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**The Evolving Relationship between the
Union of Palestinian Medical Relief Committees
and the Palestinian Authority**

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ACRONYMS

CBR	Community Based Rehabilitation
DFLP	Democratic Front for the Liberation of Palestine
DOP	Declaration of Principles
HCP	Health Care Project
HDIP	Health, Development, Information, and Policy Institute
HSC	Health Services Council
LACC	Local Aid Coordinating Committee
MOH	Ministry of Health
NGO	Non-Governmental Organization
NIS	New Israeli Shekels
PA	Palestinian Authority
PARC	Palestinian Agricultural Relief Committees
PCP	Palestine Communist Party
PFLP	Popular Front for the Liberation of Palestine
PHC	Palestine Health Council
PLC	Palestine Legislative Council
PLO	Palestine Liberation Organization
PNGO	Palestinian NGO network
PRCS	Palestinian Red Crescent Society
UHCC	Union of Health Care Committees
UHWC	Union of Health Work Committees
UNRWA	United Nations Relief and Works Agency for Palestinian Refugees in the Near East
UPMRC	Union of Palestinian Medical Relief Committees

The Evolving Relationship between the Union of Palestinian Medical Relief Committees and the Palestinian Authority¹

Rima Habasch

I. Introduction

The creation of Israel in 1948 led to the destruction of the Palestinian entity and the dispersion of approximately 750,000 Palestinians into neighboring Arab and into Western countries. The Arab-Israeli war of 1967 and the subsequent Israeli military control over the West Bank and the Gaza Strip caused a second wave of refugees. In an attempt to integrate and to mobilize the dispersed Palestinian community against the Israeli occupation, the Palestine Liberation Organization (PLO) was created in 1964 and has constituted since then the embodiment of the Palestinian national struggle.

The peace negotiations that were initiated between Palestinians and Israelis in Madrid in 1991 culminated in the signing of the Declaration of Principles (DOP) on 13 September 1993. The DOP outlined the framework for the resolution of the Israeli-Palestinian conflict. Its components relate to the political and economic arrangements between the two parties for a transitional period of five years, to be concluded by a final settlement to the conflict. Several additional agreements were concluded between the two parties to detail the implementation of the arrangements laid out in the DOP. These agreements are the Gaza Jericho Agreement (May 1994), the Interim Agreement (September 1995), the Hebron Accord (January 1997), and the Wye Memorandum (October 1998).

Following the signing of the DOP and the Gaza-Jericho Agreement, the Palestinian Authority (PA) was created. In accordance with the DOP and the Gaza-Jericho Agreement, the PA assumed limited control in five spheres (education and culture, health, social welfare, direct taxation, and tourism) over confined areas in the West Bank and the Gaza Strip. Detailed arrangements for the PA's rule for a five-year interim period were laid down in the Interim Agreement.

The Interim Agreement furthermore divided the West Bank into three zones, A, B, and C, that are controlled to varying degrees by Israel and the PA. In addition to Gaza and Jericho, which were handed over to the PA following the Gaza-Jericho Agreement, the PA exercises control over Area A, which includes the towns of Jenin, Nablus, Tulkarm, Qalqilya, Ramallah, and Bethlehem. Area A comprises 3 percent of the West Bank and approximately 20 percent of the Palestinian population. Area B includes 450 villages (70 percent of the population) or approximately 24 percent of the West Bank territory. In this area Israelis and Palestinians share control. In Area C, which constitutes more than 70 percent of the West Bank and where 150,000 Jewish settlers live

¹ The Mellon Reports series, and the studies upon which they are based, are supported by a generous grant from the Andrew W. Mellon Foundation.

in 144 settlements, Israel retains full control.² Israeli settlements in Area C are connected by a network of by-pass roads, that is, roads that by-pass Palestinian villages and towns and are designated for the use of Israelis only.³

The isolation brought on by West Bank partition has been exacerbated by Israel's policy of closure. Although the peace agreements envisage the establishment of a 'safe passage' between the Gaza Strip and the West Bank, the increased use of the policy of closure by Israel has rendered these areas separate entities. Closure refers to the sealing off of the West Bank or the Gaza Strip from Israel, Jordan, or Egypt by Israel and prohibits the movement of goods and people between these political entities. Closure has been imposed by Israel when it views its security threatened. While before 1990 closure was only used irregularly, it has become more frequently used since then.

Furthermore, Palestinian access to Jerusalem has been restricted through a system of permits that are issued by the Israeli authorities. Limiting access to Jerusalem has had a severe impact on the political, social and economic development of Palestinian society, as Jerusalem is the seat of many Palestinian institutions.

Thus, the area controlled by the PA is fragmented and dispersed. In the absence of a safe passage between them, the West Bank and the Gaza Strip in effect constitute two separate entities, and only a limited number of Palestinians who hold permits issued by the Israeli authorities are allowed to move between the two areas.

Although the PA possesses limited sovereignty, as the Israeli occupation persists in most parts of the West Bank and the Gaza Strip, the significance of its creation lies in the fact that, for the first time in modern Palestinian history, the foundations of a future Palestinian state have been laid. The establishment of the PA created a new political situation, which requires defining the relationship between the PA and institutions of civil society. From its inception the PA has tended to marginalize organizations not affiliated with its rule, including the NGO sector.

The attempts of the PA to marginalize and control the NGO sector are reflected most significantly in the PA's proposed associational law, which would curtail the freedom of associational life. In addition to requiring registration, the proposed law compels NGOs to obtain a license for their operation from the Ministry of Interior. Furthermore, this law would give control and approval over NGO revenues to the Ministry of Interior. Thus, this law has been regarded by the NGO sector as an attempt by the PA to control it.

² According to the Statistical Yearbook, Jerusalem, 1996, in 1995 there were 250 settlements beyond the Green Line, that is, in the West Bank and the Gaza Strip, and 300 in 1996 with a population of 301,000 and 313,000 respectively. From Geoffrey Aronson, "Settlement Monitor," *Journal of Palestine Studies* 27, no. 1 (Fall 1997): 126-135.

³ Elaine C. Hagopian, "Is the Peace Process a Process for Peace? A Retrospective Analysis of Oslo," *Arab Studies Quarterly* 19, no. 3 (Summer 1997): 1-28 and Graham Usher, "The Politics of Internal Security: The Palestinian Authority's New Security Services," in *After Oslo: New Realities, Old Problems*, ed. George Giacaman and Dag Lønning (London and Chicago: Pluto Press, 1998), 147.

The PA's attempts at control have also been directed at the health sector, in particular in its dealing with health NGOs. When the PA took over a weak, underdeveloped, and fragmented public health sector, it was faced with the task of health reform. While the PA initially seemed successful in solidifying its vision of health care, its position was challenged by the strategic moves of the Union of Palestinian Medical Relief Committees (UPMRC). Based on its historic role in Palestinian civil society, its popular legitimacy, and clear vision of health care, the UPMRC has succeeded in effecting changes in health policy. In addition, the UPMRC played a vital role in the creation of a network of over 80 Palestinian NGOs, the Palestinian NGO network (PNGO). The PNGO's objective is to act as a lobby and pressure group for a more democratic PA.

In the absence of a national authority prior to the establishment of the PA, Palestinian NGOs had assumed an instrumental role in Palestinian society. They provided services to the affected Palestinian population in the Occupied Territories, served as a rallying point of political mobilization against the Israeli occupation, and most importantly assumed the role of agents of development.

This situation was disrupted with the establishment of the Palestinian Authority (PA). The ensuing shift of the political center from the NGO sector, and from civil society in general, to the PA, forced the NGOs to re-orient their mandates. Generally, the NGO sector had expected an increased involvement in policy design, drawing from its substantial experience in Palestinian social and economic development. In the face of the PA's efforts to control the NGO sector with its proposed associational law, however, relations between the PA and most NGOs are generally non-cooperative and/or hostile.⁴ An important exception to this, however, is the UPMRC. Whereas the vast majority of NGOs has maintained a hostile relationship with the PA or was coopted by it, the UPMRC has succeeded in improving its initially hostile relationship with the PA. It has even established institutional linkages with the PA and is currently involved in joint projects with several of the Authority's ministries. More importantly, it has initiated a policy dialogue with the PA aimed at furthering its interests and those of the NGO sector in general.

What factors have enabled the UPMRC to develop and maintain this cooperative relationship with the PA? The means and strategies that account for the success of the UPRMC are the subject of this study.

II. Scope of the Study

This study begins in the following section by describing the authoritarian nature of the PA, especially with regard to its treatment of the NGO sector. In this context, the PA's proposed associational law is discussed. The next section provides an outline of the health situation in the Occupied Territories and focuses on the four health care providers in the West Bank and the Gaza Strip. This part ends by evaluating the health sector. Next, the study explains how the UPMRC's

⁴ Denis J. Sullivan, *Non-governmental Organizations and Freedom of Association: Palestine and Egypt, A Comparative Analysis* (Jerusalem: PASSIA, December 1995).

emergence is part of a wider movement for health and social reform. This part then deals with the means the UPMRC has adopted to create and sustain its grassroots ties. Further, this section discusses the horizontal linkages the UPMRC has established with NGOs in the health and other sectors. Through these horizontal linkages, the UPMRC has not only promoted its vision of health care, but has acted as a lobby group for a democratic political order. In this function it has assumed a leading role in the Palestinian NGO network, PNGO, which aims to curb the authoritarian traits of the PA. This part also deals with the means the UPMRC has adopted to further its agenda on a national level. It discusses the nature of the vertical linkages the UPMRC has established with the PA to achieve its goals. The final part of this study summarizes the major findings and highlights the factors that have aided the UPRMC in building a cooperative relationship with ministries of the PA.

In addition to secondary sources, the source-base for this study consists of field research in the West Bank. The latter included extensive interviews with the director of the UPMRC, Dr. Mustafa Barghouthi, as well as with officials of the Ministry of Health and NGOs, and with the director of the health department at UNRWA, Dr. Ummayah Khammash. The author also made visits to clinics that constitute the joint projects of the UPMRC and the PA. In addition, information and secondary data on the health care providers in the West Bank and the Gaza Strip as well as on the various proposed national health plans were collected.

III. The Authoritarian Nature of the Palestinian Authority

Since its creation in May 1994, the PA has developed authoritarian traits, particularly reflected in the absence of the rule of law, the high concentration of power in the executive, and its treatment of organizations opposed to its rule.⁵ The PA has created a vast security network that has been increasingly used to oppress the opposition. The marginalization of organizations not allied with the PA is especially reflected in the Authority's relationship with the NGO sector.

The NGO regulatory framework up to that time was inconsistent and stemmed from different legal traditions. West Bank NGOs were subject to Jordanian law as amended by Israel after 1967. Gaza's NGOs were regulated by Egyptian law, also as amended by Israel. Palestinian NGOs in Jerusalem were registered with the Israeli authorities.

The PA's proposed associational law was drafted in May 1995 in collaboration with the Ministry of Social Affairs and the Ministry of Justice and modeled after the quasi-authoritarian Egyptian law. The associational law not only required the registration of NGOs, but even their very licensing by the PA. Furthermore, the PA also sought to control NGOs' sources of funding. Thus the PA demanded that in addition to names of senior officers, sources of funds also be disclosed. The major concern of NGOs was that this legislation would constrain their activities. Furthermore, NGOs feared that the suggested law would empower the ministry to revoke the licenses in an arbitrary fashion.

⁵ The proposed Basic Law, which was sent to the president of the executive, Yasser Arafat, on 31 October 1996, has not been signed to date.

While Gazan NGOs tended to comply with the PA's call to register with the Ministry of Interior, the NGOs in the West Bank viewed the proposed law as a means of controlling NGOs and curtailing their activities. In response, they formed the PNGO, which, in an effort to safeguard the autonomy of NGOs, called a boycott of registration.

Following criticism from all sides and in particular from PNGO, the PA produced a second draft associational law in October 1995. The most contentious issue—the requirement for NGOs to obtain a license from the Ministry of Interior—was not removed, however.⁶ As of this writing there has been no law regulating relations between the NGO sector and the PA.

