap is remarkable and warrants much professional efforts; the assumption here is that 'male chauvinism' is prevailing. It is well-known that the needs and interests of women and man differ in times of peace; but seems different during periods of emergency, disaster, and conflicts, is less acknowledged, [17].

From social role perspective, children with disability are capable to perform social activities independently; 43.2 %; 39.6% wishing to change life expectation; 39.6% understand new personal life; and 32.2% coping with need life requirements. It is my assumption that the Palestinians of war- victims can adapt with such emergency situations faster than whose disabilities are attributed to congenital or heredity factors. Although informal social activities are extremely significant on participated children but the study suggests that children with disability are encountering difficulties; for instance, 17.9 percent feel that they do not participate in making own decisions and 16.4 percent are facing restrictions on their life.

Regarding life status, there is a significant link between results of life status; 81.6 percent of children

reported that female- parent take care of them and 74.7 % of male-parent are adequately taking care of them. This is likely attributed to the application of gender issues among the families of people with disability. Social role acknowledgment is growing and recognized as a right and need for family development.

The study suggests that self-esteem and self-concept are interacted; 64.2 % expressed need to belongingness and need for success greater than in the past. From the perspective of self-concept, 51.4% expressed that they can make a success, 46.6 percent are proud of their potentials, and 39.6% feel confident in front of others. Education is extremely important for people with disability in life in general, and in personality development in particular. Low literacy rates among children with disability are a direct result of the availability and accessibility of education; 45.5% of children with disability are illiterate: 23.3% for male and 22.2% for female, as well as the literacy of parents; 72.8% of female-parent is illiterate compared to 37.8 % for male-parents.

Conclusion and Recommendation

Our study showed that Palestinian disabled children need security and they think that parents do sufficient efforts to take care of them, and they have a desire to continue their education. Such findings highlight the needs for formulating comprehensive policies that address all disable children needs, providing assistance to voluntary organizations for provision of the aids and appliances at minimal cost; facilitating appropriate rehabilitation of disabled children by establishment of special schools; advocating the practice of integrated education for such children, offering adequate opportunities to the children in their field of interest to excel in their talent; implementing reservation provisions in different educational/vocational establishments; and extending benefits to disabled children in different aspects of day-to-day life (travel, medical care, etc.).

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