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AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

WEST BANK AND GAZA

PALESTINIAN HEALTH SYSTEMS

DEVELOPMENT WORKING GROUP

294-0003

PROJECT PAPER

DATED SIGNED: 12/13/93

UNCLASSIFIED

U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

DEC 13 1993

ACTION MEMORANDUM FOR THE SPECIAL COORDINATOR, MIDDLE EAST PEACE PROCESS

FROM: ANE/NE//DP, Vivikka Molldrem
Chair, Institutional Development Working Group

SUBJECT: Palestinian Health Systems Support Project (294-0003)

ACTION: Your approval is needed for the authorization of the Palestinian Health Systems Support Project (294-0003), with a life-of-project funding of $23 million in Economic Support Funds (ESF) and Development Assistance (DA) Funds for a six year period beginning in FY 94.

BACKGROUND: The USAID Program Strategy for the West Bank and Gaza Strip for the 1993 - 1997 period emphasizes concern for the humanitarian needs of the Palestinian people and stresses three long term strategic objectives: (1) increased marketed production of agricultural and manufactured goods; (2) increased use of selected improved health care services; and, (3) improved planning and management of development activities by selected Palestinian institutions. The Palestinian Health Systems Support (PHSS) project is designed to address two of these central strategic objectives, those of increasing use of health care services and improving planning and management in Palestinian institutions.

A complex array of primary health care service providers has emerged over time. This current network of PHC services providers includes the Israeli-controlled Government Health Services (GHS), the United Nations Relief and Works Agency (UNRWA) health services, international and indigenous NGOs, and individual private sector providers. Of these, the local Palestinian NGOs play an important role (estimated at 40%) in the delivery of PHC services at the community level. Government Health Services contributes a larger share of primary health care services in the Gaza Strip (estimated at 60% - 80%) than in the Occupied Territory as a whole.

USAID has been committed for some time to strengthening the health sector. In recent months, the Agency has determined that it would approach this objective by developing a single, consolidated project to improve the effectiveness of both the Palestinian NGOs engaged in PHC services delivery at the community level and a new central Palestinian public sector authority for health. Strengthening the institutional and

financial management of the entire system has been identified as the key need for this new project. The Project Paper was prepared by Bureau staff, with assistance from consultants, and in consultation with West Bank/Gaza staff. It was reviewed by the Institutional Development Working Group on November 4, and reviewed and approved by the Core Working Group on November 23, 1993.

DISCUSSION: Life of project funding for the Palestinian Health Systems Support Project is $ 23 million over a six year period, of which approximately $ 4 million will be obligated in FY 94, depending on funds availability.

The project goal is the improved health of Palestinians in the Occupied Territory of West Bank and Gaza. The sub-goal is increased use of quality family health services by women of reproductive age and children under five. The project purposes are: 1) Palestinian self-governing health authority creates and maintains functioning key planning, management, monitoring/evaluation, and health education systems; and 2) selected Palestinian NGOs engages in primary and family health care at the community level institute and maintains improved planning, management, monitoring/evaluation and health education systems. The project has been designed to cover: sector-wide management issues, financial management, information systems requirements, and health promotion. It will also provide rapid assistance to support priority management and information needs of the newly emerging Palestinian health system, including: basic demographic and health data, census planning, epidemiological data collection, and support for improved health financing systems.

By the end of this project, the public sector health authority will be capable of: undertaking a continuous strategic planning process, managing and monitoring quality assurance throughout the Palestinian health system, managing public finances for the health care system, operating and utilizing the results of a management information system for health, and carrying out effective public health promotion activities. Selected NGOs will also have been strengthened in these same areas of management and financial control.

Implementation of the project will emphasize interventions designed to improved the sustainability of the health sector and will rely on a range of mechanisms to ensure that the specialized technical assistance that is required can be provided in a timely manner. These will include: a series of buy-ins or OYB transfers to centrally funded support mechanisms as a means of rapidly initiating priority tasks involving the collection and analysis of data on the status of public health and health management and financing; one principal institutional contract or grant for technical services; a RSSA with the Public Health Services

administration of the Department of Health and Human Services to initiate long-term linkages between important public health institutions in the U.S., such as the Center for Disease Control, and their emerging counterparts in West Bank/Gaza; and a cooperative agreement to establish a partnership between a U.S. and a Palestinian hospital.

BUREAU PP REVIEW: Below is a summary of issues discussed when the Project was reviewed. The Core Group of the West Bank/Gaza Task Force Committee Review was held on November 23, 1993 and recommended approval of the project. Suggestions from that meeting have been incorporated into a revised Project Paper which was circulated on December 3, 1993.

Project Management Just as the political situation is evolving in the West Bank/Gaza, so are USAID programs and their management. Implementation of the various elements of the project and continuing assessments of evolving sectoral needs suggests a significant project management requirement that can not be handled long distance. A USDH Health Officer in the field is required to implement the project. The Officer will have primary responsibility for this project with an appropriate level of assistance from FSN staff and, if required, a PSC.

Implementation Flexibility The Project has been designed to ensure that maximum flexibility in responding to the changing political and implementation environment can occur. Thus, in-depth annual reviews will be held to modify the project as needed, including revising the log frame if required. The creation of a new Palestinian health sector authority provides an opportunity to participate in setting public sector policy at an early stage. The policy orientation of this new health authority will be reviewed annually to ensure that mutually agreed upon areas of emphasis are established. The Technical Assistance Team may specify a policy reform agenda with which the project itself can assist.

Family Planning Services West Bank/Gaza have one of the highest population growth rates in the world, yet family planning remains a sensitive topic for Palestinians. Nevertheless, as greater political stability occurs, more Palestinians are likely to see the health and economic benefits of birth spacing and planning the size of their families. The project is prepared to offer guidance on how to include birth spacing into the primary health care sector, and when appropriate, to assist Palestinians to develop a full family planning program commensurate with their needs. Depending upon funds availability, the Global Bureau may provide up to $3 million worth of assistance for birth-spacing and related activities for the West Bank and Gaza.

These, and additional clarifications, raised in the review have been incorporated into the Project Paper.

C

ELIGIBLE SOURCE/ORIGIN/NATIONALITY: It is anticipated that services (technical assistance and training) will be procured primarily from the U.S. or the West Bank/Gaza. Geographic code 000 and procurement from West Bank/Gaza and Israel will apply for all commodities procured under this project unless specific source/origin waivers are approved by the delegated authority or already have been obtained by a central project. Local procurement only of eligible items from geographic code 935 will be allowed up to $5,000 per transaction. The Agency's updated guidelines on "Buy America" will prevail for this project.

NOTIFICATION TO CONGRESS: A Congressional Notification (CN) for the project (at a LOP funding level of $20 million) expired without objection on November 30, 1993. This CN, however, described the project being funded by ESF resources and ESF levels are now insufficient to do so. A new CN notifying Congress that the Bureau now intends to fund the project using Development Assistance (DA) funds and that the LOP funding level has been increased to $23 million was sent to the Hill on December 8, 1993.

INITIAL ENVIRONMENTAL EXAMINATION: A categorical exclusion of environmental impact assessment for the project under USAID Regulation 216 Section 216.2 (c) (2) (viii) which covers "Programs involving nutrition, health care, or population and family planning activities" has been granted by the Assistant Administrator for Asia/Near East on November 3, 1993 and amended Dec 9, 1993 (see Annex D of the Project Paper).

CO-FINANCING: With the shift in funding to DA, the question arises of possible application of Section 110 (a) of the Foreign Assistance Act which, unless waived as to relatively less developed countries, requires that DA beneficiary countries provide from their own resources at least 25 percent of the cost of each DA-funded activity. GC advises on this point that 110 (a) has traditionally been interpreted so as to apply only to assistance to a government provided through a bilateral project agreement and not to assistance provided through other obligating mechanisms, such as grants. (The latter is of course the model we propose for this project.) It would also be anomalous, GC believes, to consider WB/G as "countries" for 110 (a) purposes since neither is yet recognized as such nor is there yet a functioning Palestinian government. For these reasons, GC concludes that 110 (a) is inapplicable to this DA-funded project. However, as project implementation procedes we will seek local contributions in line with Agency policies on participation and local contributions.

FINANCIAL SUMMARY: The Project anticipates the expenditure of $23 million over a six year period. Of this, approximately $11.9 million for Technical Assistance, $3 million for training, $0.8 million for commodities, $0.3 million for monitoring and

evaluation and $7 million for other.

PROJECT EVALUATION: Two evaluations are planned - one at the end of Year 2, and the other at the end of Year 5 or early in year 6. The first evaluation will focus mainly on implementation effectiveness and will assess whether the project, as originally designed, is still appropriate for the evolving needs of Palestinians. If necessary, the project design will be amended at this time. The second evaluation will review progress toward achieving the Project's broad objectives as well as specific outputs.

DELEGATION OF AUTHORITY: Pursuant to General Notice No.1 of October 1, 1993, the AA/ANE has been delegated all authorities held by the Associate Administrator for Operations (AA/OPS). Pursuant to DOA No. 400, dated August 16, 1991, the AA/OPS was designated project approval authority. Further pursuant to the Bureau for Asia and Near East Interim Organization Notice No. 1, you have been delegated full authorization to act for the AA/ANE as to West Bank/Gaza and related matters. Therefore, you may approve the action now proposed.

RECOMMENDATION: That, by signing below, the PP face sheet and the project authorization, you approve the Project Paper and authorize the Palestinian Health Systems Support Project with a life-of-project funding (LOP) of $23 million for a six year period beginning in FY 94.

Approve: Dennis M. Chandler

Disapprove: ____________

Date: 12/13/93

Attachments:

Project Authorization

U:\NEDRHR\DOCS\AUTH.HEA

Draft:ANE/Inst. Working Group:12/07/93

Clearance:	ANE/NE/ME/WB/G:DSwain	(draft)
	ANE/NE/ME:RMachmer	(draft)
	ANE/NE/DR:SShah	(draft)
	ANE/NE/DR/HR:WJansen	(draft)
	ANE/NE/DP:VMolldrem	(draft)
	ANE/ASIA/DR/PD:JDempsey	(draft)
	GC/ANE:KO'Donnell	(draft)
	G/RD/:DGillespie	(draft)
	G/RD/POP:EMaquire	(draft)
	FA/OP/O:TBeans	(draft)

PROJECT AUTHORIZATION

Name of Country/Entity: West Bank/Gaza Strip

Name of Project: Palestinian Health Systems Support

Project Number : 294-0003

1. Pursuant to Part II, Chapter 4, Section 531, of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Palestinian Health Systems Support Project (the "project") for the West Bank and Gaza Strip. The project will provide technical assistance, training, equipment and other selected support activities to strengthen the institutions engaged in primary health care services delivery in Gaza and the West Bank.

2. The project consists of the provision of goods and services, to be provided through grants, contracts and other means, intended to strengthen the analysis, planning, and management capacities of both the central Palestinian public sector authority to be established for the Gaza Strip and the West Bank and the NGOs which are active in providing primary health care services to the people there. The estimated life of project is five years and eleven months from the date of authorization.

3. Contracts, grants and other documents necessary to implement the project, which may be negotiated and executed by the officers to whom such authority is delegated in accordance with USAID regulations and Delegations of Authority, shall be subject to the following essential terms and covenants as USAID may deem appropriate.

4. Except as USAID may otherwise agree in writing: (a) commodities and the suppliers of commodities financed by USAID under the Project shall have their source, origin and place of nationality the West Bank, Gaza Strip, United States or Israel; (b) the suppliers of services, other than ocean shipping, financed under the project, shall have the West Bank, Gaza Strip, the United States as their place of nationality; and (c) ocean shipping financed by USAID under the Project shall be financed only on vessels of the United States registry.

Approved:

Dennis Chandler
Special Coordinator,
Middle East Peace Process

Date: 12/13/93

U:\NEDRHR\DOCS\AUTH.HEA

Draft:ANE/Inst. Working Group:12/07/93

Clearance:		
	ANE/NE/ME/WB/G:DSwain	(draft)
	ANE/NE/ME:RMachmer	(draft)
	ANE/NE/DR:SShah	(draft)
	ANE/NE/DR/HR:WJansen	(draft)
	ANE/NE/DP:VMolldrem	(draft)
	ANE/ASIA/DR/PD:JDempsey	(draft)
	GC/ANE:KO'Donnell	(draft)
	FA/OP/O:TBeans	(draft)

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A = Add, C = Change, D = Delete — Amendment Number: ______

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: West Bank/Gaza

3. PROJECT NUMBER: 294-0003

4. BUREAU/OFFICE: NE/ME/WB/G

5. PROJECT TITLE (maximum 40 characters): Palestinian Health Systems Support

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM DD YY — 09 30 99

7. ESTIMATED DATE OF OBLIGATION (Under 'B:' below, enter 1, 2, 3, or 4)
A. Initial FY 94 — B. Quarter ☐ — C. Final FY 98

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY '94 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	5,000					23,000
(Grant)	(5,000)	( )	( )	( )	( )	( )
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country						
Other Donor(s)						
TOTALS	5,000					23,000

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	C. 2. Loan	D. OBLIGATIONS TO DATE 1. Grant	D. 2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	E. 2. Loan	F. LIFE OF PROJECT 1. Grant	F. 2. Loan
(1)	HESD					3,750		17,250	
(2)	PNPD					1,250		5,750	
(3)									
(4)									
TOTALS						5,000		23,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)
HEFI | HECS | PNSD | SFI | WDI

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code							
B. Amount							

13. PROJECT PURPOSE (maximum 480 characters)

To institute strengthen planning, management, monitoring/evaluation and health education systems in both the emerging Palestinian public sector health authority and selected indigeneous Palestinian NGOs.

14. SCHEDULED EVALUATIONS
Interim MM YY: 09 9 — MM YY: — Final MM YY: 10 98

15. SOURCE/ORIGIN OF GOODS AND SERVICES
☒ 000 ☐ 941 ☒ Local ☐ Other (Specify) ______

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment.)

17. APPROVED BY
Signature: Dennis Chandler [signature]
Title: Special Coordinator for the Middle East Peace Process
Date Signed: MM DD YY 12 13 93

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

Palestinian Health Systems Support Project

294-0003

PROJECT PAPER

Acronyms Used

PHSS	Palestinian Health Systems Support
NGO	Non-governmental Organization
UNRWA	United Nations Works Relief Agency
(I)GHS	(Israeli) Government Health Services
WHO	World Health Organization
CIVAD	Civil Administration
PHC	Primary Health Care
MCH	Maternal and Child Health
PASA	Participating Agency Service Agreement
CDC	Centers for Disease Control
BUCEN	Bureau of the Census
OYB	Operational Year Budget
IEC	Information, Education and Communication
GDP	Gross Domestic Product

PALESTINIAN HEALTH SYSTEMS SUPPORT PROJECT

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I. EXECUTIVE SUMMARY

The Palestinian Health Systems Support (PHSS) Project is designed to build public and private sector capacity to better deliver family health services in the Gaza Strip and the West Bank. This 6 year project has a life of project funding level of $23 million which will provide for technical assistance, training, equipment and selected activities in support of strengthening the institutions engaged in family health services delivery as the responsibility for the health sector is transferred from Israeli to Palestinian leadership.

When the design activities for this Project began, there was no official Palestinian government, and it was expected that the Project would concentrate on strengthening the management capacity of those indigenous NGOs engaged in primary and family health care services delivery in the Gaza Strip and the West Bank. However, recent dramatic progress toward the ending of the Israeli occupation of the Gaza Strip and the West Bank has produced a new peace accord which includes plans for the establishment of a central Palestinian public sector authority for health.

The design of this Project shifted accordingly to include a major contribution to the establishment of a strong policy and management capacity within a new, public sector Palestinian health authority. An important aspect of an emerging public sector health authority will be the choices about what responsibilities the public sector should assume and what health roles effectively can be delegated to the private sector. These considerations will effect the long term sustainability of the health sector. This project is designed to provide some of the inputs necessary to make more knowledgeable and informed choices toward this end.

Because the NGOs are expected to continue to play an important role in primary health care services delivery at the community level, irrespective of how the new central authority comes to be defined, the Project also includes significant assistance to NGOs. Technical analyses undertaken during the design stage indicate that other donors are likely to continue operational support to NGOs, provide various types of assistance to hospitals, but are less likely to focus on the overall strategic planning and management aspects of primary health care, the focus of this project.

The PHSS Project will provide technical assistance, training, equipment and selected activity support to strengthen the analysis, planning and management capacities of both the central Palestinian public sector authority to be established for the Gaza Strip and the West Bank and the NGOs which are active in providing primary health care services to the people of the

Occupied Territory. As the transfer of modern health sector management technology is the central objective of the Project, the training of Palestinian health officials is one of the most important development interventions supported by the Project. The Training Plan presented in Section IV.E describes how nearly all of the Project's inputs are to be investments in capacity-building through: training; long and short term technical assistance (often followed by in-service training workshops or study tours); limited commodities; and, other costs such as surveys and NGO grants.

The **Sector Goal** of this six year Project is improved health of Palestinians in the Occupied Territories of West Bank and Gaza. The **Project Sub-Goal** is increased use of quality family health services by Women of Reproductive Age and Children Under Five. The **Project Purposes** are: 1) Palestinian self-governing health authority creates and maintains functioning key planning, management, monitoring/evaluation, and health education systems; and 2) Selected Palestinian NGOs engaged in primary health care at the community level institute and maintain improved planning, management, monitoring/evaluation, and health education systems.

The development assistance to be provided to strengthen the management and technical capacity of these institutions toward the objective of greater sustainability is described in the context of the four technical components of the Project:

- **Sectoral Administration/Management**
- **Financial Administration/Management**
- **Information Systems**
- **Health Promotion**

For each of these components there are two subcomponents, one for strengthening the public sector health authority and the other for strengthening NGOs active in primary health care.

The Project will establish a Project Office (either in the Gaza Strip or in the West Bank) which will be staffed by three resident senior public health professionals; three middle level public health professionals (who may be hired locally); and, local support staff. In addition to 28.5 years of long term technical assistance, the Project will support the provision of about 156 months of specialized short term technical assistance, approximately 30 study tours, 40-50 focused in-country management training workshops, 10-15 special studies, 25-30 NGO program support grants and limited commodities and activities support related to institutional management and health promotion. These resources will strengthen the management capacity of the new central Palestinian public sector authority for health and the NGOs. Details of the assistance are presented in the Project Description section of this Project Paper.

The assistance provided through the PHSS Project will develop the administrative capacity and enhance a central analysis and planning unit within the new central health authority which will ultimately be able to engage in continuous strategic planning and produce regular health plan revisions and demographic and health status reports. The Project will also help to establish the financial management and health promotion units of the central authority, and these will permit the use of modern financial management methods to ensure the optimal use of limited resources and the planning and implementation of health promotion activities, respectively. In essence, the Project will help the public sector to make logical choices while putting in place a sustainable health care system. The Project will also work to integrate birth spacing and family planning information and services as part of an overall family-health orientation.

Project assistance to the NGOs of the Gaza Strip and the West Bank is similarly designed to help these important, communi-ty-based organizations to increase their capacity to: assess community needs; plan projects systematically; manage services for quality assurance; and, ensure the financial sustainability of their programs. The Project contains a special small grants element which will be used to reinforce the enhanced analytic, planning and management skills imparted through Project-supported training and technical assistance. These grants will not be used to provide standard operational support.

In order to permit USAID to respond quickly to the urgent institutional development needs of a new Palestinian health sector authority as it begins to operate in Gaza, the Project also includes a "Quick Start" package of short term technical assistance and activity support through existing central pro-jects. This element of the Project would permit the initiation of institutional strengthening as much as six months before resident technical advisory personnel are likely to be fielded. The details of the "Quick Start" element of the Project are presented in the Information Systems section of the Project Description.

The Project has been designed to strike a balance between sufficient detail to ensure the achievement of defined develop-ment objectives and sufficient flexibility to accommodate a rapidly changing institutional environment without requiring major redesign. Therefore, it will be important for USAID to regularly reassess the appropriateness of the Project design, with particular attention to the balance of support between the public and non-governmental sectors and to review internal project management. It is expected that the Annual Work Plan will be thoroughly reviewed by appropriate USAID, Palestinian and contractor personnel to ensure that it is reflective of changing circumstances. It is likely that the logical framework for the Project will need to be revised after the first year of implemen-

tation. A mid-term evaluation will be scheduled and revisions to the Project will be made then, if not required earlier.

The Project design includes the establishment of a Palestinian Steering Committee to meet regularly with USAID and Project staff to provide guidance for the Project and to help ensure that the Project remains responsive to the changing needs of primary health care in Gaza and the West Bank. The Steering Committee is further discussed in the Technical Assistance Plan of Section IV.

