Transitional Development Within Shifting Spheres of Conflict:  
The Union of Palestinian Medical Relief Committee  

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Submitted to the Department of Urban Studies and Planning  
in partial fulfillment of the requirements for the degree of  

Master in City Planning  

at the  

MASSACHUSETTS INSTITUTE OF TECHNOLOGY  

September 2009  
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ABSTRACT

This thesis examines how an NGO can function and create change within the shifting domains of Palestinian stability and conflict through the case study of the Union of Palestinian Medical Relief Committee (UPMRC). Palestinian society today heavily relies on NGO’s for an array of service provisions. However, Palestinian NGO’s continue to face various challenges since their inception. The long history of Israeli occupation has forced NGO’s to focus their efforts on relief work and caused them to negate long term development issues. This has also led to a very fragmented NGO sector in Palestine. The creation of the Palestinian National Authority (PNA) in 1994 brought with it further impediments to the NGO sector in Palestine. The authoritarian political nature of the PNA meant that a number of NGO’s were marginalized from the national development agenda. The shift of international aid during this period from NGO’s to the Palestinian government led to a decline in NGO funds. As a result of these factors, and despite the plethora of NGO’s in Palestine, many of the NGO’s have failed to promote sustainable development. An exception to the overall picture of NGO’s in Palestine is the UPMRC. Despite facing similar challenges as the rest of the NGO sector, the UPMRC has been successful in fostering its grassroots ties, implementing effective development projects, building horizontal linkages with other NGO’s, as well as creating vertical linkages with the PNA and influencing national policy. The success of the UPMRC has significant implications for other NGO’s in Palestine as well as NGO’s in other post-conflict areas.

Thesis Supervisor: Diane E. Davis
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Acknowledgments

I am grateful to a countless number of people who provided me with support and encouragement throughout the preparation of this thesis.

First of all, I would like to thank the members of my committee, Professor Diane Davis from MIT and Professor Amany Jamal from Princeton University for their invaluable insight and guidance on the subject matter. In addition, I am grateful to have had the opportunity to study with Professor Judith Tendler, whose work has greatly influenced my thinking and the analysis presented in this thesis.

This thesis would not have been possible without the interviews and time graciously offered to me by the members of the Union of Palestinian Medical Relief. I am also grateful to Nabil Dowaikat for providing me with valuable contacts in order to conduct my research. A special thank you to the various residents of many of the villages in Palestine for allowing me into their homes and for taking the time to speak with me.

On a personal note, I am extremely grateful to all my friends, and in particular my best friend Matthew Totillo for his undying encouragement throughout the process. I am also thankful to Debbie Mullin for pushing me to believe in myself. Finally, I would like to thank my parents for their continuous support of my goals and education.
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<tr>
<td>CARE</td>
<td>Cooperative for American Relief Everywhere</td>
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<td>CBR</td>
<td>Community-Based Rehabilitation Program</td>
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<td>FFW</td>
<td>Food-For-Work Program</td>
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<td>HDIP</td>
<td>Health, Development, Information, and Policy Institute</td>
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<td>IMA</td>
<td>Israeli Medical Association</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>NGO</td>
<td>Non-governmental Organization</td>
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<td>OCHA</td>
<td>Office for the Coordination of Humanitarian Affairs</td>
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<tr>
<td>US PATRIOT Act</td>
<td>Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act</td>
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<tr>
<td>PCBS</td>
<td>Palestinian Central Bureau of Statistics (PCBS)</td>
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<td>PCP</td>
<td>Palestine Communist Party</td>
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<td>PECDAR</td>
<td>Palestinian Economic Council for Development and Reconstruction</td>
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<td>PFLP</td>
<td>Popular Front for the Liberation of Palestine</td>
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<td>PLC</td>
<td>Palestinian Legislative Council</td>
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<td>PLO</td>
<td>Palestine Liberation Organization</td>
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<td>PNA</td>
<td>Palestinian National Authority</td>
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<td>PNGO</td>
<td>Palestinian NGO Network</td>
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<td>UNRWA</td>
<td>United Nations Relief and Works Agency for Palestinian Refugees in the Near East</td>
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<td>UPMRC</td>
<td>Union of Palestinian Medical Relief Committee</td>
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<tr>
<td>USAID</td>
<td>The United States Agency for International Development</td>
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<td>WFP</td>
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Chapter 1: Introduction & Methodology

The Palestinian society relies heavily on NGO’s in providing services, institution building, and promoting development. Palestinian NGO’s, which began mainly as welfare organizations in the 1920’s and 1930’s, developed into a full-blown sector following the Israeli occupation of the West Bank and Gaza in 1967, and continued to grow following the arrival of the Palestinian National Authority (PNA) in 1993 (Brynen, 2000).

Prior to the establishment of the Palestinian National Authority (PNA) in 1993, the West Bank and Gaza Strip had the political space necessary for the emergence of a strong network of NGO’s both despite and because of the Israeli occupation (Hamami, 2000). Years of Israeli occupation, roadblocks, and closures have led to the continuous economic and social decline in Palestine. The lack of a sovereign Palestinian government meant that charitable organizations and grassroots movements had to provide an array of services to the Palestinian society. By the early 1990’s there were around 1,200-1,500 NGO’s employing around 20,000 to 30,000 people (Sullivan, 1996).

While the creation of the PNA in 1993 brought with it tremendous hope for the Palestinian state, it soon became clear that the PNA lacked the tools and experience necessary to address many of the fundamental issues for the development of Palestine. This meant that NGO’s in Palestine had to remain the main service providers in the development process. Palestinian NGO’s today still provide the majority of the services in the West Bank from health care, education, agriculture, housing assistance, human rights, and legal aid (Sullivan, 1996). Therefore, the experience of NGO’s in Palestine has critical implications for the future of the Palestinian state as well as post-conflict reconstruction.
While an earlier debate envisioned that Palestinian NGO’s would serve as an alternative to the inadequate PNA, many of the NGO’s later came under criticism for being corrupt, elitist, and detached from the local communities needs. International aid agendas that accompanied the funding during the Post-Oslo period imposed western models of development that negated the local needs. Furthermore, the authoritarian nature of the PNA created a hostile relationship between the NGO’s and the PNA (Habasch, 1999). The PNA, in its attempt to maintain political control, drafted an associational law that aimed to monitor and control the NGO’s in Palestine. In addition, the international aid agencies shifted their funding from the NGO’s to the PNA.

The shift in funding to the PNA and its hostile relationship to the NGO’s, combined with the international aid agendas and restrictions, made it extremely difficult for the local NGO’s to influence national policy and development efforts. Furthermore, the absence of local community development from the international aid projects left little room for the local NGO’s to build trust at the local level and promote community development. However, while a large number of NGO’s in Palestine have been critiqued for their inability to address development needs, the Union of Palestinian Medical Relief Committee (UPMRC), a healthcare NGO, presents a different story for the NGO’s in Palestine.

The UPMRC, which is headed by Dr. Mustafa Barghouti and has been affiliated with the communist party, stands as a success story amongst the NGO’s in Palestine. Despite facing similar challenges as the rest of the NGO sector, the UPMRC has been successful in fostering its grassroots ties, which later allowed it to build horizontal linkages with other NGO’s, as well as create vertical linkages with the PNA despite their political differences. The ability of the UPMRC to answer to the local needs, while at the same time work at the national arena,
illustrates the importance of grassroots empowerment and the relationship between civil society and the State in post-conflict development.

The UPMRC began as a group of volunteer doctors who came together in April 1979 when the City of Hebron underwent severe Israeli closures. For over a month, the residents of Hebron underwent a strict curfew and were not allowed to enter or exit the city. Twenty doctors and nurses from Jerusalem saw the need for urgent relief efforts, gathered medicine and equipments, and drove to Hebron, forming the first informal mobile clinic. Over the years, the UPMRC expanded its services to different areas and received its first official funding in 1983. The UPMRC continued to grow in its networks and structures according to the expanding needs of the Palestinian people and in response to various historical moments of the Israeli occupation. In 1996, the UPMRC was a key player in the establishment of the Palestinian NGO network (PNGO’s), and taking a leading role in coordinating the health network as well as influencing national policy.

Throughout its work, and particularly during the post Oslo period, the UPMRC had faced similar challenges as other NGO’s in Palestine. These challenges included: International aid restrictions, fragmentation within the NGO’s, and the formation of the PNA. However, despite these challenges, the UPMRC managed to shift from being a relief agent to a development agent, and to play a critical role on the national policy level. The success of the UPMRC in its developmental efforts lies in its ability to negotiate its position between being a grassroots player at the community level, establishing horizontal linkages with other NGO’s, and working with the State at the top-down level. Thus, by creating alternative development projects, building cooperation with other NGO’s, and reaching out to the PNA, the UPMRC became a key player in the development efforts in Palestine.
But how and why was the UPMRC able to negotiate its various linkages in its development process? And what are the ways in which it operated differently from other NGO’s?

This thesis examines the factors that led to the success of the UPMRC in its developmental efforts in order to provide a case study for how an NGO can function and create change within the shifting domains of instability and conflict. The thesis illustrates how the unintended consequences of the Israeli occupation led to the strengthening of the UPMRC grassroots links, while the ability of the UPMRC to recognize and attain the opportunities within the political challenges during the Post-Oslo period allowed it to expand its linkages and projects and become a key agent of development. Furthermore, the fact that the UPMRC is a health provider meant its mission to provide relief made it more possible for the organization to supersede constraining political agendas and local politics, for it had to provide health care to Palestinian residents regardless of their political affiliations. Thus, while Palestinian NGO’s have been criticized for abandoning their political mobilization work, it is precisely the fact that the UPMRC remained politically neutral that allowed it to play a significant role in development.

In order to examine the exceptions and successes of the UPMRC, it is critical to understand the history and critique of the NGO sector in Palestine, and the various factors that impacted its formation.

1.1 Background

1.1.1 The Growth of Palestinian NGO’s

A number of factors played a role in the growth of the NGO’s sector in Palestine over the last few decades: One, the increase of the Palestinian income and education in the 1970’s led to the increase of the middle class and professional, political, and student groups. Two, while Israel
has continuously attempted to weaken the Palestinian groups, especially those linked to the nationalists movement, it is precisely the increase of Israeli occupation that had encouraged community organizing and the strengthening of NGO’s in service provision. Three, the consistent increase of the channeling of foreign aid into the NGO’s played a major role in their growth, where the funding reached $140 million to $220 million in the early 1990’s (Brynen, 2000).

However, while a plethora of NGO’s emerged over the years, the historical political foundation of the NGO’s formation and their need to respond to the Israeli occupation, combined with the fragmentation of aid channels, meant growing contradiction within the NGO’s structures: One, the NGO’s had to navigate their work between political mobilization and grassroots development; two, the structures of the NGO’s needed to be defined as either party hierarchy, professional staff, or community participation; three, the funding had to be politically driven, donor money, or for community support (Hammami, 1995). These paradoxes within the different organizations led to the emergence of a fragmented and duplicated NGO sector.

1.1.2 Fragmentation and Duplication of the NGO Services

Political Fragmentation

“The majority of [Palestinian] NGO’s had their roots in the PLO’s mass mobilization or national front strategy, which emerged following the 1977 Camp David Accords” (Hammami, 2000, p.16). During the earlier years grassroots movements were made up of “non-factional” groups that focused on national resistance and self help, but by the late 1970’s, most of the movements were formed into faction based organizations.
The institutionalization of these organizations began once they became factionalized and funding became available (Hammami, 2000). The political Palestinian spectrum that made up the factional groups can be categorized into three main political parties:

- **Fateh**: Being the largest Palestinian nationalist organization, Fateh has dominated the Palestinian Liberation Organization (PLO). The majority of the Fateh leadership has supported the Madrid Peace Process and the Oslo Accords.

- **The Left**: Made up mainly of the Popular Front for the Liberation of Palestine (PFLP), the Democratic Front for the Liberation of Palestine (DFLP), the Palestinian Democratic Union (FIDA), and the Palestinian People’s Party (PPP, formerly the Palestinian Communist Party). The left has been critical of the peace process and the PNA.

- **The Islamists**: The Islamists movements, Hamas and Islamic Jihad emerged in the late 1980’s as the opposition to Fateh and the nationalist mainstream. Hamas has been heavily involved in providing social services, such as educational and health in both the West Bank and Gaza.

  During the early 1980’s, the PLO funded the Fatah organizations, while the left parties began forming alliances with the European donors in order to subsidize their factional funding (Hammimi, 2000). The Islamist NGO’s, on the other hand, raised most of their funding locally (Brynen, 2000). Thus, the internal divisions within the political national movements led each faction to have its own NGO’s, and as a result a large number of NGOs providing duplicate services.

*Fragmentation of International Aid Agencies*

The fragmentation of international aid creates coordination problems and high overhead costs for both recipient and the donors (Easterly, 2008). The challenge of fragmentation amongst
the international agencies is apparent in the Palestinian case. According to the world Bank, there 
are more than forty donors, more than twenty four multi-lateral organization and UN agencies, as 
well as hundreds of local and international NGO’s taking part in the development efforts of the 
Palestinian territories. This has led to the mobilization of “excessive human resources” and 
resulted in “more fragmentation than cooperation” (Giacamani, 2003, p.64) amongst the 
international aid in Palestine. The fragmentation of international aid in Palestine also led to the 
duplication of NGO’s operating within the same sector.

The political factionalism and international aid fragmentation that impacted the efficacy of NGO’s in Palestine also led to a fragmented and uncoordinated healthcare sector.

1.1.3 Fragmentation of Healthcare Services

The healthcare NGO’s, having developed from competition among nationalist secular parties, resulted in a fragmented health system where a number of healthcare providers worked without coordinating their services. The non-governmental sector in Palestine is made up of charitable organizations and the health committees (Habasch, 1999). Healthcare committees that emerged in the 1970’ and 80’s in Palestine are associated with four major political factions: Fatah, the PFLP, the DFLP, and the PCP (Giacaman, 1997). While the charitable organizations focus their work in the urban areas, the health committees view health as “the outcome of a combination of economic, social and political factors and therefore can only be understood in its socio-economic context” (Habasch, 1999, p.20) and focus their work on promoting health and development within the rural areas. The presence of various health committees, organizations, and services led to a fragmented healthcare system that failed to address the marginalized communities, and was concentrated in the urban areas.
Furthermore, as a result of the need for immediate assistance to the vulnerable communities and in response to the Israeli occupation, relief and emergency, instead of long term development goals, became the priority for most of the health care providers and NGO’s. The focus on relief and emergency meant limited impact as well as duplicated effort amongst the healthcare providers (Mataria-Moatti, 2009). Thus, in making access to health care strenuous, the Israeli occupation caused many of the NGO’s to focus their efforts on emergency relief and limited their capacity for long-term goals towards a more cohesive healthcare system.

However, in 1996, the UPMRC began mitigating these services and established a strong network of Palestinian NGO’s in general, and healthcare services in particular. Furthermore, although the focus of the health NGO has been on emergency relief, the UPMRC began designing projects that combine both relief and development.

