Evaluation of the Strategic Cancer Care Initiative (SCCI) Phase I&II

Palestine

Report

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Laarstraat 43, B-2840 Reet Belgium
E-mail hera@hera.eu
tel. +32-3-8445930
fax. +32-3-8448221
www.hera.eu

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Consultant Team:

Garth Singleton
Dr Abdul Muti Al Azzeh
Dr Bassam Abu Hamad
Dr Maesa Irfaeya
Eman Abu Hamra

TABLE OF CONTENTS

Table of Contents ii
List of figures and Tables iii
List of Boxes iii
Acknowledgements iv
List of abbreviations and acronyms v
Executive Summary vi
Recommendations ix
1 Introduction & background to the evaluation 1
2 Evaluation methodology/limitations/constraints 1
2.1 Document Review & Inception Report 1
2.2 The Substantive Evaluation 1
2.3 Reporting 2
2.4 Limitations and Constraints to the Evaluation 2
3 Findings 3
3.1 Project Description 3
3.2 Relevance 4
3.3 Impact 7
3.5 Effectiveness 18
3.6 Efficiency 20
3.7 Sustainability 23
4 Annexes 26
Annex 1: Terms of Reference 26
Annex 2: Documents Reviewed. 30
Annex 3: Stakeholders consulted 31
Annex 4: Progress against indicators 33
Annex 5: Project Finances 43
Annex 6: Findings from focus group discussions 45
Annex 7: Gaza referrals data and discussion 55
Annex 8: Short biographies of consultants 59

LIST OF FIGURES AND TABLES

Figure 1: Cancer incidence in Gaza per 100,000 population, 2008-2014 5

Table 1: Information on cancer in West Bank and Gaza, 2013 4
Table 2: Patients and Out-Patients reported as attending AVH for cancer treatment: 2009-2012 10
Table 3: Patients reported as registering at AVH for cancer treatment: 2012/13 & 2013/14 11
Table 4: Patients reported as registering at AVH for cancer treatment* 12
Table 5: SCCI Phase I & II budgets and expenditure 21

LIST OF BOXES

Box 1: Summary of SCCI Phase I project achievements against indicators 8
Box 2: FGD Findings 19

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In particular we would like to thank the current and past patients who participated in focus group discussions and individual in-depth interviews for the evaluation. Despite undergoing difficult treatment regimens, they were happy to contribute their views to the evaluation.

The Evaluation Team would like to pay tribute to Dr Tawfiq Nasser, Chief Executive Officer of AVH, who sadly passed away just before the arrival of the evaluation team. He was clearly an inspiration to the staff of AVH, a driving force for cancer services at AVH and a great champion of Palestine. He will be sadly missed.

The Evaluation Team
July 2015

LIST OF ABBREVIATIONS AND ACRONYMS

AVH	Augusta Victoria Hospital
BUS	Betanien University College
DAC-OECD	Development Advisory Committee of the Organisation for Economic Cooperation and Development
EDL	Essential Drug List
EU	European Union
€	Euro
FGDs	Focus Group Discussions
GS	Gaza Strip
hera	Health Research for Action
KII	Key Informant Interview
LSS	Life Support Skills
MFA	(Norwegian) Ministry of Foreign Affairs
MOH	Ministry of Health
N/A	Not Applicable
NCA	Norwegian Church Aid
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NOK	Norwegian Krona
OIS	Oncology Information System
OPT	Occupied Palestinian Territory
PA	Palestinian Authority
SCCI	Strategic Cancer Care Initiative
SMART	Specific, Measurable, Attainable, Relevant, Time bound
SO	Stiftelsen Oljeberget (Mount of Olives Foundation)
UNRWA	United Nations Relief Works Agency for Palestine Refugees in the Near East
WB	West Bank

EXECUTIVE SUMMARY

The Ministry of Foreign Affairs (MFA) of Norway funded a six year (2009-2015) programme, the Strategic Cancer Care Initiative (SCCI), to support the development of specialist cancer care services for the Occupied Palestinian Territory (OPT) in the West Bank (WB), Gaza Strip (GS) and East Jerusalem. This support, implemented over two phases; Phase I from March 2009 until March 2012, and then Phase II which is to be completed in July 2015; was valued at over 47 Million Norwegian Krone (NOK) and has been implemented through Norwegian Church Aid (NCA). SCCI has focussed on building the capacity of the Augusta Victoria Hospital (AVH) in Jerusalem. The overall project goal for Phase I was that '*Cancer services for the Palestinian people have been improved through developing and building a sustainable and comprehensive national cancer referral centre at AVH that is a centre of excellence in treatment for adults and children and supports the needs of the Ministry of Health*'. The overall project goal for Phase II was to '*Strengthen the health system in occupied Palestinian Territory and the Palestinian presence in East Jerusalem*'.

Both phases planned to undertake activities to build human capacity at AVH as well as contribute to the development of the cancer care infrastructure at the hospital. In addition phase I anticipated building research capacity at AVH while phase II anticipated contributing to increasing access to AVH for patients from Gaza as well as including a small component for advocacy for AVH within Norway. The phase I project anticipated support to the development of comprehensive 'system' of prevention, control and treatment of cancer. Implementation focussed almost entirely on treatment with very little emphasis on prevention or control.

A team consisting of five consultants was contracted to undertake an evaluation of both phases of the SCCI in May 2015. The evaluation, which was to comply with the DAC/OECD guidelines on evaluation consisted of a literature review of relevant documents, focus group discussions and key informant interviews with patients and other project stakeholders in East Jerusalem, the WB, Gaza and Norway. A presentation of the initial evaluation findings was made to project stakeholders in Jerusalem at the end of the field work.

Project performance

Capacity Development: a training plan for AVH medical, nursing and technical staff was developed, with active AVH involvement that directly addressed the felt needs of AVH. The plans were implemented through a series of training exercises and attachments conducted in Palestine and Oslo with contributions from the Betanien University College, Radium and Diakonhjemme Hospitals in Norway and the Palestinian NGO Juzoor. Participants reported being very satisfied with the training programme contents, format and conduct. There is evidence that new services have been introduced as a result of the capacity development activities of the SCCI as well as improvements in various aspects of hospital performance.

The Post Graduate Diploma in Cancer Nursing, carried out over 3 years during phase II was particularly innovative and, as a result, modules on oncology and palliative care nursing are being trialled for introduction to the basic nursing curriculum in Palestine, subjects that had previously not been included.

Infrastructure development: SCCI supported the development of AVH infrastructure based on annual work plans that complemented the inputs of a variety of other donors. SCCI was flexible in its approach to enable the benefits of other, less flexible donors, to be maximised, resulting in a coherent infrastructure development programme for the hospital.

The reprogramming of funds away from the purchase of a mammography van was unfortunate in view of the real need to increase early detection of breast cancer in OPT. However the need to raise additional funds for the running costs, for what would have been a second such mammography van being run by AVH, would have been difficult and would not have added to the central focus of the project to strengthen the tertiary services available within AVH.

Research: one intention of Phase I had been to develop the policy oriented research capacity of AVH. This was not implemented as the capacity of the clinicians within AVH to be involved in research

alongside their clinical duties was limited. This was unfortunate as there is limited information about the types, treatment and outcomes of cancer treatment in Palestine. The new Oncology Information System (OIS), introduced by the project, should be able to provide better information, than had previously available to monitor cancer in Palestine.

Access: A number of factors make access to AVH services difficult, particularly for the people of Gaza: (i) they are required to obtain a permit to travel outside Gaza from the Israeli authorities. This is a difficult and time consuming process, and (ii) some treatments at AVH require patients to have intermittent treatments over an extended period of time. The difficulties of travel from Gaza to Jerusalem make it more practical for the patient stay in Jerusalem for their entire period of treatment. However space within AVH is limited and it would not be cost effective to keep Gaza patients as inpatients for the duration of their treatment. Consequently the project supported the hotel accommodation costs that enabled Gaza patients to stay in Jerusalem during their treatment. This enabled around 140 Gaza patients per month to be accepted for treatment during phase II of the project.

International advocacy: Phase II included a very small component that supported the ongoing involvement of a Norwegian body, *Stiftelsen Oljeberget (SO),* to have a continuing role in the oversight of AVH through participation in management board meetings. This link proved valuable when arrears owing to AVH had become excessive; SO was able to advocate with the Norwegian Government which, in turn, advocated with the EU for payment to enable the Palestinian Authority (PA) to pay the arrears.

Relevance: Cancer is a major reported cause of death in Palestine being the second leading cause of death in the WB and Gaza. The incidence of cancer is roughly equal between males and females with breast cancer being the commonest cancer for women while lung and colon cancer are the commonest amongst men. Incidence is reported to be slightly higher in Gaza than on the WB but increased in both parts of Palestine between 2008 and 2014: 54 to 80/100,000 in the WB and 66 to 86/100,000 in Gaza. A high proportion of cancers are identified at a late stage, 48 – 60% of breast cancers diagnosed through screening were at stages 3 or 4 indicating a poor prognosis for treatment.
Eight MOH and NGO hospitals provide oncology services (4 in WB, 3 in Gaza and 1 in East Jerusalem) but only AVH in East Jerusalem can provide a comprehensive service of radiotherapy as well as surgery and chemotherapy treatments for cancer. Israel does not permit radiotherapy services to be developed in the WB or Gaza. Treatment services within WB and, particularly, Gaza are reported to be weak with shortages of facilities for specialised oncology care and of oncology medicines.
The Strategic Health Plans (2014 -16) for both Gaza and the WB define the development of prevention and early detection of Non Communicable Diseases (including cancer) as priorities. The WB plan identifies supporting the development of East Jerusalem NGO hospitals, including AVH, as tertiary care facilities as a priority. In view of the difficulties for residents to leave to Gaza, the Gaza plan seeks to develop a specialist oncology facility, although, due to Israeli restrictions, radiotherapy facilities are unlikely to be permitted.
East Jerusalem is internationally considered as part of the OPT and not recognised as the capital of Israel, however there is clear Israeli pressure on the Palestinian presence in East Jerusalem. The presence of tertiary health services within East Jerusalem, which are accessed (albeit with difficulty) by residents from WB and Gaza maintain the claim by Palestine for East Jerusalem to be included in any future Palestinian state.
The evaluation concludes that the project was relevant in relation to both the medical needs of Palestine to have access to tertiary oncology services and to strengthen the Palestinian presence in East Jerusalem.

Impact: The evaluation was hampered by a weak project design, particularly for phase I, with problems with the project logic and poorly designed indicators. This weakness continued through into project reporting when many of the original indicators were not reported upon and new indicators introduced. One of the project objectives, to '*Strengthen the Palestinian presence in East Jerusalem*' was explicitly political in nature, but no indicators were, perhaps understandably, developed to monitor this.

No baseline figure for oncology treatment numbers at AVH was established and data providing information on utilisation of cancer services was weak until the OIS became operational in mid-2013. Since mid-2013 the number of patients accepted for treatment at AVH has gradually increased from 617 to 720 per month.

More females than males have been accepted for treatment, reflecting the importance of breast cancer as a major diagnosis. Fewer Gazans have been accepted for treatment than might have been expected based on population numbers and cancer incidence. There may be a number of explanations for this.

Effectiveness: The d*e facto* MOH policy is for AVH to be the first hospital for consideration for those in need of oncology referral outside of OPT. The data concerning referrals from Gaza would suggest that this policy is being successfully implemented with oncology referrals to AVH increasing from 16% of all referrals in 2008 to 37% in 2014 while referrals to Jordan and Egypt have fallen significantly. The number of referrals to Israeli hospitals has grown slightly but, as a proportion of all oncology referrals has fallen from about a half to about a third.

In May 2013, AVH was accredited by a US based international hospital accreditation body, Joint Commission International, which provides a level of assurance about the quality of care provided at AVH. However the focus group discussions conducted amongst AVH patients by the evaluation team revealed mixed views, ranging from poor to excellent, over the perceived quality of care provided. Many criticisms related to the hotel accommodation provided for Gazans. The FGDs also revealed a multitude of problems with many aspects of the patient journey from initial diagnosis through the referral process of the MOH to treatment at AVH.

No data is available to demonstrate post treatment survival rates, however the late diagnosis of many cases makes long term prognosis poor

Efficiency: Expenditure on infrastructure increased from the planned 47% of budget to 63% of actual expenditure. This was 'paid for' by reduction in expenditure on Research & Advocacy, from 32% to 19%, and also, to a lesser extent, on capacity development.

The cost of training the 11 Certified Oncology Nurses was around NOK 250,000 (EUR 28,300) per trainee which constitutes very good value for money, resulting from the use of volunteer trainers from Norway.

The largest budget component, infrastructure development, was always likely to be expensive as AVH is an historic building and work had to be carried out without limiting the capacity of the hospital to continue to operate. Strong procurement procedures were used so value for money should be assured.

Project management constituted around 10% of budget and expenditure, a common proportion of overhead costs for international projects. Project management was effectively delivered apart from weaknesses in reporting.

Sustainability: the project is politically sustainable in view of the Palestinian Authority support for developing East Jerusalem hospitals.

A national shortage of the highly specialised staff needed to run oncology services could limit the technical sustainability of some AVH services. The hospital is addressing this by supporting the training of key cadres.

Financially, AVH is almost entirely dependent on PA for payment of oncology services. In turn, the PA is largely dependent on donors for such payments. AVH recognises this weakness and is looking to diversify its sources of funding.

Conclusion: Despite weaknesses in project design that necessitated significant changes during implementation and hindered effective monitoring, the project has supported AVH in developing a specialist oncology centre which Palestinians can be proud of. The project has also facilitated and normalised the use of the East Jerusalem hospital by the residents of Gaza.

Together, these actions, we believe, have contributed to strengthening the Palestinian rights to East Jerusalem.

RECOMMENDATIONS

Future Collaboration It is unfortunate that the strand of the SCCI project that had hoped to develop policy oriented research was not implemented as AVH already has much useful data that could be utilised to contribute to the policy debate in Palestine. AVH, perhaps with the assistance of NCA, should look for partnerships with institutions that can assist AVH in contributing to the policy debate through the preparation and presentation of policy briefs, academic articles and the preparation of newspaper articles that push for a greater preventive activities by the MOH and the community.

Capacity Development AVH has assisted in the development of oncology and palliative care modules that are currently being trialled in two WB nursing schools. AVH should continue to support these trials and to advocate for, and support, their inclusion in all Palestinian nursing schools. In addition AVH should continue to advocate for the introduction of a higher level qualification course for nursing oncology.
The project supported Nursing Oncology certificate that will be obtained by the AVH nurses is not yet recognised by the PA Ministry of Higher Education. AVH should continue to advocate for its formal recognition in Palestine in order that the qualification is accepted in other institutions in OPT which would enable the graduates to formally teach nursing oncology in other institutions.

Sustainability The provision of hotel accommodation for patients from Gaza has been essential to enable referrals from Gaza to be accepted by AVH. Without this facility, it would not have been possible to accommodate the large number of patients in the hospital. Patients from Gaza would have to have been referred to other hospitals at greater expense to the PA MOH. Now that the SCCI funds for this have finished, AVH is having to fund hotel costs from its own resources. AVH, with the support of NCA, should actively advocate with the MOH to ensure that they are aware of this additional cost for Gaza patients, and with the donor community in order to obtain further funding.

Patient's Opinions It is recommended that AVH actively monitor the views of patients and where possible address complaints as they arise. More frequent communication with patients, explaining the limitations of the hospital's capacity to effect changes might be helpful.

Psycho Social Support In addition to the support provided by AVH, there are other organisations, such as the Patient's Friend Society, that are involved in the non-medical aspects of cancer care that might be interested to be involved in supporting patients while they are in Jerusalem and who might be able to provide additional support to patients.

Prevention and early Detection With a high proportion of cases of breast cancer as well as other cancers being diagnosed at the palliative stage, and in line with the stated priorities stated in the Palestinian health plans, it would be important that programmes for the prevention and early detection of cancers are reinvigorated. AVH should use its position as specialist cancer facility to actively advocate with the MOH for this.

Project Design While there is evidence of an improvement between phases I and II in the logical framework approach used to design the two phases, in both cases there were serious weaknesses in the project design, particularly in the definition of indicators. It is recommended that NCA provides support or training in the logical framework approach for NCA country offices and their prospective project partners , prior to future project design work taking place.

1 INTRODUCTION & BACKGROUND TO THE EVALUATION

The Ministry of Foreign Affairs (MFA) of Norway funded a six year (2009-2015) programme, the Strategic Cancer Care Initiative (SCCI), to support the development of specialist cancer care services for the populations of the Occupied Palestinian Territory (OPT) in the West Bank (WB) and Gaza Strip. This support, implemented over two phases, from March 2009 and to be completed in July 2015, was valued at over 47 Million Norwegian Krona (NOK) and has been implemented through Norwegian Church Aid (NCA). The SCCI aimed to focus on building the capacity of the Augusta Victoria Hospital (AVH) in Jerusalem to enable the implementation of a National Strategic Cancer Care Plan as well as contribute to Palestinian nation building and the building of a national health system for Palestinians.

The overall project goal for Phase I was that '*Cancer services for the Palestinian people have been improved through developing and building a sustainable and comprehensive national cancer referral centre at AVH that is a centre of excellence in treatment for adults and children and supports the needs of the (Palestinian) Ministry of Health*'.

The overall project goal for Phase II was to '*Strengthen the health system in occupied Palestinian Territory and the Palestinian presence in East Jerusalem*'.

As the second, and final, SCCI phase is coming to an end, NCA contracted a consultancy team to conduct an independent external evaluation. The terms of reference for the evaluation are shown in Annex 1. This is the first draft report of the evaluation findings and contains, in addition to an executive summary and list of recommendations, an outline of the methodology used in the evaluation (Section 2) followed by the evaluation findings (Section 3) covering, in turn, project relevance, impact, effectiveness, efficiency and sustainability. A series of annexes provide greater information on some aspects of the evaluation and its findings.

2 EVALUATION METHODOLOGY/LIMITATIONS/CONSTRAINTS

The evaluation was carried out in a number of phases; an initial document review and the preparation of an inception report; followed by the substantive evaluation phase itself which consisted of a more detailed document review followed by key informant interviews (KIIs) and five focus group discussions (FGD). A finalisation phase in which the evaluation report was drafted, reviewed and completed was then undertaken.

2.1 Document Review & Inception Report

The starting point of the evaluation was an initial document review. NCA made available a number of documents while an internet search identified a number of other useful documents. The documents reviewed are listed in Annex 2. Following an initial review of the NCA documents, a draft inception report was prepared and agreed amongst the Evaluation Team members and forwarded to NCA, on 24 April 2015, for comments. The inception report proposed a detailed methodology for the evaluation and, following discussion with NCA Palestine which resulted in some minor modifications, this was adopted as the methodology to be used for the evaluation.

2.2 The Substantive Evaluation

Project performance, based on a more detailed review of project reports, was assessed by comparing the reported performance of the various project indicators against the initial objectives as defined in the planning documents for each of the two phases. This resulted in a greater

understanding of the project and its performance and informed the direction of the subsequent KIIs and FGDs undertaken during the field visits.

The field visit took place over the period 18th – 29th May 2015. With the assistance of NCA in Jerusalem, key informants were identified, contacted and a programme of meetings arranged. The names of the individual informants is shown in Annex 3.

In order to overcome the barriers to working in Palestine, the field work was undertaken by two teams, one team based in Gaza while a second team undertook the work in Jerusalem and the West Bank. The two teams undertook a series of KIIs with stakeholders, including the MOH, based on the methodology agreed in the inception report. The two female team members, one in Gaza, one in West Bank, undertook the FGDs as well as some KIIs, again based on the agreed methodology, which, where appropriate, were conducted with all female or all male participants to ensure, as far as possible, particular gender views were not constrained by Palestinian social constraints. In addition, the evaluation team conducted several site visits and field observations at oncology facilities in Jerusalem, Gaza and West Bank. A number of Norwegian stakeholders were contacted by Skype/ telephone/email to answer questions related to their involvement in the project (see Annex 3 for names).