IV. The Health Sector and Health-Care Providers in the Occupied Territories

A. The Health Situation in the Occupied Territories

The health situation in the Occupied Territories is characterized by the prevalence of health indicators reflecting socio-economic and political underdevelopment as well as those found primarily in developed countries, such as cardiovascular diseases, hypertension, cancer, and diabetes.

Health indicators relating to underdevelopment are mainly the result of the effects of the Israeli occupation. These indicators are especially reflected in the high infant mortality rate. According to official statistics of 1993, 40-45 out of 1,000 newborn infants died.⁷ Unofficial estimates, however, indicate a much higher figure—between 50 and 70 deaths out of 1,000 newborn infants—based on the assumption that many infant deaths are not reported. Seventy percent of infant deaths are caused by infectious diseases, predominantly respiratory diseases. The high number of infant deaths is related to poor environmental conditions and sanitation as well as overcrowding.⁸

The ratio of human resources in health (physicians and nurses) per population is comparable to the regional average in the Middle East. According to the World Bank, there are .56 doctors per

⁶ Sullivan.

⁷ Heiberg and Øvensen estimate infant mortality at 48. Marianne Heiberg and Geir Øvensen, *Palestinian Society in Gaza, West Bank and Arab Jerusalem: A Survey of Living Conditions* (Ramallah, 1994), 60. This figure compares to a rate of 34 in Jordan and 10.3 in Israel. Palestinian Red Crescent Society and Palestine Health Council, *Interim Action Plan: Addressing Immediate Health Needs for Palestinians (1 January, 1994 - 31 December 1995)* (PRCS and PHC, October 1994). [ed: UNICEF offers the following comparative infant mortality rates for 1994: Israel, 7; Jordan, 21; Syria, 32; Egypt, 41; U.S., 8. From UNICEF, *The State of the World's Children, 1996* (Oxford: Oxford University Press, 1996).]

⁸ Mustafa Barghouthi and Jean Lennox, *Health in Palestine: Potential and Challenges* (Jerusalem and Ramallah: Palestine Economic Policy Research Institute, March 1997), 10-12 and World Bank, *Developing the Occupied Territories: An Investment in Peace* (Washington: The World Bank, 1993), 17.

1,000 people in the West Bank and .78 doctors per 1,000 in the Gaza Strip compared to an average of .8 doctors per 1,000 people in the Middle East as a whole.⁹

While these figures thus do not indicate a major deficiency, there are great disparities across the regions of the West Bank. The central region of the West Bank, that is, Jerusalem, Bethlehem, Ramallah, and Nablus, reveal higher ratios of physicians or nurses per population. In Jerusalem there are 1.22 physicians and 2.97 nurses per 1,000 population. In Jenin, North West Bank, in contrast, there are only 0.53 physicians and 0.52 nurses per 1,000. These figures suggest that human resources in the health sector are very unevenly distributed, with high concentrations in some regions at the expense of others.¹⁰

Although a high proportion of the GNP (7 percent in 1991) has been spent on health care in the Occupied Territories, a correspondingly high health status has not been achieved (See below). The average expenditure on health in the Middle East is 4.1 percent of GNP, while in established economies the GNP proportion spent on health is approximately 9 percent.¹¹ The high levels of expenditure on health compared to the low outcomes point to a distortion or imbalance in the health sector. These are predominantly related to the effects of the Israeli occupation on the social, economic and political development in the Occupied Territories but also to inefficiency in health care delivery.¹²

B. The Palestinian Health Sector

1. Introduction

Before the Israeli occupation following the 1967 war, health care in the West Bank and the Gaza Strip was provided by the UN Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), the private sector, charitable organizations, and the government health sector—that is, the Egyptian government in the Gaza Strip and the Jordanian government in the West Bank. With the onset of the Israeli occupation, the Israeli authorities assumed control of the government health sector. In addition to the existing providers, health committees emerged in the late 1970s and 1980s and have constituted, together with charitable organizations, the non-governmental sector.

Thus, when the PA assumed control there were four health providers: UNRWA, the private sector, the non-governmental sector, and the government sector. The latter was transferred to the PA in May 1994 for the Gaza Strip and the Jericho Area, and in December of the same year for

⁹ World Bank, *Developing the Occupied Territories*.

¹⁰ Palestine Health Council, *Primary Health Care Training: An Assessment of Needs in the West Bank and Gaza Strip* (Birzeit University, Department of Community Health, 1995), 8.

¹¹ World Bank, *World Development Report, 1993*, quoted in Robert Hecht and Philip Musgrove, “Rethinking the Government’s Role in Health,” *Finance and Development* (September 1993): 6-9.

¹² Jean Lennox, *Health Insurance and Health Service Utilization in the West Bank and Gaza Strip* (Ramallah and Jerusalem: Health Development Information Project, 1998), 23-24.

the remainder of the West Bank. At the time the PA assumed control over the public health sector, responsibility for primary health care provision was distributed among the providers as shown in Table 1.

Table 1
Primary Health Care Provision in the West Bank and the Gaza Strip (1992)¹³

Provider	Share in health care provision (in percent of total facilities)	
	1967	1992
Public health sector	75	28
Non-governmental sector (1)	8	68
UNRWA	17	4
Total	100	100

(1) the non-governmental sector includes NGOs, charitable organizations, and the private sector.

Table 1 reveals that the shares in primary health care underwent substantial change, with the public sector declining in importance while, in contrast, the non-governmental sector expanded considerably, at least until the early 1990s (see Section B.4 below). More particularly, between 1988 and 1990, more than 100 clinics were established by the non-governmental sector.¹⁴ As a result the NGO sector had the highest number of primary health care clinics in the early 1990s (see Table 2). Since 1992, however, approximately 150 clinics providing primary health care were compelled to close as a result of declining funds.¹⁵

¹³ From Ibrahim Daibes and Mustafa Barghouthi, *Infrastructure and Health Services in the Gaza Strip: The Gaza Strip Primary Health Care Survey* (Ramallah: Health Development Information Project, 1996), 50; Barghouthi and Lennox, 33; and Mustafa Barghouthi and Ibrahim Daibes, *Infrastructure and Health Services in the West Bank: Guidelines for Health Care Planning* (Ramallah and Jerusalem: Health Development Information Project, 1993), 69, 291.

¹⁴ Daibes and Barghouthi, 49.

¹⁵ Palestine Health Council, 7.

Table 2
Number of Clinics providing Primary Health Care in the West Bank & Gaza Strip (1992)¹⁶

Region	Government	UNRWA	NGOs (1)	Total
West Bank	178	33	202	413
Gaza Strip	28	9	28	65
Total	206	42	230	478

(1) The non-governmental sector includes NGOs, charitable organizations, and the private sector.

In the provision of secondary and tertiary health care, the number of NGO clinics approximated that of the government health sector. As access to government clinics required enrollment in the government health insurance plan, the utilization of government clinics under Israeli control remained limited (see Table 3). Enrollment in government health insurance was limited to Palestinians employed with the Israeli authorities or in Israel.

Table 3
Number of Clinics Providing Secondary and Tertiary Health Care in the West Bank and the Gaza Strip (1992)¹⁷

Region	Government	UNRWA	NGOs	Total
West Bank	9	1	10	19
Gaza Strip	5	N/A	1	5
Total	14 (1)	1	11	24

(1) This figure includes one psychiatric hospital in Bethlehem, West Bank, and one in the Gaza Strip.

2. The Government Sector

When Israel took control over the Palestinian public health sector in 1967, Israeli authorities placed health care under Israel's Civil Administration. Health care was run by a coordinator at the Israeli Ministry of Health and by the Ministry of Defense. This administration has had

¹⁶ From Ibid., 14-15; The Planning and Research Center, *The Palestinian Health Services in the West Bank and Gaza Strip, Facts and Figures* (The Planning and Research Center, August 1994), 8-9; Daibes and Barghouthi, 50; Barghouthi and Daibes, 69.

¹⁷ From World Bank, *West Bank and Gaza: Medium Term Development Strategy and Public Financing, Priorities of the Health Sector* (Washington: The World Bank, 1997), 5; The Planning and Research Center, 10; PRCS and PHC, *Interim Action Plan*; Lennox, 24-29; Barghouthi and Daibes, 292.

profound effects on the transformation of the health sector as the following statistics show. Prior to the Israeli occupation of the West Bank and the Gaza Strip in 1967, the public health sector's share of health provision constituted 75 percent. Since the occupation this share declined to 28 percent in 1992 (see Table 1). The decline of the public sector is the result of Israel's policy of "de-institutionalization."¹⁸

The Israeli administration neither expanded the public health sector under its control nor encouraged the development of a Palestinian health sector. Thus, the number of hospitals was not increased to keep pace with natural population increase. While new clinics were established by the Israeli government,¹⁹ the number of hospital beds remained unchanged from 1967 until the mid-1990s, although the population had more than doubled since the beginning of the occupation.²⁰ At the same time, development of the Palestinian health sector was discouraged, mainly through denying licenses for the establishment of health institutions or imposing high taxes on them.²¹

The Israeli authorities also restricted access of Palestinians to public health care by introducing a government health insurance scheme in 1974. As a result, only insured Palestinians could benefit from free-of-charge government health services. Voluntary enrollment was restricted due to high insurance premiums, although political reasons were certainly a factor as well.²² Only 5-8 percent of the Palestinian population not employed in Israel enrolled in the government health insurance program and thus benefited from the government health services. (Enrollment in the plan by Palestinians employed in Israel was mandatory.) The percentage of the population that was insured in the Israeli health insurance scheme decreased continuously and reached the lowest rate of health-insured people in the entire Middle East. Prior to the take-over of the health sector by the Palestinian Authority in 1992, only an estimated 25 percent of Palestinians were enrolled in the government health insurance plan.²³

The marginalization of the public sector is also reflected in the per capita expenditure by the Israeli government on health in the Occupied Territories. Whereas in 1991 the Israeli government spent US \$350 per capita on health care in Israel, its annual expenditure on health in the Occupied Territories is estimated at only US \$30 per capita. As a result of Israel's policy to keep the public sector underdeveloped, half of the US\$ 32 million of Israel's health budget for the Occupied Territories was spent on treatment in Israeli health institutions.²⁴

¹⁸ Mustafa Barghouthi and Rita Giacaman, "The Emergence of an Infrastructure of Resistance: The Case of Health," in *Intifada: Palestine at the Crossroads*, ed. Jamal R. Nassar and Roger Heacock (New York: Praeger, 1990), 75.

¹⁹ For example, six new clinics were established in the Gaza Strip between 1967 and 1976, eleven between 1977 and 1986, and three between 1987 and 1992. Daibes and Barghouthi, 93.

²⁰ Barghouthi and Lennox.

²¹ Barghouthi and Giacaman, 77-78.

²² Barghouthi and Lennox, 28; Daibes and Barghouthi.

²³ The 25 percent figure includes all Palestinians in the Occupied Territories, whether or not employed in Israel.

²⁴ Daibes and Barghouthi, 47. According to the World Bank, the Israeli government spent US \$43.8 million on health care in 1991, of which 61 percent was spent on secondary health care and only 28 percent on primary health care. World Bank, *Developing the Occupied Territories*, 25.

In addition, most of the clinics operated only on a part-time basis. This is especially true for the West Bank where, in 90 percent of the clinics, a physician was available for not more than two days per week.²⁵ The quality of public health services was also kept underdeveloped, and specialized doctors were few. There were only 19 specialists in the Gaza Strip and 26 in the West Bank.²⁶

Health policy in the Occupied Territories remained Israel's responsibility. Although the majority of the employees in the public health sector in the Occupied Territories were Palestinian, decision-making was confined to a small number of Israeli army officers responsible for public health.²⁷

Prior to the PA's take-over, the government health care system consisted of 178 clinics in the West Bank and 28 in the Gaza Strip as well as 14 hospitals (9 in the West Bank and 5 in the Gaza Strip). When the PA took over the public health sector, it inherited a health care system that suffered from both structural and infrastructural weaknesses.