1.1.4 Relief, Development, and Grassroots

While the mainstream discourse of post-conflict rebuilding tends to view relief and development as either/or practices, given the high aid budget spent on emergencies, which can divert the funds from local institutions and create less responsive practices to developmental needs, and because it is misleading to think of relief and development as a linear process of reconstruction (Smith & Maxwell, 1994), it is important that relief efforts promote people-centered development (Duffield, 1997).

Conflict settings similar to the Palestinian case require the restructuring of external policies in order to develop civil society, and create a process of “rehabilitation” (Pugh, 1998). Pugh defines rehabilitation as “a process of social, political, and economic adjustment to, and underpinning of, conditions of relative peace in which the participants, especially those who have been disempowered and immiserated by violence, can begin to prioritize future goals.
beyond immediate survival” (Pugh, 1998). Successful rehabilitation projects are contingent upon including both relief and development principle: Building relations and working with the local institutions, involving the local population and understating its needs, and linking the rehabilitation projects with existing ones (Smith & Maxwell, 1994).

However, often in post conflict reconstruction, external actors assume the power role of promoting development and reconstruction without allowing the local actors to control their destiny. Reshaping aid external policies is essential to developing society and improving accountability so that more power is granted to the local communities in the rebuilding of post-conflict areas. As Michael Pugh argues:

There is overwhelming evidence from many sources that external actors should act on the presumption that using grass roots knowledge and expertise and the building of local capacity for non-violent survival strategies is likely to be more effective in underpinning transitions to relative peace than in developing a blueprint designed in western capital (Pugh, 1998, p3).

International aid agencies operating in post conflict countries however, do not promote such strategies. Almost all of the international aid projects are politically motivated and driven by agendas that are particular to each agency. Aid and development efforts in conflict setting are often “conditioned by the perceived national and international interests of Western governments” (Duffield, 1997). In addition, within the projects funded by the international community in post-conflict areas, there are very few that promote the developments of local communities, and instead most focus on large-scale programs that are “visible reconstruction programmes.”

Just like the ideas of relief and development have become more blurred, the assumption that states either exist in conflict or post conflict settings is flawed. As in the case of Bosnia in the 1990’s, it was not in a developmental state, but rather ‘in transition from aid to something else that is not traditional development’ (Pugh, 1998). The same argument applies to the case of the West Bank. The belief that NGO’s in Palestine need to either provide relief aid or take part
of a developmental agenda is in contradiction with the reality on the ground. Palestine is going through a process of transition, and developmental efforts, whether by the government, the international community, or the local NGO’s need to take its uncertain transitional state into consideration.

The UPMRC projects fall on the blurred line between relief and development, and fit within the rehabilitation framework more than the Western development discourse. Recognizing the importance of local actors and capacity building in long term development goals, the UPMRC expanded its health projects in the rural areas to adopt similar models of rehabilitation. Despite facing similar international aid agendas as other NGO’s, the UPMRC was successful in promoting projects that answer to the local needs of the population and provide both relief and development.

A number of the UPMRC small projects aim at providing relief to the underprivileged communities and at the same time promote capacity building and local resources. The UPMRC places the local community at the center of their projects, and views community empowerment as a key element in the development of Palestinian society. Why has the UPMRC been more successful in its rehabilitation efforts than other NGO’s despite facing similar international agendas?

Furthermore, one of the central critiques of the NGO sector in Palestine has been around the fact that NGO’s in Palestine have shifted from being grassroots mobilizers and relief agents to “developmental agents,” in order to accommodate the democratic Western agenda of international aid. As a result, a number of NGO’s failed to establish strong ties with the local communities at the grassroots level. The international agencies that fund NGO’s mainly focus on the economic and physical infrastructures during post conflict reconstruction (Pouligny, 2005). The focus of the NGO’s and the international community on immediate rebuilding and democratization negates the truth that economic, physical, and institutional infrastructures are
not the only foundations that are destroyed during conflict. “Trust, hope, identity, family, and social ties” are also vital foundations that get destroyed during wars. In order to rebuild such foundations, more emphasis needs to be placed on the grassroots communities (Pouligny, 2005).

Unlike most of the NGO’s in Palestine, the UPMRC continued to focus on service provisions in grassroots communities despite the international aid agendas. As a result of the Israeli restrictions, the UPMRC had to prioritize the local actors in the marginalized communities in order to ensure the availability of health services in the rural areas. The UPMRC began training and hiring local doctors to meet the urgent needs of the local population. This allowed for the UPMRC to build strong grassroots networks and empower the local actors to take part in the development efforts.

1.1.5 The State and Civil Society

Non-governmental agencies play a major role in the development of war-torn societies and countries, both locally and internationally. The creation of NGO’s in these areas is considered part of the democratization process. With many of the states in post conflict countries being weak or new, the NGO’s take on the role of pushing the state in assuming its responsibility of democratic elections, the rule of law, and human rights. In the 1990’s civil society was seen as an alternative sphere to failing or authoritarian state structures, and the NGO’s served as alternative agents of developments to the state. But can there be separation from civil society and the State in the rebuilding of conflict settings? Or is the negotiation between state and civil organizations necessary for cohesive development?

Furthermore, in the 1980’s donor funding policies shifted the focus from governmental support to the private sector and NGO’s, which reflected a shift in the support for large-scale developments to smaller projects. The move towards supporting the NGO’s sector was a way for donors to distance themselves from authoritarian and repressive governments, and create a new
partnership (Duffield, 1997). This shift in policy is evident in the case of Ethiopia where international donors contracted out their aid programs to NGO’s, while at the same time, the State’s capacity was on the decline. This resulted in the NGO’s having influence at the policy and operational level (Duffield, 1997).

The Palestinian case provides a very different picture from the donor’s policies of the 1980’s. With the creation of the PNA in 1993, most of the international funding shifted its focus from the NGO’s and the private sector to the Palestinian Authority. The reason for this is the interest of the International community in the Israeli-Palestinian peace process. By supporting the PNA, the international community hoped to play a role in sustaining the peace negotiations. The shift of funding to the PNA meant a decrease in the funding for the NGO’s, including the UPMRC. This led the UPMRC to close a number of its clinic during the Post-Oslo period.

Furthermore, the PNA attempted to marginalize NGO’s that are not in political agreement with its rule by creating an associational law, which would aim to monitor and control the activities of the NGO sector. This built a hostile relationship between a large number of the NGO’s and the PNA. As a result, the NGO’s had little room to exert influence on the national development front.

Although most of the NGO’s stood in opposition to the PNA, the UPMRC saw this as an opportunity to both collaborate with the PNA on the national health agenda as well as challenge its national policies and NGO law. The shifts of international politics, and the hostility of the PNA towards the NGO’s pushed the UPMRC to build its alliance with other NGO’s and approach the PNA for collaborative efforts instead of merely serving as an alternative agent of development. Recognizing the need for a strong NGO network in order to exert such influence,
the UPMRC was a key player in establishing the Palestinian NGO network (PNGO’s) (Habasch, 1999).

The historical grassroots linkages of the UPMRC placed it in a very strategic position within other NGO’s as well as with the PNA. One, the pre-established linkages of the UPMRC with local actors over the years allowed it to expand its relationships to create a Palestinian NGO network. And two, the extensive knowledge of the UPMRC of Palestinian health needs in the rural communities made it as an asset to the fledgling governmental health system. Thus, the PNA needed the UPMRC in order to manage the health system in Palestine. As a result, the coordination efforts with other NGO’s and the PNA meant more cohesive health services in the West Bank.

Furthermore, by establishing a strong NGO network, while continuing to work with the PNA, the UPMRC was a key player in pressuring the PNA into changing the NGO law from being an authoritarian oppressive law into one of the most liberal NGO laws in the Middle East. By navigating its various relationships with government members and international actors, the UPMRC led the NGO’s into challenging the PNA and its authoritarian rule.

The Israeli occupation, which aimed at destroying Palestinian infrastructures and isolating the marginalized communities, is precisely what led to the unintended consequences of strengthening the UPMRC’s grassroots ties. Furthermore, the shift of the international and local politics during the post-Oslo period, which negatively impacted the NGO’s in Palestine, pushed the UPMRC to establish horizontal linkages with other NGO’s in order to challenge the PNA as well as the international community. The establishment of the horizontal linkages by the UPMRC granted it a very strategic position in influencing national policy and the international community. Thus, while the formation of the UPMRC was historically a form of political
resistance embedded in community and grassroots efforts, the ways in which it responded to the occupation, and the local and international politics presents vital lessons for other NGO’s both in Palestine and other post-conflict settings.

Chapter two of this thesis examines the ways in which the strong grassroots network of the UPMRC have emerged as unintended consequences of the Israeli occupation and closures. Section 2.1 provides an overview of the Palestinian-Israeli conflict and its impact on Palestinian development. Section 2.3 illustrates how the formation of the UPMRC has been intrinsically linked with the Israeli occupation. It examines the historical processes of the UPMRC and the ways in which the increase of the Israeli occupation over the years is precisely what led to the emphasis on the rural communities and the strong UPMRC grassroots linkages in the various areas. Chapter three examines the impact of the shifts of the international aid politics and agendas on Palestinian NGO’s during the post-Oslo period. Section 3.1 provides a brief overview of international aid prior to Oslo. Section 3.2 describes the shifts of international aid agendas during the post-Oslo period and the challenges they imposed onto the NGO’s. Section 3.3 argues that it is in response to such changes that the UPMRC began shifting its projects to include development and rehabilitation work. It also provides an analysis of the UPMRC alternative projects and illustrates how the emphasis on social capital, transparency, and local informal networks is crucial for local community development. Chapter four examines how the challenges that emerged as a result of the shift of local politics and the creation of the PNA presented opportunities for the UPMRC to work on the national front. Sections 4.1 and 4.2 detail the challenges the PNA posed to the NGO’s. Section 4.3 examines the ways in which the UPMRC seized the opportunity during the Oslo period to build a strong health network and get
involved on the national front. Finally, chapter five concludes the thesis with lessons for NGO’s in post-conflict reconstruction.
Methodology

This thesis is based on findings from field interviews with directors from the UPMRC and the HWC, Program coordinators, residents of Palestinian villages, officials from the Ministry of Health, as well as academic experts in this field. I conducted fieldwork for this thesis in the West Bank for five weeks from July 6, 2008 through August 14, 2008. In addition, a large part of the analysis is based on the findings by Rima Habasch for her working paper titled: “The Evolving Relationship between the Union of Palestine Medical Relief Committee and the Palestinian Authority.” Information and literature on the UPMRC was mainly taken from their website.

In order to examine the projects and health services in the West Bank, it was important to have representatives from both the providers and the beneficiaries, as well as government and NGO health care agents. All contacts with the health care NGO’s were acquired through the “snowball” effect, where new contacts stem from a previous contact. The majority of the interviews were conducted in Arabic and I later translated them during the transcription. Being Palestinian and fluent in Arabic gave me an advantage in creating an openness in the interviews. However, also being American and from the US created a bit of hesitancy with the interviewees when it came to speaking about US policy and politics. This limited the amount of information I could receive about specific USAID projects. In addition, my last name, which automatically connected me with a PNA official, created a sense of distrust when it came to questions about the PNA legitimacy. Finally, the short-time frame and difficulty of movement in the West Bank limited the number of villages I could visit and survey. As a result, I limited my field surveys to three villages in which joint clinics with the PNA existed.
Chapter 2: The Israeli Occupation and the UPMRC Grassroots Linkages

2.1 A Brief Overview of the Palestinian Israeli Conflict

In 1949, following the 1948 Balfour Declaration, Israel, Jordan, Egypt, Syria, and Lebanon signed the Armistice Line Agreement, which placed the West Bank under the Jordanian rule and Gaza under the Egyptian rule. In 1967, following the Six-Day War, Israel occupied East Jerusalem, the West Bank, and Gaza. Despite the peace efforts in 1993 and the creation of the Palestinian National Authority, the West Bank and Gaza today remain under Israeli military control.

In 1987, the First Palestinian uprising (the Intifada) began in Gaza, quickly spread to the rest of the West Bank, and continued until 1993. Between 1987 and 1993, an estimated 1,300 Palestinians were killed. During this time, the Palestinian movements organized demonstrations, strikes, stone throwing, and petrol bombs. The movement was organized at the grassroots level, led by Fateh, the Popular Front for the Liberation of Palestine (PFLP), and Hamas. The same political factions would later play an important role in forming Palestinian Civil Society and the NGO sector. The First Intifada came to an end with the signing of the Oslo Accord in 1993.

In September 1993, The Palestine Liberation Organization (PLO) leader Yasir Arafat, Israeli Prime Minister Yitzhak Rabin, and U.S president Bill Clinton met in Washington D.C to sign the Oslo Agreement. The agreement called on the two parties to put an end o the conflict and recognize their mutual rights to exist; and the creation of a Palestinian State within the 1967 borders. In October 1993, international donors met in Washington D.C and pledged over $2 billion to aid in the development of a Palestinian state during a five-year interim period.

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1 The PLO is a Fateh dominated organization, and would later make up the Palestinian National Authority (PNA).
A high amount of aid pledged by the foreign donors reflected the significance of the Palestinian-Israeli peace process in the international arena (Brynen, 2000). However, while high hopes for the economic well-being and the development of a Palestinian state accompanied the signing of the Oslo Agreement, the worst economic conditions and occupation of the Palestinian territories were yet to come.

In 1996, Benjamin Netanyahu, a member of the hard-line Likud party, became Prime Minister. The new government did not follow the Oslo Agreement and did not complete the withdrawal from the Palestinian Territories as agreed. Instead, they increased their settlements activities in Palestinian areas and intensified the closures and occupation. By 1997, the Israeli closures that prevented movement of Palestinian people and goods, cost millions of dollars in lost employment, lost investment, and halted development efforts. Thus, despite a spending of $1.5 billion in foreign aid by that time, the period following the peace process has in fact harmed the economy. Further deterioration of the Palestinian social and economic well-being was later caused by the erection of the Israeli Separation Wall.

In 2002, Israel began the construction of the Separation Wall (also known as the security fence, or apartheid wall) in the West Bank. The wall encroaches upon the agreed borders of 1967, and dissects and encloses the Palestinian cities into gated areas controlled by the Israeli military (see Image 1). Upon the completion of the wall, it is estimated to be 730 kilometers long, or 454 miles. It will isolate a total of 42 villages, and 60,500 Palestinian people (Anti-Apartheid Wall Campaign, 2009). While Israel continues to claim that the wall is necessary for its security, the dissections and isolations caused by the wall has led to tremendous social and economical deterioration of the Palestinian society.
The Separation Barrier
In the West Bank
February, 2008

Source: B’tselem: The Israeli Information Center for Human Rights
2.2 The Impact of the Israeli Occupation on Palestinian Development

2.2.1 Economic Decline

The period following the Oslo Accords witnessed the worst economic decline since the 1967 occupation. Two main conditions contributed to the economic decline of the Oslo period: One, the continuation of the dependency of the Palestinian economy on external markets, and two, the intensification of Israeli closures in the Palestinian areas (Roy, 2001).

