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"Perceptions of Beneficiaries and International Partners on Effectiveness of Health Aid Coordination in the oPt, 2002-2008"

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"Perceptions of Beneficiaries and International Partners on Effectiveness of Health Aid Coordination in the oPt, 2002-2008"

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"Perceptions of Beneficiaries and International Partners on Effectiveness of Health Aid Coordination in the oPt 2002-2008"

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Al-Quds University-Jerusalem

2010

Dedication

I dedicate this study to my late parents, for their great efforts in supporting me all through my life and for their great sacrifice, to my lovely wife and children.

To the Palestinian health sector which I wish a prosperous future with effective coordinated efforts to provide the best health services for the Palestinian people

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Declaration

I certify that this thesis submitted for the degree of master is the result of my own research, except where otherwise acknowledged, and that this thesis-or any part of the same material-has not been submitted for a higher degree to any other university or institution.

Signed:

Yousef Ahmad Muhaisen

Date: 7 August, 2010

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Abstract:

The study assessed the effectiveness of health aid coordination in occupied Palestinian territory (oPt) between the years 2002-2008. The perceptions of the providers of aid (international partners) and recipient of funds (beneficiaries) were explored with focus on how coordination meetings are supporting positively the health aid coordination, obstacles and factors negatively influencing the effectiveness of health aid coordination, the types of relationships among stakeholders. In addition to assessing the aid coordination effectiveness using Paris Deceleration Principles (2005) for partnership; in specific ownership, alignment and harmonization that were set in Rome Agenda (2003) and used in OECD survey in 2004.

The period of aid coordination between 2002-2008 was very important as it witnessed the eruption of the Second Intifada, which drew the health sector into chronic emergency and shifted the type of aid mainly from developmental intended for serving the state-building agenda to a response to the consequent humanitarian and emergency needs. Thus, there was a precipitous shift from development to humanitarian aid.

The study was conducted due to significant fragmentation of the funding and provision mechanisms in the Palestinian health care system with high number of local and international players in the system and the believe of weaknesses of health coordination mechanisms.

Currently there are about 83 bilateral international partners providing support to the oPt. The United Nations (UN) system is present with 22 agencies. The number of international NGOs stands at approximately 150, and there are up to 200 national NGOs working in the oPt. In health sector there are around 40 main players including international partners and beneficiaries at central level in addition to tens of health organizations at districts level.

The study adopted a cross sectional descriptive approach to assess the perceptions of stakeholders (beneficiaries and international partners) on aid coordination effectiveness in oPt. Two different questionnaires (for beneficiaries and international partners) were developed based on the Organization for Economic Cooperation & Development (OECD)

health surveys that were conducted in 14 countries in 2004 to monitor ownership, harmonization and alignment. The tools were adapted to the Palestinian context.
. The study populations consisted of all key informants representing all national and international stakeholders (agencies, institutions) who are participating directly in the health aid coordination meetings (37stakeholders). All these agencies were targeted and approached during the data collection. However, 73% of the total or targeted key informants in the health sector replied positively and took part in the study. .

Health aid coordination meetings are the forum for harmonization in health sector through sharing information, exchanging ideas and experience, exchanging reports and disseminating information to health partners. The study attributed the low effectiveness of aid coordination in the Palestinian health sector to three main factors; political agendas of stakeholders (more than 90%), international partners' practices (98% of beneficiaries complained from international partners agendas and the lack of follow up by the MoH (85% agree).

Aid effectiveness was assessed by stakeholders (national and international) using Paris Deceleration principles. The results showed that health aid effectiveness in ownership, alignment and harmonization is still weak and there is a need to improve it by both the beneficiaries and the international partners.

The study concedes, based on the perceptions of both beneficiaries and international partners, that there is still a gap in the relationships between them, it is not transparent (54% agree) and there is lack of trust (67% agree).

Finally the study recommends the need to review and strengthen the coordination effectiveness in order to improve the performance of the health aid coordination, improve the aid effectiveness in partnership principles, ownership, alignment and harmonization. The study recommends also to strengthen the relationship between the beneficiaries and the international partners according to Rome agenda and Paris declaration on harmonization, alignment and harmonization.

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List of abbreviations

AHLC	Ad Hoc Liaison Committee
CAP	Consolidated Appeal Process
DAC	Development Assistance Committee
EC	European Commission
GDP	Goss Domestic produ
GS	Gaza Strip
HDCM	health district coordination meetings
HECM	Health Emergency Coordination Meeting
HI	Health Inforum
IC	Italian Cooperation
HSR	Health Sector Review
HTGs	Health Thematic Groups
HWC	Health Work Committees
HSWG	Health Sector Working Group
INGOs	International Non Governmental Organizations
JLC	Joint Liaison Committee
LACC	Local Aid Coordination Committee
LACS	Local Aid Coordination Secretariat
LDF	Local Development Forum
MoPIC	Ministry of Planning & International Cooperation
MTDP	Medium Term Development Plan
NGOs	Palestinian Non Governmental Organizations
NHP	National Health Plan
OCHA UN	Office for the Coordination of Humanitarian Affairs
OECD	Organization for Economic Cooperation & Development
oPt	Occupied Palestinian Territory
PNA	Palestinian National Authority
PCBS	Palestinian Central Bureau of Statistics

PLC	Palestinian Legislative Council
PMRS	Palestine Medical Relief Society
PRCS	Palestine Red Crescent Society
TG	Thematic Group
UN	United Nations
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNRWA	United Nations for Relief & Works Agency
UNSCO	Office of the United Nations Special Coordinator for the Middle East Peace Process
USAID	United States Agency for International Development
WB	West Bank
WBG	West Bank and Gaza
WHO	World Health Organization

Chapter one

Introduction

The health care system in occupied Palestinian territory (oPt) is characterised by fragmentation of funding and provision mechanisms. There is inadequate funding mechanisms and dependence on external sources for funding the system. External aid represented 48% of health expenditures in oPt at 2003 (HSR 2007).

Moreover, there is high number of local and international players in the system and at the same time there is weakness of coordination mechanisms among different actors. According to the Palestinian National Authority (PNA), there are currently 83 bilateral international partners providing support to the oPt. The United Nations (UN) system is present with 22 agencies. The number of international NGOs stands at approximately 150, and there are up to 200 national NGOs working in the oPt (UNSCO, 2010).

1.1 Problem statement and significance

There is significant fragmentation of the funding and provision mechanisms of the Palestinian health care system with high number of local and international players in the system and the weakness of health coordination mechanisms.

Currently, health cluster has 23 international partners, including 5 United Nations agencies (UN), 9 bi-lateral/multilateral donors, 9 international non governmental organizations (INGOs) agencies, while the main beneficiaries in health sector are the Palestinian ministry

of health (MoH) and four main local health non governmental organizations (NGOs) (Health cluster records 2009), in addition to tens Palestinian charitable health organizations at districts level. This situation complicates the ability to harmonise international partners' policies and align aid with the country needs and priorities. Aid effectiveness is jeopardised by varied international partners agenda and weak coordination mechanisms.

There has been few studies tackled the aid coordination in general in oPt during the years 2000-2007 (Mokoro 2003 and 2007). However, none has focused on the aid coordination in health sector development and practices in oPt.

1.2 Justification of the study

Experiences in the oPt and other contexts have shown that international partners have different agendas and competition among health stakeholders leading to duplication and wasting of limited resources. Both international partners and local agencies select projects that coincide with their own priorities, which might not necessary among the real needs of the country. Coordination among different stakeholders is essential function within such an environment and highly required. Although the international community has been supporting the Palestinian health care system through various international aids and funding mechanisms, there is still doubt on the effectiveness of the health aid coordination.

The assessment on the perceptions of beneficiaries and international partners on health aid effectiveness in oPt, 2002-2008 looked at the health aid coordination in place and made recommendations to strengthen it. Information was drawn from participants in the coordination processes.

1.3 Purpose of the study

The purpose of this study is to assess the effectiveness of health aid coordination in the Palestinian health sector between the years 2002-2008 as perceived by the international partners (donors and international agencies) and beneficiaries.

1.4 Study objectives

1. To assess the perceptions of beneficiaries and international partners on the types (focus) of health aid during the period 2002-2008.
2. To assess the perceptions of beneficiaries and international partners on how the health coordination meetings are supporting the effectiveness of health aid.
3. To assess the perceptions of beneficiaries and international partners on the obstacles and factors negatively influencing the effectiveness of health aid coordination.
4. To assess the perceptions of beneficiaries and international partners on the types of relationships among stakeholders.
5. To assess the beneficiaries perceptions on international partners practices in health aid.
6. To assess the international partners and beneficiaries perceptions on aid effectiveness using Paris Deceleration Principles (2005) for partnership; in specific ownership, alignment and harmonization that were set in Rome Agenda (2003) and used in the Organization for Economic Cooperation and Development (OECD) survey in 2004.
7. To compare the perception of beneficiaries and international partners on aid effectiveness in the health sector including: the importance of coordination meetings, obstacles and factors negatively influencing aid coordination meetings, types of relationships between stakeholders, and perceptions about effectiveness of aid according to Paris Deceleration Principles.

1.5 Research Questions

1. What are the types (focus) of health aid during the period 2002-2008?
2. What are the perceptions of beneficiaries and international partners on the issues included in heath aid coordination meetings and how do these meetings support health aid coordination?
3. What are the perceptions of beneficiaries' and international partners about obstacles and factors negatively influencing the effectiveness of health aid coordination?

4. What are the perceptions on the type of relationships among beneficiaries and international partners?
5. What are the perceptions of beneficiaries' on international partners practices in health aid?
6. What are the perceptions of beneficiaries' and international partners on aid effectiveness according to Paris Declaration Principles, in specific harmonization, alignment and ownership?
7. Are there any significant differences in the perceptions of beneficiaries and international partners on aid effectiveness in the health sectors including: the importance of coordination meetings, obstacle and factors negatively influencing aid coordination meetings, types of relationship between stakeholders, and perceptions about effectiveness of aid according to Paris Deceleration Principles?

1.6 Study Limitations:

1. Lack of accurate and comprehensive data about international aid and distribution of funds in the health sector.
2. The long period of the study (2002-2008), some of the international partners' representatives were replaced during this period.
3. Lack of awareness on health aid coordination effectiveness measures among some of the surveyed stakeholders,

1.7 Study Assumptions

- Information provided by the studied participants is reliable, accurate and represents the point views of the participants' institutions.

Chapter Two

Situation Analysis

This chapter gives an overview on the Palestinian context and a situation analysis of the Palestinian health care system, then it discuses in details the aid coordination development in oPt in general and the coordination in health sector in specific.

2.1 Demography

The total number of population in oPt is 3,767,126 in 2007 (PCBS, 2007). 43% of them are registered refugees.

The WB (WB) is a more mountainous region comprising 11 governorates. The WB population was in 2007, 2,350,583 inhabitants dispersed in 422 cities, villages and camps. About 400 villages are scattered in remote and rural places, with a combined area of around 6000 Km^2. The refugee population represents about 28.1% of the total WB population (PCBS 2008)

The Gaza Strip (GS) comprises 5 governorates and a population of 1,416,543 inhabitants: about 67.9**%** of them are refugees (The population is concentrated in 7 towns, 10 villages and 8 camps with a total area of 360 Km^2 (PCBS, 2009).

2.2 Political context

UN defines the occupied Palestinian territory (oPt) as the areas that were occupied after the Israeli Arab war in 1967. oPt consist of WB, including East Jerusalem and GS Strip.

The Palestinian National Authority (PNA) was established in 1994 after the signature of the Oslo Agreement. It is a parliamentary system with three distinctive powers: Legislative, Executive and Judiciary. The Legislative Council with elected members conducts legislative practices. The President is the head of the state and is directly elected from the oPt population. The President, with the agreement of the Legislative Council, nominates the Prime Minister (Iskander 2007).

The eruption of the second intifada in September 2000 and the increase in Israeli military action had a dramatic effect. It resulted in weakening the capacity of the Palestinian Authority and the destruction of public infrastructure.

In January 2006 elections, Hamas won the majority in the Palestinian Legislative Council (PLC) elections which lead to an international boycott of the PNA resulted in economic and development crisis in the oPt.

After Hamas took control of in the Gaza Strip, Caretaker government was formed in WB on June 17, 2007. The international community endorsed the Caretaker Government and began to reinstate financial and technical assistance.

2.3 Health status

In general health status in oPt is acceptable, as of 2008, life expectancy at birth in Palestine is about 72 years; infant mortality rate was 25 per 1,000 live births. The following table shows more indicators on health status (MoH,2010).

*Table 2.1: Health status indicators in oPt

Indicators	oPt	Region	
		WB	GS Strip
Life expectancy mid year 2008 (male)	70.20	70.56	69.65
Life expectancy mid year 2008 (female)	72.92	73.43	72.11
Total fertility rate	4.6	4.2	5.4
Infant mortality rate (MoH)	25		
Dependency ratio mid year 2008	83.6	78.8	92.2
Population natural increase rate mid year 2008	2.87	2.65	3.23
Percentage of refugees 2007	42.7	27.4	67.9
Proportion of pop aged under 5 years mid year 2008	14.9	13.9	16.4
Proportion of pop aged under 15 years mid year 2008	42.5	40.7	45.5
Proportion of pop aged 65 years and above mid year 2008	3.1	3.4	2.5
Reported CBR per 1000 pop mid year 2008	32.65	30.16	36.77
Reported CDR per 1000 pop mid year 2008	4.36	4.48	4.17
Percentage of low birth weight (<2500 gm) of total births (MoH data)	7.3	7.5	7.0
Percentage of unemployment 2008	26.0	19.0	40.6

*Source: (MoH, 2010)

2.4 The socioeconomic status

Despite large inflows of aid, the unemployment in the oPt .Unemploement rate for the 1st quarter of 2010 was 22.0% (16.5% in the West Bank and 33.9% in Gaza), (PCBS 2010).

Unemployment rate was in WB 17.7% in 2007 and 19% in the first quarter of 2008, and the unemployment in GS was 29.7% in 2007 to 29.8%. in 2008 These figures do not give an accurate picture of the full impact of the economic crisis, because they do not take into account underemployed workers such as the large number who have turned to unpaid family labor or seasonal agriculture (World Bank Country Brief, 2009).

Because of the crisis, poverty continues to increase in GS where the official poverty rate rose from 47.9% in 2006 to 51.8% in 2007. In the WB poverty slightly declined, falling

from 22% in 2006 to about 19.1% in 2007. The percentage of Gazans in deep poverty also continued to rise, increasing from 33.2% in 2006 to 35% in (World Bank 2008)

This illustrates the high levels of aid dependency in the WB and GS, especially when you take into account the fact that the majority of the income of government employees is financed with foreign aid (World Bank Country brief 2009).

2.5 Historical developments of the health sector

The health Palestinian system passed through several developments up and down since 1920 until now, the governments of British, Jordan, Egypt and the Israeli military government took over the health system until transferring the health sector to PNA in 1994.

2.5.1 Health Care during the British Mandate 1920-1947

The period of the British mandate over Palestine 1920-1947 marked a decisive phase of political upheaval, economic transformation, social displacement and colonial rule. This phase ended with the 1948 Arab-Israeli war which along with the total collapse of a geographically cohesive Palestinian community, lead to complete breakdown of health services provided by the British mandatory government in Palestine.

The Department of health in Palestine established in 1920, the country was divided into four health districts (Jerusalem, Nablus, Haifa and Jaffa) each of eighteen sub districts was supervised by a British medical officer (Barnea & Husseini 2002).

Christian missionary had established medical facilities in most cities and holy places during Ottoman rule. The establishment of these institutions was responsible on presentation of Western medicine into Palestine. Until the last decade of the mandate period, missionary hospitals sponsored by the British, French, German, and Italian communities outnumbered government hospitals (Barnea & Husseini 2002).

2.5.2 Jordanian and Egyptian administration 1948-1967

Prior the Israeli occupation to WB and GS in 1967. GS was administered by Egypt, while the WB was part of Jordan. Health services in WB and GS followed different systems and regulations. GS followed Egyptian protocols for medical licensing and other relevant issues, while the WB followed Jordanian protocols.

Following the displacement of the Palestinians 1948 from theire homes to neighbouring Arab countries, UNRWA was established by United Nations General Assembly resolution 302 (IV) of 8 December 1949 to carry out direct relief and works programmes for Palestine refugees. The Agency began operations on 1 May 1950. Since then UNRWA has had the responsibility in providing basic health services to registered Palestinian refugees (and their descendants) in the WB and GS, Jordan, Lebanon and Syria. (Barnea & Husseini 2002).

2.5.3 The Israeli military administration 1967 and 1994

After the occupation of the WB and GS in 1967 and until 1994, the health services were run by Israeli Civil Administration which was created by Israeli Government as a division of the Israeli Ministry of Defence and to run the social services for the population at the occupied Palestinian territory (oPt). The system was based on taxes collected from Palestinian and the health services were suffering from budgetary constraints and lack of development–oriented approaches. During that period, GS and WB health services had separate Israeli chief medical officers and administrative structures, and they continued to follow different protocols in certain health policy areas, particularly those relating to medical licensing and supervision of health facilities. There were also some differences between the two areas, including differences in vaccination programs, maternal and child health programs, primary care services, and health insurance. (Schoenbaum et al 2005).

Israel managed to maintain two separate health systems, one for Israeli citizens including settlers in the oPt and one for the Palestinians in oPt. This gap leads to an increased dependence of Palestinian health consumers on medical services in Israel. The absence of

development plan or investment in infrastructure (physical and human) created an unbalanced Palestinian health system that was ultimately transferred to the PNA within the framework of Oslo accords (Ziv 2002).

The increase of the non-governmental organizations (NGOs) has been a creative example of the Palestinian response in all areas and in every level, particularly in the health sector. These NGOs have adopted a variety of approaches since the 1967 occupation and in serving as alternatives to provide health care for the people. The NGOs, civil society, non-profit health committees, were born in the 1980s and expanded their activities in the first Intifada (1987-1993) out of the urgent need to support communities that were not receiving adequate health services. The Palestinian health NGOs was extensive and the services of these NGOs extended from primary health care to secondary and tertiary health care.

2.5.4 Transfer of health sector to the Palestinian National Authority in 1994

Following the Oslo Peace Agreement between the Palestinian Liberation Organization and the Government of Israel in September in 1993, the Palestinian National Authority (PNA) and Israel negotiated the transfer of responsibility for health services and health policy from Israeli military administration to the PNA. The PNA assumed health sector responsibility for GS and Jericho in May 1994 and for the rest of the WB at the end of that year.

The health system transferred to the PNA was clearly insufficient, both at primary and secondary health levels. The situation was worse in GS than in the WB, since the latter having a well-developed NGOs and private sector.

The Palestinian MoH quickly emphasized curative medicine as a priority, and focused investments on improving hospital care. Human and financial resources were diverted in that direction, MoH managed public health services and delivery of primary, secondary, and tertiary care in government facilities.

2.5.5 Health system between 2000-2005

Since the eruption of second Intifada in September 2000, the health situation has evolved from acute to chronic emergency. Especially, during the Israeli military re-occupation of Palestinian towns and cities in the WB in 2002 and imposition of harsh restrictions on the movement of Palestinians. MoH faced difficulties to provide services due closures and curfews, Health Inforum (HI) as a joint initiative from the international community in cooperation with MoH and full supervision from WHO, the Italian Cooperation, the US Agency for International Development (USAID) took the responsibility of ensuring effective operational coordination among the international community that was working in oPt to meet the needs of the health sector mainly MoH. Developmental projects almost stopped during this period and MoH worked mainly to respond to emergency need. (OCHA 2005)

2.5.6 Health system between 2006- 2007

As a result of January 2006 elections and the political changes after winning the elections by Hamas, health sector in general and MoH in particular faced an acute financial crisis after complete termination transfer of tax revenues by Israel to the PNA. In addition, there was a sharp decline in the foreign aid, which led to the interruption in salaries and the inability to ensure the operational expenses. The sector's disbursements nearly tripled from 2005 to 2006—mostly as a result of emergency humanitarian funding to the sector, directly implemented by aid agencies. In 2007, disbursements dropped off, reaching a rate lower even than 2005 (MoPIC 2008)

2.6 Health System Organization

As we mentioned before, the Palestinian health care system is extraordinarily complex and fragmented. It has various players. MoH is responsible on the health of Palestinians; it is the regulating body of the system. The main roles and

responsibilities of MoH according to the Palestinian Public Health Law are (MoH plan 2008):

1- Regulating and supervising the provision of health care in Palestine
2- Planning the health care services in coordination with different stakeholders
3- Enhance health promotion to improve the health status
4- Development of the human resources in health sector
5- Management and dissemination of health information
6- Ensure national health expenditure being allocated according to population needs

2.6.1 Governance

MoH has the stewardship in setting policies, national strategies and plans, As indicated in the National Health Strategy document, the priority of the MoH is to standardize and institutionalize its regulatory functions and processes to ensure their continuation despite changes in staff and management (MoH 2010).

2.6.2 Health Care Delivery System

The Palestinian health care system has a complex and fragmented health care delivery system. Various agencies and sectors with different delivery systems and objectives provide services. Today there are at least five key health providers: MoH, NGOs, UNRWA, private and Medical Military Services**.**

MoH health services

(MoH) provides services to the entire Palestinian population, regardless of health insurance or refugee status, immunizations, prenatal and postnatal care, preventive and curative care for children until age three, basic preventive services, hospital care, and community mental health services, without patient cost sharing. The predominant source of health insurance in oPt is currently the government insurance program, which covers primary, secondary, and tertiary curative care. As shown in table2.2 MoH is operating 414 out of 621 Primary Health Care (PHC) facilities which represent 66.6% (MoH 2008).

*Table2.2: Distribution of Primary Health Care services in oPt by region and provider, 2007

Region	Population	Health Care Provider				
		MoH	UNRWA	NGOs	Total	PHC Center/10,000
West Bank	2,350,583	356	35	141	**541**	2.29
Gaza Strip	1,416,543	58	18	57	**133**	.093
Grand Total	**3,767,126**	414	53	198	**621**	**1.65**

*Source: (MoH 2008)

MoH is the main hospital service provider as shown in table 2.3 below, it operates 24 out of the 78 hospitals in the WB and GS with a total of 2,923 beds which represent 59 % of the hospital beds in oPt (MoH 2008).

*Table2.3: Distribution of hospitals' beds in oPt by region and provider, 2007

Region	Population	Provider					
		MoH	UNRWA	NGOs	Private	Total	Bed/ 10,000 population
West Bank	2,350,583	1,336	63	1,143	397	2939	12.50
Gaza Strip	1,416,543	1,587	0	382	34	2003	14.1
Grand Total	**3,767,126**	**2923**	**63**	**1525**	**431**	**4942**	**13.10**

*Source: (MoH 2008)

Medical Military Services

Medical Military Services of the Police and General Security (MSP) is another governmental sector. It provides medical services for police and general security forces members. their families and prisoners.

UNRWA services

UNRWA's health services focus on disease prevention and control, primary care, family health, health education, physiotherapy, school health, psychosocial support services, and environmental health. Services are provided mainly through a network of UNRWA outpatient clinics throughout the WB and GS, primarily in areas with significant concentrations of refugees. UNRWA operates 61primary health centres in oPt in addition to one hospital in WB and 21 community rehabilitation centre (UNRWA 2010)

NGOs health services

NGOs have played a very important role in all levels of the Palestinian health care system. They were established in the 1980s to cover the lack of health services and expanded their activities in the first Intifada (1987-1993) out of the urgent need to support communities that were not receiving adequate health services. NGOs include organizations with social, political, and religious motivations. Historically and today, NGOs have provided services including Outpatient and inpatient care, psychosocial support, rehabilitation, health education, and emergency care.

Health NGOs run 30 hospitals (20 in WB and 10 in GS), which represents 30.8% of hospital beds. Moreover, they own 198 health centres, about 31.6% of primary health facilities in the WB&GS (PHIC 2007) . These health NGOs have adopted a variety of approaches since the 1967 occupation and in serving as alternatives. Following are the main health NGOs:

1. Palestine Red Crescent Society (PRCS), it provides PHC, Emergency medical Services , rehabilitation and few Maternity hospitals at district levels.

2. Palestine Medical Relief Society, which provides mainly PHC and some rehabilitation services.
3. Union of Health Care Committees provides PHC mainly in the Northern area of the WB.
4. Health Work Committees also provides PHC.
5. Zakat Committees and Charitable Societies, which operates few PHC centres and some hospitals.
6. East Jerusalem Hospitals Net work
7. Patients Friends Socities at districts level

Private Sector

Private investment in the health sector was relatively limited before 1994 but grew considerably between 1994 and 2000. The private health sector now includes clinics and hospitals; pharmacies; laboratories; radiology, physiotherapy, and rehabilitation centres; and medical equipment manufacturing facilities. In addition, there is a growing domestic pharmaceutical industry, there have been some attempts to establish private health insurance programs, but private coverage has never exceeded 2–3 percent of the population. Private insurance plans have essentially been eliminated by the economic hardships accompanying the second intifada. However, private expenditures on health remain considerable (Rand, 2000).

