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Foreign Aid and the Health Sector: A Case Study from the Palestinian National Authority

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Department of Public Policy & Administration
School of Global Affairs & Public Policy
The American University in Cairo
New Cairo 11835, Egypt.

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ppadworkingpaperseries@aucegypt.edu

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Foreign Aid and the Health Sector:

A Case Study from the Palestinian National Authority

Wafa Ahmad Mataria*

Working Paper No. 5

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* This paper is based on the author's MPA thesis entitled "Foreign Aid and the Health Sector: A Case study from the Palestinian National Authority" submitted to the Department of Public Policy and Administration in Fall2017. Any questions or queries related to this working paper may be sent directly to wafamataria@aucegypt.edu.

Abstract

Foreign Aid (FA) is considered a tool for promoting economic and human development. Considerable amounts of FA is directed towards the health sector. The role of FA in development, as well as in health, has been a subject of debate with inconclusive results on its impact. This study concentrates on FA in the health sector in Palestine during the period following the establishment of the Palestinian National Authority in 1994. A qualitative research approach was used throughout the study to explore, describe and explain the roles, procedures and challenges of FA in the health sector. The research concluded that FA has a positive impact on the health sector outcomes in Palestine. FA contributed to the establishment of institutional structures and capacities within the health sector, as well as in service provision. Nevertheless, the following challenges still need to be addressed in order to increase FA effectiveness: the Israeli occupation; the continuing influence of donors' agendas; the politicization of aid; the competition between different FA recipients; the low accountability of donors towards recipients; and the miscommunication and inadequate coordination between various actors.

1. Introduction

Foreign Aid (FA) has become the safety boat for many developing countries. Apart from the developed world, all other countries are lagging behind on the route to development – economically and socially (Tarp, 2003). Economically, developing countries have low economic growth and high poverty rates. Socially, developing countries have relatively low life expectancy, and high illiteracy and mortality rates. Among others, these are a few trailing areas which FA is intended to further improve. FA was introduced in the 1960s to alleviate poverty and ameliorate the quality of life for people in developing countries through providing the necessary funds to build infrastructure and the capacities required for development (Tarp, 2003). FA is equally used to fund humanitarian needs in case of crisis, being man-made as in the case of wars and conflicts, or natural, as in the case of earthquakes and floods.

The role of FA on development in recipient countries has been the center of debate due to inconclusive results on its effectiveness. Although the results of FA on a small scale in specific programs and projects were mostly positive, the overall role of FA on development is controversial (Doucouliagos & Paldam, 2009). Despite this ambiguity, FA is still considered as one of the tools to reduce poverty. In the 2005 UNDP Annual Report, it was stated that, "International aid is one of the most powerful weapons in the war against poverty. Today that weapon is underused and badly targeted. There is too little aid and too much of what is provided is weakly linked to human development" (UNDP, 2005). The latter part of the UNDP statement emphasizes two realities: the unceasing international interest in FA and the need to increase FA's effectiveness in promoting development.

Since the 1970s, and more specifically following the Alma Atta Declaration of 1987, health gained considerable attention as a precursor and as an end for the development process. The emphasis on health in development continued throughout the years, specifically in 2000 with the Millennium Development Goals (MDGs), and in 2015 with the Sustainable Development Goals (SDGs), both of which specified several targets for development in health systems (HS). The global interest in health resulted in increasing amounts of FA directed to health initiatives. Between 2000 and 2015, FA for health increased from USD 2,208.98 million to USD 6,077.1 million[1]. The increased flow of FA for health was accompanied with an international expectation for better health outcomes. This interest in FA for health makes the HS a valuable and important sector for studying the effectiveness of FA.

This study concentrates on HS in a specific country context, that of Palestine. Palestine is one of the countries that has benefited from FA for many years. As such, it has, to a large extent, become dependent on FA economically and socially, primarily due to its political instability (Sarsour, Naser & Atallah, 2011). FA

[1] OECD data: http://stats.oecd.org/Index.aspx?DataSetCode=SOCX_AGG#

for the HS in Palestine went through multiple stages in which the amount of FA, its allocation across various sectors, as well as its impact on development varied greatly. This study considers the period that started with the establishment of the Palestinian National Authority (PNA) in 1994; as the first formal entity responsible for health in Palestine – the Ministry of Health (MoH).

Accordingly, the main research question of this study is: What are the roles of FA on the HS in Palestine since the establishment of the Palestinian National Authority?

2. Background and Context

Palestine has been in a conflict for almost a century now. War and struggle over lands have deeply affected the country on multiple levels: politically, socially, and economically. This situation resulted in totally disjointed Palestinian territories, which rendered Palestine to be an aid dependent country.

2.1 Trends and channels of funds to Palestine

Aid to Palestine differed in both the amount and channels of supply over the years. However, the most significant changes occurred following the start of the Israeli occupation, as aid directed to Palestine increased significantly, and following the establishment of the PNA, where FA was directed towards the newly established authority, rather than the existing NGOs.

FA to Palestine following 1994 has been increasing (Figure 2). This increase has several peaks which mark major political incidences in Palestine. These peaks occur in 2000, 2008 and 2014 which mark the Second Intifada, the Gaza War, and the Israel-Gaza conflict, respectively.

Following each of these incidences, FA increased to provide the necessary means for humanitarian aid and the reconstruction of the damaged areas to take place.

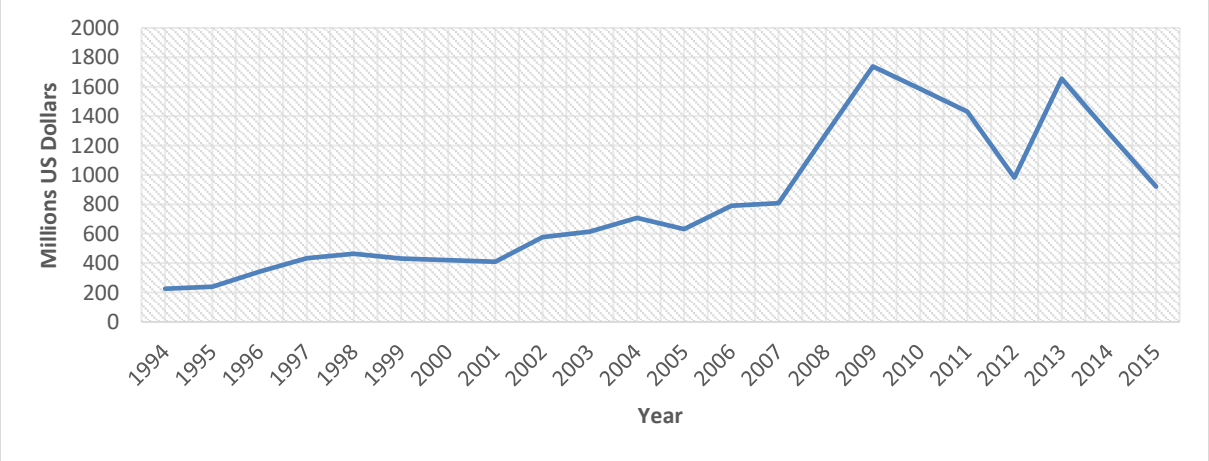

Figure 1: Net ODA to Palestine
Source: OECD. Stat accessed August 28, 2017

Data on major donors to Palestine varies according to the source. According to the OECD, the main donors to Palestine since the establishment of the PNA are, the European Union (EU), the United States, and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (see Figure 3). However, according to an ESCWA Report (2013), the Gulf countries, including Kuwait, Saudi Arabia and the United Arab Emirates have contributed significantly to the FA flows into Palestine.

