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International assistance to the Palestinian health sector is reviewed in this thesis. Assistance to the health sector has been the major force towards developing a sound health infrastructure in the Palestinian territories. I argue that Palestinians are much like other recipients of aid for the health sector. This thesis explores the high aid dependence of Palestinians and the great influence of donors. I highlight that donors used aid conditionality, in its different forms, to intrusively interfere in Palestinian national planning and reform. Palestinians are no exception and they, like other countries, have been subject to relatively similar kinds of conditionalities. However, they were exceptional in the timing, in the great need for aid, and in the political context, which has impacted the effectiveness of the aid.

HUMANITARIAN AND TECHNICAL

ASSISTANCE TO THE PALESTINIAN HEALTH

SECTOR: DONORS' POLICY AND BEHAVIOR ANALYSIS

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# HUMANITARIAN AND TECHNICAL ASSISTANCE TO THE PALESTINIAN HEALTH SECTOR: DONORS' POLICY AND BEHAVIOR ANALYSIS.

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## Geography

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The West bank and Gaza Strip (WBG) are geographically separated areas. They are separated by Israel. The whole area of WBG is 6,170 $Km^2$ of which the WB is 5800 $Km^2$, and Gaza Strip area 360 $Km^2$. The two geographic areas have different geographical landscapes, population distribution and legal systems. The total population is 3,827,914 (mid 2004) of which 2,421,491live in the WB with a population density of 417 inhabitants per $Km^2$ and 1,406,423 lives in the Gaza Strip, one of the most densely populated areas of the world, with a population density of 3,853 inhabitants per $Km^2$. The world's average is 45 person per $km^2$, being 335 persons per $km^2$ in Japan (Hamdan, 2002). Sixty five per cent of the populations in Gaza and 29.5 per cent of those in the West Bank are refugees (Palestine Central Bureau of Statistics, 2004).

## History

The tragedy of Palestine starts with Zionism, a movement founded by Theodor Herzl, called for a "national homeland for Jews". In 1904, the Fourth Zionist Congress decided to establish a national home for Jews in Argentina or Uganda (Payne, 2001). Instead, it decided in 1906 that the Jewish homeland should be in Palestine.

For centuries Palestine was under Ottoman Empire control. In 1914 and with the outbreak of World War I, Britain promised the independence of Arab lands under Ottoman rule, including Palestine, in return for Arab support against Turkey which entered the war on the side of Germany. However, in 1916 Britain and France signed the Sykes-Picot Agreement, which divided the Arab region into zones of influence. Lebanon and Syria were assigned to France, Jordan and Iraq to Britain and Palestine was to be internationalized. On November 2, 1917, the British government issued the Balfour Declaration, in the form of a letter to a British Zionist leader from the foreign secretary Arthur J. Balfour promising him the establishment of a national home for the Jewish people in Palestine.

Aided by the Arabs (1917-1918), the British captured Palestine from the Ottoman Turks. After the end of WW I (1918), and because of the oppression they faced in Europe, Jewish migration increased to Palestine, which was set aside as a British mandate with the approval of the League of Nations in 1922. Large-scale Jewish settlement and extensive Zionist agricultural and industrial enterprises in Palestine began during the British mandatory period, which lasted until 1948.

The Palestinians convened their first National Conference (1919) and expressed their opposition to the Balfour Declaration. The San Remo Conference (1920) granted Britain a mandate over Palestine. Sir Herbert Samuel, a Jew and Zionist, was sent as Britain's first High Commissioner to Palestine (H. Samuel, biography). In 1929, large-scale attacks on Jews by Arabs rocked Jerusalem. Palestinians killed 133 Jews and suffered 116 deaths. Sparked by a dispute over use of the Western Wall of Al-Aqsa

Mosque (this site is sacred to Muslims, and Jews claim it is the remnants of an ancient Jewish temple). The roots of the conflict lay deeper in Arab fears of the Zionist movement which aimed to make at least part of British-administered Palestine a Jewish state.

In 1936 The Palestinians held a six-month General Strike to protest against the confiscation of land and Jewish immigration. To solve the situation, the British government published a White Paper (1939) restricting Jewish immigration and offering independence for Palestine within ten years. This was rejected by the Zionists, some of whom then organized terrorist groups and launched a bloody campaign against the British and Palestinians. As a result of this and the political wake of the holocaust, Great Britain decided to leave Palestine (1947). In 1947, the UN adapted the plan of partition of Palestine into Jewish and Arab states, with Jerusalem as an international zone under UN jurisdiction. Arabs protested against partition which erupted in violence, with attacks of Jewish terrorist groups against Arab towns and villages and attacks on Jewish settlements. A few massacres against Palestinians drove many others to flee in fear.

On May 15, 1948, Britain left. Jewish leaders implemented that part of the partition plan calling for establishment of a Jewish state. The same day, the armies of Egypt, Jordan, Syria, Lebanon, and Iraq joined Palestinian and other Arab guerrillas in a full-scale war (first Arab-Israeli War). The Arabs failed to prevent establishment of a Jewish state, and the war ended with four UN-arranged armistice agreements between Israel and Egypt, Lebanon, Jordan, and Syria. The small Gaza Strip was left under Egyptian control, and the West Bank was controlled by Jordan. Of the more than

800,000 Arabs who lived in Israeli-held territory before 1948, only about 170,000 remained. The rest became refugees in the surrounding Arab countries, ending the Arab majority in the Jewish state.

In 1965, the Palestine Liberation Organization (PLO) was established. Israel attacked Egypt, Jordan, and Syria simultaneously on June 5, 1967 in a pre-emptive war. The war ended six days later with an Israeli victory. Israel occupied the Gaza Strip, Sinai Peninsula, Arab East Jerusalem, the West Bank, and the Golan Heights. In the 1967 war, several guerrilla organizations within the Palestine Liberation Organization (PLO) carried out guerrilla attacks on Israeli military targets, with the stated objective of "redeeming Palestine."

In 1973, Egypt joined Syria in a war on Israel to regain the territories lost in 1967. The two Arab states struck unexpectedly on October 6. After crossing the Suez Canal, the Arab forces gained many advanced positions in the Sinai Peninsula and Golan Heights and overwhelmed Israel forces. Israeli forces with massive U.S. economic and military assistance turned back Arab forces after a three-week fight. The Arab oil-producing states cut off petroleum exports to the United States and other Western nations in retaliation for their aid to Israel.

In 1974 the Arab Summit in Rabat recognized the PLO as the sole legitimate representative of the Palestinian people. Relations between Israel and the Palestinians entered a new phase with the first Intifada (in 1987), a series of uprisings in the occupied territories that included demonstrations, strikes, and rock-throwing attacks on Israeli soldiers. The Palestinian National Council (PNC) declared the State of Palestine as

outlined in the UN Partition Plan 181 in Algeria, 1988. The same year, Jordan gave up its administrative control over the WB.

The first comprehensive peace talks between Israel and delegations representing the Palestinians and neighboring Arab states started 1991. In 1993, and after secret negotiations, Prime Minister Rabin and PLO Chairman Yasser Arafat signed the historic peace agenda known as the Oslo Accords. Israel agreed to allow for Palestinian self-rule, first in the Gaza Strip and the West Bank town of Jericho, and later in other areas of the West Bank.

In May 1994, in Cairo, Yasser Arafat, and Yitzhak Rabin, signed the final version of the Declaration of Principles. In November 1995, Israeli Prime Minister Yitzhak Rabin was assassinated in Tel Aviv by a right-wing Israeli extremist. PLO Chairman Yasser Arafat was elected President of the Palestinian National Authority. In spite of agreements between the two parties, Israeli authorities released plans to expand Jewish settlements in Arab east Jerusalem, which caused outrage among Palestinians.

Israeli Prime Minister Benjamin Netanyahu and Palestinian President Yasser Arafat signed a peace-for-land agreement (known as Wye River Agreement) at the conclusion of negotiations in the U.S. The agreement called for Israel to relinquish control of portions of the West Bank in return for active measures to be taken by Palestinians against terrorism (1998). In 1999, Ehud Barak became the new PM and promised to forge a secure peace with the Palestinians. An agreement was reached with Israel concerning the release of Palestinian prisoners. Such release was a major point of contention in negotiations concerning the implementation of the Wye River accord. Israel

and the Palestinians agreed to establish the first open land link between the West Bank and the Gaza Strip so-called "safe passage".

In 2000, the Palestinian leadership refused a draft for a final solution to the Palestinian Israeli conflict supported by Israel and the United States. Palestinians felt that this solution would not fulfill the dream of a comprehensive lasting and just peace because it did not satisfactorily address major issues such as Jerusalem, the Jewish settlements, the borders, and the repatriation of the refugees (the right of return).
In September 28th 2000, Ariel Sharon, a minister in the Israeli cabinet, visited the East Jerusalem mosque compound. Palestinians protested, and 25 were injured when the Israeli police opened fire. In Sept. 29th, and as retaliation against stone-throwing at the Wailing Wall, Israeli forces assaulted Al-Aqsa Mosque area, killing 7 Palestinians and wounding 220. Violence broke and the second *Intifada* (uprising) was born.

At the end of 2003, Israel unilaterally proposed a pull-out and end of occupation in the Gaza Strip. This plan is in jeopardy due to internal Israeli pressures and disagreement in Israeli political circles. Another unilateral move was the building of a separation barrier that will isolate the Palestinian communities in the WB from Israel, providing, as Israel claims, more security. This *apartheid-wall*, as the Palestinians call it, is expected to exacerbate deterioration of the economy, limit access to vital points through the WB and take over hundreds of square kilometers from Palestinians and add them to Israel (Palestine Solidarity, 2003).

(See Graph 1.3)

Although, the International Court of Justice ruled in July, 2004 that this wall is illegal and is in breach of humanitarian law, Israel ignored it. (Haaretz, 2004) In addition, new plans have been issued by the Israeli government, with support from the US administration, to expand current settlements in the WB. All these activities are occurring without coordination with the Palestinians and ignoring previous accords between the two sides.

## The Development of the Palestinian Health System

### Ottoman Period (The period prior to 1918)

Since Palestine was part of the Ottoman Empire, it fell under the ultimate jurisdiction of the central government in Istanbul, but each religious community retained a certain amount of internal autonomy (Hagopian and Zahlan, 1974). Until the end of the Ottoman period, the Greek 'Hippocratic-Galenic doctrine', which had been improved by medieval Muslim medicine, was the predominant medicine in the Holy Land. The presentation of modern medicine into the region was a slow process, advancing step by step over the years, until its solidification in the 19th century. According to a Swiss physician who traveled several times to Palestine during the 19th century, hospitals were first established in Jerusalem by European physicians (Lev, 2004). The natural increase in population appears to have been modest until the end of the Turkish rule. Mortality rates were high for both children and adults, and fertility underwent little change until the 1960s (Giacaman, 1994).

British Mandate (1919-1948)

Under the British Mandate, health services were provided by the Department of Health, between 1920 and 1948. As the occupying power, Britain limited investment in the field of social services, and as a result most of the poor Palestinians who resided in rural areas (67% in 1944) had very limited access to health services (Hagopian and Zahlan, 1974). Palestinians in these rural areas depended mainly on traditional cures. Better services were provided in major cities. The rest of the Palestinians, who lived in urban areas were able to access better health services and utilize missionary and government hospitals (Giacaman, 1994, 2003). This contributed to the increase in life expectancy. For instance, the life expectancy of Christian males had been 52.57 in 1933-35 and reached 57.4 in 1942-44. The Muslim figure for the same period was 42 in 1933-35 and 49.35 in 1942-44, showing a net improvement over the years. With the start of the Mandate the infant mortality rate was also very high. Due to the process of urbanization, the situation improved by the early 1940s and infant and child mortality rates decreased among Muslims, Christians and Jews (Hagopian and Zahlan, 1974). In spite of the inequality of health service consumption during that period, the British Mandate brought significant changes notably in the standard of living, economic development, the use of immunizations, and modern medicine. These developments improved health conditions over previous periods, especially before World War I. Although public expenditure on health was low, sharp declines in morbidity and mortality rates were observed throughout the British Mandate (Giacaman, 1994),

probably through improved standard of living and better public health rather than medical care.

Egyptian & Jordanian Administrations (1948-1967)

Large numbers of Palestinians, approximately 750,000, became refugees in many countries worldwide after the creation of Israel in 1948 (Lilienfield, 1986). The majority of these refugees were in the West Bank and Gaza Strip, and the rest scattered in Lebanon, Jordan, and Syria. After the 1948 war, Jordan kept control over the West Bank, and Egypt controlled the Gaza Strip. Under conditions of poverty and refuge, the standards of health among Palestinians decreased substantially. For example, UNRWA sources gave an infant mortality rate of 172/1000 in the Qalandia refugee camp, during 1954-55 (Hagopian & Zahlan, 1974).

Two health systems emerged as a result of the presence of the different Jordanian and Egyptian legal and cultural systems. These still affect the development of the health system as a whole. The major reasons for the current *de facto* health systems and for the differences in the epidemiological picture are those legal and social differences between the two governmental systems that controlled the territories. For example, Palestinians of the West Bank, who hold Jordanian passports, moved freely to Jordan and other countries. This helped the development of a culture that was socially and economically more developed. Additionally, most of the refugees in the West Bank (>65%) lived in urban areas and a minority lived in the refugee camps. These refugees enjoyed better urban lifestyle than those who were displaced to the Gaza strip (Hagopian & Zahlan, 1974). The refugees in Gaza lived in worse conditions, especially in the camps. The

Gaza Strip always has been known as '*a virtual prison*' for its inhabitants. There was very limited access for the people of Gaza to travel, and their movements were severely restricted by the Egyptian military authorities (Hagopian & Zahlan, 1974). The Gaza residents could only travel under harsh conditions to get secondary and/or tertiary health services in foreign countries, or even Egypt. As a result of travel restrictions, poverty, and lower income than those in the WB, the community in the Gaza Strip became socially very conservative and less tolerant of change. The Egyptian administration over the Gaza Strip was successful in setting up patients' records and registration system, while the Jordanian system was weak in this aspect. The Jordanians encouraged establishment of Non Governmental Organizations (NGOs) and voluntary organizations, and the strong infrastructure of those organizations and community foundations is evident today, especially, in the West Bank. The absence of professional associations in the Gaza Strip and development of those in the WB, led to legal and technical obstacles towards uniting the efforts of those associations trying to emerge today besides already existing ones (R. Zanoun, Personal communication, August, 26' 2004). Prior to 1967, no system of health insurance existed under Jordanian rule in the WB. Instead, a fee for service was charged. A culture emerged in the WB to utilize private hospitals, clinics, and practices. Although this system cost more, it may have provided better services.

In spite of the limited information available about the health status before 1967, Giacaman (1994) suggests that infant and child mortality in the region continued to fall during the 1950s. While the Egyptian and Jordanian governments provided biomedical and curative services, they did not pay enough attention to primary and preventive health

care. As a result the infant mortality rate (IMR) increased by 1967, especially in rural areas in the West Bank. In general by 1967 the Palestinians health status had deteriorated.

Israeli Occupation (1967-1994)

Israel occupied the rest of Palestine after the 1967 war. An additional 400,000 residents of the WB fled to Jordan, and 50,000 fled out of the Gaza Strip. As of August – September 1967, there were 600,000 Arabs in the WB and 350,000 in the Gaza Strip.

A dramatic change in the available services and health status confronted the Palestinians. The Israeli Ministry of Health had no authority in the OPT. The Israeli occupation administered the health system under the Israeli Ministry of Defense and through what was titled the Civil Administration. The Joint Committee of Israeli Chief Medical Officer and Palestinian representatives were the people who dealt with the health sector issues. In addition, there was for the most part a complete separation between Israeli and Palestinian health systems. A serious and deliberate weakening of the local health services took place through the military occupation. Israeli authorities disempowered the Palestinians and limited their role in management, policy formulation or planning. Israel policy in the WBG was based on keeping good public health; especially in child and maternal health, but any development beyond primary care was always a lower priority (Ziv, 2002). The Israeli authorities always justified their relative under-funding of the secondary and tertiary sectors of the Palestinian health services on the grounds that specialist facilities were available in Israel and there was no need to duplicate services (Rigby, 1991).

The financial resources for the public health sector services, in the occupied territories under the Israeli control, came from the Civil Administration's health insurance premiums, from fees and stamps, and from taxes paid by Palestinians. There was no budget allocated to the OPT from the Israeli government to support the development of social services. In finance, this system is called a closed economic circuit, where expenditures do not exceed revenues (Ziv, 2002). The military government allocation for health services in the OPT was very low compared to that that made in the health system of Israel. For instance, it was found that the West Bank health services budget for 1975 was equivalent to about 60 per cent of the budget of one 260-bed Israeli hospital for the same year (Giacaman, 1994). In 1983, the health sector budget was $10 million, which was a small figure in comparison with the Israeli MOH budget. In addition, 30 per cent of this budget was paid to Israeli hospitals for referrals and tertiary care, because these services were not available in the OPT. Thus in 1983, the Israeli Civil Administration's average annual expenditure on health services in the West Bank and Gaza Strip per capita was $13 in OPT, compared to $200 in Israel (Henley, Bergholtz & Olofssont, 1986). In 1986, the figures did not exceed US$ 30 per person per year, compared to US$ 350 per capita in Israel. In the same year, the budget of one Israeli hospital (Akhilof) was six times the amount allocated to all nine government hospitals in the West Bank. In 1986, the West Bank health budget was raised to about US$ 20 million, and remained close to this figure in 1987, 1988 and 1989, despite Israeli shekel devaluations, rising costs of living, population increases averaging 3 per cent per year, and rising demand for health services (Giacaman, 1994). It is worth mentioning that

Israel allowed Jordan to pay Jordanian civil servants' salaries in the WB including those in the health sector (Brynen, 2000).

In the WBG, IMRs were not accurate since birth and death registrations were incomplete and inaccurate. In addition, existing estimates varied greatly, depending on the source of information. In 1966, IMR in the WB was estimated at 150. By the 1970s, the Israeli Central Bureau of Statistics estimated it at 100. This figure was higher than that reported by the Israeli MOH at 86 in 1969-1972, and 43 in 1974-75. This discrepancy had no clear reasons, although the low figures might represent data only for hospital births, which for the WB estimated to be 43.6% in 1981. By 1985, the IMR dropped to 25.6 in the WB and 43.1 in the Gaza Strip according to the Israeli MOH. According to Palestinian researchers and health professionals the estimated IMR in the WB in late 1970s and early 1980s was in the range 50 (urban and refugee camps & UNRWA) to 100 (Rural areas & the majority lives) (Henley, Bergholt & Olofsson, 1986; Robinson, 1993). After 1976, several social and economic changes resulted in improvement in health status that was not related to any development in the government health sector (Giacaman, 1994, 2003). The reasons for this were due to the local voluntary and social movements, improvements in the local economy, and an increase in the level and standards of education.

(See Table 1.1)

In 1991, there were 394 health centers in the West Bank (Giacaman, 1994). These included curative clinics, maternal and child health centers, and village health rooms. Of the total, 45% were centers operated by the Civil Administration, and 55%

were run by the private Palestinian sector (including charitable societies, the popular committees, and international aid agencies). For the Gaza Strip, there were some 70 clinics operated by the Civil Administration system, in addition to a variety of local and international institutions, and UNRWA. Of these, about 60 % were located in Gaza City where 30 % of the population of the Gaza Strip lives.

The number of public hospitals in the WB decreased from eleven functioning hospitals and three were about to open in 1967, to nine functioning hospitals in 1986 (Henly, Bergholtz & Olofsson, 1986). There were three Civil Administration hospitals in the Gaza Strip. Many observers and international organizations noted that equipment and supplies were insufficient, and that government hospitals lacked essential services. For example, some hospitals in the WB lacked beds for chest diseases, isolation rooms for infectious diseases, emergency or accident services, intensive care unit, facilities for specialized surgical procedures, and dental clinics. There were very few specialized clinics: five in WB and two in Gaza (Henley, Bergholtz & Olofssont, 1986). In addition, most hospitals operated by Israel lacked morbid anatomy services, dental services, physical therapy, and psychotherapy services. Laboratories and radiology services were out-of-date or defective, and some were installed in 1948. Other hospitals lacked basic services like lighting, heating, sanitation, and laundry facilities. (Health Hazard of West Bank Hospitals, 1981; Henley, Bergholtz & Olofssont, 1986)

From 1974 to 1985, the ratio of hospital bed/population ratio decreased from 2.2 to 1.6 per 1,000 in the WBG. By comparison in Israel in 1985, there were 6.1 hospital bed per 1,000 people. Some facilities were closed by the Israeli occupation authorities,

and others were deprived of needed personnel. For example, the physician to population ratio reached the low level of 6-8 per 10,000 in the WBG in 1986, compared with 28 in Israel and 22 in Jordan. (Robinson, 1993; Health Hazard in West Bank Hospitals, 1981) Moreover, facilities providing specialties were not allowed to exist under the Israeli occupation in the WBG. Although there were some local initiatives in the private sector, these were hindered by the occupying authorities (Giacaman, 1994). By 1991, about 40 ambulances were operating in the West Bank, and 30 in the Gaza Strip. Some were public ambulances and others were run by the Palestinian private sector. American Doctors for Human Rights, in February 1988, gave a detailed description of the health situations in WBG after field visits to several health Centers in the OPT. In their description of the health conditions, they stated that: "the conditions of the hospitals we visited are very low even if compared with low-level health services in the Third World countries" (Palestinian National Information System, 2004).

In addition to inadequate services, there were serious human resources bottlenecks. For example, in 1986, there was one radiologist in the WBG. Specialists were not hired by the Israeli administration. In 1986, there were 360 physicians employed in public, private, and charitable establishments in the WB, and 202 physicians in the Gaza Strip. In addition, there were 200 unemployed physicians in the WB and 150 in Gaza Strip (Henley, Bergholtz & Olofssont, 1986). The civil administration did not have any plan for the development of Palestinian physicians or other health occupations. Some physicians were able to travel abroad and get some training; most could not. The few who worked for the Civil Administration health sector and went for training in Israel did

not receive any specialist certificates from the Israeli MOH because they were not Israeli. In addition, Palestinians were not allowed to enter medical school in Israel. This overall restriction on human resource development led to a shortage of specialists while a surplus of trained personnel in other fields emerged (Ziv, 2002).

Prior to 1967, no system of health insurance existed under Jordanian rule in the WB. Instead, a fee for service was charged. Although, Israel introduced government health insurance after occupying WBG, only 40 per cent of the WB population was enrolled. Enrollees were mostly government employees or workers in Israeli companies, for whom subscription was compulsory. Very few Palestinians joined the insurance voluntarily. Others were either rich enough to purchase private services, or too poor to afford the Israeli health insurance (Ziv, 2002). Thus, the majority was forced into the fee-for service system or sought services provided by NGOs and charitable organizations. This became a serious concern, since a one day stay in a hospital in 1984 cost about US$125. Many people postponed seeking medical service until the diseases progressed, or they died at home. (Henley, Bergholtz & Olofssont, 1986) Another distinct feature of the differences is the utilization of medical services between Gaza and the WB was that the population in the WB became likely to rely on private and NGOs facilities, and a fraction of the population became willing to pay substantially higher fees, compared to the Gaza Strip population who utilized public hospitals where they received free care if they were insured. Also, the Gaza residents did not have the variety of private or NGOs like those in the WB (World Bank, 1997).

The World Health Organizations (WHO), in its 38 World Health Assembly (Geneva, May 16,1985), condemned Israel for its arbitrary practices, the appropriation of water resources, its role in devastating the mental and physical health conditions of the population, the policy of making the Palestinians dependent upon the Israeli health system by hindering the normal course and development of the Palestinian health institutions, and for not permitting the establishment of three WHO health centers in the OPT (World Health Organization,1985).

During the first Intifada, health care was used as an instrument of collective punishment (Rigby, 1991). The Israeli authorities raised hospital fees and reduced the budget for the OPT. They slashed the budget for treatment of the Palestinians in Israeli hospitals and denied access to injured Palestinians to Israeli hospitals for specialized care. It became clear that the Israelis used the cut in the health services' budget as tool to pressure the Palestinians to reduce the rhythm of the resistance. Israel reversed its policies in 1989, after local and international pressure, and good use of media by the Palestinians. The number of referrals to Israel was restored to approximately 70 per cent of original (Rigby, 1991; Ziv, 2002).

By the mid-1980s, it became apparent that secondary and tertiary health services were inadequate, and the health system suffered from serious inequalities in the distribution of health services, low levels of health insurance, and limited primary health care and general health in the rural areas (Robinson, 1993). The role of private, volunteer agencies and charitable societies evolved trying to close the gap in the provision of health and medical services.

Private Health Sector (non-for-profit and for–profit)

As a result to the deteriorating conditions of public health services under the occupation, many Palestinians depended on the private health sector to consume better and appropriate health services. According to the World Bank (1997), NGOs played a significant role in health care financing, during and after the Israeli occupation. This amount exceeded 40 per cent, including UNRWA, while direct household expenditures accounted for 40 per cent of the total health expenditures. The Palestinian national movement devoted time and attention to health and health care as part of the Palestinian question. In addition, the main goals of Palestinian scholars and researchers were to prove the deterioration in the health status of the population under occupation and to uncover and reveal the occupation policies and practices to the world (Giacaman, 1989). The private Palestinian medical and health sector, including private voluntary, charitable and for-profit institutions, developed health services both inside and outside the boundaries of military law and regulations.

Non-for-profit Sector

In the mid 1970s, these organizations emerged and became important players in the Palestinian health infrastructure. Robinson (1993) reported their role in diminishing dependency on outsiders and overcoming some fragmentation of the health system. These organizations represented and/or were affiliated with secular, religious, ideological, and philanthropic streams.

Palestinian non-governmental organizations may be divided into three types. The first type includes the *charitable/philanthropic societies* operating major hospitals and

diagnostic centers. These provide secondary services in urban areas, a focus on curative medicine, the improvement of technical skills and the use of technology and specialization. The second type includes *charitable/philanthropic societies* operating primary health-care centers. Examples of these are the International Christian Committee primary care centers, which have existed since 1961. These provided the basic services. These services ranged from primary and basic services, to curative medicine, drugs, and diagnostics. Their services covered urban and rural areas. The third type includes the *popular health movements*. These organizations focused on providing primary and preventive care services for rural areas, with workers who were mostly volunteers. Their services covered preventive measures such as health education (especially of mothers), baby clinics, nutritional assessment, and related health conditions to the wider socio-economic setting (Giacaman, 1994).

Politics played a major role in the emergence of voluntary movements that would help the Palestinians maintain and stand on their lands n the face of the occupation. Many factions of the Palestine Liberation Organization (PLO), such as Fateh, the Popular Front of the Liberation of Palestine (PFLP), the Democratic front for the Liberation of Palestine (DFLP), as well as the Palestine Communist Party (PCP). The PLO never issued a program to support social or economic reform under occupation. However, Steadfastness Funds, from the PLO-Jordanian Joint Committee, were established primarily to maintain existing institutions of all the Palestinian factions (Mandell, 1985). Instead, these funds were politicized, went to the Fateh Health Services Committees (HSC), but were denied to other politically-affiliated rival health committees, such as the

Union of Palestinian Medical Relief Committees (PCP-affiliated), Popular Committees for Health Services (PFLP-affiliated), and the Union of Health Care Committees (DFLP-affiliated). Also, institutions were supported by Palestinians residing in the Persian Gulf countries, international organizations like Oxfam and Christian Aid, and by local funding activities (Robinson, 1993). This sector's activities were hindered by Israeli regulations and restrictions on the acquisition of permits to establish and develop further health services. In addition, political factionalism, waste duplications of resource, and unevenness in quality were major challenges. Robinson (1993) explained that, although these popular committees were loosely tied to one of the major four factions of the PLO, they succeeded in establishing a structure of health care that had never existed before the 1980s. This structure could be a nucleus, with other health facilities, of a successful health system under an independent Palestinians State.

In addition, the first Intifada (1987-1994) played a major role in the increase of activities and support for these NGOs. One reason was the policies imposed by the Israeli military authorities. The occupation ordered the hospitals to provide the military with the names of all injured who were admitted to hospitals. As a result, people sought fewer services at public facilities for fear of being reported and arrested. Clinics and emergency service in rural villages, especially, in the WB arose as a serious health need during the Intifada. Local emergency teams in most towns and villages were trained by NGOs to help the help the victims of the occupation. The decentralization and volunteerism principles helped those organizations to be popular. Moreover, health conditions reached their worst during the Gulf Crisis, in 1991. Owing to harsh

restrictions, such as strict 24-hour curfew, the access to health and medical care facilities were severely limited and resulted in unnecessary deaths. Unemployment dried the financial sources of the Palestinians, and under long curfews many could not buy food or drugs (Giacaman, 1994).

For-Profit Sector

In spite of the fact that the private sector is based on a fee-for-service, Palestinians have no choice but to turn to its providers as an alternative to the shortage of health service and for the better quality and attention they receive in private settings. General practitioners and specialists were mainly working in urban areas, providing curative services to people coming from urban and rural areas. The latter, with 65 per cent of the population, lacked services of any kind. Health professionals within the governmental sector were poorly paid, earning on average one-half to one-third of what a physician could earn in the private Palestinian sector and up to only one-fifth of what a physician earned by working with the foreign non-governmental organizations operating locally. Thus, increasingly, physicians and other health staff were pulled into the private sector or left the country seeking better opportunities (Health Hazard of WB Hospitals, 1981). Due to the absence of any regulations, doctors working for the public sector also practiced in the private sector, and the government virtually eased regulations to prevent the turnover in its personnel.

