Centre for Business Research, Cambridge Judge Business School, University of Cambridge

The Political Economy of Health in the Gaza Strip

(Occupied Palestinian Territory)

Nov. 2021

Report Author

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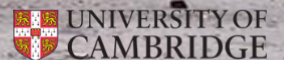

- Mural by Ali Jabali, Gaza City.
- Photograph by Mona Kriegler

2008/19

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Foreword to the Report

By Professor Simon Deakin (CBR director)

This is an important report, in terms of its subject-matter, its approach, and its findings. First, its subject matter. Health is a public good, and how well it is delivered depends on there being an effective public space. In contexts affected by conflict, that cannot be taken for granted. In the case of Gaza, it is not simply the physical consequences of war and occupation that have to be considered. In an unstable geopolitical environment, organisations and institutions are constantly being undermined. The provision of healthcare is fragmented, on the one hand, and highly politicised, on the other. Aid is vital, but long-term reliance on external funding creates a relationship of dependence. A partisan politics leaves little space for civil society. Families and communities, while a source of resilience, also generate patriarchal and conservative social values, which can impede access to services for vulnerable groups.

Second, the approach. The report is the result of intensive research and analysis. The author has leveraged her knowledge of the Gazan situation with rare access to actors at all levels. Through in-depth interviewing, she captures the lived experiences of policy makers, officials and carers. Their voices, normally beyond the reach of an external audience, can now be heard. The interviews are framed by a data-rich account spanning the history, politics and culture of the territory.

Third, the findings. The situation in Gaza is one, as the report notes, of 'continuous suffering and emergency'. A near-perpetual crisis of this kind generates multiple reactions. Factional politics operate alongside communal solidarities. Healthcare is at one and the same time a priority but also a luxury for most families. Healthcare systems must contend with the sheer scale of the physical destruction, and the lack of systematic reconstruction, entailed by decades of occupation and blockade. Formal processes, for example with respect to health insurance and human resource management, designed for a more stable environment, operate alongside an informal reality. The state is fragile and yet implicated in resource allocation at all levels of society. Patients and carers seeking to access the system are confronted with severe shortages of drugs and equipment and constant threats to physical safety, on the one hand, and to a lack of organizational transparency and accountability, on the other.

Much is written about Gaza, in particular when the crisis there is periodically escalated, but little is known about the conditions of life for its population. There is a dearth of systematic research on Gazan society and institutions. This report is a dispassionate account, which is sobering in its implications. In detail, and with evidence of a kind which is all too infrequently available, it offers a diagnosis, and the beginning of a way forward, for a situation which those who read it will surely regard as unsustainable.

Simon Deakin
Director, Centre for Business Research,
Professor of Law, University of Cambridge

November 2021

Gaza Pandemic Quandary

"As acute effects of the pandemic mix with complex political and economic dynamics, Gazan leadership struggles to address an increasingly politicized healthcare crisis".

By Mona Jebril (Sada Journal, March 11, 2021)

Photo credit: Abed Rahim Khatib/ Shutterstock.com

* For an overview of how Covid-19 affected Gaza and its healthcare, see author's published article at Carnegie Endowment for International Peace [Sada Journal]: https://carnegieendowment.org/sada/84054

The Political Economy of Health in the Gaza Strip

(Occupied Palestinian Territories)

Study Timeframe

Work for this report took place between (2019-2021). The fieldwork interviews were conducted between (Sep. -Dec. 2019).

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Executive summary

- This document Presents the results of a political economy analysis (PEA) of the health sector in Gaza. It is based on a literature review spanning multiple source types, and in-depth semi-structured interviews with policy makers, health officials and carers of patients (family members caring for patients) in the Gaza Strip.

Summary Findings

Historical Legacies:

The data from the literature review and the interviews pointed to five legacies which remain powerful in influencing the Gaza healthcare today. These legacies are classified under two main themes: (1) The health sector as a site of political conflict; and (2) decision-taking and the lack of a unified Palestinian vision. Palestinians' right to health is highly politicized. The health sector in Gaza has emerged within the constraints and agendas of several occupations and internal conflict. Consequently, the Gaza health system has been shaped by a context of "de-development" - a past (and present) that is characterized by fragmentation, negligence, marginalisation, and dependency, and which continues to affect the population in Gaza.

Because of decades of occupation, health and activism in Gaza has become largely intertwined. Planning for the health system in Gaza was also typically an activity that is taken by 'outsiders', including Israel and foreign agencies. This has created inherit weaknesses in the system and a chronic lack of coordination since the health sector was ignored or misused for political purposes. Until today, the Gaza health system lacks a unified vision. In this context, the United Nations Refugee and Work Agency (UNRWA) has enjoyed a competitive advantage over other health providers as a "co-ordinating body", despite an 'enduring trust barrier' between UNRWA and the Palestinians in Gaza continue as they perceive UNRWA's neutrality as an attempt to normalize the occupation rather than fulfilling its protection mandate of searching for durable solution to the Palestinian problem. All in all, the health sector in Gaza continues to be a site of political conflict. For more details, see (Section. 4.2).

Politics and the macroeconomic picture in Gaza today:

The siege on the Gaza Strip which has been intensified since 2007, coupled with a history of economic fragmentation and dependency on Israel has forced Gaza's economy to turn inward, leading to over-reliance on donor funds, and practices of rent-seeking, mainly the establishment of a network of tunnels that run underground of the Gaza- Egypt border. Most of these tunnels were destroyed, leaving the economic conditions in Gaza to deteriorate. Gaza economy cannot stand on its own because it is a fragile economy. Thus, changes in transfers, reductions in donor funds and the escalation of the conflict can cause serious decline in the Palestinian National Authority's (PNA) budget that limits its ability to contribute to Gaza Ministry of Health (Gaza- MOH).

Broad features of the population health in Gaza:

Most of the population in Gaza are young, and registered refugees. There are eight refugee camps in Gaza, with the majority of the refugee population living outside these camps. The literature explains that, because of undergoing a "rapid epidemiological transition", Gaza suffers from an increasing burden of non-communicable diseases (NCDs), including mental health disorders. Exposure to trauma is one of the causes of mental health diseases and disability, which also shows that the conflict has far-reaching repercussions on the population health in Gaza.

Current form and function of the health sector in Gaza

Actors' roles and responsibilities: There are four main health providers in Gaza (UNRWA, Health NGOs, Palestinian health ministry/ies, and the private sector). For specialized tertiary health care, however, patient transfers to Israel and neighbouring Arab countries are essential. Traditional alternative or the so-called indigenous medicine also still exists, alongside modern medicine, in Gaza. In (Section 5), the roles and responsibilities of selected actors are listed. The literature does not provide accurate and updated information on all the roles and responsibilities of the different institutions in the health sector in Gaza. In general, the work of health actors in Gaza seem to complement each other as well as overlap. Hence, actors' scope of work is neither coordinated nor defined in a way that allows a delineation of their exact roles and responsibilities in relation to each other. That said, a glimpse on health actors' interaction shows that cooperation exists but remains limited to need and emergency.

Ownership structure and financing: Under Hamas government, the health sector has undergone an expansion. Nonetheless, the scope of Hamas ownership within the health sector is not outlaid in the literature, *inter alia*, for security reasons. Hamas depends on a variety of sources for financing the health sector in Gaza, with the realization that political changes on the ground may affect the availability of these sources. That said, funding the health sector could conversely provide a tool that can be used to influence politics of Hamas government. Both Gaza and Ramallah MoHs also suffer from overstaffing in the public health administration that does not necessarily seem to reflect on the quality of the provision. This is placing additional burdens on an already over-stretched budget. Import restrictions have also exhausted the ministries' financial capacity to improve the health sector. For more details on ownership and financing of the health sector in Gaza, see (Section 5.2).

Power relations, and bargaining: The health sector in Gaza is an unregulated field of power relations. The interplay of competitive power relations in the health sector is a historical legacy that the Gaza health system has inherited from decades of occupation. In the politically laden context of Gaza, "institutions and individuals involved in political and economic life are finding it difficult to remain nonaligned. In a less direct way, this applies to a growing number of foreign donors as well"[244]. Whether between the two Palestinian ministries of health in Gaza and the West Bank, or in relation to international organizations and Israel, the health sector has been affected by competitive, often adversarial, political agendas. (Section 5.2) gives two examples on this, focusing firstly on political clientelism in health institutions in Gaza, and secondly on how international assistance is so often double-edged. A few bargaining strategies that are used to deal with this context are also discussed.

Ideology and values: The health sector is affected directly and indirectly by society's ideological beliefs and values in which it functions. This, however, has been rarely discussed in the health-related literature about Gaza. The Gaza society is comprised of an overwhelming majority of Sunni Muslims and, about 74.5 per cent of people in Gaza are registered refugees[270]. Changes in the socio- political in the Occupied Palestinian Territories' (OPT) context emphasized different components of Palestinian collective identity in Gaza at different times, although in general the trend has been a shifting to localism[271], emphasizing a structure of de-development in Gaza. In this report, (Section 5.4) gives an overview of a few ideological and value features of the Gaza health sector today, which are presented through a discussion on (1) traditional constructs; (2) factionalisms vs social solidarity, (3) co-existence of both indigenous and modern medical practice, and the (4) binary perception to health and healthcare.

Service delivery: The Gazan health system is struggling to deliver health services. Currently the system is on the verge of "implosion"[292], debilitated by increased demand and shortages of supplies such as

drugs and equipment, and a confusing insurance system. It is also functioning under extreme challenges such as lack of protection for healthcare staff and facilities amid conflict, and an exhausting referral system to Israeli hospitals, all impacting negatively on people's access to health in the occupied territory. For more details, see (Section 5.5).

Decision making: Decision making and health planning for the sector in Gaza does not seem to be under the full control of the ministry, or any of the other health providers, alone or altogether. The health sector is fragmented and has been shaped by a legacy of 'decision taking' rather than making. Currently, decision making in the Gaza health sector is characterized by three features: (1) Ad hoc and authoritarian decisions, (2) policy and coordination vacuum, and (3) fragmented and politicized data. These features will be discussed in (Section 5.6).

Implementation: Turning plans into successful implementation is difficult to achieve in the Gaza context. Similarly, "in the Palestinian health system, as in many other health systems, planning has frequently functioned better than policy implementation, and many of the aims of current and prior health plans have not been achieved"[333]. This is because there are "serious structural and systematic problems that come in the way of turning plans into successful realities"[334]. These problems can be found on the macro, meso, and micro levels, which are inherently interrelated, posing serious challenges for implementation in the health sector, a few of which will be indicated in (Section 5.7).

Reform priorities and potential for change

Reforming the health sector in Gaza requires active collaboration among all actors, stakeholders, and political powers. But, given the politicization of the health sector in Gaza, this seems difficult to achieve. Reform efforts also remain at a disjuncture between addressing short term issues, or long-term objectives, i.e., working to address continuous humanitarian emergencies in Gaza and working towards a political solution to the Palestinian problem. However, this 'mixing approach' leads to a deadlock since some of the humanitarian projects may in fact work to increase Palestinians' dependency and fragmentation. Reform priorities at the current time should focus on a few points outlined in (Section 6.2) that would empower the health sector under the current conditions in Gaza, taking responsibility for the present, and yet simultaneously creating a route forward towards future developing. In doing so, human agency, the rationalization of services, and advocacy for the health sector in Gaza are important potentials for change.

Future Research Agenda

Literature (Library) and fieldwork research are needed on issues including the history and context of the health sector in Gaza, particularly in relation to the Arab world, and general trends such as neo-liberalism; natural resources and health protection; and the interrelatedness of the health sector with other sectors in Gaza. Exploring issues of distribution and equity in more details (e.g., rural vs urban; people with disability; and Hamas and other factional members access to health under Israeli restrictions), as well as understanding service delivery, for example, for children with noncommunicable diseases, and other issues such as health supply chains are also important. The relationship among international players and local players in the OPT, and Israel requires further exploration. Researching the health sector's challenges and opportunities in Gaza post- Covid-19, as well as studying how the developments on the political scene, for example, the Palestinian elections, would reflect on Gaza health sector are also necessary. A topic that requires a larger scale of research is reforming and planning for health in conflict zones, for example, what models are available (e.g., through UNRWA), that can be useful for health institutions in Gaza.

Abbreviations, acronyms, and Arabic terms

Abbreviation/ Acronym	Full Term
OPT	Occupied Palestinian Territories
WBGS/ WBG	West Band and the Gaza Strip
UNRWA	United Nations Refugee and Work Agency
PNA/PA	Palestinian National Authority
MoH	Ministry of health, used in text also as Gaza MoH, Ramallah MoH
NCDs	Non-Communicable Diseases
Hamas	Harakat Al-Muqawamah Al-Isalmiyyah (In Arabic) = Islamic Resistance Movement (In English)
Fatah	An Arabic word that refers to Palestinian National Liberation Movement
(P) NGOs	(Palestinian) Non-governmental Organizations
PLO	Palestinian Liberation Organization
Intifada	An Arabic word that refers to Palestinian uprising
MENA	Middle East and North Africa
ME	Middle East
PTSD	Post-traumatic Stress Disorder
WASH	Water, Sanitation, and Health
UHC	Universal Health Coverage
SDGs	Sustainable Development Goals
UNDP	United Nations Development Programme
OCHA	United Nations' Office for the Coordination of Humanitarian Affairs
UNCTAD	United Nations Conference on Trade and Development
PCBS	Palestinian Central Bureau of Statistics
Arabic Term	**Meaning**
wasta	Nepotism
Al-ghadab	Anger or emotional upset

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1. Introduction

1.1 Background[1]

Health systems in Jordan, Lebanon, Palestine and Turkey face significant, common challenges including a rising non-communicable disease (NCD) burden and managing the near and long-term impacts of conflict (notably in neighbouring Syria). There are, however, important differences in the historical trajectory of health system development in each of these countries, in the capacity of system stakeholders to produce and use evidence in developing policy, and at a basic level, in the level of investment in both public health systems and health research in each country. Powerful actors with vested interests - governments, donors, NGOs and the private sector - shape national health agendas, including the formation of social protection systems across all four countries.

1.2 Conceptual aspects

Below are two conceptual aspects that need to be mentioned in advance with regard to this report on Gaza:

- The report is premediated on the assumption that there are no sharp lines that separate armed conflict from social conflict. Hence, armed conflict so often results from social conflict, for example, as political groups follow competitive social agendas. Conversely, several writings have pointed out the social consequences of armed conflict and how it affects community's cohesion (see for example: Jebril, 2018). Particularly regarding the political economy of health, the analysis of topics such as ideology, decision making, and bargaining process among actors require an understanding of conflict as both a political and social phenomenon.

- The Gaza Strip is conceptualized in this report as an area both in conflict and under occupation. Giving multiple descriptions highlights the Contestation over definitions is a common problem for conflict studies as an emerging field of knowledge. For example, Strand & Dahl, (2010) explain that Gaza can be considered in inter-state conflict (with Israel); or in "internal conflict (as per the Palestinian schism), or in peace (in effect of the Oslo agreement of 1993) (See: Jebril, 2018). The Gaza Strip is also referred to as under occupation, since it is part of the Occupied Palestinian Territories, and its borders (land, air, and sea) are controlled by Israel. In this report, such a contestation of defining Gaza is highlighted rather than obscured by considering it as both an area of conflict and under occupation.

Health system focus

The focus of this report is on the political economy aspects of health in Gaza. It focuses principally on governance and leadership, financing and service delivery, and on human resources. Supply chains and health information systems are not addressed in depth.

[1] This paragraph was written by Sharif Ismail as part of the template for Political Economy Analysis (PEAs) for Lebanon, Jordan, Turkey, and the Occupied Palestinian Territories.

1.3 Purpose of the report[2]

The purpose of the four, country political economy analyses (PEAs) of which this report - focused on Gaza - forms part is to provide a sector-specific analyses culminating in assessments of barriers and opportunities to change in health, framed through the overarching goal of universal health coverage. This analysis is hoped to bring to the fore distinctive aspects of the political economy of health in each of the participating countries, and to the keyways in which this has been influenced by conflict – both within country borders and in neighbouring countries (particularly, in contemporary terms, the conflict in Syria but also considering the historical experiences of conflict in each of these countries).

1.4 Guiding research questions[3]

The material presented in this report has been drawn together in response to the following guiding questions:

1. What are the key historical legacies and contextual factors determining the direction and formulation of health policy in Gaza? What role has the occupation and conflict played in shaping this?
2. Who are the key actors/stakeholders in the health sector in Gaza?
3. What are the characteristics of bargaining processes by which health policy in Gaza is made? How inclusive/exclusive are these processes and what are the main currencies used for bargaining?
4. What key values/ideas underpin the identification of priority health policy issues/formulation of health policy?
5. What main opportunities/incentives for health reform exist in each country, and what are the principal barriers to reform?

1.5 Structure of the document

The report comprises seven sections: **Section 1**, in hand, introduces the study; its background, conceptual aspects, purpose, and guiding questions. **Section 2** outlines the methodology of the study including security and ethical consideration, and the approach to reviewing and analysing the literature and the interviews. **Section 3**, comments on the state of the literature on the political economy of health in Gaza. **Section 4** explains the periodisation of the conflict, and the evolution of the Palestinian health sector, highlighting five historical legacies that remain power in shaping healthcare in Gaza today. **Section 5** discusses the current form and function of the health sector in Gaza, focusing on the roles and responsibilities of main actors, ownership and financing structures, power relations, bargaining processes, ideology and values, service delivery, decision making and implementation. **Section 6** discusses reform priorities and the potential for change. Then, **Section 7** presents the concluding remarks which summarize the headline findings from the PEA with a note on evidence clarity, and recommendations of an onward research agenda on the political economy of health in Gaza.

[2] This paragraph was written by Sharif Ismail as part of the template for Political Economy Analysis (PEAs) for Lebanon, Jordan, Turkey, and the Occupied Palestinian Territories.
[3] This paragraph was written by Sharif Ismail as part of the template for Political Economy Analysis (PEAs) for Lebanon, Jordan, Turkey, and the Occupied Palestinian Territories.

2. Methodology

2.1 Security and ethical considerations

Ethical approval for the work described in this report was sought and received from the University of Cambridge in the UK: The Sociology Ethics Committee, on 25 February 2019. The report is based on cross-sectional research, interviewing people across different institutions using the snowballing method to learn about their own thoughts and experiences; in this case, institutional ethical approval was not required.

The study in hand has been conducted for academic and policy purposes; it does not aim to advocate for or to serve the interests of any particular group. It is an independent inquiry that was conducted by a Palestinian researcher, the author of this report, who is an experienced interdisciplinary social scientist, combining between insider and outsider positionality to the Gaza Strip.

Prior to conducting the interviews, an invitation letter (Appendix 1), and a research participant factsheet (Appendix 2) were distributed to the participants to inform them of their rights of anonymity, confidentiality and withdrawal from the study at any point before the completion of the interviews and up to three days afterwards. Consent forms (in English and in Arabic, as appropriate) were also sent to the participants to sign. Oral consent was also accepted as an alternative whenever it was necessary. For security reasons, and since the Gaza Strip is part of the Arab culture, which is largely an oral culture, obtaining signed consent forms from all participants did not prove practically possible, especially as some interviewees also had limited access to the internet.

The interviews were recorded by the researcher with permission from the participants. The recorded interviews were then also transcribed, coded, and analysed by the researcher herself in order to preserve the anonymity of the participants. Interview data was stored safely, and without identifiable information during all the stages of transcription, coding, analysis and writing. All recordings and consent forms will be destroyed upon the completion of the study. Both the research participants and their institutions were anonymised in this report and will continue to be so during any future publications or other disseminations of the research. Table 2.1 below includes details on codes used to indicate the types of institutions, and the related number of participants. Table 2.2 provides a list of participants' pseudonyms.

Note: Recommendation for the readers of the report

- ❖ It is recommended that the reader reviews Table 2.1, and Table 2.2 for codes and pseudonyms before continuing to other sections of the report, as these will appear frequently in text.

Table 2.1 Institutions: Types, Codes & Participants

Type of Institution	Code	Participants References	No. of Participants
International Organisation	IO	IO1| IO2| IO3|IO4	4
Governmental\Public Institution	G	G1|G2	2
Academic Institution	AC	AC1	1
Non-Governmental Institution	NGO	NGO1| NGO2	2
Private Institution	PI	PI1| PI2	2
Carer of Patient	CP	CP1| CP2|CP3	3
Total No. of Participants	---	---	14

Table 2.2 Pseudonyms of Research Participants

No.	Policy Makers	Institution	Pseudonym
1.	Interviewee 1	International Organisation	(Interviewee 1, IO1)
2.	Interviewee 2	Academic Institution	(Interviewee 2, AC1)
3.	Interviewee 3	International Organization	(Interviewee 3, IO3)
4.	Interviewee 4	Governmental/Public Institution	(Interviewee 4, G1)
5.	Interviewee 5	Non-Governmental Organisation	(Interviewee 5, NGO1)
6.	Interviewee 6	International Organization	(Interviewee 6, IO3)
7.	Interviewee 7	Private Institution	(Interviewee 7, PI1)
No.	**Health Officials**	**Institution**	**Pseudonym**
8.	Interviewee 8	Non- Governmental Institution	(Interviewee 8, NGO2)
9.	Interviewee 9	International Organisation	(Interviewee 9, IO4)
10.	Interviewee 10	Governmental/Public Institution	(Interviewee 10, G2)
11.	Interviewee 11	Private Institution	(Interviewee 11, PI2)
No.	**Carers of Patients**	**Institution**	**Pseudonym**
12.	Interviewee 12	Carer of cancer patient	(Interviewee 12, CP1)
13.	Interviewee 13	Carer of diabetes patient	(Interviewee 13, CP2)
14.	Interviewee 14	Carer of mental health patients	(Interviewee 14, CP3)

2.2 Approach to the literature

Since the Gaza Strip is a significantly under-researched context, it was necessary that this study widens the literature search criteria as much as possible. The literature search was conducted using broad keywords and phrases, such as (Gaza, Palestine, Occupied Palestinian Territories, political economy in Gaza, political economy of health in Gaza, health in Gaza, and cancer in Gaza). It also used a variety of sources (books, peer reviewed articles, other journal articles, organization and media reports, thesis, e-thesis, and grey literature). The timeline of the studies reviewed extends to a few decades ago in order to gain a perspective into the historical context, in which the health sector functions in Gaza. From these, the researcher selected only the information that reflects the situation of the health sector in Gaza today, as informed by other literature sources, and based on the researcher's first-hand academic and living experience in Gaza. The report synthesizes insights from interdisciplinary sources, including articles on politics, economics, health, and social sciences due to the scarcity of writings on the political economy of health in Gaza, and since there is no dichotomy between these disciplines, especially in a conflict-affected area such as the Gaza Strip. All in all, it is important to acknowledge from the onset of this study that there are significant gaps in the literature on this topic. The report worked to actively synthesize and analyse information, as accurately as possible, from the available literature, as well as complementing any gaps by collecting a strong set of interview data on the political economy of health in Gaza from local participants, and those who work in the area.

2.3 Interviews

This section provides an overview of the broad categories of research interviewees and the researcher's approach to their selection. It also briefly explains how the interviews were conducted.

2.3.1 Broad categories of interviewees and approach to selection

The research sampling (target group, criteria of selection, sampling method, and the research participants) are explained below:

Target group

The researcher aimed to reach participants from three main categories: *(1) Experts/policy makers; (2) health officials; and (3) carers of patients (family members caring for patients).* Initially, the researcher also wanted to recruit patients, but this idea was later cancelled for ethical considerations. Interviewing participants from the three above-mentioned categories was useful. It enriched the research with different perspectives on the research themes, as well as helped verifying some information across the participants, or gain more details including examples on some of the issues discussed.

Sampling method

The study used convenience sampling - the snowballing method. This method was also a necessity because participants' CVs and contact details were almost unavailable on the internet. The researcher also did not want to contact the institutions for participant announcement, in order to protect the participants from any possible harm from their employer, and to avoid institutional bias in the interview data. Using trusted contacts for snowballing provided a safer approach to communication on this sensitive research topic, while also maintaining participants' anonymity.

Sampling Criteria

As a general sampling criterion, the researcher looked for participants from different types of institutions (international organizations, government/ public institutions, non-governmental organization (for profit, and for-no-profit), and the private sector (For more details on distribution, see Table 2.1 and 2.2 above). The researcher also attempted to observe gender balance in the sampling, as much as was possible. Overall, the researcher interviewed 14 male and female participants distributed as follows: 'six' females (1 policy maker; 2 health officials, and 3 carers of patients), and 'eight' males (6 policy makers; and 2 health officials). The researcher approached three more participants, who agreed to participate initially, but then seemed to repeatedly delay/ avoid correspondence regarding the interview. The researcher noticed their reluctance maybe linked to political sensitivities in relation to Gaza, and so she did not follow up any further with these interviewee candidates in respect for their rights to withdrawal, and to save them from any social embarrassment towards the people who approached them through the snowballing process.

Regarding the specific criteria of selection, it was not the same across the different categories of the interviewees. For example, (category #1) for experts and policy makers, the researcher looked for those who have been working in the health sector for several years (academic/ policy/ practitioner), and in senior positions linked to decision making; for (Category #2) health officials, the selection was flexible, aiming generally at health workers/officials at mid-career level or with a few years of

experience; and for (Category #3), the researcher looked for carers of patients (family members who were caring for patients with noncommunicable diseases).

2.3.2 Interviewing

This summary explains the type of the study, its method, mode and language of interviewing, interview preparation, duration, and the themes and questions of the interviews.

Type & Method

The research conducted for this report is qualitative in nature. In particular, the researcher used the method of in-depth semi-structured interviews, which helped her to ask questions related to the main themes of the political economy of health in Gaza while simultaneously allowing a space for new questions and contesting narratives to emerge in the conversation with the participants.

Mode of Interviewing

Due to restrictions on access to the Gaza Strip, the interviews were conducted via telephone, Skype, and mobile from Cambridge. The researcher has prior academic experience in using these methods for interviewing[4]. In fact, using these alternative modes of interviewing proved to be less time-consuming, and provided a better convenience and a sense of anonymity for the participants, which improved the overall quality of the interview conversations[5].

Language of Interviewing

The participants were given the choice regarding the language of the interview: Arabic or English. For those who chose to speak in Arabic (10 out of 14 participants), the researcher (a native speaker in Arabic language, and with academic and practical experience in translation) has transcribed, and also applied the coding and analysis in the same language in which each interview was conducted. The researcher only translated selected quotes from the Arabic interviews into English so as to include them in this report.

The Interview Preparation

As indicated in (Section 2.1), a formal invitation letter (Appendix 1), and a Research Fact Sheet (Appendix 2), which includes information about the study and the participation in the interviews was emailed to participants. For those who did not use email, the researcher briefed them on the main content of the factsheet prior to starting the conversation. Consent forms were also signed electronically, although consent was obtained orally from a few participants. Prior to conducting the interviews, the researcher contemplated in advance the possible interplay of power-relations with each participant, and how best to deal with it for a balanced interviewee-interviewer encounter.

Duration

The interviews were conducted between Sep. 2019 – Jan. 2020. Each interview lasted between 90-135 minutes. The researcher explained to the interviewees in advance that they could ask for a short

[4] The researcher used a similar methodology in her PhD study on higher education in Gaza (see: Jebril, 2006).

[5] (Also see: Jebril, 2006).

break 10-15 minutes if necessary and has checked with them during the interview whether they wanted to take it, however, all preferred to continue without any interruption.

Interview Themes and Questions

The interview schedule was developed taking into consideration the main questions that this PEA report aims to explore, but also working to tailor these questions to be relevant to each interviewee's experience. In Figure 2.1 below, the interview themes (A-F) are presented. A more detailed Interview Guide that outlines the aims of the interviews, interview themes, and interview indicative questions can be found in (Appendix 3). The guide also includes supporting material (probes by historical events, and by institution), which assisted the interviewer/researcher for a more engaging and useful conversation with the participants.

Figure 2.1 Interview Themes

To recap, taking all the above steps helped the researcher to take an ethical and active approach to the interview situation, building rapport and trust with the participants, and encouraging useful (and interesting) discussions on various themes of this research.

2.4 Data analysis and synthesis

This section gives an overview of how the analyses and syntheses of the literature, and the interviews were conducted.

