



MEAL Planning in Practice

Lesson text (English original)



Lesson 1

Introduction

Welcome to this training on planning for monitoring, evaluation, accountability and learning.

If you are new to MEAL, that's perfect — we're going to demystify what MEAL is in practice. If you have more experience, you'll get fresh, practical ways to make your MEAL systems work better.

This is a foundational session, designed for smaller NGOs that may not have a dedicated monitoring and evaluation section or M&E staff. If you're looking for more advanced technical exploration of MEAL, this may not quite be that, but you will still walk away with tools that you can use almost immediately.

By the end of this training, you'll have:

- A clear grasp of what MEAL is and why it matters for your work
- A practical framework to build your first MEAL plan, even with limited resources
- Ready-to-use tools, including a MEAL Framework Table and a Monthly Learning Meeting template
- Real-world proof of how monitoring, evaluation, accountability and learning work together as a system

You'll have the confidence that you can do this without creating unnecessarily complex systems.

Throughout this training, we'll follow Dr. Sita's journey — from managing a maternal health project across seven remote villages in Nepal, to building a simple MEAL system that helps her track progress, adapt fast, and prove impact.

Pause and Reflect

What questions about your own project keep you awake at night?

What do you hope to be able to do differently after this training?



Lesson 2

Understanding the Project Context

This is Dr. Sita Sharma. She is a medical doctor working for a small health NGO in Rukum district in Nepal. She is a program officer responsible for maternal health activities in one cluster. In that cluster, there are seven villages with a population of around 2,300 people. She coordinates with two field staff: Ramesh, who is her field officer, and Rashmi, who is her female community health volunteer (FCHV) coordinator.

So she manages this cluster — seven villages in a remote district, population 2,300, a three-person team. There are five health posts in the cluster with 10 government health workers, and seven female community health volunteers.

Don't worry if you don't know a lot about the health sector or maternal health. The challenges that Sita faces are the same challenges that even the most experienced of us face, whatever sector we are working in — whether that is WASH, education, agriculture, livelihoods, and so on.

What keeps Sita awake at night?

Firstly, is she reaching the right people? Is she reaching the most vulnerable, or is she just providing services to those who are easy to reach? It is very easy to be distracted by delivering services to those who are more accessible, rather than reaching out to those where it requires extra effort or consideration.

She wonders if she is really making a difference. She feels busy all the time, but how does she know if she is really creating positive change?

How does she know where her support is needed most — which villages need her attention, extra services, or a different approach?

And this is a very common worry: how are we going to demonstrate the impact and positive changes of our project at the end? How can we base that on evidence?

She needs a system to answer these questions, and that system is MEAL — Monitoring, Evaluation, Accountability, and Learning.

The Four Components of MEAL

MEAL answers four types of questions throughout your project:

Monitoring asks whether things are on track. Is implementation happening as planned? It lets us know what is happening on the ground, when we meet roadblocks, and when things do not unfold



the way we expect — and why.

Evaluation is more reflective. It asks: did it work? Did we achieve the change that we set out to create? If monitoring asks "are we on track?", evaluation asks "does that track lead where we thought it would?"

Accountability is about listening and communicating. Do communities have any complaints? Do they have any issues? Are they facing any challenges accessing services? Are we listening, and are we transparent around our project implementation and decision-making?

Learning asks: what should we change? What do we need to do differently to deliver positive results for our target groups and communities?

MEAL is not just a performative act for donor reporting. MEAL is how we manage our work and our projects effectively.

The Problem Sita is Trying to Solve

In her cluster, only 31% of pregnant women attend four or more antenatal care visits. This is the basic minimum standard we should be aiming for.

A donor has just provided new antenatal care equipment — blood pressure monitors, handheld ultrasound devices, examination supplies — to the five health posts in her cluster. The equipment is installed and ready to use.

