Palestinian National Authority
Ministry of Health

Palestinian National Health Strategy

2011 - 2013

Setting Direction - Getting Results

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PALESTINIAN NATIONAL HEALTH STRATEGY 2011-2013

Vision

An integrated health system that promotes and sustains the health status of Palestinians and addresses the key determinants of health in Palestine.

Ministry of Health Mission Statement

In partnership with stakeholders, to develop the institutional capacity of the Ministry of Health of a future independent State of Palestine in order to ensure good governance of the health sector, leadership in policy making and regulation of the health system, the promotion of better health and the provision of accessible, quality health services in both the public and private sectors.

Ministry of Health Values

Right to health for all Palestinians

Access to equitable, affordable, quality health services and public health interventions

Care for vulnerable groups, including those isolated in the Gaza Strip, the Jordan Valley, adjacent to the Apartheid Wall and living in East Jerusalem

Good governance

Forward

It is my pleasure to present the 2011-2013 National Health Strategy for Palestine. This is a strategy for the Palestinian health sector developed by stakeholders in Palestine, from the government, donors, NGOs, the private sector and UN agencies. The process was led by the Ministry of Health planning team, comprising personnel from my office, the health policy and planning general directorate and the international cooperation department.

Our three year strategy outlines priorities that will lead to further development of the Ministry of Health as a state institution providing good governance and leadership in overseeing and regulating the Palestinian health sector. This strategy serves as a major building block to further develop the Ministry of Health into a state institution that will serve the independent Palestinian state. Unlike previous strategies, this strategy is not a shopping list or wish list of projects. Instead, this strategy gives strategic areas for support within the framework of internationally agreed criteria for what constitutes a sound strategy. It also provides for a concerted effort that will ultimately ensure that ill health is prevented among Palestinian people and that those who need it have access to and receive quality, safe health care.

It is a Ministry of Health deeply held value that all Palestinians have the right to health. As such, the priority areas focus on state building and better governance, health promotion, accessible, quality and safe service delivery, and sustainability through appropriate health financing mechanisms and competent human resources.

I would like to extend my appreciation to the many stakeholders who worked with our strategic planning team. A number of you attended consultative meetings, reviewed the draft versions of the strategy and provided your insights and wisdom. Together we will work to implement this strategy, focused on results.

And as always, thank you for supporting the Palestinian health system.

Sincerely,

Dr. Fathi Abumoghli
Minister of Health
Ramallah, 2010

CHAPTER 1. OVERVIEW

1.1 WHAT IS DIFFERENT ABOUT THIS STRATEGY?

This strategy is different from previous strategies. It:

- focuses on a few specified **priorities**
- highlights the need for **good governance and for state building** in the health sector
- provides the **policy framework** for the development and implementation of priorities

The strategy is **evidence based** – every attempt has been made to ensure that national and international evidence and policy analysis have been taken into consideration. In addition, we have continuously questioned whether what we are proposing is realistic. The occupation and other political factors present an almost unprecedented challenge in this respect. Getting valid information in Palestine or, as the UN officially refers to our country, the occupied Palestinian territories (oPt), is sometimes a daunting exercise.

The strategy focuses on **getting results** through the **strategic framework** at annex A and **results framework** at annex B. Annex A summarizes the strategic direction of work 2011 – 2013 including objectives, planned outcomes, strategic actions, planned results, indicators of achievement, estimated costs and lead responsibility. Annex B gives the planned outputs and outcomes, indicators of achievement, baselines, targets and means of verification. The challenge has been to be realistic given the complex and sometimes rapidly changing context in Palestine.

Last but not least, the strategy is a major step towards **reforming the way aid is delivered and managed** - a move away from the current predominance of ad hoc health projects towards program and/or strategy support in line with national government programs, the Paris Principles and the Accra Declaration**.**

1.2 APPROACHES TO STRATEGY DEVELOPMENT

1.2.1 Planning process

During 2009, the Ministry of Health (MoH) developed and institutionalized a comprehensive and inclusive planning process. For this new strategy it also developed a planning cycle – see diagram below. This process and the cycle should help ensure that this national health strategy:

- Has a widely shared and understood vision and is owned by all stakeholders
- Takes account of what works, options for the way forward and what successful implementation depends upon
- Has a mix of bottom up and top down approaches
- Clearly reflects the priorities within the Palestinian health system and is not a shopping list of activities and projects
- Answers the questions - where are we now? Where do we want to be? And how are we going to get there?

Policy and strategy making in the volatile context of Palestine is a complex undertaking. But such decision-making is relatively easy compared with the challenge of implementation, to make the strategy reality. It is not easy to ensure equity, access and the means for implementation given the physical manifestations of the Apartheid Wall, barriers and economic strangulation and other aspects of the Israeli siege. However, we will ensure support for those responsible for implementation by encouraging flexibility, freedom of management action and an effective health system.

The Health Policy and Planning Directorate General (HPPGD) of the MoH is driving the planning process. For this strategy, the process began in early 2009 with a review and evaluation of the 2008-2010 National Strategic Health Plan. Meetings were also held with the Ministry of Planning and Administrative Development (MoPAD) who has overall responsibility for the development of the 2011 – 2013 Palestinian National Plan. The MoPAD is leading the process by which each public entity has to develop a new national sectoral strategy to fall within the framework of the Palestinian National Plan. MoPAD guidelines on strategy development, approved by the PNA Cabinet, were circulated to all relevant government bodies. The purpose of the guidelines was to facilitate strategy development and ensure that, at a minimum, certain issues were addressed in each sector strategy.

In May 2009, the Minister of Health initiated the first annual National Health Conference. This brought together a wide variety of stakeholders to discuss the current situation, to develop a conceptual framework for improving the quality and sustainability of health services and to discuss the future health priorities for the period 2011-2013.

The conference recommendations for future priorities fell under the headings of: health financing, service delivery, public-private partnerships and human resource development. It can be seen in Chapter 3 that these have indeed been incorporated as priorities in this new strategy.

Between May and the final production of this strategy, a number of consultative meetings were held with a variety of stakeholders. These encouraged people to talk openly about the challenges facing the health sector. Relevant data and academic literature were also researched to help provide the evidence base. Furthermore, a number of reports on reviews and situational analysis of the health sector by various stakeholders were read[1]. The different types of sectoral analysis from different perspectives have greatly enriched our decision making about the policy and strategic direction for 2011 – 2013.

1.2.2 Participatory approach

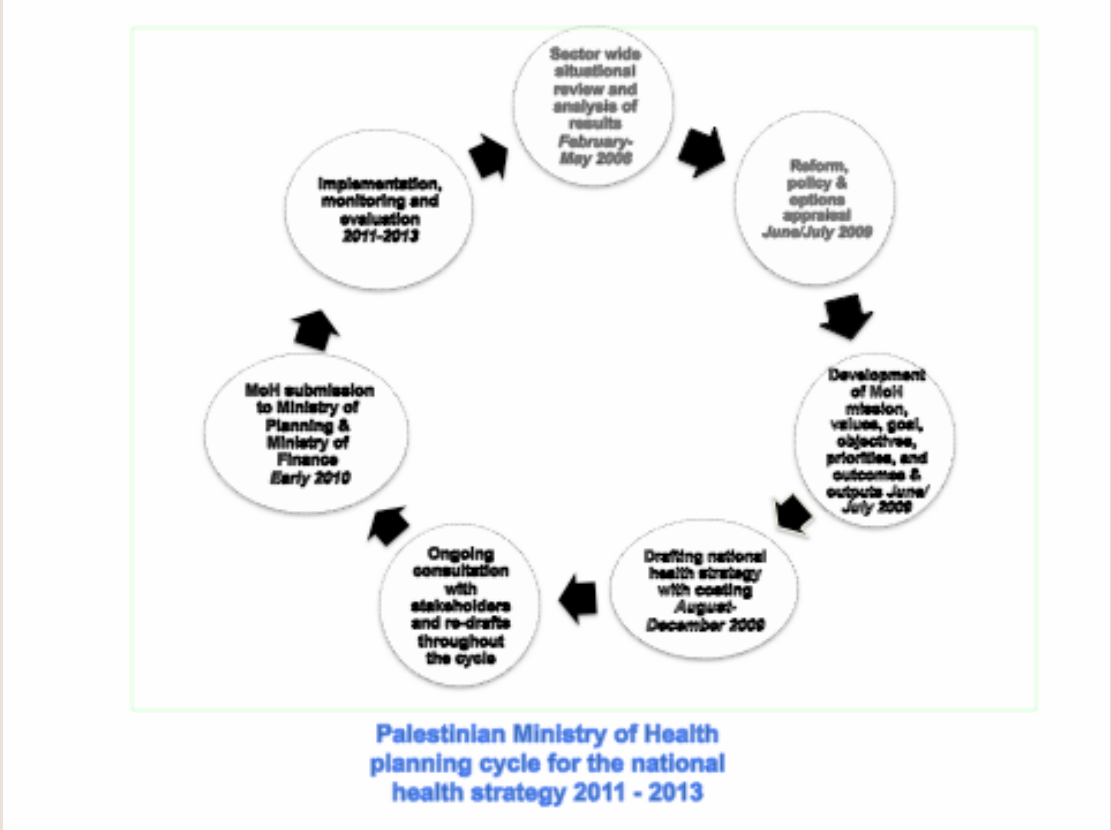
As indicated above this national health strategy was not developed by a few select MoH staff members in a closed room. Rather, the approach adopted was participatory including local and international stakeholders as well as relevant line ministries. One approach to ensure comprehensive participation was the utilization of existing committees and current coordinating structures to have a constructive dialogue and

1 For example: Dr Yehia Abed (editor) Health Sector Review: a summary report 2007. A collaboration between UK Department for International Development, European Commission, Italian Cooperation, Palestinian National Authority, World Bank and WHO

share drafts of the strategy for input and feedback. The various arrangements are:

- MoH Monitoring and Evaluation Committee and the Office of the Minister – The HPPGD worked closely with the committee to develop the draft priorities for the improvement of the health system in Palestine. The HPPGD also shared early drafts of the strategy with the MoH leadership, the Office of the Minister, to ensure consensus on the areas of focus for the coming years.
- Thematic Groups – Thematic groups comprise technical experts who are tasked by the Health Sector Working Group (HSWG) to focus on specific subjects. Thematic groups report back to the HSWG.
- National Council for Health Policy and Strategic Planning is chaired by the Minister and comprises leaders from various parts of the health sector including medical schools, local NGO's, syndicates, the Palestine Medical Council, relevant line ministries and the private sector. The national council therefore includes representation from all facets of society.

See annex C for a detailed look at stakeholder participation in the development of this strategy. The Council of Ministers endorsed the content of this strategy.



Palestinian Ministry of Health planning cycle for the national health strategy 2011 - 2013

1.2.3 Building on the past

There have been several national health strategies in the past including the 1994-1998 National Strategic Health Plan, and the 1994-1996 Interim Action Plan during the transition period after the Oslo Accords. The MoH also produced a National Strategic Health Plan for the period of 1999-2003. In 2001, as a joint effort between the MoH and the Ministry of Higher Education, a Human Resource Development and Education plan was developed.

The most recent plan, the National Health Strategic Plan 2008-2010, was focused primarily on improving the main building blocks of the health system, specifically in the areas of improved health service delivery and infrastructure, human resource development, and sustainable health financing. Achievements over these three years include the drafting of the national health insurance law, and the initiation of the Palestine Medical Complex that will bring improved quality and state of the art health services to Palestinian citizens under the realm of a decentralized management structure. In addition, access has improved as clinics have been established in many remote villages.

During the 2008-2010 period, the MoH strengthened the institutional planning process by development of annual action plans in line with the 3 year strategy as well as the annual budget submission. In addition, a monitoring and evaluation (M&E) mechanism was established to track activities outlined in the annual action plans. It enables those responsible to be held accountable. The M&E process at the MoH is in line with the national process established by MoPAD.

1.3 SITUATIONAL ANALYSIS

The following situational analysis has been taken from various sources including on-the-ground practical experience, conference presentations and recommendations, studies and surveys by national authorities and other stakeholders and academic literature.

1.3.1 Key determinants of health

Politics and sovereignty

The political situation is one of the key determinants of health in Palestine affecting human rights and justice. Manifestations of the overwhelming injustices across the West Bank, Gaza and in East Jerusalem include the Israeli Occupation, the longest in modern history, the construction and expansion of Israeli settlements, the existence of the apartheid wall, sieges, military barriers and other restrictions on where Palestinians and agricultural and other products can and cannot go. All have ongoing effects on the quality of the lives of Palestinians. They also make attempts to build a capable, responsive health system and an effectively functioning public sector institution for health an almost unprecedented challenge.

To further complicate matters, the PNA does not have sovereignty over borders,

movement of people and goods and its' land and water. Israeli restrictions and aggression are placing severe constraints on the ability of the PNA to govern and build a state. Over the last years and in particular in 2009, the PNA has been promoting state building and good governance. Human rights and social justice have long been values of the PNA.

Economic blockade and other economic contextual issues

2007 data indicated that the Palestinian gross domestic product (GDP) was estimated to be US$ 4,672.4 millions or about US$ 1,337 per capita[2]. However, restrictions on labour movements and the movements of goods are contributing to ever increasing levels of poverty. In 2007 the percentage of Gazans who lived under the national poverty line was 51.8 % compared to 24 % in 1998, while in West Bank it was 34.53 % and 18 %; and the overall poverty rate in Palestine in 2007 was 45.7 %[3]. In Gaza the grim effects of the Israeli siege on economic and social conditions have been devastating. In 2007 unemployment in Palestine was estimated was 26 %, in Gaza was estimated at 40.6 % compared with approximately 19 % in the West Bank[4].

The PNA is dependent on donor financial aid and the multiplicity of donors with different agendas has contributed to program fragmentation[5]. Most donors have also tended to prefer to support buildings and equipment over the operating expenses of the PNA. This is particularly the case in the health sector, although more recently the European Union (EU) for example has been providing substantial support solely for salaries and pensions. The lack of government control over financial and other resources undermines attempts at state building.