II. PROJECT BACKGROUND and RATIONALE

The USAID Program Strategy for the West Bank and Gaza Strip for the 1993 - 1997 period emphasizes concern for the humanitarian needs of the Palestinian people and stresses three long-term strategic objectives: (1) increased marketed production of agricultural and manufactured goods; (2) increased use of selected improved health care services; and, (3) improved planning and management of development activities by selected Palestinian institutions. The Palestinian Health Systems Support (PHSS) Project is designed to address two of these central strategic objectives, those of increasing use of health care services and improving planning and management in Palestinian institutions.

As a reflection of the unique set of constraints faced by those trying to ensure health services in Gaza and the West Bank, a somewhat complex array of Primary Health Care service providers has emerged over time. This complex of PHC services providers includes the Israeli-controlled "government" health services (GHS), the international UNWRA health services, numerous international and indigenous NGOs and individual private sector providers. Of these, the local Palestinian NGOs play an important role (estimated at 40%) in the delivery of PHC services at the community level. These indigenous NGOs in the Occupied Territory include "grassroots" NGOs, charitable organizations and others such as "Patient Friends" organizations and the Planning and Research Center (PRC). Government Health Services contribute a larger share of primary health care services in the Gaza Strip (estimated at 60% - 80%) than in the Occupied Territory as a whole.

USAID has been committed for some time to strengthening the health sector, and in recent months the Agency has determined that it would approach this objective by developing a single, consolidated project through which assistance could be directed at strengthening the effectiveness of both the Palestinian NGOs engaged in PHC services delivery at the community level and a new central Palestinian public sector authority for health. An analysis of the current primary health care providers in the Occupied Territory (see Annex B: Institutional Analysis) reveals that both the current Government Health System and the Palestinian NGOs engaged in service provision are unlikely to have the

capacity to manage the transformation of the health system required by changing political circumstances without considerable external assistance.

As a result, this Project was designed to take a comprehensive approach to strengthening the system of community-based PHC services delivery at the NGO level, including the more central level of PHC services coordination which will eventually be within the purview of whatever official body emerges as the central Palestinian authority for the health sector. The phasing and relative emphasis put on various activities described in this Paper will be determined by the speed by which Israelis turn over responsibility to the Palestinians for the GHS.

The Project, recognizing that an official central Palestinian health sector authority has yet to emerge, allows those project activities aimed at strengthening the management capacity of indigenous NGOs to begin even before the central coordinating authority has been defined. A flexible approach to the implementation of project activities is necessary to introduce those activities designed to strengthen the central coordinating authority as soon as it is practical -- even before an implementing organization can be engaged. The Project has also been designed so that it includes elements of assistance that could absorb a considerable increase in funding if this subsequently becomes appropriate.

The following sections provide more detail regarding the setting of the Project in terms of the health profile of the Palestinians, the characteristics of present health care providers, and the response of USAID and other donors to health sector needs in light of the changes in the setting related to the transfer of health sector authority from the Israelis to the Palestinians under the new peace accord.

A. Setting of the Health Sector

1. Summary Health Status of the Palestinian Population

Although accurate data are unavailable, the total population of the Palestinians in Gaza and the West Bank is estimated to be about 1,950,000. The West Bank's population is estimated at 1,200,000, of which 35% are registered refugees. Around 26% of the West Bank refugees live in refugee camps. The Gaza Strip's population is estimated at 750,000, of which 75% are registered refugees. 55% of Gaza refugees lives in refugee camps.

It is clear that there is a rapid increase of population. The recorded birth rate is 41/1000 in the West Bank and 48/1000 in the Gaza Strip. The total fertility rate in the Gaza Strip is about 7.4; figures are not available for the West Bank. A population profile indicates that the general population is very

young: children below the age of 5 years represent about 18% of the population; persons under 15 years of age represent around 47% of the population.

Estimates of the infant mortality rate range from 30 to 40/1000. The main causes of infant deaths are respiratory tract infections, prematurity (i.e. high risk births), diseases of newborn and early infancy, intestinal infections, and birth defects. The under-5 child mortality rate has been estimated at 35/1000 for the Gaza Strip. The main causes of young child death are respiratory tract infections, accidents, and congenital anomalies. Life expectancy is 62 years for females and 60 years for males.

The annual rate of natural increase is about 4.6%. This indicates a population doubling time of only 16 years, among the fastest in the world.

Nutritional status

Anemia is the most obvious nutritional problem in Gaza. It particularly affects young children and women of childbearing age. The level of anemia is most likely due to iron deficiency. Beans and bread are basic, inexpensive food items through which people get much of their protein and carbohydrates. Given the low cost of the basic carbohydrates and protein, cases of severe malnutrition are likely to have social as well as economic causes.

Infectious diseases

The opportunity for epidemics to spread is very high, due to factors such as high and dense population, poor sewage and garbage disposal, and children playing around sewage and garbage.

Vaccinations are given to infants and young children by the Government Health Service and UNRWA, according to WHO recommendations, with some alterations to suit the health situation in Gaza. For example, the BCG vaccine for tuberculosis is still given in Gaza, though it has been stopped in several places in the world. Vaccination coverage is high at over 95%, although the accuracy of this data has been questioned.

Injury

As the Intifada continues, general curfews, night curfews, violence and counter violence between Israeli soldiers and Palestinians continue. This violence has left the area with many young men and children who have physical disabilities. They need rehabilitation and, later on, support to help them earn their living.

Occupational health

Laborers and other workers often do their work in the absence of laws, insurance or care from health organizations for injuries related to occupational hazards. Factories and work places in Gaza do not have safety measures and there is no protection for workers. This means that if a laborer is injured, he could suffer the consequences without compensation. People who are enrolled at the labor office in the West Bank and Gaza to work in Israel get "some compensation" in case of a work injury, but for those who are young this will not help them to regain a normal life.

Mental health

After six years of Intifada, there is medical evidence that many children suffer the effects of injury, loss or separation, phobia, withdrawal, anxiety, depression, sleep disturbance, and behavioral problems. Many parents are unable to cope with the changes in their lives and have difficulty expressing their grief. Ex-prisoners may soon constitute a large group needing counselling and psychiatric care.

Drug addiction

Drug addiction had been increasing before the Intifada. In the first three years of Intifada, many drug addicts were treated and the level of addiction has relatively decreased. Although there is no documented evidence, it appeared by the end of 1990 and 1991 that addiction to different kinds of drugs had started growing again, especially among wage laborers in Israel.

2. Primary Health Care Services Providers

Health services in the West Bank and Gaza Strip are provided by the Israeli Government Health Services, UNRWA, charitable organizations and local NGOs and the private sector.

In Gaza Strip, the population is served by around 150 clinics, just under half of which are general clinics with specialized mother and child, dental, physiotherapy and rehabilitation services. In the West Bank, several hundred primary health care facilities exist. Currently, local organizations are preparing more reliable data on the number and type of clinics, particularly for the NGO sector which includes five main organizations that also operate in Gaza: Union of Palestinian Medical Relief Committees (UPMRC), Union of Health Work Committees (UHWC), Health Services Council (HSC), Union of Health Care Committees (UHCC), and the Zakkat Committees (ZC).

Recent research also indicates that around 14% of the population lives in communities with no primary health care

facilities. Existing regional surveys indicate that many PHC clinics lack basic sanitary facilities and that preventive services are limited.

UNRWA, which is responsible for health care for nearly one million Palestinian refugees, provides free health services to all registered refugees. Its facilities are also used by some non-refugees. Government (CIVAD) clinic and hospital services are provided free to West Bank and Gaza Strip Palestinians holding valid government insurance, to children below three years and to pregnant women. Most Palestinians, however, do not participate in Israeli health insurance schemes for a variety of reasons.

Government Health Services (GHS)

The GHS is part of the Civil Administration (CIVAD). Up to the time of the writing of this project paper, the GHS is the only public sector authority for health care in the Occupied Territory. Most employees are local Palestinians, with a few Israeli staff who are the main decision-makers for organization--wide policy and strategies. The administration of the GHS is handled through two channels. The first is from the Ministry of Health in Jerusalem through a Coordinator for health in the Occupied Territory. The second level is from the Civil Administration, through the Ministry of Defense in Israel. The Civil Administration runs 177 clinics in the West Bank; 144 of them provide MCH services. There are 28 CIVAD clinics in the Gaza Strip, 22 of which provide MCH services.

The current beneficiaries of the GHS are primarily those people who pay for health insurance. The number of insured Palestinians have decreased enormously since 1986. Now, only 30% of the total population of the Gaza Strip have health insurance. These are mainly government employees, wage workers in Israel who are registered at the labor office and a small percentage of the rest of the population, estimated at 5-8%. Services are free for children up to age three, and for pregnancy care. The GHS presently provides roughly 30% of PHC services in the WB and about 55% of PHC services in the Gaza Strip.

The Government Health Service offers a variety of health services. It provides primary health care, which includes maternal and child health care such as immunization and delivery facilities. GHS hospitals also provide secondary and tertiary health care in different medical and surgical specialties. Currently the system is financed by payments of people who are obligatorily enrolled (employees) and some other small percentage of the population. The rest of the operating expenses are covered by some of the tax revenues collected from Palestinians living in the Occupied Territory. It is not easy to estimate the real recurrent budget of the GHS; but, a rough estimation of the

expenditures of the Government of Israel on health in the Occupied Territory is at least $30/person/year (some estimates place this figure at a much higher rate).

UNRWA Health Service

The United Nations Relief and Works Agency for Palestine Refugees provides health care for Palestinian refugees in the Occupied Territory. They follow the health policy and instructions from Headquarters in Vienna. UNRWA health services are based on WHO health regulations and policy.

The United Nations Relief and Works Agency for Palestine Refugees health care program is basically community-health oriented, providing primary health care to the eligible refugee population. The program includes: medical care services (both preventive and curative), environmental health in the camps, and nutrition and supplementary feeding to vulnerable population groups. UNRWA operates 33 health centers in the West Bank and 17 in Gaza. All of the health centers provide MCH services. PHC services provided by UNRWA in the West Bank and Gaza represent 10% and 25% of the total PHC offered to the Palestinians in the Occupied Territory.

Non Governmental Organizations (NGOs) in Health

Several voluntary organizations provide health care as part of their services. These NGOs provide a wide variety of health services such as outpatient clinics with different specialties of medical care, MCH, health education, and outreach (see Annex B for more details). The services are offered for minimal fees to all sectors of the population. NGOs dominate PHC in the West Bank (about 60% or more of the total services provided). They also provide about 15% of PHC in the Gaza Strip.

Examples are: Union of Palestinian Medical Relief Committees, Health Services Council, Union of Health Works Committees, Union of Health Care Committees, Zakkat Committees, Palestinian Red Crescent Society and Patients Friends Benevolent Societies and others. Many of these NGOs were established during occupation, and they often have more roots in the community than other health providers.

Private Providers

There are many private hospitals, practices, pharmacies, and laboratories run by individual persons or groups. Private practices for physicians are widespread in the West Bank and the Gaza Strip. Private clinics are mainly open in the afternoon, since they are frequently run by physicians who also work in the public or non-profit health sector.

Areas of General Need

At present health services are fragmented due to the different goals and priorities perceived by the different providers. This is even more true with regard to family planning services. There is usually insufficient accountability, and there has been little evaluation of programs that have been implemented. There is a lack of reliable information that is required to provide a basis for strategic planning; there is a lack of comprehensive assessment of the needs and demands of the population. Many organizations have been diligently providing services to fill the gaps in the health system, and they have had a crucial role in the development of the existing "system." However, there is a lack of effective utilization of health services and resources due to duplication, minimal coordination, and a shortage in assets.

Given the complexity of the situation in the West Bank and Gaza Strip, it is quite apparent that there needs to be a central body that will monitor the health sector generally, develop new long-range health plans, and guide the implementation of health service delivery. It is expected that the new central Palestinian public sector authority for health will be responsible for coordinating all health services for Palestinians in the Occupied Territory. These services will most likely be delivered by some combination of public sector and private sector including NGO and international donor and charitable institutions. It is important that early on, the Project help decision-makers figure how ways to integrate all health care delivery into a coherent system that is both user-friendly, but cost efficient.

The Public Sector

Under the present Government Health System, most personnel operating the system are Palestinian. But even the middle-level Palestinian administrators who manage the system do not control it; they have no power to determine policy, choose strategic directions, or make plans. Instead, a small group of Israeli army officers controls the public health system in the Occupied Territory. When the Palestinian Central Health Authority assumes control of the public health system, it must designate those whose responsibility it will be to plan, set policy, establish goals and standards, coordinate health services delivery, and so forth. They must also create a decentralized system so that there is a balance between central decisions and decentralized decisions explicitly responsive to the end users. This group will have had little experience in the Occupied Territory with these tasks. They will need assistance in developing the skills to meet these responsibilities, especially in the early years of Palestinian self-rule.

In addition, those Palestinian middle-level managers of the public health system who have gained some experience in management under the Israelis are likely to be looked upon as "collaborators," and it may be politically unacceptable to keep them in place and utilize their experience. Therefore, these middle-level positions will probably be filled with new appointees who have had no such public health administration or management experience in either West Bank or Gaza Strip. These new administrators may have had experience in other countries (such as countries of the Gulf), but their backgrounds will be diverse, as the systems under which they worked were different. Turning these disparate individuals into a cohesive health team working within a unified Palestinian health system will be a challenge, and donor assistance with organization and management will be quite valuable.

Another challenge for the Central Health Authority may well be the large influx of financial aid that is now expected from international sources. If financial resources for the Public Health Sector increase rapidly, the program, staff, capital investment, and services will also rapidly increase, imposing additional responsibilities and burdens on the system's administration. This rapid growth will challenge the new public sector to manage the resources well.

Other challenges will be in the realm of health care financing: 1) how to mobilize sufficient funds to finance health care; 2) how to allocate funds and organize and coordinate health care delivery to produce maximum possible health care benefits; and 3) how to control health care costs. Palestinians in the GHS staff have had little opportunity to gain experience in financial administration. This is particularly true in the areas of planning, budgeting, and policy-making. Even hospital directors have had to refer their financial requests to Israeli officers for decision-making. Palestinians do have experience in keeping financial records such as bookkeeping and accounting and some experience in financial reporting. The current system has not provided experience in financial oversight or cost analysis, however, and very few GHS staff have had adequate training in financial management.

Achieving progress in these areas will be constrained by poor information systems throughout the health sector in the Occupied Territory and little experience in health promotion and health education. The quality of the GHS work in collecting, analyzing, and disseminating information is widely questioned and these efforts seem to have had little impact on the health sector. As a result, there is, at present, no well-designed, unified information system. The Israeli-controlled GHS also has little experience in health promotion and health education. The few health promotion and education campaigns which have been held have relied primarily on Israeli materials translated into

Arabic. These materials were not adapted for cultural differences and certainly were not created specifically for the Palestinian target audience.

Perhaps the greatest challenge to an emerging public sector health authority will be definition of an optimal role for the public sector, particularly given the presence of an active private sector health care community. Palestinians have a rare opportunity to create a new public sector health authority that is not encumbered with a pre-existing structure or pre-set functions. Deciding what the government should not do in health may be just as important for the sustainability of the health sector as what the public sector will do.

The Non-Governmental Sector

Non-governmental organizations delivering health services may be divided into two principal kinds of organizations: 1) charitable societies, with benevolent purposes and 2) organizations with political affiliations. Most of the charitable societies have broad missions, with health services being only one of their foci. The political organizations all concentrate on delivery of health services. There is no general NGO organizational pattern. Although the NGOs all have Boards (or "Committees"), the degree (and kind) of involvement of these Boards varies greatly and rarely do members with health backgrounds make policy. Usually the Director represents the highest authority in the organization, and, unless the Board exercises its power, he makes all major decisions. The Directors of NGOs come from a variety of educational and experiential backgrounds and they as well as other people do not seem to be chosen for their knowledge of either medicine or management.

Most NGO organizations do not have organization charts or clarified lines of internal communication. Most do not conduct community needs assessments, and only a few engage in strategic planning for the organization, its programs, and its projects. None of the health NGOs have formal periodic evaluations. Daily operations of clinics are usually in the hands of the clinic directors (usually the senior physician). Policy and programmatic decisions are controlled either by the board, the central committee, or the chairman of the board---depending on where the power lies. Almost all NGOs depend on donations for the support of their programs. Programs are often determined by donor preferences and availability of funds. There is, however, growing awareness throughout the health sector that management matters, that management affects service delivery, and that medical skills are not enough.

Few, if any, NGO personnel have had training in financial management. They have had some practical experience, although funds available have been relatively limited and financial

planning has been on an ad hoc basis. Although there is a general weakness in budgeting, goal-setting, and planning to obtain needed resources, the requirement to be accountable to donors has resulted in the NGOs having more ability in these areas than the GHS. Nevertheless, at present, cost analysis and accounting is not practiced. There is almost no gathering and analysis of data on inputs and outputs of health clinics and centers.

The statement that "poor information systems are a serious weakness throughout the health sector" applies as much to NGOs as to the Public Sector. Effective health practice rests on the use of accurate information. NGOs generally produce a variety of reports, but they do not have a well thought out, standardized system of collecting, analyzing, disseminating, and using information. Many NGOs do not collect critical information; data collected are not standardized and therefore cannot be compared with information from other health providers; data are not shared with other organizations; if data are released, the time between collection and dissemination is so long it precludes effective use of the information. Until there is a Palestinian Central Health Authority that is recognized as legitimate by the NGOs delivering health care, NGOs are likely to continue being reluctant to share information. A major problem is that there is a severe shortage of trained, skilled personnel to collect, analyze, and report health information.

Health promotion activities of NGOs have been limited in the past. Still, some NGOs have conducted limited health promotion and education campaigns, often with UNICEF's encouragement, and several NGOs have actually begun continuous health promotion programs. There remains considerable potential for development and growth among NGOs in this area and they should be encouraged to coordinate with the Central Health Authority on such programs.

B. Project Design History

The USAID/West Bank and Gaza Strip assistance program had its origins in 1975 when Congress set aside $1 million of the Special Middle East Requirements Fund to demonstrate U.S. concern for the welfare of the Palestinian people. Over time the program emphasis evolved further and reached its FY 92 funding level of $25 million.

In its recent strategy paper, the West Bank and Gaza Strip program of USAID stressed the importance of improving the capabilities of local health institutions to provide accessible quality primary health services for the Palestinian people living in the area. USAID initially commissioned a team of experts to design a project which aims to improve the managerial capacity of the local NGOs, and later added the capacity to assist the future

central Palestinian entity that will be guiding the development of the post-accord health sector in the Gaza Strip and the West Bank. Throughout the design effort, maximizing the future sustainability of the health sector was a guiding principle in looking at development assistance options.

C. Impact of the New Peace Accord

In the early stages of project design, emphasis was placed on strengthening the management capacity of Palestinian NGOs providing primary health care services in the Gaza Strip and the West Bank. Because there was a recognized need for greater coordination of NGO health services and some degree of regulation and service delivery standard setting, the Project was also to include limited assistance to a central public sector authority to strengthen its administrative capacity in these areas. With the peace accord which has just been signed, however, it is now clearly recognized that the designation of an official central Palestinian public sector authority for health is imminent, and that transferral of responsibility for the Government Health Services from Israeli to Palestinian leadership could have implications throughout the health sector.

The emphasis on strengthening NGO primary health care services delivery reflects the fact that Palestinians have often preferred NGO services to those of the Israeli-controlled GHS for a variety of reasons. With the GHS soon to be become Palestinian-controlled, it is anticipated that many people in Gaza and the West Bank may shift their preference for health services from the NGOs to the GHS. In the Gaza Strip, where the transferral of authority for the health sector will occur at least a year before the West Bank, the GHS already is providing more primary health care services than the NGOs.

To achieve the broadest sustainable benefit from the resources available, the Project shifted its original emphasis on assistance to NGOs to include a major investment in the establishment of a capable Palestinian public sector health authority. The support to a central health authority will initially be directed to the new Palestinian authority for health services in the Gaza Strip. It is anticipated that this body will eventually be responsible for the health services in the West Bank as well, after the West Bank is also given a measure of self-rule.

This shift of project emphasis to include the public sector has been accomplished through the allocation of additional funding and has not resulted in reduction of assistance planned for Palestinian NGOs. Support for NGOs remains an important element of the Project because it is clear that local NGOs will continue to play an important role in the overall delivery of primary health care services at the community level.

Due to the rapidly changing situation with respect to responsibility for health services delivery in the Occupied Territory and a desire to make project funds available as soon as possible to facilitate the Palestinian assumption of responsibilities, the Project design also includes elements which can absorb greater levels of project support at a later date. To ensure that project resources continue to correspond to the priorities of the emerging Palestinian authority and its capacity to absorb assistance, it will be important for USAID to assess the context of project support and implementation mechanisms more frequently than is customary under more stable conditions.

D. Coordination with Other Donors

Financial aid to Palestinian health organizations comes largely in the form of grants issued by governments, international agencies, and non-governmental organizations. Although this aid has facilitated health sector development, support has usually been given without paying attention to the importance of coordination among the donors. This has often resulted in duplication of projects and programs.

