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**The American University in Cairo
School of Global Affairs and Public Policy**

**FOREIGN AID and THE HEALTH SECTOR: A Case Study from
PALESTINIAN NATIONAL AUTHORITY**

**A Thesis Submitted to the
Public Policy and Administration Department
In partial fulfillment of the requirements for the degree of
Master of Public Administration**

**By
Wafa Ahmed MATARIA**

Fall 2017

Table of Contents

Table of Figures	4
Abbreviations	5
Abstract	7
Acknowledgments	8
Chapter 1: Introduction	9
1.1 Introduction	9
1.2 Research significance and motivation	11
1.3 Background and context	11
1.3.1 Context, demography and health indicators	11
1.3.2 Health system in Palestine	14
1.3.3 Foreign Aid to Palestine	16
1.4 Background summary	17
1.5 Thesis structure	17
Chapter 2: Literature review	19
2.1 Origin and underlying intentions in the existence of FA	19
2.2 Theories underlying FA:	21
2.3 Development and the reconsideration of the FA model:	22
2.4 FA and development (pros and cons)	23
2.5 Factors affecting the impact of FA on development	25

2.6 FA in the health sector	28
2.7 Summary of the literature review	29
2.8 Research question.....	30
2.8.1 Main Research question:	30
2.8.2 Research sub-questions:	30
Chapter 3: Conceptual (analytical) framework.....	31
Chapter 4: Methodology	34
4.1 Approach	34
4.2 Research design.....	34
4.3 Data collection Methods:	36
4.4 Sampling:	36
4.5 Data Analysis:	38
4.6 Validity and Reliability:	38
4.7 Generalizability and Limitations:.....	38
4.8 Ethics:.....	39
4.9 Research journey	39
Chapter 5: Analysis and Discussion	41
5.1 Descriptive analysis.....	41
5.1.1 Trends and channels of fund to Palestine	41
5.1.2 Development vs. humanitarian aid	42

5.1.3 ODA per capita and Ratio of ODA to GNI Overtime	43
5.1.4 FA to the health sector	45
5.3 Qualitative analysis	47
5.3.1 The progress in FA process	47
5.3.2 The competition on the FA	49
5.3.3 The under communication between different actors	51
5.3.4 The coordination structures	53
5.3.5 The donors' preference of funding routes	56
5.3.6 The influence of political situation on FA to HS	58
5.3.7 Humanitarian aid vs. development aid	59
5.3.8 The decrease in the amount of FA to the HS and aid volatility	60
5.3.9 The disparity in the quantitative data	61
5.3.10 Transparency and accountability	62
5.3.11 Despite of the challenges the health status is good, is it the FA?	63
Chapter 6: Conclusion and policy recommendations	64
6.1 Conclusion	64
6.2 Policy recommendations:	65
References	67
Annexes	75
Annex (1) Aid management structure in Palestine	75

Annex (2) Consent Form.....	76
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Table of Figures

Figure 1:Conceptual (analytical) framework	31
Figure 2: Net ODA to Palestine	41
Figure 3: Top ten donors to Palestine in 2015	42
Figure 4: ODA/capita.....	44
Figure 5: Percent ODA of GNI.....	44
Figure 6: Bilateral ODA by sector 2014- 2015.....	45
Figure 7: ODA to the health sector in Palestine	46
Figure 8:ODA distribution in health sector, Palestine 2015	46

Abbreviations

AHLC	Ad Hoc Liaison Committee
FA	Foreign Aid
ICD	International Coordination Unit
HSWG	Health Sector Working Group
IMF	International Monetary Fund
LACS	Local Aid Coordination Secretariat
MoFP	Ministry of Finance and Planning
MoH	Ministry of Health
MoIA	Ministry of Interior Affairs
NGOs	Non-governmental organizations
PNA	Palestinian National Authority
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
OPT	Occupied Palestinian Territory
PEGASE	Programme D'Experimentation D'une Gestion Automatisee et Securisee / Experimental Program of Automated Management and Security
PCBS	Palestinian Central Bureau of Statistics
UN	United Nations

UNRWA United Nations Relief and Works Agency

WB World Bank

WHO World Health Organization

Abstract

Foreign Aid (FA) is considered a tool for promoting economic and human development. Considerable amounts of FA are directed to Health. The role of FA in development, as well as, in health, has been a subject of debate with inconclusive results on its impact. This study concentrates on FA in the Health Sector in Palestine, in the period following the establishment of the Palestinian National Authority in 1994. A qualitative research approach was used throughout the study to explore, describe and explain the roles, procedures and challenges of FA in the health sector. The research concluded that FA has a positive impact on the health sector outcomes in Palestine. FA contributed to the establishment of institutional structures and capacities within the health sector, as well as, in service provision. Nevertheless, the following challenges still need to be addressed in order to increase FA effectiveness: the Israeli occupation; the continuing influence of donors' agendas; the politicization of aid; the competition between different FA recipients; the low accountability of donors towards recipients; and the miscommunication and inadequate coordination between various actors.

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Chapter 1: Introduction

1.1 Introduction

Foreign Aid (FA) has become the safety boat for many developing countries. Apart from the developed world, all other countries are lagging behind on the route to development – economically and socially (Tarp, 2003). Economically, developing countries have low economic growth and high poverty rates. Socially, developing countries have relatively low life expectancy, and high illiteracy and mortality rates. Among others, these are few trailing areas and FA is intended to further improve these areas. FA was introduced in the 1960s to alleviate poverty and ameliorate the quality of life for people in developing countries through providing the necessary funds to build infrastructure and the capacities required for development (Tarp, 2003). FA is equally used to fund humanitarian needs in case of crisis, being man-made as in the case of wars and conflicts, or natural, as in the case of earthquakes and floods.

The role of FA on development in recipient countries has been the center of debate due to inconclusive results on its effectiveness. Although the results of FA on a small scale in specific programs and projects were mostly positive, the overall role of FA on development is controversial (Doucouliagos & Paldam, 2009). Despite this ambiguity, FA is still considered as one of the tools to reduce poverty. In the 2005 UNDP Annual Report, it was stated that “International aid is one of the most powerful weapons in the war against poverty. Today that weapon is underused and badly targeted. There is too little aid and too much of what is provided is weakly linked to human development” (UNDP, 2005). The latter part of the UNDP statement emphasizes two realities: the unceasing international interest in FA and the need to increase FA’s effectiveness in promoting development.

Since the 1970s, and more specifically following the Alma Atta Declaration of 1987, health gained considerable attention as a precursor and as an end for the development process. The emphasis on health in development continued throughout the years specifically in 2000 with the Millennium Development Goals (MDGs), and in 2015 with the Sustainable Development Goals (SDGs), both of which specified several targets for development in the HS. The global interest in health resulted in increasing amounts of FA directed to health initiatives. Between 2000 and 2015, FA for health increased from USD 2,208.98 million to USD 6,077.1 million¹. The increased flow of FA for health was accompanied with an international expectation for better health outcomes. This interest in FA for health makes the HS a valuable and important sector for studying the effectiveness of FA.

This study concentrates on HS in a specific country context, which is Palestine. Palestine is one of the countries that has benefited from FA for many years. As such, it and has, to a large extent, become dependent on FA economically and socially primarily due to its political instability (Sarsour, Naser & Atallah, 2011). FA for the HS in Palestine went through multiple stages in which the amount of FA, its allocation across various sectors, as well as its impact on development, varied greatly. This study considers the period that started with the establishment of the Palestinian National Authority (PNA) in 1994; as the first formal entity responsible for health in Palestine – the Ministry of Health (MoH).

Accordingly, the main research question of this study is: What are the roles of FA on the HS in Palestine since the establishment of the Palestinian National Authority?

¹ OECD data: http://stats.oecd.org/Index.aspx?DataSetCode=SOCX_AGG#

1.2 Research significance and motivation

The significance of this research emerges from the knowledge it adds to the field of FA and its role on social and health components of development in a context that is characterized by chronic and acute conflicts, Palestine.

This study has been motivated by two observations. First, there is considerable amount of funds received by the Palestinian HS; which are essential for its daily functioning and sustainability. Second, the presence of a wide discussion among the aid community on whether the Palestinian HS is making the most out of the FA it receives. These observations, along with the increasing international interest in FA for health, as a means for development, and the high level discussions in many world summits such as in Paris 2005, Accra in 2008 and Busan in 2011 were the motivations behind this research.

1.3 Background and context

1.3.1 Context, demography and health indicators

Palestine has been in a conflict for almost a century now. War and struggle over lands have deeply affected the country on multiple levels: politically, economically and socially. Beginning in the 1920s until today, Palestinian people were ruled by four different authority regimes; the British mandate, the Israeli occupation, the Palestinian National Authority (PNA) and now the separate authorities of Hamas and PNA in the Gaza Strip and the West Bank, respectively.

After World War I and until 1948, the Palestinians were under the British Mandate. The British Civil Administrative system was responsible for civil services, including health provision in Palestine. In 1948, and after the Arab-Israel War, and with the creation of the State of Israel, the

Palestinian identity was destroyed and about 750,000 Palestinians were expelled from their cities and villages becoming refugees. With the creation of Israel, Palestinian land became restricted to two separate areas: the Gaza Strip and the West Bank. The Gaza Strip came under the control of the Egyptian military government and the West Bank under the Jordanian government. In 1967, and as a result of a subsequent Arab-Israel War, the West Bank and the Gaza Strip were taken by Israel and another wave of refugees was expelled.

The PNA was formed in 1994 and was responsible for the Palestinian territories until 2006 when Hamas participated in the parliamentary elections and won. This victory was not welcomed by Israel, nor by the international community. This non-acceptance resulted in two isolated Palestinian regions within the Palestinian territory, the Gaza Strip and the West Bank.

As of now, the total area of the occupied Palestinian Territory is 6,020 km², divided into two separate parts, the West Bank and Gaza strip. These two parts are the result of the present political situation, i.e. the occupation and its isolation policy against the Palestinians in Gaza and the political disagreement between the ruling authorities in each area. This political situation is affecting the living conditions in both areas, resulting in two different area profiles for the Palestinian regions.

The estimated total Palestinian population at the end of 2016 was 4,884,336 with a population density of 811person/km². The population density, along with the other indicators, differ enormously between the two Palestinian territories. The following Table illustrates these differences:

Table 1: Demographic and Socioeconomic Indicators

Indicator	Palestine	West Bank	Gaza Strip
Estimated Population End 2016	4,884,336	2,972,069	1,912,267
Total Area (km ²)	6,020	5,655	365
Population Density (Capita/km ²) End 2016	811	526	5,239
Unemployment Rate for Population Aged 15 Years and Over, 2016	26.9	18.2	41.7
Gross Domestic Product (Million USD), 2015 (Constant Price)	7,719.3	5,906.1	1,813.2
Gross Domestic Product Per Capita (USD), 2015	1,744.5	2,267.2	996.3
Poverty rate 2011	25.8	17.8	38.8

*Source: PCBS (Palestine in Figures 2016)

These differences in the two territories have affected the overall health sector, specifically in terms of the access to both services and funding. As for accessibility, Palestinians in both the Gaza Strip and in the West Bank have difficulty accessing health services.

In the Gaza Strip, the population is denied by the Israeli government the ability to leave the area to receive treatment in either the West Bank or outside of the country, unless they receive special permission from Israel, which are difficult to obtain. This is illustrated more clearly through the total number of patients referred to treatment outside MoH facilities. In the Gaza Strip, the number of referred patients was 23,972 whereas in the West Bank, it was 63,648. Also, the difficult economic situation, and in particular, high unemployment, diminishes the accessibility of Palestinians, within the Gaza Strip, to available services. In the case of the West Bank, accessibility to health services is also limited. The West Bank is divided into areas A, B, and C. Area C and East Jerusalem constitute 70% of the area and are not under the control of the PNA. This means that the PNA cannot provide services to people living in those specific areas.