2.4.1 Analysis and synthesis of the Literature

The literature was reviewed and coded into political economy themes using the MAXQDA software. Figure 2.2 includes an illustration of this process:

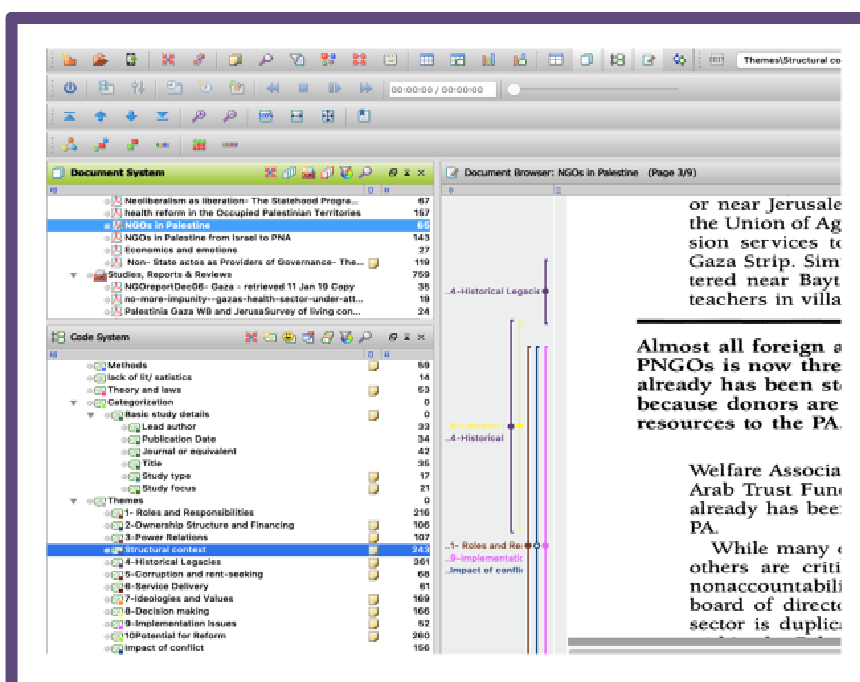

Figure 2.2 Illustration on Using MAXQDA for Coding the Literature

Each of the coded themes was then printed out separately in preparation for the analysis stage. For an illustration, see Figure 2.3:

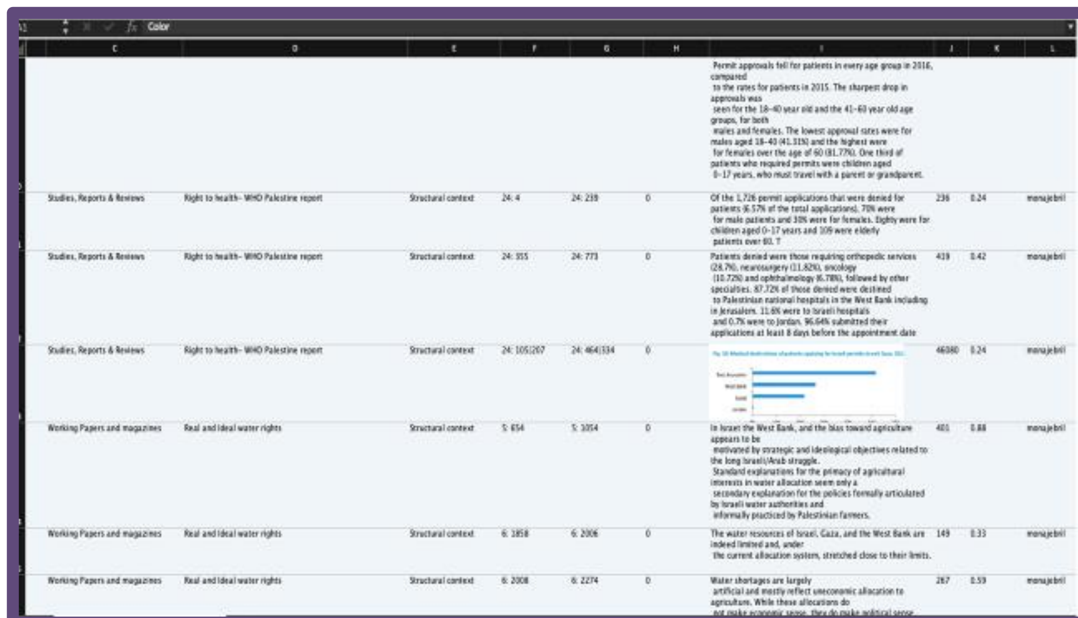

Figure 2.3 Illustration on Using MAXQDA for Theme Compilation

A reflective digital journal (Scrivener file) was used to document the researcher's thoughts and reflections on the different topics that she was working on both during the literature review and analysis. An example of this digital journal is shown in Figure 2.4:

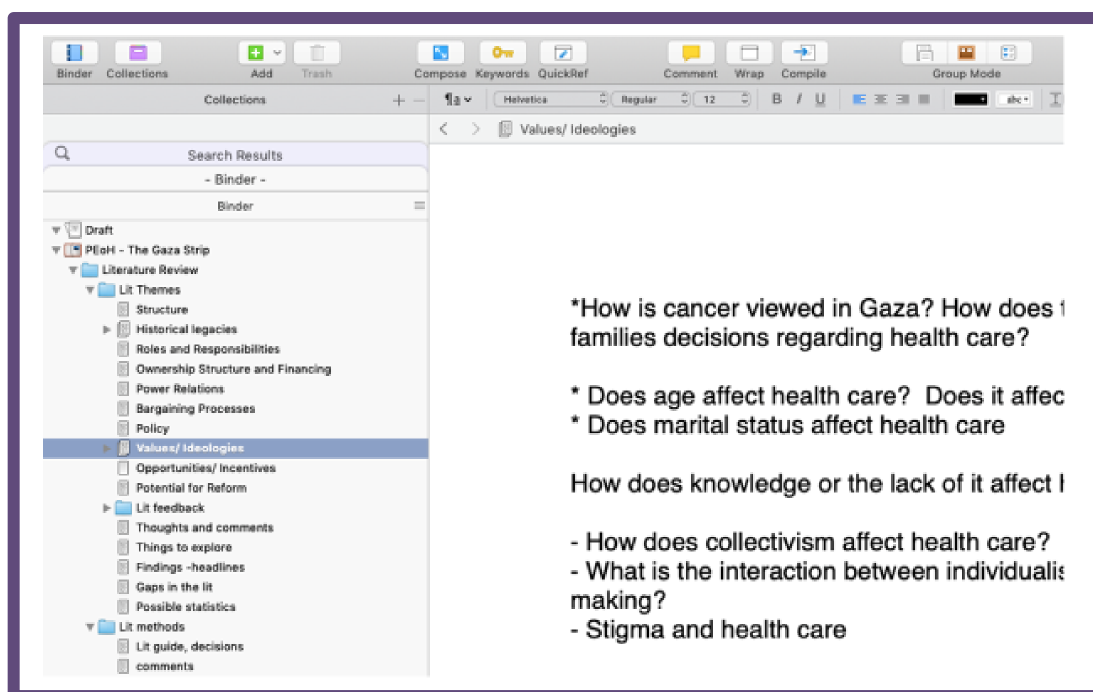

Figure 2.4 Illustration on Using Scrivener as Digital Reflective Journal

Using the MAXQDA software for literature reading, analysis and synthesis was both challenging and useful. Unless the researcher has conducted all the readings by herself, it would have been difficult to link the coded pieces back to their wider context and timeframe. That said, taking this approach would be more feasible to apply in research situations where one person only is working on the literature review. This was the case in this report where the author of this work has done the literature reading, analysis and synthesis by herself. Using the software was useful as it provided an opportunity for a

birds-eye view on each topic, combining both the depth and breadth of information. This method also proved environmentally friendly, lessening the amount of printed material, and thus facilitating green management and storge of the literature reviewed.

2.4.2 Analysis and synthesis of the Interviews

All audio-recorded interviews were transcribed by the researcher. The transcriptions were then coded into the relevant political economy themes using MAXQDA analysis software. The coded material was printed out in their categories of themes. These themes were reviewed and analysed by the researcher who then applied the traditional method of piling and sorting on the data, which allowed both main and sub-classifications of the data to emerge. Like above, a separate Scrivener file was used as a reflective digital journal to document researcher's thoughts and reflections on the interview data during the process of analysis. Using the **social constructionist approach**, the researcher then interpreted the emerging interview data themes in relation to the literature and her own reflections, weaving meanings together, and creating new informed knowledge on the topic of the research.

3. The state of the literature on political economy and health in the Gaza Strip

Writings on the political economy of health in Gaza are almost non-existent. What is available is medical or technical publications that are produced in a top-down manner, i.e. by MoHs and humanitarian, relief and emergency institutions, and a few relevant academic articles on the health sector in the Occupied Palestinian Territories (OPT), notably the work of Professor Rita Giacaman whom I cite extensively in this report.

The academic literature (books and peer-reviewed journal articles), perhaps mirroring the situation for the Gaza health system *per se,* is fragmented across time and disciplines, and does not include updated information that captures the continuously changing circumstances on the ground in Gaza. The literature also includes the following gaps: (1) writings so often use information of the OPT to make inferences about the Gaza health system although the situation in Gaza is significantly different from that of East Jerusalem and the West Bank; (2) political sensitivities on the ground in Gaza especially after the Palestinian schism affect the data reliability. For example, MoH - Palestine (2017), the annual health report produced by Ramallah-based MoH considers Gaza health facilities as still under its supervision, although Hamas' taking over the Gaza Strip added complexity to Ramallah's capacity of supervision over Gaza facilities. The annual report also refers to military hospitals in Gaza, but taken the Palestinian schism into consideration, how it would be possible for Palestinian National Authority (PNA) military hospitals to continue to function in Gaza is unclear. The lack of accurate statistics could also be attributed to a lack of a modern information system. Malka (2012) also explains that Hamas, for instance, avoids publicizing details about its health NGOs and financing to protect its resources from being attacked by both Israel and the PNA, as will be pointed out later in (Section 5.2) of the report.

That said, the report has worked to synthesize insights from the academic literature on health in the OPT, as well as benefiting from interdisciplinary academic resources including writings on politics, economics, development, and social studies of the OPT. Information from medical or technical publications and secondary sources such those published by well-respected News corporations, for example, Al Jazeera, and BBC. Other web publications of health institutions were also considered.

4. Contextual features in Gaza

4.1 Periodising conflict in Gaza

The Gaza Strip is characterized by a turbulent past, a blockaded present and an uncertain future. Despite short periods of relative stability, conflict in Gaza is the predominant feature and continues to shape the Gaza society and its various sectors, as we shall see shortly in the report. In order to understand the challenges for the health sector in Gaza today, it is important to review the major historical and political events that affected Gaza. Below is an overview of the main periods of conflict, followed by a chronology of the development of the health sector in Gaza.

Over decades, Gaza (41 K) has witnessed successive patterns of occupation and dispossession[6]. For example, the Gaza Strip was ruled by the Ottoman Empire (1516-1917), British Mandate (1917-1948), Egyptian Civil and Military Administration (1948-1967), and starting from 1967 by the Israeli occupation. In December 1987, mass demonstrations took to the streets of Gaza, in what is known as the first Palestinian Intifada (uprising). People began a stone-throwing campaign[7], putting barricades, and burning car tires in resistance to Israeli troops in the OPT. It was not until 1993-4, the signing of the Oslo Agreement and the start of the Peace Process, that a Palestinian National Authority (PNA) was established, which put an end to the intifada.

The Peace Process has proved to be a fatally flawed process that has exacerbated conflict rather than resolving it[8]. Towards the end of September 2002, Al Aqsa Intifada (a second uprising) has erupted signalling “a breakdown of the peace process”[9]. When Israel implemented a Unilateral Disengagement Plan in 2005, dismantling Israeli settlements[10], and the associated military network on more than %40 of Gaza land[11], the PNA’s position became very critical, as it was then assumed fully responsible for the prosperity and development of Gaza as a ‘mini-state’[12]. But severe restrictions were imposed by Israel on the Gaza Strip, affecting PNA’s ability for leadership on the ground.

These restrictions on Gaza have intensified after Hamas, a competing political faction to the Fatah dominated PNA, won the Palestinian Legislative Council elections by majority support in 2006. Being classified by Washington (1993) and the EU (2003) as a ‘terrorist organization’, this success was sanctioned by Israel and other important actors in the international community, “boycotting and isolating the newly elected administration”[13]. In response, Hamas attempted to create a national unity government with Fatah. The “Fatah- Hamas skirmishes developed into a full-fledged military confrontation between the two parties in the Gaza Strip”[14], resulting in Hamas complete takeover of the Gaza Strip. The two parties have “split into two rival governments [Hamas in Gaza, and the PNA presidency in the West Bank city of Ramallah], each claiming constitutional legitimacy and backed by its own armed forces”[15]. Since then, Gaza was exposed to further International and Israeli sanctions. Israel launched three large scale Israeli military attacks on Gaza (2008; 2012; and 2014). Israel also

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[6] (Roy, 1995).
[7] (Thabet & Vostanis, 2011, p. 214).
[8] (Rynhold, 2008). (See also: Jebril 2006; Nicolai, 2007; Roy, 2007).
[9] (Sayigh, 2007, p. 7).
[10] These Israeli settlements in Gaza were established in 1967.
[11] (Thabet & Vostanis, 2011, p. 215).
[12] (Roy, 2005)
[13] (Giacaman et al., 2009, p. 840); (Sayigh, 2007, p. 17); (Also see: Jebril, 2006).
[14] (Berti, 2015)
[15] (Sayigh, 2007, p. 7). (See also: Berti, 2015, p. 13).

remains in control of Gaza's airspace, maritime space, and land crossings[16]. After Al Sisi assumed presidency of Egypt, the Gaza-Rafah Egyptian border became also permanently closed, tightening the siege on people in the coastal enclave. On 30 March 2018, thousands of Palestinians marched to the Israeli Gaza fence in what is known 'The Great March of Return'. The protesters are "demanding their right to return to the homes and land their families were expelled from 70 years ago" [17], and the lifting of a crippling blockade on Gaza.

[16] (UNCTAD, 2015, p. 9).
[17] (Al Jazeera, 2018, p. no pagination).

4.2 Historical legacies and evolution of the health sector in Gaza

The right to health in the Occupied Palestinian Territories is highly politicized. The health sector in Gaza has emerged within the constraints and agendas of several occupations and internal political conflict. Table 4.1 presents a chronological review of how the health sector has evolved over time. Figure 4.1 gives an overview of the major characteristics from this table[18]. The historical legacies that continue to influence the health sector today are also discussed.

Table 4.1 Chronology of the Development of the Health Sector in Gaza

Historical Period	Overview of Key Health Services/ Aspects
Ottoman Rule 1516-1917	○ A few Western **missionary hospitals**[19]. ○ **charitable and relief organisations** (on family, tribal or religious basis)[20].
British Mandate (1917-1948)	○ **British Civil Administration health clinics** (provided by Government Department of Health)[21]. ○ **Christian missionary hospitals**.
Egyptian Administration (1948-1967)	○ Three systems of health provision in the OPT towards the end of this period[22]: - **UNRWA** (established in 1949 and started to operate in 1950 in response to Al Nakba: the Arab- Israeli war in 1948) - **Egyptian system (in Gaza)** and Jordanian system (in West Bank). - **Palestinian network of charitable health services, and Palestinian private medical services.**
Israeli Administration (1967-1994)	○ **Israeli Civil Administration** (Health System is under the Israeli Ministry of Defence not MoH). General features include:[23] - **Referrals to Israeli hospitals** for tertiary care - Total **dependence on the Israeli health system** - **Politically affiliated grassroots health committees** (affiliated with Palestinian political movements, emerged in the late 1970s).
Palestinian Authority (1994-2006)	○ **First Palestinian Ministry of Health,** with the following[24]**:** - Four providers of health services, governmental (%40), UNRWA (31%), and private and NGOs at (%29) - Development of **private health insurance schemes**

[18] This review benefits from (Malka, 2012; Giacaman, Abdul-Rahim, & Wick, 2003; Giacaman et al., 2009; Sullivan, 1996).
[19] (Giacaman et al., 2009, p. 844).
[20] (Sullivan, 1996, p. 31).
[21] (Giacaman et al., 2003, p. 4).
[22] (Giacaman et al., 2003).
[23] (Giacaman et al., 2003, p. 5).
[24] (Giacaman et al., 2003, p. 5).

Palestinian Division (2007 – present)	○ **Two Palestinian Health Ministries** (one Gaza and in the West Bank), with the following main observations: - Expansion of the Health Sector in Gaza under Hamas Government[25] - Replacing PNA employees with Hamas loyalists. - Exhaustive Referral system to Israeli hospitals.

An overview of the historical timeline of Palestinian health system evolution:

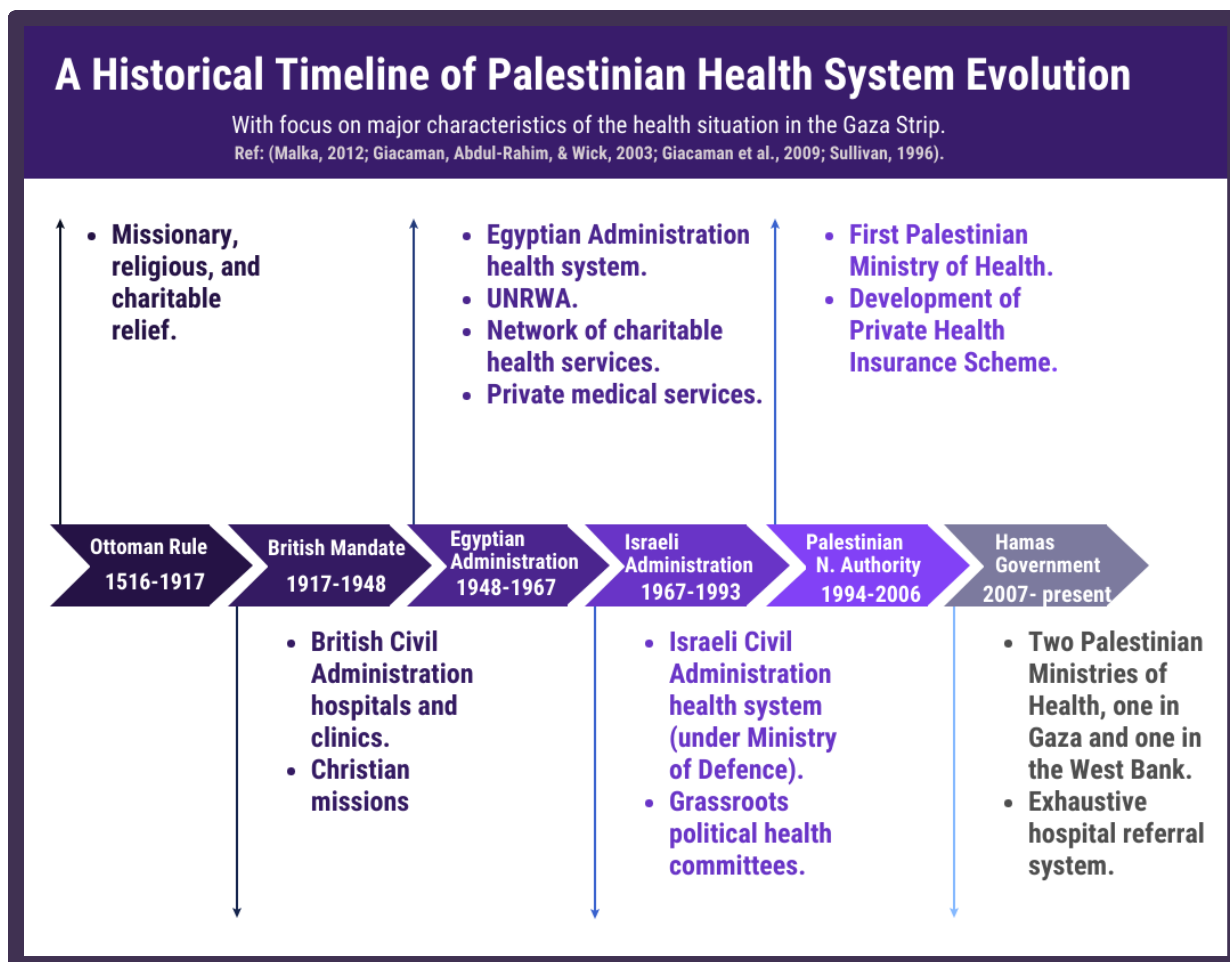

Figure 4.1 A Historical Timeline of Palestinian (Gaza) Health System Evolution

A history of "colonization and military occupation [has] shaped the capacity of the [Palestinian] health system and defined its main actors"[26]. This has made the health sector highly politicized. For example, Post 1948, the health system in the West Bank and Gaza became under two different administrations, respectively, the Jordanian and the Egyptian. Between 1967 -1994, as both has fallen under Israeli military rule, "Gaza and the West Bank had separate chief medical officers [...,] administrative structures, and continued to follow different protocols in certain health policy areas, particularly those relating to medical licensing and supervision of health facilities"[27]. During the Israeli Administration, healthcare for Palestinians was used to the advantage of Israeli authorities. For example, a senior

[25] (Malka, 2012).
[26] (Giacaman et al., 2003, p. 4).
[27] (Schoenbaum et al., 2005a, p. 16).

policy maker (Interviewee 7, PI) who used to work in one of Gaza's hospitals during the Israeli Administration (1967-1994), said:

> ***"The Israeli Administration was trying to maintain health services in Gaza at a low level, so that it would benefit from the cost of Palestinian transfers to its hospitals. We also had information, and people who went there also confirmed it, that their doctors used to train on surgeries using our patients. The situation was very bad".***
>
> *Senior Policy Maker: (Interviewee 7, PI)*

After the Oslo Agreement (1993), the politicization of healthcare continued. The peace process was a transitional period in which "**there were lots of economic development at that time, and an attempt to improve everything, including the health sector**" (Interviewee 6, IO). Nonetheless, **"one of the worst consequences of the Peace agreement is that it continued to link Palestinian economic and health systems in Israel, which did not allow to develop health services in Gaza"** (Interviewee 7, PI). Even when the first Palestinian Ministry of Health was established in 1994, it inherited a weak and fragmented system, facing serious challenges towards reform and development. A senior policy maker also regretted the following:

> ***"We lost a historic opportunity in 1994. When the Palestinian Authority was established, both Arab and foreign countries wanted to offer their help and financial support. Until today, I do not know where all this money has gone! We did not build decent hospitals, or well-equipped the available ones […]. Instead, health budget was used to cover the salaries of new appointments, ministers, employees and managers. We mismanaged the funds because there was no planning".***
>
> *Senior Policy Maker: (Interviewee 7, PI)*

Despite this, **"between 1994 -2001, there has been massive development, starting from building hospitals and more centres**"[28] (Interviewee 3, IO). The breakout of the Peace Process by Al Aqsa intifada has changed this as **"the situation became stagnant […] On the contrary some of the equations**[29] **went back, because of several Israeli attacks during the past 15 years"** (Interviewee 3, IO). With this, the **"health sector became more fragile and in need of emergency support"** (Interviewee 3, IO).

[28] "For example, in 2000, the number of primary health care centres has risen approximately from 20-50, and the number of hospital beds from 6000 to more than 2000" (Interviewee 3, IO).

[29] "The health sector did not match the increasing demands as a result of the natural growth" (Interviewee 3, IO).

After the conflict between Hamas and Fatah in 2007, "**the political separation dictated the agenda on the performance of the health sector, leading Palestinians to have one health ministry in the West Bank and one in Gaza"** (Interviewee 3, IO)**.** International sanctions and restrictions on movement have also intensified on Gaza. Most of the interviewees (policy makers and health officials) complained about how the Palestinian Schism has caused a duplication of health staff roles and services, exhausting the already scarce Palestinian resources.

The politicization and fragmentation of Palestinian healthcare and how it is manifested in everyday Gaza health experience will be discussed throughout the report.

Historical Legacies

Palestinians "are still facing the same challenges as they were a decade ago; […including the] building [of] strong institutions, […] and dynamic civil society"[30]. The data from the literature review and the interviews points to five legacies which remain powerful in influencing the Gaza Strip healthcare today. The following is a brief account of the historical legacies, classified under two main themes:

- The health sector as a site of political conflict.
- 'Decision-taking' and the lack of a unified Palestinian vision.

4.2.1 The health sector as a site of political conflict.

Two legacies are included under this theme, elaborating on how the health sector has been (and continues to be) a site of conflict between the occupier (for example, Israel) and the occupied Palestinian Territories (e.g., Gaza). The conflict to control the sector is also evident between the competing political factions (for example, Fatah and Hamas), especially after the Palestinian schism.

Legacy #1: fragmentation and institutional collapse

The Palestinian health sector is "made up of fragmented services that grew and developed over generations and across different regimes", by circumstances rather than by deliberation[31]. The fragmentation of the health sector was actively sought and implemented by Israel through detrimental polices[32], which was "tailored to legitimise and normalise the restrictions imposed on the Palestinian people and their nascent institutions"[33]. For example, a senior policy commented:

> ***"Our health system could not develop as independent, because the occupation was [creating barriers for us] in order to make Palestinian health and economics peripheral to an Israeli system".***
>
> *Senior Policy Maker: (Interviewee, 4, G1)*

30 (Bank, 2006, p.14).
31 (Giacaman et al., 2009, p. 844).
32 (Giacaman, 1994).
33 (Abuiyada & Abdulkarim, 2016, p. 37).

With the Israeli occupation, the OPT has witnessed "increasing territorial, socio-economic and political fragmentation"[34]. This "disintegration of the whole into isolated parts is a characteristic feature of de-development"[35], which is the general state for the OPT:

On the geopolitical level, there has been a process of "bantusanisation" of the OPT, in which the WBGS are turned into "de-facto 'population cantons' or 'reservoirs' out of which [people] cannot exit without the possession of a permit issued by" Israel[36]. Hence "the occupied territories […] became a chaplet of small islands, with little possibility for mobility, even for medical staff"[37]. On the economic level, there has been a process of "economic enclavization" in which there is a "growing economic separation or partition and bifurcation that strikingly parallels its political counterpart, Bantustanisation"[38] (p. 68).

On a governance level, The OPT "display all the conditions of state collapse"[39]. Among other things[40], these conditions include "institutional decline and degraded governance"[41]. Since "institutions are perhaps the only remaining resource in Gaza with semblance of power or influence within the community, and as such have become the new political battleground"[42]. In addition, the OPT has been suffering from a "broader process of de-democratization"[43]. For example, "Oslo has led to the fragmentation of the PLO and the Palestinian body politic at large […whereby] the voice of Palestinian refugees and that of the diaspora seem to have disappeared [or marginalized in terms of] international focus and assistance [compared to] the PA and the population living inside the occupied territory"[44]. Also, the Fatah- Hamas split has created "two *de facto* governments in Ramallah and Gaza with parallel Ministries of Health"[45], with implications of political clientelism and restrictions on freedom of expression in both areas, resulting in "the creation of *constituencies* in institutional guise"[46], including in the health sector. Although Hamas worked to improve "co-ordination and transparency", practices of political clientelism, authoritarianism, and unaccountability were also noted in Gaza health institutions under Hamas government[47]. For example, "while securing economic and social rights seemed to be a priority of the Hamas government […], the situation was substantially different when it came to civil and political rights"[48]. That "Ramallah largely contributed to footing the [health] bill [in Gaza] by paying salaries of PA employees"[49] is also critical, affecting the cohesion of institutions, including health institutions in Gaza, as we shall see in the report.

On the social level, the Palestinian society has witnessed "regressive social trends, characterized by rising alienation and tribalism, especially in Gaza"[50]. The blockade has also contributed negatively to this closure of identity. Thus, "rather than moving towards a common Palestinian identity, Gazans have been reverting to the clan for security, identity, and a sense of belonging"[51]. (For more details,

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[34] (Le More, 2005, p. 983).
[35] (Roy, 1999, p. 78).
[36] (Farsakh, 2003, p. 25, also see Roy 1999).
[37] (Challand, 2008, p. 233).
[38] (Roy, 1999, p.68).
[39] (Sayigh, 2007, p. 26).
[40] (Sayigh, 2007, p. 26).
[41] (Sayigh, 2007, p. 6).
[42] (Roy, 1993, p.25). (Also see: Jebril, 2006).
[43] (Le More, 2005, p. 987).
[44] (Le More, 2005, p. 987).
[45] (Malka, 2012, p. 4).
[46] (Roy, 1993, p. 25).
[47] (Berti, 2015, p. 25).
[48] (Berti, 2015, p. 26).
[49] (Berti, 2015, p. 25).
[50] (Roy, 1999, p. 77).
[51] (Roy, 1999, p. 77).

see Section 5.4.1). Educational institutions in Gaza were affected by this structure of de-development, which undermined academic work and activities at Gaza's universities[52]. Hence, a structure of 'de-development' can be observed on various parallel levels in Gaza, affecting the health sector, as we shall see shortly in the report.

Legacy #2: an interplay between health and political (and factional) activism[53]

In order to fill the policy and delivery voids neglected by the occupation, political (factional) activism has emerged to take the responsibility for helping the Palestinian community by providing crucial health services. During the Egyptian political administration in Gaza, for example, health infrastructure reached the countryside but "these services were rudimentary restricted largely to the biomedical and curative variety"[54]. The Israeli authorities were also not concerned with improving the health services in Gaza. That said, "starting in the early 1970s, the main PLO factions created popular committees in the territories to promote political participation, to fight against Israeli policies of de-development, and to provide basic services to the population" under occupation conditions[55]. Palestinian charitable and civil society organizations were "mobilized […] to fill the void and provide basic community services to rural and needy urban areas and refugee camps"[56]. With the help of volunteers from the population, they "started working in outreach clinics, camps and villages under the slogan 'the health service is a right for whoever needs it' "[57].

In the late 1970s, Palestinian Non-Governmental organizations (PNGOs) "started proliferating [and] these were […] largely linked to the Palestinian political factions"[58]. Combining activist with professional work, these organisations "aimed to compete with the [Israeli government in the health sector] for political reasons"[59], such as challenging the occupation. They also competed among themselves. After the Oslo agreement, the PNA attempted to absorb "or at least regulate the NGO sector operating under its authority"[60]. Among other things, this attempt was to contain their political role which "was not [always] in harmony with the PNA's agenda"[61].

Towards the Second Intifada, "professionalized" NGOs, supported by a variety of international donors, "have again become major actors in providing vital resources to the Palestinian population"[62]. These secular NGOs, linking their "relief efforts to the unclear political intensions of international donors", "seeking privileges for themselves and abandoning the common interests", have become unreliable institutions in the perception of many Palestinian people[63], especially in comparison with the charitable NGOs, Islamic and Islamist[64], who provided services that were "at the heart of local communities"[65]. For example, Hamas, as an Islamic Palestinian movement, gained political

[52] (Jebril, 2018).
[53] (Challand, 2008, p. 229)
[54] (Giacaman, 1994, p. 13).
[55] (Challand, 2008, p. 230).
[56] (Abuiyada & Abdulkarim, 2016, p. 31).
[57] (Abuiyada & Abdulkarim, 2016, p. 31).
[58] (Bank, 2006, p. 14).
[59] (Schoenbaum et al., 2005b, p. 27)
[60] (Abuiyada & Abdulkarim, 2016, p. 32).
[61] (Abuiyada & Abdulkarim, 2016, p. 37).
[62] (Challand, 2008, p. 234).
[63] (Challand, 2008, p. 234).
[64] Although there is not much difference between Islamic and Islamist in the Palestinian (Gaza) context, the term 'Islamic' can refer to those NGOs who are generally offering charities for religious reasons, while 'Islamist' NGOs are more politically focused, using religion to advance agendas that serve their parties.
[65] (Challand, 2008, p. 235).

momentum "through activism in the charitable sector"[66], since "social work and 'social solidarity' have always been two core priorities for Hamas. On its establishment, the group inherited the social welfare structure that the Gaza branch of the Muslim Brotherhood had created over the previous decades, relying on charities, mosques, and other religious institutions" [67].

Thus, the charitable sector is "linked in part to a [conservative and religious] discourse that is in opposition to [the secular left, and] the parlance advanced by large Western donors and relayed by professional NGOs"[68]. This oppositional stand reflects on PNGOs relationship with each other, and with government. For example, after the split between Hamas and PNA in 2007, "Hamas government boosted its direct control of the state welfare apparatus and strove to establish control over civic and international social services networks" in Gaza[69]. Concurrently, "Hamas movement continued to maintain its social network structure"[70]. Hamas "actively tries not to publicise which health institutions it controls to avoid crackdowns by both Fatah […] and Israel on its facilities"[71].

An interplay between political (and factional) activism and health can still be seen in Gaza[72]. A senior policy maker from the NGOs sector explained the following:

> ***"After the peace process in 1994, the [Fatah- dominated PNA] established its NGOs. These NGOs did not live long because their work as NGOs conflicted with their accountability to government. Hamas also had its charity associations since the 70s and has established several NGOs in Gaza. According to the Interior Ministry which has a registrar of these NGOs, around 1000 NGO were registered after Hamas took control of the Gaza Strip. This doesn't mean that all these NGOs are Hamas' institutions, but many of them are, or at least were backed by Hamas Movement. Not all these NGOs are active. There is competition between the NGOs because of competing political background or because each has a different working goal".***
>
> *Senior Policy Maker: (Interviewee 5, NGO)*

One major drawback of the Palestinian schism is that it has increased the fragmentation of the health sector. For example, a senior academic participant complained:

66 (Challand, 2008, p. 227).
67 (Berti, 2015, p.11).
68 (Challand, 2008, p. 227).
69 (Berti, 2015, p. 26)
70 (Berti, 2015, p. 26).
71 (Batniji et al., 2014, p. 349).
72 (Jebril, 2018; Pace, 2013; Roy, 2011, p. 4).

> ***"We have to blame both parties, Hamas and Fatah because they are responsible for the division of the Palestinian people, and the duplication of services".***
>
> *Senior Policy Maker: (Interviewee 2, AC1)*

The above quotations have provided insights into health as a site of political conflict. This is further explored throughout the report, particularly how PNGOs agendas and international assistance continue to affect the health sector in Gaza will be explained in (Section 5.3).

4.2.2 Decision 'taking', and the lack of a unified Palestinian vision

Establishing a unified Palestinian vision in the health sector in Gaza is challenging. Previously, planning for the healthcare was an outsider activity (#Legacy 3), carried by the occupying regime, for example Israel and other funding bodies, while excluding Palestinians' voice in shaping its priorities. The persistent fragmentation of the health sector today indicates that health planning continues to be characterized by a lack of coordination (#Legacy 4). UNRWA's situation seems to be comparatively advantageous (Legacy #5) to other health providers, as it enjoys relative autonomy and can forge its own cooperative relations, although due to historical reasons, enduring trust barriers remains between UNRWA and Palestinians in Gaza.