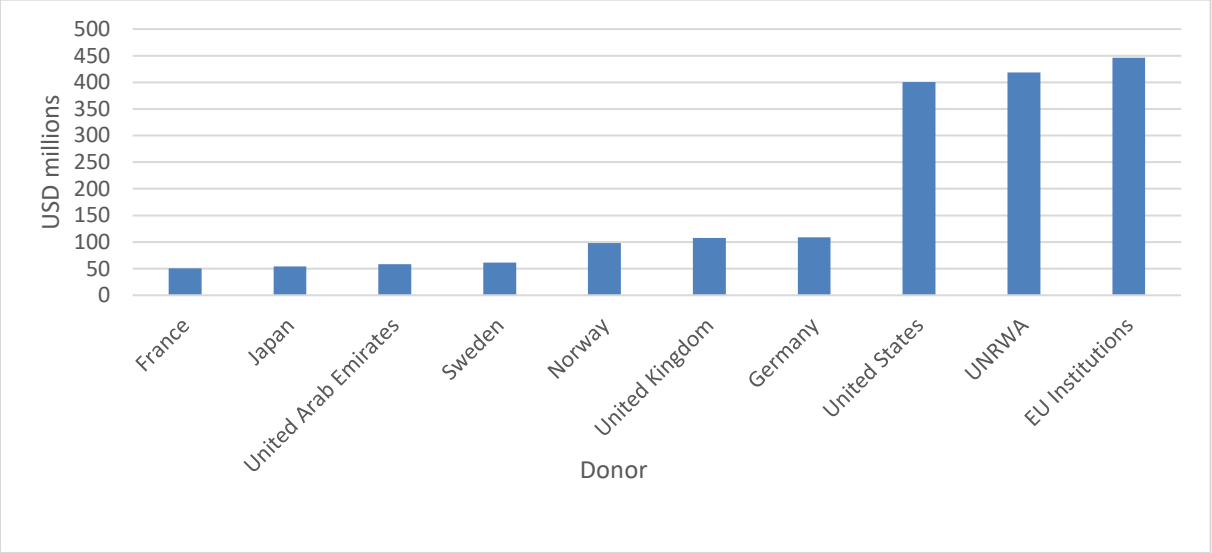

Figure 2: Top ten donors to Palestine in 2015[2]

2.2 Development vs. humanitarian aid

Although development and humanitarian aid are diverted into two different pools, they come from the same donors. The allocation of aid to either development or humanitarian aid is context dependent. This is due to the fact that FA allocation in different sectors is correlated with the ongoing occupation and its consequences. In addition, the recurrent Israeli politics and repressive military actions in Palestine, as well as the war on Gaza, steered FA in the direction of humanitarian aid rather than development aid. Hever (2006) noted that the assistance does not really facilitate development, but is rather used to support the weak Palestinian economic system.

Between 2005 and 2009, 78.9% of FA to Palestine was humanitarian assistance and not development aid. In addition, almost 61% of the humanitarian assistance was utilized in direct budget support (Sarsour, Naser & Atallah, 2011). For example, in 2010, the budget deficit reached USD1.2 billion, and at the same time there were 150,000 Palestinian Authority (PA) employees needing to be paid whose salaries were covered by FA.

[2]http://www.oecd.org/dac/financing-sustainable-development/development-finance-data/aid-at-a-glance.htm

2.3 ODA per capita and ratio of ODA to GNI overtime

These are two measurements that reflect the recipient country dependency on FA: the higher the ratio, the higher the dependency. In the case of Palestine, Official Development Assistance (ODA) constituted a significant amount of the individual and national income. The Israeli closure and dominance over resources resulted in a high unemployment rate and rendered the Palestinian economy highly fragile and malformed (Sarsour, Naser & Atallah, 2011), and thus highly dependent on external aid flow (MoP, 2014).

There is an increasing pattern in fluctuation in the two ratios over the years with a peak in the year 2008 and between 2013-2014, which is when the ODA amount increased to overcome the destruction and the humanitarian distress following the two wars on Gaza.

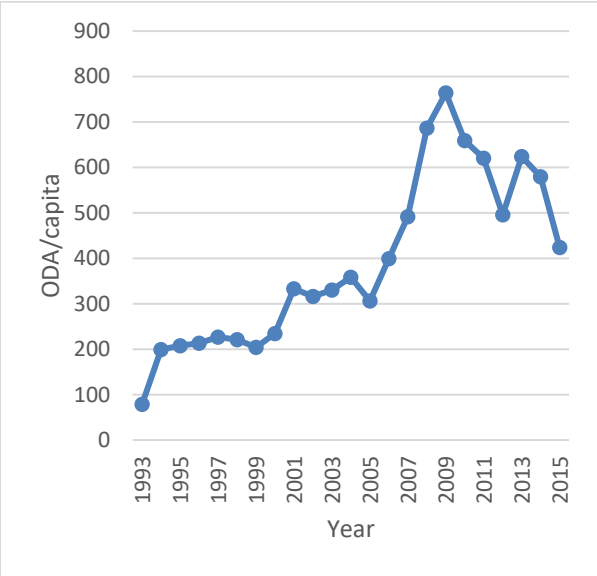

Figure 3: ODA/capita[3]

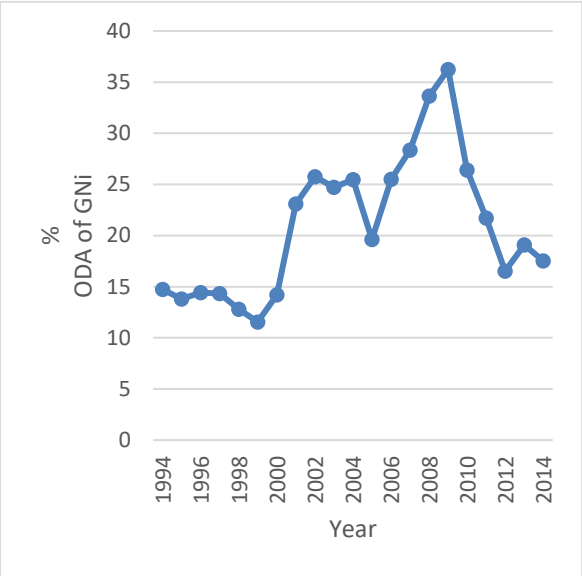

Figure 4: Percent ODA of GNI[4]

2.4 FA to the health sector

With the establishment of the PNA, four major health providers including the MoH, NGOs, UNRWA and the private sector are serving the Palestinian population. Health spending is mostly through the government. The total current expenditure on health in Palestine has been increasing throughout the years. According to the PCBS, it has reached 1,321.3 million in 2015. This total health expenditure constitutes 10.7% of the Gross Domestic Product (GDP), which is relatively high, while the total health expenditure per capita (USD 282.2) is average (PCBS, 2017) .