Sita's job is to manage a 12-month project to increase antenatal care attendance from 31% to 55%. She will train health workers to deliver quality care, and mobilize communities through education and awareness sessions so that women actually show up for their check-ups.

That sounds simple, right?

The Complexity

The terrain is very difficult. Two of the villages have no health posts at all — women need to travel to a neighbouring village or wait for a mobile health worker to visit. Some households are still two hours' walk from the nearest post, which is quite a challenge, especially late in pregnancy. Some villages require crossing a river to access care.

The community also has varying attitudes towards antenatal care and varying levels of awareness. Some communities may never have heard of this, or they may prefer to seek out an auntie, grandmother, or local elder rather than turn to a health post. There are issues of awareness, attitudes, and trust of government health services.



This is messy, real-world complexity. Sita needs to improve attendance across all of it — not just the easy-to-reach people.

This complexity is exactly why she needs MEAL: to track what is working and where, to adapt to what she discovers, and to prove impact despite those challenges.

Pause and Reflect

Think about your own context. How do things like geography, religion, culture, tribal differences, economic disparities, education, and language make your working environment more complex?

Which of Sita's worries resonates most with your current situation?



Lesson 3

The Results Chain

Given this complexity, what is Sita's plan?

It is a 12-month project with two components.

First, to train the 10 health workers so they can use the new equipment and deliver quality antenatal care.

Second, to educate communities on the importance of mothers getting check-ups, so they are aware of the danger signs during pregnancy.

Those are simple activities. It seems straightforward, but her challenge is how to turn these into a MEAL plan. What exactly should she measure? When? How?

To answer that, she needs to map out her logic. What change is she trying to create? And how will these activities lead to that change? This is called her results chain.

The Results Chain

Activities — At the bottom, we have the activities. These are the things the project actually does:

- Conducting a five-day intensive antenatal care training for health workers
- Providing monthly clinical mentorship for health workers
- Training the female community health volunteers as community educators
- Running community education sessions
- Developing education and awareness-raising materials

These are all actions, all verbs, all things we do. This is where most of us start, because we know what we are doing.

Outputs — What do these activities produce? Two outputs:

Output 1: Health workers in the target facilities (the five health posts) are competent in antenatal care service delivery.

Notice the language here. This is a state, not an activity. It is not "train health workers" — that is what she does. The output is that health workers ARE competent. That is what exists at the end of those activities.

Output 2: Target communities have increased knowledge of maternal health.



Again, this is a state. Communities HAVE knowledge — not "conduct sessions." The output is the change in knowledge that exists.

So she is producing competent health workers and knowledgeable communities. What does that create?

Outcome — The specific change Sita aims to create in 12 months is that more pregnant women are receiving quality antenatal care. Remember, it was 31%. The target is 55% of mothers getting four or more ANC sessions.

This is the change in behaviour, change in access, change in what is actually happening for women.

Impact — What does that contribute to? The impact is why we are doing this. Here, it is a contribution to reduced maternal mortality — the bigger, longer-term change.

Can Sita's project address this alone? Not likely. Maternal mortality has many causes: nutrition, lack of emergency obstetric care, lack of transportation. But her project contributes to reducing it.

Sita's Theory of Change

This is Sita's theory of change, or logic model:

If she produces competent health workers AND knowledgeable communities, more women will receive quality antenatal care, which will contribute to reduced maternal mortality.

Pause and Reflect

Can you articulate your project's outcome in one sentence — as a state, not an activity?

What are your outputs? Are they written as states ("communities have knowledge") or activities ("conduct sessions")?

What is the impact your project contributes to — and why can't your project achieve it alone?



Lesson 4

The MEAL Framework

Sita has her results chain — she knows what she is trying to achieve. Now come the critical questions:

- How will she track if it is working?
- How will she know if health worker skills have improved?
- How will she measure whether community attitudes and knowledge have changed?
- How will she know if more women are actually receiving care?
- Among those seven villages, which ones are improving and which are falling behind?
- How will she keep communities, health workers, and her donor informed about what is working and what is not?
- At the end of 12 months, how will she provide evidence of change?
- And crucially: if things aren't working, how will she catch it early enough to fix it?