Despite this situation, the health indicators in Palestine compared with other countries in the region are relatively good. Life expectancy at birth is 73.5 years; Infant Mortality Rate per 1,000 is 10.9,

and the number of hospital beds per 1000 population in 2015 was 1.28 (Palestinian-Central-Bureau-of-Statistics, 2017) .

1.3.2 Health system in Palestine

1.3.2.1 Description

The Palestinian HS is comprised of four main actors which are responsible for service provision: The governmental sector, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), Non- governmental organizations (NGOs), and the private sector.

The governmental sector includes the MoH and the Palestinian Military Medical Services (PMMS). MoH services started with the establishment of PNA in 1994. MoH became the administrative and regulatory body for the Palestinian health system and shoulders the highest burden of health services in Palestine. It provides primary and secondary health care services as well as limited tertiary health care services in its facilities. The MoH also operates specific health programs, such as health education and community involvement, school health, and human resources development. PMMS delivers services to military and police personnel and their families (National Health Strategy, 2014-2016).

UNRWA was created in 1949 and it was a key provider of health and education services in Palestine. It served registered Palestinian refugees in the OPT and outside. UNRWA's main contribution is in the primary health care, however, it depends on resources from government, private and from NGO sources in order to provide secondary health care services. UNRWA either partially reimburses hospitals for treated cases, or negotiates contracts with government, NGOs and private hospitals. Over the years, UNRWA's contribution in health provision decreased to only 4% in 1992 due to constraints in funding and increasing population (Habasch, 1999).

NGOs were the first actors to provide health services in Palestine. They started as charitable organizations during the British Mandate. During the Israeli occupation, local NGOs increased in number and in service. (Sullivan, 1996). After the establishment of the Palestinian National Authority, NGOs continued to be a major health service provider however, they did so under the new MoH. Currently, NGOs are the second main providers of health services. They cover the shortages and gaps of the MoH, especially in poorly accessible areas. These areas are more easily accessed by NGOs as they have better outreach to Area C and East Jerusalem.

The Palestinian private health sector is owned and run by individual physicians on a fee-for-service basis and has grown remarkably in recent years. Many private hospitals, clinics, laboratories, rehabilitation centers and the pharmaceutical industry have developed as a result.

1.3.2.2 Finance and expenditure

The total current expenditure on health in Palestine has been increasing throughout the years. According to the PCBS, it has reached 1,321.3 million in 2015. This total health expenditure constitutes 10.7% of the Gross Domestic Product (GDP) and results in total health expenditure per capita of USD 282.2.

The expenditures on health in Palestine are funded through governmental contribution, Household out-of-pocket payment, and direct FA transfer. The governmental contribution covers 41.1% of the total health expenditure while the Household out-of-pocket payment covers 43.1% and finally FA covers 4.4% (PCBS, 2017).

1.3.3 Foreign Aid to Palestine

1.3.3.1 FA to Palestine before the establishment of the PNA

Before the establishment of the PNA in 1994, there was no official government in Palestine which gave rise to the civil society sector to become a service provider. Accordingly, all the FA was directed towards civil sector organizations.

The civil sector in Palestine started during the British mandate in the 1920s as grassroots organizations that focused on the national struggle (ICNL, 2014,). They were charitable religious organizations that depended mostly on internal donations.

Starting with the Israeli occupation in 1948, Palestinian civil society developed and became more professional and structured in the form of NGOs (Challand, 2008). During this period, these NGOs became the providers of essential services as well as the development agents in Palestine. This change in role and the increased responsibility was reinforced with a change in funding. FA started to come from different directions: the European Union, individual European States, Japan, the United States, UNICEF, UNDP, Oxfam and the Arab Trust Fund (Sullivan, 1996). Nevertheless, the external funding rendered the NGOs dependent on external aid. It was estimated that on average 80% of the NGOs budget was funded by external donors (Gerster, 2012).

1.3.3.2 Redirection of the FA

In 1994 the PNA was established and for the first time there was an official Palestinian governmental body. At this point, most of the FA was directed towards PNA instead of the NGOs with the aim of helping to develop and build the governmental organizations (Sarsour, Naser & Atallah, 2011), so as to reach the two state solution proposed in Oslo Accords the year before.

FA received by the PNA was distributed among different sectors such as education, health and population, production, as well as administrative costs and humanitarian aid. FA helped in establishing these sectors and in covering the cost of services provided by these sectors.

1.4 Background summary

Following the start of the Israeli occupation the aid directed to Palestine increased. The Israeli occupation resulted in two separated Palestinian regions: the Gaza Strip and the West Bank. This separation affected their socio-economic indicators as well as access to services. FA was directed towards local NGOs, which were the main health service providers. With the establishment of the PNA, four major health providers including the MoH, NGOs, UNRWA and the private sector are serving the Palestinian population. Subsequently, most of the aid donated to Palestine was redirected to the MoH. Health spending is mostly through the government. The total health expenditure as a percentage of the GDP is relatively high whereas the total health expenditure per capita is average compared to countries of similar income in the region. At present, FA constitutes almost 5% of total health spending in Palestine (PCBS, 2017) .

1.5 Thesis structure

This thesis is divided into six chapters. Chapter One discusses the introductory issues: research significance and motivation, the Palestinian context and provides a background on changes in FA to Palestine over time. Chapter Two is the literature review. It begins with a historical review of FA and its theories, followed by a review of the empirical evidence on FA effectiveness; and ends with a summary of the literature on FA to the health sector. Chapter Three is the conceptual framework. Chapter Four addresses the methodology of the study. In this chapter, the research

approach, design, methods, and ethical concerns are explained. Chapter Five is comprised of two main sections: first, the descriptive analysis section which concentrates on the FA directed to Palestine, the major donors, the distribution of FA among different sectors, and FA targeted to the HS. Second, qualitative analysis section which explores the stakeholders' perception of the FA process in Palestine in general and in health sector in particular. The sixth and final chapter is the conclusion and recommendations.

Chapter 2: Literature review

The literature on FA is vast and covers many areas from the conception of FA itself to the debate surrounding its role. As the study is intended to be explorative, descriptive and analytical in nature, the literature review covers these different areas but concentrates specifically on the role of FA and its influence. The literature review is organized as follows: the first part focuses on the origin and underlying intentions with the existence of FA. The second part explores the theories underlying FA. The third part of the literature review covers the development and reconsideration of the FA model. The fourth part talks about FA and development (pros and cons). The fifth part concentrates on the factors affecting the impact of FA on development. The sixth part of the literature review discusses research done on FA directed to the HS. And the final part is a synthesis of the literature review.

2.1 Origin and underlying intentions in the existence of FA

FA as a notion started with developed countries which, in the aftermath of World War II, saw it as a means of restoring peace, helping the less fortunate countries that were affected by the war, and aiding in the healing and in the process of becoming developed. (Lancaster, 2008).

In 1961, world leaders acknowledged this fact officially and created the Organization for Economic Co-operation and Development (OECD) as an agency responsible for helping governments assume their roles in enhancing prosperity and economic growth through providing aid to less fortunate countries². The OECD publishes annual statistics on ODA, concerning the donors, recipients, amounts and sectors of investment. This information is used to monitor the

²<http://www.oecd.org/about/history/>

countries' compliance to the high level conventions already agreed upon and the progress (in terms of development indicators) achieved in the recipient countries.

Although growth and development are the core purpose of FA and the reason for its presence, it is evident through the literature that different intentions guided the evolution of FA. As described by Jean-Philippe Thérien (Thérien, 2002, p. 449), "Foreign aid is one of the most original political innovations of the twentieth century, where it constitutes an important element in the North- South relationships". FA is seen as the political invention that defines these new relations between developed and developing countries.

These new relations are also influenced by the interests of donor countries. (Polidano, 2001). Although researchers have noted that the development of poorer nations is the official purpose of FA, and in most cases it is the primary purpose, they found that FA is almost always accompanied with other hidden purposes (Alesina & Dollar, 2000). Lancaster (2008) noted that states around the world, and more specifically the developed ones, utilize FA to expand their power, ensure their national security and assure the coverage of their needs. Other authors (Schraeder, Hook, & Taylor, 1998) identified other underlying intentions of FA such as commercial, cultural, and diplomatic intentions (Lancaster, 2008).

The above are the defined drivers for donor countries. As for the recipient countries, FA is used for two main purposes: to face humanitarian crises and/or for developmental purposes. Humanitarian aid is support received to overcome a humanitarian crisis and for emergency relief, as is the case now in Syria, while developmental aid is used to build infrastructure and capacities in recipient countries (Anyangwe, 2015).

2.2 Theories underlying FA:

Given the international political and economic importance of FA, the researchers have referenced economic theories to interpret the underlying intentions of donors and recipients using FA as a means of development as well as for other purposes.

With regards to the relation between FA and development, Panjak (2005) has referred to FA as a source of capital for the recipient countries, which enables the promotion of development in these countries. His referral is based on the Economic Development Theory as mentioned in the Harrod Domar growth model (Domar, 1946). This model understands capital to be the most significant factor in a country's growth and development, in that capital is needed for production of services and goods in a country, leading to economic growth and thus development.

Likewise, Williamson (2010), as well as, Sachs and Riedel (2005) have indicated that governments use FA to overcome poverty and accomplish development to serve the interest of the public. They depended on the Public Interest Theory (Pigou, 1932; Posner, 1974) to reach these indications. Public interest theory is an economic theory. It assumes that the government functions in the interest of the public through producing regulations and compensating for the inefficiencies and inequities of the market.

So as to further understand how FA relates to governmental interests, researchers have utilized another theory, which is referred to as the Public Choice Theory. (Black, 1948; Buchanan and Tollison, 1984; Arrow and Kruz, 2013; Sabatier, 1999). This economic theory contradicts the former (Public Interest Theory) and assumes that the governments' motives are not connected to the public's interest but rather to the public's choice. According to the Public Choice Theory, governments utilize economic tools to influence the public political behavior. In other words, governments use FA, and the economic development it produces, to politically persuade the public

in such a way to influence re-election. In this case, FA does not necessarily promote development but rather it serves the intentions of the donor countries which might be harmful to the recipient countries (Easterly, 2001).

2.3 Development and the reconsideration of the FA model:

Given the importance of FA for both sides, donors and recipients, the amount of money globally injected into FA has continued to increase throughout the years. Nevertheless, FA did not always lead to the desired outcome (Hansen & Tarp, 2000) of promoting development in one or more of the three dimensions: social, economic and environmental. This perceived inconsistency concerning the effectiveness and impact of FA indicated the need for the reconsideration of the FA model.

This reconsideration of the FA model was done with the aim of developing a two-direction rather than one-direction model, where both the recipient and the donor country assume active roles in the FA process. The reconsideration took place through several high level events that are highly important in the evolution of FA. The most important of these are:

1. The Paris Declaration in 2005 which concentrated on the effectiveness of FA to recipient countries through five principles (OECD, 2005) :
 - a. Ownership: developing countries must lead their own development policies and strategies, and manage their own development work on the ground.
 - b. Alignment: donors must line up their aid firmly behind the priorities outlined in developing countries' national development strategies.
 - c. Harmonization: donors must coordinate their development work better amongst themselves to avoid duplication and high transaction costs for poor countries.

- d. Managing for results: all parties in the aid relationship must focus more on the results of aid.
 - e. Mutual accountability: donors and developing countries must account more transparently.
2. The Accra Agenda for Action in 2008, which was a political document signed by ministers, emphasized the areas in aid effectiveness which were unmet, such as country ownership, effective and inclusive partnership, and developmental results achievement.
 3. The Busan Partnership Agreement in 2011 where the forum of Global Partnership for Effective Development was created to be an inclusive political forum to advance the development impact of FA in recipient countries³.
 4. The Global Partnership for Sustainable Development Data: a global network of governments, NGOs, and businesses that collect data to be used in evidence-based policy-making concerning development⁴.