Following the 1991 Madrid Conference, the PLO initiated plans to rehabilitate the health sector. A special body, the Palestine Health Council (PHC), was formed in July 1992 by the PLO as the central health authority in the Occupied Territories. It was charged with administering and coordinating health services in the West Bank and the Gaza Strip and with implementing health plans for the areas under Palestinian control.²⁸ The vision of health sector reform is reflected in the National Health Plan and the Interim Action Plan.²⁹ Both were developed by the Palestine Red Crescent Society (PRCS).³⁰

In 1990, a commission was created to formulate a Palestinian National Health Plan for the Occupied Territories. A first draft was concluded in April 1994. The National Health Plan involves three elements: disease prevention, health promotion, and health protection.

In addition to the National Health Plan, an Interim Health Plan was developed, which focuses on the five-year interim period of Palestinian self-rule. The major focus of the Interim Health Plan is a detailed implementation strategy of the National Health Plan.

²⁵ World Bank, *Developing the Occupied Territories*, 29.

²⁶ Barghouthi and Lennox, 14; World Bank, *Developing the Occupied Territories*, 29.

²⁷ USAID, *Palestinian Health Systems Support Project*, December 1993, 10.

²⁸ Dina Craissati, *Neue Soziale Bewegungen in Palästina: Zivilgesellschaft und Demokratie*, in *Friedensuche in Nahost. Wege aus dem Labyrinth?* ed. Margret Johannsen and Claudia Schmid (Baden-Baden: Nomos Verlagsanstalt, 1997), 140.

²⁹ Palestinian Red Crescent Society and Palestine Health Council, *The National Health Plan for the Palestinian People: Objectives and Strategies* (Jerusalem: PRCS and PHC, April, 1994) and PRCS and PHC, *Interim Action Plan*.

³⁰ The PRCS was created in 1969 as a PLO body and was responsible for health provision for Palestinians and health policy formulation. As it was regarded by Israel as illegal, it operated mainly outside the Occupied Territories. Since the PA took over, the PRCS has developed into a quasi-governmental organization. Barghouthi and Lennox, 18.

The two plans constitute the first-ever Palestinian national health plans; they emphasized making optimal use of existing resources. In order to fulfill this goal, the plans suggest coordination between the government and private sectors as well as with UNRWA. Nowhere do the plans refer to health NGOs, nor do they advocate inclusion of NGOs in the coordination schemes.³¹

Criticism of the plans has centered around several issues. It has been claimed that the plans fail to design an overall strategy for the rehabilitation of the health-care system. The plans have also been criticized for emphasizing the rehabilitation of infrastructure without paying sufficient attention to structural problems such as the absence of protocols and standards and coordination between different health providers. Furthermore, the plans' rationale that secondary and tertiary health care form the foundation for a comprehensive primary health care system has been challenged.³²

The emphasis on the rehabilitation of the physical infrastructure at the expense of primary health care is financially damaging, as it further increases the current budget deficit of the Ministry of Health (MOH).³³ Moreover, studies on the rehabilitation of health care systems in post-conflict situations have indicated the risk associated with strategies focusing on infrastructural development without considering long-term development objectives.³⁴

Given the inherited weaknesses of the health care system, a focus on the rehabilitation of infrastructure, while at the same time neglecting the development of primary health care, will likely produce a dual health care system. More specifically, the health care system that is likely to emerge will be one consisting of costly secondary and tertiary sectors for the well-off parts of society and an underdeveloped primary health care sector for the poor strata of society.³⁵

Finally the plans fail to take into account the innovative approaches developed by the health NGOs, in particular by the health committees that emerged in the late 1970s and 1980s. These focus on primary health care as a means to develop a more equitable health care system (see Section IV.B.4). Furthermore, the health plans do not attribute a role to NGOs in formulating national health policy. In addition, a major weakness is the projected expenditure on health of an annual 11.2 percent of GDP, a figure which remains high and unsustainable.³⁶

³¹ See also Umayyeh Khammash, *Non-governmental Organizations in the Health Sector at a Turning Point: The United Nations International NGO Meeting and the European NGO Symposium on the Question of Palestine, 29 August - 1 September 1994*.

³² Palestine Health Council, 2; Jan J. Schnitzer and Sara M. Roy, "Health Services in Gaza Under the Autonomy Plan," *The Lancet* 343 (June 25, 1994): 1614-1617; and Barghouthi and Lennox, 51-53.

³³ Barghouthi and Lennox, 51-52.

³⁴ Joanna Macrae, Anthony B. Zwi and Lucy Gilson, "A Triple Burden for Health Sector Reform: 'Post'-Conflict Rehabilitation in Uganda," *Social Sciences and Medicine* 42, no. 7 (1996): 1095-1108.

³⁵ Barghouthi and Lennox, 53.

³⁶ This figure is projected until the year 2002. PRCS and PHC, *The National Health Plan*, 128. See also Schnitzer and Roy.

The marginalization of the indigenous NGO sector in health care reforms is also reflected at an institutional level.³⁷ The PA initially attempted to marginalize the indigenous health sector and health institutions. This was done in two ways. First, the PA created new institutions that were to assume control over the health sector. In addition to creating a central health authority—the PHC—the PA also established local health councils in the West Bank and the Gaza Strip that were to assume responsibility for the health sector. Similar to the PHC, the local health councils neither included NGOs, nor took NGO experience into account.³⁸

Second, the PA also imposed control through the appointment of its own cronies to lead local NGOs. The most visible example is that of the al-Maqassed Hospital in Jerusalem. Following the Israeli occupation in 1967, this hospital was changed from a government to a non-governmental hospital in order to evade or minimize Israeli control. When the PA took over responsibility for the health sector it appointed Fathi Arafat, former head of the PRCS in Cairo, as the new leader of the al-Maqassed.³⁹

Indigenous health NGOs criticized the PA's move to marginalize them. Criticism, however, was not evenly shared among NGOs. The different attitudes towards the PA's approach are mirrored among the four health committees: the Health Services Council (HSC), the Union of Health Work Committees (UHWC), the Union of Health Care Committees (UHCC), and the Union of Palestinian Medical Relief Committees (UPMRC). These emerged during the 1970s and 1980s and form part of the non-governmental sector. Since the mid 1980s, they have been, to varying degrees, instrumental in primary health care delivery.⁴⁰

The approach of the HSC to health care was very similar to that of the PHC. The HSC viewed primary health care delivery as mainly the concern of the PA rather than that of health NGOs. Moreover, the HSC merged with the Ministry of Health. As a result, most of the HSC's clinics were closed and its employees incorporated into the Ministry of Health.⁴¹

Criticism by two other health committees—the UHWC and the UHCC—centered around the composition and structure of the PHC. Both maintained that its structure is undemocratic and centralized. Furthermore, they criticized the composition of the PHC which, according to them, was based on political considerations. Neither NGO, however, presented an alternative vision of the composition and role of the central health authority.⁴²

The UPMRC went a step further than the above mentioned health committees. It criticized not only the structure of the PHC, but also the health plans for their approach to health care delivery. Moreover, unlike the UHWC and the UHCC, the UPMRC presented its own alternative vision.

³⁷ Craissati, 139-140.

³⁸ Khammash, and Craissati, 142.

³⁹ Craissati, 138.

⁴⁰ Lisa Taraki, "Mass Organizations in the West Bank," in *Occupation: Israel Over Palestine*, ed. Naseer Aruri (Belmont, MA: AAUG Press, 1989), 431-463.

⁴¹ Craissati, 140 and Daibes and Barghouthi, 49.

⁴² Craissati, 142.

This vision emphasized the important role of NGOs in providing the necessary expertise for health policy formulation at the national level. Furthermore, health care reform, according to the UPMRC, should be a joint effort by all health care providers, with the primary function of the MOH being the design of health policy. Health policy should further address the issue of equity in health care; in particular, it should be responsive to the needs of the underprivileged.⁴³

The neglect of primary health care by the MOH is reflected in the latter's expenditures. The MOH is currently engaged in the expansion and building of 13 new clinics and 1 hospital, and otherwise expanding current facilities. According to the Ministry's priorities, the MOH is planning to expand the government sector by 97 additional clinics by the year 2002. More specifically, the MOH plans to increase hospital capacity by 60 percent and primary health care clinics by 20 percent by the year 2002.⁴⁴

Through an investment of US \$69.4 million, the objective of the MOH is to increase the number of hospital beds from 1.2 beds (in 1995) to 1.7 per 1,000 persons. This would mean an increase from 1327 hospital beds in the West Bank and the Gaza Strip (both governmental and non-governmental) to 4317 beds.⁴⁵ The expenditure on hospital expansion and development will add a yearly US \$19 million in recurrent costs and will further increase the MOH's budget deficit of almost US \$63 million (in 1995), that is, 59 percent of its budget.⁴⁶ In 1995, the MOH collected almost US \$23 million from insurance and about US \$8.2 million from patients' co-payments. The total revenue of the MOH amounted to just over US \$31 million (see Table 4).

Table 4
Revenue and expenditure of the Ministry of Health (1995)⁴⁷

	In US \$ million
Allocated Budget for 1995	76.2
Revenue from insurance	22.933
Revenue from patients' co-payments	8.254
Total Revenue	31.187
Actual Expenditure	77.398
Budget Deficit	46.21

⁴³ Ibid., 143.

⁴⁴ MOH Priorities, June 1997, quoted in World Bank, *West Bank and Gaza*, 5.

⁴⁵ This compares to 6.1 hospital beds per 1,000 persons in Israel. Barghouthi and Lennox, 37.

⁴⁶ Ibid., 28.

⁴⁷ From Ibid., 30.

Analysis of the MOH's expenditures reveals that the MOH is concerned above all with secondary and tertiary care. While primary health care represents approximately 90 percent of health care usage, only 16 percent of the overall budget of the MOH is allocated to primary health care.⁴⁸ In contrast, secondary and tertiary health care, which constitute 10 percent of the usage in the health sector, consume 80 percent of the MOH's expenditure on health. Furthermore, the priorities of the MOH of June 1997 reveal that expenditure on primary health care from 1997-2002 will constitute only 15.9 percent out of a total expenditure of almost US \$271 million during this period.

As the PA's tax collection system remains weak and ineffective and revenue from insurance premiums and patients' co-payments insufficient, the MOH relies mainly on external funding for its budget. In 1995, only 41 percent of the MOH's recurrent costs could be covered by internal sources (see Table 4).⁴⁹

The MOH introduced improvements by lowering the premium levels for government health insurance and by expanding insurance coverage. While insurance enrollment prior to the take-over by the PA was only 25 percent, it has been increasing since then. Insured households increased from 134,000 in 1993 to 161,454 in 1996, or 33 percent of the population. By 1998, 42 percent of the households and 38 percent of the population were insured.⁵⁰

Although participation in the insurance scheme increased, total revenue from insurance premiums has fallen. The short-fall has been covered by budgetary allocation from the government's general revenue sources. Government health financing is derived from three sources: general taxation (60 percent), insurance premiums (25-30 percent) and co-payments (10-15 percent). According to Lennox, given the existing arrangement between the MOH and the Ministry of Finance (MOF), there is little incentive for the MOH to increase the level of its revenue or to improve its system of revenue collection. While the MOH collects revenue from health insurance, the amount is transferred to the MOF. The latter then approves the yearly budget of the MOH regardless of the level of revenue collected by the MOH.⁵¹

With expenditures rising, especially on secondary and tertiary health care, an inefficient revenue collection system is likely to exacerbate the budget deficit of the MOH. The deficit in turn is then covered through the PA's central budget, an arrangement that will deplete the PA's limited resources.

Furthermore, a high proportion of the MOH's budget, 18 percent, is spent on referrals to non-MOH clinics, including clinics of the NGO sector, but also to Israel, Jordan and Egypt. Moreover, referrals to the Israeli hospitals consume approximately 70 percent of the referral

⁴⁸ Daibes and Barghouthi.

⁴⁹ Barghouthi and Lennox, 30.

⁵⁰ Health, Development, and Information Project, *Policy Watch Bulletin*, no. 2, July 1998 (Ramallah: Health, Development and Information Project, 1998), and Barghouthi and Lennox, 26.