The MEAL Framework

This is where the MEAL framework comes in. It is a planning table that answers these questions.

The framework tells us:

- **What** we will measure — our indicators
- **How** we will measure it — data sources and methods
- **When** we will measure it — frequency
- **Who** is responsible — for collecting and analysing data
- **How it will be reported** — not just to donors, but to the team and communities

The MEAL framework gives us the monitoring and evaluation foundation. The learning and adaptation happens through the discipline of monthly review meetings, which we will cover later.

The Nine Columns

- **Results Level** — Outcome and outputs
- **What We're Achieving** — The results chain statements
- **Indicator** — What you will measure
- **Definition** — How to calculate it, so everyone calculates consistently
- **Baseline** — The starting point



- **Target** — What we want to achieve
- **Data Source** — Where the evidence comes from
- **Frequency** — When we will collect data
- **Responsible** — Who collects and compiles the data
- **Reporting & Accountability** — Who gets informed and how

Sita's Complete MEAL Framework

Five indicators across outcome and outputs:

Outcome indicator: Percentage of pregnant women receiving four or more ANC visits — the main measure of success.

Output 1 indicators:

- Number of health workers trained (reach)
- Percentage demonstrating competency (quality)

Output 2 indicators:

- Community members reached through education sessions (reach)
- Percentage who can identify danger signs in pregnancy (quality)

Notice the pattern: for each output, she measures both reach (how many) and quality (how well).

The Definition Column

Look at the outcome definition: "Number of pregnant women with 4+ ANC visits ÷ total pregnant women identified × 100." This formula ensures everyone calculates consistently, regardless of who collects the data.

What's NOT in the Framework

- **No impact indicators** — Maternal mortality is measured through national surveys every five years. A 12-month project cannot measure mortality change.
- **No activity indicators** — Activity completion is tracked through regular workplans, not the MEAL framework.
- **Only five indicators** — For a three-person team, every indicator has a cost: time for design, testing, collection, analysis, and reporting. A functioning MEAL system focuses on indicators needed to demonstrate and track progress.



Key Decisions Behind the Framework

Decision 1: Why target 55%, not 100%?

The baseline is 31%. A 24 percentage point increase in 12 months is ambitious but achievable. 100% would require solving every barrier — transport, culture, health system capacity — beyond her project scope. 55% is realistic progress. Four or more ANC contacts is the WHO minimum standard, so it is practical for this context.

Decision 2: Why use both health facility registers AND FCHV lists?

Health facility registers show who came for ANC, but miss women who never came. FCHVs track all pregnant women in their villages. Combining both gives the true denominator — you cannot calculate a percentage without knowing the total.

Decision 3: Why measure the outcome at baseline, midline, and endline — not monthly?

This is an outcome. Behaviour change takes time. You will not see meaningful change month-to-month. Save your energy for periodic evaluation at key moments.

Decision 4: Why target 80% competency, not 100%?

Two workers are nearing retirement and struggle with newer technology. One health post has high turnover. Perfect competency across all 10 workers is not realistic. 80% means 8 of 10 demonstrate competency — achievable but still high quality. Those who struggle can be paired with more competent colleagues. This is honest target-setting, not aspirational fantasy.

Decision 5: Why observe competency quarterly, not monthly?

Monthly observation would disrupt services too much. Staff would spend more time being observed than working. Quarterly gives them time to practice between assessments while still catching problems before they become entrenched.

Decision 6: Why target 500 community members, not all 2,300?

Seven villages, roughly 330 people per village. About 25% are women of reproductive age or their husbands — the primary audience. That is about 80 people per village, or 560 across seven villages. Realistically, we will reach 500 because not everyone will attend. This is a target based in reality.

