

MAP PROGRAMMES STRATEGY 2020-2022 (EXTERNAL)

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MAP'S VISION

Our vision is of a future in which all Palestinians can access an effective, sustainable and locally-led system of healthcare and the full realisation of their rights to health and dignity.

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 equity, 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 and promote the well-being of Palestinians, strengthening the capacity of local partners.

This captures our twin goals of building capacity as well as improving health. Well-being has been added to emphasise the importance of individual and community-centred resilience and hope.

MAP's understanding of 'health' is in accordance with that of the World Health Organisation, which defines health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO, 1948). Health is a resource for living a full life, which also refers to the ability to recover and bounce back from illness and other problems.

SUSTAINABLE DEVELOPMENT GOALS

MAP's vision, mission, goal and key objectives align with the UN's Sustainable Development Goals for 2030. We recognise that SDG 3 – *to ensure healthy lives and promote well-being for all at all ages* – goes hand in hand with the UN's accompanying SDGs calling for urgent action to spur economic growth; reduce inequalities; ensure a safe and clean environment; promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.

ORGANISATIONAL OBJECTIVES

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

- Measurable improvements in health and well-being indicators.
- Enhanced professional, technical and/or organisational capacity of our local programme partners.
- Raised awareness of the social and political determinants of health and increased advocacy; locally through our programmes, in the UK and internationally to enable actions to improve health outcomes.

In attempting to achieve these objectives we aim to:

- Help fill gaps and improve the quality of **essential** health services
- Support the most **impacted** members of already **marginalised** communities
- Respond to **emergencies**

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, which are now likely to be further exacerbated following the outbreak of the global Coronavirus pandemic at the beginning of 2020. There is limited capacity in terms of infrastructure, equipment, human resources and essential drugs and consumables throughout the region. There is also a lack of coordination and cooperation between service providers in the public, UN, NGO and private sectors. This is resulting in inefficient delivery of health care services and undermining long-term policy/investment planning and the overall governance of the health sector. Throughout the region there is a need for more comprehensive and reliable health information systems, improved resource allocation mechanisms, tighter control of hospital referrals, and strengthened monitoring and evaluation frameworks.

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 full-scale crisis.

After a relative absence of armed conflict since the 2014 Israeli offensive, there has been a sharp deterioration in the humanitarian, human rights, security and political situation in the Gaza Strip over the past 18 months. The health system, on the verge of collapse following years of blockade and de-development, is now overburdened with massive casualties from the ongoing “Great March of Return” demonstrations. Thousands of patients with live ammunition gunshot wounds will require specialist limb reconstruction, with multiple operations and long-term rehabilitation over the coming years, at an unprecedented cost to them, their families, the health sector and society at large. There have also been a series of Israeli airstrikes that have threatened to escalate into another major offensive.

The economy is in ‘free fall’ and poverty, unemployment and food insecurity are increasing (World Bank, 2018), as are other core drivers of humanitarian need. The coastal aquifer, Gaza’s sole water source, has been depleted by over-extraction and the intrusion of seawater, forcing the impoverished population to buy trucked water, often of poor quality, at up to 20 times the expense of water from the network. There is a palpable sense of hopelessness and desperation among the population in Gaza, which is eroding coping mechanisms and resilience, while rising violence and tension are fuelling concerns of a renewed escalation of hostilities. This deterioration is exacerbated by significant shortfalls in donor support for the Palestinian Authority (PA), UNRWA and humanitarian operations in general, undermining the ability of the international community to respond effectively to increasing need.

While the humanitarian situation in the West Bank is less acute, the economy continues to deteriorate. Israel’s direct military occupation continues and with it the appropriation of land and resources. In the West Bank alone, 705 permanent physical obstacles restrict the movement of Palestinian people and goods (UNCTAD, Sept 2019). Night raids and house searches by Israeli forces, the prolonged and arbitrary detention of Palestinians, including the practice of administrative detention, continue to be a major human rights concern. After a decline in recent years, settler violence, resulting in Palestinian casualties or in damage to property, is increasing. The failure to resolve the intra-Palestinian political divide is deepening territorial and political fragmentation and contributing to cynicism and hopelessness among Palestinian youth. All of these developments are accompanied by unprecedented shortfalls in funding, alongside growing restrictions and attacks on humanitarian partners, which are generating an increasingly constrained operational context.

