MAP HEALTH PROGRAMME STRATEGY 2017-2019

FORWARD

In recent years our income and expenditure increased significantly and our programmes have evolved to respond to shifting health needs and opportunities, particularly in Gaza.

The preparation of this plan has provided the opportunity to reflect on our role, to consider if we are focusing on the right objectives and achieving the best possible health outcomes for our beneficiaries; Palestinians living under occupation and as refugees.

We hope the plan will provide: greater internal and external transparency; better targeting of our resources on areas of greatest need and with the greatest potential for positive change; and a framework by which we can better assess the impact of our work.

OUR MISSION STATEMENT, GOAL AND OVERALL OBJECTIVES

Mission Statement

Our mission has always been:

- To work for the health and dignity of Palestinians living under occupation and as refugees

We believe this statement elegantly captures the essence of what we are and what we do. The inclusion of the word 'dignity' implies equality, self-respect, and self-determination – qualities too often lacking in aid programmes.

Goal

Our goal can also be stated quite simply:

- To improve the health of Palestinians and the capacity of local partners

This captures our twin goals of building capacity as well as improving health.

Overall Objectives

Our organisational objectives specify briefly but, so far as possible, precisely and measurably, what we are seeking to achieve:

- Measurable improvements in health indicators
- Enhanced professional, technical and/or organisational capacity of our local programme partners
- Raised awareness of, and reductions in, violations of the right to health of Palestinians

In summary we aim to:

- Help fill gaps and improve the quality of ***essential*** health services
- Support the most ***vulnerable*** members of our target communities
- Respond to ***emergencies***

And we do this in ***collaboration*** with communities and local partners and with a focus on ***sustainable*** development.

HEALTH OF PALESTINIANS: SITUATIONAL ANALYSIS

Overview

The health systems serving Palestinians continue to be impacted by major challenges. There is a lack of coordination and cooperation between service providers in the public, UN, NGO and private sectors. This results in inefficient delivery of health care services, and also undermines long-term policy and investment planning and the overall governance of the health sector. Throughout the region there is a need for improved, equitable access to essential primary and public health care, more comprehensive and reliable health information systems, improved resource allocation mechanisms, tighter control of secondary and tertiary care referrals, and strengthened monitoring and evaluation frameworks.

There is a growing need to restore trust in the public health system. Comprehensive health sector reforms are planned, with the goal of achieving universal health coverage; to ensure all Palestinians have access to appropriate, quality health care services, without suffering financial hardship paying for them. However, given the difficulties outlined above, significant funding limitations, a hostile and volatile security situation, and the ongoing forced migration of extremely vulnerable communities, there is little prospect of positive change and a real danger of the ongoing emergency becoming a crisis.

The changing disease pattern among Palestinians is also challenging. An ageing population intensifies existing health trends, with increasing numbers of older Palestinians at risk of non-communicable diseases (NCDs). The prevalence of NCDs, particularly diabetes and cardiovascular disease, is rising consistently by approximately 5.0% per year (UNRWA, 2015). This has resulted in a greater and more complex caseload for health workers and a further financial burden for health institutions. For Palestinians with mental health problems and disabilities the increasing pressure on overstretched and under-resourced health and social services further compromises the availability and quality of specialist services addressing their needs; there is an increasing need for civil society to augment the extremely limited mental health and disability services provided within the public and UN care systems.

The global reduction in infant and neonatal mortality rates continues to be slower for Palestinians than in many parts of the region, and a recent UNRWA survey confirmed that, for the first time in decades, the mortality rate among new-borns in Gaza actually increased. Similarly, whilst there has been a sharp reduction in maternal mortality and morbidity over the past 40 years, the improvement is slower for Palestinians than elsewhere in the region (World Bank, PCBS, 2015). Globally women are 14 times more likely than men to die in a crisis, and 60% of preventable maternal deaths occur in crises and fragile settings. These figures alone explain why women and child health services remain a priority in the region.

Emergency services also remain a priority. Traumatic injuries continue to account for 35-50% of all emergency admissions to major hospitals in Gaza and the West Bank (PCBS, 2014), with the most common cause of serious injury or death being the ongoing conflict, followed by road traffic accidents and social violence. Pre-hospital and hospital services need to be able to respond quickly and effectively, and cope with unpredictable surges in demand during escalations in the conflict.