The indicator measures "unique individuals attending at least one session." This seems like a low bar, but it is a measure of reach, not retention. It tells us how many people we touched. The quality indicator (percentage naming danger signs) tells us what they actually learned.

Getting 500 people to attend even once in rural villages with competing demands — farming seasons, market days, household responsibilities — is already an achievement.



Decision 7: Why target 70% naming danger signs, not 100%?

Education sessions are voluntary and informal. Some attendees may be distracted, arrive late, or forget. 100% retention is unrealistic. 70% means the majority learned and retained key messages — that is good education quality.

The baseline is established in month one from the first sessions. No preliminary assessment needed — a rapid baseline is practical and acceptable.

Decision 8: What does she NOT measure?

This indicator only measures people who attend sessions. We will not have quantitative data on non-attendees' knowledge — that is a gap. But through adaptations later, FCHVs will teach danger signs during home visits, mobile clinics will reach non-attendees, and participants will share knowledge with neighbours. This extends reach beyond the 500 who attend.

Decision 9: How will she measure knowledge?

Post-session verbal assessments with sampling. At the end of each session, the FCHV randomly selects 3-5 participants and asks: "Can you tell me the danger signs during pregnancy?" She listens and counts how many they correctly name. If they name 3 or more out of 8, they know the danger signs.

Why verbal, not written? Many participants have low literacy. Verbal is faster and less intimidating. It matches how FCHVs naturally communicate. We are testing knowledge recall, not reading or writing ability.

Why sample 3-5, not everyone? Testing all 20-30 participants would take at least half an hour per session. A sample gives a good enough sense of session quality and is manageable for volunteers with limited time.

This is context-appropriate measurement. The method fits the audience, the data collector's capacity, and the setting.

The Pattern Across All Decisions

- Realistic targets based on capacity and context
- Both reach AND quality for each output
- Frequency that matches what is feasible and meaningful
- Methods appropriate for the audience and data collectors
- Honest about limitations and gaps

This is Sita's MEAL framework — the backbone of her system. But a framework alone does not create learning. For that, she needs a practice.



Pause and Reflect

For one of your outputs, what would prove it exists? (This is your indicator)

Do your current indicators measure both reach AND quality — or just one?

Is there an indicator you're currently collecting that wouldn't change any decision? Could you drop it?



Lesson 5

MEAL Components

Monitoring

Monitoring asks: Are we doing what we planned to do? Are things on track?

Practical monitoring questions include:

- Are we conducting community education sessions as planned?
- Did we train the 10 health workers?
- Are health workers using the new equipment?
- Are supplies reaching the health posts?

The monthly MEAL meeting is where you answer these questions. These meetings are where we look at the data collected and examine what is on track, what is off track, and what we need to adjust.

The power of monitoring is that it catches problems early, so you can fix them. Without regular monitoring, problems only surface at the end when it is too late to do anything about them.

Evaluation

Evaluation asks: Did we create the change we intended?

Practical evaluation questions include:

- Did the percentage of women attending four or more ANC visits increase from 31% to 55%?
- Did health workers actually improve their skills and competency?
- Can community members now identify danger signs during pregnancy?

Sita evaluates at three points:

- **Baseline** — Where are we starting?
- **Midline** — Are we making progress?
- **Endline** (Month 12) — Did we achieve our outcome?

Baseline data matters. Without it, you cannot prove change.

What makes this realistic for a small team: she does not measure everything. She uses existing data systems — health facility registers, FCHV pregnancy lists. She is not hiring an external



evaluator for baseline or midline. For her output indicators, she uses simple tools suitable for the data collectors and the community, and accepts good enough data.

Accountability

Accountability asks: Are we keeping our promises? Are we listening to and responding to feedback?

Accountability flows in three directions:

To donors — Monthly monitoring summaries become quarterly donor reports. The monitoring data becomes the donor report — not a separate job.

To the team — Monthly review meetings, already scheduled as the key tool for MEAL in practice.