[3] http://data.worldbank.org/indicator/DT.ODA.ODAT.PC.ZS?locations=PS

[4] http://data.worldbank.org/indicator/DT.ODA.ODAT.GN.ZS?locations=PS

The expenditures on health in Palestine are funded through governmental contribution, household out-of-pocket payment, and direct FA transfer, as most of the aid donated to Palestine was redirected to the MoH. Health spending is mostly through the government. The governmental contribution covers 41.1% of the total health expenditure, while the household out-of-pocket payment covers 43.1%. Finally, FA covers 4.4% (PCBS, 2017).

After excluding the humanitarian aid, the portion of FA devoted to development in Palestine is distributed among different sectors and services. As seen in Figure 6, the health sector receives a small portion (3%) of the ODA coming to Palestine.

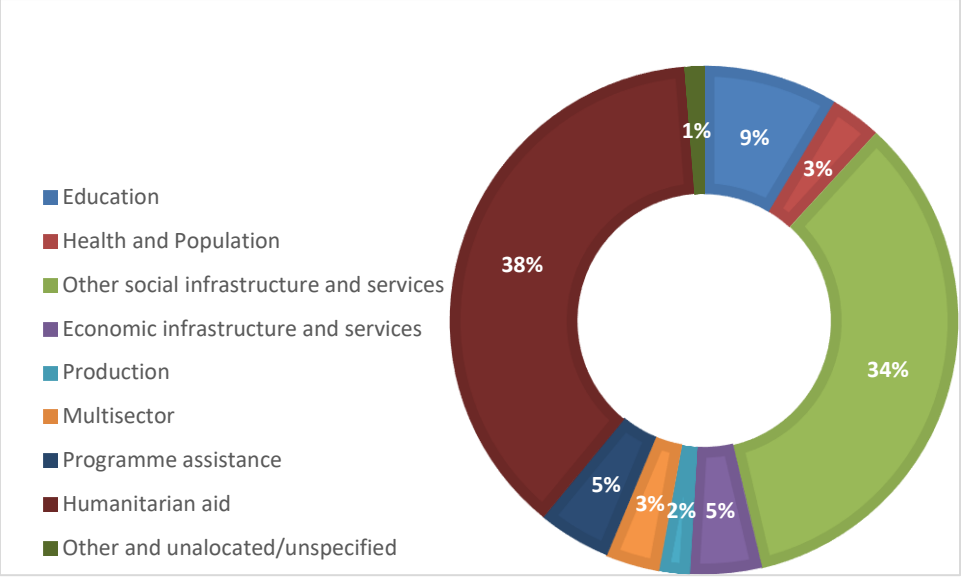

Figure 5: Bilateral ODA by sector 2014- 2015
Source: OECD.Stat accessed August 30, 2017

Although the HS in Palestine consume only a small amount of the ODA, this amount has been steadily increasing since 1994. In 1994, the amount received by the MoH was approximately USD 1,837 million, while in 2015 it reached USD 15,063 million (Figure 7). This increase can be attributed to – among other things – an increased global interest in health and the inclusion of the health dimension in international policy recommendations, such as the MDGs. These MDGs led to donor countries concentrating more heavily on health within their projects.

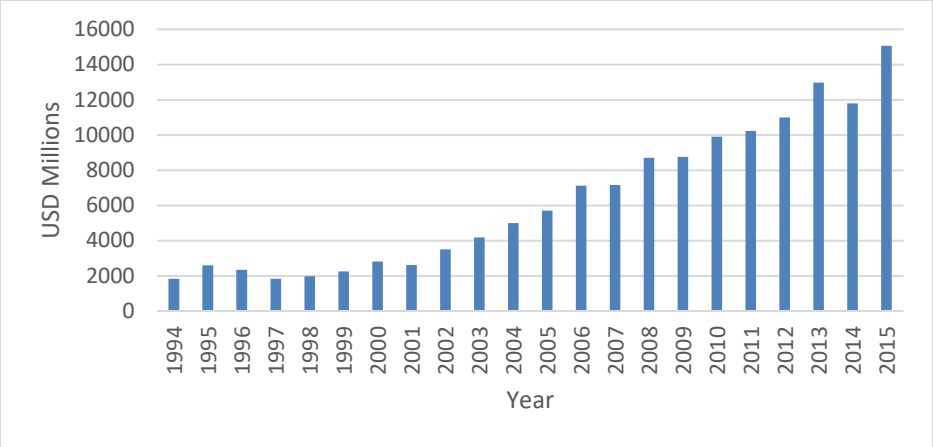

Figure 6: ODA to the health sector in Palestine

Within the HS, FA is divided into different sub-sectors. Most of the FA coming to the HS is spent on service provision, while the rest is spent on administrative expenditures and on medical education and training, while a very small amount is spent on medical research. In 2015, 84.6% of FA to the HS was spent on service provision (Figure 8).

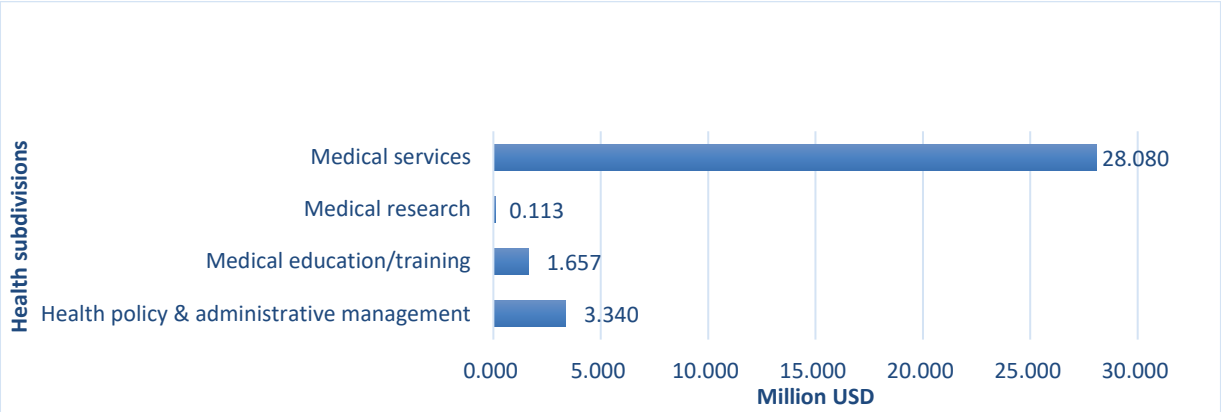

Figure 7: ODA distribution in health sector, Palestine 2015
Source: OECD.Stat

3. Literature Review

There is no consensus on the impact of FA on developing countries. The impact and effectiveness of FA has been, and still is, the center of debate. Several studies, such as Easterly (2001), have concluded that FA has no impact on poverty or on enhancing development in recipient countries. He expressed how forty years of FA to African countries did not result in growth and development. Before Easterly, Boone (1996) also found that FA did not have an impact on the overall growth in developing countries. These studies, among others, have explained their results through relating FA impact to the presence of certain conditions, such as presence of good policies (Leeson, 2008) and conditionality of FA (Gibson, 2005).

On the other hand, other studies (Abouraia, 2014; Chenery & Strout, 1966) have found that FA has a positive impact on growth and development. For example, Arndt, Jones and Tarp (2007) concluded that FA is effective in alleviating poverty and in promoting growth and development as was the case in Mozambique.