In Lebanon, Palestinian refugees live mostly in deplorable social, economic and environmental conditions. Since 2012, the protracted crisis in Syria and influx of refugees has put further pressure on the physical and social infrastructure of the camps and gatherings. The volatile security situation, compounded by exclusion and isolation within the camps, negatively affects refugees from Lebanon and Syria, places even greater demands on already under-resourced health services and heightens risk factors related to child protection, gender-based violence, mental health and developmental well-being.

The changing disease pattern among Palestinians is also challenging. An ageing population intensifies existing health trends, with the prevalence of non-communicable diseases (NCDs), particularly diabetes and cardiovascular disease, having tripled in the past 20 years (UNRWA, 2018). 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. Although the prevalence of mental illness has increased dramatically in the region as a result of all the security, political, social, economic and environmental stressors described above, mental health services continue to suffer from: a lack of trained/experienced mental health workers; a poorly coordinated mental health emergency response; a chronic shortage of psychotropic drugs; and a critical lack of prevention, intervention and rehabilitation programmes. Palestinians with disability continue to battle inequitable access to health services and limited educational, social and economic opportunities.

The global reduction in infant mortality rates continues to be slower for Palestinians than in many parts of the world. Even more worryingly a recent study conducted by UNRWA, subsequently validated by the World Health Organisation (WHO), reported a levelling off and slight increase in the neonatal mortality rate in Gaza. There are many reasons for this finding: the worsening nutritional status of mothers; increasing rates of prematurity and low birth weight babies (both linked to maternal malnutrition and stress); the limited availability of some equipment, essential drugs and consumables; significant overcrowding of the available neonatal intensive care units; and increasing difficulty/delay transferring critically ill babies outside Gaza.

The nutritional status of Palestinian children is also worrying, with high levels of anaemia and essential vitamin deficiencies and rising levels of stunting (short for age). Stunting is a marker of chronic malnutrition, is irreversible, and has convincingly been linked to sub-optimal social, academic, economic and health outcomes in those children affected. It is a particular concern in Gaza and the West Bank, with a 2017 study conducted by the Palestinian National Institute of Public Health and WHO in the Jordan Valley reporting that 16% of children under five years of age were stunted - linked strongly with poverty, inadequate/interrupted food supplies and, to a lesser extent, poor feeding practices.

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. Reasons include a high proportion of "at risk" pregnancies, a high prevalence of maternal malnutrition and anaemia, early marriage, consanguineous marriage and poor birth-spacing. These factors partially explain why women are 14 times more likely than men to die in a crisis and why 60% of preventable maternal deaths occur in crises and fragile settings. However, gender inequity, in terms of access to services, the range/quality of services provided and healthcare seeking behaviour, also contributes to such poor health outcomes for women.

West Bank

Socio-political background

The West Bank has a population of 2.88 million Palestinians, with 27% registered as refugees and a quarter of these refugees living in one of 19 camps. Palestinians have been living in a protracted protection crisis due to the ongoing Israeli occupation. Israel's direct military occupation in the West Bank continues and with it the appropriation of land and resources. The PA is prevented from operating in East Jerusalem and Area C, which together represent more than 60% of the West Bank and contain the most valuable natural resources. In addition, the internal Palestinian divide between Hamas and the PA continues.

In East Jerusalem, there are 320,000 Palestinians and 200,000 Israeli settlers. The Palestinian civilian population is at risk of forcible displacement and dispossession of land and housing, triggered by multiple factors, including: demolitions and destruction of property; relocation plans; settler violence; military training exercises near residential areas; revocation of residency status; night raids; house searches by Israeli forces; restrictions on access to livelihoods and education facilities, or any combination of these factors.