It is worth mentioning that the Palestinian private sector operated 13 hospitals in the West Bank, including five in Jerusalem; and one in the Gaza Strip. The development of private hospitals and secondary care services continued in the 1980s, but was

insufficient and uncoordinated. Israeli authorities imposed restrictions on expansion by controlling the issuance of permits to operate health facilities which was one of the main problems facing Palestinian institutions in their attempt to develop. For instance, in 1980, the Red Crescent Society tried to obtain a license to operate a general hospital in the Gaza Strip, but the Israeli authorities never issued this permit. As a result of shortage of secondary and tertiary care, 2000 Palestinians were referred to Israel every year to utilize costly treatment (Mandell, 1985). Others traveled to Egypt and others traveled to Jordan. Those who were wealthy sought treatment in Europe. Accurate numbers about these categories are not available due to the absence of any monitoring system of secondary or tertiary care.

## The Role of UNRWA

### History

The United Nations Relief and Work Agency for Palestine Refugees (UNRWA) was established in 1949 as an *economic solution* for the problem of the Palestinian refugees. UNRWA was established specifically to dispense aid and at the same time to work towards ending international relief to the refugees. In its early days the UN worked toward two contradictory goals, one goal was to protect the refugee's right of return, and the other was to create an organization with the specific mission of retraining and resettling the refugees in their new locations (Talhami, 2003). UNRWA realized that the employment of refugees was five times as costly as maintaining them on relief. Therefore, providing 'Work' project was abandoned by 1955. As a result UNRWA focused on education and health activities in the refugee camps. The relation between

UNRWA and the Israeli occupation was problematic. Israel saw in UNRWA as a living body that is a reminder of the refugee tragedy, UNRWA's reports of Israeli violations in the OPT to the UN general assembly, and because UNRWA's was the major competitor that spent larger amounts on education and health service. However, Israel tempered UNRWA because it reduced the financial burden which Israel would have had to assume.

The experience of UNRWA was remarkable and is exemplary in the organization, management, and the productivity of its activities for the refugee populations. Although UNRWA faced the same obstacles faced by local Palestinian health providers, UNRWA's ability to practice and develop was unique. This may be a result of the political and social stability UNRWA facilitated to help settling the refugees. In addition, UNRWA had the resources and support from the international community. These allowed it to grow and develop its basic services for the refugees; including health, education, relief, and social services. The personnel of UNRWA consist of skilled Palestinian professionals and workers, except the top posts in the field offices. In spite of the size of its health facilities compared with population, it appears that UNRWA operates some of the most comprehensive and well-planned essential services in the West Bank and Gaza Strip. However, UNRWA suffers from high patient loads. Thus, keeping the quality of these services remains a challenge with the growing population of the refugees and the financial constraints and slashes in its operating budget, especially, since the 1990s.

In spite of many challenges, UNRWA succeeded in being a major primary health service provider for the refugees, especially in the Gaza Strip. UNRWA does not provide directly the needed secondary or tertiary services, with the exception of one 36-bed

hospital in the West Bank. Instead, UNRWA purchases services from local private hospitals; one hospital in the Gaza Strip, four in the West Bank. Mental health beds are also available at the government hospital in Bethlehem for refugees' use. UNRWA services included delivering preventive, sanitary and ancillary services to refugees, including family planning, communicable disease control, mother and child health, oral health, school health, water supply provision, waste disposal systems, and rodent and insect control programs. In addition, during the First Intifada, UNRWA established special emergency services consisting of both medical services; such as paramedics and ambulances, and food programs. (UNRWA official website, 2004)

# CHAPTER II

# HEALTH CONDITIONS AND HEALTH SERVICES DELIVERY IN THE OPT

## Introduction: A Weakened Palestinian Authority & Economy

Many people agree that both Israeli and Palestinian civilians are paying a high price for the ongoing conflict. For security reasons, Israel responds with policies that breach International Humanitarian Law (IHL) and forces restriction on the movement of people, goods, and humanitarian access; assassinations and military operations; land confiscations; and the leveling of houses. Armed Palestinian groups, responsible for military attacks and martyrdom bombings, also are in breach of IHL (OCHA, 2004).

In spite of this, Palestinians seem to be the major loser in this conflict. The major policy of the Israeli occupation in the WBG is *closure*; where Palestinians are not allowed to enter Israel or to travel to and among other Palestinian villages and cities. The policy of closure is an old policy that goes back to 1993. The closure policy became normative with Oslo Accords in 1994, and is still going on as a reaction to the turnovers of the fragile peace process and primarily to the ongoing *Intifada*. For Palestinians the closure policy is considered a tool for collective civic punishment and humiliation, while for Israel, these measures are considered security measures, and Israelis argue that it is their way of preventing martyrdom attackers from reaching Israeli cities (Qato, 2004). Closures and curfews have led to high levels of unemployment, a collapse in investment and trade, and a sharp decrease in labor income from Israel. Together with the destruction

of the infrastructure of Palestinian cities and villages by Israeli military forces and the collapse in domestic revenues, the Palestinian economy has experienced a sharp decline since September 2000 (Bocco, 2002). The decline in real per capita GDP reached almost 40% by the end of 2002, exceeding that of the US in the Great Depression in 1929 (GDP drop by 25-27 per cent), Argentina between 1998-2002 (GDP drop by 28 per cent), or in Iraq in 2003 (GDP drop by 31 per cent). According to the World Bank, unemployment had reached a level of more than 40 per cent, and more than 60 per cent of the population was below the poverty line of US$2/day (World Bank, 2004).

In mid 2004, the monthly salary bill of the Ministry of Finance (MOF) was 28 per cent higher than in 2002, and 64 per cent higher than in 1999. The 2004 PA budget showed a US$650 million budget deficit before receiving external financing. Donors covered more than half of this deficit. With no other resources the PA have been obliged, as in the past, to cut operating costs and incur debt to private suppliers. For political and social stability in the OPT, and as a result of the high dependency on external assistance, donors increased their support to the Palestinian people (World Bank, 2004). According to the World Bank, "sixteen percent of the total population, and one quarter of all Gaza Strip citizens, live in deep or absolute poverty (US$1.5 per person per day). As a result of the deteriorating situation many Palestinians (30 per cent) lost their sources of income and exhausted their saving" (World Bank, 2004).

Health Status of the Palestinians

The population in the WBG enjoys a relatively good health status compared to other countries with similar income level (Lower Middle Income). The life expectancy is 72.3

years and the Infant Mortality Rate (IMR) is 24 per 1000 live births (compared with the average of 39 per 1000 live births in middle income countries) (MOH, 2003). However, there is a wide geographical disparity in health and economic status, with the Gaza Strip population showing significantly worse health outcomes and lower income than the WB population. The epidemiological profile is a mix of communicable diseases and a highly growing prevalence of chronic diseases. Many cases, related to chronic diseases, seek treatment in foreign countries, such as Egypt, Jordan, and Israel, due to the lack of medical specialties in the WBG. The most commonly referred cases are in cardiology, nephrology, neurology, and plastic surgery.

(See Table 2.1)

Although health indicators are relatively good, other factors play a major role in shaping the health of population. Threats have increased with the beginning of the second Intifada and the re-occupation of the Palestinian Authority territories. A discussion of the issues of access to health services and utilization of primary health care services is vital. Many social, psychological and physical factors add dangerous elements to the ongoing tragedy. In addition, the groups that are most vulnerable under these health conditions are infants, children and chronic patients who lack access to basic immunizations, medications and other health services.

Refugee Health

Most refugees, and after 50 years of living in WBG, still live in camps and utilize primarily UNRWA health services, in addition to governmental secondary health care and other private and NGOs services. The epidemiological picture differs little for the

entire population in the WBG. The average IMR for WHO Eastern Mediterranean Region Office (EMRO) countries was estimated at 66.5 per 1000 live births in 2002. According to a study conducted by UNRWA in 2003, the IMR among Palestine refugees in the Gaza Strip was 25.2 per 1,000 live births and the West Bank was 15.3 per 1,000 live births. A significant difference exists between the Gaza Strip and the WB. The IMRs in Palestine and hosting countries vary according to the source of information.

(See table 2.8)

Chronic diseases (diabetes, hypertension, heart diseases) are the current major risks for the Palestinian refugees, with a complete absence of communicable diseases such as poliomyelitis, neonatal tetanus, diphtheria, syphilis, cholera, or measles. However, owing to the poor environmental conditions, vehicle-borne and vector-borne diseases are still endemic-especially hepatitis, brucellosis, typhoid fevers and intestinal infestations.

Services Provided by the Health Sector Players

When the Palestinian Authority assumed responsibility in WBG, it had to improve the basic services provided to the Palestinians. The highest priorities were education and health. As a result, the MOH was established in 1994 as a national body to rebuild and develop the health services and health status of the Palestinians (citizens and refugees). In the current context, the MOH is the primary provider of health services to the population, with about 40 per cent of health care visits taking place at government facilities, 31 per cent at UNRWA, and 29 per cent at private and NGOs facilities (MOH, 2004).

A health system can be described as "An organized arrangement to provide specified promotive, preventive, curative and rehabilitative to designated persons using resources allocated for the purpose"(James, 2003). This is not applicable in the OPT. For several historical, social, economical factors, the Palestinian health sector is fragmented. Many health agencies provide services in a heterogeneous and uncoordinated manner. These are the MOH, Medical Services for Security Forces, UNRWA, NGOs, and the private sector. "The fragmentation of health services has been a limiting factor in the development of an integrated, efficient health system" (European Union, 2004). For instance, the harmonization of policies between UNRWA and the MOH has been limited, and has not been extended to include non-governmental organizations and the private sector to formulate a national health policy. In spite of the fragmentation of the health system, a degree of coherence exists among them (Hamdan, 2003).

The Ministry of Health

The Palestinian territories are an excellent example of the growing interest of the international donor community in supporting rehabilitation and peace building in 'post-conflict' countries (Hamdan, 2002). The Palestinian Authority is one of the largest recipients of aid undertaken by the international aid community (World Bank and Japan, 2000). Substantial international assistance was devoted to reconfiguring the health sector. The efforts started with budget support and then moved then to capital investment, such as upgrading and expanding the infrastructure, MOH institution building, and training of human resources. As a result, new hospitals and new primary health care

clinics were built in the WBG. Plans for a national health information system, a national health insurance scheme, and a plan for human resources development were developed (Giacaman, 2003), but unfortunately these were unsuccessfully implemented. A more detailed analysis of aid to the health sector is discussed in Chapter Three.

**The MOH Health Services**

First of all, the MOH provides health services for both citizens and refugee except those Palestinians in East Jerusalem which Israel considers part of its state. The MOH is the main provider of primary health services in WBG, running 391 primary health centers (PHC), followed by UNRWA, running 51 centers, and NGOs which have 177 centers. Since the establishment of the MOH in 1994, there has been an obvious increase of PHC from 205 in 1994 to 391 in 2003, with an increasing percentage of 90.7 per cent (MOH, 2002, 2003). The services are characterized by overload and high utilization rates, especially in the Gaza Strip, with short time of consultation per patient. There are 23 hospitals run by the MOH with 2,614 beds constituting 55.9 per cent of the total hospital beds in WBG. The number of MOH hospital beds increased from 30.4 per cent from 1999, while the admission rate increased by 40 per cent and emergency services increased by 65 per cent. There are eleven hospitals in the WB of with a total of 1,152 hospital bed (44.1 per cent) and 12 hospitals in the Gaza Strip that contains the rest of the hospital beds. In Palestine, the number of beds per 10,000 population was 12.52 in 2003.

The health services provided by the MOH lack quality and standardization. Physicians with different overseas educational backgrounds practice medicine in different ways. The problem is that there are no uniform standards or a common work style.

Recently, the Quality Improvement Project (QIP) developed Palestinian treatment guidelines for different diseases and illnesses, but the concern is the absence of a strong will to use these in MOH hospitals and clinics. Hamdan (2003) states that one key concept, in describing the health services in any country, is the availability and accessibility of health services. In fact health services are available throughout the Palestinian territories, but the problem is with accessibility of these available services. Hamdan (2003) defines accessibility as the degree to which individuals are able to contact needed health services, reflecting the appropriateness of the distribution and organization of health care in a country. In Palestine the health facilities that are distributed over the geographical regions, are inadequate in terms of the number, level and type of service. This issue was not a major concern before the current crisis, where people used to move freely and traveled to major cities to seek services. In the Gaza Strip, health facilities are very close to Palestinian houses, in contrast to the WB population. The Intifada and Israeli policies disrupted the functionality of health delivery in the OPT, leading to challenges and threats.

Emergency Status in the Occupied Palestinian Territories

Since September 2000, violence and destruction affecting the Palestinian Authority remains the main reason for the deterioration of the socio-economic status of the Palestinians. The most affected of this conflict are Palestinians, specially women, children, and the elderly. International children and human rights movements had documented the death of over 500 Palestinian children, under the age of 18 years, and

estimated that 10,000 were wounded. The majority of these children were killed and injured while going about normal daily activities.

Within the past year, Israel continues the building and construction of the separation wall between Israel and the Palestinian territories. The completed sections, consisting of concrete walls, electronic and electrified fences, patrol roads, ditches, and trenches, stretch for 180 Kilometers, will affect 60 towns, villages and refugee camp. Israel has encircled districts and individual villages cutting them off the WB (Ziv, 2002). The estimated number of affected people is 270,000 citizens (about 12 per cent of the WB population), who have lost land, water, and agricultural resources in the construction of the barrier, and experienced problems in accessing essential services. Most of these people rely on services provided by the MOH, UNRWA and NGOs in major cities in the WB. Due to the absence of any map of this wall, it is estimated that the completion of the wall will result in 15-50% (up to 1000 $Km^2$) of the WB's most fertile land being annexed to Israel along with the richest water resources (Palestine Solidarity Campaign, 2004; OCHA, 2003).

Access to Health

The barrier and the partition policy of Israeli occupation increase the problems of access to health facilities and services. Health providers' ambulances, outreach mobile clinics and distribution teams require special entry permits from the Israeli army to conduct regular and emergency programs. These restrictions on the movements of health workers are more serious when there are military operations in the OPT, and get easier in some situations; but they are never removed (UNRWA, 2003). Most of the time, access

to crisis areas is denied. Thus, evacuation of injured or wounded Palestinians is not guaranteed under the general policy that the occupation imposes on the ground. Qata (2004) mentioned that "according to the US Agency of International Development internal closures directly prevented receipt of care by 33 percent of patients in need of urgent emergency medical services, 21 percent of women seeking antenatal care, 17 percent of patients in need of kidney dialysis, and 46 percent of cancer patients needing life-saving chemotherapy." The movement of health personnel is restricted by more than 600 check-points in the West Bank and several in the Gaza Strip. Medical professionals commonly have great difficulty reaching their hospitals and clinics. Moreover, since September 2000, there have been more than 254 incidents of attacks on medical personnel, of which 15 medical staff have been killed while carrying out their duties. Many complaints also have been reported concerning Israeli army attacks on hospitals and clinics (PRCS, 2004), in pursue of injured resistance fighters.

Palestinians in the WBG are not able to travel freely to major cities to seek medical services, especially in cases of childbirth, chronic diseases and emergency medical needs. They have to wait for many hours at the checkpoints to get in, or are turned back. The Israeli Army has been accused of displaying too little consideration for the humanitarian needs of these civilians and especially the right to health (Qata, 2004; Ziv, 2002). In August 2003, a WHO survey revealed that more than 50 per cent of survey respondents had to change health care provider facilities, and that in 90 per cent of these cases the change was due to restriction of access. In many cases, women delivered their children at checkpoints, and other sick adults died while waiting to get through.

Moreover, the occupancy rate of hospitals suffered a significant decline in bed occupancy rate. For instance, in UNRWA's Qalqilia Hospital in the WB, the occupancy rate fell from 67.5 per cent to 43.5 per cent, between 200 and 2003. The number of patients from outside the city, who usually have received their treatment in the hospital, has declined from 38.6 per cent to only 16.7 per cent within the same period. The number of surgical procedures performed has fallen from an average of 1,154 to 305 annually (UNRWA, 2003). Referrals of injured or chronic patients by professional Palestinian health providers to Israeli hospitals often has been denied, and many cases were prevented from traveling abroad to seek specialized surgeries and treatment. These policies have been noticed by Israeli (BT'selem, PHR-Israel), Palestinian (MOH, PRCS) and international organizations (UNRWA, OCHA, IRCS, USAID, CARE).

Impact on Health Status

In addition to the human loss in the OPT, many injuries and injury-related traumas end with permanent disabilities. A 40 per cent increase in upper respiratory tract infections (pneumonia) was reported in children during the first two months of the Intifada. Most infections take place in the refugee camps where people lack sewage system, clean drinking water and proper social and economic conditions (Qata, 2004). The incidence of low birth weight has increased, while births attended by health workers have decreased. Shortage of water and the demolition of homes have left hundreds of Palestinians homeless, created poor conditions of hygiene, and increased the incidence of water-born diseases, like diarrhea (UNRWA, 2003). The risk of disease outbreaks

remains high, because national immunization schedules have been interrupted by the curfews, closures and electricity outages (USAID, 2003).

Chronic malnutrition among children under five has reached emergency rates, and over 40 per cent of children in that age group were anemic. Anemia rates among women in Gaza reached 53 per cent (Care International). According to humanitarian relief agencies, 50 per cent of the Palestinians are largely dependant on food aid. The Office of Coordination of Humanitarian Assistance (OCHA) has estimated that 600,000 Palestinians (17 per cent of the population) "are depending almost entirely on outside aid". FAO, WFP, EU and USAID conducted the Food Security Assessment and found that the access and affordability are limited due to physical or economic reasons (FAO, 2003). Approximately, 40 per cent of the population in WBG is food insecure and 30 per cent is under threat of being insecure. Despite the food aid program, adequate food supplies are not reaching all households, and diets are of low quality in terms of vitamin and mineral content. Without donor assistance, nutritional status would be similar to that of poorer countries. Per capita food consumption has decreased by 30-35% since 1999, and donors have increased their food aid five-fold since 2000 (World Bank, 2004). Moreover, the surrounding environment of continuous death, injury, and violence has resulted in a high rate (54 per cent) of post-traumatic stress syndrome (PTSD) symptoms, especially among children. More than 30 per cent of the cases required psychological intervention.

National Health Policy and Management

The first National Strategic Health Plan emerged in 1994. The plan was designed in exile by the Planning and Research Center, an office under the Palestinian Red Crescent Society, a declared NGO but with strong relations with the PLO. An inference can be drawn that polices in this plan were formulated by Palestinian professionals in exile and *returnees* with no experience with the local community and their needs. Officials claim coordination with local experienced health workers and Palestinian NGOs, but it seems that the ultimate goal for the PA was to take over the health sector. This plan was implemented during a 5-year period, which was the period for transition from the self-autonomy state to the independent state (1994-1998). Then, a second national health plan was created by the MOH, as part of the Palestine Development Plan, for the period 1999-2003. Currently, donors are in the process of reviewing the health sector in terms of development level and current emergency status in the OPT, in order to pave the road for a new plan that takes into consideration possible *health reform* (Lubna Sharif, Personal Communication, 2004).

In the first plan, the MOH strategy emphasized the rehabilitation and expansion of the health delivery system to achieve measurable improvements in Palestinians daily life. MOH (1998) states that it was a priority to expand the physical infrastructure of its facilities to promote good indicators of health. However, these investments were rapid and were undertaken without enough study of the societal needs. As a result, uneven and inefficient distribution and utilization of services affected both the public and private sectors. The MOH placed more emphasis on expanding hospital capacity. The policy

was intended to correct the limited investment in secondary and tertiary care under the Israeli occupation and to reduce the costly reliance on the Israeli hospitals.

The second health plan concentrated on sustainability, cost containment, and sharing of resources between the public and private sectors. The MOH started a strategy of utilizing both local private for-profit and not-for-profit facilities instead of referring patients abroad. These contracts were limited, due to the small capacity of MOH to manage contracts. The MOH and private sector trends in investment in hospitals were to build hospitals with 100 bed or less. However, these small hospitals are suboptimal in terms of cost-effectiveness and quality of care provided. Again, these investments took place without proper analysis of population clinical needs, appropriateness of technology, and affordability. This resulted, especially in the private sector, in the presence of high intensive technology and duplication of resources.

The quality and safety of care remains a big concern to the population in the WBG. Although there are projects that focus on improving the quality of care in MOH facilities, the improvement is very small. MOH succeeded in establishing the essential drug list, standard formularies, and treatments guidelines. The issue is that these programs could not be institutionalized ministry-wide. High prevalence of hospital infections, unsafe radiology, irrational use of prescription drugs and inappropriate diagnosis of and treatment of chronic diseases are examples of quality problems that contribute to wasteful and unsafe practices (World Bank, 2000).

As a governmental body, the MOH health services are highly centralized. The administration and control functions originate in the center and spread outward to the

divisions and units in the WBG. The MOH, compared to other PA ministries, was built on the remnants of the health administration of the Israeli occupation. Still, as in other ministries in the Palestinian Authority, it was unclear who the powerbrokers were. For instance, according to the original plan that was set up for the MOH in 1995, three Directors General (DG) positions for the WBG should be established. But during 1995-2002, there were 58 DGs, and from 2002-2004, this number increased to 100 (R. Zanoun, Personal Communication, 2004). There was a mismatch between real and formal power. Many decisions that were made by the top management were ignored by lower-rank management, who were supposed to support the whole policy of the formal leadership. The assignment of jobs by the Palestinian political leadership always had been characterized by *cronyism and patronage,* as a political tool to keep control and stay in power. Thus, the MOH is a victim of this inherited policy in the Palestinian culture. Positions and authority are given according to political loyalty and have little to do with experience and professionalism. In addition, the position of the Minister of Health, traditionally has been held by a medical practitioner, and usually has fallen to the candidate who is ineffective politically. Within the PA, increased public sector hiring reflected political pressures to absorb returning PLO cadres, integrate ex-detainees and other local activists, and offset high unemployment in a rapidly growing labor force. In 1994, there was a total of 4,000 persons employed by the government. This number increased sharply to approximately 8,500 by 2003 and still growing. Two factors contributed to this increase. The first factor is the growth and expansion of health facilities. The second factor is that a job is considered to be a *dividend* that the political

leadership pays to increase political support, keep control, and decrease unemployment. During an interview with a former Minister of Health, (Personal Communications, 2004), he spoke openly that of 8,500 employees, about 2,500 employees are of no real value to the MOH, and they were forced on the MOH by the higher authorities. They are a heavy burden on the MOH budget.

For political and cultural reasons and the lack of experience with development and national planning, the MOH was part of a whole system that played a role of politicizing the public sector. The efforts and interest about reforming the government health sector were limited by many factors. For decades under occupation and foreign control, the result was a chronic weakening of the organizational capacity in both public and private institutions in WBG. The main contributors were the Israeli measures designed to weaken the external and internal environment of the institutions, leaving little if any control over institutional decision-making in the hands of Palestinians. "Such weakness has rendered institutions unable to correct their problems, let alone launch new programs" (Roy, 1995).

There have been limited efforts by normal interest, lobbying and advocacy groups. The health policy and decision-making process, as it seems, is always practiced at the upper management level or imported from abroad. Professional syndicates or associations always have been established by *presidential decree,* according to political factional considerations. Normally, such organizations have statuary powers for professional self-regulation and the right to be consulted on policy issues. As such organizations play roles in representation, lobbying and education in other societies, we hardly see this in the

Palestinian health sector; especially in the Gaza Strip. Officials always use the policy of *blame the occupation* to justify shortage in improving and enforcing policies.

The Palestinian Legislative Council (PLC) functionality is under questioning, as they mostly represents the political leadership agenda with little concern and limited power in issues that can be described as critical, such as professional associations and reform. PLC has issued some laws like the Civil Services Law, which improved the level of salaries for the public sector's professionals and health workers. The Public Health Law and the Palestinian Nursing and Midwifery Law have been accepted for discussion; the Palestinian Medical Council Law and the Government Health Insurance Law have been postponed (Palestine Legislative Council, 2004).

Financing the Public Sector

As a consequences of the second Intifada, starting in 2000, the revenues of the PA declined sharply resulting in a decline in the public revenues and consequently in expenditures for major sectors, mainly health and education. In 2000 the Gross National Production (GNP) was estimated by the MOF at US$ 5,274 million and in 2003, this figure declined to US$ 3,705 million. In 2000, on the other hand, the Gross Domestic Production (GDP) was US$ 4,442 million and declined in 2003 to 3,257. GNP and GDP per capita in 2000 and 2003 were US$ 1,020 and US$ 896 respectively.

In 2003, the revenues of the MOH came from the Government Health Insurance (GHI) premiums (26.5 per cent), co-payments and fees collected at health facilities (10-30 per cent); the largest portion come from the general tax revenues (60 per cent). Starting in 1995, the MOH decreased the premiums when the PA assumed

responsibilities in the OPT in order to allow people to utilize the health services provided by the public sector at cheap prices. Enrollment increased by 50 per cent in 1998, and 53.5 per cent in 1999. But, because of the current economy and low income in the WBG, enrollment in the GHI has declined by 31 per cent in 2003. Workers are no longer allowed to work in Israel. As a result an important portion of the GHI premiums, which used to be transferred from Israel to the PA, has vanished (13% in the WB and 30% in Gaza of total participants) (World Bank[b], 1997).

(See Graph 2.3)

All funds collected are transferred to the MOF, which in turn transfers a monthly advance to the MOH's current expenditure account based on the annual budget. MOH does not have direct access to the funds it collects through the different sources of revenues. In addition, financial management is done at the MOH central ministry level with a complete absence at the facilities level (World Bank[b], 1997).

In 1997 the health expenditure was estimated by the World Bank (1997) at US$ 122 per capita. The same year, the national health expenditures share of GDP was estimated between 6.60 per cent and 8.20 per cent. In 2002, the MOH expenditure of GDP was 3.20 per cent and in 2003, it declined to 3.02 per cent. The crisis in the WBG affected the budget of the MOH in 2003. The MOH requested an annual budget of US$ 108.6 million, but because of the general decrease in government revenues the MOF transferred US$ 98.42 million, with a deficit of US$ 10.2 million. This deficit affected MOH expenditures on medications and medical supplies.

(See Table 2.2, Graph 2.2)

The current expenditure pattern shows that the major portion of the budget went to salaries (44.4 per cent) in 2003. Hamdan (2003) argues that this figure was lower than in other ministries of health in developing and transitional countries. In 2003, treatment abroad consumed 12.9 per cent of the MOH budget, with an increase of 100 per cent of the 2002 expenditure on this field. The drug and disposables budget was 17.9 per cent, and other operating expenditures were 13.9 per cent (MOH, 2003).

The total number of patients referred for hospitalization and consultation has increased from 8,123 (in 2000) to 20,235 (in 2003), or an increase of 149.1 per cent. It is interesting to note that the president's office referred 32 per cent of the total cases for treatment abroad. Out of the total referrals only four per cent were injured in the Intifada and needed specialized care outside the MOH facilities. Oncology cases were the first on the list of the costly referrals (16 per cent of the total costs), followed by infertility (8.8 per cent of the total costs) (MOH, 2003). Unwise decisions concerning expenditures should be reconsidered, though 8.8% of total expenditures to be spent on infertility and under the current crisis should be totally unaccepted by the MOH leadership.

## UNRWA

### UNRWA Health Services

UNRWA runs very effective preventive/promotive primary health activities that include integrated maternal and child health services, family planning services and integrated control of communicable and chronic diseases. According to the World Bank (1997), the UNRWA strategy and approach to health delivery has been efficient and could provide a basis for the development of a sustainable Palestinian health system.

However, the PA has refused to take over the facilities of UNRWA for political and financial reasons, pending a final solution of the refugees' question.

(See Table 2.4)

UNRWA provides assistance in performing essential hospital services, either by contracting beds at non-governmental and private hospitals or through partial reimbursement of costs incurred by refugees for their treatment at NGO or government hospitals. UNRWA runs only one hospital in the WB. The low utilization in Gaza was mainly due to inadequate provision of subsidized beds, obstacles to humanitarian access to the only contracted hospital in Gaza City and use of hospitals run by the MOH.

(See Table 2.5)

Environmental projects to ensure sustainability in refugee camps are underway, especially in Gaza, where water and sanitation conditions are very poor. Food aid is provided for vulnerable groups, especially pregnant women and nursing mothers. A program of psychological counseling was implemented in the WBG within the framework of UNRWA's program of emergency humanitarian assistance to the OPT.

(See Tables 2.6, 2.7)

- **Management & Coordination**

As the second employer of health professionals, UNRWA employs 639 individuals in the Gaza Strip and 498 in the West Bank. These professionals are employed in different professional and administrative positions. The staff/population ratios remained very low compared with the host authorities. This means, for example,

that a doctor sees 101 patients per day, which is considered a heavy load on the UNRWA staff and raises questions about the quality of services.

In order to reduce the adverse consequences of heavy workloads, special emphasis is placed on training. In 2003, a total of 7,657 person/days of training were provided. The training covered major program activities, including maternal and child health, disease control, rationales for medical prescription, laboratory techniques and oral health. Since 1950, the WHO has been providing UNRWA with technical supervision and sustained support of the World Health Organization Regional Office for the Eastern Mediterranean (EMRO). The WHO also covers the salaries and related expenses. UNRWA historically has maintained close working relationships with the public health departments of the host authorities. UNRWA senior health staff in the WBG enjoy membership in all technical committees established by the MOH to review practical aspects of health policy and to co-ordinate action in the health sector. The MOH provided all vaccines included in the expanded national program on immunization in the WBG as an in-kind contribution to UNRWA. The department of health at UNRWA maintains working relations with the United States Agency for International Development (USAID), Palestinian Red Crescent Society (PRCS), and other organizations.