Furthermore, the meta-analysis of Doucouliagos and Paldam (2009), who collected and analyzed forty years of research on FA, found that 74% of the research on FA effectiveness is positive. Nevertheless, Doucouliagos and Paldam also noted that the results of the studies on FA effectiveness are polished. They noted that the research community was keen to publish positive results and to ignore the fact that FA ineffectiveness could be explained by the Dutch disease (Doucouliagos & Paldam, 2009).

The variation in the results concerning the impact and effectiveness of FA emerges from the variation in the underlying theory, development model, and data used by the researchers (Thorbecke, 2000). The studies on the impact and effectiveness of FA on growth and development could be divided into three groups (Hansen & Tarp, 2000).

The first group refers to economic concepts to justify the impact of FA. Some of them, such as Mosely (1980), used savings and investments and related them to growth. Mosely found that FA has a negative effect on domestic savings, and thus, a negative effect on growth and development. Others use the trade gap concept, which relates growth to the country's ability to export in order to supply import of capital goods necessary for growth (Chenery & Strout, 1966).

The second group concentrated on the direct relationship between FA and growth, such as the study of Papanek (1973), who concluded that FA is positively related to higher growth rates and development in recipient countries.

The results from the first and second group were not consistent, which gave rise to the third group of studies. The third group focused on studying the impact of FA on development under certain conditions, such as: Political instability (Chauvet & Guillaumont, 2003), conditionality (Collier, 1997), fungibility (Devarajan and Swaroop, 1998), and good governance (World Bank, World Development Report 1989 : Financial Systems and Development, 1989).

As for FA in the HS, there is limited research dedicated to investigate the impact of FA on health (Jackson & Mills, 2007; Mishra & Newhouse, 2007) when compared with the amount of research dedicated to assess FA impact on growth. The lack of information on aid for health limits the amount of research done on FA directed to health and its impact.

Most of the research on the impact of FA on health was quantitative. Studies used certain health indicators, such as infant mortality (Mishra & Newhouse, 2007), avoidable mortality (Shpak, 2012) and immunization and life expectancy (Williamson, 2008) to assess the impact of FA on health. The results were mixed; some found that FA is ineffective in improving health (Williamson, 2008), while others found that FA has a positive impact on health (Mishra & Newhouse, 2009).

Other researchers have investigated factors affecting the impact of FA on health. Jackson and Mills (2007) found improved results of FA interventions on the HS when information on the financial resources to health was available, stressing on the quality of this information in terms of reliability and timeliness. In addition, Croghan *et al* (2006) found that in targeted health interventions, FA and technical assistance were more important factors in improving health outcomes than contextual factors such as strong HS or good governance.

4. Conceptual Framework

Building on the literature review, this study aims to relate the different factors which affect the pathway of FA to the health system and subsequently the health outcomes.

FA coming into the health sector is highly influenced by the following two factors: first, the international health policies and second, the donors' agenda (Alesina & Dollar, 2000). Due to globalization and the increase in human mobility, diseases are no longer restricted to defined areas, making health a primary subject for international social policies. The increased attention to health policies was accompanied with shifts in funding priorities where more funds were directed towards the health sector (Timothy Besley, Maitreesh Ghatak, 2016).

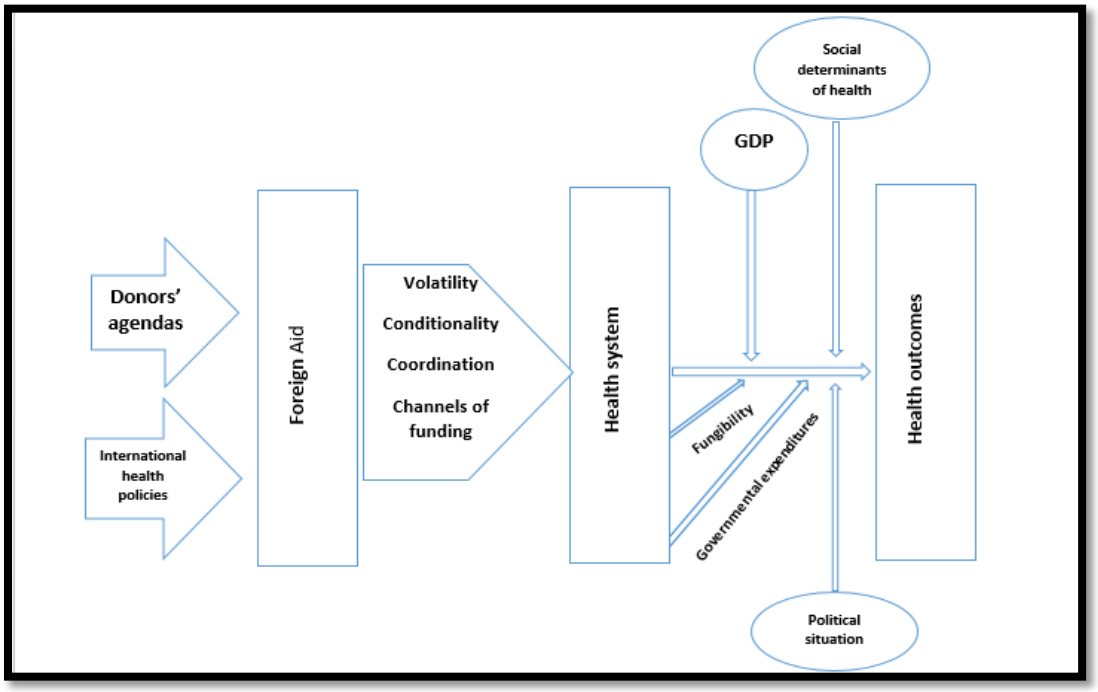

Figure 8: Conceptual Framework
Source: Author

Moreover, the international policies adopted by international organizations, such as WHO, were influenced by two factors: the power differential of member states and the type of international organizations in terms of donor control (Ervik, Kildal, & Nilssen, 2009). The donors' influence does not stop there. The

donors' effect on the national polices through FA is highly influenced by the donors' agenda and intentions (Polidano, 2001).

Once the amount of FA dedicated to the HS is decided upon, the donors' influence over the practices of delivering FA beings. The donor controls four main areas:

- The channels of funding: The donor decides the channels of funding - whether it is bilateral or multilateral as well as to which part of the health sector funds will be directed to government or civil society.
- The predictability and stability of funding: volatility of FA highly affects its broader impact (Agenor & Aizenman, 2010). Projects and programs, and subsequently, the sustainability of organizations implementing them, are dependent on the volatility of aid.
- The conditionality of funding: the donor has the power to attach certain conditions and requirements to the aid, which might sometimes increase the transitional cost and burden for the recipient (Collier, 1997).
- The coordination between the donors themselves and the government also influences the impact of FA. The coordination between donors helps in avoiding duplication while the coordination with the recipient helps in the alignment of donors' agendas with national priorities and strategies (OECD, 2005).

