ENHANCING MINISTRY OF HEALTH-NGOS PARTNERSHIP IN PALESTINE FOR EFFECTIVE HEALTH SERVICES DELIVERY: ADVANCING TOWARDS UNIVERSAL HEALTH COVERAGE

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Contents

Acronyms

MoH	Ministry of Health
MoI	Ministry of Interior
NGOs	Nongovernmental Organizations
PHC	Primary Health Center
PLC	Palestinian Legislative Council
PMMS	Palestinian Military Medical Services
PNA	Palestinian National Authority
UHC	Universal Health Coverage
UNRWA	United Nations Relief and Works Agency for Palestine Refugees

Abstract

Governmental health sectors around the world are facing financial and administrative deficiencies and inefficiencies. These deficiencies impact populations health and give space to other actors to emerge. NGOs have been known for their role in gap filling for the government. A positive relation between the government and NGOs is an indispensable to help in reaching a higher level of health care provision and accessibility. In Palestine, NGOs play a major role in the provision and financing of health care. However, the performance of Palestinian NGOs is affected by their relation with the MoH. This study aims at determining the factors affecting the relation between the government and NGOs working in the health sectors in Palestine for better health sector performance.

Descriptive quantitative and explorative qualitative methods where used in this study. Data was collected through desk review and semi-structured in depth interviews. The sample was a purposive sample done through snowballing. An oral consent was obtained from each participant prior to the interview.

The study concluded that NGOs are prominent service providers with many advantages needed by the MoH to access marginalized populations, the relation between MoH and health centered NGOs is progressing towards complementarity despite the differences in viewpoints and minor competition and the main factors affecting MoH- NGO relation are: the political background of the PNA and NGOs, the unclear role of each side, the un-institutionalization of the rules governing the MoH-NGOs relation, the absence of the legislative body, donors influence and the changing role of NGOs.

1.Introduction

Health is a human right. Accessibility to health services is at the core of the right to health. Globally, governments are looking towards achieving universal health coverage (UHC) to ensure the attainment of health right by all. Nevertheless, deficiencies in health systems results in depriving people from their right. Health system deficiencies are due to the increased demands by the growing populations and changing patterns of disease accompanied by reduced resources.

Non-Governmental Organizations (NGOs) have been known for their role in gap filling for the government; as well as, for their contribution to societies' welfare. In the health sector, they play a dynamic role in the society as service providers. Recently, the number of NGOs has been increasing considerably. They are becoming prominent actors directly impacting national economies by significantly contributing to GDP growth. A positive relation between governments and NGOs is indispensable to help improve health care provision increase accessibility to health services and achieve UHC.

In Palestine, NGOs play a major role in the provision and financing of health care. Like in other developing countries, Palestinian NGOs became pioneers in operating projects. However, the performance of Palestinian NGOs is affected by their relation with the MoH.

This study aims at determining the factors affecting the relation between the government and NGOs working in the health sectors in Palestine. Determining these factors is fundamental for a better engagement of NGOs in service provision and hence increase health services accessibility to the population in Palestine.

2.literature review

Health systems around the world are facing many deficiencies. These deficiencies are more prominent in developing and poor countries. Within these countries, health systems suffer from financial as well as administrative deficiencies and inefficiencies (Pick S, Givaudan M, Reich MR, 2008). These weak points in the government health sector institutions and their impact on the national and international levels have given space to other actors to emerge and take action (Ejaz I, Shaikh BT, Rizvi , 2011).

NGOs have been known for their role in gap filling for the government (Lorgen CC. , 1998) and for their contribution to the social welfare (Cammett M, MacLean LM, editors, 2014). They play a dynamic role in the society as service providers in health care (Bratton M, 1989). NGOs has been increasing considerably that they grew to become prominent actors directly impacting the national economy of countries by contributing significantly to their GDP (Eakin L, Richmond T., 2009). A positive relation between the government and Non-Governmental Organizations is an indispensable element to help in reaching a higher level of health care provision and population needs satisfaction.

NGOs are social change advocators, they do what the government is unable, does not or refuses to do (Najam A., 2000). Thereafter, the character of NGOs and their services have a political and social effect (Cammett M, MacLean LM, editors, 2014) (Young DR., 2000). In 1994 Edwards and Hulmes indicated that according to the NGO choice regarding their role in the society the relation between them and the government is shaped: either the NGO concentrates on expanding its role in service delivery or concentrates on the political process in the country (Edwards M, Hulme D. , 1994). The choice made by the NGO and the space given to them by the government give rise to three possible types of relations: adversarial, dependency or collaborative (Tandon R., 1989).

In the case where the government look at NGOs as adverse or competitors, its policies towards NGOs would be more restrictive and dominant giving the government more control over the autonomy seeking NGOs (Bratton M, 1989). Consequently, the chance of positive relation and collaboration between both sides becomes difficult. In the other two cases, the NGO concentrates on services delivery. In case of dependency, the government plays the role of the supportive as in the case of the United States, where the government funds some programs delivered by NGOs making NGOs dependent on the government. An alternative is where a collaborative relation in certain fields develops.

Although one might think that the common relation between governments and NGOs is an adversarial one, Salamon in his research emphasized that the relation between the government and NGOs in most cases is a collaborative one (Salamon, L. M., 1994). This is due to the facts that: NGOs would not be able to replace the government because of the limited resources and capacities of small separate entities; and the fact that NGOs could not cover for governments' decrease in expenditure in service provision, which will eventually drives both sides for collaboration (Salamon, L. M., 1994), (Bremner RH., 1988).