The Palestinian economy has been heavily dependent on external income sources since 1967, particularly in the labor market. Between 1972 and 1990, the Palestinian labor force increased by 64%, but domestic employment increased by only 28%. The reason for this is that although labor is a key export of the Palestinian economy, nearly 50% of the Palestinian labor force worked in external markets (Roy, 1999). In addition, since 2005 Israel has increased its security measures, closure, military incursions, and restriction on movement of people and goods in the West Bank (Vandijk, 2008). The increase of external closures brought on by the construction of the wall led to a significant economic decline and limited the movement of the Palestinian people and goods. The wall and closures impacted two major economic sectors: the trade industry, in which agriculture is the dominant sector, and the service sector (mainly the low-paid jobs in Israel).

Making up the dominant sector of the Palestinian economy, agriculture has historically contributed to 50% of the Palestinian GDP. However, in 2004, two years after the beginning of the wall construction, this number fell to 10.8% of GDP (Grass Roots International, 2005). As a direct consequence of the building of the wall, 10% of agricultural land had thus far been confiscated 60% of the farming families on the west of the wall are unable to access their land. In addition, upon its completion, the wall will annex 62 water springs and 134 Palestinian water
wells (Palestine Monitor, 2009) further impacting the agricultural industry in the West Bank. Besides the land confiscation and loss of resources, the wall has also impeded the flow of produce within the Palestinian areas and to Israel.

Trade with Israel constitutes 77% of Palestine’s foreign trade. In 2002 Palestinian exports declined by 42%, and import dropped by 41.5% from the previous three years. The increased closures and the wall caused three major changes on the ground that negatively impacted the foreign trade: One, increased closures and obstacles meant higher cost of transportation and decline in competitiveness; two, closures meant repeated delays in delivery of products and undependable producers, and importers opted for more reliable exporters; and three, Due to the difficulties of exporting, Palestinian producers focused more on the local market demands (Palestine Human Development report, 2004). Thus, the export trade industry in Palestine witnessed significant decrease during the post-Oslo period.

Another major sector that has been impacted by the construction of the wall is the Palestinian labor force in Israel. Prior to 2003, 110,000 Palestinians from the West Bank worked in Israel, comprising 22% of the Palestinian workforce. In 2007, only 68,000 Palestinian were able to legally work in Israel (B’TSELEM, 2009). The decline in the labor force has been the result of the wall and the intensification of the Israeli permitting process. Thus, the construction of the wall, which had significantly impacted the two major economic sectors in Palestine, led to a sharp decrease in employment and income. The overall economic situation in Palestine declined significantly with the construction of the wall (See Figure 1).
2.2.2 Poverty

By 2002, the World Bank estimated that 40-50% of the Palestinian population was living below the poverty line, and by 2003, the average reached 60% (Le More, 2008). In 2007, more than 21.5% of the working population was unemployed. According to the Palestinian Central Bureau of Statistics (PCBS), the Palestinian poverty rates in the West Bank and Gaza has reached 65.8% of households (PCBS, 2006). Therefore, despite all the international aid efforts since the Oslo Accords, the poverty in Palestine increased during the preceding years (see Figures 2 & 3). The poverty level particularly affected those in the vulnerable communities, such as refugees and the rural areas (Le More, 2008).
Figure 2

Per capita Gross Domestic Income (GDI) in US dollars

<table>
<thead>
<tr>
<th>Year</th>
<th>Total in the Occupied Territories</th>
<th>In the West Bank**</th>
<th>In the Gaza Strip</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>1,896</td>
<td>2,113</td>
<td>1,555</td>
</tr>
<tr>
<td>2000</td>
<td>1,839</td>
<td>2,035</td>
<td>1,532</td>
</tr>
<tr>
<td>2001</td>
<td>1,513</td>
<td>1,662</td>
<td>1,282</td>
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<tr>
<td>2002</td>
<td>1,326</td>
<td>1,452</td>
<td>1,130</td>
</tr>
<tr>
<td>2003</td>
<td>1,467</td>
<td>1,621</td>
<td>1,227</td>
</tr>
</tbody>
</table>

Source: B'tselem: The Israeli Information Center for Human Rights

Figure 3

Poverty rate by percentage

<table>
<thead>
<tr>
<th>Year</th>
<th>Total in the Occupied Territories</th>
<th>In the West Bank</th>
<th>In the Gaza Strip</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>20</td>
<td>13</td>
<td>32</td>
</tr>
<tr>
<td>2000</td>
<td>27</td>
<td>18</td>
<td>42</td>
</tr>
<tr>
<td>2001</td>
<td>37</td>
<td>27</td>
<td>54</td>
</tr>
<tr>
<td>2002</td>
<td>51</td>
<td>41</td>
<td>68</td>
</tr>
<tr>
<td>2003</td>
<td>47</td>
<td>37</td>
<td>64</td>
</tr>
</tbody>
</table>

Source: B’tselem: The Israeli Information Center for Human Rights

2.2.3 Education

Similar to the economy of Palestine, the Palestinian education sector has been greatly impacted by the Israeli occupation. A number of educational facilities have either been closed or purposely destroyed by the Israeli military. Between 2000 and 2004, 1289 schools were closed and 282 destroyed (Palestine Human Development Report, 2004). The amount of financial losses in the education sector has reached $5.2 million in the primary and secondary institutions, and $4.8 million in the universities. In addition to the financial losses, closures and checkpoints
made the students’ mobility from their homes to their schools extremely difficult. As a result, many of the students, and particularly women, opted to quit school and discontinue their education. Thus, the decline in education contributed to the continuing decline of the Palestinian development.

As a result of the continued decline of Palestinian development in the Post-Oslo period, NGO’s continued to be major service providers in the sectors of health, employment, and education. The UPMRC, although a health NGO, began incorporating projects that address the employment and poverty issues in various areas.

2.2.4 The Impact of the Israeli Occupation on Healthcare Access

The Palestinian healthcare sector is comprised of four main types of providers: One, the United Nations Relief and Works Agency for Palestine (UNRWA), which was created following the catastrophe of 1948 in order to aid refugees in education and health; two, the healthcare NGO’s, which provide most of the services in the rural areas; three, the private sector, which is for profit and is unaffordable to many of the population; and four, the governmental sector, which has been run by the PNA since 1994.

Prior to 1993, the healthcare system in Palestine was controlled by Israel, who used it as a tool to maintain military control in the West Bank and Gaza. Israel continuously attempted to undermine the healthcare system by destroying facilities, closing clinics, and denying permits for the expansion of existing centers or the building of new ones (UPMRC, 2003). Faced with continued Israeli restrictions, Palestinians in the West bank had to rely on themselves in providing and managing services. As a result, a large number of healthcare volunteer organizations and NGO’s emerged over the years. Similar to the impact of closures and the wall on the Palestinian economy and education, the biggest challenge the health providers face today
is the result of closures and restrictions by the Israelis (Interviews, 2008).

Following the Oslo agreement and the construction of the Separation Wall, Israel’s severe restrictions on the movement of Palestinians greatly impacted the Palestinians’ ability to access adequate medical treatment. The construction of the Separation Wall, the hundreds of checkpoint, and the permitting restrictions have made mobility for both the patients and the providers extremely difficult, and in particular for those living in the rural areas to reach the medical facilities in the urban centers (see Image 2).

Besides creating obstacles to the access of the medical facilities, the Israeli checkpoint caused great delays for emergency cases. In 2005, 18% of the emergency cases were delayed at checkpoints (Rytter- Helweg-Larsen, 2006). A 2003 survey conducted by PCBS found that the number of people requiring one hour or more to reach a medical facility has grown by ten times in three years. In addition, forty cases of ambulances being denied access on checkpoints were recorded in July 2007 (Mataria-Moatti, 2009).

In response to the Israeli restrictions and inaccessibility of the medical facilities, “the quality of the medical responses offered by governmental and non governmental health institutions depended on their capacity to decentralize services or on their presence (or absence) in peripheral zones,” and the NGO’s had to play a major role in compensating for the lack of services in the rural areas. (Challand, 2000).

The need for emergency response to Israeli military incursions in the marginalized communities in Palestine was at the foundation of the inception of the UPMRC. Furthermore, the increased closures and occupation pushed the UPMRC to establish local centers in the rural areas in order to cater to the needs of the residents. The need to respond to Israeli closures in these communities allowed the UPMRC to establish strong relationships with the local residents
as well as local institutions. The strong foundation of the UPMRC at the grassroots level later placed the UPMRC in a strategic position that allowed it to expand its horizontal linkages with other NGO’s and vertical linkages with the PNA and the international donors.
Distribution of and access to health facilities in the West Bank.

Source: www.thelancet.com
2.3 The UPMRC Formation As A response To Israeli Occupation

The history of the UPMRC and its conception is intrinsically linked to the Israeli occupation. The UPMRC’s first activities began in 1979 as a grassroots movement in response to the Israeli restrictions and closures that were crippling the health care system in Palestine. In addition, the initial inception of the UPMRC was rooted in community work and continued to do so throughout its development. Over the years the UPMRC grew in its networks and structures according to the expanding needs of the Palestinian people and in response to various historical moments of the Israeli occupation. Thus, the formation of the UPMRC has been a form of political resistance embedded in community and grassroots efforts, and continued to be so throughout its developmental efforts. It is precisely the Israeli occupation that shaped the work of the UPMRC and caused it to strengthen its ties at the grassroots level in various rural communities. Furthermore, the focus of the UPMRC on the health needs of the population, instead of political mobilization, allowed to build ties with various groups and institutions.

2.3.1 The First Mobile Clinic: A Response to Israeli Curfew

The UPMRC began as a group of volunteer doctors who came together in 1979 to address the needs of the underprivileged, and in particular those in the rural areas. In April 1997 the City of Hebron underwent severe Israeli closures. For over a month, the residents of Hebron underwent a strict curfew and were not allowed to enter or exit the city. This meant that the residents could not access adequate medical care, and the doctors who lived outside the city could not reach the hospital or the residents. Twenty doctors and nurses from Jerusalem saw the need for the urgent relief efforts, gathered medicine and equipments, and formed the first informal mobile clinic. Upon arriving in Hebron, however, the doctors faced challenges from both their Palestinian counterparts and the Israelis (UPMRC, 2003).
While the Palestinian counterparts saw the new concept of mobile clinic as “cheapening medicine” and referred to the group as “barbers,” the Israeli army refused to let the group into Hebron. Faced with opposition of the occupation, the group would not abandon their mission and set to provide the services to another needed area. The doctors decided to go to Deheisha Refugee Camp (located between Hebron and Jerusalem) and cater their services there. Upon their arrival in the refugee camp, the doctors were received with overwhelming enthusiasm, and saw the tremendous needs for their services. As a result of this experience, the group of doctors decided to run the mobile clinics more often on their free days, and the “medical relief committee” was formed (UPMRC, 2003). Other healthcare NGO’s would later adapt the mobile clinic concept in their practice. Thus, the response to the Israeli curfew allowed for the formation of the first mobile clinic, which would later play a major role in the provision of services in rural areas during the Intifada and future closures.

2.3.2 Community Organizing Beyond Emergency Relief

As the doctors expanded their services, more communities heard of their work and requested their services. Within one year, the volunteers of the Medical Relief treated over 2,000 people. During their services, the Medical Relief would engage the local doctors and health facilities in their work. Through creating direct contact with the local doctors, the Medical Relief fostered community mobilization and encouraged them to take part in servicing their local population. This developed into a large network of volunteers and was later formed into various committees (UPMRC, 2003).

In addition to fostering relations with their local counterparts, the doctors of the Medical Relief further developed their work by engaging different community actors and coordinating their services with students, labor, and women’s groups. By building a relationship with the
local structures, the Medical Relief expanded its projects to include health education and literacy training. As the projects of the Medical Relief grew in their scope and included various local groups and committees, the Medical Relief recognized the need for a more comprehensive health system that would address the needs of the rural communities and those in financial need, within the framework of the Israeli occupation (UPMRC, 2003).

2.3.3 The Formation of Union of Palestinian Medical Relief Committees (UPMRC): 1980’s

By the 1980’s, the Medical Relief had expanded its operations to Jerusalem, the Jordan Valley, Ramallah, Nablus, Hebron, Bethlehem, Gaza, Tulkarem, Qalqilya, and Jenin, where nine different committees were operating. Recognizing the need for organizing the efforts between the hundreds of doctors and the committees, the various branches linked together and officially formed the Union of Palestinian Medical Relief Committee, receiving its first official funding in 1983 (UPMRC, 2003).

Despite institutionalizing their work, the UPMRC developed a democratic system to ensure the various committees maintain their influential independence. Each committee, with members of the local communities, would elect a local executive committee to manage the work in their area. The executive committees would elect representatives to serve on the central board. Many of these board members also sat on the organization’s secretariat. The joining of the various committees under one union, combined with an increase in Israeli aggression in the early 1980’s, allowed the UPMRC to create an overall strategy that went beyond immediate care and shifted to primary healthcare (UPMRC, 2003).

2.3.4 From Relief to Primary

In the mid 1980’s, following the invasion of Southern Lebanon, Israel increased its military occupation and land confiscation of Palestine in order to expand its settlements. As a
result, a large number of Palestinians lost their land. In addition, Israel began destroying the Palestinian services provided by the NGO’s. The physician to population ratio during this period was 8:10,000, and it became clear that the healthcare infrastructure in Palestine needed to be re-examined. A Palestinian healthcare system that took into account the impact of the occupation became essential for addressing the needs of the Palestinian society (UPMRC, 2003).

Recognizing the need to respond to the health conditions in Palestine, the UPMRC modified its focus to include primary healthcare. The UPMRC began focusing on preemptive health services that prevented health problems and promoted the well being of the population, instead of only using curative measures. The shift in focus from relief to primary care meant long term planning and the establishment of permanent centers within the local communities (UPMRC, 2003).

Up until 1984, the UPMRC workers were made up of volunteers. However, the long term planning and coordination meant the need for more permanent staff in order to effectively develop the UPMRC’s goals and vision. Thus, in 1984, the UPMRC hired its first full time staff and began establishing permanent health centers in many of the villages they had been working in. With the establishment of the centers, the UPMRC began developing healthcare programs such as General Practice, Women’s Health, and Children’s Health (UPMRC, 2003).

2.3.5 The First Intifada and Policy Adjustment

The Palestinian uprising in 1987 demanded that the healthcare providers in the West Bank increase their relief efforts and adjust their policies. As a result of the closures that accompanied the uprising, many of the villages were closed off. In addition, the Israeli soldiers limited the number of doctors allowed in each village. In response to the closures, the UPMRC began establishing permanent centers in more of the villages. By the end of 1991, the UPMRC
had established more than 34 community health centers in the West Bank and Gaza. Thus the intensification of Israeli closures, and Israel’s attempt to seal off medical care from the rural areas is precisely what led the UPMRC to establish more centers in the rural areas. Although they could not but focus on immediate relief during this period, they also incorporated various programs into their healthcare services, such as diabetic, dermatological, and gastrointestinal services (UPMRC, 2003).