The Private Health Sector runs 22 hospitals in oPt (20 in WB and 2 in GS) which represents 8.7% of hospital beds in oPt and hundreds of private settings are operated by private individual medical specialists, physicians, dentists, pharmacists, laboratory technicians and X-ray technicians. There is some Maternity and specialized private hospitals (MoH 2007).

2.7 Finance of Health Sector

According to disbursements 2005-2007, the health sector has the largest number of International partners contributing less than 10% of the sectors disbursements. The two largest international partners, the EC (42%) and USA (13%) were responsible for just over half of disbursements to the sector (MoPIC 2008).

The largest sources of funds injecting finances into the system are international partners assistance, tax revenues and private out-of-pocket household spending. The largest source, international partners assistance contributes up to 42 percent in the form of budget support and project financing, supporting both the PNA and NGOs. An estimated 25 percent of this external funding flows to UNRWA. A certain proportion of international partners funds are also given as in-kind contributions and are often not included in the reporting of international partners assistance. The next largest source, private households, is responsible for 40 percent of total health financing. Households spend money directly on health insurance premiums, co-payments, pharmaceuticals and health services. The last source, government tax receipts and fees, provides 18 percent of health financing. These figures are 2004 estimates based on data collected from government sources, international partners and household surveys (World Bank 2008).

In the first years of the 2nd Intifada from 2001-2002, international partners financing comprised about 50 percent of the budget allocated by the Ministry of Finance to cover MOH non-salary recurrent expenditures – USD 47.3 million out of USD 95.3 million. This percentage of international partners support increased to around 87 percent during 2003-2004 as the Ministry of Finance (MoF) transfers dropped to zero. By 2005, international partners assistance itself decreased to 29 percent of the approved MOH budget increasing the financing gap and leading to large accumulated MOH arrears with local and overseas suppliers of drugs, medical supplies and health services. One year later, in 2006, International partners assistance to cover this non-salary spending rebounded to 80 percent, similar to levels in earlier years (World Bank 2008).

The annual budget of the MOH used to be around US$ 100 million up to 2003. The proportional distribution of the MOH expenditure was 58% for salaries, 25% for drugs, medical supplies and vaccines, 10.8% for operating services, and 6.4% for referrals for treatments abroad(HSR 2007).

The MOH (recurrent and capital budget) received 61% (US$ 145 million) of the total fund allocated to the health sector (Islamic Development Bank (IDB) not included). UNRWA and NGOs represent respectively 9% and 23% (HSR 2007).

2007 data indicated that the GDP of Palestine was estimated to be US$ 4,672.3 million (current price) or about US$ 1,337 per capita. Palestine allocates a significant part of its resources to the health sector. The average health expenditure between 2000- 2006 is estimated to be about 11% of GDP which is higher than in many other developing countries. (NHP 2010-2013). Despite the magnitude of international partners aid, the external assistance appears fragmented in the absence of a clear framework for health sector and aid effectiveness policy.

2.8 Aid coordination development in the oPt

The local aid coordination structure brings together all and is organized around four strategy groups: 1. Economic Strategy Group (ESG), 2- Governance Strategy Group (GSG), 3- Infrastructure Strategy Group (ISG) and 4- Social Development Strategy Group (SDSG). The structure is supported by the Local Aid Coordination Secretariat (LACS), which also maintains the web portal of the Local Development Forum (LDF) supporting the members of the aid coordination structure in the oPt.

Regarding the humanitarian coordination, cluster approach was implemented in oPt for different sectors including the health cluster approach early 2009. It has worked closely with all health stakeholders,

2.8.1 Aid Coordination after Oslo (1994-2000)

An elaborate set of aid coordination arrangements developed in the oPt after Oslo. They were shaped by the political context, the unusually large number of international partners, a desire for rapid delivery of substantial amounts of aid (to help secure the "peace dividend"

from Oslo) and the uncertain and evolving status of the main recipient institution. On the other hand, Arab States were not represented (Lister & Le More, 2003) .
Coordination structure was top-down and involved a third party; Israel. The coordination structures were mainly the Ad hoc Liaison Committee (AHLC), the Joint Liaison Committee (JLC), Local Aid Coordination Committee (LACC) with Norway, World Bank and UNSCO being the co-chairs of LACC, and finally the SWGs which were numerous and progressing at different paces according to the strength of the focal points especially at line ministries (Lister & Le More, 2003).

Development agenda was driven mainly by the LACC co-chairs, US and EC; the same responsible for the diplomatic and political aspects of the peace process which confirms the international partners' actions were political driven and the need to keep the peace process alive. Their procedures were not harmonized. The competition was highly for political visibility. International partners found it was easier for them to do the job without delays caused by consultations with local partners (Lister & Le More, 2003).

No holistic development vision was there. Health, Education and Employment Generation SWGs were efficient. (Le More, 2004a)

2.8.2 Aid Coordination during the Second Intifada (2000-2003)

Following the eruption of the second *Intifada* end of 1999 and the humanitarian situation in the oPt, a shift was witnessed in aid coordination from developmental towards emergency agenda and an increase in the number of international NGOs (INGOs), international partners-driven aid and the marginalization of the PNA.

Aid in 2003 represented about 41% of the oPt GDP according to World Bank (2003). The Arab league became an important player since 2001, accounting for about 30.8% of all disbursements by 2002 (Le More, 2004a).

2.8.3 Aid Coordination during (2004-2005)

This period came after the second Intifada which witnessed great progress in terms of national ownership, international partners coordination and alignment compared to previous years. The responsibility of the Aid Management and Coordination (AMC) was handled to MoPIC. In 2004 there was a re-modelling of the SWGs. Later, the Local Development Forum (LDF) and four strategy groups (SG) were formed based on the recommendations of the AHLC in London conference in 2005. During 2005, a shift towards a medium-term planning perspective emerged. MoPIC issued a draft Medium Term Development Plan (MTDP) setting out multi-annual investment priorities under four broadly defined national programmes (MTDP 2005). While the UN's annual Consolidated Appeal Process (CAP) has remained a mechanism for responding to immediate needs in the oPt, bilateral international partners have increasingly begun to consider longer-term investment options. Several UN agencies took initial steps to return to a more normalized cycle of longer term programming in coordination with the PNA. Increasingly, policy dialogue within the international community focused on the need to strengthen the role of the PNA in managing and coordinating international aid investments, and to better integrate the PNA's aid management and governance efforts (WHO 2005).

2.8.4 Aid Coordination after the PLC Elections (2006):

Due the results of the PLC elections in 2006 and the international boycott to the PNA, the progress of aid coordination was frozen and the reform processes were jeopardized. International partners bypassed the government and the agenda was even more politicized and international partners-driven; the MTDP became irrelevant and a shift to humanitarian aid took place again as it was in the beginning of Second Intifada.
(Iskander2007)

2.8.5 Aid Coordination after the Palestinian political changes (2007-2008)

Aid coordination strengthen and increased after the political changes in oPt and after forming the new Palestinian government in Ramallah in July 2007. It became more developmental and changes were done on the structure of aid coordination.

2.8.6 Health coordination Mechanisms

Following the Oslo agreement 1994, WHO, the technical adviser for the MoH, with the Italian Cooperation (co-chair) took a leading role together with MoPIC and MoH in re-engineering the aid management coordination to health sector in the oPt, taking in consideration that sharing valid and reliable health information is essential to facilitate and maintain the proper coordination among international partners, MoH and all health stake holders (WHO 2005).

The HSWG was the main body to harmonize the aid coordination to health sector, while the other bodies at the coordination structure dealt with the activities and the tools to support them: information pooling and sharing, joint statements, project planning and review, ways of providing technical assistance, administrative and managerial issues.

2.8.7 Health Sector Working Group

The HSWG was established in 1995 and meets at least twice per year to discuss issues related to general policy and strategy, macroeconomic indicators and resources within the health sector. It was chaired by the MoH co-chaired by Italian Cooperation (the Sheppard of the health sector) and WHO is the technical adviser.

The main purpose of the HSWG is to act as a coordination forum between the PNA and international partners. It serves as a platform for discussing policy priorities, progress in implementation of the health- related programs and assist international partners in aligning

assistance in relation to national Palestinian Reform development Plan (PRDP) and strategies for the sector (WHO 2005).

HSWG affected by the political changes in oPt, after the eruption of the second Intifada HSWG role affected negatively because of the political atmosphere and the emergency status in oPt during the period of 2000-2003. Through the years of 2004-2005 HSWG activated again due to the political changes while it is frozen completely after the PLC elections in January 2006. It was activated in July 2007 after the political changes again. The HSWG reports regularly to the Social Development Strategy Group (SHSG) on a regular basis.

2.8.8 Core Group on Health

The need to improve effective coordination as well as the recent Emergency linked to the Second Intifada highlighted the call to make the HSWG more informative and responsive to the issues arising in the health sector. Core Group on Health aims to ensure effective coordination among institutions participating in the HSWG on Health mechanism by (1) improving the organization of HSWG meetings and monitoring the implementation of HSWG decisions/ resolutions and facilitating the creation of sub-groups according to specific technical areas (thematic groups). Evaluating the proposals received from the thematic groups, making decisions according to updated National Health priorities and reporting to HSWG. (WHO 2005)

2.8.9 Health Thematic Groups

In order to enable more thorough technical discussions on specific health themes, informal permanent sub-groups called Thematic Groups (TGs) have been created to promote collaboration and complementarity in specific health areas. TGs aimed also to facilitate more operational, focused and thorough discussion among key players, involving representatives of both MoH and services providers. The goal of thematic groups is to come out with an agreed operational plan of action for the specific thematic area to be forwarded to the HSWG. Membership in the group was limited to international partners who can add substantial financial or analytical value, relevant PNA institutions and representatives of relevant NGOs. Following are the current available thematic groups: Health Information

System (HIS), Nutrition, Pharmaceuticals, Mental Health, Non-Communicable Diseases (NCD), and Children's and Women's Health TGs. TGs are chaired by the MoH relevant technical units. Some of these groups are more active than others WHO 2005)

2.8.10 Central Health Emergency Coordination Meetings

The Health Emergency Coordination Meetings HECM started through Health Inforum in 2002 as a bi-monthly meeting and changed to monthly schedules, international and national nongovernmental organizations in addition to UN agencies involved in the emergency response participated in the meetings.

HI evolved out of the emergency operations room that was established by the Health Action Response Team (HART) mission to the oPt in April to June 2002 during the Israeli military re-occupation of Palestinian towns and cities in the WB. It was a joint initiative by WHO, the Italian Cooperation, the USAID and the MoH, with support from other Palestinian health providers, and from UNDP and UNSCO. GS.(WHO 2005)

Responsibility for ensuring effective coordination in the Palestinian health sector lies with the MoH and with the WHO support. HI was set up as a coordination tool to assist the MoH and WHO in operational coordination during emergencies.

The Health Emergency coordination meetings were involved in assessing and monitoring the situation, disseminating and exchanging information developing advocacy strategies, coordinating the emergency response and providing direct relief to address identified gaps. The meeting was co-chaired by MoH and WHO. (Minutes of HECM 2003-2007)

2.8.11 District Health Coordination Meetings

MoH together with the WHO initiated the health district coordination meetings (HDCM) due to lack of coordination at the district level. The meetings are also filling a gap in local health information-sharing and have highlighted certain issues (e.g. the impact on health of the Separation Wall construction) that require more input from participants.

The main intent of the district group is to coordinate, monitor and follow-up activities related to emergency preparedness and response as well as to longer term programs and services. Different health providers were attending these meetings (MoH, NGOs, INGOs and UN) are attended these meetings (Minutes of HDCM 2004-2007)

2.8.12 UN health coordination

A UN health coordination group was established in 2004 with the participation of health-related UN agencies namely WHO, UNICEF, UNFPA, UNDP and UNRWA. OCHA and UNSCO are also involved for their coordinating role. WHO took the leadership role in establishing the group, and organizes, and chairs, monthly meetings. The group has been effective in debating critical issues, and developing consensus on situation analysis, needs, priorities and relevant strategies. (WHO 2005)

Chapter Three

Aid Literature Review

Aid Coordination is ensuring progress towards more harmonization in providing health care either on local level or at the external aid interventions in the health sector by supporting the Government in dealing with agencies coordination in relation with sector planning. Other general reasons for supporting the impetus towards more comprehensive and coherent approaches to coordinating and managing resources in the health sector. Health needs are increasing, as populations expand and age; widespread poverty continues to take its toll on health, and increasing inequalities within and between countries are of growing concern. Conflicts continue to disrupt civil life, and emerging diseases challenge already weak health services.

> According to WHO " Aid effectiveness is particularly challenging in health, not just because of the complexity of the aid architecture, but because of the large numbers of international partners, the extent of unmet needs, cross-sectoral implementation challenges, private sector involvement in health services, and the long-term recurrent nature of most health needs" (WHO 2007).

International partners' countries generally give aid because it is in their own interest to do so. Some aid is given with humanitarian motives; however, most foreign aid is given for variety of political, strategic and economic reasons that benefit the international partners' countries in the longer term.

A paper studies the pattern of allocation of foreign aid from various international partners to receiving countries, found considerable evidence that the direction of foreign aid is dictated as much by political and strategic considerations, as by the economic needs and policy

performance of the recipients. Colonial past and political alliances are major determinants of foreign aid (Alberto et al 2000).

3.1 History of global aid effectiveness development

The international aid effectiveness movement began taking shape in the late 1990s. International partners/aid agencies, in particular, began to realize the costs they imposed on aid recipients by their many different approaches and requirements. They began working with each other, and with partner countries, to harmonize these approaches and requirements.

In 2002 at the international Conference on Financing for Development in Monterrey, Mexico, the international community agreed that it would be important to provide more financing for development—but more money alone was not enough. international partners and partner countries alike wanted to know that aid would be used as effectively as possible.

International partners, and partner countries met at the first Rome High-Level Forum in 2003. Leaders of the major multilateral development banks and international and bilateral organizations, and international partners and recipient country representatives gathered in Rome for the High-Level Forum on Harmonization (HLF-Rome 2003). They committed to take action to improve the management and effectiveness of aid and to take stock of concrete progress, The Rome Declaration on Harmonization set out an ambitious program of activities (Rome Declaration, 2003):

- To ensure that harmonization efforts are adapted to the country context and that international partners' assistance is aligned with the development recipient's priorities.
- To expand country-led efforts to streamline international partners procedures and practices.
- To review and identify ways to adapt institutions' and countries' policies, procedures, and practices to facilitate harmonization.

- To implement the good practices principles and standards formulated by the development community as the foundation for harmonization.

In 2005, the international community came together again at the Paris High-Level Forum where over 100 signatories—from partner governments, bilateral and multilateral international partners agencies, regional development banks, and international agencies—endorsed the Paris Declaration on Aid Effectiveness, committing to specific actions that would promote the effective use of aid funds.

Principles of Paris Declaration are grounded on five mutually reinforcing principles Paris Declaration (OECD DAC 2006)

- ***Ownership:*** Partner countries exercise effective leadership over their development policies and strategies, and coordinate development actions.
- ***Alignment:*** international partners base their overall support on partner countries' national development strategies, institutions, and procedures.
- ***Harmonization:*** International partners' actions are more harmonized, transparent, and collectively effective.
- ***Managing for results:*** Managing resources and improving decision making for development results.
- ***Mutual accountability:*** International partners and partners are accountable for development results.

In addition to that Paris Declaration also sets out 12 indicators to provide a measurable and evidence-based way to track progress, and sets targets for 11 of the indicators for the year 2010.

In 2008, the Third High-Level Forum on Aid Effectiveness took place in Accra with the participation of about 1,700 participants, including more than 100 ministries and heads of agencies from developing and international partners countries, emerging economies, UN and multilateral institutions, global funds, foundations, and 80 civil society organizations. The high-level engagement at Accra helped bring about agreement on the Accra Agenda for

Action which expresses the international community's commitment to further increase aid effectiveness.(Accra Agenda 2008)

3.1.1 Principles for good international engagement in fragile States (OECD 2007):

1. Take context as the starting point.
2. Do no harm.
3. Focus on state-building as the central objective.
4. Prioritise prevention.
5. Recognise the links between political, security and development objectives.
6. Promote non-discrimination as a basis for inclusive and stable societies.
7. Align with different priorities in different ways in different contexts.
8. Agree on practical coordination mechanisms between international actors.
9. Act fast ... but stay engaged long enough to give success a chance.
10. Avoid pockets of exclusion.

3.1.2. Approaches to the provision of aid

There are several international approaches and methods for coordination mechanisms for aid coordination

- **One aspect of aligning around the partner country's priorities** is how the aid is provided. Project support remains the dominant aid instrument in most partner countries and will continue to be important. Some international partners in several countries are increasingly shifting from stand-alone project aid to participation in sector-wide programmes and budget support.
- **Sector-wide Approaches (SWAP)**. It is an approach to providing support that has the following characteristics: a clear sector policy, with targets defined in qualitative and quantitative terms; a formalized process of international partners coordination, with agreed roles and rules; a medium-term expenditure programme, matching sources and uses of funds; a results-based monitoring system for all major inputs, outputs, and outcomes; and, to the extent possible, common implementation systems.

World Health Organization (WHO) adopted the SWAP approach which came at the mid of nineties as a good instrument for coordination.

- **Budget Support** For an increasing number of international partners, budget support is emerging as an important modality for greater alignment and harmonization, because it provides direct support, at the economy wide or sectoral level (usually as part of a SWAP), to the government's own budget and priorities.

3.2 Global studies

The case studies that follow review different countries' experiences with external resources in the health sector in the low-income, high aid-dependent countries of Bangladesh, 'post'-conflict Cambodia, Mozambique, and Zambia, ending with South Africa, comparatively well-off and independent of international partners. The reviews included the experiences from all the mentioned countries, and evidence from elsewhere, and asks what lessons emerge from these cases, particularly with respect to management of the sector as a whole, and how far they may inform the current impetus for sector-wide approaches (SWAPs) for managing aid (Walt et al, 1999).

The experience of Viet Nam encapsulates the problem of aid coordination. In 2003, Viet Nam received approximately 400 separate missions from international partners, of which just 2% were undertaken jointly. International partners' use of country systems in Viet Nam is extremely low: the share of international partners projects using national monitoring and evaluation systems is just 13%; national procurement systems, 18%; and national auditing systems, 9%. In the health sector, coordination among the many international partners was reportedly poor, and there were no systems in place to harmonize international partners' activities. Further, no international partners are using national health monitoring systems (OECD/DAC Survey 2005).

The situation in Viet Nam is neither atypical nor new. As early as the 1980s, there was concern that a proliferation of international partners projects - combined with differences in international partners policies, operational procedures, and reporting mechanisms - was not

only hindering the effectiveness of aid, but also creating obstacles to development by over burdening countries' administrative and reporting systems and reducing country ownership.

Cambodia's policy environment during the early years of the 1990s was extremely fragile. ; Factors constraining the management of aid by ministries of health were grouped under three themes: context and timing, institutional capacities and the interplay of power and influence in negotiations over aid. Two factors, often underplayed, were found to be important in facilitating management of resources: the inter-relationship of formal and informal relationships and the extent to which incremental changes are tolerated.

The main conclusion is that coordination and management of external resources is inherently unstable, involving a changing group of actors, many of whom enjoy considerable autonomy, but who need each other to materialize their often somewhat different goals. Managing aid is not a linear process, but is subject to set-backs and crises, although it can also produce positive spin-offs unexpectedly. It is highly dependent on institutional and systemic issues within both international partners and recipient environments (OECD/DAC Survey 2005).

It took those countries a few years, and resolute leadership, to move towards a more conducive policy environment, in which the MoH and some international partners actually worked well towards a coordinated plan of action for the health sector.

3.3 Regional studies on aid effectiveness

A survey was conducted in Morocco (OECD/DAC 2005) to measure objective evidence of progress against 13 key indicators on harmonization and alignment in different sectors. In health sector strategy has been presented, but it is neither costed nor linked to budget priorities. International partners and government disagree over the extent to which a formal international partners co-ordination process exists in the sector: International partners feel there is none, and the government feels that efforts are being made, at least amongst the

main international partners. Government performance monitoring systems exist, but are weak, and there is no sector medium-term expenditure framework.

3.4 Studies on aid effectiveness in the oPt

"Aid Effectiveness in the West Bank and Gaza" assessment (AHLC 1999) fully reflected requirements and constraints of aid effectiveness in oPt. The oPt represents a complex operational environment for the international partners community, characterized by a highly dynamic economic and political context. Moreover, international partners assistance had been intended to meet not only the traditional goals of sustainable development, but also the imperatives of peace building (AHLC, 1999).

An elaborate set of aid coordination arrangements developed in oPt after Oslo. They were shaped by the political context, the unusually large number of international partners, a desire for rapid delivery of substantial amounts of aid (to help secure the "peace dividend" from Oslo) and the uncertain and evolving status of the main recipient institution (Lister et al, 2003).

The principal effects of the intifada on how aid is managed thus seem to be (Stephen Lister et al 2003):

- A shift from development towards emergency/humanitarian activities. Progressively, less aid has been applied to development and more to emergency and humanitarian activities.

- An increasingly international partners-driven process accompanied by increasing marginalization of the PNA and a shift from international partners coordination with the central level (MoPIC) towards the governorate and municipal levels. This can be explained by problems of access and the severe movement restrictions affecting the Palestinians, and the fact that PA capacity has been dramatically weakened, as well as by the emergency situation's operational requirements.

As involvement of international partners in reforming health sector, MoH signed in 2003 an agreement to initiate the Sector Health Review a project aimed at revising the Palestinian Health Sector , the partners of MoH were the WHO, Italian Cooperation, the EC, and the DFID.(HSR 2007)

The HSR project was designed to be an analytical exercise aimed to provide the MOH and the Health care providers with a clear overview and analysis of the Health sector performance, to propose a set of priorities and recommendations to improve the Health status, and to suggest future midterm strategies (HSR 2007).

In a survey by Birzet University Development Studies Program in 2004 (Said, 2005), 62% believed that funding priorities were set by political agendas of international partners. People were sceptical about the developmental role of aid. The same survey revealed that 40% believed that aid contributed to development of society, 38% believed it did to some extent while 21 % thought the opposite.

Lister et al study 2007, study concluded that PNA institutions built up over the years have been severely undermined, and there has been a sharp deterioration in transparency and accountability of public financial management. Much of this is directly attributable to international partners' behaviour.

The study added that when international partners' kept distance from the PNA (2006/2007) is the antithesis of standard good practices concerning ownership and alignment, and the aggregate effectiveness of aid has obviously declined. The study added that oPt is witnessing a return to the classic vicious circle that the international guidelines on aid effectiveness were intended to get away from, in which distrust of state institutions leads to bypass, which leads to further degradation of state institutions and a stronger incentive to bypass.

Chapter Four

Conceptual Framework

This chapter presents the conceptual framework of the study, that was developed after reviewing the theoretical background and previous studies. Definitions of aid coordination, its' determinants and factors affecting aid coordination were identified. Level of aid coordination and effectiveness were measured through the perceptions of international partners and beneficiaries using resembles surveys and studies were done by OECD mentioned earlier (OECD 2005)

4.1 Making aid effective

The perceptions of international partners and beneficiaries are used to assess the aid effectiveness in health sector in oPt using the three of five Paris principles, mainly in ownership, alignment and harmonization because these were highlighted in Rome agenda for aid effectiveness in 2003, and these principles were used in the OECD survey in 2004 in 14 countries.

The five Paris principles on aid effectiveness are the followings (OECD/DAC 2005).

- **Ownership** - Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.
- **Alignment** - International partners countries align behind these objectives and use local systems.
- **Harmonization** - International partners countries coordinate, simplify procedures and share information to avoid duplication.

- **Mutual Accountability** – International partners and recipients are accountable for development results.
- **Results** - Developing countries and international partners shift focus to development results and results get measured.

4.2 Aid effectiveness progress measurement indicators

The Paris Declaration includes a dozen progress indicators to be measured at country level and monitored internationally table 4.1. The indicators of progress emphasise *mutual accountability* between international partners and partner governments. They provide a framework through which collective behaviour at country level can be measured and provide benchmarks for individual international partners and partner governments to measure their performance.