After the FA enters the health sector it is influenced by several internal and external HS factors which affect health outcomes:

- The governmental expenditure on health and the fungibility of aid: the higher the governmental expenditure on health, the better the health outcomes. Nevertheless, these expenditures may decrease as the government uses the FA to cover these expenditures rather than its intended purpose (McGillivray and Morrissey, 2000).
- The health outcomes are also affected by the GDP. Poverty is one of the main reasons for bad health outcomes, therefore, low GDP affects health negatively (UNDP, 2005). Depending on the proportion of FA to the country's GDP, a low GDP can impact the effectiveness of FA (Easterly, 2007b).
- Political situations with instability, violence and war negatively affects the health outcomes and keeps the country in a continuous state of emergency (Alesina et al., 1996).
- Social determinants of health, such as lack of access to clean water, also affect the health outcomes.

Furthermore, Gebhard *et al* (2008) suggest that disaggregated data, which evaluate the outcomes of each project to its predetermined objectives, would give a better understanding of the role of FA on health.

5. Methodology

The role of FA on HS in Palestine is a complex and a context dependent issue with many interfering factors. In order to better understand this role, a qualitative research approach was used in this study. The study is descriptive, explorative and explanatory in nature. The descriptive part was developed through secondary data analysis collected through various official documents and published literature from different sources, such as the WHO, OECD, World Bank, and the Palestinian Central Bureau of Statistics (PCBS). These data sources were used to develop an overall view of the FA disbursed to the PA in general, and to the HS in particular through the time period covered by the study. The explanatory and explorative parts used different stakeholders' perspectives to further understand the results obtained from the descriptive part and to deepen the knowledge concerning the process and impact of FA on HS in Palestine. The impact on the health system is measured through the perceptions of different stakeholders from the side of the donors, as well as the recipients. Data were collected through semi-structured interviews. The interviews were based on a group of open-ended and close-ended questions on the previously identified topic areas that were identified through the desk review stage. The open ended questions allowed the researcher to probe the interviewees in order to develop further knowledge on new areas in the topic that emerged during the discussion. In addition, open-ended questions helped investigate different areas of the topic and allowed the interviewees to provide detailed input. This work was followed by qualitative content analysis, where the content of the interviews has been transcribed, data was categorized, and finally grouped into themes to be analyzed descriptively and interpretatively.

The interviewees sample started as a purposive sample and continued through snowballing. All interviewees were selected according to their relation and knowledge of the subject. Snowballing was used to overcome the difficulty of reaching other interviewees. The sensitivity of the subject made the access for interviewees difficult and the fact the names of the new interviewees were recommend by their acquaintances made these interviewees more prone to accept the request for an interview. Fifteen semi-structured interviews were conducted. The sample covered all groups of stakeholders: Government (i.e. MoFP and the International Cooperation Department, Planning Department, and Projects Department of the MOH), International multilateral organizations (i.e. UNRWA, UNDP, WHO), donors (i.e. EU, Sweden, and Italy), Coordination bodies (i.e. LACS and PEGAS) and Local NGOs (i.e. Palestinian Medical Relief society (PMRS) and Juzoor for Health and Social Development).

Validity and reliability in qualitative research were assured through the use of the triangulation technique (Golafshani, 2003). Data source triangulation was conducted through data collection from different sources: official records of international organizations' websites, previously published reports and research and through interviewing different groups' stakeholders. Different groups' stakeholders were interviewed to avoid response bias and ensure reliability.

6. Analysis and Discussion

6.1 The progress in the FA process

FA to Palestine has been donated for decades, and the process of FA has developed throughout the years to increase the effectiveness of FA.

According to one of the interviewees working in the MoH, "The FA process has improved tremendously since 1994. Now we have a strategy and priorities (homemade), there are more facilities like hospitals and specialized facilities to reduce referrals." Before the PNA, FA was directed to NGOs to overcome the difficult situation and crises created by the occupation; there was no consideration of development. It was mainly multilateral humanitarian aid either directed to local NGOs or to international organization like UNRWA. After the establishment of the PNA, the nature of FA changed; a large portion of the aid became bilateral aid directed to the government with the aim of building systems and institutions. FA became more oriented towards development aid than humanitarian aid.

Nevertheless, the government was in its formation phase. It lacked the resources and capacities to be able to set its needs, priorities and strategies. At this stage, the development projects were highly influenced by the donors' agenda and strategies. Along the way, the ministries were able to build capacities through their efforts and with the aid of donors' expertise. This decreased the donors' influence on defining priorities and formulating strategies. This in turn increased the Palestinians' ownership over the implemented projects and programs through being able to choose specific projects more aligned with the needs and national strategy of the Palestinians.

However, there were some concerns based on strategies being affected by externalities, like the international health agendas, e.g. the MDGs and SDGs, for two main reasons. First, the international organizations, such as the WHO, are consulted on the matter of strategy making and priority setting and its inputs are taken into consideration. An interviewee from the WHO stated, "We as WHO, help the MoH to define priorities within which FA should be used." Second, there are projects that are decided upon by both the MoH and the donors. These projects are not always aligned with the national priorities, but frequently are on the donors' priority agenda, and thus have funding. An interviewee from the ICD stated, "It happens that we do not like some of the projects proposed by some donors, nevertheless we agree to them." In these cases, the MoH might agree to the proposed projects out of political obligations or to gain political support.

Another concern is the lack of details in the national strategy. An interviewee from the donor group stated, "The strategy is not detailed, it is general enough to include all the proposed projects." The new national strategy 2017-2022 has three main pillars: path to independence, governance, and sustainable development. Under these pillars there are priorities, policies and interventions. Most of the health interventions are under sustainable development. Thus, any project proposed by the donor within development in the HS is considered

aligned with the national strategy. Moreover, the details of the projects and programs have been frequently decided upon by the donor, as one of the interviewees from an international organization stated, “The implementation of the strategy is donor driven, they can chose what to do within each priority.” The MoH approves the project but does not discuss the details of the implementation.

The last concern is the implementation of the strategy as funding is needed for the implementation. The FA going to the MoH should enter the Ministry of Finance and Planning (MoFP) before going to the MoH, which means that the proportion of FA directed to the MoH is decided upon by the MoFP and should pass through the governmental bureaucratic system. This results in delays with overall implementation.

6.2 The competition for the FA

It has been observed that there is a competition and tension between the government and civil society in Palestine as both are competing for control and resources.

Regarding control, the government and civil society have two different viewpoints: The MoH considers itself the main service provider and the overarching body in the HS, and thus tries to control the resources and other actors in the HS. Under these considerations, the MoH wants to be involved in all the services. An interviewee from the NGO group stated that, “MoH wants to do all the work, so they ignore our services.” Nevertheless, the health sector is a large sector with a wide range of functions and services that requires an adequate number of human resources and expertise, as well as access. Therefore, the MoH should partner with other providers to reduce its burden. Also, the government is attempting to regulate the civil society sector. The civil society law in Palestine only requires that the NGOs be registered with the Ministry of Interior and not licensed. In addition, there is no specification in the law regarding the domain of activities that NGOs can perform or their funding resources. Nevertheless, the government wants to have more control over the NGOs. Another interviewee from the MoH described the MoH’s view of the NGOs by saying, “We do not really know what the NGOs are spending their money on, we need to have more control.” Therefore, the Ministry tries to reach a consensus where all the FA programs and projects are scrutinized by them before being implemented.