To ensure the achievement of this project's objectives, coordination with other donors involved in the health sector must be addressed. The design team had several meetings with international donors to explain the objectives and limits of the Project. In addition, several meetings were held with the Palestinian Technical Committee for Health which has been guiding international donations.

While it is clear that such meetings will contribute to coordination among donors, it is difficult to ensure coordination at this time when all of the donors are reassessing their own programs and none of them can accurately predict what they will be doing. Most donors expect to increase their support to the health sector, and many are leaning toward infrastructure development, contributing directly to services delivery or medical specialty training. For example, the European Community is expected to invest in hospital construction, and there will be a Norwegian program to increase the number of board-qualified medical specialists. These programs will be complementary to this Project. At present, there is no indication that any other donor is preparing to tackle the complex of activities proposed by this Project.

Nevertheless, continued effort will be required to ensure the complementarity between this Project and other donor assistance, especially in the areas of management information systems development and the establishment of a national health insurance program. Therefore, the PHSS Project Steering Committee will be charged with the responsibility of monitoring other donors' activities in the health sector to ensure that

there is no duplication or conflict between this Project and other assistance efforts.

E. Participatory Development Framework

In keeping with the new focus of the Agency, the Project is predicated on a participatory framework for both design and implementation. This implies not only working closely with local NGOs, but involving the beneficiaries not simply as passive recipients of health care, but as active players influencing the supply of health services. USAID has learned that the sustainability of many social services depends on their compatibility with the strategies and priorities of the target populations. From policy to programming to actual service provision, the delicate balance between centralized and decentralized decision-making will need to be factored into all Project assistance.

To ensure that beneficiaries can voice their needs in the health sector, the Project will establish a process which requires the providers to listen to the beneficiaries. One method may be through the provision of fora such as a community center, or through holding town meetings, where the population can express their needs and priorities with respect to the provision of health services.

The provision of health service should take into consideration the age and gender-differentiated needs of the potential clientele. Women and children currently are the primary users of NGO health services, and women usually are the voice of the family, especially on behalf of children and the elderly, with respect to family members' welfare. It will be important that close attention be given to ensuring that women's voices are heard as the new primary health care system evolves.

A key mechanism to promote a responsiveness to communities and community desires is the development and use of health information systems which focus upon the clients or users of the health care system. The information generated from such a system can actually quantify the health care seeking behavior of communities and identify, through household level surveys, areas of unmet need that the populace perceives.

F. Gender Framework

Most of the health issues in the Gaza Strip and West Bank affect men, women and children differently. In order to capture these differences and to determine appropriate responses, the project will improve the gender-analytical and methodological capacities of both public and private institutions involved in primary health care. The central health authority needs to have gender-disaggregated data and a gender-balanced and/or informed

capacity to assess health needs, do health planning, define and set health policies, coordinate health services, monitor health care service delivery and evaluate for quality assurance.

NGOs also need to disaggregate data by gender and have a gender-balanced and/or informed capacity to: analyze the needs of the communities they serve; engage in strategic planning to produce an organizational plan and statement of mission which best corresponds to priority needs and available resources; plan and manage primary health care programs and/or projects; and ensure that service delivery meets appropriate standards for quality. The health promotion and education component of the project should also be sensitive to gender issues.

The Project will attempt to identify and recruit men and women in equal numbers for participation as both trainers and trainees in its training programs and technical assistance activities.

III. PROJECT DESCRIPTION

The Palestinian Health Systems Support Project (PHSS) emphasizes institutional development in a rapidly changing environment. It builds upon the strengths of the NGO institutions which have been responsible for an important share of community level primary health care service delivery during the Israeli occupation of the Gaza Strip and the West Bank and provides support for the development of a new Palestinian public sector authority to be established as Palestinians are given the responsibility for managing their own health programs in Gaza and the West Bank. The Project proposes to assist in the development of a sustainable health care system in the Occupied Territory by building on the comparative advantages of public and private (including NGO) service providers.

The **Sector Goal** of this six year Project is improved health of Palestinians in the Occupied Territories of West Bank and Gaza. The **Project Sub-Goal** is increased use of quality family health services by Women of Reproductive Age and Children Under Five. The **Project Purposes** are: 1) Palestinian self-governing health authority creates and maintains functioning key planning, management, monitoring/evaluation, and health education systems; and 2) Selected Palestinian NGOs engaged in primary health care at the community level institute and maintain improved planning, management, monitoring/evaluation, and health education systems. The institutions targeted for strengthening by the Project are the central Palestinian public sector authority for the health sector, as yet to be officially designated or defined, and the NGO institutions which are active in primary health care service delivery.

The development assistance to be provided for strengthening the sustainability and management capacity of these institutions is described in the context of the four main components of the Project:

1. **Sectoral Administration/Management**
2. **Financial Administration/Management**
3. **Information Systems**
4. **Health Promotion**

Three of the four components are further divided into two subcomponents, one to assist an emergent public sector health authority and the other to strengthen NGOs active in primary health care.

Although the public sector support provided by the Project will eventually strengthen the central Palestinian authority responsible for health services in both the Gaza Strip and the West Bank, the largest benefit of the resources provided probably will flow to public sector authority activities in Gaza. This is because the transition from Israeli to Palestinian responsibility for the health sector is expected to occur in the Gaza Strip a year or more before it takes place for the West Bank.

Since the Palestinian public sector authority for health has not yet been officially designated at the time of project authorization, the Project builds on what is known about the strengths and weaknesses of the existing, Israeli-dominated Government Health Service and what can be projected concerning the nature and needs of the central Palestinian health authority of the future. The assistance package for the public sector is sufficiently detailed to permit a rapid mobilization of assistance resources once the authority is designated while also being sufficiently flexible to permit the Project to focus resources on the priority institutional strengthening needs. Specific needs can only be accurately ascertained after the Palestinian authority has been officially designated and will be reflected in detailed annual implementation plans.

By contrast, the NGOs to be strengthened through Project assistance already exist, and their management strengths and weaknesses can be directly studied. Separate studies of the institutional capabilities of the NGOs in the Gaza Strip and in the West Bank were commissioned as part of the design activity for this Project. The summary reports of these studies are included in Annex B, Institutional Analysis. Although there is a wide range of management strengths and weaknesses exhibited by the NGOs which are active in primary health care service delivery in the Gaza Strip and in the West Bank, it is clear that many NGOs can benefit from assistance in the four technical component areas designated for support by the Project.

Within the first three months after the signing of the contract, the institutional contractor will develop, in close consultation with USAID, final criteria for the selection of NGOs[1] to participate in project activities. Selection criteria might include: history of involvement with PHC, to be established minimal number of clients served; compatibility of the NGOs stated objectives with those of the Project; coverage of otherwise under-served areas and so forth.

Three of the four technical components of the Project are described below in terms of a subcomponent for strengthening the public sector health authority (which will operate mainly in Gaza during the first years of the Project) and a subcomponent for strengthening NGOs. Each subcomponent is presented in terms of its development objectives, the activities which will be supported to achieve these objectives and the resources required. The Health Promotion component, however, combines assistance to the public sector and to NGOs within a single component.

The PHSS Project will establish a Project Office in the Occupied Territory. When the central Palestinian public sector authority for health has been officially designated, it may be desirable for the Project Office ultimately to be located on the grounds of the new health authority. Due to the scheduled advent of limited self rule in the Gaza Strip well before the West Bank, it may be most appropriate to establish the Project Office in the Gaza Strip initially so that it will be close to the offices of the central Palestinian authority to be supported. Nevertheless, security considerations may require that the Project Office be located elsewhere.

The Project Office ideally will be staffed by: three resident expatriate public health professionals; three local professionals; and, local support personnel. In addition to the proposed 28.5 person-years of long term technical assistance, the Project will support the provision of about 156 person-months of specialized short term technical assistance, 20-30 study tours, 35-50 focused in-country management training workshops, 10-15 special studies, 20-30 NGO program support grants and limited commodities related to institutional development and management. A description of these resources is presented below in the sections concerning each of the four main components of the Project. Where appropriate, the Project will take advantage of TA and training from the region where USAID has already invested resources building up local capacity suitable for adaptation to the situation in Gaza and West Bank.

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[1] Here, and elsewhere in the PP, when the term NGO is used, it refers both to individual NGOs or to formal or informal umbrella-type associations or federations which will be eligible for assistance.

Since a central Palestinian public sector authority for health services in the Gaza Strip is expected to be designated soon, it is important for the Project to be able to initiate some support activities in less time than normally required to commence regular implementation activities. For this reason the implementation plan for the Project includes an initial period in which the Project will support a group of related "quick start" activities through "buy-ins" or OYB transfers to access services from existing central projects. However, implementation of most Project components will be accomplished through an institutional contractor or other implementing organizations.

A. SECTOR ADMINISTRATION/MANAGEMENT COMPONENT

The objectives of the Sector Management component of the Project are similar for the Public Sector subcomponent and the NGO subcomponent. In each case the Project will provide a combination of technical assistance, training and equipment to strengthen the ability of the institutions to: assess the needs of the communities being served; engage in strategic planning to produce an organization plan and a statement of mission which best corresponds to priority needs and available resources; plan and manage PHC programs and/or projects; and, ensure that services delivery meets appropriate standards for quality.

1. Public Sector Administration/Management Strengthening

In the absence of an officially designated Palestinian public sector authority for health, the design team assembled a group of Palestinian leaders from both the Government Health Services and the NGO community to define the likely management strengths and weaknesses that such an authority will have once it is named. It was the consensus of those participating that the new central authority for health would probably be drawn largely from the existing Government Health Services and that it would need to strengthen a variety of management areas. The future functions of the central authority are expected to include:

- Planning
- Monitoring and Evaluation
- Coordination
- Policy-Making
- Financial Management
- Health Insurance
- Priority Setting
- Standards Setting
- Legislation/Regulation
- Registration
- Quality Assurance
- Data Collection
- Management Information System
- International Relations

- (Disease) Surveillance
- Logistics Management
- Personnel Management
- Promotion for Health/Health Education
- Delivery of Services (including birth spacing)

As soon as the central Palestinian public sector authority for health services in the Gaza Strip is designated, the Project will provide technical assistance, training, limited equipment and activities support to the central authority to enhance its capability in all of the above areas. Under the Sector Management Component of the Project, assistance will be provided to increase the capacity of the central health authority to: assess health needs and perform various forms of health planning (including for birth spacing); define and set health policies; coordinate health services; establish health care standards; supervise health services; and, monitor health service delivery and evaluate for quality assurance. The central health authority should ensure that all data collected is desegregated by gender and that policy and programmatic decisions are gender informed.

By the end of the Project, the central Palestinian public sector authority for health services should be strengthened to the level at which there is an established continuous strategic planning process which generates annual mission statements, health plan revisions and workplans which are based on reliable health sector data. There should also be an established system for monitoring, regulating and coordinating the delivery of primary health care services by all service providers working at the community level.

Under the Sector Administration/Management Component, the Project will provide both long and short term technical assistance to the central authority. There will be one senior management professional and one mid-level management professional attached to the Project Office for this technical component, and they will work closely with the central authority professionals to design and install the analysis, planning and management systems that will be needed. To complement this direct assistance from resident advisors, the Project will provide 30 months of Short term consultation in strategic planning, quality assurance and logistics management.

The Project will also sponsor in-country training workshops for male and female public sector managers in strategic planning, quality assurance, logistics management, personnel management and gender analysis. To reinforce the public sector management skills being developed, the Project will also support 4-5 quality assurance studies and provide limited computer equipment.

2. NGO Sector Management Strengthening

Most assessments of the needs of the NGOs currently playing an important role in the delivery of primary health care services in the Occupied Territory cite improvement of management skills as the most urgent need. The broad management responsibilities are essentially the same as those cited above for the public sector authority, except that the NGOs are more concerned about the specific needs of the people in its catchment area and less involved with standard setting and regulation (see Annex B). Part of the strategic planning identified below, will involve objective assessments of the catchment areas of various NGOs in order to ensure that the Project does not reinforce a duplication of services. Efforts will be made to assess specifically the degree to which coverage as it exists reaches those most at risk.

Under the Sector Management component of the Project, the NGOs will receive technical assistance, training and equipment support aimed at strengthening their ability to: analyze the needs of the communities they serve; engage in strategic planning to produce an organization plan and a statement of mission which best corresponds to priority needs and available resources; plan and manage primary health care programs and/or projects; and, ensure that services delivery meets appropriate standards for quality. Assistance will be provided to NGOs to strengthen their ability to gather gender-disaggregated data and to make strategic policy and programming decisions informed by gender concerns. By the end of the Project, the NGOs strengthened should have on-going continuous strategic planning which generates annual program evaluations, mission statements, and work plans.

To achieve these objectives, the three-part capacity building activities: training, technical assistance, and application of new systems will be supported by the grants programs. NGO grants will fund pilot approaches and other small-scale experimental activities to allow application of new management techniques learned during training. Short term training and technical assistance will be timed to complement grant activities. This strategy will facilitate the application of new skills and new management systems within the participating organizations.

The Project Office long term management advisors mentioned above will spend approximately one third of their time working directly with the NGOs. They will be joined by short term consultants with expertise in needs assessment and managing for quality assurance. NGO leaders, both male and female, will also be given workshop training in the areas of needs assessment, personnel management, logistics management, quality assurance and gender analysis. This component will also support a series of short workshops aimed at establishing a common understanding concerning the roles and responsibilities of NGO Boards in the governance of the organizations.

Although the Project does not provide direct support for actual service delivery by NGOs, it will provide small program support grants in order to create opportunities to reinforce the strengthened management skills developed through technical assistance and training provided by the Project. This small grants program will be administered by the Project Office and will require NGOs to submit grant proposals in order to receive funding. Each successful grant proposal will adequately describe the needs of the community being served, demonstrate how the proposed activity corresponds with priority needs, present a sound implementation plan which includes defined achievement targets, and presents a detailed budget. Once funded, the Project will use its monitoring of grant activities to determine how well new management skills are being applied and to provide opportunities for field reinforcement of classroom teaching.

B. FINANCIAL ADMINISTRATION/MANAGEMENT COMPONENT

The need for improved financial management by organizations delivering PHC services to Palestinians derives from two main factors. First, most existing NGOs rely for their primary source of funding on local and external donations, which are unpredictable over time. Such unpredictability in funding constrains the ability of NGOs to implement their development plans effectively. Nearly all NGOs also find their total revenues insufficient for the level of services currently required by their catchment population, but have been unable or unwilling to increase revenues by raising user charges due to the deteriorating economic situation in the Occupied Territory. While nearly all NGOs have some accounting staff, their activities rarely exceed the requirements for basic cash management and end-of-period reporting. Many NGO managers do not receive the type of information about the cost of delivering services that could facilitate improved cost-efficiency of service delivery, nor do they have the information and the analytical skills needed to develop other, more predictable, sources of revenue, such as from user charges.

Another factor is that most health care delivered by the future Palestinian public sector entity may eventually be financed primarily through a national system of universal health insurance, using a mixed network of providers and financed from a mixture of sources. All existing health providers are likely to be included in one way or another. As described in a recent study, the 'most preferred option' for health insurance would have operating costs for existing GHS and UNRWA facilities paid directly by the insurance fund, while NGO facilities would be contracted with to provide services to defined populations (not excluding the possibility that NGOs that have their own secure funding sources could opt out of the system). Most private general practitioners would serve the system on a capitation basis.

With cost recovery an issue in the future, early analysis should be done about potential user fees and the ability and willingness of the beneficiaries to pay. These studies should be addressed at the family level since capacity to pay determines not only whether the service is accessed but also who in the family controls access to health services.

Regardless of the organizational structure ultimately chosen (and whether or not private insurance will play a role), there will be a need for accurate service cost data and system-wide financial information to determine economically efficient levels of capitation fees for private providers and NGO contract reimbursements. Individual NGO providers will need to know and control the costs of providing services in order to operate on a sustainable basis and negotiate successfully with the insurance authority, and the government health services will need to plan, budget, and control their activities so that health objectives can be met under given budgets. Economic information about the populations served will be needed to inform the setting of fees, premiums, and co-payments. In addition, there are specific cost-containment issues, such as those related to rational drug use and centralized procurement, that could potentially benefit individual NGOs, the entire government sector, or the entire insurance scheme.

Since it is probable that other donors will assist in the major task of planning and developing the national health insurance scheme, this component of the Project is intended to play only a supporting role in that effort. The activities and outputs of this component are designed to be building blocks that fill essential needs of a future insurance system, and also to be useful to the NGOs and the public sector central health authority even if an insurance scheme is not implemented during the life of the Project.

1. Public Sector Financial Administration/Management Strengthening

Assistance will be provided to strengthen the management capacity of the central health authority in the following areas: accounting systems development and implementation; planning and budgeting; financial planning for a health insurance system and interim revenue generation; general financial management, including cost accounting and cost containment; and financial reporting.

Most of this assistance is expected to commence in Year 2 of the project, to allow time for the establishment of the central authority in the Gaza Strip. The objective of this component is to establish within a central public health authority the capacity to:

- determine in a timely manner, and forecast with reasonable accuracy, the costs of delivering all PHC services, broken down by individual facility and/or program, including NGOs and private practitioners.

- maximize revenues obtained for curative services at the PHC level and higher, commensurate with equity considerations.

- use cost and service demand data to allocate budgets in the most efficient manner and to control expenditures, whether this is through an insurance system or another mechanism.

Establishing this capacity will be accomplished by providing the following assistance: approximately 2/3 time each of an expatriate long-term health economist and a long-term accounting specialist. Twenty-four person-months (6 pm/year in years 2-5) of appropriate short-term specialists. It is likely that most expertise will be required in the area of financial accounting and controls. Depending on the level of involvement of other donors, expertise in health insurance may be required. Training will include up to 4 study tours (for 5 central authority staff and one project staff member) to other countries which are implementing health insurance and other innovative modes of health financing.

The types of commodities required include: high-capacity desk top computers with accounting software, laser printers, photocopiers and fax machines. Special Studies might include: 1) a review of the National Health Plan from an economic perspective, to determine if cost-efficient alternatives exist for improving access to PHC services besides the proposed large increase in the number of rural PHC service delivery sites or 2) a review of the feasibility of implementing policies and programs to promote the rational use of pharmaceuticals, including specific cost-containment measures as central procurement and distribution systems. Another study might consider users views of health services. This study would assess the capacity of the family and its members to utilize the proposed health services. The study should examine changing trends in family structure, control and generation of family income and identify who is responsible for decisions regarding the use of and payment for health services. An understanding of family members' time allocation is also required since this will strongly influence the type and degree of local participation in the health service project by the beneficiaries.

By the end of the Project, the Central Health Authority should have acquired the capacity to manage in an efficient and sustainable manner the financing and routine operations of the

public health sector, including a universal health insurance system.

2. NGO Financial Management Strengthening

Assistance will be provided to strengthen the management capacity of individual NGOs in the following areas: accounting systems development and implementation; procurement and rational drug use; planning and budgeting; cost accounting, and cost containment; and revenue generation. The objective of this project component is to establish within NGOs, that play a significant role in delivering community-based primary health care services, the capacity to:

- determine in a timely manner, and forecast with reasonable accuracy, the costs of delivering services.

- maximize revenues obtained for curative services under a fee-for-service system, commensurate with equity considerations, or, to be able to justify requests for reimbursement levels from an insurance system that permit the organization to operate on a sustainable basis.

- use cost and service demand data to allocate budgets in the most efficient manner and to control expenditures.

This will be accomplished by providing the following types of assistance: approximately 1/3 time each of the long-term expatriate health economist with experience in the above areas and of the long-term host-country accounting specialist. About 15 person-months per year of appropriate short-term specialists to work with individual NGOs. It is likely that most expertise will be required in the areas of financial analysis, financial management systems, and assessment of pricing systems. Training could include 4-5 in-country courses of 2 weeks duration, with 15 trainees per course. These courses would cover the range of financial management skills described above, divided according to the level of management staff. A possible range of courses includes: financial planning and budgeting (for senior managers), pricing and revenue generation (policy-makers/senior managers), fee collection and revenue management (middle managers), cost accounting (accounting staff), and cost-containment (middle management). Depending on the number of participating NGOs, the following commodities could be provided: desk top computers with accounting software, laser printers, photocopiers, fax machines, printing data entry forms. By the end of the Project, the beneficiary NGOs will have acquired the capacity to manage on an efficient and sustainable basis their financing and routine operations.

C. INFORMATION SYSTEMS COMPONENT

Information collection, organization, data storage and retrieval are important functions of any health services provider institution, and being able to carry out these functions effectively is an absolute prerequisite to being able to conduct the sector management and financial management functions described in the previous sections. Under Israeli occupation, the Government Health Services for the Occupied Territory did not develop a strong central capacity for data collection and analysis, and the local Palestinian NGOs involved in the health sector in the Gaza Strip and the West Bank have taken a variety of different approaches to gathering the information they use to plan, manage and evaluate their respective programs.