Table 4.1: Paris Declaration Commitments and Indicators of Progress (*Paris Declaration (OECD DAC 2005)*

Ownership	**Partner countries exercise effective leadership over their development policies and strategies and coordinate development activities.**
Indicator 1	Partners have operational development strategies
Alignment	International partners base their overall support on partner countries. national development strategies, institutions and procedures.
Indicator 2	Reliable country systems for procurement and public financial management
Indicator 3	Aid flows are aligned on national priorities
Indicator 4	Strengthen [national] capacity by coordinated [International partners] support
Indicator 5a	Use of country procurement systems
Indicator 5b	Use of country public financial management systems
Indicator 6	Strengthen capacity by avoiding parallel implementation structures
Indicator 7	Aid is more predictable
Indicator 8	Aid is untied
Harmonisation	International partners' actions are more harmonised, transparent and collectively effective.
Indicator 9	Use of common arrangements or procedures [programme-based approaches]
Indicator 10	Encourage shared analysis
Managing for Results	Managing Resources and improved decision-making for results.
Indicator 11	Results-oriented frameworks
Mutual Accountability	International partners and partners are accountable for development results.
Indicator 12	Mechanisms for mutual accountability

Following up to Paris commitments, many aid agencies have developed harmonisation action plans, and aid effectiveness action plans have also been formulated by international

partners and partner governments at country level. The Paris Declaration makes the point that its provisions, indicators and benchmarks need to be adapted and applied in ways that take account of differing country situations. Consequently, country action plans do not follow a rigid pattern – they are adapted to the particular context of each country.

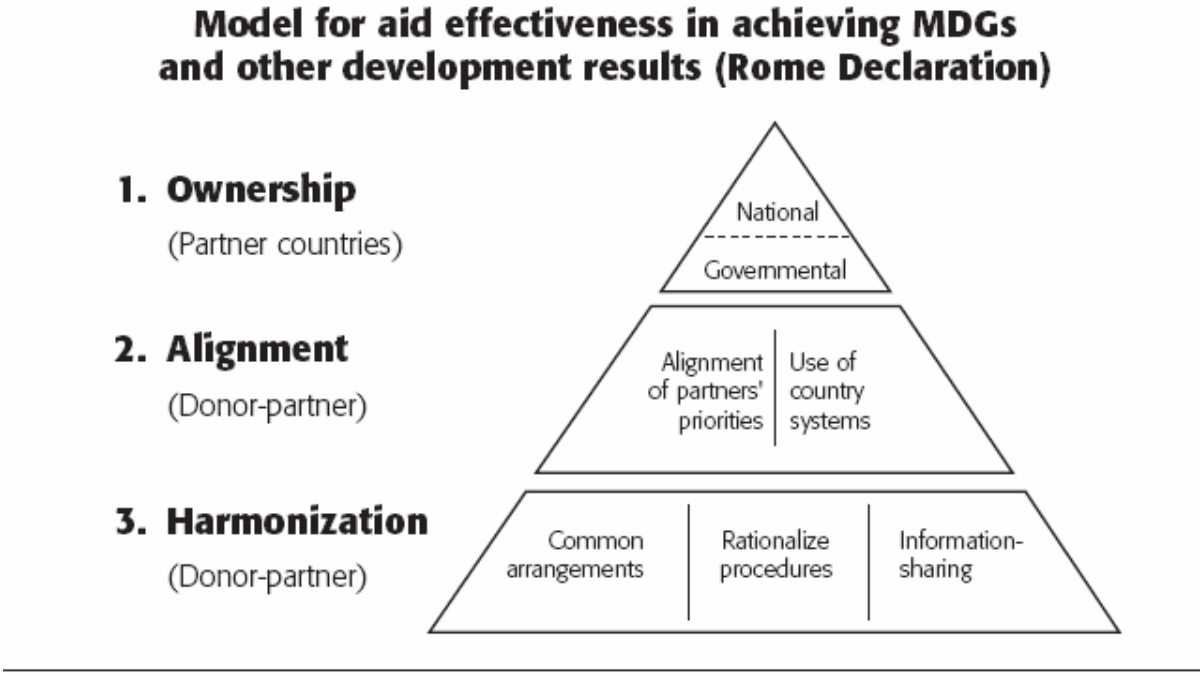

Figure 4.1: A pyramid shows the Rome Dclaration in achieving effectiveness (WHO 2006)

The four broad areas of the Rome and Marrakech commitments, schematically depicted in a pyramid, are the organizing principle of the study (HLF 2005)

Interpreting the Pyramid: Whether read top-down or bottom-up, the pyramid provides insights about the harmonization/alignment/managing for results agenda.

Top-down: Partners begin by setting the agenda for achieving development results (such as the Millennium Development Goals MDGs), and international partners respond to this lead by aligning their support with the countries' results-oriented strategies and relying on partners' systems. At both of these levels, capacity strengthening and institutional development are essential. At the base of the pyramid, international partners initiate the complementary actions of establishing common arrangements, simplifying procedures, and sharing information. At all levels of the pyramid, a focus on results is essential: the

country's development agenda must be oriented toward the growth and poverty reduction results it expects to achieve.

Bottom-up: Read from bottom to top, the pyramid illustrates the stages of maturity in the aid relationship and the separable, but reinforcing, gains expected at each stage. In almost any circumstance, including in the most fragile country environments, the bottom-tier actions —adopting common approaches (e.g., for disbursement, procurement, and accounting), simplifying procedures (e.g., reporting requirements), and sharing analysis— can improve the impact of aid or at least reduce its costs. The ultimate objective is to move up the pyramid. In the most evolved country situations, partner governments not only establish clear priorities and results-based strategies, but also communicate how they want international partners to collaborate and in what forms. If an international partner remains unwilling to join this common effort, the partner nation may decide to for go that source of aid. (OECD 2005)

4.3 Study variables

As illustrated in table 4.2, aid effectiveness measures and variables are shown in the table according to partnership Rome agenda (2003) and Paris declaration (2005)

Table 4.2: Aid effectiveness principles and their indicators and variables

Partnership principle	Indicator	Content of items
Ownership	Indicator 1: Partners have operational development strategies	• MoH is proactive with international partners • MoH is in the driving seat • Clear health sector policy in place
Alignment	Indicator 2: Reliable country systems for procurement and public financial management	• National health Sector systems are in place • International partners are using the government • Health sector monitoring system is in place?
	Indicator 3: Aid flows are aligned on national priorities	• International partners systems are aligned with government policies
	Indicator 4: Strengthen [national] capacity by coordinated [International partners] support	• There is a formalized process for dialogue in health sector
	Indicator 5: Use of country procurement systems	**Not applicable**
	Indicator 6: Use of country public financial management systems	**Not applicable**
	Indicator 7: Strengthen capacity by avoiding parallel implementation structures	• There are proper health co-ordination meetings
	Indicator 8: Aid is more predictable	**Not applicable**
	Indicator 9: Aid is untied	• International partners are prioritizing their national agendas • Funds are international partners' driven agenda
Harmonization	Indicator 10: Use of common arrangements or procedures [programme-based approaches]	• Different international partners systems are being harmonized • International partners rules are supporting harmonization • Provide information and support to specific health activities
	Indicator 11: Encourage shared analysis	• Joint assessments and analysis,
Mutual Accountability	Indicator 12: Mechanisms for mutual accountability	**Not Applicable**

4.4 Summary

The researcher developed the conceptual framework depending on the Rome agenda 2003 and Paris Decleration. The OECD conducted a survey in 14 countries on aid effectiveness in 2004 (OECD 2005), to measure in particular ownership, alignment and harmonization, based on that the variables of aid coordination determinants were used according to the Palestinian context.

As was mentioned in chapter one, the purpose of this study was to assess the effectiveness of health aid coordination in the Palestinian health sector between the years 2002-2008 as perceived by the international partners (donors and international agencies) and beneficiaries through assessing their perceptions on types of funds, how the health coordination meetings are supporting the effectiveness of health aid, obstacles and factors negatively influencing the effectiveness of health aid coordination, types of relationships among stakeholders, international partners practices and finally the perceptions on aid effectiveness using Paris Deceleration Principles (2005) for partnership; in specific ownership, alignment and harmonization

Chapter Five

Methodology

This chapter describes the methodology of the study that includes study design, instrument, target group and sampling methodology, criteria of sampling, pilot testing, data collection and ethical consideration.

5.1 Study design

The study adopted a cross-sectional descriptive approach to explore and analytically describes the situation understudy, aid coordination effectiveness in the oPt. It explores the aid process and coordination mechanism between 2000-2008, and assesses and analyzes the perceptions of beneficiaries and providers on the following:

- Issues included in health aid coordination meetings
- Issues supported positively by health aid coordination meetings
- obstacles and factors influencing negatively the effectiveness of health aid coordination
- Types of relationships among the international partners and beneficiaries
- International partners practices in health aid
- Aid effectiveness principles in oPt according to Paris declaration principles, in specific ownership, alignment and harmonization.

5.2 Target Population and sample

The sample considered under this study is defined as: all key informants from all stakeholders who are participating directly in the health aid coordination in the oPt. Key

informants are all the directors/officers/staff designated for aid coordination who have at least two years experience in the following institutions: Government (Ministry of Health MoH, Ministry of Planning and International Cooperation MoPIC, which is called since July 2009 Ministry of Planning and Administrative Development MoPAD). Non Governmental Organizations (NGOs), International Non Governmental Organizations (INGOs), donor countries (International Cooperation agencies) and UN agencies

The total number of key informants involved in health aid was estimated to 37. All these agencies were targeted and approached during the data collection. However, only 27 replied positively to take part in the study. Respondents represented 22 international and local organizations including MoH. Only the MoH participated with six questionnaires from different departments as shown in table (5.1) below. The interviews were face-to face during July-December 2009 by the researcher.

The respondents form about 73% of the targeted key informants' for the study. The respondent from bilateral international/multilateral partners was low (30%).Those who responded positively and agreed to participate from the bi-lateral international partners were Italian Cooperation (IC), Swedish International Development Agency (SIDA) and United States Agency for Development (USAID) through the Flagship Project The number of approached organizations and responses are shown in table 5.1 below.

Table 5.1: Distribution of the institutions targeted by name and the percentage of those responded positively

Type of organization	Name of organization	Number	No. of respondents	% Response
PNA	1. MoH: • International Cooperation Department • Palestinian Health Information Centre • Planning Department • Primary Health Care Department • Ministry of Planning and international Cooperation	6	6	100%

Table 5.1 A: Distribution of the institutions targeted by name and the percentage of those responded positively

Type of organization	Name of organization	Number	No. of respondents	% Response
NGOs	• Ard El Atfal, • Health Care Committees • Health Work Committees, • Juzoor for Health and Social Development • Palestine RED Crescent Society (PRCS) • Palestinian Medical Relief Society (PMRS)	6	6	100%
Bi-lateral donors	• Belgium Cooperation, • European Commission • French Cooperation, • Italian Cooperation, • Swedish International Development agency • Spanish Cooperation • United States Agency for International Development • World Bank,	9	3	33%
INGOs	• American Near East Refugee Aid CARE International • International Committee of Red Cross, • International Relief Development • Islamic Relief, • Medical Aid for Palestinian , England • Merlin • Save the Children UK • Welfare association	9	7	78%
UN agencies	• LACS • OCHA • United Nations Population Fund • The United Nations Children's Fund • United Nations for Relief & Works Agency, • World Health organization,	6	5	83%
Total		**37**	**27**	

5.3 Study Instrument

Two separate questionnaires for beneficiaries and international partners were developed (appendix 2 and appendix 3) based on the OECD health surveys (OECD Survey 2005) to monitor three out of five of Paris declaration principles on aid effectiveness in particular owner ship, harmonization and alignment.

The tools was adapted to the Palestinian context The questionnaire focused on the perceptions of beneficiaries and international partners on health aid coordination..

Five Likert scale was used to assess the international partners and beneficiary perceptions on health aid effectiveness.

5.3.1 Reliability and validity of the instrument

The reliability of the tools was ensured through the following points:

1. The tool used is similar to the OECD tool which used in the international survey in 14 countries to monitor the aid effectiveness measures on ownership alignment and harmonization (OECD survey 2004).
2. The tool was reviewed by 3 technical people who has long experience with aid coordination
3. As for the reliability and to check its internal consistency. Cronbach Alpha Coefficient was conducted. In general the internal consistency of tool was good (Cronbach Alpha coefficient ranges from 0.92—0.42) as shown in table 5.2 below

5.2: Table Cronbach Alpha coefficient and No. of questions for Iinternational partners and beneficiaries by Fields of Study

Fields of Study	Beneficiaries		International partners		Both together		
	Cronbach Alpha coefficient	No. of questions	Cronbach Alpha coefficient	No. of questions	Cronbach Alpha coefficient	No. of questions	Note
Issues in health coordination	0.83	9	0.90	9	0.90	9	High internal consistency
Coordination meetings are supporting positively	0.96	15	0.79	15	0.92	15	High internal consistency
obstacles for health coordination	0.59	10	0.49	10	0.52	10	Low internal consistency for both.
International partners Practices	0.81	7	-	-	-	-	High internal consistency
Type of relation ship among the international partners and beneficiaries/	0.64	5	0.70	5	0.66	5	Moderate internal consistency
Effects on health aid	0.42	7	0.57	6	0.42	7	Low internal consistency for both.

5.4 Pilot testing

The questionnaire was administered to four persons in international partners and beneficiary organisations by the researcher in March 2009. Based on the piloting results minor changes were done to the questionnaires to make them more users friendly and easier to understand. These questionnaires were not included in the analysis.

5.5 Data collection

The questionnaires were administered to the selected participants by the researcher. Total of (27) questionnaires were filled out. Data were collected during the period between June-December 2009.

5.6 Data entry and analysis

Collected data were coded, entered and analyzed using SPSS version 13.The statistical tools used were: Frequencies, percentages, means, standard deviations and t – test of the two independent samples.

5.7 Ethical consideration

The researcher followed the ethical consideration for the study. A letter was sent to the target organizations explaining the objective of the study and asking for an appointment of the person who will represent the organisation to meet with to complete the survey. During the meeting the researcher explained again the purpose of the study and replied the queries of interviewee. The researcher first guaranteed the consent of the representative for voluntarily participation in the study and assured them the confidentiality of the data collected from the organization.

Chapter Six

Results and Discussion

This chapter gives an overview on the characteristics of the sample used for the study, and presents the perceptions of beneficiaries and international partners on health aid coordination, and their opinions on health aid effectiveness in oPt.

Moreover, the chapter includes statistical comparisons between the perceptions of beneficiaries and international partners' perceptions on health aid coordination.

6.1 Sample characteristics:

As shown in table (6.1), there was good participation for different stakeholders at the study; the PNA represents 22%, bi-lateral international partners 11%, UN agencies 19%, INGOs 26% and NGOs 22%.

Table 6.1: Distribution of the participant key informants by type of organisation

Institution	Number of participant key informants	Percentages
PNA	6	22%.
Bilateral/Multilateral international partners	3	11%
UN agencies	5	19%
INGOs	7	26%
NGOs	6	22%
Total	**27**	**100%**

6.2 Beneficiaries Perceptions

In this part of the study, the issues included in health aid coordination meetings will first be overviewed in general. In further sections, more specific questions concerning the respondents' perceptions are discussed about (1) Type of funded(focus) health programs 2000-2008 (2) Issues that coordination meetings are supporting positively, (3) Obstacles of health aid coordination, (4) Type of relationships between international partners and beneficiaries, (5) Factors influencing negatively health aid coordination, and finally the (6) Aid effectiveness principles in oPt according to Paris declaration, in particular ownership, alignment and harmonization.

6.2.1 Type of funded (focus) health programs 2002-2008

To show the focus of funds for health programs during years of 2000-2008, The key informants from beneficiary and international partners were asked to indicate the type of aid programmes they were involved in.

As shown in figure (6.1) below and in appendix (1), , international partners focused on emergency aid for programmes on drugs, medical supplies and equipments (64.3%); while 78.6% of the beneficiaries also indicated that these programs received emergency aid from international partners. 57% of the beneficiaries indicated that they received aid for infrastructure programs while 78% of the international partners indicated that they provided aid for maintenance programmes. Regarding the capacity building programs, both beneficiaries and international partners replied that they received and funded programs (28.6%). There were few differences between the responses of the beneficiaries and international partners were found in the areas of (1) infrastructure (2) staff salaries, (3) and technical assistance.

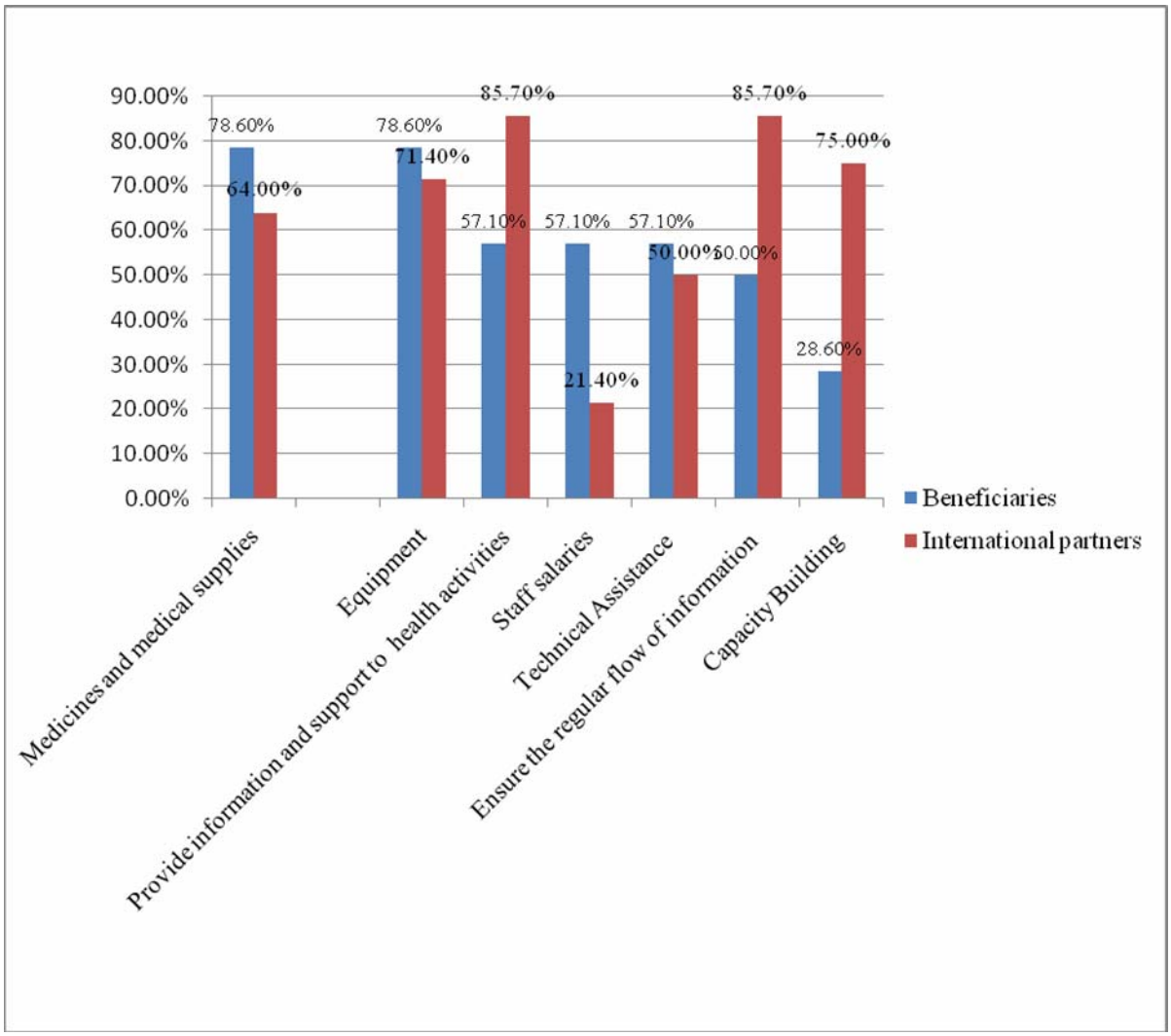

Figure 6.1: Type of funded (focus) health programs 2002-2008 according to beneficiaries and international partners' opinions

6.2.2 Issues included in health aid coordination meetings

The beneficiaries were asked to express their opinions on the issues that are included in the health aid coordination meetings. As shown in figure (6.2) below and appendix (2) beneficiaries were satisfied with the issues discussed in the health aid coordination meetings, particularly the information and reports sharing (100%), monitoring and evaluation (92.8%) then the advocacy and dissemination (85.5%) got the highest percentages of agreements ranges from 85%-100%

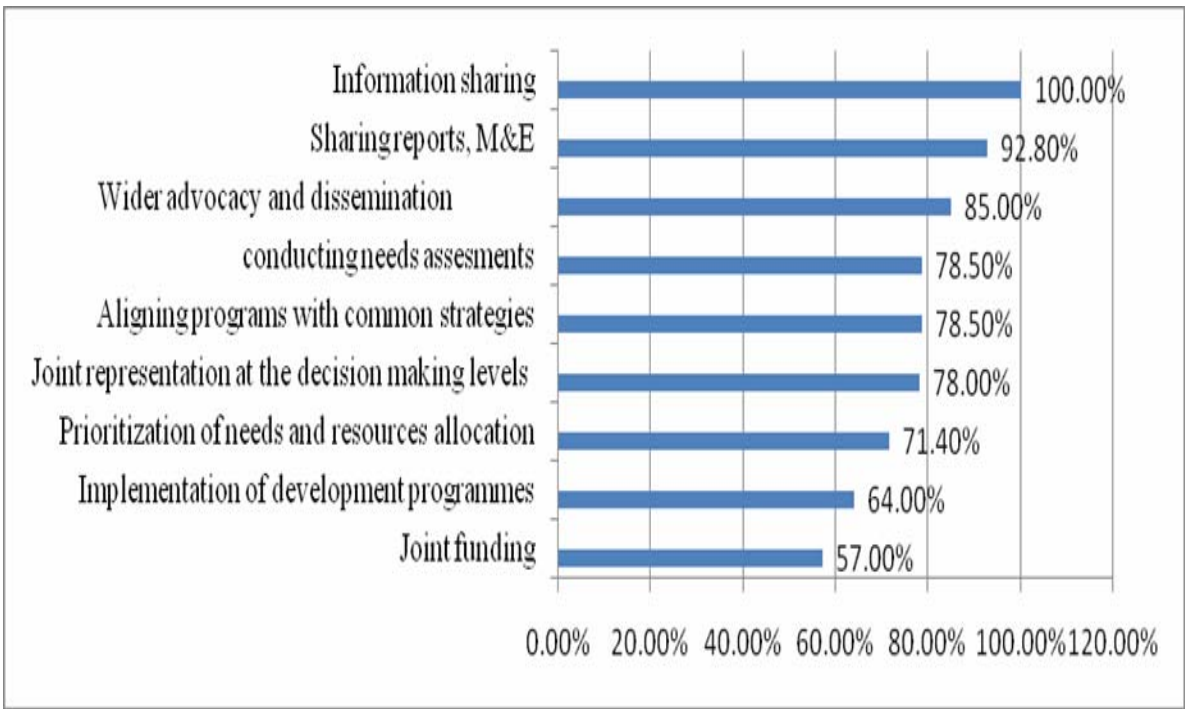

Figure 6.2: Beneficiaries opinions (% of agreement) on issues included in the health aid coordination

It is clear that the beneficiaries highly rated the information sharing as one of the issues tackled in the coordination meetings (100% Concentrated between totally agree and agree). Information is the key factor affecting the overall impact of the international response first because of its implications for strategic planning and second because of its implications for coordination.

oPt is said to be data rich and information poor (Pfeiffer 2001). This might be relevant to the fact that there is no clear policy on data collection, and weaknesses of data analysis and dissemination for use in the health sector.

In regard to aligning the programs of beneficiaries with common national objectives and strategies and joint representation at the decision making levels of strategies and plans, 78% of beneficiaries said it is included in the meetings.

Regarding the question on the of prioritization of needs and resources allocation in the aid coordination meetings, 71.4% of them agreed while 64% agreed that coordination meetings discussed the implementation of development programmes. Finally the agreement on joint funding was low, only 57% thought the joint funding is included in the coordination meetings.