Funding to the region has dramatically decreased, partly due to donor fatigue and other priorities beyond the occupied Palestinian territory (oPt). Moreover, in 2018, the United States Agency for International Development (USAID) ceased all assistance to Palestinians in the occupied West Bank, putting essential services under further strain.

Health

Essential health services are available and provided by the Ministry of Health (MoH), UNRWA, and various NGOs. 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 loss of income described above has negatively impacted the delivery of core health services and availability of essential drugs and consumables. Since February 2019, public employees have been receiving only 60% of their salaries. The PA debt continues to rise, including the debt of the MoH to pharmaceutical companies and service providers.

The legislative and physical division of the West Bank presents obstacles to effective health care provision for vulnerable communities, such as those in Area C. Discriminatory planning policies restrict the development of permanent health facilities in this area, with many communities reliant on mobile clinics for primary health care. Over a third of Palestinians living in Area C have limited access to such care.

Historically, the Palestinian health system has relied on hospitals in East Jerusalem for the provision of specialist care to patients, with many of those patients requiring permits from Israeli authorities to access the area. There are no radiotherapy or nuclear medicine facilities in the oPt outside of East Jerusalem, severely compromising cancer care across the region. While the East Jerusalem Hospitals serve as the main referral centres for the Palestinian health system, the growing PA debt to these hospitals is impacting their ability to continue to provide services.

It is also important to note the MoH decision in early 2019, in response to the growing tension with Israel, to stop all medical referrals to Israeli facilities, worsening the already precarious access to health services for Palestinians in the oPt.

The mental health of Palestinians is affected by exposure to violence and the harsh reality of chronic occupation; it represents one of the most significant public health challenges. The integration of mental health into primary health care services has been a key strategic objective of the MoH and other stakeholders since 2008. The approach has been to strengthen the role of primary health care services in promoting good mental health, identifying common mental health problems, the provision of first level intervention and the referral of more complex cases to community mental health centres

or other suitable care providers. The Mental Health Gap Action Programme (mhGAP), developed by the WHO, has been the key intervention for both the MoH and UNRWA. These organisations have made efforts to provide comprehensive mhGAP-based training for health workers over the past 10 years, but with limited impact on service delivery to date. Despite these initiatives, the mental health system in the West Bank remains under-financed, under-staffed, and insufficiently developed in relation to the ever growing and complex needs of patients.

A survey conducted by the Palestine Central Bureau of Statistics (PCBS) in 2017 reported that 5.1% of the total population of West Bank had at least one disability, with physical disabilities more prevalent than learning disabilities. The survey also reported that over a third of children with disabilities aged 15 years and over had never enrolled in education, over half were illiterate and nearly 90% were unemployed. These figures are a shocking reminder of how disadvantaged all persons with disability remain, with ongoing advocacy and improved access to health, education and employment opportunities clear priorities.

Given the bleak situation outlined above, it is critical for MAP to continue its support for essential services within the MoH, whilst also supporting the NGO sector to continue to address the significant gaps in the health system. In particular, MAP is keen to expand support to the mental health system in the West Bank and to further develop programmes working to empower people with disabilities.

A holistic approach is necessary in supporting the health of Palestinians, strengthening health promotion and disease prevention initiatives within communities to build resilience and utilising a community led approach to guide our interventions. This approach is crucial to ensure sustainable development and address the multiple factors that impact the health of individuals as well as communities.

Gaza

Socio-political background

In the Gaza Strip, 1.9 million Palestinians, including 1.4 million registered refugees, are locked within 365 square km, making it one of the most densely populated areas on earth.

Poverty levels continue to rise, with 68% of households in Gaza now moderately or severely food insecure. The unemployment rate stands at 55%, with youth unemployment at almost 70%. The electricity deficit has also become a chronic issue since 2007, impacting various aspects of Palestinian lives. Moreover, people are denied free access to the remainder of occupied Palestine and the outside world. These movement restrictions intensified following the election of Hamas in 2007 and the worsening political divide between the authorities in West Bank and Gaza.