This component of the Palestinian Health Institution Strengthening Project will provide long and short term technical assistance, in-country workshop training, limited equipment support and considerable activity support in an effort to help the central Palestinian public sector authority for health quickly establish its own information center and planning unit and to help local NGOs strengthen their own information and planning units. Training and technical assistance will be provided so that information collection and analysis will be gender-desegregated.

1. Strengthening a Public Sector Authority

It is clear that the new central Palestinian public sector authority for health will want to establish its own capacity to maintain a central information system which will permit analysis of the needs of the people and assessment of the effectiveness of health services programs. There is an urgent and immediate need for reliable data on which to base strategic planning for the health sector. The PHSS Project is designed to address this need through two separate approaches: first, it can support a series of "quick start" activities aimed at providing assistance to the central authority in the Gaza Strip during the interim period before an institutional contractor can be engaged by the Project, and later the Contractor will manage the delivery of the AID-provided goods and services described below.

The "quick start" activities through existing central projects may include:

- assisting in the planning and execution of a Demographic and Health Survey;
- providing short term technical assistance to begin design of an epidemiologic surveillance system;

- assisting in the design of a census and in the establishment of a central statistics bureau (the last official census of the area was undertaken in 1967); and,

- providing technical assistance for establishing a national health insurance system or to help program the application of project resources to assist in the installation of an approved insurance system.

- offering technical assistance in health sector planning and management.

The "quick start" element of the Project makes available a total of $2.5 million for "buy-ins", OYB transfers, etc. needed to quickly access technical assistance services from existing central projects or collaborating governmental agencies. Subject to the availability of appropriate consultants from these sources, this "quick start" capacity will provide for the early initiation of assistance.

Under the regular implementation mode, the Project will provide approximately 60 months of short-term technical assistance to the central Palestinian public sector authority for health over the six year life of the Project to help: design the central health authority's computer-assisted information system; install the hardware and software to be used; and, train the public sector health personnel in maintaining and using the system. About ten one-week workshops will be supported to engage public sector managers in the design of the new information system and to train them in its use.

The Project will also support 10 or more study tours to permit selected senior central authority leaders to visit other countries in which comparable central information systems and planning units have been developed. Limited support is also provided for computer hardware and software to be used by the information center and for the printing of forms to be used for routine reporting from public sector and other PHC services providers active at the community level.

By the end of the Project the central health authority should have an operating central information and planning unit which provides data as needed for essential continued sector planning, monitoring and evaluation activities. This information processing capacity could be used to generate annual mission statements, annual health plan revisions and an annual health sector statistical yearbook for planning. The planning unit and its information system could also be used in logistical, personnel and program/project management as well as for quality assur-

ance and coordination of health services for the sector as a whole.

2. NGO Information Systems Strengthening

Although the NGOs delivering primary health care services in the Occupied Territory have had to develop some facility with information use in order to attract the grants and donations needed for their continued existence, few of them are collecting data about the communities they serve or about the costs and effectiveness of the services they provide. The Palestinian Health Institution Strengthening Project will provide a combination of technical assistance, training, equipment, and activities support to the health NGOs most active in the Gaza Strip and the West Bank to help them establish their own computer-assisted information systems which will permit them to collect and analyze client, community and service delivery data as necessary for the general management and financial management responsibilities described in the sections above.

By the end of the Project, each assisted NGO should have a functional information and planning unit which provides data as needed for continuous strategic planning. These units will be able to generate regular mission statements, annual workplan revisions and an annual health profile of the community it serves. These NGO information systems also will be applicable to logistical, personnel and program/project management as well as quality assurance and reporting to the central Palestinian authorities.

To achieve these objectives the Project will support the full time employment of a local-hire information system expert for the Project Office and about 15 months of short term technical assistance in management information system design. The Project will support three-four workshops in information system development and will provide funding to support the undertaking of rapid assessment community surveys.

D. HEALTH PROMOTION COMPONENT

At a project design workshop with Palestinian leaders in the field of health conducted on October 2, 1993, all participants agreed that a major weakness in the present health system in the Palestinian Occupied Territory is the lack of what they called "Health Promotion" and "Health Education."

Since these functions would normally be primarily, though not exclusively, the responsibility of a government or a centralized health authority, and since Gaza and the West Bank have been under foreign occupation for 26 years, it is not surprising that there has been little health promotion or health education. Those who are most committed to good health among the Palestinian

population have not been in authority to promote it widely. Another impediment to active health promotion has been cost. Indigenous NGOs, many of which might have otherwise been interested in conducting campaigns of health promotion, have not had adequate resources to do so.

Finally, there is the factor of expertise and experience. Even when the responsibility for health care in Gaza and the West Bank is transferred to Palestinians, both public sector and NGO personnel will have insufficient expertise and resources to mount effective IEC studies and promotion campaigns for health and to make sound decisions concerning regulatory and financial barriers to discourage detrimental health behavior. This component of the PHSS Project is designed to address that problem.

Objectives

This component of the Project has three principal institutional strengthening objectives which apply both to a new central Palestinian public sector authority for health and to NGOs. These objectives are to increase the gender-sensitive capacity of the public sector and selected NGOs to:

- conduct surveys of the public's health knowledge, attitudes, and practices (KAP);

- design, produce, and disseminate appropriate health promotion and health education materials; and,

- evaluate and revise health promotion and education materials.

By the end of this six year project, the Central Health Authority and the NGOs participating in the Project should be able to: conduct well-planned and well-administered health surveys; plan, design, and produce appropriate health promotion and health education materials; plan and conduct effective health promotion and health education campaigns, utilizing the materials they have produced; and, evaluate and revise health promotion and health education materials and health promotion and health education campaigns.

The PHSS Project will provide a combination of technical assistance, training, equipment and activity support to both the public sector authority and the NGOs to achieve these institutional development changes. Together, these inputs are expected to produce the following illustrative outputs:

- 6-9 in-service training workshops conducted;

- 40-60 persons from the Central Health Authority and NGOs trained in the IEC Process;

- 40-60 persons from the Central Health Authority and NGOs capable of designing and producing appropriate Health Promotion and Health Education materials;

- 2-3 KAP Studies conducted by the end of the Project;

- 2-4 media productions for use in Health Promotion and Health Education campaigns; and,

- 2 sets of educational materials (utilizing graphics) for use in clinics and 2 sets of educational materials (with appropriate graphics) for distribution to the public.

The assistance provided under this component includes the following: A communication specialist will be employed full-time (up to 5 person-years) by the Project to provide information and help develop needed skills. This specialist will help to supervise the KAP studies and oversee the production of the four media productions and the sets of materials with graphics. Short-term technical assistance will also be provided to help run the training workshops discussed above and provide specialized help to those institutions needing it to develop their health promotion programs. Staff of both the Central Health Authority and NGOs responsible for preparing and implementing IEC campaigns in health need training in the IEC process. Therefore, the PHSS Project will conduct three to four one-week IEC workshops; each workshop will train 15 participants. These workshops will cover such topics as: needs assessments and public surveys; message development; materials production; dissemination; evaluation; and revision.

In addition, in cooperation with the Central Health Authority, the PHSS Project will support the conducting of two to three KAP Studies to determine the public's knowledge, attitudes, and practices related to specific health issues. The first will be conducted early in the life of the Project to determine the emphases of health promotion activities. The second will be conducted after the health promotion program of the central government has been in operation to determine what changes, if any, have occurred in public knowledge, attitudes, and practices since the first survey was made. At least one health promotion and education campaign should have been conducted by the Central Health Authority and one by an NGO between the first KAP Study and the second. The third survey is planned to be a more specialized survey, focusing on a specific health issue (possibly family planning).

E. BIRTH-SPACING AND RELATED SERVICES

Over the life of the project, birth-spacing services will probably need to be strengthened within the family health service

delivery networks of both the West Bank and Gaza. Centrally administered (G/R&D/POP) projects are likely sources for this assistance. Depending upon the availability of central funds, it is anticipated that the Global Bureau will provide around $3 million worth of assistance from these central activities for birth spacing and related initiatives in the West Bank and Gaza.

F. PURPOSE SUMMARY

A summary of the Purpose and Objectives are included in Annex F along with the Logical Framework.

IV. IMPLEMENTATION PLAN

In order to accommodate a predictable, but as yet unidentifiable evolution in the current Palestinian political and geographic configuration toward autonomous statehood, and with it, the respective development of the roles of public and private sector health institutions, the implementation for this project is designed for flexibility and quick responsiveness, but with a main thrust toward ensuring long-term sustainability and openness to the U.S. The design anticipates some programmatic and budgetary realignments within the project, as required to assure responsiveness to the evolving environment.

A. Implementation Mechanisms

A variety of implementation mechanisms have been built into the project to ensure that activities will be able to continue no matter how political circumstances unfold. The level of emphasis on the public versus the non-governmental sector will evolve over time, thus it is essential that a broad range of implementation mechanisms be approved for use in the Project even though they may not all be in use at any one time.

It is anticipated that different implementation mechanisms will be phased in over time. To kick off the project, at least four "Quick-Start" activities have been identified which can be initiated rapidly through OYB transfers or buy-ins to existing central projects or agreements. For the long-term, the project will be implemented primarily through two mechanisms: a contractor chosen by a competitive, or limited competition, procedure and a non-competitive agreement with relevant USG institutions (i.e. PASA). A final possibility is a private-sector partnership between U.S. NGOs (hospitals and related organizations) and Palestinian health services delivery institutions which will be demand-driven.

The design of this project recognizes the importance of stream-lining USAID management responsibilities where possible. However, the range of assistance requirements in the health sector will require that different types of expertise be made

available, not all of which can be contracted to the private sector. The Scopes of Work for the PIO/T for the institutional contractor and for the PASA will clearly define the differing roles and responsibilities for USG personnel and private contractors. Furthermore, once field staffing levels are established and the Bureau reorganization is put into place a coherent management plan for the Project will be established.

1. "Quick Start Activities"

To ensure that the project kicks off quickly, four "quick start" activities will take place. The contracting for and the management of will be done by USAID/W. The Office of Population has ongoing contractual arrangements which can be tapped to begin work on a Demographic Health Survey and for assistance in Census Planning. The Office of Health has similar arrangements which will permit rapid contracting to begin work on the development of an epidemiology system and on health financing issues. An additional "quick start" might be to provide technical assistance for general health sector planning and management, provided that an appropriate contractual mechanism is available.

2. Institutional Contractor

Building institutional capacities largely through the implementation of critical management systems are the central technical assistance tasks in this project. An institutional contract will provide resident and short term assistance to both public sector and NGO institutions. The contractor is expected to bring the requisite institutional experience and talent to assist Palestinians to efficiently select and adapt tested and proven systems, management tools, manuals and management approaches for improving the existing system where possible. It is expected that the contractor will not re-invent and develop new systems and approaches, but focus on rapid and pragmatic improvements to existing systems and capacities.

In the areas of public health administration, and for the development of epidemiological, specialized sectoral planning and regulatory capacities (all of which require specialized expertise distinct from the implementation of the systems) the contractor will be required to collaborate with complementary sources of technical assistance. This complementary technical assistance will be obtained through the U.S. Public Health Service, and/or through other institutional linkages, (if appropriate), under the cooperative agreement mechanism used for the Private Sector Partnership Program described below.

Principal activity areas for the institutional contractor include: overall coordination of technical assistance and procurement; development of management support systems for public

sector: information, finance and accounting, logistics and maintenance, personnel, training, supervision; shared activities in development of sectoral planning capacities, finance and insurance mechanisms; implementation of IEC aspects of health promotion. For the NGO sector, these activities will include: reporting and overall information systems strengthening; assistance in strengthening of other management support systems. For both public and NGO sectors, the institutional contractor will develop monitoring and evaluation systems and the capacity to apply these systems.

3. PASA with the U.S.DHHS/PHS

To assist in the development of a Palestinian central health authority with public administration functions for the health sector, the unique capabilities of the U.S. Public Health Service (PHS), under the Department of Health and Human Services (DHHS) will be tapped. PHS expertise will guide the development of critical public administration functions and complement assistance by the institutional contractor to develop the planning capacity and management systems development for the central authority.

The PHS is comprised of eight agencies, including the Centers for Disease Control (CDC), the Food and Drug Administration (FDA), the Agency for Health Care Policy and Research, the Health Resources and Services Administration, etc. and the Office of the Surgeon General. A.I.D. has maintained a relationship with the PHS for more than 25 years for the purpose of drawing on the combined PHS resources and capabilities of a range of public health agencies and functions.

The PASA will be administered by the Office of International Health (OIH) of the Public Health Service, and will initially access two of the PHS agencies on a priority basis. The PASA with OIH will require a formal coordination mechanism within the PHS with CDC and the FDA to ensure timeliness and responsiveness of the accessed assistance, and its on-the-ground collaboration with the institutional contractor.

The initial agencies involved will be the Centers for Disease Control for the development of epidemiological, disease surveillance and related public health laboratory capacity, for vital registration and medical statistics; the Food and Drug Administration for food, drug and consumer protection. The U.S. FDA is the "gold standard" in the world for assuring the protection of consumers with respect to foods, drugs, cosmetics, vaccines, test kits, blood product and medical devices, including radiological products, and is increasingly called upon internationally to assist with legislative bases for developing the critical monitoring and regulatory functions of a public health

authority. Possibly later, the PASA could access the Health Care Financing Agency (HCFA) and the Substance Abuse and Mental Health Administration, or the Health Resources and Services Administration for expertise in health manpower planning, licensing, promotion of the nursing profession, etc., (depending on the functions and needs of the Palestinian public health authority).

One of the strong arguments in favor of a PASA with the PHS is not only the benefits of the specialized and unique technical expertise to the host country, but also the establishment of long-term institutional linkages with U.S. Government institutions. These have important secondary political and social benefits in fostering intellectual openness toward the U.S. and with it a continuity and sustainability of technology transfer.

Principal activity areas for the PASA will include: disease surveillance, epidemiological capacity and vital registration systems; legislation, regulatory and monitoring functions; professional and pharmaceutical registration, standards and certification; priorities and mechanisms and policy tools for health promotion (taxation, regulation, IEC, direct investment). Secondary and "shared" activities in collaboration with the institutional contractor include: sectoral planning for manpower, infrastructure and technology, finance and insurance; multi-sectoral problem solving; and, essential health services research.

4. Partnerships Cooperative Agreement

A final modality for assistance, to be selected at an appropriate time, is a limited partnership program between U.S. NGOs (hospitals) and Palestinian health services delivery institutions. Such partnerships allow American providers to assist their counterparts to address morbidity and mortality issues, improve health care organization, delivery, quality and financing, and introduce practical solutions. In the Newly Independent States (NIS) of the former Soviet Union and in Eastern Europe, U.S. partnerships were successful "quick-starts" and now the principal technical assistance vehicles that are proving practical, efficient and cost-effective, on average leveraging and additional US $3.00 from the private sector and the counterparts for each US $1.00 of A.I.D. assistance.

The implementation mechanism will be a cooperative agreement with a U.S. NGO with demonstrated experience in facilitating and managing international health partnership programs. Should there be sufficient demand, one or two partnerships could be established which focus on strengthening the clinical services quality and management of some key West Bank/Gaza health institutions (possibly, one NGO and/or one government hospital).

Should there be sufficient demand for this mechanism, project managers could decide at a later date to expand it. If demand is low initially, it will not be utilized at all. In any event, the contractor will work closely with the cooperating agency to identify the broader needs for standardized sectoral management systems development including information systems and reporting, cost accounting, logistics and maintenance systems, training and supervision systems, etc, and identify additional candidates for U.S. partnerships. The partnership program could be used in collaboration with the contractor to strengthen the major hospitals and health centers. A division of labor between contractor and the partnership cooperating agency will be decided cooperatively as the future of the Palestinian situation evolves.

In addition to the ability to leverage private sector resources, there are other arguments in favor of a partnership component. A distinctly pluralistic partnership approach to development assistance would appear to be well suited to the marked political and organizational diversity of WB/G NGO community, and perhaps also to the variability in public sector hospitals and clinic services providers. As demonstrated by the equally diverse NIS institutional variability, partnerships tend to build on and strengthen the uniqueness of individual institutions, rather than to striving toward increasing commonality of function, structure and form.

Partnerships with a diversity of external institutional linkages offer greater opportunities for leveraging of external private sector resources, for maintaining broadened social and professional contacts, and for energizing the partners and infusing a broader base of technological innovation and transfer, which ultimately diffuse to other institutions.

Activity areas under a health partnerships cooperative agreement include: individual institutional development; centers of excellence; improvement of quality of care; clinical management and efficiency; technology transfer and training; development of medical and nursing management; medical records and other medical/clinical management; etc.

5. Centrally Administered Global Projects

The "quick-start" activities identified above will be implemented primarily through pre-existing projects administered by the Global Bureau. Birth spacing and related activities will also be implemented through centrally administered projects in G/R&D/POP. It is anticipated that these birth-spacing activities would be implemented through the "core" agreements of appropriate central projects.

6. Management and Coordination

The institutional contractor will have resident advisers to provide the continuity and hands-on assistance to the governmental authority and NGOs. How collaboration with the PASA agencies will be handled will be specified in both the PASA and the Contract Statement of Work. Regular review of the cooperative planning and working relationship will be an integral part of the PIR process and the annual Implementation Plan review.

Formalized working groups will be established by the contractor with host government and non-governmental entities, the TA collaborators and USAID participation to develop joint workplans, and task agreements and timetables.

B. USAID Management

Although USAID will reconfigure its West Bank and Gaza Strip USAID Mission to accommodate the management requirements of the increased development assistance program to follow the new peace accord, the following project management plan assumes, at least initially, the continuation of the present USAID Mission structure with the headquarters remaining in Washington and USAID Affairs Officers in Jerusalem and Tel Aviv. As soon as possible, however, the burden of management responsibility will be transferred to the field in order to be more efficient and effective. One USDH project officer in the field, with up to two FSNs, will be assigned to manage the project. The "start work" order for any selected contractor will not be issued until the USDH project officer is assigned to the field.

Funds are included in the Project budget for the hiring of a PSC health professional by USAID to help manage this Project if the need is established. The Project must be closely monitored in the field in order to ensure that the project design remains appropriate in a rapidly changing situation. Given the dynamic setting of the Project, the size of its budget, the number of institutions involved, project management from Washington is inappropriate over the long-term.

Initially, USAID is expected to employ "buy-ins" or OYB transfers to access services from existing projects in an effort to mobilize support to the newly designated Palestinian public sector authority for the health sector in the Gaza Strip as soon as possible after the Project has been approved. These actions will be undertaken in USAID/W.

C. Project Steering Committee

The PHSS Project Steering Committee will be an advisory body of five to ten Palestinian health sector leaders drawn equally from the public sector and the NGO community. Steering Committee

members should be selected by the Contractor, with AID approval, to be representative of the broad range of interests now involved in primary health care services delivery in the Gaza Strip and the West Bank. The Project should attempt to have equal representation by men and women on the Committee. Selection criteria for Committee members should include participatory development experience, gender-sensitivity, understanding of grass-roots health information/services needs and constraints to utilization of services. The Steering Committee should be convened monthly by the Project Office staff, and the members' guidance should be sought regarding the continued appropriateness of the Project's approach to institutional strengthening in a rapidly changing environment. The Project Steering Committee will play an important role, both for day-to-day project implementation, but also for issues of broader health sector policy and donor coordination.

D. Annual Implementation Plans

Each year, the institutional contractor and other implementing organizations will be required to prepare a detailed implementation plan. This detailed plan will include descriptions of all activities to be undertaken during an implementation year and will identify specific short-term technical assistance, training, commodities (equipment and supplies) and other assistance to be provided. These annual implementation plans will be approved by USAID and reviewed by the Project Steering Committee.

This Annual Implementation Plan takes on greater significance than usual because of the dynamic setting for the Project. Both USAID/W and field staff will view the review of the Annual Implementation Plan as the opportunity to make radical shifts in project design and implementation, if required, to accommodate changing circumstances. To ensure that the Project stays relevant, a mid-term evaluation will be scheduled at the end of the second year and it is expected that the outcome of recommendations derived from it will be an amended project.

Although the Project does not explicitly identify a policy reform agenda for the health sector, implicit in most of the activities is the formulation of mutually-agreed policy objectives. It will be important to review health sector policies at these annual implementation plan reviews to ensure that the Palestinians and USAID are in agreement on key reforms.

E. Technical Assistance Plan

The technical assistance plan for the PHSS Project includes a "quick start" approach to fielding essential technical assistance to the new Gaza public sector authority for health immediately after the Project is approved (referred to in the Budget as 'Year 0'). The plan also calls for engaging an institutional

contractor to deliver long- and short-term technical assistance and for agreements with other U.S.G. organizations for short-term technical assistance to carry out the Project during the balance of its 6 year life.