2.4 FA and development (pros and cons)

There is no consensus on the impact of FA on developing countries. The impact and effectiveness of FA has been, and still is the center of debate. Several researches, such as Easterly (2001), have concluded that FA has no impact on poverty and on enhancing development in recipient countries. He expressed how forty years of FA to African countries did not result in growth and development. Before Easterly, Boone (1996) also found that FA did not have an impact on the overall growth in developing countries. These researchers, among others, have explained their results through

³<http://effectivecooperation.org/about/>

⁴ <http://www.data4sdgs.org/>

relating FA impact to the presence of certain conditions such as presence of good policies (Leeson, 2008) and conditionality of FA (Gibson, 2005).

On the other hand, other researchers (Abouraia, 2014; Chenery & Strout, 1966) have found that FA has a positive impact on growth and development. For example, Arndt, Jones and Tarp (2007) concluded that FA is effective in alleviating poverty and in promoting growth and development as was the case in Mozambique. Furthermore, the meta-analysis of Doucouliagos and Paldam (2009), who collected and analyzed forty years of research on FA, found that 74% of the research on FA effectiveness is positive. Nevertheless, Doucouliagos and Paldam also noted that the results of the studies on FA effectiveness are polished. They noted that the research community was keen to publish positive results and to ignore the fact that FA ineffectiveness could be explained by the Dutch disease (Doucouliagos & Paldam, 2009).

The variation in the results concerning the impact and effectiveness of FA emerges from the variation in the underlying theory, development model, and data used by the researchers (Thorbecke, 2000). The studies on the impact and effectiveness of FA on growth and development could be divided into three groups (Hansen & Tarp, 2000).

The first group refers to economic concepts to justify the impact of FA. Some of them, such as Mosely (1980), used savings and investments and related them to growth. Mosely found that FA has a negative effect on domestic savings and thus a negative effect on growth and development. Others use the trade gap concept which relates growth to the country's ability to export in order to supply import of capital goods necessary for growth (Chenery & Strout, 1966).

The second group concentrated on the direct relationship between FA and growth, such as the study of Papanek (1973) who concluded that FA is positively related to higher growth rate and development in recipient countries.

The results from the first and second group were not consistent which gave rise to the third group of studies. The third group focused on studying the impact of FA on development under certain conditions such as the presence of good policies or the volatility of aid. These conditions (discussed below) might lead to either positive or negative effect on the FA impact.

2.5 Factors affecting the impact of FA on development

2.5.1 Good governance:

The presence of good governance is of paramount importance in increasing the effectiveness of FA in developing countries. A 1989 World Bank Report stated that “underlying the litany of Africa's development problems is a crisis of governance” (WorldBank, World Development Report 1989 : Financial Systems and Development, 1989). Burnside and Dollar (1997) concluded that if FA is directed to a poor country with good fiscal, monetary, trade and aid effectiveness policies, FA will affect growth positively. Also, Leeson (2008) connected positive FA impact to the presence of right policies and an enabling institutional environment. Otherwise, and in the absence of these policies, FA might lead to several negative effects in the recipient country such as: induced corruption, increase in the government size and spending while reducing tax revenues (Remmer, 2004).

Schudel (2008, p. 523) found that some donor countries do not focus on corruption, their main objective is to secure their strategic interest even on the expense of enabling economic growth in recipient countries. He concluded that, donors sometimes play a role in the corruption within the

recipient government, where he stated that “Donors that are relatively corrupt do not seem to respond negatively to recipient corruption levels”.

2.5.2 Fungibility:

McGillivray and Morrissey (2000) defined “Fungibility” as the usage of FA for purposes other than what they have been donated for. Fungibility is also when the recipient country diverts their spending in the specific sector receiving external aid to another sector (Cashel-Cordo and Creig, 1990). Cashel-Cordo and Creig also found that the Fungibility of the recipient country impacts their growth rate as well (1990).

Fungibility is found to be higher in sector aid. This occurs when aid, directed to a specific sector, is commonly (65%) used in different areas which it was not intended for. It has also been found that Fungibility increases if the donor and recipient do not share the same vision for money allocation (Devarajan and Swaroop, 1998).

Lastly, it is important to note that Fungibility is not necessarily a negative phenomenon, especially if good policies are followed by the recipient country (Pettersson, 2007).

2.5.3 Micro-macro paradox:

The micro-macro paradox is the difference in the result of FA effectiveness, more specifically, between the effectiveness of projects funded by FA and the effectiveness of FA on the whole growth process within the recipient country. Mosley introduced this paradox and referred the difference in results and inaccurate measurement, Fungibility and the negative impact of aid on the private sector (Mosley, 1986). Afterwards, two more additional reasons were found to contribute to this paradox: the scale of analysis and the difference in the data used, socio-economic data and financial data (White, 1992).

2.5.4 Conditionality:

According to Gibson (2005), conditionality is the “carrot and stick approach” which is the enforcement of certain conditions by the donor on the recipient country on how to use FA. Conditionality, along with close monitoring, is one of the methods utilized by the donors to control Fungibility.

Conditionality has been proven to create problems in the recipient countries. The first problem is the issue of ownership (Collier, 1997). Under conditionality of FA, recipient countries lose the sense of ownership of implemented projects. This lack of ownership led to a decrease in local motivation and enthusiasm towards the proposed interventions and eventually led to low rates of success (Dollar and Svensson, 1998). Moreover, conditionality has resulted -in some cases in which the recipient country does not want to turn down a potential funding opportunity- in the redirection of the local government attention and capacities to project imposed by the donor and are not part of the local priorities (Brautigam and Knack, 2004).

2.5.5 Political stability:

Political instability has a negative effect on growth and investment (Alesina et al., 1996). This is due to the fact that in a situation of political instability there is: high violence, frequently changing governments and troubled environment, that do not support growth and thus have a negative influence on aid effectiveness (Chauvet & Guillaumont, 2003).

2.5.6 Absorptive capacity:

A challenge for recipient countries can often be their absorptive capacity of FA. Lensink and White (2001, p. 6) stated that "there is a limit to how much aid a country can absorb," while Durberry *et al.* (1998) found that if FA is given in the right amount, it will lead to growth. A small amount of FA would not have a considerably positive effect on growth and a large amount of FA would have

a negative effect on growth. The optimal level of FA was investigated by Easterly who found that a low percentage of aid to GDP will result in a positive FA impact (Easterly, 2007b).

2.5.7 Volatility:

Volatility is the uncertainty of aid flow. Aid-dependent countries are highly affected by aid volatility. In these countries, aid constitutes a significant source of capital and a considerable amount of their GDP (Pallage and Robe, 2001). Therefore, they are more sensitive to external shocks. External shocks in poor and developing countries negatively affect their functionality and plans for developing (Agenor & Aizenman, 2010) since these countries lack the resources to overcome these shocks. The uncertainty and fluctuation of FA in these countries hinders their growth (Mosley and Suleiman, 2007).

2.6 FA in the health sector

There is limited research dedicated to investigate the impact of FA on health (Jackson & Mills, 2007; Mishra & Newhouse, 2007) when compared with the amount of research dedicated to assess FA impact on growth. The lack of information on aid for health limits the amount of research done on FA directed to health and its impact.

Most of the research on the impact of FA on health was quantitative. Researchers used certain health indicators, such as infant mortality (Mishra & Newhouse, 2007), avoidable mortality (Shpak, 2012), immunization and life expectancy (Williamson, 2008) to assess the impact of FA on health. The results were mixed; some found that FA is ineffective in improving health (Williamson, 2008), while others found that FA has a positive impact on health (Mishra & Newhouse, 2009).

Other researchers have investigated factors affecting the impact of FA on health. Jackson and Mills (2007) found improved results of FA interventions on the HS when information on the financial

resources to health was available, stressing on the quality of these information in terms of reliability and timeliness. In addition, Croghan *et al* (2006) found that in targeted health interventions, FA and technical assistance were more important factors in improving health outcomes than contextual factors such as strong HS or good governance.

Furthermore, Gebhard *et al* (2008) suggest that disaggregated data, which evaluate the outcomes of each project to its predetermined objectives, would give a better understanding of the role of FA on health.

2.7 Summary of the literature review

To synthesize, FA evolved as a means to combat poverty and promote development. It was backed with economic theories, such as Economic Development Theory, Public Interest Theory and Public Choice Theory. Nevertheless, other political, cultural and commercial motives have been hidden behind combating poverty and promoting development through FA.

Throughout the years, FA was assessed for its effectiveness in assuming its role in promoting growth and development. The results were inconclusive. The inconsistency of results was attributed to the use of different measures and methods of assessment. In view of these results, researchers investigated factors affecting the impact of FA. FA was found to be subject to volatility, conditionality, fungibility, good governance and political stability, all of which, whether occurring separately or together may affect FA negatively under certain circumstances. They also found FA to be more effective if measured at the level of projects rather than at national level. Moreover, researchers found that if FA is given in a small proportion to a recipient country's GDP, it might result in a higher impact.

As for the role of FA in the HS, most the research have been quantitative research that connects health variables to FA impact. The results of these studies have been inconclusive. Some found that FA has no effect on health outcomes while others found a positive impact of FA on health outcomes. Moreover, some research have been done on the factors influencing the FA effectiveness in the HS. It has been found that: the presence of reliable timeless information on financial resources for health, targeted health interventions, and technical assistance, increase FA effectiveness in the HS.

2.8 Research question

Following the background and the literature review, the question for this research seeks to provide further understanding and evidence on a highly debated area: the role of FA. However, as FA's role is a broad topic, narrowing the scope of the study has been done through selecting a specific sector (the HS) in a specific country context (Palestine). These specifications add to the significance of this research as they have been poorly investigated.

2.8.1 Main Research question:

What are the roles of FA on the HS in Palestine since the establishment of the Palestinian National Authority?

2.8.2 Research sub-questions:

1. How is FA to the HS in Palestine allocated and managed?
2. What are the challenges facing the FA process in the HS in Palestine?
3. What measures are needed to enhanced FA effectiveness in Palestine?

Chapter 3: Conceptual (analytical) framework

Building on the literature review, this study aims to relate the different factors which affect the pathway of FA to the health system and subsequently the health outcomes.

FA coming into the health sector is highly influenced by the following two factors: first, the international health policies and second, the donors' agenda (Alesina & Dollar, 2000) . Due to globalization and the increase in human mobility, diseases are no longer restricted to defined areas, making health a primary subject for international social policies. The increased attention to health policies was accompanied with shifts in funding priorities where more funds were directed towards the health sector (Timothy Besley, Maitreesh Ghatak, 2016), according to these international health policies.