Out-of-pocket expenditure on health care is high and as the economic situation and unemployment worsens the poor could be driven into catastrophic debt. Food insecurity reached 56 % in 2008 with 60 % of households regarding emergency assistance as a secondary source of income[6].

Insecurity and other social factors

Palestinian society and the PNA have little control over the social determinants of health. There are deep inequities of power and wealth between Palestine and Israel with the latter controlling most aspects of daily life. Palestinians have a low socioeconomic position and a corresponding low quality of life. Israeli military closures and their effects have become increasingly severe in Palestine since 2006. They are causing an economic crisis with the GDP per person falling to 60 % of its 1999 value, rising unemployment and a serious decline in living standards, all of which are associated with negative health outcomes[7]. Furthermore, the absence of human

2 PCBS (2007) Palestinian Family Health Survey 2006: Preliminary Report. Palestinian Central Bureau of Statistics, 2008

3 PCBS (2008) Palestine in Figures 2007. Palestinian Central Bureau of Statistics

4 PCBS (2008) Palestine in Figures 2007 Palestinian Central Bureau of Statistics

5 Giacaman R et al. (2009) Health status and health services in the Palestinian occupied territories. Lancet 2009; published online March 5 DOI: 10.1016/S0140-6736(09)60107-0 www.thelancet.com

6 WFP/UNWRA/FAO (2008) Joint rapid food security survey in the occupied Palestinian territory http/documents.wfp.org/stellent/groups/public/documents/ena/wfp181837.pdf

7 Benach J et al (2007) Employment conditions and health inequalities. Final report to the WHO Commission on Social Determinants of Health

security is resulting in little sustainable impact of development funding.

Inequity

While there are concerted efforts to ensure equitable geographic distribution of health facilities, Israeli military barriers and road closures continue to effect access to health services for all Palestinians. Furthermore Palestinians residing in the Jordan Valley, Area C, and the other side of the Wall experience difficulty accessing health services. Due to Israeli control of these areas, the MoH is unable to establish health services for these communities. Also, in Palestine there is a greater focus on secondary services, where a majority of MoH resources are spent on hospital care.

On May 7, 2009, during the first annual national health conference, the Minister of Health's keynote opening speech affirmed the right of every Palestinian to health irrespective of their socioeconomic status. The 2003 Palestinian Law and the 2004 Public Health Law both ensure social and health protection for every Palestinian. In addition, the Public Health Law emphasizes the right of access of every Palestinian to health services.

Relevant policies and legislation

Policy making is complex in the turbulent political context that is Palestine. However, as stated earlier there is a political commitment to state building. And one of the goals of the 13th government to 'Ensure human development' includes a commitment to 'continually improving health and social services'. The PNA is also committed to ensuring social justice and providing protection to those with special needs and other vulnerable groups.

Due to political turmoil, there are times in Palestine when there is no functional legislative council. Without a parliamentary body, updating current legislation and proposing new legislation is very difficult.

International conventions

Palestine has ratified various international declarations such as the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child. It is also signed up to the MDGs – see the results framework at annex B for the health MDG targets. The PNA is committed to achieving the MDGs. However, this is a formidable challenge given, as discussed earlier, the lack of control it has over issues that are having such a negative impact on health. Key challenges within the power of the MoH towards achieving the health MDGs lie in:

- Ensuring that available funds and other resources are used on those interventions that are for the public good
- Ensuring an effective and efficient management environment
- Human resource development

Palestinian National Plan 2011 - 2013

The Palestinian National Plan 2011 – 2013 presents the Palestinian national strategic priorities and is intended to help international partners to channel support in line with these priorities. The priorities and programs in this sector strategy, agreed during a

consultative process with stakeholders, are reflected in the national plan.

Palestinian National Authority –Program of the 13th Government, August 2009

The PNA set out its priorities for 2010 in the program for the 13th Government published in August 2009. The key objectives of the Ministry of Health are included in the program. These relate mainly to the development of the health services infrastructure and human resources.

Palestine: Moving Forward – Priority Interventions for 2010

This PNA document further outlines the program of the PNA for 2010 highlighting priority interventions. It also focuses on the infrastructure needs of the health sector, as well as the development of a sustainable financing mechanism through a compulsory national health insurance system.

The Public Health Law

The Public Health Law was passed by the legislative council in 2004. This legislation outlines the responsibilities of the MoH including its role as provider and regulator of the health sector. The law also highlights the role of the MoH in aspects of public health including ensuring food, water, and environmental safety.

No Smoking Law

Legislation on the no smoking law was passed in 2005. The law bans smoking in public places and also forbids the selling of cigarettes to those less than 18 years of age. However, the law has never been enforced. There is no system to oversee and enforce compliance nor penalties implemented for non-compliance.

MoH role as regulator

The stewardship and regulatory role for the Ministry of Health include setting policies, national strategies and plans, regulations and monitoring standards for health sector, supervising and monitoring different health services and licensing of different health facilities and health professionals. A priority of the MoH is to standardize and institutionalize its regulatory functions and processes to ensure their continuation despite changes in staff and management.

1.3.2 Cross cutting issues

Disasters/emergencies

Droughts and earthquakes are among the natural disasters that are possible in our country. However the commonest disasters or emergencies in Palestine are all related to the political environment to the extent that there is an on-going state of emergency: the Israeli military occupation, siege, and aerial and ground attacks. Interventions to prevent and reduce insecurity have not kept pace with a rising burden of Israeli threats in the Palestine. Although the PNA has responded to alleviate the damage caused by the Israeli aggressions, there is a need to develop a comprehensive, national emergency response plan that involves relevant ministries and stakeholders. The national emergency response plan should include plans for natural disasters as well as man-made caused by the Israeli Occupation.

The health sector under the leadership of the MoH responds to the threats with its technical solutions but it is political solutions that will improve Palestinian security and simultaneously reduce threats to physical, mental and social health[8].

Gender

Although Palestinian society is very patriarchal, there are many female headed households as husbands and fathers are often imprisoned or murdered by Israeli aggression. The loss of the father in the household often leads the eldest male sibling to drop out of school in an effort to find odd jobs to support the family. In addition, it is very common for young Palestinian males to be imprisoned in Israeli jails for varying periods of time. Once released, it is difficult for them to return to their 'normal' lives. As such, the high school drop out rate among Palestinian male teen-agers is significant. Furthermore, reintegration of the released prisoners into society is difficult. Stress related symptoms include increased smoking and physical violence, including domestic violence within the home.

There is a national effort to mainstream gender equity within national policies and practice. The MoH has several programs in collaboration with other ministries such as the Ministry of Women Affairs and Ministry of Social Affairs to assure this perspective. The objective is to ensure that health policies, programs and other aspects of work include an analysis of gender issues in order to:

- Promote gender roles and relations that protect health, promote equality between women and men and contribute to the attainment of social justice
- Provide information and policy advice to policy makers on the influence of gender on health and health care, based on both quantitative and qualitative data.

In line with this national effort to mainstream equity a number of international stakeholders address the issue in their project planning[9].

Violence and health

A cross-sectional study published in 2010 shows that exposure to political violence is associated with increased odds of psychological, physical and sexual intimate-partner violence in occupied Palestine[10]. Another finding is that in the Gaza Strip, women whose households were financially affected by the occupation were at 139 % increased odds of reporting psychological intimate-partner violence compared with those households who were not financially affected. The paper goes on to say that the relation shown draws attention to the wide-ranging ramifications of political violence towards men and women.

A commentary in The Lancet[11] on the cross-sectional study states that the article supports a public health approach to understanding intimate-partner violence. And that the study acknowledges that family violence might be the result of multidimensional

8 Batniji R et al (2009) Health as human security in the occupied Palestinian territory. Lancet; published online March 5 DOI:10.1016/S0140-6736(09)60110-0. www.thelancet.com

9 For example: USAID, Palestinian health sector reform and development project: 'The Flagship project', March 2009

10 Clark C J et al Association between exposure to political violence and intimate-partner violence in the occupied Palestinian territory: a cross-sectional study. www.thelancet.com Vol 375 January 23, 2010

11 Giacaman R et al Domestic and political: the Palestinian predicament. www.thelancet.com Vol 375 250-260 January 23, 2010

processes, with poverty as an associated factor and with poverty itself seen as a lethal form of violence. In addition to poverty, the findings also point to Palestinian men's exposure to political violence and its social effect, which in turn can lead to violence.

Environment

The occupation means that the PNA has no control over water, land and the environment. Yet there are many environmental challenges facing the health sector in Palestine such as climate change and its impact on water availability and on agriculture, drinking water safety, food safety, solid and liquid waste management and environmental hazards of industrial establishments mostly from the illegal Israeli settlements.

The major concerns regarding water supplies are water shortages and limited access to safe water for the rural population. The sewage and waste-water management systems are insufficient. Because of financial and other resource shortages the inspection of water-supply systems and the use of water safety plans is limited.

As a result of shortages of fuel and electricity, the water authorities in Gaza Strip have been dumping daily 60,000 cubic meters of sewage into the Mediterranean Sea since January 2008 to avoid flooding residential areas. The results of the analysis of 26 sea water samples in 2008 showed that sea water in seven out of thirteen areas was polluted with faecal contamination[12].

Injuries and disabilities

Injuries and accidents in Palestine are the leading cause of death especially for young males mainly due to Israeli atrocities and accidents. According to the 2007 census nearly 108,000 persons in the West Bank suffer from at least one type of disability or difficulty - about 5.3 % of the population. The most common types of disability are vision impairment, 2.9 %, followed by physical difficulty, 2.1 %. MoH data shows that 39 % of reported disabilities in the West Bank are among the 19-29 age group (see table 1, annex E). Genetic or congenital abnormalities represent 30.0 % of disabilities in Palestine. Diseases are the second leading cause of disability at 29.5 %[13]. There are a number of people with amputations. These are mainly the result of Israeli aggression, aerial bombardments and ground attacks.

HIV and AIDS

Palestine is still reporting a low incidence rate of cases of HIV. The cumulative reported cases since 1988 are 64 cases (45 AIDS cases and 19 HIV carriers). Over 50 % of reported cases are estimated to be due to heterosexual transmission[14].

The Palestinian health system, similar to other neighboring Arab countries, faces several challenges regarding sexually transmitted diseases, including behavioral aspects, privacy, stigma, patient follow up and treatment, medical awareness, lack of qualified experts and access to, and the user-friendliness of, clinics and special centers.

12 WHO (2008) Situation report on the sea water pollution, World Health Organization, Jerusalem

13 PCBS (2008) MDGs Indicators Data in Palestine, 1994-2007, Palestinian Central Bureau of Statistics

14 MoH. (2009) Health Status in Palestine, Annual report 2008. Ministry of Health

1.3.3 Population and demography

The total population of the PNA is approximately 3.826 million of which 2.4 million is in the West Bank and 1.4 million in Gaza. The average annual population growth rate is 2.8 % and about 42 % of the population is below 15 years old - see the health Indicators at table 1 below. The average number of individuals in a household is 6.3 (5.9 in the West Bank and 7 in Gaza).

Health status

The Palestinian population is going through an epidemiological and demographic transition. Behind the standard health indicators lies much suffering. People often report being negatively affected by constant conflict and military occupation, checkpoint closures, and the Israeli siege. These may well be contributory factors to the 'epidemic' of chronic diseases that is emerging.

Within the last decade male life expectancy increased from 69.0 in 1997 to 70.2 years in 2008, while life expectancy for females did not change and stands at 73 years. Fertility is declining in both the West Bank and the Gaza Strip, but still considered relatively high. The total fertility rate in Palestine has declined from 4.6 in 2007 compared to 6.0 in 1997.In the West Bank, the fertility rate was down to 4.2 in 2007 compared to 5.6 in 1997. In the Gaza Strip, it was 5.4 in 2007 compared with 6.9 in 1997.

The average age of the population will increase as fertility declines and children make up a shrinking percentage of the population. In the West Bank, the proportion of children below 15 declined from 45.1 % in 1997 to 41.3 % in 2007. In the Gaza Strip, the decline was from 50.2 % in 1997 to 48.3 % in 2007. By contrast the percentage of working age population aged 15-64 years has increased during the same period; the proportion rose from 51.1 % in 1997 to 55.3 % in the West Bank and rose from 46.9 % to 49 % in the Gaza Strip.

Palestine would thus be facing a period of 'demographic bonus' if the growing cohort of young active men and women could be constructively absorbed in the community and economy. However, the downside is that over the next 2 decades, the number of Palestinian youth (15-24 year) will increase 80 % to 1.3 million, placing greater demands on public services and resources such as education, health, housing, employment opportunities, and natural resources. If these demands cannot be met – and in the current socio-political situation, the scenario is not positive – the 'demographic bonus' will instead become a 'youth bulge' with potentially destabilizing effects on the society. The MoH is closely observing this gradual change in the demographic structure and will adapt future strategies as the demography changes.

Table 1. Health status indicators in Palestine[15]

Indicators	Palestinian Territory	Region	
		West Bank	Gaza Strip
Total population mid year 2008	3,825,512	2,385,180	1,440,332
Males	1,941,763	1,210,881	730,882
Females	1,883,749	1,174,299	709,450
Male/female ratio mid year 2008	103	103	103
Life expectancy mid year 2008 (male)	70.20	70.56	69.65
Life expectancy mid year 2008 (female)	72.92	73.43	72.11
Total fertility rate	4.6	4.2	5.4
Infant mortality rate (MoH)	25		
Maternal mortality ratio (MoH data) 2009 (according to the most recent national committee study)	45		
Dependency ratio mid year 2008	83.6	78.8	92.2
Population natural increase rate mid year 2008	2.87	2.65	3.23
Percentage of refugees 2007	42.7	27.4	67.9
Proportion of pop aged under 5 years mid year 2008	14.9	13.9	16.4
Proportion of pop aged under 15 years mid year 2008	42.5	40.7	45.5
Proportion of pop aged 65 years and above mid year 2008	3.1	3.4	2.5
Reported CBR per 1000 pop mid year 2008	32.65	30.16	36.77
Reported CDR per 1000 pop mid year 2008	4.36	4.48	4.17
Percentage of low birth weight (<2500 gm) of total births (MoH data)	7.3	7.5	7.0
Percentage of unemployment: 2008	26.0	19.0	40.6

Maternal and child health

According to the 2009 series on health in Palestine in The Lancet, mortality rates for infants and children less than 5 years of age have changed little since the 1990s. This suggests a slowdown of health improvements, a possible increase in health disparities or an indication of deteriorating conditions[16]. The main causes of infant deaths are prematurity and low birth weight, and congenital malformations[17].