2.3.6 Community Health Centers

The UPMRC views the community health centers as the focal points for their efforts (Interview, 2008). The majorities of the centers are located in the rural areas and serve the marginalized communities. As part of its health strategy, the UPMRC hires local members of the communities to run the centers. While the UPMRC has focused on community organizing since its inception, the increase of the Israeli closures and difficult access to many of the villages further encouraged local empowerment and employment by the UPMRC (UPMRC, 2003).

While the hiring of local residents began as a way to overcome obstacles of the Israeli occupation, it also formed the basis for the UPMRC Emergency Response Program, allowed the UPMRC to capitalize on the existing social networks, and promoted community development.

Overcoming Obstacles of Accessibility

The increase of Israeli closures and difficulty of movement meant the need for local doctors and nurses to provide more immediate and accessible services. Even with ambulances and emergency cases, health care providers still faced tremendous obstacles in reaching the rural and isolated communities. In 2003 alone, a number of ambulances were either denied access, shot at, or were delayed for extensive periods of time (See Figure 4). Due to the continuous uncertainty of the accessibility of the rural areas, the hiring of local staff guaranteed the presence
of the service providers during times of closure and allowed them to immediately respond to crisis.

**Figure 4**

<table>
<thead>
<tr>
<th>Type of Incident</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Delayed from 1-4 hrs</td>
<td>22</td>
</tr>
<tr>
<td>Ambulances Denied Access</td>
<td>21</td>
</tr>
<tr>
<td>Verbal/ Physical Abuse on Medical Crew</td>
<td>4</td>
</tr>
<tr>
<td>Shooting at Ambulances</td>
<td>4</td>
</tr>
</tbody>
</table>

*Source:* Office for the Coordination of Humanitarian Affairs (OCHA).

As part of its effort to overcome the obstacles of accessibility, the UPMRC started the Emergency Response Program in 1996. The program’s main objective is to provide emergency care to people in the isolated areas that are under closure or curfew. In order to provide a prompt response to the needs of the people in a time of clashes or closures, the UPMRC recognized the need for empowering the local communities to be self-reliable. Thus, its main mission was to create a national network of First Aid providers who are qualified to respond to emergencies in their local areas (UPMRC, 2003). The program trains the members in first aid provision, medication access, and surgical treatments. The program, which was started in 1996, had trained around 18,000 first aid providers by the year 2000.

*Informal Social Networks*

An important element that is often overlooked in development efforts and service provision is the existing local social structure. Strong kinships and social trust networks are a significant component of Palestinian communities, and more predominantly so in the rural areas.
In places where formal transactions and institutions are lacking, the existing local structures serve as the basis for service provisions and institution building.

One of the most important aspects of the services of the NGO clinics, including the UPMRC, is that no patient is turned away for lack of funds. Thus, while most of the clinics charge around 10 shekels\(^2\) a visit, those who are in need are either exempted from the fee or given a sliding scale discount. The amount charged for the visits and the waiver of the fee are at the discretion of the doctor and the nurses. While there is no formal social welfare system, the health providers at the centers have a solid idea of the financial situation of the people in the village and charge accordingly.

Furthermore poverty and the inability to pay are perceived as shameful in most of the rural areas; therefore, having the knowledge of the local population allows the doctors to waive fees and grant discounts without the embarrassment of the patient having to ask for it (Interview, 2008).

In addition to the informal financial welfare system, the social networks also provide the doctors with a more comprehensive knowledge of the village health needs and individual cases. In such tight knitted communities, the health conditions of the individual residents tend to be shared knowledge. The doctors, being part of the community, know who is in need of which services, and can reach out to them accordingly through home visits. The local knowledge of the health conditions is also significant for the health teaching programs of the UPMRC.

A core component of the UPMRC services is the Health Education Program. One of the ways in which the UPMRC combats health problems is through various teachings of the communities about health practices and diseases. The UPMRC promotes health education

\(^2\) 10 Israeli Shekels is around $2.6 US Dollars.
through printed materials, organizing lectures, and interactive educational programs (UPMRC website). However, in many of the villages getting the residents to participate in formal educational lectures can be a difficult process, and in particular for women. Therefore, one of the methods the UPMRC uses in its educational efforts takes on a much less formal route that requires the basis of social trust with the health workers.

Due to the low level of education and cultural restrictions in some of the rural areas, the participation of women in organized lectures tends to be low. In order to continue its outreach in education, the UPMRC adopted a less formal method of lectures. A social worker, who is usually female, would connect with one of the residents in a particular neighborhood, and build a relationship with her. In turn, the resident would invite a number of her female neighbors to her home for an informal gathering to learn about health issues. The health worker would address the concerns of the neighbors and prepare consequent lectures that address their particular health issues and concerns (Interview, 2008). Such, the established social trust between the social worker and the residents allows her access into their homes to conduct her work.

*Three: Community Development*

A third important element of hiring the local residents to provide the services is community development. Community empowerment and collaborative partnerships are crucial to creating change and development at the local level. Local members can take part in addressing the needs of the local population as well as impact change and address the concerns of the local community (Fawcett-Lopez, 1995). One of the UPMRC’s values in development is community participation and a “bottom up” approach (UPMRC website). By focusing on the hiring of the local residents, the UPMRC empowers the local communities to be self-reliable and develop professionally. The establishment of the local networks in the rural areas granted the UPMRC
local knowledge that would later become vital in its relationship with the PNA during the Post-Oslo period.

2.3.7 Chapter Conclusion

The Israeli occupation, which aimed at destroying Palestinian infrastructures and isolating the marginalized communities, is precisely what led to the unintended consequences of strengthening the UPMRC’s grassroots ties and community work. However, although by the 1990’s the UPMRC has developed comprehensive health care services that aim at reaching all sectors of Palestinian society, it is not until the Post-Oslo period that the UPMRC began promoting long-term health development, working with other health providers, designing rehabilitation projects, and working on the national front.
Chapter 3: The Shifting of International Politics & Alternative Projects

The period following the Oslo Agreement in 1993 was accompanied with a shift in politics on the international sphere that impacted the work of NGO’s in Palestine where the international aid agencies adjusted their agendas in favor of the promotion of the Palestinian-Israeli peace process. This meant an emphasis on institution building and governance instead of social development, and an imposition of a Western agenda that aimed at the normalization of the Israeli-Palestinian conflict and democratization. Furthermore, various restrictions accompanied international aid during this period that further impeded the work of NGO’s in Palestine. However, it is precisely as a response to the shift in politics that the UPMRC began working on projects that move beyond relief to include rehabilitation and development programs.

3.1 International Aid in Palestine: Pre-Oslo

The flow of international aid into Palestine dates back to the 1948 war. Following the displacement of around 150,000 Palestinian refugees, the United Nations Relief and Works Agency (UNRWA) devoted most of its expenditures to education, health, and social relief of the refugees (Brynen, 2000). Most Western donors programs, however, were not established in the West Bank until the 1970’s.

Prior to the Oslo agreement, foreign assistance to the West Bank came from either the Western donors or Arab donors. The absence of a Palestinian government, and the lack of coordination between the donors left little reliable data for the amount of expenditures and their allocations for this period. The UNDP data available shows that in the early 1990’s aid assistance rose tremendously from $174 million in 1992 to $263 million in 1993, with the majority of the donors being from European countries (Brynen, 2000). Due to the absence of a Palestinian counter-part at the time, most of the assistance flowed through either local NGO’s or
international NGO’s. The donor agencies refused to funnel any funds through Israel, although the US did require that NGO’s obtain Israeli permission for their activities (Brynen, 2000). Although only about 200 international NGO’s were active in the West Bank and Gaza in the early 1990’s, there was little coordination between the European and non-European NGO’s. In addition to the Western donors, a large sum of assistance during the 1990’s came from Arab countries and wealthy individuals. A World Bank study shows that Arab assistance during the 1980’s ranged from $30 million to $100 million per year, with over half the funding directed towards education, health, and semipublic institutions (Brynen, 2000).

Despite the lack of accurate figures of donor assistance in the pre-Oslo period, it is clear that the funding had great impact on the development of Palestinian society. The international assistance during this period mainly targeted agricultural, health, education, and infrastructure projects. A Palestinian university system was established as a result of these international efforts (Brynen, 2000). The emphasis of international aid on education and health during this period contrasts to the high emphasis on institutional building, infrastructure, and governance that took place later during the 1990’s.

3.2 International Aid in Palestine: Post-Oslo

On October 1, 1993, a few weeks following the Oslo Accords, representatives of about forty-three countries met at the Washington Donors Conference, which was co-chaired by Russia and the US, and pledged more than 2 billion dollars in aid to the Palestinians to support the five-year interim period that was intended to lead to the Palestinian sovereignty and promote Palestinian development. This amount eventually grew to 4 billion dollars (see Figure 5). “The level of aid promised by the international community reflected the strategic importance of the Palestinian-Israeli peace process, as well as the widespread view that economic development had
a key supporting role to play” (Brynen, 2000, p.3). However, five years after the conference, the standards of the peace process and the quality of development on the ground did not match up to the amount of aid that was poured into the country (Brynen, 2000).

In addition to the Israeli closures and restrictions that impeded the effectiveness of foreign aid in Palestine, the international aid politics and agendas limited the capabilities of local NGO’s in their local developmental efforts.

3.2.1 Political Ties and agendas of International aid

“Foreign aid is invariably a highly political enterprise” (Le More, 2008). Within a conflict setting, aid becomes even more intricate with politics. The period of the 1990’s has seen an increase in the politicization of assistance, where aid became tied to the donor’s political agenda and peace-building strategy, particularly in conflict and post conflict resolutions. The driving factors of foreign aid are particular to each donor and each setting, and as to whether the assistance aims to promote development, or provide humanitarian relief. The complexity of international aid and political agendas is inherent in the foreign assistance in the Palestinian case.
### Figure 5

**Donor Assistance to the West Bank/ Gaza, 1993-1998**

<table>
<thead>
<tr>
<th>Donor Country</th>
<th>Pledge ($million)</th>
<th>Donor Country</th>
<th>Pledge ($million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algeria</td>
<td>10,000,000</td>
<td>Italy</td>
<td>156,837,000</td>
</tr>
<tr>
<td>Arab Fund</td>
<td>150,000,000</td>
<td>Japan</td>
<td>312,023,000</td>
</tr>
<tr>
<td>Argentina</td>
<td>1,368,000</td>
<td>Jordan</td>
<td>20,211,000</td>
</tr>
<tr>
<td>Australia</td>
<td>13,010,000</td>
<td>Republic of Korea</td>
<td>15,000,000</td>
</tr>
<tr>
<td>Austria</td>
<td>25,350,000</td>
<td>Kuwait</td>
<td>25,000</td>
</tr>
<tr>
<td>Belgium</td>
<td>39,080,000</td>
<td>Luxembourg</td>
<td>11,500</td>
</tr>
<tr>
<td>Brunei</td>
<td>6,000,000</td>
<td>The Netherlands</td>
<td>154,166</td>
</tr>
<tr>
<td>Canada</td>
<td>43,568,000</td>
<td>Norway</td>
<td>244,021</td>
</tr>
<tr>
<td>China</td>
<td>15,935,000</td>
<td>Portugal</td>
<td>825</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>2,718,000</td>
<td>Qatar</td>
<td>3,000</td>
</tr>
<tr>
<td>Denmark</td>
<td>50,131,000</td>
<td>Republic of Korea</td>
<td>15,000</td>
</tr>
<tr>
<td>Egypt</td>
<td>17,210,000</td>
<td>Romania</td>
<td>2,880</td>
</tr>
<tr>
<td>European Investment Bank (EIB)</td>
<td>300,000,000</td>
<td>Russia</td>
<td>4,778,000</td>
</tr>
<tr>
<td>European Union</td>
<td>421,580,000</td>
<td>Saudi Arabia</td>
<td>208,000,000</td>
</tr>
<tr>
<td>Finland</td>
<td>13,904,000</td>
<td>Spain</td>
<td>147,152,000</td>
</tr>
<tr>
<td>France</td>
<td>80,549,000</td>
<td>Sweden</td>
<td>95,774,000</td>
</tr>
<tr>
<td>Germany</td>
<td>355,422,000</td>
<td>Switzerland</td>
<td>90,316,000</td>
</tr>
<tr>
<td>Greece</td>
<td>28,231,000</td>
<td>Turkey</td>
<td>54,971,000</td>
</tr>
<tr>
<td>Iceland</td>
<td>1,300,000</td>
<td>UN Development Programme</td>
<td>12,000,000</td>
</tr>
<tr>
<td>India</td>
<td>2,000,000</td>
<td>United Arab Emirates</td>
<td>25,000,000</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2,000,000</td>
<td>United Kingdom</td>
<td>128,656,000</td>
</tr>
<tr>
<td>International Finance Corporation (IFC)</td>
<td>70,000,000</td>
<td>United States</td>
<td>500,000,000</td>
</tr>
<tr>
<td>Ireland</td>
<td>7,074,000</td>
<td>World Bank</td>
<td>228,700,000</td>
</tr>
<tr>
<td>Israel</td>
<td>102,000,000</td>
<td>World Food Programme</td>
<td>9,334,000</td>
</tr>
</tbody>
</table>

**Total**                  | **4,208,574,000** | **Total** | **4,208,574,000** |

*Source: (Brynen, Awartani, and Woodcraft, 2000)*

As mentioned earlier, the increase of foreign assistance to the Palestinians was a response to the signing of the Oslo agreement and aimed at sustaining the Palestinian-Israeli peace process (Le More, 2008). Such political ties to international aid imply an uneven power relationship.
between the donor and the recipient. In addition, international aid to conflict areas has focused on ‘democracy assistance’ that encouraged Western models of good governance, the rule of law, transparency, and human rights (Le More, 2008). This is evident in the foreign aid effort in the West Bank, where the largest amount of funds targeted state building, i.e.: institutional building and police, as well as infrastructure development. On the other hand, the social sector, including health and education, underwent a decrease in funding (see Figure 6). Thus, the high emphasis of the donors on education and health that was apparent during the pre-Oslo funding era shifted to rule of law, governance, and human rights after the peace process.

Furthermore, while higher emphasis was placed on state building, “assistance in these sectors has been heavily criticized for building a bloated, centralized, and authoritarian administration rather than promoting sustainable development.” On the other hand, a rapid growth of the population in the West Bank called for an increase in educational and health services. Although between 1994 and 1998, the healthcare centers in Palestine increased by from 207 to 369 (Brynen, 2000), the number of clinics of the UPMRC decreased from thirty one to twenty five (Challand, 2008).