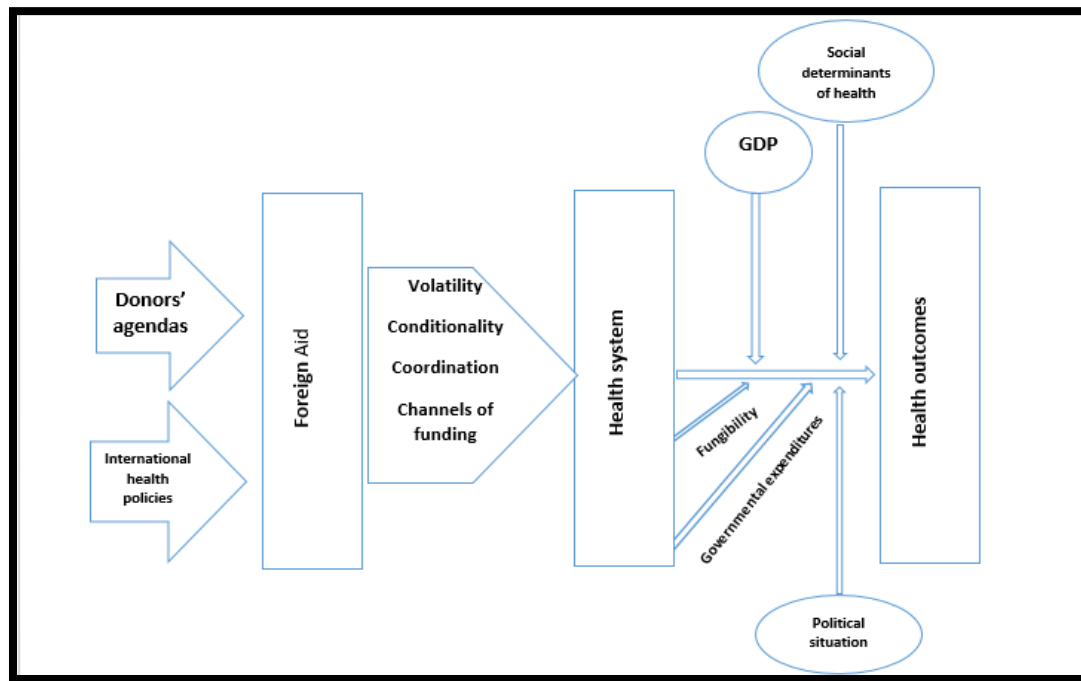


Figure 1: Conceptual –analytical- framework⁵

⁵ By the author

Moreover, the international policies adopted by international organizations, such as WHO, were influenced by two factors: the power differential of member states and the type of international organizations in terms of donor control (Ervik, Kildal, & Nilssen, 2009). The donors' influence does not stop there. The donors' effect on the national policies through FA is highly influenced by the donors' agenda and intentions (Polidano, 2001).

Once the amount of FA dedicated to the HS is decided upon, the donors' influence over the practices of delivering FA beings. The donor controls four main areas:

- The channels of funding: The donor decides the channels of funding - whether it is bilateral or multilateral as well as to which part of the health sector will be directed to (government or civil society).
- The predictability and stability of funding: volatility of FA highly affects its broader impact (Agenor & Aizenman, 2010). Projects and programs and subsequently, the sustainability of organizations implementing them, are dependent on the volatility of aid.
- The conditionality of funding: the donor has the power to attach certain conditions and requirements to the aid, which might sometimes increase the transitional cost and burden for the recipient (Collier, 1997).
- The coordination between the donors themselves and the government also influences the impact of FA. The coordination between donors helps in avoiding duplication while the coordination with the recipient helps in the alignment of donors' agendas with national priorities and strategies (OECD, 2005).

After the FA enters the health sector it is influenced by several internal and external HS factors which affect health outcomes:

- The governmental expenditure on health and the fungibility of aid: the higher the governmental expenditure on health, the better the health outcomes. Nevertheless, these expenditures may decrease as the government uses the FA to cover these expenditures rather than its intended purpose (McGillivray and Morrissey, 2000).
- The health outcomes are also affected by the GDP. Poverty is one of the main reasons for bad health outcomes, therefore, low GDP affects health negatively (UNDP, 2005). Depending on the proportion of FA to the country's GDP, a low GDP can impact the effectiveness of FA (Easterly, 2007b).
- Political situations with instability, violence and war negatively affects the health outcomes and keeps the country in a continuous state of emergency (Alesina et al., 1996).
- Social determinants of health, such as access to sanitary water, also affect the health outcomes.

Chapter 4: Methodology

This study is exploratory and descriptive in nature. It aims at deepening the understanding of the FA process in Palestine through concentrating on FA's: role, management, challenges in the HS in Palestine

4.1 Approach

According to the aim of the study, qualitative research approach is used in this research. Qualitative research approach was chosen because the role of FA on HS is a complex and a context dependent issue with many interfering factors which require an approach that provides a wide and extensive understanding of the research problem and results through addressing the research question from different stakeholders' perspectives. The perceptions of different stakeholders from the side of donors as well as recipients are required to develop a deeper understanding of FA to HS and to further explore the reality of the FA impact on the HS beyond the health indicators.

Within the qualitative approach, Case study method has been used. Case study method has been the most popular method in qualitative research approach and in Public Administration research (McNabb, 2002). Case study refers to in depth analysis of the unit of research (in this study HS in Palestine) rather than concentrating on variables. Case study method describes and analyzes the research unit based on interviews and observations, and thus offers richness of information collected.

4.2 Research design

The study is composed of two main parts:

1. The first part is descriptive analysis. It depends on secondary data from the WHO, OECD, World Bank, and the Palestinian Central Bureau of Statistics (PCBS) as well as data

collected through various official documents and published literature. These data were used to develop an overall view of the FA disbursed to the PA in general and to the HS in particular through the time period covered by the study using a descriptive analysis. It concentrated on collecting information on the following areas:

- Context, demography and health indicators in Palestine
 - Health system in Palestine
 - Description
 - Finance and expenditure
 - Foreign Aid to Palestine
 - FA to Palestine before the establishment of the PNA
 - Redirection of the FA
 - Major donors to Palestine
 - Development vs. humanitarian aid
 - ODA per capita and Ratio of ODA to GNI (overtime period)
 - FA to the health sector
 - FA management in Palestine
2. The second part is qualitative research. It is performed for two purposes: first explanatory and second explorative. The explanatory part refers to the knowledge gained from the first part and uses different stakeholders' perspectives to understand the results obtained in this part.

The explorative part concentrated on the FA as a process. Given that the results of any process is highly dependent on the way by which the process has been done, part of this research is dedicated to assessing the modality by which FA is processed in Palestine.

The process by which FA is handled, encompasses: the design, implementation and evaluation. In our case, these three stages are evaluated according to the five pillars identified in the Paris declaration of 2005 (OECD, 2005). These five pillars were assessed using different stakeholders' perspectives.

4.3 Data collection Methods:

1. Desk review was done through both reviewing documents and records from the International Cooperation Directorate (ICD) of the MoH and through online research of the international organizations websites such as OECD, World Bank, and WHO.
2. Interviews: fifteen semi-structured interviews were conducted. The interviews were based on a group of open-ended and close-ended questions on the previously identified topic areas. This method allowed to probe the interviewees to develop further knowledge on new areas in the topic that emerge during the discussion. Also, open-ended questions helped investigate different areas of the topic and allowed the interviewees to provide detailed input.

4.4 Sampling:

The sample for the fifteen interviews started as a purposive sample and continued through snowballing. The purposive sampling was used as there is no intention to generalize the findings of the study. Moreover, the main purpose of choosing purposive sampling is to focus on specific characteristics of the participants; their relation and knowledge of the subject of FA to health in Palestine; which will serve the purpose of the study in further understanding of the FA process.

The purposive sampling started with a preliminary research on the major stakeholders in the field of FA in health in Palestine and three main actors active in the field of FA were identified:

government, civil society and donors. Afterwards, individuals from these three main actors were chosen according to their accessibility and relativeness of their positions to the topic. Later these three interviewees were asked to identify main departments, entities and individuals directly related to the topic, the following entities were identified:

1. Government: within the government two ministries; MoH and MoFP; were identified to be responsible for FA for HS. Within the MoH three departments were concerned: the International Cooperation Department, Planning Department, and Projects Department.
2. International multilateral organizations (i.e. UNRWA, UNDP, WHO): these organizations are international organizations that receive donations to implement projects or provide services in Palestine.
3. Donors: countries, unions and international organizations, i.e. EU, USAID, Italy. These donors provide fund to HS in Palestine.
4. Coordination bodies: such as The Local Aid Coordination Secretariat which coordinate between the three actors (government, donors, and civil society).
5. Local NGOs: Palestinian Medical Relief society (PMRS), Juzoor for Health and Social Development. These two NGOs are of the biggest and oldest NGOs working in the HS in Palestine.

Sampling was continued through snowballing where the three interviewees were asked to recommend names of personnel in these abovementioned entities for interviews. Snowballing was used to overcome the difficulty of reaching other interviewees. The sensitivity of the subject made the access for interviewees difficult and the fact the names of the new interviewees were

recommend by their acquaintances made these interviewees more prone to accept the request for an interview.

4.5 Data Analysis:

The data analysis was done in two separate parts: descriptive quantitative analysis, and qualitative content analysis. The descriptive quantitative analysis use tables and graphs to describe data collected on FA to HS in Palestine such as: the amount of FA for health per year, ODA per capita, and the distribution of FA per sector. The qualitative content analysis, where the content of the interviews has been transcribed, data was categorized and grouped into themes to be analyze descriptively and interpretatively.

4.6 Validity and Reliability:

Validity and reliability in qualitative research can be assured through the use of the triangulation technique (Golafshani, 2003), where data are gathered through using two or more sources and/or different research methods (Bogdan & Biklen, 2006; Carter, Bryant-Lukosius, DiCenso, Blythe & Neville, 2014). Two types of triangulation will be used in this research: method triangulation, where information was gathered through both interviews and document reviewing; and data sources triangulation, where data have been collected from different interviewees as well as from official records of international organizations' websites and previously published reports and research.

4.7 Generalizability and Limitations:

This research is meant to study the role of FA on the PHS, which means that it concentrates on a specific aspect of the FA in a specific sector (health sector) in a specific context (Palestine). Consequently, the results of this research are confined to these three limitations and could not be

generalized. Nevertheless, these results add to the knowledge in the field of FA impact and the knowledge of the Palestinian HS, which are two domains that require further research and study.

4.8 Ethics:

The research ethical considerations will be taken into account as follows:

The aim and objectives of the research are fully explained to the participants to avoid deception and exaggeration. Likewise, affiliation to the AUC is declared to clear any conflict of interest.

Participation in the interviews is voluntary; and a written consent (Annex 2) is taken. The anonymity of the participants is assured through using pseudo names to ensure that the participants are not subjected to any kind of harm.

4.9 Research journey

This research was conducted through the period from April 2017 to August 2017. Through this period, the research has passed through five stages:

1. Preparatory research: this stage had two parts:
 - a. Literature review: started by a broad scan of the literature available on FA to stand upon a specific research problem followed by a focused review to of literature on FA in the health sector and FA in Palestine to identify the main research question and the research sub-questions. And finally a comprehensive literature review was done to cover all the available resources in order to develop a critical overview of the literature available on FA and relevant to the study which helped in shaping the study design.

- b. Identification of the major information resources for the primary and secondary data collection, and the preparation of a list of key informants from different stakeholders' groups.
2. Qualitative secondary data organizing, testing and analyzing
3. Contact and networking for the interviews: three main persons from three major stakeholder groups (government, NGOs, research entities) has been identified and contacted through emails. In the emails the purpose and the scope of the study were explained, then they were demanded if they accept to do an interview and if they can recommend other names for additional interviews. Through emails a total number of fifteen names were identified for interviewing.
4. Research trip and interviews: on July 5, 2017, the researcher travelled to Ramallah, Palestine, and then she contacted the interviewees again to confirm the interviews and the interviews were conducted.
5. Information review and analysis of qualitative data: the information from the interviews was transcribed, reviewed, and analyzed.

Chapter 5: Analysis and Discussion

5.1 Descriptive analysis

This section analyzes and discusses the data collected during the desk review of official documents and of national and international websites such as the OECD and the WB.

5.1.1 Trends and channels of fund to Palestine

FA to Palestine following 1994 has been increasing (Figure 2). This increase has several peaks which mark major political incidences in Palestine. These peaks occur in 2000, 2008 and 2014 which mark the Second Intifada, the Gaza War, and the Israel-Gaza conflict, respectively. Following each of these incidences, FA increased to provide the necessary means for humanitarian aid and the reconstruction of the damaged areas to take place.