From the above, the factors affecting the government-NGOs relation can be grouped into three main factors: first, the government vision of the health sector and the civil society law. This vision depends on government acceptance of institutional pluralism (Coston JM., 1998). The government possesses the controlling and regulating power, which will determine its policies towards NGOs. If the government accepts NGOs as co-providers in its policies, it will be favorable and supportive to the NGOs and enabling laws would exist. Second, the external funds coming from international development institutions: having resources enables the NGOs to carry out their activities and gives them more power. For instance, the International Monetary Fund (IMF) and the World Bank have a considerable impact on policy making and implementation especially in

countries with poverty and conflict (Macdonald L., 1994), where governments are in a weak position and NGOs are proliferating under the external support, giving them more presence and making it easier to the government to accept them as partners, and third, NGOs' economic and social value, the services they provide and their credibility (Nanetti RY.).

As for the case of Palestine, the nonprofit sector is playing a major role in the provision and financing of health care. like other developing countries NGOs became pioneers in operating projects in these countries (Galway LP, Corbett KK, Zeng L., 2012). However, the political background of most of the NGOs in Palestine and the fact that both the NGOs and the government are dependent on external fund might gave rise to some kind of competition which might have affected their relation (Tvedt T., 2002).

3. Study Objectives

3.1 General objective

The study aims at determining the factors affecting the relation between the government and NGOs working in the health sectors in Palestine. Determining these factors is fundamental for a better engagement of NGOs in service provision and hence increase health services accessibility in Palestine.

3.2 Specific objectives

1. to determine the share of the NGOs as providers in the health sector in Palestine
2. to analyze the governmental policy towards 'Health Services Providing NGOs'
3. to determine the influence of external funds on the work of NGOs and their relation with the government

4.Methodology

4.1 Study design

The study is an explorative and descriptive study. The study has two parts: a quantitative descriptive part that is dedicated to describing the status quo of the health service providing NGOs in Palestine, and an explorative part which depends on the beliefs and perceptions of different stakeholders to understand the relation between MoH and NGOs in Palestine and the factors affecting this relation.

4.2 Study setting / data sources

The study is conducted in Palestine. It covers both; NGOs working in the health sector and the Ministry of health. Data will be both primary and secondary data. Primary data will be collected through interviews with different stakeholders while the secondary data will be obtained through desk review of official documents, published articles, and online international organizations data.

4.3 Sampling method

The sample for this study started as a purposive sample and continues through snowballing. The main purpose of choosing purposive sampling is to focus on specific characteristics of the participants; their relation and knowledge of the subject; which will serve the purpose of the study in further understanding of the FA process.

Sampling is to be continued through snowballing where the interviewees are asked to recommend names of personnel in these abovementioned entities for interviews. Snowballing is used to overcome the difficulty of reaching other interviewees. The sensitivity of the subject makes the access for interviewees difficult and the fact the names of the new interviewees are recommend by their acquaintances made these interviewees more prone to accept the request for

an interview. Overall fifteen participants from different stakeholders' groups (NGOs, MoH, UNRWA, and academia) were interviewed.

4.4 Data collection and management

Data will be collected through:

1. Desk review: is to be done through both reviewing documents and records from the MoH and through online research of the international organizations websites such as OECD, World Bank, and WHO.
2. Interviews: 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.

The data was analyzed in two parts: descriptive quantitative analysis, and qualitative content analysis. The descriptive quantitative analysis use tables and graphs to describe data collected on NGOs working in the health sector in Palestine such as: their number, distribution, scope of services. And finally, the qualitative content analysis, where the content of the interviews is transcribed, data categorized and grouped into themes to be analyze descriptively and interpretatively.

4.6 Coordination, monitoring and quality control

Validity and reliability in of data will be assured through the use of the triangulation technique. 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 Ethical considerations:

Ethical issues have been taken into consideration through this research. All interview participants participated voluntarily in the study. The purpose of the study as well as the procedure of data collection through semi-structured interviews were explained to each participant before obtaining an oral consent from each one. The participants were also assured that there will not be risks or discomforts associated with this research. The information they provide for this research will anonymous and confidential. The participants were also informed that the results of the study might be presented and published.

4.8 Limitations:

The minimum acceptable number of interviews (fifteen interviews) was conducted for this research due to the sensitivity of the topic and thus difficulty to obtain appointments for interviews. High level persons were contacted. Giving their levels and the sensitivity of the topic many contacted persons were reluctant to participate in the study while others needed to seek an official approval of their institutions to be able to provide any kind of information.

5.Palestinian Health system overview

The Palestinian health system is relatively new. It has been established along with the establishment of the Palestinian National Authority (PNA)in 1994. After World War I, Palestine was under the British mandate where the British Civil Administrative system was responsible for health services. After 1948 Arab-Israel War, Palestine became occupied by the Israelis and health services were under the Israeli Military Health Department of Civil Administration until 1994. PNA is the first national administrative system to rule the Palestinians.

Within the present health Palestinian system there are five main health service providers: Ministry of Health (MOH), Palestinian Military Medical Services (PMMS), United Nations Relief and Works Agency for Palestine Refugees (UNRWA), the Palestinian nongovernmental nonprofit organizations (NGOs), and the private for-profit sector (Giacaman, R., Khatib, R., Shabaneh, L., Ramlawi, A., Sabri, B., Sabatinelli, G., Khawaja, M. and Laurance, T., 2009).

MoH is the overarching umbrella for the Palestinian health system. According to the Palestinian constitution of 2003 and the Public Health Law, the MoH is responsible for regulating the health sector as well as the provision of health services to the population (Palestinian Legislative Council, 2005). MoH provides primary, secondary and tertiary services. The MoH services quality and quantity developed considerably overtime. Nowadays, the MoH has 63.9% of the Primary Health Care(PHC) centers (Table1) and 54.3% of hospital beds (Table 2) around Palestine. The MoH also operates several health programs such as school health and community involvement Programs (Ministry of Health, 2014).