6.2.3 Issues positively supported by the health aid coordination meetings

In an attempt to identify the health issues that supported positively by the health aid coordination meetings beneficiaries were asked to specify from a predetermined list what issues supported positively by the health aid coordination meetings. As overviewed in figure (6.3) below and appendix (3), beneficiaries agree that health aid coordination meetings are supporting positively the harmonization in health sector,

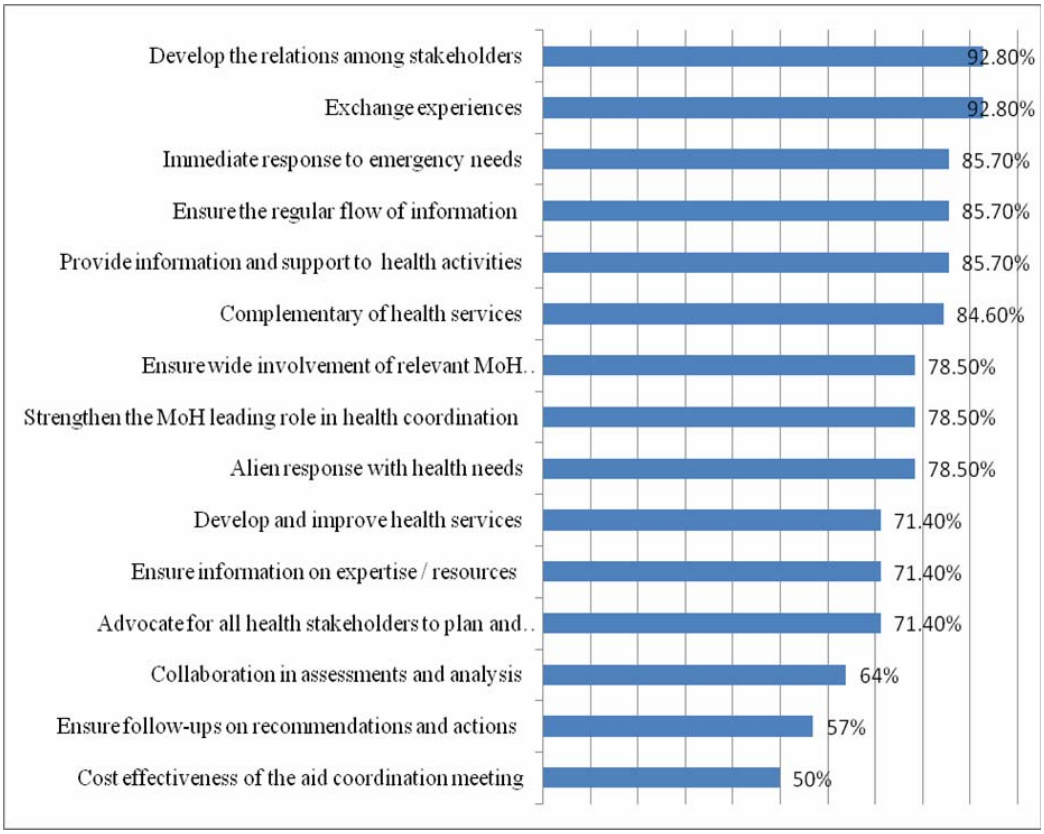

Figure 6.3:: Beneficiaries opinions (% of agreement)on the issues positively supported by the health aid coordination meetings

93% think that coordination meetings develop relationship and exchange experience among health stakeholders. In coherence with the importance of the coordination meetings (85.7%) of responses concentrated between totally agree and agree) say meetings are providing information and support to specific health activities e.g. advocacy for health as a human right field visits; surveys; monitoring of access to health services, ad-hoc meetings, and workshops, and immunization campaigns.

Furthermore, beneficiaries see emergency coordination meetings as a good tool for the immediate response to emergency needs (85.5% of responses Concentrated between totally agree and agree with a mean of 4.2 and SD of 0.9).(appendix 3).

The health emergency coordination meetings played an important role in responding to health urgent needs during the years of the Second Intifada (2002-2005) when these meetings took the responsibility to coordinate the responses of stakeholders to meet the needs of hospitals and other health facilities in oPt (OCHA 2005).

As shown in figure (6.3) above, the beneficiaries appreciated the role of the health aid coordination meetings. When they were asked if the meetings are strengthening the MoH leading role in health coordination with clearly and identified roles and responsibilities with other health stakeholders, 78.5% of the response were around agree.

Regarding a question on the role of coordination meetings in advocating for planning and implementing projects in line with national health strategic plan 71.4% of the beneficiaries responses were around agree.

According to the figure (6.3) beneficiaries believe to a certain point (71.4% concentrated around agree) that aid coordination meetings ensure information on expertise / resources available at different agencies and organizations to respond to specific needs are made available to the MoH, while 71.4% agreed that aid coordination meetings develop and improve health services. However, the joint assessments among participating organizations and analysis and assuring an effective, integrated health information system has lower

agreement (64%). Beneficiaries expressed their impressions on the weakness of the follow up of recommendations of the aid coordination meetings (57% think there was good follow up) and that coordination meetings are cost effective (only 50% agreed).

6.2.4 Obstacles of the effectiveness of the health aid coordination

Many obstacles and challenges that impede effective aid coordination exist; therefore, it was essential to identify those obstacles under this study. There were consensus on main obstacle according to beneficiaries as shown in figure (6.4) below and appendix (4), the first obstacle is limiting the meeting to presenting activities of participants rather than sharing relevant information for policy-making and effective aid coordination (100%), this obstacle is considered a weakness of the health aid coordination meetings. The secondly scored main obstacle is the different political agendas for stakeholders and the competition on resources (92.30%).

However, the third scored obstacle was the lack of MoH follow up and the lack of interest for coordination among stakeholders (84.6% of answers concentrated around agree); while the availability of different international partners is the fourth obstacle (76.9%). The remaining obstacles of health aid coordination are the fragmentation of the health sector (66.6%) and the lack of awareness (53.80%).

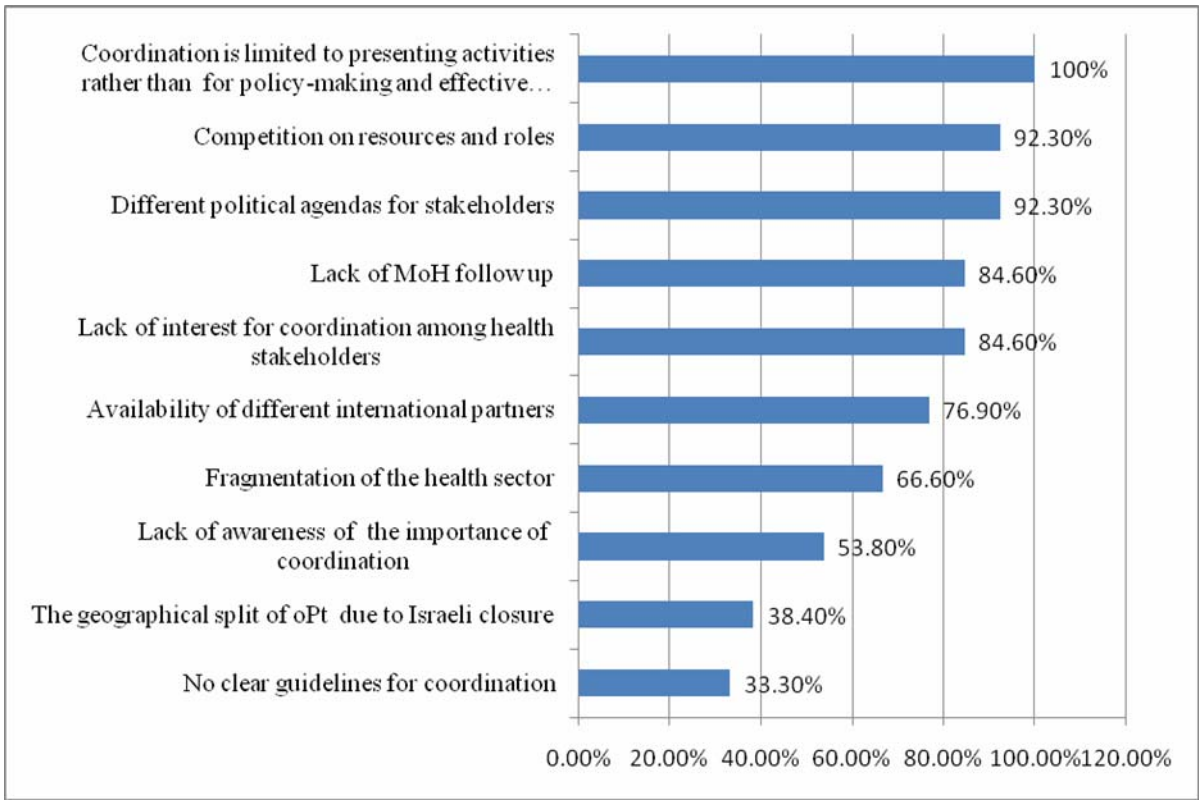

Figure 6.4: Beneficiaries opinions (% of agreement) on obstacles of the effectiveness of the health aid coordination

It is worth to note that beneficiaries didn't see the geographical split of oPt due to Israeli closure as a major obstacle (38.4% agreed), because the health aid coordination meetings are mainly held in Ramallah and the headquarters of main stakeholders are located in Ramallah, in addition there are no main health coordination meetings are held in Jerusalem which is isolated by the wall from the West Bank.33% of beneficiaries said that lack of guidelines or references for coordination are obstacles of aid coordination.

6.2.5 International partners' practices in health aid

International partners' practices with partners are the pillars of effective aid coordination, Rome and Paris declarations committed international partners to provide support for country analytical work in ways that will strengthen beneficiaries specially the governments' ability

to assume a greater leadership role and take ownership of development results (Rome Declaration, 2003).

Beneficiaries were asked to express their impressions on the international partners' practices in the international aid in oPt. The perceptions of beneficiaries are shown in figure (6.5) below and appendix (5) which indicated that international partners are not committed to Rome and Paris Declarations, because the Rome Declaration on Harmonization commits international partners to reduce their missions, reviews and reports, streamlining conditional ties, and simplifying and harmonizing documentation; but the perceptions of beneficiaries do not reflect these good practices of aid coordination.

As shown in figure (6.5) below and appendix (4), the complicated international partners procedures (91%) and the international partners driven priorities (84.6%) were the worst practices of international partners, followed by the uncoordinated international partners practices (82% agreed), and the excessive demands on time from international partners (80%), while the delay in disbursements (63%) and the undermining of the national capacities (63%) are other concerns for beneficiaries lastly, only 45% of beneficiaries believe that the demands of international partners are beyond the national capacities.

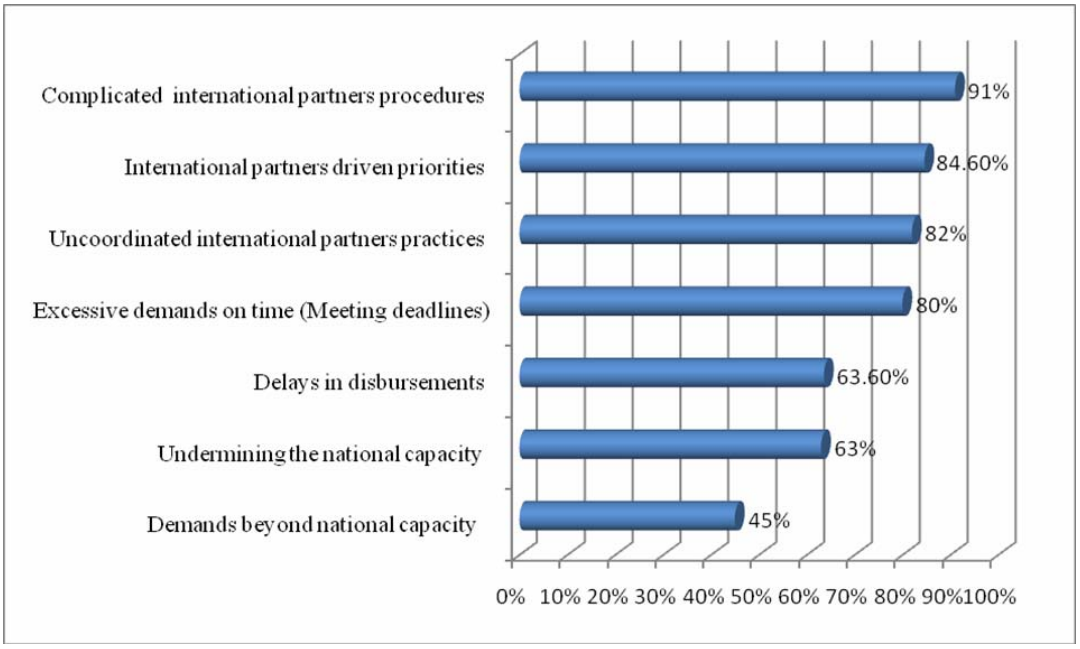

Figure 6.5: Beneficiaries opinions (% of agreement) on international partners' practices in health aid in oPt

Perceptions of beneficiaries on the international partners practices in the international aid in oPt are contradicting the Rome and Paris Declarations. Rome declaration commits international partners not to undermine the national capacities and to intensify their efforts to work through delegated cooperation at country level and increasing the flexibility of country-based staff to manage country programmes and projects more effectively. Moreover, Rome declaration commits international partners to provide budget support, sector support, or balance of payments support where it is consistent with the mandate of the international partners and where appropriate policy. In areas such as timely disbursement, international partners should agree on an assessment framework covering their own performance (Rome Declaration 2003). Also beneficiaries as shown above complained of uncoordinated practices among international partners, but Paris declaration commits international partners to respect partner countries' leadership of the division of labour process. If a lead international partners option is chosen, international partners should co-operate with that lead as defined and agreed in the country context and vest the necessary authority in that international partners. A lead international partner, in turn, will fully consult with all other international partners, drawing consensus to the maximum extent possible, and identifying any points on which consensus cannot be reached. A lead international partner will facilitate and co-ordinate the dialogue between the international partner community and the partner country (Paris declaration 2005).

6.2.6 Beneficiaries –international partners' relationship

International partners-beneficiaries relationships are important to achieve any effective results, in order to explore the type of this relation in oPt, the researcher asked the beneficiaries on their opinion on the type of relationship between them and international partners. As shown in figure (6.6) below and appendix (6), findings indicated that the relationship between international partners and beneficiaries is unstable. According to beneficiaries, international partners retort by complaining about corruption and internal divisions (80%) and their approaches of undermining the relationship with beneficiaries (80%), while 69% of them think the relationship is inconsistent, an alarming issue is the low mutual trust (66%), and far lower the transparency in the relationship with international partners (46%)

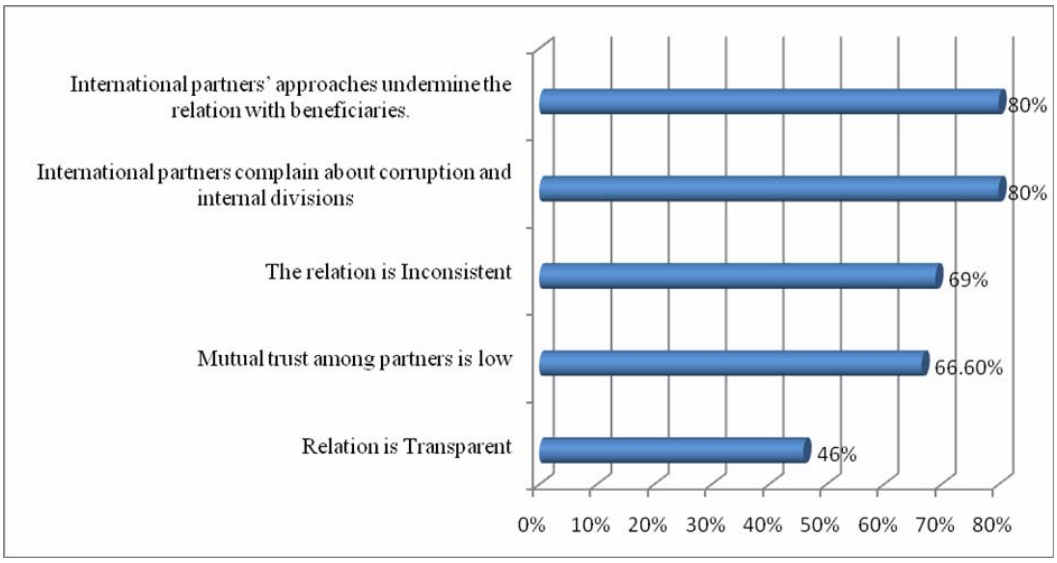

Figure 6.6: Beneficiaries opinions (% of agreement) on the types of relationships between international partners and beneficiaries

Reference to Rome declaration international partners and partners are accountable to each other for the effectiveness of their work, but it is also important to tighten the link between aid and the downward accountability of both partner governments and international partners to citizens. International partners should strengthen mutual accountability by providing comprehensive, timely, and transparent information on aid flows (Rome Declaration, 2003).

6.2.7 Factors influencing negatively health aid effectiveness

Beneficiaries were asked about their perceptions on the factors influencing the effectiveness of health aid in oPt. The results are shown in figure (6.7) below and appendix (7), the political situation factors is the most influencing factor to health aid (100%).

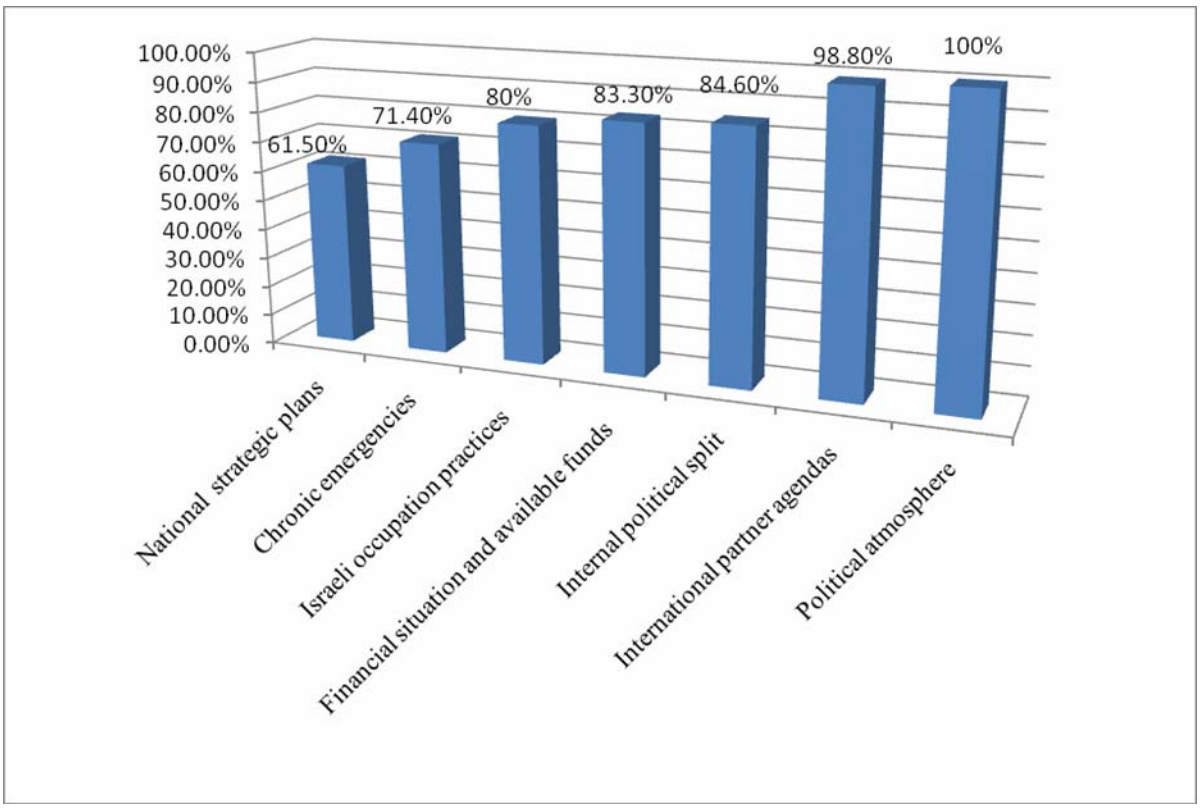

Figure 6.7: Beneficiaries opinions on the factors influencing negatively the effectiveness of health aid

Political stability is essential for true sustainable development. Israel's policies and restrictions made both the political will and economic stability absent (Denis, 2001). Due to the political changes early 2006 after the Palestinian elections, international aid has become fragmented and unaccounted for, making it difficult for international partners to target assistance effectively due the political changes after the Palestinian election. It was "aid bearing no long-term development prospects" (Oxfam, 2007b).

International partner agendas are the second influencing factor on health aid (98.8%). These findings are in agreement with another study was conducted in Bir Zeit University in 2006 (Saied 2005). Furthermore the Palestinian internal political split has (84%) of agreement, and lastly financial situation and available funds (83.3%).

Israeli occupation practices are important factor that influencing health aid (80%), Israeli closures and movement restrictions which reducing the effectiveness of aid by blocking access to those in need (Hever, 2007).

Beneficiaries highlighted also the national strategic planning (61.4%) and the chronic emergencies (71.4%) because oPt is living in chronic emergency since 2000 and that affects any attempts for efficient national planning.

6.2.8 Aid effectiveness principles in health sector

In an attempt to measure the aid effectiveness in ownership, harmonization and alignment, beneficiaries were asked their opinions on the effectiveness measures appendix (8), these principles will be discussed below mainly on ownership, alignment and harmonization.

Ownership:

Paris declaration: partner countries exercise effective leadership over their development policies and strategies and coordinate development activities.

Beneficiaries were asked if the aid effectiveness measures are available in the Palestinian health sector, the responses are shown below in table (6.2).Findings indicated that the ownership of MoH ranges between moderate and weak , according to beneficiaries there is no clear health sector policy in oPt , only 35.7% agreed there is such policy, however 42.8% had no opinion in this regard. But MoH is in driving seat according to 64% of beneficiaries and 61% of them see MoH is proactive.

Table 6.2: Perceptions of beneficiaries on ownership indicators in health sector

Indicator	Content of items	% of agreement	Note
1. Partners have operational development strategies	MoH is proactive with International partners	**64%**	**Moderate**
	MoH is in the driving seat	**61%**	**Moderate**
	Clear health sector policy in place	**35.7%**	**Weak**

Alignment:

Paris Declaration: International partners base their overall support on partner countries' national development strategies, institutions and procedures.

The perceptions of beneficiaries on alignment will be analysed depending on the alignment progress indicators that set by Paris declaration as shown in table (6.3) below.

When beneficiaries were asked on the availability of the health sector monitoring system, only 30.7% of responses agreed it is in place while 54% of beneficiaries think that health sector systems are in place (these results doesn't meet indicator 2).

Regarding the alignment of international partners systems with government policies, only 23% of responses agree that international partners are practicing that, this result contradict indicator 2, because international partners should use the country systems and strengthening them.

In spite of the availability of a formalized process for dialogue (69% of beneficiaries agreed) but there is no proper health coordination (only 35.70% of beneficiaries agreed), which indicates there is a need to strengthen the capacity of coordination at the national level to avoid parallel implementation structures (Indicator 4, 6).

As shown in table (6.3), the beneficiaries believe that international partners imposed conditionality on partners by prioritizing their national agendas (98.8% of beneficiaries responses concentrated round agree and totally agree) and making funds international partners driven (84.6% of responses concentrated round agree and totally agree). These practices are against indicator #9

Table 6.3: Perceptions of beneficiaries on alignment indicators in health sector

Indicator	Content of items	% of agreement	Note
Indicator 2: Reliable country systems for procurement and public financial management	National health Sector systems are in place	**54%**	**Weak**
	Health sector monitoring system is in place?	**30.7%**	**Very weak**
Indicator 3: Aid flows are aligned on national priorities	International partners systems are aligned with government policies	**23%**	**Very weak**
Indicator 4: Strengthen [national] capacity by coordinated [International partners] support	There is a formalized process for dialogue in health sector	**69%**	**Moderate**
Indicator 7: Strengthen capacity by avoiding parallel implementation structures	There are proper health co-ordination meetings	**35.7%**	**Very weak**
Indicator 9: Aid is untied	International partners are prioritizing their national agendas	**98.8%**	**Very weak**
	Funds are international partners' driven agenda	**84.6%**	**Very weak**

Harmonization:

Paris declaration: International partners' actions are more harmonised, transparent and collectively effective.