On the other hand, local NGOs consider themselves as indispensable partners in the HS as service providers and as a tool for protecting the public interest. They are more flexible and cover areas not accessible by the government, such as East Jerusalem and Area C (areas inhabited by Palestinians but is still under the Israeli control), which enables them to partner with the MoH.

As for the resources, MoH and NGOs compete for the same pool of FA. The HS donors in Palestine are free to fund whichever actor they want, depending on their vision and preferences. This creates competition and drives each sector to influence the donor to gain the funds. The NGOs use their longer presence in the provision of health services in Palestine, their experience, their access to inaccessible areas as well as their

personal relations to influence the donors. The MoH influences the donor through using its position as the official overarching body and regulator of the HS, as well as its need for funds, to support its institutions in order to develop and assume its role.

The competition between the ministry and the civil society has political origins. Before the establishment of the PNA, most of the NGOs were politically oriented from their inception. With the establishment of the PNA, which occurred after the Oslo Accords, the NGOs that were for Fatah (political party in the PNA) chose to merge into the PNA and be a part of the governmental structure, while the left wing and the Islamic NGOs refused to merge and remained as they were. Afterwards, the PNA wanted to contain these NGOs so as to avoid the presence of counter parties and to keep all the power in the hands of the PNA, which resulted in tension between them.

It is a fact that donors have contributed to the competition between the ministry and NGOs. Before the Oslo Accords and the establishment of the PNA, all the donations were directed towards civil society. However, after the establishment of the PNA, most of the donors redirected their funds towards the PNA to assist in building institutions specifically for the PNA, which left the NGOs in a difficult position. As mentioned by one of the interviews from a local NGO, "NGOs were left to suffer for their sustainability. After the Oslo Accords, donors supported the two state solution and directed all their funds towards building the PNA."

The donors conveyed the idea that aid should be limited to one main actor and ignored the fact that the PNA and NGOs could partner in delivering health services.

6.3 The miscommunication between different actors

In the field of FA in HS in Palestine, there are many actors working on the ground to improve the health status. Nevertheless, through the interviews it became clear that there is an issue of communication between these actors, and that due to this miscommunication, FA has a negative impact on health.

There are three main actors in the field of FA in health: the government, the civil society and the donors. Through the interviews, a communication problem was observed within each group, as well as between the three groups.

At the governmental level there are three ministries responsible for aid to health: the MoH, MoFP and the Ministry of Interior Affairs. In the interviews with MoH personnel, it was observed that information concerning FA directed to the HS according to channel and amount was not available. The unavailability of such data can only be explained by the miscommunication occurring between the different ministries responsible. This was concluded from the fact that the MoFP is the pooling ministry for the FA. Both the MoFP and the Ministry of Interior Affairs perform audits of finances and activities for NGOs working in the

HS. The three ministries need a detailed database and an information system that connects all of them together and makes the available information accessible for better decision making and FA effectiveness.

As for the NGOs, their number is increasing and their nature is diverse. There are grassroots NGOs, volunteer based NGOs and fund-driven NGOs all working in the HS. The communication between them, however, is not clear. According to an interviewee working in a local NGO, "We became so numerous that we do not know all the NGOs present in the field." Nevertheless, it was observed that there was communication between the most prominent older NGOs. This communication is mainly done to coordinate and avoid duplication in services provided and areas covered.

With regards to the third actor, which concerns the donors, according to an interviewee working in the international cooperation unit for a donor country, "There are approximately 83 donors to the HS in Palestine that have never been able to set a common platform of communication between them." Although not all the donors meet and coordinate, the major donors do communicate and discuss the main orientation of their fund to HS.

Finally, the communication between the three actors is present but it is usually between two actors and not all three actors, i.e. between the MoH and the donors, but not necessarily between the NGOs or between the NGOs and donors without the MoH.

The miscommunication and lack of coordination between these three actors weakens efforts to develop strong HS. Since each actor holds one part of the puzzle without reaching the others, it will stay an individual piece, rather than complete the whole picture. The donors have the money needed for implementation, the NGOs have the outreach to marginalized populations and the expertise, and the MoH has the power of regulation, as well as service provision. Bringing the three together through better communication and coordination would result in a robust and a resilient development in HS.

6.4 The coordination structures

These communication problems have been noticed and there have been attempts to overcome them through creating coordination structures such as the Local Aid Coordination Secretariat (LACS), The International Coordination Unit (ICD) in the MoH and the Experimental Program of Automated Management and Security (Programme D'Experimentation D'une Gestion Automatisee et Securiee PEGAS) for the European donors.

LACS is the structure that is supposed to coordinate between the MoH, the donors and the NGOs. However, the functions of the LACS have been falling behind. An interviewee from the MoH has stated that, "The LACS are useless, they only take minutes in our meetings with donors and there is nothing they do that we cannot do."

Discussing with one of the interviewees from LACS, it was observed that LACS' functions became limited to donor mapping, invitation of donors on behalf of the ministry, and taking minutes of the meetings and uploading them onto their website. Although donors like to have LACS as an intermediary in contacting the ministry – as indicated an interviewee from the donors group, LACS has no obligations on any side; there is no reporting obligations towards LACS because monitoring is not a part of its mandate.

The former situation has raised questions about the effectiveness of LACS as a coordinating structure. Recently, the World Bank did an assessment of LACS and recommended major changes in its coordination structure. This reform of LACS aimed at aligning the LACS functions with the Paris Declaration and the Busan document to increase its effectiveness.

Before the new national strategy, LACS worked in various sectors. These sectors were aligned with the development sectors in the national development plans. Now with the new national strategy of 2017-2022, there are no sectors, but rather, pillars such as: path to independence, governance and sustainable development. Under these pillars there are priorities, policies and interventions. These pillars are vertical; they are present across all sectors. Therefore, the World Bank recommended a change so that working groups have representatives of different sectors, rather than having sector working groups (World Bank, 2016). Also, the World Bank recommended changes in the membership of the working groups. The membership was limited to fifteen members: two from UN agencies, one from academia, one from the private sector, eight donors, one from civil society, and three from the government. An interviewee from LACS has explained the change in the number of members as follows, "The number is reduced to make the groups more active and to make the forum more favorable for policy discussions." The World Bank also recommended the removal of the strategy group and left the working group, so as to decrease vertical communication and facilitate information sharing at the policy-making level.

Besides LACS, there is the ICD in the MoH. This structure was created at the beginning of the establishment of the PNA to coordinate the flow and use of FA. The performance of this unit has evolved over time, just as the other structures and capacities of the MoH have. An interviewee from the MoH stated that, "At the time, the structure of the Palestinian MoH was primitive, in the phase of development in terms of structure and capacities. Today, after eighteen years, the institutional structure of the MoH has fully developed and contains an international coordination unit that is directly under the minister." This ICD unit is now responsible for the coordination between the donors and the health service providers.

The process of coordination; as described by an interviewee from the MoH, is performed as follows: the nongovernmental service providers prepare proposals for their needs and projects and submit them to interested donors. The donor can choose to get clearance from the ICD in the MoH before proceeding with the donation. This is done to ensure harmonization and avoid duplication on one side, and to guarantee that donations are supporting projects that feed into the MoH's overarching strategy and priorities. However, there

is no mainstreaming for the donations that pass through the ICD and some projects go without passing the ICD. This is especially the case for NGOs projects because their proposals given to the donor do not always pass by the MoH unless the donor contacts the MoH.