PMMS delivers services to military and police personnel and their families. PMMS has 2.3% of the PHCs and 2.2% of hospital beds in Palestine.

UNRWA concentrates on Palestinian refugees. It was created in 1949 after the Arab Israeli war to provide health and educational services to Palestinians who were forcibly displaced during the war. Today UNRWA serve 2,209,738 refugees. UNRWA mainly provides primary services and depends on the other service providers for secondary and tertiary health services.

Private sector provides secondary and tertiary services, 5.5% of hospital beds belongs to the private sector. The private sector expanded considerably in recent years, it is mainly owned by individual physicians and is based on fee-for-services payments. As for the NGOs they are major health service providers and will be discussed thorough in the next section.

Table 1 PHC centers distribution according to provider*

Provider	No. and percentage of PhC centers	
MoH	**468**	**63.9%**
NGOs	**182**	**24.6%**
UNRWA	**65**	**8.9%**
PMMS	**17**	**2.3%**

***Health Annual Report, Palestine, 2018**

Table 2 Distribution of hospitals according to provider*

provider	No. of hospitals	No. of beds	% of beds
MoH	**27**	**3,384**	**54.5%**
NGOs	**34**	**2,286**	**36.8%**
UNRWA	**1**	**63**	**1%**
Private	**16**	**344**	**5.5%**
PMMS	**3**	**136**	**2.2%**
Total	**81**	**6,213**	**100%**

***Health Annual report, Palestine, 2017**

In consequence of the political situation, the health sector in Palestine is facing serious challenges which affects the population accessibility to health services health and the MoH-NGOs relation. The main challenges are: the inaccessibility to certain Palestinian areas such as areas c and east Jerusalem, the dividedness in governance between Gaza Strip and the West Bank, and the financial constraints.

Due to the Israeli occupation and the Oslo accord, the land under the control of the PNA is composed of the West Bank and the Gaza strip. The West Bank is divided into three areas A, B, and C according to controlling authority. Area A is administered by the PNA, area B is administered by both PNA and Israel, while area C is administered by Israel. PNA although responsible for civil services in the three areas have no control and very limited access to areas C which pose a problem in terms of serving these marginalized populations. Moreover, the mobility of people in these areas is limited due to the presence of Israeli

checkpoints which poses a problem in accessing health services present in areas A and B. PNA also has no access to East Jerusalem population.

As for Gaza strip, the problem is different. In 2006, legislative elections were held in the Palestinian Territories and Hamas won the election against Fatah (the ruling party). The results of the election were not welcomed by Fatah (the counter party), Israel, the United States, and the international community. This resulted in a struggle that yielded in two separate Palestinian areas: West Bank under the authority of Fatah and Gaza strip under the authority of Hamas. This status quo entails restricted aid and resources to Gaza strip health sector and difficulty in communication between the two sides which affects health policies implementation especially in Gaza Strip.

Last but not least, the financial restrictions. As Palestine is under occupation, PNA has no control over its resources making its economy highly dependent on aid. The fluctuation and volatility in the aid according to the political situation highly affect the performance of the health system. For instance, when Hamas won the election foreign aid to Palestine declined abruptly in order to starve the PNA of money so as to weaken Hamas and force them to leave the power (LeMore, 2006). Another financial constraint is the UNRWA crisis, where the United States decided to reduce its contribution to the UNRWA to $60 million instead of $364 million which if not compensated would result in the deprivation of Palestinian refugees from essential education and health services.

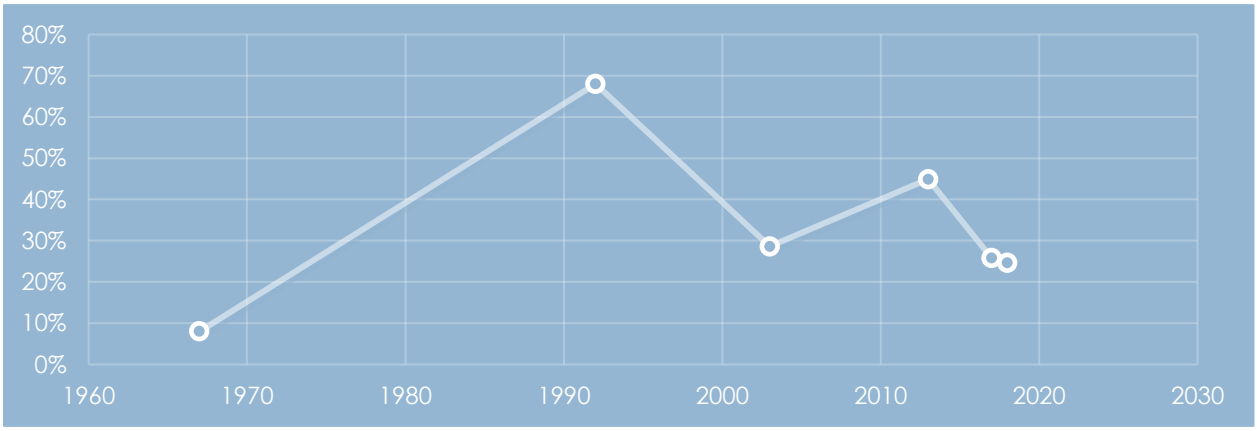
6.NGO's and health in Palestine

NGOs are significant for the Palestinian population. Their significance emerges from the fact that NGOs working in the health sector in Palestine are considered part of the society.