In addition to the ongoing blockade and closure, Gaza experienced three major Israeli military offensives between 2008 and 2014, with the civilian population bearing the brunt of the hostilities. Houses, agricultural areas, small factories, public health infrastructure, roads and health/education facilities have been destroyed or badly damaged, with significant impact on the Gaza economy and fragmentation of social networks.

In 2018, marking the Palestinian Land day on 30 March, the Great Return Marches (GRM) erupted, with people in Gaza demanding their right of return, a lifting of the blockade and improved access to their basic rights. To date, more than 33,000 people have been injured and 315 killed during these border demonstrations.

Health

Out of over 7,000 live ammunition gunshot wounds sustained during the GRM, 88% are devastating, disabling limb injuries, with the subsequent emergency, reconstructive and rehabilitative treatments crippling an already overburdened health system and equally dire economic consequences. The key health providers (MoH, UNRWA and NGOs) continue to provide reasonable but compromised health care, with other significant challenges facing the health system summarised below:

- The severe long-term shortage of medicines and medical disposables at MoH hospitals and primary health care centres is increasingly affecting the quality of care and compromising critical services. Over 50% of drugs and 30% of disposables are at zero stock levels (less than a one month supply in the central warehouse). This issue means that the MoH is unable to respond during emergencies as it does not have an adequate stock of prepositioned supplies. Shortages also affect equipment and infection control supplies, which are crucial to all aspects of health care - including neonatal and intensive care units.
- The reduced number, skills and motivation of health staff is also having a detrimental impact on the health care system. All MoH staff are receiving less than half of their contracted salaries, encouraging them to leave for better opportunities outside Gaza. More than 200 doctors left Gaza in 2018 alone. Ministry officials are concerned about a deterioration in the quality of care due to poor working conditions, a depleted workforce, professional isolation and a massive reduction in external training opportunities in the last 12 years.
- As well as massive limb reconstruction needs, the enormous rise in traumatic injuries sustained during the GRM has placed unprecedented pressure on neurosurgery, vascular and plastic/reconstructive surgical services, all of which have extremely limited capacity in Gaza.
- As the health system struggles, the need to refer some critically ill patients to health facilities outside Gaza increases. However, the rate of approval of permit requests to leave Gaza for lifesaving treatment elsewhere has fallen significantly. The approval rate was 92.5% in 2012, but only 59% in 2018. For patients injured during the GRM the approval rate was shockingly low, at 18%.
- Due to the shrinking of humanitarian space, health facilities continue to experience delays in receiving essential equipment and medical items. Health organisations continue to struggle with a lengthy and ever-changing process to secure approvals from different authorities to coordinate the movement of humanitarian goods and workers. This issue has been identified as one of the key risks for humanitarian organisations operating in the region.
- The level of micronutrient deficiencies among young children (aged six months to five years) in Gaza, linked to poverty, poor food availability and the general burden of disease in the population, is alarming (Palestine Micronutrient Survey, 2013):
 - Anaemia – over 30%
 - Vitamin A deficiency – essential for growth, eyes and the immune system – over 70%
 - Vitamin D deficiency – essential for teeth and bones – over 60%
- The level of stunting (being short for age) in young children in Gaza is also a major concern. Stunting is a marker of chronic malnutrition and permanently compromises social, academic, economic and health outcomes in affected children. Already 10% of children under the age of five years in Gaza are stunted and the figure is rising.
- The restriction on the movement of people and goods, deteriorating socio-economic situation, instability, protracted hostilities and GRM events have all increased the need for mental health and psychosocial support for patients, their families and other vulnerable groups in Gaza. This

has become a major priority, particularly for children and adolescents, with significant gaps in terms of infrastructure, essential drugs and the availability of suitably qualified and experienced mental health professionals.

- 6.8% of the population in Gaza has some form of disability (PCBS, 2017). Persons with disability (PWDs) have poor access to public services, including health and education, with that access highly dependent on continued demands made by PWDs themselves or their families. There are a number of local and international NGOs that support service provision for PWDs but significant gaps remain. Without raising awareness about the rights of PWDs and advocating for inclusion within all community activities, PWDs will continue to struggle to secure their basic rights.