2.3 Reporting

The two teams, Gaza and West Bank, each prepared a note of their findings against an agreed format. These were combined and discussed (skype/email) between the two teams in order to agree the key findings. The key findings were presented to NCA and AVH staff at a feedback meeting held prior to the departure of the evaluation team. The evaluation team subsequently developed this first draft evaluation report, incorporating the comments from the feedback meeting where appropriate.

2.4 Limitations and Constraints to the Evaluation

The major constraint for the evaluation was the weakness in project design, particularly for Phase I, but also to a lesser extent in Phase II. While elements of a logical framework structure are obvious in both phases there are significant weaknesses in the indicators used at the various levels, either being absent or not being SMART (Specific, Measurable, Attainable, Relevant, Time bound) or being at the wrong level of the results chain. This weakness was compounded by the annual reports which failed to report against the initial design indicators and introduced new indicators over time. This is demonstrated in Annex 4 where the evaluation team has attempted to chart reported progress against the indicators defined in the two phases of the project. This weakness has made it difficult to objectively assess the performance of the project against its goals.

The other major constraints were those to be anticipated working in the OPT such as (i) delays for consultants travelling between West Bank and Jerusalem, (ii) travel restrictions made it impossible for the whole team to meet together to agree a methodology and also their findings, and (iii), the unexpected absence of interviewees who had been called away and not been able to attend arranged meetings. There was not adequate time available to make a second visit to any informant who was unavailable for a first meeting.

The ongoing situation in which, to a large extent, there are two separate autonomous health ministries[1], one each for Gaza and the West Bank, also poses limitations. There are significant political sensitivities to be aware of and there are separate health information systems in Gaza and West Bank, which makes an understanding of the statistics that are available difficult.

[1] Between 2007 and May 2014, there were, in effect, separate ministries of health in Gaza and the West Bank. Since May 2014, there has been a single Minister of Health (in the West Bank) although the two ministries continue to operate largely independent of one another.

Recommendation

While there is evidence of an improvement between phases I and II in the logical framework approach used to design the two phases, in both cases there were serious weaknesses in the project design, particularly in the definition of indicators. It is recommended that NCA provides support or training in the logical framework approach for NCA country offices and their prospective project partners , prior to future project design work taking place.

3 FINDINGS

3.1 Project Description

The SCCI project was implemented over two phases with slightly different goals or objectives and outcomes for each Phase. Phase I was implemented between October 2009 and March 2012 with funds of NOK16.5 million. The overall project goal for Phase 1 was that '*Cancer services for the Palestinian people have been improved through developing and building a sustainable and comprehensive national cancer referral centre at AVH that is a centre of excellence in treatment for adults and children and supports the needs of the (Palestinian) Ministry of Health*'.

The project objectives for Phase 1 were:

- To build the capacity of health care professionals at AVH and partner health organisations working with cancer care so as to establish a system for prevention, control and treatment of cancer in Palestine.
- To upgrade facility and acquire technology to provide needed tools necessary for cancer patients, companions and trained staff serving the targeted group.
- To conduct clinical, biomedical and policy directed research to assist in the improving and upgrading clinical services and by providing policy makers with evidence-based information that will assist in the formulation of national policies for effective cancer awareness, prevention and control.

It is apparent that a logical framework approach was taken for the design of Phase I although no actual logframe was provided to the evaluation team. The goals, objectives and outputs with project indicators, along with the evidence of achievement provided by project reports, are detailed in Annex 4.

Phase II was to be implemented between April 2012 and March 2015 and with funds of NOK30.7 million. Project completion has been delayed until July 2015. The overall project goal for Phase 2 was to '*Strengthen the health system in occupied Palestinian Territory and the Palestinian presence in East Jerusalem*'. This introduced an explicitly political objective, strengthening the Palestinian presence in East Jerusalem, in addition to a simple health service objective. The health services objective no longer included any reference to prevention in the outcomes anticipated in phase II.

The anticipated outcomes for Phase II were that:

- The skills of healthcare teams have been upgraded.
- AVH has safe and well equipped facilities for the diagnosis, treatment and documentation of care of patients suffering from cancer.
- The Palestinian population has increased access to cancer treatment and care.
- *Stiftelsen Oljeberget* has advocated for the political and humanitarian significance of providing quality health care at AVH.

A logical framework approach was also taken for the design of Phase II with the logframe included in the proposal to the MFA. The goals, objectives and outputs with project indicators, along with the evidence of achievement provided by project reports, are detailed in Annex 4.

3.2 Relevance

TOR Questions

- **To what extent is the Program an appropriate response to the incidence and prevalence of cancer patients?**
- **Is the program consistent with the cancer plans in West Bank and Gaza?**
- **To what extent is the Program acceptable to cancer patients and other stakeholders?**
- **What are the factors contributing to Cancer Patients choosing other Hospitals?**
- **Do the Program objectives continue to be appropriate?**

The importance of Cancer in Palestine: The Palestinian National Health Strategies (2011 – 13 and 2014-18) and the Health Sector Strategic Plan for the Gaza Governorate (2014 – 18) [2]all highlight the importance of cancer as a public health issue. In both the WB and Gaza, malignant neoplasms are the second leading cause of death (all ages), accounting for 13% of all deaths in the WB and 12% in Gaza. Breast cancer is the most prevalent cancer amongst women while colon and lung cancers are the most common cancers among males.

The following (table 1 and graph – figure 1) provide some information on cancer in West Bank and Gaza for 2013.

Table 1: Information on cancer in West Bank and Gaza, 2013

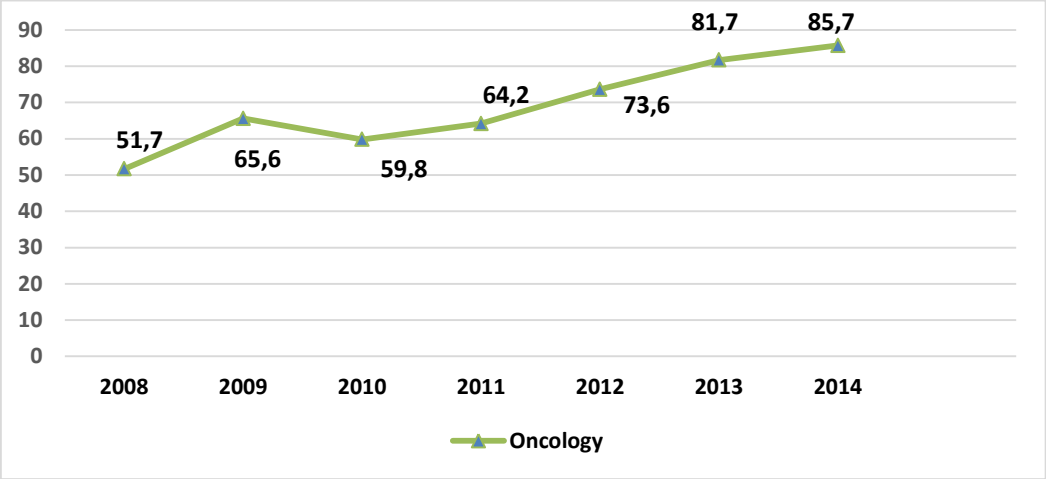
	West Bank	Gaza
New cases	2,189	1,414
% female	51.5%	54%
% less than 15 years	6%	7%
15 - 64 years	60%	80%
65 years and over	34%	13%
Incidence rate	79.5 / 100,000	81.7 / 100,000

Source: West Bank - 2013 MOH Annual Report

Gaza – Information provided to evaluation team by Gaza MOH.

[2] Sources: Health Annual Report 2013 for WB and Health Sector Strategic Plan for the Gaza Governorate (2014 – 18).

Figure 1: Cancer incidence in Gaza per 100,000 population, 2008-2014



Source: Gaza Governorate Strategic Health Plan.

MOH data (West Bank only) from the National Cancer Registry shows a similar increase in cancer incidence, from 53.7 per 100,000 in 2009 to 79.5 in 2014. The Global Burden of Disease Study 2010[3] confirms this, showing lung, breast, colorectal and liver cancers as well as leukaemia increasing in importance as causes of premature deaths between 1990 and 2010. This may be a result of increased life expectancy in the population of Palestine but may also be attributed to other factors such as improved case detection and the inclusion of more comprehensive data sources as well as possibly reflecting long term changes in lifestyle and in the prevalence of risk factors.

Prior to 2005, the MOH estimated that 60% of the cases of breast cancer identified were at the palliative stage, i.e. beyond any hope of cure. In 2014, the AVH mobile mammography unit found 48% of breast cancer cases identified were at the palliative stage.

Clearly, cancer is an important condition which is a significant cause of ill health in Palestine and, as such requires a coherent and balanced response addressing prevention, early detection, treatment and palliative care.

Facilities for the treatment of Cancer in Palestine: Cancer services are provided by a number of hospitals[4]:

West Bank	Gaza Strip	Jerusalem
• Beit-Jala Hospital • Al Najah Hospital Nablus • Jenin • Tulkaren	• European Gaza Hospital • Nasser Al-Rantisi Hospital • Al-Shifa Hospital	• Augusta Victoria Hospital

The hospitals in the West Bank and Gaza provide surgical and chemotherapy treatment services. The only comprehensive oncology centre, i.e. including radiotherapy, for the treatment of cancer within OPT is at AVH[5,6].

[3] www.healthdata.org/sites/default/files/files/country_profiles/GBD/ihme_gbd_country_report_palestine.pdf
[4] Source: Palliative Care in the Region represented by the Middle East Cancer Consortium (2006) National Cancer Institute, updated through discussions with MOH.

A large number of other institutions, including MOH and UNWRA primary care facilities and a number of NGOs, also provide oncology related services search as early detection, diagnosis, IEC activities and psychosocial support. It is understood that the fixed mammography services provided in MOH facilities in both Gaza and WB are underutilised with a reluctance for women to come forward unprompted.

The Gaza Strategic Health Plan indicates there are serious problems with the cancer services available in the GS with shortages in human resources, inappropriate infrastructure and equipment for oncology services, deficiencies in necessary drugs[7] and supplies, and an absence of clear guidelines and policies for referrals. It is thought that the shortage of drugs for chemotherapy in Gaza may contribute to increased referrals out of Gaza for treatment as well as failures in treatment.

A number of the drugs required to treat cancer do not feature on the Palestine Essential Drug List (EDL). This has resulted in significant shortages of such drugs in MOH facilities and the necessity to refer patients to facilities, generally outside the OPT, for treatment. This problem has recently been addressed with the development of Cancer Treatment Protocols[8] with an agreed list of cancer drugs being developed and, in effect, added to the EDL. The evaluation team were assured that, currently, all the agreed cancer drugs were available in the WB located central medical store although presumably future availability will be subject to the continuing problems of medicines procurement generally. Continuing drug shortages were cited in facilities visited in both WB and Gaza.

Treatment for cancer is provided free of charge in both the WB and Gaza. The treatment of any patients referred for treatment outside WBGS is also paid for by the Palestinian Authority (PA), although with the occasional small (5%) co-payment required from the patient in extremely expensive cases.

Policies for Cancer Care: The *National Health Strategy 2011 – 13* made no specific mention of cancer services but, in the third and fourth objectives of the plan, does place an emphasis on prevention and health promotion to address the emerging problem of chronic diseases and to enable access, particularly for disadvantaged groups, to quality secondary and tertiary health services.

The *National Health Strategy 2014-16* places even greater emphasis on the emerging problems of Non-Communicable Diseases (NCD) and indicates that the PA will focus its efforts towards promoting preventive health care, early detection and screening programs, and implementing national guidelines and protocols for effective NCDs management and treatment in order to decrease NCDs morbidity and mortality rates (Objective 2). With regard to secondary and tertiary care, (Objective 3, sub-program 1) the MOH seeks to reduce referrals abroad by building national capacity within its health institutions and by supporting the NGO and private sector, especially the East Jerusalem Hospitals.

The *Health Sector Strategic Plan: Gaza Governorates 2014 – 18* similarly places a considerable emphasis on health promotion and disease prevention in which cancer prevention is included.

[5] Radiotherapy equipment was installed in Al-Shifa hospital in 2004 but is no longer operating (Strategic Health Plan – Gaza)

[6] It is understood that the Israeli Authorities refuse to allow the development of radiotherapy services within the West Bank or Gaza.

[7] It was reported to the evaluation team that 5-6 of the 35 items on the Chemotherapy drug lists for Gaza are usually missing.

[8] The Gaza MOH facilities use another set of cancer treatment protocols (the National Comprehensive Cancer Network Guidelines).

However, in relation to their responsibility for providing for the treatment of a population under siege, the Gaza MOH seeks to become more self-sufficient in secondary and tertiary services. It plans to establish an advanced centre for oncology and palliative care during the plan period.

It is understood that a ten year *Hospital Master Plan* is under development by the MOH in WB which will specifically recognise AVH as the main tertiary level facility for oncology in Palestine.

All referrals[9] for cancer treatment outside the MOH, from both Gaza and WB, are reviewed by an Oncology / Haematology Referral Committee that meets weekly, chaired by the MOH. the Director of the Cancer Care Center at AVH is a member of the national referral committee . The committee reviews all cancer cases and decides where the most appropriate site for referral is. Apparently, the *de facto* MOH policy is that AVH is the preferred institution for cancer referrals that are to be made outside the MOH. There are some treatments/tests that are outside the capacity of AVH and, on occasion, a lack of physical capacity to receive patients or drug shortages prevent referral to AVH. With the increased capacity at AVH, it is understood that the number of referrals to Israeli or third country hospitals has fallen significantly[10]. Thus cancer patients, unless their treatment is not funded by the PA, do not chose the hospital they are to be treated at. If possible, treatment will be carried out at an MOH facility but if they require radiotherapy or when oncology drugs are not available, almost all should be referred to AVH. Only if some capacity constraints prevents this, should they be referred to another, probably Israeli, institution. In cases where radiotherapy is not part of the treatment, other hospitals, such as Nablus, may be the referral hospital.

The SCCI objectives were very relevant to Palestine in that they address a significant health problem to which the only alternative recourse was continued referral of patients for treatment outside OPT at considerable cost. The project enabled the capacity of the overall Palestinian health care system to expand its capacity through the introduction, through infrastructure development and human resources development, of new technologies and it enabled some access to such services to the people of Gaza. Despite this, and with the increasing incidence of cancer in Palestine, AVH is unlikely to have the capacity to meet all the radiotherapy cancer treatment needs of Palestine in the future.

The services provided at AVH are generally perceived to be of good quality and are welcomed by patients, the MOH, other health care providers and other cancer support groups. (See below for patient views obtained during FGDs).

3.3 Impact

TOR Questions:

- **The evaluation should assess the program implementation performance against original goals and specific objectives; assessing the extent to which the program has met its stated objectives, delivery plan, and highlight the success stories and the extent to which proposed objectives and results have been achieved based on indicators within the program design.**
- **What is the impact of the program on the national level?**
- **What is the impact on the Program of incorporating new technologies, in particular, mammography, radiation, and surgery?**

[9] The referral system is discussed in greater depth in Annex 7.

[10] The MOH routinely reports on the number of patients referred for treatment but this data is not separated by diagnostic group. It would be possible for the MOH to provide this data, but it was not available for the evaluation team.

Annex 4 sets out the separate goals, objectives, outputs and indicators for both phases of the project. In addition, with evidence based on the annual and three year project reports, the annex shows reported progress against the various indicators. While the phase II was clearly an extension of Phase I, there were differences in the goals, objectives, outputs and indicators for the two phases and consequently the two phases are discussed separately below.

No specific goal indicator was defined for **Phase I** of the project. Measurement of achievement of Phase I objectives is only possible through reviewing the indicators that were included for each of the three specific objectives. However a review of these indicators presents some difficulties as many of the indicators put forward in the proposal were not reported upon in the project reports or were changed with other indicators used to measure progress (See Annex 4 for details of these). The evaluation findings are summarised in Box 1 below.

Box 1: Summary of SCCI Phase I project achievements against indicators

Objective (a) To build the capacity of health care professionals at AVH and partner health organisations working with cancer care so as to establish a system for prevention, control and treatment of cancer in Palestine.

Proposal Expected results (outputs): Assessment of the resources available at AVH, a three year development plan for cancer at AVH in cooperation with Norwegian institutions, local training of medical staff in cancer care, local training of nurses and paramedical staff, local training psychosocial care, overseas short courses for medical and health care staff in Norway.

Results: Human Resources development:

- A Training plan for AVH staff was developed as planned.
- Thirteen training programmes were reported to have been carried out, 4 in Norway and 10 in AVH (one programme was held in part in Norway and in part in Jerusalem).
- The training programme in Norway for members of the radiotherapy team (Oncologist, radiation therapist and medical physicist) was designed in close liaison with AVH and so was closely tailored to the needs of the radiotherapy team

Conclusion:

A training plan was developed and implemented.

The beneficiaries of the training that were interviewed by the evaluation team had found the training programmes well designed and of a suitable duration. The programmes had been closely tailored to the perceived needs of AVH and had resulted in the implementation of new services within the hospital as well improved processes and staff morale.

Objective (b) To upgrade facility and acquire technology to provide needed tools necessary for cancer patients, companions and trained staff serving the targeted group.

Proposal Expected results (Outputs): Radiotherapy equipment and supplies, cancer surgery instruments, refurbishment of cancer care in-patient facility, refurbishment of patient and companion caring environment (Hygiene, services & dietary facilities) healing gardens and caring physical environment for treatment.

Redefined Outputs (in Final Phase I Report):

- Radiotherapy equipment and supplies for 2009.
- Cancer surgery instruments.
- Endoscopic equipment for detection of colon & digestive system cancers
- Radiotherapy equipment and supplies for 2010.
- Refurbishment of cancer care in-patient facility 2011.

- Refurbishment of patient and companion caring environment (Hygiene, services & dietary facilities).
- Refurbishment and landscaping of a healing /therapeutic garden and caring environment.
- Radiotherapy equipment and supplies

Results: Equipment Provided:

- Radiotherapy equipment – ordered 2009 delivered 2010
- Cancer surgery instruments – 2009 delivered 2010
- Endoscopic equipment - ordered 2009 delivered 2010
- Radiotherapy system and autoclave purchased
- Bio-bank donated by Radium Hospital delivered 2010 (shipping & duties paid by project)
- Planning software – 2011

Results: Infrastructure developments:

- Infrastructure works in preparation for radiation equipment – 2009/10
- Refurbishment of cancer care in-patient facility 2011
- Refurbishment of patient and companion caring environment -2011/12
- Refurbishment & landscaping of a healing/therapeutic garden/caring environment 2011/12.

Conclusion: SCCI supported the development of AVH infrastructure based on annual work plans that reflected the inputs of a variety of other donors. SCCI was flexible in its approach to enable the benefits of other, less flexible donors, to be maximised, resulting in a coherent infrastructure development programme for the hospital, although the hospital is still limited, through a lack of space, to accept all patients who would benefit from their services.

Objective (c) To conduct clinical, biomedical and policy directed research to assist in the improving and upgrading clinical services and by providing policy makers with evidence-based information that will assist in the formulation of national policies for effective cancer awareness, prevention and control.

Proposal Expected results (Outputs): Published biomedical and clinical research data and articles, scientific conferences, awareness workshops, community based research projects (e.g. screening for prevalence and incidence), publishing behavioural change and communication tools, advocacy workshops, public company's (*sic*) for cancer prevention and control.

Redefined Outputs (in Final Report):

- Establish a tumour tissue and blood bio-bank with trained person
- Implement community advocacy programmes in line with WHO guidelines.
- Initiate with local partners screening protocols and utilise data for research
- Initiate biomedical clinical research protocols using hospital based patients and data.
- Implement programs and distribute materials in behaviour change and communications with local partner organisations.

Results: Research

The focus of this objective was not, as planned, on research during implementation but focussed on three areas:

Social support for Cancer sufferers

- Support for transport, through a bus transport scheme, and accommodation in Jerusalem for cancer patient and their companions were provided.