Legacy #3 Health planning as an 'outsider activity'

In the OPT, "planning […] has traditionally been a complex process, typically undertaken by outsiders, and health planning is no exception"[73]. The rulers who governed Gaza and other parts of the OPT had their own agendas and interests which did not necessarily serve Palestinians[74]. Therefore, for decades, Palestinians' voice and input were largely excluded from shaping the health sector. For example, planning for UNRWA "was mainly conducted at UNRWA headquarters in Vienna […], with some local Palestinian input"[75]. It is also reported that "during the period of Israeli administration (1967-1994), planning for the government health sector [in Gaza] was led primarily by Israelis, with some Palestinian participation in policy formation and with Palestinian administrative support"[76]. However, this participation seems to be insignificant since other literature sources[77] explain that the Israeli Administration has completely excluded Palestinians' voice in shaping their healthcare. Even after the Oslo Agreement 1993, the PNA resorted to "outside-driven health sector reforms" that were motivated by "intense political and economic pressure exerted by large donors"[78]. For example, "the PA regime was built with international funds at the cost of democracy, transparency, accountability,

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[73] (Abuiyada & Abdulkarim, 2016, p. 34).
[74] (Abuiyada & Abdulkarim, 2016).
[75] (Schoenbaum et al., 2005, p.27).
[76] (Schoenbaum et al., 2005, p.27).
[77] (Giacaman, 1994).
[78] (Challand, 2008, p. 233).

the rule of law and respect for human rights”[79]. This institutional collapse has nearly become “irreversible” with the Palestinian Authority being “locked into [international community] policies that are bringing about the very humanitarian crisis it seeks to alleviate, while generating long-term dependence on external funding”[80].

The interview data indicate that despite efforts from Palestinian leaderships and NGOs in the West Bank and Gaza to work towards autonomy, the health sector continues to be led mainly by outsider agendas. For example, a senior policy maker from an international organization commented:

“For historical and political reasons, quite often the ministries of health [in Gaza and Ramallah] are led by bilateral donors. Therefore, the Palestinian health ministry(ies) is not the dragging feet”.

Senior Policy Maker: (interviewee 1, OI1).

For more discussion on international assistance of the health sector in Gaza, see (Section 5.3.2).

Legacy #4 Lack of co-ordination

The lack of coordination between health providers has a negative impact on the Palestinian health sector, impeding progress towards achieving National Health Plan and its actual implemental, as well as “reduc[ing] the financial viability of the health care system, and undermin[ing] public confidence in the government health system and possibility in the government generally”[81]. Decades of occupation made healthcare for people in Gaza be provided “in ad-hoc and uncoordinated manner”[82]. As indicated in (Section 4.2), “when the PA took over the public health sector in May 1994, it also inherited a health care system that suffered from [fragmentation, and] weaknesses in both structural and infrastructural development”[83]. Among the different actors in the health sector today, there is also “competition and hostility” as these actors work to “promote the provider’s own agenda and not the recipients’ interests”[84]. The PA failed in its attempt to form a council which included representatives of health providers and other decision makers. That said, “as the MOH became established [..,] many of the council’s [staff and] responsibilities […] shifted to MOH […and thus] although the council was not disbanded, it quickly stopped functioning as the national planning and coordination body for the health system” (p. 29). Under Hamas government, there has been initiatives to establish coordinating bodies that include the Ministry, UNRWA, Universities, NGOs and other providers, however, they remain **“ink on paper”** (Interviewee 5, NGO1), failing to materialize their goals on the ground. For example, a few participants from Gaza pointed out to an existing and functional **“health cluster”**, an initiative by WHO, which includes regular meetings between health

[79] (Le More, 2005, p.986).
[80] (Sayigh, 2007, p. 8).
[81] (Schoenbaum et al., 2005, p. 29).
[82] (Giacaman, 1994, p. 19).
[83] (Abuiyada & Abdulkarim, 2016, p. 35).
[84] (Abuiyada & Abdulkarim, 2016, p. 34).

providers to exchange information and discuss coordination. However, this initiative is faced by challenges. For example, a senior policy maker from the NGOs sector, commented:

> ***"There were and still attempts to make this health cluster take a larger role in the sector. As Palestinian NGOs, we refuse this body to overshadow the government, and as NGOs, we will stand against this firmly. The health cluster works to achieve co-ordination, but it does not have a strategy to achieve this coordination or the power to impose it on us".***
>
> *Senior Policy Maker: (Interviewee 5, NGO1).*

After the Palestinian schism, "the health care system was also partially transformed, with Hamas replacing staff—especially at the managerial level—with its own members, […] following a crippling strike of health care workers during the summer of 2008"[85]. How this is affecting the relationship between the Hamas and PNA ministries of health, and the staff working in governmental institutions, will be explored further in (Sections 5.3; 5.6).

Legacy # 5 UNRWA: Enduring trust barrier, and comparative advantage

a. Enduring trust barrier

Because of "UNRWA's imbrication in local, regional, and global politics"[86], there are different perceptions to its role in the OPT (see Box 4.2). For Palestinians, "UNRWA was originally created to implement small and large-scale development schemes across the main Arab states hosting refugees, a mission encapsulated in the term "Works" in its name"[87], (See box 4.1). Due to "the fact that UNRWA's 1950s development efforts were tied to a deliberate attempt to use development as a tool for refugee resettlement and as an alternative to return- a solution that the international community was officially facilitating at the time—would create an enduring trust barrier between the agency and refugees"[88]. Until today, the Palestinians fear UNRWA's "hypocrisy of proclaiming repatriation while planning resettlement […] any change in UNRWA programs [would raise[..] the bugaboo of a 'liquidation plot' and contribute […] to refugee paranoia and cynicism"[89]. For example, (Interviewee 1, IO1) said:

[85] (Berti, 2015, p. 25).
[86] (Gabiam, 2016, 61).
[87] (Gabiam, 2016, pp. 52; 53).
[88] (Gabiam, 2016, p. 54).
[89] Political scientist Benjamin Schiff (19995, 46) in (Gabiam, 2016, p. 54).

> ***"It is true that coordination is not optimum. What I can see is historical reasons and power politics. Historically, UNRWA has been there for 70 years, so it is a standalone programme. So, there is still a mentality for such a presence of UNRWA and that is big in Gaza, and not small in the West Bank. This affects coordination. This is not only in relation to UNRWA, but also to all other care providers that are quite independent, and then there is the trouble that both many not follow the Ministry"***
>
> *Senior Policy Maker: (Interviewee 1, IO1)*

Over more than 70 years, UNRWA has offered crucial food aid, health and education services, protection and infrastructure projects for camp improvement to Palestinian refugees in Gaza. A lack of trust in UNRWA continues, regardless. For example, on 20 October 2020 protesters[90] gathered in front of UNRWA Jabalia clinic to protest UNRWA's decreased support, which was prompted by UNRWA's financial crisis[91]. Despite Covid-19 guidelines, these protests attracted representatives from religious, national and public institutions in Gaza. The protesters carried flags and angry political messages[92], for example: "Our right of return did not and will not be cancelled by time progression"; and "It is the right of Palestinian people to return to their homes". Protesters fear that UNRWA's decreased support is a manipulation that is politically motivated.

b. Comparative Advantage

In comparison to other health providers in the OPT, UNRWA enjoys a more privileged status. This is due to a few reasons: UNRWA is a UN institution which is not dependent on the Israeli health system[93]. UNRWA has existed since 1949, so it is an old institution with well-developed policies and monitoring and evaluation schemes[94]. For example, (Interviewee 8, NG) said: **"UNRWA is similar to a state. Everything is clear at UNRWA"**. In addition, "UNRWA's network of offices and its large staff in the West Bank and Gaza have given it a comparative advantage over other health providers"[95]. As (Interviewee 1, OI1) explained, since **"UNRWA is the best company for people who live in Gaza, it has a very good staff"**.

This made UNRWA capable of the following: (1) Coordinating donor funds on the ground for those who wished for their assistance to remain anonymous, and for those who are outside the OPT; and (2) "Establishing formal working relationship with all the health providers including these in the public sector, which was run by the Israeli until 1994"[96].

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[90] (Maan News, 2020)
[91] (UNRWA, 2020)
[92](Maan News, 2020)
[93] (Giacaman, 1994).
[94] (See for example, UNRWA, 2019).
[95] (Abuiyada & Abdulkarim, 2016, p. 36)
[96] (Abuiyada & Abdulkarim, 2016, p. 36).

While other health providers in Gaza struggle to maintain their services under occupation, UNRWA succeeded in achieving **"lots of remarkable improvements in its services, despite the deterioration of the whole situation in Gaza"** (Interviewee 6, OI3). A senior policy maker from an international organization commented:

> ***"Regardless of the country's conflict, the ability of health services should remain intact […]. In one sense, yes, UNRWA is privileged, but only in a comparative draw […]. The problem is not that UNRWA is enjoying this privilege. The real problem is that government services are negatively affected totally unnecessarily, to a large extent, and in an accessible way".***
>
> *Senior Policy Maker: (Interviewee 1, OI1)*

Since "75 per cent of Gaza residents and 30 per cent of West Bank residents - are designated as refugees"[97], UNRWA's work seems to be at a larger scale in Gaza than in the West Bank, although exploring this in detail is beyond the focus of this report. For more details on UNRWA and its services, see (Section, 5.1).

[97] (Schoenbaum et al. 2005, p.16)

Box 4.1 **Historical Background to the Politics of UNRWA in the OPT**

In 1949, “the United High Commissioner on Refugees (UNHCR) was created […] with a mandate that engaged with Palestinian refugees who lived in other countries, providing material assistance and protection” (Akram, 2019). This mandate, however, excluded those Palestinians who remained in the Occupied Palestinian Territories” (Akram, 2019). The exclusion of Palestinians from UNHCR’s mandate was encouraged by Arab States. On the one hand, this “was mostly due to fear from Arab States that if included in UNHCR, Palestinians “would become submerged [with other categories of refugees] and would be relegated to a position of minor importance’ ” (Gabiam, 2016, p. 51). On the other hand, the Arab States wanted to keep Palestinian refugees under UN umbrella rather than taking responsibility for them. Also, “In 1948-9, the UN established a special regime comprising two agencies, the United Nations Conciliation Commission on Palestine (UNCCP) and UNRWA, with shared but distinct international obligations towards the displaced Palestinian population” (Akram, 2014, p. 228). The UNCCP had a “protection mandate toward [Palestinian refugees as] the agency was charged explicitly with implementing paragraph 11 of Resolution 194 recognizing the right of return” (Gabiam, 2016, p. 52). That said, “consequently, the UN decided to exclude Palestinians from the ‘universal’ refugee regime incorporated in the in the 1950 United Nations High Commissioner for Refugees (UNHCR) Statue and the 1951 Refugee Convention” (Akram, 2014, p. 228).

At that stage, “UNRWA […] had been given only a relief and welfare mandate” (Gabiam, 2016, p. 52). When “in the mid 1950s, UNCCP’s activities had come to a standstill because of its failure to mediate a political resolution to the Israeli-Palestinian conflict” (Gabiam, 2016, p. 52). But “UNRWA was forced to respond to new challenges by extending its mandate on an ad hoc and temporary basis” (El-Malak, 2006, p. 187).

(a) Assistance: Firstly, “the agency’s assistance mandate was translated into three regular programmes of education, health and relief and social services along with its microentrerpise and microfinance special programme” (El-Malak, 2006, p. 187).

(b) Protection: Secondly, “UNRWA agrees that on the core refugee protection right, the search for and implementation of durable solutions, it has no mandate, other than to highlight the need for a just and comprehensive solution for the refugee problem” (Akram, 2014, p. 273). But “in UNRWA’s area of operation, Arab host government are, in principle responsible for the protection of refugees living under their jurisdiction. In the OPTs, the State of Israel as the occupying power since 1967, is responsible for the protection of civilians, both refugees and non-refugees” (El-Malak, 2006, p. 188). That said, “There is a “lack of any intervention by UNHCR or UNRWA in negotiations between the parties to the Israel-Palestine conflict concerning durable solutions for Palestinian refugees” (Akram, 2014, p. 273).

However, “whether it likes it or not, UNRWA is seen by Palestinian refugees as a *de facto* ally when it comes to publicizing their suffering to the rest of the world, maintaining their visibility as refugees – and consequently the visibility of the issue of return – and acting as a symbol of international responsibility for the Palestinian refugee situation. However, the agency is concurrently seen by refugees as not fully trustworthy and as a potential threat to Palestinian political claims (Gabiam, 2016, p. 58).

Box 4.2 **Different Perceptions of UNRWA**

There is a contestation on the perception to UNRWA by Palestinians, Arabs, the international community, and Israel. Below is a summary compiled from (Gabiam, 2016) to explain this:

- **For Palestinians:** "UNRWA'S services and its continuation as an agency are partly a matter of international responsibility for the refugee problem. Such responsibility is primarily assigned to Western countries given their dominant role in the United Nations, which endorsed the partition of Palestine in 1948. Palestinians also assign the responsibility to Israel for the forced displacement of Palestinians in 1948 and 1967"(Gabiam, 2016, p. 62).

- **For Arab:** Arabs "generally share the Palestinian narrative about the causes of the Palestinian refugee issue as well as the notion that UNRWA's services and its continuation as an agency are a matter of international responsibility. This position is at least partly linked to practical considerations because Arab host states do not want to shoulder the entire cost of refugee assistance. Moreover, despite its implied solidarity with Palestinian refugees, this position does not prevent Arab host states from simultaneously viewing the refugees as a potential security risk" (Gabiam, 2016, p. 62).

- **For the international community:** As "the international community and more specifically, UNRWA's major donor countries, [they] do not provide agency funding out of a sense of collective responsibility for creating the Palestinian refugee issue but for utilitarian reasons: […for example] "as part of their broader relations with host countries, as a way of dealing with the particular complexities caused by Hamas control of Gaza and the Israeli Egyptian embargo [on Gaza], and as means of reducing the challenge of "radicalism" and "extremism" among refugees and within refugee camps" (Gabiam, 2016, p. 62). But, "few (if any) of UNRWA's major donors would regard the refugees as having any unambiguous "right of return" after three generations, and very few (if any) would regard UNGAR 194 as establishing such a right. More to the point, these are simply not issues that the Agency' major donors spend any at all times considering (Gabiam, 2016, p. 62).

- **For Israel:** "Israel rejects any significant responsibility for the forced displacement of Palestinians in 1948 and 1967, arguing that Arab opposition to the 1948 UN partition of Palestine was the source of the refugee situation" (Gabiam, 2016, p. 62). Infact, "some UNRWA views emanating from Israel and from Western donor countries, and the kinds of policy initiatives that these views encourage, are especially pertinent in terms of elucidating refugees' enduring distrust toward the agency. More generally, they help explain the contradictory and ambivalent ways in which refugees have engaged and continue to engage with internationally funded projects officially aiming to improve living conditions in the camps" (Gabiam, 2016, p. 62). But "for some time now, Israel and Western critics of UNRWA have accused the agency of encouraging refugee dependency, and political radicalization" (Gabiam, 2016, pp. 62; 63).

All in all, "the views of UNRWA's critics highlight its perceived political role in upholding the political claims of Palestinian refugees, which helps explain the ironic situation in which Palestinian refugees criticize the agency for not being supportive of their political claims while Israel and Western detractors denounce it as perpetuating those claims. The notation that UNRWA is behind continued refugee advocacy for the right of return is not particularly convincing, however, in that it does not account for why such advocacy is as strong among camp refugees as it is among noncamp refugees […] . Additionally, the reality on the ground tells a more complicated story about the relationship between UNRWA and Palestinian refugees than the narratives crafted through the perceptions of the agency's various stakeholders" (Gabiam, 2016, p. 65).

4.3 Politics and the macroeconomic picture in Gaza today

The economy of Gaza is "stalling", as indicated by (World Bank, 2019a, p.3). Two main features seem to characterize the macroeconomic landscape today: Firstly, a turning 'inward' of the economy; and secondly, 'fragility', as will be explained shortly.

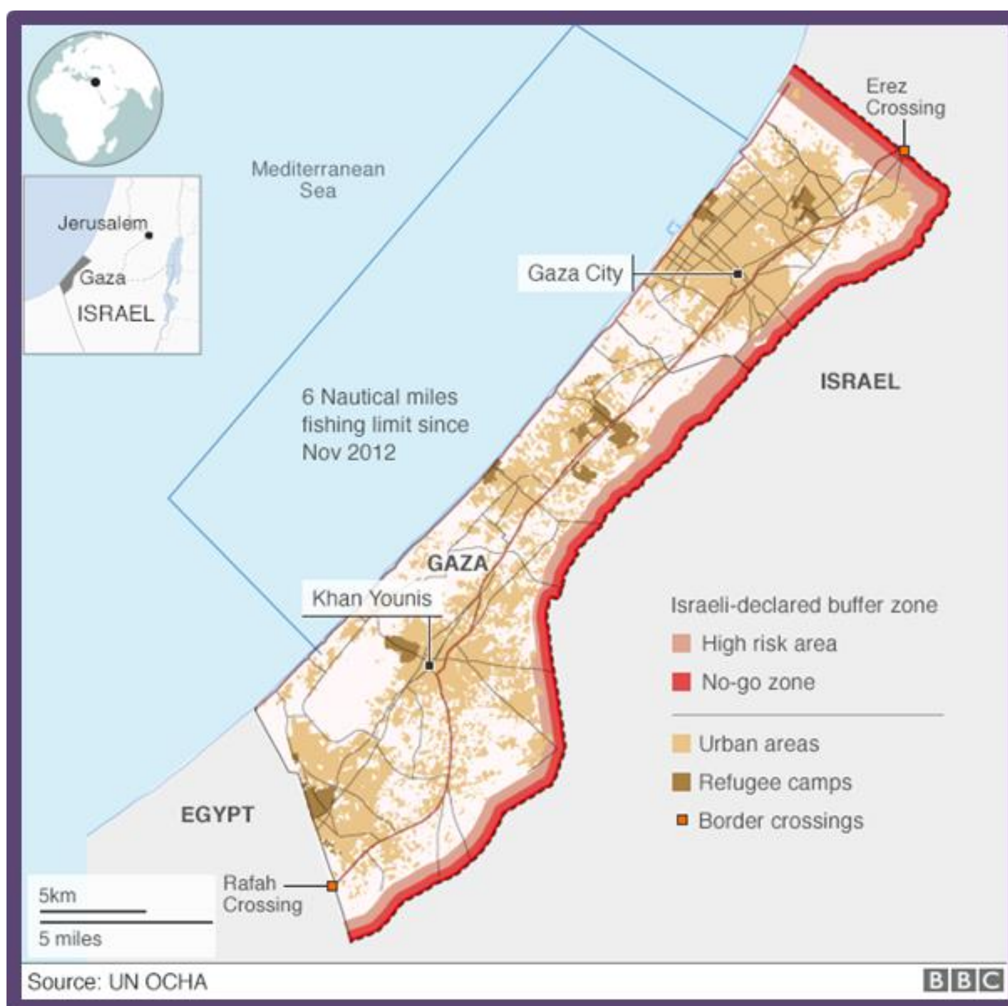
4.3.1 A 'turning inward' of the economy

The economy of Gaza is both "besieged and internally fragmented"[98]. Israeli policies in the OPT have also increased Palestinian dependency on the Israeli market "for goods and services", and as "a convenient source of Palestinian labour for the Israeli productive sector"[99]. For example, the "closure, the sealing off of the territories from Israel, from other external markets, and from each other [has become] the defining economic feature of the post Oslo period"[100]. This process of "enclavisation" created new dynamics of "economic autarky [whereby] economic behaviour [turns] away from international market relations towards more traditional activities and production modes"[101]. Economic autarky is "expressed in employment, trade, and income patterns have further crippled the Palestinian economy"[102]. With an imposed blockade on Gaza, "the Palestinian economy has adapted to siege conditions by restricting in problematic ways"[103]. (See Map 4.1 below).

The international "policy of isolation and economic restrictions" on Gaza under Hamas government indicates that "the economy in Gaza developed in a highly dysfunctional and aid dependent way"[104]. Currently, Hamas relies on funding from the PA[105], "the international humanitarian sector, especially the UNRWA", in addition to receiving "donations from regional actors, like Iran and Qatar"[106]. Under restricted conditions, Hamas "administration managed to keep the economy afloat, while devising its own revenue collection system on businesses, real estate, smuggled goods, and created its own autonomous Gaza-based bank and insurance company"[107]. Thus, "economic practices in Gaza by force of circumstance [rather than policy] have tended toward autarky and rent seeking (managing the tunnel economy)"[108].

[98] (Le More, 2005, p. 984).
[99] (Obeidallah et al., 2000, p. 8).
[100] (Roy, 1999, p.68).
[101] (Roy, 1999, p.68).
[102] (Roy, 1999, p.68).
[103] (Sayigh, 2007, p.26).
[104] (Berti, 2015, p. 20; 22).
[105] Berti (2015) explains that after Hamas took over Gaza, 'Ramallah continued to pay the salaries of more than 70,000 public employees' there, which makes it one of the "largest employers in the Strip" (p.22). UNRWA is the second largest employer, employing "approximately 11,000 people" (*ibid.*)
[106] (*ibid.,* p.22).
[107] (Berti, 2015, p. 24).
[108] (Khalidi & Samour, 2011, p.11)

Map 4.1 Gaza Blockade



(BBC News, 2018, no pagination)

In order "to mitigate the impact of the blockade on Gaza, a tunnel economy evolved and peaked between 2007 and 2013"[109]. Hamas "built huge tunnels across the border into Egypt's Sinai through which they smuggled foodstuffs, fuel, and livestock […in addition to] guns, ammunition, and rockets"[110]. A senior policy maker from the NGO sector (Interviewee 5, NGO1) indicated that the tunnel economy has not directly reflected on the health sector or caused its improvement. But **"It mainly improved the economic conditions for people, because around 10,000 people could find employment through working in the tunnel economy […]. In fact, [the tunnel economy] reflected negatively on [NGO institutions], because some unknown drugs were smuggled, and passed without monitoring".** A health official (Interviewee 10, G2) also said that **"medical equipment used to enter through formal routes, but for simple things, such as printing papers, it would arrive through the tunnels on a cheaper price. But the formal prices used to be less than today anyway, and [employees] used to have a full salary, so it would not make a difference for [them] if they bought those, which were a bit more expensive".**

[109] (UNCTAD, 2015, p.13).
[110] (Danahar, 2013, p. 167; see also: Berti, 2015; Hassan, 2015; Pace, 2013).

The number of tunnels reached "more than 1,532 […] running under the 12 km border between Gaza and Egypt"[111]. But "the majority of the tunnels have been either blocked or destroyed"[112], following the 2013 Egyptian *coup d'état* in July. The "Egyptian government [of Al Sisi has also] closed the Rafah border crossing, stopping the flow of goods and individuals that travelled between Egypt and Gaza"[113]. Today, that tunnel economy may still be operating underground, albeit in a much more restricted form. For example, a senior policy maker explains:

"More than 90 or 95% of tunnels were demolished both by the Palestinian and Israeli sides, so the tunnel [economy] has almost ended, but there are violations that happen sometimes […]. The distance between Palestinian and Egyptian Rafah is [about] 50 metres, so some people can make a tunnel that extends from their home staircase to their relative's home staircase [in Egyptian Rafah]. They can then smuggle whatever they want. Today, this is very difficult because Egyptian Rafah has become like a ghost town".

Senior Policy Maker: (Interviewee 4, G1)

Decline in living standards

As shown in Figure 4.2 below, "the gap between the West Bank and Gaza has increased substantially in 2016/17 with 46 percent of the population below the US$5.5 poverty line in Gaza, compared to 9 percent in the West Bank"[114]. The devastating siege on Gaza resulted in a "great shortage of fuel and cooking gas, and power cuts are frequent"[115]. BBC News (2018) reports, for example, that "on average, Gazans get only three-six hours of electricity a day"[116]. Gaza's "living conditions have [also] worsened with almost 1 in every three in the labor force unemployed and 24 percent of Palestinians living below the US $5.5 2011 PPP a day"[117]. Currently, "unemployment among Gaza's youth exceeded 67% per cent"[118].

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[111] (UNCTAD, 2015, p.13).
[112] (Berti, 2015, p. 23).
[113] (Dickstein, 2014, p. 10; also see: Gilbert, 2016, p. 60).
[114] (World Bank, 2019a, p. 171).
[115] (Giacaman et al., 2009, p. 841).
[116] (BBC News, 2018, no pagination).
[117] (World Bank, 2019a, p. 170).
[118] (World Bank, 2019a, p. 170).

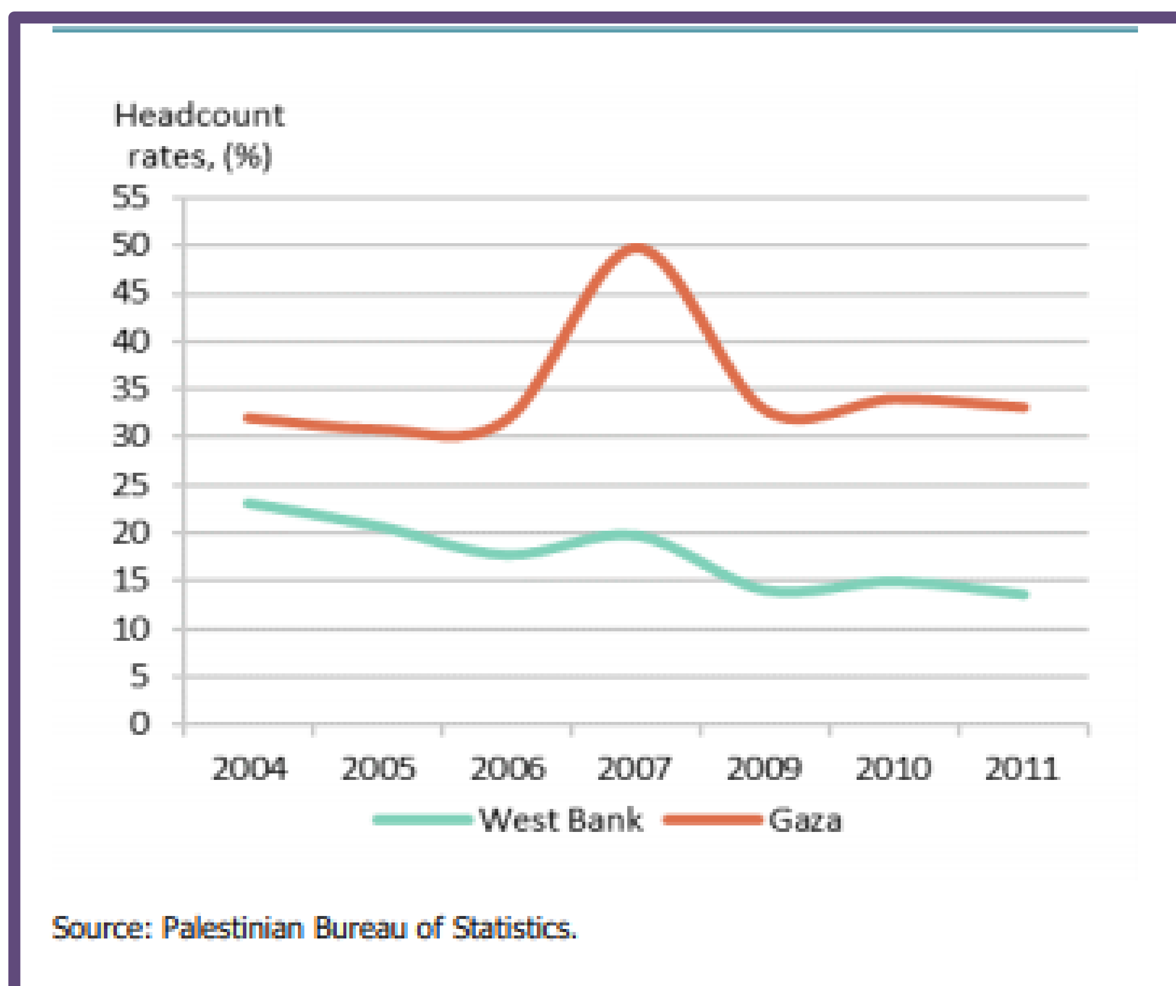

Figure 4.2 Poverty Gap between the West Bank and Gaza

(World Bank, 2018, p. 1)

Israel also continues to put restrictions on "key production inputs, namely those deemed as 'dual use[119]'" with notable "economic costs on Palestinian economy"[120]. For example, (WHO, 2017c) reports that "the heavy use of [electricity] generators have increased the maintenance required, which is difficult to provide, as spare parts are on the 'dual-use list' and restricted from entry to Gaza" (no pagination). But these generators are needed by different institutions (including health institutions) and production factories to deal with long hours of power cuts in Gaza. This as well as years of blockade have incapacitated Gaza economy, leaving it "reliant on consumption-driven growth"[121]. As for 2018, there was "a 7 percent contraction in [real growth in] Gaza"[122]. World Bank (2019a) forecasts a "continuous decline in real per capital income and further rise in unemployment and poverty"[123].

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[119] World Bank (2019a) defines 'dual use' as "products and technologies normally used for civilian purposes, but which may have military applications. Like many other advanced economies, Israel controls its exports of dual use goods. However, when it comes to exports to the Palestinian territories, the GoI enforces additional controls on top of those established by the relevant international treaties. These controls were first reflected in a 2007 law, but the list has since been significantly expanded" (p.4).

[120] (World Bank, 2019b, p. 4).

[121] (World Bank, 2019b, p. 4).

[122] (World Bank, 2019a, p. 3).

[123] (World Bank, 2019a, p. 4)

4.3.2 Fragility

The economy of Gaza is considerably "fragile"[124]. Thus, it can be susceptible to significant risks pending on changes in two interrelated factors[125]: (1) reductions in transfers; and (2) the changes in conflict.

Firstly, "any change in social assistance [monetary] flows can significantly affect the population's wellbeing"[126]. This is because Gaza is largely and mainly dependent on "donor aid and spending through the budget of the Palestinian Authority (PA), both of which amounted to 70-80 percent of Gaza's GDP"[127]. But "these two sources have significantly declined recently"[128]. For example, there has been a decline of aid to the PA between 2017-2018[129]. (See Figure 4.3 below). Furthermore, "a continued decline in foreign aid is also expected"[130]. For example, "the Trump administration has announced it will cut all US funding" for UNRWA for Palestinian refugees including Gaza[131]. Since UNRWA's "funding gap persists, this […had] a severe impact on economic activity, service provision and social conditions in the Gaza Strip"[132].

Table 1: Aid to the Palestinian Authority's budget

External Financing (US$ million)	2017	2018
Budget Support	543	516
a. Arab Donors	145	305
Saudi Arabia	92	222
Algeria	52	27
Qatar	0	0
Oman	0	0
Egypt	1.1	4
Kuwait	0	53
b. International Donors	398	210
PEGASE	240	184
USA	73	0
India	0	0
France	9.2	9
Malaysia	0	0
Turkey	0	6
World Bank	76	10
DPG	30	0
PRDP TF	46	10
Development Financing	175	160
Total	**718**	**676**

Source: PA MoFP.

Figure 4.3 Decline in Aid to the Palestinian Authority's Budget

(World Bank, 2019b, p. 9)

124 (World Bank, 2019a, p. 170).
125 (World Bank, 2019b).
126 (World Bank, 2019a, p. 171).
127 (World Bank, 2019b, p. 170).
128 (World Bank, 2019b, p. 170).
129 (World Bank, 2019b, p. 170).
130 (World Bank, 2019b, p. 170).
131 (The Guardian, 2018).
132 (World Bank, 2019a, p. 171).