The long term technical assistance required by the Project is to be delivered by the institutional contractor. The Contractor will provide a long term team of 6 professionals to staff the Project Office in the Occupied Territory as follows:

Policy and Management Specialist (COP)	5.0 years
Health Care Financing Specialist	5.0 years
Health Promotion Specialist	4.5 years
Information Systems Specialist (local hire)	5.0 years
Accounting Specialist (local hire)	5.0 years
Grants Manager (local hire)	4.0 years

In addition to the above long term technical assistance, the institutional contractor, and/or the USG through a PASA, will be responsible for providing and/or coordinating specialized short term technical assistance in four categories as follows:

Sector Management	41 months
Financial Management	40 months
MIS and Surveillance Systems	75 months
IEC	15 months

These short term advisors will be provided on an as needed basis throughout the Project, and a provisional schedule for their utilization appears in Annex C.

In addition to the work of technical assistance personnel provided by the Contractor and the close involvement of AID project managers, the PHSS Project will draw upon the leadership of the health sector in the Occupied Territory to provide guidance during project implementation. The mechanism for the involvement of key Palestinian representatives from the public sector and the NGO community will be the establishment of a Project Steering Committee.

F. Training Plan

After examining the existing public health sector and the NGOs delivering primary health care in the Palestinian Occupied Territory, it is clear that training should be a principal development intervention. If the capacity of these institutions is to increase, the knowledge and skills of their personnel must be upgraded.

The training of public health sector and NGOs personnel will take several forms: training workshops delivered in-country; through counterpart relationship with technical assistance

experts, both short- and long-term; short study tours abroad; and a health projects grants program. The grants program actually represents a means of financing the application of knowledge and systems which have been learned through the training process. Grants to NGOs will fund pilot approaches and represent "laboratories of learning" for building capacity in the participating organizations. Short term technical assistance is planned to coincide with these grants (in conjunction with training) to help in the application of skills and in instituting new management systems within the participating organizations.

Of these four methods or approaches to training public health sector and NGO administrators and managers, the most important is technical assistance. Though technical assistance is discussed separately in the Project Description, it is really an integral part of the training process. The long-term and short-term technical assistance, which is direct consultation with the personnel whose skills are being strengthened, can be considered on-the-job or in-service training.

Technical assistance trains people on a personal, rather than a larger group, basis; it provides more opportunity for questions and feedback; it proceeds at the pace of the trainees' abilities and mastery of the knowledge and skills to be transferred; it is on-going, rather than a one-time effort; and it extends over a longer period of time, so as to permit better absorption and retention of the information being learned. The longest workshop in the PHSS Project is two weeks; technical assistance extends over the entire six year life of the Project.

Because of the scarcity of senior and mid-level health professionals in the Occupied Territory, it was deemed most appropriate to provide most of the project training through short-term in-country workshops, so as not to take the professionals participating in workshop training away from their regular duties. Project training workshops concentrate on providing needed basic information about organization and management and on developing needed management skills through participation in short-term workshops (the shortest being 2 days, and the longest being 2 weeks), grouped into four categories corresponding to the four technical components of the Project: Health Sector Management, Financial Management, Information Systems, and Health Promotion.

All training should be dual purpose: 1) to train Palestinian health professionals; and 2) to train trainers (TOT) to continue these activities once the Project has ended. Training of trainers may mean working with public or private institutions, universities or consulting firms to develop an in-country training capacity.

Some training workshops are planned for staff in the Public Sector, others are planned for those in positions of management in NGOs, and occasionally it may be possible to involve participants from both the public sector and the NGOs in the same workshops. Technical assistance builds on the information imparted in the training workshops and continues the training and capacity-building process.

The following list of planned training outlines potential workshops in each of the four categories; divides training activities into subcategories based on participation (Public Sector, NGOs, and Joint); indicates the potential duration of each workshop and the likely number of times it will be offered during the Project; and, suggests the number of participants in workshops and the potential total of participants in each workshop series.

Component 1: Health Sector Management

#	TOPIC	DURATION	PARTICIPANTS PER WORKSHOP	TOTALS WORKSHOPS	PART.
PUBLIC SECTOR:					
1A	Strategic Planning	1 week	20	5	100
1B	Logistics Mgt.	1 week	20	1	20
1C	Quality Assurance	1 week	20	1	20
1D	Personnel: Supervision	1 week	20	1	20
1E	Personnel: Training	1 week	20	1	20
NGOs:					
1F	Governance	2 days	25	3	75
1G	Management	2 weeks	20	3	60

Component 2: Financial Management

PUBLIC SECTOR:

Financial management training of public sector officials will employ direct technical assistance as opposed to workshop

training. In addition, the Project will sponsor approximately 20 study tours (10 each in years 1 and 2) to permit public sector officials to directly observe how comparable countries are dealing with health care financing issues and systems development.

#	TOPIC	DURATION	PARTICIPANTS PER WORKSHOP	TOTALS WORKSHOPS	PART.
NGOs:					
2A	Financial Management I	2 weeks	15	5	75
2B	Financial Management II	2 weeks	15	5	75

Component 3: Information Systems

#	TOPIC	DURATION	PARTICIPANTS PER WORKSHOP	TOTALS WORKSHOPS	PART.
PUBLIC SECTOR:					
3A	Epidemiology Surveil. I	1 week	20	5	100
3B	Epidemiology Surveil. II	1 week	20	5	100
NGOs:					
3C	Data Collection & Analysis	2 weeks	15	4	60

Component

#	TOPIC	DURATION	PARTICIPANTS PER WORKSHOP	TOTALS WORKSHOPS	PART.
JOINT: PUBLIC SECTOR and NGOs:					
4A	IEC Process	1 week	15	4	60
4B	IEC Methods	2 weeks	15	5	75

Another method of training top-level public health sector and NGO administrators is short study tours abroad. Approximately thirty study tours are included in the Project, all occurring within the first two years. These tours permit administrators to see first-hand the experience of other countries in establishing

and managing the systems which they will be responsible for setting up, expanding, or strengthening. These tours provide Palestinian health administrators opportunities to discuss matters of common concern with counterparts in other countries and to ask questions and learn from their experience.

As mentioned above, the small health projects grants program is also an extension of the training and an integral part of the 3-step capacity-building process (training, technical assistance, and applications of new systems). The workshops raise important issues for discussion and clarification; the technical assistance continues the training through direct consultation with experts; the study tours permit "trainees" to learn from seeing and hearing about the experience of others; the small health grants program provides for experiential learning -- "learning by doing." In this phase of training (limited to NGOs), NGOs select and plan small health management-related projects, propose them for funding, and, when they are approved, implement and manage them. Because they get feedback from specialists in the Project, they learn from this experience. Each participating NGO could receive two grants over the life of the Project, thus, they should demonstrate improvement in management in the second project they implement.

G. Procurement Plan

Procurement of goods and services needed to implement the Project will occur through several channels. The "quick start" activities programmed during the first year of the project can all be procured by means of "buy-ins", OYB transfers or cooperative agreements. It is anticipated that this will take place within the first three months following project authorization, so that "quick start" activities may be just that, while the institutional contract selection continues through a lengthier competitive procurement process.

The second major procurement action will be a full or limited competitive procurement for an institutional contractor which will also begin at the same time. The PIO/T is expected to be sent to Contracts by 12/15/93, with an award made within six months following the CBD announcement. The contractor should begin operation in the West Bank/Gaza by July of 1994. The initial contract will be for a limited time period of two or three years, subject to an extension at the government's convenience (cost plus options contract) to allow modifications in the implementation approach if required. ENI/NIS experience with accelerated and "streamlined" procurements is being reviewed for application to the West Bank/Gaza situations.

The project will encourage the participation of small business concerns, small disadvantaged businesses (SDB), and women-owned small businesses in this activity as contractors or

subcontractors. In addition, prime contractors will be required to set aside no less than ten (10) percent of the total value of any awards for subcontracts with Gray Amendment entities, SDB firms (including women-owned), historically Black colleges and universities, U.S. colleges and universities with forty (40) percent or more Hispanic American students, and minority private voluntary organizations. It is anticipated that prime contractors will make maximum use of these concerns.

A PASA established with PHS/OIH using an OYB transfer of funds is the third action, and may be of secondary priority in terms of timing.

Should the demand exist, a potential "quick start" mechanism could be a cooperative agreement (sole source) with a U.S. institution based on unique capability, to establish the initial partnerships between U.S. and Palestinian medical services institutions. The recipient of the cooperative agreement would make subgrants to establish these partnerships.

It is possible that during implementation, the Central Health Authority, will want to pay explicit attention to the provision of family planning services. To ensure that the Project could be responsive to this need, the Global Affairs and Field Support's Bureau has agreed to provide up to $ 3 million of core funding, provided funds are available, for this purpose. This is in addition to other short- and long-term technical assistance and training which could focus on family planning needs.

With the exception of local-hire salaries and a small proportion of the commodities and travel and training costs, most procurement will be from U.S. sources or other developing countries.

H. Constraints Analysis and Implementation Issues

As previously discussed, the PHSS Project is being launched under a particularly unique and fluid set of circumstances related to the history of Israeli occupation of the Gaza Strip and the West Bank and the wide range of uncertainties about the future as the Palestinians organize themselves to take over responsibility for the health sector as one of the terms of the recent peace accord. Whether these unique and dynamic conditions are perceived as constraints or opportunities depends in part upon the observer. A limited number of "constraints" are discussed below.

1. The Lack of a Central Health Authority:

Although an important objective of the Project is the strengthening of the public sector authority for health, the definition and designation of the central health authority must

occur before significant implementation toward this objective occurs. An obvious implementation issue, therefore, will be the need of the field office to define when such a public sector health authority has been designated. Similarly, USAID will need to instruct implementing organizations concerning who/what are appropriate public sector counterparts.

2. Changing Roles for the Public Sector and NGOs:

At present the NGOs in the Occupied Territory are delivering an important percentage of the primary health care services delivered at the community level. The relationship between NGOs engaged in primary health care services is characterized by a modest effort at coordination (and a considerable need for more) and by a considerable degree of competition. The potential emergence of a new public health authority will change the role of NGOs in community health care and may also affect the ways NGOs coordinate the health services they offer.

Due to the limited opportunity for professional and institutional development within the public sector under Israeli control, many of the Occupied Territory's most talented professionals have stayed outside of the public sector and developed largely autonomous NGOs. For years, NGOs have flourished without regulation by a central authority. Some are uncertain about their roles and level of autonomy with the presence of a central authority.

The new central authority for health and any donors wishing to strengthen this central authority face the challenge of acquiring the necessary talent to be responsible for planning and managing the health sector programs while so much of the talent that is now outside the public sector wants to remain outside. It appears that most of the health professional leaders in the NGO community would prefer to remain outside the public sector and make their services available to the public sector through contracts. At the same time, they appear to be actively working to ensure that they are in a position to influence public sector policy.

If a significant factor in the Palestinian people's low utilization of Government Health Services has been avoidance of an Israeli-controlled institution, demand for public sector health services might increase dramatically when the authority for running them passes into Palestinian hands. This could result in a sizable shift in the balance between GHS-delivered and NGO-delivered health services.

3. Earlier Self-Rule for Gaza:

With the transfer of responsibilities from Israeli to Palestinian hands occurring first in Gaza, there may be con-

straints to maintaining a proportionate balance in Project assistance to Gaza and the West Bank. However, beginning implementation in Gaza permits project assistance for the public sector to begin at a smaller and perhaps more feasible level by concentrating on a single, more manageable area (the Gaza Strip). NGO assistance should not be markedly affected by the delay in self-rule for the West Bank.

As the preponderance of foreign assistance to the Occupied Territory in the past has been directed at the West Bank, most Palestinian institutions serving the Occupied Territory have their headquarters in Jerusalem or the West Bank. Thus, there is relatively less indigenous management ability in the Gaza Strip, and this may limit the absorptive capacity of Palestinian institutions in the Gaza Strip to utilize the resources available from the Project.

4. The Relative Unpredictability of the Economy:

The high degree of unemployment and the relatively unpredictable rate of economic growth in the post-accord Occupied Territory make it difficult to plan for health care financing programs such as the proposed national health insurance scheme and difficult to forecast the sustainability of Project achievements.

5. Lack of Comparability in Previous Health Training:

The public sector authority for health will have to establish its staff from a pool of health workers whose training has been received from a wide variety of different programs. This authority and the donors helping it to establish itself will be faced with the need to devise some manpower planning approach which will accommodate the lack of standard credentials.

6. Equipment Importation:

USAID and the Contractor/implementing organizations will have to determine how to best arrange for the entry of project equipment and supplies during the transition period when both Israeli and Palestinian importation and customs regulations may be applicable.

V. PROJECT MONITORING AND EVALUATION PLAN

On-going internal monitoring and external evaluations are important to the success and sustainability of any project, but they will be particularly crucial to the PHSS Project.

As the structure and nature of the central health authority were not clear at the time of designing the Project, assumptions about the public sector health authority and other aspects of the

context of project implementation will have to be validated regularly and often over the life of the Project. Some changes in the Implementation Plan will probably have to be made if the predictions about the nature and capacities of the Palestinian central health authority do not prove to be accurate.

The contractor/implementing organizations will have to cooperate with USAID in on-going monitoring. The contractor/implementing organizations will submit quarterly reports on project progress and problems. In the second quarterly report (i.e. after six months), the contractor should be prepared to provide a detailed monitoring plan for the project. This should include refined and/or revised indicators from the logframe and additional indicators as appropriate. The quarterly reports should take into account the detailed annual implementation plans, indicate achievement of Project objectives and expected outputs, and relate activities to projected deadlines and target dates. The contractor/implementing organizations will report regularly on key, mutually agreed on, indicators. The contractor/implementing organizations also will submit to USAID, with the final quarterly report each year a summary of the year's activities and accomplishments.

Two major external evaluations will also be held: one at the end of Year 2 of the Project, and the other at the end of Year 5 or the beginning of Year 6. If experience indicates that there are major adjustments in the design framework or the timetable of the Project that should be made, it should be apparent by the end of Year 2, if not before. For that assessment, a thorough external evaluation by an impartial professional team should be conducted. The team report should be submitted by the beginning of Year 3 to permit any needed corrections to be made and, if needed, for the Project to be amended.

The second major external evaluation should be held late enough in the Project's life to give a clear picture of progress toward achieving the Project's objectives and producing expected outputs and early enough to permit requesting an extension of time to complete the Project, should that be required, or designing and submitting a proposal for a second phase of the Project, should that be desirable.

This second evaluation, conducted by a professional team, which would include experts both in Health Management and in Health Economics, would use the End of Project Status Objectives as basic criteria for analysis and evaluation of the Project. This team's report should be submitted early in Year 6.

VI. COST ESTIMATE AND FINANCIAL PLAN

The total cost for this six-year project will be $20 million. The Project will be incrementally funded beginning in FY

'94 with a proposed initial year obligation of $5.8 million. Although implementation activities will extend into FY '99, all obligations are expected to be completed by FY '98.

Illustrative costs for Project components and activity areas are described in Table 1. Estimated costs for Project elements by fiscal year are presented in Table 2 (cost assumptions and related information are presented in Annex I). Over the life of the Project, total funding for technical assistance constitutes about 48% of Project resources. Other costs represent about 29% of total resources; training, 9%; commodities, about 3%; and, contingency about 9%. A contingency line item is particularly important in this Project because of the uncertainty surrounding the specific needs and absorptive capacity of the emerging public sector in Palestine.

Financing of the "quick start" Activities is expected to be done through "buy-ins," OYB transfers or other mechanisms needed to access existing central projects or agreements with U.S. Government organizations. Financing of the main project components will be accomplished through either institutional contracts or other agreements with appropriate implementing organizations.

Table 1
PHSS Project
Illustrative Budget by Component, Element and Fiscal Year
($ 000)

	FY'94	FY'95	FY'96	FY'97	FY'98	TOTAL
I. Quick Start Activities						
A. DHS Assistance						
1. Technical Assistance	225	-	-	-	-	225
2. Training	40	-	-	-	-	40
3. Commodities	40	-	-	-	-	40
4. Other	1,160	-	-	-	-	1,160
Sub-Total	1,465	0	0	0	0	1,465
B. Epidemiology System						
1. Technical Assistance	160	-	-	-	-	160
2. Training	40	-	-	-	-	40
3. Commodities	25	-	-	-	-	25
4. Other	50	-	-	-	-	50
Sub-Total	275	0	0	0	0	275
C. Census Planning/Assist						
1. Technical Assistance	250	-	-	-	-	250
2. Training	40	-	-	-	-	40
3. Commodities	35	-	-	-	-	35
4. Other	215	-	-	-	-	215
Sub-Total	540	0	0	0	0	540
D. Health Financing						
1. Technical Assistance	120	-	-	-	-	120
E. Health Planning/Mgt.						
1. Technical Assistance	100	0	0	0	0	100
Activity total	2,500	0	0	0	0	2,500

Table 1
PHSS Project
Illustrative Budget by Component, Element and Fiscal Year
($ 000)

	FY'94	FY'95	FY'96	FY'97	FY'98	TOTAL
II. Sector Management Component						
A. Public Sector						
1. Technical Assistance	340	400	410	410	380	1,940
2. Training	85	80	25	25	25	240
3. Commodities	50	-	-	-	-	
4. Other	50	50	50	100	-	250
Sub-Total	525	530	485	535	405	2,480
B. NGOs						
1. Technical Assistance	285	320	310	300	295	1,510
2. Training	80	60	-	-	-	140
3. Commodities	25	-	-	-	-	25
4. Other	250	400	400	150	50	1,250
Sub-Total	640	780	710	450	345	2,925
Component Total	1,165	1,310	1,195	985	750	5,405
III. Financial Management Component						
A. Public Sector						
1. Technical training	300	320	310	300	260	1,490
2. Training	80	80	-	-	-	160
3. Commodities	15	15	-	-	-	30
4. Other	30	30	-	30	-	90
Sub-Total	425	445	310	330	260	1,770
B. NGOs						
1. Technical Assistance	150	160	160	150	125	745
2. Training	130	200	70	-	-	400
3. Commodities	110	125	100	-	-	335
4. Other	30	25	20	-	-	75
Sub-Total	420	510	350	150	125	1,555
Component Total	845	955	660	480	385	3,325

Table 1
PHSS Project
Illustrative Budget by Component, Element and Fiscal Year
($ 000)

	FY'94	FY'95	FY'96	FY'97	FY'98	TOTAL
IV. Information System Component						
A. Public Sector						
1. Technical Assistance	240	260	260	250	190	1,200
2. Training	-	90	100	90	-	280
3. Commodities	-	30	20	-	-	50
4. Other	-	10	460	810	-	1,280
Sub-Total	240	390	840	1,150	190	2,810
B. NGOs						
1. Technical Assistance	100	100	100	100	85	485
2. Training	-	80	80	-	-	160
3. Commodities	-	15	10	-	-	25
4. Other	75	100	75	75	50	375
Sub-Total	175	295	265	175	135	1,045
Component Total	415	685	1,105	1,325	325	3,855
V. Health Promotion Component						
A. Technical Assistance	310	310	320	310	300	1,550
B. Training	20	80	80	60	40	230
C. Other	100	330	140	330	100	1,000
Sub-Total	430	720	540	700	440	2,830
VI. Central Activities (Birth-Spacing)	-	1,000	1,000	1,000	-	3,000
VII. Evaluation and Audits	-	100	-	150	-	250
VIII. Contingency (includes local PSC)	450	425	400	360	200	1,835
Total	5,805	5,195	4,900	5,000	2,100	23,000

Table 2
PHSS Project
Illustrative Budget by Element and Fiscal Year

	FY'94	FY'95	FY'96	FY'97	FY'98	TOTAL
I. Technical Assistance						
A. "Quick Start"	855	-	-	-	-	855
B. Sector Management	625	720	720	710	675	3,450
C. Financial Management	450	480	470	450	385	2,235
D. Information Systems	340	360	360	350	275	1,685
E. Health Promotion	310	310	320	310	300	1,550
Sub-Total	2,480	1,870	1,870	1,820	1,635	9,775
II. Training						
A. "Quick Start"	120	-	-	-	-	120
B. Sector Management	165	140	25	25	25	380
C. Financial Management	210	280	70	-	-	560
D. Information Systems	-	170	180	90	-	440
E. Health Promotion	20	80	80	60	40	280
Sub-Total	515	670	355	175	65	1,780
III. Commodities						
A. "Quick Start"	100	-	-	-	-	100
B. Sector Management	75	-	-	-	-	75
C. Financial Management	125	140	100	-	-	365
D. Information Systems	-	45	30	-	-	75
E. Health Promotion	-	-	-	-	-	0
Sub-Total	300	185	130	-	-	615
IV. Other Costs						
A. Quick Start	1,425	-	-	-	-	1,425
B. Sector Management	300	450	450	250	50	1,500
C. Financial Management	60	55	20	30	-	165
D. Information Systems	75	110	535	885	50	1,655
E. Health Promotion	100	330	140	330	100	1,000

Table 2
PHSS Project
Illustrative Budget by Element and Fiscal Year

	FY'94	FY'95	FY'96	FY'97	FY'98	TOTAL
Sub-Total	1,960	945	1,145	1,495	200	5,745
V. Central Activities						
(Birth Spacing Assistance)	-	1,000	1,000	1,000	-	3,000
VI. Evaluation and Audits	-	100	-	150	-	250
VII. Contingency (includes local PSC)	450	425	400	360	200	1,835
Total	5,805	5,195	4,900	5,000	2,100	23,000

ANNEXES

A. Economic and Financial Analysis
B. Institutional Analysis
C. Technical Analysis
D. Environmental Analysis
E. Social Analysis
F. Project Summary
G. Logical Framework
H. Job Descriptions
I. Budget and Cost Notes

ANNEX A. ECONOMIC AND FINANCIAL ANALYSES

Economic analysis of social sector development projects is always problematic due to the difficulty of placing monetary values on direct outcomes (e.g., improved health status, increased life span, fewer sick days, etc.). An alternative approach sometimes used is comparison of the costs of the inputs proposed for a given project with other combinations of inputs that could achieve the identical results. This, too, is problematic in the case of the PHSS Project, which relies primarily on indirect inputs to the health sector such as technical assistance and training, to which it is extremely difficult to ascribe, alone and/or in combination, quantifiable benefits in terms of the Project's long term impact.