⁵¹ Lennox, 34-37, 154.

budget.⁵² In order to reduce dependency on the Israeli health system, the MOH has focused on expanding the number of hospitals as well as encouraging the development of the private health sector. The expansion of secondary and tertiary health care is ultimately damaging to the Palestinian health care system.⁵³ A UN report highlights the necessity of expanding primary health care rather than secondary and tertiary health. According to the report, the insufficient use of primary health care facilities in the past have caused many patients to turn to hospitals for treatment that could have been provided at lower cost at the Primary Health Care level.⁵⁴ Another financial burden for the health budget is the high number of social welfare cases (19 percent of the insured) and police officers (11 percent). Both are exempt from paying insurance premiums.⁵⁵

The MOH's focus on the rehabilitation and expansion of secondary and tertiary care has been supported by the policy priorities of international donor agencies as well. Moreover, given the lack of a coherent national health plan, the influence of international donors has been increased, as these tend to focus on financing separate projects. In July 1996, the Secretariat of the Local Aid Coordinating Committee (LACC)⁵⁶ indicated that the priorities for 1997 are infrastructural—including particular clinics, hospitals, and equipment—rather than structural development.⁵⁷

A prominent example of the imposition of donor preferences is the recently built hospital in Jericho. Although the MOH had planned to upgrade the existing government hospital in Jericho, the Japanese government, the single largest donor, insisted on building a new 50-bed hospital at a cost of US \$19 million. Given the government hospital's low occupancy rate of 28 percent, the new hospital will add to a waste of resources.⁵⁸

3. UNRWA

UNRWA was established in 1949 to provide relief and social services, basic education, and health care to Palestinians who were displaced as a result of the 1948 war. In the Occupied Territories it provides primary health care through its 42 clinics. As it has only one hospital (located in Qalqilya, West Bank), UNRWA provides most of its secondary health care through contractual agreements with NGOs, government hospitals, and private clinics. Co-payments for hospital care

⁵² Most of the Palestinian patients insured with the MOH referred to Israel are treated in the Israeli Hadassah Hospital. Barghouthi and Lennox, 35.

⁵³ *Ibid.*, 45.

⁵⁴ United Nations Office of the Special Coordinator in the Occupied Territories, *Program of Cooperation for the West Bank and Gaza Strip 1998-1999*.

⁵⁵ Daibes and Barghouthi, 61.

⁵⁶ The Local Aid Coordination Committee was established in November 1994 to coordinate aid provided by the major aid agencies. Rex Brynen, *The (Very) Political Economy of the West Bank and Gaza: Learning Lessons About Peace-building and Development Assistance* (Montreal: Montreal Studies on the Contemporary Arab World, 1995), 3.

⁵⁷ Barghouthi and Lennox, 42.

⁵⁸ *Ibid.*, 30.

range from 12 percent to 40 percent of treatment costs,⁵⁹ but UNRWA's services are currently offered free of charge for registered refugees. Because the majority of the registered refugees live in the Gaza Strip, UNRWA has its strongest presence there. In December 1993, 72 percent of the population in the Gaza Strip were registered refugees.⁶⁰

Similar to the government health sector, UNRWA's share in health care provision has dropped considerably. While in 1967 17 percent of total primary health care was provided by UNRWA, this share had declined to 4 percent by 1992 (see Table 1). The decline of UNRWA's health care provision also reflects its lack of adaptation to population growth and the increasing needs that resulted. Sixty percent of UNRWA's clinics were established before 1967. The Qalqilya hospital has only 43 beds and was built in 1950.⁶¹

As a result, UNRWA has the highest consultation rate per day, reaching as high as 118 patients per physician per day.⁶² This development has a negative impact on the quality of health care. The high consultation rate is also reflected in the average time physicians spend with their patients. In comparison with other health care providers, UNRWA has by far the lowest figure (see Table 5). While UNRWA's budget was increased 46 percent above 1991 levels between 1992-3 and 1994-5, its provision of services has remained constrained due to funding shortages.⁶³

Table 5
Average Physician Time per Patient in the West Bank⁶⁴

Health Care Provider	Physician's Average time spent with a patient
Government	5.7 minutes
UNRWA	4.2 minutes
NGO	31 minutes
Charitable Organizations	20 minutes
Private Sector	37 minutes

Furthermore, UNRWA clinics in the West Bank are concentrated in populated urban areas. As a result, only 50 percent of the registered refugees in rural areas have access to UNRWA services.⁶⁵

⁵⁹ Ibid., 17.

⁶⁰ Daibes and Barghouthi, 20. The population in the Gaza Strip is 772,555. Of these 556,000 are registered refugees (figures for 1996, from Daibes and Barghouthi, 20.)

⁶¹ Barghouthi and Daibes.

⁶² Dr. Umayyah Khammash, head of Department of Health, UNRWA, interview by author, October 1998. This is more than twice the recommended consultation rate. Barghouthi and Lennox, 17.

⁶³ World Bank, *Developing the Occupied Territories*.

⁶⁴ From Barghouthi and Daibes, 155.

Analysis of UNRWA's expenditures reveals a different focus in the West Bank and the Gaza Strip. Of the budget allocated to the West Bank, 47 percent was spent on primary health care and the remainder on secondary health care. In the Gaza Strip, in contrast, 65 percent was allocated to primary health care and 35 percent to secondary health care. This difference is explained by the larger proportion of registered refugees in the Gaza Strip who have been making use of UNRWA's primary health care services.

UNRWA will eventually merge its services with those of the MOH and thus will become part of the public health sector.⁶⁶ UNRWA has already increased cooperation with the MOH by referring many of its patients to government hospitals.⁶⁷ This development comes at the expense of the NGO sector. Prior to the establishment of the PA, UNRWA had referred its patients to NGO clinics. As UNRWA has focused on the delivery of primary health care, an eventual merger with the MOH might involve a shift from the MOH's current emphasis on secondary and tertiary health care to an increased focus on primary health care.

Although UNRWA is currently not actively involved in any policy making in the Palestinian areas, it has extensive coordination with the MOH.⁶⁸ The recently appointed head of UNRWA's health department, Dr. Ummayah Khammash, is one of the founders of the UPMRC and therefore an advocate of primary health care as the pillar of health care provision.⁶⁹

4. NGOs

Whereas prior to the take-over of the health sector by the PA both the public health sector and UNRWA had experienced a considerable decline in their shares of total health care provision, the reverse was true for the NGO sector. From 1967 to 1992 the NGO sector's share of total health care provision increased from 8 percent to 68 percent. According to Daibes and Barghouthi, 84 percent of the clinics that were established after 1967 were non-governmental ones.⁷⁰ Sixty percent of these clinics were established by health committees while the remaining 40 percent of the clinics were established by charitable organizations and the private sector. Furthermore, 49 percent of secondary and tertiary health care and all rehabilitation services are provided by health committees and charitable organizations. As will be discussed below, this situation was to change in the 1990s.

⁶⁵ Ibid, 77.

⁶⁶ The PA, however, is unlikely to take over UNRWA's responsibilities without a political settlement of the refugee problem.

⁶⁷ Lennox, 27.

⁶⁸ In addition, UNRWA is a member of several technical committees headed by the MOH. These committees deal with women's health, TB, epidemics, and other issues. Interview with Ummayah Khammash, October, 1998.

⁶⁹ Ummayah Khammash, interview by author.

⁷⁰ Daibes and Barghouthi, 90; see also Palestine Health Council, 26.

The non-governmental sector is composed of charitable organizations and the health committees that emerged during the late 1970s and 1980s. These two types of organizations differ considerably in their approach to health care. While charitable organizations have focused on a biomedical approach to health care and have tended to concentrate their services in urban areas, the approach of the health committees marks a radical departure from the biomedical approach. According to the committees, health is the outcome of a combination of economic, social and political factors and therefore can be understood only in its socio-economic context. As a result, the committees view effective primary health care as crucial for minimizing costs at the level of secondary and tertiary health care. Their focus is on health education and preventive health care.⁷¹

The leaders of the health committees argue that through the expansion of primary health care it is possible to achieve a more equitable health care system. To this end health committees established clinics in underserved and rural areas, thus providing health services to previously marginalized groups. Charitable organizations, in contrast, have tended to concentrate their services in urban areas. A survey of rural clinics in the West Bank conducted at the beginning of the 1990s revealed that 25 percent of the clinics are run by NGOs. In contrast only 14 percent of clinics in rural areas are run by charitable organizations⁷² (see Table 6).

Table 6
Rural Clinics in the West Bank⁷³

Provider	Percentage of All Rural Clinics
NGO	25
Government	28
UNRWA	4
Private Sector	29
Charitable Organizations	14
Total	100

Furthermore, the clinics run by the committees are concentrated in the most deprived areas in the north and south of the West Bank, and in the Jordan Valley. In contrast, the majority of government and private clinics are in the urban and central regions of the West Bank. Another

⁷¹ Palestine Health Council, and Barghouthi and Daibes, 86, 123-124.

⁷² Barghouthi and Daibes, 69.

⁷³ From Ibid.

survey of 1992 found that 84 percent of committee clinics were in rural areas, compared to 47 percent of the clinics run by charitable organizations.⁷⁴

The high presence of NGOs in rural areas is of particular importance in the West Bank, where 67 percent of the population is rural. The Gaza Strip, on the other hand, is less rural; there, 43.9 percent of the population lives in four towns, 40.5 percent in refugee camps, and 15.6 percent in villages⁷⁵ (see Table 7).

Table 7
Rural and Urban Population in the West Bank and Gaza Strip⁷⁶

	Percent Rural	Percent Urban
West Bank	67	27 (1)
Gaza Strip	15.6	84.4 (2)

(1) 6 percent live in refugee camps.

(2) Of the 84.4 percent, 43.9 percent live in four towns and 40.5 percent live in refugee camps.

The considerable expansion of the NGO sector was due to the creation of the health committees in the late 1970s and 1980s⁷⁷ (see Section V). The health committee movement grew rapidly and by 1993, approximately 50 percent of rural non-profit clinics in the West Bank and one fifth (15 out of 70) of those in the Gaza Strip were run by them⁷⁸ (see Table 8).

⁷⁴ Palestine Health Council, 26.

⁷⁵ Barghouthi and Daibes, 20.

⁷⁶ From Barghouthi and Daibes, 17, and Daibes and Barghouthi, 20-21.

⁷⁷ Khammash, and Daibes and Barghouthi, 90.

⁷⁸ Daibes and Barghouthi, 48-49.

Table 8
Health committees in the Gaza Strip⁷⁹

Provider	Number of Clinics
Health Services Council (HSC)	3
Union of Health Care Committees (UHCC)	3
Union of Health Work Committees (UHCW)	5
Union of Palestinian Medical Relief Committees (UPMRC)	4
Total	15

In the Gaza Strip, for example, two of the 15 health committees were created between 1977 and 1986 and the remaining 13 between 1987 and 1992. Until the early 1990s, the Union of Health Work Committees had five clinics there, followed by the Union of Palestinian Medical Relief Committees with four clinics. The Union of Health Care Committees and the Health Services Council each had three clinics.⁸⁰ A survey of 207 NGOs in the West Bank carried out between September 1990 and May 1992 found that 132 clinics were run by NGOs and 75 by charitable organizations⁸¹ (see Table 9).

Table 9
Health committees in the West Bank⁸²

Provider	Number of Clinics
Health Services Council (HSC)	62
Union of Health Care Committees (UHCC)	20
Union of Health Work Committees (UHCW)	17
Union of Palestinian Medical Relief Committees (UPMRC)	24
Health Care Project (HCP) (1)	9
Total	132

(1) Jointly administered by the HSC and the Red Crescent Society of Tulkarm

⁷⁹ From Ibid., 60.

⁸⁰ Ibid., 60.

⁸¹ Barghouthi and Daibes, 84.

⁸² From Ibid.