West Bank

The West Bank has a total population of 2.6 million, including East Jerusalem and excluding Israeli settlers, and covers an area of 5,500 square kilometres. 770,000 Palestinians are registered as refugees, with a quarter of these refugees living in one of 19 camps. Living conditions in these camps are compromised by the inadequate quantity and quality of water and sanitation services, especially in the nine camps most affected by frequent military operations.

The region has suffered from the effects of armed conflict and internal violence, as well as from occupation policies such as: the confiscation and annexation of land; house demolitions and evictions; and the continued construction of settlements and the separation barrier. The barrier affects the lives of at least 210,000 Palestinians in 67 villages, limiting their social, cultural and economic opportunities. Since the start of the second Intifada in 2000 the income per capita has declined sharply and consistently, and the labour force unemployment rate has climbed to over 50% in those communities most affected by the barrier. This has resulted in a substantial increase in levels of deprivation, with 15.5% of families (and 26% of refugee families) now falling below the poverty line.

Essential health services are available and provided by Ministry of Health (MoH), UNRWA, NGO and Palestinian military health facilities. However, the health sector in the West Bank has faced significant challenges resulting from the impact of the Israeli occupation on the Palestinian community and institutions. The ongoing closures, arrests, settlement building and settler violence have all had a devastating effect on the health status of Palestinians and have undermined the Palestinian government's efforts to establish an integrated healthcare system. The Bedouin community's movement in Area C is always restricted by illegal settlements and checkpoints, compromising access to health services (MoH National Health Strategy 2014-16). The attacks by Israeli authorities on health workers and facilities in the West Bank and East Jerusalem during the last quarter of 2015 significantly impaired the capacity of health services. According to the Palestinian Red Crescent Society (PRCS), Israeli security forces and settlers were responsible for 386 attacks on PRCS health staff and volunteers, resulting in injuries and damage to health facilities and ambulances. PRCS also reported 123 incidents of medical access denied, and 93 significant delays of ambulances at checkpoints (OCHA, 2015).

Gaza

In Gaza 1.8 million Palestinians are locked in 365 square km, making it one of the most populated areas on earth. People are denied free access to the remainder of occupied Palestine and the outside world.

In the early 1990s movement restrictions were imposed, and these intensified to become a blockade in June 2007 following the election of Hamas. Between 2008 and 2014 Gaza experienced three major escalations in the conflict with Israel, with the civilian population bearing the brunt of these hostilities. Houses, agricultural areas, small factories, public health infrastructure, roads, and health/education facilities have been destroyed and badly damaged, with significant impact on the Gaza economy and fragmentation of social networks. The imposed blockade delays the process of repair and recovery, with Kerem Shalom the only one of four commercial crossings currently operating. By the end of April 2016 only 23% of homes

destroyed or severely damaged in 2014 had been reconstructed or repaired, leaving more than 70,000 people still internally displaced.

Gaza lies 24th out of 135 countries assessed by the Human Poverty Index. The unemployment rate stands at 43%, one of the highest in the world, with youth unemployment exceeding 60% (PCBS, 2015). Over 70% of the population are food insecure and receive aid assistance.

Essential health services are available and provided by MoH, UNRWA, NGO and Palestinian military health facilities. However, equitable access and quality of services remain problematic and in August 2015 the WHO highlighted the following issues:

- The severe shortage of medicines and medical disposables at MoH hospitals and primary health care centres is increasingly affecting the quality of care and curtailing critical services.
- The reduced number, skills and motivation of health staff. More than 50% of MoH staff are not receiving their salaries on a regular basis, encouraging them to apply for unpaid leave to seek opportunities in the private sector. Ministry officials are concerned about a deterioration in the quality of care due to poor working conditions, a depleted workforce and professional isolation (a massive reduction in external training opportunities in the last nine years).
- Urgent developmental needs, particularly within critical care and paediatric services.

Malnutrition among women and young children is a major concern in Gaza, with resulting micronutrient deficiencies (iron deficiency, leading to anaemia, and vitamin D deficiency leading to significant metabolic bone problems) and stunting (children small for their age, with permanent impairment of their socio-economic, academic and health potential) of particular concern. Both issues relate to underlying poverty, poor diet (in terms of quantity and quality) and the general burden of disease, with limited access to reproductive health care an additional risk factor for women.