OCHA OPT, (2019) also reported a deterioration in electricity conditions since April 2017, affected by a "context of disputes between the *de facto* authorities in Gaza and the West Bank-based Palestinian Authority"[133]. In turn, this "ongoing power shortage has severely impacted the availability of essential services, particularly health, water and sanitation services, and undermined Gaza's fragile economy, particularly the manufacturing and agriculture sectors"[134]. The budget for Gaza is likely to decrease, hence it is reported to be in fiscal crisis[135]. The PA is expected to deal with this crisis by "resort[ing] to domestic sources of financing including debt from local banks and arrears to the private sector and the pension fund, crowding out the private sector"[136]. This is "threatening the economic prospects […as it is] in increasing risks for the banking sectors, whose recent performance is already showing signs of concern"[137]. Future developments in this regard are likely to reflect on PA's spending on Gaza MoH and other sectors.

Secondly, the ongoing political conflict also exposes Gaza's economic and (human) resources, already scarce, to vulnerability, adding more challenges to a fragile economy. For example, MAP, (2017) states that "successive Israeli military operations in Gaza between 2008 and 2014 saw 147 hospitals and primary health clinics and 8 ambulances damaged or destroyed, and 145 medical workers injured or killed"[138]. Furthermore, "security remains volatile, with recurring incursions and airstrikes by the Israeli security forces (ISF), alongside the firing of rockets by militants, and frequent civil unrest"[139] (p.4).

To recap, the fragility of the context in Gaza has reflected on its economy, affecting current living conditions, and limiting prospects for future development, which will be causing a further deterioration of the economy for years to come.

133 (OCHA OPT, 2019, no pagination)
134 (OCHA OPT, 2019, p. no pagination).
135 (See: World Bank, 2019a, p. 171, 2019b, p. 3).
136 (World Bank, 2019a, p. 171).
137 (World Bank, 2019b, p. 3).
138 (MAP, 2017, p. 13).
139 (UNRWA, 2019, p. 4).

4.4 Broad features of the population health context in Gaza

This section outlines four features of the population health context in Gaza: The majority of people in Gaza are young and refugees (Feature #1). As a result of a rapid epidemiological transition (Feature #2), Gaza is witnessing an increase in non-communicable diseases (NCDs). There is also a prevalence of mental health conditions, which are *inter alia* caused by exposure to trauma (Feature#3). The conflict is also indicated as one of the causes for disability in Gaza (Feature #4).

4.4.1 Demographic Trends: A young and refugee society

Photo Credit: Federico neri/ Shutterstock.com

The total Palestinian population of Gaza has reached 1.9 million, with 49 per cent being females[140]. According to WHO - OPT (2018: p.24), 50%[141] of Gaza population are also under the age of 18, meaning that, "the [Gaza] Palestinian society remains a 'young society'"[142]. The life expectancy at birth for the OPT population is 73.5[143] . Also, infant mortality has reached 18 deaths per 1,000 live births; and maternal mortality 45 deaths per 100,00[144]. From another perspective, the Gaza society is a majority refugee population, with 74.5 per cent of the Palestinian population in Gaza being registered refugees

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140 (UNRWA, 2019, p.3).

141 According to (UNRWA, 2019), only 18.4 % of the Palestinian population in Gaza are between 15-24).

142 (MoH - Palestine, 2017, p. 29).

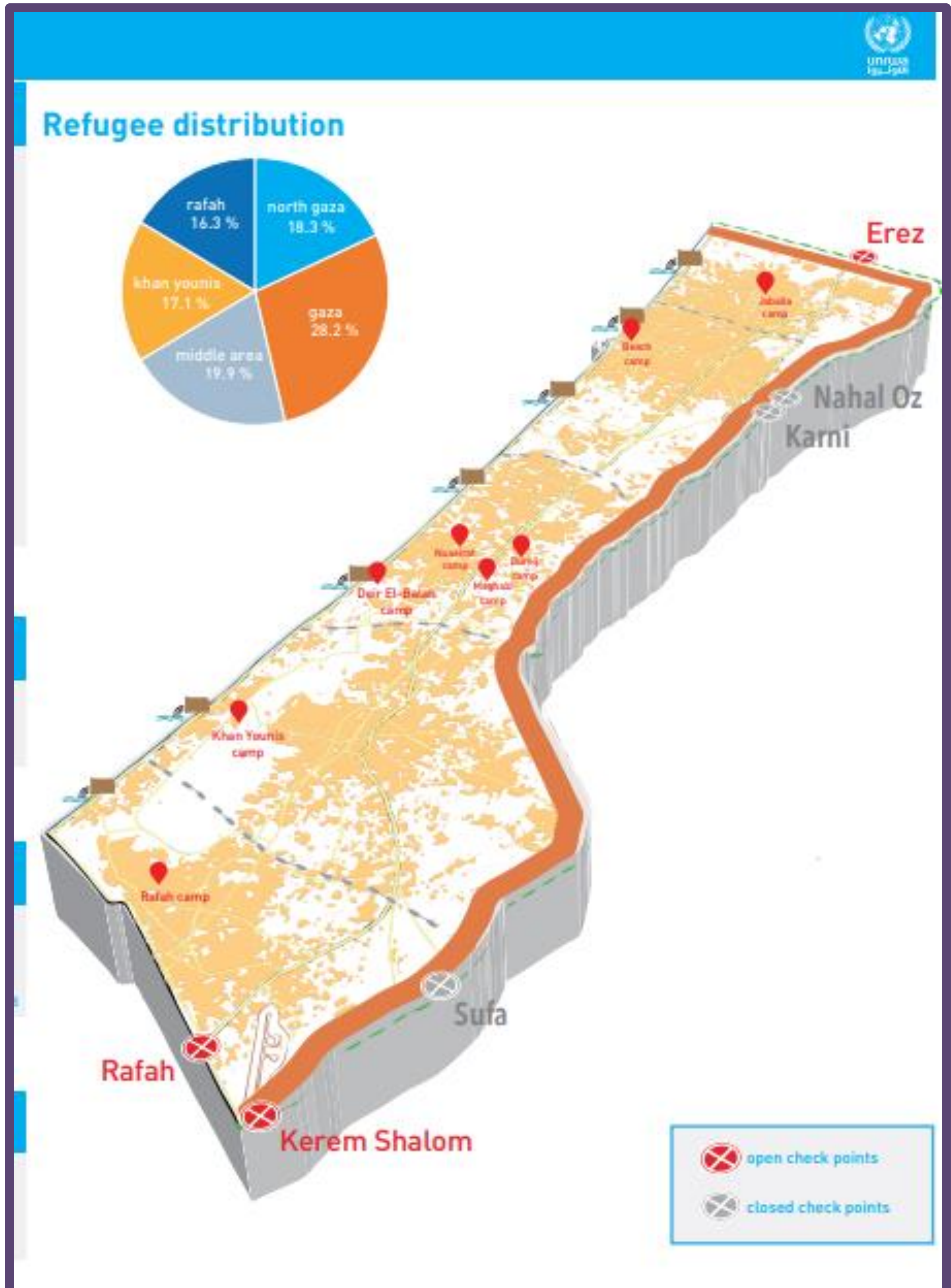
143 (World Bank, 2019b, p. 170). This is also consistent with the estimation of WHO - OPT (2018) of life expectancy at birth in Gaza at 73 years.

144 (WHO - OPT, 2018, p. 24).

at UNRWA. Of these, 581,442 live “below the abject-poverty line”[145]. That said, “socioeconomic factors associated with the blockade, the lack of employment, opportunities, political uncertainty and a chronic energy crisis continue to have significant repercussions on the lives of Palestinian refugees”[146]. Currently, there are 1.4 million registered refugees in Gaza; 42% of these refugees reside in 8 camps in, while 58% live in other areas[147]. For more details on refugee distribution in Gaza, see Map 4.2 below:

145 (UNRWA, 2019, p. 3).
146 (UNRWA, 2019).
147 (UNRWA, 2019, p. 8).

Map 4.2 Refugee Distribution in Gaza



(UNRWA, 2019, p.8)

4.4.2 NCDs: Rapid epidemiological transition

Currently, “Palestine is encountering a rapid epidemiological transition from infectious diseases to chronic diseases, with highly increasing burden and magnitude of chronic NCDs”[148]. For example, Palestinian Centre Bureau of Statistics (PCBS) states that the percentage of 18 years old and over reported suffering from at least one diagnosed chronic disease in 2010 was 18.8, compared to 11.5 in year 2000. Such an “increase in chronic diseases is [usually] associated with changes in lifestyle, behaviour, physical inactivity and poor eating habits”[149].

In fact, NCDs are becoming the main causes of morbidity and mortality in the OPT[150]. Particularly “heart diseases and cancer remain […] major burden[s] of chronic diseases”[151]. MoH - Palestine (2017) confirms this as it states that “chronic diseases including cardiovascular disease, cancer, stroke and diabetes accounted for 67.0% of all reported deaths in 2017”; with Gaza deaths accounting for “37% of the reported in Palestine”[152] . As WHO (2017a, p. 14) points out, “noncommunicable diseases are on the rise and contribute significantly to premature death and reduced life expectancy”[153].

4.4.3 Mental Health: Exposure to trauma

Photo Credit: Federico neri/ Shutterstock.com

[148] (Mosleh, Aljeesh, & Dalal, 2016, p. 265). (Also see: Giacaman et al., 2009, pp. 841–842; WHO, 2017a, p. 13).
[149] (MoH - Palestine, 2017, p.32). (Also see: WHO, 2017a, p. 15).
[150] (Giacaman et al., 2009, pp. 841–842).
[151] (Mosleh, Aljeesh, & Dalal, 2016, p. 267).
[152] (MoH - Palestine, 2017, p. 30).
[153] (WHO, 2017a, p. 14).

> ***"I can describe mental health issues in Gaza as an epidemic, because maybe no one in Gaza is not suffering from psychological and mental problems. People are trapped in this large prison, under threats of escalation, so they feel tensed all the time as they do not know what will happen to them and to their children in the future".***
>
> *Senior Policy Maker: (Interviewee 6, IO3)*

WHO (2017a) explains that "robust data are not available on the prevalence of mental disorders, which are both under-recognized and stigmatized [in Gaza] and therefore under-reported and under-treated"[154]. But what is evident is that "exposure to war trauma constitutes a risk factor for chronic mental health problems, mainly posttraumatic stress disorder, depression and anxiety"[155]. Also, "Palestinians are frequently exposed to violent conflict, especially those in Gaza who have also endured a decade of blockade and closure"[156]. They "live in alarm and pain because of current life events, but also because of the history of mass trauma that is part of their collective consciousness"[157].

WHO - OPT (2018) estimated that 21% people are in need of psycho-social support[158]. In fact, "one third of people attending Ministry of Health primary health care centers in Gaza and the West Bank report suffering symptoms of mental ill health"[159]. For example, carer of two mental health patients (Interviewee 14, CP3) said: **"there are thousands of people [approaching the mental health clinic]. When we go there, we have to queue. There are many mental health cases, because the situation in Gaza has become very difficult".** It has been estimated that "95% of those under 18 suffer some symptoms of post traumatic stress disorder (PTSD) impacting their daily lives, school performance and social interactions"[160].

For more details on this topic, listen to **Episode (3)** of *A Life Lived in Conflict Podcast*, **on "Trauma and Mental Health in Palestine"** – produced by the author in (April, 2021). In this episode, Dr Mona Jebril is in conversation with:

- Dr Yasser Abu Jamie (Director of Gaza Community Mental Health Programme).
- Dr Hanna Kienzler (Reader in Global Health, King's College London).

The discussion also includes updates on how mental health in Palestine is affected by Covid-19 global health emergency.

*Listen to Episode (3) through this link: https://soundcloud.com/monajebril/episode3

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[154] (WHO, 2017a, p.15).
[155] (Khamis, 2012,p. 2005).
[156] (MAP, 2017, p. 21).
[157] (Giacaman et al., 2009, p.843).
[158] (WHO - OPT, 2018, p. 24).
[159] (WHO, 2017a, p.15).
[160] (Thirkell, 2012, p. S107)

4.4.4 Disability: Conflict and depression are among the causes

Photo Credit: Abed Rahim Khatib/ Shutterstock.com

According to WHO - OPT (2018), 7% of the population in Gaza have disability[161]. There are different causes of disability in Gaza, including conflict and occupation. For the year 2012, "disease was the main cause of disabilities among individuals aged 18 years and above […], followed by aging […], then congenital reasons"[162]. But, for the same year, "congenital reasons were the main cause of disabilities among individuals under 18 years of age […], followed by birth- related causes […], then disease"[163]. The literature also indicates conflict as a cause of disability in Gaza. For example, MoH- Gaza (2019) estimates that Gaza March of Return demonstrations caused 114 cases of disability; 21.9 per cent were under 18 years old[164]. OCHA OPT (2018) also reports that in these demonstrations, thousands of Palestinians were injured, and "some injuries have caused long-term disability"[165]. But, for other cases, "the full implications of the injury will only become clear in the future, depending on the quality of treatment and rehabilitation"[166]. As of "26 June [2018], over 1,400 people with severe injuries [were] at risk of longer-term physical disability"[167]. For example, (Interviewee 8, NGO2) described the following:

[161] (WHO - OPT, 2018, p.24).
[162] (PCBS, 2013, p. 23).
[163] (PCBS, 2013, p. 24).
[164] (MoH- Gaza, 2019, p. vi).
[165] (OCHA OPT, 2018, p. no pagination).
[166] (OCHA OPT, 2018, p. no pagination).
[167] (OCHA OPT, 2018, p. no pagination).

“The Great March of Return resulted in a huge number of [difficult] injuries in Gaza, that were beyond the capacity of the institutions and government. Not all treatments were successful, because there is a lack of equipment, and a lack of expertise to deal with such cases […]. Some injuries led to complications that required amputation after more than a year of the surgery […]. But, Gaza is not a suitable environment for people with disability in terms of its markets, hospitals, streets, etc. This is the biggest challenge!”.

Health Official: (Interviewee 8, NGO2)

Furthermore, the frequent Israeli attacks on Gaza, a devastating blockade and the deteriorating economic conditions in Gaza are also determinants of disability. For example, WHO, (2017a) states that “depression ranks among the top five causes of disability” in the OPT[168].

For more details on this topic, listen to **Episode (1)** *of A Life Lived in Conflict Podcast* **on “Disability and Covid-19 in Gaza”,** produced by the author in (June, 2020). In this episode, Dr Mona Jebril is in conversation with:

- Ms Dalal Taji (Head of Continuing Education - Department of the Programme of Special Education and Rehabilitation – Palesitnian Red Crescent Society, Gaza)
- Dr Farida Larry (Dean and Assistant Professor at School of Health, Behavioural Sciences and Education, Dar El Hikma University, Jeddah).
- Dr Valerie Karr, (Assistant Professor - International Development, School for Global Inclusion and Social Development, University of Massachusetts, Boston).

*Listen to Episode (1) through this link: https://soundcloud.com/monajebril/episode-1

[168] (WHO, 2017a, p. 15).

5. Current form and function in the health sector

The health system in Gaza is “difficult to examine adequately”[169] . This is because “a defining feature of the health system in Palestine is its fragmentation at the historical, geographic, institutional and organizational levels”[170]. The following, therefore, is an attempt to synthesise insights from the literature and the interviews on the current form and function in the health sector in Gaza, and present them, despite gaps, in a coherent narrative. This section focuses on the following: main health providers in Gaza and the roles and responsibilities of selected actors, an overview of ownership and financing structure, power-relations and related interactions, ideology and values, service delivery, decision making and the challenges of implementation.

5.1 Roles and responsibilities

There are four main health providers in Gaza: UNRWA (since 1948), health NGO sector including those profit and non-profit (developed in early 1970s); the Palestinian MoHs (Ramallah MoH / 1994; and the Gaza MOH / 2007); and the private medical sector, which is according to, “increasingly occupies a major role in service provision”[171]. But, there are other actors, which also contribute to health care in Gaza such as UN agencies including WHO whose role is outlined in Table 5.1 below. The data from the interviews also pointed out that after the Palestinian split in 2007, the role of **“WHO came more strongly in this context, trying to coordinate efforts; for example, clarifying who is doing what, and in which area of health […] in order not to duplicate”** (Interviewee 3, IO2). Also, “traditional alternative medicine continues to play an important role in health care”[172]. (For more details, see in Section 5.4.3). People in Gaza use services in the West Bank and “specialized medical care that is available only in Israel or abroad”[173]. In this case, “permits must be obtained for each health consultation requiring travel to Jerusalem or to neighbouring countries, including Israel, as well as for Gaza patients to travel to the West Bank, and applications for permits are often delayed or denied without apparent reason”[174]. That said, (Interviewee 3, IO2) explains the following:

> ***“Israel is very much involved [in the health sector in Gaza], because everything should pass through Israel: supplies, materials, people who want to travel from or come to Gaza. Without a proper and close coordination with the Israeli authorities, we cannot function […]. So, close coordination is mandatory and inevitable. They are the power on the ground. They control everything”.***
>
> *Senior Policy Maker: (Interviewee 3, IO2).*

[169] (WHO, 2017a, p. 16).
[170] (WHO, 2017a, p. 15).
[171] (WHO, 2017a, p. 16).
[172] (WHO, 2017a, p. 16). (See also: Giacaman, 1994)
[173] (Malka, 2012, p. 10).
[174] (WHO, 2017a, p.16).

Table 5.1 presents a summary of the roles and responsibilities of the main health providers in Gaza, as well as including other selected actors. There is also a colour key which assists the reader to identify the category under which each actor is classified. The roles of each actor are also highlighted with bold formatting.

Table 5.1 Roles and Responsibilities of Selected Actors in the Health Sector in Gaza

Colour Key:

	Not for profit	For-profit		
Public	**NGOs**		**International Organization**	**Occupier**

	Actor	Category	Description of Roles and Responsibilities
1.	**UNRWA**	*International Organization*	- UNRWA "delivers basic health services" which are "both preventive and curative" (WHO, 2017a, p. 21; Ballout et al., 2018). It is also responsible for providing a healthy living environment for Palestinian refugees" (WHO, 2017a, p. 21). UNRWA's services "encompass education, healthcare, relief and social services, camp infrastructure and improvement, microfinance and emergency assistance' (Ballout et al., 2018). Its role include **delivery**, "**monitoring**, **reporting** and **advocacy**" (UNRWA, 2019, p. 1).
2.	**Non-for-profit NGOs**	*Charitable (traditional), political, secular, and religious*	- Non-for-profit NGOs provide welfare, humanitarian and emergency assistance. Some of these NGOs may also (plan, undertake, or implement) development, empowerment, and advocacy work programmes.
	For-profit NGOs	*Private*	- For-profit NGOs provide services such as "outpatient and inpatient care, psychosocial **support**, rehabilitation, health **education**, and emergency care. They have also been active in health promotion and health education, consumer **activism**, health **planning**, infrastructure **development**, human resource development, and other aspects of the health system" (Schoenbaum et al., 2005a, p. 25). PS/The same may apply to non-for-profit NGOs.

3.	**Ramallah MoH**	*Public*	- Firstly, "Apart from its role as the **policy and planning** body, the MoH is by far the largest **provider** of primary and secondary health care services" in the OPT (WHO, 2006, p. 9). - Secondly, MOH **funds** Gaza's services including "paying salaries of PA employees in Gaza's Health, Social Affairs, and Education Ministries" (Malka, 2012, pp. 6–7). - Thirdly, MOH also **manages** referrals to Israeli and outside hospitals.
4.	**Gaza MoH**	*Public*	- The Hamas-run MoH carries responsibilities of **policy**, and **planning** for health within the areas of Hamas governance, **providing** health care for people in Gaza. It also **runs** clinics and "**oversees** half of Gaza's […] hospitals, […and] roughly half of health clinics" (Malka, 2012, p. 6).
5.	**Palestinian Medical Board**	*Public (Gaza MoH)*	- Palestinian Medical Board was established as part of Gaza MoH in order to "**coordinate[…] and oversee […]** medical education and training" (Malka, 2012, p. 9).
6.	**Israel**	*Occupier*	- In terms of services, "Israeli hospitals **admit patients** referred from both the Gaza Strip and the West Bank at a very high cost" (WHO, 2017a, p. 16). Israel also **places restrictions** on imports to Gaza, including medicines and drugs.
7.	**WHO**	*International Organization*	- WHO, "along with UN agencies and partners, […] **leads** health **coordination** to meet the national health strategy needs and heads humanitarian health coordination efforts through the Health and Nutrition Cluster together with the Ministry of Health' (WHO, 2017a, p. 20). It also "**supports** refugees' access to health care services through coordination with the health cluster and advocacy efforts for health access for referral patients [in Gaza]" (*ibid.*). - WHO "provides technical **assistance** to the Ministry and partners for **developing** preparedness plans and **strengthening capacities** for implementing the International Health Regulations" (*ibid.*).

8.	**UNICEF**	*International Organization*	- UNICEF "works with the Palestinian Authority and a broad range of partners to **protect** children and women from the impact of violence, and to prevent further deterioration in their conditions and well-being" (WHO, 2017a, p. 20). - UNICEF's "programme [...] focus[es] on health and nutrition and water, sanitation and health [WASH] in addition to the **procurement** and **distribution** of medical supplies in crisis" (*ibid.*)
9.	**World Bank**	*International Organization*	- The World Bank "**support** the health sector through **institutional capacity development** of the health system as well as through **financial assistance** for specific projects" (WHO, 2017a, p. 20). For example, "in 2015, the World Bank **launched a project** to strengthen Palestinian health system resilience and to cover service sector debts for hospitals in Gaza' (*ibid.*, p. 22).
10.	**EU**	*International Organization*	- EU Supports the Ramallah MoH through "**institution building**" mechanisms (WHO, 2017a, p. 22). - Also, EU "**aids** the health sector by providing budget support to pay the Palestinian authority referral service debts to the East Jerusalem hospitals" (*ibid.*). - EU also "has been supporting the **reform** of the mental health services in Palestine" (*ibid.*).
11.	**USAID**	*International Organization*	- USAID is "an active **supporter** of various health projects, including a substantial **initiative** in Gaza (Envision Gaza 2020), which **promotes** recovery, reconstruction and redevelopment in Gaza through four major activities: water and sanitation, private sector development, health and humanitarian assistance" (WHO, 2017a, p. 22)

Notes

- It is contested in the literature whether the private sector is considered a main health provider. For example, all of (Challand, 2008; MoH - Palestine, 2017; WHO, 2017a) either do not list the private sector as a main health provider or consider it as part of the for-profit NGOs.

- In reports of the PNA and others, Hamas government MoH is not acknowledged as a main health provider for political reasons[175]. This is different from writings such as (Malka, 2012; OCHA OPT, 2018) which clearly mentions Hamas MoH. For the website of Hamas MoH, see:

[175] (see for example, MoH - Palestine, 2017; WHO, 2017a).

https://www.moh.gov.ps/portal/en/ (accessed 15/08/2019); for Ramallah- MoH, see: http://site.moh.ps/ (accessed 15/08/2019). On the ground, there is "limited contact between the Gaza and Ramallah ministries and this is usually coordinated by Gaza MoH employees who are considered "loyalists" to the Ramallah PA and are paid by Ramallah" (Malka, 2012, p. 7).

- It should be noted that Some NGOs have shifted their focus: For example, the "Palestinian Red Crescent Society, with its extended network of volunteers, has gradually shifted the focus of its programmes to emergency services"[176].

5.1.1 Health actors: 'Cooperation exists, but limited to addressing emergency needs'

Cooperation is limited among health actors in Gaza in terms of planning, data generation, financing mechanisms and the offering of services despite efforts exerted to collaboration at times of emergency. This topic will be touched upon in detail in section (5.3). Below is a brief introduction:

After the Palestinian reconciliation government, the two Ministries of health became united under the supervision of the health minister in Ramallah, with an undersecretary in Gaza, but the sector remains divided among two competitive agenda, that of the PNA and of Hamas government, with minimum cooperation between the undersecretary and the minister (see Section 5.7). For example, Senior Policy Maker, (Interviewee 5, NGO1) argued: **"Sometimes there is cooperation, but not the way we want. We want full cooperation between all sides [that offer health] for our nation".**

From another perspective, a senior policy maker from an international organization argued that **"within this schism, UNRWA works very well with Gaza through UNRWA in Gaza, and with Ramallah through UNRWA in Ramallah […]. Both the Ministry of health in Gaza and Ramallah are technically the same and they follow the same technical procedures, so in technical collaboration, there is no big difference"** (Interviewee 1, IO1). Another senior policy maker explained that UNRWA follows the Ministry in programmes, such as the national immunization programme, so in this regard **"there is excellent cooperation […however, UNRWA] "has its own entity, programmes, guidelines, and instructions […, so UNRWA] is not part of the Ministry of Health. This does not mean that [they are not] partners, […but] UNRWA follows UN regulatory framework"** (Interviewee 6, IO3). UNRWA has co-operations with academia, NGOs and **"have established contracts with some hospitals [in Gaza] to provide secondary health care services to the Palestinian refugees"** (Interviewee 6, IO3). On this (Interviewee 1, IO1) said:

[176] (WHO, 2017a, p. 16).

> ***"We all work together […]. During the course of the Great March of Return, [UNRWA] knew that on Fridays, […] people would go to the borders then get injured, and […] operations would be needed. So, what the Ministry of Health in Gaza did […] was that they evacuated their hospitals on every Thursday so that they could accommodate any casualties that come on Fridays. UNRWA worked with the Ministry of Health that those who left from its hospitals on Thursdays could often come to UNRWA health services, although UNRWA offers primary health care, and nonsurgical treatment, […] but for some serious cases UNRWA took care of them. UNRWA worked with the Ministry of Health and ICRC and MSF to improve UNRWA operation care and provide the service".***
>
> *Senior Policy Maker: (Interviewee 1, IO2).*

In addition to UNRWA, the data also pointed that Gaza MoH having co-operations and exchanges with health actors from academia, NGOs, and the private sector, and with other international actors. For example, (Interviewee 2, AC1) indicated that health-related conferences were organized in collaboration with Gaza MoH. Another senior policy maker (Interviewee 7, PI1) said: "**Gaza MoH is the general supervisor on all health services in NGOs […]. NGOs contribute significantly [to Gaza MoH,…] for example, during some difficult days of the Great March of Return, [NGOs] sent their ambulances […], opened their emergency departments for receiving the injured, and contributed with doctors […], so there is a big cooperation between NGOs and Gaza MoH".** As for private hospitals, **"they need money, so if [Gaza MoH] has international funding [to pay for them], they will accept [their injured] patients"** (Interviewee 2, AC1). Gaza MoH also seems keen on cooperation with international organizations. On this, (Interviewee 3, IO2) argued: **"In Gaza [MoH], they are very cooperative, and very flexible, when it comes to working with the international community. This is for sure […], because they need the international community, but also because they want to work [with the international community], and in many occasions they also have good people to work with"** (Interviewee 3, IO2).

For more details on the relationship between health providers in Gaza, see (Section 5.3).

5.2 Ownership structure and financing

There is limited information on Palestinian health sector ownership and financing in Gaza. This could be due to a lack of transparency, and the limited research on this topic. Reviewing Ramallah and Gaza – MoH reports, there does not seem to be coordination between these two sources of information in terms of data synthesis. A general overview of sector's ownership is presented below.

5.2.1 Ownership

In brief, "all four main health-service providers (the *Palestinian Ministr [ies?] of Health*, the [UNRWA], non-governmental organisations, and the private medical sector contribute to all areas of health care" [177]. The Ramallah-based "Ministry of Health is considered the main provider of secondary health care services (hospitals in Palestine)"[178]. However, "tens of thousands of patients are referred for treatment outside the Palestinian healthcare system when the medical treatment they require is unavailable in the Palestinian territory"[179]. In Gaza, for example, there is no cardiac surgery, specialist cancer care, children's DIALYSIS, Specialist Rehabilitation services or complex eye surgery[180]. Of all, "cancer treatments were by far the top need for both West Bank and Gaza referrals"[181] That said, "the cost of [referral] treatment is covered by the Palestinian Ministry of Health" in Ramallah[182].

Because of the conflict, statistics regarding existing health facilities should be taken tentatively. Hence, an accurate number of existing hospitals in Gaza is difficult to discern from the literature/interviews. For example, MAP, Al Mezan & Lawyers for Palestinian Human Rights (n.d.) report that "17 hospitals and 56 primary healthcare facilities were hit during the 2014 attacks on Gaza as well as 45 ambulances, with the consequences ranging from total destruction to minor damage"[183]. The attack also destroyed one hospital and five primary health clinics in Gaza[184].

Despite this, under Hamas government, the health system in Gaza seems to have "undergone a period of expansion"[185]. This includes increasing the number of hospital beds and beds in special care units, appointing new professional, clinical, and administrative staff[186]. Hamas also "established the Palestinian Medical board, which coordinates and oversees medical education and training"[187]. On this a senior policy maker (Interviewee 4, G1) explained:

[177] (Giacaman et al., 2009, p.844).
[178] (MoH - Palestine, 2017, p.31)
[179] (MAP, 2017, p.5).
[180] (see: MAP, 2017, p. 6).
[181] (WHO - OPT, 2018, p. 14).
[182] (MoH - Palestine, 2017, p. 5).
[183] (MAP, Al Mezan & Lawyers for Palestinian Human Rights, n.d., p.4).
[184] (MAP, Al Mezan & Lawyers for Palestinian Human Rights, n.d., p.4).
[185] (Malka, 2012, p.9).
[186] (Malka, 2012, p.9).
[187] (Malka, 2012, p.9).

"The system had no option but to build itself by itself. MoH established a Palestinian medical council, and it started sending doctors on scholarships to Qatar, Egypt, and Turkey in all specialization areas. When these doctors returned, a 'health renaissance' started to take place in the Strip […]. On a regional level, Palestinians have good health indicators, despite the challenges and the difficulties".

Senior Policy Maker: (Interviewee 4, G1)

One paradoxical consequence of the Palestinian schism and an imposed blockade and sanctions on Gaza was the expansion of the health sector under Hamas government. Currently, there are 32 hospitals in Gaza (13 owned by MoH, 16 by NGOs, Two by Ministry of Interior and National Security, and one by the Private Sector)[188]. Gaza MoH is also responsible for 76.1 per cent of all hospital beds which reached 2.943[189]. According to an earlier estimation by UNDP, also, "the Hamas-run MoH oversees […] roughly half of health clinics[190]. UNRWA (2018b) states that UNRWA runs 22 primary health care facilities, 7 women's programme centers; and 7 community rehabilitation centers in Gaza.

5.2.2 Financing the Gaza health sector under Hamas Government

As indicated above, "it is difficult to assemble a fully accurate accounting of Hamas's Gaza network, or the extent to which the Hamas movement funds Gaza government expenditure and vice versa"[191]. The financing of the health sector under the government of Hamas in Gaza relies on a variety of sources: (1) transfers from Ramallah-PA which pays "tens of thousands of salaries" to its employees from those who are "loyalists" to the PA and to "purchase fuel for the Gaza power plant and district water system"; (2) "taxes [Hamas] collects on goods smuggled through hundreds of tunnels between Gaza and the Egyptian Sinai"; (3) contributions from foreign sources including Iran and Qatar, which constitutes "the vast majority of its remaining budget"; and (4) "nearly $200 million a year from UNRWA operations and nearly $98 million from various USAID projects as well as donations from other international organization operating in Gaza".[192] Furthermore, "Hamas also coordinates with numerous international and Islamic charities inside and outside of Gaza that provide additional medication, medical supplies, and other donations" [193]. MoH- Gaza (2019) also states that the MoH has collected 7.9 million Israeli Shekel (ILS) from the formal system of health insurance[194], so insurance can also be added as financing route, although the interview data indicates that this source is both limited and unreliable. For example, Gaza MoH waived about 98.2 million (ILS) of due insurance cost

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188 (MoH- Gaza, 2019, p. 12).
189 (MoH- Gaza, 2019, p.iii).
190 (Malka, 2012, p.6).
191 (Malka, 2012, p.7).
192 (Malka, 2012, p. 7; 8).
193 (Malka, 2012, p. 8).
194 MoH- Gaza (2019).