In contrast to the governmental sector and UNRWA, both of which restrict their services to either insured persons or registered refugees, NGOs offer their services to all segments of the population. Furthermore, the fees charged by NGOs are considerably lower than the fees charged by the governmental sector. While fees charged by NGO clinics range between US \$1.50 and \$5.00 for a medical examination and US \$55 for a hospital stay, the governmental sector charged US \$20 and US \$200 respectively for these services.⁸³

The predominance of the NGO sector, however, was challenged in the 1990s, during which time—in particular following the establishment of the PA—the NGO sector experienced a substantial decline. As all NGOs have relied on external funding for their operations, the shift of funding by international donors from the NGO sector to the PA has deprived them of their main source of revenue. It is estimated that the expenditures of all NGOs (including health NGOs) declined from an estimated US \$170-240 million in the early 1990s to US \$90 million in 1993. By 1995, the estimated NGO expenditures declined by an additional 30 percent.⁸⁴ The decline in expenditures has also been true for the health NGO sector. As a result, numerous NGO clinics have had to close. A survey of rural clinics in the West Bank shows that their number decreased from 210 in 1992 to 128 in 1996. The largest decline, of approximately one third of the rural clinics, occurred between December 1992 and December 1994, from 210 to 145 clinics.⁸⁵

However, not all health NGOs were equally affected by the decline in international funding. Charitable organizations that typically had relied on Arab funding were affected most by the declining funds. Among the health committees, the Health Services Council suffered most from declining funds. Most of its clinics dissolved and were taken over by the quasi-governmental body of the PRCS, and the employees of the HSC were incorporated into the MOH. A sample survey of 439 clinics in the West Bank shows that 38 NGO clinics closed between 1992 and 1994 (see Table 10). Among these, 71 percent were run by the HSC and the charitable organizations. The effect of declining funds was not evenly distributed across regions; the decline was felt most strongly in the West Bank, where most of the NGOs have been located.

⁸³ Khammash, and World Bank, *Developing the Occupied Territories*, 23-24.

⁸⁴ World Bank, *Developing the Occupied Territories*, 15 and Barghouthi and Lennox, 39.

⁸⁵ Barghouthi and Lennox, 18.

Table 10
Number of clinics in the West Bank Closed Between 1992 and 1994, by Provider⁸⁶

Health Committee	Number Closed
Health Services Council (HSC)	19
Union of Palestinian Medical Relief Committees (UPMRC)	1
Union of Health Work Committees (UHCW)	2
Union of Health Care Committees (UHCC)	8
Charitable Organizations	8
Total	38

The decline in the number of NGO clinics has profound implications for the health sector. While the shift in international funding to the governmental sector has increased the budget of the MOH, the latter has been unable to substitute for the services previously provided by the NGO sector. Furthermore, as the majority of NGO clinics are located in rural areas, the rural population has been disproportionately affected by the closure of NGO clinics. Moreover, the closure of NGO clinics reverses some of the achievements of the NGO sector toward establishing a more equitable health system. This trend has been exacerbated by the general tendency of the MOH to focus on the rehabilitation of the health infrastructure while neglecting structural distortions in health care provision in the West Bank and the Gaza Strip.

The health sector as a whole did not suffer such a severe decline; UNRWA and especially the public health sector were not affected by the decline in funding. Yet, 20 percent of health care facilities in the West Bank and the Gaza Strip closed in the years following the signing of the peace agreement in 1993.⁸⁷

Despite the decline of the NGO sector, the latter remains important, as it currently provides a significant share of health care: 62 percent of primary health care, 50 percent of secondary health care, and all rehabilitation services. But an expanding private health care sector constitutes an additional challenge to the beleaguered public sector.

⁸⁶ From Palestine Health Council, 86.

⁸⁷ Daibes and Barghouthi, 49.

5. The Private Sector

In contrast to the decline in the NGO sector, the private sector has been expanding considerably. This has been particularly true during the 1990s and especially in the period following the creation of the PA. The expansion of the private sector is reflected in the establishment of new clinics. Between 1992 and the end of 1994, 51 new private clinics opened. The total number of private clinics at the end of 1994 reached 164, approximating the number in the NGO sector.⁸⁸ However, in contrast to NGO clinics, the majority of private clinics are located in urban areas.

In addition to private clinics, private health insurance companies have been created. The two largest companies are Al-Mashriq and the Arab Insurance Company. While the development of the private sector was encouraged by the MOH as a means to reduce dependence on the Israeli health sector, the MOH failed to regulate its development. Private clinics are characterized by their emphasis on costly advanced diagnostic and secondary health care. The growing private sector, with high fees for services, has not only encouraged oversupply in the health sector, but has also restricted access to these services to the well-to-do parts of society.⁸⁹

The private sector has been increasingly attracting highly skilled medical staff not only from the NGO and the public health sector, but from UNRWA as well.⁹⁰ This trend is promoted by the considerable difference in salaries between the various sectors (Table 11). Although a law exists that prohibits general practitioners and specialists in the public health sector in the West Bank from maintaining a private practice, the MOH does not enforce this law.⁹¹ While the majority of health personnel were employed in the NGO sector in the early 1990s, the increasing employment of physicians in the private sector is likely to change this trend (for 1991 see Table 12).

Table 11
Basic Monthly Salaries for Physicians per Sector⁹²

Provider	US \$
Ministry of Health (MOH)	629
United Nations Relief and Works Agency (UNRWA)	921
Non-Governmental Organizations (NGOs)	900-1,000
Private Sector	1,000-1,200

⁸⁸ Lenock, 29. The two largest private health care providers are Arabcare Medical Services and MedLab Palestine.

⁸⁹ Barghouthi and Lenock, 22-24.

⁹⁰ According to UNRWA regulations, UNRWA doctors are allowed to run a private practice.

⁹¹ In contrast, specialists in the Gaza Strip are allowed to run a private practice, according to MOH regulations.

⁹² From Palestine Health Council, 86.

Table 12
Employment in the Health Sector by Provider in 1991⁹³

Provider	Share of Employment
Government Health Sector	22
United Nations Relief and Works Agency (UNRWA)	4
Non-Governmental Organizations (NGOs)	52
Private Sector	22
Total	100

The growth of the private sector has compounded the problem stemming from the MOH's emphasis on secondary and tertiary health care by contributing to the development of a dual health system, with a private sector monopolizing advanced diagnostic health care at the expense of expanding primary health care.

C. Israel's Policy of Closure

The development of the health sector has also been shaped by Israel's policy of closure. This policy refers to the partial or complete sealing off of the West Bank and the Gaza Strip from Israel (including Jerusalem) as well as from Jordan and Egypt.⁹⁴ In addition to sealing off the West Bank and the Gaza Strip from the neighboring countries, the Israeli authorities have also frequently imposed a "comprehensive closure" in the Occupied Territories. In these cases areas under Palestinian rule are isolated from the remainder of the Occupied Territories, their residents prevented from leaving or entering.

During closure the movement of people and goods is either restricted or prohibited. Closure typically follows bomb attacks in Israel, or is based on considerations of what Israel perceives as a threat to its security. While prior to the 1990s the policy of closure was implemented only irregularly, it has been used increasingly since then. Moreover, since February 1996, it has led to a de-facto separation of the West Bank and the Gaza Strip and has limited Palestinian access to Jerusalem considerably.⁹⁵

⁹³ Ibid., 91.

⁹⁴ Israel annexed Jerusalem unilaterally in 1970.

⁹⁵ The peace agreements stipulate the creation of a 'safe passage' between the West Bank and the Gaza Strip. This would allow Palestinians to move between the two entities without passing Israeli checkpoints.

Israel's policy of closure not only constitutes a violation of Article 33 of the 4th Geneva Convention on the Protection of Civilian Persons in Times of War, but has also been detrimental for the economic and social situation in the Occupied Territories. According to World Bank estimates, the total loss resulting from closures between 1993 and 1996 amounted to US \$2.8 billion, which corresponds to 70 percent of the annual Palestinian GNP. Furthermore, frequent closures have contributed to the development of poverty in the Occupied Territories, reaching 40 percent of the population in the Gaza Strip and 10 percent of the West Bank population.⁹⁶

The effects of closure on the health sector became apparent in February 1996. Complete closure was imposed on the Occupied Territories following the suicide bombing in Jerusalem and Asqelon on 25 February 1996.⁹⁷ As a threat to those who broke the curfew, the Central Command of the Israeli Defense Forces distributed a leaflet stating that anyone caught on foot or by car by the Israeli authorities would be treated in a 'ruthless and unforgiving manner.'⁹⁸ As a result, neither health care providers nor patients could reach health facilities during this time. This included emergency cases and led to the deaths of several Palestinians. A survey carried out by the Health, Development, Information and Policy Institute (HDIP) on 13 March 1996, revealed that 38 percent of health care providers in the West Bank could not attend work. Jerusalem was especially affected by the closure, as it is the seat of major Palestinian health institutions. Moreover, Jerusalem is the seat of the only tertiary Palestinian health care facility, the al-Maqassed Hospital. The HDIP survey indicated that 51 percent of al-Maqassed's personnel could not reach the hospital. Similarly, St. John's and the Augusta Victoria Hospitals in Jerusalem were severely affected. Fifty and 57 percent of their personnel, respectively, were unable to reach their workplaces.

Closure also interrupted the delivery of pharmaceutical supplies from Israel to the West Bank and the Gaza Strip. As a consequence, the program to vaccinate 1.1 million Palestinian children that had started in March 1996 had to be interrupted due to the inability of medical staff to carry out the programs and the interruption in the delivery of vaccines. The above mentioned impact of Israel's policy of closure on the health sector exacerbates the effects of the distortions in the Palestinian health sector. The obstacles imposed on health care delivery highlight the importance of the availability of a well-developed primary health care system.

D. Distortions in the Health Sector

The above outline of the four health care providers reveals that several weaknesses and distortions characterize the health sector in the West Bank and the Gaza Strip. When the PA took over responsibility for health care it was faced with a fragmented health system in which several health care providers coexisted without coordinating their services. While improvements have been

⁹⁶ World Bank, *West Bank and Gaza*, 2.

⁹⁷ In addition to closure, the Israeli government reaction included mass arrests of Palestinians and the demolition of Palestinian homes.

⁹⁸ Translated in Mustafa Barghouthi, Ibrahim Daibes, and A. Shbayta, *Health Care Under Siege: The February 1996 Closure of the Occupied Territories* (Ramallah: Health Development Information Project, 1996), 4.

achieved, in particular the expansion of the public health insurance scheme to a growing number of people and the rehabilitation of some of the health infrastructure, grave distortions remain unaddressed. In particular, the disparity in health care provision between rural and urban areas remains.

In the absence of a comprehensive health plan that focuses on addressing marginalized groups and regions and the regulation of health care provision, the health sector has tended to concentrate in urban areas. This development has led to shortages of services in some rural areas. In addition, the MOH's focus on secondary health care, as well as the expansion of the private health sector, have increasingly restricted access to health care for the poorer segments of society.

Current developments reveal that the persistence of distortions in the health sector has contributed to an evolving dual health care system with expensive secondary health care developing at the expense of primary health care. Given the limited resources available, health reform should therefore address the improvement of primary health care as a means first to minimize expenditure for secondary and tertiary health care, and second to promote an equitable health care system that is accessible to all of society. Both issues have been adopted by the UPMRC as primary policy objectives. The development of the UPMRC is outlined in the following section, including the means it has taken to effect change in health policy at the national level.