Protocol development

- Protocols for the mobile mammography unit developed.
- Unified protocol for all adult and paediatric cancer treatments developed for use in the

WB. The evaluation team was informed that different protocols are used in Gaza.

Information, Education and Communications

- IEC materials distributed through mobile mammography unit.
- A breast cancer awareness day was organised.
- Illuminated breast cancer awareness signs were displayed in 8 cities, although none in Gaza.

Conclusion: The original project objectives of undertaking policy focussed research was not achieved due to a lack of human resources capacity within AVH to develop such a research programme.
In such circumstances, the shift in focus to social support for cancer sufferers, protocol development and IEC activities for prevention seems sensible.

While it is not clear from the original proposal, one might expect the goal of a programme to improve cancer treatment services might be to see an increase in patient numbers undergoing treatment for cancer. While a number of the original indicators sought to measure the number of patients using the equipment or facilities provided by the project, such data was not reported upon (it would have been difficult to provide). However, over the three years of project support, patients treated for cancer at AVH apparently increased (table 2).

Table 2: Patients and Out-Patients reported as attending AVH for cancer treatment: 2009-2012

	Gaza	West Bank	Jerusalem[11]	Total
Patients				
2009	275	1,825	1,030	3,130
2010	379	1,418	267	2,064
2011-12	265	2,959	2,961	6,185
Outpatient/Visits				
2009	676	5,903	2,405	8,984
2010	1,214	13,919	1,801	16,934
2011-12	1,432	12,367	3,867	17,666

Sources: Final report for SCCI Phase 1. November 2012.

Note: The figures for 2009 & 2010 cover two complete calendar years and so the figures for 2011-12 are not directly comparable with the previous 2 years as they are for an unknown duration, greater than a year.
'Patients' refer to the number of individuals registered at the hospital for treatment during the year from each location. 'Visits' refers to the numbers of visits made by patients to the hospital for treatment.
There are certain inconsistencies in the data:

- The average number of visits per patient should be around 4. In 2009 and 2011-12 it is <3 while in 2010 it is >8.
- The variation in the number of patients from Jerusalem seems extreme.

Putting aside the apparent data limitations, it would appear that cancer patient numbers at AVH increased between 2009 and 2011/12 although there was a fall in the numbers registered in 2010. Admissions of patients from the West Bank increased by around 60% between 2009 and 20011/12

[11] AVH previously provided secondary hospital care services for UNWRA but now is almost entirely dependent on referrals from the MOH and so takes very few patients from within Jerusalem. Most Palestinian residents of East Jerusalem will have Israeli health insurance which requires them to seek treatment in Israeli hospitals.

and by nearly 200% for patients from Jerusalem. There was a slight drop in the number of admissions from Gaza.

The data from the Gaza MOH (see Annex 7) demonstrates that oncology referrals to AVH rose from 477 in 2008 to 1,680 in 2014, a more than five-fold increase over the period.

The number of visits also more than doubled between 2009 and 2011/12 with a rise in numbers in each year. The number of visits from both Gaza and West Bank increased by 110% between 2009 and 2011/12, while the numbers of visits from Jerusalemites rose by 60 %. For the Gaza patients the average number of visits per patient rose from 2.4 per patient in 2009 to 5.3 in 2011-12. This may reflect the improvement in the ability to obtain passes to travel from Gaza to Jerusalem (discussed below).

Thus while it was not a stated objective of Phase I of the project, the project support period saw a significant increase in cancer treatment activity in AVH. The growth in visit numbers was most significant for patients coming from Gaza and the West Bank while patient numbers grew most for Jerusalem and then West Bank based patients while there was no growth in the number of patients from Gaza.

The **Phase II** proposal was better defined than Phase I with more coherent indicators although many of these were still not reported upon in the annual reports suggesting that they were not SMART in some regard.

The Phase II goal – a **Strengthened health system in OPT and the Palestinian presence in East Jerusalem** – was to be measured through four indicators of which two have not been reported upon. Two of the goal indicators, (i) an *increase of Palestinian patients with access to treatment at AVH in East Jerusalem, including patients from Gaza*, and (ii) an *increase in the number of referrals to AVH per year* effectively measure the same thing and were reported upon. The following table shows the data reported by NCA in their annual project reports[12]

Table 3: Patients reported as registering at AVH for cancer treatment: 2012/13 & 2013/14

		2012/13			2013/14		
		Gaza	**WB**	**Total**	**Gaza**	**WB**	**Total**
Adult	**Male**			365	462	1561	2023
	Female			600	791	2783	3574
Paediatric	**Male**			68	20	264	284
	Female			51	7	198	205
Total		894	190	1084	1280	4806	6086

Source: Annual Reports SCCI 2012/13 and 2013/14.

Note: Greater detail in patient numbers became available following the introduction of the new oncology information system by AVH.

Inconsistencies remain in the data, such as the low number of patients from WB in 2012/13 and the very high number (25) of visits per patient suggesting errors.

The introduction, by SCCI, of the new computerised Oncology Information System (OIS) in May 2013 has enabled the production of more detailed records. The following table shows the data available since then.

[12] As the project has not yet completed, no year 3 data has yet been reported.

Table 4: Patients reported as registering at AVH for cancer treatment*

		2013 (7 months)			2014			2015 (4 months)		
		Gaza	WB	Total	Gaza	WB	Total	Gaza	WB	Total
Adult	**Male**	330	1108	1438	560	2098	2658	181	817	998
	Female	472	1983	2455	853	3588	4441	418	1268	1686
Paediatric	**Male**	16	232	248	50	371	421	8	93	101
	Female	14	163	177	35	276	311	26	69	95
Total		832	3486	4318	1498	6333	7831	633	2247	2880
Avg/month		119	498	617	125	528	653	158	562	720

***2013 (7 months), 2014 (12 months) & 2015 (4 months)**
Source: Data provided by AVH Statistics Department.

Based on this data, a number of tentative conclusions can be reached:

- The number of patients being accepted for treatment at AVH has increased from the period of phase I support with the monthly average increasing from 617 per month in 2013 to being around 720 patients per month in 2015.
- A higher proportion of females (61%) are accepted for treatment than males (39%), consistent with the high incidence of breast cancer. The gender balance is reversed for cases of paediatric cancer where there is a higher proportion of males accepted. This may reflect a higher incidence of childhood cancer amongst male children or reflect some gender bias in the process of seeking and obtaining care for children.
- West Bank holds around 61% of the OPT population compared to 39% in Gaza. Over the three part years (2013-15), the proportion of West Bank residents to those from Gaza accessing care has been around 80:20; a higher number from WB than might be expected from population proportions[13]. This could be explained by a number of possible factors:
  - A real difference in the incidence of cancer (although MOH statistics would suggest higher rates of cancer in Gaza) or a difference in the incidence of cancer cases requiring referral for radiotherapy treatment.
  - A greater ease for WB patients to obtain a referral from the MOH to go to AVH / more difficulties for Gaza patients to travel to AVH for treatment[14].
  - Gaza patients being referred for treatment at other hospitals.
  - Social factors reducing the number of Gaza residents seeking care for cancer.
  - Gaza patients obtain treatment through other mechanisms (although this is likely to be a very small number).
  - The data only covers a short period and may not reflect long term referral rates.

Further studies would be required to ascertain what the major contributing factors to the difference in referral rates between the two parts of Palestine are.

[13] The Evaluation team was informed that the proportion of patients from Gaza receiving radiotherapy is close to the expected 40% of all patients and so it would seem that it is for chemotherapy and/or surgery that the lower than expected proportion of Gaza patients applies.

[14] WHO reports monthly on the number of all Gaza patients (not just cancer referrals) who have been denied permission from the Israeli authorities to travel outside Gaza for medical treatment. In the first quarter of 2015, 17 (1.67% of all patients applying) were denied permission while no response was received for a further 259 applications (16%). http://www.emro.who.int/pse/publications-who/monthly-referral-reports.html

Of the two other indicators, one, a *decrease in patients' referrals to hospitals in Israel, Jordan and Egypt*, is not routinely published by the MOH specifically for cancer patients[15]. In fact the MOH annual reports demonstrate a steady increase in the number of referrals (for all conditions) outside the MOH, from 8,161 in 2009 to 11,233 in 2013, an increase of 38%, faster than the rate of population increase over the period (14%).

Data provided to the Evaluation team by the Gaza MOH shows that, while overall oncology referrals from Gaza increased by 65% between 2008 and 2014, referrals to Egypt and Jordan fell significantly. While the number of patients referred to Israeli hospitals actually increased slightly, from 1,497 to 1,626, as a proportion of total oncology referrals they fell from 50% of all referrals in 2008 to 33% in 2014. This data only refers to referrals from Gaza, it is not known whether a similar change also occurred in referrals from the WB. (The Gaza referral data is presented in more detail in Annex 7).

The final indicator, the *Number of rights holders receiving health services* was introduced for year 3 and has not yet been reported upon. It is not clear what this indicator means.

There was no indicator that attempted to assess part of the goal – a **Strengthened Palestinian presence in East Jerusalem** - although it would be hard to define an indicator for this. It is the assessment of the evaluation team that the project has strengthened the Palestinian presence in Jerusalem:

- The project has significantly strengthened the capacity of AVH to provide specialised services that are not available anywhere else in the OPT. If the residents of West Bank or Gaza were at any time to be denied access to the hospital's lifesaving services there would be clear evidence of human rights abuse, a matter that one would hope that the international community would take very seriously.
- The project has supported AVH and the PA to enable the Gaza residents to obtain permits to attend AVH for treatment. In 2009, permission to travel for Gazans was difficult and generally only extended to day permits with patients having to return each night. Now, while still difficult, there is a general acceptance by the Israelis that permits to stay for extended periods are necessary to enable treatments for cancer.

Objectives and Activities Phase II

Outcome 1: Skills of healthcare teams upgraded

Indicator: Cancer healthcare team capacity increased to treat and support cancer patients more effectively at AVH.

This is not a SMART indicator and cannot be objectively measured.

Activities/Discussion
The component activities, planned on an annual basis were:

[15] This indicator is not SMART as it does not refer specifically to cancer patients and one might not expect a project that concentrates on just one condition to have an effect on overall referrals. While the better indicator *decrease in patients referrals to hospitals in Israel, Jordan and Egypt for cancer treatment,* is not routinely reported by MOH, it is likely that it would be possible for them to obtain this data from their records.

- Training, by trainers from the organisation Juzoor[16], of selected clinical staff in Life Support Skills (LSS) (Basic, Paediatric Advanced and Advanced Cardiac) Care Support. Non clinical staff were trained in Cardiac Pulmonary Resuscitation.
- Juzoor trained AVH staff to become trainers of LSS and have supported these trainers in the ongoing training of other staff in the hospital.
- Betanien University College (BUS), with inputs from Juzoor, developed and implemented a curriculum for an Oncology Nursing Certificate. This course was delivered over the three year programme with periodic teaching visits from BUS trainers with support from instructors from AVH and short attachments in Norway for the students. Eleven students are likely to graduate with the certificate in June 2015 with a post graduate Cancer qualification that is the first in Palestine.
- Training at Oslo University Hospital in radiation therapy, cancer surgery and head & neck surgery; stem cell transplantation techniques for medical, nursing and technicians were shared in anticipation of AVH commencing stem cell transplantation services shortly.

Discussion:
While not reported, there is evidence of the success of the SCCI training programme in that:

- AVH has created the post of Director of Nursing Education & Development with responsibility for ensuring the continuous professional training of AVH staff.
- Continuous training of staff is carrying on with the trainers, trained by Juzoor, being recognised as such and supported in their activities.
- Improved nursing standards have been evidenced by a reduction in toxicity in patients undergoing chemotherapy.
- An external professional observer witnessed, and was very impressed by, the hospital response to a cardiac emergency that occurred when he was visiting the hospital.
- The training programmes provided by the project have enabled the introduction of new techniques such as 3D radiotherapy treatment techniques for breast cancer.
- The Nursing Oncology Certificate, a first for Palestine, with the graduates better trained in oncology than any other nurses in the country. There has been interest by the nurse training schools and the MOH to use these skills to improve basic nursing training at other nursing schools. There is also an interest in developing a post-basic nursing oncology training programme linked to one of the university nursing schools.
- The whole patient centred approach to nursing oncology patients, introduced through the 3 year course, was seen as highly innovative for Palestine and was much appreciated by students.
- AVH has successfully advocated for the introduction of oncology and palliative care components to be included in the basic nursing curriculum. Oncology and palliative care modules have been trialled at two Palestinian nursing schools and, if this proves successful, it will be extended to all nursing schools.

The training programme implemented in Phase II seems to have been very successful in upgrading the skills of the workforce at AVH.

Recommendations

While personal links have developed between the recipients of training programmes and their Norwegian counterparts, it would be appropriate to try to foster institutional links to enable continuing ad hoc support to AVH as well as to perhaps foster research collaboration to enable the extensive data available within AVH to be published.

[16] http://www.juzoor.org/portal/index.php?lang=en

AVH has assisted in the development of oncology and palliative care modules that are currently being trialled in two nursing schools. AVH should continue to support these trials and to advocate for, and support their inclusion in all Palestinian nursing schools. In addition AVH should continue to advocate for the introduction of a higher level qualification course for nursing oncology.

The Nursing Oncology certificate that will be obtained by the AVH nurses is not yet recognised by the PA Ministry of Higher Education. AVH should continue to advocate for its formal recognition in Palestine in order that the qualification is accepted in other institutions in OPT, which would enable the graduates to formally teach nursing oncology in other institutions.

Outcome 2: AVH has safe and well-equipped facilities for diagnosis, treatment and documentation of care of patients suffering from cancer.

Indicator: AVH increased their capacity to treat more cancer patients in a health (*sic*) organised environment.

This is not a SMART indicator and cannot be objectively measured.

Activities:
The component activities, planned on an annual basis were:

- The introduction of an Oncology Information System (OIS) to electronically link all AVH patient records, lab results etc. The system introduced had been recommended by consultants as a system that would link with the existing financial management system. A systems manager has been employed by AVH and staff have ongoing training in the use of the system.
- A haematology oncology (liquid tumours) facility with 12 beds was developed within the hospital.
- A surgical oncology suite with 16 beds is currently under development within the hospital, with completion scheduled for June 2015.

Discussion:

- The planned infrastructure programme is nearing completion with some delay to the final works. Infrastructure works have to take place within an historic building while hospital services continue to operate. Thus there has been a need for both sensitivity in design and care in implementation in order not to disrupt ongoing services.
- AVH is the recipient of a variety of donor funds, some that may be specifically targeted on particular works (such as the USAID donation of a radiotherapy machine). The SCCI funds have been managed flexibly to enable the benefit of other funds to be maximised.
- The OIS has replaced a paper based health management information system in the hospital and can produce simple activity reports as well improve the potential to better monitor treatment outcomes and facilitate research.
- The purchase of a second mobile mammography van was originally planned to increase the capacity of AVH for early detection of breast cancers. The funds for this were reprogrammed (with the appropriate approvals) as (a) AVH is dependent on donor funds for the running of its current mammography services and it was felt that to have to continuously seek funding for two vans would be difficult and (b) while a highly appropriate response to Palestine's need to increase the early detection of breast cancers, this was not central to the project's focus on services within AVH.

The SCCI has supported AVH to implement an appropriate programme of infrastructure development that has enabled the hospital to expand the services available there and thus contribute to achieving the objectives of the project.

The reprogramming of funds away from the Purchase of a mammography van was unfortunate in view of the real need to increase early detection breast cancer in OPT, but was understandable under the circumstances.

Outcome 3: The Palestinian population has increased access to cancer treatment.

Indicator: 700 Gaza patients per year have got the permit to access AVH
A second indicator relating to mammography screening became irrelevant given the decision to re-programme funds for the purchase of a second mammography van to other activities.

Activities:
This component was primarily focussed on paying for the hotel, the psychosocial support for the patients, through the payment of salaries of social workers, and, to a lesser extent, the transport costs, of patients and their companions from Gaza who had been accepted for treatment at AVH.

Discussion:
- Based on the AVH data on origin of patients (see Table 3 above), the project has supported around 140 Gaza based patients and their companions to stay in Jerusalem per month (around 1,680 per year) for extended periods in order to enable them to undertake treatment at AVH, considerably exceeding the project target.
- The MOH does not pay for this aspect of care when agreeing funding for referrals to the hospital. It seems unlikely that this aspect of the cost of care will be accepted by the MOH until such a time as the PA financial situation is much improved[17].
- Without the capacity for Gazan patients to be kept in a hotel, the hospital would not be able to accept as many patients for treatment – the space in the hospital is extremely limited and the capacity of Gazans to pay for their own accommodation costs during extended treatment periods would be low. Sending patients back to Gaza between treatments would likely result in a high rate of failure to return due to the difficulties of traveling between Gaza and Jerusalem.
- The SCCI funds for hotel costs have now finished. AVH is currently paying for this aspect of care from its own resources while seeking alternative funding.

The SCCI has enabled a high number of patient to come from Gaza to AVH for treatment, exceeding the project target. Without the support to the hotel costs much fewer patients from Gaza would have received treatment at AVH. They would then have had to be treated at higher cost in other country facilities.

The enabling of large numbers of Gazans to come to Jerusalem for treatment has reinforced the position that Jerusalem is an essential part of the Palestinian health care system, reinforcing the Palestinian presence there.

Recommendation:

The provision of hotel accommodation for patients from Gaza has been essential to enable referrals from Gaza to be accepted by AVH. Without this facility, it would not have been possible to accommodate such large number of patients in the hospital. Patients from Gaza would have to have been referred to other hospitals at greater expense to the PA MOH. Now that the SCCI funds for this have finished, AVH is having to fund hotel costs from its own resources. In addition, patients from Gaza have to pay additional costs for travel to Jerusalem and the costs of treatment for other (non-

[17] The evaluation team was told that the Gaza Referral Committee was not aware that the hotel costs had been paid by the SCCI (and now AVH) rather than as part of the hospital fee for service paid for by the PA.

cancer) illnesses that can cause significant hardships. AVH, with the support of NCA, should actively advocate with the MOH to ensure that they are aware of these additional costs for Gaza patients, and with the donor community, including UNWRA, in order to obtain further funding for this.

Outcome 4: *Stiftelsen Oljeberget (SO)* has advocated for the political and humanitarian significance of providing quality health care at AVH.

Indicator: Constituencies in Norway are aware of health rights for Palestinians.
This is not a SMART indicator.

Activities:
This component was to support both the meetings of SO itself, the involvement of SO in meetings of the governing body that is responsible for the management of AVH as well as to advocate for AVH and cancer care for Palestinians within Norway.

- SO held 4 board meetings in 2012/13 and 4 in 2013/14.
- SO representatives attended 2 AVH board meetings in 2014 as well as two AVH Land Committee meetings.

In 2014, with AVH experiencing an acute cash flow crisis, SO obtained support from the Norwegian Government to apply pressure to the EU which had delayed PEGASE[18] payments to the PA. This had, in turn, resulted in delays in the payment of outstanding monies owed to AVH resulting in the cash flow crisis. This was successful in that payments were made, however payment delays continue, with significant arears owed to AVH by the PA.

Conclusion:
SO undertook the planned project activities however with no indicators[19] established to measure the achievements that might have been anticipated from this project component, it is hard to assess the success of this component of the project.

The involvement of SO representatives on both the AVH board and the Mount of Olives Land Committee probably benefits these two bodies by increasing their international representation, and thus voice and credibility, as well as strengthens the link between SO and AVH.

The wide Norwegian church representation on SO itself serves to share information about Palestine generally and AVH in particular to significant members of the church community in Norway. This will enable SO members to disseminate knowledge about Palestine amongst their parent churches.

SO did successfully lobby the MFA to lobby with the EU to make outstanding social security payments.

[18] PEGASE is the EU mechanism to support the Palestinian Authority in achieving the ambitions of the three-year *Palestinian Reform and Development Plan* (PRDP) from which a number of social payments, such as for hospital costs, are made.
[19] It is to be noted that establishing indicators for this component would have been difficult as the outcomes were always likely to be somewhat ephemeral and the level of funding very small.