Over the past few years the MAP programme in Gaza has expanded significantly to meet ever-growing health needs. However, the challenges highlighted above confirm the need for further development and carefully planned, incremental and sustainable expansion.

MAP's work in Gaza will continue to address critical gaps in emergency services and emerging needs, with all activities coordinated with the MoH, health cluster and other key stakeholders. We will continue to help build local capacity in increasingly vital services such as limb reconstruction, neurosurgery, burns care, neonatal care, infection control and general surgery. At the community level, MAP is keen to expand our support for disability and mental health services and will continue to address the needs of vulnerable women and children through partnership with local NGOs.

Lebanon

Socio-political background

Today, there are over 450,000 Palestinian refugees registered with UNRWA in Lebanon (PRL), although a census conducted in 2017 recorded a Palestinian population of 174,000 living in the refugee camps and informal gatherings. Their situation can be described as one of chronic crisis, intensified by the acute crises affecting this volatile region. Since August 2012, the arrival of large numbers of Palestinian refugees from Syria (PRS) – currently around 32,400 PRS continue to reside in the country – has exacerbated the already dire situation in the camps: worsening environmental conditions and increasing health hazards make health service delivery ever more challenging and directly impact 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 those state public services that 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. Recently, the Minister of Labour imposed strict measures related to foreign labourers, including Palestinian refugees. These measures prompted large-scale protests by Palestinian refugees demanding more rights, including the right to work. If these measures stay in place, they are likely to further increase unemployment rates.

For more than a month, the Lebanese population have come out in continuous and widespread popular protest against the political system and what they see as corruption that could lead to economic collapse, following worsening living conditions and declining purchasing power to

unprecedented levels. In this context, Palestinian refugees, who were living in miserable conditions before the crisis and popular movement erupted, are set to become even worse off.

As a result of social exclusion, Palestinians in Lebanon already face significant economic hardship. According to the AUB-UNRWA survey, 65% of Palestinian refugees live in poverty (with an income of less than \$6 per person/day).

Health

UNRWA is the main provider of health services to the Palestinian refugee community in Lebanon. A network of 27 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 (less than three 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 Lebanese hospitals. Whilst the cost of these services is almost entirely covered by UNRWA, the quality of care (especially in PRCS hospitals) is often sub-optimal, with structural, administrative and clinical improvements needed to reach acceptable quality standards. In and out-patient tertiary care is offered in Lebanese hospitals, with UNRWA covering only 60% of the usually very high costs. The unit cost of hospitalisation in Lebanon is the highest among all UNRWA's fields and, in many cases, treatment for advanced conditions is prohibitively expensive for patients and their families.

There is a strong correlation between the high levels of poverty outlined above and ill health, with each impacting negatively on the other, often triggering a downward spiral which may affect entire families across generations.

Due to poor housing conditions, overcrowding, and lack of proper sanitation and infrastructure in the camps, communicable diseases are common among the refugee population. The AUB-UNRWA survey showed that two thirds of refugees had suffered from acute illnesses in the previous six months, with respiratory and gastrointestinal infections (the commonest causes of disease and death in young children) accounting for over half of all illnesses. However, the incidence of communicable diseases in Lebanon remains the lowest among the five UNRWA fields of operation, with the exception of sexually transmitted infections which are more common in Lebanon than in neighbouring countries, possibly due to better surveillance/more accurate reporting. On the other hand, the prevalence of NCDs is increasing; as elsewhere in the region the prevalence of diabetes and cardiovascular disease, major causes of morbidity and premature mortality, has tripled in the past 20 years (UNRWA, 2018).

Data from studies prior to 2010 indicate that whilst the infant mortality rate among Palestinian refugees in Lebanon is on a par with other UNRWA fields, still birth, perinatal and maternal mortality rates are higher than in any other UNRWA field, suggesting weaknesses in antenatal, delivery, and postnatal care services. UNRWA's annual health reports in recent years indicate a decline in maternal mortality to a level similar to that of other UNRWA fields, with MAP's maternal and child health project undoubtedly contributing to this welcome improvement.