Before the mushrooming of NGOs in Palestine, NGOs were formed either on charitable, religious basis (Challand, B., 2008)or political background. In both cases, NGOs were representatives of the population and responsive to their needs. NGOs were considered, along with UNRWA, as the safety net for the Palestinians. They covered the deficiency in social services including health services during the British mandate and the Israeli occupation before the establishment of the PNA. Moreover, NGOs have a role in the Palestinian economy, they contribute to the labor market by 10% (Karin A. Gerster, 2011).

NGOs role as well as their scope of services fluctuated overtime (figure 1). Health NGOs number increased, from 1967 till 1993, where there was a need during the occupation years for other service providers to compensate for the Israeli poorly administrated hospitals and neglected health services and due to the increased amount of foreign aid.

Figure 1 Percentage of the NGOs primary health care centers in Palestine through the years[1]



Upon the arrival of the PNA, the number of NGOs started to decline due to: first, the establishment of PNA health facilities and joining of some NGOs facilities to the MoH (Sullivan, 1996). Second, foreign aid reduction to NGOs and redirection of aid towards PNA (Sarsour, S., Naser, R., & Atallah, M., 2011). According to the MoH records, in the West Bank and Gaza strip, there are 158 registered health

[1] According to: (Habasch, R., 1999) , MoH annual health reports

centered NGO. These NGOs are distributed within different governorates as shown in figure 2.

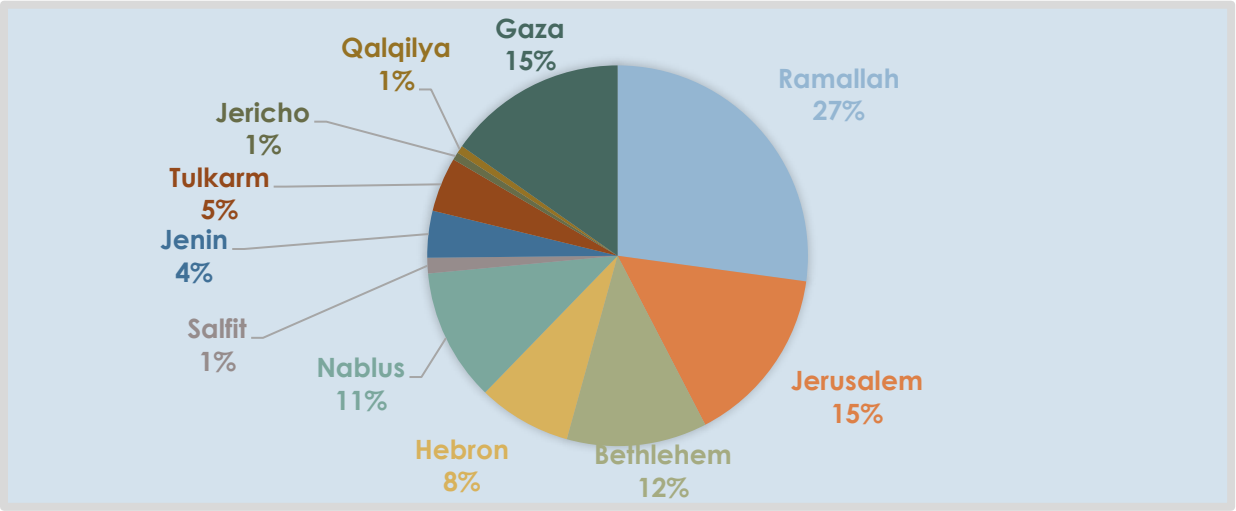


Figure 2 health centered NGOs distribution

NGOs remain to be main actors in the health sector in Palestine. Their programs are mostly derived from the society needs and their services are complimenting the governmental services. NGOs provides services to whoever is in need and concentrates on marginalized populations. NGOs' Hospitals (figure 2), PHCs and mobile clinics are distributed throughout Palestine which enhance health services access of marginalized populations separated politically and living in areas C, east Jerusalem and Gaza strip.

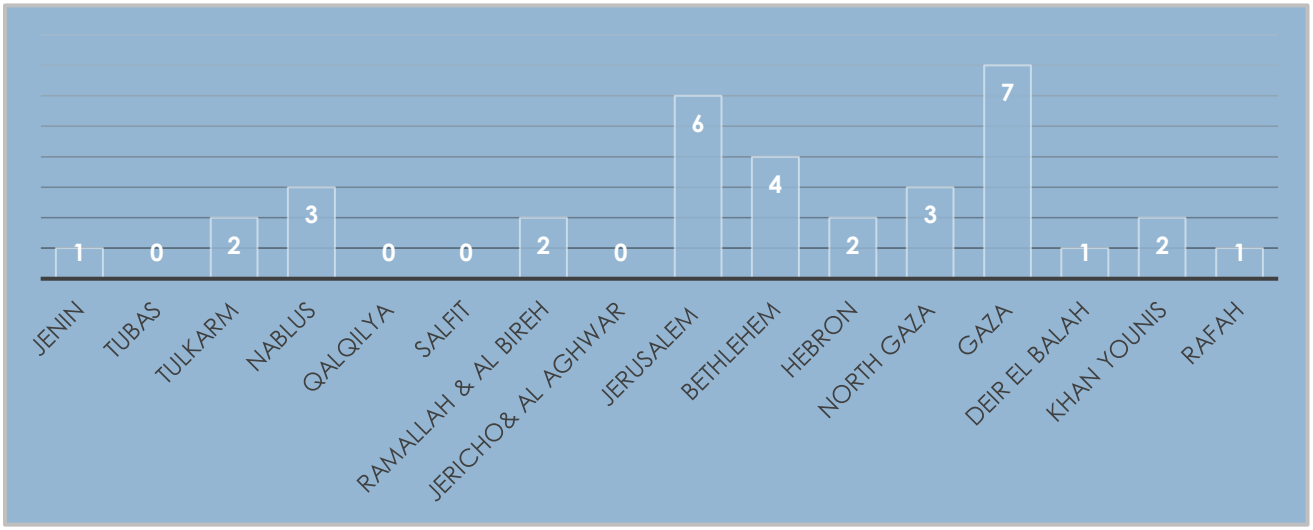


Figure 3 No. of NGOs' hospitals per governorate (annex 1)