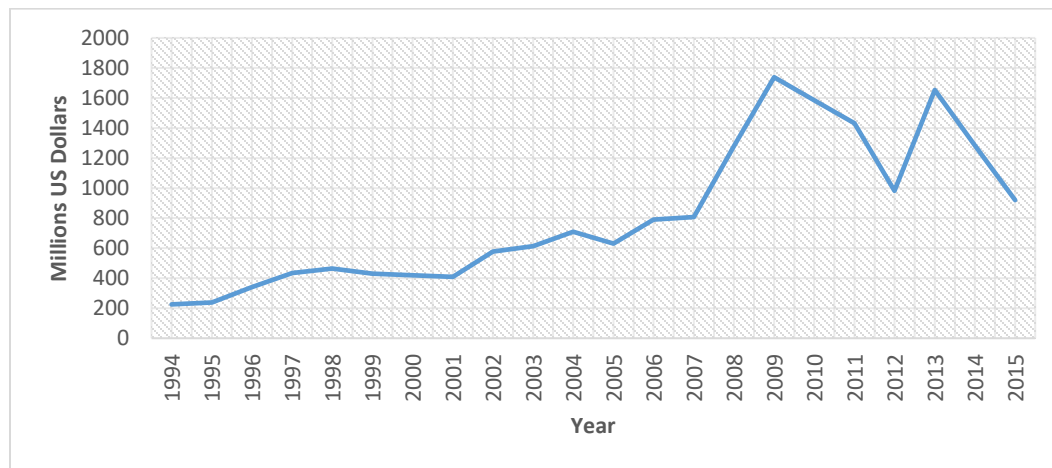


Figure 2: Net ODA to Palestine⁶

⁶Data extracted on 28 Aug 2017 09:55 UTC (GMT) from [OECD.Stat](http://data.oecd.org)

Data on major donors to Palestine varies according to the source. According to the OECD data, the main donors to Palestine, since the establishment of the PNA, are the European Union (EU), United States, and UNRWA (Figure 3). However, according to an ESCWA Report (2013), the gulf countries, including Kuwait, Saudi Arabia and the United Arab Emirates have contributed significantly to the FA flowing to Palestine.

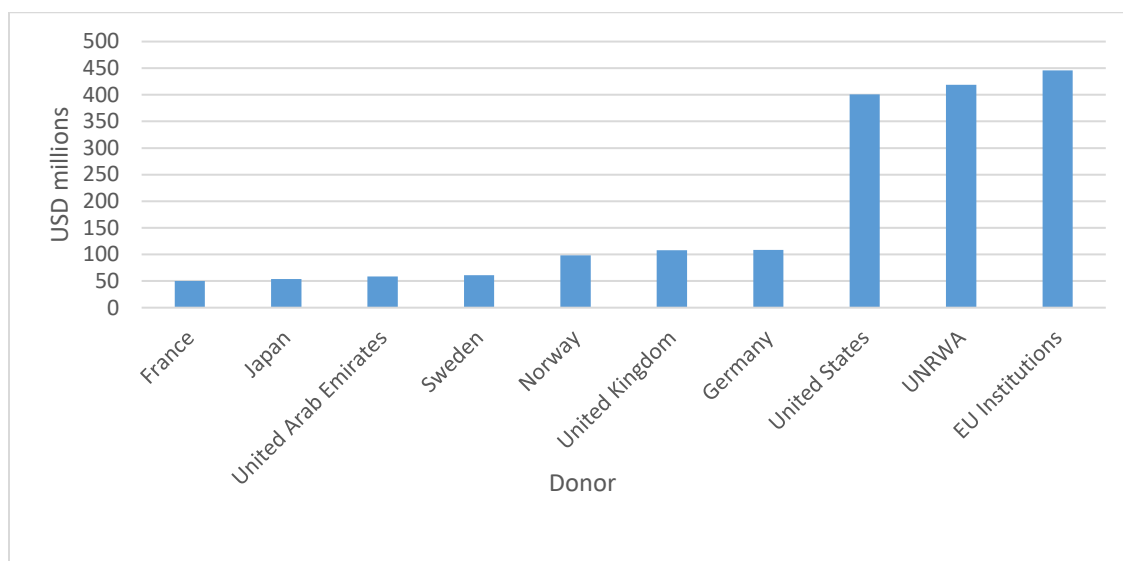


Figure 3: Top ten donors to Palestine in 2015⁷

5.1.2 Development vs. humanitarian aid

Although development and humanitarian aid are diverted into two different pools, they come from the same donors. The allocation of aid to either development or humanitarian aid is context

⁷<http://www.oecd.org/dac/financing-sustainable-development/development-finance-data/aid-at-a-glance.htm>

dependent. This is due to the fact that FA allocation in different sectors is correlated with the ongoing occupation and its consequences. Moreover, the recurrent Israeli politics and repressive military actions in Palestine, as well as the war on Gaza, steered FA in the direction of humanitarian aid rather than development aid. Hever (2006) noted that the assistance does not really facilitate development, but is rather used to support the weak Palestinian economic system.

Between 2005 and 2009, 78.9% of FA to Palestine was humanitarian assistance and not development aid. In addition, almost 61% of the humanitarian assistance was utilized in direct budget support (Sarsour, Naser & Atallah, 2011). For example, in 2010, the budget deficit reached USD1.2 billion, and at the same time there were 150,000 Palestinian Authority (PA) employees needing to be paid whose salaries were covered by FA.

5.1.3 ODA per capita and Ratio of ODA to GNI Overtime

These are two measurements that reflect the recipient country dependency on FA: the higher the ratio, the higher the dependency. In the case of Palestine, Official Development Assistance (ODA) constituted a significant amount of the individual and national income. The Israeli closure and dominance over resources resulted in a high unemployment rate and rendered the Palestinian economy highly fragile and malformed (Sarsour, Naser & Atallah, 2011) and thus highly dependent on external aid flow (MoP, 2014).

There is an increasing pattern in fluctuation in the two ratios over the years with a peak in the year 2008 and between 2013-2014, which is when the ODA amount increased to overcome the destruction and the humanitarian distress following the two wars on Gaza.

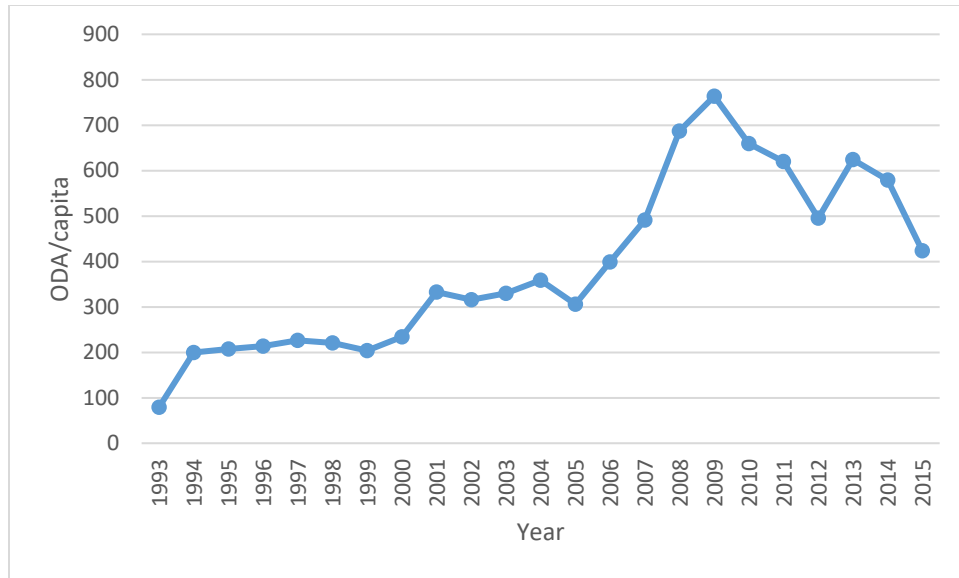


Figure 4: ODA/capita⁸

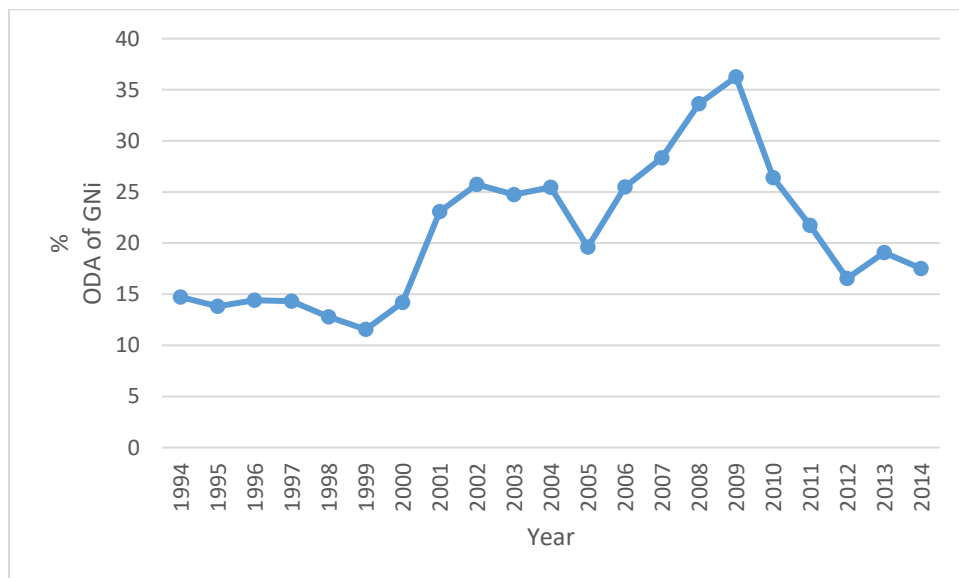


Figure 5: Percent ODA of GNI⁹

⁸<http://data.worldbank.org/indicator/DT.ODA.ODAT.PC.ZS?locations=PS>

⁹<http://data.worldbank.org/indicator/DT.ODA.ODAT.GN.ZS?locations=PS>

5.1.4 FA to the health sector

After excluding the humanitarian aid, the portion of FA devoted to development in Palestine is distributed among different sectors and services. As seen in Figure 6, the health sector receives a small portion (3%) of the ODA coming to Palestine.

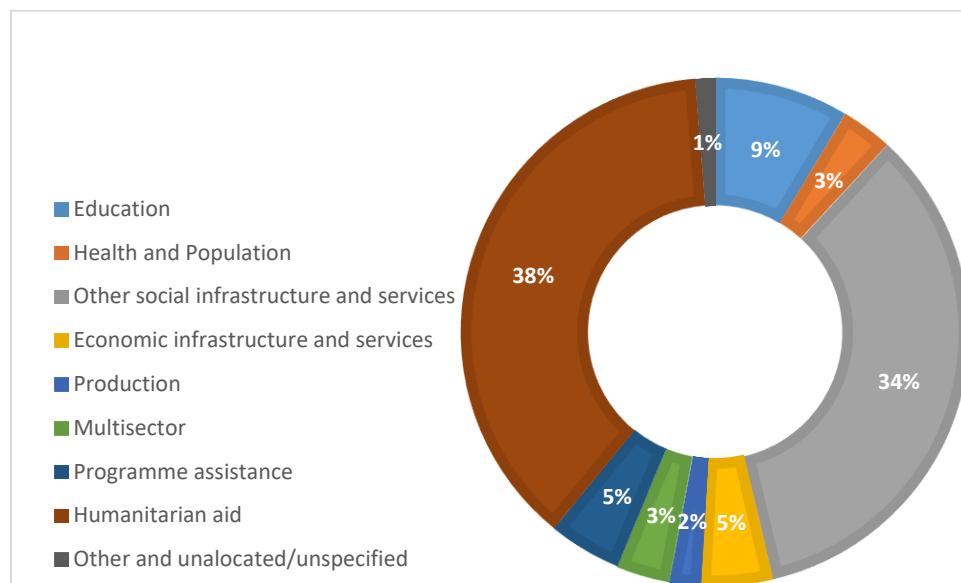


Figure 6: Bilateral ODA by sector 2014- 2015¹⁰

Although the HS in Palestine consumes only a small amount of the ODA, this amount has been steadily increasing since 1994. In 1994, the amount received by the MoH was approximately USD 1837 million while in 2015 it reached USD 15,063million (Figure 7). This increase can be attributed to – among other reasons –an increased global interest in health and the inclusion of the health dimension in international policy recommendations, such as the MDGs. These MDGs led to donor countries concentrating more heavily on health within their projects.