Lebanon

Over 280,000 Palestinian refugees live in Lebanon in some of the most challenging conditions for refugees across the Middle East. Their situation can be described as one of chronic crisis which makes the acute crises, arising in this volatile region, more problematic. Since August 2012, the arrival of large numbers of Palestinian refugees from Syria (PRS) – as of June 2016, more than 40,000 PRS reside in the country – has exacerbated the already dire situation in the camps; worsening environmental conditions, increasing health hazards, making health service delivery ever more challenging and directly impacting on key determinants of physical, psychological and social well-being, including poverty, human insecurity, violence and abuse.

In Lebanon, unlike other host countries, Palestinian refugees have no access to state public services which are available to the Lebanese. They are also prevented from accessing several professions including medicine, law and engineering; they are not allowed to own property and their freedom to travel outside the country is often constrained. A 2015 socio-economic survey of the Palestinian refugee communities, conducted by the American University of Beirut

(AUB) and UNRWA, found that 23% of the PRL and 52.5% of the PRS are unemployed. According to the same survey, 65% of the population live in poverty (less than $6 per person/day), whilst 3.1% of the PRL population, and 9% of the PRS live in abject poverty (less than $2.7/day, which is the minimum amount to meet basic food needs). There is a strong correlation between poverty and ill health, with each impacting negatively on the other, often triggering a downward spiral which may affect entire families across generations.

UNRWA is the main provider of health services to the Palestinian refugee community. In Lebanon, a network of 28 health centres, staffed by family health teams, provide a basic package of essential primary health care services with universal coverage and almost entirely free of charge. The quality of service provision is variable, with high demand, very short consultation times (as little as 2.5 minutes), and a limited drug formulary (although generally well stocked) compromising care.

Secondary care services are provided by the Palestinian Red Crescent Society (PRCS) hospital network and other contracted hospitals, and whilst their cost is almost entirely covered by UNRWA, their quality (especially in PRCS hospitals) is often sub-optimal, with structural, administrative and clinical improvements needed to meet key quality standards. In and out-patient tertiary care is offered in Lebanese hospitals, with UNRWA covering only 60% of the usually very high costs.

THEMATIC/PROGRAMME PRIORITIES

Introduction

The above situation analyses, together with our organisational history and current capacity, the expressed needs of members of our target communities, the availability and quality of project partners (governmental and civil society), and the level of input/cooperation from other service providers, helped us identify the following thematic/programme priorities. As all these factors vary considerably between our regional offices, activity will also vary between them, but with consistency in terms of our overall approach.

Within each thematic/programme area key objectives have been identified that contribute to achieving the organisational objectives outlined above. In turn, the objectives identified for each individual project should contribute to achieving one or more programme objectives. Through this process we hope to provide greater transparency for donors, partner organisations and beneficiaries, and greater accountability with respect to achieving our targets.

Essential primary/public health care

The main providers of primary health care (PHC) for Palestinians are the Ministry of Health (in Gaza and the West Bank) and UNRWA (for registered refugees in Lebanon, Gaza and the West Bank), with a small proportion of services provided by NGOs, the Palestinian military and the private sector.

Overall, despite the success of some vertical programmes (ante-natal care, childhood vaccinations), the PHC system is struggling greatly with the ever-increasing burden of non-communicable diseases (especially diabetes and heart disease), an ageing population and mental health problems. Services are overwhelmed by demand, and undermined by a loss of public trust (leading to patients bypassing PHC), a lack of staff trained in the principles of family practice, and a structure that is not designed to support such practice. All these issues

contribute to suboptimal population health indicators and an exponential and unsustainable rise in secondary and tertiary care costs. Furthermore, the occupation, Gaza blockade and Syrian crisis all promote inequitable access to essential PHC services, with the greatest impact on the poorest and most vulnerable members of already disadvantaged communities.

Myriad public health concerns affect our target communities. The most pressing include inadequate access to potable water (especially in Gaza where salination and nitrate contamination further complicate the issue), inadequate sanitation systems, and food insecurity (with the limited quantity and quality of food contributing to increasing levels of childhood malnutrition and adult obesity). To date it is only the combination of good hygiene practices and high childhood vaccination coverage that has prevented more devastating outbreaks of communicable diseases.

In hospitals there is limited availability and use of standardised guidelines/policies for the emergency and elective care of patients, compromising such care and increasing the risk of clinical/administrative errors and hospital acquired infections. There is significant scope for improving practice without additional long-term cost.