The prevalence of stunting in children is on the increase. Since 2006, living conditions

15 Source of all data is the Palestinian Central Bureau of Statistics except where noted

16 Giacaman R et al. Health status and health services in the Palestinian occupied territories. Lancet 2009; published online March 5 DOI:10.1016/S0140-6736(09)60107-0. www.thelancet.com

17 PCBS (2008) Palestine in Figures 2007. Palestinian Central Bureau of Statistics

have worsened and the Israeli imposed system of several hundred checkpoints and barriers to movement has severely restricted access to health services. The restrictions are especially crucial in perinatal and child health emergencies and access to maternity facilities has become increasingly unpredictable[18].

Palestine's high fertility rate of 4.6 (see table 1) may be attributed to early marriage, the political situation and/or restricted opportunities for women to work. MoH data shows that the main contraceptive method used in Palestine is the oral pill. In 2008 in the West Bank 47.4 % of the women used the Pill, while 31 % used IUDs; in the Gaza strip 18.9 % of the women used IUDs, while 48.8 % of the women used the Pill[19]. Male condom use is low.

Youth and adolescent health

Youth and adolescents constitute a high proportion of the Palestinian population and are considered the future of Palestine with two thirds of the population under the age of 24. Early marriage and early pregnancy are consistently high with increased complication rates occurring among young pregnant women.

Information, counseling and care among young people in Palestine is mainly accessed through informal or peer networks. There is no information targeted at young people about their physical, sexual and mental health. Nor are health services particularly user-friendly for them.

High levels of psychological disorders caused by exposure to violence are not being addressed as young people are not considered to be a vulnerable group. However, the combination of factors of violence, high levels of unemployment, and lack of control over their lives means that mental and psychosocial health of youth in Palestinian society needs special emphasis.

Chronic diseases

Chronic or non-communicable diseases (NCDs) are now a key challenge for the health system in Palestine. Several factors including politics, urbanization, globalization, the stressful Israeli occupation, poverty and unemployment and transitions in food consumption patterns are contributing to the increasing prevalence of risk factors such as smoking, unhealthy diet and lack of physical activity. This corresponds with a rise in the incidence of NCDs in Palestine and the increasing prevalence of diabetes, cardiovascular diseases and neoplasm.

One in ten people living in Palestine and two thirds of those older than 60 years old have at least one chronic disease according to 2006 Palestinian family health survey[20]. Based on MoH mortality data for the West Bank, the leading causes of deaths are heart diseases, cerebro-vascular diseases and malignant neoplasms. Among women, breast cancer is the most prevalent cancer while lung cancer is the most common cancer

18 Rahim HFA et al (2009) Maternal and child health in the occupied Palestinian territories. Lancet 2009; published online March 5. DOI:10,1016/S0140-6736(09)60108-2. www.thelancet.com

19 MoH (2009) Health status in Palestine Annual Report. Palestinian Health Information Center, Ministry of Health

20 PCBS (2008) Palestine in Figures 2007 Palestinian Central Bureau of Statistics

among males[21].

Communicable diseases

Due to the successful immunization programme, the communicable diseases of childhood are largely controlled. And some, such as polio have been eradicated. However, communicable diseases such as tuberculosis, diarrhoeal diseases and acute respiratory infections, plus zoonotic diseases such as brucellosis still persist. This is especially common where there are high levels of poverty and overcrowding.

Community mental health

Among Palestinians, personal psychological or medical problems are inseparable from societal issues. The list of issues due to the Israeli occupation are endless and includes threats to personal safety, loss of income, home and land, interruption of utilities such as electricity and water, curfews, bombing and shooting. Violence includes chronic exposure to humiliation, which is associated with negative mental health[22]. Other significantly defined risk factors include poverty, low level of education and gender based violence.

A number of surveys over the last decade report high distress, fear, insomnia and incontinence, the latter especially among children, sometimes but not always associated with a recent traumatic event such as invasion by the Israeli military, bombardment or witnessing seeing a relative being killed[23]. Recent annual reports consistently indicate increases in mental disorders[24]. Table 2 in annex E indicates the higher prevalence of mental illnesses in Gaza compared to the West Bank (which is also higher than the neighbouring countries).

1.3.4 Human resources

According to 2006 MoH figures, there were approximately 40,000 staff working in the health sector[25], also see table 2 below. The MoH as the main health care provider is the main employer. Table 3 below shows the distribution of MoH health professionals in Palestine. Approximately 59 % of MoH staff are employed in hospitals, 27 % in PHC and 14 % in other MoH departments[26].

21 MoH (2009) Health status in Palestine Annual Report Palestinian Health Information Center, Ministry of Health

22 Giacaman R et al (2007) Humiliation: the invisible trauma of war for Palestinian youth. Public Health 121: 563-71

23 Giacaman R et al. Health status and health services in the Palestinian occupied territories. Lancet 2009; published online March 5 DOI:10.1016/S0140-6736(09)60107-0. www.thelancet.com

24 WHO (2006) Community mental health development in the occupied Palestinian territory: a work in progress with WHO. World Health Organization Office West Bank and Gaza Office

25 MoH (2009) Health Status in Palestine Annual report 2006 Ministry of Health

26 MoH report and WHO mission reports

Table 2. Distribution of human resources for health by region, Palestine 2007

Profession	West Bank		Gaza Strip		Total in Palestine	
	Number	Per 10,000 pop	Number	Per 10,000 pop	Number	Per 10,000 pop
Physicians	4,551	19.4	3,842	27.1	8,393	22.3
Dentists	1,358	5.8	700	4.9	2,058	5.5
Pharmacists	2,261	9.6	1,595	11.3	3,856	10.3
Nurses	2,681	11.4	4,277	30.2	6,958	18.5
Midwives	487	2.1	234	1.7	721	1.9
Paramedics	7,501	32	3,245	22.9	10,746	28.6
Total	18,439	80.3	13,893	98.1	32,732	87
Administration	4,492	19.2	3,505	24.7	7,997	21.3
Grand Total	**22,931**	**99.5**	**17,398**	**122.8**	**40,729**	**108.3**

Source: WHO country cooperation strategy 2009-201

Palestine has fewer physicians per head compared with neighbouring countries and fewer dentists, nurses and midwives compared with Egypt and Jordan but falls within the overall regional average[27].

While some progressive steps have been initiated including the infrastructure development of Ibn Sina College, and the process of upgrading some major MoH hospitals into training hospitals, many further steps are needed to achieve comprehensive human resources development.

1.3.5 Health financing

2007 data indicated that the GDP of Palestine was estimated to be US$ 4,672.3 million (current price) or about US$ 1,337 per capita. Palestine allocates a significant part of its resources to the health sector. The average health expenditure between 2000-2006 is estimated to be about 11 % of GDP which is higher than in many other developing countries.

Reliable and accurate information on the financing of the health sector is an essential basis for wise policy development in the area of health sector reform. Analysis of health care financing should begin with sound estimates of national health expenditure-total spending, the contribution of spending from different sources and the claims on spending by different uses of funds.

The MoH has been working closely with Palestine Central Bureau of Statistics since 2004 to estimate the financial state of the Palestinian health system. The primary data shows that the government sector expenditure on health accounts is about 40 % of

27 MoH (2008) Annual Health Report 2007 Ministry of Health

total health expenditure, where the other financial sources(out-of pocket, rest of the world, NGOs ..Etc..) consist of about 60 % of the total expenditures.

Table 3. MoH revenues for the year 2009

Revenue Item	2009 (in Thousands NIS)
Health insurance	103,294
Co-payment	32,000
Other revenues (international donation, taxes, etc.)	1,094,340

Table 4. MoH expenditure for the year 2009

Indicator / Palestine	2009 (in Thousands NIS)
Actual MoH expenditure	1,229, 634
Expenditure on salaries	586,863
Purchasing services outside MoH facilities	421,014
Drugs	140,000
Other Operating expenditure	81,757
Percentage of expenditures on salaries	48 %

MoH expenditures amounted to 10.5 % of the total PNA budget for the year 2009. Financing of the health sector is derived from taxes, health insurance premiums, co-payments, out-of-pocket payments, international aid and grants as well as non-governmental resources. MoH expenditure increased by 39 % between 2000 and 2005 and during this time the GDP fluctuated. In 2007, MoH spending reached about US$ 223 million[28] and $315m in 2008. In the 2008 – 2010 Palestinian Reconstruction and Development Plan, $100 million was allocated for the Health Quality Improvement Plan and $20 million for the Health Care Affordability Plan both overarching frameworks for work in the health sector 2008 - 2010[29].

As can be seen from the above table, staff salaries accounted for 48 % of the budget and other operational spending (mainly referrals abroad and medicines and supplies) 52 %. The cost of treatment abroad (outside of MoH facilities) was around US$ 111 million, of which 60 % was spent for patients referred to treatment in local non MoH health facilities[30]. Recent MoH data is showing that the number of referrals abroad from the West Bank decreased substantially in 2009. Cases referred to Israeli hospitals were reportedly reduced by 50 %. Furthermore, costs have been reduced by improved

28 MoH report and WHO mission reports

29 MoH Health Status in Palestine: Annual report 2006

30 MoH Health Status in Palestine: Annual report 2006

contracting procedures between MoH and the non-governmental Palestinian sector, and Jordanian and Egyptian health providers. Pharmaceutical expenditures by the MoH increased from US$ 20.8 million in 2005 to US$ 26.8 million in 2007, and US $37 million in 2009 – an estimated 29 %and 38 % increase consequently .

There is a new proposed Palestinian national health insurance scheme. The objective of the scheme is to increase the umbrella of services available to citizens to meet their needs, while protecting their rights. The current health insurance system in Palestine has provided a generous basket of services and drug benefits for its citizens compared with surrounding countries. The available basket of services is large in comparison to the allocated budget within the MoH and the PNA. As such, the debt burden is heavy, especially for health care abroad. In 2009, the health insurance covered approximately 350,460 families, or 60.4 % of the Palestinian population. Of the beneficiaries 29.9 % pay premiums, while 30.5 % receive benefits without paying into the system.

The current health insurance includes a compulsory component covering civil servants, and retirees. This equals 45.3 % of the total participants in the system, and 56.9 % of the total income generated. In addition, there is another component that covers Palestinian workers who work inside Israel. Participation within this component has decreased from 19.6 % in 2000 to 1.9 % in 2007. Also, there is the voluntary component where Palestinians choose to purchase the national health insurance to cover their personal health care needs. Participants in this component have decreased from 5.2 % in 2000 to 2.1 % in 2006. And finally, participation from private companies and institutions that contract with the Ministry of Health to provide health care services to their employees has also decreased from 23 % in 2000 to 13 % in 2007.

The Ministry of Social Affairs also pays into the current health insurance system to provide for the poor and needy within society. In this instance, the level of participation has increased from 17.3 % in 2000 to 32.9 % in 2006. The Ministry of Prisoners pays into the national insurance system to provide coverage for the families of Palestinian prisoners held in Israeli prisons.

Box 1. Health Financing-National Health Insurance

Proposed law for health insurance reform

1. Summary: The overall goal of the proposed health insurance reform law is to a) separate the healthcare care provider from the healthcare purchaser increasing competition in the market/sector, b) ensure the system's sustainability financially through compulsory participation; and c) and improve access to quality healthcare services which will result in decreased referrals abroad. Premium contributions will be prorated for each person based on a percentage of his/her salary, therefore, ensuring equity in the provision of health services. The insurance will also provide coverage to the unemployed and the poor by involving the line ministries.

2. An autonomous entity: The proposed health insurance reform law establishes an autonomous entity, administratively and financially, for the health insurance system. An independent director will lead this autonomous organization. However, the director will be accountable to a board of trustees who will oversee the operations of the health insurance system. The board will be accountable to the Ministerial Cabinet.

3. Services provided:
A basket of services will be provided that will include public health services, specialty outpatient care, laboratory testing, radiology services, medications, hospital stays, emergency care, and basic dental services. The board will determine the actual services that will be provided within the basket. Care for the following will be provided free of charge: 1) Children under 5 years, 2) pregnant women, 3) treatment for the following diseases: cancers, communicable diseases, mental illnesses, and drug addiction/substance abuse.

4. Financing of the health insurance system

- Premiums
- Co-payments
- Budget allocation from the PNA
- Donations
- Ministry of Labor will provide the premiums for the unemployed
- Ministry of Social Affairs will provide the premiums for the poor

5. Participation in the system will be mandatory for the entire Palestinian population and enforced through salary deductions and employer taxes to cover their employees.

1.3.6 Health service delivery

The four main health providers of health services in Palestine are MoH, UNRWA, NGOs and private for profit. MoH bears the heaviest burden as it has the responsibility for ensuring equitable and affordable access to quality health services for all Palestinians. Health services in Gaza have been in a critical situation for some years now as a result both of the Israeli siege and of the infrastructure damage caused through the Israeli invasion in December 2008 – January 2009. Fifteen hospitals and 41 PHC clinics in the Gaza Strip were damaged during the strike. Twenty-nine ambulances were damaged or destroyed[31].