V. The Union of Palestinian Medical Relief Committees

A. The UPMRC as Part of a Health Movement

The UPMRC emerged as a health committee in the wider context of a social movement that took shape in the late 1970s. This social movement marks a departure from previous responses to the Israeli occupation of the West Bank and the Gaza Strip in 1967.⁹⁹

Under the Israeli occupation the health sector underwent three different phases, each characterized by a different vision of health care as well as a different attitude towards the Israeli occupation. From 1967 to the early 1970s, the Israeli occupation was largely perceived as a new status quo. During this period the health sector accommodated to the new situation. Moreover, the existing medical elite, which adhered to the old medical school with an emphasis on biomedical health care, accepted Israeli control of the health sector. However, as a result of the increasing deterioration of health care under Israel control, a new response emerged in the early 1970s. This response consisted in an attempt to develop and upgrade Palestinian health care institutions that were free from Israeli control, as the deteriorating health care situation was viewed as resulting from the Israeli occupation. This phase is characterized by attempts on the part of health care providers to obtain permits from the Israeli authorities to create independent Palestinian health care facilities. While during this period and until the late 1970s there was an increase in the number of health institutions, in particular charitable organizations, permits were

⁹⁹ Taraki, and Joost R. Hiltermann, *Behind the Intifada: Labor and Women's Movements in the Occupied Territories* (Princeton: Princeton University Press, 1991).

granted only selectively and based on political considerations. Thus, Israel retained its control over the development of the health sector. Like their predecessors, the health institutions that were created during this period adopted a biomedical approach to health care. Similarly, the majority of health care facilities remained urban based. As a result, the rural population, which in the West Bank constitutes the majority, received disproportionately less access to health care. It was this marginalization of the rural and remote areas in the West Bank that led to the rise of a new health movement in the late 1970s and 1980s.¹⁰⁰

The new health movement formed part of a larger social movement that sought to disengage from Israel's control over Palestinian development by creating alternative Palestinian structures. Based on the realization that operation within Israeli rules created an impediment, these committees chose not to register with the Israeli authorities.

A major characteristic of this movement was the involvement of previously marginalized segments of society, in particular the rural population, in the formulation and implementation of its projects. This was achieved through the creation of committees at the local level covering all sectors of society, such as women's, youth, or health issues.

The committees were generally linked to the four major Palestinian political factions: Fatah; the Popular Front for the Liberation of Palestine (PFLP); the Democratic Front for the Liberation of Palestine (DFLP); and the Palestine Communist Party (PCP).¹⁰¹ Four agricultural, women's, health, and other committees were created, each associated with these political factions.

In the health sector, the first committee—the Union of Palestinian Medical Relief Committees—was established in 1979. It developed into the largest union of health committees and was affiliated with the Palestine Communist Party (PCP). It was followed by the creation of three additional ones during the 1980s, each affiliated with a political faction.

In 1985, the Union of the Health Work Committees (affiliated with the PFLP) and the Union of the Health Care Committees (affiliated with the DFLP) were created. The health committee affiliated with Fatah, the Health Services Council, was formally established only five years later, in 1990.

The UPMRC, the UHCC, and the UHWC were especially instrumental in developing an alternative approach to health care. They understood the absence of equity in the health system as a result of economic and social factors and advocated change of the health care system as part of a larger social reform. In contrast to the biomedical approach applied by charitable organizations and in hospitals, which requires an expensive infrastructure, the committees focused on preventive health care and health education, particularly in marginalized regions.

¹⁰⁰ Rita Giacaman, "The Health as a Social Construction: The Debate in the Occupied Territories," *Middle East Report* 161 (1989): 16-20 and Glenn E. Robinson, *Building a Palestinian State: The Incomplete Revolution* (Bloomington: Indiana University Press, 1997), 38.

¹⁰¹ Fatah is the largest Palestinian political faction, followed by the three leftist factions, the PFLP, the DFLP, and the PCP. The latter was renamed the People's Party after 1991.

When health was situated in the larger socio-economic context, the Israeli occupation ceased to be the sole factor accounting for the deteriorating health system. Rather, the health situation was also seen to be the result of inequalities within Palestinian society.¹⁰² The objective of the committees was to address the structural problems in the Palestinian health system.¹⁰³ This included the establishment of clinics in rural and underprivileged areas, particularly in the West Bank. The ultimate goal was to provide an alternative to the existing health care delivery system controlled to a large extent by the Israeli authorities.

In brief, the committees followed the recommendations of the 1978 Alma Ata Conference, dubbed “Health for all by the year 2000,” with its emphasis on primary health care.¹⁰⁴ According to the Alma Ata Declaration of 1978, primary health care is defined as:

...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.¹⁰⁵

The health committees gained prominence during the intifada, the Palestinian uprising against the Israeli occupation, which began in 1987. Existing health providers imposed extreme limitations on treating the injured. In the first year of the intifada 389 deaths and 20,000 injured were reported.¹⁰⁶ Treatment in the Israeli controlled government hospitals constituted a risk for injured Palestinians, who feared arrest by the Israeli authorities. Moreover, the Israeli authorities decreased the availability of government health services by reducing its health budget for government hospitals by half and by raising fees for hospitalization. UNRWA’s services, in turn, were free of charge only for registered refugees. In addition, as noted above, the majority of UNRWA’s health facilities are located in urban areas, leaving the rural areas under-served. In response to the inability of existing health care facilities to cope with the situation created by the intifada, the health committees systematically extended their services to rural areas in order to provide for the injured there. Initially, the UPMRC, the UHCW, and the UHCC provided their services through mobile clinics, which provided the means to reach marginalized and rural areas. Only later were permanent clinics established. As the health committees rejected Israeli control

¹⁰² Craissati, 132.

¹⁰³ Khammash, and Glenn E. Robinson, “The Role of the Professional Middle Class in the Mobilization of Palestinian Society: The Medical and Agricultural Committees,” *International Journal of Middle East Studies* 25 (1993): 302-3.

¹⁰⁴ Khammash; Craissati, 132; and Barghouthi and Giacaman, 80.

¹⁰⁵ World Health Organization, “Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Jointly sponsored by the World Health Organization and the United Nations Children’s Fund” (Geneva: World Health Organization, 1978), page 3, Article VI.

¹⁰⁶ Barghouthi and Giacaman, 81 and Robinson, “The Role of the Professional Middle Class,” 302.

over the health sector, they refused to register with the Israeli authorities, and mobile clinics facilitated effective evasion from Israeli control.¹⁰⁷

In addition, treatment of large numbers of injured Palestinians required the availability of a national blood bank. While a national blood bank had existed before the Israeli occupation, the Israeli authorities closed it in 1967.¹⁰⁸ The UPMRC assumed a leading role in the establishment of a national blood bank in February 1998, which catalogued 24,000 potential blood donors. This number increased to 40,000 in 1994.¹⁰⁹ Health committees were also instrumental in establishing First Aid centers that involved the participation of members of the community. The UPMRC trained 22,000 Palestinians to respond to the high incidence of injuries during the intifada.¹¹⁰

The UPMRC revived this program in September 1996, after clashes occurred between Palestinians and Israeli soldiers. These clashes erupted after the opening of the Hasmonean Tunnel,¹¹¹ and led to 63 casualties and 1400 injured Palestinians. Since the end of 1996 the UPMRC has trained more than 1900 Palestinians in first aid. The ultimate objective of this program is to establish a nation-wide network of first aid units that can be mobilized in emergency cases such as those caused by clashes between Israeli soldiers and Palestinians.¹¹²

The health committees were instrumental not only in creating a health network that responded to needs that arose during the intifada, but also in developing health education. The UPMRC has assumed a leading role in this field. Health education has constituted a cornerstone of its focus on primary health care. The UPMRC's health education material is distributed not only within the West Bank and the Gaza Strip but also in neighboring Arab countries.

By addressing the needs of marginalized and rural areas, the health committees gained a high level of popular support and legitimacy in these communities. Their legitimacy was further enhanced by the fact that they offered their services free of charge for patients who faced economic hardship.¹¹³ Before analyzing the UPMRC, a brief overview of the HSC, the UHCC and the UHCW is given below.

1. The Health Services Council

The Health Services Council was the last of the health committees to form. It was established formally in 1990 and has been affiliated with Fatah. In contrast to the other health committees, it was not affiliated with a leftist political faction.

¹⁰⁷ Glenn E. Robinson, *Building a Palestinian State*, 40. The exception is the HSC, which was registered with the Israeli authorities.

¹⁰⁸ Barghouthi and Giacaman, 75.

¹⁰⁹ Robinson, "The Role of the Professional Middle Class," 304.

¹¹⁰ Robinson, *Building a Palestinian State*, 41.

¹¹¹ The tunnel, which was excavated by Israel, is located below the Muslim holy site of the Dome of the Rock and runs along the Western wall of the Dome to a cistern beneath Islamic Waqf property.

¹¹² Mustafa Barghouthi, President of the UPMRC, interview by author, October, 1998.

¹¹³ Craissati, 131-132.

Like the other health committees, the HSC concentrated its services in rural and underprivileged areas. However, in contrast to them, it largely followed a biomedical approach. Moreover, it regarded itself as a charitable organization and was, like other charitable organizations, registered with the Israeli authorities.¹¹⁴

Another distinctive feature of the HSC is its structure. Although it is generally regarded as part of the health committee movement, the HSC, unlike the other committees, does not constitute a union but a council. More specifically, the involvement of the community, which is characteristic of the other health committees, is limited in the case of the HSC. Thus, decision-making is highly centralized and confined to its board of directors. Furthermore, the program of the HSC is implemented by paid personnel instead of volunteers. The other health committees, in contrast, have relied on a high number of volunteers from the communities to operate their programs.¹¹⁵

Following the establishment of the PA, most of the HSC clinics were closed and its employees absorbed into the MOH. During the early 1990s, 19 of its 21 clinics in the West Bank closed and by 1998 the HSC ceased to exist.¹¹⁶

2. The Union of Health Care Committees

The UHCC was created in 1985 as a health committee affiliated with the leftist Democratic Front for the Liberation of Palestine (DFLP). In the 1980s the UHCC's network of clinics expanded considerably. Prior to the intifada the UHCC had 12 clinics, but by the early 1990s the number of clinics had grown to 26.

The UHCC, however, suffered a major blow when the DFLP split. The division of the DFLP was mirrored at the level of the UHCC and led to the closure of 14 clinics in 1992. As a result, the UHCC is marginalized and weakened. It is neither included in the network of health NGOs nor in that of the PNGO.¹¹⁷

3. The Union of Health Work Committees

The UHWC was established in 1985 and has been affiliated with the Popular Front for the Liberation of Palestine. In contrast to the other committees, which provided their services primarily in the West Bank, the UHWC had a stronger presence in the Gaza Strip.¹¹⁸

¹¹⁴ Robinson, "The Role of the Professional Middle Class," 308-309.

¹¹⁵ Daibes and Barghouthi, 49; Craissati, 137; and Robinson, "The Role of the Professional Middle Class," 308-309.

¹¹⁶ Palestine Health Council, 86.

¹¹⁷ Muhammad Jadallah, director of UHCC, interview by author, October 1998, Jerusalem.

¹¹⁸ Robinson, "The Role of the Professional Middle Class," 306.

During the intifada the UHWC expanded the number of its clinics considerably, from 13 to 40. However, declining external funding in the early 1990s forced the UHWC to close over one third of its clinics, all of them in the West Bank. In contrast to the UHCC, the UHWC is involved in the network of health NGOs (See Part C below).

Thus, the financial decline brought about in the early 1990s transformed the health committees. While the HSC ceased to exist, the UHCC was weakened through the closure of 50 percent of its clinics, followed by the UHWC with 30 percent of its clinics closed.

4. The Union of Palestinian Medical Relief Committees

The UPMRC was created in 1979 and has been affiliated with the Palestine Communist Party and its successor, the People's Party. Since its creation, it has played a crucial role in the new health movement. Its target groups have been the marginalized and deprived segments of society that have been neglected by the existing health care system. In its programs the UPMRC has focused on primary and preventive health care. Furthermore, in contrast to the UHWC and the UHCC, which both focused on improving access to health care services, the UPMRC added another component—namely, an effort to change attitudes towards health. To this end it engaged in extensive health education campaigns.

Given the distortions in the health sector, the UPMRC's approach to health has been to fill in the gap. This approach to health is based on the assumption that health is determined by a range of factors and not solely by the quality of the health infrastructure. Situating health in a socio-economic context, the UPMRC has focused on enhancing equitable access to health care, while at the same time including health education as a means to improve the overall health of the population. Based on its concepts of health care, the UPMRC established a system that involved the community through its active participation in decision-making and program implementation.