[195]. This suggests that the difficult economic conditions in Gaza affect people's ability to pay for health care, which in turn reflects on Gaza-MoH. For more details on insurance, see (Section 5.5.1).

However, the above-mentioned sources of funding upon which Hamas government relies are not stable and may even cease to be available. For example, "UNRWA is funded almost entirely by voluntary contributions and financial support has been outpaced by the growth in needs"[196]. Also, Iran's financial support "may be in jeopardy following Hamas' departure from and impending break with the Bashar al-assad regime in Syria, a key Iranian ally"[197]. From another perspective, "Ramallah's funds have also given it the power to provide and withhold payments and medicines depending on the political environment"[198]. That said, in July 2009, Ramallah was paying "approximately 8,500 health staff worked in MoH facilities in Gaza [...with] an additional 2,000 trained health workers whom the Ramallah PA pays not to work"[199]. However, among other things, "the aid cuts and refusal to accept partial tax[200] transfers have plunged the Palestinian Authority into a deep crisis, leaving it able to pay its workers only half of their salaries"[201] .

Financing Ramallah-based MoH

For PNA- run MoH, "three main sources of health finance exist: these are general taxation %60, health insurance premiums 25-30% and co-payments about 8.4 of the total"[202]. The OPT "overall health expenditures (public and private) more than tripled in the last decade, reaching US$1.3 billion in 2012, or 12% of GDP--one of the highest shares of GDP in the world"[203]. See Figure 5.1 below:

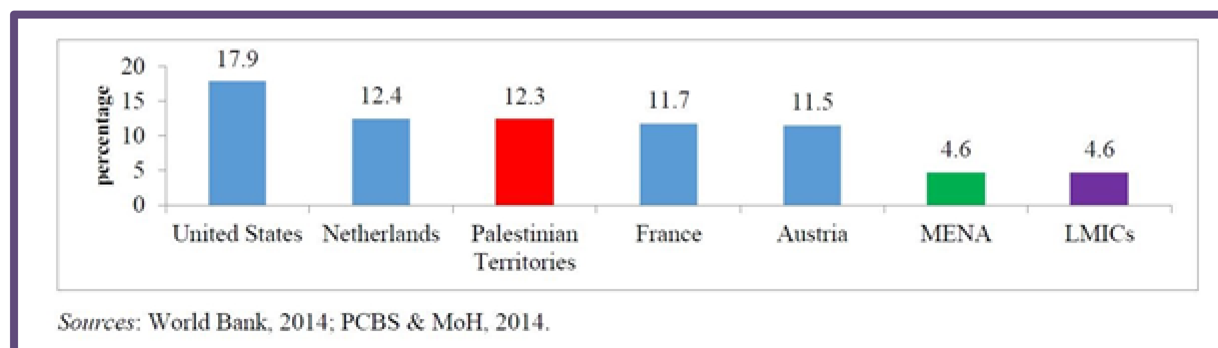

Figure 5.1 Total Health Expenditure as Percentage of GDP in 2012

(World Bank, 2016, p. xxi)

[195] (MoH- Gaza, 2019, p. 26)
[196] (UNRWA, 2018a, p. no pagination).
[197] (Malka, 2012, p. 8).
[198] (Malka, 2012, p. 8).
[199] (Malka, 2012, p. 7). Malka (2012) explains that "these [employees whom Ramallah PA pays not to work] include staff who went on strike in the second half of 2008 and whom Hamas had barred from returning to their jobs" (p.7).
[200] The Peninsulaqatar daily newspaper (20 Feb 2019) reported that "The Palestinian Authority (PA) will no longer accept tax revenues collected on its behalf by Israel following its decision to trim the sum over the PA's financial support of militants' families, Palestinian President Mahmoud Abbas said": (for more details, see https://www.thepeninsulaqatar.com/article/20/02/2019/Palestinian-president-rejects-tax-money-from-Israel .
[201] (The Guardian, 2019, p. no pagination)
[202] (WHO, 2006, p.10).
[203] (World Bank, 2016, p.xxi). (See also: Hamidi et al., 2015, p. 861; WHO, 2017a, p. 18).

The significant increase in “per Capita total health expenditure […reflects] high out-of-pocket spending, especially for pharmaceuticals”[204]. This is because of the restrictions on pharmaceutical imports “which have resulted in an average cost of publicly procured medicines almost 7 times above global market costs, debt arrears, delays in payments and limited Ministry of Health capacity to negotiate better prices”[205].

Furthermore, in 2017, MoH was paying 51% of the ministry’s total budget for salaries[206]. But “administrative workers account for 35 percent of all public health staff in the West Bank and Gaza, which is very high by international standards, and suggests significant overstaffing in the public health administration”[207]. In fact, “direct financial assistance to the Palestinian Authority from the EU, selected EU member states, World Bank, Saudi Arabia, Iraq, Algeria and others continues to contribute substantially to the payment of pensions, salaries and social allowances, and to cover debt payments to East Jerusalem Hospitals for referral patients”[208].

[204] (WHO, 2017a, p. 18).
[205] (WHO, 2017a, p. 18).
[206] (MoH - Palestine, 2017, p. 32).
[207] (World Bank, 2016, p.18).
[208] (WHO, 2017a, p. 20).

5.3 Power relations, and bargaining in the health sector

The health sector in Gaza is an unregulated field of power relations. The interplay of competitive power relations in the health sector is a historical legacy that the Gaza health system has inherited from decades of occupation. In the politically laden context of Gaza, "institutions and individuals involved in political and economic life are finding it difficult to remain nonaligned. In a less direct way, this applies to a growing number of foreign donors as well"[209]. Whether between the two Palestinian ministries of health in Gaza and the West Bank, or in relation to international organizations and Israel, the health sector has been affected by competitive, often adversarial, political agendas. This section gives two examples on this, focusing firstly on political clientelism in health institutions in Gaza, and secondly on how international assistance is so often double-edged. A few bargaining strategies that are used to deal with this context are also discussed.

5.3.1 Adversarial relationship and cautious bargaining.

The split between Hamas and Fatah-dominated PA resulted has increased counterproductive power dynamics in the health sector in Gaza. Two examples are political clientelism, and the PA's attempt to squeeze Hamas government using health, as will be explained below.

Political clientelism is noticeable in both the history and the present of the Palestinian health sector in Gaza. For example, over the years there has been "rapid increase in the number of health-service employees of the Palestinian National Authority without evident improvement in the quality of the health services"[210]. Also, "public revenues and the opaque allocation of business contracts notably in the case of PA monopolies also became a political resource to buy support for the regime, leading to the waste and misuse of public funds"[211]. Although Hamas, "unlike other political factions, […] understands the importance of effective institutions", after the Palestinian schism, its "governance style has been certainly pragmatic, but also authoritarian and unaccountable"[212]. For example, in response to PA health worker wide strike, "Hamas not only [was able] to rely on new hires and volunteers [mainly from its own faction or sympathizers], but also to […] force essential [PA civil service] staff to return to work"[213]. On this, a senior policy maker who works in a governmental health institution in Gaza explained:

> ***"The ministry of health in Ramallah has the power to paralyse the ministry of health in Gaza, but they did not want to do this in one go; they wanted to do it gradually. Firstly, they asked the employees to leave their offices in Gaza at 11 am, and then they asked them to stop working completely. This caused a shock to the health sector in Gaza because all of a sudden, all the services were reduced. Hamas government had to do something. So, they went to the doctors' houses and obliged them to return to work or else go to jail […]. The doctors responded […], only around 20% abstained.***
>
> *Senior Policy Maker: (Interviewee4, G1).*

[209] (Roy, 1993, p. 26).
[210] (Giacaman et al., 2009, p. 845).
[211] (Le More, 2005, p. 985). (See also: Berti, 2015).
[212] (Berti, 2015, p. 30).
[213] (Berti, 2015, p. 25).

Factional nepotism in recruitment was reported in the interviews. For example, (Interviewee 8, NG2) explained that when he applied to work in a government health institution in Gaza, the interview panel in the job interview asked questions, such as "what is the mosque near you**"**; "what was the latest battle initiated by faction x". This experience made the participant became convinced that **"government institutions are based on a political background"**, despite the fact that their services are offered to all people in Gaza. Another participant, (Interviewee 10, M2), indicated that in Gaza, **"factional affiliation may affect one's opportunities of promotion",** rather than the recruitment in a governmental health institution. However, a senior government policy maker (Interviewee 4, G1) emphasized that the staff at health government institutions in Gaza comprise people of different factions including Fatah, as well as those who are independent. In fact, "many perceived Hamas-run clinics and dispensaries might be run by supporters of the group but have no formal affiliation with the organisation"[214]. (Interviewee 7, PI) stated: **"some institutions are packed up financially by certain factions and they have a reputation of this link, so although the management and administrative board may not be affiliated to the funder, people still perceive them as factional institutions"** (Also see: Section 4.2).

The data shows that the PA used health as a political tool to squeeze Hamas government: For example, a senior policy maker from an international organization (Interviewee 3, IO2) pointed out that the following: **"Palestinian authority is using health in order to pressurize Hamas government in Gaza"**. This is achieved by several means including: **"using referrals to outside hospitals"** by giving privileges to some people over others (as we shall see below), the **"reduction of financial approvals [which resulted in the] reduction of salaries of the PA employees"** who work in the Gaza health sector**, and "the payment of 70% only of salaries to Hamas government employees";** and through control over **"the delivery of supplies [such as drugs] from the West Bank to Gaza".** Another senior policy maker (Interviewee 4, M1) added that the PA also has **"move[d] many of those who reached the age of 45 to early retirement"**, which poses a challenge for the Ministry of Health in Gaza since these are experienced doctors and health workers. The ministry is currently facing a shortage in expertise to a new observed brain drain trend in Gaza.

The PA has also manipulated health insurance to support its political goals prior and post the Palestinian schism. After 1994, Ramallah MoH "allowed voluntary enrolment by individuals and households and by employee groups that were not required previously to participate" in governmental health insurance, encouraging enrolment through making insurance premiums more affordable[215]. But, accepting voluntary enrolment proved to have a negative impact on the health system as it allowed healthy people to choose to enrol only when they were ill; which meant that overall, "the people who chose to enrol were disproportionately sick"[216] . This move of Ramallah MoH was largely political as "the net effect of these changes was to increase the government systems' liabilities more than it increased revenue, deepening the operating deficit that has existed since 1994"[217]. This approach of using health insurance as a means to achieve political gains became more evident after the Palestinian Split in 2007, as indicated by at least two senior policy makers (Interviewee 5, NG), and (Interviewee 4, G1). For example, see the following quote:

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214 (Batniji et al., 2014, p.349).
215 (Schoenbaum et al., 2005, p.35).
216 (Schoenbaum et al., 2005, p.35).
217 (Schoenbaum et al., 2005, p.35).

> ***"After the Palestinian schism, the PA president [Mahmoud Abbas] waived the health insurance for people in Gaza, while keeping it for people in the West Bank […]. This decision was intended to make the health system in Gaza collapse […]. But it did not work here, so the insurance system continues in Gaza".***
>
> *Senior Policy Maker: (Interviewee, 4, G1).*

For more details on insurance, see the discussion in (Section 5.5.1).

To sum up, the adversarial relationship between the Fatah-dominated PA and Hamas government has affected negatively the health sector in Gaza, which made (interviewee 11, PI2) convinced that **"the Palestinian schism is a tool created by the Israeli Occupation as [allegedly] it harmed [People in Gaza] more than the occupation itself"**.

Cautious bargaining

The Hamas- run MoH, PA-run MoH, and collaborators from the international community such as donors, maintain a cautious relationship of interaction. The MoH in Gaza relies on transfers from the PA, and thus it is under pressure to "accommodate" Ramallah-based MoH, even when "payments have been periodically delayed"[218]. After the Palestinian Unity Government in 2014, both ministries became under the supervision of one health minister in the West Bank. The MoH in Gaza is currently run by an undersecretary (not a minister) from Hamas government (Interviewee 4, G1). This shows, that despite the continuation of the Palestinian schism between Hamas and the Fatah-dominated PNA, the government in Gaza has accepted to give the upper hand of the health sector to its competitor.

Conversely, the MoH in Ramallah is also wary to withhold payment for Hamas MoH, as it wants to "carefully balance its desire […] to undermine the Hamas government against creating a deeper crisis in Gaza's health services, which would worsen Gaza's economic crisis and erode the Ramallah leadership's claim to be the legitimate government of Palestinians"[219]. After the establishment of a Palestinian Unity Government in 2014, the situation became administratively confused. This is reflected with caution on the those of the international community who are keen to offer projects and financial support to the health sector in Gaza. Gaza MoH seems to be aware of this and attempts to accommodate it so as not to miss on opportunities for support that are desperately needed for the health sector. For example, (Interviewee 4, G1) said:

[218] (Malka, 2012, p.8; 7).
[219] (Malka, 2012, p.8).

> ***"After the unity government, the funders became embarrassed on how to deal with MoH in Gaza. Some funders such as the UNICEF and UNDP may hold an agreement on projects with Ramallah, which includes Gaza, and so they would come afterwards, and implement the project in Gaza. Other funders would not want to go to Ramallah. In order to avoid political embarrassment, they prefer to strike a deal on a lower management level, for example, with a hospital administration in Gaza rather than with Gaza MoH itself. These funders would be negotiating with MoH first, and after agreeing with them on all terms, they would inform the hospital of the details and of MoH's approval. In that sense, if the funders prefer to strike a deal on a lower level of management, it is not a problem for Gaza MoH!".***
>
> *Senior Policy Maker: (Interviewee, 4, G1).*

5.3.2 Double-edged international assistance: adaptation

International assistance in the OPT including assistance offered by international organizations such as WHO, UNRWA, and donors is double-edged. On the one hand, this assistance is offering crucial services, technical help, and life-saving support for health in Gaza. On the other hand, such assistance usually carries or leaves behind a political agenda. Despite efforts towards neutrality and impartiality, international assistance in a politically laden Palestinian-Israeli context is contributing to shaping the political reality for people in Gaza.

UNRWA adopts a neutral stance in its relationship with Palestinians and Israel, focusing on offering technical assistance to refugees in the West Bank and Gaza Strip. This neutrality is political since it is perceived by Palestinians as an abandonment of UNRWA's protection mandate towards Palestinian refugees. As explained in Section (4.2.2), UNRWA's work in Gaza signals an international commitment towards Palestinians' right of return (See Box 4.1; 4.2). It is UNRWA's responsibility to "highlight the need for a just and comprehensive solution for the refugee problem"[220]. However, in reality, there is a "lack of any intervention by […] UNRWA in negotiations between the parties to the Israel-Palestine conflict concerning durable solutions for Palestinian refugees"[221]. In fact, "some UNRWA views emanating from Israel and from Western donor countries, and the kinds of policy initiatives that these views encourage, are especially pertinent in terms of elucidating refugees' enduring distrust toward the agency"[222]. But UNRWA has also been criticized by Israel and Western critics of UNRWA [who] have accused the agency of encouraging refugee dependency, and political radicalization"[223]. Given

[220] (Akram, 2014, p. 237).
[221] (Akram, 2014, p. 237).
[222] (Gabiam, 2016, p. 62).
[223] (Gabiam, 2016, p. 62;63).

this contestation over UNRWA's mandate in the OPT, UNRWA seems to prefer taking a neutral position, adopting a technical approach to its work in Gaza and the West Bank. For example, a senior policy maker from an international organization said:

"UNRWA is a UN body, so [it] should be neutral. UN organizations and missions can work in many areas of conflicts and war, so [UNRWA has] this neutrality and impartiality. It also has impunity".

Senior Policy Maker: (Interviewee 1, OI1).

The WHO seems also keen to present itself as a neutral UN institution. For example, a senior policy maker from an international organization described the WHO as follows:

"WHO should not be affected by politics as [WHO] is an organization of an international system. It is committed to the population in emergency. WHO is part of the international community, respecting its values of neutrality and impartiality, and other values".

Senior Policy Maker: (Interviewee 3, OI2).

The Palestinian Schism has challenged WHO's neutral position. Although the WHO continues to work well with both the PNA ministry of health in Ramallah and Hamas government ministry of health in Gaza, it's official mandate in the OPT is linked to the Palestinian Authority.

Donor assistance in Gaza, including assistance to PNGOs, is also politicized. For example, After the Oslo agreement, funders' agendas were largely adapted around the orbit of Israeli policies and restrictions, although "rhetorically […] frame[d…] within a broader state-building objective"[224]. Despite the failure of the peace process, "donors continued to treat the West Bank and Gaza as quasi normal 'sovereign' country, focusing on the PA having to be kept on the "peace process track by means of a complex mix of carrots and sticks"[225]. This international assistance seems to have "manitain[ed] aid flows and the status quo"[226]. Since the international community "appears wholly unable or unwilling to induce meaningful change in Israeli policy, […it] is therefore in the awkward position of subsidising the occupation"[227] (p. 22-23). Aid actors strengthen the occupation by paying for Palestinians rather than making Israel as an occupying power taking the responsibility for people in the OPT[228]. Therefore, "providing short-term, unsustainable emergency assistance and pumping large

[224] (Le More, 2005, p. 991).
[225] (Le More, 2005, p. 996).
[226] (Sayigh, 2007, 28).
[227] (Sayigh, 2007, pp. 22–23)
[228] (Murad, Tartir, & Aid Watch Palestine, 2018).

sums of money into an ever more aid-dependent territory which has become ever less viable geographically, economically and politically", is double-edged. Donor assistance is crucially needed in the Gaza Strip, and yet the "different agendas and the dependence of the Palestinian National Authority on donor financial assistance have […] caused programme fragmentation, [, especially that] most [OPT} budget is financed by donor agencies"[229].

Assistance given to PNGOs "was political in nature, and it is only in the last decade that developmental thinking started to influence [their] actions"[230]. However, this development thinking has been faced with continuous emergencies and attacks on Gaza. PNGOs are "almost entirely dependent on foreign aid from a range of sources, including the European Union"[231]. This over-dependency has limited their role in policy and decision making as they became "among the most affected by externally-oriented planning process"[232]. A senior policy maker from the NGOs sector stated:

"This has negative consequences. We are living under the mercy of the funder, who is at the end serving his own agenda".

Senior Policy Maker: (Interviewee 5, NGO1).

The Palestinian schism has affected donor investment in Gaza MoH. For example, **there has not been recently "many big international or European donors in Gaza. MoH relies on a few donors such as Norway, Qatar, Japan, and the Islamic Bank**" (Interviewee 4, G1).

229 (Giacaman et al., 2009, p. 846).
230 (Abuiyada & Abdulkarim, 2016, p. 32).
231 (Sullivan, 1996, p. 94).
232 (Abuiyada & Abdulkarim, 2016, p. 32).

(Two-way) Adaptation as a bargaining strategy

"The Ministry of Health in Gaza organizes a press conference and a protest and warns of the fuel crisis in the hospital Crescent UAE, in southern Gaza Strip, on Jan 13, 2019)".

|Photo description & credit: Abed Rahim Khatib/Shutterstock.com

Supporting the health sector in Gaza is a common objective for both local health providers, and sources of international assistance. Therefore, despite occasional disagreement, they are concerned to strike a deal of cooperation by adapting as much as necessary to each other's conditions.

Hamas-run MoH relies substantially on foreign support "for covering the majority of its daily operations"[233]. However, "coordination [with international donors and aid groups in Gaza] is complicated, and tension occasionally flares into crisis"[234]. In a way, Hamas is obliged to resolve such tension, even if it was sometimes, by overlooking the "surveillance and monitoring of foreign NGOs working in Gaza" to avoid a "cut off humanitarian aid"[235]. This "demonstrates the precariousness of foreign aid operations in Gaza as well as Hamas's dependence on externally funded and operated humanitarian services"[236].

Hamas-run MoH, and other Gaza health providers cannot "compel [international aid] organizations to implement a particular project"[237]. Their adaptation to funders is pragmatism rather than passivity. For example, (Interviewee 1, OI1) commented:

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233 (Malka, 2012, p.8).
234 (Malka, 2012, p.9).
235 (Malka, 2012, p. 9).
236 (Malka, 2012, p.8).
237 (Schoenbaum et al., 2005, p.33).

> ***"Ah, mixture. We have to be realistic that donors money is a tax payer money, so they have a responsibility to respond to the tax payers and their interests. Donors may have a certain focus [...]. For example, some would be keen to work on gender related issues, so we need to accommodate their needs, because we want their support, but in the way that also helps us. So, it is not like we do something that is totally irrelevant or unproductive because of donors' interests. No, we discuss and we agree which area we want to provide this, but naturally the donors have their interests because it is their money".***
>
> *Senior policy maker: (Interviewee 1, IO1).*

The competition over donor assistance has prompted some "large NGOs [...] to shift to using "puzzwords promoted by the majority of Western donors", and to working on "grand projects" related to empowerment and civil society rather than focusing on serving the needs of the local population[238]. (Interviewee 5, NG1) also explained how donor funding is directive:

> ***"As PNGOs, we do not accept conditional support since we are not permitted to do this by NGO law. When the donor announces calls for projects or financial support, they decide in advance on the scope of the project. They do not oblige us, but if we want to apply for these calls, we have to frame the project within their scope of funding [...]. Lately, all fundings became limited to certain objectives [...]. For example, about 90 per cent of funding in the last two years was directed to providing health services to those who were injured in the Great March of Return, so [...] we cannot use it for other purposes such as purchasing an equipment which we need [...]. In that sense, the support is directive".***
>
> *Senior policy maker: (Interviewee 5, NG1)*

The limited scope of projects combined with deteriorating economic conditions in Gaza has pushed a few institutions towards corruption practices:

[238] (Challand, 2008, p. 234).

> ***“A few institutions would amend the items of the project. For example, if a grant was obtained on the basis of buying drugs, they would instead use the money to pay for their employees. This is because they do not have money to pay them, so they resort to misusing the funds”***
>
> *Senior policy maker: (Interviewee 7, PI1).*

PNGOs and actors from the private sector have also been adapting to restrictions on financial assistance, by initiating projects and applying to different sources: “**We send the project we have to all the list of donors on our computer. Some of them respond, others do not, or maybe they would respond partially. The response rate is lower than before. What can we do? We just have to adapt to the situation**” (Interviewee 7, PI1).

The data indicates that adaptation may also be taken as a copying strategy by international sources. Hamas-run MoH is aware of funders’ need for their approval and the cooperation with local health providers, such as NGOs, in order to be able to implement their projects on the ground. This has given MoH and local health providers the power to push for their priorities to be included in the funders’ agendas, prompting two-way adaptation that includes the funder. For example, (Interviewee 4, G1) commented:

> **“The global community’s policy towards Gaza is that they want to keep it alive […]. They certainly do not want an explosion of the humanitarian situation in Gaza, since this may affect the entire region. As far as health is concerned, the international community must be careful. MoH has refused a few projects completely […], then, funders came back [to negotiate…]. Sometimes they will come back and [MoH and local health providers] would be able to change things as [they] wish”.**
>
> *Senior policy maker: (Interviewee 4, G1)*

All in all, within a context of adversarial relationship and a double-edged assistance, health institutions in Gaza and their supporters such as donors referred to caution and adaptation as bargaining strategies. These in turn indicate a health sector that is largely characterised by a lack of trust which is a challenge for generating a unified response of local and international actors to improving health in Gaza.

5.4 Ideology and values

The health sector is affected both directly and indirectly by society's ideological beliefs and values in which it functions. This, however, has been rarely discussed in the health-related literature about Gaza. The Gaza society is comprised of an overwhelming majority of Sunni Muslims. As indicated in (Section 4.4), about 74.5 per cent of people in Gaza are registered refugees[239]. Changes in the socio-political in the OPT context emphasized different components of Palestinian collective identity in Gaza at different times, although in general the trend has been a shifting to localism[240], emphasizing a structure of de-development in Gaza (see box 5.1). The following is an overview of a few ideological and value features of the Gaza health sector today, which are presented through a discussion on (1) traditional constructs; (2) factionalisms vs social solidarity, (3) co-existence of both indigenous and modern medical practice, and a (4) binary perception to health and healthcare.

5.4.1 (Feature # 1) Traditional constructs

The health sector in Gaza functions in a conservative culture, which is characterized by hierarchies and traditional loyalties. Gaza as part of the Arab world is a "hybrid […'] neopatriarchal society, which is neither modern nor traditional, but which limits participation by its members because of the continued dominance exercised by single leaders"[241]. Consequently, "the social institutions […] are dominated either by a single patriarchal figure –the father in the family; the ruler in politics; […] – or by a few elites"[242]. Hence, "in all of these, a father figure rules over others, monopolizing authority, expecting strict obedience, and showing little tolerance of dissent"[243]. This (neo) patriarchal order can also be found in the health sector in Gaza[244]. For example, a health official from the NGO sector complained:

> ***"If I have any objection, my boss will be standing to me as if he is my father, […and] he may even threaten me. Although I work on an international project, the institution administration is Palestinian and [factional…]. Even when my objection is related to a technical issue, my boss will be taking matters personally, expecting me to obey whatever he says […]. Sometimes, there is oppression […or] maybe it is arrogance […]. The Arab mentality remains powerful […]. There are people who are old, and you need to deal with them based on their age […] because they are from a different generation".***
>
> *Health Official: (Interviewee 8, NGO2)*

239 (UNRWA, 2019).
240 (Mi'ari, 2009).
241 (Barakat, 1993, p. 23).
242 (Barakat, 1993, p.xii).
243 (Barakat, 1993, p. 23).
244 (UNDP 2005; Jebril 2018).

There is also a hierarchy of sex in Gaza, including a prevalence of traditional gendered assumptions regarding male-female roles and interactions[245]. For example, women are less represented than men in the labour market, with "low […] labour force participation of 20 per cent"[246]. The majority working

Box 5.1 **Gaza identity development: Shifting to localism**

According to Mi'ari, (2009), changes in the socio-political context emphasized different components of Palestinian collective identity at different times. Prior to the 1948 war, Palestinians' sense of their Arabism was stronger than their national identity. On the contrary, Palestinians' sense of common struggle was intensified after the 1967 Israeli occupation of the West Bank and Gaza, and Israel's "repressive policy" towards the increase of PLO influence in the OPT (Mi'ari, 2009, p. 594). Furthermore, the "widespread international recognition of Palestinian rights to self-determination and Arabs massacre towards Palestinians" also strengthened their Palestinian identity, compared to their previous sense of belonging to the Arab community which started to wane (*ibid.*). The formation of Palestinian civil society organizations, which was supported by the PLO has also contributed to strengthening their Palestinian identity (*ibid.*).

The period after Oslo witnessed an intensification of Palestinians' Muslim identity, alongside their Palestinianism. The emphasis on adopting a religious identity came as a result of an "increasing popularity of Hamas", "the worsening of socioeconomic conditions, the failure of the political peace process and the issue of corruption within the PA" (Mi'ari, 2009, p.594). Due to these reason, "traditional parochial identities, such as local and clan identities" became also more strengthened after Oslo (Mi'ari, 2009, p. 592). According to Le More (2005), "Palestinian politics also became increasingly localized: mayors and governors, family clans, tribes, political groups and armed militias have gained in power and authority, competing against one another, often for a narrower political interests (p. 987). Thus, "rather than moving toward a common Palestinian identity, Gazans [were] reverting to the clan for security, identity, and a sense of belonging" (Roy,1999,p. 77). (See also Sayigh, 2007, p. 26). It should be noted, however, as Roy (1999) argue:

> ***"such emerging social patterns […], are strikingly similar to those seen at the economic level, where the development of an integrated economy slowly is giving way to the formation of localized economic units and where insularity and introversion increasingly define group behaviour'*** *(Roy, 1999, pp. 77–78).*

When Hamas took over the Gaza Strip in 2007, it "acted to stop these groups' public display and use of weapons, while asserting its monopoly on force" (Berti, 2015, p. 18). The Information and Communication Technology has also had an opening up impact on the society, especially, on the young population in Gaza, however, such an impact collides with the reality of severe blockade on Gaza since 2007, reproducing society's features, some of which are counterproductive, and emphasizing the structure of de-development in Gaza, which was referred to in Section (4.2) of the report.

in traditional jobs such as teaching and not in leadership positions[247]. For example, (interviewee 4, G1) said: **"there are female managers and other females working in responsible positions at Gaza MoH, but there aren't many of them, although the MoH accepts female participation in leadership".** Although female employees in the health sector seem aware of their capabilities, their participation in leading positions remain novel in the Gaza society. For example, (Interviewee 6, IO3) explained:

245 (See: Barakat, 1993; Jebril, 2018).
246 (UNDP, 2005, p.172).
247 (PCBS, 2015; See also: Jebril, 2018).

"In the interview, they asked me: Do you think it is challenging for you to be [in a management position] in the health sector?I thought this was funny! I told them, the manager can be tall or short, fat or thin, black or white, or man or woman. What important is your personality, […technical capacity, skills, knowledge and experience]".

Senior policy maker: (Interviewee 6, IO3)

Females working in the health sector continue to face challenges arising from traditional societal assumptions on their gender roles. For example, (Interviewee 9, IO4) commented:

"As females, we suffer when we go for a meeting with a male colleague. People will refer to us as 'the ones with him", even if we are all doing the same thing. Let us face it, our society is patriarchal […]. Most women depend on the social network of their husbands or brothers or sons, or the men of their families to get a faster response [from institutions]".

Health Official: (Interviewee 9, IO4)

Two mothers who are carers of patients also reported discomfort with people's (including health staff's) perception to their daughters whom they expressed sympathy towards because they were sick females. (Interviewee 12, CP1; Interviewee 13P, CP2). Interviewee 12, CP1 also complained:

"Imagine, when we returned in 2015 from Israel, my daughter had 40 stiches on her back. The person responsible for referrals in Gaza told me: your daughter is beautiful so she cannot be a cancer patient. Who knows what she goes to do in Israel?!"

Carer of patient: (Interviewee 12, CP1).

As indicated above, traditional loyalties is also an important feature of the Gaza society. Thus, “the network of interdependent kinship relations [and solidarity among them] continues to prevail”[248]. As a result, “wasta (nepotism) [has] become a common place” in Gaza[249]. The difficult economic conditions coupled with the restrictions on mobility has “reinforced social dependency as a ‘way of life’ ”[250]. The overwhelming majority of the interviewees mentioned kinship and social and professional acquaintances as the main factors enhancing wasta practices in the health sector in Gaza, helping people jump queues, get opportunities of employment, and receive better treatment and attention from their doctors.