Through its activities in the area of financial management, the Project will have significant impact on the financing of the health sector. Savings due to higher efficiency of delivery of health services would enhance the realization of a system of universal health insurance by reducing the subsidy needed to make the system sustainable, leaving more general revenues for investment in the health system or other productive sectors. Any such savings could in effect also reduce premiums or the tax burden on households, leaving a higher proportion of personal income available for consumption.

Secondarily, the financial management elements in the PHSS Project will contribute to the efficient operation of the eventual health insurance system at the central level by providing accurate and timely service and cost data to managers, and allowing the service providers to manage their activities in an environment of stable financial resources generated through reimbursement and co-payments.

The following sections discuss some of the health financing issues that the Project can be expected to impact.

A. Health Sector Financing and Universal Health Insurance

> "Remaining barriers to health services, where they harm the quality and effectiveness of care, must be eliminated. If geographical and financial barriers to health services inhibit access, where such services are known (or reasonably assumed) to improve health status, such barriers must be eliminated, or at least minimized." (from the draft National Health Plan)

In the absence of a Palestinian central government and something comparable to a Ministry of Health's budget, it is difficult to analyze trends in health sector financing in the customary fashion. It is said that the Israeli financing of

Government Health Services in the Occupied Territory has decreased by almost half, on a per capita basis, and is now at approximately 5% of the level of funding in Israel.

Although the impact of the Palestinians receiving only one twentieth of the amount of government provided health services that Israelis receive may have been largely offset by the high level of NGO activity in healthy care services delivery, Palestinians have markedly higher morbidity and mortality and lower life expectancy than their Israeli neighbors.

With the recent peace accord and the health sector designated as an area to be transferred to Palestinian self-rule authority, there is concern that the Israeli government will cease its support of the health sector abruptly, before the newly designated Palestinian authority for the health sector can mobilize the funds necessary to continue the present level of services delivery, let alone move on to the challenge of improving health services delivery. It is clear that the international donor community is planning to contribute heavily to helping the Palestinian authorities establish their own social services for the Occupied Territory, but it is too soon to determine how this will affect the health sector.

There is apparently general agreement that health care in the Palestinian entity will be financed primarily through a system of comprehensive health insurance using a mixed network of providers and financed from a mixture of sources. While the details of the status of providers and modes of reimbursement remain to be worked out, it is the question of adequacy of revenues that is the major financing concern.

The following tables contain estimates of current (1991) health expenditures and revenues in Gaza and the West Bank.

Indicative Health Expenditures in West Bank and Gaza, 1991
(From: Approaches to Health Insurance for the Occupied Palestinian Territory)

Health Expenditure	Cost in $US million	Total Costs in $US million
Acute Hospitals		**69.2**
GHS	33.1	
UNRWA	5.5	
NGO's and Other	29.0	
Mental Hospital (GHS)	1.6	
Public Health & PHC		**49.3**
GHS	15.6	
UNRWA	7.8	
NGO's	8.6	
Physicians (private)	14.1	
Private Labs	3.2	
Pharmaceuticals		**28.0-61.0**
GHS	5.0	
NGO,s	1.0	
Community	22.0-55.0	
Optometrics/opticians services		**3.2**
Dentists		**9.3**
Ambulances		**0.8**
Community Mental Health		**0.7**
Medical Devices		**3.0**
Total Operating		**163.5-196.5**
Capital Investment		**10.1**
GHS	8.4	
UNRWA	1.0	
NGO's	0.7	
Total Health Expenditures		**173.6-206.6**

As a proportion of Gross Domestic Product (estimated at $US 1,634 million for 1991), health expenditure in the O.P.T. is relatively high at an estimated 10.5%-12.6%. This is because of the intensive inputs by international organizations and NGOs, and also because of the relatively low GDP.

Indicative Sources of Health Funding, 1991 (ibid)

Source of Fund	Estimated Amount in $US million	Totals in $US million
1) UNRWA		13.3
2) Individuals paying for		
Premiums, GHS plan	35.7	
Premiums, other plans	1.6	
Patient charges	10.4	
Pharmaceuticals	21.8-54.2	
Private physicians	14.1	
Ambulance	0.1	
Dentists	9.3	
Optometrics/opticians	3.2	
Medical devices	1.0	
		97.2-130.2
3. NGO		
Private donations	18.4	
Arab funds	59.0	
		77.4
4. Civil Administration		20.3
Totals		194.9-227.9

Health Sector Financing Under a Palestinian Entity

Deducting the present estimated level of private expenditures on drugs and certain other services, the cost of a comprehensive, universal health insurance scheme has been estimated at $157 million per annum. Palestinian experts estimate that the total revenue budget for a Palestinian administration would be about $500 million per annum of which $150 million derives directly from income tax. The average tax rate is 12.4%. Funding the insurance system from the revenue budget would reduce the budget for non-health government services by nearly one-third. Funding it from a levy on taxable income would increase the average tax rate by an additional 13.2%. Some

combination of sources is the most likely to be used, with 10% of the revenue budget ($50 million) earmarked for health insurance, and co-payments ($14 million) leaving a deficit of $93 million. This could be financed by a health insurance levy on taxable income which would raise the average tax rate to about 20%.

B. Economic Effects of the PHSS Project

The economic effects of this Project can be described in terms of the potential for long-term efficiency gains in the Palestinian health sector. The Project is expected to have an impact on efficiency in several ways:

Sector Cost Savings

By supporting the development of central health planning, savings will result from having fewer duplicated services among NGOs and public sector facilities, especially at the primary health care level. Even if the present lack of coordination results in an efficiency loss of only 10%, and if the cost of PHC in the Territory is taken to be $40 million, better planning and management will save the equivalent value in services of $4 million per year.

By supporting improvements in the quality of and demand for primary care services, the Project will have assisted in reducing the demand for secondary and tertiary care, now estimated to cost about $70 million per year. A 10% reduction in hospital use could be expected to reduce the marginal operating costs of these facilities by somewhat less than 10%, resulting in a savings of up to $7 million per year. This figure would increase proportionally as new hospitals were built over the course of the life of the Project, or, more accurately, proportionally fewer new beds would be needed than if the Project's improvements to PHC service delivery were not made.

By instituting policies and programs for rational drug use, central procurement, etc., savings of up to 30% of the cost of pharmaceuticals could easily be realized. A typical NGO having multiple service delivery sites may pay about $50,000 per year for drugs and supplies. For the 25 NGOs participating in the Project, savings could total $375,000 per year. If the total public sector and NGO drug requirements were $10 million per year for PHC (based on a cost of essential drugs of $5/year per capita), this would offer the potential for saving about $3 million per year for

primary health care, with far more saved on drugs for secondary and tertiary care.

Comparing the Project cost of about $5 million per year with the above estimates, in terms of cost savings alone, the Project would have a highly positive rate of return. If overall health sector savings due to the above components of $14 million were achieved, the additional tax burden on households to cover insurance premiums would be reduced from 7.4% to 6.3%. However, it will be difficult to verify these savings at the end of the Project unless a baseline economic analysis is carried out. This should be one of the "quick start" tasks undertaken by the Health Financing and Sustainability Project.

Other Project Effects

It is estimated that only 10% of households in the O.P.T. are now covered by health insurance. By supporting the development of universal health insurance, the Project will help improve the access of the covered population to health services, and reduce the risk of households incurring catastrophic health expenses.

Improved financial management capabilities will allow both public sector and NGO institutions to progress toward financial sustainability, whether under a health insurance scheme that reimburses them for services, or under a fee-for-service system.

The Project itself will introduce only minor recurrent costs that will have to be assumed by the beneficiaries at the end of the Project. These are largely limited to consumables, such as forms and IEC materials.

ANNEX B. INSTITUTIONAL ANALYSIS

I. INTRODUCTION

The Palestine Health Institution Strengthening Project is designed to improve the organization and management of primary health care institutions in Gaza and the West Bank, which, in turn, will improve the delivery of primary health care in the Palestine Occupied Territory. To accomplish this purpose, the Project will provide four different categories of assistance to the central Palestinian health authority responsible for the health care sector and to the NGOs active in delivering primary health care at the community level. This Project seeks to strengthen the capacities of these institutions in the four technical categories identified as major emphases of the Project. Project assistance is designed to address the current weaknesses in organization and management and to build on the present strengths.

Before designing the capacity-building components of this Project, it was necessary to assess the present state of organization and management in the Government Health Service, currently controlled by the Israeli forces in the Occupied Territory, and in the non-governmental organizations (NGOs) delivering primary health care. That meant examining institutional capabilities and the capacity of these organizations to utilize Project assistance.

In addition to the Palestinian institutions being involved with the Project as beneficiaries, they will also be expected to participate as cooperating institutions. For this reason, the institutional analysis is divided into two major sections: Institutional Capabilities and Institutional Absorptive Capacity.

II. Institutional Capabilities

A. Public Sector

The Public Sector's institutional capabilities are assessed in general and then in terms of the four major technical components of the Project: Sector Management, Financial Management, Information Systems, and Health Promotion.

1. General

At the October 2, 1993, workshop, Palestinian leaders in the field of health from both the public and private sectors listed the following functions of a Central Authority:

Planning
Monitoring and Evaluation
Coordination
Policy-Making

Financial Management
Health Insurance
Priority Setting
Standard Setting
Legislation/Regulation
Registration
Quality Assurance
Data Collection
Management Information System
International Relations
(Disease) Surveillance
Logistics Management
Personnel Management
Promotion for Health/Health Education
Delivery of Services

Then they agreed that the present Israeli-controlled GHS is weak in almost every area listed. This is the public health system that a Palestinian Central Health Authority will inherit and will have to administer very soon.

2. Sector Management

Under the present Government Health System, most personnel operating the system -- both the administration and delivery of services -- are Palestinian. Even middle-level administrators are Palestinians. These middle-level administrators manage the system, but they do not control it; they have no power to determine policy, choose strategic directions, or make plans. Instead, a small group of Israeli army officers controls the public health system in the Occupied Territory.

When the Palestinian Central Health Authority assumes control of the public health system, it must designate those whose responsibility it will be to plan, set policy, establish goals and standards, coordinate health services delivery, etc. This group will have had little experience in Palestine with these tasks. They will need assistance in developing the skills to meet these responsibilities, especially in the early years of Palestinian self-rule.

In addition, those Palestinian middle-level managers of the public health system who have gained some experience in management under the Israelis are likely to be looked upon as "collaborators," and it may be politically unacceptable to keep them in place and utilize their experience. Therefore, these middle-level positions will probably be filled with new appointees who have had no such public health management experience in Palestine. These new managers may have had experience in other countries (such as countries of the Gulf), but their backgrounds will be diverse, as the systems under which they worked were different. Turning these disparate individuals into a cohesive health team working within a

unified Palestinian health system will be a challenge, and donor assistance with organization and management will be quite valuable.

One of the challenges to the Central Health Authority may well be the large influx of financial aid that is now expected from international sources. If financial resources for the Public Health Sector increase rapidly, the program, staff, capital investment, and services will also rapidly increase, imposing additional responsibilities and burdens on the system's administration. This rapid growth will challenge the new Public Sector to manage the resources well.

3. Financial Management

When the health system is turned over to the Palestinian Central Health Authority, it will face three major health care financing issues: how to mobilize sufficient funds to finance health care, how to allocate funds and organize and coordinate health care delivery to produce maximum possible health care benefits, and how to control health care costs.

During the period of occupation, Palestinians in the GHS staff have had little opportunity to gain experience in financial management. This is particularly true in the areas of planning, budgeting, and policy-making. Even hospital Directors have had to refer their financial requests to Israeli officers for decision-making. Palestinians do have experience in keeping financial records such as bookkeeping and accounting and some experience in financial reporting. The current system has not provided experience in financial oversight or cost analysis, however, and very few GHS staff have had adequate training in financial management.

4. Information Systems

Poor information systems are a serious weakness throughout the health sector in Palestine. The GHS does have research centers staffed by Palestinians, which has at least introduced the idea of information systems, but the quality of the GHS work in collecting, analyzing, and disseminating information is widely questioned. These efforts seem to have had little impact on the health sector. There is, at present, no well-designed, unified information system. Palestinians have been able to gain some experience in collecting data, but analysis and dissemination have been kept in the hands of Israelis. "Information" thus generated and disseminated is not yet respected and used.

5. Health Promotion

The Israeli-controlled GHS also has little experience in health promotion and health education. There have been a few campaigns, but GHS has relied primarily on Israeli materials

translated into Arabic. These materials were not adapted for cultural differences and certainly were not created specifically for the Palestinian target audience.

B. Non-governmental Organizations (NGOs)

After examining the NGOs' institutional capabilities in general, we will look at those capabilities in terms of the four major technical components of the Project: Sector Management, Financial Management, Information Systems, and Health Promotion.

1. General

Non-governmental organizations delivering health services may be divided into two principal kinds of organizations:

charitable societies, with benevolent purposes, such as

Zakkat Committees,
Palestinian Red Crescent,
Patients' Friends Benevolent Society,
Near East Council of Churches;

organizations with political affiliations, such as

Union of Palestinian Medical Relief Committees,
Union of Health Work Committees,
Health Services Council,
Health Care Committees.

Most of the charitable societies have broad missions, with health services being only one of their foci. An exception is the Patients' Friends Benevolent Society. The organizations with formal or informal political affiliations listed above all concentrate on delivery of health services.

There is no general NGO organizational pattern. Although the NGOs all have Boards (or "Committees"), the degree (and kind) of involvement of these Boards varies greatly. Even in the organizations in which the boards are called "Committees" the committee members may or may not be active. In a few organizations they may make policy, but in most they are purely advisory, and power in the organization rests elsewhere. Some organizations have a central committee, usually based in Jerusalem, which makes decisions about health services delivery in the field (both in Gaza and the West Bank).

Directors (chief executive officers) of the NGO organizations often also hold the position of Chairman of the Board. Usually the Director represents the highest authority in the organization, and, unless the Board exercises its power, he makes all major decisions. The Directors of NGOs come from a variety of educational and

experiential backgrounds. They do not seem to be chosen for their know-ledge of either medicine or management. Indeed, very few people in any part of the health sector have received formal training in management.

2. Sector Management

Most NGO organizations do not have organization charts or clarified lines of internal communication. Most do not conduct community needs assessments, and only a few engage in strategic planning for the organization, its programs, and its projects. None of the health NGOs have formal periodic evaluations.

NGO administrative patterns vary; some are centralized, and others are decentralized. Daily operations of clinics are usually in the hands of the clinic directors (usually the senior physician). Policy and programmatic decisions are controlled either by the board, the central committee, or the chairman of the board---depending on where the power lies. Almost all NGOs depend on donations for the support of their programs. Programs are often determined by donor preferences and availability of funds.

Although few people in NGOs delivering PHC have been trained in management, there is growing awareness throughout the health sector that management matters, that management affects service delivery, and that medical skills are not enough.

3. Financial Management

Few, if any, NGO personnel have had training in financial management. They have had some practical experience, although funds available have been relatively limited and financial planning has been on an ad hoc basis. Although there is a general weakness in budgeting, goal-setting, and planning to obtain needed resources, the requirement to be accountable to donors has resulted in the NGOs having more ability in these areas than the GHS.

In NGOs at present, cost analysis and accounting is not practiced. There is almost no gathering and analysis of data on inputs and outputs of health clinics and centers. Only one NGO delivering PHC in Gaza is using a computerized accounting system with a simple accounting software package. Record-keeping in NGOs will have to be improved to meet international donor standards.

4. Information Systems

The statement that "poor information systems are a serious weakness throughout the health sector" applies as much to NGOs as to the Public Sector. Effective health practice rests on the use of accurate information. NGOs generally produce a variety of reports, but they do not have a well thought out, standardized system of collecting, analyzing, disseminating, and using informa-

tion. Many NGOs do not collect critical information; data collected are not standardized and therefore cannot be compared with information from other health providers; data are not shared with other organizations; if data are released, the time between collection and dissemination is so long it precludes effective use of the information. Until there is a Palestinian Central Health Authority that is recognized as legitimate by the NGOs delivering health care, NGOs are likely to continue being reluctant to share information. A major problem is that there is a severe shortage of trained, skilled personnel to collect, analyze, and report health information.

5. Health Promotion

Restraints related to the occupation and the lack of cooperation among the various health providers have limited health promotion activities of NGOs in the past. Still, some NGOs have conducted limited health promotion and education campaigns, often with UNICEF's encouragement, and several NGOs have actually begun continuous health promotion programs. There appears to be considerable potential for development and growth among NGOs in this area.

III. Institutional Absorptive Capacity

The previous section dealt with the issue of institutional capabilities---strengths and weaknesses---of both the Public Sector and NGOs, thus addressing the need for assistance. This section addresses the issue of institutional absorptive capacity---the ability of both the Public Sector and NGOs to utilize Project assistance productively. The following questions are explored:

Will they be able to absorb the technical assistance?

Will they be able to participate in, and profit from, the training planned?

Will they be able to use the equipment provided productively?

Will they be able to undertake the activities for which support is provided?

A. Public Sector Ability to Meet Project Expectations

1. Ability to absorb technical assistance

Most administrative personnel in the Public Sector have university degrees. Both those presently working in the Public Sector and those who are likely to be hired in the future will be educated and capable of benefiting from consul-

tation with experts in various areas of organization and management.

Public Sector personnel have not been exposed to technical assistance under occupation, but there is every reason to believe that under a Palestinian authority, technical assistance would be welcomed and used.

The new autonomous Palestinian authority will be challenged to provide better quality health service and an improved health system. There are Palestinians available with excellent medical and technical qualifications, but they have had little experience in organizing and managing a national health system. Technical assistance will meet a real need and find a willing reception.

2. Ability to participate in training

In the past, training has not often been aimed at the public sector, but it has been offered in Gaza and the West Bank to improve administrative skills in NGOs. It is encouraging to note that some of the higher level administrators of the GHS came, on their own initiative, and participated in the NGO training programs. Also, when training for secretaries and lower level managers has been offered in Gaza and the West Bank, personnel from GHS have voluntarily attended.

It is anticipated that the Palestinian Central Health Authority will want to have its personnel benefit from opportunities to get more training, but there will be such a scarcity of health personnel with sufficient experience to work in the central authority that few of them will be able to leave their responsibilities long enough to participate in long term training programs. The Project's emphasis on short in-country workshops should allow maximum participation by public sector personnel.

3. Ability to use new equipment

There is a tremendous lack of equipment in the GHS administrative offices and clinics. There is a shortage of typewriters, computers, photocopying machines, fax machines, and even telephones. They will be able to use the equipment provided, although personnel will need technical assistance to prepare them to use computers.

4. Ability to undertake Project-supported activities

The Central Health Authority is expected to be able to conduct the activities for which Project support will be provided, such as the Demographic and Health Survey and the KAP Studies, but they will need the assistance of the experts available from the Project to carry out these activities.

B. NGOs' Ability to Meet Project Expectations

1. Ability to absorb technical assistance

The NGOs of Gaza and the West Bank have already demonstrated their ability to absorb technical assistance when it has been provided.

2. Ability to participate in training

Just as in the case of technical assistance, NGOs in the POT have demonstrated their ability to participate in training, especially short-term training, in the past. There may be changes in the higher levels of administration in the NGOs during and after the transition to self-rule. NGOs delivering PHC services may move away from the practice of choosing Directors on the basis of political affiliation and commitment. The new, more professional administrators may well be even more inclined than their predecessors to take advantage of training available to them from the Project.