Nowadays, NGOs health services are distributed within the whole ranges of health services. As for primary care, NGOs owns 24.6% of PHC centers in Palestine. Secondary and tertiary care are also provided by NGOs in Palestine where 36.8% of hospital beds belongs to NGOs. Within these 36% of beds, NGOs number of beds in maternity and specialized services, such as cancer therapy, outnumber those of the MoH. Moreover, NGOs are the only rehabilitation services providers in Palestine (table 4) and as Palestinian population faces repeated aggressive confrontation with the occupation which results in high number of injuries, rehabilitation services are crucial. Moreover, some NGOs own mobile clinics that can reach marginalized population, especially in areas C.

Table 3 Distribution of hospital beds by provider and specialty[2]

provider	General	Specialized	Rehabilitation	Maternity
MoH	**2,832**	**473**	**-**	**43**
NGOs	**1,206**	**487**	**189**	**179**
UNRWA	**63**	**-**	**-**	**-**

[2] Health Annual report, Palestine, 2017 retrieved on 18/10/2019 http://site.moh.ps/Content/Books/38pf7Q9KpsHKGjWZxroQEuJ1OZeOJw8mhssgDKBJGnoAu5C4oKFpoW_kUFGingMuntfG2fm4rVu2grDremJD77xH9P5xgfSFQPvvxcOPgeyD7.pdf

Private	**218**	**288**	**-**	**74**
PMMS	**161**	**-**	**-**	**-**
Total	**4,480**	**1,248**	**189**	**296**

7.Government – NGOs' relation

The relation between the government and heath centered NGOs in Palestine is complicated. It is characterized to have multiple facades as a result of the politically forced situation and the resultant health demand. The relation between the government and NGOs can take any and all of the three following shapes: collaboration, dependency, and adversarial.

Collaboration, the MOH and the NGOs are collaborating in providing services in Palestine in different manners and levels. The political situation in Palestine, the division of the Palestinian territories, and the inability of the PNA to access certain areas and provide health services in these areas, necessitates the collaboration with the NGOs to provide essential health services in these areas. Moreover, there is a complementarity in the range of services provided by both the MOH and NGOs. Rehabilitation services are mainly provided by NGOs while primary health services are mainly provided by the MoH in Areas A and B and by NGOs in areas C. Tertiary health services are provided by both.

Dependency, this form of relation is limited, it is present in the context of the red crescent and the government. The red crescent is considered as a "para-governmental institution". Although it was created before the establishment of the PNA, with the presence of the PNA, the red crescent kept its role in providing ambulance services in Palestine under the supervision of the MoH. The red crescent is also partially funded by the Palestinian Liberation Organization(PLO) which has Fatah (the faction leading the PNA in the West Bank) as the largest faction.

Adversarial, the relation is described to be adversarial due to the competition between the government and NGOs over power and financial resources. Most of the NGOs in Palestine were formed by major political parties in Palestine during the period of the Israeli occupation and before the formation of the Palestinian National Authority (PNA). This political background of the NGOs; although diminished is still present and constitute one of the causes for adversarial relation between the government and NGOs.

The competition between MoH and NGOs manifests in the services they provide. The MoH and NGOs provide several common services such as primary, and tertiary services. According to NGOs they were present long before the MoH, they have developed the needed experience and expertise in the field, they have hospitals, PHC centers and mobile clinics which are providing good quality services in different areas and have the outreach to marginalized population, therefore the MoH should respect their presence. Whereas, as for the MoH, it considers that the provision of services to the whole population as its responsibility. These two different perspectives led to misunderstanding between the MoH and the NGOs and resulted in certain incidents giving the impression of ongoing competition. An interviewee from NGOs pointed out that, the MoH has intended to provide services already covered by NGOs in several locations without taking into consideration the presence of NGOs services. This happened mainly with PHC centers and some tertiary services. Another NGOs interviewee stated that MoH have requested them to give up their centers to the MoH to operate. The MoH, however, defended their acts by indicating that the services provided by NGOs were sometimes inadequate in terms of quantity and quality and that it is the ministry's responsibility to provide the proper services.

Along with the fact that both MoH and NGOs provide similar services as an underlying reason for the competitive relation, another reason is the funding. Foreign Aid (FA) is a major funding source for both the NGOs and the Ministry of

Health (MoH) in Palestine. Both, MoH and NGOs are highly dependent on foreign aid. NGOs are mostly dependent on foreign aid for their sustainability. Except for minimal fees charged by some NGOs for their health services, there is no other source of income to NGOs in Palestine other than FA. On the other hand, the relatively newly formed Palestinian government is also dependent on FA. This dependability along with the redirection of aid from NGOs towards the establishment of the PNA and its different ministries in 1994 and afterwards, helped in creating this negative competitive atmosphere over resources.

Giving the evolution of the current health system in Palestine and the many factors inherited in this evolution, the MoH-NGOs' relation could be threatened by potential mistrust on both sides. MoH reproach NGOs for performing projects that do not necessarily align with the national plan and for low transparency as well as the incompliance to quality standards. The MoH is looking for more control over NGOs. The MoH requested NGOs to demonstrate more transparency regarding their resources, projects, services, and financial records. Today, all NGOs are requested to provide technical report to the MoH and financial reports to the MoI, also all NGOs facilities which provide health services are licensed by the MoH. Likewise, NGOs reproach the government for not enabling these NGOs and trying to minimize their role. According to interviewees, NGO's are not looking for competition with the MoH, according to them if service provision is to be based on competitive bases, this competition should be backed up with the necessary regulation that guarantee a healthy competition atmosphere with professionalism and competency as the main criteria. other interviewees stated that" accountability measures and regulations need to be universal applied on all service providers even governmental ones".