5.4.2 (Feature # 2) Factionalism vs social solidarity

Photo credit: Abed Rahim Khatib/ Shutterstock.com

Continuous suffering and emergency in Gaza have created contradictory impulses, namely practices of factionalism and social solidarity, that reflect on the health sector. In the politically laden context of Gaza, “institutions and individuals involved in political and economic life are finding it difficult to remain nonaligned. Somehow, this applies to a growing number of foreign donors as well”[251]. This political alignment reflects on the health sector, as we have seen in (Section 5.3). So often, institutions and individuals’ “decisions become motivated by political rather than professional considerations”[252]. The result is a “severe lack of coordination [...] and no assigning of priorities to needs according to any

[248] (Barakat, 1993, p. 23).
[249] (Jebril, 2018, p. 94).
[250] (Jebril, 2018, p. 94).
[251] (Roy, 1993, p. 26).
[252] (Roy, 1993, p. 25).

commonly defined criteria"[253]. Despite this, the data from the interviews indicate that at times of emergency, factional decisions wane, in favor of community's social solidarity. People's solidarity seems to be motivated by nationalistic feelings, religious beliefs, Arab chivalry, or as (Interviewee 4, G1) points out: **a "situational sense"** of the need for help at emergency time. For example, (Interviewee 11, PI2) explained that during the 2008 war on Gaza, the number of injured was huge, compared to the capacity of the main hospital in Gaza, so people from all backgrounds rushed to offer their help:

"Gazan people have chivalry […]. Although our humanitarian and economic conditions may be the worst globally, there is solidarity among the people in Gaza. Political divisions disappear [when there is an emergency]. During the 2008 war on Gaza, […] I saw people [in the hospital] donating blood, and others giving first aid, or helping as doctors. All these were individual initiatives [not organized by any institution or society]. People wanted to offer whatever they could […]. We are Muslims, and we believe this entails a big reward from Allah, the almighty".

Health Official: (Interviewee 11, PI2)

Another health official who was attacked by a son, who was desperate for the medical staff to help his sick father, said: **"The policeman told me that he could jail the man if I wanted to. Am I going to jail someone whose father is sick? Psychologically, I cannot do that. If you ask the medical team, they will also say the same"** (Interviewee, 10, G2). Describing his experience under Israeli administration, (Interviewee 7, PI) also argued the following:

"There were only 50-60 doctors, so I had an overload of work. I used to see 100 patients in one day […]. We used to work like donkeys. However, we were feeling contented and productive, because we had a very strong commitment to our community, and we were in the position to help".

Senior Policy Maker: (Interviewee 7, PI)

[253] (*ibid.*). (See also: Giacaman, 1994; Jebril, 2018).

5.4.3 (Feature #3) Coexistence of both indigenous and modern medical practice.

Poverty, tradition, and a lack of trust in the health system have emphasized indigenous medical practice in the Gaza society. The literature explains that medical practice in Palestine is "based on classical Arabic medicine as well as a mixture of other practices apparently incorporating historical social transformations"[254]. Today, both the indigenous and "the modern scientific medical establishment are likely to coexist"[255], although Western scientific medicine in the OPT is predominant[256]. In Gaza, the "methods of healing can […be] physical, herbal, dietary and spiritual"[257]. Thus, "people are likely to attempt to use popular indigenous means of healing themselves; if this fails, they will then seek the help of the modern scientific medical establishment" [258], starting in the first instance with pharmacies for medical diagnosis and treatment. Interviewee 9, IO4 explained:

> ***"People do not trust the system […]. Some people liken the hospital to a butcher place; they fear if they go there, they will return with additional problems. So, people […] prefer [to go to] the pharmacy, because it is [also] cheaper under a difficult economic condition. However, patients such as cancer patients are obliged to go to hospital because there isn't any place that can offer them the medicine, treatment, or therapy except a governmental hospital".***
>
> *Health Official: (Interviewee 9, IO4)*

From another perspective, people in Gaza perceive "the occurrence of disease […] in social-relational terms, as well as in biological terms"[259]. For example, "hypertension is viewed as being brought about by a constellation of forces […including] age [but] ultimately […by] al-ghadab (anger or emotional upset)"[260]. Consequently, people may look for alternative ways to treat chronic diseases, including traditional medicine, and the readings of religious texts. For example, a mother of a diabetic patient (Interviewee 13, CP2) explained:

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[254] (Giacaman, 1994, p.35).
[255] (Giacaman, 1994, p.37).
[256] (Giacaman, 1994).
[257] (Giacaman, 1994, p.35).
[258] (Giacaman, 1994, p.37).
[259] (Giacaman, 1994, p.36).
[260] (Giacaman, 1994, p.36).

"Everyone knows that Diabetes 2 is a chronic disease that requires a certain dieting […]. People advised me to use olive leaves and other traditional prescriptions […and] to take my daughter to a Sheikh to read Quran on her [as…] she might have been harmed/ possessed by Jinn […]. I also used to blame myself […]. I used to scream when there is a bombardment [during the 2008 war on Gaza], and she would feel afraid. Before the war, she was very healthy […,so maybe] she developed diabetes as a result of fear. Other times, I thought maybe it was caused by an antibiotic that I have taken when I was pregnant. Now, I think it is her fate and destiny. Allah choses what is best for her".

Carer of Patient: (Interviewee 13, CP2)

5.4.4 (Feature# 4) Binary perception to health and healthcare

Health in Gaza seems to be perceived by people and their institutions in binary terms: Caring for health is prioritized when there is an emergency issue; otherwise, it is a luxury. This binary health seeking behaviour is influenced by the living experience of people's and their health institutions under conditions of occupation, and severe blockade conditions. Social expectations from the health sector are being shaped accordingly, increasing pressure on increasingly exhausted health institutions.

Due to the occupation, people in Gaza suffered *inter alia* significant financial and human losses. This made **"people value themselves, their families, […and their] health […], so family members will make everything possible to receive the best care possible, whether this is for a male, female, elderly, a child or an infant. This social pressure may produce corruption sometimes […., for example] they will push to get a referral outside Gaza"** (Interviewee 3, IO2). On this, senior policy makers: (Interviewee 4, GI), and (Interviewee 3, IO2) explained:

"Because Gaza people are poor, and have been all their lives enduring injustices, and living under wars […and] uprisings […,], their expectations from health services are very high".

Senior Policy Maker: (Interviewee, 4, G1)

"Everybody in Gaza is expecting to receive free of charge health service, […and] to go to hospital and receive immediate care. Sometimes, we see […] attacks on health care personnel because of the differences between the expectations of the person who is seeking healthcare, and […that] of the providers. […] It is very, very difficult for [people in Gaza] to [accept] being on the waiting list for a few months for a surgery […]. If this happens, the person will be calling everybody and trying to get every possible support to get […the scan/ appointment] tomorrow or the day after".

Senior Policy Maker: (Interviewee 3, IO2)

For Gaza hospitals and healthcare institutions which are lacking in staff, capacity and equipment, this is a real challenge particularly at times of Israeli attacks and other emergencies such as the conditions of the Great March of Return. For example, (Interviewee 13, CP2), when she took her daughter who was feeling very sick due to Diabetes 2 to Al Shifa hospital in Gaza, **"the emergency centre and even the reception were full due to many injuries arriving from the Friday Great March of Return, so compared to other emergency cases, diabetes was considered nothing. Also, the [hospital staff] were not able to concentrate with you".**

As a result of the frequency of emergencies in Gaza, (Interviewee 11, PI2) was convinced that **"neither in the perception of big government hospitals, nor the citizens, health is a priority. Hospitals only take major cases".** In addition, (Interviewee 6, IO3) explained that **"the situation in Gaza is very complicated […]. Sometimes, people may care about their physical and mental health, but suddenly, when there is an escalation, they just keep thinking about being alive, and keep their children alive".**

The blockade and an increasingly deteriorating economic conditions in Gaza have made people perceive non-emergency healthcare (e.g., nutrition, wellbeing, regular dental ups), as a luxury. But for those who cannot afford it, emergency treatment has also become an unattainable privilege. For example, (Interviewee 9, IO4) said: **"If a woman has 10 Shekels at home, she prefers to bring food to her kids and postpone the treatment of her back, buy a medicine or undergo a surgery, even if she has a cartilage damage".** A senior policy maker also commented:

"For youngsters, number one priority is to leave Gaza, and to find a new life. For the majority for people, […], the main problem is the lack of hope and dignity […]. People have more important issues [to worry about] than health, such as having stable electricity at night, heat, and protection from the rain [during winter]".

Senior Policy Maker: (Interviewee1, IO1).

The above was a highlight of a few ideological and value features that affect the Gaza health sector. More details on issues mentioned here such as referrals will follow in the coming section.

5.5 Service delivery

The Gazan health system is struggling to deliver health services. Currently the system is on the verge of "implosion"[261], deliberated by increased demand and shortages of supplies such as drugs and equipment, and a confusing insurance system. It is also functioning under extreme challenges such as lack of protection for healthcare staff and facilities amid conflict, and an exhausting referral system to Israeli hospitals, all impacting negatively on people's access to health in the occupied territory.

As a result of the occupation, "the scale of the destruction and the lack of reconstruction [….] have reduced Gaza's health sector to a […] desperate state with very limited facilities to care for the tens of thousands of newly injured and long-term disabled persons in Gaza"[262]. Furthermore, "several types of health services fail to meet consistent standards for training, equipment, and overall quality"[263]. Restricted mobility affected "the health system['s] function, management, and accountability; [for example, it resulted in] the presence of under-qualified health-care providers, and weak institutional capacity for monitoring and assessment"[264]. For example, "many health service delivery entities, including major hospitals in the area, are currently bogged down by administrative problems instead of concentrating on technical questions"[265], which will be explained in (Section 5.7). Also, "the blockade's stifling effect on Gaza's economy, ongoing political divisions with the West Bank, and Israel's 'dual use' list [which] limit the availability of essential medicines and equipment in Gaza"[266] resulted in "hospitals and clinics in Gaza […being in] constant stock shortages"[267]. Furthermore, the blockade and repeated wars on Gaza are "creating a pervasive, empirically provable sense of powerlessness" for the community in Gaza, an overload on its health workers, and a burden on its weak and incapacitated health facilities which are not able to offer beyond emergency primary and secondary care[268]. Social protection in Gaza is also weak as people suffer a "lack of control of the most basic elements of modern life such as electricity, communications technology, public water sanitation and waste disposal as well as means to income"[269].

5.5.1 Confusing Insurance

Figure 5.2 shows Palestinian population by health insurance coverage (for the year 2017)[270], according to Palestinian Central Bureau of Statistics:

261 (Roy, 1993, p. 31).
262 (MAP, Al Mezan & Lawyers for Palestinian Human Rights, n.d., p. 24).
263 (Giacaman et al., 2009, p. 845).
264 (Giacaman et al., 2009, p. 845).
265 (Giacaman, 1994, p. 50).
266 (MAP, 2017, p. 34).
267 (MAP, 2017, p. 34).
268 (Thirkell, 2012, p. S106).
269 (Thirkell, 2012, p. S106).
270 This is based on a total population estimate of 4,780,978 (Palestine), and 2,881,687 (West Bank), and 1,899,291 (Gaza) for 2017.

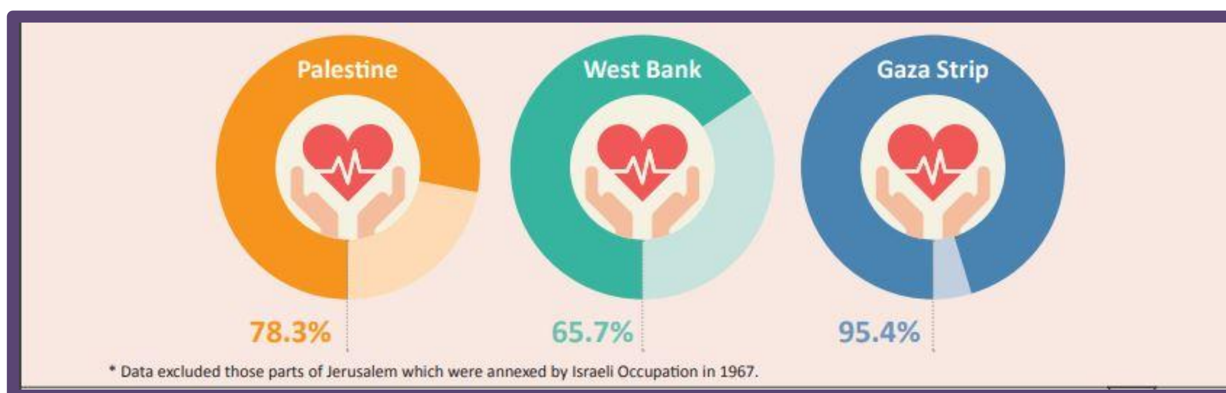

Figure 5.2 Palestinian Population by Health Insurance Coverage (for the year 2017).

(PCBS, 2018, p. 13)

After the Palestinian schism, the Palestinian President Mahmoud Abbas waived insurance for people in Gaza, in what was thought to be an attempt to undermine Hamas government (for more details, see section 5.3.1). Gaza Ministry of Heath continued to require payment for insurance.

> ***"In the last three years, Hamas government's Ministry of Health required from people who wanted to have a surgery in one of its facilities to have medical insurance. However, an insurance is not required for services offered by the PNA such as referrals [for example, to Israeli hospitals] because the referral office employees are paid by the PNA [so they follow Mohamoud Abbas's instructions]. It is a difficult and somehow a complex issue".***
>
> *Senior Policy Maker: (Interviewee 5, NGO1)*

MoH- Gaza (2019), explains that the ministry in Gaza applies two systems of insurance with cost (formal), and without (free) cost. Nonetheless, in 2018, MoH waived due insurance cost by 6.2 per cent more than in 2017. A government senior policy maker (Interviewee 4, G1) explained:

> ***"Those people who are not able to pay are referred to a social committee at Gaza Ministry of Health, which would consider reducing [or waiving the fee as necessary".***
>
> *Senior Policy Maker, (Interviewee 4, G1)*

Also, a health official (Interviewee 10, G2) pointed out the following:

> ***"At the hospital, we accept all patients whether they have got an insurance or not. We take the patient's identity card, and we make him/her sign a financial commitment, which he/she has to fulfil during a certain period. Sometimes, the hospital may also waive it, or file a court case to get the payment. This depends on the circumstances of each case".***
>
> *Health Official: (Interviewee 10, G2)*

The number of those insured in Gaza for the year 2018 has decreased by 7 per cent than in 2017, as Figure 5.3 indicates:

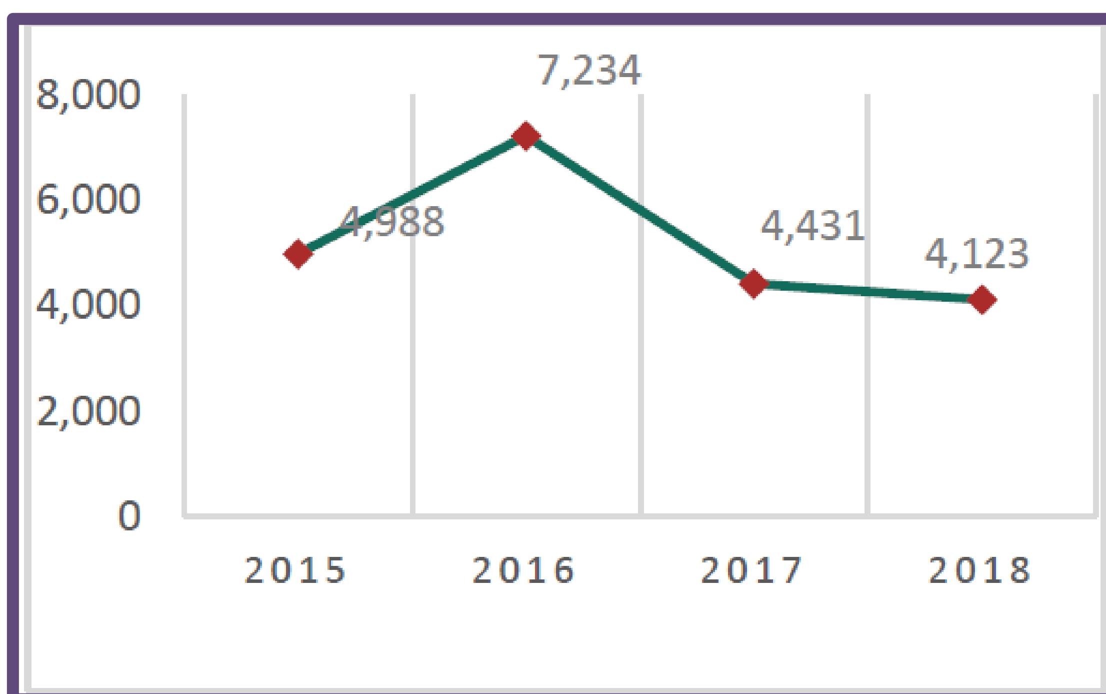

Figure 5.3: Number of Health Insurance during the Period (2015-2018)

(MoH- Gaza, 2019, p. 26)

This indicates a growing unaffordability of the formal health insurance system in Gaza. MoH- Gaza (2019) does not explain more details on those covered by the free insurance system, or on those who left the formal insurance scheme.

Given the limited treatment covered by the insurance and the shortages in drugs, a few interviewees perceived the insurance as a waste of money, and unhelpful. For example, a senior policy maker explained: **"Treatment for cancer patients should be completely free, there is a lack of 30%-50% of**

drugs. Ramallah Ministry of Health does not transfer the necessary drugs, leaves patients responsible to find and pay for their drugs" (Interviewee 5, NGO1). A **carer of patient** (Interviewee 12, CP 1) commented: "**The insurance does not cover except limited treatments […]. We have not benefited anything from this insurance".** Another carer of patient whose daughter has diabetes, also explained the following:

> ***"Insulin syringe were [hurting] and frightening for my daughter [as a child, so we wanted to use] insulin pens instead, but these were not available in the Governmental hospital […]. We went to Islamic Relief and UNRWA instead […But,] during the 2014 war, UNRWA stopped offering the pen insulin for some time. This was a nightmare for me, because […] the pharmacies have doubled or tripled the price for the insulin pins. My daughter would need 4 or 5 pens per month, and there weren't [financial] support available".***
>
> *Carer of Patient: (Interviewee 13, CP2)*

The drug market in the OPT "lacks any form of regulation over either buyer or seller"[271]. This allows some private businesses to perceive healthcare as a commodity, and drugs as "consumer items"[272]. For example, "physicians can and in fact do own a considerable proportion of shares in local pharmaceutical companies, with the risk that prescription medication may be seen and disseminated as a profit-making operation"[273]. The literature[274] has pointed out to a neo-liberal orientation of the Palestinian health sector more generally. Nonetheless, this topic requires separate research. But some health NGOs had also to increase the price of drugs because of financial challenges. A senior policy maker said: **"Due to decreased international assistance, most health institutions […] had to buy drugs from its own budget, and then sell them to patients with low, or no cost. In the past, [they] used to receive drugs as donations, so [they] would distribute them to people as a donation"** (Interviewee 5, NGO1).

271 (Giacaman, 1994, p. 48).
272 (Giacaman, 1994, p. 48).
273 (Giacaman, 1994, p. 48).
274 (Giacaman, 1994; Khalidi & Samour 2011, p. 11).

5.5.2 Weak protection for healthcare in Gaza

Photo credit: Abed Rahim Khatib/ Shutterstock.com

One of the major challenges for health work in Gaza is the lack of protection for health staff and facilities amid conflict, since “medical teams [are] sometimes [exposed to] harm and medical facilities [are] damaged or destroyed as a result of Israeli military action”[275]. Also, (Interviewee 2, AC1) criticized that “**there is no real protection for health professionals, not only from the Israeli side, but also from within the Palestinian people”,** as indicated in (Section 5.4.2). But “when violations against the health sector occur in a culture of impunity, the international norms which ensure the essential protection of civilian infrastructure and humanitarian personnel in conflicts worldwide are eroded”[276]. Consequently, this lack of accountability increases health workers’ vulnerability in a context of protracted conflict such as Gaza[277]. For example, “the Israeli military claims that, during its 2014 offensive, there were instances when they targeted civilian infrastructure, because it was being used for military purposes. This includes the Al Wafa rehabilitation hospital”[278]. Although, “the hospital’s Director and other testimony contests this”, with the lack of adequate international investigations, accountability for this damage is not being pursued[279]. Also, (Interviewee 5, NGO1) explained:

[275] (MAP, 201, p.12).
[276] (MAP, 2017, p. 12).
[277] (MAP, 2017, p. 12).
[278] (MAP, 2017, p. 17).
[279] (MAP, 2017, p. 17).

"The Israeli authority is an occupier, and its soldiers […] do not respect Human International law […]. Until now, four supervisors of volunteer health workers in the Great March of Return were killed, one of them is called Razan El Najjar […]. There were also more than 500 other cases of attack on health personnel [during the Great March of Return]".

Senior Policy Maker: (Interviewee 5, NGO1)

Although international organizations benefit from a better impunity than local health providers, functioning in the context of Gaza still entails a significant risk for the staff as individuals, and also for healthcare facilities. For example, (Interviewee 3, IO2) said: "**Within our offices […] we are usually protected. […But] the staff as individuals […] are part of the community […so there is a] feeling of lack of security as similar to the population".** Another senior policy maker explained:

"In the war, […] around 92 of UNRWA schools became shelters, for those displaced from their home, and around 300, 000 people stayed there. The majority of the schools remained intact, however, […] one of the schools [in Jabalia] was shot by the tanks, and around 10-20 people were killed, while they were escaping […] the class […]. This has been highly criticized […,] and it is totally unacceptable, but it was the one major incident that UNRWA had.

Senior Policy Maker: (Interviewee 1, IO1).

One additional devastating consequence for the lack of protection for healthcare facilities is that international donors became reluctant to invest in solid projects of development since there is a risk that "their money turned to rubble"[280].

5.5.3 Exhausting referral system to Israeli hospitals

As occupation procedures mix with bureaucratic and economic barriers, patients who require referrals for tertiary care outside Gaza face traumatizing conditions. Due to "the dearth of quality medical services" in Gaza, "a much higher percentage of Gaza patients need to leave the Gaza Strip for tertiary

[280] (Thirkell, 2012, p. S107).

medical care"[281]. Since **"Israel is preventing the entry of radiation into Gaza, […] cases that require radiation and cancer patients whose drugs are unavailable in Gaza have to be referred outside"** (Interviewee 7, PI1). The lack of alternatives force Patients and their families to undergo an exhausting referral process to Israeli hospitals that is costly and "extensive[ly] bureaucratic"[282], especially since the Rafah border could be completely closed even for humanitarian cases[283].

A senior policy maker explained: that "**Gaza patients can either travel through Rafah Gaza-Egyptian border or through Erez border with Israel. As for Rafah border [in 2019], it only open[ned] for a few days (about 30 days) of a calendar year, and it has a very limited capacity, so approximately 200 people could pass. As for Erez border, the procedures are very complicated, and require applying at least three weeks in advance"** (Interviewee 5, NGO1). But **"many patients have died because they could not get a permit at all"** (Interviewee 10, G2).

Gaza "patients are required to apply for permits from Israeli authorities […] in order to travel to referral hospitals located outside of the Gaza Strip"[284], including in the West Bank and East Jerusalem. Gazan referral "applications can be approved, denied, or delayed" by Israel[285]; often on security grounds. For example, (Interviewee 6, IO3) witnessed the following:

I was in a meeting. There "were young patients with Leukaemia […,] and they should go outside to receive therapy which is not available in Gaza [, but… the Israeli authorities] would prevent them one time, two times, and four times. One of them was dying […]. Even I have a colleague […whose] husband has cancer […,but] the [Israeli authorities] refused to give him a permit for security reasons […]. His condition continued to deteriorate for three months until a Human Rights organization interfered. […They] succeeded only when he became in […] a very bad condition […]. We have a lot of stories like that".

Senior Policy Maker: (Interviewee 6, IO3).

Delays also occur "when the date of the patients' hospital appointment passes without the patient having received a response"[286]. For example, "permits were denied as a result of political events or Israeli holidays"[287]. A senior policy maker from an international organization (Interviewee 1, IO1) explained that **"once permits are denied, the WHO and the Ministry in [Ramallah] will console and work with the Israeli authorities […]. Whenever the WHO raises concern as a neutral party or as a United Nations party, [UNRWA] would join them, because naturally some of those who are seeking referrals are refugees".** A carer of patient (Interviewee 12, CP1) resorted to human rights

[281] (WHO, 2017b, p. 13).
[282] (WHO, 2017b, 26).
[283] (WHO, 2017b, 26).
[284] (WHO, 2017b, p. 18).
[285] (WHO, 2017b, p. 18).
[286] (WHO, 2017b, p. 13).
[287] (MAP, 2017, p. 5).

organizations in Gaza to help getting a permit to Israeli hospitals; however, this was a prolonged and bureaucratic process that did not prove helpful.

As for the patients whose permits were approved by the Israeli authorities, they were deliberated by further challenges. For example, when "patients are granted a permit, they are not informed until the day prior to their scheduled appointment and travel"[288]. The lack of information from the Israeli authorities on when a patient and his companions can leave Gaza for the referral treatment, "creates uncertainty and unnecessary stress for a sick person and their family and complicates the scheduling of medical procedures by receiving hospitals"[289].

Since November 2015, the Israeli authorities have "requir[ed] patients' companions up to the age of 55 years to undergo more intensive security investigation in order to receive permits"[290]. Also, "on more than one occasion in 2016 patient accompaniers were arrested at the crossing, leaving the patient, sometimes a young child, to wait alone at the checkpoint until a relative can be contacted to take them back to Gaza"[291]. Also, "the Israeli authorities have […] taken advantage of patients seeking exit permits to undertake interrogations for the purpose of gathering information about communities in Gaza, as a prerequisite before requests are considered"[292]. A carer of patient who had to accompany a daughter for cancer treatment reported the following:

"At Erez, the [Israeli authorities] used to ask us questions. My daughter would be facing inspection. She had spears and clips in her stomach, so when she passes through the X-ray machine, it will ring on the security inspection. This security check is very dangerous. They had to see [my daughter's] stomach and ask her questions, maybe six or seven times, and they also would ask me […]. Also, both Hamas and PNA government officials would require us to fill a permit sheet and put our photos […]. Hamas government officials will also check us, and then [after the Israeli inspection,] when we go to Fatah side (PNA- West Bank), they will check us again, and also see our identity cards, so we had to make two [further] registrations".

Carer of Patient: (Interviewee, 12, CP1)

As indicated in the quote, the Palestinian schism has resulted in additional procedures for people from Gaza who seek referrals to the West Bank or Israeli hospitals. Participants from Gaza also reported Palestinian wasta (nepotism) and factionalism practices in getting referral permits. (Interviewee 12, CP1) said: **"At some point, a decision was taken by Ramallah not to refer cancer patients especially to Israel. They wanted to save money, as there was a deficit in PNA budget".** The interviewee also indicated a manipulation of, and bad service delivery and hotel conditions for cancer patients and their carers while in the West Bank on the assumption that cancer patients were going to die anyway. This alleged claim was also mentioned in relation to Gaza, although both needs further investigation that is beyond the scope of this report. (Interviewee 12, CP1) said:

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[288] (WHO, 2017b, p. 7).
[289] (WHO, 2017b, p. 7).
[290] (MAP, 2017, p. 8).
[291] (MAP, 2017, p. 8).
[292] (MAP, 2017, p. 8).

> **"Unfortunately, [in both Gaza and the West Bank], the human being does not have value […]. When the Ministry of Health [in Ramallah] would want to adjust its budget, […] cancer patients […] will be the first persons to be cancelled. Even those in Gaza, they would approve the referral when they are confident that the patient is [seriously ill or] about to die […,] so that they would feel relieved that the patient has died in Tel Aviv, and not under their supervision"**
>
> *Carer of Patient: (Interviewee 12, CP1)*

But "exiting Gaza […is] a lengthy, unpredictable process"[293]. Exhausting steps follow passing the Erez border, before the patient and their carers can reach the hospital. Figure 5.4 below gives an illustration of how patients from Gaza go to hospital care in East Jerusalem:

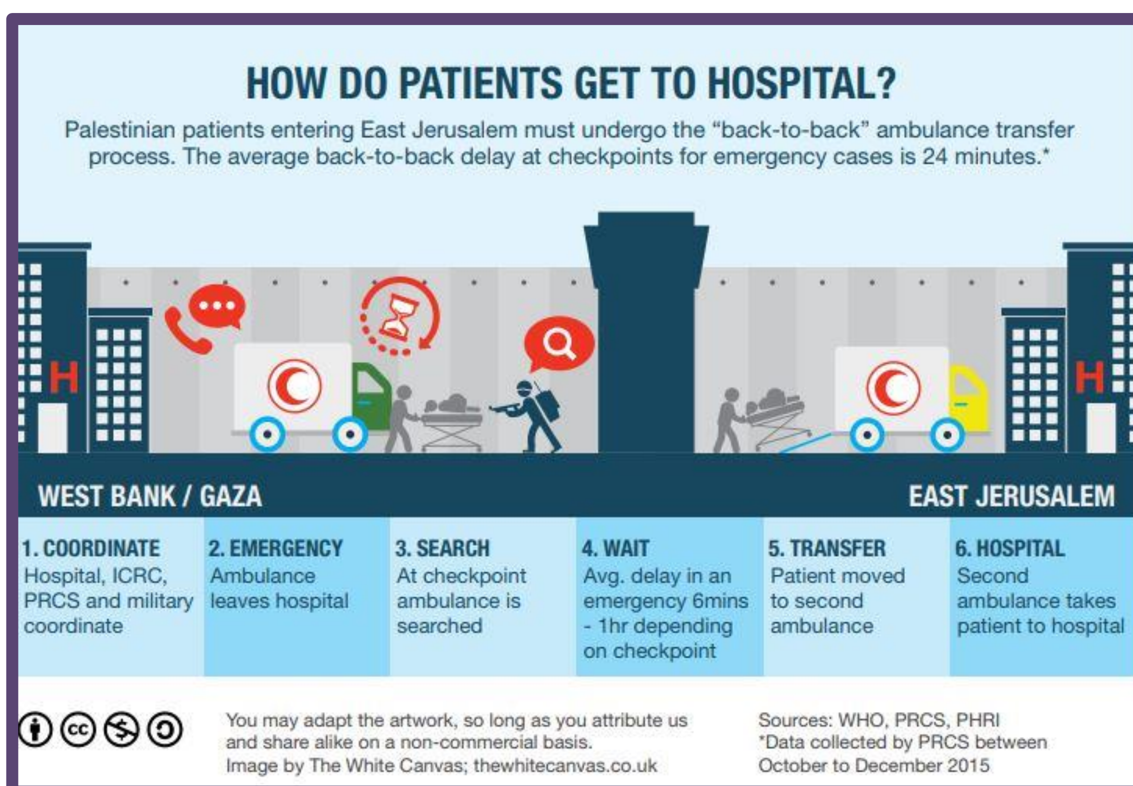

Figure 5.4 How Do Palestinian Patients Get to Hospital?

(MAP, 2017, p. 6)

The interviewee pointed out to further difficulties on the Israeli side, including a feeling of insecurity and surveillance in Tel Aviv. Patients from Gaza also struggled because of financial reasons:

293 (WHO, 2017b, p. 7).