As shown in table (6.4) below, beneficiaries are not sure if international partners' rules are supporting the government's harmonization agenda in the sector, 23% of them agree that different systems are being harmonized. When asking beneficiaries if international partners' rules are supporting harmonization, the responses were dispersed, 41.6% of the responses agreed while the same percentage of beneficiaries have no opinion

Table 6.4: Perceptions of beneficiaries on harmonization indicators in health sector

Indicator	Content of items	% of agreement	Note
Indicator 10: Use of common arrangements or procedures [programme-based approaches]	Different international partners systems are being harmonized	**23%**	**Very weak**
	International partners rules are supporting harmonization	**41.6%**	**Very weak**
	Provide information and support to specific health activities	**85.7%**	**Very good**
Indicator 11: Encourage shared analysis	Joint assessments and analysis,	**64%**	**Moderate**

When beneficiaries were asked if there is collaboration among participating organizations in assessments and analysis, 64% of them agree. (Indicator 10)

6.3 International partners' Perceptions

Similar to the first part of the study, this part will discuss the perceptions of international partners on the issues included in health aid coordination meetings that include: (1) Type of funded(focus) health programs 2000-2008 (2) issues that coordination meetings are supporting positively, (3) obstacles of health aid coordination, (4) type of relationships between international partners and beneficiaries, (5) factors influencing negatively health aid coordination, and finally the (6) aid effectiveness principles in oPt according to Paris declaration, in particular ownership, alignment and harmonization.

6.3.1 International partners' opinions on issues included in health coordination meetings

It is important to overview the perceptions of international partners in general on the issues included in the health aid coordination meetings before going into depth concerning the aid coordination. Therefore, the international partners were asked to express their opinions on the issues are included in health coordination meetings, The perceptions are shown in figure (6.8) below and appendix (9) , the majority of participants gave the information sharing the highest rank (85%), secondly is the sharing reports, monitoring and evaluation (64.3%), while the issues of conducting needs assessments, prioritization of needs and resources allocation, advocacy have agreement ranges between (50%-57%).

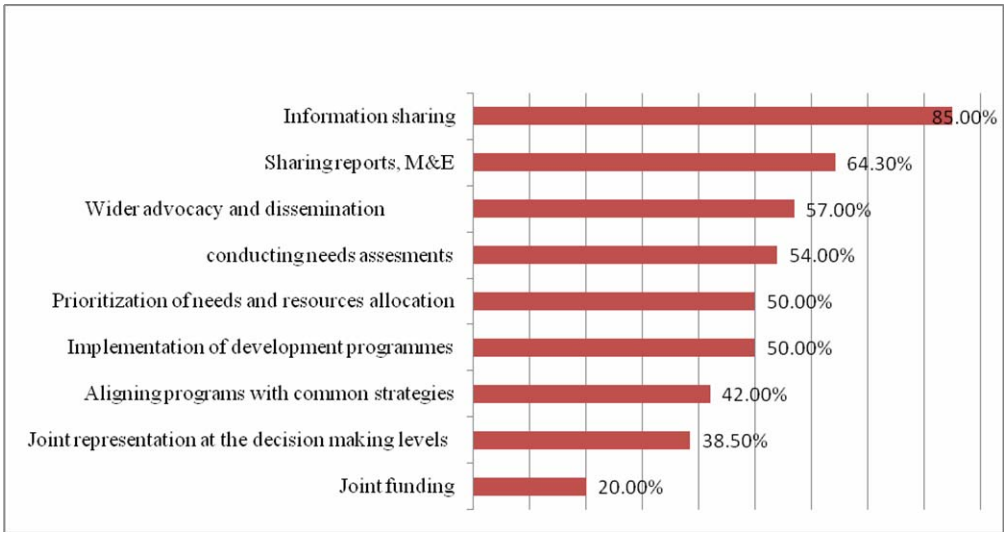

Figure 6.8: International partners opinions on issues included in health aid coordination

The remaining issues as shown in figure 6.11 above have far lower agreement among international partners (20%-42%) which include joint funding, aligning programs with common objectives and strategies and Joint representation at the decision making levels of strategies and plans. Findings show that health aid coordination meetings main strength has been as a forum for information-sharing, exchange of ideas, and where participants get to know what each other is doing. In contradictory, the main weaknesses of health aid coordination meetings, include mainly lack of joint assessments (only 20% agreed).

6.3.2 Issues positively supported by the health aid coordination meetings

In order to assess the advantages of the health aid coordination meetings. International partners were asked to specify from a predetermined list what issues are supported positively by the health aid coordination meetings.

International partners see providing information and support to specific health activities is the first issue supported positively by the health aid coordination meetings (85.7%) as shown in figure (6.9) below and appendix (10), incoherence to that ensuring the regular flow of information among health stakeholders, the HSWG and other related thematic groups gets the same rank (85.7%), however strengthen the MoH leading role in health coordination with clearly and identified roles and responsibilities with other health stakeholders comes in third rank (78,5%) and the immediate response to emergency needs has (75%) of agreement.

Furthermore, coordination meetings support positively the developing of the relations among stakeholders (71.4%) and exchanging experiences (64%).

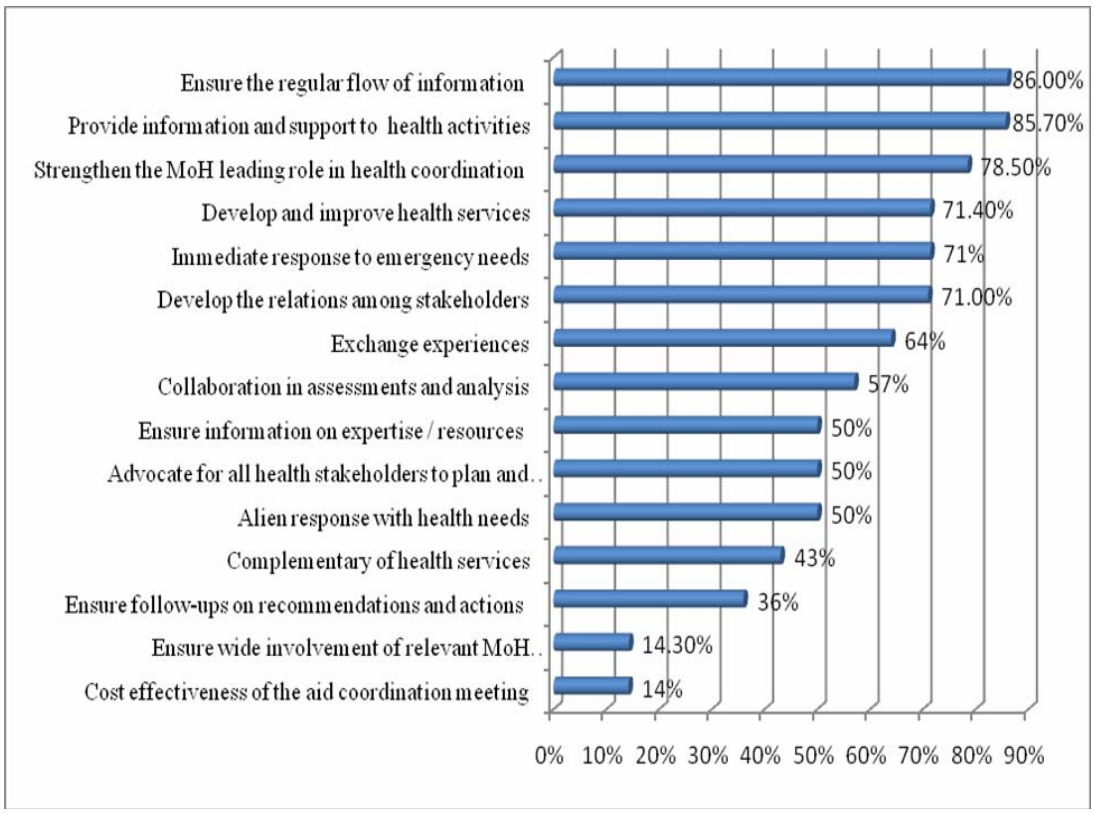

Figure 6.9: International partners opinions (% of agreement) on the issues supported positively by the health aid coordination meetings

As shown in figure (6.9) above, the following issues are supported partially by the health aid coordination (50% to 57%) (1) collaboration among participating organizations in assessments and analysis, and in assuring an effective, integrated health information system (2) ensure information on expertise/ resources available at different agencies and organizations to respond to specific needs are made available to the MoH; (3) advocate for all health stakeholders to plan and implement projects in the line with National Health Strategic Plan level, (4) exchange experiences, (5) develop and improve health services, (6) alien response with health needs. The alarming findings in particular that coordination meetings didn't manage to ensure wide involvement of relevant MoH departments (only 14.3% % of respondents think that health aid coordination meetings couldn't develop and improve the health services and the complementary of health services while only 36% of respondents were satisfied of the follow-ups on recommendations and actions.

6.3.3 Obstacles of the effectiveness of the health aid coordination

When international partners where inquired on their opinions on the obstacles of health aid coordination in oPt. As shown in figure (6.10) below and appendix (11) the three most important obstacles ranked were: (1) The competition on resources and roles, (2) Lack of MoH follow up, (3) Coordination is very often limited to presenting activities of participants rather than sharing relevant information for policy-making and effective aid coordination (92.3% for each). Other important obstacles are the political agenda for international partners (85.70%), and the availability of different international partners (80%) and the lack of clear guidelines or references for coordination and the lack of interest for coordination among health stakeholders (79%) for each. The remaining other obstacles are the fragmentation of the health sector (64%), lack of awareness of the importance of coordination among stakeholders (50%), and the geographical split of oPt due to Israeli closure (64%)

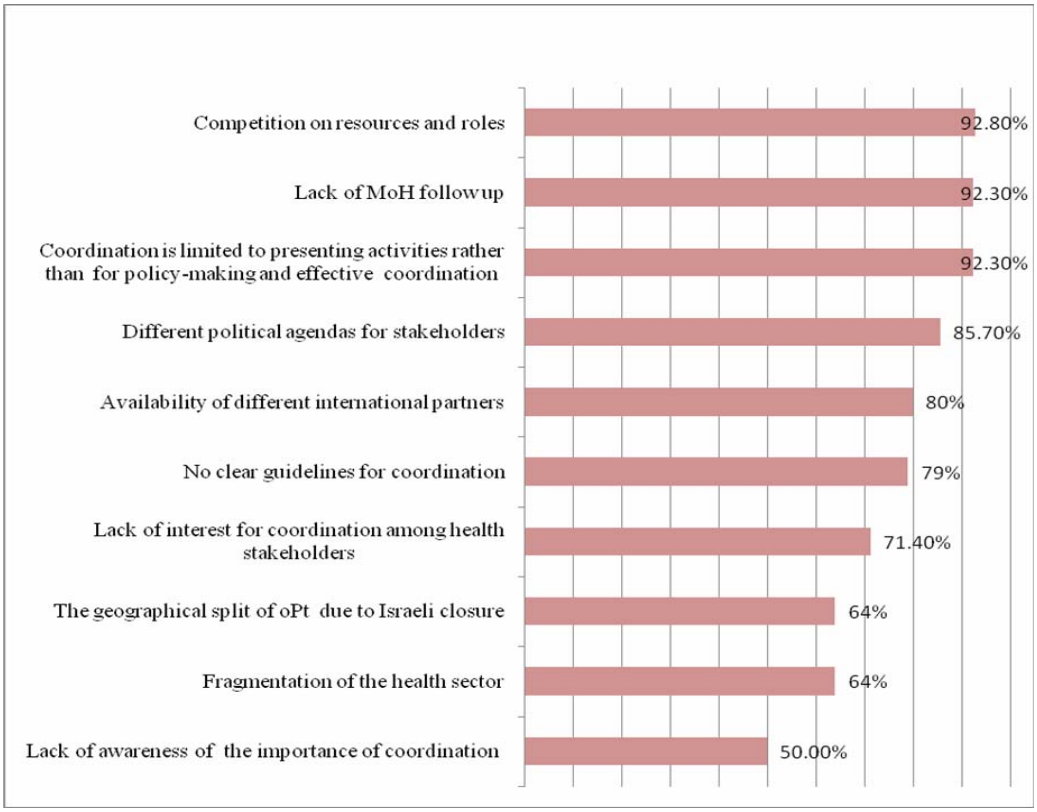

Figure 6.10: International partners opinions (% of agreement) on obstacles of the effectiveness of the health aid coordination

6.3.4 International partners' relationships with beneficiaries

Similar to beneficiaries, international partners were questioned on their opinion on the relationship with the beneficiaries, due to their perceptions the relations with beneficiaries are complicated and vague.

When international partners were asked their opinions on the type of relationship with beneficiaries, their responses were dispersed around no opinion and disagree.

As shown in figure (6.11) below and appendix (12), there is no consistency in relationship with beneficiaries only 21.5% of international partners agree that there is consistent relationship while 50% of international partners have no opinion.

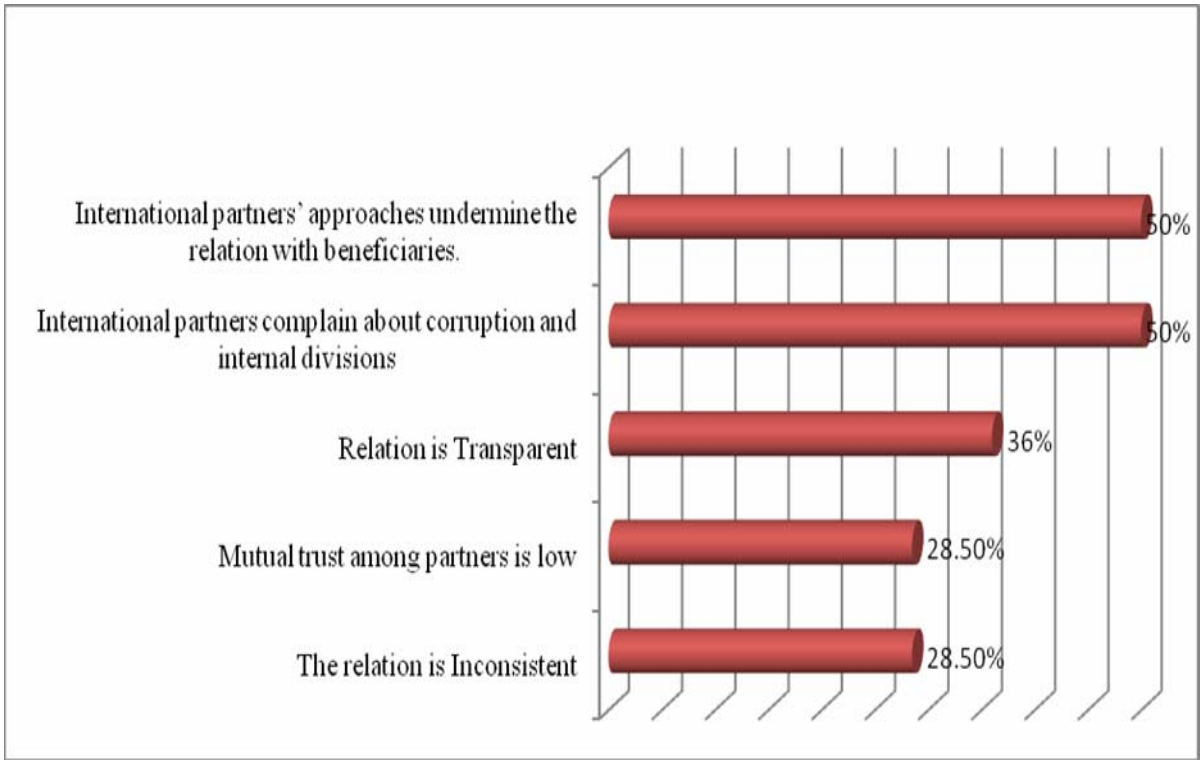

Figure 6.11: International partners opinions (% of agreement) on the types of relationships between international partners and beneficiaries

When they were asked if they are undermining relation with beneficiaries, 50% agree. Concerning the low mutual trust with beneficiaries, 50% of them have no opinion, 21.5% disagree, and 28.5% of the interviewed agree. In addition international partners were asked if they always complain about corruption and internal divisions among beneficiaries, 42.8% of them disagree, while 50% have no opinion. However, transparency with beneficiaries is low, only 35.7% of international partners agree that there is transparency with beneficiaries

6.3.5 Factors influencing negatively the health aid effectiveness

When international partners were asked their opinion on the factors influencing negatively health aid, there was consensus with high means and low SD values (88.8%-100%) as shown in appendix (13) and figure (6.12) below, these factors are: (1) Financial situation and available funds (2) Israeli occupation practices (e.g. checkpoints & access) (3) Political atmosphere (4) Chronic emergencies, (5) International partners' agendas, (6) Internal political split.

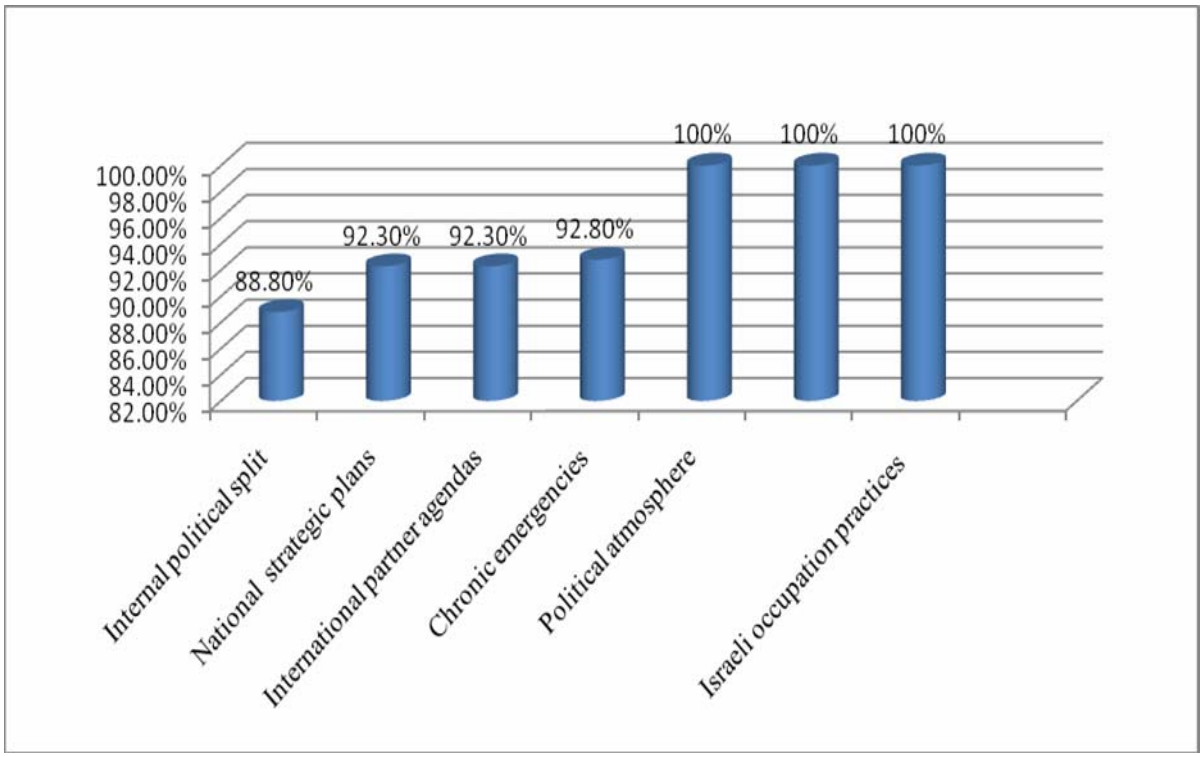

Figure 6.12: International partners opinions (% of agreement) on the factors influencing negatively the health aid effectiveness

6.3.6 Perception of international partners' on aid effectiveness principles in the health aid coordination

In an attempt to measure the aid effectiveness for ownership, harmonization and alignment, beneficiaries were asked about their opinions on the effectiveness measures listed in appendix (14). These principles will be discussed below mainly on ownership, alignment and harmonization.

Ownership:

Paris declaration: Partner countries exercise effective leadership over their development policies and strategies and coordinate development activities.

Table 6.5 Perceptions of international partners on ownership indicators in health sector

Indicator	Content of items	% of agreement	Note
1. Partners have operational development strategies	MoH is proactive with International partners	**14%**	**Very weak**
	MoH is in the driving seat	**23%**	**Very weak**
	Clear health sector policy in place	**38.5%**	**Very weak**

As shown in table (6.5) above, the responses of international partners were dispersed, only 23% of them believed that MoH is in the driving seat while 14% of them agreed that MoH is proactive However 38.5% of international partners believe that there is a clear health sector policy, the uncertainty of health sector policy and the lack of clarity made the position of the international partners ambiguous, in spite of producing several MoH national strategic health plans since 1994. (Indicator 1).

Alignment:

Paris Declaration: **International partners base their overall support on partner countries' national development strategies, institutions and procedures.**

As summarized by table (6.6) below and appendix (14), on alignment indicators in oPt, none international partners agree that there is a health sector monitoring system in place (91.7% disagree and 8.3 have no opinions), only 18% of the international partners believe that health sector systems are in place (these results doesn't meet indicator 2). Furthermore, only 15.4% of responses agreed that international partners are aligning their systems with government policies, this result contradict indicator 3.

When asking if there is a formalized process for dialogue 30.8% agree but according to them there is no proper health coordination (only 25% agree), which indicates that there is a need to strengthen the capacity of coordination at the national level (Indicator 4) and there is a need to strengthening the capacity to avoid parallel implementation structures (Indicator 7).

As shown in table (6.6) below, international partners' believe they are imposing conditionality on partners by prioritizing their national agendas (92.3% (responses concentrated around agree and totally agree), and funds are international partners driven 84.6% agree (these practices against indicator 9).

Table 6.6 Perceptions of international partners on alignment indicators in health sector

Indicator	Content of items	% of agreement	Note
Indicator 2: Reliable country systems for procurement and public financial management	National health Sector systems are in place	**18%**	**Very weak**
	Health sector monitoring system is in place?	**0%**	**Very weak**
Indicator 3: Aid flows are aligned on national priorities	International partners systems are aligned with government policies	**15.4%**	**Very weak**
Indicator 4: Strengthen [national] capacity by coordinated [International partners] support	There is a formalized process for dialogue in health sector	**30.8%**	**Very weak**
Indicator 7: Strengthen capacity by avoiding parallel implementation structures	There are proper health co-ordination meetings	**25%**	**Very weak**
Indicator 9: Aid is untied	International partners are prioritizing their national agendas Why did you put number for this!!!	**92.3%**	**Very weak**
	Funds are international partners' driven agenda	**84.6%**	**Very weak**

Harmonization:

Paris declaration: International partners' actions are more harmonised, transparent and collectively effective.

When examining the harmonization indicators by asking the international partners as shown in table (6.7) below only 15% of them believe that their rules are supporting the government's harmonization agenda in the sector, 84.6% think that different systems are not being harmonized, and 61% of respondents don't agree that rules of international partners are supporting harmonization (Indicator 9 is not met).

Table 6.7: Perceptions of international partners on harmonization indicators in health sector

Indicator	Content of items	% of agreement	Note
Indicator 10: Use of common arrangements or procedures [programme-based approaches]	Different international partners systems are being harmonized	**23%**	**Very low**
	International partners rules are supporting harmonization	**15%**	**Very low**
	Provide information and support to specific health activities	**85.7%**	**Very good**
Indicator 11: Encourage shared analysis	Joint assessments and analysis	**57%**	**low**

57% of international partners agreed that there is collaboration among participating organizations in assessments and analysis, and in assuring an effective integrated health information system (Indicator 10).

The findings are alarming as international partners should commit themselves to Rome agenda and Paris declaration on aid effectiveness.

6.4 Comparison between the perceptions of beneficiaries and international partners on health coordination aid

6.4.1 Introduction:

In order to be able to get a better idea about the gaps in perceptions between beneficiaries and international partners, comparisons were done between both perceptions for the fields of the study. Then the statistical significance of the difference between the means of the responses of the two independent groups were tested using the t-test. Following are the compared fields:

- Issues included in health aid coordination meetings
- Issues are positively supported by health aid coordination meetings
- Obstacles of health aid coordination
- Type of relationships between international partners and beneficiaries
- Factors influencing negatively on the health aid coordination
- The aid effectiveness principles according Paris Declaration for health aid in oPt, in particular ownership, alignment and harmonization.

6.4.2 Issues included in health aid coordination

As shown in figure (6.13) below and appendix (15) there is a significant difference (p-value < or = 0.05) regarding the **i**ssues included in the health aid coordination between the international partners and beneficiaries on the following issues:

- Sharing reports, monitoring and evaluation
- Implementation of development programmes
- Wider advocacy and dissemination
- Joint representation at the decision making levels of strategies and plans.