- Health Financing

Although donor contributions to UNRWA expanded in the early 1990s, the budget did not keep up with the rapid refugee population growth rate. UNRWA faced major financial problems because international donors reduced their financial support,

preferring to support the PA bilaterally. This resulted in financial deficits in the following years. The threat of unsustainable financial resources will always endanger the quantity and quality of health services provided by UNRWA to the refugee population. The approved 2003 UNRWA health budget under the regular program was established at US$ 60.662 million. Total expenditures amounted to US$ 53 million. According to the WHO analysis of finances of health care systems (World health report 2003), UNRWA's annual health spending compare with that of very low-income countries, whereas program achievements place it closer to those of middle-income countries (UNRWA, 2003). Health allocations are similar in Gaza (US$19.10) and the West Bank (US$19.20). The refugees are active participants in the cost of health care. Primary health care is free, but refugees are participants towards the cost of hospitalization (up to 25 per cent), advanced diagnostic procedures, and prosthetic devices.

(See Table 2.9)

UNRWA's Role in Responding to the Emergency Status in the OPT

UNRWA launched appeals to implement a comprehensive program of emergency humanitarian assistance, including emergency employment generation, emergency food aid, emergency shelter repair and reconstruction and emergency medical care. UNRWA was forced to reprogram its activities, because of a shortage of funds- especially in the fields of food aid, direct employment, and cash assistance. Lack of funds meant cancellation of programs in education, health and shelter rehabilitation. UNRWA distributed 3.4 million food parcels since the year 2000 (200,000 families in WBG= 2/3

of the refugee population and 1/3 of total population in OPT). Assistance to non-refugees is provided in close coordination between WFP and PA.

(See Table 2.11)

Medical Services of Security Forces

The medical services of the security forces play a major role in providing primary, secondary, and tertiary health services to Palestinian security force personnel and their families (about 300,000 visits in 2003)(PCBS, 2003). This sector is represented through two hospitals in the Gaza Strip, with total beds capacity of 92. The two hospitals reported 756 and 899 admissions and provided 1,841 and 2,057 hospitalization days, respectively. The hospitals offered outpatient consultations to 100,964 care beneficiaries, and conducted 1,735 surgical operations. The hospitals provide lab and radiology tests, as well (MOH, 2003). The finances of the military medical services come from the Military Finance Administration, which is not under the supervision of the MOF. This separate entity is directly linked to the President's office.

Not-for-profit Non-Governmental Organizations

NGOs, in the pre-Oslo period, played an important role in the delivery of many services, particularly in the health sector. NGOs generally filled a gap in the provision of health services. They provided services not provided by neither UNRWA nor government; such as curative services in primary health care clinics targeting underserved communities (Barghouthi, Lennock & Shaban, 1999). Supported with local, Arabic, and international assistance, these organizations succeeded in doubling their numbers during the first Intifada in the 1980s (World Bank, 1999). World Bank data

suggest that US$140-215 million in external funding was received by NGOs in 1992, the peak year for external funding-a sum that declined to perhaps US$60 million per annum in 1995 (of which 60% fund was used to health activities). The precipitous cut in the funding base for NGOs came about as the result of two factors: the reduction of Arab and PLO support in the wake of the first Gulf War; and a switch by donors of a considerable proportion of their health financing to the PA, away from NGOs and UNRWA (World Bank[a] 1997; World Bank 1999).

NGOs adapted to the reduction in their financial resources in different ways. A few attempted to introduce fee-for-service arrangements, though this proved difficult, especially in the period since the second Intifada and the deterioration of the economy. Others elected to work for the PA. However, the majority cut back on services by closing rural clinics and/or by reducing the range and frequency of services offered. A lack of funds for operating budgets appears to be a major reason for declining rates of occupancy in NGO hospitals, current movement restrictions and closure policy, competition with the public sector, and the lack of insurance coverage for NGO services. The World Bank (1999) estimated that the number of clinics run by NGOs through the WB declined from 210 in 1992 to 128 in June 1996.

Hamdan (2003) mentioned that there were 49 not-for profit NGOs that provided health services to the Palestinians. However, there is no proper coordination between these organizations due to conflicts of interest, and different political and ideological backgrounds. For the current health emergency in Palestine, NGOs and not-for-profit organizations are major players in the delivery of medical and health services. NGOs run

about 30 per cent of PHC in WBG. The services provided by NGOs include primary health care, laboratory services, diagnostic technology, and pharmacy care (MOH, 2003). NGOs cover an important area of curative care, especially to those persons in rural areas, through a network of primary health care clinics scattered in the WB. These clinics are very important, due to the major problems of absence of physical access and underserved communities. In addition, out of all providers, NGOs have the highest number of specialized doctors. Twenty five per cent of the NGO clinics in the WB have specialties in diabetes, obstetrics & gynecology, ophthalmology, and dermatology (Barghouthi, Lennock & Shaban, 1999).

The NGOs own and operate 31 hospitals with 1,489 beds constituting 31.8 per cent of the total hospital bed pool in WBG. The NGO hospitals are more prominent in Jerusalem and the WB, and a very small number operate in the Gaza Strip. The NGO hospitals have increased in number over the last few years. The number of hospitals increased from 24 in 1999 to 31 hospital in 2003, and total bed capacity increased from 1,408 beds to 1,489 beds in the same period. In the Gaza Strip, the NGOs own and operate 10 hospitals at total bed capacity of 416 beds. The NGO beds in the Gaza Strip constituted 27.9 per cent of the total NGO bed capacity and were equivalent to 21.7 per cent of the total bed pool in the region. About 55.3 per cent of the NGO bed capacity in the Gaza Strip was available in Gaza City. In the WB, the NGOs own and operate 21 hospitals at a total bed capacity of 1,073 constituting 72.2 per cent of the total NGO beds and are equivalent to 38.8 per cent of the total bed pool in the region. The NGOs are still absent in several major cities in the WBG (MOH, 2003). Al-Makassed Hospital in East

Jerusalem is the primary Palestinian facility for secondary/tertiary health services for WB residents and to a lesser extent, for those in the Gaza Strip. The hospital provides advanced surgery in cardiology, neurology, plastic surgery and gynecology (Giacaman, 1997; World Bank, 1999).

The change in MOH strategy relatively improved the relationship between the MOH and NGOs, making it more *cooperative*, rather than competitive. The MOH buy a number of services from the NGOs. These services include patient referrals to hospitals in Jerusalem and to diagnostic centers in the West bank, as well as referring patients for MRI services from Gaza to the WB because MRI is not available in Gaza. Sharing of resources has led to less dependency on foreign countries, but this growing strategy is faced with Israel's continuing policy of closures and partitions, affecting movement of patients to and from the Gaza Strip and the WB.

For-profit Sector

In 1997, the World Bank estimated that the direct household expenditures on medical care accounted for 40 per cent of total health expenditures in the WBG. According to the Palestinian Central Bureau of Statistics, 3.5 per cent of the average monthly household expenditures were spent on medical care (40 per cent drugs, 18 per cent physician services) and health insurance premiums (19 per cent). The data about hundreds of private practitioners including their practice volume are very limited, though the private sector accounts for a significant percentage of physician visits in the WBG. This shortage of data is mainly due to lack of any regulations in this sector. Private practitioners receive fees for services from the patients and through contractual

arrangements with private insurance companies (World Bank[b], 1997). A large number of health professionals work in this sector, including physicians, pharmacists, dentists, lab technicians, physiotherapists, and diagnostics experts. Many work full-time for the public sector, UNRWA, NGOs and/or private sector at the same time.

Private investments have grown since 1994. These investments were primarily in high-tech and advanced diagnostics and specialized medical services and polyclinics. Large private health care companies have been formed in the WBG. These are start-up new businesses and/or buy-out operations from the financially strapped NGOs. The growth of this sector has been beneficial for the MOH, as private organizations charge less for services than that used to be sought in Israel, Egypt or Jordan.

The private sector owns and operates 23 hospitals in Palestine, with a total capacity of 518 beds. In the WB, the private sector owns and operates 18 hospitals at total capacity of 450 beds accounting for 78.2 per cent of the total private sector capacity in the region. In Jerusalem, there are three private Palestinian hospitals with a total capacity of 74 beds. This figure constitutes 14.3 per cent of the total private beds in Palestine and 14.1 per cent of the total bed pool in the Holy City. In the Gaza Strip, there are two private hospitals with a total capacity of 39 beds, constituting 7.5 per cent of total private sector beds and two per cent of the total capacity in the region. The last two hospitals are located in Gaza City (MOH, 2003).

While actual enrollment figures are not available, private health insurance coverage appears to be very limited. In 2000, private insurance covered only 11% of the total population (Hamdan, 2003). These companies cover employees in private

businesses, and a large portion of many private business employees have no health coverage due to lack of job benefits. Most private sector employees enroll in the GHI, or do not enroll at all and instead rely on private providers. There are seven local insurance companies that offer private health insurance plans. Moreover, the private insurance premiums are higher than the GHI's and their services packages provide limited services (Hamdan, 2003). Insurance companies experience problems because of the economic crisis in the area. These companies began to introduce measures to select out the high risk population and exclude individuals with pre–existing conditions in order to maintain financial solvency.

Performance of the Health System

A serious concern is the quality of health services provided in primary health clinics and hospitals. Within the MOH, the absence of a quality assurance program that controls and monitors the performance of public/private hospitals and clinics raises many questions about the outcomes of the development and variety of health services. In addition, the investment strategies in the WBG have focused on upgrading of medical technology and expansion of tertiary level capacities. Rapid growth and an absence of coordination among partners in the health sector have led to duplicate services and initiatives that did not address the needs of this vital sector. As much of the literature argues, in spite of the development of the hospital sector and the national strategy of developing the health sector, this strategy resulted in a *two-tier* health care system (Barghouthi, Lennock & Shaban, 1999). The first tier has low quality services and is represented in government and private sectors. This tier has paid less attention to

preventive programs that reduce the incidence of diseases, illnesses, and injuries eventually requiring expensive secondary or tertiary care services. The second tier provides high quality biomedical and curative services for the rich class. These developments could ultimately result in deteriorating aggregate health indicators for the population, as the need for primary and preventive health care increasing. More research on the following points should be considered: the change in the quality of human resources in the health care sector; the affordability and appropriateness of the health care provided, and the sustainability of current services and capital investments (World Bank and Japan 2000).

Coordination among Different Health Providers

A de facto harmonization of policies and services delivery between the MOH and the other stakeholders would create the basis for a more efficient, less fragmented and more effective health system (World Bank[a], 1997). As the need for primary health care and public health increases, especially in the WB, the need for more coordination and change in the current policy should take place. The MOH strategy, from the beginning, was to expand its own delivery system rather than purchasing or contracting services from private providers or NGOs. The result of this strategy has been a highly centralized and bureaucratic system that would result in increased inefficiency of the system. Cooperation with private providers and NGOs will increase overall macro efficiency of the system, as it would make use of excess capacity in the NGO sector, and incorporate previous experience and special knowledge of community needs. However, such

collaboration between the public and private sectors requires development of appropriate regulatory and monitoring mechanisms that address financial performance.

# CHAPTER III

## AID TO THE PALESTINIAN HEALTH SECTOR

Humanitarism includes as actions to save lives, alleviate suffering and maintain human dignity in the aftermath of man-made crises and natural disasters (Dalton, Hippel, Kent & Maurer, 2003). Historically, humanitarian assistance was distinct from development aid because of the particular ethics of humanitarian assistance. Donor governments see themselves as not only providers of assistance, but also as states with the responsibility for achieving international peace and security, as well as protecting their domestic interests. Governments have a duty to ensure that the aid programs they support contribute to effective conflict management and provide the effective use of public funds. Dalton et al (2003) argue that humanitarian policy over the past decade has emphasized that the absence of political engagement, not inadequate assistance, is the primary threat to populations suffering the consequences of war and other forms of strife.

Attention should be paid to how donors influence the quality and effectiveness of humanitarian and development action. This may be through their choice of disbursement channels, and through the management of this aid. Still, the quality and effectiveness of aid is affected not only by donors, but also by several factors that donors face on the ground, and this is very obvious in the Palestinian case (Dalton et al, 2003).

Generally, aid is designated as being for relief or for development, and is provided in a number of different ways; for projects or programs and as loans or grants (Dalton, Hippel, Kent, Maurer, 2003). The form of aid partly determines the *channels* through which it is disbursed. Ideally aid should be provided according to need, not according to the interests of a particular state. Aid may be provided directly to recipient governments, through multilateral organizations, through international organizations, or through local non-governmental organizations. Different forms of aid, and different disbursement mechanisms, require different systems to manage and coordinate assistance. Multilateral assistance can be defined as non-earmarked contributions to multilateral organizations. All other aid, including earmarked contributions to the UN and grants to NGOs, is by definition, bilateral.

Aid: Political Tool

On the one hand, donors use humanitarian assistance as a substitute for more appropriate political action. On the other hand, humanitarian assistance is considered for symptomatic relief of crises, with little emphasis on dealing with causation or those factors that lead to human vulnerability and its reduction (Dalton, Hippel, Kent & Maurer, 2003).

In the WBG there are 50 bilateral and multilateral active donors. The common goal of *"let the peace process work"* has brought together those donors who came with different political and economic interests. It is widely understood that the ultimate goal of the Oslo peace process was to provide security for Israel and the independent Palestinian State, and that the role of donors was to secure funds to accomplish these

goals. Generally, multilateral alliances are driven by cooperative forces (economic, political, and security-related) and rent apart by competitive ones (relations to the conflict region, domestic political and commercial pressures, larger geopolitical/strategic considerations, and country/bloc competitions and rivalries) (Precis, 1999). In multilateral institutions, internal mandates and membership determine policies, programs, and constraints. Also, donors bring to the table different levels and kinds of economic assistance, including political and economic conditionalities (Precis, 1999). It is notable that the EU is the major donor and economic player in the cases of the WBG and Bosnia, while the US is the political broker. This situation led to competition for political leadership and raised concerns that the US and other donors should equitably share the burden of aid.

It became apparent that aid to Palestinians failed in meeting the development aspirations of both donors and recipients and was converted into a vital life-support machine, which without Palestinians would suffer tragic consequences. Basalou (2003) noted that the limitations of the provision of aid as a development strategy became apparent almost from the start of the peace talks.

> "The consequent disruption of the Palestinian economy has had a crucial impact on the shape and effectiveness of foreign aid to the Palestinians during the Oslo period and beyond. Problems in the provision of foreign aid became especially visible with Israel's reoccupation of substantial portions of the WBG in 2002, during which extensive portions of the Palestinian infrastructure and thousands of public and private buildings- in part paid by foreign aid- were damaged or destroyed. Chronic malnutrition and a mounting humanitarian crisis in WBG have been ameliorated, but not eliminated, by a massive outpouring of humanitarian assistance from the international community."

In addition, the US, as the shepherd of the peace process, does not provide direct aid to the PA as it does to Israel. The US announced that it would cut off its humanitarian aid to the PA, once the US considered President Arafat to have lost his title as *"partner in peace"*. It is worth mentioning that US funds flow to the Palestinians through the UNRWA, the World Bank, and NGOs. President Bush's national security advisor, Condoleezza Rice, threatened to cut the aid if Mr. Arafat were to be re-elected in the coming elections. This was an indication of the rude US intervention in the internal affairs of the PA, by using aid as political tool (Middle East Economic Survey, 2002).

Total Assistance to Palestinians prior to 1994

While the history of humanitarian relief organizations in Palestine goes back to the end of the 19th century, the great bulk of international NGOs and Western bilateral and multilateral agencies started their activities in the OPT in the 1970s and 1980s. The absence of a counterpart national body, that coordinates and manages external aid to Palestinians, complicated the role and function of international aid. Most external assistance came from Western and Arab countries, including the PLO; the latter utilized Arab and Palestinians donations.

Coordination was relatively weak among working NGOs (International and Palestinian NGOs), which carried out projects on behalf of these countries. To offer acceptable aid, international NGOs rejected the utilization of funds through the Israel Civil Administration. International NGOs lacked proper cooperation, and between late 1980s and early 1990s, NGOs started competing in the field, with the start of peace talks. It was estimated that more than 200 local NGOs (Brynen, 2000) and 60 international

NGOs (Roy, 1995) worked in different fields, primarily providing humanitarian assistance and social welfare, in the OPT by the 1990s. The UNRWA was the largest NGO working in the OPT. The UNDP reported estimates of the external aid provided by bilateral and multilateral donors and agencies in 1992-93.

(See Table 3.1)

Discrepancies exist in the estimates of Arab and PLO assistance to NGOs. There is limited information about the actual flows of assistance because secrecy accompanied the flow of these funds to the OPT to avoid the restrictions imposed by the Israeli occupation, and because transparency and accountability were relatively unimportant at that time. Other funds came from foreign Islamic groups and some funds came from wealthy Palestinians in Diaspora. These funds were tied with national steadfastness, mobilization and factional competition. However, some of these funds were associated with corruption and patronage.

Some of these funds were also tied to political allegiances, turning political factions into networks of economic and social support, as well. In the absence of social security and limited educational opportunities, political factions functioned in lieu of this system. For instance, allegiance to one party or another would be rewarded with a scholarship for faction members and their family members to study at universities in foreign countries. It is a fact that the role of these political factions of providing scholarships and other forms of funds were crucial in providing access to education for students from poor backgrounds. The former Soviet Union was a major sponsor for these opportunities, especially in the 1970s. This could be considered an important

contribution to the overall change in providing public health and health services from 1970s onward. This change became apparent with the dramatic shift in the approach that medical professions adopted by focusing on primary health care (Rita Giacaman, personal communications September, 2004).

In 1991, PLO financial resources dried up as a result of its political stance towards the Iraqi-Kuwaiti conflict. As a result the major PLO supporters (Saudi Arabia and Kuwait) stopped their funding to the Palestinians in the OPT and to the PLO. This resulted in harsh conditions in the WBG, especially when we know that the PLO suspended its social support to martyr's families and PLO institutions in the OPT.

External funds to local NGOs were crucial to their survival and continuous operation. The World Bank estimated that two thirds of the budget of the Palestinian charitable organizations came from external assistance (Brynen, 2000). As a result of years of occupation and a long period of under-development in the health system, Palestinians relied heavily on international assistance, especially under the conditions of a complete absence of a national government. Under normal conditions, the national government would handle the delivery of health services and shoulder the heavy responsibilities, created by time, on the NGOs' agendas. Certainly, this led to a relatively high level of dependence and vulnerability for the Palestinians (Giacaman, 1994).

Total Assistance after 1994: Overview

Following the Oslo accords in 1994, the international community committed to support the newly born Palestinian Authority. It appeared that donors were enthusiastic at the available chance for comprehensive peace in the Middle East and were eager to

participate in this prestigious development process for the sake of peace. Although these peace accords were not a final peace agreement, donors rushed into pledging financial and technical assistance as in a post-conflict situation. Donors believed that to support the peace, they had to create tangible results out of this peace, especially for the Palestinians.

Precis (1999) suggests that, to support a post-conflict peace process, three interdependent and mutually reinforcing pillars must exist. These are political, economic and military pillars. The absence, neglect, or deterioration of one of them threatens the whole peace process. Thus, a strong economy cannot be built on a weak peace, and a strong peace cannot be built on the basis of a weak economy. In spite of the Israeli occupation, the PLO personnel, with their revolutionary background and their limited experience in operating governmental institutions, succeeded throughout the years following the Oslo accords, depending mostly on international assistance to establish and run a large number of institutions.

Dramatic Increase of Aid volume

As soon as the Palestinians and the Israelis signed the Declaration of Principles in 1993, an increase in aid disbursement was recorded. Aid levels increased from US$174 million in 1992, to US$263 million by the end of 1993. Thereafter, aid increased dramatically as donors increased their support for the peace process. So, between 1994 and 2002, pledges of aid by foreign donors amounted to nearly US$6.5 billion, with US$4.4 billion actually being disbursed.

In the period between 1994 and 1998, donor disbursements averaged US$464 million per year, translating into nearly US$180-200 a year on per capita basis --one of the highest levels of per capita foreign assistance in the world. Given the weak economic and revenue raising capacities of the PA during this period, almost half of these funds were spent on recurrent type of expenditures, rather than on development projects (UNCTAD, 2003).

From 1999-2000, this pattern started to shift towards investments in human and capital infrastructure. More than 88 per cent of the US$1.057 billion disbursed by donors were directed towards development projects. Only 2.6 per cent was allocated to budget support and 9.4 per cent for emergency needs. Budgetary support accounted for almost 46 per cent of the US$2.297 billion disbursed during this period. Development projects and emergency assistance equally split the remaining amount, with shares of 26.6 per cent and 27.6 per cent, respectively (UNCTAD, 2003).

Assistance after 2000

With the onset of the second Intifada, in September 2000, donors changed from development efforts to relief, in response to the devastating conditions imposed on the Palestinians. The per capita donor assistance increased to US$315 per person per pear. This compared favorably to per capita aid-disbursements of approximately US$215 per person per year in Bosnia over a five-year period and disbursement of US$235 per person per year for two years in East Timor. In the 2001-2003 periods, the Al-Aqsa Fund of the Arab League was the major donor with US$825 million, mainly for budgetary support. The UNRWA increased its funds from 2.2 per cent to 10.4 per cent of the total disbursed

funds. The EU increased its contribution to 14.5 per cent. Some bilateral donors doubled their support such as the US, Norway and Italy. Many other donors continue to contribute through multilateral institutions. The World Bank development indicators for the WBG estimate the aid per capita in 2003 at US$ 500, which is extremely high (World Bank, 2004).

As generous as the donor community has been, however, Basalou (2003) believes 'that foreign aid is substantially less than what Palestinians actually need.' The ratio between donor commitments and actual disbursements averaged 67 per cent between 1994 and 1999, which compares favorably to many other settings, such as Bosnia-Herzegovina, where the ratio averaged 53 per cent in the period 1996-1998. This ratio is the evidence of the seriousness with which donors made their pledges at the height of the Oslo period (Basalou, 2003).

(See Graph 3.1)

Israel: An Indirect Aid Recipient

Due to the strong linkage between the Israeli and the Palestinian economies, a dependant relationship emerged through decades of occupation. The fact that Israel plays a crucial role in controlling the Palestinian economy, trade, and borders makes Israel the prime profiteer of the financial aid provided to Palestine. The share of the Palestinian imports from Israel, in domestic private consumption, was estimated at 55 per cent in 2002. UNCTAD (2004) reported that

> "The ratio of the Palestinian trade deficit with Israel to Palestinian GDP was estimated in 2002 at 45%. This means that for every dollar produced domestically, 45 cents are channeled to the Israeli economy. The implication for Palestinian development and employment generation programs is significant, as it

> cannot be expected under the present circumstances that donor funds injected into the Palestinian economy would have a noticeable positive income multiplier effect in the Palestinian territories. On the contrary, a positive multiplier effect of these funds would be felt in the Israeli economy".

The leakage of international aid out of the domestic economy should be a major concern. In the issue of the health sector, the major portion of International NGOs, Palestinian NGOs, the MOH, and private purchases come through Israel and its ports, where Israel is considered to be the first beneficiary of any business emerges in the WBG.

## Health Sector Aid

### Aid to the Health Sector Prior to 1994

The UNRWA was a major health sector player, and its budget remains completely dependant upon aid and in-kind donations. The annual health budget of the UNRWA was close to US$15 million, and an additional US$ 2 to 3 million per annum was allocated by 1991, for emergency purposes. The UNRWA's contributions to the development of the health system, especially for refugees, ranked it as a leader in the OPT.

Donors, in the period 1987-1994, channeled their aid through the Palestinian health NGOs and UN agencies, rather than working in the field, despite their presence in many crisis areas worldwide. It may be inferred that this situation was due to political reasons and relations with Israel. Another important point is that donors minimized their work with the Israeli-administered health sector, for reasons of political sensitivity and acceptability to Palestinians, but some agencies and organizations -namely USAID, the

WHO, UNDP, and Italy- worked on some programs to develop the infrastructure of some clinics and hospitals and to run some basic health programs. Aid to the health sector, during the first Intifada was not well documented, due to the lack of coordination and secrecy. But, Bleek and Gritzner (2002) and Giacaman (1997) estimate the international donor expenditure on health in the WBG, between 1988 and 1993, to be around US$70-80 million per year.

Aid Coordination, Management and Effectiveness prior to 1994

Thus, Palestinians became dependent on external assistance, not because they chose to, but mainly because aid was forced upon them in response to five decades of occupation and due to the loss of state institutions, infrastructure, and under-development in all aspects of daily life. The restrictions that were imposed by the occupation forced the refugees to seek assistance for humanitarian needs at the doors of international agencies. These organizations came to the region, beginning in the 1950s and later in 1970s and 1980s, assuming that they had the short assignment of providing health services and humanitarian aid. They became shocked at the fact that the Palestinian case was unique. This was a continuous, ongoing occupation that limited any local activities initiated by the Palestinians to develop their social system.

In the 1980s, there were two trends regarding the approach to health services. The first trend involved the apparently passive charitable organizations. Those organizations worked on maintaining the health status in the cities and villages, while working very little on development. The other involved the innovation and creation of a local social action and movements, especially in the 1980s (Giacaman, Personal

Communications, 2004). These movements created the Palestinian primary health care movement and model and, later, the Palestinian community-based rehabilitation model. Apparently, there was no space for serious development efforts by the Israeli Civil Administration health infrastructure, mainly because of the occupation policies and not because of shortage of funds (Sneh, 2002). On the contrary, the Palestinian NGOs and social movements succeeded with limited resources, at the beginning, in establishing an alternative and parallel network for health services. NGOs gradually developed their capacity to raise funds and, at the same time, to be partially self-sustainable through sliding scale payment from patients and others, especially in the 1980s onwards. Most funds from international donors were poured into the Palestinian NGOs as implementing agencies, with very little presence in the OPT (Bleek & Grotzinger, 2002).

International donors always focused on developing the physical infrastructure, in addition to public health projects. According to Giacaman (1994), donors did not take into consideration the financial burden that Palestinians had to face when they operated clinics or health projects. In the absence of fixed and constant financial sources, the shortage of cash flows needed to run these projects affected the productivity and outcomes. Eventually, many projects had to shut down, because donors changed their policies or stopped funding. Moreover, some of these local NGOs faced limited chances to raise money from the locals, because of critical decline in income through the first Intifada (1987-1994). Giacaman (1994) stated that "Another problem often encountered with development aid is that even if agencies do, in fact, support operating costs, they are usually unwilling to support operating costs over several continuous years. Yet, once the

flow of funds stops, so do the health projects themselves. Alternatively, some projects are sustained, but in a distorted and unacceptably weak form."

As a result of the ongoing conflict in the OPT (1948-1994) and the strategic importance of the Palestinian-Israeli conflict on the security and prosperity of the region, many international donors found the area *hot* enough to work and help in the humanitarian relief and development, especially the UN (for political reasons) and Nordic countries (mainly because of their domestic public acceptance of aid). Dozens of international NGOs operated in the OPT, and dozens of Palestinian NGOs were established to contribute to the relief of the Palestinians and to provide social welfare.

The international organizations, due to the lack of coordination presented different and duplicate orientations. In addition, the absence of coordination among Palestinian NGOs, themselves, complicated the situation, and the overall result was random and unplanned activities with improper implementation and short life spans. In spite of the above picture, donors and NGOs continued investments in the area, which had an overall good result in the improvement of access to basic health services, especially in rural areas.

Investments were mixed between short run projects and/or limited infrastructural projects that lacked continuous financial tools to survive and others that resisted and survived. For donor country domestic concerns, international NGOs considered the measurement of a program's success more on the basis of the *number* of projects implemented, rather than on the *kinds* of projects implemented. However, health projects were, to a lesser extent, directly or indirectly imposed upon the Palestinians according to

donors' priorities and agendas. Consequently, after factoring-in Israel intervention, one can say that Israel and international donors defined assistance goals (Roy, 1995).

In many cases, the Israeli military authorities controlled the disbursement of funding and project implementation. Sharkawi (2002) reported that one of the results of the direct interventions of Israel in the NGOs work was that Israel would not allow projects with a Palestinian national identity. So, Israel facilitated localized projects in particular towns or neighborhoods. International observers criticized donors for providing services that were considered to be the responsibility of the occupying authorities and for providing those services in ways that facilitated occupation and Israeli control (Roy, 1995).

Another area of concern was the difference wage levels between international agencies and local institutions. For instance, the UNRWA paid their health sector's employees higher wages than they could obtain elsewhere in the OPT. BY doing this, these organizations created conflict between their personnel and public ones and made it difficult for other local institutions to compete in the quality of services provided, because employees did not have the motive to excel. In addition, the drainage of professionals and highly-qualified personnel to the higher-paid positions led to the desertion from public institutions by newly-graduated general practitioners, who constituted more than 80% of doctors in the Israeli-run health facilities (Barghouthi, Lennock & Shaban, 2002).

Aid to Health Sector 1994-1997

Donors targeted the health sector in order to achieve quick and tangible results for the ordinary Palestinians. In contrary to other sectors, the MOH was able to build on the nucleus of the previous Israeli Civil Administration, due to its relatively high degree of institutionalization. This made it easier to attract donor investments, as the health system was relatively efficient, transparent, and enjoyed good reputation in Palestinian civil society and among donors because of donors' previous experience in the region before 1994.

The goals included improving access to and quality of care, and rationalizing resource allocation in the health sector. The donors supported the MOH in its efforts to restructure the health care system and introduce various reforms in health policy and practice. Donor support of health care included: hospital construction and improvement, training and technical assistance, medicines and supplies, budget support and program development (UNSCO and World Bank, 1999).