3. Ability to use new equipment

The provision of equipment needed in NGO administration, especially in financial management and information systems, does not stand alone in the PHSS Project. There is also technical assistance available to prepare NGO personnel to utilize the equipment in their work. There have been some problems in the past when equipment was donated to organizations without providing for related training or technical assistance, but even in such cases, some NGOs were resourceful enough to obtain the training needed to put the equipment to good use.

4. Ability to undertake Project-supported activities

NGOs often have closer ties to the local communities than the GHS, and they have already demonstrated their ability to implement programs and projects. They have attempted to produce materials for health promotion and health education campaigns, and they have collected some information and issued reports. With the training, technical assistance, equipment, and supplies available from

the PHSS Project, the NGOs should be able to undertake the activities and sustain the improvements in their own administrations.

One major activity of the PHSS Project is the small grants program which will provide the opportunity for NGOs to select, plan, propose, implement, manage, monitor, and evaluate health-related projects. This program will permit NGOs to implement projects which they themselves choose and manage.

ANNEX C. TECHNICAL ANALYSES

This annex simply examines the technology requirements of the Project in terms of whether the necessary technology exists, whether appropriate methods for its transferral are known and the degree to which the Project is expected to be able to exploit the state-of-the-art technology available in each of the four technical component areas of the Project.

SECTOR MANAGEMENT

It is widely recognized among Palestinian leaders in the health field that high level administrators as well as middle managers of both the new central Palestinian health authority and Palestinian NGO personnel delivering health services will lack (and need) training and experience in organization and management. They need to know and understand the commonly accepted principles and widely used practices of efficient and effective organization and management.

This body of information has been developed over the past seventy-five years (principally, but not exclusively, in the developed world) and is available for study and teaching. Extensive studies have been conducted regarding required skills and effective organizational and management methods. Previous efforts in the region have demonstrated that management principles and practices developed in the West can be effectively adapted and applied in the Middle East among Arab organizations.

This Project will emphasize the development of enhanced public sector and NGO competence in the management areas of:

Planning
Monitoring and Evaluation
Coordination
Policy-Making
Financial Management
Health Insurance
Priority Setting
Standard Setting
Legislation/Regulation
Registration
Quality Assurance
Data Collection
Management Information System
International Relations
(Disease) Surveillance
Logistics Management
Personnel Management
Health Promotion and
Services Delivery

FINANCIAL MANAGEMENT

Most failures of organizations are for financial reasons, and nearly all such failures can be traced back to deficiencies in planning, setting financial targets, and controlling financial flows. Failure to plan properly is most often due to a lack of orientation and training on the part of management, which additionally might not have access to the type of financial and other data that reveals significant trends that would affect decisions. Failure to control financial flows is most often due to deficiencies of information; often the information reaches management too late and/or in a form that cannot easily be interpreted for making timely decisions.

The technology for overcoming deficiencies in financial management has existed since the dawn of modern commerce, and has been much refined in the past few decades. This financial management technology is readily transferred through training. Courses and texts on all levels are widely available, often relying on the use of cases to demonstrate or reinforce the main principles. The problem of controlling financial flows has up until recently been the domain of the accounting profession, but the proliferation of personal computers and user-friendly accounting software now allow less highly-trained personnel to perform the same functions with greater accuracy, and in any case have simplified the production of financial reports to the point that they can be provided to managers on a more frequent basis than was previously feasible. This technology also enables managers to perform cost accounting tasks that formerly were previously not often done because of their complexity.

The technology for performing other types of economic analyses relating to revenue generation is also fairly widely known, and has been developed intensively in the past decade due to the proliferating need for achieving financial sustainability in the health sector in developing countries. USAID has contributed to the development of this body of knowledge, and it is readily available through several centrally-funded projects.

INFORMATION SYSTEMS

At present, the Israeli-controlled government health service (GHS) and most Palestinian NGOs in the Gaza Strip and the West Bank do not have even minimally adequate management information systems in place. The technology is available, however, to establish and operate a centralized information system and to help set up and manage information systems in NGOs participating in the PHSS Project.

Scientific survey instruments have already been developed and are in wide use in developing countries that could be adapted to collect information through the central Palestinian authority for

the health sector when it assumes the responsibilities to be relinquished by the Israeli GHS. The survey instruments, such as those developed in the United States for Demographic and Health Surveys, could also be used by NGOs to facilitate their data collection.

The management information and surveillance expertise is available that could assist the emerging Palestinian central health authority to set up an information system and to conduct needed studies and surveys. Experts from the Demographic and Health Survey Project, for example, could be used as technical advisors; the Center for Disease Control has experts in epidemiologic surveillance systems design; and the U.S. Bureau of Census has experts in census design---all of which would be useful resources in the early months of the PHSS Project.

Analysis, storage, and retrieval of information has been made much easier with the wide availability of computers and appropriate computer software. There are already some trained, experienced computer programmers in the POT who could design appropriate needed software or adapt existing software programs. Together with technical advisors from the Project, they could help to install appropriately user-oriented information systems in the central Palestinian authority and the NGOs. The advent of fax machines making exchange and reporting of information quick and simple will affect the design of these systems.

In summary, the technology and expertise exists that would be required to set up the needed central health information system and to establish the needed information system capabilities in public sector health delivery institutions and in NGOs, and AID has experience in the transfer of this technology. The Project should be successful in assisting the central Palestinian health authority and participating NGOs to access the necessary technology and expertise and to develop their own information systems.

HEALTH PROMOTION

There have been few efforts in the Occupied Territory in the field of health promotion and health education during the years of Israeli occupation. The Government Health Service (GHS) has virtually ignored this aspect of public health, and NGOs have had resources to mount only limited campaigns.

The lack of attention to health promotion and health education has not been for lack of technology, however. The technology exists, is in wide use in the rest of the developing world and is available for use by the emerging Palestinian Central Health Authority and Palestinian NGOs.

Four areas of health promotion technology are of particular relevance to the project:

* public surveys and studies
* message development and testing
* materials production
* information dissemination and public persuasion

Public Surveys and Studies

Instruments called KAP Studies have been developed to discover and analyze the public's knowledge, attitudes, and practices related to major issues of public health. Specialized instruments, focusing on specific issues are also available, and others, using the same methodology, can be devised. These scientific surveys are useful in two respects. They can reveal the status of the public's awareness of, and knowledge about, health. Also, they can assess the impact of health promotion and health education efforts to inform the public, modify the public's attitudes, or change the public's behaviors in matters of health.

Message Development and Testing

If health education and health promotion campaigns are to be successful; i.e., if they are to have the desired impact and influence on the targeted public; the messages must be specifically tailored to target audiences. The intellectual content, emotional appeals, and cultural approach must be adapted to the specific public addressed. The technology exists to prepare and adapt material. Two basic methods used for this purpose are focus groups and pilot testing. The first permits typical members of the public to discuss the health matters to be addressed in the education or promotion campaign. The participants' input can be valuable in shaping the content of the messages. The second permits trying the tentatively designed messages on a typical segment of the public and testing the results. These results can be analyzed and the tentative messages revised.

Materials Production

All the technology needed for producing interesting, attractive, effective materials exists in Palestine. Posters, charts, pamphlets, and brochures can be printed in color; professional production facilities exist capable of producing on-the-air quality radio and television spots and programs; and technology exists to produce (and reproduce) professional quality video tapes. Graphics artists, designers, and printers are available to work on print

materials production. The studios and technicians needed to produce audio and video materials are also available.

Information Dissemination and Public Persuasion

The technology exists to get health promotion and health education messages to the public. Printed matter, such as pamphlets and brochures, can be distributed at the clinics or in the homes of community members by health workers. Charts can be shown at small gatherings in clinics or in communities; posters can be displayed at clinics or in public places.

Audio cassettes and video tape players are available for dissemination of material on audio and video tape. Radio and television broadcast facilities exist, although there is not yet a Palestinian owned and operated television station. Such a station will probably be established early after a central Palestinian authority is set up. Since both Israeli and Jordanian radio and television broadcasts are heard and seen in the Palestinian Occupied Territory, arrangements might be made to broadcast the Palestinian health education and promotion materials on those stations until Palestinian stations come on line.

ANNEX D. ENVIRONMENTAL ANALYSIS

THRESHOLD DECISION BASED ON INITIAL ENVIRONMENTAL EXAMINATION

(A) Project Location: West Bank/Gaza Strip

(B) Project Title/ID: Palestinian Health Systems Support Project (294-0003)

(C) Funding: $5.8 million ($23 million over 5 years)

(D) Period of Funding: FY 94

(E) IEE Prepared by: J.P.E. desRosiers, Senior Environmental Advisor
ANE/NE/DR/ENR
Signature ______ Date: November 3, 1993

(F) Environmental Action Recommended: Categorical Exclusion per 22 CFR 216.2 (c)(1)(i) and (2)(i)(iii)(viii)

Decision of the ANE Assistant Administrator:

Approved: ______

Date: 11/3/93

Decision of the ANE Environmental Coordinator:

Approved: ______

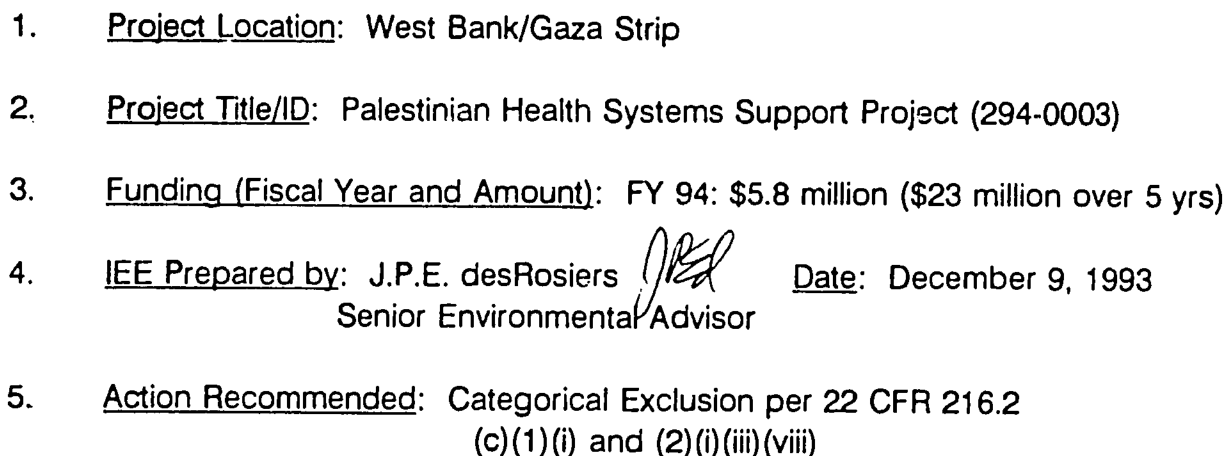
Date: 11/3/93

Clearance:

GC ______

NE/ME ______

INITIAL ENVIRONMENTAL EXAMINATION



1. Project Location: West Bank/Gaza Strip

2. Project Title/ID: Palestinian Health Systems Support Project (294-0003)

3. Funding (Fiscal Year and Amount): FY 94: $5.8 million ($23 million over 5 yrs)

4. IEE Prepared by: J.P.E. desRosiers Date: December 9, 1993
   Senior Environmental Advisor

5. Action Recommended: Categorical Exclusion per 22 CFR 216.2
   (c)(1)(i) and (2)(i)(iii)(viii)

PROJECT DESCRIPTION:

The Palestinian Health Systems Support Project (PHSS) emphasizes institutional development in a dynamic environment. It builds upon the strengths of the NGO institutions that have been responsible for an important share of community-level, primary health care service delivery during the Israeli occupation of the Gaza Strip and the West Bank and provides support for the development of a new Palestinian public sector authority to be established as the Palestinians are given the responsibility for managing their own health programs in Gaza and the West Bank.

The Goal of this five year Project is to improve the health of the people living in Gaza and the West Bank. The Project Purpose is to improve the management capacity of Palestinian institutions engaged in the delivery of primary health care services at the community level in the Gaza Strip and the West Bank. The institutions targeted for strengthening by the Project are the central Palestinian public sector authority for the health sector--as yet to be officially designated or defined--and the NGO institutions that are active in primary health care service delivery.

The development assistance to be provided to strengthen the management capacity of these institutions is described in the context of the four main components of the Project:

- Sectoral Management

- Financial Management
- Information Systems
- Health Promotion

All but the last component--Health Promotion--are further subdivided into two subcomponents:

- Assistance of an emergent public sector health authority
- Strengthening NGOs active in primary health care

USAID's Environmental Procedures, as defined in 22 CFR 216.2 (c)(1)(i), categorically exclude projects under 22 CFR 216.2 (c)(2)(i), (iii) and (viii), which include education, technical assistance, training programs, analyses, studies, academic or research workshops and meetings, and programs involving... health care.... Hence, this project is exempt from such environmental procedures.

ANNEX E. SOCIAL ANALYSIS

The Politicization of Health Care Alternatives for Palestinians

Over the years, health care in the West Bank and Gaza has become highly politicized. This politicization affected each of the three main sources (Government Health Service, UNRWA and the NGO community) of health care for the Palestinian population. The Government Health Service (GHS), being operated under the auspices of the Israeli occupying authorities, offered health services which for some Palestinians represented a politically unacceptable source of care. The political sensitivity of the GHS was further heightened during the civil unrest of the Intifada. Obviously, persons with Intifada-related injuries might be hesitant to seek services from a health care system with ties to the Israeli occupying forces.

The health care system operated by UNRWA ostensibly was established to provide services to that portion of the Palestinian population in Gaza and the West Bank that could qualify for refugee status. UNRWA health facilities even were located to coincide with refugee camp areas. The UNRWA health care system, with international inputs, provides fundamentally free health care to the refugee population. UNRWA, therefore, caters its health services to the refugee constituency of the population who enjoy relatively good quality health care basically free of cost.

The NGO community, long active in basic health care services, became a much more significant source of health care during the Israeli occupation. A variety of external interests concerned with the plight of the Palestinian population provided funds for social service delivery through the NGO community. Furthermore, most of the main political factions active within the Palestinian community tried to demonstrate their attentiveness to community needs by supporting NGO-supplied health services. Consequently, many of the NGOs with health service networks have historical ties to one or more of the various Palestinian health factions.

The political rational for financing NGO health care services often resulted in clinics being opened and operated in the same community -- even competing for patients within the same or overlapping encatchment areas. Virtually all NGO health systems provided services for free (or for a very nominal charge) and were financed by the donations of interest groups.

The Changing Socio-Political Environment

Following the Gulf War and the signing of the Israeli-PLO peace accord, the socio-political environment for health care services has begun to change significantly. The position of some Palestinian groups (not-supporting the anti-Iraq coalition) during the Gulf War, for example, resulted in the withdrawal of funding

from several Gulf states. Several NGOs witnessed a decline in funding for health services and are looking for alternative sources to cover the recurrent costs of health care delivery.

The peace accord illustrates the emergence of a new political order in which at least one political faction is emerging with considerable power. Health service NGOs with affiliations with less powerful political factions (there are at least four) are uncertain about their future and about the reliability of financial donations to continue service delivery activities on the same scale.

The NGO community of health care providers have a history of competition and independence of operation. Common approaches to health care delivery and to the prioritization of health issues are rare. Factionalism within the Palestinian community also pertains to health NGOs and cooperation between NGOs or groups of NGOs is difficult to maintain.

Similarly, the prospect of a Palestinian-run GHS suggests a whole new role for public sector health care. A public sector health entity which is more widely viewed as a politically acceptable source of health care could reduce the demand for NGO-operated health services. Also, a central health authority may have some regulatory responsibilities for the NGO health care community. Such regulation may be new for some NGOs used to considerable operational freedom and necessitate a period of adjustment to new roles by both NGOs and the central health authority.

Socio-Cultural Factors in Fee-For-Service

Throughout much of the Arab World, there are long traditions associated with popular views about the rights of citizens to health care. These traditions frequently are founded in the concept that health is a "social good" which governments (or rulers) have an obligation to provide in return for the allegiance of the citizenry. In Arab societies, this "social good" is often provided free of charge or only for a nominal fee.

The tendency to offer health care services free or at very low costs is also rooted in a concept of equity for the poor. Health care, as a result, is frequently offered in a manner that it is "priced" so that even the very poor can afford services.

In such an environment, the private (for profit) sector often represents a health care alternative for those households with the means and will to pay for health care. The private sector is perceived to offer higher "quality" of care by many users. The public sector, particularly at the primary care level, then is often perceived as the avenue of first choice for health care among the poor and disadvantaged households.

UNRWA and most NGOs in Gaza and the West Bank already operate their health care systems in a manner consistent with these general socio-cultural concepts. If cost recovery is to become a management principle in health care systems, then these precepts to the pricing and delivery of health care will have to be modified. It is unclear, at present, what posture the central health authority will take with regard to cost recovery or options for financing the recurrent cost needs of a national health care system. Nevertheless, if a fee-for-service or a monthly "premium" system is introduced, the willingness to pay among clients will most likely be conditioned by the perceived quality of care being offered (the lower the quality, the less the willingness to pay).

Beneficiaries

The direct beneficiaries of this project will be the health care provider community (both the public sector and NGOs). The assistance health care providers receive, however, should enable them to better respond to the needs of health care users and Palestinian communities that participate in health care networks. Data collection systems, for example, established through the project should be more sensitive to changes in health care use patterns and the evolving health care needs of communities.

Popular access to and use of vital health care services will be quantified and incorporated within service delivery management decisions. Services to the community level should become more responsive to prevailing health care seeking behaviors and enhance the participation (measured through usage statistics) of communities within the health care system. Therefore, the users of health care services should become indirect beneficiaries of successful project implementation.

ANNEX F. PROJECT SUMMARY

The project has two purposes:

1) Palestinian self-governing health authority creates and maintains key planning, management, monitoring/evaluation and health education systems; and

2) Selected Palestinian NGOs engaged in primary health care at the community level institute and maintain improved planning, management, monitoring/evaluation, and health education systems.

Below is presented, for each of the four components of the Project, a listing of the key systems to be developed/improved and what they should be able to do by the end of the project. The components are (with the exception of the fourth component) subdivided into two subcomponents (Public Sector and NGOs).

SECTOR MANAGEMENT

PUBLIC SECTOR

This sub-component of the Sector Management component will focus on increasing the following capacities of the Palestinian Central Health Authority:

to plan;

to set policy;

to coordinate health services;

to establish standards;

to supervise; and

to monitor and evaluate.

By the end of the Project, the Palestinian Central Health Authority should be able to:

continue an established, on-going strategic planning process;

generate annual mission statements, health plan revisions, and workplans;

utilize an established system for monitoring, regulating, and coordinating the delivery of primary health care services by all service providers working at the community level.

NGOs

This sub-component of the Health Sector Management component will focus on increasing the following capacities of NGOs participating in the Project:

to plan,
to initiate,
to manage,
to monitor,
to evaluate,
to finance, and
to sustain PHC services to their communities.

By the end of the Project, the NGOs participating in the Project should be able to:

continue an established, on-going strategic planning process;

make and revise workplans for programs and projects;

generate annual mission statements, determine organizational policies, and choose organizational strategies;

conduct program and project evaluations;

supervise personnel for quality assurance;

select, plan, propose, implement, and manage a small project in PHC services.

FINANCIAL MANAGEMENT

PUBLIC SECTOR

This sub-component of the Financial Management component will focus on increasing the following capacities of the Palestinian Central Health Authority:

planning and budgeting;

accounting systems development and implementation;

financial planning for interim revenue generation and a health insurance system;

general financial management; and financial reporting.

By the end of the Project, the Palestinian Central Health Authority should be able to:

plan and prepare a system-wide GHS budget;

develop an appropriate accounting system for the Palestinian GHS;

implement and monitor the GHS accounting system;

determine in a timely manner, and forecast with reasonable accuracy, the costs of delivering all primary health care services, broken down by individual facility and/or program, including NGOs and private practitioners;

maximize revenues obtained for curative services at the PHC level and higher, commensurate with equity considerations;

generate sufficient user fees to operate facilities and programs on a sustainable basis when added to other sources of revenue and subsidies;

obtain, process, and use cost and service demand data to allocate resources in the most cost-efficient manner;

use cost and service demand data to control expenditures and implement cost-containment measures where appropriate;

implement significant system-wide cost-control measures, such as centralized procurement and a program for ensuring rational use of drugs;

help plan and develop a health insurance system, and, if it is established, manage it on a financially sustainable basis.

NGOs

This sub-component of the Financial Management component will focus on increasing the following capacities of NGOs participating in the Project:

planning and budgeting;

accounting systems development and implementation;

general financial management;

financial reporting.

By the end of the Project, the Palestinian NGOs participating in the Project should be able to:

plan and prepare an annual organizational budget, including a complete budget for health programs and projects;

develop, implement, and monitor an appropriate accounting system for their health programs and projects;

determine in a timely manner, and forecast with reasonable accuracy, the costs of delivering all primary health care services;
maximize revenues obtained for curative services under a fee-for-services basis, commensurate with equity considerations;

generate sufficient user fees to operate facilities and programs on a sustainable basis when added to other sources of revenue and subsidies;

justify requests for reimbursement from a health insurance system;

obtain, process, and use cost and service demand data to allocate resources in the most cost-efficient manner;

use cost and service demand data to control expenditures and implement cost-containment measures where appropriate; and

implement centralized purchasing of pharmaceuticals and supplies.