The MoH worked throughout the last decade on promoting and strengthening service delivery facilities. The number of PHC centres in the West Bank has increased from 176 in 1994 to 357 in 2008. In Gaza the increase was from 29 in 1995 to 55 in 2008. The number of governmental hospital in the West Bank increased from 1026 in 1994 to 1289 in 2008; in Gaza there were 826 beds in 1994 and by 2008, 1584.

Primary care

A total of 672 PHC centers are in Palestine, 542 in the West Bank and 130 in Gaza. In the Gaza Strip there are 55 MoH primary health care (PHC) centers and in the West Bank, 370. UNRWA operates 53 PHC centers, 18 PHC centers scattered in 8 refugee camps in the Gaza Strip and 35 in the West Bank. The NGO sector operates 178 PHC centers and general clinics, 57 of them in the Gaza Strip, and in the West Bank,121.

The health services are distributed throughout Palestine. In addition, MoH provides a number of specific health programs such as: health education/community involvement, community health, immunization, and school health programs.

Table (5) Distribution of PHC facilities by Health Provider, Palestine 2008

Governorate	No. of Population	Providers			Total	Pop. Per Centre
		MOH	NGOs	UNRWA*		
West Bank	**2,385,180**	**370**	**121**	**35**	**542**	**4,401**
Jerusalem	368,394	17	19	3	39	9,446
Jenin & Tubas	311,408	51	19	4	74	4,208
Tulkarm	159,594	27	7	2	36	4,433
Qalqiliah	92,506	17	14	2	33	2,803
Salfit	60,309	17	10	1	28	2,154
Nablus	324,816	41	16	6	63	5,156
Ramallah	284,195	50	15	5	70	4,060
Bethlehem	178,853	17	17	2	36	4,968
Jericho	42,964	9	4	3	16	2,685
ALKhaleil	562,141	124	16	7	147	3,824
Gaza Strip	1,440,332	55	57	18	130	11,079
Gaza North	275,687	12	9	3	24	11,487
Gaza City	504,047	12	24	4	40	12,601
Mid-Zone	209,014	15	10	5	30	6,967
KhanYounis	275,134	12	6	2	20	13,757
Rafah	176,450	4	8	4	16	11,028
Grand Total	3,825,512	425	178	53	672	5,693

31 WHO (2009) Gaza Strip: Initial health needs assessment. World Health Organization

Table (6) Distribution of governmental PHC centers by level, Palestine 2008

Region	Level I	Level II	Level III	Level IV	Total		Specialized	Oral	LAB
						Family Planning	Clinics	Clinics	
Total	73	187	89	8	357	97	145	23	**116**
Jerusalem	0	7	9	1	**17**	3	9	2	16
Jenin & Tubas	0	38	12	1	**51**	16	27	4	16
Tulkarm	0	15	11	1	**27**	9	4	2	11
Qalqiliah	0	6	10	1	**17**	16	15	1	11
Salfit	0	12	4	1	**17**	8	14	1	8
Nablus	0	35	5	1	**41**	12	14	1	8
Ramallah	0	32	17	1	**50**	10	29	3	19
Bethlehem	0	12	5	0	**17**	12	24	3	8
Jericho	2	6	0	1	**9**	1	3	1	2
ALKhaleil	81	24	16	3	**124**	10	6	5	17
Total	**0**	**29**	**19**	**7**	**55**	**18**	**55**	**23**	**33**
North Gaza		6	5	1	**12**	3	12	4	5
Gaza		2	8	2	**12**	8	15	9	10
Gaza Mid zone		12	2	1	**15**	1	12	4	10
KhanYounis		8	2	2	**12**	4	12	4	5
Rafah		1	2	1	**4**	2	4	2	3
Total*	**73**	**216**	**108**	**15**	**425**	**115**	**200**	**46**	**149**

Blank= No Service

Definition for primary health care levels: see annex E

Secondary and tertiary care

The hospital services are operated by both the government and non-government sectors. There are 76 hospitals in Palestine resulting in 12.8 beds per 10,000 population (12.2 in the West Bank and 14.6 in the Gaza Strip).[32]

Some progressive steps have been initiated to improve the hospital infrastructure of the MoH, including the establishment of the Palestine Medical Complex in Ramallah. This consists of two newly established hospitals and two existing facilities. With the addition of the central blood bank, the consolidation of the 5 facilities into one entity serves as a national centre of excellence and is a pilot approach to decentralized hospital management.

Private and NGO hospitals make an important contribution to the provision of

32 MoH (2009) Health Status in Palestine Annual report 2008 Ministry of Health

secondary and tertiary care services. About 40 % of total hospital beds, in 51 hospitals, are managed by NGOs and the private sector, with much focus on specialized medical services and rehabilitation. The NGO sector is the second largest provider of hospital beds with a total of 1517 beds. This includes 6 distinguished East Jerusalem hospitals providing specialized medical care services.

Tertiary care services not available in government facilities are purchased by the ministry from the local private sector, East Jerusalem hospitals, and from some hospitals in neighbouring countries. In 2008, a total of 43,047 patients were referred for treatment to non-MoH hospitals of which 20,894 were referred to East Jerusalem hospitals[33]. In 2008, the number of referrals for West Bank patients has decreased as capacity within the government has increased. However, during 2009 the need for referrals abroad from Gaza increased because of the effects of the war on Gaza and the ongoing siege.

Table (7)Distribution of Hospitals by Provider, Palestine 2008

Provider	West Bank**			Gaza Strip			Total		
	Hospital #	Beds #	Beds %	Hospital #	Beds #	Beds %	Hospital #	Beds #	Beds %
Ministry of Health	12	1,289	44.1	12	1,568	80.1	24	2,857	58.6
UNRWA	1	63	2.2	0	0	0	1	63	1.3
NGOs	20	1,162	39.8	10	355	18.1	30	1,517	31.1
Private	19	407	13.9	2	34	1.7	21	441	9
Total	52	2,921	59.5	24	1,957	40.1	76	4,878	100
Bed/10,000 pop		12.2			14.6			12.8	

**Including East Jerusalem Hospitals

1.3.7 Institutional and health system development

Since its establishment in 1994 as part of the Oslo Accords, the MoH has developed as an institution at varying paces. Various aspects of MoH institutional issues, its context, processes and stakeholder factors are addressed in different sections of this strategy. Within the framework of the PNAs program of working towards being an effective state, the MoH is preoccupied with identifying and meeting the challenges of:

- What, as an institution, needs to change within the ministry. Among, for example, the formal rules of legislation, ways technical and political decision making is made and the roles of both the MoH itself and its stakeholders.
- What informal constraints the MoH faces. For example, norms of behavior and conventional and self imposed codes of conduct.
- Where the power lies and who are the drivers of change
- Whether the sum total of both building on what works well and on implementing

33 MoH (2009) Health Status in Palestine, Annual report 2008 Ministry of Health

new approaches such as focusing on a few priorities, reforming the way aid is delivered and managed and developing a results culture make a difference.

The MoH is the steward of the health sector and is in charge of defining its vision and direction and establishing a strategic policy framework. It has been making progressive steps since 2008 in promoting the development of the health sector and in strengthening its governance role. For example, the development of the National Health Strategic Plan 2008 – 2010 in line with the PRDP of the same dates represented an important step in setting a clear framework for development. The PRDP and now its successor, the Palestinian National Plan 2011-2013, is an important element in health planning, policy making and budgeting. It is an initiating step for comprehensive policy framework and for the estimation of the future cost of public sector activities.

Box 2 shows the functions of the MoH at the national and district levels. A summary of key strengths, weakness, opportunities and threats in the health system can be seen in box 3.

Box 2. Key functions of the Palestinian Ministry of Health at different levels of the health system

National level

- Governance, leadership and oversight sector wide
- Setting national health and specific subject policy, strategy, priorities and planned results
- Strategic and annual planning, monitoring and evaluation cycles
- Regulation and legislation of the health sector
- Financial mobilization and management
- Coordination of the public and private health sectors
- Standard setting and quality assurance
- Implementation and management of public health, health promotion, primary health care and secondary and tertiary medical services
- Supervision and guidance

District level

- Assessment of needs
- Coordination
- Annual and other work plans
- Implementation of public health and health service delivery
- Implementation and management of public health, health promotion, primary health care and hospital medical care
- Supervision and guidance

Box 3. SWOT of the Palestinian health system 2010

Strengths - National Council for Health Policy and Strategic Planning active - Active national planning process, led by the National Council and the MoH - Active role of civil society organizations and academic institutions. - Human resource capacity in health sector - National and health planning documents available - Initiative to decentralize hospital management through developing the Palestine medical complex	**Weaknesses** Lack of: - Medical specialists - Enforcement of laws and regulations, health research - Health information system - M&E system - Quality system/culture - Incentive system for staff - Job description - National disaster plan - Adequate health promotion programmes to combat life style related diseases and conditions - Cooperation & communication between health care providers & between MoH inter-departments - Capacity in policy development - Evidence based decision making - Compliance/enforcement by various MoH committees of policies and procedures
Opportunities - Active, supportive donors and international community - Government perceives health sector to be important - Increase in investment in health sector	**Threats** - Reliance on donors for program implementation and funds - Israeli occupation – restriction on Palestinian movement and confiscation of land - Israeli siege of Gaza, East Jerusalem and Jordan Valley, Apartheid Wall - Increasing poverty - Increasing unemployment & emigration

CHAPTER 2. THE HEALTH POLICY CONTEXT

2.1 GOVERNANCE AND STATE BUILDING

2.1.1 Towards good governance in the MoH

As stated in the August 2009 *Program of the 13th Government. Palestine: Ending the Occupation, Establishing the State,* 'Achieving our national goals depends on the adoption of the basic principles and practices of good governance throughout the public sector, the private sector and civil society. In the light of the occupation regime's continued measures that hamper the efficiency and effectiveness of our national institutions, the establishment and promotion of good governance in the occupied territory is elevated to the status of a national goal in and of itself.'

Good governance in the health sector means setting and achieving clear goals such as ensuring equity in access to services, quality of services, and patients' rights. Unless governance improves, poor people will continue to suffer from a lack of security, of adequate public services and economic opportunities. Governance is also concerned with ensuring that health services and public health are responsive to people's needs; and with transparency and accountability - citizens and civil society should have the right to scrutinise the work of the MoH and hold it accountable for achieving national health objectives and planned results. It is increasingly recognized in Palestine that the provision of development assistance needs to be geared to achieving good governance.

The MoH is working on developing good governance in health including:

- Leadership in guiding the strategic direction for health policy development and implementation
- Advocating for health as a priority in national development
- Regulating the behavior of stakeholders involved in the delivery of health interventions
- Establishing accountability mechanisms
- Promoting public policy and legislation in other areas of government that impact on peoples' health
- Decentralization of management

2.1.2 State building

Building the capacity of the State to increase security, govern effectively and better provide services is core to the work of the PNA. Because of the highly complex political context, the process of State building is messy and loaded with tensions. It sometimes takes steps forward and then strides backward. This obviously affects the pace of change. Awareness of such issues among our development partners in the health sector helps to reduce frustrations and to ensure more realistic time frames and expectations. However, the political context must not be used as an excuse for failure - for not strengthening the health system and service delivery.
State building specific to the MoH is both about improving its ability to function as a

State institution and its working across the State on those issues that have a multi-sectoral perspective. These include public health issues such as accidents and epidemics and health systems strengthening especially human resources and health financing.

2.2 AID EFFECTIVENESS, COORDINATION AND PARTNERSHIPS

2.2.1 Aid effectiveness

Within the broad framework of preparing for Palestinian sovereignty and statehood the MoPAD is promoting better aid effectiveness in partnership with the international community. The first PNA Aid Effectiveness Action Plan 2008 - 2010 and its update 2011 – 2013, and other similar initiatives taken by MoPAD are instrumental to achieving aid effectiveness.

Palestinians are among the highest recipient of aid in per capita terms. This is likely to effect PNA policies and strategies, including priority setting and resource allocation across and within sectors. Support from the international community is a very critical determinant of the health and wellbeing of the Palestinian population. The use of financial aid must therefore be carefully monitored to ensure the highest effectiveness in terms of health outcomes, impact and human development.

Coordination among development partners and the PNA is continually evolving. Attempts to reach a consensus among development partners on how best to proceed in implementing the Paris Principles and Accra Agenda for Action are producing mixed results. But overall, the MoH is clear about the how it sees the application of the 5 principles of aid effectiveness in the 2005 Paris Declaration on Aid Effectiveness in the development and implementation of this strategy. For example:

Ownership — as stated earlier, the process for developing this strategy included a number of consultative meetings and opportunities to comment on drafts of the document. The MoH has exercised leadership in the development of the policy statements and of this strategy and is also in the driving seat for the coordination of the health development work. It is hoped that donors show their support by respecting the policies and programs in the strategy and stating their intention to help strengthen capacity to implement them. We hope that other partners such as NGOs will express their intent and willingness to work within the framework of the policies and strategy.

Alignment — we hope donors will base their support in the health sector on this national strategy and align as far as possible their support with MoH and government procedures.

Harmonization —The MoH hopes that donors will be more harmonized, transparent and collectively effective in their support to the health sector and that they will support programs in this strategy rather than having other overlapping projects.

Managing for results —We are determined to focus on results. We have a results framework, which clearly shows the planned outputs within the 3 year time frame and

intended outcomes by 2015. Indicators of achievement have also been set for each of the programs.

Mutual accountability —The MoH intends that the Ministry and donors should hold each other mutually accountable for achieving the planned results in this strategy. The MoH has highlighted its commitment and dedication with these five principles and started to work to strengthen its role in aid management by ensuring the consistency of the funded projects with national priorities / objectives, avoiding project duplication, and strengthening transparency and accountability of the aid management process to maximize achievements within the available resources. A document on national guidelines for aid management was adopted and published by the Ministry in 2008[34]. To better achieve the implementation of these guidelines, the MoH started work on building its national database on health projects, donor-supported programs and other forms of external aid.