To communities — Every education session ends with "What should we improve?" Field officers bring feedback to monthly meetings. The team responds and shares back what they are doing.

Accountability is not extra bureaucracy or paperwork. It is building listening and transparency into what you already do.

The monthly meeting is not just for the team — it is where donor accountability, team coordination, and community feedback all come together.

Learning

Learning asks three questions:

- What is working?
- What is not working?
- What should we change?

Learning requires disciplined practice: monthly learning meetings with the same agenda.

The Four-Part Agenda:

- **Review last month's actions** — Did we do what we committed to?
- **Review this month's data** — What are the numbers telling us?
- **What's working? What's not?** — Discussion
- **Actions for next month** — Who is going to do what, by when?

The learning meeting is a discipline:

- Same time each month (e.g. first Tuesday at 2pm)
- Same agenda



- Written actions (who, what, when)
- Review actions next month for accountability

Without this regular discipline, data just sits unused. The meeting forces your team to look at the data, discuss what it means, and decide what to change.

That is learning in practice.

How M-E-A-L Work Together

Monitoring, evaluation, accountability, and learning are not four separate things. They work together.

- Monitoring might raise the alarm
- Evaluation might pick up a trend or issue
- Accountability reveals why the numbers look the way they do
- Learning decides what to change

Sometimes you monitor first and find a problem. Sometimes evaluation reveals a pattern you hadn't noticed. The components feed into each other — there is no fixed sequence. Together, they operate as one complete system.

Pause and Reflect

Which component feels weakest in your current work: Monitoring, Evaluation, Accountability, or Learning?

How do you currently get feedback from communities — and what do you do with it?

When did you last change something in your project based on data? What prompted it?



Lesson 6

Monitoring in Action

MEAL in Action: The Full Story

Now we look at MEAL in action across Sita's 12-month project — this is where everything comes together in practice.

Remember her questions from the beginning:

- Is she reaching the most vulnerable, or just those who are easy to reach?
- How does she know if she's creating positive change, or just being busy?
- How will she know which villages need more support?
- How will she have evidence to show the donor at the end?

Here is how MEAL answered each question throughout the year.

Month 3: Monitoring Catches a Problem

Ramesh is compiling the monthly monitoring summary, looking at the FCHV pregnancy identification lists from each village. Most villages show 10 to 20 identified pregnant women, but one village — the most remote, with no health post — shows only two.

This doesn't make sense.

This is monitoring in action: regular monthly data review spotting an anomaly.

Ramesh flags it in the monthly team meeting — the disciplined practice of reviewing data together every month.

What they learn: The FCHV in that village admits she stopped actively tracking. "What's the point?" she says. "We've got no health post. Where am I going to send these women?"

It's not just about workload — it's motivation. She doesn't believe the health system can help her women.

But there's more. In the Month 3 focus groups — part of the routine accountability mechanism — Rashmi, the FCHV Coordinator, had already been hearing this. Other volunteers from remote areas report that many pregnant women won't travel when they're far along in pregnancy. The terrain is too difficult. They need services to come to them.

The adaptation: Sita commits to weekly visits from Ramesh to encourage the FCHV and show support. But more importantly, she promises: "We'll have mobile clinics by Month 6. I'll get district



approval."

Sita's thinking: The focus groups confirmed what the data is showing — they're losing the most vulnerable women. Mobile clinics have worked in other districts; she's seen it. But it means getting the district to commit a vehicle and health worker two to three days a month. That's not just an operational tweak she can make herself — she needs district approval and donor agreement. She hasn't secured either yet, but she needs to restore faith now, or there'll be no data from these villages at all.

The result: Within two months, the village identifies seven pregnant women — more realistic. The FCHV's motivation returned, sustained by the promise of mobile clinics coming.

The lesson: Without monthly data review, this village would have stayed invisible until endline. The denominator would be wrong, the outcome data meaningless, and pregnant women invisible.