The third coordination structure is PEGAS, which is involved with donations from the EU and reports to them only. An interviewee from the donor group stated, "The European countries coordinate their donations through PEGAS, they have a joint strategy and a common framework for performance monitoring." PEGAS manages the financial aspects of aid coming from the countries of the EU. It is a collecting pool from which the countries can decide which sector they wanted to allocate the donation to. Therefore, the money can go to the government for implementing development programs. Year after year, support is declining for PEGAS because it is considered to be "band aid" which does not yield the required development.

Other than PEGAS, the coordination between the donors outside the EU is weak. An interviewee from the donor group stated, "Coordination with non EU donors depends on individual efforts from personnel working in each donor embassy or international coordination unit." This lack of coordination results in donations which are not organized strategically and are an unnecessary duplication of efforts.

Overall, these structures seem to be isolated; each of them works alone. There is a need for a coordination platform and a better mechanism for dialogue where the level of voluntary information sharing exceeds an obligatory level and a mechanism for inclusive policy- making and better use of FA is made.

6.5 The donors' preference of funding routes

There are many donors to the HS in Palestine, but the main donors are the United States and Italy. These two major donors have a completely different preference in funding channels. According to a MoH interviewee, "The United States prefers donating for implementing programs and projects while the Italians prefer budget support to the ministry." These are not the only funding channels in Palestine. As per the field observation, other channels of funding have been identified. These channels are classified depending on to whom the donations are being directed, the conditions of implementation, and whether its core is project funding or budget support.

Some of the donors believe that the best way to achieve development in the HS is through building institutions and a comprehensive system. The Italians believe that budget support and direct donations to the government will help in building a sustainable structure of institutions and systems. According to an interviewee from the Italian Agency for development, "This way of funding is the best way to reach the independency of the HS and will serve the purpose of the Oslo Accords, which is the two state solution – the ultimate aim of the donations." He also specified that this channel of donation has been there for more than a decade, and it has proved to be efficient as it helped to build infrastructure and capacities. The disadvantage of this channel are that it minimizes the role of civil society as a partner in development.

Other donors like to donate through programs and projects. Within this category, donors were found to be divided into three subgroups: the first subgroup consists of the donors who implement through the ministry, others choose NGOs and the rest prefer implementing projects themselves. Donors who implement through the ministry start by discussing the agreed upon projects with the ministry. Afterwards, the projects are implemented under the ministry's control. This channel has the same disadvantage as the first channel (budget support); it neglects the NGOs.

The second subgroup of donors who prefer funding projects through NGOs are donors seeking a lower level of engagement; an interviewee from a local NGO has stated that, "Some donors do not want to be engaged in immense financial obligations of building systems, that is why they chose to work with NGOs." They chose the NGOs' projects that align with their agenda and fund them.

The last subgroup of donors are those who prefer implementing through their respective agencies. An interviewee from a local NGO stated, "Some donors come with their implementing people, they try to benefit from every penny they donate to us." The disadvantage of this channel of funding (i.e. implementing through donor agencies) is the reduction of the drilldown of aid to the HS. The reduced drilldown of aid to HS was due to an increase in overhead and equipment procurement expenses. Donors' implementing agencies tend to hire employees and procure equipment from their own countries.

In addition, the projects funding channel has major disadvantages; an interviewee from the NGOs group has stated, "Project funding is disastrous, these projects are isolated attempts that never lead to a lasting impact." The separate projects are of a short period and limited outcomes. The donors want to make changes and have an impact, but they do not want to have long lasting obligations. This affects the development negatively, as producing change and impact requires an integral approach and time.

6.6 The influence of political situation on FA to HS

It was mentioned through most of the interviews that the presence of the occupation has resulted in a series of complications that limited the impact of any development effort in Palestine. The occupation has created a fragmented system due to the geographical isolation of different parts of Palestine (West Bank Areas, A and B, West Bank Area C, Gaza Strip, and East Jerusalem). The PNA had control over only half of the Palestinian areas (West Bank Areas, A and B). The other parts are not accessible to the PNA, which hinders the development effort in these regions.

The other complication created by the occupation is the loss of control over resources which creates political and economic vulnerability. This loss of control makes the government dependent on FA and bound to the donors' political and developmental agendas.

The political instability effect on FA to HS became apparent after reviewing the history of FA and the practices of the donors. It was found that the funding was influenced by the political atmosphere. An

interviewee from the NGO group stated that, “At times, when the Palestinians get into peace negotiations with the Israelis, the amount of aid augments, while in cases of instability or disagreements with the international point of view of what should happen in Palestine (i.e. Hamas winning the election), the amount of aid decreases.”

The funding channels in Palestine have been subject to political changes. Before the PNA, and until the Oslo Accords, funding was directed to NGOs. Following the Oslo Accords, the funds were directed towards the government. The government received donations until the election of Hamas. Following the election of Hamas, the funding was redirected to NGOs as the donors objected to Hamas’ political orientation. Afterwards, and with the return of the old PNA, donations have been redirected towards the government again.

Another point which demonstrates that aid has been highly politicized is that some donors chose the FA recipient entities according to their political orientation. Donors vet the people working in the HS before giving the money and they require that the recipient organization sign the terrorism clause in order to receive the donations.

The important point is that the actual aid (from 1994 until today) coming into Palestine began with the Oslo Accords. According to those Accords, there was an obligation on the donors’ part towards the Palestinians, in which Palestinians were promised their own state. Nevertheless, it should be noted that creating a fully functional Palestinian state requires a parallel advancement in both the political and aid process to produce development. An interviewee from the donor group stated, “The fact that the political process has stopped at some stage while the aid process continued hindered the process of development.”

This politicization of aid is affecting the HS; an interviewee from the donor group stated that, “We refuse to work with donors who ask for the signing of the terrorism clause.” Many of the NGOs and academic institutions, such as the Public Health Institute, refuse aid coming from donors demanding the signing of the terrorism clause. Also, it was found in several interviews that the portion of aid coming to HS has been affected by the political situation, where a considerable amount of aid went to sectors related to stabilizing the political situation, such as the security sector, while a small amount (3% as mentioned earlier) went to the HS.

6.7 Humanitarian aid vs. development aid

Humanitarian aid and development aid are completely separated pools of aid in Palestine. This helps to avoid overlap between the two. Otherwise, because of the ongoing and long lasting crises in Palestine, humanitarian aid would become a priority over development aid.

To ensure the complete separation of aid pools in HS in Palestine, they are managed by two separate structures: the developmental aid is managed through the health sector working group while the humanitarian aid is managed through the health cluster. Both structures are headed by members of the MoH and have members from different stakeholders on the ground.

Through interviews with both the local NGOs and the MoH representatives, it was noted that there is another type of separation of aid that has developed within the Palestinian context. It appeared that most of the developmental aid was directed towards the government, while most of the humanitarian aid went to civil society. This separation came about as a result of several factors. First, the need to build the institutional structure led to absorbing most of the development aid into the government. Second, the ability of NGOs to cover areas that were in need to essential services and were not accessible by the ministry made it easier for the NGOs to receive humanitarian aid rather than developmental aid. Humanitarian aid was faster to receive and less demanding in terms of paperwork.