INFORMATION SYSTEMS

PUBLIC SECTOR

This sub-component of the Information Systems component will focus on increasing the following capacities of the Palestinian Central Health Authority:

to establish a central information system;

to organize the collection, analysis, storage, retrieval, and dissemination of health data in Gaza and the West Bank;

to standardize data collection and reporting in both the public and private sectors of health;

to obtain and provide accurate, reliable information that can be used in assessing needs as well as effectiveness of health service programs and projects.

By the end of the Project, the Palestinian Central Health Authority should be able to:

operate a central information system;

set standards for the collection and reporting of health data for both the Public Sector and Palestinian NGOs delivering health services;

analyze, store, and retrieve the data obtained;

provide reliable information to those in the central Palestinian public sector authority responsible for planning, policy-making, monitoring, and coordination in the field of health;

design an tentative epidemiologic surveillance system.

NGOs

This sub-component of the Information Systems component will focus on increasing the following capacities of NGOs participating in the Project. By the end of the Project, the participating NGOs should be able to:

collect data in a systematic way, following standard formats;

conduct rapid assessment community surveys;

analyze data needed by their organization in planning and decision-making;

report information to the Central Health Authority's Information Unit, following standardized formats and procedures;

use computers in the storing, retrieval, and analysis of data;

produce an annual health profile of the community the NGO serves.

HEALTH PROMOTION

PUBLIC SECTOR and NGOs

The Health Promotion component will focus on increasing the following capacities of the Palestinian Central Health Authority and the NGOs participating in the Project:

to conduct surveys of the public's health knowledge, attitudes, and practices;

to plan, produce, and disseminate appropriate health promotion and health education materials; and

to evaluate and revise health promotion and education materials.

By the end of the Project, the Palestinian Central Health Authority and the NGOs participating in the Project should be able to:

conduct well-planned and well-administered health surveys;

plan, design, and produce appropriate health promotion and health education materials;

plan and conduct effective health promotion and health education campaigns, utilizing the materials they have produced; and

evaluate and revise health promotion and health education materials and health promotion and health education campaigns.

ANNEX G. LOGICAL FRAMEWORK

LOGICAL FRAMEWORK

Logframe indicators will be revised as necessary by the contract team working in conjunction with USAID staff. For the most part, targets for the indicators cannot be established at this time due to the lack of reliable baseline data. These will be set by month six of the contract, or later in the instance of indicators relying on a DHS for baseline. Explicit criteria for how measurement will be done will need to be established for all those indicators which do not have standard definitions.

Narrative Summary	Objectively Verifiable Indicators (OVIs)	Means of Verification	Critical Assumptions
Goal: Improved Health of Palestinians in the Occupied Territories of West Bank and Gaza	1) IMR 2) CMR 3) MMR	Data Sources: DHS (to be undertaken)	Major epidemics or health-threatening disasters do not occur
Sub-Goal: Increased Use of Quality Family Health Services by Women of Reproductive Age and Children under Five (to be refined)	1) Vaccination coverage 2) Percent of diarrheal disease cases provided with ORS 3) Percent of pregnant women receiving pre-natal care 4) contraceptive prevalence/couple years of protection	DHS, service statistics	Other donors will provide support for infrastructure, commodities, and improved MCH/FP services

Narrative Summary	Objectively Verifiable Indicators (OVIs)	Means of Verification	Critical Assumptions
Purpose: 1) Palestinian self-governing health authority creates and maintains functioning key planning, management, monitoring/evaluation, and health education systems Key Systems perform the following: 1.1 Continuous strategic planning process 1.2 Maintain an adequate stock of drugs and other supplies at health facilities, and maintain equipment 1.3 Health education provided to the public on key PHC topics via health facilities and media	EOPs (end-of-project status): 1.1 periodic plans/revisions of plans, based on accurate cost/revenue data 1.2.1 % facilities (by type) with stock outages 1.2.2 % equipment out of order for more than 4 months 1.3.1 % health facilities providing health education on a systematic basis 1.3.2 Number of media campaigns which address key MCH problems as	Data Sources: Health authority records; project records; sample surveys; audit firm reports	1) Palestinian authority can cover recurrent costs 2) Stability in senior personnel appointments 3) Political and economic climate remain favorable for institutional development

Narrative Summary	Objectively Verifiable Indicators (OVIs)	Means of Verification	Critical Assumptions
	determined by KAP surveys & strategic plan priorities		
1.4 Training system provides quality training on a continuous basis	1.4.1 % of staff rec'd in-service training (by selected type) 1.4.2 % of workshops evaluated/# curricula revised (by selected type)		
1.5 Financial management system produces timely and accurate financial reports and budgets adequately predicated on expected costs and revenues	1.5.1 % financial reports produced on time 1.5.2 % audited and found adequate 1.5.3 # realistic budgets produced in a timely manner		
1.6 Cost and service demand data used to control expenditures and implement cost-containment measures	1.6 # cost containment measures/$$ saved		
1.7 Reliable health data provided to decision-makers	1.7.1 % PHC clinics reporting timely & reliable statistics 1.7.2 # reports produced		
1.8 Personnel system recruits and monitors qualified personnel	1.8.1 % PHC clinics understaffed 1.8.2 % personnel whose qualifications fit job description		

Narrative Summary	Objectively Verifiable Indicators (OVIs)	Means of Verification	Critical Assumptions
1.9 Clinics monitored for compliance w/ quality assurance standard	1.9 % facilities routinely monitored/% of those monitored taking corrective action		
1.10 Cost & service demand data used to allocate resources in a cost-efficient manner	1.10 Analysis of changes in resource patterns (criteria TBD)		
1.11 Cost recovery system (insurance scheme, etc) takes account of actual costs	1.11 % of costs recovered (?)		

Narrative Summary	Objectively Verifiable Indicators (OVIs)	Means of Verification	Critical Assumptions
Purpose continued: 2) Selected Palestinian NGOs engaged in primary health care at the community level institute and maintain improved planning, management, monitoring/evaluation, and health education systems NGOs perform the following functions: 2.1 Continuous strategic planning process 2.2 Financial management system produces timely and accurate financial reports and budgets adequately predicated on expected costs and revenues 2.3 Cost and service demand data used to control expenditures and implement cost	2.1.2 Mission statements & periodic strategic plans based on realistic cost/revenue data and service demand 2.1.2 Annual work plans 2.2.1 % financial reports produced on time 2.2.2 % audited and found adequate 2.2.3 % of reimbursement requests rejected by health insurance scheme 2.2.4 # realistic budgets produced in a timely manner	Data Sources: NGO records; project records; audit firm reports; sample surveys	

Narrative Summary	Objectively Verifiable Indicators (OVIs)	Means of Verification	Critical Assumptions
2.4 Cost & service demand data used to allocate resources in a cost-efficient manner	2.4 Analysis of changes in resource allocation patterns (criteria TBD) or % facilities over/under staffed based on demand		
2.5 User fees cover an increasing proportion of costs	2.5 % of costs covered by fees		
2.6 Health education conducted on key health problems	2.6 % clinics (by NGO) conducting		
2.7 Reliable health data produced in timely fashion, according to procedures, for central health authority	2.7 % of reliable reports submitted on time		
2.8 implement centralized purchasing of pharmaceuticals and supplies.			

Narrative Summary	Objectively Verifiable Indicators (OVIs)	Means of Verification	Critical Assumptions
Outputs: 1. Self-Governing Health Authority: 1.a #s trained by skill 1.b # workshops/days training 1.c # training curricula/materials 1.d Integrated Central Information System 1.e Computerized service statistics system 1.f Reporting standards 1.g Tentative design of epidemiological survey system 1.h Personnel policies 1.i Computerized personnel records 1.j Procurement policies 1.k Procurement records computerized 1.l Computerized financial management system 1.m Accounting procedures 1.n Financial reporting standards 1.o Cost Analyses	595 trained 24 workshops 30 study tours		Palestinian entities will elect to participate; project will be effectively managed by USAID and the contractor; security concerns will not hold up the timely provision of inputs

Narrative Summary	Objectively Verifiable Indicators (OVIs)	Means of Verification	Critical Assumptions
1.p Equipment maintenance system & protocol for PHC & essential diagnostic equipm.			
1.q Computerized logistics system 1.r Logistics management procedures			
1.s PHC health educ. materials	4 media productions; 2 sets educational materials		
1.t Coordination plan/mechanisms			
1.u Quality Assurance standard 1.v clinical supervisory system			
1.w Studies (DHS, Census, KAP, evaluation)	1 DHS; 3 KAP; 11 other studies		

Narrative Summary	Objectively Verifiable Indicators (OVIs)	Means of Verification	Critical Assumptions
2. NGOs 1.a #s trained by skill 1.b # workshops/days training 1.c # training curricula/materials	405 trained 24 workshops		
1.d Computerized financial management system 1.e Accounting procedures 1.f Financial reporting standards 1.g Cost Analyses			
1.h Community surveys 1.i Annual community health profile 1.j program & project evaluations	50 rapid assessments		
1.k grant proposals submitted 1.l # PHC projects 1.m # organizational policies instituted			
1.n PHC health educ. materials 1.o Quality Assurance standard 1.p clinical supervisory system	1.k 50 proposals submitted by 25 NGOs 50 implemented		

Narrative Summary	Objectively Verifiable Indicators (OVIs)	Means of Verification	Critical Assumptions
Inputs: Long Term TA 30 work years Short Term TA 156 work months Training Workshops 48 workshops funded Training Tours 30 tours funded Studies 15 studies funded NGO Grants 50 grants funded Commodities funded @ $1.2 M Other Costs funded @ $7.2 M	Inputs: see left hand column; PP budget	Data Sources: Project records	

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ANNEX H. JOB DESCRIPTIONS OF KEY PERSONNEL

There are six key personnel to be employed in the PHSS Project: a Senior Management Specialist (Chief of Party), a Health Financing Specialist, a Health Promotion Specialist, an Information Systems Specialist, an Accounting Specialist, and a Grants Management Coordinator. A brief job description for each position follows; each job description is divided into two sections, Responsibilities and Qualifications.

SENIOR MANAGEMENT SPECIALIST (CHIEF of PARTY)

Responsibilities

The Senior Management Specialist will be responsible for:

overseeing establishment of the Project office;

overseeing management of the Project office and staff;

coordinating delivery of all goods and services by the contractor;

establishing a professional working relationship with the new Palestinian central health authority and the NGOs participating in the Project;

providing technical assistance to the Palestinian central health authority and NGOs participating in the Project in such areas as:

strategic planning,
policy-making,
coordination,
monitoring and evaluation,
standard setting,
quality assurance,
logistics management,
personnel management,
supervision,
organizing,
leadership,
governing/Board development (in NGOs).

Qualifications

The Senior Management Specialist must meet the following qualifications requirements:

hold an earned doctorate in a relevant field of Public Health management;

have a minimum of ten years of experience in national health care and management in the Third World;

have demonstrated effective leadership skills in health program direction.

It would be <u>desirable</u> for the Senior Management Specialist to have the following qualifications:

hold an M.D. degree;

have previous health care and management experience in the Middle East;

be proficient in written and spoken Arabic.

HEALTH FINANCING SPECIALIST

<u>Responsibilities</u>

The Health Finances Specialist will be responsible for:

establishing a professional working relationship with the new Palestinian central health authority and the NGOs participating in the Project;

providing technical assistance to the Palestinian central health authority and NGOs participating in the Project in such areas as:

financial planning and budgeting,
patient user fee setting,
health insurance plans,
accounting and bookkeeping,
financial oversight,
cost analysis,
cost containment,
financial reporting,
use of computers and computer software.

<u>Qualifications</u>

The Health Financing Specialist <u>must</u> meet the following qualifications requirements:

hold an earned doctorate in a field related to health care financing or its equivalent;

have a minimum of five years of experience in national health finance in the Third World.

It would be desirable for the Health Finances Specialist to have the following qualifications:

have previous experience in health finance and management in the Middle East;

be proficient in written and spoken Arabic.

HEALTH PROMOTION SPECIALIST

Responsibilities

The Health Promotion Specialist will be responsible for:

establishing a professional working relationship with the new Palestinian central health authority and the NGOs participating in the Project;

providing technical assistance to the Palestinian central health authority and NGOs participating in the Project in such areas as:

the IEC process;
production of health promotion materials;
use of media---both print and electronic.

Qualifications

The Health Promotion Specialist must meet the following qualifications requirements:

hold a master's degree in a field related to health promotion;

have a minimum of five years of experience in health promotion in the Third World.

It would be desirable for the Health Promotion Specialist to have the following qualifications:

have previous experience in health promotion in the Middle East;

be proficient in written and spoken Arabic.

INFORMATION SPECIALIST (Local Hire)

Responsibilities

The Information Specialist will be responsible for:

establishing a professional working relationship with the new Palestinian central health authority and the NGOs participating in the Project;

providing technical assistance to the Palestinian central health authority and NGOs participating in the Project in:

designing and establishing their respective information systems;

installing computer hardware and software for the information systems;

training personnel in the use of the information systems.

Qualifications

The Information Specialist must meet the following qualifications requirements:

hold a master's degree level of training in Public Health;

be familiar with MIS for the health sector;

have demonstrated expertise in application of computer technology to a health information system;

have a minimum of two years of experience in information systems.

ACCOUNTING SPECIALIST (Local Hire)

Responsibilities

The Accounting Specialist will be responsible for:

providing technical assistance to the Palestinian central health authority and NGOs participating in the Project in:

standard bookkeeping and accounting practices;

use of standard accounting computer software.

Qualifications

The Accounting Specialist must meet the following qualifications requirements:

hold a bachelor's degree in Accounting;

be thoroughly familiar with standard, internationally accepted accounting standards and practices, including cost accounting techniques;

be able to use a variety of standard accounting computer software packages;

have two years of expedience in accounting.

GRANTS MANAGEMENT OFFICER (Local Hire)

Responsibilities

The Grants Management Officer will be responsible for:

providing technical assistance to the NGOs participating in the Project in:

proposal preparation and submission;

selection, planning, and implementation of projects;

project management and monitoring.

overseeing projects for which grants have been awarded.

Qualifications

The Grants Management Officer must meet the following qualifications requirements:

hold a master's degree in Public Health;

have two years of experience in the health sector.

ANNEX I NOTES ON BUDGET AND COSTS

A. SUMMARY BUDGET NOTES

1) An inflation rate of 5% is built into salaries, training and short-term TA costs, office running costs, NGO grants, backstop costs, and travel (i.e., not on most commodities because cost estimates are only indicative).

2) All training costs are based on in-country training by a team of 3 specialists. The unit cost per course is assumed to average $20,000/week and includes all trainer, facility, and participant costs.

3) Computer hardware will be supplied to 25 NGOs for financial management and data analysis, to 2 Central Authority offices for financial management, and to 7 Central Authority offices for data management (including 5 portables for field data collection). Average hardware costs are estimated to cover an up-to-date desk top or lap top computer and a laser printer. Software would include a basic applications suite plus an accounting package or a statistical package. Costs are estimated using the assumption that some software could be licensed to several sites for less than the cost of multiple copies. Hardware maintenance contract costs are based on 10% of equipment costs for 2 years.

4) Project office equipment includes 9 desk top computers and software packages, 2 printers, 1 photocopier, 1 fax machine, 1 overhead projector, and 2 lap top computers.

5) Central Authority and NGO office equipment (furnished along with computers) includes photocopiers, overhead projectors and fax machines.

6) The cost of an IEC materials production facility is a crude estimate and will have to be verified.

7) The cost of special studies includes salaries for approximately 15 field data enumerators for 4 months and 4 months of professional data analysis and report preparation.

8) Form printing costs include all requirements for establishing and operating the financial management and MIS systems.

9) Project office running costs include salaries and benefits for 2 secretaries, one administrative assistant, one accountant and 3 drivers, plus office rent, utilities, vehicle operating costs, etc.

10) Contractor's direct backstop costs are based on 4 months time each for an executive director, a project manager, secretary, and administrator, plus operating costs.

11) Travel for in-country project staff includes 2 overseas trips per year per expatriate staff member.

12) IEC production costs are rough estimates and need to be verified.

13) Study tours are to study health insurance systems (20 tours) and management information systems (10 tours) in the region or Europe, and include travel and per diem costs for one staff member and two national staff for one week each.

B. Associated Project Office Costs (in the field)

1) Expatriate Resident Advisors

- 1 Health Management/Planning Specialist
  5 person years
- 1 Cost Accounting/Health Financing Specialist
  5 person years
- 1 Health Promotion/IEC Specialist
  4.5 person years

2) Host Country Professional Staff

- 1 Financial Management Specialist
  5 person years @ $30,000/yr.
- 1 Data Collection/Statistics Analyst
  5 person years @ $30,000/yr.
- 1 Grants Manager
  5 person years @ $30,000/yr.

3) Host Country Support Staff

- 1 Administrative Assistant
  5 person years @ $20,000
- 1 Accountant
  5 person years @ $20,000
- 1 Secretary
  5 person years @ $20,000
- 2 Drivers
  5 person years @ $20,000 x 2

4) In-Country Travel
   $5,000/year x 5 years

5) Office Rental
   $32,000/yr x 5 years

6) Office Utilities
   $6,800/yr x 5 years

7) Office Furniture
$12,000

8) Equipment (computers, copiers, etc)
$45,000

9) Vehicles (duty free)
3 vehicles @ $25,000 each

10) Expendable Supplies
$5,0000/year x 5 years

11) Other costs
$23,000

C. Assumptions by Project Component

1) Health Sector Manangement Component

Public Sector Subcomponent:

(a) Long-Term Technical Assistance:

66% time of senior, full time resident specialist x 5 years

(b) Short-Term Technical Assistance:

6 pm/yr x 5 years

(c) Technical Assistance Support:

50% of in-country project office costs attributed to this component

(d) In-Country Training:

12 one-week courses (20 persons/course)

(e) Other:

5 quality assurance studies at an average cost of about $50,000 each

NGO Subcomponent:

(a) Long-Term Technical Assistance:

33% time of senior, full-time resident specialist x 5 years

(b) Short-Term Technical Assistance:

5 pm/year x 3 years
3 pm/year x 2 years

(c) Technical Assistance Support:

50% of in-country project office costs attributed to this sub-component

(d) In-Country Training:

3 two-week courses (25 persons/course)
3 Board/CEO Workshops (25 persons/workshop)

(e) Other Costs:

NGO small grants program (generally averaging around $25,000 or less each)

2. <u>Financial Administration/Management Component</u>

<u>Public Sector Sub-Component</u>:

(a) Long-Term Technical Assistance:

66% time of full-time, resident specialist x 5 years

(b) Short-Term Technical Assistance:

6 pm/year x 4 years

(c) Training:

20 persons sent on study tours

(d) Commodities:

2 computer/software packages

(e) Other:

Three pricing studies at an average cost of about $30,000 each

<u>NGO Sub-Component</u>:

(a) Long-Term Technical Assistance:

33% time of full-time, resident specialist x 5 years

(b) Short-Term Technical Assistance:

A total of 16 pm over a 5 year period

(c) In-Country Training:

Two two-week courses/year x 5 years (15 persons per course)

(d) Commodities:

25 sets of computer packages, faxes, photo-copiers and printers at an average cost of about $14,000/set.

(e) Other:

Equipment service costs
printing of data-entry forms

3. Information Systems Component:

Public Sector Sub-Component:

(a) Long-Term Technical Assistance:

%50 time of full-time, host-country professional

(b) Short-Term Technical Assistance:

12 pm/year x 5 years

(c) In-Country Training:

Two one-week courses/year x 5 years (20 persons per course)

(d) Commodities:

Two computer/software packages
Five laptop computers

(e) Other Costs:

One national level demographic/health household survey

Printing of data-entry forms

NGO Sub-Component:

(a) Long-Term Technical Assistance:

%50 time of resident, host-country professional

(b) Short-Term Technical Assistance:

3 pm/yr x 5 years

(c) In-Training:

One two-week course/year x 4 years (15 persons per course)

(d) Commodities:

25 software only packages at an average cost of $1,000 each

(e) Other:

25 mini-community surveys x 2 times a year x 5 years (at an average cost of about $5,000 each)

4. <u>Health Promotion Component</u>:

(a) Long-Term Technical Assistance:

100% time of resident, long-term specialist x 5 years

(b) Short-Term Technical Assistance:

3 pm/year x 5 years

(c) In-Country Training:

4 one-week courses (15 persons/course)
5 two-week courses (20 persons/course)

(d) Other Costs:

2 multi-community KAP surveys
printing of health education/promotional materials
limited media production costs