3.5 Effectiveness

TOR Questions:

- **To what extent is the Program available and accessible to all eligible cancer patients?**
- **Are quality assurance mechanisms ensuring a high standard of quality within Cancer treatment at AVH?**
- **What impact has the Program had on cancer mortality?**
- **How are gender issues addressed within the program?**

Accessibility: AVH is a tertiary care institution that derives its entire cancer workload from referrals from the OPT MOH. The full clinical notes of any patients diagnosed with cancer and considered by their physician to need referral, in either WB or Gaza, are sent for review by the Cancer and Haematology Referral Committee that meets weekly in Ramallah[20]. This committee decides on the most appropriate hospital for referral. It is stated that all patients in need of referral outside the OPT are referred with no consideration of cost. There is however a preference for patients requiring surgery and/or chemotherapy only to be treated in an MOH hospital (such as Beit Jalal) or other WB facility (e.g. Al Najah University Hospital in Nablus or Maqased Hospital in E. Jerusalem) where possible. For cases requiring radiotherapy (as well as possibly surgery and/or chemotherapy) and also when chemotherapeutics are not available within the MOH, AVH is the referral centre of first choice. Only when AVH is unable to accept a patient (bed capacity/some very advanced treatments) will patients be referred to non-Palestinian hospitals.

No national data[21] is available to demonstrate that this policy is adhered to.

Thus, in theory, all patients from WBGS have access to the cancer care offered by AVH if the referral committee considers it the appropriate venue for their treatment. It is likely that a proportion of patients are never properly diagnosed with cancer and thus do not enter the referral system and the treatment figures (see table 4) would suggest that a lower proportion of Gazans receive care from AVH than might be expected. There may be a number of possible explanations for this discrepancy (see above for discussion of this). The FGD revealed a number of significant problems that patients had experienced in gaining access to services at AVH as well as other hospitals. There were also mixed views on the quality of care provided (next section). The detailed findings of the FGDs are given in Annex 6, with the highlights given in the adjacent box (Box 2).

[20] Patients from Gaza are referred through a similar committee in Gaza and then onto the West Bank based committee which has the final decision.

[21] The evaluation team was provided with data from Gaza, which is discussed in Annex 7.

Box 2: FGD Findings

- **All patients had sought care as a result of having symptoms rather than being identified through screening programmes**
- **Many patients had experienced long and difficult patient journeys before being diagnosed and offered treatment.**
- **Obtaining permits to travel for treatment from Gaza is a lengthy process, taking 6-8 weeks. Permits for WB residents are much quicker, 2-3 days.**
- **Some permits to travel are not accepted, males aged between 20 & 40 years are unlikely to get permission to travel.**
- **Patient views on treatment at AVH are generally positive although there were some complaints:**
- **Delays in treatment**
- **Being sent back to Gaza due to drug shortages and having to start the process again.**
- **The attitude of some medical staff was felt to be unsympathetic.**
- **However the work of the Psycho-Social worker was much appreciated.**
- **Patients reported a number of associated costs that made life difficult – travel to AVH from Gaza and the travel from the hotels for treatment, food costs (only breakfast provided by the hotel), and some drug costs.**
- **There were a number of complaints about the hotel**

Outcomes and Quality of care: AVH is unable to provide any data on the post treatment life expectancy of patients who have undergone treatment. The new OIS should enable better information to become available in order to monitor treatment outcomes.

The high proportion of breast cancer cases that are only diagnosed at the palliative stage[22] means that the long term prognosis of many patients will be poor.

In 2013, AVH received accreditation from the Joint Commission International, a United States institution that confirms that the hospital provides services at a recognised international standard. Accreditation comes after an inspection of hospital services and systems and is regularly monitored to ensure continuation of the required standards.

AVH conducts mortality reviews of all unexpected deaths within AVH as well as deaths of all newly admitted patients in order that the cause of death might be ascertained and the hospital might learn if there was any way that hospital practice could have been improved to prevent the death.

Concerns were raised to the evaluation team about the lack of communication from AVH to the referring facilities in Gaza strip. Referring facilities indicated that they were often not informed about delays in appointments nor provided information about necessary follow up actions for the patients.

Gender disaggregated data is monitored in the project, both for the immediate beneficiaries – the recipients of training provided by the project – and the ultimate beneficiaries – patients receiving treatment, although NCA has little opportunity to influence either.

[22] According to AVH, in 2005 the MOH estimated that 60% of all breast cancers were diagnosed at the palliative stage. Initial findings from the AVH mammography programme found the 48% of breast cancers identified were similarly at the palliative stage. It is likely that other cancers are also only diagnosed late making treatment much more difficult and to have limited success.

Table 3 above demonstrates that more women (61%) than men benefitted from oncology treatment at AVH reflecting the importance of breast cancer in the disease profile in Palestine. Compared to MOH statistics which show (2014) that 51.5% of cancers were amongst females and 48.5% amongst males, this suggests that females are over represented amongst AVH cancer patients. However this may be a reflection of the higher proportion of female cancers requiring radiotherapy.

AVH exceeds its target of having 40% female staff. However this overall figure masks significant imbalances in the gender ratio of the major technical cadres (nurses, doctors) that were the beneficiaries of much of the training provided by the project. Thus much of the training provided by the project benefitted more males than females. For example, eight of the eleven nurses undertaking the Oncology Nursing course are male. However, this is a reflection of the gender imbalance of these cadres within AVH. It is understood that social factors (shift work, difficulties in travel from the WB to East Jerusalem) lead to a higher proportion of male nurses being employed in AVH than females. The hospital is very aware of gender sensitivities and, for example, all the staff, except the driver, of the mobile mammography unit are female.

The project has been effective in delivering services although the FGDs would suggest that there are problems with the 'patient experience[23]'. Many difficulties regarding access, such as the referral system and obtaining permits from the Israelis, are out of the control of AVH. Others, such as those related to the quality of the hotel accommodation may have cost implications which could add to the burden of AVH which, on completion of SCCI, is paying for accommodation costs.

Recommendation:

It is recommended that AVH actively monitor the views of patients and where possible address complaints as they arise. Greater communication with patients, explaining the limitations of the hospital's capacity to effect changes might be helpful.

In addition there are other organisations, such as the Patient's Friend Society, that are involved in the non-medical aspects of cancer care that might be interested to be involved in supporting patients while they are in Jerusalem and who might be able to provide additional support to patients.

3.6 Efficiency

TOR Questions:

- **Is the relationship between the program costs and results reasonable?**
- **Have the most efficient approaches been used during the implementation of the activities?**
- **Are the current Program management and governance arrangements delivering the best possible outcomes?**
- **What is the added value of NCA towards this program?**
- **To what extent does the project live up to accountability principles, in particular in relation sharing of information, participation, and handling complaints, provided a complaint system is in place?**

[23] The FGDs were conducted with a very small sample of overall patient numbers and may not have been representative of overall patient views. However there were some comments that featured consistently and merit further investigation.

While there were some differences in approach between the two project phases, with an additional objective being added for Phase II, they were very similar in design and so have been considered as one for the purposes of a financial analysis. The following analysis is based on data provided by NCA with the source tables and notes being shown in Annex 5.

Financial Efficiency

The following table demonstrates the SCCI project budget and expenditure by the different project components.

Table 5: SCCI Phase I & II budgets and expenditure

	Budget (NOK)				Expenditure (NOK)			
Project Component	**Phase I**	**Phase II**	**TOTAL**	**%**	**Phase I**	**Phase II**	**TOTAL**	**%**
1. Capacity building, knowledge transfer and training	1,776,000	3,576,000	5,352,000	11%	707,992	3,010,215	3,718,207	8%
2. Technology and facility	10,545,000	11,600,680	22,145,680	47%	12,379,594	17,126,244	29,505,838	63%
3. Research and advocacy	6,105,000	8,904,000	15,009,000	32%	1,638,837	7,271,393	8,910,230	19%
4. International Advocacy	-	300,000	300,000	1%		307,669	307,669	1%
Management & Administration	1,842,600	2,619,320	4,461,920	9%	1,772,402	2,909,820	4,682,221	10%
Total	**20,268,600**	**27,000,000**	**47,268,600**	**100%**	**16,498,825**	**30,625,340**	**47,124,165**	**100%**

Source: Project Documents, See Annex 5 for details and explanatory notes.

A comparison between budget and execution demonstrates that there were some shifts from the original project intention when the project was implemented. Most notably, the component for infrastructure development increased significantly from 47% of intended budget to 63% of implemented expenditure. This increased expenditure on infrastructure was 'paid for' mainly by a decrease in expenditure on research and advocacy, from 32% of budget to 19% of expenditure. There was also some reduction in the expenditure intended for capacity building, reduced from 11% of budget to 8% of overall expenditure.

Within Research & Advocacy, the major change came within Phase I, when it was agreed that the intended research component would not proceed, due to a lack of capacity within AVH, and funds were transferred to infrastructure.

The infrastructure programme was always going to be a significant cost, with funds being used to modify an historic building at a high specification suitable for modern high specification medical care and being undertaken in manner that enabled the hospital to continue to function with minimal disruption. Procurement of both infrastructure works, medical equipment and the OIS were carried out using a robust procurement system that is undertaken for all Lutheran World Federation[24] procurements in Palestine. Tender processes open to national and international bidders were used with selection of preferred bidders being based on a mix of lowest price for the best quality. Value for money should have been achieved by these procurements.

The implementation of the Capacity Building component was organised in a cost effective way with volunteer trainers from Norway being used to undertake training programmes in AVH, restricting the cost of training to travel, subsistence and training materials. A limited number of study tours and work attachments for AVH trainees in Norway were also conducted. The cost of the (anticipated) eleven graduates of the Nursing Oncology Certificate programme has been calculated at

[24] The Lutheran World Federation is the parent institution of AVH.

NOK250,000 per student, less than €30,000 at current exchange rates (See Annex 5). This represents remarkably good value for the delivery of such a specialised nursing course.

Expenditure on the hotel costs for patients represented nearly 20% of total project expenditure. In 2014, the year for which there is robust information about the number patients from Gaza, the project spent nearly 2.4 million Krona on hotel costs for nearly 1,500 patients from Gaza along with a companion for each. This works out at around NOK1,600 (US$210) per patient for accommodation for patients over extended periods. This also seems remarkably good value for money[25].

Management costs were fixed at around 10% of budget, a reasonable level of overhead widely used in international development projects.

Project expenditure seems to have been appropriately allocated for a project of this nature and good value for money is likely to have been obtained for this expenditure, particular for the Capacity Building and support to hotel costs components.

Project Management

Phase I project design was initiated by AVH and agreed through discussion with NCD and then MFA in Oslo. Project management was through a joint committee consisting of representatives from AVH as well as the NCA project manager. This project management committee met at least monthly during the two phases of the project, monitoring progress and agreeing on future activities. Where significant project variations were required (such as the decision to reallocate the research component or not to proceed with the procurement of the mammography van), the rationale for the change was agreed within the management committee and put forward to MFA.

Annual work plans as well as the Phase II project proposal were developed and agreed within the committee and put forward by NCA to MFA for approval. MFA accepted the project changes as recommended by the committee as well as the proposal for phase II with no significant alterations. It is understood that, due to a change in procedures required by MFA, while they indicatively agreed the entire phase II project budget, they required successive annual work plans and budgets for approval before releasing the three annual budgets.

The various elements of the project funds were managed separately with NCA being responsible for the management budget (with a component going to the Oslo headquarters) and also the part of the capacity development budget that related to the participation of the Norwegian partners. AVH was responsible for the element of the capacity development budget that related to Jerusalem based training (through Juzoor) as well as the infrastructure development component. SO similarly were responsible for the expenditure and reporting of their component of Phase II budget.

Infrastructure expenditure (renovations, equipment etc.) was conducted using the LWF procurement procedures. NCA had previously examined these procedures and deemed them robust. The NCA Project Manager was an observer on the procurement committee for decisions relating to project procurements by AVH.

[25] Perhaps too good and so it is possible that a significant number of Gaza patients are not obtaining accommodation through the hospital or some other funds are also being used to pay hotel costs.

Financial reporting requirements were detailed in contracts between NCA and AVH with AVH providing regular financial reports. Annual project financial reports were prepared and project funding was subject to annual independent audit.

The project management committee prepared periodic (phase I) and annual narrative reports (phase II) for submission to MFA. Because of the problems with the indicators (discussed above) it is not easy to track progress though the project.

The NCA added value to the project by its role as intermediary between AVH and both MFA and the Norwegian training institutions that participated in the project. The Norwegian institutions are long term collaborators with NCA, providing a level of common understanding and in addition NCA liaised between AVH over the timing of Norwegian inputs and also provided logistical support for personnel traveling between Norway and Palestine. NCA also facilitated discussions with MFA over the project.

It is not clear how widely project reports were circulated. The WB MOH officials met during the evaluation were not very familiar with the SCCI project but it is possible that project reports had been circulated to the MOH but not widely shared. Gaza stakeholders consulted, in the MOH, UNWRA and NGOs, were aware of the AVH role in cancer care but had no knowledge of the SCCI project.

AVH has a complaints procedure which was utilized by Gazan patients in complaints about the hotel accommodation paid for by the project, with follow up actions reported to have been taken by the hospital. The findings of the FGDs would suggest that AVH could do more to communicate with patients,

The management of the project seems to have been conducted efficiently with good management procedures involving AVH and NCA. Project reporting could have been clearer if SMART indicators had been defined and reported against by the project.

As recommended earlier, it is suggested that NCA support field offices in utilizing the log frame approach to ensure improved project design. Improved project indicators should facilitate more coherent project reporting and monitoring of future projects.

3.7 Sustainability

TOR Questions:

- **Inclusion of cancer treatment services provided by AVH within the MOH National Health Plan**
- **The cost-benefit on the national health expenditure.**
- **To what extent this hospital contributed to the nation building and the national health system.**
- **The use of health care and medicine to unify and reconcile Palestine.**

Political sustainability: The Palestine health policy is highly supportive of the strengthening the East Jerusalem hospitals, including AVH, as national referral hospitals. AVH is likely to be further confirmed as the national referral centre for oncology by a Hospital Master Plan that is currently under development in the WB. The possibility of any hospital in either Gaza or West Bank being allowed, by the Israeli authorities, to develop radiotherapy treatment services is slim and so AVH will remain as the most comprehensive oncology referral centre for the people of Palestine.

The issue of financial sustainability is more problematic. The PA MOH refers patients for treatment and accepts liability for the treatment costs of all patients it refers. The MOH Annual Reports show that, between 2009 and 2013, there was an 84% increase in the cost of treatment abroad (all conditions), far exceeding the rate of population growth over the period (14%) and the growth in numbers being referred for treatment abroad (34%).

However payment of outstanding treatment costs comes primarily from donor payments to the PA. In recent years the EU has provided €13 million per annum[26],[27] from which payments for 'Treatment Abroad[28]' are made. It is understood that in 2014 the USA also made a payment of US$25 million for such payments. Despite the donor funds, it is understood that there is still a significant outstanding debt owed by the PA to AVH (and other hospitals). In 2013 the level of debt was imperilling AVH operations and the project, through SO, made representations through the Norwegian Government to the EU to encourage payment.

It is understood that Jordanian hospitals are no longer accepting patients referred from Palestine due to outstanding debts.

The situation for Israeli hospitals is somewhat different as the accounts for Palestinian patients being treated in Israeli hospitals are debited directly by the Israeli authorities from the money received from VAT, collected by the Israelis on behalf of the PA, before the revenue is handed over[29].

Oncology services at AVH are subsidised in a number of ways and so the MOH is not paying their full cost. The MOH does not reimburse the hotel costs for Gaza patients that were paid for by the SCCI. They are now being paid by the parent organisation, LWF, while an alternative donor is sought. The running costs of the mammography outreach services are paid by a donor (currently Finland). LWF is prepared to subsidise the continued running of this service when funding ends and before any new donor is found. Any sustained period of support for the oncology services from the hospitals own resources, in the event of halt in payments by the MOH, is unlikely to be tenable for long.

While no figures were available to quantify the cost benefit of the oncology services at AVH, the MOH informed the evaluation team that AVH services were at a considerably lower cost than similar services provided elsewhere. AVH estimate that the referral of patients to AVH rather than to Israeli hospitals will save the PA around IRS 4 million per month[30]. However as there is greater cost control on payments to AVH and the services provided by AVH are subsidised by direct payments from other donors (such as SCCI) or LWF itself, it is likely that cost benefit to the PA is positive.

An alternative cost: benefit comparison might be between prevention/early detection and treatment services. The Palestinian Strategic Health Plans consistently emphasise the need for prevention as a more cost effective approach than treatment. This seems particularly evident for the case of breast cancer where there is a proven technology to identify early cases of the disease and

[26] With an overall contribution of €38.5 million, the EU and donors have supported referral costs over a period of two years (January 2012 to December 2013).
http://eeas.europa.eu/delegations/westbank/documents/news/2014/20150212_pr_fin_support_ejh_en.pdf
The evaluation team was informed that the 2015 payment from the EU was to be €25 million, although whether this increased amount is to continue is not known.

[27] The EU has recently confirmed that it will be maintaining its multi-sector support and continue to invest in sectors such as health and education (EU Single Support Framework: Palestine 2014-2015).

[28] There are two categories of 'Treatment Abroad' in the MOH Annual Reports:
Outside of MOH Facilities but within Palestine. As it is sited in East Jerusalem, AVH is within Palestine.
Outside of MOH facilities and outside Palestine – usually Israel, Jordan, Egypt.

[29] It is understood that there has been little control of these deductions for Israeli hospital costs with no oversight by the MOH over what is charged for. A USAID project is currently supporting the PA to monitor these costs and, it is understood, has been successful in controlling unwarranted charges.

[30] These figures could not be verified.

where the treatment of early diagnosed cases is likely to be simpler, cheaper and more likely to be effective than the treatment of late diagnosed cases.

With 48-60% of cases of breast cancer being diagnosed at the palliative stage, it would be important that the MOH mammography services are reinvigorated to provide a more cost effective solution to the problem of breast cancer in Palestine.

Technical sustainability: the medical, nursing and technical skills required with AVH to provide high quality oncology services are high and very rare commodities within Palestine. The project has contributed to increasing these technical skills. Staff with these skills are in great demand both inside and outside Palestine and with such small numbers of highly skilled staff, the loss of just one or two key personnel could result in the suspension of a particular service. The hospital is aware of this and continues to invest in training of additional specialist staff. It also actively seeks to maintain its existing staff through competitive terms and conditions as well as other benefits such as continuing professional training.

Nation Building: AVH is a health facility for which Palestinians can be justifiably proud. It provides high level oncology services that are available, through a referral system managed by the MOH with AVH, to all Palestinians in WB and Gaza. As the only such facility in the OPT, the hospital has contributed to the Palestinian health system and through its capacity to provide tertiary care services, contributes to building the nation.

West Bank – Gaza Reconciliation: The SCCI was not designed with reconciliation between the two parts of Palestine in mind. The project is operating with a particular emphasis on ensuring some access to tertiary cancer services in Jerusalem for cancer patients from Gaza. This it has achieved, however the difficulties faced by Gazans in the whole process (obtaining diagnosis, acceptance for 'treatment abroad', obtaining a permit from Israel and then travel and the treatment itself), is a more difficult process than for West Bankers, and might well reinforce the Gazans feeling of separation.

While most of these factors are beyond the control of AVH, let alone the SCCI project, the FGDs revealed a number of issues where Gazan patients feel discriminated against and which AVH might make more effort to explain or, where possible, address. (See section 3.4 above)

Recommendation

While the project has successfully supported the development of Palestinian cancer services, these are already running at near full capacity. The continuing increase in the incidence of cancer in Palestine, as reported by the MOH, along with the alarmingly high incidence of breast (and other) cancers that present or are identified at very late stages would suggest that much greater effort should be made to prevent or detect early cancer cases in the community. The AVH run mobile mammography service seems to provide a useful model for such a service.