> ***"There were patients whose parents were unemployed, so even when they were in Gaza, they were not able to afford the taxi fee. A bottle of water in Tel Aviv [was much more expensive than in Gaza]. There were women who did not have money to buy water for their child if they cried […], or to buy them nappies. So, that some people could make it to Tel Aviv, does not necessarily mean that they are able to afford the living expenses."***
>
> *Carer of patient: (Interviewee 12, CP1)*

On the positive side, Israeli doctors were noticed to do their best with the patients from Gaza. (Interviewee 12, CP1) said: **"A doctor in Gaza told my daughter: 'you have to get accustomed to pain as we cannot do anything for you. On the contrary, the doctors in the Israeli hospital used to tell her "you have to live a quality of life, you should not suffer […]. During the war, there was no referrals and after the war, there were no drugs in Gaza, so the doctors in Israel used to send her drugs with other returning patients"**. This is a testimonial to the humanity of those doctors in Israeli hospitals who refuse to politicize their profession. The interviewee also praised human rights volunteers in Israel for campaigning against their government to generate support for Palestinian patient children, in order to be given referrals to Israeli hospitals. Conversely, the fatalistic perspective of the doctor from Gaza towards suffering show how the incapacitation of Gaza hospitals and the complexities of the referrals to Israel became the status quo for cancer patients in the costal enclave. Referrals were not given as a right for the patients in Gaza, but as a costly and limited privilege. For example, (Interviewee 12, CP1) said:

> ***"My daughter was required to take chemotherapy in Gaza for 8 days, and then go back to Tel Aviv in the 9th day […]. There was no systematic treatment […]. They would not give her a permit […]. In Gaza, sometimes they [also told us] that her file was lost, or that it was still in Ramallah. The Ministry would think three trips outside Gaza is enough for one patient, rather than consider the needs of the patient as this would cost them a lot […]. Because my daughter did not receive a systematic treatment, [her cancer situation has seriously deteriorated]".***
>
> *Carer of Patient: (Interviewee 12, CP1).*

But "the localisation and nationalisation of referral care has been a strategic objective of the Palestinian Ministry of Health in recent years in order to improve patient access and to control referral costs"[294]. Nonetheless, within the current political and economic context in the OPT, achieving this objective is a challenge that seems beyond the capacity of Palestinian MoHs. Furthermore, "the

[294] (WHO, 2017b, p. 13).

Palestinian [MOH] in Ramallah announced on March 26 [, 2019] the halting of medical transfers to Israeli hospitals and vowed to find alternatives for Palestinian patients in private and governmental hospitals"[295]. This is because "Israel has been overcharging [Ramallah MoH] for medical services and taking funds for medical bills without [their] permission"[296]. Whether the PA will be able to withhold to this decision of a "medical boycott", and if so, what repercussions this will have on Gaza patients, remains yet to be seen[297].

A context of increased demand for health care with limited and weak supply in Gaza, in addition to lack of protection for healthcare workers and dependency on an exhausting referral system to Israeli hospitals leaves the Palestinian health system on the verge of implosion. In working in and navigating health care, health professionals and patients in Gaza, find themselves exposed to a "site of renewed trauma in the short term and foreseeable future, enmeshing the mental [and physical] health of its future generation inseparably with the international politics it inhibits"[298].

[295] (Amer, 2019, no pagination)
[296] (Rasgon, 2019, p. no pagination) This was said by PA Health Ministry spokesman Osama al-Najjar in an interview with The Times of Israel.
[297] (Kuttab, 2019, p. no pagination).
[298] (Thirkell, 2012, p. S106).

5.6 Decision making

Decision making and health planning for the sector does not seem to be under the full control of the ministry, or any of the other health providers, alone or altogether. As discussed in Section (4.2), the health sector is fragmented and has been shaped by a legacy of 'decision taking' rather than making. Currently, decision making in the Gaza health sector is characterized by three features: (1) Ad hoc and authoritarian decisions, (2) policy and coordination vacuum, and (3) fragmented and politicized data.

5.6.1 (Feature #1) Ad hoc and authoritarian decisions

Health decisions **"on a strategic level, and at a national level are taken by the Ministry of Health. When it comes to the practical, and administrative levels, decisions are taken by the entity itself [whether it is governmental, international, NGO or private institution…]. When it comes to financial decisions, the Ministry in Gaza does not have much control. For instance, the referral outside Gaza is all covered by the PNA government"** (Interviewee 3, IO2). Today neither the PNA nor Hamas government has "sovereignty over borders, movement of people and goods, and control over land and water"[299]. Consequently, this causes irregularity in the decision-making processes; strategic plans can be made and then altered based on the changes in the socio-political circumstances in the OPT. For example, (Interviewee7, PI1) said:

"The Ministry of Health in Gaza invites us regularly for meetings which include, for example, university Deans of health faculties, and other health experts, but […] we feel our ideas are put on the shelf. A few years ago, we produced a 5- year strategic plan for health in Gaza, the Ministry could only take 20 or 30% of it forward for implementation […]. This is because there is no stability in Gaza. Financial issues also have an impact […], which resulted in the Ministry of health currently suffering from mind migration".

Senior Policy Maker: (Interviewee 7, PI).

On a micro-governmental level, centrality, authoritarianism, and lack of transparency and accountability seem also to be characteristic of decision-marking processes in Gaza[300]. For example, a senior policy maker from the NGO sector (Interviewee 5, NGO1) explained that a committee, which was set by one of the Gaza MoH heads was changed by his successor, and was then dissolved by the successor of the successor who wanted to initiate a completely new committee, although all belonged to the same political party. The interviewee reported that **"such changes are not based on a scientific study or a strategic plan, but according to their own convictions"**.

[299] (Giacaman et al., 2009, p. 838).
[300] (Berti, 2015)

5.6.2 (Feature #2) A policy and coordination vacuum

The Palestinian schism has also made health decision-making difficult to coordinate. After the reconciliation government in 2014, health policy making in Gaza became even more politicized. A senior policy maker from the government sector explained:

> ***"Between 2007-2014, there was two governments one in Gaza and one in the West Bank. After that, a National Unity Government led by Mr. Al Hamduallah was established. With this, there became one minister of health for both the West Bank and Gaza […]. But, [Gaza MoH] noticed a negligence of the health situation in Gaza […], and so it innovated an administrative committee to fill the admin/ policy vacuum […]. But, with interference from Egypt which is the guardian of the reconciliation, Hamas government had to cancel this committee. Since the policy vacuum remained, Hamas formed a committee from undersecretaries rather than from ministers, so Gaza MoH is currently run by an undersecretary from Hamas government, although the minister remains in Ramallah. The undersecretary has an authority to take final decisions. There are many decisions that come from the West Bank that are unrealistic, and do not suit the conditions of work in Gaza".***
>
> *Senior Policy Maker: (Interviewee, 4, G1)*

Communication between the Gaza undersecretary and the Ministry of health in Ramallah remain at a low level, as the PNA ministry in Ramallah preferred to communicate with its loyalists instead: **"If the Minister wants something from Gaza MoH, she will correspond directly with three or four people in the Gaza MoH […]. If the response came from anyone else, including the undersecretary, they will not engage with it […]. They only accept information from their connecting points within Gaza MoH"** (Interviewee 4, G1). Despite this, some **"political violations"** may happen, for example, if **"the Minister, who is governed by the political system of the PNA in Ramallah, wanted to support health in Gaza, this can happen through communication between the pharmaceutical Heads in MoHs in Gaza and the West Bank, i.e on a lower level of authority […]. This, however, does not reach the stage of coordination"** (Senior Policy Maker, Interviewee 4, G1).

The policy vacuum in the health sector in Gaza is also a result of the absence of the Legislative Council role since 2007, the Palestinian schism. This suggests that many of the legislations that govern the health sector in both Gaza and the West Bank are outdated, and irrelevant to the current circumstances in the OPT. On this, a senior policy maker from the NGO sector commented: **"Until now, the health sector is governed by the law which was issued by the Legislative council in 2002. It has been [19] years since then. The laws need revisions and additions. The sector is affected by the absence of the Legislative Council and the central government and the legislations**" (Interviewee 5, NG1). That both Hamas government, and the PNA MOHs had to invent their own legislations to

cover this policy vacuum would suggest that such legislations could possibly have been framed around their political interests, although this point needs further research.

All in all, at least two health officials perceived that they had no decision maker to trust on supporting them or improving the health sector in Gaza. For example, (Interviewee 8, NGO1) said: **"I think there is no decision maker […]. We have a political and community schism"**; and (Interviewee 11, PI2) also criticized: **"in Gaza, we lack the decision maker. We do not have any institution or ministry or syndicate that […] takes accountability for us […]. This not only is in relation to the health sector; it also is in relation to all sectors"**.

5.6.3 (Feature #3) Fragmented and politicized data

Creating and sharing data is another challenge for decision-making in the health sector in Gaza. Despite efforts towards modernization, the lack of modern health information system is a persistent problem, which limits the functioning and data exchanges among health providers in Gaza. For example, (Interviewee 10, G2) explains that in public institutions **"Not everything is computerized […], because there are not enough computers, […] and those available are not good quality".** The lack of modern health information system "makes it very difficult [for institutions] to implement an efficient system of local accountability, since it inhibits planning and evaluation of facility performance"[301]. Another issue is the politicization of data in the Gaza context, which reflects negatively on the decision-making and implementation processes of health providers including international organizations. For example, (Interviewee 3, IO2) explained:

> ***"When one of the parties [Hamas or the Fatah-dominated PNA] is claiming something, and the other party is claiming the contrary of it, [as an international organization] we are put in the middle. We need to find the best sources and evidence that can support our narrative. For this, we are seeking information from different sources […]. In many of the occasions we were criticized by all parties, and we are still criticized".***
>
> *Senior Policy Maker: (Interviewee 3, IO2)*

International organizations as well as other governmental and nongovernmental institutions produce their own data. According to a senior policy maker from the governmental sector, **"most of [Gaza MoH systems] are computerized, but not all of them"** (Interviewee 4, G1). The data from the interviews indicate that exchanges of information among the different actors do happen, during the health cluster meetings, through web and report publications, or upon request. For example, a senior policy maker from an international organization explained:

[301] (Schoenbaum et al., 2005a, p. 36).

> ***"UNRWA data is published every year. For specific ones, for example, the 2014 war data, we shared our daily statistics […with the Ministry, but] our data is not interlinked, and our systems are not connected to the Ministry of Health systems, so they cannot [in normal circumstances] get the daily data, but during the course of the meetings [for example, Health Cluster meetings] we share as needed".***
>
> *Senior Policy Maker: (Interviewee 1, IO1)*

Data production and documentation should be used in order to examine and support the national priorities of the health sector in Gaza; however, a lack of coordination in this matter adds to the challenges of policy and decision-making on a national level. From the above, data records are produced separately by each health institution based on its priorities, IT capacity, and quality standards. One reason for this lack of coordination has been highlighted by (Interviewee, 4, G1) who said: **"Gaza MoH tried to cooperate with Ramallah MoH, […] but we have not succeeded in that. They wait for us to issue our report, so that they can take the information from us […]. We issue general and specified reports"** (Interviewee 4, G1). But even in relation to NGOs or UNRWA, the Gaza MoH seems to be at the receiving end of other providers' generated data, which it aggregates with its own data, rather than taking the lead in administering a unified platform for data quality and production for health in Gaza. For example, (Interviewee 6, IO3) commented: **"UNRWA has a good [electronic] reporting system […] which is called e-health that offers paperless reporting […that] can be generated by one click […but] UNRWA sends [Gaza MoH] the report [on any issue, for example, noncommunicable diseases] to be included in their report".**

To recap, decision-making in the health sector in Gaza is challenged *inter alia* by continuous instability and lack of sovereignty over borders and resources, authoritarianism, and an outdated, fragmented and politicized data.

5.7. Implementation

Turning plans into successful implementation is difficult to achieve in the Gaza context. Similarly, "in the Palestinian health system, as in many other health systems, planning has frequently functioned better than policy implementation, and many of the aims of current and prior health plans have not been achieved"[302]. There are "serious structural and systematic problems that come in the way of turning plans into successful realities"[303]. These problems can be found on the macro, meso, and micro levels, which are inherently interrelated, posing serious challenges for implementation in the health sector, a few of which will be indicated in this section.

5.7.1 Macro-level challenges: Instability, restricted mobility, and lack of control over resources.

The implementation of health plans and projects in Gaza is largely affected by its context of instability including frequent attacks and more than 15 years of blockade on its borders, which puts the sector in a state of continuous emergency.

Photo credit: Federico neri/ Shutterstock.com

Restricted mobility has also incapacitated the sector as staff were not able to undertake necessary qualifications and training, or to attend conferences. Consequently, a senior policy maker explained that **"there are some specializations and services that [the health sector is] still unable to offer in Gaza"**, which increases its dependency on referrals to Israeli and outside hospitals (Interviewee 4, G1). Furthermore, "the continued restricted mobility would inhibit or prevent policymakers from meeting; inhibit or prevent oversight of health system functioning, including all types of data collection; and

302 (Schoenbaum et al., 2005, p. 33).
303 (Giacaman et al., 2003, p. 12).

make implementation of new policies and programs more difficult and more costly"[304]. For example, a senior policy maker from an international organization explained:

> ***"I have a permit which is valid for six months. So, every six months, it has to be renewed, but it happened previously that [the Israeli authorities] have refused to renew it. Many of my colleagues could not have permits for security reasons […]. When we have a workshop [outside Gaza], we send more staff members because we know that some of them will have their permits rejected. But, we are still somehow privileged […], because we are an international organization".***
>
> *Senior Policy Maker: (Interviewee 6, IO3).*

But, local staff working for international organizations do not seem to enjoy equal privileges as their international counterparts. For example, a health official who works as a local staff member for an international organization criticized the following:

> ***"In Gaza, being an international staff member is advantageous […]. International colleagues have better chances of reach, so their voices are louder than our voices […]. There is lots of discrimination […]. As a local employee, if I want to travel [through Erez], I am not allowed to take with me my laptop, or the charger of my mobile […], but international colleagues can travel with their cars back and forth […]. Whether we like it or not, the local person needs the international person. If the international colleague is travelling to Jerusalem, I will ask him/her to take my laptop. This creates a power relationship between us [...]. When there is a point of argument between us at work, I will remember that he has done me a favour. This should not be a favour, but [compared to us], the international staff have protection, impunity, […] rights and privileges; otherwise, they would not have chosen to come and work here".***
>
> *Health official: (Interviewee 9, IO4)*

The implementation of projects is also undermined by Gaza's lack of control over resources and a weak social protection environment in Gaza. For example, the "prevention [of illnesses and deaths caused by water shortages and pollution] requires not only greater investment in primary health care, but also control over and maintenance of water resources", which is in the case of Gaza not

[304] (Schoenbaum et al., 2005a, p. 34).

available[305]. A senior policy maker (Interviewee 7, PI1) also explained that **"UNRWA cannot change how the streets are designed, how the electricity is installed, or the capacity of water wells […]. UNRWA employees can examine and work with what is available. UNRWA can give recommendations to government"**. Another senior policy (Interviewee 1, IO1) also pointed out the following: **"The overall environment in Gaza is not conducive to offering good services. This affects mental health and increases domestic violence […, increasing the burden on UNRWA's mental health services]. For UNRWA, the social, economic, and political reality affect the implementation"** (Interviewee1, IO1).

5.7.2 Meso-level challenges: Lack of coordination, absence of a legal framework, and the instability of funds

The health sector is also struggling with issues such as the lack of coordination, absence of a modern and effective legal framework, and the instability of funds.

There is "a general lack of coordination in policy development and implementation across parts of the PA, between the West Bank and Gaza, and across the four major sectors of the health system (government, NGO, private, and UNRWA)"[306]. Despite, Ramallah run MoH's putting forward a national health plan, challenges such as the separation between Hamas and the Fatah- dominated PNA and restrictions on mobility indicate that there is still "no systematic national process for ensuring that health system development is tailored to the goals articulated in the national health plan or other relevant planning document"[307] .

The absence of the Legislative Council in Gaza indicates that it remains that "there are no modern standards for many key aspects of [OPT] health system operation and minimal enforcement of the standards that do exist"[308]. This has come up in the interviews through criticisms regarding the lack of accountability towards medical errors. For example, a carer of patient (Interviewee 12, CP1) said: **"There is a need to put into effect a law of accountability towards medical errors. There are big medical errors that take place"**. Conversely, a senior policy maker from the NGOs sector, said:

> ***"Until today, there is no law or legislation that addresses medical errors. Unfortunately, the courts have imposed high fines on people who work in the health sector […], although it is difficult to prove if a person died out of a medical error or something else. They asked a health worker/doctor at a government institution to pay $70,000, this is similar to compensation payment [a Sharia law required payment to compensate for someone who is killed by mistake]. Although this person is an employee of the Ministry of Health in Gaza, the Ministry did not stand by him. This had a negative psychological impact on the employees; it affected their motivation to work".***
>
> *Senior Policy Maker: (Interviewee 5, NGO1)*

305 (Bellisari, 1994, p. 61),
306 (Schoenbaum et al., 2005, p. 29)
307 (Schoenbaum et al., 2005, p. 29).
308 (Schoenbaum et al., 2005, p. 29).

Another issue that came up in the interviews is the double job loyalty of doctors. Several interviewees pointed out that **"there are doctors who use their privileges to revert patients to their private clinics. People would pay money and bribe them to be promoted on the referral list"** (Interviewee 12, CP1). Working in both the public and private sector is tolerated even by international organizations such as UNRWA which only requests that they would get approval in advance (Interviewee 6, IO3). The difficult economic conditions in Gaza combined with the salary cuts at governmental institutions makes it difficult to impose a no-private rule on doctors, especially as the health sector in Gaza has increasingly been suffering from a lack of specialists due to both mind migration and financial limitations of the health institution. For example, (Interviewee 1, IO1) argued: **"We need more doctors to provide high quality services […and] to improve this, we simply need more doctors […but] this we need a good financial background to make this happen".** However, there is also a serious "limited capacity of Palestinian health institutions to implement reform"[309].

The instability of funds also disturbs implementation. The dependency of Palestinian governments and NGOs on donor money has meant that sometimes "projects are initiated and then closed down, or turned into poor providers of service for lack of operating funds"[310]. Furthermore, the dependency of NGOs and health institution on donor funds indicates that "the efforts of many professional cadres in the health sector are often directed towards acquiring and maintaining donor funds, keeping them out of their fields of practice, where they are most needed to maintain continuity in the implementation of the projects"[311].

But, the "absence of a legal framework to govern and regulate the NGO sector has made it more difficult for these NGOs to operate and plan"[312], and therefore to attract further investment. Another main implementation "problem in the NGO sector is duplication, often caused by factionalism" (p.94). This duplication is also caused by the "multiplicity of donors with different agendas and the dependence […] on donor financial assistance have also caused programme fragmentation"[313]. (For more details, see Sections 4.2; 6). That "donor nationals, […] often have limited time in the field and are not familiar with the culture or the language" also affects planning and may reflect negatively on the implementation process[314].

5.7.3 Micro-level challenges: Centralization, Bureaucracy, and a lack of transparency

Implementation of health plans projects and services in Gaza is hindered by practices of centralization, bureaucracy, and by a lack of transparency. There is a "relatively centralized management structure of the public sector [which] offers few positive incentives to facility administrators and individual clinicians to provide health care efficiently"[315]. For example, (interviewee 5, NGO1) commented: **"There is a high level of centrality in all institutions in Gaza, including NGOs, government and at UNRWA"**.

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309 (Giacaman et al., 2003, p.8).
310 (Giacaman, 1994, p. 45).
311 (Giacaman et al., 2003, p.9).
312 (Hammami, 2000, p. 39).
313 (Giacaman et al., 2009, p. 846).
314 (Giacaman et al., 2003, p.9).
315 (Schoenbaum et al., 2005a, p. 36).

Bureaucracy affects the health sector on various levels. For example, with no adequate health service in the Gaza Strip, patients had to face "bureaucratic barriers […] caused by policies of the occupation that restrict access for patients, health personnel and ambulances"[316]. Bureaucracy is also one of the reasons for "why a patient may need more than one referral decision as they proceed through medical treatment"[317]. Health care is so often slowed down by routine Palestinian and donor administrative policies and tasks which include exhaustive and "excessive paper work in a context of limited resources"[318]. A health official who works in a public institution reported that **"someone who gets his BA degree [, could be promoted based on an exam], but this exam happens every two or three years]"** (Interviewee 10, G2)**.** The same interviewee also described the following:

> ***"We face administrative complications […]. If I want to ask for something from another department, my request should go to my first boss, then to my second boss, and then to my third boss. This takes time […]. If I want to borrow a printer […], I will have to seek permission from my manager, who would then write to both his manager, and to the administrative manager. The administrative manager will also write to the medical manager, and to the manager of all hospitals/clinics, who would then send the request to the Undersecretary, and so on".***
>
> *Health Official: (Interviewee 10, G2).*

Also, a health official from an international organization complained about how the Palestinian schism has increased difficulties of arranging meetings and preparing for workshops:

> ***"When I prepare for a workshop […,] and I invite both the West Bank MoH, and Gaza MoH to participate, I am faced by conflict on who is going to deliver the opening remarks […]. We try to balance our preparations between the two parties, but these technical issues exhaust our time and energy […]. Palestinian schism has affected our work on daily basis".***
>
> *Health Official: (Interviewee 9, IO4).*

The health sector suffers from a lack of transparency, in which there are restrictions on information, domestication of complaints, and practices of wasta and manipulation. For example, (Interviewee 5, NGO1) said: **"There is a clear lack of transparency and accountability […], which differs between institutions. As someone who is both working and interested in the health sector, I cannot obtain information […], for example, on the financing of the Gaza MoH, and how the budget is distributed […or] know what its revenues are. Regarding this, transparency is non-existent"**. Also, (Interviewee

316 (WHO, 2017b, p. 5).
317 (WHO, 2017b, p. 16).
318 (Giacaman et al., 2003, p. 10; see also WHO, 2017b).

9, IO4) explained that Gaza MoH **"may not want to share and publish information regarding an internal attack, for example, if a patient attacked a doctor […] they would want to protect him and cover up this issue, […] but it would share information on other political and factional issues".**

Gaza MoH has made efforts to encourage citizens to submit complaints, for example, (Interviewee 4, G1) argued: **"Gaza MoH asks the citizens to submit their complaint through the internet or on 103 number […]. Gaza MoH tries to address all complaints that it receives, and if it concludes that the doctor has done wrong, it will hold him accountable. But people fear to submit complaints because they do not want to harm the doctor"**. However, carers of patients had different opinions for why they were not complaining. For example, (Interviewee 12, CP1) said: **"If you write a complaint, they will take it and throw it in the rubbish bin"**, and (Interviewee 13, CP2) explained:

"My husband and I had once submitted a complaint against a nurse. Everyone in the hospital started to put pressure on us to withdraw it […]. Also, my husband had submitted a formal complaint, no one cared about it […]. He kept following it up, but no one asked about him or called him or inquired about what happened […]. The government system tries to reconcile any problem […]. If you insist to pursue your right, the problem may become tribal or familial".

Carer of Patient: (Interviewee 13, CP2).

Also, health officials such as (Interviewee 8, NGO2) argued: **"The employee fears to submit a complaint […], because those in authority […] might react against him/her. In Gaza, there is still fear from people in authority".** The same interviewee also said: **"If an employee asks for rights or objects to anything, they will dismiss him. They use the bad economic conditions and [unemployment] as pre-text [to threaten the employees that they can replace them easily, at any time]"** (Interviewee 8, NGO2). Similarly, (Interviewee 9, IO4) indicated: **"The final word remains in the hand of the person who has a higher position than me"**.

The lack of transparency was also reported in recruitment practices. For example, a senior policy maker who works in a private institution (Interviewee 7, PI1) pointed out that **"If someone has relatives who are unemployed, he will follow an untransparent way to bring them to work at the institution, […] He will firstly bring them to work as volunteers with pocket money, and then he would make for them an easy exam and give them a permanent employment. So, this is a way of beautifying wasta […], but this is still not a phenomenon" in Gaza.** Also, (interviewee 8, NGO2) explained the following:

"Institutions use contracts for manipulation. They employ on 9 months basis and then renew for further 9months and further 9 months, so as to avoid giving rights of permanent employment for its people. This system is followed everywhere in Gaza, including governmental institutions, so as to avoid liabilities".

Health official: (Interviewee 8, NGO2).

The lack of transparency was also reported through practices such as wasta, manipulation of international projects, and escape from taxes. For example, (Interviewee 7, PI1) explained:

> ***"Wasta is much more existent in governmental institutions than in NGOs. […] There are institutions that manipulate projects. For example, if the project is awarded for an institution on the basis of buying drugs, it could use the money to pay employees' salaries instead, because it cannot afford paying them otherwise, so they misuse the project's fund. There are institutions which won't charge the patient because of recommendation from somebody. There is escape from taxes. But these instances do not amount to the stage of corruption. They are mainly a result of the bad [political and economic] situation in Gaza".***

To recap, implementation in the health sector is challenged by several factors, such as the context of instability, Gaza restricted mobility and the lack of control over resources on the macro level; weak coordination, an absence of a legal framework, and instability of funds on the meso level, and centrality, bureaucracy and a lack of transparency on the micro level, although all levels are largely interrelated.

6. Reform priorities and the potential for change

Photo credit: Abed Rahim Khatib/ Shutterstock.com

Reforming the health sector in Gaza requires an active collaboration among all actors, stakeholders, and political powers. But, given the politicization of the health sector in Gaza, this seems difficult to achieve. For example, "at the local level even the actual processes of consultation in relation to proposed plans are flawed, appearing to […] be more rhetoric than substance"[319] . The relationship between local actors and donors does not also amount to real partnership since it is "inherently unequal relationship of donor and beneficiary"[320]. The Israeli authorities are not taking a responsible stand as an occupier, one that fulfils its obligations by International Law; its current practices seem to reduce Palestinians' right to health in adaptation to its political rules and restrictions[321]. Consequently, efforts for reforming the health sector in Gaza seem to be constantly at a disjuncture, fragmented between long term aspirations and short-term emergency projects.

The health system in Gaza is "fused with the political situation"[322], so "as long as Israel retains control of all entry and crossing points into Gaza, its borders, air space, water, etc, […] any viable Palestinian economic and political development remains very limited indeed"[323]. For example, "Palestinians' right to health cannot be realized under perpetual occupation, which poses constant threats not only to

[319] (Giacaman et al., 2003, p.11).
[320] (Giacaman et al., 2003, p.12).
[321] (see for example: WHO, 2017b).
[322] (Thirkell, 2012, p. S107).
[323] (Le More, 2005, p. 994).

physical safety, but also psychological and emotional wellbeing"[324]. Hence, most of the interviewees perceived addressing the root problem, which is the occupation, and also the Palestinian schism should be the way forward for reforming the health sector in Gaza. For example, Interviewee 5, NGO1 argued that the **"ending the occupation is the main step"** towards reform; (Interviewee 13, CP2) explained that **"when the blockade on Gaza ends, opportunities [for reform] becomes available";** and interviewee 7, PI) pointed out that **"real reform starts by ending the Palestinian schism".**

Because the situation in Gaza is one of constant emergency, humanitarian and emergency assistance is lifesaving, (Interviewee 5, NGO1) argued: **"we need additional and new opportunities of international funding".** This short-term support should take place together with working on the long-term project of peace, because "aid in the context of the Israeli-Palestinian conflict […] can buttress but not replace a political process"[325].

6.1 The deadlock of a 'mixing approach' to reform

For balancing long with short term efforts for reform, it is thought that "polices need to be guided by the principle of mixing selected possible and realizable reform measures with relief and emergency operations, rehabilitation and reconstruction"[326]. In fact, a mixing approach which attempts to focus on "what is possible and what is not possible to achieve without reforming the political system itself first"[327], could be workable. However, whether such an approach that combines fragmented bits and pieces could lead to development of the health sector is doubtful. Hence, rather than resolving the disjuncture, a mixing approach seems to lead to a deadlock.

That said, foreign emergency and humanitarian projects which are necessary for the health sector in Gaza to rely on in the short term may be motivated by different political agenda to that which Palestinians aim to achieve on the long term. For example, "international donor community has financed not only Israel's continued occupation, but also its expansionist agenda at the expense […], of the well-being of the Palestinian population […] and of the international community's own stated developmental and political objectives" [328]. Donor short-term projects, "portraying the [Palestinian] crisis as an emergency may also have contributed to […] normalising the conflict […as it] distracts efforts away from tackling the diplomatic challenges and obstacles […] by focusing on its socio-economic consequences"[329]. Also, "the international community has adapted itself continuously to the constantly changing physical and administrative restrictions […] rather than challenge Israeli policy or insist on transparent and predictable procedures and regulations"[330].

The impact of donor aid has been to "alleviate some of the short-term effects of a socioeconomic crisis, [but, aid] does not tackle the root causes of ill health" in the OPT[331]. Also, "while emergency assistance has without doubt helped prevent further socio-economic deterioration and enabled vital social services to continue to function, it has contributed to developing neither the infrastructure, nor the economy nor self-sustaining institutions"[332]. In fact, technical and administrative solutions

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[324] (MAP, 2017, p. 20).
[325] (Le More, 2005, p. 982).
[326] (Giacaman et al., 2003, p.7).
[327] (Giacaman et al., 2003, p. 7).
[328] (Le More, 2005, p. 983).
[329] (Le More, 2005, p. 995).
[330] (Sayigh, 2007, p. 22).
[331] (Giacaman et al., 2009, p. 847)
[332] (Le More, 2005, p. 993).

supported by donor projects have created an "illusion" of reform"[333], leaving quality, equity and social protection problems be reproduced repeatedly, in different forms. On this, the literature explains:

> ***"Serious doubts have arisen as to the long-term effectiveness and sustainability of the donor interventions beyond dramatically increasing the aid dependence of Palestinian households. Moreover, the short term impact of relief is equally not that encouraging".***
>
> *Le More (2005: p. 993)*

What is needed for reform is an approach that neither adapt to the occupation, nor attempt to go around it by mixing inherently self-defeating short- and long-term projects that take place in a context of Palestinian health policy vacuum. Hence, "the absence of internal Palestinian debate on the type and direction of reform the country needs to take" should be seriously addressed[334]. This debate needs to happen in collaboration, and "at an appropriate speed in relation to the requirements"[335].

This does not mean that a mixing approach should be rejected. But this mixing should be based on Palestinians' priorities, and a well-informed and unified plan for how to improve the Palestinian health sector in Gaza. Instead of defining what is possible and achievable from the point of dependency and helplessness, a national effort is required that builds this definition based on an existing Palestinian vision and plan, that would use any international support towards empowering the agency and independence of the health sector in Gaza.

6.2 Reform priorities

It is not possible for any future local (and international) agenda for reforming the health sector in Gaza to achieve development without addressing the following:

- **De-politicizing the health sector in Gaza** by working through a political process to end the occupation. The depoliticization should also take place from within the Palestinian community in the OPT by ending the Palestinian schism. There is also a need for global stance that works to insulate the health sector in Gaza from politics, considering this a merely humanitarian issue, and offering necessary support and interventions in case of any violation.
- **Creating a trusted technical collaboration** platform that would encourage not only the exchange of information, but also coordination of data production, resources, and expertise among the various health providers in the OPT.
- **Unifying the administrative front of the Palestinian Ministry of Health**, including salaries and employment scales.
- **Developing a national manifesto of vision for reform,** supervised by a unified Palestinian Ministry of Health. This should be done in collaboration with all providers of health care in

[333] (Giacaman et al., 2003, p. 2)
[334] (Giacaman et al., 2003, p. 1).
[335] (Giacaman et al., 2003, p. 11).

Gaza and the West Bank, and in all fields including facilities, equipment, drugs, data, capacity building initiatives, and expertise.

- **Budgeting for the health sector in a practical way** that considers instability, military attacks, and disruptions in this area of conflict.
- **Directing/encouraging funding for purpose, based on a national manifesto of vision for reform,** in order to make maximum benefit of the resources towards national objectives, limit duplications of projects and services, and protect the health sector from adversarial political agendas.
- **Empowering a technological infra-structure**, that would equip the Gaza health system under conditions of severe blockade on its borders with a modern health information system, and provide opportunities for health administration, staff and patients to benefit from online trainings, support, guidance and resources. This will also help to alleviate some of the bureaucratic practices in the sector.
- **Linking the health sector in Gaza to an international lifeline of expertise support** that strengthens the development of its capacity, and thus makes it possible for the sector to move in the direction of national independency from Israel in the future.
- **Revising, updating, unifying, and enforcing a legal framework for the health sector** that is based on modern standards of health in the OPT, and which is consistent with the national vision and Universal Health Coverage (UHC) and Sustainable Development Goals (SDG).
- **Enforcing clear, comprehensive and just measures for monitor accountability**, and **transparency** among all health institutions.