<table>
<thead>
<tr>
<th>Sector</th>
<th>Total Investment ($ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infrastructure</strong></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>704</td>
</tr>
<tr>
<td>Environment</td>
<td>112</td>
</tr>
<tr>
<td>Water &amp; wastewater</td>
<td>972</td>
</tr>
<tr>
<td>Post &amp; telecommunication</td>
<td>66</td>
</tr>
<tr>
<td>Energy</td>
<td>110</td>
</tr>
<tr>
<td>Solid Waste</td>
<td>79</td>
</tr>
<tr>
<td>Housing</td>
<td>55</td>
</tr>
<tr>
<td>General Infrastructure</td>
<td>110</td>
</tr>
<tr>
<td><strong>Institutional capacity</strong></td>
<td></td>
</tr>
<tr>
<td>Institutional Development</td>
<td>203</td>
</tr>
<tr>
<td>Legal &amp; Regulatory Framework</td>
<td>69</td>
</tr>
<tr>
<td>Police</td>
<td>85</td>
</tr>
<tr>
<td>Democratic Development</td>
<td>49</td>
</tr>
<tr>
<td><strong>Human resources/ Social Development</strong></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>429</td>
</tr>
<tr>
<td>Health</td>
<td>293</td>
</tr>
<tr>
<td>Humanitarian Assistance</td>
<td>23</td>
</tr>
<tr>
<td>Ex-Detainees and Returnees</td>
<td>23</td>
</tr>
<tr>
<td>Women</td>
<td>34</td>
</tr>
<tr>
<td>Human Rights &amp; Civil Society</td>
<td>11</td>
</tr>
<tr>
<td>Youth</td>
<td>28</td>
</tr>
<tr>
<td>Culture</td>
<td>39</td>
</tr>
<tr>
<td>Refugee Camps</td>
<td>248</td>
</tr>
<tr>
<td><strong>Productive Sectors</strong></td>
<td></td>
</tr>
<tr>
<td>Agriculture</td>
<td>207</td>
</tr>
<tr>
<td>Industrial Development</td>
<td>191</td>
</tr>
<tr>
<td>Tourism</td>
<td>232</td>
</tr>
<tr>
<td>Other Support Projects</td>
<td>138</td>
</tr>
</tbody>
</table>

*Source:* (Brynnen, 2000)
In 2004, the PNA presented its “Medium Term Development Plan 2005-2007” that set out a strategy to reduce poverty by shifting donor assistance from emergency relief to job creation. The US, roughly fitting its aid allocation within the Palestinian development plan, distributed its $41 million funds as the following:

**Amounts Allocated by the US to the Palestine Development Plan**

<table>
<thead>
<tr>
<th>Sector</th>
<th>Amount Allocated (In US millions of dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher Education</td>
<td>$7.3</td>
</tr>
<tr>
<td>Community Services &amp; Job Creation</td>
<td>$8.9</td>
</tr>
<tr>
<td>The Private Sector</td>
<td>$7.9</td>
</tr>
<tr>
<td>Pipeline and Wells</td>
<td>$13.9</td>
</tr>
<tr>
<td>Healthcare</td>
<td>$3</td>
</tr>
<tr>
<td>Total</td>
<td>$41</td>
</tr>
</tbody>
</table>

*Source: Blecher, 2005*

Yet, despite the development plans for job creations, unemployment soared at its highest rates during the post-Oslo period. In addition, Food for Work programs (FFW) dominated the projects of the USAID in job creations.

**Food For Work Programs**

The majority of the projects of the international agencies that aim at mitigating poverty and improving health through employment have focused on temporary employments for food, such as the food-for-work program (FFW). The FFW projects, which are run by CARE on behalf of USAID, and by Food for Work Programme (FWP) include donors from the European Union and the US, and are administered using wheat from the US (Braun, 1995). While those projects provide direct food relief and promote short-term work for individuals, they do not
address the role of local capacity building, or the promotion of local resources in community
development. The FFW projects negate the importance of social capital and collective efforts.
Furthermore, the projects that are chosen are decided upon at the agencies’ level, do not take into
account the local communities priorities and needs, and only provide temporary food relief. As a
result, the FFW projects turn the beneficiaries into dependent refugees, without any attention to
long-term development efforts that would allow the community to operate as its own agent
(Interview, 2008).

A Western Agenda

Furthermore, foreign funding in Palestine played a role, though not an exclusive one, in
transforming the Palestinian NGO’s from mass political movements into community of elite
professionals and politically autonomous institutions. A set of constraints on organizations led
many of their leaders to end programs and activities that were built by grassroots movements as a
result of political decisions that were imposed by “democratic centralism.” The projects of the
NGO’s, as a result of international aid restrictions, had to meet developmental rather than
political goals (Hammami, 2000).

Furthermore, one of the main events that took place in the Palestinian civil society during
the post Oslo period is the placement of a western political agenda, that is not Palestinian and not
culturally aware. As a result many of the NGO’s turned from being institutions that use local
ideas to promote development, to a fiscal funding agents that blindly comply with the
international funding agenda and programs, and implement them on the ground. As a result, the
ability of Palestinian NGO’s to have impact on the development on the ground has been limited
(Interview with Dr. Jarrar, MRC).
3.2.2 International Aid Restrictions

Related to the issue of the international political agendas are the restrictions that accompany international aid from the donors. Foreign Aid agencies demanded a certain level of long-term planning, transparency, and projects that linked to education and service provision, instead of political mobilization (Hammami, 1995). Many of the donors preferred funding projects that are “measurable,” such as computers, technologies, and offices. The developmental restrictions of international aid led to NGO’s changing their direction and work on projects that would “displace mass campaigns and voluntary work camps as the main method of relating to the community…What this means is that little by little, NGO’s became distant from the wider community of which they were once an organic part” (Hammami, 1995, p.57).

Although the detachment of many of the NGO’s from political mobilization had caused them to be distant from the community, it is precisely the fact that the UPMRC placed health needs ahead of its political agendas that allowed it to reach to the wider community.
Furthermore, the neutral political stance that the UPMRC took during the post-Oslo period granted it a strategic position to approach the PNA for collaboration. These implications will be discussed in more details in chapter 3.

USA PATRIOT Act

In addition to the developmental and political restrictions that accompanied aid, the USA PATRIOT Act\(^3\), which was enacted in 2001, set forth new obstacles for the NGO’s. Following the implementation of the PATRIOT Act, the USAID paperwork certified that aid recipients will do everything in their power to avoid providing services to anyone who may be associated with terrorist organizations or have committed or attempted to commit any “terrorist acts.”

\(^3\) US PATRIOT Act stands for: Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act.
terrorists listings of the PATRIOT Act include Hamas, Jihad, and the PFLP, which make up a large percentage of the Palestinian population and are an integral part of the Palestinian society (Seitz, 2005). The healthcare and education NGO’s were particularly impacted by such restriction, since they could not refuse to provide health and education services to a large number of the population.

In addition to the restrictions of the PATRIOTIC Act, the USAID funding comes with pre-set projects and programs that impose a particular Western policy with no regards to the Palestinian needs (interview, Jarrar, 2008). The focus of the USAID programs has been on democracy and institutional building instead of community development, education, and health. It is evident from their budget summary that the majority of their allocations support projects that focus on infrastructure and institutional building, while much less is allocated to health and education (see Figure 7)

**Figure 7**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Sector Development</td>
<td>13,950</td>
<td>7,649</td>
<td>23,000</td>
</tr>
<tr>
<td>Water Resources Development</td>
<td>22,808</td>
<td>31,943</td>
<td>51,000</td>
</tr>
<tr>
<td>Democracy and Governance</td>
<td>13,350</td>
<td>23,255</td>
<td>20,000</td>
</tr>
<tr>
<td>Higher Education and Training</td>
<td>2,250</td>
<td>700</td>
<td>14,000</td>
</tr>
<tr>
<td>Family Health</td>
<td>6,200</td>
<td>4,823</td>
<td>16,000</td>
</tr>
</tbody>
</table>

*Source: USAID*
3.2.3 International Aid and Corruption

Easterly argues that “the foremost best practice of an international aid agency is transparency, since without transparency, all other evaluations of best practices are impossible” (Easterly, 2008, p.1). Without transparency and accountability, favoritism and kickbacks lead to corruption within governments and NGO’s. Palestinian accountability and transparency proved to be a challenge to the donors in the implementation of aid programs in 1994-95. These concerns resurfaced in 1996-98 with reports suggesting that aid funds were being mishandled within ministries and contracts being granted between officials of close connections (Brynen, 2000). In 1997, the PA’s Public Monitoring Department (PMD) released a report showing around $329 million in excessive spending by the PA ministries and officials. The PA defended its position by stating that these revenues were deliberate policy decisions and not of wrongdoing.

3.3 Alternative Development Projects of the UPMRC: Responding to International Aid

Local NGO’s and agencies are valuable players in developing alternative projects that best address the needs of the local population and development (Fisher, 1997). In order to address the issue of declining employment during the post-Oslo period, and in response to the FFW projects and the lack of international focus on the needs of the local population, the UPMRC initiated a number of alternative projects that aim at promoting community building, social capital, transparency, and employment in the rural areas.

Thus, it is as a result of the shifting agendas of the international community that the UPMRC began expanding its work from being a relief agent to an actor of development. The historical roots of the UPMRC in the rural areas and the established trust it had created over the
years placed it in a strategic position to work with local communities to identify their needs and promote social capital.

Part of the definition of social capital refers to the “social solidarity” and the “capacity for collective action” (Richards-Vincent, 2004). One of the strategies for strengthening social capital is finding incentives of common grounds amongst the population or the groups (Putnam, 2002). The UPMRC alternative projects are directed at the enhancement of social capital benefits through the strengthening of the capacity of the communities. The proceeding sections focus on the small projects of the UPMRC and the ways in which these projects link employment and the environment to health, while simultaneously promoting capacity building, local resources, and accountability. In addition, these projects serve as a way to cope with some of the international aid restrictions.

3.3.1 Employment and Health

Health and employment are areas that are intrinsically linked. Not only does health impact the mental conditions of the population (Ross and Mirowsky, 1995), employment means better economic conditions and healthier environments. Furthermore, while rehabilitation of the health systems in post-conflict reconstruction has focused on the relief effort to immediate needs, the rebuilding of health services, and the development of the health system itself (Waters-Burnham, 2007), it is important to view health and development beyond the framework of medical services and direct health rehabilitation. Employment, capacity building, and development of local resources are also intrinsically linked to the health of society, and more significantly so in areas transitioning out of conflict.

Long periods of conflict impact employment, community networks, and local capacity through political wars and segregation. The Israeli occupation, having impacted the employment
and educational developments of Palestinian society, led to the deterioration of health in the communities. Thus, the deterioration of employment, schools, and infrastructures impacts the health conditions of the individuals.

In response to the FFW projects and by linking health, education, and employment in its funding proposals, the UPMRC created its own set of projects that provide temporary employment for pay, while at the same time promote local capacity building (Interview, 2008). The UPMRC works with local community agencies on small projects that are linked to health issues, such as improvement of schools, recreation centers, and cleaning the water resources, while it uses methods of capacity building and promotion of local resources in its execution.

One of the small projects of the UPMRC that links to health is the tiling of the Elementary Public School in Beit Kahil, which is a village located 7 km northwest of Hebron. After visiting the village and meeting with community member, the UPMRC found that the classrooms of the school lacked the appropriate flooring and stood directly on dirt. The unsound environment of the classrooms caused negative health issues for the students as a result of dust and the dirt. After speaking with members of the community, the UPMRC decided to fund the organizing and execution of the project.

3.3.2 Building Local Power

Promoting public participation and capacity building measures for the local institutions and communities are an important part of planning for rehabilitation (Pugh, 1998). As one of the first steps in organizing the execution of the Beit Kahil School project, The UPMRC coordinated the creation of a local committee responsible for overseeing the project. The committee was made up of students, youth center organizers, and teachers. In addition, the UPMRC coordinated the efforts between the local committee, the Ministry of Education, and the Municipality. In
forming a local committee, the UPMRC places the agency of the execution work in the hands of the local members allowing them to address their collective needs, while it facilitates the process. However, even though the UPMRC grants the local committee the agency to execute the projects, the UPMRC requires certain strategies to be taken, and continues to monitor the execution. In the Beit Kahil School project, the UPMRC required that the committee hire local residents to carry out the work, purchase the equipments and materials from local vendors, and adhere to methods of transparency and accountability. In return, the UPMRC fully funded the project and paid the workers' wages.

3.3.3 Promoting Local Resources

An important aspect of community development is the capacity building of the local population in their skill sets and labor. With soaring unemployment rates in Palestine, and more so in the rural areas, as well as low education rates, the training and hiring of the local population serves as a vital tool for the development of the local population. One of the requirements of the UPMRC in the funding of the school project is the hiring of the local population.

Instead of hiring their own contractors to rebuild the school, the UPMRC approached this project as a tool for community development and job creation, and required that the local committee hire the local residents to carry out the work. Part of the funding included the training of the labor as well. Also, in order to maximize the benefits of most of the residents, the project provided temporary employment of two weeks only. Any given worker was not allowed to work for more than two weeks on the project in order to provide as many opportunities as possible to the residents. But unlike the FWP programme, the UPMRC projects pay the workers in salary and not in food, thus allowing the workers more freedom in their spending. What is interesting is that when the UPMRC submitted a similar proposal for 22 million dollars to the European Union
to fund further similar projects, they were rejected and the EU offered to provide food relief instead. The UPMRC refused their proposal and continued seeking funding elsewhere to continue with its vision (Interview, 2008).

Furthermore, the UPMRC also required the committee to purchase the materials and equipments locally. Thus, by doing so, the UPMRC hopes to maximize positive externalities for the community from the execution of small projects. In other projects where the materials were not available in the exact village, they were required to be bought from the next nearest vendor. “The project is local, the workers are local, and the supplies are local” (Interview 2008). By focusing on the empowerment of the local agencies and actors, and linking them to higher agencies, such as the Ministry of Education, the UPMRC builds a strong network of social capital aiming at maximizing local development and benefits.

3.3.4 Transparency and Accountability

In addition to the social benefits, the creation of a local committee made up of different actors aims at mitigating corruption and nepotism. By working with multiple agencies and actors in the village, the UPMRC overcomes nepotism and favoritism by focusing on the creation of shared interest of the members instead of individual interests. Furthermore, the UPMRC requires the committees to prepare budget spending details and post them at the local mosque on a regular basis for the rest of the village to see (Interview, 2008). While the UPMRC successfully completed the school project within the allocated budget and without issues of corruption, the creation of a local committee does not always guarantee transparency. In another project that the UPMRC worked on, the problem of over-expenditure of funds surfaced despite the creation of a similar committee.
Another project the UPMRC was working on during my interviews was the building of a soccer stadium in a small village West of Ramallah. The allocated budget and the disbursed funds for the project was 10,000 euros. However, the committee requested an additional 3,000 euros from the UPMRC in order to complete the project. Although the UPMRC approved the additional funding, the project remained uncompleted and the committee sent a letter to the local residents asking for donations. The committee was able to collect an additional 8,000 Shekels.\(^4\) However, upon examining the budget details, the UPMRC found that out of the additional 8,000 Shekels collected, the local committee only used 2,500 shekels for the actual construction of the stadium, and had spent the rest on “administrative expenses” for themselves (Interview, 2008).