6.8 The decrease in the amount of FA to the HS and aid volatility

There was a collective agreement among all of the interviewees that there is a decrease in the amount of FA coming to the HS. They attributed this decrease to several factors: first, donors' fatigue, which stems from frustration as there is no political progress and second, the donors' perception that at some point, the Palestinian state should be able to support its systems through better tax collection and through more diligent spending and saving practices. Donors attributed the decrease in FA to the instability in the region and the emergence of new needs in neighboring countries that absorb parts of the aid coming to the region.

Although these might be the reasons for the decrease in aid to health, other factors should not be excluded. Other factors include the worldwide economic crises, the election of right wing parties in some donor governments, which would be less favorable to donating to Palestinians, the presence of other global priorities and finally, favoring other sectors over health in the Palestinian context.

This decrease and volatility of aid to the HS mostly affects the NGOs as they are aid dependent. Since NGOs are the second major health service provider, covering underserved areas, this affects the overall health situation in Palestine.

6.9 The disparity in the quantitative data

According to the data obtained from the OECD, and which are used elsewhere, FA to the HS has been increasing with time. On the other hand, during the interviews, all of the interviewees confirmed that FA to the HS is decreasing. According to the interviewees, this discrepancy in data referred to the following:

1. There is no information system or a database that includes information about all the funding channels to Palestine.
2. Missing data on expenditures and no connection between revenues and expenditures.
3. Only projects directly funded by the donor would have been documented as FA expenditure on health. Thus, if the donor was supporting the budget of the MoH, this would not have been mentioned as expenditure covered by the FA.
4. There is no mainstreaming of donations through the international coordination unit.

5. Some activities supported by the donors specifically for the HS were not labeled as FA for health, i.e. the Palestinian National Institute of Public Health has been established through donations from the Norwegian government, which considers this to be institutional building support rather than health support. Donors are labeling their money differently.
6. Donations directed to the MoH entered the accounts of the MoFP under item lines directed to the MoH, while the donations going to civil society organizations that specialized in health went directly to these organizations and did not enter the MoFP records.
7. In some cases, the donor supported NGOs working on health under the heading of human rights.

6.10 Transparency and accountability

Ideally, the different actors in the field of FA to health should be transparent and be held accountable for their expenditures to ensure good governance of allocated resources. Nevertheless, with the absence an accessible database for each actor, they cannot be held accountable. There is a different degree of accountability between the actors depending on the results measurements and the reporting system they use.

According to an NGO representative (interviewee), NGOs had to submit reports to the following: to the government (MoH as the concerned ministry, the Ministry of Interior, and the MoFP), and to the donor, as well as internal reports. The MoH does the internal reporting system, as well as reports to donors on results and expenditures, while the donor only has internal reports.

This signifies that all parties are accountable towards the donors (MoH and NGOs), but the donors are not accountable to either party. The donors cannot be held accountable by the recipient party. The discretion around the expenditure of donors augments the problem of reducing the drilldown to the Palestinian HS through recycling the money to their country by means of increasing the foreign overhead. This brings unnecessary expertise and procurement of equipment from their country of origin. In turn, this can contribute to lowering the efficiency and role of FA in impacting the HS.

6.11 Despite the challenges, the overall health status is good. Is it the FA?

The Palestinian context is complicated. Despite the occupation and an ongoing crisis situation and declining aid the health status in Palestine is relatively good. In spite of all the challenges, the HS has managed to produce good health indicators compared to other countries in the region, which indicates improvement in the health of ordinary people.

One of the interviewees contributed these results to the strong commitment of the MoH, while another one contributed them to the timely arrival of aid in cases of crises, such as the war in Gaza. Nevertheless, health status has never been a result of one thing; health is dependent on many factors, such as the social

determinants of health (access to sanitary water, education, etc.). Therefore, these good outcomes are the result of all these factors combined, including FA.

Therefore, FA is one of these factors. As we have seen, FA helped in establishing a health system and in building institutions and facilities. It also enabled different services providers to provide health services in Palestine. The fact that FA has been decreasing throughout the years, reaching 13% of the governmental budget for health, and that there is a good health status, leads to the conclusion that there are other sources covering for FA. The main source is taxes; the government has been able to develop an efficient tax collection system.

7. Conclusion

FA has a positive role on the HS in Palestine. Still, there is work to be done to improve the effectiveness and efficiency of FA in the HS in Palestine so as to increase the impact of FA.

FA has contributed to the establishment of the institutional structure and capacities of the HS in Palestine through core funding and budget support. It has also contributed to the provision of health services through funding specific programs and projects.

FA in Palestine is allocated by the government according to pre-identified needs and discussions between the donors and the different actors in the HS. These discussions take place through the various coordination structures present in Palestine. The management of FA to the HS depends on the entity receiving the aid. However, all the recipient entities report their activities, as well as their expenditures on a specific project. This means to the donor funding this project, while donors do not report to any recipient entity, except to their governments.

The effectiveness of FA in Palestine has been improving. The acquired knowledge and experience by the human resources in the HS resulted in better compliance with the Paris Declaration and its five principles. The ability of the MoH personnel to assess the Palestinian health needs and to formulate them into priorities and strategies increased the ownership and alignment of FA-funded projects. However, FA to Palestine is still influenced by donors' agendas, either out of political obligations or in order to gain the political support.

The donors' effect extends further and impacts the relation between the MoH and local NGOs. Both the donors' choice to support a specific party and the channel of funds create competition between the MoH and NGOs, exacerbating an already existing tension between the two.

FA for health in Palestine is facing many challenges. The lack of communication between different stakeholders, the absence of an effective coordination structure or an inclusive discussion platform, as well as

the low accountability of donors towards the recipients are all challenges that negatively affect the efficiency of FA for health in Palestine.

The biggest challenge facing development and the FA process in Palestine is the Israeli occupation. The Israeli occupation and the unstable political situation have put Palestine in a state of continuous crisis which has rendered the development process very difficult. The recurrent wars and the continuous state of crisis weaken the HS and its performance. In addition, it directs international attention towards humanitarian aid rather than development aid. Furthermore, the fragmentation of land, the closure and the loss of control over resources have all resulted in a fragile economic system, which is dependent on FA. This fragile economic system is accompanied with high unemployment rates and increased rates of poverty, which are all precursors of bad health status in any country.

Finally, the health status in Palestine has been found to be relatively good compared with neighboring countries. However, the good health indicators cannot be directly attributed to solely FA alone as the outcome of the health sector depends on many factors, including social and economic determinants, besides the presence of supporting institutions.

8. Policy recommendations

Based on interviewees' perspectives and suggestions along with the results of this research several policy recommendations are suggested. The recommendations are: the complete separation between the administration of the HS and the provision of services from any political pressure, reconsideration of the priorities in the distribution of FA between different sectors, the creation of a healthy, yet competitive environment between health service providers, the creation of an inclusive communication and coordination platform, the development of an information system to enhance communication and accountability, partnership between foreign funding agencies and local NGOs in projects implementation, support local NGOs through capacity building, financially, to decrease the influence of donors' agendas and finally, donors need to push towards a political solution along with the aid for development.

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