The MOH strategic plan calls for a greater emphasis on prevention and primary treatment and so the policy environment is in place in Palestine for increased preventive work.

It is unfortunate that the strand of the SCCI project that had hoped to develop policy oriented research was not implemented as AVH already has much useful data that could be utilised to contribute to the policy debate. AVH, perhaps with the assistance of NCA, should look for partnerships with institutions that can assist AVH in contributing to the policy debate through the preparation and presentation of academic articles and the preparation of newspaper articles that push for a greater preventive activities by the MOH and the community

4 ANNEXES

Annex 1: Terms of Reference

NORWEGIAN CHURCH AID
actalliance

Terms of Reference (TOR)
EVALUATION OF THE STRATEGIC CANCER CARE INITIATIVE (SCCI) Phase I &II

Context and Programme Background
Access to quality health services is a fundamental element of the right to health and hindrances to access can compromise health status. Patients require timely attention in order to minimize their exposure to increased pain, anxiety and suffering during travel for care and reduce health risk, for example, for kidney dialysis, cancer radiotherapy or chemotherapy treatments, neurosurgery, and cardiac disease diagnostics. International humanitarian law and human rights law both uphold the right to health as a basic human right, and particularly call for states to safeguard access to health care, even during conditions of conflict. The Palestinian Ministry of Health (PMoH) referred 5,303 patients to East Jerusalem hospitals in 2013, approximately 35% of total referrals in 2013.
The Norwegian Ministry of Foreign Affairs (MFA) funded a six years programme (2009-2015), called The Strategic Cancer Care Initiative (SCCI) phase I and II, with more than 47 Million NOK. The programme in Palestine focused on building up the capacity of the Augusta Victoria Hospital (AVH) to meet the needs of the community and provide quality health services, consolidating its role as the national referral hospital for cancer. The programme targeted three major areas; 1- Capacity building and Knowledge transfer in cooperation with Norwegian institutions, 2- Construction, refurbishment, and upgrade of technology and facilities, and 3- Advocacy for rights to access quality health for Palestinian women in particular, and Gaza cancer patients access treatment in East Jerusalem.
The Norwegian Stiftelsen Oljeberget (SO) together with Norwegian Church Aid (NCA) and Norwegian Ministry of Foreign Affairs (MFA) define their roles to contribute towards Palestinian nation building by strengthening Palestinian faith-based organisations and their institutions that serves community needs. Institution building is an important political measure to reserve lands and properties in East Jerusalem and provide services to Palestinians that are living under Israeli occupation. In addition, the support will reduce the referral cost for the Palestinian Authority of cancer treatment to neighbouring countries. The assumption is that building the capacity at AVH is central in a national cancer strategic plan and an important part of the national health plan of Palestinian Ministry of Health (PMoH), thus the Palestinian health care system will improve and the Palestinian presence in East Jerusalem will be strengthened. This empowerment will both lead to a positive change for the Palestinian patients and support the Palestinian position in the protracted conflict with Israel.

Brief stakeholder analysis/partner information
NCA is an ecumenical non-governmental organization working to protect and uphold people's rights. NCA has supported local organizations and institutions in the Middle East since the 1950s and has had an office in Jerusalem since 2005, which covers the Middle East including Palestine.

AVH is a church-hospital complex located on the Mount of Olives in Jerusalem, and has been a program of the Lutheran World Federation (LWF) since 1950. Its main task has been to provide services for Palestinian refugees in cooperation with UNRWA, the United Nations agency that has been responsible for the refugee programs in the region since 1948. Today, the hospital continues to develop services for the Palestinian community. AVH is now the second-largest hospital in East Jerusalem with 161 beds, as well as being the sole remaining specialized-care hospital located in the West Bank or Gaza Strip. AVH is central in a national cancer strategic plan and an important part of the national health plan of PMoH, where AVH will be the expert national cancer institution with specialized medical staff within diagnosis and treatment of most cancer types (surgery, chemotherapy and radiation treatment) and responsible for training staff in local hospitals.
SO was established in 1998 with the purpose to ensure international, ecumenical presence and cooperation with local Christian Palestinian interests at the Mount of Olives in East Jerusalem. SO supports the Lutheran World Federation in their development and running of the Mount of Olives property and the Augusta Victoria Hospital. The members of the SO are NCA, Church of Norway Council of Ecumenical and International Relations, The Christian Council of Norway, The Church City Mission, YWCA-YMCA Global and Foundation Betanien. The Board meets 2-4 times a year and since 2012 the Radium Hospital has taken part in the meetings as observer.

Purpose of the Evaluation
Norwegian Church Aid seeks to conduct an external evaluation of the SCCI-I&II program implemented by AVH during 2009-2015. The program is funded by the Norwegian Ministry of Foreign Affairs with a total amount of NOK 47 Million. (£4.5 million)
The intended use of the evaluation for the different stakeholders is to document results, learn from analysis and facilitate learning from this experience. Findings and recommendations will be used to improve future programming.

Expected output
The evaluation will result in an English report within the length of 1-3-25 pages; one page recommendations, 3 pages executive summary and 25 pages presentation of the findings – outlining as well the overall evaluation methods, their appropriateness and evaluation constraints faced, if any. The annexes should contain any literature consulted, data collection instruments, the ToR, list of interviewees and any additional information required.
Prior to finalizing the evaluation report, the evaluation team will submit a draft to NCA for comments and inputs.
The evaluation team will make a presentation of the main findings, conclusions, and recommendations in a meeting / workshop with NCA and other stakeholders.

Evaluation Methodology
The evaluation team will prepare an inception report prior to the commencement of the evaluation field work. The inception report will detail the evaluation methodology, methodologies and instruments that will be used for the purpose of data collection in the field. At a minimum, the evaluation methodology should include a desk review, interviews and focus group discussions with key stakeholders (patients, AVH staff, local health authorities/Ministry of Health, health coordination mechanisms, and so on), taking into account gender, age and other considerations.
The evaluation should be carried out by multi-disciplinary team with experience in evaluation of Health programs, management, and organizational development. The evaluation team leader will be held responsible for the final output of the evaluation report, and for liaising with NCA.

Evaluation Questions
The evaluation should asses the following:

The program implementation performance against original goals and specific objectives; assessing the extent to which the program has met its stated objectives, delivery plan, and highlight the success stories.
The extent to which proposed objectives and results have been achieved based on indicators within the program design.
The cost-benefit on the national health expenditure.
To what extent this hospital contributed to the nation building and the national health system.
The use of health care and medicine to unify and reconcile Palestine.
The evaluation will be guided by the OECD-DAC Criteria for Evaluating Development Assistance, with a focus on Relevance, Effectiveness, Efficiency, Impact, and Sustainability.

Some specific questions for the evaluation –to be refined by the evaluating team in the inception report- are:

- What impact has the Program had on cancer mortality?
- To what extent is the Program an appropriate response to the incidence and prevalence of cancer patients?
- To what extent is the Program available and accessible to all eligible cancer patients?
- To what extent is the Program acceptable to cancer patients and other stakeholders?
- What are the factors contributing to Cancer Patients choosing other Hospitals?
- What is the impact of the program on the national level?
- Are the current Program management and governance arrangements delivering the best possible outcomes?
- Are quality assurance mechanisms ensuring a high standard of quality within Cancer treatment at AVH?
- What is the impact on the Program of incorporating new technologies, in particular, mammography, Radiation, and surgery?
- Do the Program objectives continue to be appropriate?
- Is the relationship between the program costs and results reasonable? Have the most efficient approaches been used during the implementation of the activities?
- What is the added value of NCA towards this program?
- How is gender issues addressed within the program?
- To what extent does the project live up to accountability principles, in particular in relation sharing of information, participation, and handling complaints, provided a complaint system is in place?

Skills and Competencies

NCA is looking for a team of 2-3 experienced consultants. The team should have the following competences and skills:

- At least 5 years' experience in carrying out evaluations.
- Experience in participatory methods that includes right holders.
- Understanding of the Rights-Based Approach.
- Extensive knowledge in cancer treatment, with knowledge of the public health field and of the socio-political context in Palestine.
- Any local expertise included in the team should be impartial and unbiased in relation to the East Jerusalem hospital sector.
- Excellent facilitation skills.
- Other criteria for selection will be:
- Reflection in the evaluation proposal with regards to how to carry through an evaluation process that will secure learning in the involved organizations.

- Documented ability to write well formulated evaluations that are written in a form that facilitated learning with clear recommendations.

Deliverables and Time frame

Time frame for the evaluation is 2-3 months, which will include site visits for 1-2 weeks in November 2014.

Deliverables	*Submitted to NCA by*
Inception report	No later than 10 days after signing of the contract
Draft report 1, for feedback	Max. 10 days after field visit
Draft report 2, for feedback	Max. 8 days after receiving feedback to Draft 1
Final report	Max. 7 days after receiving feedback to Draft 2
Presentation of evaluation report	To be agreed with NCA

Consultants' Proposal

The consulting firm/candidates shall submit the following documentation:

• Evaluation proposal of no more than five pages with a one page budget sent in one document.

• CVs of consultants that will carry out the evaluation.

The proposal must be sent by email to info-jerusalem@nca.no by COB on 8 of October 2014.

Annex 2: Documents Reviewed.

- **Project Documents**

Project proposal from NCA to MFA (March 2009)

Contract between MFA & NCA for 3 year project (October 2009)

Annual work plan for 2010 with narrative statement of progress and finances (Feb 2010)

Annual narrative project report for 2009 (April 2010)

Audit report for 2009

Annual narrative report 2009 (Oct 2012)

Final report of SCCI Phase 1 2009 – 2012, With Audit report for 3 years (November 2012)

Application for further funding Apr 2012 – Dec 2014 (Mar 2012)

Application for further funding from April 2013 (January 2013)

Annual report April 2012 – Mar 2013 (October 2013)

Annual report April 2013 – Mar 2014 (November 2014)

Application for further funding Apr 2014 – Mar 2015 (February 2014)

Mid-term Narrative report 1.4.2014-30.09.2014

- **Ministry of Health Documents**

Palestinian National Strategy on Cancer Prevention and Control (undated) Ministry of Health

Palestinian National Health Strategy 2011 – 2013 (2010) Ministry of Health

National Health Strategy 2014 – 2016 (12.2.2014) Ministry of Health

Health Sector Strategic Plan: Gaza Governorates 2013- 2018 (2013) Ministry of Health

2009 Annual Report (June 2010) Ministry of Health

2013 Annual Report (June 2014) Ministry of Health

- **Other Documents**

Palliative Care in the region represented by the Middle East Cancer Consortium: A review and comparative analysis (2006) US National Cancer Institute

Annual Report (2013) UNWRA

Health Sector Review in West Bank and Gaza (October 2003) Report to European Commission

Raising Awareness, Screening and Early Identification of Breast Cancer in Palestine (2015) AVH

http://www.researchgate.net/publication/24183912_Cardiovascular_diseases_diabetes_mellitus_and_cancer_in_the_occupied_Palestinian_territory

Annex 3: Stakeholders consulted

Name	Job Title	Location
Dr. Walid Nammour	Acting CEO of AVH	Jerusalem
Ms Amira Juha	Director of Development Projects and Deputy Chief Finance Officer	Jerusalem
Dr. Yousef Hamamreh	Director of Cancer Care Center	Jerusalem
Mr. Ahmad Abu Al Halawa	Director of Community Programs	Jerusalem
Ms Maha Yasmineh Tarayrah	Director of Nursing Education and Development	Jerusalem
Ms Lana Nasser Eldin	Community Based Breast Screening Programme	Jerusalem
Dr Fadel Rawashdeh	Radiation Oncologist, AVH	Jerusalem
Mr. Ismail Abuawwad	Medical Physicist	Jerusalem
RN. Ameer Thawabteh	Oncology Nurse	Jerusalem
RN. Jehad Hawamdah	Oncology Nurse	Jerusalem
Ministry of Health – West Bank		
Dr. Jawad Bitar	Director, Palestinian Health Information Centre	Nablus
Dr. Rania S. Shahin	Director of Pharmacy Department	Nablus
Dr. Ola Al Aker	Deputy Director, Health Policy and Planning	Nablus
Mrs. Maria Al Aqra	Director of International Cooperation	Ramallah
Mr. Nizar Masalma	Director General of Health Insurance	Ramallah
Dr. Amira Hindi	Director General of Referral Unit	Ramallah
Dr. Abdul Razaq Salhab	Head of Oncology Dept., Beit Jala MoH Hospital	BeitLehim
Ministry of Health – Gaza		
Dr Yousief Abu Reesh	Deputy Minister	Gaza
Dr Mohammad Zaggout	Director of nursing Haematology and Oncology	Gaza
Dr Maher Shamia	Director of Minister's Cabinet in Gaza – in charge of referrals from Gaza	Gaza
Dr Abed Latif Haj	Director of Hospitals	Gaza
Monier El Borsh	Director of Pharmacy	Gaza
Ashraf Abu Mohadi	Director of International Cooperation	Gaza
Bassam Al Bari	Director of Treatment Abroad	Gaza
Dr Khalid Thabit	Director of Oncology	Gaza
Dr Bian Saqqa	Director of Haematology	Gaza
Dr Faud Issawi	Director of PHC-NCD	Gaza
Jehad Okasha	Information Department	Gaza
Hani Wehadi	Health Statistics Department	Gaza
Dr Madhat Abass	Director of Units – HIS and Referrals	Gaza
Norwegian Church Aid		
Mr Arne Naess-Holm	Area representative	Jerusalem
Mr. Ihab Barakat	Project Manager	Jerusalem
Ms. Haldis Kårstad (t)	Senior Advisor Health	Norway
Ms. Magrethe Volden (t)	Middle East Adviser	Norway
Others		
Dr Noor Khan	First Secretary (Political/Development), Representative Office of Norway	Jerusalem
Dr. Salwa Najjab	Executive Director, Juzoor	Ramallah
Ms Dina Nasser	Training Officer, Juzoor	Ramallah
Dr. Umaiyeh Khammash	Chief Field Health Programme, UNRWA	Jerusalem
Dr Amna Shourbasi	Acting Director UNRWA Health Program	Gaza

Issa saleh	Director of NCD at UNRWA	Gaza
Mariam Wadi	Director, MCH/Breast Cancer Program, UNWRA	Gaza
Mohammad Khasief	Coordinator, Medical Board	Gaza
Jehad Hesi	NCD lecturer and internist	Gaza
Dr. Jehad Shawar	Medical Director, AlAhli NGO Hospital	Hebron
Samera Farah	Acting Director, Ahli Arab (NGO) Hospital	Gaza
Osama Balawi	Cancer Patients Friends Society	Gaza
Berit Hagen Agøy (t)	Chairperson, Stiftelsen Oljeberget	Norway
Liv Anne Berven (t)	Assistant Professor Betanian University College	Norway

Note: (t) indicates discussion held using telephone or Skype.

We have not given the names of Patients who were interviewed for reasons of patient confidentiality. Other information about the patients is given in the annex 6.

Annex 4: Progress against indicators

Phase I

The March 2009 proposal defined an overall goal that '*Cancer services for the Palestinian people have been improved through developing and building a sustainable and comprehensive national cancer referral centre at AVH that is a centre of excellence in treatment for adults and children and supports the needs of the (Palestinian) Ministry of Health*'.

No overall goal indicator was defined.

It defined three specific objectives and for each of the objectives a number of indicators were defined. These are shown in the following table along with information about progress against the various indicators obtained from the annual reports from NCA to the Norwegian MFA. The indicators changed for objectives (b) and (c) over the life of the project with different indicators being reported upon in the final (2009 – 12) report than had been defined in the original agreed proposal.

Indicators Phase I

Objective (a) To build the capacity of health care professionals at AVH and partner health organisations working with cancer care so as to establish a system for prevention, control and treatment of cancer in Palestine.		
Expected results (outputs): Assessment of the resources available at AVH, a three year development plan for cancer at AVH in cooperation with Norwegian institutions, local training of medical staff in cancer care, local training of nurses and paramedical staff, local training psychosocial care, overseas short courses for medical and health care staff in Norway.		
Indicators	*2009 report*	*Final report for 2009 – 12*
Planning workshop	A number of meetings were conducted in June/July 2009 resulting in an agreed training plan in September 2009. Achieved.	Achieved in 2009
Assessment report of AVH needs	Other than the training plan (above) no mention of any assessment report of AVH needs.	No assessment report mentioned.
Courses, numbers & types of participants, participant evaluations.	Training activities reported: 1. October 2009 (by Radium Hosp) 2. December 2009 (by Diakonhjemmet)	13 Training courses implemented over the three years.
Participant evaluation in training abroad. *No and type of professionals trained by core TOT teams, evaluation of local participants*		SCCI project report indicates that an appendix 3 provides more details. This was not seen by the Evaluation Team.

Objective (b) To upgrade facility and acquire technology to provide needed tools necessary for cancer patients, companions and trained staff serving the targeted group.

Expected results (Outputs): Radiotherapy equipment and supplies, cancer surgery instruments, refurbishment of cancer care in-patient facility, refurbishment of patient and companion caring environment (Hygiene, services & dietary facilities) healing gardens and caring physical environment for treatment.

Redefined Outputs (in Final Report):

1. Radiotherapy equipment and supplies for 2009.
2. Cancer surgery instruments.
3. Endoscopic equipment for detection of colon & digestive system cancers
4. Radiotherapy equipment and supplies for 2010.
5. Refurbishment of cancer care in-patient facility 2011.
6. Refurbishment of patient and companion caring environment (Hygiene, services & dietary facilities).
7. Refurbishment and landscaping of a healing /therapeutic garden and caring environment.
8. Radiotherapy equipment and supplies

Indicators	*2009 report*	*Final report for 2009 – 12*
No. of equipment purchased, No. of staff trained in new equipment, No. of patients treated on new equipment.	Equipment purchased: see annex. Most not delivered until 2010. Staff trained: see annex Average of 40 patients (per day?) from Gaza	Radiotherapy: equipment delivered. Infrastructure works carried out Surgery instruments: delivered in 2010 Endoscopic equipment delivered in 2010. Cancer care in-patient facility refurbished. Patient & companions caring environment refurbished. Therapeutic garden installed.
No. of surgeries performed with new instrumentation	Not reported although as most equipment had not yet been delivered likely to have been zero.	Not reported
No. Of procedures performed and patients screened for colon cancer on new equipment.	Not reported although as most equipment had not yet been delivered likely to have been zero.	Not reported
No. of in-patient admissions in new refurbished area	Not reported	Not reported
No. of patients and their families using hygiene, support services and dietary facilities.	Not reported	Not reported
No. of patients treated in healing gardens, no. of programs implemented in the new areas of the property, no. of staff working in these areas, no. of patient families & companions using refurbished support facilities.	Not reported	Not reported
No. of specimens, data points collected at the research facility, number of published research.	Not reported	Not reported

Objective (b) indicators as reported in final report	*Final report for 2009 – 12*
Radiotherapy equipment and supplies for 2009.	Equipment delivered. Infrastructure works carried out.
Cancer surgery instruments.	Delivered in 2010
Endoscopic equipment for detection of colon & digestive system cancers.	Delivered in 2010.
Radiotherapy equipment and supplies for 2010.	Radiotherapy system and autoclave purchased. Bio-bank donated by Radium Hospital (shipping and import duties paid by project)
Refurbishment of cancer care in-patient facility 2011.	Cancer care in-patient facility refurbished with 16 beds.
Refurbishment of patient and companion caring environment (Hygiene, services & dietary facilities).	Patient & companions caring environment refurbished.
Refurbishment and landscaping of a healing /therapeutic garden and caring environment.	Therapeutic garden installed
Radiotherapy equipment and supplies.	Planning software installed.

While no achievements are reported against the originally defined indicators of objective (b), the final report does provide the following activity statistics for AVH over Phase 1 of the project period.