Although there is a certain degree of mistrust and unhealthy competition, these two negativities are declining as time passes. Both the MoH and NGOs appreciate the gravity of the depleting continuous political and economic situation in

Palestine and its effect on the health of the population. Apart from their disagreements they acknowledge the necessity of collaboration in order to be able to provide health service for the whole population. Since the establishment of the PNA, NGOs are trying to adapt to the changing situation in Palestine while preserving their role as being representative of the community and responsive to their needs. NGOs concentrated on donors which were interested with funding NGOs or those looking for short term commitments through small projects to ensure their sustainability. Some NGOs changed their areas of services and sometimes their role to evolve more towards being advocates for health. At the same time, NGOs accepted the MoH as the overarching umbrella for the Palestinian health system and try to conform to the government requirements while calling for the establishment of a high health council with active representation of all stakeholders. As for the MoH, its governance capacities have been developing through the years, many advancement has been achieved and the personnel of the MoH understand the importance of the NGOs, their presence and services especially in areas not accessible by the MoH (e.g. area C and East Jerusalem).

The relation between MoH and NGOs is far for being a complete partnership. The MoH-NGOs' relation is evolving towards complementary – each side is becoming more aware of the politically imposed situation, its limitations and the capacity of the other side, which is a step in the right direction.

8.Modes of MoH-NGOs collaboration

8.1 Health sector planning

National health strategies in Palestine are examples of collaboration between the MoH and NGOs in Palestine. In the latest Palestinian national health strategy of 2017-2020 and the one before 2014-2016, the MoH used the participatory approach to prepare these two documents. Different stakeholders including

NGOs were solicited to participate in developing these national health strategies. A national team lead by the minister of health and including representatives from different stakeholders' groups was established. This was followed by several workshops and consultations where the national team decided upon priorities and objectives of the strategy and discussed the strategy draft prepared by the MoH (Palestinian Ministry of Health, 2017) (Palestinian Ministry of Health , 2014).

Although MoH exerted efforts to ensure collaboration between health sector stakeholders to develop the strategic health plans the collaboration was not satisfactory for some NGOs. According to NGOs interviewees, their participation in the strategy development did not reach partnership. Their participation was more of a complementary participation. One interviewee stated that "although we attended the meetings, our views and suggestions were not included in the strategy". Another interviewee indicated that "NGOs participation was solicited at later stages to approve the already made strategy ".

In addition to the strategy, the MoH solicited NGOs collaboration in its latest initiative to advance the Palestinian health system. Recently and according to the Health Minister request, a Health National Committee of 24 members, mostly previous minsters and some other actors in the health sectors including NGOs was formed. The committee was asked to provide recommendations and an executive plan to advance the health system in five main areas: UHC, health insurance, Ambulance and emergency, service quality, and nationalization of health services. Four subcommittees were formed, they met several times and provided their recommendation for discussion and approval.

8.2 East-Jerusalem Palestinian Hospitals

In East Jerusalem there are six civil society hospitals (Augusta Victoria Hospital, Makassed Hospital, St Joseph Hospital, St John's Eye Hospital, Palestinian Red Crescent Maternity Hospital and Princess Basma Rehabilitation Centre) that are vital for the Palestinian population, according to one interviewee "these six

hospitals are the backbone of the Palestinian health system". These hospitals serve as the center for specialized health services in the Palestinian health system. Specialized services such as oncology, renal care and cardiac surgeries are not available in the West Bank and Gaza Strip. Patients from both areas are treated in these hospitals.

The collaboration between these hospitals and the MoH consists of purchasing tertiary services from these hospitals. MoH refers patients to these hospitals for treatment and pay for these services. According to the Health Annual report 66,180 patient were admitted to East Jerusalem Hospitals in 2017 (table5).

Moreover, these hospitals play a major role in developing human capacities to work in the Palestinian health system through training and teaching of post-graduate medical students as well as nursing students. These institutions are recognized for their high quality services and for being granted the International Organization for Standardization (ISO) certification and JCI accreditation, which adds to the value of their training.

However, some challenges face the MOH collaboration with these hospitals. The most important ones are: the delay or inability of the MoH to cover referral cost which expose these hospitals to increased financial burden and crisis, the accessibility of patients as well as workers to these hospitals due to Israeli imposed permits and barriers, and finally the limited capacity of these hospitals.

As part of the health system, the MoH ought to support these hospitals by ensuring their sustainability through financial support and well positioning in the health system structure.

Table 4 Jerusalem Hospitals Utilization[3]

Hospital	No. of Beds	No. of patient admitted

[3] Health Annual report, Palestine, 2017 retrieved on 18/10/2019 http://site.moh.ps/Content/Books/38pf7Q9KpsHKGjWZxroQEuJ1OZeOJw8mhssgDKBJGnoAu5C4oKFpoW_kUFGingMuntfG2fm4rVu2grDremJD77xH9P5xgfSFQPvvxcOPgeyD7.pdf

Al-Makassed	**250**	**15,499**
Augusta Victoria	**171**	**22,175**
PRCS	**30**	**4,038**
St. Joseph's	**155**	**22,213**
St. John(ophthalmic)	**36**	**1,765**
Basma rehabilitation	**20**	**490**
Total	**662**	**66,180**

8.3 East Jerusalem school programs

School health programs are programs provided by the MoH as a means to enhance population health. School health programs include: medical screening, health education for students, school-based vaccination, and environmental health and safety in schools. In areas accessible by the MoH, MoH personnel are responsible of implementing these programs. However, in East Jerusalem, the MoH has no access. In order to cover these schools, the MoH collaborate with NGOs to implement these programs.