Key objectives:

- Improve patient safety mechanisms, including infection control, within health care services
- Improve access to and quality of essential primary health care services
- Promote fully comprehensive, integrated family health care services (including reproductive/sexual health services for men and women) within the primary health care system

Women and child health care

Maternal and child health is still a cause for serious concern in developing countries. Rates of morbidity and mortality in pregnant women, mothers and newborn remain unacceptably high, especially among poorer groups. Access to good quality family planning, reproductive health and general gynaecological services for women also remains limited. Among the Palestinians living under occupation, displacement and as refugees infant and child mortality have not decreased as quickly as elsewhere in the region. Conflict, poverty, socio-economic vulnerability and gender bias are factors that contribute to hinder the pace of health development; health systems need to be strengthened to meet these challenges. In addition, in times of crisis, girls are more likely to be married off at a young age, and women and girls are at an increased risk of trafficking, domestic violence and sexual assault.

Increasing access to quality care and promoting health and care seeking behaviors among communities and households are both key to improving maternal, neonatal and child health, and the health of women in general. In turn this can enable families to break out of a cycle of ill health and poverty that may otherwise continue for generations. In line with the strategic approach of the Global Partnership for Maternal, New Born and Child Health, MAP advocates for and supports a continuum of care ensuring availability and access to quality maternal and newborn care at home, in the community, in the health centre and in the hospital. We also support the further development of other essential women and child health services within the public and NGO sectors, and services that promote and protect the rights of women and children. Primarily MAP supports local initiatives that fill gaps in service provision, improve

quality of care, increase access to underserved groups and strengthen coordination among health care providers and key community, national and international stakeholders working at different levels.

Key objectives:

- Integrate gender and child rights considerations into health and wider public policies/programmes
- Improve population level maternal, infant and child mortality/morbidity rates
- Improve population level maternal, infant and child malnutrition rates
- Improve access to high quality reproductive health care information and services, including family planning and comprehensive ante and post-natal care

Mental health and psycho-social support (MHPSS)

MHPSS refers to the range of interventions which promote individual and/or community psychological well-being and prevent or treat mental health problems.

There are a number of reasons why MHPSS has been adopted as one of MAP's thematic priorities:

- There are high levels of stress and psycho-social disorder as a result of the occupation, displacement and related factors and, hence, a clear need for support of this kind.
- For many Palestinians there has been a complete breakdown of normal family and community support networks, leaving them isolated and vulnerable.
- The priority of the main health providers (MoH and UNRWA) is physical illness and they lack the resources and capacity to respond adequately to mental health and psycho-social needs.
- There are some competent local NGOs with whom we can partner who have built the capacity to provide an effective response.

There are also issues that make MHPSS services particularly problematic:

- Professional standards are not well established (even internationally) nor well-regulated.
- Providers vary greatly in their approach, competency and experience.
- It is a difficult area to monitor and evaluate because it is hard to define and measure results.
- There is a risk that some interventions may be ineffective or even cause harm.
- Beneficiaries are particularly vulnerable and face significant stigma associated with the diagnosis of a mental health problem within their families and the wider community.

We believe, however, that these issues make it even more important to support and further develop those community-based initiatives with the potential to overcome such difficulties, whilst also recognising the need to establish robust monitoring and evaluation frameworks in conjunction with our partners.

MAP recognises that psycho-social and mental health problems among the Palestinians are, in many cases, the product of their social and political conditions; inequality, discrimination, oppression and violence. Whilst we acknowledge that specialised mental health support is sometimes required by individuals and groups exposed to different forms of acute or chronic trauma, we do not endorse an exclusively medical approach to psycho-social and mental health problems. Our psycho-social interventions include a focus on prevention, aimed at building individual and community resilience and agency; and they are linked with advocacy and protection work at local, national and international levels.

Key objectives:

- Promote MHPSS services that utilise rights-based, community-based, participatory approaches
- Strengthen family/community resources and support networks
- Improve access to and quality of non-specialised and specialised MHPSS services

Disability

People with disability are often amongst the poorest and most vulnerable groups in all societies, but particularly in developing countries with poor levels of basic services, and limited or no social and legal protection mechanisms. Palestinians with disability, living under occupation, displacement and as refugees, are especially vulnerable. Lack of opportunities and access to health, education, livelihood and social services compounds the cycle of disability as both a cause and consequence of associated poverty. A weak, fragmented and unrepresentative disability movement often allows stigma, discrimination and human rights violations (particularly concerning women with disabilities and people with complex impairments) to go unchecked. The situation is componded by the dominance of the medical approach within services, which can further disempower and stigmatise people with disability.