¹⁰Data extracted on 30 Aug 2017 09:55 UTC (GMT) from OECD.Stat

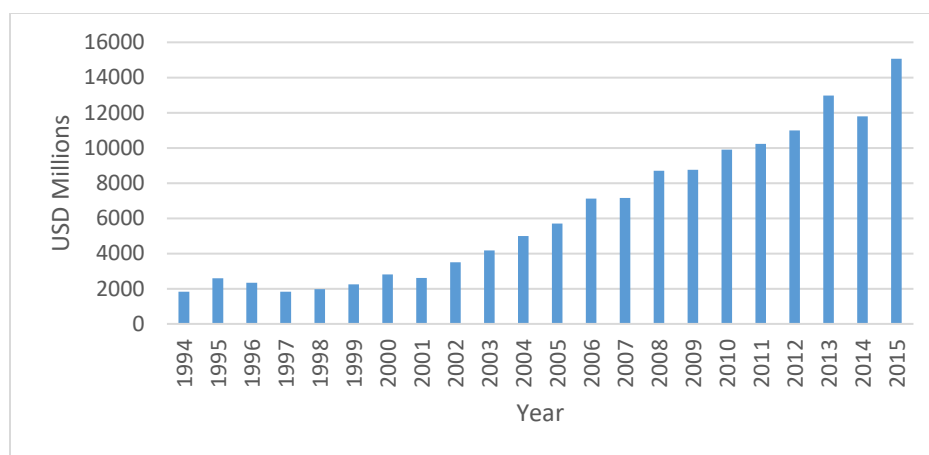


Figure 7: ODA to the health sector in Palestine

Within the HS, FA is divided into different sub-sectors. Most of the FA coming to the HS is spent on service provision while the rest is spent on administrative expenditures and on medical education and training while a very small amount is spent on medical research. In 2015, 84.6% of FA to the HS was spent on service provision (Figure8).

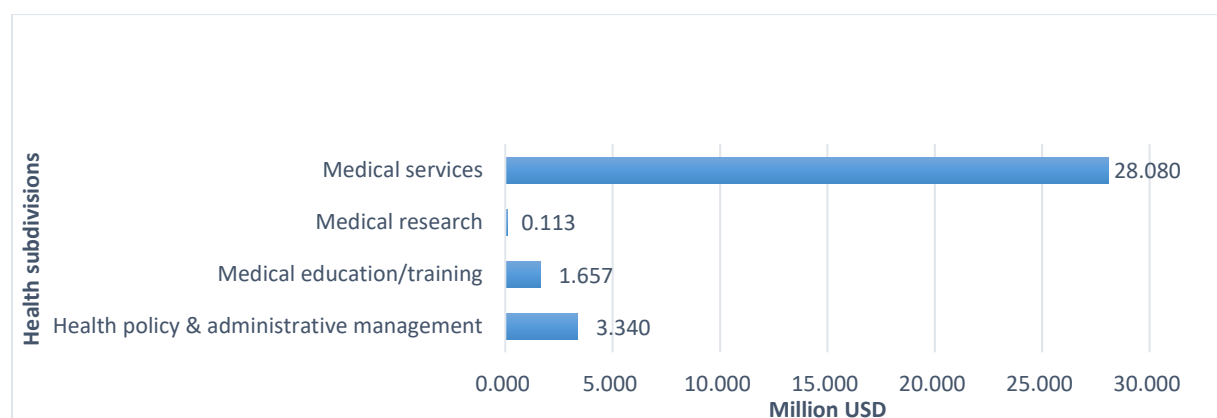


Figure 8: ODA distribution in health sector, Palestine 2015¹¹

¹¹<http://stats.oecd.org/Index.aspx?QueryId=58193#>

5.3 Qualitative analysis

This part of the thesis depends on data collected through interviewing different stakeholders in the area of FA directed to the HS. The themes in this section were chosen after analyzing the data collected and identifying the most important points affecting the role of FA on the HS. The analysis has two main purposes: to better interpret the results of the descriptive part and to further understand the process of FA to the HS in terms of progress and challenges.

5.3.1 The progress in FA process

FA to Palestine has been donated for decades, and the process of FA has developed throughout the years to increase the effectiveness of FA.

According to one of the interviewees working in the MoH “The FA process has improved tremendously since 1994. Now we have a strategy and priorities (homemade), there are more facilities like hospitals and specialized facilities to reduce referrals.” Before the PNA, FA was directed to NGOs to overcome the difficult situation and crises created by the occupation; there was no consideration of development. It was mainly multilateral humanitarian aid either directed to local NGOs or to international organization like UNRWA. After the establishment of PNA, the nature of FA changed; a large portion of the aid became bilateral aid directed to the government with the aim of building systems and institutions. FA became more oriented towards development aid than humanitarian aid.

Nevertheless, the government was in its formation phase, it lacked the resources and capacities to be able to set its needs, priorities and strategies. At this stage, the development projects were highly influenced by the donors’ agenda and strategies. Along the way, the ministries were able to build capacities through their efforts and with the aid of donors’ expertise. This decreased the donors’ influence on defining priorities and formulating strategies. This in turn increased the Palestinians’

ownership over the implemented projects and programs through being able to choose specific projects more aligned with the needs and national strategy of the Palestinians.

However, there were some concerns such as strategies being affected by externalities such as the international health agendas, e.g. the MDGs and SDGs, for two reasons: first, the international organizations, such as the WHO, are consulted on the matter of strategy making and priority setting and its inputs are taken into consideration. An interviewee from the WHO stated: “We as WHO, help the MoH to define priorities within which FA should be used.” Second, there are projects that are decided upon by both the MoH and the donors. These projects are not always aligned with the national priorities but frequently are on the donors’ priority agenda and thus have funding. An interviewee from the ICD stated “it happens that we do not like some of the projects proposed by some donors, nevertheless we agree on them” in these cases, the MoH might agree on the proposed projects out of political obligations or to gain political support.

Another concern is the lack of details in the national strategy. An interviewee from the donor group stated that “The strategy is not detailed, it is general enough to include all the proposed projects.” The new national strategy 2017-2022 has three main pillars: path to independence, governance, and sustainable development. Under them, there are priorities, policies and interventions. Most of the health interventions are under sustainable development. Thus any project proposed by the donor within development in the HS is considered aligned with the national strategy. Moreover, the details of the projects and programs were frequently decided upon by the donor, as one of the interviewees from an international organization stated: “The implementation of the strategy is donor driven, they can chose what to do within each priority.” The MoH approves the project but does not discuss the details of the implementation.

The last concern was the implementation of the strategy. Funding was needed for the implementation. The FA going to the MoH should enter the Ministry of Finance and Planning (MoFP) before going to the MoH which means that the proportion of FA directed to the MoH was decided upon by the MoFP and should pass through the governmental bureaucratic system, which results in delays with its implementation.

5.3.2 The competition on the FA

It was observed that there was a competition and tension between the government and civil society in Palestine in that both were competing for control and resources.

As for the control, the government and civil society have two different viewpoints: The MoH considers itself the main service provider and the overarching body in the HS and thus tries to control the resources and other actors in the HS. Under these considerations, the MoH wants to be involved in all the services: an interviewee from the NGO group stated that “MoH wants to do all the work, they ignore our services”. Nevertheless, the health sector is a large sector with a wide range of functions and services that requires an adequate number of human resources and expertise as well as access. Therefore, the MoH should partner with other providers to alleviate its burden. Also, the government was attempting to regulate the civil society sector. The civil society law in Palestine only requires that the NGOs be registered with the Ministry of Interior and not licensed. In addition, there was no specification in the law regarding the domain of activities that NGOs can perform or the funding resources. Nevertheless, the government wants to have more control over the NGOs: an interviewee from the MoH described the MoH’s view of the NGOs by saying “we do not really know what the NGOs are spending their money on , we need to have more control”. Therefore, the Ministry tries to reach a consensus where all the FA programs and projects are scrutinized by them before being implemented.

On the other hand, local NGOs considered themselves as indispensable partners in the HS as service providers and as a tool for protecting the public interest. They were more flexible and covered areas not accessible by the government, such as East Jerusalem and area C (areas inhabited by Palestinians but is still under the Israeli control), which enabled them to partner with the MoH.

As for the resources, MoH and NGOs compete for the same pool of FA. The HS donors in Palestine were free to fund whichever actor they want depending on their vision and preferences, which creates competition and drives each part to influence the donor and gain the fund. The NGOs use their longer presence in the provision of health services in Palestine, their experience, their access to inaccessible areas as well as their personal relations to influence the donors. The MoH influences the donor through using its position as the official overarching body and regulator of the HS, as well as its need for funds, to support its institutions in order to develop or assume its role.

The competition between the ministry and the civil society has political origins. Before the establishment of the PNA, most of the NGOs were politically oriented from their inception. With the establishment of the PNA, after the Oslo Accords, the NGOs that were for Fatah (political party in the PNA) chose to merge into the PNA and be a part of the governmental structure, while the left wing and the Islamic NGOs refused to merge and remained as they were. Afterwards, the PNA wanted to contain these NGOs so as to avoid the presence of counter parties and to keep all the power in the hands of the PNA, which resulted in tension between them.

It is a fact that donors have contributed to the competition between the ministry and NGOs. Before the Oslo Accords, and the establishment of the PNA, all the donations were directed towards civil society. However, after the establishment of the PNA, most of the donors redirected their funds towards the PNA to assist in building institutions specifically for the PNA, which left the NGOs in a difficult position. As mentioned by one of the interviews from a local NGO, “NGOs were left

to suffer for their sustainability. After Oslo Accords, donors supported the two state solution and directed all their funds towards building the PNA.”

The donors conveyed the idea that aid should be limited to one main actor and ignored the fact that the PNA and NGOs could partner in delivering health services.

5.3.3 The under communication between different actors

In the field of FA in HS in Palestine, there are many actors working on the ground to improve the health status. Nevertheless, through the interviews it became clear that there is an issue of communication between these actors, and that due to this miscommunication FA has a negative impact on health.

There are three main actors in the field of FA in health: the government, the civil society and the donors. Through the interviews, a communication problem was observed within each group as well as between the three groups.

At the government level, there are three ministries responsible for aid to health: the MoH, MoFP and the Ministry of Interior Affairs. In the interviews with MoH personnel, it was observed that information concerning FA directed to the HS according to channel and amount was not available. The unavailability of such data can only be explained by the miscommunication occurring between the different ministries responsible. This was concluded from the fact that the MoFP is the pooling ministry for the FA. Both the MoFP and the Ministry of Interior Affairs perform audits of finances and activities for NGOs working in the HS. The three ministries need a detailed database and an information system that connects all of them together and makes the available information accessible for better decision making and FA effectiveness.