8.4 Joint PHC centers

Prior to the PNA, PHC centers belonged to NGOs. NGOs provided primary health care through their PHC centers and mobile clinics covering most of the Palestinian areas. After the establishment of the MoH, although the MoH opened its own PHC centers collaboration between the MoH and NGOs took place. MoH and NGOs collaborate through joint PHC centers. Some services by the MOH such as vaccinations by MoH staff were added to the already NGOs PHC centers services. The main reasons behind the joint PHC centers were: to ensure service coverage

of areas inaccessible by the MoH, to avoid service duplication and to maximize the efficiency of resources utilization.

Although this type of collaboration succeeded in several PHC centers, some cases failed and the collaboration ended and the MoH opened its PHC center and the NGO either closed its PHC center or faced decrease in demand and thus changed scope of services provided.

8.5 Project based collaboration

Some NGOs working in the health field execute projects in collaboration with the MoH. These NGOs develop projects that are aligned with the MoH needs and prospective for health services in Palestine. These projects are funded by the donors, executed by the NGO for the MoH in accordance with the MoH. Example of these projects are projects where NGOs develop a training program according to protocols based on international standards and agreed upon by the NGOs and the MoH. These trainings are designed for the staff of MoH and other service providers. According to one of the interviewee" our NGO develop Continuous Professional Development programs according to evidence-based guidelines and practices such as the Child Health Diploma from the UK's Royal College of Pediatrics and Child Health, and our beneficiaries are service providers including the MoH". Moreover, some NGOs run service evaluation and need assessments to help the MoH in ameliorating their services.

9.Factors influencing Government – NGOs' relation

9.1 political background

Political background is an important factors affecting the relation between the MoH and NGOs in Palestine. Apart from the charitable organizations most of the NGOs created in the 1980s are or were affiliated to political parties present in Palestine at the time such as Fatah, Palestinian People's Party, Democratic Front

for the Liberation of Palestine, etc. These parties represent the political powers in Palestine and the Palestinians' struggle against the occupation.

Following the Oslo accord and upon the establishment of the PNA the equilibrium of powers was disturbed as the PNA was managed by mainly one political party "Fatah". The tension between NGOs and PNA started. PNA sought its role as the national authority while the other parties defended their positions as representatives of the rest of the population. This power struggle included NGOs and their activities. As for health centered NGOs, the ones supporting Fatah passed their PHC centers to the MoH while others work on keeping their PHC centers while figuring out means to work with the MoH.

Today, many of these NGOs claim that they are no longer into political work, they are only service providers and thus, they demand to be treated accordingly. Likewise, the MoH claim that its decisions and dealings with different actors is professional without political bias. Nevertheless, in the interviews, participants referred several times to political background as an underlying cause for the tension in the relation between NGOs and MoH.

9.2 Governance and administration of the health system

The administration and governance in Palestine is complex due to the political situation of occupation and dividedness in the country. This present situation demands special arrangement in services delivery in order to cover the whole population. These arrangements necessitate cooperation between all stakeholders and require a system of governance and administration capable of establishing this cooperation.

In principle, the MoH is the overarching umbrella for the health system in Palestine. MoH responsibilities, according to the law, is to ensure the provision of health services to the whole population as well as to regulate the health sector. The MoH is struggling to assume its role due to the above mentioned challenges and due

to the unclear MoH perspective of the health system structure and roles of different actors.

At present, MoH is a service provider, purchaser and regulator. At the same time, other service providers are present in the field; their presence is crucial due to the services they provide (e.g. East Jerusalem Hospitals) and their access to marginalized populations (e.g. NGOs access to areas C). The MoH as the regulating body did not articulate clearly what is the role needed from other providers in accordance to its role, also the MoH did not institutionalize means of collaboration with these providers. These unclear roles resulted in state of misunderstanding between both sides resulting in a relation where collaboration, competition and mistrust exist.

As the MoH is relatively new, and there is some struggle over power, this situation is normal. Looking backwards and as time passes both the MoH and NGOs realize their dependency on each other. The MoH recognizes its need for other service providers in order to cover the whole population and the NGOs admit the role of the ministry as the overarching body for the health system. The next step would be clarifying each side role and institutionalizing the relation between the MoH and NGOs in the health system, where clear rules are present and used.
In addition, if the MoH change its understanding of the overarching role in the health sector, this will reduce the tension in its relation with other actors. Being the overarching umbrella for the health sector does not require being the purchaser, provider and regulator of the health sector. Concentrating on the regulating part having a separate service purchasing body and service providers will provide a healthy competitive environment under the control of the MoH.

9.3 Absence of the legislative body

Palestinian Legislative Council (PLC) is the legislature of the PNA. It is elected by the Palestinians and is composed of 132 members. Last PLC elections took place in 2006. The election was won by Hamas and was followed by a period of unrest,

which resulted in the separation of Gaza and West Bank. The West Bank was regained by Fatah and in 2007 the PLC was dissolved. Since then the President "relied on a provision in the Palestinian Authority Interim constitution to exercise full law making authority in the West Bank" (Anabtawi, S. & Brown J. N., 2019). The absence of the PLC signifies the absence of laws agreed upon democratically. As for what concerns the health sector, there is a need for the PLC to regulate the relations between different stakeholders. NGO's demand being principle actors in the health sector and therefore insist on creating the bases for this role through founding prerequisite conditions such as the laws and regulations. In the absence of the PLC, NGOs call for the creation and activation of population health council composed of all actors in the health sector and where all the health sector planning takes place. According to a NGO interviewee "we are stuck in this situation due to the absence of a democratic representing body where all population representatives can contribute to decision making". Another interviewee stated that "a national health council where all actors are represented should be established, in this council we would be able to contribute to the health decision making and our views would be included in future planning".