2.2.2 Working together to achieve results

To achieve results, all stakeholders need to understand and accept that the MoH has overall responsibility for the health sector. It is in the driving seat for all health issues including implementation of this national strategy. We hope and anticipate that stakeholders such as bilateral donors, UN agencies, Palestinian and international NGOs will support the MoH in implementing this strategy through effective partnerships.

Against this background development partners should aim to:

- Allocate all financial support and technical assistance for the health sector in Palestine to programs under this strategy
- Increasingly strive to use common procedures for financial disbursement and reporting and, where ever possible, rely on the use of government procedures
- Foster joint policy dialogue among development partners and with the MoH on health sector objectives, results and overall progress of strategy implementation in line with the Palestinian National Plan 2011 - 2013
- Undertake joint analytical work, joint annual sector M&E reviews, joint monitoring missions and share draft terms of references for program design and technical assistance with the HSWG

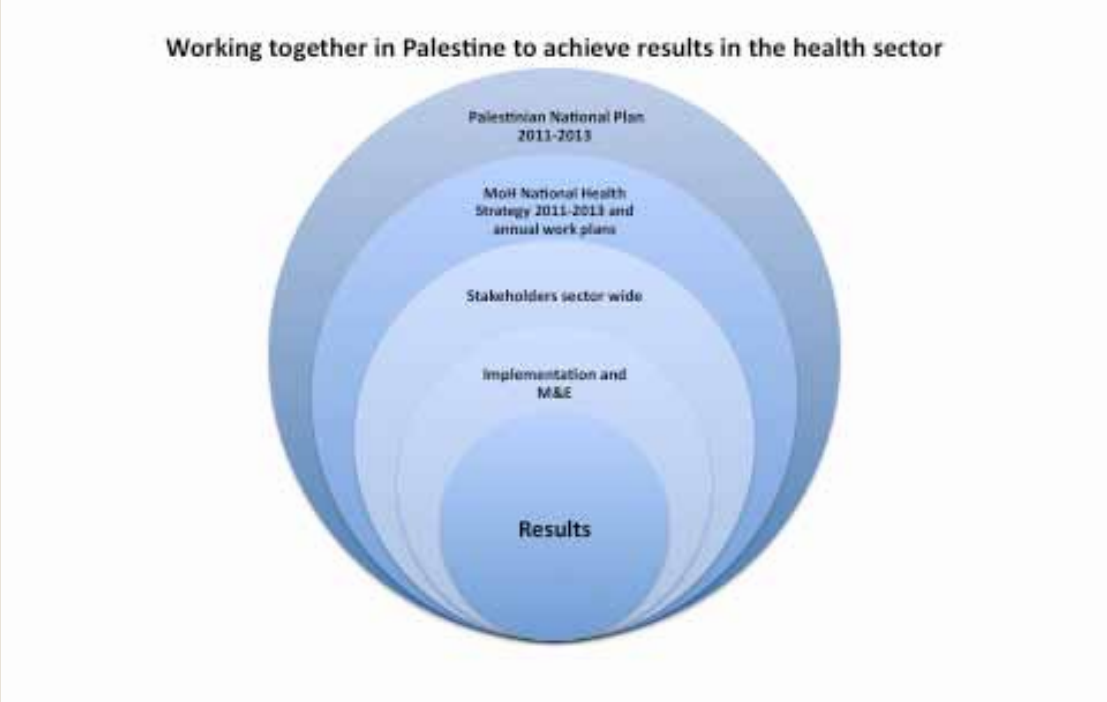
The MoH, on behalf of the PNA, will facilitate the successful implementation of this strategy in line with the Palestinian National Plan 2011 – 2013 and to that end will:

- Draw up annual work plans and budgets at district and central levels in accordance with, and in clear support of, the strategic objectives and make them available to all partners
- Monitor and evaluate the implementation of this strategy
- Decline projects, programs and any other support which are not in line with this strategy
- Share with development partners the financial audit reports and the health budget and provide any clarification needed
- Devote dedicated human resources to sector harmonization, for channelling

34 MoH 2008 Guidelines for Aid Management The International Cooperation Department, Ministry of Health

information and preparation of HSWG meetings and for the annual joint review
- Ensure, that all interested stakeholders can contribute to, and benefit from, the joint annual review
- Provide information to the HSWG on technical assistance planned and received

It is the intention of the MoH that, in the interest of harmonization and alignment there be a move away from ad hoc projects and project implementation units. Development assistance should be provided through modalities such as basket and sector budget support. The choice of aid modality will of course depend, on the one hand, on donor and other perceptions of the capacity of the MoH to manage coordination, the performance assessment of the public financial management system and results in the health sector. And, on the other hand, on the different rules and regulations governing disbursement of aid for development partners.
Within Palestine there is a general agreement between development partners and the PNA of the desirability of developing a sector wide approach (SWAp) as a mechanism for orienting and managing national and international participation in support of Palestine's development. It is appreciated that the SWAp requires a number of changes in the ways in which the MoH and partners co-operate. Adjustments will need to be made over time by both parties on how health resources are planned, managed and accounted for, and these adjustments will need to be negotiated over time as systems and confidence are developed.



2.2.3 Coordination, collaboration and partnerships

As described in section 1.2, there are several bodies in place to ensure coordination and collaboration among health sector stakeholders in Palestine. These entities ensure that relevant stakeholders are involved in policy making and strategy development in priority areas of the health sector. In addition, the MoH works with various organizations as partners by contracting or developing a memorandum of understanding (MoU). For example, there is a MoU with the Palestine Red Crescent Society to establish a National Blood Bank in Palestine, and there are contracts with private clinics to provide mammography services for MoH patients.

The MoH sees inter-ministerial work as being very important. There is close coordination and collaboration between the MoH and other Ministries particularly the Ministry of Social Affairs, the Ministry of Education and Higher Education, the Ministry of Women's Affairs, the Ministry of Planning and Administrative Development and Ministry of Finance.

2.3 PRIORITIES AND POLICIES

The national strategy has been developed on the basis of the situational analysis to address areas of work that are in urgent need of further development with the aim of achieving results over the next 3-5 years. An agreed principle was that development had to be based on incremental changes - there would be no major sudden changes.

The priorities for development are based on evidence garnered from experience on the ground. The main challenge facing the MoH is 'how' to move forward. 'What' needs attention was relatively easy to identify.

Concurrent with the development of this health strategy, the MoH has developed policy statements based on policy analysis. We examined factors influencing the patterns and effectiveness of policy change and how we can move forward in order to improve health. Undertaking such an analysis was particularly important in the highly complex Palestinian context. Factors that were considered included the:

- Role of the State and its values and principles
- Interests or agendas of, and power groups among, various stakeholders
- Perceived and actual role of civil society in policy processes
- Rules of the game regarding informal and formal policy processes
- Likely impact of any policy
- Evidence base and lessons learned
- Need for constant review of any established policy

It is hoped that the policy statements will facilitate better communication about important issues in health to a wide audience. The first 8 of the following policy statements are the key priorities for development. The remaining statements are on topics that the ministry also feels are important.

2.3.1 The priorities and their policy statements

Governance and institutional development

The Ministry of Health of the Palestinian National Authority believes that good governance is a pre-requisite to the successful delivery of equitable, quality, and sustainable health services. Leadership, accountability and transparency are particularly important and will be a dominant feature. Within the framework of building the Ministry towards being a State institution, it is essential that the Ministry has the capacity to perform certain functions, including developing and implementing policies, developing and enforcing sound laws and regulations, and making sure health services and public health interventions meet peoples' needs.

As an institution, the Ministry will hold its leaders accountable for achievement. It will also develop a more flexible institutional structure that can effectively address needed reforms, facilitate decentralization and work towards the better enforcement of regulations and adherence to its values

Human resource development

There is an urgent need to change human resource policy and practice including ad hoc and subjective personnel promotions and appointments, and weak performance appraisal processes. It is vital that there be systematic planning of staffing needs, a performance appraisal process based on set criteria, meaningful job descriptions and transparent recognition and promotion systems. This will result in improved staff motivation and morale and contribute to an increase in work outputs and results.

The Palestinian Ministry of Health values all personnel working for the better health of Palestinians. It is the intention of the Ministry to:

- Ensure personnel are working in the right place at the right time with the right job description, according to their skills, knowledge and experience and who are appointed on merit through open competition
- Ensure that basic training curricula are based on international and national standards
- Have sustainable professional continuing education programs and other capacity development initiatives that all staff will be free to choose
- Develop a work ethic that is based on performance and ensures a supportive working environment

The above four issues require that the Ministry of Health work with the Cabinet, the Ministry of Planning and Administrative Development and the Ministry of Education and Higher Education and with the private sector and development partners on developing user-friendly systems, processes and mechanisms such as a data base of personnel, a routine system to fill vacant posts and a sustainable system of incentives.

Healthy behaviors

The MoH has focused efforts predominately on medical services and health care. But with the increasing prevalence of chronic diseases, the MoH needs to rebalance policies and strategies to give increasing priority to health promotion and the prevention

of disease. Changing to give greater importance to health and healthy lifestyles will result in increased efficiency and enhanced quality of life.

Promoting the health of individuals and communities is part of the role of the Ministry of Health. In Palestine, politics is a key determinant of health. Through inter-ministerial working, the Ministry will address this and other determinants of health such as inequity and insecurity and other social factors plus factors like road traffic accidents and tobacco use especially the better enforcement of the law against smoking in public places.

While acknowledging the negative impact of political and other factors in the wider context on health, the ministry believes that individuals and groups or communities can do things to improve their health and need to be better informed about health risks. Individuals and communities must be empowered to take responsibility for health through exercise, reducing smoking, having a good diet, safe driving and wearing seat belts.

Access to quality health services

Currently too much of the national budget is spent on medical referrals abroad. In addition to the cost to government, there are enormous hidden financial and social costs to the families of those referred abroad; costs that put some families in debt or are only affordable for the better off. The MoH needs to change the way it deals with the need for tertiary specialist care. Capacity needs to be developed within Palestine through human resource development and the establishment of quality facilities. There also needs to be a change from the ad hoc building of health facilities to construction within the framework of a health coverage plan. All these changes to service delivery will result in improvement in equity in health service delivery, an increase in client satisfaction and a reduction in referrals abroad.

The MoH will seek to strike a balance between preventing illness and promoting health and increasing access to specialist hospital services within the Palestinian territories, especially to those in East Jerusalem. Through its network of primary, secondary and tertiary care facilities and other providers in the sector. It will ensure that services help to alleviate suffering, are of high quality and reduce inequalities in health.

The Ministry will continue to work to achieve better accessibility to high quality primary health care services with its various programs; immunization, school health, mental health and reproductive health, improved gender equity, equality and empowerment of women, and health awareness programs amongst youth and adolescents.

The Ministry also emphasizes the need for better management of health facilities, especially hospitals, to improve the quality of service delivery, reduce inefficiencies and contain costs. Furthermore, it supports the efficient decentralization of the health system to enable the better functioning of quality, effective and efficient services.

Health financing and financial management

The Palestinian National Authority is committed to ensuring access to affordable and

quality health services through the national health insurance scheme. There will be a change from voluntary participation in health insurance to compulsory national health insurance. This will improve equity and access to those health services covered by the insurance, especially for the poor and unemployed. The Ministry of Health in close collaboration with the Ministry of Labor and Ministry of Social Affairs will guarantee that the unemployed and those too poor to pay for health services are able to access every health service covered by the health insurance.

The Ministry of Health is also committed to the efficient management of its financial resources. It will ensure that there is a health financing strategy, and sound expenditure framework with reliable costing. There will also be transparent allocation of funds based on priorities and more evidence based, cost effective services and treatment. The Ministry, in collaboration with the Ministry of Finance, Ministry of Planning and Administrative Development and development partners will also ensure that its financial management is transparent and accountable.

The Ministry anticipates that a future health financing mechanism will be in the form of funding the national health strategy through a sector wide approach (SWAp) and/or direct budgetary support.

Aid effectiveness

The Palestinian National Authority appreciates the support for the health sector from the international community. The Ministry of Health is committed to ensuring such aid is effective. The Ministry will work with its partners on the development and implementation of all the principles in the 2005 Paris Declaration and in the 2008 Accra Agenda for Action.

To varying degrees the principles of ownership, alignment, harmonization, results, mutual accountability, predictability, country systems and untying restrictions on goods and services in the Paris and Accra statements are all relevant and important in the health sector. The Ministry of Health will particularly direct a move away from ad hoc project support to support for the Ministry's national health strategy which is in line with the intentions of the Palestinian National Plan.

Public-private partnerships

The Ministry of Health believes that, within the framework of sector-wide governance, effective public private partnerships are crucial. It is important to strengthen coordination, collaboration and regulatory mechanisms and their enforcement and to reduce duplication of effort between the Ministry, UNWRA, private-not-for profit organizations and private for profit health stakeholders. This is in order to improve accessibility, quality and affordability of health services, especially for the poor.

Cross-sectoral collaboration and cooperation

The Ministry of Health will work with other sectors and ministries to ensure that cross cutting issues, such as in the education, labor, economic and social sectors are addressed. In addition, the Ministry will lead the effort to ensure that 'health' is included in all national policies and plans, particularly in the area of emergency/disaster management.

Conflict and other emergencies are unfortunately all too common in Palestine. Therefore, the Ministry of Health in collaboration with other Palestinian National Authority entities will work on ensuring that a national comprehensive, effective, efficient emergency/disaster management plan exists that will alleviate human suffering, advocate for the rights of people in need, promote preparedness and prevention and facilitate sustainable solutions.

The Ministry of Health will also ensure that the health component and response is of high quality with the right resources available to respond effectively and efficiently. The PNA is extremely appreciative of the national and international responses to humanitarian emergencies such as the war on Gaza December 2008 – January 2009. It is hoped that stakeholders will respect both what the MoH says is, and is not, needed as humanitarian assistance at the time of an emergency.

All Ministry of Health staff will be prepared to act according to pre-defined roles whether on or off duty. Where the emergency is of an emerging new disease, the Ministry will ensure that its general disease preparedness framework accords with international standards. Cross border cooperation in disease prevention and control will override any political blocks.