Recognizing that some form of corruption may be at play, the UPMRC intended to hold a meeting with the local committee and residents to discuss the issue of the funds. In asking one of the main observers involved in the project as to whether or not any form of punishment would take place, he responded by stating, “No, we will not deal with this by withdrawing any of the funds or stopping the project, this is for the community’s benefit, and we will be holding a workshop to educate the members about transparency and the importance of the collective benefits for the community behind this project. Also, since this is a small community, we hope that the people who used the money would feel ashamed.”\(^5\)

Thus, recognizing the importance of education and using alternative methods to punishment, the UPMRC hopes to address issues of accountability through education and cultural shaming, as opposed to punishment. The ability of the UPMRC to address issues of corruption and transparency respond to the international aid concerns through the use of grassroots informal norms.

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4 Israeli Shekel is around 0.18 euros. 8,000 shekels is around 1,500 euros.
5 Anonymous Interview, 2008. Translated by the author.
3.3.5 Training and Health education

As mentioned in chapter two, one of the difficulties of health education has been reaching out to the village women through formal workshops and lectures. Therefore, in addition to promoting capacity building and local resources through their projects, the UPMRC also approaches some of their alternative projects as additional tools for health education. One of the projects the UPMRC funds is the training of rural women in embroidery and aiding them in employment placement. During the embroidery training sessions, the UPMRC also sends a nurse to the sessions to conduct health workshops about various women’s health issues (Interview, 2008). Thus, through making the training the main point of entry, and later combining employment training and health in one setting, the UPMRC is able to capitalize on its resources and reach out to the women in the community.

3.3.6 Coping With the US PATRIOT Act & USAID

Following the passing of the US PATRIOT Act in 2001, the United States Agency for International Development (USAID) funding to the NGO’s in Palestine was accompanied with a greater number of restrictions that conflicted with the UPMRC’s vision. Under the US PATRIOT Act, NGO’s in Palestine were not allowed to use the funding for providing services to any members affiliated with “terrorist” organizations. According to the US, Hamas and a number of Palestinian organizations are considered “terrorist” organizations. Also, many of the Palestinian individuals whose family members have been imprisoned or whom themselves have been imprisoned by the Israeli Authorities fall under the “terrorist” category. This posed a major problem for the UPMRC (as well as other NGO’s) since it would prohibit the provision of services to a large sector of the population. In addition, the UPMRC and Palestinian civil society do not view these actors as terrorists, but rather as freedom fighters. The families of the
imprisoned and the martyrs are also usually the ones most in need of the free services. In addition to the restrictions, the USAID proposed projects are pre-designed packages that negate the local context (Interview, 2008). Therefore, the UPMRC rejects many of the projects the USAID proposes.

However, although the UPMRC rejects the projects that conflict with its vision and values, they capitalize on the funding through other streams. According to one of the heads of the UPMRC, the NGO uses the USAID funds for technical developments and facilities, such as purchasing computers and the physical renovation of clinics. In addition, the UPMRC uses these funds to renovate community centers and their facilities. Thus, by using the USAID funding for physical and technical development, the UPMRC bypasses the restrictions on the services to the Palestinian communities.
Chapter 4: The Shift of Local Politics and National Development

The creation of the Palestinian National Authority (PNA) in 1994 presented the NGO’s with a new situation. The impact of the formation of the PNA on the NGO’s is summarized in two points: One, the formation of the PNA brought with it the question of regularization of the NGO’s sector and the introduction of an NGO law that aimed at controlling and monitoring the NGO sector. Two, the formation of the PNA meant shifting a significant amount of the international funding from the NGO’s to the PNA, which led to the loss of a number of services provided by the NGO’s. These two implications created a hostile relationship between the NGO’s and the PNA, which left the majority of the NGO’s outside the national development front.

As a result of the shift of the local politics, the fragmented NGO sector in Palestine found itself with shortage of funds, international aid restrictions, and a hostile relationship with the PNA. However, it is precisely within these challenges that the UPMRC found opportunities to expand its work beyond relief to influence the national health agenda. The ability of the UPMRC to recognize the advantage of being politically neutral with the PNA in order to influence long-term development granted a successful position on the national front. Furthermore, the historical work of the UPMRC in grassroots communities was a key factor in its success as an agent of development during this period.

4.1 Regularizing the NGO’s: The Oppressive NGO Law

NGO’s are regulated in almost every civil society. The fact that the NGO’s existed long before the formation of the PNA awarded them prominence and knowledge, but yet at the same time played a role in the duplication of services and a loose regulatory structure (Sullivan, 1996).
In the absence of a functioning government prior to the formation of the PNA, the NGO’s assumed the role of agents of developments and played a significant role in rallying against the Israeli occupation. At the same time, prior to the creation of the PNA, the NGO’s had an inconsistent and regulatory framework that followed different models. The NGO’s in the West Bank followed the Jordanian law, the NGO’s in Gaza followed the Egyptian law, while those in Jerusalem were subject to the Israeli Authority (Habasch, 1999). Thus the plethora of NGOs, prior to the formation of a functioning state, meant better coordination and regularization by the new government was necessary (Sullivan, 1996).

The fact that the PNA would play a role in regularizing the NGO’s was never in question. However, the ways in which such regularization would take place has been an uncertain process. Initially, an interim ministerial steering committee was established to coordinate NGO activities and regulations. However, the establishment of this committee left uncertain which ministry would handle the NGO’s (Sullivan, 1999). In addition, due to the authoritarian nature of the PNA and its strong alliance with Fateh, the PNA sought to oppress any of its opposition, including those in the NGO sector (Habasch, 1999). Meanwhile, the Mukhabarat (general intelligence) continued to monitor the NGO’s activities.

In May 1995, the PNA drafted an associational law with the Ministry of Social Affairs and the Ministry of Justice. The original draft NGO law was based on the restrictive Egyptian law, which aimed at monitoring and controlling the activities of the NGO’s in Palestine (Elbayyar, 2005). The law required the registration of the NGO’s as well as their licensing by the PNA. In addition, the PNA aimed to control the sources of funding of the NGO’s. The associational law raised the concerns amongst the NGO’s that this legislation would constrain
their activities. The attempt of the PNA to control the NGO’s led to a hostile relationship between the two groups (Habasch, 1999).

4.2 Funding Redirected: Declining Funds in the NGO Sector

With the creation of the PNA, a large amount of international aid was redirected towards the Palestinian government from the NGO’s. International donors became more concerned with the political implications of sustaining the Israeli-Palestinian peace process than with the social development of Palestine. “As all NGO’s have relied on external funding for their operations, the shift of funding by international donors from the NGO sector to the PNA has deprived them of their main source of revenue” (Habasch, 1999, p.23). After the signing of the Oslo Agreement, the amount of funds directed to NGO’s fell from $170-$240 million to $100-$120 million since the peace agreement (Sullivan, 1996). By 1995, the NGO’s funding had declined by 30 percent.

The health NGO’s were also impacted by the decline in funds. As a result, a number of NGO’s had to close down a number of their clinics. The number of rural clinics in the West Bank decreased from 210 in 1992 to 128 in 1996 (Habasch, 1999). The closure of these clinics poses the challenge to the healthcare NGO’s developmental goals of an equitable health system. In addition, while the shift in funds meant an increased budget for the MOH, the government services remained unable to substitute for the services provided by the NGO’s (Habasch, 1999).

Furthermore, with the formation of the Palestinian National Authority (PNA) in 1994, the Ministry of Health (MOH) became responsible for the national health structure. In addition, many of the NGO’s shut down either as a result of the shifting in funds or because their services fell under the role of the PNA.
The yearly budget for the UPMRC is estimated to be around $6 million USD. The majority of the funding for the UPMRC comes from the Norwegian and Swedish governments, and the European Union (EU). The USAID is also a key agency in the funding of the UPMRC. However, with the creation of the PNA and the signing of the Oslo Accords, the UPMRC found itself with decreased amount of funding.

The decreased funds and the lack of coordination amongst the donors meant that the funding for the UPMRC is not permanent or consistent. While some donors fund projects for a period of one year, others fund them for three. Also, once the period of funding a particular project is over, the UPMRC must wait a few months for the evaluation and reinstatement of funds. This leaves the UPMRC with long periods without international funding, while it needs to continue with their services (Interview, 2008).

In addition, the creation of a Palestinian state shifted the funding agendas from those of solidarity to groups under occupation to international political motivations of the Israeli-Palestinian peace process. Much of the international donors agendas aimed at normalizing the Israeli-Palestinian conflict instead of providing projects that would aid in the development of Palestine. The healthcare NGO's faced similar conditionalities from their international donors. The lack of a Palestinian health NGO network and the fragmentation of the providers placed the health agents in a weak position with the international donors.

4.3 The UPMRC Attains the Opportunities Within Challenges

As a result of the negative impact the creation of the PNA had on civil society, most Palestinian NGO's viewed the PNA as hostile and remained autonomous in their work. This led to most of the NGO's being left outside of the national development front. However, unlike the
other NGO’s, the UPMRC seized the opportunity of the creation of the national government to extend its vertical linkages in order to work with the PNA on a national health agenda, consolidate their health clinics, while at the same time pressure the PNA into modifying its NGO authoritarian law.

Furthermore, recognizing the need for a strong NGO network in order to pressure the PNA as well as consolidate their services, the UPMRC began extending its horizontal linkages and was a key player in forming the Palestinian NGO network. As a result of the need to form a strong NGO network, the UPMRC was also successful in mitigating the duplication and fragmentation that has historically characterized the healthcare providers in Palestine. Thus, it is precisely by having to answer to the challenges posed by the creation of the PNA that the UPMRC began working on building an NGO and health network.

4.3.1 Extending Horizontal Linkages: Coordinating Health Services

One of the main challenges many of the NGO’s faced in Palestine is fragmentation. Political factionalism, varying international agendas, and a history of unregulated services due to a lack of historical government, created a large number of fragmented, competitive, and repetitive NGO’s in Palestine. This led to an insufficient provision of services and a lack of collaborative efforts in addressing various developmental issues. With the health sector in particular, this led to some villages receiving services from multiple NGO’s, while others lacking any kind of service. In addition, with the creation of the PNA, a number of health NGO’s had to close their clinics because of the decrease in funding, while further duplications of services became a concern for the health providers.

Recognizing the need to: one, work with the PNA in order to create a national health strategy that would prevent the emergence of a dual health system, and mitigate hostility with the
government, and two, the need for a strong network in order to overcome international aid conditionality that can undermine a national health policy, the UPMRC initiated a policy dialogue with other healthcare NGO’s in Palestine in order to create a “unified vision” to be able to exert influence at the national sphere (Habasch, 1999) as well as the global level. The need for a unified network to overcome national and international restrictions was the driving force for the coordination of services and work amongst the health NGO’s.

In May 1996, the UPMRC played a central role in organizing the first workshop of the Health, Development, Information, and Policy Institute (HDIP)\(^6\), which was titled “Coordination Within the Sector of Health NGO’s.” The workshop brought together over 25 health NGO’s in order to create a unified health vision in Palestine, and address the need for coordinating financial resources, services, programs, and centers amongst the health NGO’s. In addition, the health NGO’s agreed on the need to cooperate with the MOH in order to complement their services and mitigate competition. Two months later, the HDIP held a second workshop that included members of the PNA and MOH (Habasch, 1999) in order to reach out to the national actors.

4.3.2 Vertical Linkages: The UPMRC and the PNA, A Relationship Despite Challenges

A key ingredient to development, particularly in a post conflict setting is the relationship between civil society and the State. NGO’s, being key players in civil society, are major contributors to the needs of the underprivileged and underrepresented population. While some NGO’s choose to work in parallel paths to the State, others work in opposition. Critical to the development of civil society, however, are the NGO’s that move from the “supply side” approach to “demand side” emphasis in their developmental efforts and relationship with the

\(^6\) HDIP was created in 1989 by a group of health professionals to promote better health policies that focus on marginalized groups. It is also headed by Mostafa Barghouti (head of UPMRC).
government (Clark, 1995). The latter NGO’s help local communities in voicing their needs and concerns and get involved in the development process. In addition, these NGO’s persuade and help the government in addressing the priorities of the underrepresented communities (Clark, 1995).

With the formation of the PNA, many of the NGO’s, particularly those in political opposition to Fateh, became hostile towards the new government. However, despite the fact that the new government had a weak relationship with the NGO’s and that the UPMRC ‘s political origin lies on the left, the UPMRC chose to approach the PNA and work with it on national healthcare provisions and policy. What is interesting about the UPMRC-PNA relationship is that it did not have the ingredients that are arguably needed for the foundation of a healthy State-NGO relationship. In fact, a number of challenges to developing such a relationship were inherent in the PNA’s agenda and the Palestinian context.

Challenges

“A healthy relationship [between NGO and State] is only conceivable where both parties share common objectives” (Clark, 1996). The objectives and the priorities of the MOH and UPMRC differed in vision and priorities. While the MOH main objective was to rehabilitation of the physical structures and not the development of the primary health care in the area (Habasch, 1999), the UPMRC main objective is to provide health services to the poor and marginalized communities, as well as develop a national health plan that promotes development (Interview, 2008).

Another challenge facing the State-NGO relationship in the UPMRC case is the “policy environment.” Clark argues that NGO’s in political opposition to the State would not help the State improve its services if doing so would legitimize the government’s work (Clark, 1996).
Ironically, most of the residents of a village where the UPMRC had a joint clinic with the PNA, were under the impression that the government was providing the service (Field interviews). Therefore, the fact that working with the PNA may increase its popularity amongst the Palestinians did not stop the UPMRC from building the relationship with the State.

In addition to the predicted hostility towards an oppressive government by the local NGO’s, Clark also states that “governments would not lend legitimacy to agencies which they view as political opponents” (Clark, 1996). The UPMRC has been politically affiliated with the communist party and thus would be viewed as a political opposition to the PNA. Yet, regardless of their political difference, the PNA agreed to work with the UPMRC on building a cooperative health system. How then was the UPMRC successful in building the relationship and why was the PNA cooperative?

*What’s In It for the PNA?*

Despite the challenges facing the developing relationship between the UPMRC and the PNA, the UPMRC was the first NGO to approach the PNA in order to initiate collaboration (Interview: Al-Deek, 2008). Various factors contributed to the success of the UPMRC in its involvement with the PNA: One, the UPMRC, had the ability to reach out to the rural population because of their previous work and projects; two the PNA had established links and trust with various communities prior to the PNA; three, the UPMRC having had years of experience in the health movement, was a valuable source of information and expertise for the PNA; four, the UPMRC had established horizontal linkages with other NGO’s as well as healthcare NGO’s.