MAP is committed to supporting a social and human rights approach to disability which focuses on the empowerment of children and adults with disabilities. MAP's commitment is to promote and uphold the principles defined by the 2008 UN Convention on the Rights of Persons with Disability (CRPD) and to promote an inclusive and holistic approach to disability services in line with the WHO community based rehabilitation (CBR) guidelines (WHO, 2010). CBR is a fully developmental approach to disability focusing not just on rehabilitation but on equal opportunities and social inclusion. People with disabilities (with their families and communities), governments and NGOs, all have a role to play. It embraces the full range of developmental efforts and social services including health (with a bio-psycho-social model rather than a purely medical approach), education, employment and empowerment.

MAP supports a twin track approach promoting the mainstreaming of disability within society, as well as supporting disability specific interventions as required. In both approaches, initiatives are refined in response to needs and contexts, and encourage the active participation and influence of people with disabilities, their families and communities.

Key objectives:

- Reduce disparities in the key health indicators and social determinants of health in people with disabilities
- Identify and reduce inequitable access to health care services for people with disabilities
- Advocate for the rights of people with disabilities and empower them to advocate for themselves
- Promote social inclusion and participation of people with disabilities within CBR services

Emergency response/preparedness

Palestinian communities have endured frequent escalations of an ongoing chronic emergency, triggered by conflict, mass displacement, sectarian violence, political change and volatile domestic and international policies. As an organisation MAP recognises the importance of both preparing for, and responding to, these emergencies. This encompasses our own organisational response, together with supporting our governmental and NGO partners and our target communities to build resilience and respond quickly and effectively to emergency situations.

In all areas of operation we have developed emergency preparedness and response plans, with a strong focus on security to ensure that we can respond safely and do not increase the vulnerability of staff or partners.

The ability to work effectively in emergencies is heavily dependent upon community acceptance and trust. Therefore, MAP places a high value not only on the imperative to respond, but also the imperative to work through partnership and have well established relationships in place with key stakeholders, ahead of any crisis. This approach ensures appropriate levels of coordination and helps avoid duplication. One of our main strengths in emergencies is the ability to respond quickly and with flexibility, helping partners and communities meet needs not addressed by other agencies. Such responses are facilitated by the pre-positioning of emergency drugs/consumables and essential non-food items, but we also have the capacity to adapt to the needs of a given situation.

Preparing for emergencies is a complex, multi-dimensional process. MAP is committed to linking this work with support for the ongoing development of core health services. This has incorporated the introduction of Primary Trauma Care within all our areas of operation, increasing the knowledge and skills of doctors, nurses and paramedics to manage major trauma. Within Gaza, given the exceptionally high burden of trauma, this support has extended to other related services such as limb reconstruction, general/neurosurgery and emergency departments.

We actively participate in the prioritisation of emergency responses within the wider humanitarian community, including the UN cluster system. We support emergency interventions that strengthen rather than undermine health systems, and support partners to base emergency response plans on evidence of effectiveness, and to ensure that those plans address the needs of the most vulnerable members of target communities.

Key objectives:

- Increase the efficiency, effectiveness and impact of health related emergency response mechanisms at community, regional and national levels

- Enhance the capacity of communities and partner organisations to prepare for and respond to emergencies
- Ensure the needs of the most vulnerable (children, elderly, people with disabilities/mental health problems and those with life threatening illnesses) are addressed within emergency response plans

Cross cutting issues

Within each project and programme area there are a number of cross cutting issues that will always be considered:

Capacity building/sustainability; we are committed to building the technical and administrative capacity of our project partners, helping to ensure the long-term sustainability of services. Partner capacity will be assessed at the outset, with activities designed to enhance capacity incorporated within project plans and budgets.

Gender; gender will be considered during the planning, delivery, monitoring and evaluation of all project activities. Such consideration will include, but not necessarily be limited to, the accessibility, acceptability, staffing, reporting and impact of those activities.

Protection; the protection of project staff and beneficiaries will be considered in the planning and delivery of all project activities. Such protection extends beyond personal security, to ideas/beliefs, rights and property. When relevant, specific reference will be made to the protection of children and MAP's Child Protection Policy, and any other potentially vulnerable groups within our target population.