2.3.2 Other policy statements

Public health

The Palestinian National Authority believes that individuals and communities in Palestine have the right to health. The Authority is committed to resolving the wider determinants of health such as politics, security, economics and the environment that are currently having a key negative impact on health. The Ministry of Health perceives public health as a priority and as everyone's responsibility. The key public health functions are to protect the health of the population, improve and promote health, and to improve the equity and quality of health service delivery. Through cross sectoral, multidisciplinary partnerships, the MoH will ensure successful policy implementation.

Chronic diseases

Epidemiological trends in the Palestinian territories are showing that, while there are still occasional communicable disease outbreaks, there is an increasing shift towards an 'epidemic' of chronic diseases. This is contributing to increasing demands on health care and therefore, increasing the cost of health services.

The Ministry of Health is committed to an effective response to this public health problem. The ministry has produced a national policy and strategy on non-communicable diseases. It will primarily work with all stakeholders on the prevention of ill health, and on the promotion of health. We will put greater effort into work on effective interventions to decrease the burden of chronic diseases. Such interventions include the enforcement of the public health and anti-smoking laws, the implementation of effective educational programs for adolescents and the promotion of healthy lifestyle initiatives.

The establishment of the National Center for Non Communicable Diseases is expected to have a major role in the development of a national surveillance system for non-communicable diseases that will address the number, type and location of evidence based screening facilities. It will also address the development and implementation of disease specific national strategies and guidelines for early detection and treatment programs

Health systems strengthening

The Ministry of Health is committed to strengthening health systems to better enable the effective, efficient and integrated delivery of health services in Palestine. The Ministry will help ensure that management and organizational arrangements facilitate the attempts of managers and implementers to make effective decisions, provide quality services and undertake their work properly. The focus therefore is on processes, roles, structures and specific systems capacity building. When strengthened these will enable the effective use of staff and facilities who can then more effectively use their skills and tools.

Under the broad heading of 'health systems strengthening' the Ministry of Health includes the following:

- Governance, institutional development, organization and management of the national health system
- Health financing
- Human resources development
- Health planning, information, monitoring and evaluation
- District level strengthening
- Quality assurance
- Coordination of development and humanitarian assistance
- Laws and regulations covering both the public and private health sectors
- Emergency preparedness
- Environmental health
- Health research
- Systems for procurement and logistics; construction and maintenance; and for information technology and communications

Health management

The Ministry of Health is committed to the effective management of resources, human, financial and other. The Ministry will work towards strengthening leadership and management among individuals, in its institutions and in health facilities. Among the skills to be strengthened are financial management, supervision, communication, collaboration, networking within and across institutions and organizations, and flexibility.

The need for better management in health facilities, especially hospitals, is recognized as a priority. Good management will improve the quality of service delivery, reduce inefficiencies and contain costs. The ministry is committed to ensuring that:

- The national master plan for hospitals is adhered to by all stakeholders
- Each hospital has a mission statement, policy or strategy and an annual

business or work plan
- There is a working link between the mapping of health facilities and the services they offer and decisions on new facilities and services
- Better physical assets management and medical waste management in all health facilities

Health policy, information, planning, monitoring and evaluation and research

The Palestinian Ministry of Health is committed to ensuring that its priorities, policies, strategies, participatory planning processes, and health outcomes and outputs are based upon evidence based decision making. The ministry will, through an inter-ministerial approach and in collaboration with its development partners, work towards further strengthening leadership, management change, communication, operational research, the health information system, the monitoring and evaluation system, and the development of indicators.

Quality assurance

The Ministry of Health perceives that it is the right of every Palestinian to quality health and health care. Furthermore, that society as a whole has the right to demand that the Ministry of Health is a quality institution - an institution that functions effectively and efficiently and is responsive to people's need and provides quality, evidence based services and other interventions.

The Ministry is therefore committed to strengthening both the quality of management and the quality of clinical care and public health. It will do this through working with its partners to develop and implement standards and indicators, encourage and help develop a change in the management culture and change the attitudes and practices of health care providers. It will also inform and encourage consumers to demand better quality in the health sector.

Information technology and communications

The Palestinian Ministry of Health appreciates the need for both improved information technology and for better communication. The latter is especially needed across departments and units within the Ministry, between Ministries and other governmental institutions, within and between health facilities, and with and among its many stakeholders.

The ministry is committed to further developing an affordable, useful and functioning communications network using modern information and technology systems at all levels of the health system. Increased access to, and training in the use and maintenance of, the communications information network is a priority.

Infrastructure

The Ministry of Health is in the process of developing a national health facilities coverage plan. This will highlight the number and type of health facilities that are and are not needed as part of developing equitable and accessible public sector health services.

The ministry values the role of quality private sector health facilities as it can purchase services from them when it does not have the capacity. However, it is hoped that the private sector will take the coverage plan into consideration when proposing the construction of a health facility. The private sector must obtain a certificate of need from the Ministry of Health before constructing any health facility.

The recurrent costs of any proposed capital investment will be seriously examined for their immediate and long term financial implications for the MoH before agreement to construction. In addition, the coverage plan is being produced in coordination with the development of a national human resource development strategy. This is with the intention of helping ensure that once built there are the right number of personnel with the right skills to staff the facilities. The coverage plan will also lead to the development of a hospital master plan which will help provide evidence when responding to political pressure to construct a facility.

The ministry will ensure that any newly constructed health facilities are well designed, are built at an affordable cost and meet the needs of patients and staff. A maintenance or estate management program is also being developed.

CHAPTER 3. SETTING THE STRATEGIC DIRECTION IN HEALTH 2011 - 2013

The national strategic direction for health 2011 – 2013 has been set within the national health policy framework outlined in chapter 2. The direction of work is towards achieving the following goal.

3.1 NATIONAL HEALTH STRATEGY: GOAL AND OBJECTIVES 2011 - 2013

NATIONAL HEALTH STRATEGY GOAL

Palestinian National Health Strategy
Goal 2011 – 2013

State building and health system and services strengthening to realize an effectively functioning health sector that facilitates implementation and the achievement of planned results in Palestine

NATIONAL HEALTH OBJECTIVES

The MoH has turned the eight priorities set out in chapter 2 into eight strategic objectives for 2011-13. They will contribute to achieving the above goal. For budgeting purposes, the objectives have been consolidated into four programs –see the strategic framework at annex A. The objectives reflect the determination of the MoH to change from a medical service culture to that of promoting health and ensuring good governance in order to further improve the health of Palestinians. Without good governance with its' institutional development and effective partnerships and collaboration, the health system in Palestine will struggle to ensure equity, quality, efficiency, effectiveness and results. Everyone needs access to quality health and medical services at different times in their life. Everyone needs and wants to be healthy all the time.

1. Strengthen the governance and institutional development of the Ministry of Health including oversight, policy, planning and evidence based decision making, monitoring and evaluation, regulation, licensing, health information, health management and health systems development through joint sector wide and inter-ministerial work and developing a results, accountability and learning culture and strengthening strategic thinking & working and the ministry as a learning institution.

2. Strengthen human resources in the health sector through improving the planning, management, training and education and financing of human resources and facilitating a multi-professional contribution to better health and management in collaboration with other ministries, academia and other relevant stakeholders.

3. Promote healthy behaviors and improve disease prevention as upstream policy and practice in the Palestinian health system through advocacy, raising public awareness to change behavioral practices, identifying and managing current and emerging chronic diseases and conditions and development of disease prevention and management country strategies in partnership with local authorities and civil society in particular and other relevant stakeholders such as public health professionals.

4. Assure the rights of all citizens to access quality sustainable primary, secondary and tertiary health services, in particular primary health care, for the poor, vulnerable, and unemployed, as well as those displaced and/or living in hard to reach areas through setting facility policies, working towards meeting international standards and ensuring adherence to a national health facilities coverage plan in collaboration with all stakeholders but particularly ministry of health staff, UNRWA and NGOs.

5. Ensure sustainable health financing mechanisms and effective, efficient and transparent financial management through establishing and monitoring different mechanisms to finance health, ensuring spending is in line with priorities, controlling expenditure on hospital care and on pharmaceuticals and ensuring the efficient functioning of an integrated budgeting and planning system.

6. Strengthen aid effectiveness through reaching a joint consensus on how best to implement the Paris and Accra principles, implementing joint working such as joint annual results reviews and annual work plans at district and national level that reflect the inputs of all stakeholders, working on using common procedures for financial disbursement and reporting, having regular joint financial and technical audits and coordinating all technical assistance.

7. Maintain and strengthen public-private partnerships especially between MoH, UNRWA, NGO's and the private-for-profit sector to facilitate harmonization, coordination, and comprehensiveness of efforts to ensure access for all Palestinians to health and health services and to meet the national health objectives efficiently and effectively through having memorandum of understanding that reflect the Paris principles and the value added of the players in any partnership.

8. Develop the role of the Ministry of Health in cross-sectoral work with other ministries and national institutions to assure the strengthening of the health component in national plans such as education, environment, labor and emergency and disaster planning and management through improving the dialogue, establishing special ad hoc committees to address specific topical subjects and ensuring that 'health' is addressed in other sectoral policies, strategies and plans.

All eight objectives need to be implemented simultaneously as they are inter-linked and complementary. A national level strategy gives the direction and scope of work. It

therefore should not go into any more detail than giving objectives and strategic actions for the three years. It is up to districts and other cost centres to decide on detailed activities and put them in their annual work plans. Some specific technical subjects such as nutrition and chronic diseases also have policies, strategic plans and/or guidelines, which provide more subject specific information.

The eight objectives can also be found in the strategic framework at annex A where it can be seen that they have been consolidated into four programs that have key strategic actions, the costs and lead MoH responsibility. At annex B the planned outputs have been put in the format of a results framework to further clarify what should be the achievements by the end of 2013. Planned outcomes are also given in the results framework but with a longer time frame, to end 2015. This is because 3 years is too short a period to achieve outcomes but we wanted to demonstrate that we have a longer term vision and perspective in our planning and other work. Annex B also has the MDGs and their 2015 targets.

3.2 Planned results

National health strategy outputs

It is planned that by end 2013 the following outputs (also in the results framework at annex B) will be achieved. The outcomes to be achieved by 2015 are also listed below and are in annex B. They will contribute to achieving the health MDGs.

In developing the objectives and planned results we considered issues such as feasibility, realistic time frames and sustainability. Given the turbulent, complex political context in Palestine time spent discussing such issues was especially important.

Outputs

Access to quality health services

- Comprehensive, efficient monitoring system producing regular, useful information on adherence to standards and plans
- Improved governance in hospitals
- Universal use of guidelines, protocols, and standards of care

Sustainable health financing

- Integrated budgeting & planning
- Efficient, useful financial management system
- Comprehensive sustainable financial system in health sector
- Health insurance fund functioning according to principles of equity & universal coverage

Public-private partnerships

- MoU between MoH and major health providers

Healthy behaviors and disease prevention

- Major public awareness campaigns

- Increased number of health professionals trained in primary health care
- Ensure implementation of protocols and guidelines

Governance and institutional development
- M&E, HMIS and quality assurance systems functioning effectively
- Non-compliance with laws and regulations reduced
- Accreditation/Licensure/Certification Systems in place and enforced
- Annual performance review
- Percentage of central budget reaching local facility level
- Decision making, accountability and transparency systems and practices adhered to
- Efficient, accountable and effective governance

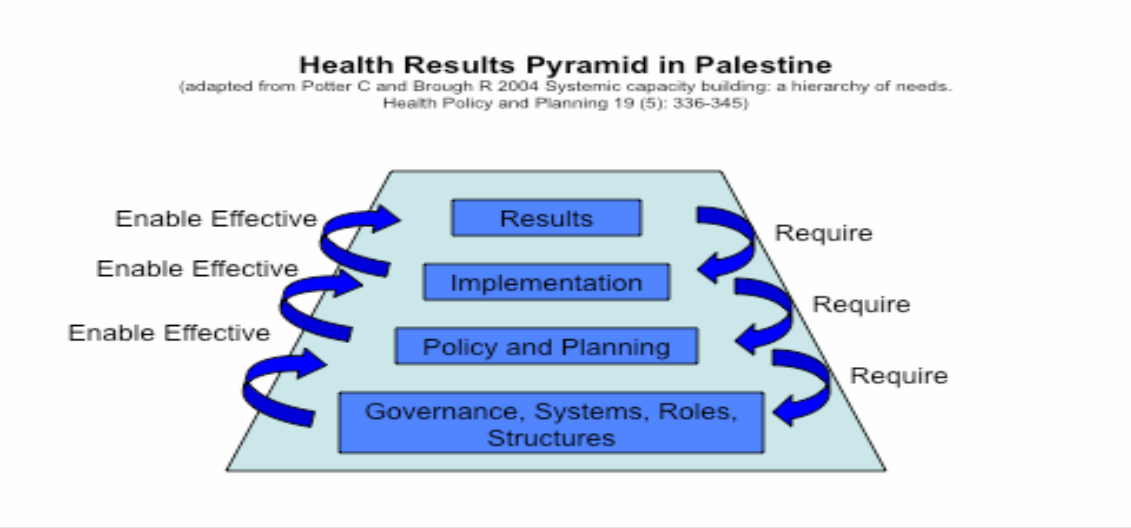
Aid effectiveness
- All support to the health sector in line with National Health Strategy 2011 - 2013
- Transparency in type & financial amounts of aid
- Coordination in place between MoH and MoPAD, including complete match within databases

Human resource development
- Human resource policy and strategy completed and comprehensively implemented
- New academic programs accredited and offered by universities
- Continuing education requirements are established for licensed health professionals
- More efficient human resource management systems, including performance appraisal system

Cross-sectoral collaboration and cooperation
- Inter-sectoral emergency preparedness plan in place
- 100 % of health staff trained in emergency response
- 'Health' addressed in all multi-sectoral national policies