*4.3.3 Collaborations & Partnerships with the PNA*

As a result of the shifting of funds that accompanied the formation of the PNA, around 70% of the NGO’s primary health clinics were shut down in the West Bank and Gaza.
Recognizing the danger facing the health movement as a result, and the urgent need for collaboration efforts, the UPMRC met with the MOH to build a relationship and examine the roles each would play. The fact that the UPMRC has had a long experience in the field of health in Palestine, and had established a network of health NGO’s, granted it the power to initiate a dialogue with the MOH (UPMRC).

In July 16, 1996, the HDIP held a workshop titled “Sharing Responsibilities: Coordination Workshop between the Health NGO Sector and the Palestinian Ministry of Health.” Forty NGO’s, government health officials, as well as representatives from UNRWA were present at the workshop. This was the first meeting in which officials from MOH came together with NGO’s to discuss health policies and implications in Palestine (Habasch, 1999). During this workshop, the Minister of Health expressed the government’s need for a collaborative effort with the NGO’s in order to fill the gaps in the public healthcare service delivery. Thus, the inability of the MOH to provide adequate services, combined with its need for legitimacy amongst the Palestinians, led to its positive response to collaboration. At the end of the workshop, the MOH and the NGO’s agreed to create specific methods of collaboration, which were finalized five months later in a subsequent workshop titled “Coordinating Primary Health Care.” The workshop resulted in three subcontracting arrangements in which the MOH closed their clinics and merged all their services of insured patients with NGO clinics (Habasch, 1999). By 2000, the UPMRC and the MOH had seven subcontracted clinics (UPMRC webpage).

The agreement of the subcontracted clinics allows government insured patients to use the UPMRC clinics between the hours of 9 am-2 pm with the national health coverage. In addition, the government supplies the medications for its insured patients to be distributed under the health
coverage. The UPMRC patients have access to the services at the regular operating hours and to medication that is provided by the UPMRC. Thus, by consolidating their services, the UPMRC serves both kind of patients in the same clinic and by the same doctors, reducing duplicity of services and cost (Interview, 2008).

Furthermore, the UPMRC also built a partnership with the MOH and other ministries in their health and educational programs. A government-NGO committee was created to review and prepare plans for the national school health program as well as women’s health programs. In addition, the UPMRC also worked with the Ministries of Labor and Transportation, and the police to address the issues of road accidents and fatality (Habasch, 1999).

School Health Program

The UPMRC began a Comprehensive School Health Program in 1992 in order to address issues of health amongst youth ages 4-18 in the poor areas. With the coming of the PNA, the UPMRC set out to coordinate their efforts with the Ministry of Education and Ministry of Health in order to build links between the parents, teachers, and students in the school health system. The program includes free health screenings as well as educational health programs for parents and training workshops for teachers. By working with the Ministries of Health and Education, the UPMRC addresses health care on the national level, as well as educate impoverished communities about important health issues. The program was able to serve 41,538 beneficiaries in the year 2000 alone (UPMRC, 2009).

4.4 Influencing National Policy

John Clark argues that while NGO’s can help in providing services to the poor, it is only by influencing the national agenda that their efforts become sustainable (Clark, 1995). The
UPMRC, having sustained its grassroots, horizontal, and vertical linkages was able to exert influence at the national level further enhance its legitimacy.

The creation of partnerships by the UPMRC with the various ministries in the PNA laid the foundation for two significant changes in the national policy: First, in response to the oppressive NGO law that was drafted by the PNA in 1995, the UPMRC mobilized other NGO’s in pressuring the PNA to change the law into one of “the most liberal and least restrictive NGO law in the Middle East” (Elbayar, 2005). Second, The UPMRC was a key player in the formulation of the Disability Rights law, which was signed by former President Yasser Arafat in 1999.

4.4.1 Influencing National Policy: The NGO Law in Palestine

The original NGO law that was drafted by the PNA was based on the restrictive Egyptian law, which aimed at monitoring and controlling the activities of the NGO’s in Palestine (Elbayyar, 2005). Foreseeing the danger of the passing of such law and the negative impact it would have on their work, the UPMRC built a strong NGO network, and at the same time began working with the PNA on national health issues. By establishing linkages with other NGO’s, as well as a cooperative relationship with the PNA, the UPMRC played a strategic and critical role in influencing the national policy.

The fact that the Palestinian NGO’s had formed a strong network allowed them the collective influence to exert pressure on both the national and international levels. The Palestinian Economic Council for Development and Reconstruction (PECDAR), which is responsible for coordinating development efforts in Palestine, was concerned that the PNGO authoritarian and restrictive law would push international donors to withhold their funding, and restrict the NGO’s work (Brown, 2003). As a result, the PNGO’s began leveraging their
collective local as well as international connections to pressure the PNA into redrafting the law (Habasch, 1999).

Furthermore, the PNGO’s amended nine articles of the law. The UPMRC, having already began working with the PNA, built relations with 60 out of the 88 members of the Palestine Legislative Council (PLC) in order to get the amendments passed. In 1998, the PLC accepted six of the nine amendments. Finally, in 2000, and after much oscillation between the PNA and the NGO’s, President Arafat signed the PNGO law that required the NGO’s to only register with the PNA.

The UPMRC’s established networks with both the local NGO’s as well as members of the PNA played a critical role in the victory of the PNGO’s with the PNA. By forming a strong NGO network, the PNGO’s were able to pressure the PNA into redrafting the law into being one of the most liberal NGO laws in the Arab world. In addition to influencing the NGO law, the UPMRC also played a critical role in the drafting and passing of the Disability law in Palestine.

4.4.2 Influencing National Policy: The Right of the Disabled

Prior to 1999, there was no law in Palestine to protect the rights of the disabled. Disability in Palestine is a highly stigmatized social issue that is perceived as shameful. Many families isolate their disabled children and keep them indoors in shame of the public viewing them. The disabled people are also often marginalized from the rest of society and confined to disabled centers (UPMRC). Recognizing the need for a national policy in supporting the efforts of disability in Palestine, the UPMRC formed committees made of government ministries, NGO’s, and members of the communities in five regions in order expand its linkages begin a campaign to address the issue of disability.
In order to address the issue of disability in Palestine, the UPMRC worked on both the national front, as well as the community level to intervene, educate, and eventually sway the national government in passing the Disability Act in 1999. The UPMRC worked directly with the national government on the drafting and the signing of the Law #4\(^7\) for the rights of the disabled by former President Yasser Arafat (Interview, 2008). In addition, the UPMRC was successful in including the disabled in the General Palestinian Census in 2008 (Interview, 2008).

The work of the UPMRC on disability dates back to its grassroots efforts in the early 1990’s. The extensive knowledge of the UPMRC about disability in the rural areas granted it a very important position with the PNA. The UPMRC began addressing disability by intervening at the local level with both communities and families. With the formation of the PNA, the UPMRC worked on pressuring the national government in not only passing, but also implementing the law. Finally, the UPMRC continues working with the Ministry of Education in training teachers about issues of disability, and including the disabled in the governmental school system.

The fact that the UPMRC had already established a working relationship with the PNA and the various ministries placed it in a strategic position to influence national policy around disability. In addition, the grassroots efforts of the UPMRC in the years preceding the formation of the PNA are precisely what granted it the knowledge necessary to influence drafting of the Disability Act.

*Grassroots Efforts: From Taxi Drivers to Local Institutions*

The UPMRC began its disability program, The Community-Based Rehabilitation Program (CBR) in the early 1990’s in Biddo village (northwest of Jerusalem). The program

\(^7\) See Appendix II for a copy of the law
began with one doctor, Dr. Ghosh, going to the village and conducting door-to-door visits in order to identify the disabled in the community (UPMRC). The process was based on social networks and word of mouth from the village residents. Dr. Ghosh worked with families in their private homes on educating them about disability and empowering the disabled by training them to be more self-sufficient. In addition, and in an effort to integrate a more comprehensive strategy, Dr. Gosh would work on educating the community about disability and promoting the integration of the disabled into society (UPMRC). Once there was a growing need to accommodate the program, the UPMRC opened a center for the disabled in Biddo village. Today, the CBR serves over 96 localities. Although, the centers are the main place for the care of the disabled, the UPMRC staff continues to visit the disabled in their homes and follow up on their conditions.

With the growth of the program, the UPMRC focused on community participation as a main tool for further educating the Palestinian society about disability. For example, in their educational efforts about disability, the UPMRC targeted the education of the taxi drivers in the communities about disability. Taxi drivers are key actors in Palestinian villages, and they are well acquainted with all the members of the village more than any other resident. This is because transportation is vital to people’s movements, especially in small rural areas that are isolated. Thus, by recognizing the position of the drivers in Palestinian rural areas, the UPMRC saw their value as grassroots network in educating the rest of the population. Such informal networks are crucial to the development of civil society, and yet often overlooked by those not familiar with the local context. In addition to reaching out to the local people in the villages, the UPMRC also worked with other healthcare NGO’s on coordinating the disability efforts in Palestine (Interview, 2008).
Currently, the UPMRC works with nine other NGO’s and local organizations in running their disability program. While the organizations have one strategy for all of their locations, the quality of services and response varies from one area to another. The northern areas have the most successful programs. This is due to the fact that the northern Palestinian areas tend to be more educated and less conservative than the south. Also, the monetary investment in the North is much more than that of the South. In addition, implementing the same methods amongst the nine different organizations has been a difficult process. Each organization varies in its level of community involvement and its perception of what is important. While some of the organizations are stronger at the community level, others have more strength in policy work. In addition, the segregation caused by the Israeli occupation presents difficulties in the collaboration (Interview, 2008). However, despite the obstacles in the collaborative efforts with other NGO’s, the UPMRC also worked with the national government in protecting the right of the disabled.

*National Effort: Law Number 4*

The UPMRC lobbied the PLC, the Ministries of Interior and Social Affairs, as well as the General Union of Palestinian Disabled and the Central National Committee for Rehabilitation in its efforts to pass a law protecting the disabled. However, while the UPMRC was successful in drafting and advocating the adoption of Law #4, the law has not been fully implemented on the ground. The UPMRC continues working with multiple channels in ensuring the future of the protection of the disabled in Palestine.

*Multiple Avenues: Implementing the Law*

In order to affect change at the national level, the UPMRC began working with the ministry of education on training and educating teachers and students on issues of disability. The
aim behind the educational programs is to include the disabled people within the mainstream education system and include them into society.

While the law protecting the disabled was passed at the national level, the government has put in very little effort to implement it. Thus, the UPMRC continues to apply pressure on the government to develop and implement programs that would ensure the rights of the disabled in accordance to the law (Interview, 2008). The UPMRC works on persuading the government in the implementation of the programs through media campaigns and educational programs that aim at integrating the disabled into the schools.

The UPMRC has developed hundreds of awareness and promotional campaigns aiming at educating the Palestinian community about disability. In addition, the UPMRC conducts a number of training programs that target teachers at the schools around issues of disability and the education of the disabled. Understanding that change at the top-level is not sufficient in creating impact, the UPMRC views the teachers as being the main vehicle for the implementation of Law #4 and changing the perception of the disabled in Palestinian society (Interview, 2008). In 1999, the number of enrolled disabled students in the mainstream educational facilities increased by 76% from 1998. More than 200 disabled children were enrolled in mainstream schools in 1999, bringing the number to 823. By 2001, the UPMRC has organized 19 summer camps with the participation of over 400 disabled children. Volunteers from the local communities run most of the camps’ activities (Relief Web, 2001). Furthermore, the UPMRC also conducts vocational training programs for adults to integrate them into the mainstream workforce.

Influencing the General Census

Despite the UPMRC’s efforts on disability issues, many of the services and programs are still lacking. For example, there are no tools to assess the quality and amount of services
provided, and no comprehensive database of the disabled. Therefore, the UPMRC has been working on integrating the disabled into the Palestinian General Census in order to have a better understanding of the range of the issue.

In 2008, the UPMRC was successful in influencing the Palestinian Central Bureau of Statistics (PCBS) in including a count of the disabled in their general census. This will allow the UPMRC and other NGO’s to have a better assessment of the disabled in Palestine, including reasons, types of disability, age, and gender. In turn, the UPMRC will be able to improve their programs based on the specific needs of Palestinian society (Interview, 2008).

Thus, it is precisely the historical position of the UPMRC in the grassroots movement that granted it the knowledge necessary to work on the national level. Furthermore, the formation of the PNA allowed the UPMRC to further expand its programs and teachings on disability, leading to national success and better understanding of the needs of the disabled. The ways in which the UPMRC implemented its grassroots work at the national level signifies the importance of State-civil society relationship in the development of Palestine.

4.4.3 International Influence

In addition to changing the NGO law, coordinating health services, and influencing the national agenda, the formation of the strong network of NGO’s also granted them the collective power to influence much of the international agendas. With the shift of politics during the post-Oslo period, the NGO’s faced the imposition of projects that aimed at normalizing the Israeli-Palestinian peace process. In response to such projects, the NGO network continues to work on exerting pressure at the international level.

In June 2005, 20 health NGO’s signed an open letter addressed to the international community protesting the promotion of projects that aim at encouraging collaboration with the
Israelis on projects that do not address the local Palestinian needs but rather aim at normalizing the Israeli-Palestinian conflict. The letter objects to projects that aim at implementing the international agenda of "peace building" without taking into consideration the imbalances of power between Israelis and Palestinians.  

Furthermore, in 2007, a number of NGO’s led by the UPMRC, launched a boycott of the Israeli Medical Associations (IMA) because of its support for the occupation and the invasion of Lebanon (Monitor Report, 2007). The health NGO network continuously uses its collective effort to exert international pressure on the donor countries.

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8 See Appendix I for copy of letter
Chapter 5: Conclusion

The ways in which the UPMRC managed to maintain its grassroots ties and projects within the Palestinian communities, while at the same time extend its horizontal and vertical linkages to better address development at the national level, have significant implications for state building and development in post-conflict areas.

One, the unintended consequences of the Israeli occupation, which led to the decentralization of health services and emphasis on community building, illustrate the importance of the historical processes of development within conflict. In addition, the ability of the UPMRC to establish strong grassroots as a response to the Israeli occupation placed it in a strategic position by the time of the formation of the PNA. The position of the UPMRC and its strong roots ties illustrate the importance of emphasis on the local fabric in post-conflict development.

However, despite the importance of the local fabric in development, international aid agencies often view the post conflict country as a tabula-rasa, as if no systems or structures had emerged or existed over the years, or even before the conflict. They fail to capitalize on the local knowledge, ignore the local processes, and fail to create a balanced relationship with the local NGO’s and agencies.

In addition, the international aid community looks at the local NGO’s of non-western countries as civil society vehicles that promote Western models of democratic development and practices. The international agencies focus most of their projects on immediate rebuilding and democratization structures, such as large-scale infrastructures and rule of law, instead of encouraging community rebuilding. Thus many of the local NGO’s, dependent on the international’s actors funding, fail to establish strong ties with the local community and
capitalize on local traditions. However, the role of traditional structures, whether formal or informal, is critical to the development of a place that has been destroyed by years of war, occupation, and repression (Pouligny, 2005).