6.3 Potential for change

Whilst a comprehensive and just political process is being debated, three windows for reform seem to carry a potential for change: (1) human agency; (2) rationalization of services; and (3) advocacy.

Although interviewees, such as carer of patient (Interviewee 14, CP3), have lamented the possibility for improving the health sector in Gaza, saying: **"From where the change is going to come. You do not rely on anyone. You only rely on Allah",** or put a hope of reform on ending the occupation and the blockade, there were a few other interviewees who were seemed optimistic, viewing change as something that can start even within the current constraints and limited resources. For example, (Interviewee 3, IO2) highlights the commitment of people as a valuable resource, by pointing out the following:

> ***"For reform to be implemented, there is a need for stability, financial resources, and other factors that support reform such as security. But there are open windows for reform because of the commitment of the people themselves. People are highly motivated despite the challenges. The human resource, i.e people themselves are the most valuable resources in [the Gaza] context. They are still committed and working [hard], and this is why we are not seeing a deterioration of indicators, for example, mortality indicators. It was stagnant a few decades ago but have not deteriorated".***
>
> *Senior Policy Maker, (Interviewee 3, IO2).*

Another senior policy maker from an international organization also explained that rationalizing the services through finding effective ways of operation can be the way forward:

> ***"Improvement of quality does not always need money, sometimes it just needs minds to think […]. Improvement of the services and approaches to delivering the health care services, like the [UNRWA] family team approach, did not need a lot of money. On the opposite, it saved money, as it improved the quality in addition to empowering the capacity of management to work more effectively and efficiently, […which led to] a more rationalization of services […] managing the available minimum resources in a good way […that would] produce excellent results […]. UNRWA succeeded to work within the financial and economic deterioration of Gaza without collapsing".***
>
> *Senior Policy Maker: (Interviewee 6, IO3)*

A health official (Interviewee 9, IO4) also indicated although advocacy may not lead to tangible results on the ground, it is important to highlight the violations, inaccessibility, and ask for protection and support for the health sector under conditions of occupation in Gaza:

> ***"The complexity of the situation in the OPT is very difficult. We try to highlight different kinds of issues from those on our priorities, but the extent to which this advocacy leads to changing local, regional, or international policies is not much […]. There are obligations on the international community, and on Israel as an occupier, so they should be called upon!"***
>
> *Health Official: (Interviewee 9, IO4).*

Building on the potential of people's commitment can be achieved through a focus on capacity building, and the organization of this human resource in the best ways that support the health sector. Young people's connectivity to internet communities and resources is advantageous, especially under conditions of blockade on Gaza. Institutional reform is also required that gives employees' equal rights, and benefits, and a less bureaucratic and factional context to work in. It is also important to link local with international expertise, through travel, and (if not possible) through the internet. In order to be able to rationalize the services, efforts should be directed to encouraging collaboration among the various health providers and creating opportunities of ideas and data exchange. A national plan backed by a legal agreement can help in this direction. Advocacy is also necessary to support the health sector in Gaza. It should be a continuous activity done by all institutions, and at all times. This is crucial so as to provide assistance to people under difficult humanitarian conditions, generate financial and project support, as well as contributing to ending the occupation, and the blockade, which are putting people's health in Gaza in a state of continuous risk and emergency. Such a state

can lead only to more violence, since "not only peace is necessary for health but also health is necessary for peace"[336].

7. Concluding remarks

7.1 Headline findings from the PEA

The political economy of health scene in Gaza is loaded with legacies of fragmentation, dependency, and division that continued to be powerful in shaping the health care experience of Palestinians today. Consequently, the health sector in Gaza remains a battlefield of different actors and agendas in a fragile and continuously changing political, economic, and social dynamics of conflict. The repercussions of this on policy making in Gaza health sector is leading to further 'de-development', and yet these repercussions are not easy to capture, especially since Gaza continue to be a significantly under-researched area.

External and internal challenges have pushed the health system in Gaza to the point where it struggles to survive, by any means, to avoid a humanitarian crisis. Taken this into consideration, the main health providers, divided themselves, do not seem to be able (or willing) to risk the game changing scenario of setting up policies that encourage their interdependence from an ever entrenched and expanding web of donor aid and assistance that is helpful and yet counterproductive to a long term political solution in the OPT. Israel does not seem to accord due respect to its International obligations towards Palestinians as occupied, causing dehumanizing conditions in Gaza, and a devastating economy that makes it impossible for Palestinians to plan towards Universal Health Coverage (UHC) and Sustainable Development Goals (SDG), or to maintain the health and dignity of people in Gaza.

In this context, reforming the health sector in Gaza remains a serious challenge. Thus, efforts are stuck at a disjuncture between long- and short-term reform projects that seem to strengthen the *status quo* rather than resolving it. Until a unified Palestinian debate is initiated, and informed tangible home-grown policies implemented, Palestinians in Gaza will continue to suffer the consequences of a health system that is shaped by ad-hoc decisions and policies adopted from outsiders by the top (international and Palestinian governments and organizations in Gaza and the West Bank) who, helplessly, cling to an 'illusion' of reform.

7.2 Evidence strength and clarity: Gaps and limitations

This report provides an overall picture of the political economy of health in Gaza. The analysis provided in this document is based on the analysis of both the literature review on health in Gaza (see Section 2.2), and data collected from in-depth semi-structured interviews with policy makers, health officials, and carers of patients from the Gaza Strip who shared their views on, and experiences in navigating the health sector in Gaza, as well as the researcher's reflections on all data. As an early study on the topic of the political economy of health in Gaza, several gaps and limitations should be noted:

The state of the literature on Gaza health sector (see Section 3), combined with a lack of transparency of health information from institutions in Gaza may have limited the ability of the researcher for accurate or detailed interpretation of part of the data. Also, the limited time of conducting the research project means that this research could not go further to track important political economy information such as changes to the financing of the health sector overtime, supply chains, rent-

[336] (Schoenbaum et al., 2005a, p. 2).

seeking, and the inter-relatedness between the health sector and other sectors in Gaza and the West Bank, or include further studies that became available towards the completion of the project. Political bias, and a weak digital infrastructure for health institutions in Gaza have also indicated that available statistics may not be trusted, except in their generality, as indicators/impressions rather than actual numbers. The continuously changing political context in Gaza suggest that as the researcher was writing this report, details of the situation in the health sector in Gaza may have changed too, although the researcher took this point into consideration, as much as possible, trying to focus more on themes, trends, characteristics, and features, rather than on specific incidents or data.

The study could have benefited from including a larger number of participations from policy makers, health officials, and carers of patients, with more representations from each institution. Due to the difficulty of access to Gaza, the researcher had no option but to use the snowballing method to reach participants in the interviews. But, using the snowballing method was also challenging because some people may have feared to contribute to the study for security reasons, and thus were reluctant to participate in the interviews.

To conclude, this study is exploratory research, which although may have limitations and include gaps that have been acknowledged in this section, remains a significant contribution to knowledge on the political economy of health in Gaza. The report at hand could also inspire further academic studies, and policy reform in Gaza and beyond.

7.3 Framing an onward research agenda

In order to enhance our understanding of the political economy of health in Gaza, further library and fieldwork research on various issues are needed. The following are a few topic suggestions:

- **History & context:** To what extent the history of the political economy of health in the Arab world have influenced the health sector in Gaza, and whether this has been impacted by the Arab Spring, if at all? To what extent has a neo-liberal trend been affecting the health sector in Gaza?
- **Natural resources and health protection:** How does the occupation control over Palestinian natural resources including agricultural land, water, and energy affect the functioning of the health sector in Gaza?
- **Interaction with other sectors:** What is the relationship between the health sector and other ministries and sectors in Gaza, and how did the Palestinian schism reflect on this relationship?
- **Distribution and Equity:** What is the distribution of health budget, facilities, personnel, and services between rural and urban areas in Gaza? What support is available for people with disabilities, and what changes are required? What difficulties do Hamas affiliated members and members of other factions face in accessing tertiary healthcare in other countries and in Israel, and to what extent the Palestinian schism reflect on their experience? What are the practices of pharmaceutical companies in Gaza, and how does this reflect on distribution and equity?
- **Service delivery:** How are mobile clinics utilized in Gaza, when, and by whom? To what extent does the service delivery for patients with noncommunicable diseases differ between adults and children in Gaza? What are the supply chains for the sector?
- **Laws and Policies:** What are the laws and policies that govern the health sector in Gaza? What is the employment system used within the health sector, and to what extent does it support or hinder the functioning of the system?
- **International players:** What is the relationship between the different international health organizations in Gaza, if at all? What are the relationship between these organizations and

the Israeli authorities? What is the relationship between these organizations and the Palestinian ministries of health?

- **Reform and planning in conflict zones:** What is the planning models used by the Palestinian ministries of health? What alternative models might be available, or can be learnt from UNRWA and other international organizations' work in the OPT, and other conflict- affected areas?
- **Post Covid-19 situation:** What are the new ramifications and challenges posed to the health sector in Gaza as affected by Covid-19 crises? Are there any opportunities?
- **Latest Development:** How does the latest normalisation deals between Israel and Arab States reflect on the health sector in Gaza, if at all? What do increased cuts to UNRWA mean to the health sector in Gaza?
- **Promised Palestinian elections:** How would the ending of the Palestinian schism reflect on the health sector in Gaza? What would happen if Hamas won the elections, and how would this impact on international aid, and referrals to Israeli hospitals? What would happen if the PNA won the elections, and what does this mean for the reorganization of health sector leadership in Gaza?

Appendices

Appendix (1): Invitation Letter

Invitation Letter

Date: ------------------------

Dear ____________

I am writing to invite you for an interview as a part of a research on Political Economy of Health in Gaza. I am a Research Fellow at the University of Cambridge. This study is conducted as part of a Global Challenge Fund Project: R4HC-MENA. (For more details, see: https://r4hc-mena.org/). This research has been reviewed by, and received ethical clearance from the University of Cambridge.

In researching this topic, I am interested in looking at how the health system in Gaza is influenced by its macro-economic and political context under conditions of conflict and occupation. The participation is voluntary, and you can withdraw from the study at any time. All transcripts of interviews will be kept confidential. For more details on the research and your participation, please see the Research Factsheet attached.

I hope that you would be interested in participating in this study's interviews and that I may contact you by telephone/e-mail within the next few days to make an appointment.

Thank you for your help,

Kind Regards,
Dr. Mona Jebril
Research Fellow
Center for Business Research
University of Cambridge
m.jebril@cbr.cam.ac.uk

Appendix (2): Participant Research Factsheet[337]: A Sample

Research Participant Factsheet (Experts and Policy Makers)

The Overall Project	This research is part of a Global Challenge Research Fund Project (GCRF) which is entitled: "Research for Health in Conflict: Developing Capability, Partnerships and Research in the Middle East and North Africa (R4HC-MENA). For more details, see: https://r4hc-mena.org/
This Study	The study is supervised by the Centre for Business Research at Cambridge University Judge Business School. It investigates the political economy of health (PEoH) in the Gaza Strip, and by this, it contributes to the second component of the above GCRF project.
Researcher's Name & Contact Details	**Dr. Mona Jebril** Research Fellow Center for Business Research Judge Business School, 11-12 Trumpington Street, Cambridge, CB2 1QA, UK Tel: +44 (0) 1223 765327 m.jebril@cbr.cam.ac.uk
PEoH Leader at Cambridge	Dr. Adam Coutts (apc31@cam.ac.uk)
PEoH Supervisor at Cambridge	Dr. Simon Deakin (s.deakin@cbr.cam.ac.uk)

Dear ***Participant***,

Please have the time to read this factsheet which will give you useful information regarding your participation in this study. If you have any further questions, please do not hesitate to contact me at m.jebril@cbr.cam.ac.uk .

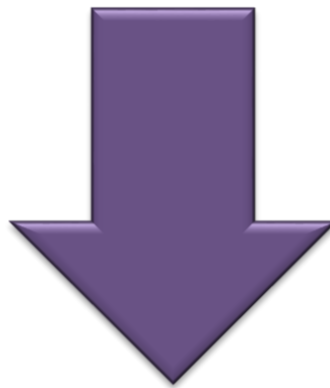
Thank you for your help,

Best wishes,
Mona

[337] This research factsheet is adapted from (Jebril, 2018).

1	What is this study about?
	This study explores the political economy of health in the Gaza Strip.
2	**What does this research aim to achieve?**
	The research aims to outline how the health sector in Gaza is shaped by its macro-economic and political contexts in terms of outlining the historical legacies of the sector, its main stakeholders, decision making processes, incentives, and the potential for reform.
3	**Why is this research important?**
	Understanding the political economy of health in Gaza is important to identify the incentives for change and development in the health sector in this area which could influence the decision-making process and contribute to shaping policy priorities in health in Gaza. It will also inform our ability to build capacity for health research excellence in Gaza and in other conflict-affected areas in the Middle East and North Africa region.
4	**What are the broader research questions?**
	Q1. What are the key contextual factors determining the direction and health policy in Gaza? And what role has conflict in Gaza played in shaping this? *Q2.* Who are the key actors/stakeholders in the health sector in Gaza? How has the map changed under the pressure of the conflict in Gaza? *Q3.* What are the characteristics of bargaining processes by which health policy in Gaza is made? *Q4.* What key values/ideas underpin the identification of priority health policy issues/formulation of health policy? *Q5.* What main opportunities/incentives for health reform exist in Gaza, and what are the principal barriers to reform?
5	**Why have I been chosen?**
	All choice of interviewees is based on a selection criterion. Thus, you have been chosen because of the relevance and value of your experience to this research project.
6	**How many people are participating in this study?**
	In total, 18 participants will be interviewed from Gaza. These participants are from health experts/ policy makers, health professionals, and the local community (patients and their carers).
7	**What rights do I have as participant? (anonymity, confidentiality, withdrawal, no harm)**
	You have the right for anonymity, confidentiality, withdrawal and no harm. Below are more details on this: • **Anonymity:** You name and biographical details will not be shared in this research or in the following stages of report and academic writing publications. • **Confidentiality:** Your request to keep any information confidential will be respected, in which case the information you mention will be presented in an unidentifiable manner. • **Withdrawal:** You can withdraw from participation any time before the interview or shortly (3 days) afterwards. • **No harm:** The researcher will take all possible measure to protect your anonymity, and if necessary, the identity of your institution in which case data will be presented as aggregated themes. Recorded interviews will be destroyed after the end of this project.

8	**How will the interviews be conducted?**
	If you are in Gaza, the main mode of interviewing is Skype. However, it is also possible to conduct the interview by phone or mobile if this would be a more convenient option. If you are in Cambridge, we could meet up in person for the interview.
9	**Can I choose the mode of interviewing?**
	Yes, you can choose whether to conduct the interview via Skype, phone or mobile.
10	**If in the Skype interview, can I turn off the camera?**
	Absolutely, you can choose Skype with no camera if you prefer that.
11	**Can I choose the language of interviewing?**
	Yes, you can choose whether the interview is conducted in English or in Arabic.
12	**Will the interview be recorded?**
	Yes, it is important to record the interview so as to facilitate the processes of analysis.
13	**Will I have a copy of the recording or to be able to review the transcripts of the interview afterwards?**
	No, it is not possible to have a copy of the recording or review the interview the transcript.
14	**How will the data be analysed?**
	Using a coding software, the data will be analysed thematically.
15	**What voice does this research represent?**
	This research is an academic study.
16	**How will the information I provide be used?**
	The interviews will be transcribed and then coded and analysed thematically. Your information will be used to inform or support the literature on the political economy of health in Gaza.
17	**Will this study be published?**
	Yes, this study maybe published separately or as part of other documents (book, journal, thematic report).
18	**Why is my contribution important?**
	The Political Economy of Health in Gaza is a significantly under-researched topic. Your contribution is very valuable. It will enrich our understanding of the health sector in Gaza, and assist us in developing research capacity building initiatives that would improve the healthcare experience for patients as well creating a centre of research excellence in the region.
19	**How will I benefit from my participation?**
	Participating in this interview will be an opportunity to contribute to improving the healthcare experience for people in Gaza, as well as enriching this research on the political economy of health with your valuable perspective. There is no financial reward for participation in this study, but we hope that the interview situation will be a friendly and interesting conversation that you will enjoy and find useful.



Appendix (3): Interview Guide[338]

Interview Guide*

Contents of the Interview Guide

I. Interview aims
II. Themes and sub-themes for exploration
III. Indicative interview questions by interviewee category
IV. Interview supporting material:
1V.I Probes by institutional category
IV.II Probes by historical events
V. Notes on the Interview Guide

I. Interview Aims

- The aims of interviews with experts/ policy makers are to:

  - Elicit their Birdseye views regarding the different themes of political economy in health in Gaza.
  - Explore the potential for reform from a top-down perspective.
  - Evaluate their experiences in decision making in relation to the health sector and ways in which these experiences have been affected by the conflict
  - Identify the challenges and opportunities for the health

- The aims of interviews with health professionals are to:

  - Explore how the conflict reflects on their work experiences in the health sector.
  - Examine how the political economy of health affect their work in their institution
  - Identify their perspectives regarding the main barriers and opportunities for reforming the health sector in Gaza from a practical point of view.

[338] This interview guide is adapted/ benefits from (Jebril, 2018).

- The aims of interviews with the local community (patients and their carers) are to:

- Explore the experience of political economy of health in Gaza from a bottom up perspective
- Elicit the impact of bargaining processes and decision making in the health sector in Gaza on people's lives
- Listen to people's experiences in navigating the Gaza health care system and how it is affected by the conflict
- Identify structural and cultural barriers to reforming in the health sector in Gaza.
- Explore the extent to which the local community is involved in the process of decision making in the health sector.

II. Themes for exploration:

- Sub-themes

Sub-themes	
Theme # A Contextual Factors	
A.1 Structural Variables	• **Health Economic base:** (Poverty and distributional effects, Employment, humanitarian aid, social protection and insurance) • **Health Geographical base:** (Urban vs Rural, Refugee distribution, location of health sector institutions) • **Health Political base:** (Political system, funding and governance of health institutions, and the relationship between governmental, NGOs, donors and the private system) • **Health Cultural base:** (Key cultural characteristics and social expectations) • **Health Social base:** (Social protection and insurance, social groups (refugee, non-refugee, others), Class and lifestyle) • **Health Institutional base:** (Vision for health system, leadership of health institutions, quality of healthcare, equity of healthcare, health development) • **Highlight:** the dynamics of conflict and how it impacted on the above
A.2 Historical Legacies	• **History** of the health sector • **Development** of the health sector • **Current challenges** of the health sector • **Highlight:** Impact of conflict (occupation and Arab Spring) on the health sector

Theme # B Actors/ Stakeholders	
B.1 Roles and Responsibilities	• Key **stakeholders** in the sector (domestically) • **Formality vs informality** (roles and mandates of different players) • **Central/local authorities** and their role in the provision of services • "**Veto** players" • Key **global actors** and their priorities
B.2 Ownership Structure and Financing	• Public vs private **ownership** • **Financing** of the health sector • **Highlight:** Impact of the conflict in shaping ownership and financing structures in Gaza.

Theme # C Bargaining Processes	
C.1 Power Relations	• **(Who)** Specific individuals/ groups of power • **Extent** of their power • **Ways of using this power** for influencing policy making
C.2 Corruption and Rent Seeking	• **Extent/significance** • **Where** prevalent (delivery, procurement, allocation of jobs, etc) • **Patronage** used • **Beneficiaries from corruption**
C.3 Service Delivery	
Theme # D Policy	
D.1 Decision Making	III. **Decision making** in the health sector (How, who, where and what)
D.2 Implementation	**IV. Effectiveness** **V. Bottlenecks** VI. Reasons for **failure**
Theme # E Values/ Ideologies	
E.1 Social expectations, health-seeking behavior, and challenges to health development	• **Gender** and health • **Religion** and health • **Social expectations** and health • **Education** and health • **Class** and health? • **Race** and health? • **Political ideologies** and health? ➢ **Highlight:** Impact of conflict on values/ ideologies
Theme # F Opportunities/ Incentives	
F.1 Potential for Reform	VII. **Winners and losers** from particular reforms VIII. **Reform champions** (if at all) IX. **Resistance** of reform (Who and why) X. **Second best reforms** to overcome opposition

III. Indicative Interview Schedule by Category of Interviewee:

❖ Table 1: The Interviews with **'Experts / Policy Makers'**

Interview Theme	Interviewee: '**Experts/ Policy Makers**'
Theme # A **Contextual Factors**	• Can you tell me about your work in relation to the health sector in Gaza? • Overall, what impact do you think the siege and conflict is having on the health sector in Gaza?

	• Are there any changes in the political scene (latest/ selected events) that have particularly reflected on the Gaza health sector, if at all? • Over the years of you work in the health sector, how do you think the health sector has developed? • What are current challenges of the health sector in Gaza? • Given these challenges, what would be the vision for improving the health sector in Gaza? • Are you/ your institution involved in any programs/ campaigns for health promotion and development in Gaza?
Theme # B **Actors/ Stakeholders**	• To what extent do you think the political situation in Gaza affect all health institutions similarly? • From your experience, who seems to have the power of decision making in the health sector? • Have you experienced any difference in working with global and local actors (or between MoHs/ NGOs/ UNRWA as relevant)? • To what extent you think the roles and mandates of health actors in Gaza differ (has differed over time)? Who has the central role in health provision? • What impact did the Palestinian schism have on the relationship among the actors in the Gaza health sector? If yes, how? • Who is more influential in the health sector: the public or the private sector? • Under difficult conditions in Gaza, what do you think are the channels for financing the health sectors? To what extent these channels are sustainable?
Theme # C **Bargaining Processes**	• How easy is it (was it/ would it be) for you to contribute to the decision-making process in health in Gaza? • Who is influential in the decision-making process in the health sector in Gaza? What is the extent of their power? How are they using it? • To what extent are practices of Wasta and corruption prevalent in the health sector in Gaza at a managerial level? What is motivating these practices (if at all)? What is their impact on the health sector in Gaza? Who are the beneficiaries from this?
Theme # D **Policy**	• Is reliable data and information on the health sector available to support decision making and policy formation? • What is the contribution of your institution to the decision making and policy process in the health sector?

	• How do you describe the process of coordination between your institution and other actors in the health sector in Gaza (if any)? How is this relation mediated? • Is there any cooperation between the healthcare sector and academia in policy formation? • Are there any factors that affect this coordination? • How effective is policy implementation in the health sector? • Are there any failure in implementing policy? (if yes), what/who are the reasons?
Theme # E **Values/ Ideologies**	• Does your identity (gender, religion, class, race, political ideology) affect your ability and the ability of others to contribute to the decision making process? If yes, how? • To what extent does identity affect the content of policy making? • Does the conflict in Gaza shape social expectations/ perception of health? If yes, how? • What impact does social expectation/ perception of health have on policy making and implementation in Gaza?
Theme # F **Opportunities/ Incentives**	❖ How can reform happen in the health sector in Gaza and who is able to champion it? ❖ Are there any winners or losers in the process of reform? If yes, who are they? ❖ Who is hindering/ resisting reform and why? ❖ In case of resistance, what alternative reforms can be considered?

❖ Table 2: The Interviews with **'health professionals'**

Interview Theme	Interviewee: '**Health Professionals**'
Theme # A **Contextual Factors**	• Can you tell me about your work in institution x and the health sector? • How does the conflict and siege reflect on your work, if at all? • Are there any changes in the political scene (latest/selected) events that have affected your work in health care? • Over the years of your work in this/ health institution/s, how do you think the health sector has developed? • What are the challenges that you face in your work in the health sector and how do you deal with them? • Are you/ your institution involved in any programs/ campaigns for promotion and development in Gaza? • What trainings are available to you as a health professional in Gaza? • What protection is available to you as a health professional in Gaza?

Theme # B **Actors/ Stakeholders**	• From your experience, who seems to have the power of decision making in the health sector? • If relevant, have you experienced any difference in working with global and local actors (or between MoHs/ NGOs/ UNRWA)? • Does your institution has a central role in health care provision? If yes, how? If no, who then? • How did the Palestinian schism reflect on your work and your institution? To what extent did it affect the relationship among actors in health care? • Does your work involve cooperation with other institutions of health care in Gaza? How effective is this communication? • To what extent does the deteriorating economic situation in Gaza affect your salary and the financing/ activities of your institution?
Theme # C **Bargaining Processes**	• How easy is it (was it/ would it be) for you to contribute to the decision making process in your institution? • To what extent does your institution contribute to decision making and policy formation in the health sector? • Who else do you think is influential in the decision making process in the health sector in Gaza? What is the extent of their power? How are they using it? • To what extent do practices of Wasta and corruption affect your work/ your institution/ the health sector in Gaza? What is motivating these practices (if at all)? What is their impact on your work/ the health sector in Gaza? Who are the beneficiaries from this? Did you also have to use it in your work or to get employment in the sector?
Theme # D **Policy**	• What role does your institution play in health policy formation? • How do you describe the process of coordination between your institution and other actors in the health sector in Gaza (if any)? How is this relation mediated? • Are there any factors that affect this coordination? How does this impact on your work? • How effective is policy implementation in your institution/ the health sector? • Are there any failure in implementing policy that you have experienced? If yes, what/who are the reasons?

Theme # E **Values/ Ideologies**	• How does social expectation/ perception of health affect health-seeking behavior in Gaza? • Does your identity (gender, religion, class, race, political ideology) impact on your work in any way? If yes, how? • To what extent does identity affect the content of policy/decision making at your institution/ in the health sector?
Theme # F **Opportunities/ Incentives**	• What reforms have been effective at your institution/ health sector? Who were the champions of this? • What reforms have been ineffective? Who were the winners/ losers of these failed reforms? • What are the barriers to initiating/implementing reform? • In your view, what reforms are required to improve your work at (this) health institution/s? Are they possible to achieve? In case of resistance/ impossibility, what would be the alternative/ second best reforms and how can they be achieved?

- Table 3: The Interviews with **'local community'**:

Interview Theme	Interviewee: '**Local Community**'
Theme # A **Contextual Factors**	• Can you tell us about your experience (as a citizen/ refugee) with healthcare in Gaza? • Do you think this experience differ between facilities/ institutions in urban, rural, and camp areas? • What institutions do you approach for healthcare (private, public, NGOs, UNRWA) and why? • To what extent are you able to afford healthcare, and what means of financial support are available to you? • Do you consider the area where you live healthy? How, Or why not? • How do you rate the quality of health care/ services (infra-structure, treatment, drugs, staff) that you receive in Gaza? Is it equal for all people? • Over the years of using health care services in Gaza, to what extent you think these services have improved? • What impact did political changes and the siege in Gaza have on your access to health care, if at all? • Did you have any experience with the referral system? If yes, how was it?

	• What health information/ education do you have access to, and by what means are they available (traditional, technological)? By whom is this information provided? • Do you have access to drugs? How? What do you think of their quality/ affordability?
Theme # B **Actors/ Stakeholders**	• In your viewpoint, who controls decision making in the health sector? • Which actors are more effective/ professional in providing healthcare? Is there any difference between services of UNRWA, NGOs, private and public institutions of healthcare? • How do you perceive the role of global actors in healthcare in Gaza? • Do you pay any tax/insurance to support healthcare in Gaza?
Theme # C **Bargaining Processes**	• Who has the power to improve healthcare for people in Gaza? Are they using it in the right way? (how, or why not?) • From your experience of navigating healthcare in Gaza, how effective is decision making processes/ coordination among the different institutions of health? How did this affect you? • What is the impact of Palestinian schism on your experience in the healthcare system, if any? • Using the healthcare, are the services offered on an equal and transparent basis? Have you experienced any instances of corruption or Wasta? • To what extent do you think Wasta is necessary to access healthcare? What kind of Wasta is needed (political, kinship, money, educational, religious)? • Who benefits from Wasta and corruption in healthcare in Gaza? How can this problem be solved?
Theme # D **Policy**	• From your experience, who was effective in making decisions that facilitated your access to healthcare? What were these decision, and at what level/institutions have they been taken? • As a patient/ carer, are you asked about your opinion/ experiences in navigating healthcare to improve these services? Have you been invited to participate in any research/ survey that assess the quality of health care in Gaza? • To what extent you think the implementation of health policies and decision are effective and useful? • In your viewpoint, what needs to be done to improve implementation of health policies and decisions on the ground?

Theme # E **Values/ Ideologies**	• Does your identity (gender, religion, class, race, political ideology) affect your access to healthcare in Gaza? If yes, in what way? • What impact do social expectations have on your healthcare seeking behavior, if at all?
Theme # F **Opportunities/ Incentives**	• In your view, what reforms are needed to improve healthcare in Gaza? • Whom do you trust to carry out reform and improve the healthcare experience for you? • From your perception, what are the barriers and opportunities to achieving this reform?

IV. Supporting material

IV.I Probes by institutional category

UNRWA	• Relationship with Ramallah-based and Gaza-based MoHs • UNRWA coordination with other health providers in Gaza • Relationship with Israel • Policy implementation and challenges • Capacity building for decision making • Unregistered refugees • Financing, and US cut of funds for UNRWA • Protection for healthcare professionals
Gaza-MoH and public institutions	• Relationship with Ramallah-based MoH (funding, exchange of information, coordination, military hospitals). • Palestinian schism and clientelism in the sector • Financing • Relationship with NGOs and global actors • Vision/ challenges for the health sector under the government of Hamas
NGOs	• Funding sources • Local or international agenda • Relationship with MoHs • Coordination with other health providers • Geographical distribution (urban, rural, camp) • Role in referrals system • Relationship with Israel (if relevant) • Any particular challenges • Impact of Palestinian schism

International organizations	• Role in planning for the health sector in Gaza • Relationship with MoHs • Coordination among each other • Relationship with Israel • Protection for health workers and facilities • Health research • Challenges of working in Gaza
Academia	• Involvement in health planning and policy • Challenges faced by the conflict and the Palestinian schism • Vision for the health sector • Capacity building in the health sector

IV.II Probes by selected Gaza historical/ political events

Oslo Agreement (1993) and the Peace Process	• Transparency, authoritarianism and centrality in management and decision making. • Political clientelism • Planning and coordinating for health among different actors
Al Aqsa Intifada (2002)	• Re-occupation of Gaza and how it impacted the health sector
Hamas Election (2006) and the Palestinian schism (2007)	• Impact of Palestinian schism • Political clientelism • Relationship, decision making, and health planning between Ramallah-based and Gaza-based MoH • Impact of the siege and financial sanctions on the health sector • Political popularity and the health system • Transparency, authoritarianism and centrality in management and decision making. • PNA military hospitals in Gaza • Hamas network of NGOs • Tunnel economy • Arab Spring
Israeli attacks on Gaza (2008, 2012, and 2014)	• Impact of these attacks on health planning, and resources • Protection for health workers and facilities • Referrals system among conditions of high emergency
Great March of Return (started in March 2018 and still ongoing)	• Protection for health workers and facilities • Decision making and coordination in a context of emergency • Referrals system among conditions of high emergency

V. Notes on the Interview Guide

- I will benefit from this guide in a flexible manner that suits each participants' interview situation and (work) experience. Hence, the interview questions may be answered by one or more participants to achieve the aim from interviewing the target group.
- The interview questions are indicative, and may be reduced or added to, as necessary.
- Taking into consideration that the interviews will be conducted as semi-structured, the supporting material is included to enable a creative and relevant encounter between the interviewee and the interviewer.

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