In its attempt to mobilize marginalized groups for the implementation of its programs, the UPMRC has succeeded in involving a high number of women at all levels of the organization, including the leadership. Moreover, women played a key role in the founding of the UPMRC. In contrast to the low percentage of female Palestinian doctors (6 percent of total), one third of the UPMRC's doctors are women.¹¹⁹

The UPMRC has addressed the needs of different population groups through programs that are specifically tailored to these needs. The UPMRC provides its services through a network of clinics. It currently runs 25 clinics in the West Bank and the Gaza Strip. Furthermore, a major component of its activities are 11 rehabilitation programs for 80 communities as well as seven mobile dental clinics serving 50 communities. It operates a women's health program and community-based rehabilitation projects for the disabled in 95 communities, reaching 310,000

¹¹⁹ Barghouthi and Giacaman, 79 and Robinson, "The Role of the Professional Middle Class," 304.

people. In addition to its outreach program to rural and marginalized communities, the UPMRC holds health fairs in the communities. Through these, the UPMRC provides free check-ups and distributes material on health education. The health fairs are regularly attended by 1,000-3,000 people. The UPMRC has also addressed the need for psychological counseling by developing a counseling program in 1992. This program was based on the UPMRC's conclusion that only one third of those needing psychological counseling received any such care.

The UPMRC has reached a considerable part of the population, with 370,000 patients consulting it in 1993.¹²⁰ Currently, the UPMRC is active in 220 communities and reaches 390,000 people. Of these, 45 percent are women and 42 percent children. These figures reveal that the UPMRC is successful in reaching the marginalized groups in society.

Because of financial difficulties resulting from the diversion of international funds, the UPMRC had to reduce the number of its clinics in 1992 from 34 to 25, a reduction of 28 percent. Compared with other NGOs, however, the UPMRC was less vulnerable to declining international funds in the 1990s, especially after the establishment of the PA. The UPMRC was able to maintain its leading position in the health sector, and at present UPMRC clinics constitute 52 percent of NGO clinics, excluding charitable organizations.¹²¹

According to its director, Mustafa Barghouthi, the relatively small decline in the number of UPMRC clinics resulted from its earlier decision not to expand its facilities, despite the availability of external funding at the time. In addition, the UPMRC responded to the decline of funds later on by establishing an income-generating project, the Optometry Center in Ramallah, West Bank, in September 1995. This project currently provides around 15 percent of the UPMRC's budget with the potential to be raised to 30 percent, according to the UPMRC's director.

Currently the UPMRC runs a network of mobile clinics that serves 180 communities. The location of the mobile clinics is determined both by the UPMRC staff and by representatives from the communities. The mobile clinics, which are staffed with doctors and village health workers, provide screening and preventive health care as well as specialized services, such as dermatology and dental care.

The UPMRC has also used mobile clinics to provide services to displaced persons such as the Jahalin Bedouins. In March 1997, the confiscation of land owned by Palestinians¹²² led to the displacement of 42 Jahalin Bedouin families who had been living on this land. The Jahalin were then moved by the Israeli authorities to a site near the Jerusalem Municipal Garbage Dump, an area that is regarded as hazardous to human health.¹²³

¹²⁰ Robinson, *Building a Palestinian State*, 43.

¹²¹ Mustafa Barghouthi, interview by author, October, 1998.

¹²² Israel confiscated the land in order to expand the Israeli settlement of Ma'ale Adumim in the vicinity of Jerusalem.

¹²³ UPMRC, UPMRC Newsletter, no. 26 (June 1997).

B. Grassroots Links

Through its emphasis on community involvement and participation in health care delivery, the UPMRC has succeeded in developing strong grassroots ties. These are reflected in three characteristics: its organizational structure, in particular the inclusion of community representatives; its responsiveness to the needs of the community; and the involvement of the community in health care delivery.

The UPMRC is characterized by the involvement of community representatives in health care delivery. This is reflected in the organizational structure of the UPMRC. Community members, mainly volunteers, are represented in nine regional committees. Representation of the communities in the UPMRC in turn is ensured through the election of community representatives to the board of the UPMRC. These representatives meet on a weekly or bi-weekly basis to address issues of community concern.

The UPMRC includes community representatives not only in its organization but also in the implementation of its programs. In the operation of its health centers, the UPMRC involves a high number volunteers, in particular village health workers. These are selected by the UPMRC staff together with the community leaders and then trained at the UPMRC's Community Health School.¹²⁴

Furthermore, village workers play an important role in the UPMRC's special programs, such as health education, women's health programs, and the emergency program. In addition, the volunteers organize visits of the mobile clinics to the communities after identifying local needs. The volunteers have assumed a crucial role during closures by providing primary health care services to the population under curfew.

In addition, in order for the UPMRC to remain responsive to local needs, it has been organizing workshops in the communities which involve community members. In this framework and in response to the problems identified by the UPMRC together with community representatives, the UPMRC has been focusing on marginalized groups, such as women, youth, the disabled, and the elderly.¹²⁵ These workshops have provided an opportunity for community representatives to address problems of health care delivery in the communities and to identify priorities. In its effort to address disabled people, the UPMRC started its Community Based Rehabilitation program (CBR) in 1986. This program aims at integrating mental health into UPMRC's primary health care structures. The program has expanded and currently offers CBR in ninety-five rural communities and in two cities, serving half a million people. In addition, the UPMRC initiated a

¹²⁴ The UPMRC established its Community Health School in 1987 and received accreditation by the PA's MOH in 1996.

¹²⁵ Workshops conducted include: "Women's Issues and Health Policy" (27 January 1997 in Nablus); "Youth Issues and Health Policy" (27 February 1997 in Ramallah); "Disability Issues and Health Policy" (7 March 1997 in Ramallah); "Health Policy for the Elderly" (3 April 1997 in Ramallah), and "Health Insurance and the Social Security System," (27 May 1998 in Jenin). Health, Development, and Information Project, *Policy Watch Bulletin*, no. 1 (January 1998) and Health, Development, and Information Project, *Policy Watch Bulletin*, no. 2 (July 1998).

women's health program. This program has developed into the fastest growing program of the UPMRC, with the number of women served increasing from 16,514 in 1993 to 22,117 in 1996.

As shown above, since its creation in 1979 the UPMRC has succeeded in expanding and maintaining its grassroots links. Through its policy of promoting a health care system that involves the participation of the community and that is responsive to its needs, the UPMRC has increased its legitimacy at the popular level. In addition to its popular legitimacy, the UPMRC has succeeded in securing a leading role in the health NGO sector. Given the weakening of the other health committees, the lack of vision shown in their evaluation of the National Health Plan, and the absence of a coherent alternative strategy, the UPMRC has emerged as the only committee with a clear vision of health care provision.

Thus, through the advantages it enjoys, the UPMRC considers itself in a strategic position to further the promotion of primary health care, a policy it has pursued since its establishment. In order to do this, the UPMRC has established horizontal linkages with other NGOs and vertical ones with several ministries of the PA. Being situated at the intersection of these linkages, the UPMRC exerts influence on health policy at the national level. The horizontal and vertical linkages forged by the UPMRC are discussed in the following sections.

C. Horizontal Linkages - The UPMRC and Health NGOs

In an interview in early 1996 UPMRC director Dr. Mustafa Barghouthi outlined his vision of health care provision. He highlighted the danger of an emerging dual health system characterized by one system serving the poor population while the other caters to the needs of the wealthy segments of society. According to Barghouthi, in order to stem this development, the expansion of primary health care is required. A focus on primary health care would not only minimize costs at the secondary and tertiary level, but would also ensure a more equitable health system that would take into account the needs of all segments of society. More specifically, by attributing to NGOs a more prominent role in coordination and cooperation with other health providers, Barghouthi argues, health policy at the national level could be influenced towards more emphasis on primary health care. According to him, a precondition for the involvement of NGOs, however, is the creation of a unified vision of health care among them. Only then can they be successful in exerting influence on national health policy.

In the above-mentioned interview Barghouthi outlined the consecutive steps that coordination among health care providers should follow. As a first step a unified vision among health NGOs should be established. Coordination with the MOH, in turn, should proceed in two stages: coordination at the policy level followed by coordination of services.¹²⁶

In order to further its agenda and to translate its vision into concrete mechanisms of cooperation, the UPMRC and in particular its director assumed a central role in a policy dialogue project that

¹²⁶ Mustafa Barghouthi, interview by author, October, 1998.

was initiated by the Health, Development, Information and Policy Institute (HDIP) in 1996. The HDIP had been created in 1989 by a group of researchers and health professionals, and like the UPMRC is headed by Mustafa Barghouthi. The HDIP's aim has been to advocate better health policies—in particular for marginalized groups, such as women, youth, and the disabled. The HDIP and the policy dialogue project served as an ideal forum to translate Barghouthi's vision of health into concrete steps. More importantly, the policy dialogue project has been aided by the substantial data compiled by the HDIP. HDIP's data include information on the vast majority of the health care facilities, including types of services provided, health personnel, and consultation fees. At a general level, HDIP has conducted demographic surveys as well as surveys on the physical infrastructure in the West Bank and the Gaza Strip. The significance of the policy dialogue is underscored by the fact that there had been no similar forum prior to its creation.

In the framework of the policy dialogue the HDIP conducted a series of workshops. The establishment of coordination between the different health care providers proceeded in line with Barghouthi's vision of cooperation. In order to consolidate its position within the sector of health NGOs, the UPMRC, in a strategic move, forged links with other health NGOs before initiating a policy dialogue with the MOH and other PA ministries.

At the HDIP's first workshop on "Coordination Within the Sector of Health NGOs," held on 13 May 1996, the UPMRC assumed a leading role in formulating a common vision among the participating NGOs. This was viewed as necessary in order to identify the role of each health care provider. In addition, the workshop dealt with the nature of cooperation between NGOs and the government sector. In this context three levels of coordination were identified as modes of cooperation that seek to minimize duplication and maximize the effective use of available resources.

The first level of coordination relates to general issues of health policy, such as the financial aspects of resource allocation.¹²⁷ The second level of coordination addresses cooperation in the different sectors of health care provision, such as health care, hospital care, and first aid. The third level of coordination focuses on health care for marginalized groups, namely women, children, the disabled, and the elderly.

Through this workshop a forum was created that brought health NGOs together. More than 25 health NGOs participated, including charitable organizations and two health committees, the UPRMC and the UHWC. In addition to identifying the three levels that constitute coordination between health NGOs and the MOH, the major achievement of the workshop was the formulation of a unified vision on the role of health NGOs in the delivery of health care. Specifically, the participating NGOs viewed their role as complementary to that of the government. In line with Barghouthi's vision on cooperation between the MOH and health NGOs, the HDIP conducted a second workshop that included not only health NGOs but also the MOH.

¹²⁷ UPMRC, *UPMRC Newsletter*, no. 22 (January/February, 1996).

D. Vertical Linkages with the PA

1. Policy Dialogue Project

After having established a common vision on health care delivery and the role of NGOs in health care, the UPMRC proceeded to enlarge the forum of the policy dialogue project. The second HDIP workshop on 16 July 1996, “Sharing Responsibilities: Coordination Workshop between the Health NGO Sector and the Palestinian Ministry of Health,” included, in addition to more than 40 participating health NGOs, representatives from the government health sector and from UNRWA (See Annex I for a list of the major participating health NGOs). The significance of the forum lies in the fact that for the first time health NGOs and the MOH were brought together. Its significance is further enhanced by the participation of the Minister of Health, Riad Za’noun.

In this workshop the NGOs’ perspective on health care was presented by Barghouthi. The Minister of Health, Za’noun, in turn, outlined the MOH’s position. In his opening note to the workshop Za’noun acknowledged the importance of the NGO sector in complementing the government in health services. He further highlighted that the government is unable to provide comprehensive health care to the entire Palestinian population because of its limited capacity, and that therefore the public health sector should include health NGOs as well.

The workshop concluded with an agreement to establish mechanisms of cooperation between the MOH and health NGOs. A separate executive committee composed of representatives from the participating NGOs was elected on 30 July 1996. This committee is composed of 9 NGOs, while the HDIP was elected as the committee coordinator (See Annex II for the list of elected NGOs).