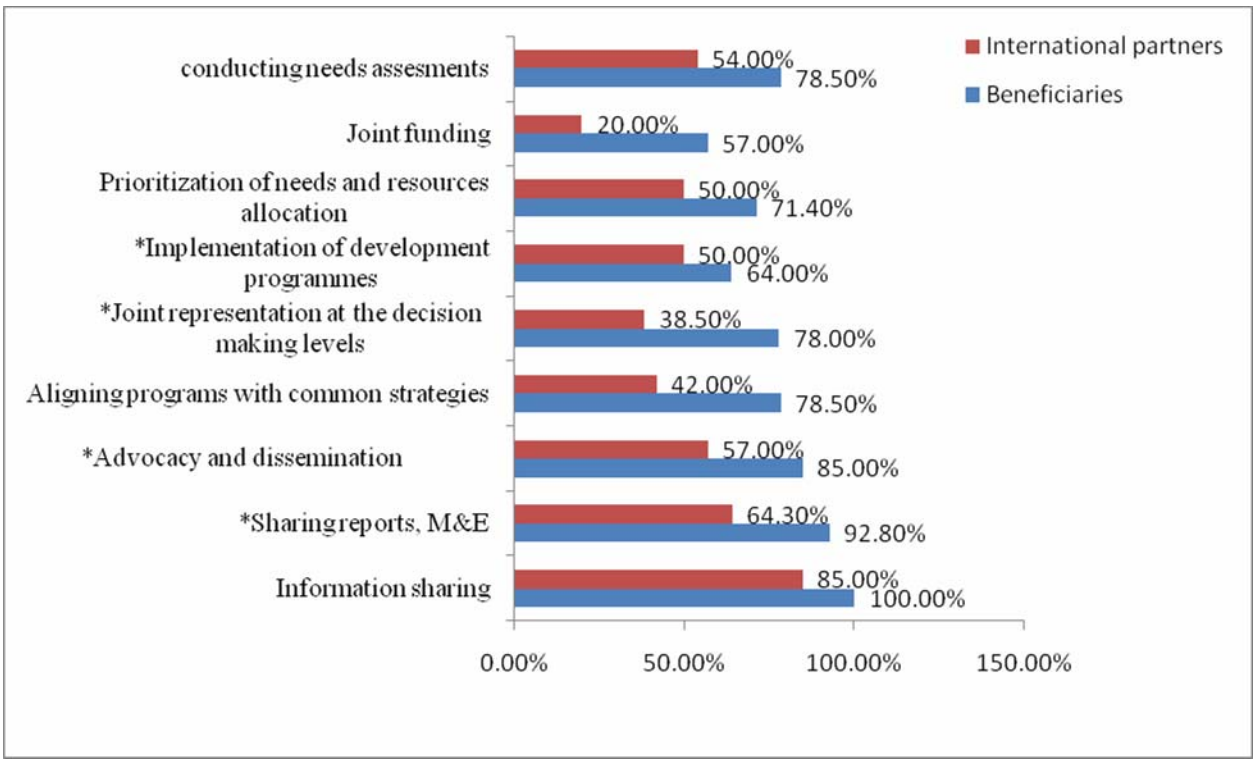

Figure 6.13: Comparison between the international partners and beneficiaries opinions on the issues included in health aid coordination and significant difference *)

While there was no significant difference on the following issues:

- Information sharing
- Conducting needs assessments
- Aligning programs with common objectives and strategies
- Prioritization of needs and resources allocation
- Joint funding

6.4.3 Issues supported positively by health aid coordination meetings

Regarding the issues supported positively by the health aid coordination meetings, international partners gave lower evaluation than beneficiaries and there is significant difference, as shown in figure (6.14) below and appendix (16) there was a significant difference between the following issues:

- Ensure wide involvement of relevant MoH departments and health stakeholders
- Complementary of health services

- Exchange experiences
- Cost effectiveness
- Alien response with health needs
- Immediate response to emergency needs.

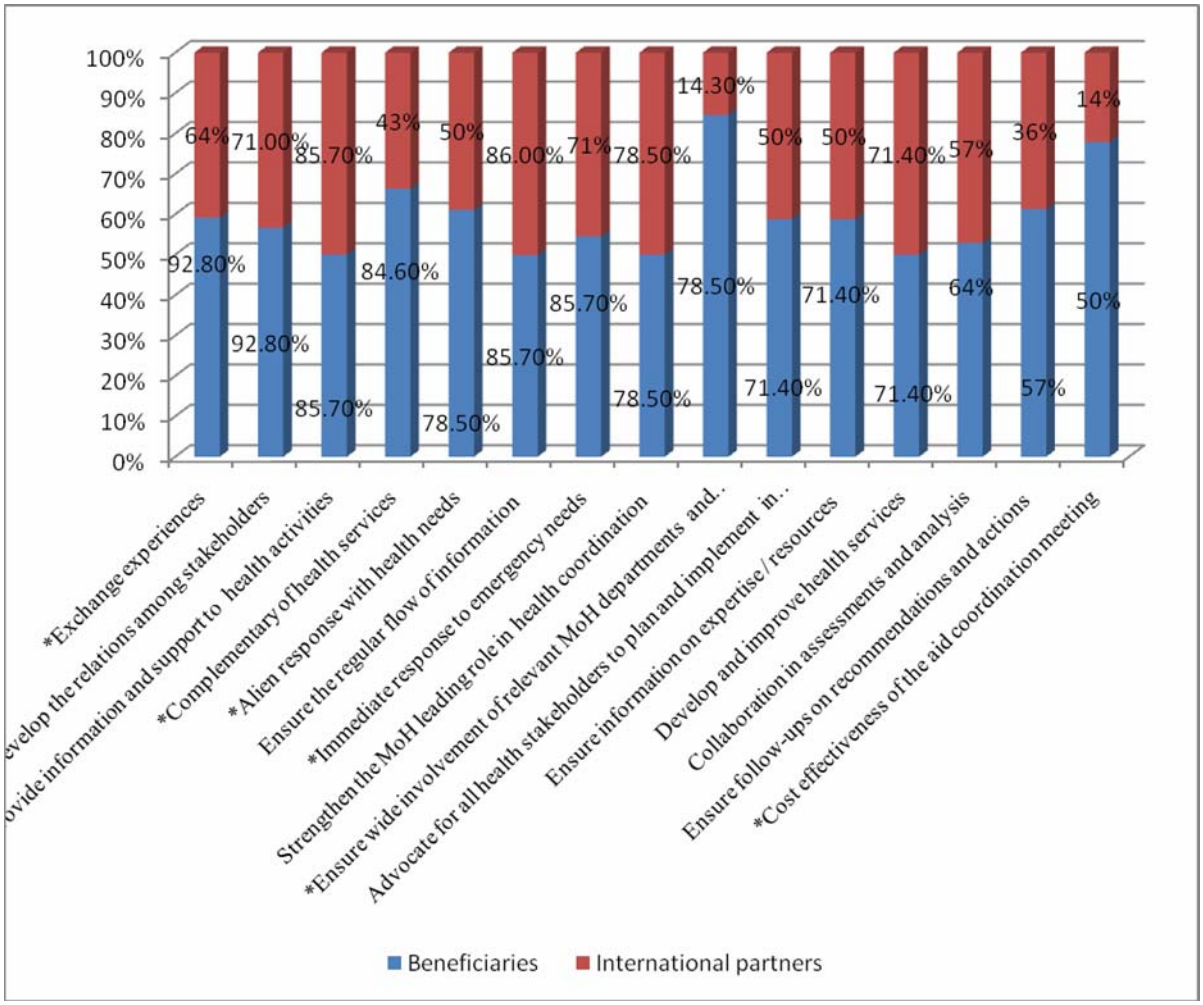

Figure 6.14: Comparison between the international partners and beneficiaries opinions on the issues supported positively by health aid coordination meetings and significant difference *)

On the other hand, there was no significant difference between the perception of beneficiaries and international partners on the majority of issues supported positively by health aid coordination as following:

- Strengthen the MoH leading role in health coordination with clearly and identified roles and responsibilities of the Ministry and other health stakeholders
- Provide information and support to specific health activities (e.g. advocacy for health as a human right ,field visits; surveys; monitoring of access to health services, ad-hoc meetings, and workshops, immunization campaigns, etc)
- Ensure the regular flow of information among health stakeholders, the HSWG and other related thematic groups
- Collaboration among participating organizations in assessments and analysis, and in assuring an effective, integrated health information system
- Ensure Information on expertise / resources available at different agencies and organizations to respond to specific needs are made available to the MoH;
- Ensure Follow-ups on recommendations and actions are made regularly.
- Advocate for all health stakeholders to plan and implement projects in the line with National Health Strategic Plan level.
- Develop the relations among stakeholders
- Develop and improve health services

6.4.4 Obstacles of the effectiveness of the health aid coordination

As shown in figure (6.15) and appendix (17) , there is no significant difference (p-value> or =0.05 for all obstacles listed) between the perceptions means of beneficiaries and International partners. There is a consensus on the obstacles of between international partners and beneficiaries health aid in oPt.

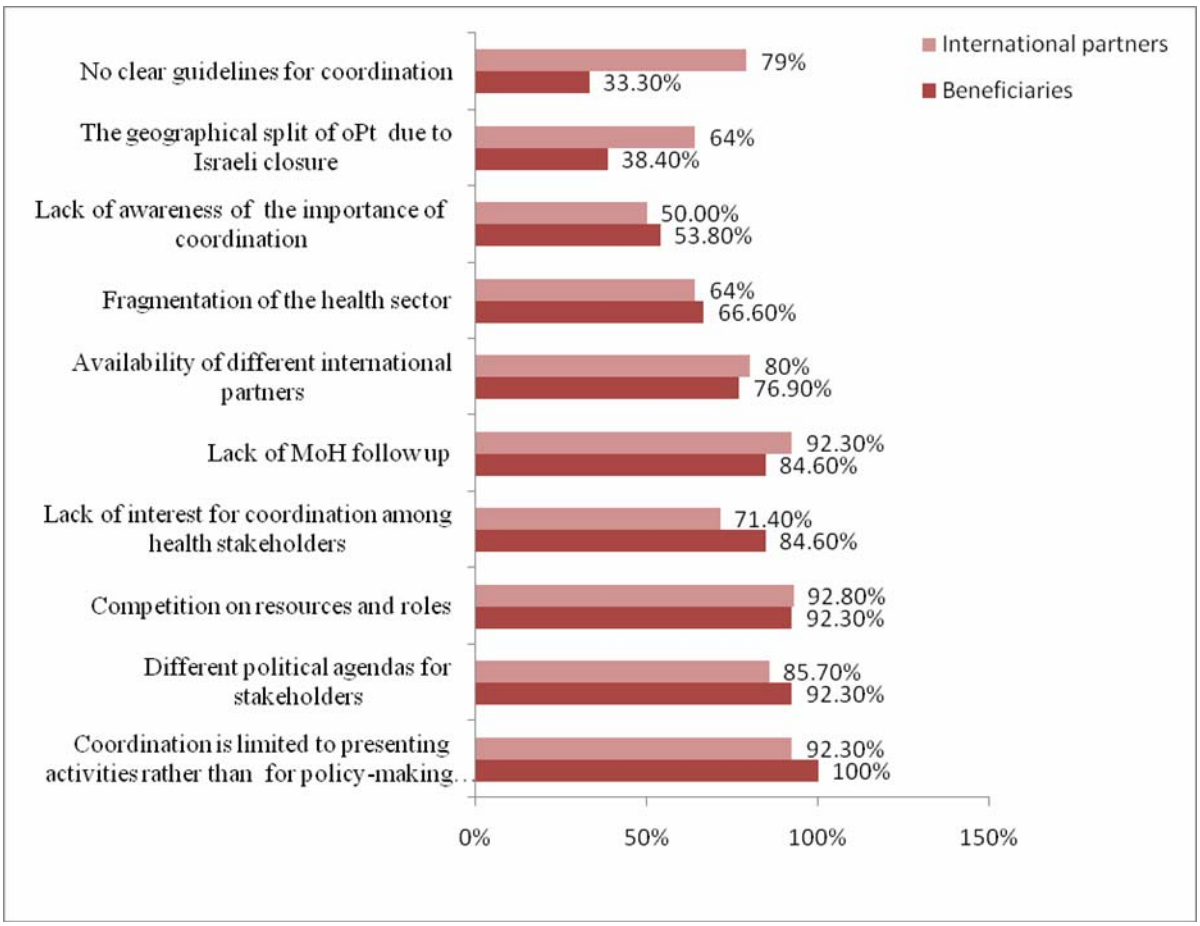

Figure 6.15: Comparison between the international partners and beneficiaries opinions on the obstacles of the effectiveness of the health aid coordination

6.4.5 Relation ship between international partners and beneficiaries

Regarding the relationship between international partners and beneficiaries and as shown in figure (6.16) below and appendix (18) there is significant difference only in mutual trust between beneficiaries and international partners

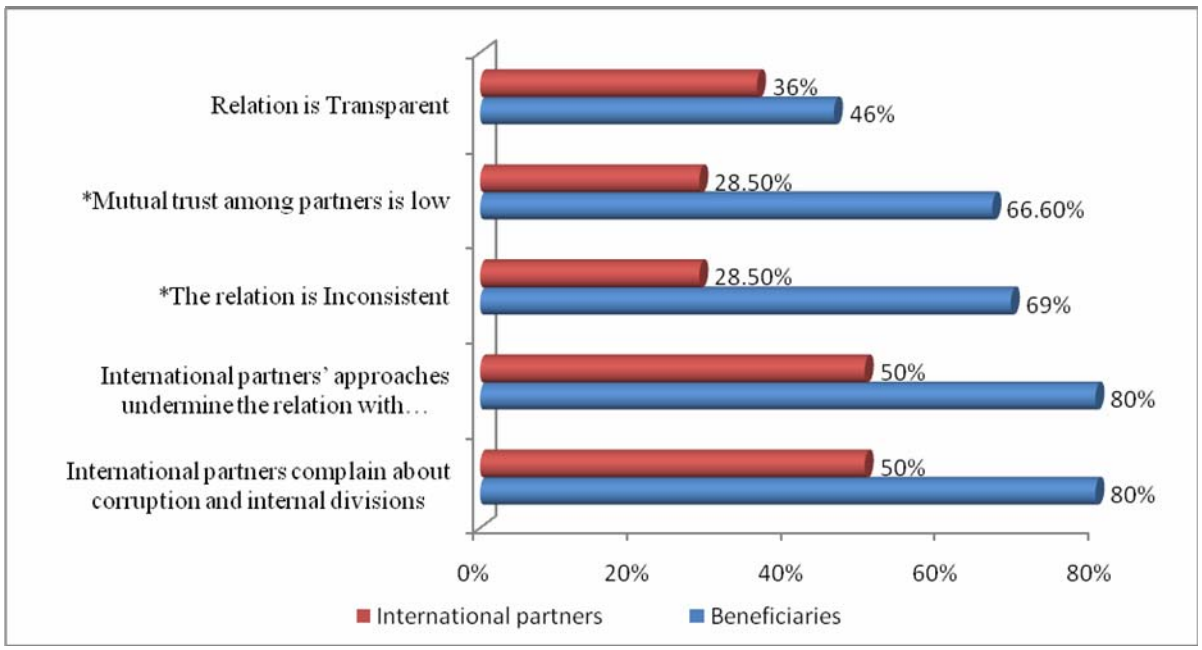

Figure 6.16: Comparison between the international partners and beneficiaries opinions on the types of relationships and significant difference *)

6.4.6 Factors influencing negatively the health aid coordination

There was agreement among beneficiaries and international partners on the factors influencing negatively the health aid coordination with no significant difference as shown in appendix (19) and figure (6.17) below.

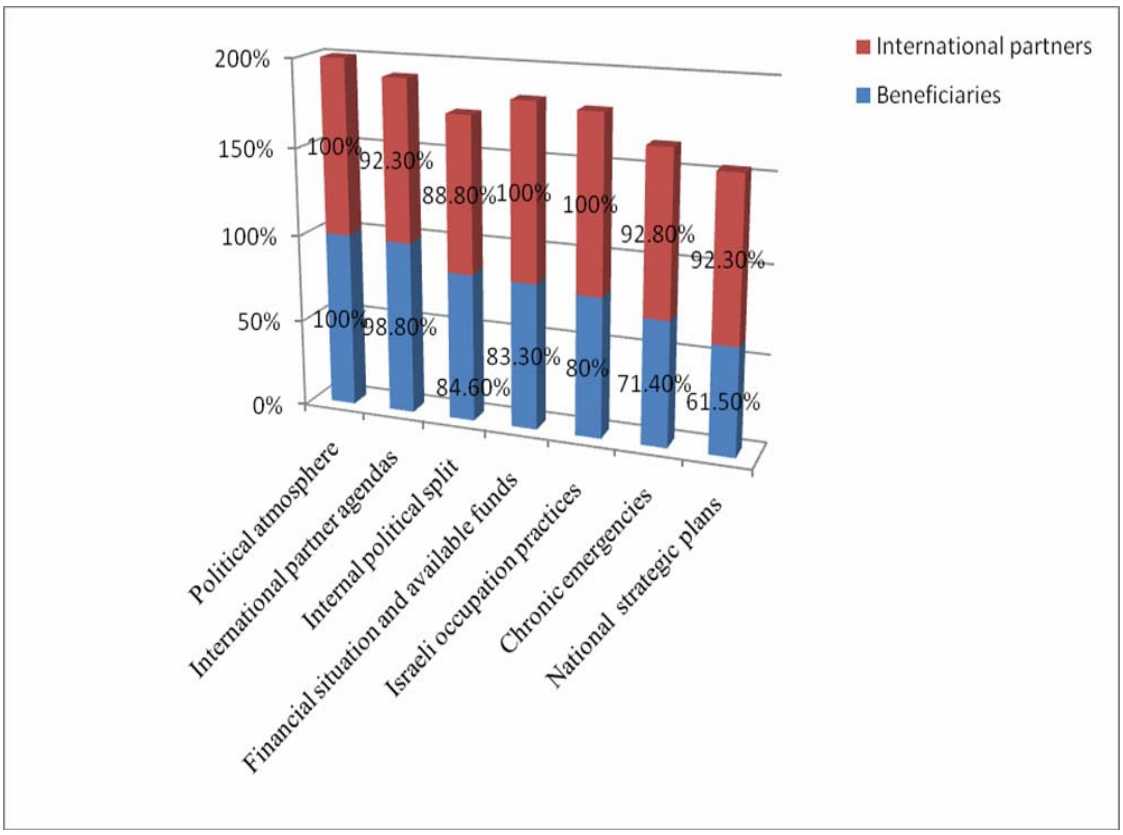

Figure 6.17: Comparison between the international partners and beneficiaries opinions on the factors influencing negatively the health aid coordination

6.4.7 Aid effectiveness principles in health sector

When assessed the perceptions of beneficiaries and international partners statistically on the aid effectiveness measures, there was significant difference between the beneficiaries and international partners perceptions on health aid effectiveness measures (p-value<0.05) of effectiveness indicators as shown in figure (6.18) below and appendix (20)

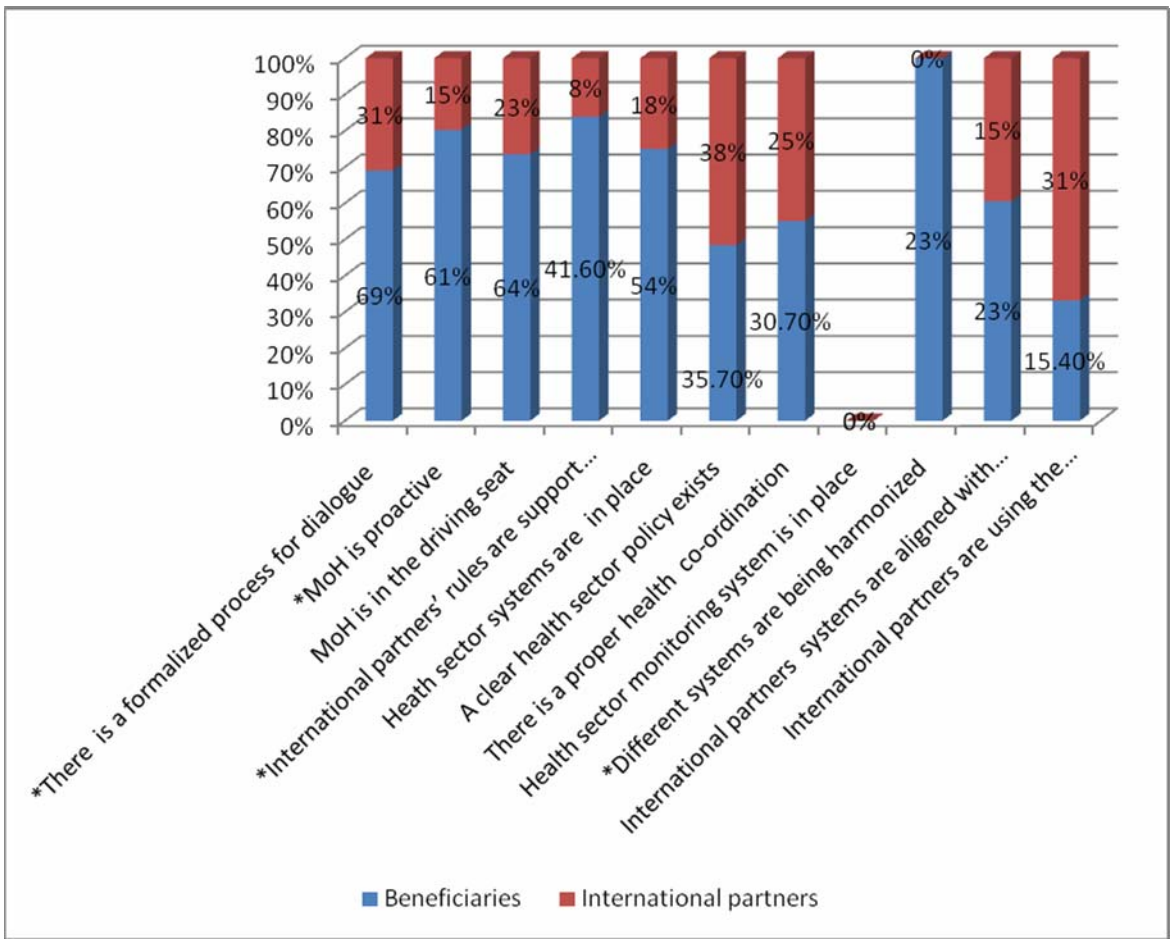

Figure 6.18**:** Comparison between the international partners and beneficiaries opinions on the aid effectiveness principles in health sector and significant difference *)

- There is a formalized process for dialogue
- MoH is proactive
- MoH is in the driving seat
- International partners' rules are support harmonization
- Different systems are being harmonized

On the other hand, there was no significant difference on the following aid effectiveness measures:

- Heath sector systems are in place
- A clear health sector policy exists
- There is a proper health co-ordination

- Health sector monitoring system is in place?
- International partners systems are aligned with government policies
- International partners are using the government monitoring system

6.4.8 Summary:

Table (6.8): below is summarizing the significant differences between beneficiaries and international partners on the following issues of aid coordination:

- Issues included in health aid coordination
- Issues supported positively by health aid coordination meetings

But, in general, there is an agreement among beneficiaries and international partners with no significant on the following issues:

- obstacles effective health aid coordination
- Type of relationship among the international partners and beneficiaries
- factors influencing negatively the health aid coordination

Table 6.8: Significant differences for beneficiaries and international partners' perceptions for the different fields of the study.

Field of Study	Beneficiaries		International partners		p-value	Note
	Mean	Standard Deviation	Mean	Standard Deviation		
Issues included in health aid coordination	4.1	0.5	3.4	1.00	0.03	International partners give Lower evaluation
Issues supported positively by health aid coordination meetings	4.0	0.7	3.3	0.4	0.01	International partners give Lower evaluatio
obstacles effective health aid coordination	3.8	0.4	3.9	0.4	0.91	No Difference
Type of relationship among the International partners and beneficiaries	3.4	0.6	3.5	0.6	0.68	No Difference
factors influencing negatively the health aid coordination	4.1	0.4	4.3	0.4	0.14	No Difference
Aid effectiveness indicators	3.0	0.5	2.6	0.7	0.15	No Difference

Chapter Seven

Conclusions and Recommendations

In order to explore and understand this experience, this research studied the perceptions of beneficiaries and international partners on issues related to health aid coordination under the following themes:

- Issues included in health aid coordination
- Issues positively supported by health aid coordination meetings
- Obstacles for health aid coordination
- Type of relationships between international partners and beneficiaries
- Factors influencing health aid coordination
- The measurement of aid effectiveness in oPt

7.1 Conclusions

The study attributed the low effectiveness of aid coordination in the health sector to three main factors; the first related to the international political agendas and the political situation, it is the most important factor which reflects the politicising of aid in the oPt. , The second main factor was the international partners practices with the beneficiaries and the imposing of their driven priorities and agendas and the third factor is the lack of the MoH follow up for different coordination meetings and their recommendations.