According to a 2015 study conducted by Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), nearly 90% of both PRL and PRS have experienced moderate to high exposure to hugely stressful circumstances, including forced displacement and violence, with high levels of subsequent psychological distress. Children and adolescents are among the most affected. A WHO school-based survey in 2017 reported shocking indicators of adolescent and youth health (specifically 13-17yr olds), with virtually no services addressing the need:

- 14.2% had seriously considered attempting suicide in the preceding 12 months
- 16.6% had been bullied on one or more days in the preceding 30 days
- 18.9% had drunk alcohol on one or more days in the preceding 30 days (alarming within highly conservative communities)

Child protection violations, including neglect, physical and emotional abuse, violence against children and sexual abuse and exploitation is also reportedly increasing.

Disability services remain inadequate to meet the needs of Palestinian refugees. UNRWA's disability programme is unable to provide the type of comprehensive, person-centred case management and specialised services that are required to meet the health, protection and social needs of PWDs and their families. This highly vulnerable group thus relies on local and international NGOs to fill gaps, with significant geographic variability in the range and quality of available services.

Priorities for service development thus include mental health, psychosocial and disability services, particularly as Palestinians in Lebanon continue to suffer a protection gap – remaining highly vulnerable to different forms of violence, abuse and exploitation, with extremely limited opportunities to access legal, welfare and other support services. Together with women and child health and emergency care services within the hospital system, MAP will prioritise these areas through a combination of new partnerships and an expansion of existing projects.

THEMATIC/PROGRAMME PRIORITIES

Introduction

The above situational analyses, together with our organisational history and current capacity, a desk review of relevant UN and governmental strategic documents, the expressed needs of our existing partners and other key stakeholders, 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. These programme level objectives are each accompanied by suggested indicators of achievement. 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.

Capacity Building

A core organisational objective is to enhance the professional, technical and organisational capacity of our programme/project partners, helping to ensure the long-term sustainability of services. This is hugely important, not only in terms of having a meaningful impact on the health and dignity of Palestinians but also to demonstrate the added value that MAP brings to our partnerships; if we do not contribute to the building of such capacity then donors and other stakeholders would, quite appropriately, work directly with our partners. This approach aligns perfectly with SDG-16: “....build effective, accountable and inclusive institutions at all levels”.

Elements to be considered within the different capacity-building components will include, but not be restricted to, the following:

- Professional; leadership, strategic vision and system development
- Technical; knowledge and skills of health professionals and other project staff
- Organisational; administrative, financial, monitoring/evaluation and fundraising systems

Priorities will be agreed with our partners following completion of initial needs assessment, project planning and due diligence processes. Capacity building will be incorporated within initial work plans and budgets and reviewed on an annual basis. Resources may be identified within MAP, our network of partners and/or external agencies, with all anticipated costs included within operational budgets.

Women and Child Health

The health of women and children is still a cause for serious concern in countries affected by conflict and mass displacement. Rates of morbidity and mortality in pregnant women, mothers and the newborn remain unacceptably high, especially among poorer groups. Access to good quality family planning, reproductive health and general gynaecological services for women remains limited. Among the Palestinians living under occupation, displacement and as refugees, infant and child mortality rates 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 will continue to advocate for and support 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 will 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 will continue to support 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, family and child rights considerations into health and wider public policies/programmes
- Improve target group +/- population level women, infant and child mortality/morbidity rates
- Improve target group +/- population level women, infant and child malnutrition rates
- Improve access to good 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 a range of interventions that promote individual and/or community psychological well-being and prevent or treat mental health problems.

Globally mental health problems and substance misuse account for nearly 15% of disability-adjusted life years lost to illness. Depression alone is one of the largest single causes of disability worldwide, accounting for 11% of all years lived with disability. There is a close reciprocal relationship between poverty, conflict, and mental illness. And there is a wide gap between the burden of such illness and the availability of mental health services.