After signing the Oslo Accords, donor commitments to the health sector were 11 per cent of the total aid -approximately US$224m- between 1994 and 1997. (Bleek and Gritzner, 2002) Others report that the estimate of aid to the health sector was 8.2 per cent of total commitments, from 1994-1998, and about 7.7 per cent of total disbursements; 67 per cent of health care commitments were disbursed (UNSCO and World Bank, 1999). These committed funds were designed to be allocated as the following: US$64 million for unspecified purposes, US$76 million were mixed, US$32 million for equipment, US$17 million for construction and renovation, US$12 million for recurrent costs, and

US$22 million for technical assistance. This appears to be good start in the mobilization of aid funds. Conversely, when we take a look at the actual disbursements of these committed funds, we find that, from 1994-1997, the total aid, including humanitarian aid, was US$175 million. Reports by the Ministry of Planning and International Cooperation (MOPIC) (now Ministry of Planning), which is the aid coordinating body in the PA, indicated that, out of the recorded donor aid to the health sector, 73 per cent (US$111m) of total health aid went to the MOH projects and programs, while 20 per cent (US$30m) went to the NGO sector and 7 per cent (US$12m) to the UNRWA. The actual funds provided to the NGOs may be three times the reported figures as a result of a lack of coordination between MOPIC and many NGOs (Bleek & Gritzner, 2002).

(See Table 3.2)

There are approximately 50 major donors, ranging from states and international organizations to private foundations, church groups, and other organizations addressing Palestinian needs. The UN boosted its presence from three agencies to 29 after signing the Declaration of Principles. The European Union, the US and the Arab league respectively are the main donors. The EU, its member states and the multilateral European Commission have been the most generous donors to the Palestinians. Out of 24 donors who were involved, in one way or another, in assistance to the health sector, nearly half of the total actual disbursements came from Japan (33% of total health support or US$29.1 million).

Japan's support for this sector consisted primarily of upgrading hospital equipment and facilities in Gaza and the west Bank (about US$30 million) and building

the new Jericho hospital (US$21.1 million). Spanish aid to the sector consisted of a range of smaller projects, principally supporting clinics and health centers. Italy had worked before 1993 in the OPT and concentrated its aid on upgrading the health sector infrastructure, such as renovating and equipping two government hospitals in the WB through the UNDP. After 1994, Italy strategically shifted its assistance to capacity building and primary care within the public health sector. Italy funded the Health Services Management Unit, in conjugation with the MOH and UNICEF, specializing in services management and evaluation training. Italy also funded other projects such as public health laboratory and school health programs in the WBG.

Still, while the current financial mechanisms provide an insight into official funding patterns, peculiarities in reporting prevent an accurate assessment of aid flows. A number of financial flows are not tracked at all. Significant unofficial aid flows include contributions from non-Development Assistance Committee countries; voluntary donations by the general public or through private voluntary organizations; financial support from Palestinians in Diaspora; other informal fund transfer systems, such as wire transactions, and religious contributions such as Islamic 'Zakat' (Dalton, Hippel, Kent & Maurer, 2003).

(See Graph 3.2 and Graph 3.3)

Aid and development assistance to the health sector was directed mainly to several sub-sector areas. According to the Organization for Economic Cooperation and Development (OECD), statistical classification of health sub-sectors included: *Health Policy and Administrative Management* (health sector policy, planning and programs, aid

to health ministry, public health administration, institution capacity building and advice, unspecified health activities), *Medical Services*, research and services (medical training and education for tertiary level services, laboratories, specialized clinics and hospitals, ambulances, dental, mental, medical rehabilitation, control of non-infectious diseases), *Basic Health Care* (basic and primary health care programs, paramedical and nursing care programs, supply of drugs, medicines and vaccines), *Basic Health Infrastructure* (district level hospitals, clinics and dispensaries, and related medical equipment, excluding specialized hospitals and clinics), *Population Policy and Administrative Management* (Population/development policies, census work, vital registration, demographic research/analysis, reproductive health research, others), and Reproductive Health and STD Control (promotion of RH, prenatal and postnatal care including delivery, prevention and treatment of infertility , abortion, safe motherhood activities) (OECD, 2000).

Decline in Donor Pledges and Disbursements between 1998 and 2000

The Palestine Development Plan annual estimate for the health sector development, for the period 1999-2003, was $60 million. In general, the donor commitments and disbursements, during the period of January 1998-June 2000, declined by 57% to $97m and $69m, respectively.

(See Table 3.3)

To warn of this decline, the MOH presented at one of the donors meetings its own figures showing the decline of funds (Bleek & Gritzner, 2002).

(See Table 3.4)

Health Sector Aid Coordination after 1993

The large number of donors who were willing to provide aid to the health sector and the perception of a large amount of available funds for this sector imposed the necessity for greater consultation and coordination among donors than is usually the case. The literature contains arguments that the Palestinian case has set new precedents in the amount of effort and resources invested by donors in the coordination process (Barsalou, 2003). The Local Aid Coordination Committee (LACC) is chaired jointly by UNSCO, the World Bank's representative which also represents the chair of the Ad Hoc Liaison Committee (AHLC). The LACC established 12 sector working groups (SWGs) to improve operational coordination and sector planning. One of these SWGs is the health committee. The MOH is the Gavel Holder, where it leads the SWG and coordinates the efforts of the PA. Its duties include commissioning studies, strategies, and plans for the sector; helping to raise funds for the sector and preparing issues for the agenda (Ministry of Health, 2004). A donor was appointed as a Shepherd (Italy) to coordinate international donor efforts within the Palestinian National Health Plan framework, identify needs, and ensure that emphasis was placed on projects and infrastructure which would lead to sustainability of the health care system (Bleek & Gritzner, 2002). A United Nations agency was appointed as a Secretariat (WHO) to provide technical assistance and consulting.

Aid to Health Sector after 2000: Change in trends

As mentioned above, international donors typically prefer to invest in the building of infrastructure and in medium and long term development projects. Yet, after the

Intifada, the picture changed with a dramatic shift of the bulk of aid going to recurrent expenditures, PA budgetary support and humanitarian and emergency relief funding. Between October 2000 and July 2001, only eight per cent of total aid was spent on medium-term capacity building or infrastructure. The international aid for recurrent costs was supported by donors, especially when donors were convinced that funding to the PA, cash assistance, job-creation programs, and food assistance were important means to put resources in the hands of ordinary Palestinians (Barlasou, 2003).

In response to the Intifada, a large portion of total development funds were shifted to meet sector-related needs related to the crisis, particularly in the health sector. Total emergency funds increased by more than six-fold after the Intifada and reached US$633 million, representing 81 per cent of the funds committed by the donor community for that purpose and almost 28 per cent of the total international aid disbursed to Palestinians people between 2001 and 2003. Out of this amount, 37.8 per cent (US$239.4 million) was disbursed to the UNRWA. Health, infrastructure, and food security were among the emergency categories that consumed a significant portion of the emergency funds (UNCTAD, 2003).

(See Table 3.5 and Table 3.6)

The PA launched a Socio Economic Stabilization Plan (SESP), for the years 2004-2005. The SESP covers: humanitarian and social assistance, rehabilitation and reconstruction damage, public infrastructure development, private-sector support, reform and institution capacity building. The requested funds for 2004-2005, amount to US$1.568 billion. Out of that, US$22.7 million is allocated for the health sector under

Public Infrastructure Development. By October 2004, out of the US$14 million requested for that year, US$10 million was actually disbursed. Other sectors under the plan that are indirectly related to health sectors include: food and cash aid (US$13 million disbursed) and emergency education, and health and drinking water (US$9 million disbursed) (MOP, 2004).

# CHAPTER IV

## AID DEPENDENCE

When aid intensity continues over long periods of time, it can create aid dependence. Aid dependence can be defined as 'a situation in which a country cannot perform many of the core functions of government, such as operations and maintenance, or the delivery of basic public services, without foreign aid funding and expertise' (Bräutigam, 2000). The term 'aid dependence' can be used to describe 'receiving aid at all or aid above a certain level; receiving more aid than can usefully be utilized; ineffective aid; when aid itself generates either the "need" for aid or mitigates against achieving its intended objectives; and when policies are dominated by the donor community' (Lensink & White, 1999).

Aid plays an important role in international relationships, especially among poor and rich countries, in addition to aid in disasters and wars. In addition, aid business has become a major enterprise: debt servicing is almost three times larger than the total aid flow (Tjønneland, 1998). After the collapse of the Soviet Union, the number of countries that receive high amounts of aid has been increasing. High demands for aid may be related to humanitarian and relief needs, development needs, political instability, post-conflict constructions, or debt. Instability of political or economic conditions leads to continuous demand for external aid in the form of grants, loans. or a mix of both.

Aid intensity/dependence can be measured by several means: aid as a percentage of GNP, central government expenditure, current revenue, gross domestic investment, or

imports. It is apparent from the literature that high intensities of aid are associated with 'poverty, economic crisis, and a history of political instability'. Despite similar conditions, many countries have never become heavily dependent on aid. This implies that aid dependence is not inevitable in any of these situations.

Studies have found that although post-conflict countries' aid absorptive capacity is low during, roughly, the first three years after the end of instability, absorptive capacity tends to double by the end of the first decade. One research study suggests that it may be best not to create an "aid surge" in the immediate years after the cessation of violence, but rather to phase in assistance over the first decade. However, post-conflict countries often receive the highest levels of foreign aid early on, and such assistance often tapers off over the ensuing years (Weiss, 2004).

The World Bank's research suggested that the "saturation" level for aid may be reached at 20 percent of GNP (Burnside & Dollar, 1997). Other researchers put the level at a much larger 40 to 60 percent of GNP (Lensink & White, 1999). Depending on the strength of their institutions and the way that aid is delivered, countries may differ in the amount of aid they can absorb.

Knack's analyses of cross-country data provide evidence that higher aid levels erode the quality of governance, as measured by indices of bureaucratic quality, corruption, and the rule of law. Studies found that the impact of aid on economic growth and infant mortality is conditional on policy and institutional gaps. Knack's results indicate that the size of the institutional gap itself increases with aid levels (Knack, 2000).

Methodology

Donors agree that Palestine is one of the largest aid recipients in the world (World Bank & Japan, 2000; Brynen, 2000). Yet, one should consider the overall context in which aid is mobilized and delivered: an unstable political environment and severe periodic economic crises resulting from border closures. The Palestinian case has illustrated ups and downs in the level of aid delivered and in the reasons for this aid. Since 1948, Palestine has been dependent on aid because of chronic political turmoil, occupation, and underdevelopment. In order to explore the Palestinian case, I made a comparative analysis of different aid recipient countries that belong to the World Bank classification of 'lower middle income economies' of 2002. Lower middle income countries are those countries with a GNI per capita between US$766 - $3,035, as in 2003. I filtered these countries and considered those which received aid at levels higher than the average aid percentage of GNI and greater than five percent for the period 1994 to 2002.

(See Table 4.1)

The trend in aid in Palestine, as a percentage of GNI, indicates that aid intensity has been on a steady rise since 1994, with a sharp increase starting in 2000, as a consequence of the Intifada.

(See Graph 4.1)

To demonstrate the Palestine position among other countries, data from the Organization for Economic Co-operation and Development (OECD) International Development Statistics On-line Data Base was used (OECD, 2004). The Palestine aid

trend has been rising, while other courtiers' aid levels have been decreasing or have remained stable since 1997.

(See Graph 4.2)

According to UNCTAD (2004), the PA is 'almost incapable' of financing any capital expenditures, which represented less than 3 per cent of total expenditure in 2003 ($36 million) (UNCTAD, 2004). This draws the picture of the fiscal constraints under which the Palestinian budget suffers. The Palestinian Minister of Finance has complained of the shortage of donors' funds, without which the PA is not able to pay salaries and keep its already minimized functions and services. Total aid to Palestine has increased to 1.6 billion dollars in 2002, due to the almost total collapse of the economy and the humanitarian and emergency nature of the crisis. In other words, this means that aid per capita has mushroomed from US$215 (in early 2000) to US$503 (in 2002).

(See Graphs 4.3, 4.4, 4.5, 4.5)

Palestine has occupied a higher position in terms of aid per capita and aid as a percentage of the Gross National Product (GNI) among other countries, since 2000. Aid increased and constituted about 48 per cent of GNI. As shown in the graphs (Graph 4.15 and Graph 4.16), Palestine GNI and GDP have declined dramatically since 2000, leading, of course, to the increase of aid. The current volume of aid to Palestine indicates a chronic need for external resources. This is because of one single factor: the Israeli re-occupation of the Palestinian Authority territories. As a result of occupation and closure policies, poverty has increased, tax revenues have decreased, government expenditures have increased, and most development indicators show an apparent deterioration.

(See Graphs 4.17, 4.18, 4.19, 4.20, 4.21, and 4.22).

In response to the humanitarian crisis, emergency aid has increased while development aid has declined. Donors want to prevent the collapse of the PA and keep its institutions workable, as the international community agrees that the sustainability of any projected growth in the Palestinian economy is uncertain without movement towards ending Israeli occupation of Palestine with an approach of the two-state solution. In addition, to reduce the poverty of the Palestinian people and to keep a decent supply of basic social services, donors funded recurrent costs because they knew that their money go to the poor. The UNRWA budget has also increased in response to the increasing needs of the Palestinian refugees.

(See Graph 4.23)

In spite of the humanitarian and socio-economic crisis in the OPT, donors, mainly European countries, have poured their efforts towards establishing and developing "an independent, democratic and viable State of Palestine," according to the United Nations Security Council Resolution 1397 (2002) and the international community's "Performance-based Road Map to a Permanent Two-State Solution to the Israeli–Palestinian Conflict" (UNCTAD, 2004). However, these efforts need political support from the US and cooperation from both Israel and Palestine.

Mixing humanitarian aid with development aid is a concept that helps evolving countries avoid war and conflict in the relief and rebuilding efforts. The fact that Palestine is still under occupation hinders the development efforts and minimizes the effectiveness of aid. Donors and the PA insist that development should be part of aid

grants, although donors changed their strategies from short and medium plans to short-term and low-cost development projects, as well as those in critical areas such as social infrastructure. Examples of social infrastructures are health and education. In 1994, Palestine received aid in social fields that was comparable to other countries, but in 2002, it received a higher volume of aid than did other countries. However, development in these areas is still considered emergency assistance, because the deterioration or damage is directly related to the conflict. The huge bulk of aid is allocated for humanitarian relief and PA budget support. For instance, in 2002 more than half a billion dollars went to budget support, which came primarily from Arab countries. According to UNCTAD (2002), the share of development assistance (after 2000) constituted only 26 per cent of total aid in 2002, with a drop from 88 per cent.

(See Graphs 4.12, 4.13, 4.14, and 4.27)

Researchers suggest that donor support should consist of a combination of relief and development for both the medium and long terms to permit movement along 'a continuum from relief through rehabilitation to development' (UNCTAD, 2004). The problem with this approach is one of how to pursue medium and long term development plans under unstable political and economic conditions. The challenges that donors and the PA face are greater than providing development funds. Palestinians are now consuming aid funds with no development impact because of the Israeli measures. In addition, most of the funds that are ranked under development are mostly emergency funds to rebuild or rehabilitate buildings, schools, or health facilities.

"The impact of one dollar of aid injected into the economy normally leads to a more than one-dollar increase in GDP. But the multiplier declines, or can become negative, if most of the relief goods consumed are not domestically produced or have large imported components "(UNCTAD, 2004).

Impact of Aid Dependence

In the literature, foreign assistance has been considered to displace processes of 'institutional maturation', which then leads to dependence. Also, aid others argued that 'foreign assistance represented a side payment to elites in recipient countries, designed to buy their compliance in maintaining the economic and political dominance of the industrialized countries' (Azam, Devarajan & O'Connell, 1999). Foreign aid has frequently been used to influence policies in the recipient country to promote foreign policy goals and generally to boost the values and the objectives of the donor (Tjønneland, 1998).

South Africa is an example of a country with a low aid dependence ratio (less than two per cent of government expenditures), and as a result one does not see the disruptive effects of aid. South Africa succeeded in establishing a degree of equilibrium in a relationship normally regarded as unbalanced in other African countries. As a result, the ability of donors to impose policy objectives or conditionalities on South Africa has been limited (Schneider & Gilson, 1999). Rent seeking is apparent in Poland, and not in South Africa, where both at an individual and societal level there is a wish to obtain something for nothing (Sabbat, 1997).

While Palestinians have always been dependent on aid since 1948, and especially after 1994, aid intensity increased, and the problems of aid became apparent among the different players. The political leadership used external assistance to manipulate the domestic revenues and became very authoritarian. The PA encouraged patronage and corruption. The paradox of this situation is that the international community and Israel facilitated patronage and the use of PA financial resources, especially domestic revenues such as the clearance tax revenues. Israel agreed, at the beginning of the PA, to transfer clearance tax money directly to the political leadership's personal accounts and not to the PA general revenues account, which made it easy for the PA leaders to use money with no legal monitoring. Money has always been used as a political tool to gain power and political control, and the Palestinian case is one example. Sadly saying, donors knew this from the start and did nothing. They encouraged it "under the table" because they knew that there are many opponents for the Oslo Accords and they thought that money is an excellent incentive to buy people's loyalty and political support, especially when people are in deep strive.

Since 1994 tremendous amount of development, humanitarian and technical assistance aid have been poured into the Palestinian Territories. International countries fueled -the so called- Oslo Peace Accords with generous financial and technical support in order to facilitate the success of the peace process and help the Palestinian people in establishing its independent institutions and build statehood structures. (See Graph 4.11) Donors, as well as Palestinians, thought it would be a smooth process of development, with the fact of incredible international support and involvement of more than 50 donors

in this process. I assume that no such aid efforts took place before in terms of the variety of countries and agencies involved in aid. The strategic importance of an end of the Israeli-Palestinian conflict overwhelmed governments world wide and gave hope in peace and in future economic prosperity that would serve the interests of all parties; Palestinians, Israelis, and donors. So, all parties competed to gain a strong spot in this process to gain future economic and political profits.

However, the real world is different from development plans, and aid money is not always the fuel or the ignition for peace or economic growth. The aspirations of all parties became chaotic. With annual millions of dollars of foreign aid, Palestinians succeeded in establishing their institutions and the aid efforts were very successful in the period 1994-1998. But, before "harvest- time" of aid results, as measured in sustainable economic growth, the peace process witnessed the beginning of its end. Directly and with the collapse of peace talks in Camp David in 2000, both Israel and donors started pointing attention to the "bad policies" and "misuse of domestic revenue money". Israel, in 1996, and in fear of –what it calls- terrorist activities, imposed the policy of closures and partition that led to dangerous effects on the Palestine economy. The decline of economy indicators led to the increased of dependency on foreign aid, especially for funding capital and development projects and then in large programs known as "job creation programs". The purpose of these programs was to fight the high rate of unemployment that resulted from preventing Palestinian workers from labor in Israel.

In Dollar and Burnside (1997) proved that aid has a positive impact on growth in developing courtiers with good fiscal monetary, and trade policies. They examined the

relationships among foreign aid, economic policies, and growth of per capita GDP. In the presence of poor policies, aid has no positive effect on growth. Through analysis of the Palestinian case I found the there is no real growth in GNI per capita in spite of the high volume of aid, and real GNI per capita is actually decreasing (See Graph 4.17 and 4.4.21). In addition, they found no evidence that aid has systematically affected policies, either for good or for ill; the tendency for aid to reward good policies has been overwhelmed by donor's pursuit of their own strategic interests. Reallocation of aid, reducing the role of donor interests and increasing the importance of policy would have a large positive effect on developing countries' growth rates (Burnside & Dollar, 1997).

Donors believed that to maintain the peace process alive, aid should continue to keep the poorly-functioning institutions of the Palestinian Authority and encourage conflict-parties to settle issues on the basis of two-state solution. After the break-out of the Intifada as a result of the aggregated frustration of the Palestinians from the Israeli policies and dying peace process, donors, speaking for political reasons, started talking about "reform" in the PA and how they *"discovered"* [emphasis added] that aid facilitated corruption and patronage in the PA public sector, affecting the society as a whole. Literature described donors to be "naïve" in handling aid to Palestine in terms of planning and outcomes. This would be acceptable if we talk about inexperienced donors or those who are new in this "business". Donors share a huge portion of responsibility of setting up these policies that led to financial leakage in the PA and to poor performance of some development projects. Donors should have been careful when they switched their position from an inefficient monitor to a completely new attitude that calls for strict

regulations and procedures to guarantee a transparent PA. This shift occurred after the broke out of the Intifada in 2000 and after accusation of the political leadership of using aid money in financing Palestinian resistance groups and militants. Consequently-not surprisingly- donors changed their policies and demanded major reforms in financing and measures to ensure "transparency and accountability" in the PA. The actual reasons were to practice political and financial pressures on the Palestinian leadership and to dry its financial resources as its political role should shrink now.

As the literature describes the impact of aid on recipient countries, aid has always been accompanied with corruption and patronage, especially in economies of high dependency on aid. As Robinson (1997) quoted from a Palestinian source:

> "The preeminent lesson from state-building enterprises throughout the ex-colonial world in the past few decades is ….. 'How you start significantly determines how you finish.' That is, many well-meaning officials in emerging states rationalized early excess as necessary, or emergency, compromises that would be corrected in the future, only to discover that these mistakes often become permanent features' of the new states, with their own bureaucratic defenders."

Svensson (2000) discussed the effect of aid and stated that 'aid primarily goes to consumption and that there is no relationship between aid and growth, nor does it benefit the poor as measured by improvements in human development indicators.' Currently, the PA suffers fragile public institutions and receives more than US$1 billion as annual external aid to finance its recurrent budget and keep providing social services. Palestine is one of the highest aided countries in the world in terms of aid per capita. Many critics

wonder of the legitimacy of this aid. This would be a reasonable question if the context under which Palestinians live is not the way it is now. The gap between the needs of the Palestinian people and the ability of the PA to respond to that needs is very big, due to many factors.

(Graphs 4.19 and 4.20)

Donors changed their agenda from development and peace support to humanitarian agenda, where relief and emergency aid is mostly needed. The fear of future raises concerns of how long would donors keep giving aid, as World Bank describes it as "donors' fatigue". The experience of other countries shows a decline in aid after the relief of disasters (Bosnia, Rwanda) or a constant state of receiving aid (Marshall Islands, Micronesia). Palestinians have been dependent on aid since 1948. Refugees were the first class of Palestinians to be totally dependent on services provided by UNRWA and funded by international community.

(See Graphs 4.1 and 4.2)

The PA's commercial borrowing options are almost exhausted. As well as the ongoing problem of meeting monthly expenditures with inadequate revenues, the PA faces a further fiscal crisis in 2005, when its civil service pension fund is likely to run out of money (CAP-Palestine, 2004). (See Graphs 4.19 and 4.20) Complete economic collapse during the Intifada has been avoided through donor budgetary support to the PA and Palestinian coping mechanisms. A high degree of flexibility is required within programs and projects. Currently, and after the deterioration in economy, aid to a bankrupt and fragile authority will continue to keep the pace of providing essential

services. In addition, the PA faces internal challenges like dependence on Israel economy, population growth, high unemployment, and political instability. Dependence on aid is apparent in the way Palestinians accept aid and the way donors decide to give aid. To sum up this part, donors and Israel, in the zeal of peace process, led Palestinians to a swamp using the euphoria of initial economic and financial support. Palestinians are stuck alone now with high dependency on external assistance, emergency commodities and food aid.

Allocating Aid to Palestine

In Palestine, as in other post conflict countries in the period of 1994-2000, the goals of aid included two objectives. The first objective is emergency assistance to the emerging PA, and the second is to support the reconstruction efforts to build and/or repair the infrastructure and improve basic public services. Development aid targeted improvement the fiscal function of PA, supplies domestic savings, encourage long-term investments, and reduce poverty (Demekas, McHugh & Kosma, 2002). However, due to the limited cooperation of Israel the results of such efforts were very limited.

The ultimate goal is to provide people with tangible improvements in the quality of their lives measured by increase in their income and the quality of services provided. Donors believed that these socioeconomic achievements will encourage *buy-in* and increase support to peace efforts. In a different case, the goal after helping a country getting out of its conflict will be a decline in external aid as the country start to get dependent on its own resources and investments. But, Palestine enjoyed an unprecedented case in the field of international development, where development

initiatives started under the impression of stability, while the reality on ground indicated from the beginning that Israel still in control and practices policies that undermined donor's efforts.

> "As post conflict aid can reach extraordinarily high levels, both in per capita terms and relative to the size of the recipient economy, but typically declines very rapidly once the emergency phase is over. In the case of civil war in Rwanda, foreign aid flows reached a staggering 95% of GDP in 1994, but declined to under 20% with in five years. In Bosnia & Herzegovina, aid flows reached almost 75% of GDP after the end of the war in 1994, but fell to less than 25% by 1999. In Kosovo, foreign aid reached an estimated 65% of GDP immediately after the end of the war in 1999, but expected to fall to10-15% by 2004. In contrast, conventional development aid fluctuates much less and at much lower levels: official development assistance to the group of low income countries ranged between 2.5-3% of gross national income during 1995-2000. To put it starkly: post conflict aid comes in a large sudden burst while, compared to that, development aid is a steady trickle." (Demekas, McHugh & Kosma, 2002)

It is important to emphasize that there are major differences between WBG and other post-conflict situations. Palestinians enjoy a high education level and high quality of human resources. In addition, the presence of some functioning structures of the former Israeli civil administration considered as a nucleus for development efforts. "The key distinguishing features of Palestine to which the funding and programming of post-conflict reconstruction had to adapt were the constraints posed by Israel, the excessive centralization of decision-making in the Palestinian Authority, and the patchwork nature of the territories under Palestinian control" (Schiavo-Campo, 2003).

Donors agreed in many publications that to keep the momentum of the peace process tangible results on the ground are required. Thus donors focused in their assistance on the already functioning sectors like health and education while they neglected agriculture and industry, for example. According to the World Bank and Japan

Aid Effectiveness study in WBG (2000) 'too many donors pay relatively little attention to PA priorities in deciding where to allocate support for capacity-building.' The World Bank reported a higher disbursement than targeted such as education, 343 percent and health, 161 percent (Brynen, 2000). Concerning the health sector, aid started to decline after an extensive aid in building infrastructure and providing developmental assistance and then needs in health sector started to increase with the effects of the Intifada and the re-occupation of the Palestinian territories. Aid shifted to humanitarian to include food assistance, medical supplies, ambulances and other needs. However, development efforts are still present in re-building the destroyed and affected infrastructure of the health system. Capacity building has been enforced back onto the MOH as donors believe reform is one key towards independent Palestinian state.

In 2000, donors have responded to the heat of conflict by switching their aid to humanitarian aid and as a result 'the ratio of development to emergency assistance flipped from 7:1 in 2000 to 1:5 in 2002' (CAP-Palestine, 2004). The tremendous increase in aid has not prevented an increase in poverty, and will not reduce it much without progress on the peace process. A projected scenario of the disengagement plan was studied by the World Bank. If donors injected –under political settlement and Israeli facilitation of trade and movement- US$2.8 billion of dollars over the period 2004-2006, the macroeconomic indicators will improve a little with a decrease in unemployment rate, for example, from 26% to 23% at 2006, and a decrease of poverty rate from 47% to 46% in 2006. If donors increased the aid to US$4.3 billion, unemployment rate may decrease to 20% in 2006 and poverty rate to 37% (World Bank, 2004). The dramatic decline in

income and increase in poverty since 2000 is more striking given the difference in average income between Palestinians ($930) and Israelis ($16,710) (CAP-Palestine, 2004).

In 2003 an increase in development aid by 80.2% (from US$197 million in 2002 to US$355 million in 2003) is an indicator of donor increased interest in development programs with a decline in humanitarian and emergency assistance. The needs of emergency and humanitarian assistance depend on the severity of the occupation. For instance, in 2002 the total emergency disbursements amounted to US$829 million or US$365 million after budget support. In 2003 the emergency and humanitarian assistance ranged between US$200-250 million. In addition, a decline in budgetary support from US$464 million in 2002 to US$281 million in 2003. 2003 budgetary assistance represented 30% of overall disbursements as opposed to 45% in 2002. However, disbursements to other sectors actually increased. In 2002 the ratio of emergency to development was 4:1, while in 2003 this ratio became 3:2. Assistance through NGOs amounted to 9.4% of donors support in 2003. Due to lack of information, it is impossible to know if this is an improvement or not in aid to NGOs (MOP, 2004).

(See Graphs 4.7, 4.25, and 4.26)

Aid and NGOs

In Kenya, Zambia and Bangladesh NGOs have long been involved in the provision of primary health, basic education and adult literacy, agricultural extension, small-business finance, and a number of traditional governmental functions; aid donors, aware of the government's weakness as a service provider, have happily used these

NGOs as a supplementary channel for aid flow. (Mosley, Hudson & Verschoor, 2004) This is an excellent picture of using local and international NGOs that already dominant in one field or another, and developing their experience and infrastructure in order to expand services in quality and quantity.

Donors' long experience in aid business in other countries failed to help the PA in establishing a strong government sector, and participated, on the other hand, in weakening the civil society by cutting traditional aid to Palestinians NGOs and, instead, shifting aid to the PA. Donors' purpose was to strengthening the Palestinian leadership in controlling the forces that opposes Oslo Accords and because they ran big projects that NGOs could not handle. This affected most NGOs as they worked in social field and relief, namely health. Many NGO personnel agree that this became a serious threat for the civil society and its institution by giving serious authoritarian control over the limited financial resources they used to enjoy before the PA. Another important element of conflict between the PA and NGOs was the difference of the way or the approach by which services should be handled. The government did minor efforts in considering local experts opinion and further more, did not use much of their professional experiences. Donors, actually, fed the government practices by shifting assistance to the public health sector and leaving many NGOs suffer. This behavior gave the World Bank and other donors much higher control over things. It is very apparent who made policies and defined priorities, especially in the early stages of the PA. Furthermore, as one NGO informed me, the Minister of Health could not refuse development aid projects and he knew they are not for the good of the Palestinians. The consequences of these expensive

projects are more dependence on external aid as the PA became unable to pay the recurrent and the operating costs of such facilities. This is a major reason why NGOs and the MOH do not go along with each other. In addition NGOs suffer the over-control of the Palestinian security apparatus in order to observe financial resources and political competition. NGOs have been, as other part of the Palestinian society, a victim of the Israeli policies. Israel froze several bank accounts for active NGOs providing aid to the Palestinians, especially NGOs that are suspected of having ties with the Islamic Resistance.