Health aid coordination meetings are the forum for harmonization in health sector through sharing information, exchanging ideas and experience, exchanging reports and disseminating information to health partners, these meetings are also the tools for advocacy.

Participants highly rated the information sharing as one of the issues tackled in the health aid coordination meetings. Information is the key factor affecting the overall impact of the international response first because of its implications for strategic planning and second because of its implications for coordination.

The main weaknesses in the issues tackled in the meetings of health aid coordination meetings were: the lack of conducting joint assessments, lack of joint funding, not aligning programs of international partners with common objectives and strategies in addition to the lack of joint representation at the decision making levels of strategies and plans forums.

7.1.1 Aid effectiveness

Through the analysis of aid effectiveness measures it was clear that there is still a great need to improve health aid effectiveness mainly in the following principles:

Ownership:

There is a need to strengthen the MoH ownership in health sector since beneficiaries evaluated it between weak and moderate, according to beneficiaries MoH is little proactive and in the driving seat but there is no clear sector policy in place. International partners evaluated the ownership of MoH as weak.

Alignment

Alignment of aid coordination in health sector is weak in spite of availability of National Health Sector systems and a dialogue process but international partners systems are not aligned with government policies and there is no monitoring system for health sector.

Harmonization

There was no agreement among participants on the harmonization in health sector, international partners systems should be harmonized and their rules should support harmonization efforts.

7.1.2 Issues that are positively supported by health aid coordination meetings

Health aid coordination meetings are supporting positively the harmonization in health sector to a certain extent by encouraging the following roles:

- Strengthening the MoH leading role in health coordination with clearly and identified roles and responsibilities with other health stakeholders,
- Advocating for planning and implementing projects in line with national health strategic plan.
- Developing relationship and exchanging experience among health stakeholders.
- Providing information and support to specific health activities e.g. advocacy for health as a human right field visits; surveys; monitoring of access to health services, ad-hoc meetings, and workshops, and immunization campaigns and responding to immediate emergency needs.
- Coordinating the responses of stakeholders to meet the health urgent needs of hospitals and other health facilities in crisis.
- Ensuring the regular flow of information among health stakeholders, the HSWG and other related thematic groups.
- Ensuring information on expertise / resources available at different agencies and organizations to respond to specific needs are made available to the MoH;

7.1.3 Obstacles impeding effective health coordination

Many obstacles and challenges that impede effective aid coordination have been expressed by the key informants with almost consensus in the perceptions. These are:

- Different political agendas for stakeholders
- Competition on resources and roles
- Availability of different international partners
- Fragmentation of the health sector
- Lack of interest for coordination among health stakeholders

7.1.4 International partners Practices with beneficiaries

As was discussed in chapter 5, international partners practices with partners are the pillars of effective aid coordination, Rome and Paris declarations committed international partners to strengthen beneficiaries' ability to assume a greater leadership role and to take ownership of development results. In reference to the beneficiaries' perceptions the following are the main practices of international partners in oPt:

- Complicated international partners procedures
- International partners driven priorities
- Uncoordinated international partners practices
- Excessive demands on time (Meeting deadlines)
- Delays in disbursements
- Undermining the national capacities

7.1.5 Type of relationship between international partners and beneficiaries:

In spite of the importance of the relationship between international partners and beneficiaries to achieve better harmonization and alignment there is still a gap in this regard. There were no significant statistical differences in the perceptions of both international partners and beneficiaries on type of international partners-beneficiaries relationship. Following are the types of relationships:

- International partners usually complain about corruption and internal divisions
- International partners' approaches undermine the relation with beneficiaries
- Inconsistent relationship, it is changeable
- Low mutual trust with beneficiaries
- International partners are not transparent with beneficiaries

7.1.6 Factors influencing negatively the effectiveness of health aid coordination

The main influencing factors that affected negatively the effectiveness of health aid coordination were identified by the participants in the study with no significant statistical differences as follow:

- Political atmosphere
- National and international partners' agendas
- The Palestinian internal political split
- Financial situation and available funds.

7.2 Recommendations

Following are the main recommendations of the study:

1. **Improve the performance of health aid coordination meetings by:**

- Increasing collaboration among participating organizations in joint assessments and analysis, and in assuring an effective, integrated health information system.
- Ensuring wider involvement of relevant MoH departments and health stakeholders.
- Ensuring that information on expertise / resources available at the different agencies and organizations to respond to specific needs are also made available to the MoH.
- Ensuring the follow-up on recommendations and actions suggested or agreed upon are conducted following the meeting especially those fall upon the MoH.
- Advocating for all health stakeholders to plan and implement projects in line with National Strategic Health Plans and priorities.
- Alien response of international partners with health needs
- Prioritization of needs and resources allocation
- Improving the reporting system within the health aid coordination structure (coordination meetings, thematic groups and Sector Working groups)

2- **Improve aid effectiveness in ownership, alignment and harmonization in health sector through the following:**

<u>MoH should:</u>

- Strengthening the formalized process for dialogue with different stakeholders; MoH should take lead and be proactive in managing the aid activities.
- MoH should have a clear health sector policy in place.
- MoH should establish a monitoring mechanism for the sector system.

International partners should be committed to:

- International partners' rules should support harmonization in the health sector
- Different international partners systems should be harmonized among themselves.
- International partners systems should be aligned with government policies
- International partners should work with MoH to establish its monitoring system and use it.
- International partners should simplify their complicated procedures.
- International partners should develop the national capacity and not undermine it.

3. Improve Beneficiaries-international partners relationships through:

- International partners should deal with national capacities and developing it without undermining their capacities
- International agencies should build a consistent relationships with beneficiaries build on mutual trust, transparency and respect.

4. Improve international partners' practices with beneficiaries by:

- Simplify international partners' procedures and provide training for local staff on these procedures.
- International partners should use country priorities, international partners to respect the country priorities
- International partners should coordinate their practices
- International partners should minimize the delays in disbursements

5. Minimize the impact of obstacles on aid effectiveness through:

- International partners to minimize the political impacts on the aid agenda in oPt
- Increase awareness on the importance of health aid coordination among stakeholders and encourage them to avoid different agendas.
- Make clear guidelines and responsibilities for health aid coordination

7.4 Further research needed

W suggest to conduct further research on aid effectiveness to cover the period of 2008-2010 by to examine the improvement in aid coordination in particular in Mutual accountability and managing for results principles since the study did not include them, in addition that PNA endorsed Paris Declaration in 2008 and the MoH developed its guide lines for aid effectiveness in health sector depending on Paris declaration.

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Appendices

Appendix 1: Type of funded (focus) health programs 2000-2008 according to beneficiaries and international partners' opinions

Types of health programmes	**Frequency**		**Percentages**	
	Beneficiaries	International partners	Beneficiaries	International partners
Medicines and medical	11	10	78.6%	71.4%
Equipment	11	9	78.6%	64.3%
Infrastructure	8	5	57.1%	35.7%
Staff salaries	8	3	57.1%	21.4%
Technical Assistance	8	5	57.1%	35.7%
Maintenance	7	11	50.0%	78.6%
Capacity Building	4	4	28.6%	28.6%

Appendix 2: Beneficiaries opinions on issues included in the health aid coordination

Included Issues	Totally disagree	Dis-agree	No opinion	Agree	Totally agree	Mean	SD	Note
Information sharing	0	0	0	6	8	4.6	0.5	(100%) Concentrated between totally agree and agree
Sharing reports, monitoring and evaluation	0	0	1	9	4	4.2	0.6	(92.8) Concentrated round agree
Wider advocacy and dissemination	0	0	2	9	3	4.2	0.4	(85%) Concentrated round agree
Conducting needs assessments	0		3	7	4	4.1	0.7	(78.5%) Concentrated round agree
Aligning programs with common objectives and strategies	0	2	1	7	4	3.9	1.0	(78.5%)Concentrated round agree
Joint representation at the decision making levels of strategies ,plans	0	2	1	8	3	3.9	1.0	(78%) Concentrated between Agree and totally agree
Prioritization of needs and resources allocation	0	2	2	5	5	3.9	1.1	(71.4%) Concentrated round agree
Implementation of development programmes	0	1	4	6	3	4.2	0.4	(64%) Concentrated round agree
Joint funding	1	4	1	8	0	3.3	0.9	(57%) Concentrated between Agree and disagree

Appendix 3: Beneficiaries' opinions on the issues positively supported by the health aid coordination meetings

Issues supported positively	Totally disagree	Dis-agree	No opinion	Agree	Totally agree	Mean	SD	Note
Exchange experiences	0	0	1	10	3	4.1	0.5	(92.8%) Concentrated round agree
Develop the relations among stakeholders	0	0	1	9	4	4.2	0.6	(92.8%) Concentrated round agree
Provide information and support to specific health activities	0	0	2	6	6	4.3	0.7	(85.7%) Concentrated between totally Agree and agree
Complementary of health services	0	1	1	8	3	4.0	0.8	(84.6%)Concentrated round agree
Alien response with health needs	0	1	2	8	3	3.9	0.8	(78.5%) Concentrated round agree
Ensure the regular flow of information among health stakeholders, the HSWG and other related thematic groups.	0	1	1	6	6	4.2	0.9	(85.7%) Concentrated between totally Agree and agree
Immediate response to emergency needs	0	1	1	6	6	4.2	0.9	(85.7%) Concentrated between totally Agree and agree

Appendix 3:: continue....

Issues supported positively	Totally disagree	Dis-agree	No opinion	Agree	Totally agree	Mean	SD	Note
Strengthen the MoH leading role in health coordination with clearly and identified roles and responsibilities with other health stakeholders	0	1	2	7	4	4.0	0.9	(78.5%) Concentrated round agree
Ensure wide involvement of relevant MoH departments and health stakeholders	0	2	1	8	3	3.9	0.9	(78.5%) Concentrated round agree
Advocate for all health stakeholders to plan and implement projects in the line with National Health Strategic Plan level.	0	1	3	7	3	3.9	0.9	(71.4%) Concentrated round agree
Ensure information on expertise / resources available at different agencies and organizations to respond to specific needs are made available to the MoH;	0	2	2	6	4	3.9	1.0	(71.4%) Concentrated round agree
Develop and improve health services	0	2	2	6	4	3.9	1.0	(71.4%) around agree

Appendix 3:: continue....

Issues supported positively	Totally disagree	Dis-agree	No opinion	Agree	Totally agree	Mean	SD	Note
Collaboration among participating organizations in assessments and analysis, and in assuring an effective, integrated health information system	0	3	2	5	4	3.7	1.1	(64%) Concentrated round agree
Ensure follow-ups on recommendations and actions are made regularly.	0	2	4	5	3	3.6	1.0	(57%) concentrated round agree
Cost effectiveness of the aid coordination meeting	0	2	5	4	3	3.6	1.0	(50%) round agree

Appendix 4: Beneficiaries' opinions on obstacles of the effectiveness of the health aid coordination

obstacles	Totally disagree	Dis-agree	No opinion	Agree	Totally agree	Mean	SD	Note
Coordination is limited to presenting activities rather than sharing relevant information for policy-making and effective aid coordination	0	0	0	10	2	4.2	0.4	(100%) Concentrated round agree
Different political agendas for stakeholders	0	0	1	4	8	4.5	0.7	(92.30%)Concentrated between totally Agree and agree
Competition on resources and roles	0	1	0	6	6	4.3	0.9	(92.30%) Concentrated between totally Agree and agree
Lack of interest for coordination among health stakeholders	0	0	2	7	4	4.2	0.7	(84.6%) Concentrated round agree
Lack of MoH follow up	0	0	2	7	4	4.2	0.7	(84.6%) Concentrated round agree
Availability of different international partners	0	1	2	6	4	4.0	0.9	(76.9%) Concentrated round agree
Fragmentation of the health sector	1	3	0	5	3	3.5	1.4	(66.6%) round agree
Lack of awareness of the importance of coordination among stakeholders	0	5	1	5	2	3.3	1.2	(53.8%) concentrated round agree
The geographical split of oPt due to Israeli closure	1	5	2	4	1	2.9	1.2	(38.4%) round agree
No clear guidelines for coordination	0	4	4	1	3	3.3	1.2	(33.3%) round agree

Appendix 5: Beneficiaries' opinions on international partners' practices in health aid in oPt

International partners Practices	Totally disagree	Dis-agree	No opinion	Agree	Totally agree	Mean	SD	Note
Complicated international partners procedures	0	1	0	4	6	4.4	0.9	(91%) Concentrated between totally Agree and agree
International partners driven priorities	0		2	6	5	4.5	0.5	(84.6%)Concentrated between totally Agree and agree
Uncoordinated international partners practices	0	2	0	6	3	3.9	1.0	(82%) Concentrated round agree
Excessive demands on time (Meeting deadlines)	0	1	1	6	2	3.9	0.9	(80%) around agree
Delays in disbursements	0	3	1	5	2	3.5	1.1	(63.6%) around agree
Undermining the national capacity	0	3	2	6	1	3.5	1.0	63% around agree
Demands beyond national capacity	0	4	2	3	2	3.3	1.2	45% around agree

Appendix 6: Beneficiaries opinions on the types of relationships between international partners and beneficiaries

Type of relation ship	Totally disagree	Dis-agree	No opinion	Agree	Totally agree	Mean	SD	Note
International partners retort by complaining about corruption and internal divisions	1	2	0	10	0	3.5	1.1	80% Concentrated round agree
International partners' approaches undermine the relation with beneficiaries.	1	2	3	7	0	3.2	1.0	80% Concentrated round agree
Inconsistent	0	2	2	7	2	3.7	0.9	69% Concentrated round agree
Low mutual trust	0	2	2	8	0	3.5	0.8	66.6% Concentrated round agree
Transparency	0	2	5	6	0	3.3	0.8	46% round agree

Appendix 7: Beneficiaries' opinions on the factors influencing negatively the effectiveness of health aid

Effects on health aid	Totally disagree	Dis agree	No opinion	Agree	Totally agree	Mean	SD	Note
Political atmosphere	0	0	0	4	10	4.7	0.5	100% Concentrated between totally Agree and agree
International partner agendas	0	0	1	6	7	4.4	0.6	98.8% Concentrated between totally Agree and agree
Internal political split	0	0	2	8	3	4.1	0.6	84.6% Concentrated round agree
Financial situation and available funds	0	1	1	8	2	3.9	0.8	83.3% Concentrated between totally Agree and agree
Israeli occupation practices	0	0	3	4	6	4.2	0.8	80% Concentrated between totally Agree and agree
Chronic emergencies	0	2	2	9	1	3.6	0.8	71.4% Concentrated between totally Agree and agree
National strategic plans	0	4	1	8	0	3.3	0.9	61.5% Concentrated between totally Agree and agree

Appendix 8: Beneficiary opinions on the aid effectiveness principles in the health aid coordination in oPt

Effectiveness measures	Totally disagree	Dis-agree	No opinion	Agree	Totally agree	Mean	SD	Note
There is a formalized process for dialogue	0	1	2	7	2	3.8	0.8	69% concentrated round agree
MoH is proactive	0	2	3	8	0	3.5	0.8	61% concentrated round agree
MoH is in the driving seat	0	3	2	9	0	3.4	0.9	64% concentrated round agree
International partners' rules are support harmonization	0	2	5	5	0	3.3	0.8	41.6% round agree,41.6 % no opinion
Heath sector systems are in place	0	4	3	6	0	3.2	0.9	54% round agree
A clear health sector policy exists	1	6	2	5	0	2.8	1.1	35.7% round agree, 50% disagree
There is a proper health co-ordination	0	5	4	4	0	2.9	0.9	30.7% round agree,
Health sector monitoring system is in place	0	9	3	0	0	2.3	0.5	Concentrated round disagree
Different systems are being harmonized	0	7	3	3	0	2.7	0.9	Concentrated round disagree
International partners systems are aligned with government policies	0	6	4	3	0	2.8	0.8	Concentrated round disagree
International partners are using the government monitoring system	0	7	4	2	0	2.6	0.8	Concentrated round disagree

Appendix 9: International partners opinions on issues included in health aid coordination

Issues included in health coordination	Totally disagree	Dis-agree	No opinion	Agree	Totally agree	Mean	SD	Note
Information sharing	1	1	0	4	8	4.2	1.3	(85%) Concentrated between totally Agree and agree
Sharing reports, monitoring and evaluation	1	4	0	7	2	3.4	1.3	(64.3%) Concentrated round Agree
Conducting needs assessments	1	5	0	4	3	3.2	1.4	(54%)round agree
Aligning programs with common objectives and strategies	0	7	1	1	5	3.3	1.4	(42%) round agree
Prioritization of needs and resources allocation	0	5	2	2	5	3.5	1.3	(50%) round agree
Joint funding	0	7	3	2	1	2.8	1.0	(20%) round agree
Implementation of development programmes	0	4	1	6	1	3.3	1.1	(50%) round agree
Wider advocacy and dissemination	0	5	1	6	2	3.4	1.2	(57%) concentrated between agree and totally agree
Joint representation at the decision making levels of strategies and plans	0	6	2	4	1	3.0	1.1	.(38.5%) around agree

Appendix 10: International partners opinions on the issues supported positively by the health aid coordination meetings

issues supported positively by coordination	Totally disagree	Dis-agree	No opinion	Agree	Totally agree	Mean	SD	Note
Provide information and support to specific health activities	0	2	0	8	4	4.0	1.0	(85.7%)Concentrated between totally Agree and agree
Ensure the regular flow of information among health stakeholders, the HSWG and other related thematic groups.	0	1	1	9	3	4.0	0.8	(85.7) Concentrated between totally Agree and agree
Strengthen the MoH leading role in health coordination with clearly and identified roles and responsibilities of the Ministry and other health stakeholders	0	1	2	7	4	4.0	0.9	(78.5%) Concentrated between totally Agree and agree
Immediate response to emergency needs	1	2	1	9	0	3.4	1.0	(75%) Concentrated round agree
Develop the relations among stakeholders	0	1	2	8	2	3.8	0.8	(71.4%)Concentrated round agree
Exchange experiences	0	3	2	8	1	3.5	0.9	(64%) Concentrated round agree

Appendix 10 (continue)...:

Issues supported positively by coordination	Totally disagree	Dis-agree	No opinion	Agree	Totally agree	Mean	SD	Note
Collaboration among participating organizations in assessments and analysis, and in assuring an effective, integrated health information system	0	6		7	1	3.2	1.1	57% round agree
Ensure Information on expertise / resources available at different agencies and organizations to respond to specific needs are made available to the MoH;	0	4	3	7	0	3.2	0.9	50% round agree
Alien response with health needs	0	4	2	7	0	3.2	0.9	50% round agree
Advocate for all health stakeholders to plan and implement projects in the line with National Health Strategic Plan level.	0	4	3	7	0	3.2	0.9	50% round agree
Complementary of health services	0	6	2	6	0	3.0	1.0	(43%) agree,
Ensure Follow-ups on recommendations and actions are made regularly.	0	5	4	5	0	3.0	0.9	(36%) agree
Develop and improve health services	0	6	3	4	0	2.8	0.9	(30.8%) agree,
Ensure Wide involvement of relevant MoH departments and health stakeholders	1	5	6	2	0	2.6	0.8	(14.3%) agree.
Cost effectiveness	1	7	4	1	1	2.6	1.0	50% no opinion

Appendix 11: International partners opinions on obstacles of the effectiveness of the health aid coordination

International partners Practices	Totally disagree	Dis-agree	No opinion	Agree	Totally agree	Mean	SD	Note
Competition on resources and roles	0	0	1	9	4	4.2	0.6	(92.8%)Concentrated round agree
Lack of MoH follow up	0	0	1	4	8	4.5	0.7	(92.3%)Concentrated between totally Agree and agree
Coordination is very often is limited to presenting activities of participants rather than sharing relevant information for policy-making and effective aid coordination	0	0	1	9	3	4.2	0.6	(92.3%) Concentrated round agree
Different Political agendas for stakeholders	0	1	1	8	4	4.1	0.8	(85.7%) Concentrated between totally Agree and agree
Availability of different international partners	0	2	1	7	3	3.8	1.0	(80%) Concentrated between totally Agree and agree
No clear guidelines or references for coordination	0	2	1	9	2	3.8	0.9	(79%) Concentrated between totally Agree and agree
Lack of interest for coordination among health stakeholders	0	1	3	8	2	3.8	0.8	(71.4) Concentrated round agree
The geographical split of oPt due to Israeli closure	0	5	0	6	3	3.5	1.2	(64%) round agree
Fragmentation of the health sector	0	3	2	7	2	3.6	1.0	(64%) Concentrated round agree
Lack of awareness of the importance of coordination among stakeholders	0	6	1	6	1	3.1	1.1	(50%) round agree

Appendix 12: International partners opinions on the types of relationships between international partners and beneficiaries

Type of relation ship	Totally disagree	Dis-agree	No opinion	Agree	Totally agree	Mean	SD	Note
Inconsistent	1	2	7	2	2	3.7	0.9	(28.5%) round agree, (50%) no opinion and (21.5%) round disagree
International partners' approaches undermine the relation with beneficiaries.	0	1	6	4	3	3.8	1.1	(50% round agree, (42.8%) no opinion
Low mutual trust	2	1	7	2	2	3.8	1.0	28.5% agree, 50% no opinion
International partners retort by complaining about corruption and internal divisions		6	7		1	3.4	0.6	Dispersed
Transparency		7	2	1	4	3.0	0.9	50% Concentrated round disagree,

Appendix 13: International partners opinions on the factors influencing negatively the health aid effectiveness

Effects on health aid	Totally disagree	Dis-agree	No opinion	Agree	Totally agree	Mean	SD	Note
Financial situation and available funds	0	0	0	6	3	4.3	0.5	100% Concentrated between totally Agree and agree
Israeli occupation practices	0	0	0	4	10	4.7	0.5	100% Concentrated between totally Agree and agree
Political atmosphere	0	0	0	4	10	4.7	0.5	100% Concentrated between totally Agree and agree
Chronic emergencies	0	0	1	9	4	4.2	0.6	92.8% Concentrated between totally Agree and agree
National international partners agendas	0	0	1	4	8	4.5	0.7	92.3% Concentrated between totally Agree and agree
Internal political split	0	0	1	2	6	4.6	0.7	88.8% Concentrated between totally Agree and agree

Appendix 14: International partners opinions on the aid effectiveness indicators in the health aid coordination in oPt

Aid effectiveness measure	Totally disagree	Dis-agree	No opinion	Agree	Totally agree	Mean	SD	Note
There is a formalized process for dialogue	1	7	1	2	2	2.8	1.3	31%concentrated round agree
MoH is proactive	2	6	3	2	0	2.4	1.0	15%Concentrated round agree
MoH is in the driving seat	1	6	3	3	0	2.6	1.0	23%Concentrated round agree
International partners' rules are support harmonization	1	7	4	1	0	2.4	0.8	8%Concentrated round agree
Heath sector systems are in place	1	6	2	2	0	2.5	0.9	18%Concentrated round agree
A clear health sector policy exists	1	7	0	5	0	2.7	1.1	38%Concentrated round agree
There is a proper health co-ordination	1	6	2	3	0	2.6	1.0	25%Concentrated round agree
Health sector monitoring system is in place?	1	10	1	0	0	2.0	0.4	0%Concentrated round agree
Different systems are being harmonized	2	11	0	0	0	1.8	0.4	0%Concentrated round agree
International partners systems are aligned with government policies	1	7	3	2	0	2.5	0.9	15%Concentrated round agree
International partners are using the government monitoring system	2	7	2	1	1	2.4	1.1	31%Concentrated round agree

Appendix 15: Means of international partners and beneficiaries by opinions on issues included in health aid coordination

Issues in health coordination	Beneficiaries		International partners		p-value	Note
	Mean	Standard Deviation	Mean	Standard Deviation		
Information sharing	4.6	0.5	4.2	1.3	0.33	No Difference
Sharing reports, monitoring and evaluation	4.2	0.6	3.4	1.3	0.03	International partners give Lower evaluation
Conducting needs assessments	4.1	0.7	3.2	1.4	0.06	No Difference
Aligning programs with common objectives and strategies	3.9	1.0	3.3	1.4	0.18	No Difference
Prioritization of needs and resources allocation	3.9	1.1	3.5	1.3	0.36	No Difference
Joint funding	3.3	0.9	2.8	1.0	0.17	No Difference
Implementation of development programmes	4.2	0.4	3.3	1.1	0.01	International partners give Lower evaluation
Wider advocacy and dissemination	4.2	0.4	3.4	1.2	0.02	International partners give Lower evaluation
Joint representation at the decision making levels of strategies and plans	3.9	1.0	3.0	1.1	0.03	International partners give Lower evaluation

Appendix 16: Means of international partners and beneficiaries by opinions on issues supported positively by health aid coordination meetings

Coordination meetings supporting	Beneficiaries		International partners		p-value	Note
	Mean	Standard Deviation	Mean	Standard Deviation		
Strengthen the MoH leading role in health coordination with clearly and identified roles and responsibilities of the Ministry and other health stakeholders	4.0	0.9	4.0	0.9	1.00	No Difference
Provide information and support to specific health activities (e.g. advocacy for health as a human right ,field visits; surveys; monitoring of access to health services, ad-hoc meetings, and workshops, immunization campaigns, etc)	4.3	0.7	4.0	1.0	0.38	No Difference
Ensure the regular flow of information among health stakeholders, the HSWG and other related thematic groups.	4.2	0.9	4.0	0.8	0.51	No Difference
Collaboration among participating organizations in assessments and analysis, and in assuring an effective, integrated health information system	3.7	1.1	3.2	1.1	0.25	No Difference
Ensure Wide involvement of relevant MoH departments and health stakeholders	3.9	0.9	2.6	0.8	0.00	International partners give Lower evaluation
Ensure Information on expertise / resources available agencies and organizations to respond to specific needs are made available to the MoH;	3.9	1.0	3.2	0.9	0.09	No Difference
Ensure Follow-ups on recommendations and actions are made regularly.	3.6	1.0	3.0	0.9	0.08	No Difference
Advocate for all health stakeholders to plan and implement projects in the line with NHP.	3.9	0.9	3.2	0.9	0.06	No Difference

Appendix 16: continue...