While this workshop focused on the necessity and the nature of cooperation, a third workshop, “Coordinating Primary Health Care” on 19 December 1996, dealt with the establishment of concrete mechanisms of cooperation between the MOH and the NGO sector. More specifically, these mechanisms involved the delivery of primary health care, in particular the subcontracting of MOH services to the NGO sector. As a result of the mechanisms of cooperation created, three subcontracting agreements were signed on 24 September 1997. (Subcontracting arrangements and joint projects are discussed in the following sections.)

In a fourth HDIP workshop, “Better and Cost Effective Hospital Care: The Coordination Workshop Between MOH, NGOs, UNRWA and Private Hospitals,” on 11 March 1998, the UPMRC succeeded in increasing the number of participants and included for the first time representatives from the private sector. The workshop addressed the issue of coordinating hospital care provided by all sectors in order to contain the high expenditure on secondary health care. In addition to the workshops, a series of roundtable meetings between the MOH and NGOs were held.¹²⁸ Their objective has been to translate the agreed upon cooperation into concrete steps of implementation.

¹²⁸ The first of these meetings took place on 24 September 1997.

In summary, the policy dialogue project has developed into an important forum for increased coordination and cooperation among the health NGOs and the MOH. The HDIP has chosen to expand cooperation gradually. It moved from an initially pure NGO forum to include other health care providers. Similarly, the issues dealt with in this forum have been expanded from general issues of health to more specific issues dealing with the various sectors of health. Through the forum and the creation of a mechanism of cooperation, the UPMRC has succeeded not only in including the MOH but also in institutionalizing cooperation.

2. Sub-Contracting Arrangements

The foundation for the subcontracting of MOH services to the NGO sector was established at the third HDIP workshop. Three subcontracting agreements between health NGOs and the MOH were signed on 24 September 1997. In these arrangements existing health care facilities were merged. In all cases the MOH closed its facilities and subcontracted services for their insured patients to NGO clinics. Furthermore, the administration and the technical responsibilities were assumed by the health NGOs. In addition, the health NGOs continued to provide their own services to patients who were not insured with the government.

The first sub-contract agreement between an NGO (the UPMRC) and the MOH was signed for the village of Mghayer in the West Bank.¹²⁹ This subcontract was concluded on 1 November 1997. The second agreement was concluded between the MOH and the Palestine Red Crescent Society (PRCS) for the village of Biddo in the West Bank. The third contract, in turn, was signed by the MOH and a charitable health organization, the Birzeit Charity Association.

Further agreements were signed on 1 September 1998 between the UPRMC and the MOH for the health centers in Sinjil and Turmus 'Ayya, both villages in the West Bank.¹³⁰ As in the case of the other agreements, the MOH closed down its own clinics in these villages and patients with government insurance have been treated by the UPMRC.

3. Partnerships in Joint Projects

In addition to the policy dialogue project and the subcontracting arrangements, the UPMRC has established partnerships with the MOH as well as with other ministries. In contrast to subcontracting arrangements, partnerships between ministries of the PA and health NGOs have not involved the closure of MOH facilities and services. Rather, the aim of a partnership is to institutionalize cooperation in the implementation of the various programs of the MOH and other

¹²⁹ The primary health care center in Mghayer was opened by the UPMRC in 1991 (UPMRC, *UPMRC Newsletter* no. 28 (January/February 1998)).

¹³⁰ In Sinjil the municipality provided the building, the Japanese government the equipment, and the UPMRC took over staff and medicine. Patients who are enrolled in the government insurance plan are treated as well as those without insurance. The fee ranges from 3 to 10 NIS (New Israeli Shekels). Staff from the Sinjil clinic, interview by author.

ministries. The objective is to avoid duplication of services and to make optimal use of available resources. These partnerships have typically involved issues related to national health programs.

For example, an agreement to cooperate was reached in the implementation of the national school health program and the women's health program. Specifically, in order to address these issues a joint government-NGO committee was established in which the UPMRC is a member. The task of this committee has been to review existing plans as well as to prepare short-term plans.

Similar kinds of cooperation also exist with other ministries. In order to address the high incidence of deaths resulting from road traffic accidents in the West Bank and the Gaza Strip,¹³¹ the UPMRC initiated the establishment of a committee on road traffic accidents, which has required the involvement of several ministries and governmental bodies, including the MOH, the Ministries of Education, Transport, and Labor, as well as the Traffic Police.¹³²

The UPMRC has also been instrumental in fighting zoonosis.¹³³ The zoonosis program was started in 1993 as a research program and has expanded since then to include awareness-raising. In order to address the issue at a national level, a committee was created in which the Ministries of Agriculture and Health, the Palestinian Agriculture Relief Committees (PARC), the Union of Health Works Committees, the Union of Agricultural Work Committees, and the Maqassed Hospital are represented.

E. The UPMRC and the PNGO

The primary objective of the UPMRC has been to establish an equitable health system. Its policy has been based on the assumption that an equitable health care system can be achieved only through the democratization of the Palestinian political order. As a result, its endeavors have addressed not only inequalities in the health system but also the attainment of a democratic order.

Based on its historic role as part of a social movement that has promoted the creation of an equitable social and political order, the UPMRC has supported the important role of NGOs in contributing to the establishment of this order. Moreover, the UPMRC has played a crucial role in mobilizing NGOs and other civil society institutions to curb the authoritarian nature of the PA. The UPMRC played an instrumental role in the creation of the Palestinian NGO network, for example. PNGO was created in response to the PA's attempt to marginalize and to control the NGO sector, efforts reflected in its proposed associational law.

¹³¹ Accidents constitute 14 percent of all deaths and account for 28 percent of deaths of children below the age of five. Lennox and Barghouthi, 12.

¹³² Mustafa Barghouthi, interview by author, October, 1998.

¹³³ Zoonosis is the transmission of diseases from animals to humans. A major component of the zoonosis program addresses brucellosis (Maltese fever). Official reports indicate that there are 278 cases of Maltese fever per 100,000 population. The actual figure, however, is estimated to be much higher.

PNGO's particular concern has been this law and it has formulated its own proposal, which involves the amendment of nine articles of the PA's version. In order to lobby for the adoption of PNGO's amendments, the UPMRC established contact with some 60 members of the 88-member Palestine Legislative Council (PLC). As a result of the UPMRC's efforts, the PLC adopted six of the nine proposed amendments in a second reading in mid-1998.¹³⁴ Although (as of mid-1999) the law has still to pass the third reading, and more importantly to be approved by Arafat, PNGO has viewed the PLC's adoption of the majority of the proposed articles as a major success.

The articles proposed by PNGO and adopted by the PLC foresee that NGOs will register with a bureau at the Ministry of Justice instead of at the Ministry of Interior as suggested by the PA. Furthermore, in contrast to the PA's law as originally conceived, the associational law proposed by PNGO will require NGOs only to register and not to obtain a license from the Ministry of Interior.¹³⁵

The UPMRC's role has not been confined to promoting its vision of an equitable health system and acting as an advocate for democratic relations between the PA and the NGO sector. In addition, the UPMRC has played an important role as a lobby group for marginalized groups, such as the disabled. In 1998 the UPMRC assisted the General Union of Palestinian Disabled in the formulation of a law on the rights of the disabled.¹³⁶

VI. Conclusion

The UPMRC has been able to further its agenda by pursuing a strategy of gradually extending cooperation with health care providers and the PA. As an initial step it established a network to harmonize NGO activities and to create a unified position towards the PA. In this process the UPMRC consolidated its position as a leader in the sector of health NGOs.

As a second step, the UPMRC chose to expand cooperation to include additional health care providers. Through the consecutive workshops organized by the HDIP, the UPMRC involved the MOH, UNRWA, and the private sector. It has thus succeeded in establishing a forum that for the first time brought all health care providers together. Moreover, the UPMRC succeeded in situating itself at the intersection of horizontal links with the health NGO sector and vertical ties with the PA. Being at the center of these horizontal and vertical linkages, the UPMRC has been able to further its own interests as well as those of the NGO sector in general. It thus followed Cernea's recommendation that, "in order to achieve relevance and gain replicability for their initiatives on a large scale, NGOs must influence government bodies."¹³⁷ In this achievement the UPMRC has been aided by its historic role in the community, its continuous grassroots support, and by its clear vision and strategy to achieve an equitable health care system.

¹³⁴ Moustafa Barghouthi, interview by author, October, 1998.

¹³⁵ UPMRC, *UPMRC Newsletter* no. 30 (September 1998).

¹³⁶ Health, Development, and Information Project, *Policy Watch Bulletin*, no. 2 (July 1998).

¹³⁷ Michael M. Cernea, *Nongovernmental Organizations and Local Development*, World Bank Discussion Paper, no. 40 (Washington: The World Bank, 1988), 50.

Cooperation between the PA and the health NGOs has been exceptional when compared to the cooperation between the PA and other NGOs. Moreover, the PA has benefited from health care provided by the NGOs, as their involvement in the joint projects has also enhanced the PA's own legitimacy. Given the dominant role of the UPMRC with both other NGOs and the PA, its suppression by the PA would reduce the latter's credibility and would constitute a destabilizing factor for the PA. Furthermore, many services provided by NGOs cannot be provided by the PA, as it does not possess the institutional capacity to do so. These services include especially care for the disabled, health promotion, and preschool education.

In its current position the UPMRC has the potential to influence PA policy and to further its interests, those of other NGOs, and those of civil society at large. In this context, the UPMRC carries the potential to contribute to the development of civil society and democracy in general.

Annex I

Major NGOs Involved in the Policy Dialogue Project of the Health, Development, Information and Policy Institute (HDIP)

1. Abu Rayya Rehabilitation Center
2. al-Ahli Hospital
3. al-Atta Society
4. Bethlehem Arab Society
5. Center for Primary Health Care Development
6. Central National Committee for Rehabilitation
7. Community and Public Health Department, Birzeit University
8. General Union of Palestinian Disabled
9. Happy Child Center
10. Ittihad Hospital
11. al-Maqassed Hospital
12. Palestinian Coalition for Women's Health
13. Patients' Friends Society, Hebron
14. Patients' Friends Society, Nablus
15. Physicians Union
16. Pontifical Mission to Palestine
17. Princess Basma Rehabilitation Center
18. Public Health Society
19. Red Crescent Society, Nablus
20. Roman Catholic Health Center

21. St. Luke's Hospital
22. Union of Health Work Committees (UHWC)
23. Union of Palestinian Medical Relief Committees (UPMRC)
24. YMCA, Bayt Sahur
25. Zakat Fund, Jenin
26. Zakat Fund, Nablus
27. Zakat Fund, Tulkarm
28. Zoonotic Research and Education Center

Annex II

Members of the NGOs' Coordinating Committee of the Policy Dialogue Project

As a result of the second workshop of the policy dialogue project, an executive committee of nine NGOs was created to coordinate cooperation with the Ministry of Health. The committee included:

1. al-Maqassed Hospital, Jerusalem
2. al-Ahli Hospital, Hebron
3. Ittihad Hospital
4. Union of Health Work Committees (UHWC)
5. Central National Committee for Rehabilitation
6. Health, Development, Information and Policy Institute (HDIP)
7. Pharmacists Union (on behalf on the Professional Union)
8. St. Luke's Hospital
9. Patients' Friends Society, Jenin

Furthermore, a secretariat was elected that consists of:

1. al-Maqassed Hospital, Jerusalem
2. Union of Health Work Committees (UHWC)
3. Central National Committee for Rehabilitation
4. Health, Development, Information and Policy Institute (HDIP)

Annex III

Major NGOs with which the UPMRC Coordinates Activities

1. al-Ahli Hospital
2. Bethlehem Arab Society
3. Central National Committee for Rehabilitation
4. Community and Public Health Department, Birzeit University
5. Family Planning Association
6. Gaza Blood Bank
7. Gaza Mental Hospital
8. al-Maqassed Hospital
9. al-Murabitat
10. Palestinian Agricultural Relief Committees
11. Palestinian Red Crescent Society
12. Patients' Friends Society, Jenin
13. PNGO
14. St. John's Ophthalmic Hospital
15. Women's Counseling Center
16. Women's Health Coalition
17. Women's Study Center
18. YMCA
19. YWCA

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