However, and after re-consideration of fields that the Palestinian Authority would give much care, aid that aims to strengthen groups in civic society and promote popular participation at grass-roots level flowed popped up again to be a priority. It is more effective if aid channeled through NGOs or private sector to serve certain purposes. NGOs, working on social field, learned the lesson and they innovated new techniques to lessen the dependence on external aid. However, as external funding flew in some fields and for specific purposes new organizations were established with little or no legitimacy, and led to rivalries, and sometimes conflicts, between NGOs over allocation of funds. Sometimes NGOs have increasingly distanced themselves from their traditional development or welfare objectives in favour of these new initiatives.

Recently, donors started re-channeling aid through NGOs due to the current political and humanitarian crisis. However, the Palestinian Authority still call donors to increase their coordination and '*consultation*' [emphasis added] with the Ministry of Planning in order to ease "the process of planning and programming" (MOP, 2004). The

coordination processes between NGOs and donors, donors and PA, and NGOs and PA are still very problematic and resulted in aid mismanagement.

Effectiveness of Aid to Health Sector between 1994 and 2000

In a 1999 report, donors were proud of the achievements they accomplished in Palestine. They mentioned setting up the organizational structure of the MOH, developing sectoral priorities and policies and addressing the sector's requirements in the area of human resources and basic needs. As its main supporter, donors flattered the achievements of the MOH. The number of MOH personnel in the WB increased from 2,032 in 1994 to 3,254 in 1998, and those in the Gaza Strip increased from 1,952 in 1994 to 3,300 in 1998. Key indicators of service availability improved significantly: MOH primary health care centers expanded by 52 per cent from a total of 205 in WBG in 1994, to 336 in 1998. However, the number of NGO clinics fell by 26 per cent. Over all there was relatively little creation of new primary health care assets (World Bank & Japan, 2000). Also, hospital bed capacity increased by 25 per cent, from 1,606 to 2103 beds, over the same period. Institutional development achievements, all supported through donor funding, included: the development and implementation of a participatory planning process involving the public and private sector, the initiation of a quality improvement project, and the development of a national health information system (UNSCO & World Bank, 1999). Although, this does not mean these projects were successful. In 1999, and in spite of the economic deterioration of the economic conditions, ordinary Palestinians reported substantial improvements in the transportation, education and positive views of the functioning of health, financed substantially by foreign aid (Barsalou, 2003).

Sharkawi (2002) reported that in 1994, Palestine Council of Health (PCH)-the seed of the current MOH- presented, to the donor community, a document concerning the consequences of peace building in Cambodia and used it as a warning sign at that time. These donor-related reasons for the lack of progress in meeting public needs in Cambodia were: "

- Inadequate assessment of needs, resource availability, and priorities.
- Hasty design and implementation of projects.
- Lack of real consultation with the government.
- Using "neutrality" as a pretext for not funding government services.
- Donors following own development-assistance agendas.
- Donors rejecting funding of the maintenance of basic services.
- International agencies recruiting the relatively few trained and experienced staff away from public administration.
- Stimulating creation of NGOs where intentions are largely divorced from real needs. "

Unfortunately, and according to Sharkawi (2002), Bleek and Gritzner (2002), and personal communications (2004), it seems that donors and Palestinians did not give the required attention to that document. Literature goes into details about the *pitfalls* the donors faced in Palestine. It is obvious that the extensive international experience, donor countries and their organizations have, did not help better performance or was not invested properly to reach optimum results. The experience of UNRWA and other local expertise, especially those in Palestinian NGO sector were not considered seriously. Blueprint-type of planning and implementing projects or programs did not work because every situation has its own peculiarities and limitations and that what may work in other developing country may not work at all in Palestine. The political influence that remained dominant, by Israel on the ground was actually a major reason for the obstacles

that faced both donors and PA to achieve better results in the health sector (Giacaman R., personal Communications, 2004).

The coordination between donors and PA was relatively good. However, it was not excellent due to the large number of donors and recipients involved in aid. Another reason for this imperfect coordination is the PA's need to keep coordination process fragmented in order to keep different financing channels always open (Brynen, 2000). This resulted sometimes in duplication of efforts or miscommunication. In addition donors have varying demands, bureaucratic reporting, and accounting requirements.

Donor Policies and Attitudes towards the Health Sector

Bleek and Grotzner (2002) summarize the donor policy towards funding the health sector after 1994 as follows: "

- To support the emerging Palestinian government sector.
- To support the peace process as donors "acknowledge that their primary role for being here is to influence the peace process."
- To support the NGO sector in order to provide a viable alternative to the government sector, thereby strengthening civil society and democracy in Palestine.
- To reduce the role of UNRWA by harmonizing its services with the PMOH, in preparation for their merger when the political circumstances permit. This can be seen in the regular reduction and shortfall of the UNRWA budget in the last few years."

Representative of main donor agencies (UNRWA, WHO, ANERA, Italian Cooperation) in the field of health were interviewed by Bleek and Gritzner (2002) concerning the work of their agencies. Conclusions were based on their perceptions and authors' experience, and these conclusions were: "

- Donors have lost some of their enthusiasm. This was reflected by the Italian consul-general who called during a health SWG meeting in 1999 for the need to reform, improve quality, and rationalize the sector.
- Representatives of donor implementing agencies wish to increase their activities but find their respective governments more reluctant to keep to the same levels of commitments as in earlier years (1994-1997).
- Donors wish to observe real improvements in efficiency and effectiveness in the health system.
- Donors wish to witness real harmonization taking place between PMOH, NGO and UNRWA services which would lead to better utilization of all existing facilities in the "public domain" before expanding existing facilities and services.
- Sustaining services and recurrent costs is another area of concerns for donors who do not wish to continue supporting such costs.
- Donors wish to see more emphasis by the POMH and NGOs on primary care services and less on tertiary (specialized) services."

Donors exercised tight control over how aid is spent and on what. However, the recent Palestinian reforms increased donor's confidence in giving aid directly to the PA. The White House in July 2003 and for the first time announced government plans to provide direct aid to the PA rather than channeling it through the UN or NGOs (Barsalou, 2003). This dramatic change can be related to increased confidence in the financial accountability of the PA and/or for political reasons, especially after the assignment of the first Palestinian Prime Minister Mr. M. Abbas and the great expectations of the US and Israel to put and end for Intifada. No similar announcement was declared or even implemented after that date.

Brynen (2000) analyzed the donors' attitudes and found that agenda setting has been a far more complex process than simply identifying sectoral needs. The interaction between developmental and political objectives and other "extraneous" considerations had little to do with peace-building and reconstruction. He also ranked the goals of

international assistance to Palestinians. First economic interest, followed by domestic lobby groups in donor country, the desire to produce immediate local benefits, and the desire to politically strengthen the Palestinian Authority.

It is apparent that there is no clear policy. Policy seems to be driven by individual or group interests. The provocative for policy could be financial incentives, rent-seeking among donors personnel themselves (officials define sectoral preferences), or the outcome of meetings. The productivity of donors determines the sustainability of funds because they are responsible before their parliaments and decision-makers. The productivity can be measured in terms of 'advancing foreign policy, securing new trade and investment opportunities, or upholding a broader set of values.' However, there is no regulation of questioning the foreign staff who set programs and projects if the outcomes were less than expected

In addition, donors want to show off. One manifestation of this is these projects driven overwhelmingly by political rationales. The EU-funded Gaza-European Hospital was an expensive ($60 million), which remained un-functional for two years because the PA refused to run it because of the high operating costs and shortage of trained staff. Finally, both PA and EU opened the hospital in 2000. The project was problematic because of its location, estimated and real cost, running cost and the assigning of UNRWA, a primary care provider, to run it. Japan insisted on building a new hospital in Jericho despite the rejection of the Minister of Health. The importance of political profile in shaping donor programs in the PA has a number of other implications. Donors sometimes are reluctant to support multilateral aid projects that do not highlight their own

particular contribution. Other examples are those projects that focused on capacity building such as the Harvard Consultancy to support institutional building of the MOH. This project failed to achieve its goals and proved inefficient after the second year. Also the British Department for International Development 1995 project to strengthen MOH managerial capability also ended prematurely and without tangible results. The Italian government/UNICEF Project to support the establishment of health services management unit of the MOH, aimed at training health managers, but had limited impact and faced the threat of closures several times. The quality Improvement Project (QIP), supported by the World Bank, lost its momentum in the West Bank before producing the desired effects on the government health system. The QIP office in the Gaza Strip produced tangible results in the field of training, and production of the first Palestinian treatment guidelines and introducing computer use in primary health care clinics. Yet, these are pilot projects and need to expand to all clinics, and a political settlement will lead to expand the experience to other clinics.

# CHAPTER V

## AID AND CONDITIONALITY

Conditionality can be defined simply as the terms of an agreement between a multilateral donor (e.g. The World Bank, International Monetary Fund, and European Union) or a bilateral donor country, and the borrower or granted country about how the loan/grant money should be used to promote certain policies (Wood & Lockwood, 1999). Agreements of trade, different types of aid and grants, and any co-operation can provide very useful tools for promoting a certain policy. Grants, in particular, give donor important leverage at hand: 'to give assistance it is legitimate to ask for something in return' (Metcalf, 2003). Increased conditionality of aid is an important tool used by more and more donors.

The International Monetary Fund (IMF) has been using conditionality since the 1950s. It was criticized as intrusive, confusing and inappropriate. Most of donors use their nationals in humanitarian programs and in key positions. Others tie humanitarian funding for UN agencies to the use of their national NGOs, consultants, and companies. Some countries give preferences to "their own" NGOs because of the visibility their work commands on the home front. (Smillie & Minear, 2003)

Donors, particularly the IFI's, often insist on fiscal policy reforms as a condition for aid. Their main objective in most cases is to curtail governmental budget deficits so as to foster macroeconomic stability. Yet this is not the only aspect of fiscal policy where conditionality can play a useful role, nor is it necessarily the most important. In addition

to the size of revenue and expenditure, government priorities for public spending, and the impacts of taxation and expenditure on the distribution of income. Though continues focus on macroeconomic management, growing emphasis has been placed on efficiency issues, microeconomic measures, structural policies and legal and institutional reform. This shift led to a wider scope of conditionality either in content or in approach (Lastra, 2002).

Collingwood (2003) states that the *new conditionality* of IMF focuses on three areas: *simplifying conditionality*, to be applied to critical areas only such as: fiscal, financial, exchange rate policies, privatization, governance, and public sector reform; increasing *recipient-country ownership*, and *improve coordination* among international financial institutions. This new approach was criticized for conditionality seems to be 'indispensable' and yet, there is no alternative for it. Also, there are few limits on conditionality and the IMF still can control the number of conditions attached to loans or grants. The need for recipient governments' capacity building to improve agreements processing and to enhance the success of reform plans.

Many studies reported weak results of conventional macroeconomic conditionality, suggesting that successful reforms can not be imposed from outside (Singh, 2002). *Selectivity* is an approach by which donors encourage countries which already adopted good economic policies or started reform programs. Donors expect this will encourage reluctant countries to change their poor policies in order to get aid. However, Pronk (2001) argues against this selectivity.

*Peace conditionality* was introduced first in 1995 by a World Bank and IMF study recommending making aid conditional on steps taken by the Salvadoran government to promote peace (Boyce, 2002). Peace conditionality involves using 'carrot and stick' principle to encourage specific steps by the recipients. The difference between the aims of conventional conditionality and peace conditionality is that conventional conditionality has focused on achieving short-term macroeconomic stability and long term economic reform, whereas peace conditionality focuses on conflict resolution, implementation of peace accords, and the long-term consolidation of peace. Both peace/political conditionality and economic conditionality were used smartly in the West Balkan conflict in the 1990s and succeeded to put an end for the bloodshed in the Balkans (Pippan, 2004) Withholding aid as a response risks harming the poor, especially in countries with humanitarian needs. Leaving political leaders relatively unscathed is a challenge international community faces. International donors recognize that they can not just stop all types of aid to a country. So they selectively choose to stop those types that their shortage will cause minimal harm on the poor categories of beneficiaries such as refugees. On the other hand, threats may target the political leaders and these sanctions may include targeting the international economic interests of elite leaders, for example, by freezing their foreign bank accounts and restricting their freedom of travel. Crawford (1997) found that conditions improved in only thirteen out of twenty-nine countries where aid sanctions were applied for political reasons.

Effectiveness of Conditionality

In the literature, conditionality has proven to have had limited effectiveness because of different reasons related to donors and recipient countries. Several studies describe the situation that conditionality which attempts to 'buy reform' from an unwilling partner has rarely worked, so donors should reward good performance (DFID, 2004; Dijkstra, 2002). However, that conditionality in some reforms such as exchange and trade liberalization, price decontrols, etc. can be comparatively effective, but conditionality to contain the tendencies toward proliferation of governmental structures and expansion of government personnel is weaker. External pressure to keep the money flowing plays a role in drawing the World Bank policy and mutual understanding is reached between donors and the bank on the policy in concern (Schiavo-Campo, 2003).

Comparative evidence from other countries suggests that conditionality has a mixed record. Efforts to use conditionality to press reluctant governments into reforms that they do not truly support are rarely effective, and may undermine the credibility of the reform process altogether. It is also ineffective when governments have already undertaken substantial reform, because it tends to disguise policy responsibility and complicate decision-making. Conditionality proven effective only in the early phases of reform, where signals that serious reform is required and/or needed. Bird (2002) argues that one limiting factor of conditionality is the degree of compliance and the completion rate of the IMF programs. A set of conditions formulated for debt relief to Heavily Indebted Poor Countries, which focus on government strategies to reduce poverty, on

average, 60 per cent of conditions are fulfilled and several studies show that compliance is much more limited.

Conditionality: Palestine Case

World Bank experience, as a multilateral donor, in Palestine, Bosnia, Kosovo and Afghanistan, argues that due to the 'importance of restoring peace, gaining the cooperation of the parties, and fueling the process of recovery', the Bank was unable to insist on certain policy conditions (Schiavo-Campo, 2003). Staff complained in one study that donor governments oppose any interruption in the flow of aid, and thus the World Bank could not make serious changes in local policies, especially in public administration and economic management.

Another study states that in the WBG, 'there has been little explicit economic conditionality attached to donor assistance.' The reasoning was that due to the political urgency of peace-building, conditionality could not be effectively implemented in the Palestinian context. The international community's desire to reinforce peace clearly was more significant than any immediate reforms (World Bank and Japan, 20000). Donors' plans in Palestine had not included "aid-for-ever" approach. Before 2000, there were little indicators of economic growth. This contrasts with the generous aid that went to the creation of statehood institutions. Israel policies and the impact of aid have affected the public sector and its institutions.

(See graph 4.21)

Through the period from 1994 to 2000 donors did little about promoting transparency and accountability in the PA public institutions. Definitely aid was

considered a reward for peace. Normally and in similar situations of "post-conflict" aid, donors play a major role in "setting-up the rules" of receiving and giving aid, and this was the case in Palestine. But, donors in the Palestinian-Israeli conflict had to build state institutions and transfer their various extra resources and technical experiences, whether needed or not, to build an independent government to function and fulfill its obligations according to the peace accords. To encourage this, donors, as they claim, did not enforce strict conditions on the financial performance of the PA in its blooming period. Israel, on the other hand, transferred regularly the clearance tax money-which form a high portion of the domestic revenue- to the private accounts of the PA officials facilitating more and more leakage and misuse of public financial resources. The relatively huge aid that the Palestinians got in forms of grants and capital support led to what I call *"Aid Syndrome"*. The symptoms started with the beginning of the PA take-over and include: strong and authoritarian leadership, weak legislative and legal systems, political patronage and corruption, weak government ownership, and weak civil society. In peace conditionality such as the Palestinian case, donors sometimes, and deliberately, turn a blind eye to such practices, on the grounds that they sustain political patronage networks and help to grease the wheels of the peace process. In the end, however, corruption erodes donor leverage, in addition to the corrosive effects it has on the economy (Boyce, 2002). To fight patronage and corruption donors typically respond through technical assistance, good governance programs, aid conditionality, and/or redirection of aid flows through NGOs.

The limited aid conditionality on country-wise level, at that period, did not prevent donors from practicing other conditionality forms to influence the national

policies. Although aid conditionality was *informal* and aid conditions were not written but agreed upon with the party of interest, conditions were not different from those in other countries and focused on economy, markets, human rights, democracy and others.

In Palestine, with limited resources and a high dependence on external funds donors intrusively forced on the PA what they think is a national interest or a development goal. Donors approached sectoral needs according to their priorities and with little considerations of the PA needs assessment studies. The health sector was not an exception. Donors provided unnecessary and unwelcome technical assistance, according to several Palestinian academic and professional characters I interviewed. According to a former Minister of Health, the foreign expatriates brought little assistance to the MOH. The failure of several projects and programs in the health sector was directly linked with little understanding of the politics of the region, little analysis of the situation, and because of many cultural and technical barriers. The major annoying issue for the PA was the cost of the technical assistance. Researchers estimated that between 70-90% of the technical assistance money is spent in the donor countries (World Bank and Japan, 2000). One example is the US assistance to the PA. USAID mentioned that more than 80 per cent of aid to the Palestinians, mostly technical assistance and research, goes to American contractors and mainly through American NGOs. Many Palestinians still argue the real benefits of technical assistance as it proved to be very little. Technical assistance was more supply-driven than need-driven. Now donors claim they gave the Palestinian MOP more power to require what PA needs.

After the year 2000 and with the dramatic political changes in Israel and Palestine, donors and with political backup from the US and Israel started strong use of "conditionality" and linked it directly with fundamental "reforms" in the PA political, financial and security performance. The PA made serious changes and reforms and practiced serious and extensive auditing in its financial system. The major achievements of these financial reforms took place after the assignment of a reform-supporter and a technocrat professional in the position of the Palestinian Minister of Finance. However conditionality failed to enforce political changes or to put an end to the Palestinian resistance against the Israeli occupation. In addition, the use of conditionality has proved to be a failure in imposing peace settlements upon the Palestinians as a unilateral-solution. Conditionality should be imposed on both parties of the conflict in order to make a balanced and just settlement.

Donors and Conditionality

The World Bank and Conditionality

PECDAR, the Palestinian Council for Economic Development and Reconstruction, operated under firm requirements and business principles set by the World Bank. With the beginning the Bank touched clarity, firmness and results. It was free from political patronage and interference. Shortly thereafter, however, World Bank's attempts to emphasize more development in functions and institutional development were hindered by external political pressures to prevent any interruption in flow of financial support.

Generally, the World Bank failed to condition continuation of its assistance on an acceptable PA budget reflecting key economic and social priorities and on limiting the

proliferation of public structures and employment. In addition to the huge impact of the political uncertainties and obstacles created from the Israeli side, especially after 1995. In the political context of WBG, the World Bank could not succeed in standing firm on basic policies, and the short term urgencies dominated over the longer-term aims.

The European Union and Conditionality

According to Israel and the international community, the PA has misused aid funds to finance 'terrorism' and corruption. News papers, in June 2002, even accused EU of being aware of this but did not raise this issue in the interests of a resumption of the peace process. The European Commissioner responded to these accusations in August, 2002. The EU supported about 10% of total expenditure, and the PA used the money to pay salaries for the public sector and emergency expenditure. European Union works with an IMF 'Resident Representative' who certifies that all revenues and payments are channeled through the MOF's Single Treasury Account (STA). The RR monitors spending information, received by the Minister of Finance. The IMF also regularly mounts major missions to the PA from its staff.

The cooperation between the EU and IMF in Palestine goes back to 1997 when it was agreed to establish a loan fund for the PA in response to Israel freeze of transfers of tax revenues to the PA (which constitutes 60% of total revenues). Thus the EU decided in 2001 to provide direct budgetary support to the PA to prevent its collapse and to renounce violent struggle groups. The IMF played a monitoring role. The EU's budgetary assistance is provided on the basis of a conditionality aiming at strengthening the consolidation and transparency of the PA's public finances and promoting reform in

the PA. The evaluation of the compliance with the conditionality attached to EU's budgetary assistance is carried out on the basis of monthly comfort letters provided by the IMF. This conditionality has produced results such as MF certification every month that all revenue and expenditure of the PA are channeled through the STA. Another key-condition of the budgetary support has been the approval of Judiciary Independence Law which constitutes an important step towards the reform of Judiciary in Palestine and the separations of powers. The EU's conditionality also provides for the strengthening of the auditing system. The reform of the financial management of the PA is the objective of several key conditions of the conditionality attached to the EU. For instance, conditions aim at the implementation of austerity budget of the PA, which has been prepared with the help of the IMF. They also aim at the control of the payroll and the containment of budgetary arrears. Monitoring of these conditions is provided in the IMF's monthly comfort letters, on the basis of which the Commission evaluates compliance and approves the payments (EU, 2003).

Furthermore, the international community at the last Ad Hoc Liaison Committee in Rome stated in December 2003, "EU budgetary support and its conditions as well as US support, has over the past years been successful in advancing key reform measures such as financial accountability". The conditionalities attached to EU assistance to the PA have contributed to placing, according to the IMF, "the Palestinian Authority to a level of fiscal responsibility, control, and transparency which rivals the most fiscally advanced countries in the region" (EU, 2004).

One study argues that the main strategy of conditionality used by the EU is 'reinforcement by reward' (Schimmelfennig, Engert & Knobel, 2003). In 1997, the EU tried to use this different approach with the Palestinians to fight political patronage in the PA and limit the leadership control over financial resources. It offered to establish a financial facility to pool most financial resources of the PA and organize the PA financial performance. But the offer failed (Brynen, 2000).

The United States and Conditionality

The US is the main shepherd of the peace process. It would have been more fruitful if the US tried to sustain the balances of power among the two parties of the conflict in order to prevent the collapse of the peace process or return to war. But the US has been always reluctant to exercise conditionality in dealing with Israel- the top recipient of US aid- in order to encourage progress toward a peace settlement with the Palestinians. The unconditional policy is related to the power of the right wing Christian Zionist pro-Israel lobby in the US, and the American Israel Public Affairs Committee (AIPAC) in particular, which Fortune magazine rates as and the first foreign policy lobby and the fourth most influential lobbying group in Washington (AIPAC, 2004). Most Palestinians feel deep-rooted antipathy towards them in the US politics. The consequent effects are apparent in the momentum of the peace process and the volume of either political or financial support. The Congress still refuses giving aid money directly to the PA and refused to properly fund the PA even at the peak of the peace talks in the 1990s. US money, however, find its way to the Palestinian refugees through the annual aid provided to the UN agencies that provide services to the Palestinian refugees or through

multilateral donor bodies. On contrary, Nordic countries' support for aid emerges from public opinion (Brynen, 2000).

Unsurprisingly, some private donors asked an American NGO professional 'why we are providing aid to Palestinians but not Israelis?.' Professional standard answer was that there is a gap between the needs of the Palestinian population and the ability of the PA to respond to these needs, but there was no similar gap between the needs of the Israeli population and the ability of their government to meet these needs. I would like to add that Israel receives economic and military aid of more than $15 million per day while, while the Palestinians receive $0.55 million per day (MOFA, 2004).

Congressional policy towards aid to the Palestinians is very clear and can be summarized in this quotation from a report about US assistance to Israel and Palestine:

"No US assistance goes to the PLO or to the PA. All US assistance to the Palestinians goes to private voluntary organizations (20%) or to contractors (80%), all of which are selected and monitored by the USAID. All US aid to the Palestinians is economic support funds (ESF) and is not for military purposes.
Congress has placed restrictions on US aid to the Palestinians;

- No assistance to the PLO unless authorized by the President (Section 546 of PL 107-115)
- No funds to the Palestinian Authority unless the restriction is waived by the President.
- The President may close the Palestinian office in Washington, or name constituent members of the PLO as terrorist organizations, or end assistance(except humanitarian) to the West Bank and Gaza if the President determines that PLO and the PA are not meeting their prior commitments (Section 566)
- No funds for the Palestine Broadcasting Corporation (Section 569); and
- Stop aid to the Palestinians unless the Comptroller General has access to information to review US aid uses (Section 571). " (Mark, 2002)

USAID tried to encourage moderation in Palestine Broadcasting Corporation by providing equipment, training, and access to Voice of America programming. However, these attempts were unsuccessful and USAID decided to cut off it its aid in 1998.

Palestinians rejected this interference accusing Israel of causing this, and the PBC continued its broadcasting up to this date. The fragmentation of donor coordination mechanisms helps Palestinians to keep control over financial resources for its priorities. (Brynen, 2000)

In addition to the above conditions and constraints, the "Patriot Act" did prevent aid from going to certain Palestinian groups (even some that had no connections with 'terrorism' or struggle against Israel of any kind). However, those constraints were no more than what was faced by other NGOs in other Arab or Muslim countries (Personal Communications, 2004). As a result of this 'Patriot Act', Palestinian NGOs must sign the so called "Anti Terrorism Certificate". The goal of this paper is to ensure that no American money or aid go to financing terrorism. This certificate is a world wide requirement.

Several months after the Anti-Terrorism Certification requirement was issued, some NGOs protested against the language of the certification and its definition of "terrorism" (See Appendix C). After a review by the U.S. government, USAID issued a revised version of the Anti-Terrorism Certification on March 24, 2004. The revised version bases the definition of "terrorist act" primarily on United Nations conventions that reflect internationally accepted definitions. The revised version also provides guidance on what measures NGOs should take to comply with the certification's requirements. However, the presence of "Specially Designated Nationals and Blocked Persons", which is a list of names and organizations that considered a "black list", is not recognized by most of the Palestinian Governmental and non-governmental

organizations. Most Palestinian NGOs refused to sign this document for political and national reasons related to the American definition of terrorism, although a faction of the community called to sign it because Palestinians are in need to aid.

Likewise all international donors, the U.S. government conditions its assistance on various management and policy considerations. USAID has a number of conditions to which a grantee choosing to partner with USAID must agree (USAID, 2004). Conditions may be quantitative or qualitative, but always must be specific and measurable in order to provide clear benchmarks for the disbursement of resources (USAID, 1996).

The UK and Conditionality

The British government agrees that budget support is the most effective way to address poverty under current circumstances. The British Department For International Development (DFID) links disbursements to what it describes as 'realistic but challenging reform conditions', enables a common donor approach to 'fiduciary risk'. To reduce aid transaction costs to the PA DFID works on harmonizing procedures. The effective use of resources should be used to consolidate the stance of reformers. Accountability and policy change are priorities in DFID assessment for continues cooperation with the PA. Support of PA reform and poverty reduction plans are major concerns for the British Agency (CAP, 2004).

In addition, several British NGOs work through direct government funds or through charity organizations in the UK to help in the humanitarian and relief efforts in the WBG. Conditionalities rarely accompany humanitarian aid. High portions of aid also go through the UN agencies.

UNRWA and Conditionalities

The independence of UNRWA as United Nations agency leave no space of conditionality to take place in UNRWA activities. As the major role of UNRWA is humanitarian relief and provision of social services, the intervention of politics and talks about reforms in the PA is extremely limited. However, the media attacks against UNRWA reached it peak in 2004 when Israel and Jewish groups attacked UNRWA accusing it of hiring Hamas (Islamic Resistance Movement) followers in its different departments and asked for stopping financial assistance to UNRWA. This attack came as a response to Peter Hansen, UNRWA Commissioner General, televised interview with the Canadian Broadcasting Corporation (CBC) in October 2004, when he said that 'there are Hamas members on the UNRWA payroll.' This led to an argument in Canada and voices raised to stop the annual contribution of $10 million (5% of UNRWA's yearly budget) and further to fire all those whom are Hamas sympathizers. However, the issue was solved guaranteeing that the UNRWA history in the region is well known and there was no link between UNRWA and any Hamas activities. The Canadian officials stressed that UNRWA's employees, as they always have been and in spite of their feelings towards Hamas, should conduct themselves as proper impartial nonpolitical international civil servants (DailyStar, 2004).

This position of pressure by lobby groups targeting the Palestinians in general limits the donors' willingness to give aid, in fear of domestic perception of the real use of aid money. The picture that anti-Palestinian groups try to draw in the world increases the

procedures, conditions and even the type of grants that go to the Palestinians, especially after 2000.

Japan and Conditionality

In 2004, Japanese Foreign Minister Yoriko Kawaguchi was quoted saying to the Palestinian Froeign Minister that deterioration in the security situation is making the dispatch of Japanese aid workers difficult and that the Palestinian government needs to step up efforts to improve the security situation to receive Japan's economic assistance (Kyodo News International, Inc., 2004). The bilateral relations between the PA and Japan is based mainly on humanitarian support to the Palestinians and then economic and commercial interests. Half of all bilateral aid is tied to imports of goods and services from the donor country. This is one way donors stimulate the domestic economy of their countries. Japan has very good relations with the Palestinians and keeps strong relations so that in the future Japan will gain a considerable market share in Palestine and to stay on good terms with the Arab world. To understand this I qute this from Boyce (2002): "Recipient governments usually play quietly on these fears, but occasionally they do so openly. 'Japan is taking a lead,' a Cambodian commerce ministry official declared in 1999 while denouncing political conditions on US aid. 'by the time the US shape up, if a US company is bidding on a contract against a Japanese company, do you think the US will win? I don't think so.' "

Arab Countries and Conditionality

Arab countries and local national movements that provide aid to Palestine, either financial or humanitarian, emerge from national and patriot reasons. The support for Palestine as occupied Arab and Islamic territories is primarily enough reason. Aid from Arab countries goes back to 1948 and fluctuated depending on the political relations between the Palestinian leadership and Arab countries, although it has never stopped. Recently Arab countries and through the Arab League supported the Palestinian budget with more than half a billion dollars to meet the basic needs of the Palestinians such as salaries of the public sector and basic social services. No conditionality was forced on the Palestinians except meeting the international demands of financial transparency and accountability.