It is evident from the work of the UPMRC, and development efforts in Palestine, that international models of development that negate the local fabric do not benefit the local community nor promote sustainable development. Local and international actors usually have different objectives and goals ranging from the short-term to long-term projects. It is important for the international community to engage the local society, its knowledge, and resources in the developmental processes in order to achieve post conflict rebuilding (Pouligny, 2005).

Two, in addition to the importance of the local fabric within development, the ability of the UPMRC to navigate its politics and networks in order to grab the opportunities that were presented amidst the challenges of the creation of the PNA, present vital lessons for State-civil society relations in post-conflict settings. Despite the political authoritarian rule of the PNA, the work of the UPMRC illustrates the importance of the role of the state in development efforts.

While in the 1990’s civil society was seen as an alternative sphere to failing or authoritarian state structures, and the NGO’s served as alternative agents of developments to the state, it is evident from the case of Palestine that the two could not work independently of each other. It is precisely by responding to the authoritarian nature of the PNA that the UPMRC was able to shift its work to the national arena.

Furthermore, the relationship of the UPMRC to the PNA presents a successful case study where an NGO takes an active role in pushing the state to assume its responsibility in development, rather than the NGO serving as an alternative to a failing state. Therefore it is
important for development actors in post-conflict settings to examine the possible roles of the state, despite its authoritarian or corrupt nature.

Three, the rehabilitation projects of the UPMRC, which were designed as a response to the international agenda and aid restrictions, signify the importance of agency of the local NGO’s in their development efforts. Despite facing similar challenges as the other NGO’s, the UPMRC was able to design projects that address the needs of the local population, provide relief, and at the same time promote community development. The ability of the UPMRC to link health to employment and education in order to navigate the various aid restrictions serves as a great example for the work of other NGO’s.

Furthermore, while rehabilitation of the health systems in post-conflict reconstruction has focused on the relief effort to immediate needs, the rebuilding of health services, and the development of the health system itself (Waters-Burnham, 2007), it is important to view health and development beyond the framework of medical services and direct health rehabilitation. Employment, capacity building, and development of local resources are also intrinsically linked to the health of society, and more significantly so in areas transitioning out of conflict.

Four, the ways in which the UPMRC played a key role in establishing a coordinated health network in order to overcome the obstacles with the PNA and the decline in international funds, signify the vitality of opportunities that can be hidden within places of conflict. Had the PNA not been authoritarian in its rule, and had the international community continued to favor the NGO sector over the PNA, would the UPMRC have had an incentive to consolidate the health services?

While we may never know the answer to that question, the story of the success of the UPMRC reiterates the fact that for NGO’s to be successful in post-conflict reconstruction they
need to navigate their various linkages from the bottom up, top-down, and with peer actors.

Furthermore, while there is no one formula for a successful relationship between the NGO’s and the State, the ability of an NGO to work at the grassroots level in order to influence national policy is crucial to sustainable development.
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Appendix I

June 2005:
An Open Letter To The Palestinian And International Community Regarding Palestinian-Israeli Cooperation In Health

From: pngonet@pngo.net

We, the undersigned, medical and health service providers and members of professional unions and research and training institutions working in the health sector in the Occupied Palestinian Territory, would like to register our protest and deep concern over the increasing pressure exerted upon us to enter into Palestinian-Israeli cooperation schemes in the sphere of health. Such projects, largely conceived and funded by international and/or Israeli institutions, include ventures involving Israeli institutions such as the Peres Peace Center and Galilee College with the cooperation or active involvement of Palestinian health professionals, whether such involvement is in the area of training, referral to Israeli health services, capacity building, or other joint ventures; initiatives aiming at promoting dialogue and collaboration between Palestinian and Israeli health professionals, NGOs and health institutions; projects that entail joint scientific/research cooperation and publications in international journals under the general heading Peace-building through joint Palestinian-Israeli health initiatives; conferences and workshops aiming at contributing to conflict resolution and harm reduction; and presentations in conferences in joint Israeli-Palestinians sessions under rubrics such as Working towards peace in the Middle East.

Our deep-rooted objections to such joint schemes are multiple:
1. These initiatives, no matter how well intentioned, are imposed largely from the outside, either luring professionals and academics with funds, facilities and opportunities for personal advancement in a resource starved environment, or bringing them solutions to individual medical and systemic problems that the Israeli military occupation of Palestinian land has created and maintained.
2. Such schemes, furthermore, do not reflect current Palestinian priorities and ignore the vastly unequal relationship between the two parties: one is an occupier and the other is occupied.
3. They fail to take into consideration the generally silent response of the Israeli academic and professional establishment to Palestinian scientific, medical, health, educational, economic, social and political strangulation. In some cases, such Israeli institutions have been known to participate in developing the strategies and plans of Israeli rule of Palestinians, their justification, and even providing the academic legitimacy to market such strategies and plans in the West.

4. They also reflect an unacceptable politicization of health research and other activities, and claim to be apolitical when a political agenda is in fact the driving force for such forced cooperation between Israelis and Palestinians.

5. They are largely premised on the mistaken belief that Israeli and Palestinian cooperation in the academic, scientific and professional spheres can lead to peace. While there may be reasons to believe that such cooperative ventures may contribute to reconciliation in a post-conflict setting, it is difficult, if not impossible, to believe that such cooperation can achieve much in ongoing conflict, especially when justice for Palestinians has not been achieved. To date, evidence demonstrates that joint academic Palestinian-Israeli projects are neither effective in bringing about reconciliation, nor desirable. Such ventures have in fact contributed to hindering the path to just peace, as their role has been limited to enhancing Israeli institutional reputation and legitimacy, without restoring justice to Palestinians, in the face of continued Israeli Government violations of international law and fundamental Palestinian human rights, including breaches of the Geneva Conventions.

We believe that it is more fruitful to consider investing what seems to be a large amount of funds -- dedicated by international bodies to such Israeli-Palestinian ventures -- directly into Palestinian Institutional infrastructure and capacity building, to allow Palestinians to develop the needed human resources, referral services and academic scientific infrastructure that would help them take off on the path of independence and sustainable development. We also believe that it is the right of Palestinians to choose their partners in research, training, teaching and other activities. It would thus be more fruitful to leave Palestinians to make their choice of partners and invest in developing existing research, training and Other relationships with various bodies and groups in Jordan, the Arab World, Europe, the United States and Canada, as well as Israelis who openly oppose occupation and work with Palestinians based on a platform of justice, instead of linking the acquisition of funds or
operation of projects to the condition of cooperating with Israelis. As for well meaning Israeli
academics, scientists, and health professionals, it may be well worth their while to consider
becoming actively involved in Israeli or joint Israeli-Palestinian activities aimed at ending Israeli
military occupation of Palestinian land, the removal of closures, checkpoints, siege and the
Apartheid Wall, among other manifestations of the root cause of ill health: the occupation.

Signatories:
   Central National Committee for Rehabilitation 4. Health Development Information Policy
   Institute 5. General Union of Palestinian Workers 6. General Union of Palestinian Charitable
   Societies 7. Women's Affairs Technical Committee 8. Center for the Treatment and
   Rehabilitations of the Victims of Torture 9. Gaza Community Mental Health Programme 10.Red
   Crescent Society Nablus 11. General Union of Disabled Palestinians
   12. Center for University services al-Najah University 13. Center for Development of Community
   Palestinian National Council of Non-Governmental Organizations 20. Field Research Group
Appendix II

Law Number 4 for the Year 1999
Concerning the Rights of the Disabled

The Chairman of the Executive Committee of the Palestine Liberation Organization
The President of the Palestinian National Authority

After reviewing the draft law presented by the Council of Ministers
And pursuant to the presentation of the Minister of Social Affairs
And after the approval of the Legislative Council
We hereby promulgate the following Law

Chapter One
Definitions and General Provisions
Article one
In applying the provisions of this Law, the following words and terms shall have the meanings
designated hereunder unless stipulated otherwise.

The Minister Ministry of Social Affairs.

The Minister The Minister of Social Affairs

The disabled Any individual suffering from a permanent partial or total disability
whether congenital or not in his/her senses or in his/her physical,
psychological, or mental capabilities to the extent that it restricts the
fulfillment of his/her normal living requirements in a manner not usually
faced by those without disabilities.

The disabled card The card that specifies the group of services which the disabled is entitled
to receive through an organized program.

Rehabilitation The package of services, activities and social, psychological, medical,
educational, and professional aid that enable the disabled to exercise
his/her right independently and with dignity

Protected workshops The centers which are designated for rehabilitating, sheltering, and
employing those disabled suffering from severe mental disabilities.

Public place Any building, or path, or road, or another place that provides public
services to the citizens.
Accessibility Rendering public places and work premises suitable for use by the disabled.

Article Two
The disabled have the right to enjoy a free life, dignified living, and various services in a manner equal to that of other citizens and he/she shall have the same rights and obligations that are within his/her capabilities. It is not permissible to prevent any disabled from enjoying these rights because of his/her disability.

Article Three
The state shall guarantee the protection of the rights of the disabled and shall facilitate their attainment. The Ministry shall coordinate with the competent bodies to prepare an awareness program for the disabled, his/her family, and his/her local environment regarding the rights stipulated in this Law.

Article Four
Ills permissible pursuant to this Law for the disabled to establish their own organizations and societies.

Article Five
1. The state shall provide the disabled with rehabilitation in all its forms in accordance with the requirements of the nature of the disability. The contribution of the disabled shall not exceed 25% of the expense.
2. The disabled shall be exempt from this contribution for resisting the occupation.

Article Six
Pursuant to the provisions of the law, the following shall be exempt from fees, customs, and taxes:
1. All medical and education equipment as well as aid instruments, and transportation means necessary for the registered schools and organizations of the disabled.
   2. Private transportation means for use by the disabled individuals.

Article Seven
Pursuant to a request by the Ministry, government agencies shall submit their annual reports and plans pertaining to the services provided by them to the disabled.

Article Eight
Pursuant to the provisions of this Law, and in coordination with the Ministry, the competent ministry shall issue and grant the technical licenses necessary for operating and practicing services, programs, and activities provided by the non-government sector to the disabled as well as to supervise them.
Article Nine
The state shall set the regulations and limitations that guarantee the right of the disabled to be protected against all forms of violence, exploitation, and discrimination.

Chapter Two
Responsibilities for Providing Services

Article Ten
The Ministry shall be in charge of coordination with all relevant and competent bodies to secure the welfare and rehabilitation of the disabled in the following spheres.

1. In the social sphere
   a. To determine the nature of the disability, its degree, and the extent to which it affects the family of the disabled, and to provide the appropriate assistance.
   b. To provide special shelter services to the severely disabled and deserted individuals.
   c. To support the protection centers.
   d. To issue the disabled card.

2. In the Health Sector
   a. To diagnose and classify the level of disability.
   b. To guarantee health services that are included in the government health insurance free of charge both to the disabled individual and to his/her family.
   c. To provide and upgrade the early detection services for disabilities.
   d. To provide the necessary medical equipment and tools to assist the disabled individual in accordance with Article Five of this Law.
   e. To provide curative and preventive services that aim at reducing the rate of disability in society.

3. In the education sector
   a. To guarantee the right of the disabled to attain equal opportunities to enroll in the various educational and training facilities and in universities in accordance with the curricula determined in these establishments.
   b. To provide the educational analysis essential for determining the nature of the disability and its extent.
   c. To provide appropriate educational and training curricula and approaches and other suitable facilities.
   d. To provide various types and levels of education to the disabled individuals according to their needs.
   e. To prepare qualified educators to train the disabled according to the type of disability.

4. In the rehabilitation and occupational sphere
   a. To prepare qualified technical personnel to work with the various types of disabilities.
   b. To guarantee the right to be enrolled in the various rehabilitation and vocational training facilities pursuant to the various applicable laws and bylaws on the basis of equal opportunity and to provide appropriate vocational training program for the disabled.
c. To compel government and non-government organizations to absorb a number of disabled individuals provided that the number is not less than 5% the number of staff in each organization. The absorption shall be consistent with the nature of work of these institutions, and the work place shall be suitable for the employment of these individuals.

d. To encourage the employment of the disabled in private institutions by deducting part of the salaries from the income tax fixed on these institutions.

5. In the sphere of sports and leisure

a. To provide sports and leisure opportunities to the disabled by rendering the facilities of sports grounds, halls, clubs and summer camps suitable to the conditions of the disabled and to equip them with the necessary equipment and provisions.

b. To support the participation of the disabled individuals in national and international sports activities and programs.

c. To reduce the entry fee of the disabled into the government cultural, leisurely, and historical sites by 50%.

6. In the popular awareness sector

a. To carry out public awareness Campaigns about disability in all respects including its causes, consequences and needs.

b. To publish information and data regarding prevention in order to reduce the level of disability in society.

c. To publish general guidance and awareness material for the purpose of integrating the disabled individuals in society.

d. To use sign language in television.

Article Eleven
The state shall strive to incorporate sign language in the government services and facilities.

Chapter Three
The Accessibility of Public Places for the Disabled

Article Twelve
The objective of accessibility is to achieve an appropriate environment for the disabled that ensures their easy and independent movement and the safe usage of public places.

Article Thirteen
1. Accessibility is obligatory on the relevant bodies unless:

a. It threatens the historic and ancient character of the public place.

b. It inflicts risk and danger to the safety and security of the public place.

c. It costs more than 15% of the value of the public place.

2. With respect to the aforementioned circumstances stated in clauses (a, b, and c) above, the relevant and competent bodies shall find appropriate alternatives that ensure the accessibility of the public place to the disabled individuals.
**Article Fourteen**
The Ministry of Education and the Ministry of Higher Education shall guarantee the provision of an environment suitable to the needs of the disabled in schools, colleges, and universities.

**Article Fifteen**
In Coordination with the relevant bodies, the Ministry of Local Government shall be responsible for compelling private and government institutions to adhere to the technical, engineering, and architectural requirements and standards that should be furnished in old and new public buildings and public facilities for the service of the disabled.

**Article Sixteen**
The Ministry of Transportation shall strive to prepare an appropriate environment to facilitate the movement of the disabled and Shall grant special discounts for the disabled and their companions in public transportation means.

**Article Seventeen**
The Ministry of Telecommunications shall provide the necessary facilities to enable the disabled to use the equipments, devices, end facilities of telecommunications

**Chapter Four**
**Concluding Provisions**

**Article Eighteen**
*My* provision in contravention with the provisions of this Law shall be repealed

**Article Nineteen**
The Council of Ministers shall promulgate the necessary bylaws to implement the provisions of this Law.

**Article Twenty**
All competent bodies, each according to its competencies, shall implement the provisions of this Law, which shall enter into force on the date of its publication in the official Gazette.

**Issued In Gaza city on 9 August 1999**
**Corresponding with ____/____/1419 Hegira**

**Yaser Arafat**
The Chairman of the Palestine Liberation Organization
The President of the Palestinian National Authority