	Patients	Outpatients	Treatment days	Radiation	Simulation	Chemo
2009						
Gaza	275	676	1,488			
WB	1,825	5,903	6,791			
Jerusalem	1,030	2,405	2,126			
Total	3,130	8,984	10,405	22,904	611	4,070
2010						
Gaza	379	1,214		606	695	653
WB	1,418	13,919		763	1,132	1,064
Jerusalem	267	1,801		-	-	-
Total	2,064	16,934		1,369	1,827	1,717
2011-12						
Gaza	265	1,432		4,112	324	1,088
WB	2,959	12,367		11,905	932	6,646
Jerusalem	2,961	3,867		711	149	781
Total	6,185	17,666		16,728	1,405	8,515
2009 - 2012						
Gaza	919	3,322		4,718	1,019	1,741
WB	3,243	32,189		12,668	2,064	7,710
Jerusalem	4,258	8,073		711	149	781
Total	8,420	43,584		18,097	3,232	10,232

Sources: 2009 First annual report for SCCI. April 2010
2010 and 2011/12 -Final report for SCCI Phase 1. November 2012.

Note: The project report provides combined data for the years 2011 and 2012. As the report was submitted during 2012 it can be that this data is for two full years 2011 & 2012. However it is not clear what period the report covers.

Objective (c) To conduct clinical, biomedical and policy directed research to assist in the improving and upgrading clinical services and by providing policy makers with evidence-based information that will assist in the formulation of national policies for effective cancer awareness, prevention and control.

Expected results (Outputs) (in proposal): Published biomedical and clinical research data and articles, scientific conferences, awareness workshops, community based research projects (e.g. screening for prevalence and incidence), publishing behavioural change and communication tools, advocacy workshops, public company's for cancer prevention and control.

Redefined Outputs (in Final Report):

1. Establish a tumour tissue and blood bio-bank with trained person
2. Implement community advocacy programmes in line with WHO guidelines.
3. Initiate with local partners screening protocols and utilise data for research
4. Initiate biomedical clinical research protocols using hospital based patients and data.
5. Implement programs and distribute materials in behaviour change and communications with local partner organisations.

Indicators	*2009 report*	*Final report for 2009 – 12*
No. of tumour specimens banked & catalogued.	Bio bank equipment donated in 2009	Activities postponed
No. of published research articles, data & information	Not reported	Activities postponed
No. of screening protocols of new protocols, no. of patients screened, no. of follow up field visits.	To be implemented 2010, 2011	
No. of sessions and materials implemented in community for BCC, no. of participants.	To be implemented 2010, 2011	
No. of advocacy programs, no. & type of participants	Interpreted as providing transport and accommodation + psychosocial support to patients & families from Gaza to receive treatment	Average of 40 patients and their companions per day were supported to leave Gaza and, when in Jerusalem, were accommodated by AVH

Objective (c) Indicators as reported in final report	*Final report for 2009 – 12*
Establish a tumour tissue and blood bio-bank with trained person	Postponed
Implement community advocacy programmes in line with WHO guidelines.	Cancer patient support and bussing programme established.
Initiate with local partners screening protocols and utilise data for research.	'Supported the protocols of the mobile mammography unit'
Initiate biomedical clinical research protocols using hospital based patients and data.	Developed a 'unified protocol for all cancer treatments in adult and paediatrics'.
Implement programs and distribute materials in behaviour change and communications with local partner organisations.	Distributed awareness materials through mobile mammography unit. Organised a breast cancer awareness day. Displayed illuminated awareness signs in 8 cities.

Phase II

The Phase 2 proposal defined the overall project goal to be to '*Strengthen the health system in occupied Palestinian Territory and the Palestinian presence in East Jerusalem*'.

In the proposal for funding for 2014/15, the three initial Goal indicators were removed and replaced by a single indicator (Number of rights holders receiving health services with the information to be obtained from hospital records). No explanation is given for this change and no definition of the indicator is given.

Indicators Phase II

	2012/13 report				**2013/14 report**				**2014 interim report**
Goal: Strengthened health system in oPT and the Palestinian presence in East Jerusalem									
Increase of Palestinian patients with access to treatment at AVH in East Jerusalem, including patients from Gaza		**GS**	**WB&J**	**Total**		**GS**	**WB&J**	**Total**	Not reported
	Patients	894	190	1,084	**Patients**	1,280	4,806	6,086	
	Visits			1,946	**Visits**			23,612	
Decrease in patients referrals to hospitals in Israel, Jordan and Egypt	Not reported				Not reported				Not reported
Increase in the number of referrals to AVH per year	Not reported				Not reported				Not reported
Y3: Number of rights holders receiving health services	N/A				N/A				Not reported

Outcome 1: Skills of healthcare teams upgraded

The indicator for Outcome 1 is not a measurable indicator

The Output 1 indicators also changed each year and were hard to track against the annual reports. The following table attempts to link the different indicators used for each year of the project against annual reports of project activity.

	2012 proposal for period 2012 - 2014	**2013 proposal for period 2013 - 2014**	**2014 proposal for period 2014 - 2015**
Outcome Indicator	Capacity Development and training for cancer treatment and care have been provided to 10 physicians, 40 nurses and 10 paramedical staff	Cancer healthcare team capacity increased to treat and support cancer patients more effectively at AVH	Cancer healthcare team capacity increased to treat and support cancer patients more effectively at AVH
Annual report findings	Based on output data, Outcome achieved.	Not a SMART indicator	Not a SMART indicator
Output Indicators	1.1 3 Juzoor trainers to be qualified for an ongoing in house training program TOT. 1.2 Courses, numbers & types of participants, participant evaluations 1.3 Participant evaluation in training abroad, number and type of professionals train by core TOT teams, evaluation of local participants	2.1 1 Juzoor trainers to be qualified for an ongoing in house training program TOT 2.2 Participant evaluation in training abroad, number and type of professionals train by core TOT teams, evaluation of local participants 2.3 Capacity build to develop the pathology lab at AVH.	3.1 No. of oncology AVH nurses trained & certified by Betanien Participant satisfaction with training. 3.2 No. of training courses provided/participation doctors, nurses & doctors in Cancer related courses. 3.3 Participant satisfaction with training. 3.4 No of internal training courses.
	2012/13 report	**2013/14 report**	**2014 interim report**
Annual report findings	1.1 Juzoor health adviser worked with senior nurse managers to develop a plan for: • Pre-service nursing for new staff – course established & implemented 7M, 7F • Address nursing JCIA requirements – Basic life support courses	2.1 Not reported 2.2 Oncology Nursing Course: 11 (8 male, 3 female) nurses completed the first (?second) module of a three year programme that will result in a specialised diploma in oncology nursing. Conducted by Betanian staff. 2.2 local training of Psycho-social staff: Conducted by Betanian staff.	3.1 Seven training sessions for the Oncology Nursing Course over the year with trainers from Betanian & Oslo hospitals & AVH for 11 Senior staff nurses (8 male, 3 female). 3.4 Six internal training sessions led by AVH staff. 210 AVH attended.

	✓ 149 nurses, 36 docs in Basic Life Support (LS) (66F, 119M) ✓ 12 nurses, 2 docs Paediatric Advanced LS (4F, 10M) ✓ 9 nurses, 3 docs Advanced Cardiac LS (3F, 9M) ✓ 37 general staff (all M) trained in CPR • Enable nursing leaders to become trainers ✓ 9 (3F, 6M) trained as BLS instructors. ✓ 2 trained as ACLS instructors ✓ 2 doctors trained as PALS instructors 13 nurses primary chemotherapy nursing care. 1.2 Betanian: 12 (8 male, 4 female) nurses completed the first module of a three year programme that will result in a specialised diploma in oncology nursing Radium: specialised training of doctors and nurses 1 doc trained in sinus endoscopic surgery Advice on further development of Paediatric oncology dept.	2.3 One week study visit to Radium Hospital on cellular therapy labs	

Outcome 2: AVH has a safe and well-equipped facilities for diagnosis, treatment and documentation of care of patients suffering from cancer

	2012 proposal for period 2012 – 2014	**2013 proposal for period 2013 - 2014**	**2014 proposal for period 2014 - 2015**
Outcome Indicator	No indicator defined	AVH increased their capacity to treat more cancer patients in a health organised environment.	AVH increased their capacity to treat more cancer patients in a health organised environment.
Annual report findings	N/A	Not a SMART indicator	Not a SMART indicator
Output Indicators	1.1 OIS system is installed and functioning, results of testing and no. of trained staff. 1.2 New surgical and haematology oncology facility housing 16 beds 1.3 There are 300 surgeries of in-patient admissions in new surgical oncology facility per year. 1.4 One mammography van procured	2.1 OIS system is installed and functioning, results of testing and no. of trained staff. 2.2 New surgical and haematology oncology facility housing 22 beds 2.3 There are 300 surgeries of in-patient admissions in new surgical oncology facility per year	3.1 New surgical and haematology oncology facility housing 22 beds 3.2 There are 300 surgeries of in-patient admissions in new surgical oncology facility per year
	2012/13 report	**2013/14 report**	**2014 interim report**
Annual report findings	1.1 OIS system installed and functioning, staff trained on use. 1.2 Surgical haematology oncology facility housing 12 beds refurbished. 1.3 No. of surgeries not reported. 1.4 Procurement of mammography van not reported.	2.1 OIS system installed in previous year. 2.2 Facility completed in previous year. Surgical oncology equipment procured. 2.3 No. of surgeries not reported	3.1 Work underway??? 3.2 No. of surgeries not reported

Outcome 3: The Palestinian population has increased access to cancer treatment

	2012 proposal for period 2012 - 2014	2013 proposal for period 2013 - 2014	2014 proposal for period 2014 - 2015
Outcome Indicator	7000 women are screened per year per mobile team 20075 patients & companions & care staff transportation facilitated through the advocacy programme per year	700 Gaza patients per year have got the permit to access AVH	700 Gaza patients per year have got the permit to access AVH
Annual report findings	No record of the no. of women screened. 894 patients & 894 companions from Gaza reported as participating. No record of the no. of staff transported.	1,280 Gaza patients accessed treatment during 2013/14	286 Gaza patients accessed treatment during from April to September 2014'
Output Indicators	1.1 Total of 96 villages visited per year 1.2 No. of community participants educated 1.3 Screening protocols and no. of persons screened. 1.4 Twenty patients, some accompanied with family, have stayed at the Mount of Olives Patient Hotel per month. 1.5 Twenty patients, some accompanied with family, have been transported from Hotel to hospital for treatment (per month).	2.1 700 patients receiving services 2.2 700 patients, some accompanied with family, have stayed at the Mount of Olives Patient Hotel per year. 2.3 One bus, capacity 51 passengers, transports patients and staff from Qalandia & Bethlehem checkpoints daily. 2.4 Permits for patients from Gaza & West Bank to enter Jerusalem has been advocated and claimed.	3.1 No. of patients receiving social support services 3.2 N. of patients, some accompanied with family staying in Mount of Olives patient hotel per year. 3.3 One bus, capacity 51 passengers, transports patients and staff from Qalandia & Bethlehem daily. 3.3 Permits for patients from Gaza & West Bank to enter Jerusalem has been advocated and claimed.
	2012/13 report	**2013/14 report**	**2014 interim report**
Annual report findings	1.1 Not reported on 1.2 Not reported on 1.3 Not reported on 1.4 & 1.5 Not reported on but the following no's of patients from Gaza are reported as attending for treatment. Male: 389 Female: 505 Total: 894 Avg per month: 75	2.1 1,280 patients from Gaza treated at AVH. 2.2 Project continued to provide accommodation for Gaza patients and accompanying families. 2.3 A bus has continued to transport Gaza patients to AVH. 2.4 Not reported upon, but Gaza patients accessed AVH during the year.	3.1 1,280 patients from Gaza treated at AVH. 3.2 Project continued to provide accommodation for Gaza patients and accompanying families. 3.3 A bus has continued to transport Gaza patients to AVH. 3.4 Not reported upon, but Gaza patients accessed AVH during the year.

Outcome 4: *Stiftelsen Oljeberget* has advocated for the political and humanitarian significance of providing quality health care at AVH

	2012 proposal for period 2012 - 2014	**2013 proposal for period 2013 - 2014**	**2014 proposal for period 2014 - 2015**
Outcome Indicator	The importance of the cooperation on the Mount of Olives is confirmed by the Church Council Meetings	Constituencies in Norway are aware of health rights for Palestinians	Constituencies in Norway are aware of health rights for Palestinians
Annual report findings	Not a SMART indicator	Not a SMART indicator	Not a SMART indicator
Output Indicators	1.1 SO holds 2-4 board meetings per year. 1.2 SO attend AVH board meetings and land committee meetings 1.3 SO network in Norway and advocate for the right to health and the important role of Christian diaconal institutions in East Jerusalem.	2.1 SO holds 2-4 board meetings per year. 2.2 SO attend AVH board meetings and land committee meetings 2.3 SO network in Norway and advocate for the right to health and the important role of Christian diaconal institutions in East Jerusalem. 2.4 A visit with church meetings organised.	3.1 SO holds 2-4 board meetings per year. 3.2 SO attend AVH board meetings and land committee meetings. 3.3 SO network in Norway and advocate for the right to health and the important role of Christian diaconal institutions in East Jerusalem. 3.3 A visit with church meeting organised.
	2012/13 report	**2013/14 report**	**2014 interim report**
Annual report findings	1.1 SO held 3 board meetings during the year. 1.2 Not reported on. 1.3 SO members advocated on behalf of AVH with LWF, Norwegian representative in Palestine, Israeli authorities & OCHA.	2.1 SO held 4 board meetings during the year 2.2 SO members attended 2 AVH board meetings and 2 land committee meetings 2.3 SO advocated with Norwegian Minister of Health on behalf of AVH. 2.4 Not reported on.	Not reported on.

Annex 5: Project Finances

Project documents provided information about the original budgets for phases I and II of the budget as well as reported (and audited) expenditure by the project. This information is presented in tables A5.1 and A5.2 below.

Table A5.1: SCCI Budgets, Phases I and II.

	Phase I (US$)	Phase I (NOK)	Phase II (NOK)	TOTAL	% Of Total
1. Capacity building, knowledge transfer and training	320,000	1,776,000	3,576,000	5,352,000	11%
2. Technology and facility	1,900,000	10,545,000	11,600,680	22,145,680	47%
3. Research and advocacy	1,100,000	6,105,000	8,904,000	15,009,000	32%
4. International Advocacy			300,000	300,000	1%
Management & Administration	332,000	1,842,600	2,619,320	4,461,920	9%
Total	3,652,000	20,268,600	27,000,000	47,268,600	100%

Sources: Phase I: NCA Project Proposal to MFA 4 March 2009 (AugVictH UD søknad og følgebrev 04 03 09)
Phase II: NCA Grant Application for SCCI II to MFA 6 March 2012 (Application AVH-NCA 060312).
Note: The Phase I budget was presented in US$. The exchange rate in the first year of the project was very different to that of subsequent years and so the exchange rate used in the table is an approximation of the overall exchange rate that applied over the phase I period.

Table A5.2: SCCI Budgets, Phases I and II.

	2009	2010	2011-12	2012-13	2013-14	2014-15	TOTAL	%
						projected		
1. Capacity building, knowledge transfer & training	252,992	159,000	296,000	951,027	859,188	1,200,000	3,718,207	8%
2. Technology and facility	2,336,563	2,035,653	8,007,378	8,212,844	3,905,400	5,008,000	29,505,838	63%
3. Research and advocacy	517,564	741,991	379,282	2,292,810	2,398,583	2,580,000	8,910,230	19%
4. International Advocacy				107,669	100,000	100,000	307,669	1%
5. Management & Administration	500,028	483,567	788,807	1,143,320	765,300	1,001,200	4,682,221	10%
Total	3,607,147	3,420,211	9,471,467	12,707,669	8,028,471	9,889,200	47,124,165	100%

Sources: 2009: 10-01180-19 2009 final report PAL 09-025 SCCI with Stiftelsen Oljeberget AVh and NCA PID 150009 236198_1_0.
2010: 2010 Final Report AVH 27.10.11
2011-12: 10-01180-37 120906 Final Narrative report SCCI- AVH 2009-2012.docx 315338_3_0
2012-13: 2012 LWF-AVH 7DD Project Accounts MFA
2013-14: 2013 LWF-AVH Project Accounts MFA
2014-15: 2014 Expenditure to Sept 14
Note: 2014-15 expenditure figure based on projected expenditure at September 2014 as expenditure not yet finished and final accounts not yet prepared.

There were some differences between the anticipated expenditures, of the budgets, to the actual expenditure during implementation. These are demonstrated in Table A5.3 below.

Table A5.3: Comparison of SCCI Budgets and Expenditure.

	Budget (NOK)				Expenditure (NOK)			
Project Component	**Phase I**	**Phase II**	**TOTAL**	**%**	**Phase I**	**Phase II**	**TOTAL**	**%**
1. Capacity building, knowledge transfer and training	1,776,000	3,576,000	5,352,000	11%	707,992	3,010,215	3,718,207	8%
2. Technology and facility	10,545,000	11,600,680	22,145,680	47%	12,379,594	17,126,244	29,505,838	63%
3. Research and advocacy	6,105,000	8,904,000	15,009,000	32%	1,638,837	7,271,393	8,910,230	19%
4. International Advocacy	-	300,000	300,000	1%		307,669	307,669	1%
Management & Administration	1,842,600	2,619,320	4,461,920	9%	1,772,402	2,909,820	4,682,221	10%
Total	**20,268,600**	**27,000,000**	**47,268,600**	**100%**	**16,498,825**	**30,625,340**	**47,124,165**	**100%**

The major differences between budget intention and project expenditure are:

- Expenditure on infrastructure (line item 2) was 63% of total expenditure compared to 47% pf budget.
- Line item 3, research (in Phase I) and advocacy (in Phase II) was smaller (19%) than had been anticipated (32%). This is explained mainly by the much lower than anticipated expenditure on Research during Phase I when only NOK1.6 million was spent from a budget of NOK 6.1 million.
- Slightly less than anticipated expenditure was made on Capacity Development than had been anticipated.

Calculations:

1. Expenditure on Nursing Oncology Certificate

Expenditure on Oncology Nursing course 2012-13	€104,000
Expenditure on Oncology Nursing course 2013-14	€104,104
Expenditure on Oncology Nursing course 2014-15	€104,000
Total Expenditure on Oncology Nursing course 2012-15	€312,104
Number of students graduating with certificate	11
Expenditure per student (Euro)	€28,373
Expenditure per student (NOK) @ €1 =NOK8.83	NOK250,000

2. Expenditure on hotel costs

Expenditure on Hotel accommodation 2013-14	**NOK2,398,583**
Number of Gaza patients reported as being treated in 2014	1,498
Expenditure per reported Gaza patient	NOK1,601 per patient
Expenditure per patient (US$) @ US$1 =NOK7.6	US$211

Note: Financial year is April – March and so different from AVH reported activity statistics which run from January to December.