Answering Sita's question: "How will I know which villages need more support?" Month 3 monitoring revealed the most vulnerable village was being missed entirely.

Monitoring caught it early.

Pause and Reflect

What data are you collecting that you don't actually review regularly?

Is there a "Village 7" in your project — a group or area that might be invisible in your current data?



Lesson 7

Evaluation, Accountability and Learning in Practice

Month 6: Evaluation Reveals Patterns

It's now Month 6 — midline time.

Ramesh compiles the outcome data from health facility registers and FCHV lists across all seven villages.

Overall result: 38% of pregnant women are on track for four or more visits — up from the 31% baseline. Progress, but not enough.

But we don't stop at the aggregate. We break it down by village.

What emerges:

- Villages with health posts and good access: 45-50% attendance
- Villages WITHOUT health posts: 15-20% attendance
- Villages requiring river crossing: 25-30% attendance
- One well-resourced village near town: 52% attendance

This is evaluation in action — it reveals patterns, not just one problem.

Sita sees:

- Villages without health posts are worst off
- River crossing is a major barrier
- Proximity to town helps

The data shows the patterns, but doesn't tell us why.

One bright spot: Knowledge of danger signs among session participants has risen to 45%, up from 15% baseline. The education is working — knowledge is changing, even if behaviour hasn't shifted yet.

One failure: The mobile clinics Sita promised in Month 3 weren't happening. District approval stalled — they wanted more evidence, a formal proposal, budget reallocation approvals. The FCHV from the remote village is losing faith again.



Answering Sita's question: "Am I reaching the most vulnerable, or just the easy-to-reach?"

Midline evaluation showed exactly who was being reached and who wasn't. Villages without health posts were the most vulnerable and falling behind.

Weeks After Month 6: Accountability Investigates

Sita's team doesn't just look at numbers. They go to communities to listen.

Through home visits and community meetings, they discover layered barriers.

From river-crossing villages:

- "The crossing takes an hour each way. In monsoon, it's dangerous."
- "I went once. It took my whole morning. I can't do that four times while pregnant."

From villages without health posts:

- "We don't have a health post here. Going to the next village feels strange and foreign."
- "Our volunteer stopped encouraging us — where would we even go?"

From scattered households:

- Families living up on the ridge face a two-hour walk downhill while pregnant.

Even from a well-performing village:

- "The health post closes at 2pm. Market day is Wednesday — we're all at market until 3pm. If you extended hours even one day, more working women could come."

Accountability in action: Listening systematically reveals that there isn't one barrier — there are multiple layered barriers.

What emerges:

- Geography creates different barriers in different villages
- Health system schedule doesn't match women's realities
- Lack of trust where services are absent
- Distance interacts with pregnancy stage — harder to travel later in pregnancy

Answering Sita's question: "How will I know which villages need more support?" Accountability mechanisms revealed exactly what support each village context needed — mobile clinics, transport coordination, extended hours, outreach to scattered households.



Months 7-9: Learning Drives Tailored Solutions

Sita's monthly learning meetings turn all this data into decisions.

Immediate actions (Month 7):

- **Transport coordination** — For river-crossing villages, coordinate transport on market days
- **Adjust health post hours** — Where scheduling conflicts exist, extend hours one day per week

Quick wins. Low cost. Immediate impact.

Medium-term (Months 7-8):

- **Train FCHVs in basic ANC and deploy for outreach** — Blood pressure checks, weight monitoring, danger sign screening at village level. Monthly visits to scattered households who can't reach health posts. This brings basic monitoring directly to the most remote women.

This takes longer to set up but extends reach significantly.

Systemic solution (Month 9):

- **Mobile clinics** — Finally approved by the district. A vehicle and health worker assigned two to three days a month for outreach. Prioritised for villages without health posts and river barriers.

This was the big one — the promise Sita made in Month 3. It took six months of negotiation and presenting evidence, but it arrived.

Learning in action: The monthly learning meeting forces the question: "What will we do differently based on what we know?"