Grants versus Loans

What is very exceptional in the Palestinian case is that most of the aid given was in the form of grants and out of billions of dollars of aid money, till 2002, few millions were in the form of loans. Palestine is not a member in the World Bank or IMF and receives aid through special trust fund. The few projects in Palestine were sound enough to meet the banking standards that ordinarily determined lending practices, however because of political instability and periodic economic closures there has been little disbursements as loans. For example, the EU allocated half of its assistance through European Investment Bank ($300 million), and by September 1998 only a third of this had been committed and none disbursed. Donors are not encouraged any more in investment in the PA territories and also the PA is not willing to withdraw loans. The PA

feels that the Palestinians have suffered a lot and it is the International community role to help in the compensation of their suffering and they take Israel as an example which the US gives billions of dollars in the form of grants.

(See Graph 4.8)

Palestine has one of the lowest external debts amongst the countries under my comparative analysis. This is a unique thing about the Palestinian economy. The fact that there is relatively no debt is a good base for a quick economic recovery and growth if the suitable political environment is present.

(See Graphs 4.28 and 4.29)

Tying Aid

As mentioned earlier, it is a fact that aid agencies must satisfy commercial, political and societal pressures from their home countries. In Palestine, as in other countries, donors tie aid. Tying aid means that aid money should be allocated to specific sectors or the use of grant money in donor country. Thus implementing agencies and multilateral donors allocate aid more generously toward countries that meet political criteria, and publicizing the results of their aid, preferably in projects that are clearly identified with a particular donor. Thus most aid provided to Palestine was dispensed according to donors policies and priorities with little consultancy with the Palestinians.

Technical Assistance

In the early 1990s, a World Bank Vice President stated that technical assistance "is a systematic destructive force which is undermining the development of capacity...

And most of this technical assistance is imposed, it is not welcome and there is no demand for it really, except on the donor side."

Technical co-operation or technical assistance is problematic but donors consider it to ensure control over some aspects of project implementation than to transfer skills. Higher levels of technical assistance tend to go along with higher levels of aid. However in Palestine, technical assistance increased with the economic and security crisis. Donors increased their aid for capacity building and institutions' reform. Aid sometimes takes the form of programs intended to strengthen the legal system, public financial management, or other aspects of governance. Transferring developed-nation institutions to less-developed nations via technical assistance has proven very difficult, however.

(See Graphs 4.9, 4.10 and 4.11)

It has been common worldwide and in the Palestinian experience that the failure of a series of donor-funded projects, designed to build institutions, which served short-term donor rather than domestic needs, undermined existing institutions. The payoff to government officials of building institutions according to donor specifications exceeded their payoff from building them according to domestic demands. When external funding ended, the new institutions broke down.

Technical assistance has been a primary instrument of donor efforts to support institutional development, capacity building, and policy reform. Between 1993 and mid-1999, disbursements in this area totaled over US$450 million, accounting for almost one fifth of all donor aid. Many donors argue that there is a serious need for technical assistance to address institutional bottlenecks. However, in the health sector for example,

an interview with a former Minister of Health revealed that technical experts are forced upon the MOH and foreign experts come with limited experience in their field, minimal understanding of the politics of the region, language is another barrier. Also, they come for very short periods, and most of all, they cost a lot of money. A program was initiated to use Palestinian Expatriate Professionals as an attempt to alleviate some of the weaknesses. However, this program continue to face the dilemma of having to offer higher financial incentives to attract expertise while ensuring their smooth integration into local institutions where salaries are substantially lower (World Bank and Japan, 2000).

Training programs in donor countries are also problematic. In spite of the high cost of these programs and its prestige, they attracted high rank Palestinian personnel rather than mid-level staff who would benefit most from the training. Directors and managers in public sector who had good *connections* used training opportunities to travel and for the daily allowance they enjoy in the host countries. As a result the benefits of such training end up in files in drawers with limited effects on the performance of public sector.

In the early process of building statehood institutions, Palestinian leadership almost accepted every offer of assistance like a dry sponge without considering the consequences and without proper analysis of needs and priorities. This gave donors higher control of the quantity and kind of supply. Different donors offer multiple technical experts from alternative sources, each offering differing advice or training. Wide variation among donors.

Finally, Palestinian officials were frustrated by being offered external technical assistance instead of the required equipment or financial resources- especially when local expertise is available but other resources are not. Technical assistance and ancillary activities can comprise up to half of donor support for any given (capital) project. Palestinians believe that donors insistence one assigning their own national technical experts into a project plays a major role in shaping donor priority setting (Brynen, 2000). However, technical assistance in some field that began from scratch such as establishing ministries or departments that have never existed before utilized technical assistance and the results were very positive (World Bank and Japan, 2000).

Future of Aid in Palestine

In other international situations, aid is a very uncertain and unstable source of revenue. Though in Palestine, all indicators show that aid is and will be a sustainable source of fund. The overall vision of the area implies that the international community is, and will be supporting the Palestinians for a long period of time. The fact that Palestinians do not have sovereignty over land, in addition to the limited natural resources, and disability to establish sustainable national income resources is a strong signal for the constant need for aid. Several people whom I interviewed for this thesis argued that 'donors can not stop aid to Palestinians', 'Palestinians and donors will face many consequences' referring to donor countries domestic response. Palestinians status under occupation and their weakened economy will prevent any serious threat of stopping at least humanitarian aid and economic assistance.

# APPENDIX A

## Tables

Table 1.1 IMR in Palestine from 1960s to 2003.

| | Israeli Estimates | Palestinian Estimates |
|---|---|---|
| 1966 | 150 (WB)<br>150 (GS) | 150 (WB)<br>150(GS) |
| 1970 | 100(WB) Israel B. Statistics<br>86 (WB) Israel, MOH | 50-70 (urban & refugees)<br>80-100 (rural) |
| 1980s | 25.6 (WB)Israel MOH<br>43.1 (GS) Israel MOH | 30-40 (GS) |
| 1990-1995 | N/A | 25-30 (GS)<br>20 (WB)<br>10-14 (WB in 1994) |
| 2003 | N/A | 11.2 (WB)<br>24 (GS) |

Source: Palestinian MOH Annual Report 2003 & others.

Table 1.2 Provisions of Health Services to Palestinians 1991.

| | Civil Administration | UNRWA | Non-for-Profit | For-Profit/Private Sector |
|---|---|---|---|---|
| Health Care Expenditures | US$ 43.8 million | US$ 13.3 million | US$ 38.9 million | US$ 51.2 million |

Source: Brynen R. "A very Political Economy", 2000.

Table 2.1 Health Indicators-Palestine 2003

| Indicator | GS | WB* | PA |
|---|---|---|---|
| Population Size | 1,370,345 (23.7%) | 2,367,550 (63.3%) | 3,737,895 |
| Under-five mortality rate | N/A | N/A | 20.1 |
| Infant Mortality Rate | N/A | N/A | 24 |
| Prevelence of Anemia among infants aged 8 months in MOH | N/A | N/A | 40.5% (UNRWA 38.3%) |
| Prevalence of anemia among pregnant women | NA | NA | 32.5 |
| Maternal mortality ratio per 100,000 live births among women aged 15-49 years | 21.3 | 6.7 | 12.7 |
| Abortion rate at MOH hospitals per 1000 | N/A | N/A | 111 |
| Under weight prevalence | N/A | N/A | |
| Use of safe drinking water | 86.5% | 97.6% | 93.8% |
| Antenatal care | N/A | N/A | 71% |
| Birth weight below 2.5kg | 5.3% | 5.2% | 5.2% |
| Viral Hepatitis A Incidence | N/A | N/A | 86.1% |
| Viral Hepatitis B incidence | N/A | N/A | 43.4 /100,000(Carrier) |
| Viral Hepatitis C incidence | N/A | N/A | 6/100,000 |
| Incidence of Meningioccocal | 12.6 | 0 | 4.6 |
| DPT immunization coverage | N/A | N/A | 97.7% |
| TT2 given to pregnant women | N/A | N/A | 50.4 |

*60% of the WB population lives in 400 rural villages and 19 refugee camps. *Source:* Health Status in Palestine 2003, MOH official Website.

Table 2.2 Ministry of Health Expenditure (MOH, 2004)

| | 1993 | 1995 | 1997 | 1999 | 2000 | 2001 | 2002 | 2003 |
|---|---|---|---|---|---|---|---|---|
| Total US$(1,000) | 61,976 | 77,408 | 128,734 | 82,599 | 100,336 | 81,129 | 99,538 | 98,420 |
| Distribution % | | | | | | | | |
| Salaries | 31.5 | 48.5 | 42 | 48 | 45 | 57 | 57.9 | 55.4 |
| Treatment abroad | 18.9 | 18.2 | 14 | 7 | 6 | 10 | 6.4 | 12.9 |
| Drug & Disposables | 34.7 | 21.5 | 29 | 26 | 25 | 18 | 24.9 | 17.9 |
| Operating Expenditures | 14.9 | 11.7 | 15 | 19 | 24 | 15 | 10.8 | 13.9 |
| Total | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Table 2.3: World Bank Classification of Countries by Income. (World Bank)

| Country Rank | Annual per capita income US$ | Annual Health spending in US$ |
|---|---|---|
| High-income | >8,000 | 1,000-4,000 |
| Middle-income | 1,000-8,000 | 75-550 |
| Low-income | <1,000 | 2-50 |

Table 2.4 Population Served at UNRWA Primary Health Care Facilities, 2003. (UNRWA, 2003)

| Field | Registered Population | Population Served | Percentage |
|---|---|---|---|
| Gaza Strip | 923,000 | 721,536 | 78.1% |
| West Bank | 665,000 | 465,486 | 69.9% |
| Total | 1,588,000 | 1,187,022 | 74.8% |

Table 2.5 UNRWA Utilization of Hospital Services, 2003 (UNRWA, 2003)

| | West Bank | Gaza Strip |
|---|---|---|
| General Hospitals Patients admitted | 15,968 | 3,148 |
| Bed days utilized | 41,955 | 11,942 |
| Average stay in days | 2.6 | 3.8 |

Table 2.6 UNRWA Health Services, 2003 (UNRWA, 2003)

| | West Bank | Gaza Strip |
|---|---|---|
| Primary Health Care Facilities | | |
| a. inside official camps | 17 | 11 |
| b. outside camps | 17 | 6 |
| c. Ratio of PHC per 100,000 pop | 5.3 | 1.9 |
| Services Integrated within PHC | | |
| a. Laboratories | 25 | 14 |
| b. Dental Clinics | 20 | 11 |
| c. Family planning | 34 | 17 |
| d. Special Care for non-communicable diseases | 34 | 14 |
| e. Specialists | 7 | 14 |
| f. Radiology Facilities | 6 | 5 |
| g. Physiotherapy clinics | 6 | 6 |
| h. Maternity Units | 0 | 6 |
| j. Hospitals | 1 | 0 |

Table 2.7 Comparative Resource Indicators: UNRWA and Refugee Host Countries.(UNRWA, 2003)

| Indicator | Jordan | | Lebanon | | Syria | | Palestine | | |
|---|---|---|---|---|---|---|---|---|---|
| | Country | UNRWA | Country | UNRWA | Country | UNRWA | MOH | WB | Gaza |
| No. primary health facilities Per 100,000 pop | 24 | 1.4 | 69 | 6.4 | 21 | 5.7 | 29 | 5.3 | 1.9 |
| No. doctors per 100,000 pop | 220 | 5.2 | 281 | 13.1 | 146 | 12 | 84 | 10 | 9.85 |
| No. dentists Per 100,000 pop | 45 | 1.2 | 105 | 4.1 | 85 | 3.2 | 8 | 2 | 1.5 |
| No. nurses Per 100,000 pop | 280 | 12.9 | 300 | 28.7 | 197 | 29.3 | 141 | 32.4 | 27.1 |
| Per capita allocations for Medical Care US$ | 45 | 4.6 | 45.9 | 22 | 18.6 | 12.8 | 26.9 | 14.7 | 12.8 |

Table 2.8 IMR among Refugees. (UNRWA, 2003)

| | ESCWO 2000 | WHO/EMRO 2002 |
|---|---|---|
| Jordan | 27.0 | 22.0 |
| Lebanon | 20.0 | 26.0 |
| Syria | 27.0 | 18.0 |
| Palestine | 24.0 | 23.0 |

Table 2.9: UNRWA Health Staff as of December, 2003 (UNRWA, 2003)

| | HQ | Jordan | West Bank | Gaza Strip | Lebanon | Syria | Total |
|---|---|---|---|---|---|---|---|
| Medical Care | 13 | 572 | 498 | 639 | 335 | 354 | 2411 |
| Environmental Health | 0 | 330 | 2127 | 363 | 217 | 107 | 1229 |
| Grand Total | 15 | 902 | 710 | 1002 | 552 | 461 | 3642 |

Table 2.10: Emergency Appeals Funding Status (US$ million) (UNRWA, 2003)

| | 200/2001 Appeal | 2002 Appeal | 2003 Appeal | Total |
|---|---|---|---|---|
| Amount requested | 160.3 | 172.9 | 196.6 | 723.3 |
| Confirmed pledges | 133.1 | 94.6 | 83.3 | 311 |

Table 3.1: UNDP estimates of total external Aid 1992-93 in the OPT.

| | 1992 (US$ million) | 1993 (US$ million) |
|---|---|---|
| Bilateral Donors | 42.4 | 138.7 |
| Multilateral Donors | 15.3 | 75.5 |
| Multilateral Agencies | 116.2 | 48.6 |
| Total | 173.9 | 262.8 |

Source: Brynen "A Very Political Economy', 2000 p.46

Table 3.2: Disbursements by Beneficiaries in thousands of US$ from 1994-2000

| Disbursements | MOH | | NGOs | | UNRWA | | |
|---|---|---|---|---|---|---|---|
| | 94-97 | 98-00 | 94-97 | 98-00 | 94-97 | 98-00 | Total |
| Total | 111,021 | 36,338 | 29,605 | 16,912 | 12,242 | 8,041 | 214,159 |
| % of total | 52 | 17 | 14 | 8 | 6 | 4 | 100 |
| % of total 1994-2000 | 69 | | 22 | | 9 | | 100 |

Source: Reproduced from Bleek & Gritzner, 2002

Table 3.3: Health Sector Development Commitments and Disbursements 1994-2000 in thousands of US$.

| May 1994-December 1997 | | January 98-June 2000 | | Total May1994-June 2000 | | Total (Including Humanitarian Aid) |
|---|---|---|---|---|---|---|
| Committed | Disbursed | Committed | Disbursed | Committed | Disbursed | Disbursed |
| 224,723 | 158,991 | 97,182 | 68,671 | 321,905 | 227,662 | 250,519 |

Source: Reproduced from Bleek and Gritzner, 2002

Table 3.4: MOH figures on amounts pledged and disbursed by international donors.

| Year | Amount Pledged | Amount Disbursed |
|---|---|---|
| 1994 | $72.6 million | $63 million |
| 1995 | 68 | 44 |
| 1996 | 61 | 43 |
| 1997 | 58 | 37 |
| 1998 | 33 | 15.6 |
| 1999 | 15.6 | 14 |

Source: Reproduced from Bleek and Gritzner, 2002

Table 3.5: Development Assistance by Sector

| Sectors | 2001-1st Q-2003 | |
|---|---|---|
| | Commitment Million $ | Disbursement Million $ |
| Infrastructure | 542.2 | 220.7 |
| Productive Sectors | 76.1 | 54.7 |
| Governance & Civil Society | 174 | 117.2 |
| Human Resources Development(total) | 251.7 | 187.2 |
| Health | 114.5 | 99.4 |
| Refugees | 17.6 | 20 |
| Others | 7.8 | 10.2 |
| Total | $1,069 | $610 |

Source: UNCTAD, 2003

Table 3.6: Emergency Assistance by Sector

| Sectors | 2001-1st Q-2003 | |
|---|---|---|
| | Commitment Million $ | Disbursement Million $ |
| Emergency response | 139.1 | 102.7 |
| Employment generation | 165.3 | 162.9 |
| Infrastructure | 9.3 | 36.6 |
| Productive sectors | 35.2 | 52.6 |
| Governance & Civil Society | 4 | 3.2 |
| Human Resources Development | 20.5 | 31.6 |
| -Health | 18.5 | 28.3 |
| UNRWA/Refugees | 403.9 | 239.4 |
| Others | 0.9 | 3.9 |
| Total | $778.2 | $632.9 |

Source: UNCTAD, 2003

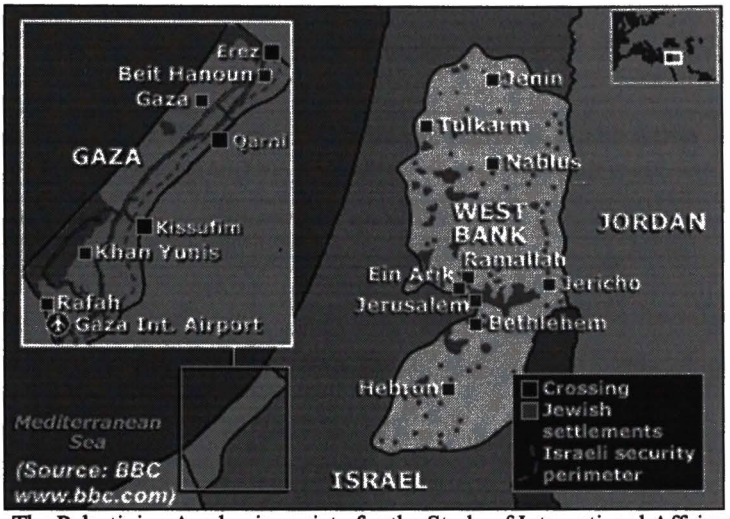
Table 4.1: Selected Upper Low Income Economies Aid percentage of Gross National Income (GNI) 1994-2002

| | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 |
|---|---|---|---|---|---|---|---|---|---|
| Albania | 8.278 | 7.333 | 8.273 | 7.082 | 8.606 | 13.041 | 8.267 | 6.336 | 6.631 |
| Armenia | 8.109 | 7.555 | 18.341 | 10.135 | 10.122 | 11.268 | 10.987 | 9.092 | 11.983 |
| Bolivia | 9.804 | 11.04 | 11.598 | 9.06 | 7.542 | 7.041 | 5.838 | 9.478 | 9.1 |
| Bosnia-Herzegovina | - | 57.376 | 33.535 | 26.126 | 20.116 | 21.619 | 15.311 | 12.655 | 10.687 |
| Burundi | 34.151 | 29.094 | 12.516 | 5.952 | 7.737 | 10.569 | 13.956 | 20.233 | 24.176 |
| Cambodia | 13.615 | 19.119 | 13.554 | 11.031 | 11.861 | 9.307 | 12.128 | 12.756 | 13.75 |
| Cape Verde | 29.814 | 24.13 | 23.53 | 22.295 | 24.345 | 23.574 | 17.199 | 13.765 | 14.798 |
| Central African R. | 20.185 | 15.312 | 16.236 | 9.218 | 11.657 | 11.37 | 8.003 | 6.887 | 5.594 |
| Djibouti | - | 20.372 | 18.998 | 16.596 | 15.425 | 13.674 | 12.545 | 9.784 | 12.752 |
| Honduras | 9.112 | 10.967 | 9.381 | 6.591 | 6.324 | 15.553 | 7.761 | 10.865 | 6.776 |
| Jordan | 6.224 | 8.265 | 7.648 | 6.57 | 5.291 | 5.414 | 6.546 | 4.892 | 5.797 |
| Kiribati | 21.929 | 21.11 | 17.575 | 17.618 | 19.233 | 23.438 | 21.793 | 17.507 | 26.088 |
| Maldives | 9.525 | 16.321 | 8 | 5.707 | 5.187 | 5.488 | 3.239 | 4.25 | 4.694 |
| Marshall Islands | 51.417 | 33.239 | 66.917 | 59.933 | 45.755 | 55.664 | 48.5 | 60.664 | 48.388 |
| Micronesia | 46.668 | 32.36 | 47.62 | 41.934 | 35.282 | 46.296 | 41.478 | 56.86 | 45.584 |
| Palestine | 12.614 | 12.189 | 13.179 | 13.14 | 11.993 | 10.199 | 11.685 | 19.204 | 48.311 |
| Rwanda | 95.509 | 54.048 | 34.087 | 12.512 | 17.654 | 19.437 | 17.93 | 17.758 | 20.741 |
| Samoa | 25.593 | 22.351 | 14.3 | 11.188 | 16.142 | 9.88 | 11.697 | 17.724 | 14.467 |
| Serbia & Montenegro | - | - | - | - | - | 6.9 | 13.19 | 11.318 | 12.507 |
| Suriname | 22.04 | 21.242 | 16.588 | 9.783 | 5.607 | 4.403 | 3.981 | 3.346 | 1.341 |
| Tajikistan | 2.363 | 2.908 | 10.496 | 7.947 | 12.705 | 11.873 | 13.351 | 16.552 | 14.221 |
| Tonga | 22.031 | 24.923 | 19.06 | 16.146 | 15.085 | 13.85 | 11.836 | 14.688 | 16.375 |
| Vanuatu | 21.853 | 22.483 | 14.059 | 11.86 | 17.903 | 16.249 | 20.913 | 14.553 | 11.858 |

# APPENDIX B

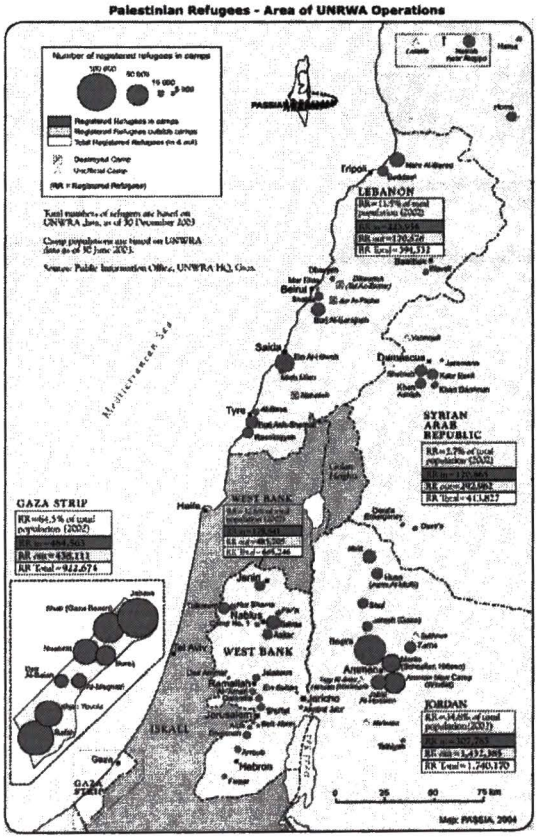
## Graphs

Graph 1.1 The West Bank and Gaza Strip.

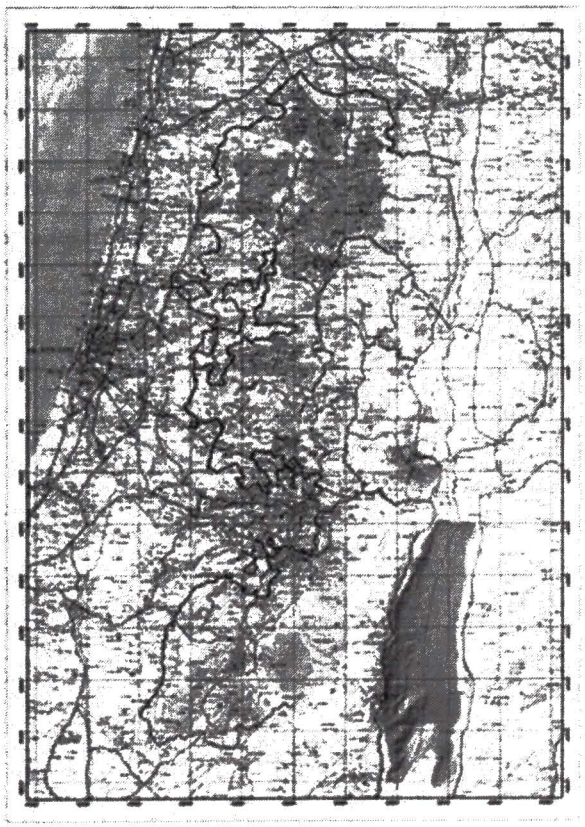



Source: The Palestinian Academic society for the Study of International Affairs (PASSIA), Jerusalem. www.passia.org

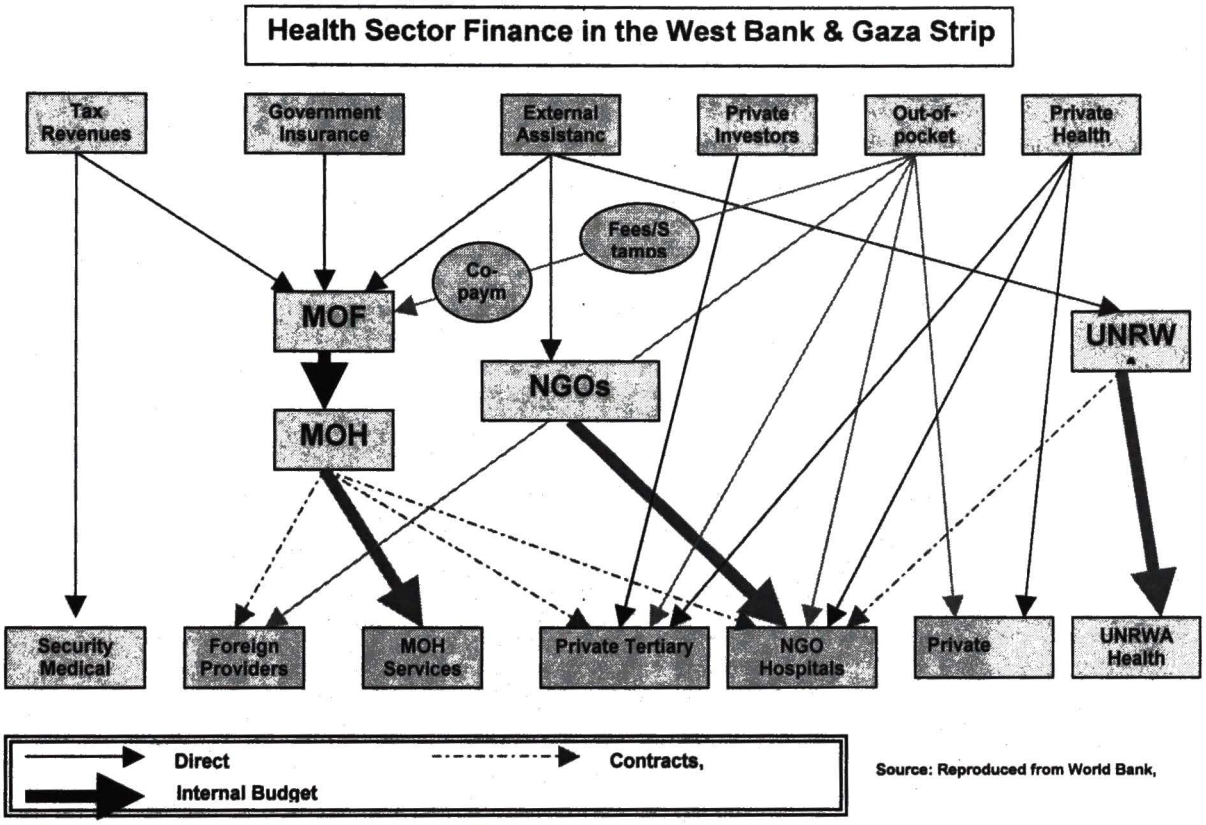
Graph 1.2: Palestinian Refugees: Area of UNRWA operations/PASSIA



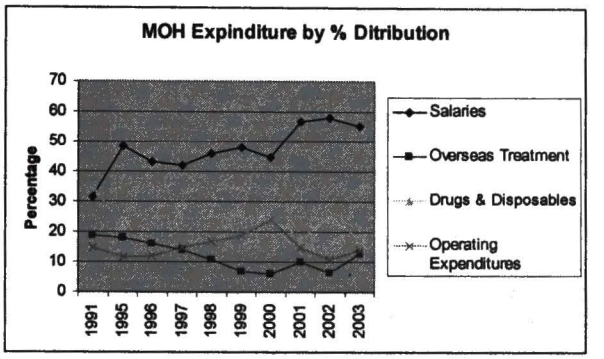

Graph1.3: Separation Wall/Security Fence/IDF



Graph 2.3: Source: World Bank official website

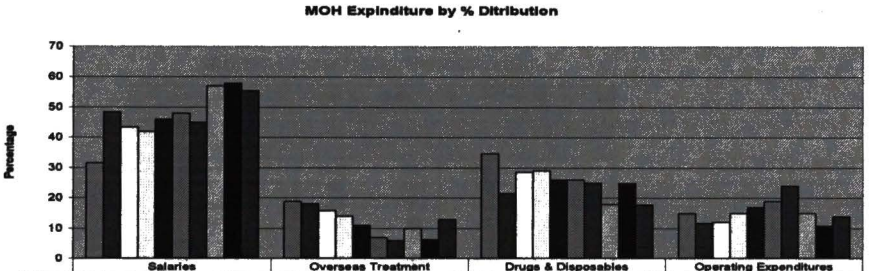


Graph 2.1




Source: Palestine MOH annual reports 1996-2003

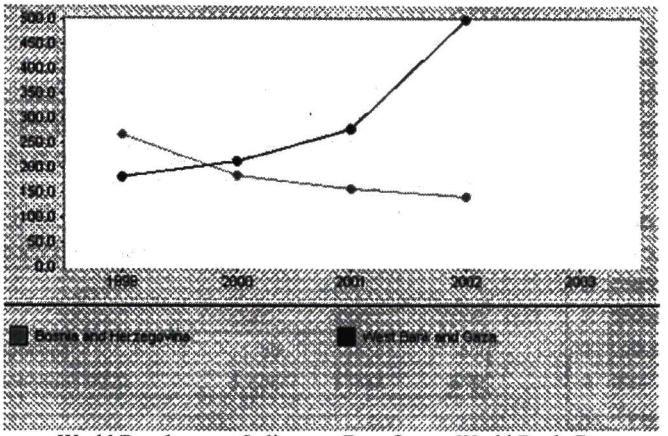
Graph 2.2




| | Salaries | Overseas Treatment | Drugs & Disposables | Operating Expenditures |
|---|---|---|---|---|
| 1991 | 31.5 | 18.9 | 34.7 | 14.9 |
| 1995 | 48.5 | 18.2 | 21.5 | 11.7 |
| 1996 | 43.4 | 15.9 | 28.6 | 12.1 |
| 1997 | 42 | 14 | 29 | 15 |
| 1998 | 46 | 11 | 26 | 17 |
| 1999 | 48 | 7 | 26 | 19 |
| 2000 | 45 | 6 | 25 | 24 |
| 2001 | 57 | 10 | 18 | 15 |
| 2002 | 57.9 | 8.4 | 24.9 | 10.8 |
| 2003 | 56.4 | 12.9 | 17.9 | 13.9 |

Source: Palestine MOH annual reports 1996-2003

Graph 3.1



Source: World Development Indicators, Data Query, World Bank Group.
http://devdata.worldbank.org/data-query/

Graph 3.2

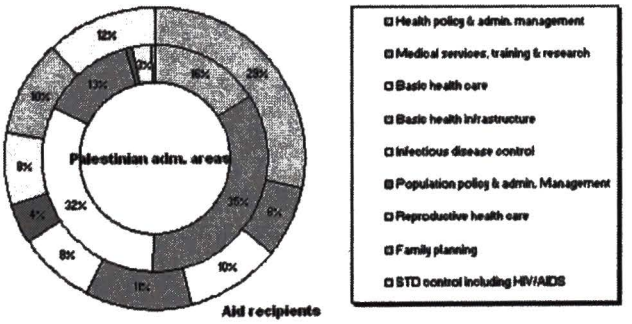
**HEALTH FOCUS FOR PALESTINIAN ADMIN. AREAS**

Top Ten Donors of ODA Commitments (1998-2000 average)

| | Health | | All Sectors | |
|---|---|---|---|---|
| | US $m (a) | % All Donors (b) | US $m (c) | % of Donor Total (d) |
| **All Donors - Total** | 28.6 | 100% | 352.3 | 8% |
| 1 Japan | 6.2 | 23% | 68.4 | 15% |
| 2 United Kingdom | 4.2 | 15% | 18.0 | 24% |
| 3 United States | 4.2 | 15% | 85.5 | 5% |
| 4 Norway | 2.2 | 8% | 31.5 | 7% |
| 5 Sweden | 2.1 | 6% | 26.3 | 8% |
| 6 Spain | 1.9 | 7% | 21.3 | 9% |
| 7 Italy | 1.9 | 7% | 21.3 | 9% |
| 8 Belgium | 1.1 | 4% | 5.6 | 20% |
| 9 Germany | 0.8 | 3% | 22.2 | 4% |
| 10 Netherlands | 0.7 | 3% | 24.8 | 3% |

*Source* : OECD, CRS Statistics.
Note : column (d) shows the share of health in total aid of donor : equals column (a) divided by column (c)

Sub-sectoral breakdown of aid to health (1998-2000)
(Inner: Palestinian adm. areas ; outer: Aid recipients)




*Source* : OECD, CRS Statistics.