Outcomes
- Accountable MoH that delivers equitable, value for money services, cost efficient services
- Sustainable financing of the health system through national health insurance program
- Improved coordination and decreased duplication
- Improved quality of life
- Reduced obesity rate
- Reduced smoking rate
- Improved diet
- All 7 Paris Principles implemented and functioning well
- Aid aligned to national health priorities
- Donors committed to supporting/funding the 3 year national health strategy
- Sufficient and competent staffing at all levels of the health system and within

headquarters
- Continuous emergency/disaster response readiness



3.3 CRITICAL SUCCESS FACTORS, IMPLICATIONS AND RISKS

3.3.1 Critical success factors

The critical success factors during implementation of this strategy are:

- Progress in the political context
- Strong, sustained political will and commitment to the strategy
- Effective leadership by the MoH
- The ministry working horizontally, as a team and with clear lines of accountability
- Ownership by all stakeholders and partnerships with donors, agencies, NGOs and others
- International donor harmonization and commitment to providing financial resources to implement this strategy
- Balancing, thinking and working strategically and dealing with day-to-day work
- Giving equal weight to simultaneous service delivery, pubic health and governance and institutional development
- Effective human resource development, particularly ways of improving the work ethic, increasing motivation and providing continuing professional education for managers and other implementers
- Effective and efficient decentralization
- Removal of barriers to accessing health services

3.3.2 Key implications

The following implications aim only to highlight some important issues that need to be considered for sound implementation of the strategy for:

PNA

- Keep health a ‘high politics’ issue, visibly, regularly on the government’s agenda

- Act as a strong advocate for the right to health

MoH
- Strong commitment to change
- Make sound decisions transparently and stick to them, be pro-active, risk taker

Donors
- Use variety of mechanisms including SWAp and budgetary support
- Use government systems to fullest extent possible

Implementers
- Renewed energy and motivation linked to improved human resource development
- Need to be open to working differently

Management
- *Financial resources* - especially recurrent cost implications of scaling up services, training, employment, incentives schemes and of any infrastructure and equipment
- *Human resources* – ensuring institutional transparent systems and processes for recruiting, hiring, appraising, and promoting staff
- *Other* - decentralization of management; integrated funding mechanism(s); use of government procedures; introduction of any incentives scheme not linked to the Civil Service Commission; capacity of management systems e.g. enforcement of laws and regulation and monitoring and evaluation systems

3.3.3 Risks to successful implementation

- Lack of political agreement, worsening of aspects of occupation
- Poor macroeconomic growth resulting in no increase in government allocation to the health sector
- Interruption of development support for the strategy from international agencies as a result of changes in their policies or because of political instability
- Stakeholders do not work within the framework of this strategy
- Resistance to change within the MoH
- Insufficient attention to equity, accessibility, utilization and quality of care

CHAPTER 4. ENABLING RESULTS BASED IMPLEMENTATION

4.1 MANAGING THE HEALTH SECTOR

Effective and efficient use of resources

Financial management

For the first time, the MoH submitted its 2010 annual budget proposal linked to the national strategic health plan and MoH programs. The MoPAD and MoF are leading the effort to link ministry budgets to their planning processes. Unfortunately, the MoH financial management department has not previously costed expenditures by program or service. As such, the 2010 budget proposal submission was an estimate, rather than scientific based. Moving forward, the budget development team within the MoH will work towards ensuring that costs are tracked and maintained by program. This will ensure that future year budget submissions reflect the actual budgetary needs of the MoH programs.

Human resources

In addition, there is a lack of a comprehensive staffing plan within the MoH. The number of MoH staff continues to increase each year with little justification. The ballooning of the staff numbers directly impacts the efficient use of resources. The MoH is dedicated to ensuring that the right staff in the right numbers and in the right positions are working for the MoH. As such, within the priority of human resource development, the ministry will work to develop a human resource strategy that will include production of a comprehensive staffing plan for MoH health facilities as well as MoH headquarters. In addition, the MoH will streamline the process of recruiting and hiring to fill vacant positions.

Administrative systems

As of October 2009, the MoH received only 44 % of its allotted budget from the MoF. Although this is due to a lack of monetary resources within the MoF, this poses major constraints on purchasing and procuring supplies and services in a timely manner to efficiently operate government services and programs. Furthermore, due to the lack of available funds, invoices remain unpaid for extended periods of time. It is common that prior year invoices are paid from budget allocations of later years, which further confuses the ability to cost MoH programs and services each year.

4.2 CAPACITY DEVELOPMENT

There is unquestionably a wealth of capacity among stakeholders in the health sector in Palestine. The challenge in the public sector is that the ongoing demoralizing and humiliating political, economic, security and social context is seriously undermining individual motivation and performance. Additionally, due to nepotism the MoH has a number of wrong people in the wrong job. Political and other constraints sometimes make it difficult to make personnel changes.

There is no generally agreed definition for capacity development among health stakeholders in Palestine. It means different things to different people. From our experience in the MoH, we have concluded that the ministry as an institution, health facilities and individuals all need capacity development. All too often, however, the focus of capacity development has been on training and developing documents or tools, with the capacity of structures and systems totally neglected. But it is the latter two issues that also need to be addressed if the institution and systems are to survive independent of changes in people.

The MoH is committed to the notion that capacity development is not just about training, with perhaps some equipment and the development of a few tools, maybe even a few buildings.

The MoH is all too familiar with international consultants. Technical assistance to help the MoH move forward on a number of issues is always needed. However, we are reviewing the approach to the use of consultants. We need to better ensure that the approach used by consultants actually empowers the ministry and its staff. The need to receive quality, useful advice and recommendations is also vital. Our experience is that the use of consultants for a one-time visit to review an area and develop a report can be ineffective. We usually read in the report what we already know.

Technical assistance should be coordinated with other stakeholders, perhaps through the HSWG. Secondly, terms of reference that include outputs and the approach to capacity development must be agreed. Thirdly, consultants must work alongside staff in a directorate/ department/unit not just in the office of their organization with a 'hello and goodbye' to the ministry. Whether the consultant work in post full time or visits on an intermittent basis depends on the nature of the work. For example, very specific technical work may be best done for a fixed time period on a full time basis. Work that is more to do with processes and systems may be best through short term visits.

4.3 MONITORING AND EVALUATION

4.3.1 National monitoring and evaluation process

MoH is committed to build and develop a culture of change and accountability. MoH is working with all stakeholders in a participatory approach to build an evidence-based policy, planning, decision making and management system. This approach involves intersectoral collaboration, community participation and empowerment especially of vulnerable groups, and the use of appropriate technology.

Monitoring and evaluation (M&E) is an integral part of our national planning cycle, which is based on a comprehensive national computerized health information system. MoH is committed to build this system at all levels; central, district, and facility level. It includes all the necessary information about health and health services; finance; cost; human resources; utilization rates; etc. In other words all inputs, processes, outputs, and outcome qualitative and quantitative data. This system is complemented by periodic health and demographic studies, research, and surveys.

All stakeholders are part of this national M&E effort. The Palestine Central Bureau of Statistics, universities, other ministries, institutions and development partners are contributing to build and manage an effective efficient national information system, and on research, planning, and monitoring and evaluation systems. It is the intention of the MoH that policies, plans, and other information should be shared by and disseminated to all parties including the community. Such a system should allow wide interaction between providers and users, be user friendly and used to send public awareness messages.

In order to track progress towards national health goals, the strategic objectives will be tracked on regular basis through an automated system of surveillance, data gathering, physical evidence and analysis by the MoH Policy and Planning General Directorate/ Monitoring and Evaluation Department. Where possible, hard data will be used, although some will be subjective in nature since they are not quantifiable. For some of these strategic objectives, baseline data is not yet available but will be gathered through a planned system to address each item.

4.3.2 Basic monitoring framework

The MoH will develop a comprehensive monitoring and evaluation system, based on policy goals and an agreed set of indicators. Work in this area has started passionately and carefully as the establishment of effective monitoring capacity takes time and effort.

The ministry is working continuously to strengthen its policy analysis capability in order to make best use of available data, respond to research requests, interpret long-term trends and develop timely and appropriate policy based on evidence. Health policy and strategy planning depends on reliable data. The ministry has already begun discussions with partners who collect data, both within and outside government, to develop mechanisms to share data and program results and agree on areas of future collaboration.

4.3.3 Health management information system

The health management information system (HMIS) will be strengthened in order to better collect, organize and maintain relevant data in a timely way. The system will have the capacity to produce reports related to health sector development, including the analysis of trends, in order to understand the evolution of the health sector over time. The integrated HMIS will cover the following:

a) Financial information
b) Human resources
c) Physical assets and equipment and inventory
d) Health care service delivery/medical records system
e) Surveillance

These components will be complemented by vital statistics, whose collection will be revitalized through the creation of a network of district offices. Information management capacity will also be developed at the district level to assist MoH health teams in their planning, management and resource allocation decisions.

The HMIS will be designed in a way that is consistent with the decentralized health structure. The rationale is that officials in charge of different levels of care must rely on data appropriate to their level of decision-making. At the district level, where most operational decisions will be taken, the system will generate detailed, disaggregated data. Conversely, information will be consolidated at the central level, where decisions will be mainly related to policy-making, planning, resource allocation and operational oversight.

Efforts will be made to incorporate the information generated by vertical programs into a coherent, unified HMIS. Routine information will be complemented and validated by field surveys, for which adequate capacity must be acquired. The HMIS includes mechanisms to feed information back to all levels of managers and field workers.

In designing the HMIS, particular attention will be given to monitoring compliance with the health policy. Thus, the HMIS will collect data in ways that will allow stakeholders to study how resources are allocated across levels of care, between central and peripheral administrative bodies, between urban and rural areas, and across districts. This will encourage an informed policy discussion about, equity, efficiency, decentralization, and adherence to the primary health care approach.

4.3.4 Performance evaluation and reviews

Annual health sector reviews will be led by the MoH with the participation of relevant ministries, such as the Ministry of Planning, Ministry of Social Welfare, Ministry of Education, Ministry of Local Government, Environment Authority, and with other key stakeholders. The aim will be to determine new policies, review implementation of this National Health Strategy 2011 – 2013, identify operational best practices and lessons learned and prepare work plans for the following year.

Annex A. National health strategic framework 2011 – 2013

National Health Strategy Goal 2011 – 2013

State building and health system and services strengthening to realize an effectively functioning health sector that facilitates implementation and the achievement of planned results in all the occupied Palestinian territory

National Health Strategy Priorities 2011 – 2013	**National Health Strategy Objectives 2011 – 2013** (See Chapter 3 for the wording of these 8 objectives)
1. Governance and institutional development of the MoH 2. Human resource development 3. Healthy behaviors 4. Access to quality health services 5. Health financing and financial management 6. Aid effectiveness 7. Public private partnerships 8. Cross-sectoral collaboration and cooperation	1. Governance and institutional development of the MoH 2. Human resource development 3. Healthy behaviors 4. Access to quality health services 5. Health financing and financial management 6. Aid effectiveness 7. Public private partnerships 8. Cross-sectoral collaboration and cooperation

National health programs 2011 – 2013	Strategic actions	Cost	MoH lead responsibility
1. Governance and institutional development of the MoH Governance and institutional development	1.1 Strengthen oversight functions, develop the MoH as a learning institution, an accountability culture, a results culture & an evidence based decision making culture & strengthen strategic thinking & working 1.2 Further develop joint sector working, inter-ministerial work & cross departmental communication & collaboration	Operational costs: US$187 million Development costs: US$40 million	Minister's Office/Health Policy and Planning General Directorate

Policy & planning Health systems development	1.3 Review and strengthen; a) regulatory role of MoH; b) implementation of laws and sanctions for non-compliance; c) licensing; d) decentralization 1.4 Ensure stakeholder wide coordination of TA for capacity development & the use by TA of sound approaches to capacity development 1.5 Strengthen & develop ownership of; a) policy & strategic development; b) MoH role in national strategic, integrated planning and budgeting processes; c) planning & M&E institution wide across the MoH 1.6 Strengthen systems for: a) HIS; b) M&E; c) managerial & clinical quality; d) decentralization; e) district level functioning; f) procurement & logistics; g) construction & maintenance & h) information technology & communications 1.7 Strengthen mechanisms to facilitate transparent decision making		

Health financing and financial management	1.8 Strengthen systems & skills in public financial management, costing, economic evaluation & relevant research 1.9 Implement national health accounts 1.10 Effective implementation of the national health insurance fund		Minister's Office/Financial and Administrative Directorate with Health Policy and Planning General Directorate and Health Insurance Directorate
Public-private partnership	1.11 Decrease duplication and waste of resources 1.12 Improve coordination and cooperation among stakeholders in the health sector		Minister's Office/PHC Directorate and Hospital Directorate
Aid effectiveness	1.13 Strengthening MoH role and capacity in coordination 1.14 Develop systems and practices to ensure adherence to Paris principles and commitment by all stakeholders 1.15 Harmonize and align aid management approach between MOH and MOPAD		International Cooperation Unit
Cross-sectoral collaboration and cooperation	1.16 Strengthen capacity in emergency preparedness 1.13 Strengthen coordination between emergency health providers 1.17 Promote/ensure 'health' in all policies		Emergency Directorate/Minister's Office/Health Policy and Planning Directorate

2. Human resource development	2.1 Develop human resource policy & strategy & review, update & implement national health human resources plan in collaboration with other relevant government institutions 2.2 Facilitate a multi-professional contribution to better health and to effective & efficient management 2.3 Work with national universities to better address gaps in professional specialties 2.4 Develop & implement continuing professional education program linked to licensing 2.4 Review and strengthen human resource management especially systems and practices for recruitment, job descriptions, appraisal and motivation	Operational costs: US$125 million Development costs: $30 million	Health Education Directorate/ Licensing Department/Directorate of Administration and Finance
3. Healthy behaviors	3.1 Raise professional & public awareness within framework of health promotion & BCC program strategy 3.2 Strengthen inter-ministerial, inter-sectoral partnerships & linkages with citizens groups 3.3 Develop and implement policy on screening 3.4 Promote implementation of guidelines and protocols and ensure effective M&E	Operational costs: US$ 87 million Development costs: US$ 20 million	PHC Directorate