Coordination meetings supporting	Beneficiaries		International partners		p-value	Note
	Mean	Standard Deviation	Mean	Standard Deviation		
Complementary of health services	4.0	0.8	3.0	1.0	0.01	International partners give Lower evaluation
Exchange experiences	4.1	0.5	3.5	0.9	0.04	International partners give Lower evaluation
Cost effectiveness	3.6	1.0	2.6	1.0	0.02	International partners give Lower evaluation
Develop the relations among stakeholders	4.2	0.6	3.8	0.8	0.18	No Difference
Develop and improve health services	3.9	1.0	2.8	0.9	0.01	No Difference
Alien response with health needs	3.9	0.8	3.2	0.9	0.05	International partners give Lower evaluation
Immediate response to emergency needs	4.2	0.9	3.4	1.0	0.04	International partners give Lower evaluation

Appendix 17: Means of international partners and beneficiaries by opinions on obstacles of the effectiveness of the health aid coordination

	Beneficiaries		International partners		p-value	Note
obstacles for health coordination	**Mean**	**Standard Deviation**	**Mean**	**Standard Deviation**		
Lack of awareness of the importance of coordination among stakeholders	3.3	1.2	3.1	1.1	0.71	No Difference
Lack of interest for coordination among health stakeholders	4.2	0.7	3.8	0.8	0.21	No Difference
Lack of MoH follow up	4.2	0.7	4.5	0.7	0.16	No Difference
Competition on resources and roles	4.3	0.9	4.2	0.6	0.74	No Difference
Different Political agendas for stakeholders	4.5	0.7	4.1	0.8	0.12	No Difference
Availability of different International partners	4.0	0.9	3.8	1.0	0.68	No Difference
No clear guidelines or references for coordination	3.3	1.2	3.8	0.9	0.21	No Difference
The geographical split of OPt due to Israeli closure	2.9	1.2	3.5	1.2	0.23	No Difference
Fragmentation of the health sector	3.5	1.4	3.6	1.0	0.88	No Difference
Coordination is limited to presenting activities of participants rather than sharing relevant information for policy-making and effective aid coordination	4.2	0.4	4.2	0.6	0.95	No Difference

Appendix 18: Means of international partners and beneficiaries by opinions on types of relationships among the international partners and beneficiaries

Type of relation ship	Beneficiaries		International partners		p-value	Note
	Mean	Standard Deviation	Mean	Standard Deviation		
Inconsistent	3.7	0.9	3.7	0.9	1.00	No Difference
International partners' approaches undermine the relation with beneficiaries.	3.2	1.0	3.8	1.1	0.19	No Difference
Low mutual trust	3.5	0.8	3.8	1.0	0.50	No Difference
International partners retort by complaining about corruption and internal divisions	3.5	1.1	3.4	0.6	0.92	No Difference
Transparency Lack of transparency	3.3	0.8	3.0	0.9	0.34	No Difference

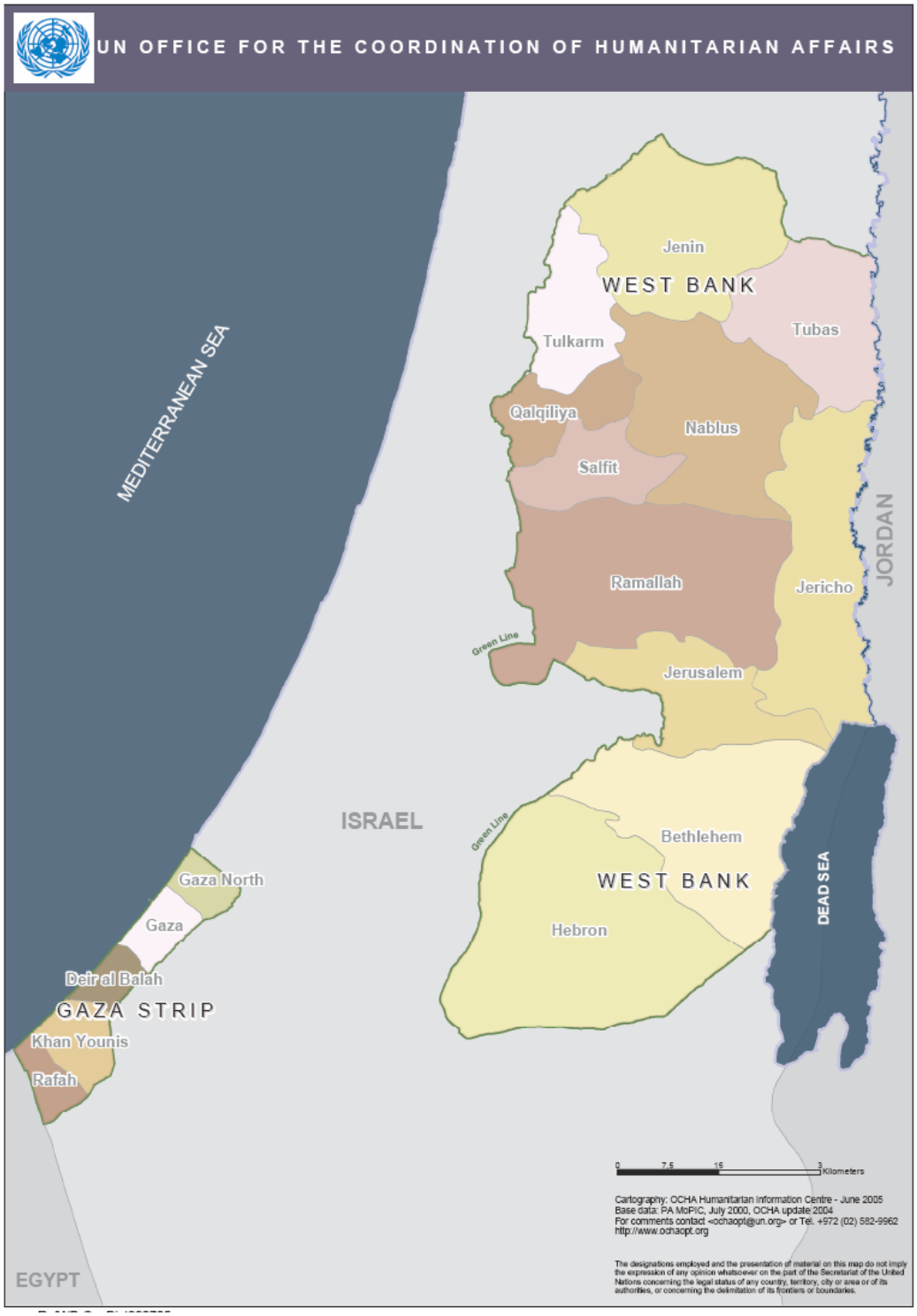
Appendix 19: Means of international partners and beneficiaries by opinions on factors negatively influencing health aid coordination

Effects on health aid	Beneficiaries		International partners		p-value	Note
	Mean	Standard Deviation	Mean	Standard Deviation		
Political atmosphere	4.7	0.5	4.7	0.5	1.00	No **Difference**
Internal political split	4.1	0.6	4.6	0.7	0.12	No **Difference**
National International partners agendas	4.4	0.6	4.5	0.7	0.67	No **Difference**
National strategic plans	3.3	0.9	3.9	0.7	0.07	No **Difference**
Chronic emergencies	3.6	0.8	4.2	0.6	0.05	No **Difference**
Israeli occupation practices	4.2	0.8	4.3	0.5	0.75	No **Difference**

Appendix 20: Means of international partners and beneficiaries by opinions on aid principles in health sector measures

Aid effectiveness measure	Beneficiaries		International partners		p-value	Note
	Mean	Standard Deviation	Mean	Standard Deviation		
There is a formalized process for dialogue	3.8	0.8	2.8	1.3	0.02	International partners give Lower evaluation
MoH is proactive	3.5	0.8	2.4	1.0	0.00	International partners give Lower evaluation
MoH is in the driving seat	3.4	0.9	2.6	1.0	0.03	International partners give Lower evaluation
International partners' rules are support harmonization	3.3	0.8	2.4	0.8	0.01	International partners give Lower evaluation
Heath sector systems are in place	3.2	0.9	2.5	0.9	0.08	No Difference
A clear health sector policy exists	2.8	1.1	2.7	1.1	0.82	No Difference
There is a proper health co-ordination	2.9	0.9	2.6	1.0	0.37	No Difference
Health sector monitoring system is in place?	2.3	0.5	2.0	0.4	0.18	No Difference
Different systems are being harmonized	2.7	0.9	1.8	0.4	0.00	International partners give Lower evaluation
International partners systems are aligned with government policies	2.8	0.8	2.5	0.9	0.37	No Difference
International partners are using the government monitoring system	2.6	0.8	2.4	1.1	0.55	No Difference

Appendix 21: Occupied Palestinian Territory: West Bank & Gaza districts (OCHA 2005)



Appendix 22: Introducing letter for interviewees

June 2009

Dear colleagues

Subject: Msc Degree in Public Health

Greetings,

I am in the process of doing my thesis for the Master degree in public health at Alquds University. The thesis is entitled "Health Aid and Coordination in occupied Palestinian territory from 2002-2008"

In this regards, I prepared the attached questionnaire to help in analyzing some of important issues in health aid coordination, therefore I will appreciate if you give me from your time to fill questionnaire

Many thanks for your kind cooperation

Yousef Muhaisen

School of Public Health
Al Quds University

Appendix 23: Beneficiaries' Questionnaire

Health Aid and Coordination in the occupied Palestinian territory from 2002-2008,

1. General Information:

Institution Name		Date of starting operations in oPt	
Director Name		Name of interviewee	
Post of interviewee		Phone	
email		Fax	
Postal Address			

Type of the Agency	□ Government □ Semi-governmental □ NGO □ INGO □ Other, specify
Area of activity/ies	
Main international partner/s for the agency	□ Bilateral donors □ INGOs □ UN □ Other, Specify

2. What types of health programs did your organization receive 2000-2008?

□ Medicines and medical supplies
□ Equipments
□ Infrastructure
□ Maintenance
□ Staff salaries
□ Technical Assistant
□ Other, please specify:

3. Which of the following issues are included in health aid coordination meetings, Select one or more of the followings:

Issues are included in health coordination	Totally agree	Agree	No opinion	Do not agree	Totally disagree
Information sharing					
Sharing reports, monitoring and evaluation					
Conducting needs assessments					
Aligning programs with common objectives and strategies					
Prioritization of needs and resources allocation					
Joint funding					
Implementation of development programmes					
Wider advocacy and dissemination					
Joint representation at the decision making levels of strategies and plans					

4. Health aid coordination meetings supposed to support positively the following issues, please choose one or more of below list:

Issues supported positively by Coordination Meetings	Strongly agree	Agree	No opinion	Do not agree	Strongly disagree
Strengthen the MoH leading role in health coordination with clearly and identified roles and responsibilities of the Ministry and other health stakeholders					
Provide information and support to specific health activities (e.g. advocacy for health as a human right ,field visits; surveys; monitoring of access to health services, ad-hoc meetings, and workshops, immunization campaigns, etc)					
Ensure the regular flow of information among health stakeholders, the HSWG and other related thematic groups.					
Collaboration among participating organizations in assessments and analysis, and in assuring an effective, integrated health information system					
Ensure Wide involvement of relevant MoH departments and health stakeholders					

Ensure Information on expertise / resources available at different agencies and organizations to respond to specific needs are made available to the MoH;					
Ensure Follow-ups on recommendations and actions are made regularly.					
Advocate for all health stakeholders to plan and implement projects in the line with National Health Strategic Plan level.					
Complementary of health services					
Exchange experiences					
Cost effectiveness					
Develop the relations among stakeholders					
Develop and improve health services					
Alien response with health needs					
Immediate response to emergency needs					

5. Please choose one or more of the following as the main obstacles for the effective health aid coordination

Obstacles	Strongly agree	Agree	No opinion	Do not agree	Strongly disagree
Lack of awareness of the importance of coordination among health stakeholders					
Lack of interest for coordination among health stakeholders					
Coordination is very often is limited to presenting activities of participants rather than sharing relevant information for policy-making and effective aid coordination					
Competition on resources and roles					
Lack of MoH follow up					
Different Political agendas for stakeholders					
Availability of different donors					
No clear guidelines or references for coordination					
The geographical split of oPt due to Israeli closure					
Fragmentation of the health sector					

6. In your opinion, which of the following are the main donors practices, please choose one or more:

Donor Practices	Totally agree	Agree	No opinion	Do not agree	Totally disagree
Donor driven priorities					
Complicated donor procedures					
Uncoordinated donor practices					
Excessive demands on time (Meeting deadlines)					
Delays in disbursements					
Demands beyond national capacity					
Undermining the national capacity					

7. In your opinion, which of the following represents the type of relationship between the international partners and beneficiaries, please choose one more type of relationship.

Type of relation ship	Strongly agree	Agree	No opinion	Do not agree	Strongly disagree
Inconsistent					
Donor's approaches undermine the relation with beneficiaries.					
Low mutual trust.					
Donor retort by complaining about corruption and internal divisions					
Lack of Transparency					

8. Please choose one or more of the following influencing factors on aid effectiveness in oPt

Influencing factors	Strongly agree	Agree	No opinion	Do not agree	Strongly disagree
Political atmosphere					
Internal political split					
National donors agendas					
MoH strategic plans					
Chronic emergencies					
Israeli occupation practices (e.g. checkpoints & access)					

9. In your opinion, which of the following effectiveness measures are available in the health sector? (You can choose more that one option)

Aid effectiveness measures	Strongly agree	Agree	No opinion	Do not agree	Strongly disagree
There is a formalized process for dialogue					
MoH is proactive					
MoH is in the driving seat					
Donors' rules are support harmonization					
Heath sector systems are in place					
A clear health sector policy exists					
There is a proper health co-ordination					
Health sector monitoring system is in place?					
Different systems are being harmonized					
Donors systems are aligned with government policies					
Donors are using the government monitoring system					

Appendix 24: International partners' Questionnaire

Health Coordination Aid in occupied Palestinian territory from 2002-2008

1. General Information:

Institution Name		Date of starting operations in oPt	
Director Name		Name of interviewee	
Post of interviewee		Phone	
email		Fax	
Postal Address			

Type of the Agency	□ Bi-lateral donor □ UN agency □ INGO □ Other, specify
Area of activity/ies	

2. What types of health programs did your organization fund since 2002-2008?

□ Medicines and medical supplies
□ Equipments
□ Infrastructure
□ Maintenance
□ Staff salaries
□ Technical Assistant
□ Other, please specify:

3. Which of the following issues are included in health aid coordination meetings,

Please select one or more :of the followings:

Issues are included in health coordination	Totally agree	Agree	No opinion	Do not agree	Totally disagree
Information sharing					
Sharing reports, monitoring and evaluation					
Conducting needs assessments					
Aligning programs with common objectives and strategies					
Prioritization of needs and resources allocation					
Joint funding					
Implementation of development programmes					
Wider advocacy and dissemination					
Joint representation at the decision making levels of strategies and plans					

4. Health aid coordination meetings supposed to support positively the following issues, please choose one or more of below list:

Issues supported positively by Coordination Meetings	Strongly agree	Agree	No opinion	Do not agree	Strongly disagree
Strengthen the MoH leading role in health coordination with clearly and identified roles and responsibilities of the Ministry and other health stakeholders					
Provide information and support to specific health activities (e.g. advocacy for health as a human right ,field visits; surveys; monitoring of access to health services, ad-hoc meetings, and workshops, immunization campaigns, etc)					
Ensure the regular flow of information among health stakeholders, the HSWG and other related thematic groups.					
Collaboration among participating organizations in assessments and analysis, and in assuring an effective, integrated health information system					
Ensure Wide involvement of relevant MoH departments and health stakeholders					
Ensure Information on expertise / resources available at different agencies and organizations to respond to specific needs are made available to the MoH;					

Ensure Follow-ups on recommendations and actions are made regularly.					
Advocate for all health stakeholders to plan and implement projects in the line with National Health Strategic Plan level.					
Complementary of health services					
Exchange experiences					
Cost effectiveness					
Develop the relations among stakeholders					
Develop and improve health services					
Alien response with health needs					
Immediate response to emergency needs					

5. Please choose one or more of the following as the main obstacles for the effective health aid coordination

Obstacles	Strongly agree	Agree	No opinion	Do not agree	Strongly disagree
Lack of awareness of the importance of coordination among health stakeholders					
Lack of interest for coordination among health stakeholders					
Coordination is very often is limited to presenting activities of participants rather than sharing relevant information for policy-making and effective aid coordination					
Competition on resources and roles					
Lack of MoH follow up					
Different Political agendas for stakeholders					
Availability of different donors					
No clear guidelines or references for coordination					
The geographical split of oPt due to Israeli closure					
Fragmentation of the health sector					

6. In your opinion, which of the following represents the type of relationship between the international partners and beneficiaries, please choose one more type of relationship.

Type of relation ship	Strongly agree	Agree	No opinion	Do not agree	Strongly disagree
Inconsistent					
Donor's approaches undermine the relation with beneficiaries.					
Low mutual trust.					
Donor retort by complaining about corruption and internal divisions					
Lack of Transparency					

7. Please choose one or more of the following influencing factors on aid effectiveness in oPt

Influencing factors	Strongly agree	Agree	No opinion	Do not agree	Strongly disagree
Political atmosphere					
Internal political split					
National donors agendas					
MoH strategic plans					
Chronic emergencies					
Israeli occupation practices (e.g. checkpoints & access)					

8. In your opinion, which of the following effectiveness measures are available in the health sector? (You can choose more that one option)

Aid effectiveness measures	Strongly agree	Agree	No opinion	Do not agree	Strongly disagree
There is a formalized process for dialogue					
MoH is proactive					
MoH is in the driving seat					
Donors' rules are support harmonization					
Heath sector systems are in place					
A clear health sector policy exists					
There is a proper health co-ordination					
Health sector monitoring system is in place?					
Different systems are being harmonized					
Donors systems are aligned with government policies					
Donors are using the government monitoring system					

ملخص:

"أراء متلقي المساعدات الدولية (المستفيدين) والشركاء الدوليين (المانحين) بخصوص كفاءة تنسيق المساعدات الصحية في الأرض الفلسطينية المحتلة، 2002-2008"

إعداد: يوسف أحمد محيسن

إشراف: د. معتصم حمدان

قامت الدراسة بتقييم نجاعة التنسيق في مجال المساعدات الصحية في الأرض الفلسطينية المحتلة خلال الفترة 2002-2008. فقد تم استطلاع آراء المانحين (الشركاء الدوليين) وكذلك آراء متلقي المساعدات الدولية (المستفيدين) في الحقل الصحي حول اذا ما كانت الإجتماعات التنسيقية تسهم إيجابيا بدعم التنسيق في المجال الصحي، وكذلك حول العقبات التي تعيق التنسيق الصحي الفعال والعوامل التي تؤثر سلبا على تنسيق المساعدات الصحية، ثم تطرقت الدراسة الى العلاقة بين الشركاء الدوليين والمحليين، وأخيرا حاولت الدراسة تقييم فعالية تنسيق المساعدات الصحية باستخدام مبادئْ بيان باريس لعام 2005 حول الشراكة وخاصة الملكية- التناغم في العمل والموائمة والتي كانت قد وضعت مبادؤها في مؤتمر روما عام 2003 وتم على اثرها أجراء رصد ميداني لتلك المبادئ في 14 دولة عام 2004

يعتبر التنسيق الصحي في الفترة 2002-2008 مهما حيث شهدت تلك الفترة اندلاع الإنتفاضة الثانية، مما جعل القطاع الصحي في حالة طواريْ مزمنةونقلته من خطة التطوير لبناء الدولة الى محاولة الإستجابة للإحتياجات الإنسانية الطارئة. وكان ذلك نقلة حادة من المجال التطويري الى الوضع الإنساني.

وقد تم القيام بالدراسة نتيجة للتشرذم في آليات التمويل والإشراف على القطاع الصحي الفلسطيني الذي يتميز بوجود العدد الكبير من المؤسسات الفاعلة سواء المحلية أو الدولية وكذلك لضعف آليات التنسيق في القطاع الصحي.

يوجد حاليا 83 هيئة دولية مانحة، بالإضافة الى 22 هيئة تابعة للأمم المتحدة وكذلك حوالي 150 مؤسسة دولية غير حكومية بالإضافة الى حوالي200 مؤسسة فلسطينية غير حكومية تعمل جميعها في الأرض المحتلة. أما في القطاع الصحي فهنالك حوالي 40 مؤسسة دولية ومحلية غير حكومية بالإضافة الى وزارة الصحة على المستوى المركزي بينما هنالك العشرات من المؤسسات الصحية غير الحكومية المنتشرة في المحافظات المختلفة.

وقد تبنت الدراسة المنهجية الوصفية التحليلية لتقييم توجهات الشركاء المحليين والدوليين حول فعالية تنسيق المساعدات الصحية، حيث تم تطوير استبيانين مختلفين اعتمادا على الدراسة المسحية التي قامت بها منظمة التجارة والتعاون الدولية في 14 دولة عام 2004 لتقييم مدى تطبيق مبادئ الملكية، التناغم والموائمة بين احتياجات المستفيدين وتوجهات المانحين.

تكون مجتمع الدراسة من المختصين ذو العلاقة الذين يمثلون مؤسسات محلية ودولية حيث بلغ عددهم 37 ، وبعد الإتصال بهم جميعا بلغت نسبة الستجابة 73% من الفئة المستهدفة. وحسب معطيات الدراسة فان اجتماعات تنسيق المساعدات الصحية تعتبر ملتقى لتناغم القطاع الصحي من حيث تبادل المعلومات والخبرات، تبادل التقارير وتعميم المعلومات الصحية على الشركاء في القطاع الصحي. وعزت الدراسة ضعف نجاعة التنسيق للمساعدات الصحية الى الأجندات السياسية المحتلفة (90%) ، ممارسات الشركاء الدوليين (الممولين) حيث تذمر 98% من المستفيدين من تلك الممارسات وكذلك عدم المتابعة من قبل وزارة الصحة (85%). وقد تم تقييم نجاعة التنسيق عبر الشركاء المحليين والدوليين من خلال استخدام مباديء بيان باريس للشراكة الفعالة. وقد أظهرت الدراسة من خلال مبادئ الملكية والتناغم والمواءمة أن التنسيق ما يزال ضعيفا وأن هناك حاجة لتحسينه حسب ما أظهرت توجهات المشاركين في الدراسة،وأظهرت الدراسة أيضا وجود فجوة في العلاقة بين المستفيدين المحليين والممولين حيث تنعدم الثقة (54%) والشفافية (67%) بين الطرفين.
وأخيرا توصي الدراسة بمراجعة و تقوية فعالية التنسيق بهدف تحسين الأداء لتنسيق المساعدات الصحية، وكذلك تحسين الكفاءة لمبادئ الشراكة المتمثلة بالملكية . التناغم بالعمل و الموائمة كذلك توصي الدراسة بتعزيز العلاقات بين الشركاء الدوليين (المانحين) ومتلقي المساعدات الدولية (المستفيدين) استنادا الى مبادئ الشراكة للمساعدات المتمثلة بأجندة روما و مبادئ باريس الخاصة بالملكية و التناغم و الموائمة.