Annex 6: Findings from focus group discussions

1. Summary of findings of FGDs held with cancer patients at AVH & Dunya Centre in Ramallah.

	Dunya	**AVH**
Numbers/gender	6 female	3 female, 1 male
Age	2 are in their thirties, 2 in their forties, 1 in her fifties and 1 in her sixties	1 in thirties, 1 in forties, 1 in fifties, 1 in sixties
Type of cancer	6 breast cancer	1 breast cancer, 1 cancer of the uterus, 1 stomach cancer 1 thymus gland cancer
Home	Ramallah governorate	Gaza
Insured	Yes	Yes
Marital status	5 are married with children one separated, no children	All married with children
Occupations	5 housewives 1 retired nurse	3 housewives 1 police officer
Where diagnosed	Four diagnosed at Dunya two at MOH (1 at PHC centre, 1 at PMC hospital)	2 diagnosed at Shifa Hospital, 1 by a private physician- Egypt. 1 by a private physician in GS.
When	3 in 2011, 1 in 2012, 2 in 2013 All finished their chemotherapy sessions, radiotherapy sessions and are now on oral medications	1 in 2012, 2 in 2014, 1 in 2015
Diagnosis process	All women had private sector ultrasound mammogram with a biopsy that took a week for results to be ready. One case had a clear mammogram at MOH, when repeated at Dunya, a mass was discovered. She then had a clips and wire guided ultrasound to prepare for the operation and she had to pay 1500 NIS (price with discount as she was the first case to have clips and wire guided biopsy)	Patients had to wait 15 days for biopsy results. One patient had to do endoscopy at the private sector as the machine in Shifa was not functioning. It cost her 600 NIS in addition to the cost of the biopsy.
Factors affecting choice of treatment location	- 5 patients had chemo therapy at Beit Jala Hospital (BJH) and 1 at AVH - All had radiotherapy at AVH All followed the recommendation of their physician Patients also mentioned that BJH is geographically easier, only one checkpoint but no need for a permit - 3 had operations at PMC, 1 in Arab	- Patients had chemotherapy at Shifa or EGH - All patients are currently having radiotherapy at AVH. One patient has to do more internal radiotherapy at Rambam Hospital in Haifa in June (she got a referral for it) - 1 patients had her operation at Shifa as it is closer to her family members

	care hospital, 1 at AVH, and 1 at BJH. From the ones who had the operation at PMC, one preferred to have the operation in Jordan as she heard that the quality of care is better, another preferred at Arab care as it is cleaner and the third at PMC where she had it The one who had it at Arab care preferred to be operated at Musallam private hospital in Ramallah but her physician advised her that the anaesthetist at Arab care hospital is better	- 1 patient had her operation at Shifa but preferred to have it done in Israel as the quality of care is known to be better (she could not get a permit due to security reasons from Israel) - 1 patient had her operation at AVH as it is well known to have good quality of care
Process of treatment coverage	Patients had to have medical reports from their physician to have treatment covered (chemotherapy and radiotherapy) Medical reports were sent by the same physician to the referral abroad department at MOH. Approval was received within two days. Patients noted that it takes a week to have referral for nuclear medicine or MRI approved Patients have to do an immunity test one day before treatment	The process is very bureaucratic. Patients have to submit their medical reports to the referral abroad department and it takes 6 to 8 weeks to get approved. When approved, the department calls the patient that the document is ready so that patients can use it to apply for a permit to enter Jerusalem.
Barriers to obtain treatment	Patients mentioned their doctor had provided great assistance in submitting their documents either for referral or for getting a permit from Israeli authorities to enter Jerusalem for treatment. It takes 2 to 3 days to get the permit ready and usually it is valid for 1 to 3 months - Crossing Qalandia checkpoint between Ramallah and Jerusalem - Companions have leave the bus and enter the checkpoint while patients stay in the bus - Long waiting time as there are tens of patients being treated Payment of transportation, biopsy or other tests not available at MOH from own pocket	- Permit: Patients have to take their referral note to the coordination office to apply for a permit to leave Gaza to enter Jerusalem. It takes 10 to 20 days to get the permit ready and is only valid for medical treatment at AVH. Sometimes they or their companions are refused by the Israelis to get a permit. In case a companion is refused, they have to submit a name of a new companion and wait another 15 to 20 days. All companions should be over 40 years old. Permits to enter Israel are put at Erez checkpoint and patients with their companions get them the day they go for treatment. After discharge from AVH, patients take the discharge note to the checkpoint to enter Gaza - Transportation costs - Long tiring trip: patients reported they leave 5 a.m. and arrive Jerusalem at 5 p.m. and then get checked by the

		physician who decides how many treatment sessions they need. The social worker then facilitates moving patients to the hotel that the hospital contracts to host Gazan patients - Patients reported they are not satisfied with the hotel they stay in Jerusalem. - Treatment at late shift: Long waiting time in the hospital as patients from other Palestinian areas are treated before Gazan patients as they go back to their cities while Gazan patients stay in the hotel - Patients and their companions reported that the hospital is not responsible for them concerning any type of disease other than what they came for. E.g. if a patient or companion has flu, the hospital cannot provide treatment. - Payment of transportation from home to hospital, hotel and back) - Payment for biopsy costs - Payment for medications prescribed by physician in the clinic
Satisfaction with care at AVH	Patients reported high satisfaction with care, treatment, staff, food, cleanliness, good atmosphere, feeling welcome by staff, they liked appointment system as well as how staff was flexible in case they come late due to checkpoints	- Patients reported their satisfaction with care and staff especially at radiotherapy section. They only reported that there is one physician who is a bit discriminative with Gazan patients - Financial burden that they have to buy their medications if prescribed in the clinic - As for hotel, patients and their companions reported their dissatisfaction with food, dirty rooms, structure, humidity in walls, bad odour from carpets, not changing bed linens or blankets. Patients reported they themselves buy soap, disinfectants…etc. One companion reported having skin infection from dirty.
Obstacles during follow up	- Qalandia checkpoint between Ramallah and Jerusalem - Sometimes, other checkpoints inside Jerusalem	- Same traveling obstacles - Patients are asked to follow up in Gaza strip after chemo or radiotherapy sessions at AVH and they sometimes get confused on how to get in touch with the physician at AVH if they do

		certain examinations in GS
Things to be improved at AVH	- Radiotherapy machine as patients reported it had problems during treatment sessions - To have transportation arranged for them the same as done for patients coming from south WB - Patients requested to have chemotherapy in Ramallah instead of going to BJH to avoid long road. - Stick to appointments	- To see better treatment and how they are dealt with, especially from physicians - Not to have treatment sessions late - To have transportation between hotel and AVH arranged - Stick to appointments given - Patients requested to have radiotherapy in GS in order to avoid all difficulties in getting referrals, permits, transportation problems…etc. (though they mentioned that they know that it is prohibited by Israel due to security reasons) - Patients reported that they know other patients who suffered to get referral and permits and the day they arrived AVH, they were told that the medication is not available or the radiotherapy machine is not functioning - Patients have long waiting lists for other examinations required to diagnose cancer such as CT scans in GS
Psychosocial support	- At AVH, support during chemotherapy - Provision of leaflets on radiotherapy - At BJH, nutritionist provided advice on food	- Patients reported high satisfaction with the work of the PW at AVH who help them in: Checking in to hotel Recreational activities Music Dancing Getting discharge note Support during treatment while being hospitalized
Satisfaction scale of care at AVH 1 =bad, 10=good	1 patient gave 7 5 patients gave 9	1 patient gave 6 1 patient gave 7 1 patient gave 9
To which other hospital you go	From the ones who had the operation at PMC, one preferred to have the operation in Jordan as she heard that the quality of care is better than in Palestine, another preferred at Arab Care Specialized Hospital as it is cleaner and the third preferred her same choice at PMC where she had it The one who had it at Arab care preferred at Musallam hospital but her physician advised her that the anaesthetist at Arab care hospital is better.	2 patients mentioned they would have preferred to be treated in Israel as treatment is known to be of high quality

Needs	Patients reported the following needs: - Chemotherapy in Ramallah - There is a need to have a specialized hospital for cancer in Palestine as in Jordan - More focus on psychosocial support to patients - More media coverage on prevention, diagnosis and treatment of cancer - Medications should be available (Tamoxifin was not available at MOH clinics for 3 months Jan-March 2015) and patients had to pay for it	- Radiotherapy in GS - to have medications available - AVH has to deal with arising needs of patients or companions while they are at AVH or the hotel

To what extent is the Program acceptable to cancer patients and other stakeholders?

- The program is highly acceptable to cancer patients as it meets one of the high health priorities. AVH is the only health facility that provides radiotherapy in Palestine. Patients reported that medical, nursing, psychosocial staff members at AVH are very cooperative and supportive.

What are the factors contributing to Cancer Patients choosing other Hospitals?

- As for chemotherapy or radiotherapy, patients mentioned that they will have them in the same place where they were treated 'they said: chemotherapy and radiotherapy are the same in Jerusalem, Jordan, USA…etc'. However, regarding operations, some patients from the WB preferred to have the operation in Jordan and others in the private sector in Palestine. Patients from GS preferred to be operated in Israel. Reasons for choosing other hospitals were better quality of care and better staff (Jordan and Israel are well known for highly qualified medical staff), having cleaner rooms and feeling more comfortable there.

To what extent is the Program available and accessible to all eligible cancer patients?

- Patients from both WB and GS face obstacles in getting referral approved, permit to enter Jerusalem though Gazan patients have to wait much longer than WB patients to get the referral approved (6 to 8 weeks vs 1 to 2 days) and the permit issued (10 to 20 days vs 2 to 3 days). Patients from WB considered themselves lucky as the physician treating them at Dunya centre is the same physician who works at BJH.
- Patients mentioned that knowing a 'mediator' or having a friend accelerates having referral or permits approved.
- Some Gazan patients and or their companions are denied to get a permit by the Israeli authorities to enter Jerusalem or Israel for political reasons. All companions below 40 are denied from having permits to enter Jerusalem or Israel.
- All patients mentioned the issue of checkpoints and transportation difficulties, cost of transportation, cost of medications or examinations that are not available in the public sector.
- Patients requested that the hospital facilitates the issue of transportation as what is done for patients from south WB.
- WB patients requested having chemotherapy to be available in Ramallah while Gazan patients requested having radiotherapy in Gaza in order to avoid all difficulties in transportation, checkpoints and permits.

Are quality assurance mechanisms ensuring a high standard of quality within Cancer treatment at AVH?

- Patient reported satisfaction with care at AVH. WB patients are more satisfied than GS patients.
- Patients mentioned that they are provided with leaflets about the disease and how to deal with it as well as getting advice from the nutritionist on type of food.
- They are provided with psychosocial support as well as with expressive activities.
- Some mentioned being financially helped by the Poor Fund available at AVH.
- There were only complaints about the hotel that the hospital contracted to host Gazan patients. Issues mentioned were like dissatisfaction with food, dirty rooms, structure, and humidity in walls and ceiling, bad odour from old dirty carpets, not changing bed linens or blankets. Patients reported they themselves buy soap, disinfectants…etc.
- One companion reported having skin infection from dirty linens at the hotel and had to be treated at Maqassed hospital and to pay around 200 NIS for treatment and medications.

How are gender issues addressed within the program?

- Program is available for both males and females from all age groups. Patients did not mention any kind of being discriminated due to gender issues while being treated at AVH or other hospitals. Patients reported that nursing staff and PS workers are very kind and cooperative.

2. Summary of findings of FGDs held with cancer patients in Gaza.

- Clients were diverse in relation to the type of cancer, some were suffering from breast cancer, colon, lung, ovary, brain, colon, prostate, parotid, and leukaemia. All of them were diagnosed in Gaza and then referred to AVH and other sites for treatment; the majority were diagnosed in Shifa hospital.
- Breast cancer was common among females. No cases were discovered through routine screening; all after experiencing symptoms such as pain.
- All participants reported experiencing very long diagnostic journeys and visited many doctors and health facilities including private clinics. The interval between initial complaint and diagnosis usually took around 2 months
- Some reported painful stories as they presented with pressing symptoms like headache, they were referred to dentists who carried out unneeded interventions, then to the ENT specialists who carried out adenoidectomy, also not needed. For the same patient, after visiting 4 or 5 doctors, and visiting many providers the diagnosis was made after nearly a year.
- Many people first diagnosed when they start to suffer from pressure symptoms-at the metastasis stage. Little sign of any early detection services being promoted.
- Results from biopsies take a lot of time (one month). MRI waiting time is reasonable (few days).
- Upon receiving chemotherapy, results of lab tests are provided without any delay.
- Having an appointment at the referral hospital is a nightmare. Most people reported waiting more than one month to get an appointment. Also there is delay at the referral hospital to get the treatment. The referral form pertaining to many people had been cancelled and renewed before receiving the services. Every time, the patient needs treatment, he must go through the referral process (it is for single use and valid only for 30 days). Some reported travelling from Gaza to Jerusalem and being returned back without receiving the services several times. Almost all mentioned that there was long interval between the start of their suffering and the confirmation of diagnosis.
- Patients reported facing difficulties moving from one provider to another with no clear flow and handling off among those providers-lack of continuity of care.
- Absence of MRI services at AVH was repeatedly mentioned cause of delay.
- Blood samples at AVH were lost or become not usable for use in some cases-coagulated.
- One patient mentioned being given six appointments at AVH and Maqassed hospital and every time there was a reason to delay the case. Frequently mentioned reasons to delay and cancel

the appointment include, lack of doctors compliance with the appointment, permit issue, travel complexities, need for further investigations, need for additional consultations and machinery failure.
- There are problems in diagnosing brain cancer and with some patients it took one year to diagnose the condition.

When diagnosed with cancer, what were the factors involved in where they were sent for treatment? (Where the patient wanted to go, where the clinician advised, where the funding organisation wanted to send them, where practical factors (family support, cost, travel restrictions etc.) allowed them to go).

- After the long journey of visiting many health providers, usually people go to the hospitals locally in Gaza.
- Many people are treated locally through surgery; sometimes at private settings.
- Neither the patient nor their own doctor have any say in where they are to be treated.
- Cases that need chemotherapy are treated locally, when there are no drugs patients are referred to WB hospitals, for those requiring radiation, to AVH
- Israeli hospitals are used for serious cases.
- Many Patient diagnosed at private clinics-received adequate attention at private clinics
- Some received two doses of chemotherapy locally in Gaza then referred after that
- Doctors provided contradictory opinions to patients which confuses them.

When diagnosed with cancer what was the process for getting funding (from insurance, MOH, UNWRA etc.) to pay for treatment at the chosen hospital? (Was there a lengthy bureaucratic process to get approval to go to the hospital? Did they or their family have to struggle to get funding approval or was it arranged by the diagnosing clinician?). If they were treated at AVH what were the barriers they had to overcome to obtain treatment? (Travel problems, waiting list before they could be seen and treated, additional costs not covered by funding agency)

- Mostly the MOH referral covers all the medical expenses.
- MOH doesn't cover the transportation costs, living expenses and some additional required co-payment.
- UNRWA also reimburses the costs of few surgical procedures done at hospitals inside and outside Gaza related to cancer with certain ceiling.
- Transportation is a heavy burden, around one hundred dollar from Erez to AVH. Also, from the Hotel to AVG also around IRS20-40 daily. Costs of catering services are also burden. The hotel provides the breakfast only. Some drivers show empathy with patients from Gaza and reduce charges. Zakat committees and charity organizations provide support through fresh hot meals especially in Ramadan.
- Each Meal costs 70 NIS as reported by patients
- Costs of drugs to reduce side effects, NIS 25 for each capsule-not provided by the hospital
- Some local NGOs provide some financial support to cover transportation fees.
- Some patient also talked about under table payment

Most people have a period of care during which they were admitted to AVH, followed by a period of follow up with weekly/monthly visits for further treatment or monitoring. For the period of inpatient care, were they satisfied with their care? (Were there any issues about the conduct of hospital staff, aspects of gender sensitivity (females treated by female staff etc.), the availability of medicines, food or other 'hotel' aspects of AVH?).

Good things

- Privacy at patients rooms with two beds per each room, curtains are installed and each patient is having an individual toilet facility and a basin
- The place is clean, there is a system, good regulations
- Quite and relaxing environment
- Water, (hot and cold) is available, there is a refrigerator for keeping patients own food.
- Instructions and a brochure about service is provided to patients.
- Calling system in emergency is available
- Hotel is also clean, with a separate room for each patient
- TV is available at each room
- Interaction with the patients is good
- Caring team
- Some mentioned that the hospital provides lunch and dinner

Things patients dislike

- Communication with doctors
- Information/interaction gaps with doctors who don't want to explain to people especially those with particular communication problem-old people
- Waiting long (40 Days although s/he needs 25 sessions) because the radiation machine is not adequately functioning
- One radiation machine for WB and Gaza is not adequate
- Delaying sessions of Gaza patients till late hours (one in the morning), because people from WB need to go home and pass Israeli crossings before 6 pm-they were given priority which annoyed Gaza people.
- Waiting long to check in at the hotel- a fax should be sent from the hospital (4 hours)
- Waiting time to see the doctor is very long 8-11 hrs
- Costly transportations from the hotel to the hospital NIS 40 daily for 50 days
- Food for inpatient admitted at the hospital; food is not kept for him/her if he or she is not available at his/her room (taking a session, or undergoing an investigation)
- Hotel doesn't serve lunch and dinner. There is a kitchen, people can cook but difficult for men to do that
- No elevator is available at the hotel, some mentioned it has been installed now
- Doctors do not keep appointments (they ask you to come at 8, they see you at 11)
- Doctors tell patient go home to Gaza and come back. They return us home for no reason. They need to understand our context better.
- Not paying attention to psychosocial needs; telling people abruptly about their cancer without preparation and with any sign of empathy.
- Not respecting people reactions; coping mechanisms, one patient was reading Quran, the doctor told her these are useless things to do=myths-she has malignant tumour and we will give her chemotherapy and radiation or she will die.
- Not providing patients with medications to reduce side effects of radiations such as stomatitis-costs NIS 25 for each
- Equipment are not reliable, always there are problems and this causes delays

For any follow up care, what were the issues around obtaining this care – problems with travel to attend, problems at the hospital that meant that they could not be treated when they attended for treatment?

- Complicated referral process at the RAD
- Referral is valid for single use only; every time you need to start from scratch

- Long waiting time
- Lack of continuity of care, they start in Gaza, then referred to AVH, then again when the medications is available they stop sending us; patients are lost between providers.
- Not receiving services from the same hospital; sometimes from AVH, then shift to Shifa in Gaza, then to Maqassed due to shortage of drugs in other places
- One said, because of the costs, I need to take the drug in Gaza. We go 10 times to the referral abroad to get the referral form!!
- Some patients mentioned that they go to AVH every three weeks just to receive a medication that is provided in 10 minutes; they have to do the referral procedure every time, it is not convenient and costly-as they said.
- Some people mentioned they waited for 5 months to get a referral for isotope scan, after 5 months they used "Wasta"-mediators-a form of corruption then they got it as they said

Being treated at AVH, what are the things that you wish to be different if you come for another session of treatment in the future?

- Securing MRI at the hospital
- Installing another radiation unit
- Securing Transportation
- Implementing Psychosocial program
- Improving doctors interactions with patients / how to deal with people with cancer
- Securing all meals
- Installing an elevator at the hotel
- Securing drugs to be provided in Gaza, thus minimizing the suffering

What psycho-social support has AVH provided to help patients and their families cope with both the practical and psychological difficulties of being diagnosed and treated for cancer?

- Nurses provide some PSS sessions
- They use drawings, colouring, it is not suitable for adults, its children games
- One patient said there is a psychologist who organizes sessions; people don't participate because of costs from the hotel to the hospital
- Most patient don't know about this service
- Family is the main source of PSS support
- Loss of hair, skin irritation constitute the main source of worry to people

For people treated at AVH, on a scale of 1 (very dissatisfied) -10 (very satisfied), how do they rate their treatment?

- There were variations in perceptions, two mentioned from 8-9 out of 10
- Two mentioned below zero
- The majority mentioned moderate around 6
- One lady mentioned, I waited long to see anyone from AVH, I feel agitated from the hospital team
- AVH teams don't communicate with our treating doctors in Gaza
- The doctor at AVH told one lady, go home and come latter, this is not candy, you will take a poison-referring to chemotherapy!!!

For those people not treated at AVH, if travel to AVH had been possible and the funders allowed it, would you have been happy to go for treatment at AVH? If not, what are the reasons?

- Preference is for Israeli hospital
- One said, the medications are the same, but treatment and interactions are different at Israeli hospitals
- In Shifa, chemotherapy is given as one shot (push), while in Israel they give it over two days-diluted. Also, frequent phlebotomy is done at Shifa
- Not having a space for the family member accompanying the patient
- At Shifa, they do harm more than do surgery to oncology patients especially brain tumour
- In Shifa hospital, they are not caring about patients, it's a dirty place, insets of all types especially cockroach
- Al Mezan in Hebron discharges patients after two days; which is dangerous. They sent people home using a regular car, not an ambulance
- AVH is the only available place for us as the MOH wants to reduce the cost
- We care a lot about how the hospital team treats us .