As for the NGOs, their number was increasing and their nature was diverse. There were grassroots NGOs, volunteer based NGOs and fund-driven NGOs, all working in the HS. The communication between them was not clear, according to an interviewee working in a local NGO “we became so numerous that we do not know all the NGOs present in the field.” Nevertheless, it was observed that there was communication between the most prominent older NGOs, was and that it was mainly done to coordinate and avoid duplication in services provided and areas covered.

With regards to the third part, which concern the donors, according to an interviewee working in the international cooperation unit for a donor country “there are approximately 83 donors to the HS in Palestine that have never been able to set a common platform of communication between them.” Although not all the donors meet and coordinate, the major donors do communicate and discuss the main orientation of their fund to HS.

Finally, the communication between the three actors is present but it is usually between two actors and not all three actors, i.e. between the MoH and the donors but not necessarily between the NGOs or between the NGOs and donors without the MoH.

The miscommunication and lack of coordination between these three actors weakens efforts to develop a strong HS. Since each actor holds one part of the puzzle without reaching the others, it will stay a piece and rather than complete the whole picture. The donors have the money needed for implementation, the NGOs have the outreach to marginalized population and the expertise, and the MoH has the power of regulation as well as service provision. Bringing the three together through better communication and coordination would result in a robust and a resilient development in the HS.

5.3.4 The coordination structures

These communication problems have been noticed and there have been attempts to overcome them through creating coordination structures such as the LACS, ICD in the MoH and the PEGAS for the European donors.

LACS was the structure that was supposed to coordinate between the MoH, the donors and the NGOs. However, the functions of the LACS have been falling behind. An interviewee from the MoH has stated that “the LACS are useless, they only take minutes in our meetings with donors, and there is nothing they do that we cannot do.”

Discussing with one of the interviewees from LACS, it was observed that LACS’ functions became limited to donor mapping, invitation of donors on behalf of the ministry, and taking minutes of the meetings and uploading them onto their website. Although donors like to have LACS as an intermediary in contacting the ministry – as indicated an interviewee from the donors group, LACS has no obligations on any side; there is no reporting obligations towards LACS because monitoring is not a part of its mandate.

The former situation has raised questions about the effectiveness of LACS as a coordinating structure. Recently, the WB did an assessment of LACS and recommended major changes in its coordination structure. This reform of LACS aimed at aligning the LACS functions with the Paris Declaration and the Busan document to increase its effectiveness.

Before the new national strategy, LACS worked in sectors. These sectors were aligned with the development sectors in the national development plans. Now with the new national strategy of 2017-2022, there were no sectors but pillars such as: path to independence, governance and sustainable development. Under these pillars there were priorities, policies and interventions.

These pillars were vertical; they were present across all the sectors. Therefore, the WB recommended a change so that working groups have representatives of different sectors rather than having sector working groups (WorldBank, 2016). Also, the WB recommended changes in the membership of the working groups. The membership was limited to fifteen members: two from UN agencies, one from academia, one from the private sector, eight donors, one from civil society, and three from the government. An interviewee from LACS has explained the change in the number of members as follows: “The number is reduced to make the groups more active. And to make the forum more favorable for policy discussions.” Also, the WB recommended the removal of the strategy group and left the working group so as to decrease vertical communication and facilitate information sharing at the policy-making level.

Besides LACS, there is the ICD in the MoH. This structure was created at the beginning of the establishment of the PNA to coordinate the flow and use of FA. The performance of this unit has evolved over time just as the other structures and capacities of the MoH. An interviewee from the MoH stated that “At the time, the structure of the Palestinian MoH was primitive, in the phase of development in terms of structure and capacities. Today, after eighteen years, the institutional structure of the MOH was fully developed and contains an international coordination unit that was directly under the minister”. This ICD unit was now responsible for the coordination between the donors and the health service providers.

The process of coordination; as described by an interviewee from the MoH, is performed as follows: the nongovernmental service providers prepare proposals for their needs and projects and submit them to interested donors. The donor can choose to get clearance from the ICD in the MoH before proceeding with the donation. This was done to ensure harmonization and avoid duplication on one side and to guarantee that donations are supporting projects that feed into the MoH

overarching strategy and priorities. However, there was no main streaming for the donations through the ICD and some projects go without passing the ICD. This especially the case for NGOs projects because their proposals, given to the donor do not always pass by the MoH unless the donor contacts the MoH.

The third coordination structure was PEGAS, which was involved with donations from the EU. An interviewee from the donor group stated “the European countries coordinate their donations through PEGAS, they have a joint strategy and a common framework for performance monitoring”. PEGAS managed the financial aspects of aid coming from the countries of the EU. It was a collecting pool and the countries could decide which sector they wanted to allocate the donation to. The money would go to the government for implementing development programs. In PEGAS reporting only to the EU. Year after year support was declining to PEGAS because it was considered to be “band aid” and did not yield the required development.

Other than PEGAS, the coordination between the donors outside the EU was weak. An interviewee from the donor group stated “coordination with non EU donors depended on individual efforts from personnel working in each donor embassy or international coordination unit”. This lack of coordination resulted in donations which were not organized strategically and were an unnecessary duplication of efforts.

Overall, these structures seem to be isolated; each of them works alone. There was a need for a coordination platform and a better mechanism for dialogue where the level of voluntary information sharing exceeded to a level where there was an obligation to share information and a mechanism for inclusive policy- making and better use of FA.

5.3.5 The donors' preference of funding routes

There are many donors to the HS in Palestine but the main donors are the United States and Italy. These two major donors have a completely different preference in funding channels. According to a MoH interviewee, “The United States prefers donating for implementing programs and projects while the Italians prefer budget support to the ministry.” These were not the only funding channels in Palestine. As per the field observation, other channels of funding have been identified. These channels were classified depending on to whom the donations were being directed, the conditions of implementation, and whether its core, project funding or budget support.

Some of the donors believe that the best way to achieve development in the HS is through building institutions and a comprehensive system. The Italians believe that budget support and direct donations to the government will help in building a sustainable structure of institutions and system. According to an interviewee from the Italian Agency for development, “this way of funding was the best way to reach the independency of the HS and would serve the purpose of the Oslo Accords, which was the two state solution – the ultimate aim of the donations.” He also specified that this channel of donation has been there for more than a decade, and it proved to be efficient as it helped to build infrastructure and capacities. The disadvantage of this channel was that it minimized the role of civil society as a partner in development.

Other donors like to donate through programs and projects. Within this category, donors were found to be divided into three subgroups: the first subgroup consists of the donors who implemented through the ministry, others choose NGOs and the rest preferred implementing projects themselves. Donors who implemented through the ministry started by discussing the agreed upon projects with the ministry. Afterwards, the projects were implemented under the

ministry's control. This channel has the same disadvantage as the first channel (budget support); it neglected the NGOs.

The second subgroup of donors who preferred funding projects through NGOs, are donors seeking a lower level of engagement; an interviewee from a local NGO has stated that "some donors do not want to be engaged in immense financial obligations of building systems, that is why they chose to work with NGOs." They chose the NGOs' projects that aligned with their agenda and funded them.

The last subgroup of donors were those who preferred implementing through their agencies. An interviewee from a local NGO stated that "some donors come with their implementing people, they try to benefit from every penny they donate us." The disadvantage of this channel of funding (i.e. implementing through donor agencies) was the reduction of the drilldown of aid to the HS. The reduced drilldown of aid to HS was due to increase in overhead and equipment procurement expenses. Donors implementing agencies tend to hire employees and procure equipment from their country.

Moreover, the projects funding channel has major disadvantages; an interviewee from the NGOs group has stated that "project funding is disastrous, these projects are isolated attempts that never lead to a lasting impact." The separate projects are of a short period and limited outcomes. The donors want to make change and have an impact but they do not want to have long lasting obligations. This affects the development negatively, as producing change and impact requires an integral approach and time.

5.3.6 The influence of political situation on FA to HS

It was mentioned through most of the interviews, that the presence of the occupation has resulted in a series of complications that limited the impact of any development effort in Palestine. The occupation has created a fragmented system due to the geographical isolation of different parts of Palestine (West Bank Area A and B, West Bank Area C, Gaza Strip, and East Jerusalem). The PNA had control over only half of the Palestinian areas (West Bank Area A and B). The other parts were not accessible to the PNA, which hindered the development effort in these regions.

The other complication created by the occupation was the loss of control over resources which created political and economic vulnerability. This loss of control made the government dependent on FA and bound by donors' political and developmental agendas.

The political instability effect on FA to HS became apparent after reviewing the history of FA and the practices of the donors. The funding was influenced by the political atmosphere. An interviewee from the NGO group stated that "At times when the Palestinians get into peace negotiations with the Israelis, the amount of aid augments while in case of instability or disagreement with the international point of view of what should happen in Palestine (i.e. Hamas winning the election) the amount of aid decreases."

The funding channels in Palestine have been subject to political changes. Before the PNA, and until the Oslo Accords, funding was directed to NGOs. Following the Oslo Accords, the funds were directed towards the government. The government received donations until the election of Hamas. Following the election of Hamas, the funding was redirected to NGOs as the donors objected to Hamas' political orientation. Afterwards, and with the return of the old PNA, donations were redirected towards the government again.

Another point which demonstrates that aid was highly politicized was that some donors chose the FA recipient entities according to the political orientation. Donors vet the people working in the HS before giving the money and they require that the recipient organization sign the terrorism clause in order to receive the donations.

The important point is that the actual aid (from 1994 until today) coming to Palestine began with the Oslo Accords. According to those Accords, there was an obligation on the donors' part, towards the Palestinians, in which Palestinians were promised their own state. Nevertheless, it should be noted that creating a fully functional Palestinian state requires a parallel advancement in both the political and aid process to produce development. An interviewee from the donor group stated "The fact that the political process has stopped at some stage while the aid process continued hindered the process of development."

This politicization of aid was affecting the HS; an interviewee from the donor group stated that "we refuse to work with donors who ask for signing of the terrorism clause." Many of the NGOs and academic institutions, such as the Public Health Institute, refused aid coming from donors demanding the signing of the terrorism eliminated. Also, it was found in several interviews, that the portion of aid coming to HS was affected by the political situation where a considerable amount of aid went to sectors related to stabilizing the political situation, such as the security sector, while a small amount (3% as mentioned in the descriptive section) went to the HS.

5.3.7 Humanitarian aid vs. development aid

Humanitarian aid and development aid are completely separated pools of aid in Palestine. This helps to avoid overlap between the two. Otherwise, because of the ongoing and long lasting crises in Palestine, humanitarian aid would become a priority over development aid.

To ensure the complete separation of aid pools in HS in Palestine, they were managed by two separate structures: the developmental aid was managed through the health sector working group while the humanitarian aid was managed through the health cluster. Both structures were headed by members of the MoH and have members from different stakeholders on the ground.

Through interviews with both the local NGOs and the MoH representatives, it was noted that there was another type of separation of aid that developed within the Palestinian context. It appeared that most of the developmental aid was directed towards the government while most of the humanitarian aid went to civil society. This separation came about as a result of several factors. First, the need to build the institutional structure led to absorbing most of the development aid into the government. Second, the ability of NGOs to cover areas that were in need to essential services and were not accessible by the ministry made it easier for the NGOs to receive humanitarian aid rather than developmental aid. Humanitarian aid was faster to receive and less demanding in terms of paperwork.

5.3.8 The decrease in the amount of FA to the HS and aid volatility

There was a collective agreement among all of the interviewees that there is a decrease in the amount of FA coming to the HS. They attributed this decrease to several factors: first, donors' fatigue, which stemmed from frustration as there was no political progress and second, the donors' perception that at some point, the Palestinian state should be able to support its systems through better tax collection and through more diligent spending and saving practices. Donors attributed the decrease in FA to the instability in the region and the emergence of new needs in neighboring countries that absorb parts of the aid coming to the region.