4. Access to quality health services	4.1 Raise political, national & international profile of key determinants of health 4.2 Review, update & ensure adherence to national health facility coverage plan 4.3 Review, further develop & ensure adherence to minimum and optimum quality standards for the public and private sectors 4.4 Strengthen hospital management through individualized hospital annual operational plans	Operational costs: $846 million Development costs: $120 million	Health Policy and Planning Directorate/ PHC Directorate and Hospital Directorate

Note: The overall budget for the coming three years 2011-2013 is estimated to be 1,245 million USD

Annex B. Palestinian National Health Strategy 2011 - 2013: Results framework (further work will be done on the outputs, refining the indicators, targets and baselines during the rest of 2010 and this results framework will be published as a separate document end 2010)

National health programs/objectives	Outputs to be achieved by end 2013	Indicators	Annual target 2011, 2012 & 2013	Baseline	Means of verification	Planned outcome by end 2015	National indicator
Governance including health financing, public-private partnerships, aid effectiveness and cross-sectoral collaboration and cooperation							
Governance and institutional development Policy & planning Health systems development	Non-compliance with laws and regulations reduced Accreditation/Licensure/ Certification Systems in place and enforced M&E, HMIS and quality assurance systems functioning effectively Decision making, accountability and transparency systems and practices adhered to	Systems in place by end 2011 All private health facilities & organizations licensed by end 2012		No M&E or quality assurance system	MoH documents Audit	Efficient, accountable and effective governance	Annual performance review % of central budget reaching local facility level

Sustainable health financing	Integrated budgeting & planning Efficient, useful financial management system Comprehensive sustainable financial system in health sector Health insurance fund functioning according to principles of equity & universal coverage	Annual budget aligned with annual work plan Data & other information easily obtainable Number of staff trained in financial management Rationalised health expenditure				Sustainable financing of the health system through national health insurance program	Health expenditure as % of GDP Ratio of household out of pocket payments to total health expenditure
Public-private partnerships	MOU between MOH and major health providers	One new partnership initiative by end of 2011			MoH cumentation	Improved coordination and decreased duplication	

Aid Effectiveness	At least 90 % of support to the health sector in line with National Health Strategy Transparency in type & financial amounts of aid Coordination in place between MOH and MOPAD, at least 95 % match within databases	# projects/ programs implemented in coordination with health stakeholders % of aid used through SWAp or budgetary support % of aid from development partners using PNA systems % agreement between MoH and MoPAD databases		Aid not harmonized, aligned or focused on getting results	Minutes of HSWG meetings and sub-groups Monitoring & audit reports	All 7 Paris Principles implemented and functioning well Aid aligned to national health priorities Donors committed to supporting/funding the 3 year national health strategy	MoH is steward of the health sector
Cross-sectoral collaboration and cooperation	Inter-sectoral emergency preparedness plan in place 100 % of health staff trained in emergency response 'Health' included in all policies	At least 4 preparedness exercises held by mid 2012 Mandatory training being held by end 2011		No plan		Continuous emergency/disaster response readiness	Post-disaster assessment reports

2. Human resource development	HR policy and strategy completed and comprehensively implemented New academic programs accredited and offered by universities Continuing education requirements are established for licensed health professionals More efficient human resource management systems, including performance appraisal system	2 new academic programs provided by end year 2 Continuing education program in place for at least 2 health professions by mid 2012 Percentage of satisfied health employees		None	MoH documents Random interviews with health staff	Sufficient and competent staffing at all levels of the health system and within headquarters	Annual number of graduates of health essions/100,000 population by level and field of education
3. Healthy behaviors	2 major public awareness campaigns Increased number of health professionals trained in primary health care Ensure implementation of protocols and guidelines	One major campaign implemented by end 2011 Reduced life threatening complications % of non-compliance		0		Improved quality of life Reduced obesity rate Reduced smoking rate Improved diet	Improvement in health indicators by reduction of morbidity, and mortality and an increase in life expectancy and the quality of life

4. Access to quality health services	Comprehensive, efficient monitoring system producing regular, useful information on adherence to standards and plans Improved governance in hospitals Universal use of guidelines, protocols, and standards of care	Decrease in death rate in hospitals Increase in health centres in line with national health facility coverage plan Policies on hospital procedures in place		1.3/1000	MoH annual report Random interviews with health staff	Accountable MoH that delivers equitable, value for money services, cost efficient services	Increased access and utilization rate of health and health related services, particularly to isolated, rural areas, and vulnerable groups Increased access to affordable drugs. Proportion of health facilities that meet basic service capacity standards

Goal 1: Eradicate extreme poverty and hunger Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.1 Prevalence of underweight children under-five years of age	3.6 (1996)	2.5	2.9	
Goal 4: Reduce child mortality Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate	33.2	28.3	28.2	20.0
	4.2 Infant mortality rate per 1,000 live births	27.3	24.2	25.3	18.0
	4.3 Proportion of 1 year-old children immunised against measles	49	92.7	96.8	99.5
Goal 5: Improve maternal health Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio	70-80 (1995)	96.8	N/A	
	5.2 Proportion of births attended by skilled health personnel	94.9 (1996)	96.8	98.6	98.0

Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate	45.2 (1996)	51.4	50.2	
	5.4 Adolescent birth rate	114.0	77.0 (1999)	59.8 (2005)	
	5.5 Antenatal care coverage (at least one visit and at least four visits	N/A	95.6	96.8	99.0
	5.6 Unmet need for family planning	N/A	N/A	12.4	
Goal 6: Combat HIV/AIDS, malaria and other diseases Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years				
	6.2 Condom use				
	6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS				
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.4 Proportion of population with advanced HIV infection with access to antiretroviral drugs				
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.5 Incidence, prevalence and death rates associated with tuberculosis				
	6.6 Proportion of tuberculosis cases detected and cured under directly observed treatment short course				

Annex C. Road map for policy and strategy development 2009

Phases	What needs to be done	When	Stakeholder participation	Responsibility	Result
Phase 1. Where are we now, March 2009?	Ministry of Health (MoH) conference (a type of situational analysis)	May 2009	NGO, private sector, unions, academia, donor stakeholders	Office of Minister of Health	Held 7 and 8 May 2009
	Publication of Lancet series of articles on health in occupied Palestinian territory (also a type of situational analysis)	March	Academic and other authors in Palestine and in UK	WHO to obtain	Published March 2009
	Review of data & other local information (also a form of situational analysis)	March – May	Local implementers	MoH Health Policy and Planning General Directorate (HPPGD)	Data and other information collated
	Review overall achievements this decade & current annual work plan progress	Mid May and mid June	MoH internal staff meetings	HPPGD	Meetings held 10, 12, 17 May
	Updated list of all donor commitments, NGO projects & of stakeholders	July		HPPGD with International Cooperation Department (ICD)	March & July

Phase 2. Where do we want to be March 2010?	Draft of National Health Strategy 2011-2013 distributed to: a) MOH Directors and Chairs of Thematic Groups and b) National Council for Health Policy and Planning (NCHPP) Feedback from both groups	October November	Thematic Groups & NCHPP	HPPD with Office of Minister of Health	Arabic & English drafts distributed end October Meeting held with MOH Directors on November 9 and NCHPP on November 17
	Re-drafting Feedback from sub-group of NCHPP	November December	NCHPP sub-group	HPPD with Office of Minister of Health	Meeting held with NCHPP sub-group on December 9
	Re-draft distributed to Roundtable Meeting Invitees Feedback from Roundtable Meeting	December mid December	MOH, NCHPP, NGO's and private sector	Office of Minister of Health & HPPGD	Meeting held December 20
	First official draft to Office of Minister of Health for Ministry of Planning and Administration (MoPAD)	10 January 2010		Office of Minister	Submitted 10 January 2010
	Final draft to MoPAD	4 March 2010		Office of Minister	Submitted 4 March 2010
Phase 3. How will we get there?	Discussions with MoPAD	February 2009 – March 2010		Office of Minister of Health with TA	Ongoing
	Develop planning cycles, notes on policy & strategy development, continuing education sessions on health policy and strategy	May		Office of Minister of Health & HPPGD with TA	Done 9-19 February 2009
	Agree focal point and use of existing coordinating & other mechanisms for lead & overview of process	Mid May		Minister of Health	HSWG with HPPD

	Develop road map	May	MoH continuing education sessions in Ramallah and in Nablus	HPPGD with TA	17 and 18 May 2009
	Discuss road map and management challenges with health donor	May	Italian Cooperation	Office of Minister of Health with TA	14 & 18 May 2009
	Review PRDP 2008-10 and National Strategic Plan 2008-10 health programs, objectives & targets then for 2011 onwards draft MoH vision, mission, priorities & objectives	June	MoH internal meetings In Nablus & Ramallah		Meetings held 3, 9 & 22 June
	Review achievements to date in 2009 work plan	July	MoH M&E group		Done
	Inter-sectoral discussions	July	Ministry of Education, Ministry of Social Affairs	Office of Minister of Health & TA	28 and 29 July
	Draft outline of health strategy	July		HPPGD & Office of Minister of Health with TA	13-29 July
	Identification of key policy issues for national health policy statements	July	MoH continuing education session in Ramallah	Office of Minister of Health with TA	26 July
	Re-draft of MoH vision, mission, values, priorities & policy statements & first draft of options for the health system, key reforms & planned results, national health policy goal, objectives & outcomes & national health strategy goal, objectives & programs	July	MoH staff	HPPGD, Office of Minister of Health, TA with MoH staff ministry wide	13-29 July
	Drafting text of policy statements & strategy	August & September	MoH staff	HPPGD, Office of Minister of Health & ministry wide staff	Done by end September
	Editing of strategy document, filling in missing information & translation	October	MoH staff	HPPGD & Office of Minister of Health, TA with staff ministry wide	Done by end October

	Meetings with MoH Directors, and heads of thematic groups	November	MoH staff	Office of Minister & HPPGD	9 November
	Meeting with NCHPP	November	MoH, inter-ministerial, NGO's, private	Office of Minister & HPPGD	17 November
	Roundtable Meeting	December	MoH, NCHPP, NGO's, private	Office of Minister & HPPGD	20 December
	Meetings of MoH Strategy Planning Team	June 2009–February 2010	MoH Staff	Office of Minister & HPPGD & TA (when in-country)	Numerous meetings
	'Donor' meeting	January 2010	Bilateral & multilateral donors, UN, NGOs	Office of Minister, HPPGD & ICD	14 January 2010
	Health reform group meeting	February 2010	Members of health reform group plus other invited participants	Office of Minister, HPPGD	1 February 2010
	Editing of strategy	February 2010	WHO, World Bank, Italian Cooperation & TA	Office of Minister, HPPGD & ICD with TA	28 February 2010
	AIDA Health Group and Local Partners Meeting	March 2010	International and Local NGOs	Office of Minister, HPPGD & ICD	4 March 2010

Annex D. List of acronyms

&	And
CPE	Continuing professional education
EMRO	Eastern Mediterranean Regional Office (of WHO)
GDP	Gross domestic product
HMIS	Health management information system
HPPGD	Health Policy and Planning General Directorate
HRD	Human resource development
HSWG	Health Sector Working Group
M&E	Monitoring and evaluation
MoEHE	Ministry of Education and Higher Education
MoF	Ministry of Finance
MoH	Ministry of Health
MoPAD	Ministry of Planning and Administrative Development
MoSA	Ministry of Social Affairs
NCDP	National chronic diseases program
NCHPP	National Council for Health Policy and Planning
NGOs	Non governmental organizations
NIS	New Israeli Shekel
PHC	Primary health care
PNA	Palestinian National Authority
PNP	Palestinian National Plan (2011 – 2013)
PRDP	Palestine Reconstruction and Development Program (2008 – 2010)
SWOT	Strengths, weaknesses, opportunities and threats
TA	Technical assistance
UNWRA	United Nations Works and Relief Agency

Annex E. Tables

Table 1. Distribution of reported cases of disability by age group in West Bank, Palestine 2000-2008*

Age group	Cases	%
Below 5 years of age	12	1
5-9	51	3
10-17	506	26
18	110	6
19-29	769	39
30-39	303	15
40-49	150	8
50+	81	4
Total	**1982**	**100**

*Complete data for the period from Gaza Strip not available

Table 2. Mental illness in West Bank compared with the Gaza Strip

Governorate	Incidence rate per 100,000 Population		
West Bank	**28.8**	**Gaza Strip**	**83.9**
Jerusalem	11.4	**Gaza North**	85.6
Jenin	69.4	**Gaza City**	38.1
Tulkarm	50.8	**Mid-Zone**	97.6
Qalqiliah	31.3	**KhanYounis**	88.7
Salfit	66.3	**Rafah**	188.2
Nablus	11.7		
Ramallah	37.7		
Jericho	83.8		
ALKhaleil	17.4		

Table (3) Classification of Primary health care facilities

Primary health care facilities are classified to four main levels as follows:

Level I:

It is a facility with one health worker or nurse that serves a location of 2000 capita or less and provides on a daily basis the basic preventive services; mother and child health care and immunization, curative services; first aid. A general practitioner would visit the facility once or twice a week.

Level II:

It is a facility where a doctor, nurse and midwife provide different services for a locality of 2001 – 6000 capita. In addition to the basic preventive services, this level also provides curative treatment and some lab tests on a daily basis.

Level III:

It is a facility which provides level II services in addition to specialized medical consultation mainly for mother and child for a locality of 6001 – 12000 capita. It also provides laboratory services.

Level IV:

It is a «comprehensive health centre» which serves more than 12000 capita,

and provides more specialized services than those provided in level III. It also provides medical consultation and psychological, dental care and radiology services mainly x –ray and ultrasound (if not present elsewhere in the service area) [35].

35 Service area: a circle of which the facility is the centre with half diameter of 5 Km.