Access for marginalised groups; we recognise the importance of ensuring access to services for marginalised groups, during periods of calm and emergencies. Depending on the service and local context such groups may include, but not necessarily be limited to, the very poor, persons with disabilities, ethnic and religious minorities, women and the elderly/infirm.

Evidence base; where available all interventions will be based on published evidence (technical and contextual) of effectiveness. Where unavailable the underlying principle will always be "do no harm", with an even stronger emphasis on the careful monitoring and evaluation of the impact of interventions.

SUPPORTING PRINCIPLES

Adherence to the Core Humanitarian Standard

MAP fully subscribes to the Core Humanitarian Standard on Quality and Accountability (CHS), which sets out nine commitments that organisations and individuals involved in humanitarian response can use to improve the quality and effectiveness of the assistance they provide. It also facilitates greater accountability to communities and people affected by crisis: knowing what humanitarian organisations have committed to will enable them to hold those organisations to account.

The CHS places communities and people affected by crisis at the centre of humanitarian action and promotes respect for their fundamental human rights. It is underpinned by the right to life with dignity, and the right to protection and security as set forth in international law, including the International Bill of Human Rights.

The nine commitments and related quality criteria are summarised below:

1. Communities and people affected by crisis receive assistance appropriate and relevant to their needs.
Quality criterion: Humanitarian response is appropriate and relevant.

2. Communities and people affected by crisis have access to the humanitarian assistance they need at the right time.
Quality criterion: Humanitarian response is effective and timely.

3. Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action.
Quality criterion: Humanitarian response strengthens local capacities and avoids negative effects.

4. Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them.
Quality criterion: Humanitarian response is based on communication, participation and feedback.

5. Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints.
Quality criterion: Complaints are welcomed and addressed.

6. Communities and people affected by crisis receive coordinated, complementary assistance.
Quality criterion: Humanitarian response is coordinated and complementary.

7. Communities and people affected by crisis can expect delivery of improved assistance as organisations learn from experience and reflection.
Quality criterion: Humanitarian actors continuously learn and improve.

8. Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers.
Quality criterion: Staff are supported to do their job effectively, and are treated fairly and equitably.

9. Communities and people affected by crisis can expect that the organisations assisting them are managing resources effectively, efficiently and ethically.
Quality criterion: Resources are managed and used responsibly for their intended purpose.

Relationship with partners

Many of the above commitments and related quality criteria inform our relationship with governmental and civil society partners, with probity and our due diligence responsibilities addressed by policy documents that draw on international humanitarian and UK Charity Commission guidelines.

MAP is a medium sized NGO which has the flexibility to work in a truly developmental way with government ministries, established NGOs and local communities/grass root groups to identify and implement projects. The relationship with all local partners is one of joint exploration of ideas and opportunities; we attempt to balance what can be an unequal relationship by embracing the concept of partnership, in which both donor and recipient are learning from each other, from the situation, and from the problems they solve together.

This approach, incorporating ongoing dialogue and collaboration, is maintained throughout the project cycle; from the initial needs assessment to the development of a project concept, proposal and budget, to implementation and the subsequent monitoring of activities and evaluation of impact.

An effective partnership is built on mutual trust, which takes time to develop. It also takes time for the true impact of developmental health projects to emerge. We recognise these factors with a commitment to multi-year funding, subject to satisfactory progress and, when relevant, a willingness to improve.

We aim to strengthen the Palestinian health sector in a sustainable fashion, building the technical and administrative (including fundraising and effective financial management) capacity of our partners. This commitment is reflected in both project plans and budgets.

Monitoring/evaluation and subsequent organisational learning

The details of this vital component of the project management cycle are contained in our new PMEAL (Planning; Monitoring; Evaluation; Accountability; and Learning) strategy. However, two key elements underpin the whole process:

The project logical framework **–** once this is agreed a comprehensive monitoring and evaluation plan will be developed and agreed with the partner, with high level project objectives contributing directly to the relevant programme objective(s) and ultimately the organisational objectives.

Learning – there is no value in developing a robust monitoring and evaluation plan without capturing the learning that emerges from it; in terms of what went well, what didn't, and why. This learning will then be shared within MAP, and with beneficiaries, partners, donors and the wider humanitarian/development sector, providing ever greater transparency and accountability.