Source: Organization for Economic Cooperation and Development (OECD) official website.

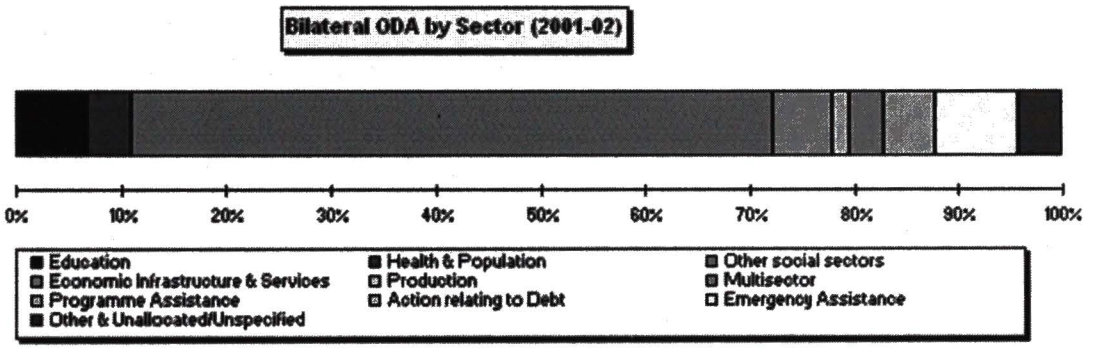
Graph 3.3

## Palestinian Adm. Areas

| Receipts | 2000 | 2001 | 2002 |
|---|---|---|---|
| Net ODA (USD million) | 637 | 870 | 1 616 |
| Bilateral share (gross ODA) | 65% | 61% | 73% |
| Net ODA / GNI | 11.7% | 19.2% | 48.3% |
| | | | |
| Net Private flows (USD million) | - 175 | - 57 | - 8 |

| *For reference* | 2000 | 2001 | 2002 |
|---|---|---|---|
| Population (million) | 3.0 | 3.1 | 3.2 |
| GNI per capita (Atlas USD) | 1 920 | 1 330 | 930 |

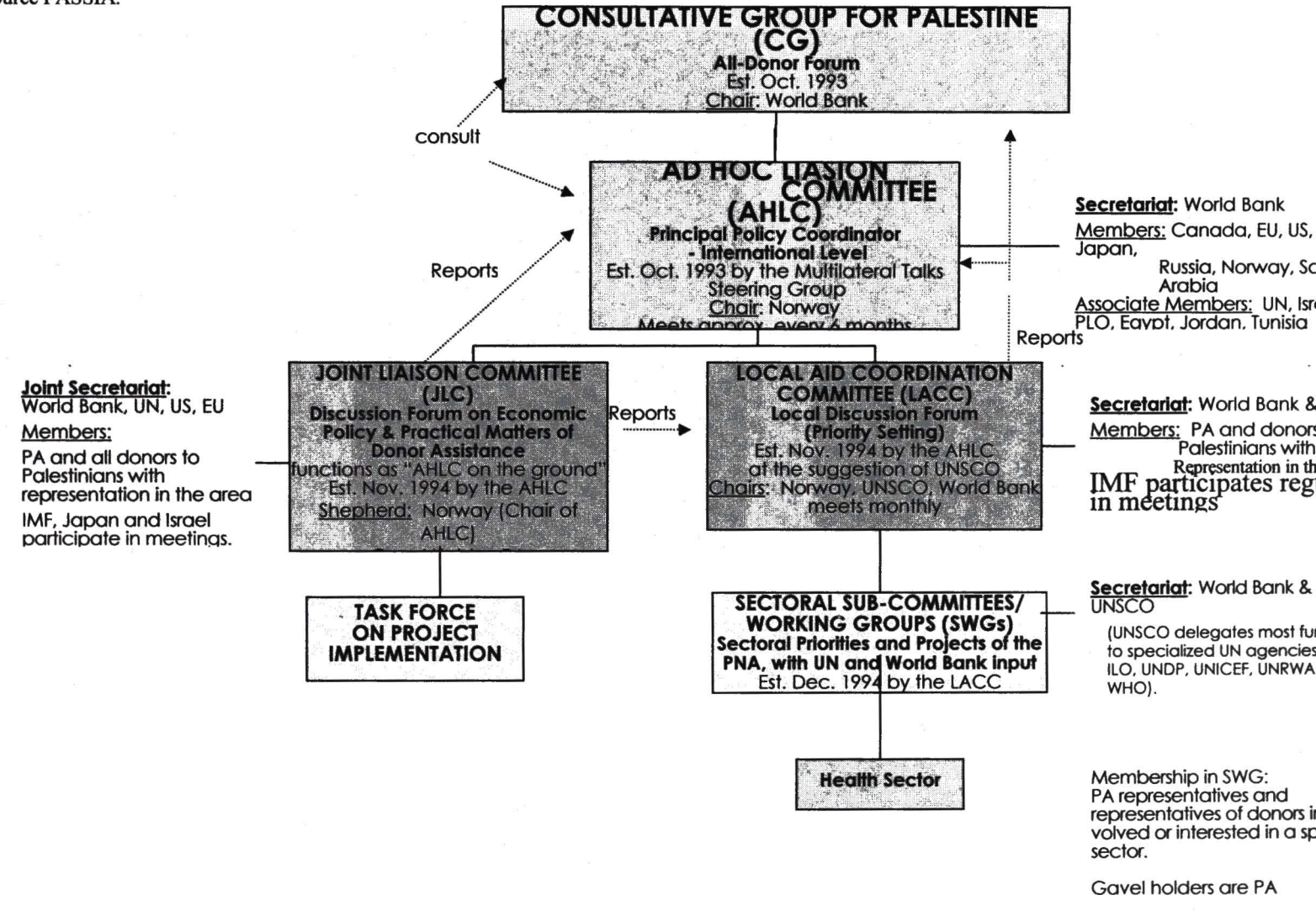
| Top Ten Donors of gross ODA (2001-02 average) | | (USD m) |
|---|---|---|
| 1 | Arab Countries | 511 |
| 2 | UNRWA | 224 |
| 3 | EC | 145 |
| 4 | United States | 111 |
| 5 | Norway | 44 |
| 6 | Germany | 28 |
| 7 | Sweden | 25 |
| 8 | United Kingdom | 20 |
| 9 | Italy | 19 |
| 10 | Japan | 17 |



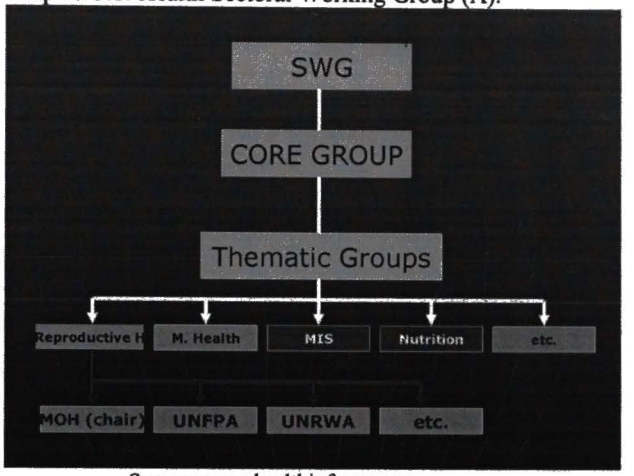

*Sources:* OECD, World Bank.

Source: Organization for Economic Cooperation and Development (OECD) official website.

Graph 3.4: Source PASSIA.

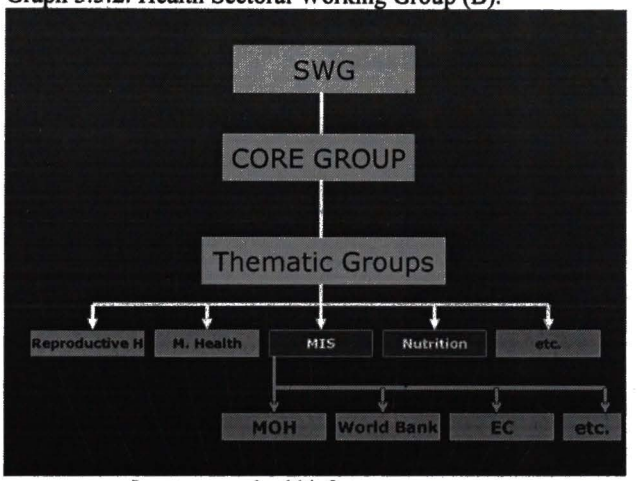


Graph 3.5.1: Health Sectoral Working Group (A).



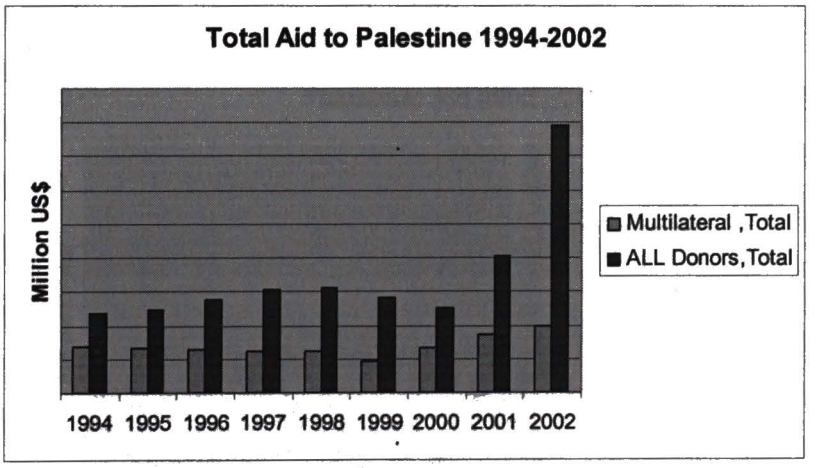

Source: www.healthinforum.org

Graph 3.5.2: Health Sectoral Working Group (B).



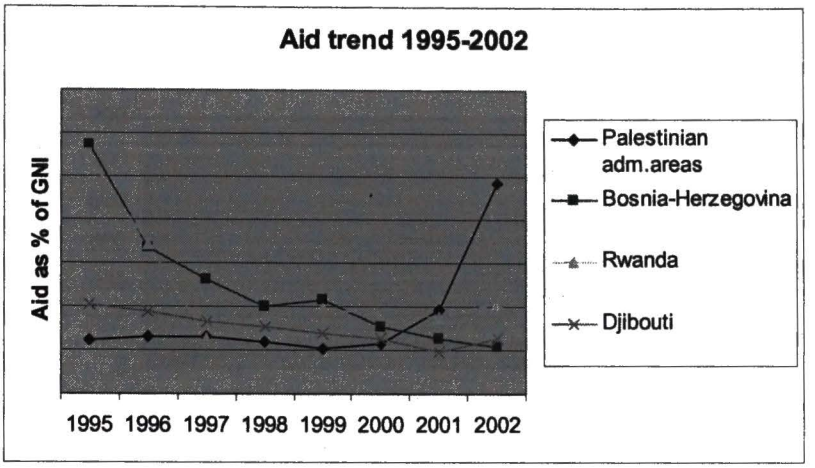

Source: www.healthinforum.org

Graph 4.1



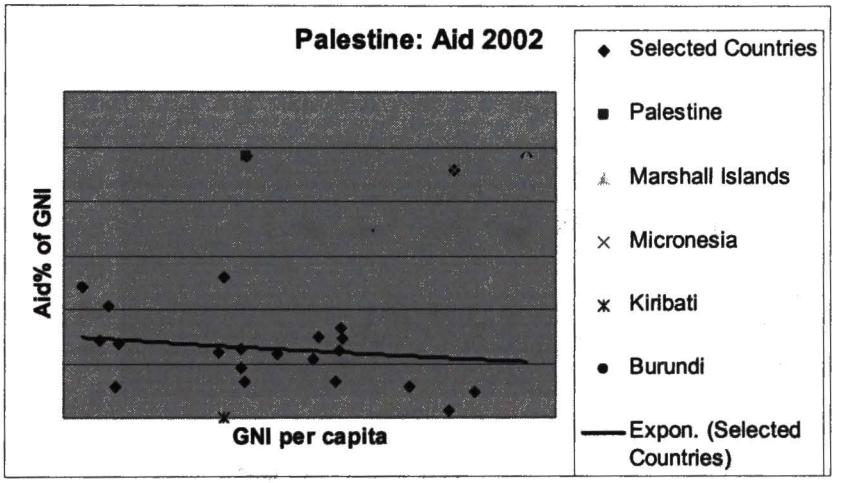

Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

Graph 4.2



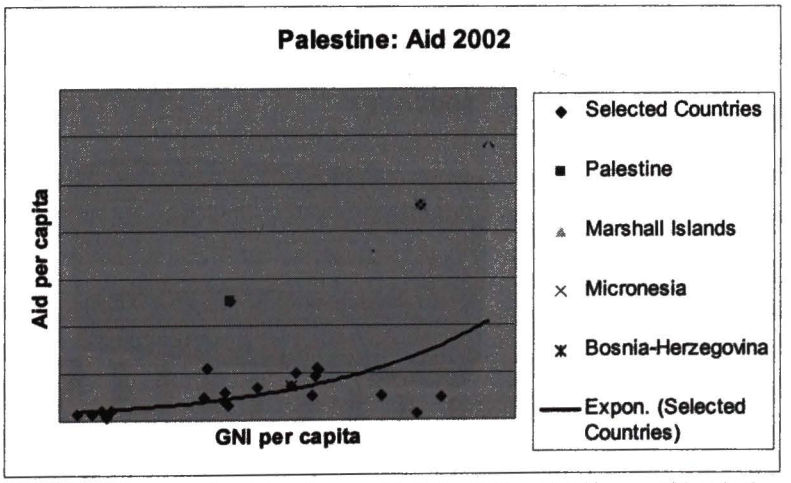

Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

Graph 4.3



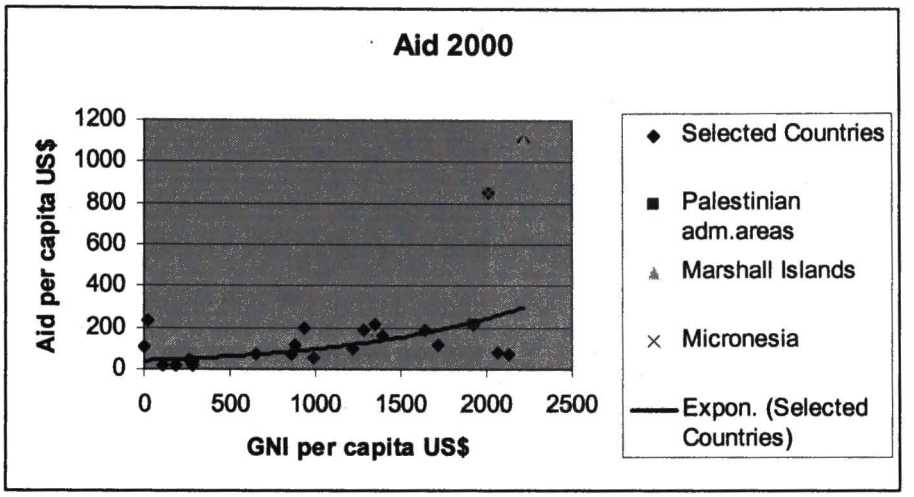

Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

Graph 4.4




Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

Graph 4.5




Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

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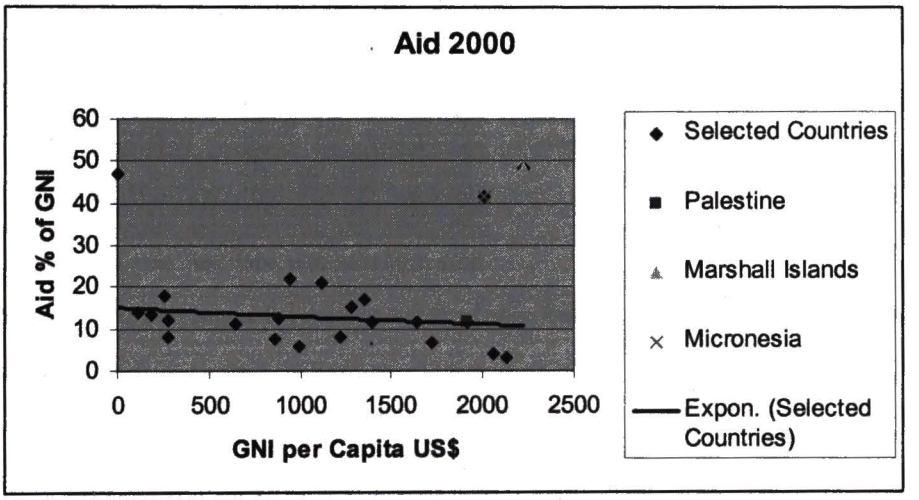


Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

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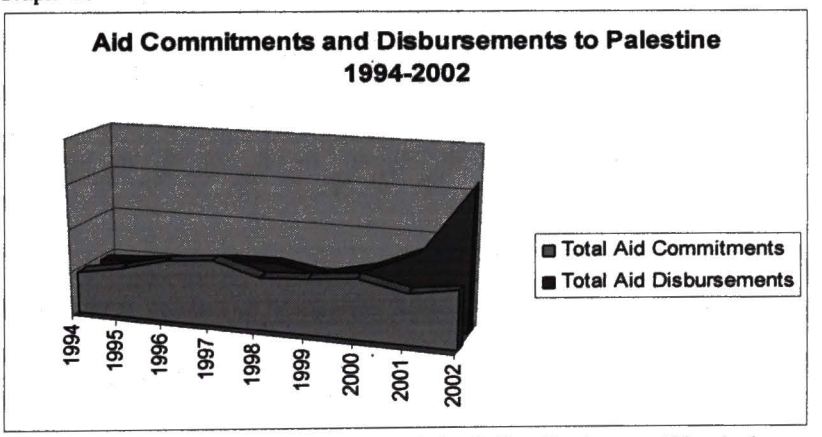


Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

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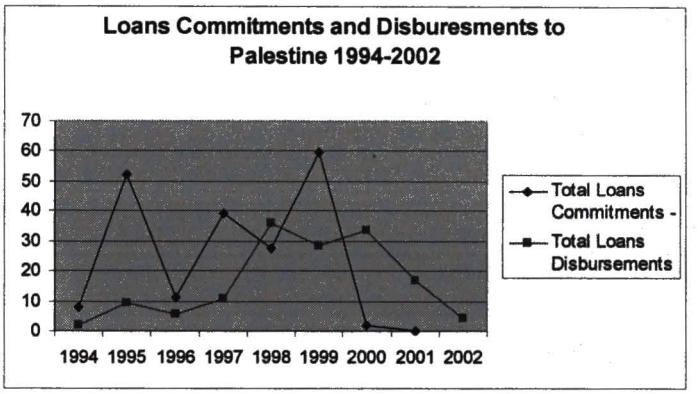


Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

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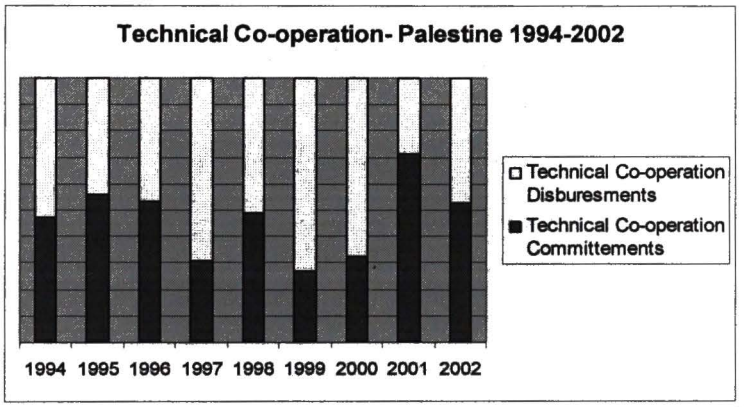


Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

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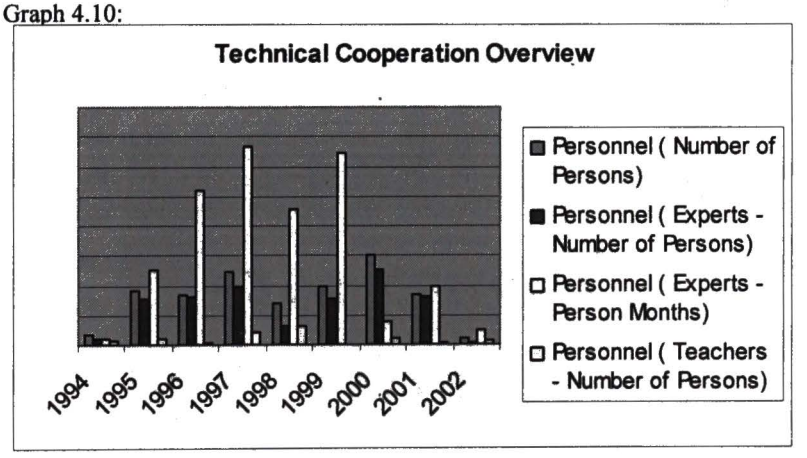


Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

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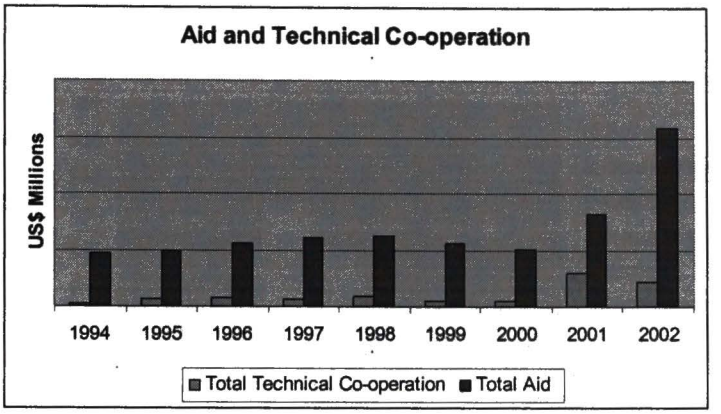


Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

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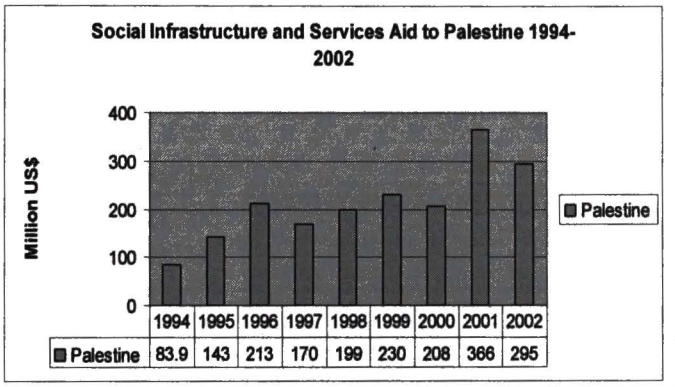


Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

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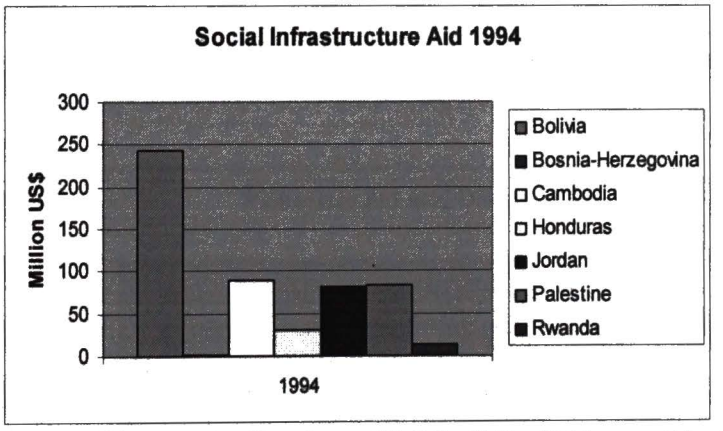


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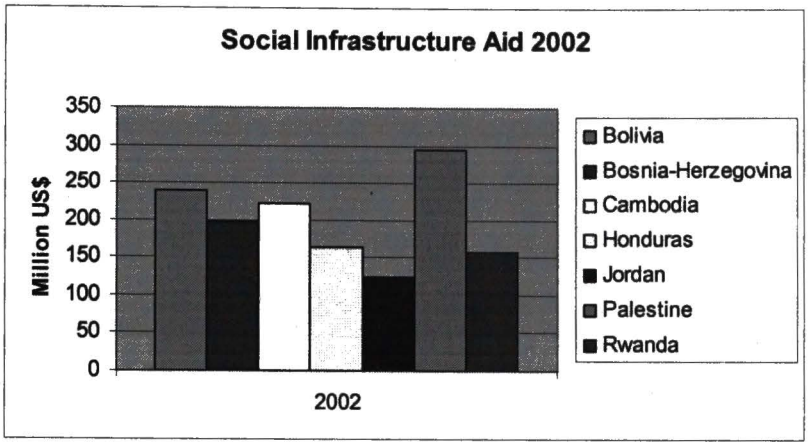


Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

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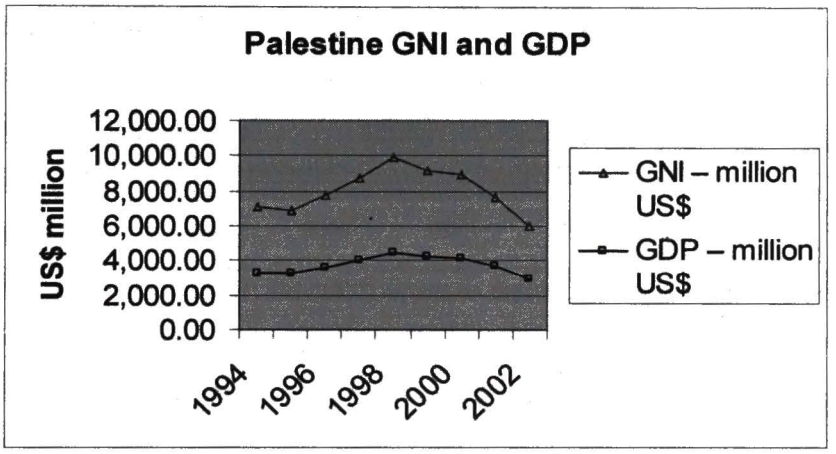


Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

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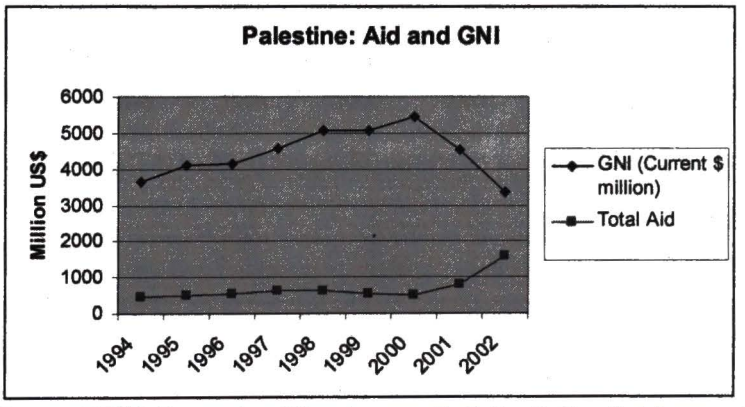


Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

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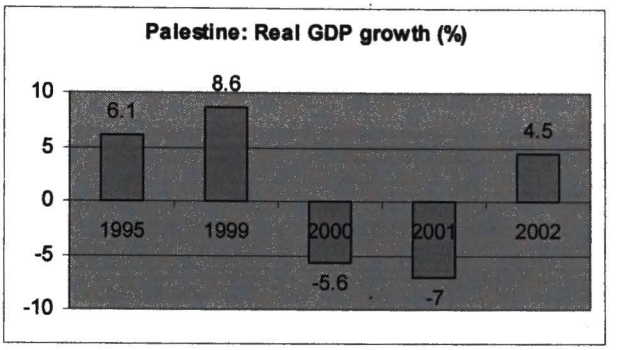
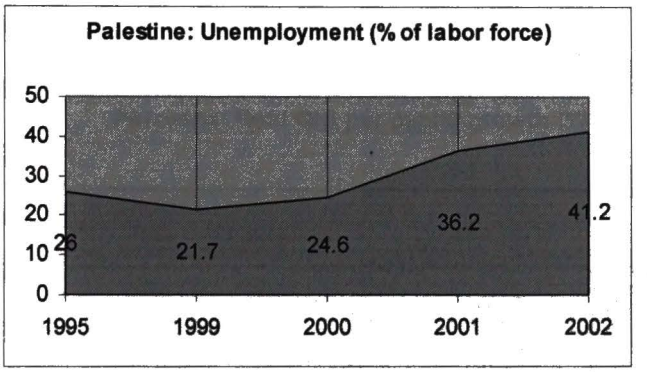



Source: UNCTAD, (2004) and (2003) reports on assistance to the Palestinian people.