Although these might be the reasons for the decrease in aid to health, other factors should not be excluded. Other factors include, the worldwide economic crises, the election of right wing parties

in some donor governments, which would be less favorable to donating to Palestinians, the presence of other global priorities and finally, favoring other sectors over health in the Palestinian context.

This decrease and volatility of aid to the HS mostly affects the NGOs as they were dependent on aid. Since NGOs were the second major health service provider, covering underserved areas, this affected the health in Palestine.

5.3.9 The disparity in the quantitative data

According to the data obtained from the OECD, and which is used elsewhere, FA to the HS has been increasing with time. On the other hand, during the interviews all of the interviewees confirmed that FA to the HS was decreasing. According to the interviewees, this discrepancy in data referred to the following:

1. There were no information system or a database that included information about all the funding channels to Palestine.
2. Missing data about expenditures and no connection between revenues and expenditures.
3. Only projects directly funded by the donor would have been documented as FA expenditure on health. Thus, if the donor was supporting the budget of the MoH this would have not been mentioned as expenditure covered by the FA.
4. There was no main streaming for the donations through the international coordination unit.
5. Some activities supported by the donors specifically for the HS were not labeled as FA for health, i.e. the Palestinian National Institute of Public Health has been established through donations from the Norwegian government, which considers this to be

institutional building support rather than health support. Donors were labeling their money differently.

6. Donations directed to the MoH entered the accounts of the MoFP under item lines directed to the MoH, while the donations going to civil society organizations that specialized in health went directly to these organizations and did not enter the MoFP records.
7. In some cases, the donor supported NGOs working on health under the heading of human rights.

5.3.10 Transparency and accountability

Ideally, the different actors in the field of FA to health should be transparent and be held accountable for their expenditures. Nevertheless, with the absence an accessible database for each actor, they cannot be held accountable. There was a different degree of accountability between the actors depending on the results measurements and the reporting system they used.

According to an NGO representative (interviewee), NGOs had to submit reports to the following: governmental side (MoH as the concerned ministry, the Ministry of Interior, and the MoFP), and to the donor, as well as, internal reports. The MoH does the internal reporting system as well as reports to donors on results and expenditures while the donor only has internal reports.

This signifies that all parties were accountable towards the donors (MoH and NGOs) but the donors were not accountable to either parties. The donors cannot be held accountable by the recipient part. The discretion around the expenditure of donors augments the problem of reducing the drilldown to the Palestinian HS through recycling the money to their country by means of increasing the foreign overhead, bringing unnecessary expertise and procurement of equipment from their country of origin. In turn, this can contribute to lowering the efficiency and role of FA in impacting the HS.

5.3.11 Despite of the challenges the health status is good, is it the FA?

The Palestinian context is complicated. Despite the occupation and an ongoing crisis situation and declining aid the health status in Palestine is relatively good. In spite of all the challenges, the HS has managed to produce good health indicators when compared with other countries in the region.

One of the interviewees contributed these results to the strong commitment of the MoH, while another one contributed them to the timely arrival of aid in cases of crises, such as the war in Gaza. Nevertheless, health status has never been a result of one thing; health was dependent on many factors such as the social determinants of health (access to sanitary water, education, etc.). Therefore, these good outcomes were the result of all these factors combined, including FA.

FA is one of these factors; as we have seen, FA helped in establishing a health system and to build institutions and facilities. It also enabled different health providers to provide health services in Palestine. The fact that FA has been decreasing throughout the years, reaching 13% of the governmental budget for health, and that there is a good health status, leads to the conclusion that, there are other sources covering for FA. The main source are taxes; the government has been able to develop an efficient tax collection system.

Chapter 6: Conclusion and policy recommendations

6.1 Conclusion

FA has a positive role on the HS in Palestine. Still, there is work to be done to improve the effectiveness and efficiency of FA in the HS in Palestine so as to increase the impact of FA.

FA contributed to the establishment of the institutional structure and capacities of the HS in Palestine, through core funding and budget support. It has also contributed to the provision of health services, through funding specific programs and projects.

FA in Palestine is allocated by the government according to pre-identified needs and discussions between the donors and the different actors in the HS. These discussions take place through the various coordination structures present in Palestine. The management of FA to the HS depends on the entity receiving the aid. However, all the recipient entities report their activities, as well as, their expenditures on a specific project, to the donor funding this project, while donors do not report to any recipient entity, except to their governments.

The effectiveness of FA in Palestine has been improving. The acquired knowledge and experience by the human resources in the HS resulted in better compliance with the Paris Declaration and its five principles. The ability of the MoH personnel to assess the Palestinian health needs and to formulate them into priorities and strategies increased the ownership and alignment of FA-funded projects. However, FA to Palestine is still influenced by donors' agendas, either out of political obligations or in order to gain the political support.

The donor's effect extends further and impacts the relation between the MoH and local NGOs. Both the donors' choice to support a specific party and the channel of funds created competition between the MoH and NGOs, exacerbating an already existing tension between the two.

FA for health in Palestine is facing many challenges. The lack of communication between different stakeholders, the absence of an effective coordination structure or an inclusive discussion platform, as well as, the low accountability of donors towards the recipients, are all challenges that negatively affect the efficiency of FA for health in Palestine.

The biggest challenge facing development and the FA process in Palestine is the Israeli occupation. The Israeli occupation and the unstable political situation have put Palestine in a state of continuous crisis which has rendered the development process very difficult. The recurrent wars and the continuous state of crisis weaken the HS and its performance. In addition, it directs international attention towards humanitarian aid rather than development aid. Furthermore, the fragmentation of land, the closure, and the loss of control over resources have all resulted in a fragile economic system, which is dependent on FA. This fragile economic system is accompanied with high unemployment rates and increased rate of poverty, which are all precursors of bad health status in any country.

Finally, the health status in Palestine was found to be relatively good compared with neighboring countries. The good health indicators cannot be directly attributed to solely FA alone as the outcome of the health sector depends on many factors, including social and economic determinants, besides the presence of supporting institutions.

6.2 Policy recommendations:

Based on interviewees' perspectives and suggestions along with the results of this research several policy recommendations are suggested. The recommendations are: the complete separation between the administration of the HS and the provision of services from any political pressure,

reconsideration of the priorities in the distribution of FA between different sectors, the creation of a healthy competition environment between health service providers, the creation of an inclusive communication and coordination platform, the development of an information system to enhance communication and accountability, partnership between foreign funding agencies and local NGOs in projects implementation, support local NGOs through capacity building, and financially, to decrease the influence of donors' agendas and finally, donors need to push towards a political solution along with the aid for development.

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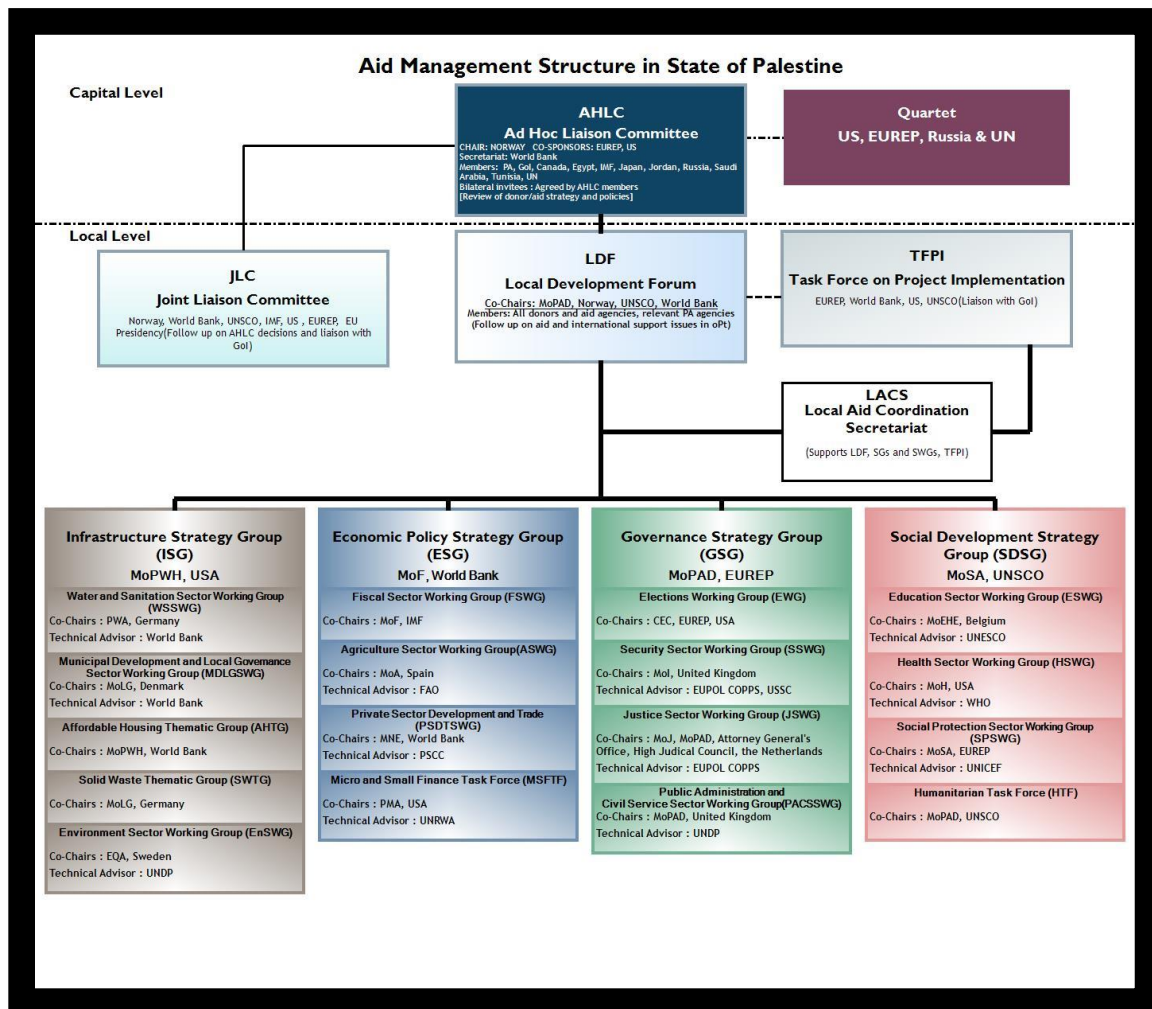
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Annexes

Annex (1) Aid management structure in Palestine



From the LDF website

<http://www.lacs.ps/OrgChartImage.aspx?ID=pq5p4ytklxqdmjesx33eyhbvCurrentImage>

Annex (2) Consent Form



Documentation of Informed Consent for Participation in Research Study

Project Title:

Foreign Aid for Health. A study on the role of Foreign Aid on the Palestinian health sector following the establishment of the National Palestinian Authority.

Principal Investigator:

Wafa Ahmed Mataria

[Tel:01276757819](tel:01276757819)

Email: wafamataria@aucegypt.edu

*You are being asked to participate in a research study. The purpose of the research is to understand the role of foreign aid in developing the Palestinian health system and in ameliorating the Palestinian health outcomes. The findings may be *presented and published*. The expected duration of your participation is half an hour.

The procedures of the research will be as follows, an interview will be conducted. The interview will be based on a group of open-ended questions to stand upon your perception of the foreign aid role in the Palestinian health sector.

*There will not be certain risks or discomforts associated with this research.

*There will not be benefits to you from this research.

*The information you provide for purposes of this research is anonymous and confidential.

*Questions about the research, my rights, or research-related injuries should be directed to Wafa Mataria at (01276757819).

*Participation in this study is voluntary. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at any time without penalty or the loss of benefits to which you are otherwise entitled.

Signature _____

Printed Name _____

Date _____