9.4 Influence of donors

The fact that both the MoH and the NGOs are aid dependent increases the influence of the donors on them. Donors follow their interests while deciding upon whom to support. They empower the side which serves their interests. Before 1994, donations were directed towards NGOs; after the establishment of the PNA, donors chose to redirect their donations towards the newly born government leaving NGOs to struggle for their existence. Donor redirected their aid to the government in the aim of advancing the progress of the Oslo accord which they agreed upon. In 2006, when Hamas won the election, donors cut their aid to the government and redirected it to NGOs to weaken the elected government which

opposed the Oslo accord and hence empowering the NGOs which happen to be at great need for aid. This fluctuation and volatility of aid resulted in creating a competitive atmosphere between the government and NGOs over funds and power and thus affects their relation.

9.5 changing role of NGOs

The role of the NGOs has been evolving over time. The change of NGOs' role was a result of two factors: first, the changing situation in Palestine where a national official body responsible for the population health was formed (MoH and PNA) which decreased NGOs' significance in service provision and enabled them to look for other areas of population need. Second, the change in donors' funding agenda. In the 1990s and afterwards donors' agendas changed, more funding was directed towards empowerment, gender issues, human rights, etc. than towards service provision. Also, donors' funding criteria changed, more focus on accountability and reporting was exerted by donors which forced NGOs to adapt their services to donors' agenda while trying to preserve their original activities; they were also forced to increase their professionalism in terms of proposal writing and projects reporting.

Thus, NGOs service evolved overtime to encompass other services, such as: awareness campaigns, elderly care, youth programs and others. Nevertheless, the most important change in NGOs role was progressing towards advocacy and assuming the role of watchdog on the governmental policies, action and services. NGOs created the Palestinian NGOs Network so as to have a stronger collective voice in advocacy and can be more influential in policy making process. The watchdog and advocacy NGOs' role creates conflict with the government. Even though NGOs have always been a prominent actor in health as service providers as well as influencers, the fact that they are playing the role of watchdog and demand to be a core part of health strategy and policy setting

is alarming to the MoH, especially that the MoH did not articulate its role in the health system clearly.

10.Conclusion and recommendations

MoH and NGOs complement each other in Palestine. NGOs in Palestine have a social, political and economic significance. In the health sector, NGOs are prominent service providers with many advantages needed by the MoH to access marginalized populations.

The complexity of the political and economic situation in Palestine obliges both the government and the NGOs to operate within the status quo and find routes for collaboration to provide services for the Palestinian population. The relation between MoH and health centered NGOs is progressing towards complementarity despite the differences in viewpoints and minor competition and mistrust. The main factors contributing to the present MoH- NGO relation are: the political background of the PNA and NGOs, the unclear role of each side, the un-institutionalization of the rules governing the MoH-NGOs relation, the absence of the legislative body, donors influence and the changing role of NGOs.

Recommendations

Based on the results of the study the following recommendations are suggested in order for the MoH-NGOs relation to progress towards collaboration and partnership:

- complete separation of Health services and administration from any political pressure
- clear articulation of the role of different actors in the health sector and preferably the separation between the three functions of the MoH where the MoH becomes the regulator of the health sector while service

purchasing is under a separate entity and service provision is based on competitiveness

- institutionalizing the rules governing the relation between different actors
- establishing a national health council to provide equal opportunities for all health sector actors to be part of the future national health plans

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Annexes

Annex 1:

Table 5 Distribution of NGOs hospitals among the West Bank & Gaza Strip governorates[4]

West Bank		Gaza Strip	
Governorate	**No. of hospitals**	**Governorate**	**No. of Hospitals**
Jenin	**1**	North Gaza	**3**
Tubas	**-**	Gaza	**7**
Tulkarm	**2**	Deir El Balah	**1**
Nablus	**3**	Khan Younis	**2**
Qalqilya	**-**	Rafah	**1**
Salfit	**-**		
Ramallah & Al Bireh	**2**		
Jericho& Al Aghwar	**-**		
Jerusalem	**6**		
Bethlehem	**4**		
Hebron	**2**		

[4] Health Annual Report, Palestine 2017 retrieved on 30/8/2019 http://site.moh.ps/Content/Books/38pf7Q9KpsHKGjWZxroQEuJ1OZeOJw8mhssgDKBJGnoAu5C4oKFpoW_kUFGingMuntfG2fm4rVu2grDremJD77xH9P5xgfSFQPvvxcOPgeyD7.pdf

Annex 2: List of participants

No.	Name	Institution
1	Dr. Walid Namour	Augusta Victoria Hospital
2	Shatha Oudeh	Health Work Committee
3	Dr. Mohamed Al-Whoush	UNFPA
4	Yaser Bouzaieh	MoH
5	Iyad Al-Agha	MoH
6	Wael Qaadan	Palestinian Red Crescent Society
7	Dua Qurie	Palestinian NGO's Network
8	Ghassan Kasabrah	NGO's Development Center
9	Yousef Mheisen	WHO- country office
10	Ammal Awadallah	Palestinian Family Planning & Protection Association
11	Moustafa El- Bargouthi	PMRS
12	Oula Aker	MoH
13	Omaya Khamash	Juzoor
14	Muhamed Awad	Al-Quds University/ Sava the Children
15	Yousef El- Takroury	Al- Ahli Hospital