Graph 4.18




Source: UNCTAD, (2004) and (2003) reports on assistance to the Palestinian people.

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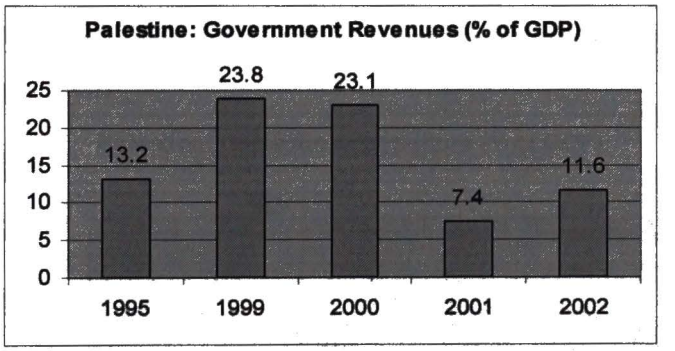
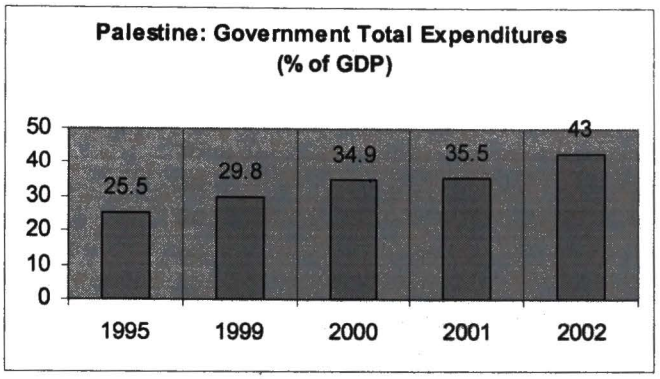



Source: UNCTAD, (2004) and (2003) reports on assistance to the Palestinian people.

Graph 4.20




Source: UNCTAD, (2004) and (2003) reports on assistance to the Palestinian people.

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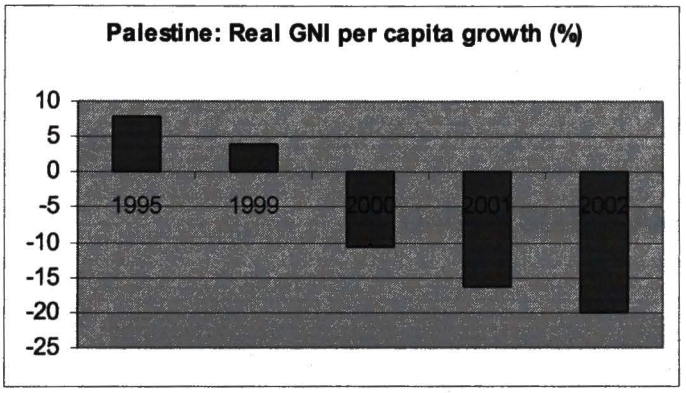
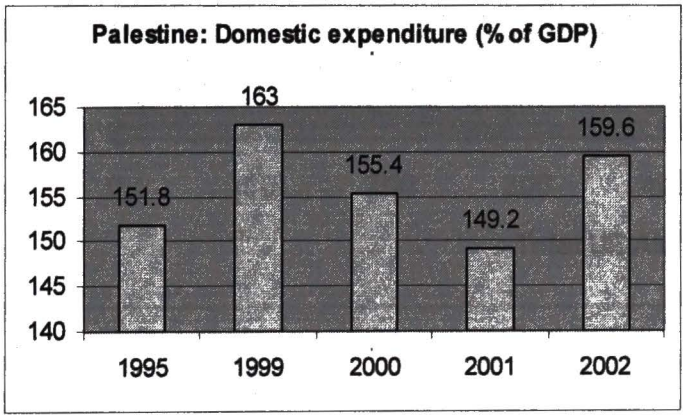


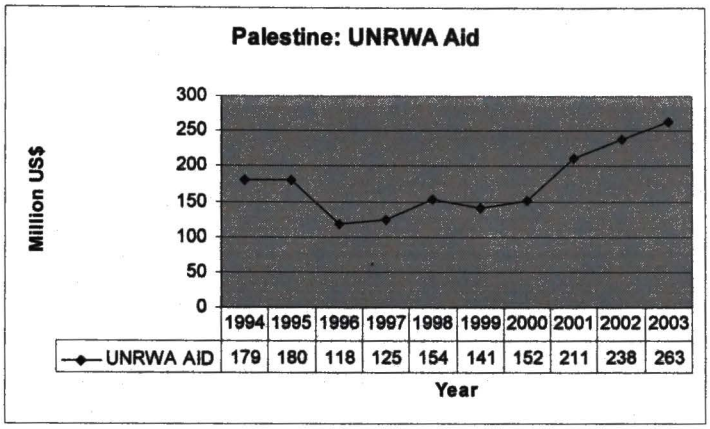

Source: UNCTAD, (2004) and (2003) reports on assistance to the Palestinian people.

Graph 4.22




Source: UNCTAD, (2004) and (2003) reports on assistance to the Palestinian people.

Graph 4.23




Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

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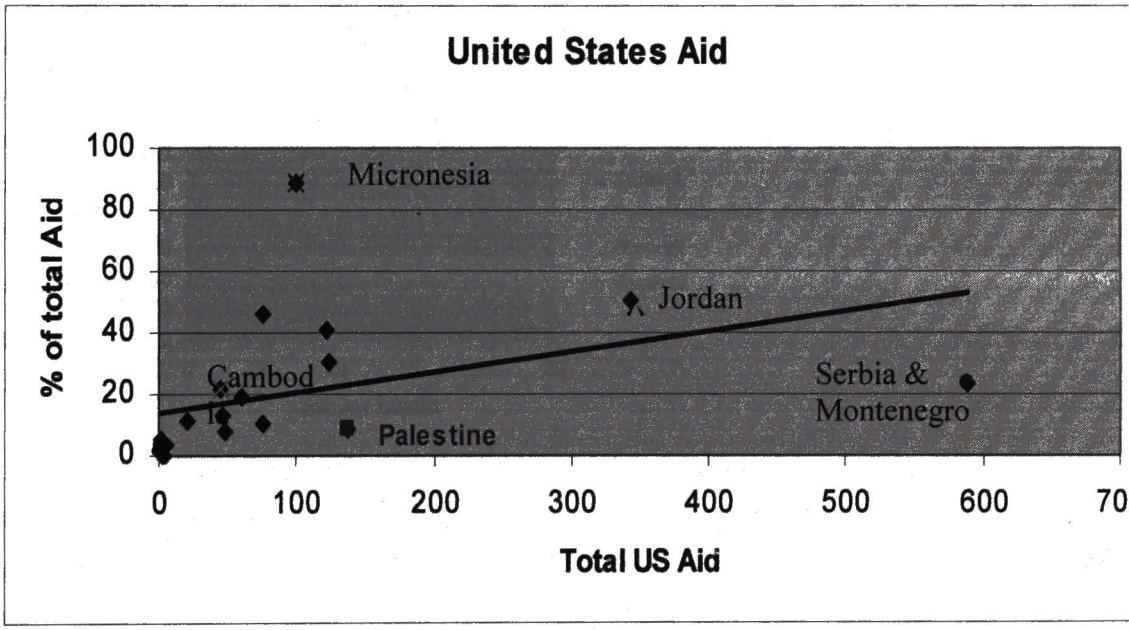


Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

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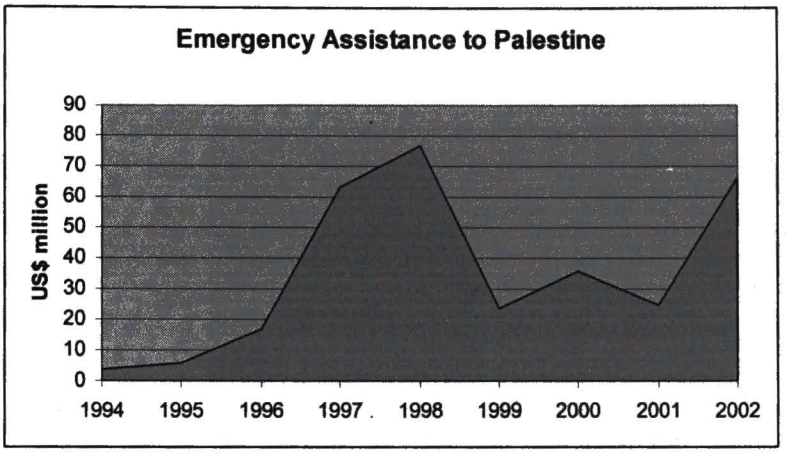


Source: OECD, International Development Statistics Online, Database on Aid and other resource flows.

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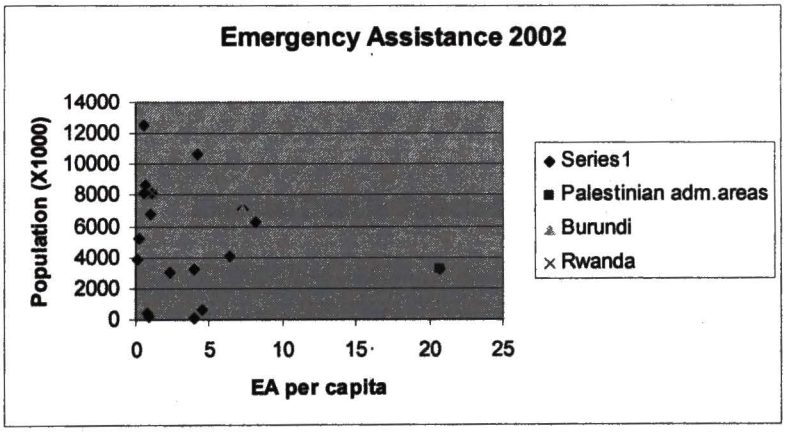
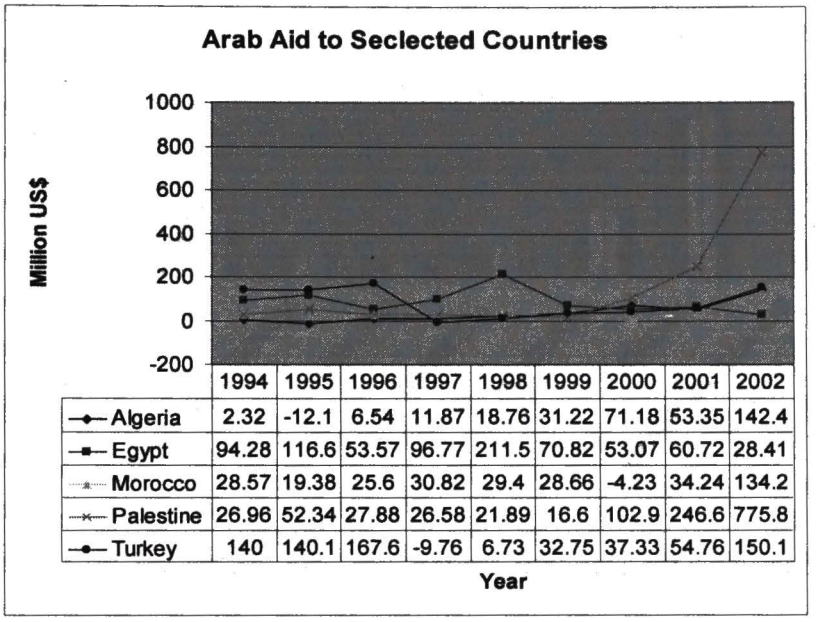



Source: OECD, International Development Statistics Online, Database on Aid and other resource flows

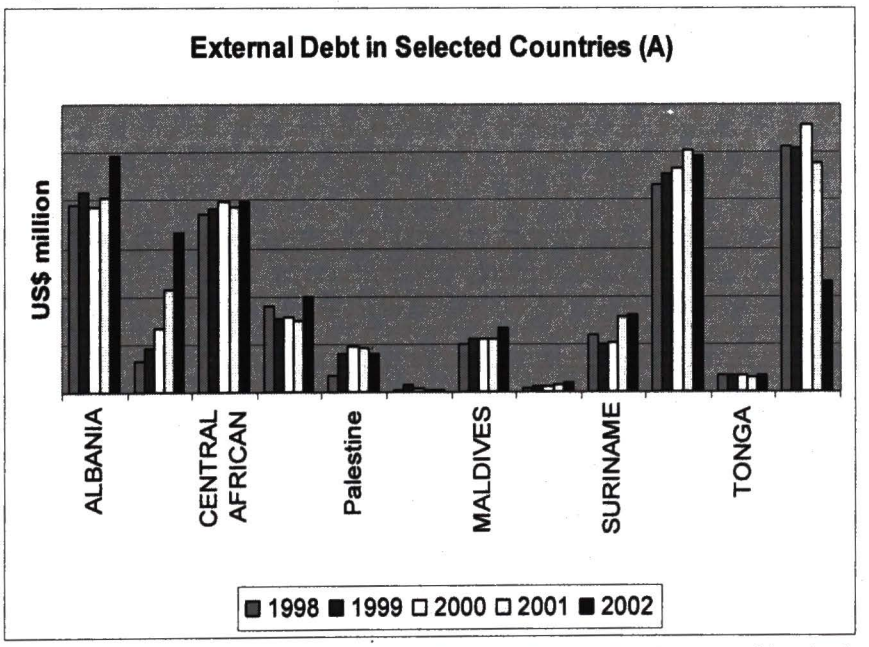
Graph 4.27




| | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 |
|---|---|---|---|---|---|---|---|---|---|
| Algeria | 2.32 | -12.1 | 6.54 | 11.87 | 18.76 | 31.22 | 71.18 | 53.35 | 142.4 |
| Egypt | 94.28 | 116.6 | 53.57 | 96.77 | 211.5 | 70.82 | 53.07 | 60.72 | 28.41 |
| Morocco | 28.57 | 19.38 | 25.6 | 30.82 | 29.4 | 28.66 | -4.23 | 34.24 | 134.2 |
| Palestine | 26.96 | 52.34 | 27.88 | 26.58 | 21.89 | 16.6 | 102.9 | 246.6 | 775.8 |
| Turkey | 140 | 140.1 | 167.6 | -9.76 | 6.73 | 32.75 | 37.33 | 54.76 | 150.1 |

Source: OECD, International Development Statistics Online, Database on Aid and other resource flows

Graph 4.28




Source: OECD, International Development Statistics Online, Database on Aid and other resource flows

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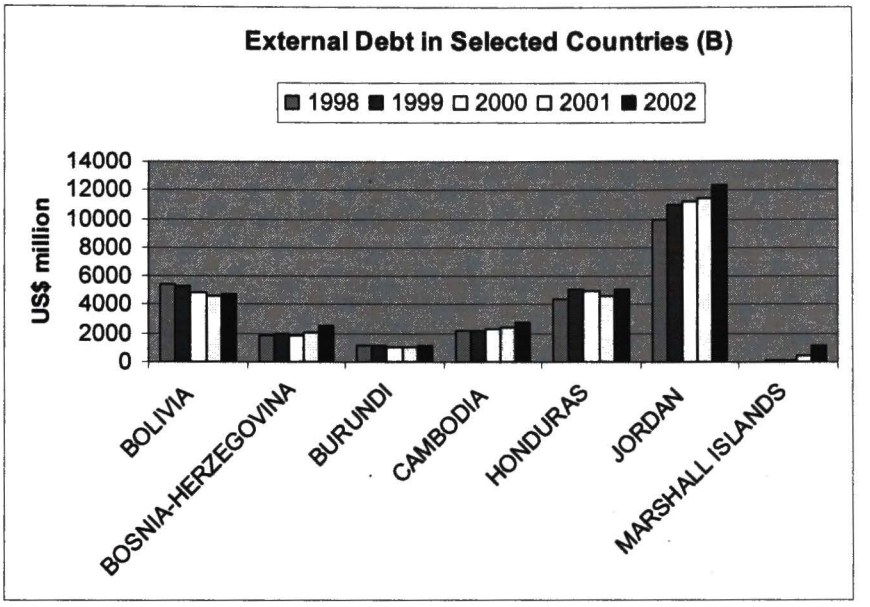


Source: OECD, International Development Statistics Online, Database on Aid and other resource flows

# APPENDIX C

## Documents

# Acquisition & Assistance Policy Directive
*(AAPD)*

**From the Director, Office of Procurement** Issued: March 24, 2004

# AAPD 04-07

## Revised Certification Regarding Terrorist Financing Implementing E.O. 13224

**Subject Category:** **Assistance**
**Type:** **Policy/Procedure**

---

AAPDs provide information of significance to all agency personnel and partners involved in the Acquisition and Assistance process. Information includes (but is not limited to): advance notification of changes in acquisition or assistance regulations; reminders; procedures; and general information. Also, AAPDs may be used to implement new requirements on short-notice, pending formal amendment of acquisition or assistance regulations.

AAPDs are **EFFECTIVE AS OF THE ISSUED DATE** unless otherwise noted in the guidance below; the directives remain in effect until this office issues a notice of cancellation.

---

**This AAPD:** ____Is New __X_Replaces/___Amends AAPD No: __02-19___

**Precedes change to:**
___ _AIDAR Part(s) _____ Appendix ___
__USAID Automated Directives System (ADS) Chapters _____
___Code of Federal Regulations _____
___ Other_____
___ No change to regulations

**Applicable to:**
___Existing awards; Modification required:
___Effective immediately
___No later than _____
___As noted in guidance below
__X__ RFAs issued on or after the effective date of this AAPD; all other Pending Awards, i.e., 8(a), sole source...
____ Other or N/A _____

**New Provision/Clause Provided Herein:**
__X__ Yes; Scheduled update to Prodoc: ____June 2004_____
____ No

*(Signature on file)*
TIMOTHY T. BEANS

## 1. PURPOSE:

The purpose of this AAPD is to reissue the Certification Regarding Terrorist Financing, originally issued in AAPD 02-19, in more clear and current language, and to provide information to assist Agreement Officers in guiding applicants to complete the certification.

## 2. BACKGROUND:

AAPD 02-19, issued December 31, 2002, required USAID Agreement Officers to obtain a certification from both U.S. and non-U.S. non-governmental organizations, before the organization could receive an award of a grant or cooperative agreement, to the effect that the organization does not support terrorism.

Some organizations found the language of the certification unclear, and were concerned that the AAPD did not provide guidance on the recipient's liability for the actions of subrecipients or beneficiaries. In response to these concerns, USAID provides the following guidance.

## 3. GUIDANCE:

Before making the award of a grant or cooperative agreement to a U.S. or non-U.S. non-governmental organization, the Agreement Officer must obtain the attached certification from the organization.

The purpose of the Certification is to provide USAID with assurances that it is not entering into an assistance agreement with an organization that provides or has provided assistance to terrorists or for terrorist activity. USAID employees could be liable under 18 U.S.C. § 2339A ("Providing material support to terrorists"), § 2339B ("Providing material support to designated foreign terrorist organizations), and § 2339C ("Prohibitions against the financing of terrorism") if they knowingly provide assistance to an organization that, in turn, provides or has provided material support or resources for terrorist acts, or to foreign terrorist organizations, or in violation of United Nations conventions and protocols. The Certification is consistent with states' obligations under United Nations Security Council (UNSC) Resolution 1373 (2001).

The Certification requires the applicant to state that it has not provided, and will take all reasonable steps to ensure that it does not and will not knowingly provide, material support or resources to any individual or entity that engages in terrorist activity. This would include, without limitation, any organization designated by the United States Government as a Foreign Terrorist Organization under § 219 of the Immigration and Nationality Act, as amended (8 U.S.C. § 1189), any individual or entity designated by the United States Government as a Specially Designated Terrorist or Specially Designated Global Terrorist, and any individual or entity designated by the United States Government in or pursuant to United States Executive Orders 12947 ("Prohibiting Transactions With Terrorists Who Threaten To Disrupt the Middle East

Peace Process") and 13224 ("Blocking Property and Prohibiting Transactions With Persons Who Commit, Threaten To Commit, or Support Terrorism").

To comply with its obligations under the Certification, the applicant must verify that it has not provided, and does not and will not knowingly provide, material support or resources to any individual or entity that appears (i) on the master list of Specially Designated Nationals and Blocked Persons maintained by the U.S. Treasury's Office of Foreign Assets Control (OFAC) or (ii) on any supplementary list of prohibited individuals or entities that may be provided by USAID to the applicant. The master list can be found at the OFAC website identified in the Certification. For purposes of the master list, "SDT" indicates Specially Designated Terrorist, "SDGT" indicates Specially Designated Global Terrorist, and "FTO" indicates a Foreign Terrorist Organization.

The applicant also must verify that it has not provided, and does not knowingly provide, material support or resources to any individual or entity designated by the UNSC sanctions committee established under UNSC Resolution 1267 (1999) (the "1267 Committee") [individuals and entities linked to the Taliban, Usama bin Laden, or the Al Qaida Organization]. To determine whether there has been a published designation of an individual or entity by the 1267 Committee, the applicant organization may refer to the consolidated list available online at the Committee's website identified in the Certification.

An applicant may be in compliance with its obligations under the Certification if it had provided material support or resources to an individual or entity that, at the time such support or resources was provided, had not been designated by the United States Government as a Foreign Terrorist Organization, or as a Specially Designated Terrorist or a Specially Designated Global Terrorist, or had not been designated by the United States Government in or pursuant to Executive Orders 12947 or 13224, or had not been designated by the 1267 Committee, and that individual or entity subsequently is so designated.

In addition to reviewing the OFAC master list and the 1267 Committee's list referred to in the preceding paragraphs, the applicant also must take into account its own knowledge and information that is public in making the Certification. This means that the applicant is expected to consider information of a person's terrorist ties that is either publicly available (such as, for example, terrorist ties identified in news media or in an official, published designation) or that, from the totality of the facts and circumstances surrounding the person's interactions with the recipient organization or related to the person's reputation in the community, the applicant should be aware of a person's terrorist ties.

The Certification also requires the recipient organization to implement reasonable monitoring and oversight procedures to safeguard against USAID assistance from being used, either directly or indirectly, to provide material support or resources to individuals or entities that engage in terrorist activity.

If the recipient organization learns that any individual or organization that it provides material resources or support to, or with which it engages in transactions or dealings in property or interests in property, has been designated by the United States Government as a Foreign Terrorist Organization, or as a Specially Designated Terrorist or a Specially Designated Global Terrorist, or has been designated by the United States Government in or pursuant to Executive Orders 12947 or 13224, or has been designated by the 1267 Committee, or otherwise engages in terrorist acts, the recipient organization must immediately notify USAID and must immediately cease such support or transactions or dealings.

The definition in the Certification for the term "material support and resources" is the same as the definition for that term used in 18 U.S.C. § 2339A(b). For purposes of the definition of the term "terrorist act" contained in clause (i) of section 3.b. of the Certification, the United Nations Conventions and Protocols referred to can be found at http://untreaty.un.org/English/Terrorism.asp. The definition contained in clause (ii) of section 3.b. of the Certification is taken from 22 U.S.C. § 2656f(d)(2), i.e., the second definition used in Foreign Terrorist Organization designations. The definition contained in clause (iii) of section 3.b. of the Certification is taken from the Convention on the Suppression of the Financing of Terrorism, art. 2(b), and can be found on the UN terrorism conventions website referred to above.

If USAID determines that a recipient organization has violated any term or condition of the Certification, USAID may immediately and unilaterally terminate the assistance agreement with the recipient organization.

**4. POINT OF CONTACT:**

Please direct any questions to Raquel Powell, M/OP/P, Phone: (202) 712-0778, e-mail: rpowell@usaid.gov or Gary Winter, GC, Phone: (202)712-1548, e-mail: gwinter@usaid.gov.

Certification

By signing and submitting this application, the prospective recipient provides the certification set out below:

1. The Recipient has not provided, and will take all reasonable steps to ensure that it does not and will not knowingly provide, material support or resources to any individual or entity that commits, attempts to commit, advocates, facilitates, or participates in terrorist acts, or has committed, attempted to commit, facilitated, or participated in terrorist acts.

2. Specifically, in order to comply with its obligations under paragraph 1, the Recipient will take the following steps:

a. Before providing any material support or resources to an individual or entity, the Recipient will verify that the individual or entity does not appear (i) on the master list of Specially Designated Nationals and Blocked Persons, which list is maintained by the U.S. Treasury's Office of Foreign Assets Control (OFAC) and is available online at OFAC's website : http://www.treas.gov/offices/eotffc/ofac/sdn/t11sdn.pdf, or (ii) on any supplementary list of prohibited individuals or entities that may be provided by USAID to the Recipient.

The Recipient also will verify that the individual or entity has not been designated by the United Nations Security (UNSC) sanctions committee established under UNSC Resolution 1267 (1999) (the "1267 Committee") [individuals and entities linked to the Taliban, Usama bin Laden, or the Al Qaida Organization]. To determine whether there has been a published designation of an individual or entity by the 1267 Committee, the Recipient should refer to the consolidated list available online at the Committee's website: http://www.un.org/Docs/sc/committees/1267/1267ListEng.htm.

b. Before providing any material support or resources to an individual or entity, the Recipient will consider all information about that individual or entity of which it is aware or that is available to the public.

c. The Recipient will implement reasonable monitoring and oversight procedures to safeguard against assistance being diverted to support terrorist activity.

3. For purposes of this Certification-

a. "Material support and resources" means currency or monetary instruments or financial securities, financial services, lodging, training, expert advice or assistance, safehouses, false documentation or identification, communications equipment, facilities, weapons, lethal substances, explosives,

personnel, transportation, and other physical assets, except medicine or religious materials.

b. "Terrorist act" means-

(i) an act prohibited pursuant to one of the 12 United Nations Conventions and Protocols related to terrorism (see UN terrorism conventions Internet site: http://untreaty.un.org/English/Terrorism.asp); or

(ii) an act of premeditated, politically motivated violence perpetrated against noncombatant targets by subnational groups or clandestine agents; or

(iii) any other act intended to cause death or serious bodily injury to a civilian, or to any other person not taking an active part in hostilities in a situation of armed conflict, when the purpose of such act, by its nature or context, is to intimidate a population, or to compel a government or an international organization to do or to abstain from doing any act.

c. "Entity" means a partnership, association, corporation, or other organization, group or subgroup.

This Certification is an express term and condition of any agreement issued as a result of this application, and any violation of it shall be grounds for unilateral termination of the agreement by USAID prior to the end of its term.

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