Suggestions for improvement

- Securing CBC machine inside the oncology department-this facilitates access and prevent losing the sample-coagulation of it
- Using one referral form for each patient to cover all his treatment journey
- Using IT to exchange information and records
- Expanding the oncology departments to accommodate the increase in number of people with cancer in Gaza
- Hiring more doctors to reduce load and increase doctors' patients contact time
- Improving quality of services in Gaza to reduce the need for referral abroad
- Regulating private practices of doctors who usually provide quality services to clients who visit their private clinics, but not the public hospital
- Training doctors abroad on oncology management

Annex 7: Gaza referrals data and discussion

The evaluation was provided with extensive statistics about referrals for cancer treatment outside of Gaza over the past seven years. This data is presented and discussed in this annex. The annex also discusses the referral system in more depth than is warranted in the main report. It is to be noted that the data analysed covers just Gaza and while similar data from the West Bank was requested, it did not arrive in time for this analysis. It would be informative if a similar analysis could be undertaken with data from the West Bank.

Cancer Referrals data (2018 – 2015)

Table A7.1 gives the total number of patients referred for cancer treatment over the period 2008 to 2015 and the referral destination. Table A7.2 gives the total estimated expenditure[31] on cancer patients, by location over the same period.

Table A7.1: Numbers of oncology patients referred outside of the Gaza MOH for treatment with the destination of referral identified (2008 – 2015).

y	AVH	Jerusalem	WB	Gaza	Israel	Egypt	Jordan	Total
2008	477	238	188	128	1,497	323	120	2,971
2009	638	225	127	200	564	614	234	2,602
2010	884	150	202	70	1,232	764	153	3,455
2011	850	163	145	130	1,642	985	205	4,120
2012	1,436	236	183	151	1,119	1,157	101	4,383
2013	1,774	242	339	140	1,753	866	11	5,125
2014	1,680	243	849	153	1,626	359	6	4,916
2015	1,023	204	562	120	699	121	4	2,733

Source: MOH key informants provided the figures from MOH records-Gaza
Notes: 2015 data not a full year and so excluded from most analysis.
Gaza refers to patients referred to private or NGO facilities outside of the MOH but within Gaza.

Table A7.2: Estimated cost (Israeli Shekels) of patients referred outside of the Gaza MOH for treatment with the destination of referral identified (2008 – 2015).

y	AVH	Jerusalem	WB	Gaza	Israel	Egypt	Jordan	Total Cost
2008	4,980,119	2,637,967	538,067	380,174	27,209,161	2,604,318	1,790,731	40,140,537
2009	5,252,771	2,391,645	443,354	210,342	8,818,842	3,796,519	3,473,368	24,386,841
2010	8,134,669	684,703	422,401	68,500	13,185,865	3,302,956	1,927,405	27,726,499
2011	8,762,811	2,854,730	376,211	146,600	32,265,581	4,258,800	3,638,100	52,302,833
2012	14,756,319	5,384,596	679,457	184,100	18,779,705	5,285,960	1,722,700	46,792,837
2013	20,591,048	3,963,524	4,480,839	172,600	27,889,213	2,959,020	60,600	60,116,844
2014	20,041,028	2,466,954	7,553,010	217,703	18,831,669	829,318	550,000	50,489,682
2015	7,607,497	567,230	2,047,068	130,700	8,310,320	484,372	24,505	19,171,692

Source: MOH key informants provided the figures from MOH records-Gaza
Notes: 2015 data not a full year and so excluded from most analysis.

Between 2008 and 2014 there was an overall increase of 65% in the number of patients referred for cancer treatment outside the Gaza MOH. This was not a steady rise, with falls in numbers recorded in some years (2008 to 2009 and 2013 to 2014). These falls may have been related to external events such as the 2014 Gaza war which would have made travel out of Gaza more difficult.

It can be seen that there has been a change in the referral patterns over the period also with some institutions or locations taking more referrals while the number of referrals to some locations has fallen dramatically. This is demonstrated in Table A7.3 where it can be seen that the number of referrals to Jordan has virtually ceased and those to Egypt, which once constituted nearly a quarter of all referrals, falling dramatically.

[31] The expenditure figure is the cost estimate made at referral which might be different from the actual cost charged after treatment.

Table A7.3: Proportion of total annual cancer referrals going to various locations (2008 – 2015).

y	AVH	Jerusalem	WB	Gaza	Israel	Egypt	Jordan
2008	16%	8%	6%	4%	50%	11%	4%
2009	25%	9%	5%	8%	22%	24%	9%
2010	26%	4%	6%	2%	36%	22%	4%
2011	21%	4%	4%	3%	40%	24%	5%
2012	33%	5%	4%	3%	26%	26%	2%
2013	35%	5%	7%	3%	34%	17%	0%
2014	34%	5%	17%	3%	33%	7%	0%
2015	37%	7%	21%	4%	26%	4%	0%

While Jordan has never been a large supplier of cancer services for Gaza, in recent years it has virtually ceased. It is understood that Jordanian hospitals are no longer accepting patients referred from Palestine due to outstanding debts. The closure of the border between Gaza and Egypt since 2014 is the likely to be one explanation for the fall in numbers being referred there.

While the actual number of patients referred to Israeli hospitals has increased slightly, the proportion has virtually halved, largely, it would appear to the benefit of hospitals in the West Bank and AVH. The proportion of annual referrals going to AVH has more than doubled while the proportion going to WB hospitals has risen five-fold from 4% to 21%.

This would suggest that the de facto[32] referrals policy of favouring Jerusalem and West Bank hospitals wherever possible has significantly benefitted AVH. AVH is now the main referral hospital for cancer patients from Gaza.

With the increase in the number of referrals, as to be expected, the estimated expenditure on these referrals has also risen, from IRS40 million in 2008 to over IRS50 million in 2014. This represents an increase of 26% over the period, lower than the 65% increase in the number of referrals over the period. This would suggest that the shift in the referral patterns away from Israel (and Jordan and Egypt) to AVH and West Bank hospitals is resulting in reduced expenditure per patient on treatment abroad. This is confirmed to some extent by the data in the following table (table A7.4) that shows the average cost per case (total cost per location divided by the number of patients referred to the location).

Table A7.4: Average cost (Israeli Shekels) per cancer referral case, by location (2008 – 2014).

y	AVH	Jerusalem	WB	Gaza	Israel	Egypt	Jordan	Annual
2008	10,441	11,084	2,862	2,970	18,176	8,063	14,923	13,511
2009	8,233	10,630	3,491	1,052	15,636	6,183	14,843	9,372
2010	9,202	4,565	2,091	979	10,703	4,323	12,597	8,025
2011	10,309	17,514	2,595	1,128	19,650	4,324	17,747	12,695
2012	10,276	22,816	3,713	1,219	16,783	4,569	17,056	10,676
2013	11,607	16,378	13,218	1,233	15,909	3,417	5,509	11,730
2014	11,929	10,152	8,896	1,423	11,582	2,310	91,667	10,270

While this calculation may not reflect the possibility that more complex (and so expensive) cases are referred to Israel and Jordan, it does show that on average the cost of treatment in Israel and Jordan is higher while Gaza, Egypt and (in most years) the West Bank the average cost of treatment is lower. AVH costs are around the average while those in other East Jerusalem hospitals seem to have risen significantly in recent years.

[32] MOH officials informed the Evaluation Team that this was the policy although there was no written policy document seen that detailed this.

The loss of Egypt, where average costs are lower, as a referral centre in recent years is likely to have resulted in some increase in the overall cost of cancer treatments.

The position relating to expenditures in Israeli hospitals deserves special mention as the situation for these hospitals is somewhat different. Unlike hospitals in other countries, and including the East Jerusalem hospitals, where the PA is invoiced directly for the hospital charges, the accounts for Palestinian patients being treated in Israeli hospitals are debited directly by the Israeli authorities from the money received from VAT payments, collected by the Israelis on behalf of the PA, before the revenue is reimbursed to the PA. It is understood that there has been little control of these deductions for Israeli hospital costs with no oversight by the MOH over what is charged. A USAID project is currently supporting the PA to monitor these costs and, it is understood, has been successful in controlling unwarranted charges. This may have the effect of reducing the costs of treatment in Israeli hospitals, but will need to be monitored.

The Referrals Process

As a result of political differences, between 2007 and May 2014 the governance of the two parts of the country were virtually autonomous with separate Ministers and Ministries of Health for Gaza and the West Bank. Since May 2014, a single Minister of Health has been appointed, but the two Ministries continue to operate largely as separate entities. However, as a result of all funding for 'Treatment Abroad', paid for by donors, being managed by the West Bank MOH, referrals for treatment from the Gaza MOH are managed, both initially within Gaza and for the ultimate decision made by the West Bank Committee, by public servants paid for by the West Bank and not directly answerable to the Gaza MOH. It can be imagined that such an arrangement could lead to accusations of favouritism, particularly in the difficult political situation in Gaza. A study (Sharief, H. 2015) of perceptions about the referral process in Gaza indicated that a high proportion (41%) felt that the system was inequitable while 60% felt they had suffered some form of discrimination[33].

All referrals for cancer treatment outside the MOH in Gaza are considered by a Gaza Referral Committee before submission to the WB based Oncology / Hematology Referral Committee[34]. This committee reviews all cancer cases before referring to the WB committee for a final decision.

The weekly meeting of the WB committee, chaired by the MOH, reviews referral requests from both Gaza and WB. It is understood that two referral hospitals, AVH and Al Najah University Hospital Nablus, are represented on this committee. This participation of hospitals that directly benefit from

[33] Findings of the study: 53.2% males and 46.8% females benefitted from the referral aboard services in 2013. Gaza City ranked the highest percentage in number of referral requests with 46%. Oncology (21.6%), cardiology (14.7%) and orthopaedic (12.9%) were the main reasons for referral. The majority of patients interviewed mentioned that the main concern was unavailability of local needed services in Gaza (75%). Perceptions about deterioration of their health status were reported by 17.7%, the majority of them (60%) were among the non-referred patients. Time to receive a response was perceived as long by 58% of the study population. The main difficulties that participants had faced while applying to the referral services were attributed to bureaucracy of procedures and the lack of connections/power. The financial burden of extra costs especially transportation was the main difficulty facing them while receiving the treatment. The unavailability of treatment either locally or in abroad institutions affected the health conditions of patients.
More importantly, referral abroad services were perceived to be inequitable by 41% of the study population. Around 60% reported suffering from some sort of discrimination while applying for the services or/and receiving treatments. The absence of national guidelines and indicators that would support the equity assessment has created ambiguity around the subject.
The reasons given for disparities in referral abroad included a lack of family power and connection (35%), type of work (24%), and political affiliation (24%). Income, age, gender, place of living, level of education and refugee status were all also ranked at least as minor sources of inequity.

[34] There are several other referral committees, serving the various geographical regions of Palestine that carry out a similar function for other, non-cancer, referrals.

the referral of patients to their facilities could be considered a conflict of interest or it could be seen as an efficient way to ensure that the correct cases are sent to the appropriate facility which has the physical capacity to take patients at that time. There are no Gaza representatives on the WB committee although, for practical reasons, any Gaza participation would have to be done through virtual internet or telephone participation. The committee reviews all cancer cases and decides on the most appropriate site for referral. It may reject some applications or refer them back for further information.

It is understood that an *ad hoc* MOH policy indicates that AVH is the preferred institution for referrals that are to be made outside the MOH. There are some treatments/tests that are outside the capacity of AVH and, on occasion, a lack of physical capacity to receive patients or drug shortages that prevent referral to AVH. With the increased capacity at AVH, the data from Gaza would suggest that the number of referrals to third country hospitals has fallen significantly while referrals to AVH have increased (see tables above).

Thus for cancer patients, unless their treatment is not funded by the PA, the preference is for treatment to be carried out at an MOH facility but if they require radiotherapy or when oncology drugs are not available, almost all will be referred to AVH.

The evaluation FGDs with patients identified considerable difficulties with navigating the referral process for patients, particularly those from Gaza. It can take up to 2 months for Gazan patients to obtain a referral from the Oncology Referral Committee, compared to around a week for WB patients. There could be a variety of valid reasons for this (communication difficulties, weaker diagnostic facilities in Gaza resulting in inadequate information for the committee, etc.), but given the suspicions between the two wings of Palestine, accusations about discrimination against Gazans were put forward in the patient FGDs. There appears to be inadequate feedback to the Gaza Committee and then to the referring institutions which compounds this feeling of discrimination.

A large number of factors affect the number and location of referrals. Macro events like the closure of the border with Egypt and the cessation of referrals to Jordan are examples, but one internal factor also seems to have an important influence. The Gaza strategic health plan explicitly identifies a shortage of chemotherapeutic agents (and weaknesses in other aspects of cancer care) as a significant problem. Anecdotal evidence obtained by the Evaluation Team in the West Bank would suggest a similar, although perhaps less extreme, problem in the West Bank. When chemotherapeutics are not available in MOH hospitals that have the capacity to deliver a cancer service, patients have to be referred outside the MOH where they will (hopefully) receive the same drugs that should be available to the MOH. Thus when the MOH has inadequate drug availability, it has to spend more money on treatment outside the MOH with funds provided by donors. This is illogical and adds difficulties for the patients.

Annex 8: Short biographies of consultants

Garth Singleton is a specialist in monitoring and evaluation of health sector projects as well as health sector planning, management and financing. He has worked several times in the Occupied Palestinian Territories as well as in Africa, Asia and the Caribbean and Pacific regions on a range of long and short term health assignments. With a Master's degree in Public Health, he has more than 25 years' experience of providing consultancy support in monitoring and evaluation, health sector analysis and planning, health financing and programme design and the development of public, private and non-governmental organisation health services in low-income countries.

Garth is an experienced team leader, having led teams in undertaking complex monitoring and evaluation exercises in a variety of countries or regions:

- In 2011 he led a Palestinian team to conduct an evaluation of Belgian support to the tertiary health care sector in West Bank and Gaza. The Belgian support has been focussed on the development of tertiary cardiac services through infrastructure development, training and equipment procurement.
- In 2011 he led a multinational team to document the outcomes and impacts of 35 years Norway's assistance to the Botswana health sector from 1975 – 2010.
- He has led the evaluation of a variety of projects for example in Nigeria (DFID – Annual Review of SUNMAP Malaria project), Ghana (DFID – Malaria, Emergency Obstetric Care), and the collaboration between the Royal College of Surgeons in Ireland and the College of Surgeons of East, Southern and Central Africa in an Irish Aid funded programme to improve and increase the training of surgeons in the region.
- He has led teams undertaking reviews of health sector programmes in Papua New Guinea (Australian Aid 2009), Barbados and Mozambique.
- He has led teams undertaking reviews of HIV/AIDS programmes in Trinidad and Tobago, the Caribbean Region as well as Malawi where, between 2005 and 2007 he led the biannual review team that monitored the National AIDS/HIV control programme.

Garth has successfully supported health planning exercises in a number of countries including Palestine (2003 - 4), Nigeria, St. Lucia, Papua New Guinea and Vanuatu.

He has facilitated strategic health surveys, using a variety of analytical tools in a variety of contexts both at national and regional levels:

- Most recently, in 2013 – 14, as part of the Irish Aid support to COSESCA he surveyed the views of stakeholders throughout the East African region to gauge opinion on the organisational performance.
- In 2013 he conducted a series of telephone interviews with international stakeholders to assess the performance of the Irish Forum for Global Health, analysing the results to provide guidance for recommendations.
- The long term collaboration between Botswana and Norway, covering 30 years of collaboration, was assessed by an international team that Garth led. This analysed the literature for evidence of health sector performance and conducted interviews with stakeholders who had been involved in the collaboration over the 30 years.
- Between 2005 & 2008 he participated in research into the utility of Home Testing Kits for sexually transmitted infections as a tool to improve GUM clinic efficiency and increase access to clinic services by underserved populations. Responsible for undertaking the economic analysis for the study.
- In Ghana, Mozambique, Malawi, Papua New Guinea he has participated in the annual reviews of Sector Wide Approaches that have analysed policy priorities against sector performance.
- In Ghana, Nigeria and Tanzania, he has lead the implementation of health sector costing studies.

He has worked directly with a wide variety of funding agencies including Asian Development and World Banks, Australian Aid, Belgian Technical Cooperation, CARICOM, DFID, European Commission, Irish Aid, NORAD, and WHO.

Dr Abdul Muti Al Azzeh is a Senior Health Expert with strong academic degrees on Health Care Management, Health Policy and Planning, International Health Systems Analysis and Reform with over 20 years of professional experience in a combination of different working settings: public, private and academic institutions as well as at national and international NGOs including UN Agencies in several countries including Jordan, Palestine, Lebanon, Syria, Libya and Yemen.

- Experience of coordination among different stakeholders including public and private organisations as well as national and International NGOs and UN agencies like UNRWA, WHO, UNICEF, UNFPA and UNHCR while considering their interests to facilitate effective and fruitful partnerships at all levels and mainly between Public and Private sectors in order to improve availability, accessibility and affordability of equitable health services with better quality.
- Extensive practical experience at senior positions in planning, implementing and management as well as monitoring and evaluation of health programmes with multiple priorities at central and district levels in order to ensure effectiveness, efficiency and sustainability of health projects as well as to use available human and material resources to the full in order to improve the health and nutrition status of the population in different communities including refugee camps.
- Excellent experience and adaptability to work under pressure and in uncertain conditions with good understanding of cultural diversity and gender sensitivity issues within regional and international environment in order to ensure effective and fruitful achievements with strong impact of development programmes in close coordination and professional cooperation among all stakeholders.
- Significant knowledge about health financing models including community participation with excellent and significant working experience within different models of health service delivery reforms including decentralised services aiming to improve availability and accessibility as well as affordability of health services in order to improve health status of the population in general and women and children and other vulnerable groups in specific.

Excellent working experience in managing and implementing of capacity building activities at individual and organisational levels including training of health professionals about essential concepts of Health Management, Planning and Budgeting and Health Economy including Health Financing models in addition to Total Quality Management and Human Resources Management in order to develop and strengthen their skills with results and impact orientation.

Dr Bassam Abu Hamad is a Public Health Specialist, Human Resources Management Specialist (Doctorate from Sheffield and former Dean of the Palestine School of Nursing), with over 29 years of work with Ministry of Health, Ministry of Social Affairs, universities, NGOs (notably as Deputy Chief of Party) focusing on teaching, training and developing systems related to management systems, economics, information system, mother child health and nutrition strategies, human resource management, quality improvement, staff motivation, research, monitoring and evaluation, program evaluation and humanitarian interventions.

- Rich experience in conducting evaluation and monitoring activities in social protection, social policy and humanitarian interventions at the program level, project level and organizational level. This includes designing and conducting monitoring and evaluation activities.
- Extensive experience in developing health strategies/plans for large and small scale programs/organizations; including but not restricted to; leading the development of the strategic plan for HANAN project (in 2005-21 Million dollar), MARAM Project (in 2001-28 Million dollar), Union of Health Work Committees (4 subsequent plans-1985-2008), Women Affair Association (2010), Near East Council of Churches (2011), and lately leading the team who developed the Strategic Health Plan-Gaza (2014-2018).

Dr Maesa Irfaeya, (Dr.PH) from a background in nursing, has worked as a lecturer in a nursing school and subsequently as Health Policy Development Officer and Health Consultant for Italian Cooperation in the West Bank. Since 2009, she has worked as an independent health consultant undertaking baseline assessments, identification of training needs and monitoring and evaluation activities. She has also designed the assessment tools for the start of a project on the introduction of laparoscopic and mini-invasive techniques in three hospitals in the West Bank.

Eman Abu Hamra (MPH - Health Management) is a qualitative researcher, most recently undertaking a Study about mental health and psychosocial support service provision for adolescent girls in post-conflict settings. Previously she had participated in an end line study of the Early Childhood Development – Right Start! Project as well as Study about Cash Transfer in Gaza.