For Palestinians, the high levels of acute and chronic stress due to the protracted occupation and related political violence are taking a heavy toll on mental health. Exposure to threats to personal safety, displacement, arrests and detention, as well as periodic outbreaks of shelling and bombardment, render the entire population more vulnerable to mental illness and psychological distress. Multiple studies indicate that the number and type of traumatic exposures is positively correlated with Post-Traumatic Stress Disorder (PTSD), depression, anxiety, risk-taking behaviour, and other emotional and behavioural problems. Specific groups including children, adolescents, women, the elderly and ex-prisoners/detainees, are all placed at a significantly higher risk of experiencing severe psychological distress under these conditions.

There are additional, powerful reasons why MHPSS has been adopted as one of MAP's thematic priorities:

- 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.

From a public health standpoint, most mental health care should not be provided by specialists. Resilience-building clinical approaches, for the prevention and management of mental health problems, should be given priority when populations have large clinical needs, but few resources and high levels of stigma that adversely affect the acceptability of mental health services. However, most tiered programmes of care are predicated on the existence of a cohort of psychiatrists to train the

trainers, to serve as consultants, and to manage sicker patients. For this reason, building psychiatric capacity within the system must also remain a priority.

Key objectives:

- Promote MHPSS services that utilise rights-based, community-based, participatory approaches
- Strengthen family/community resources, support networks and livelihood opportunities for those with mental health issues
- Improve access to and quality of MHPSS services, within the framework of the four-level intervention pyramid recommended in the Inter Agency Standing Committee (IASC) Guidelines

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 compounded 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. CBR 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 will continue to support 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 (including access to education and livelihood opportunities) 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 all community-based services and activities

Emergencies and Complex Hospital Care

Palestinian communities have endured frequent escalations of an ongoing chronic emergency, triggered by conflict, mass displacement and sectarian violence. Emergencies can also be created by political change, volatile domestic and international policies and significant demographic or environmental changes – any of which can leave particular groups or communities with compromised access to and/or poorer quality health services. 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, UN 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 an intricate, multi-dimensional process. MAP is committed to linking this work with support for the ongoing development of core health services. 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 impacted members of target communities.

Closely aligned to emergency response/preparedness are the wide-ranging complex hospital care needs in oPt and Lebanon. “Complex” refers to the management of life and limb threatening conditions that require highly technical and multidisciplinary interventions. As a result of economic pressures and the crippling isolation of health professionals in the region, these services and linked patient outcomes have suffered most from displacement and occupation. Thus, the capacity-building impact of international health specialists and training fellowships and targeted procurement is also likely to be greatest within these services. Limb reconstruction, neurosurgery and cancer care are highly successful examples from our current programme in oPt.

Key objectives:

- Increase the efficiency, effectiveness and impact of health-related emergency response mechanisms at community, national, regional and international levels
- Ensure the needs of the most impacted members of already marginalised communities (children, elderly, people with disabilities/mental health problems and those with life threatening illnesses) are addressed within emergency response plans
- Identify and respond to lifesaving complex hospital care needs, aiming to build local capacity

Advocacy and Campaigns

As well as working through local partnerships to address the health and dignity needs of Palestinian communities, MAP is committed to addressing the political, social and economic drivers of the barriers (such as displacement, occupation, marginalisation and injustice) that are the root causes of these needs.

Access, protection and sustainable development are at the heart of effective, affordable, sustainable and locally-driven health services, which MAP and our partners are working towards.

Healthcare must be accessible to have any value, and our advocacy and campaigns programme continually highlights the impact of the blockade and closure of Gaza, the permit regime, back-to-back transfers, lack of permanent health infrastructure in Area C and inadequate infrastructure and healthcare provision in Lebanon.

Health care workers and medical facilities in the oPt are repeatedly violated and attacked and, with a prevailing culture of impunity and lack of international resolve, are set to continue. Highlighting such attacks provides moral support to the health sector MAP is a part of, whilst also pointing to the wider need for adherence to international law with regards to the oPt and Palestinians. MAP is well-placed for further research and advocacy in this area in the UK and through the UN system.

The de-development of Gaza continues through well over a decade of blockade/closure, which impedes health workers' and the health sectors' advancement, and consequently negatively impacts the whole population. The prohibition on permanent health facilities in Area C likewise holds back health development dramatically in the West Bank. MAP actively strives to counteract these structural injustices.

We have a strong track record of advocating in the UK and internationally for the right of Palestinians to live in health and dignity. Through our advocacy and campaigns programme we seek not only to address key gaps, but to do so in accordance with sustainable development standards and human rights principles.

We work on our own and in coalition in order to mobilise support for the Palestinian right to health and dignity through a raft of activities and outputs. This includes issuing joint statements with well-respected Palestinian, Israeli, UK and EU organisations; giving evidence at International Development Committee hearings; securing media coverage through a variety of outlets (most recently Radio 4, Channel 4 News, The Guardian and The Sunday Times); producing short films to increase awareness of access, protection and development issues; producing briefings; organising parliamentary delegations and presenting on the Palestinian right to health and well-being at international advocacy meetings in Brussels and Geneva.

Our advocacy and campaigns activities seek to influence the public in general, civil society organisations, the media, parliament, government, international bodies including the UN and local duty-bearers whose actions directly affect Palestinian health and well-being.

Key objectives:

- To raise awareness of gender, family and child rights in health and healthcare and to enable actions to address them
- To raise awareness of the contextual drivers of psychosocial and mental health issues, including inequality, discrimination, injustice and violence and enable actions to address them

- To raise awareness of the rights and needs of people with disabilities and advocate for those rights, including by amplifying voices and enabling self-advocacy
- To raise awareness of emergency health needs and of their drivers, to help facilitate sustainable development as well as accountability for violations of international law

Cross Cutting Issues for all of MAP's programmes

Within each project and programme area there are a number of cross cutting issues, which align with the UN's SDGs, that will always be considered:

Capacity building/sustainable development: as stated above we are committed to building the professional, technical and organisational 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. Through advocacy we will also address practices and policies that are obstructing the sustainable development of the Palestinian health sector.

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, as well as Palestinian health workers in general, will be considered in the planning and delivery of our project activities. Such protection extends beyond personal security, to ideas/beliefs, rights and property and international law. When relevant, specific reference will be made to the safeguarding of children and vulnerable adults and MAP's safeguarding policy/procedures, 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 and mental health problems, 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 such evidence is 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. We intend to make a greater contribution to the evidence base, with wider dissemination of key project findings/evaluations and support for research linked to our work.

SUPPORTING PRINCIPLES

Adherence to the Core Humanitarian Standard

The Core Humanitarian Standard on Quality and Accountability (CHS) 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.

As a member of the CHS Alliance MAP completed its first self-assessment against these nine commitments in 2019. The process was a valuable learning opportunity as it involved obtaining feedback from a range of MAP stakeholders, including direct feedback from beneficiaries in Lebanon, Gaza and the West Bank. Whilst much of the feedback from our partners, staff and local communities was reassuring and reinforced MAP's position as a respected, trusted and accountable humanitarian and development organisation, it also helped us identify several areas needing further work:

- Developing more robust, accessible programmes feedback and complaints mechanisms for MAP and our partners
- Increasing opportunities for engagement with communities throughout the project cycle
- Providing even greater support to staff working in demanding conditions
- Maximising the rich learning from our projects and identifying new ways to disseminate and share that learning with a wider audience

In 2020 and 2021 MAP will implement an improvement plan with the aim of building on our performance in these and other key areas. In 2022, the final year of this strategy, we will undertake a second assessment against the same CHS indicators to measure changes in our performance.

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 that 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 we solve together.

This approach, incorporating ongoing dialogue and collaboration, is maintained throughout the project cycle – from the initial needs assessment and 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 professional, technical and organisational 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 MAP's Planning Monitoring Evaluation Accountability and Learning (PMEAL) strategy document. 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.