Each solution is tailored to specific contexts revealed through monitoring, evaluation, and accountability combined. No one-size-fits-all. No guesswork. Evidence-based adaptation.

Answering Sita's question: "Am I creating positive change, or just being busy?" Monthly learning meetings ensured every insight led to action. The team wasn't just collecting data — they were using it to adapt and improve.

These adaptations came from MEAL working together: monitoring caught data quality issues, evaluation revealed geographic patterns, accountability explained the why through listening, and learning turned insights into tailored action.

Pause and Reflect

If you disaggregated your outcome data by location, group, or context, what patterns might emerge?



What barriers might your beneficiaries face that you haven't directly asked them about?

What adaptation have you been meaning to make but haven't yet? What's blocking it?



Lesson 8

End of Project Results

Month 12: Final Results

Overall outcome: 52% of pregnant women attended four or more ANC visits — up from 31% baseline.

The target was 55%. They almost hit it — and they know exactly why they didn't.

Breakdown by village type:

- Villages with health posts and good access: 58-62% (exceeded target)
- Villages without health posts, with mobile clinics: 45-48% (substantial improvement from 15-20%)
- River villages with transport coordination: 48-52% (up from 25-30%)
- Scattered households with outreach: 42-45% (up from ~5%)

Output results:

- 10 health workers scored 85% average on competency assessment (target: 80%) ✓
- 72% of education session participants correctly identified danger signs (target: 70%) ✓

What worked:

- Health worker training: highly effective — exceeded targets
- Community education: changed knowledge more than aimed for
- Tailored adaptations: each solution worked in its own context

What didn't work as planned:

- Mobile clinic approval was delayed by three months (promised Month 6, delivered Month 9)
- Those three months of lost coverage for villages without health posts likely cost the three percentage points from the target

Answering Sita's Questions

"Am I reaching the most vulnerable, or just the easy-to-reach?"

Yes — she reached the most vulnerable. The project identified who they were (villages without health posts, river crossings, scattered households) and deployed targeted solutions for each context. They didn't just work with the accessible villages.



"Am I creating positive change, or just being busy?"

Yes — positive change. 52% attendance is a 21 percentage point improvement. Knowledge increased dramatically from 15% to 72% naming danger signs. Health workers are competent at 85% average. The data proves real change, not just activity.

"How will I know which villages need more support?"

MEAL revealed exactly which villages struggled and why. Villages without health posts got mobile clinics. River villages got transport coordination. The well-performing village got extended hours. Each got what it needed.

"How will I have evidence for the donor at the end?"

Absolutely. She can answer every question the donor asks:

"Why didn't you hit 55%?" The three-month delay in mobile clinic approval. If we had involved FCHVs in initial planning and pre-negotiated district support, we would have hit the target. That's our key lesson.

"What's replicable?" We have a proven model for addressing access barriers in varied rural settings. With continued implementation and early district engagement, 58-60% is achievable in Year 2.

This isn't making excuses. It's evidence-based program management.

Sita can answer every question. She can justify every adaptation. She can prove impact.

And she did it with: 5 indicators, 2 days per month on MEAL, 3 staff total.

This is what MEAL gives you: Evidence. Understanding. Credibility. And most importantly — a path forward based on what actually works.

Pause and Reflect

If your donor asked "why didn't you hit your target?" — could you answer with evidence?

What would you do differently if you started your current project again?



Lesson 9

Operationalizing MEAL

Your MEAL System: Two Documents

Your MEAL system needs just two documents:

- **The MEAL Framework Table** — the 9-column plan that tells you what to measure and how
- **The Monthly Learning Meeting template** — the 4-part agenda with actions

Even if your deadline is very close — say, three days away — you can still create a simple MEAL system by following these steps:

Step 1: Map your results chain. Activities → Outputs → Outcome → Impact. What are you doing? What are you producing? What change are you creating?

Step 2: Choose your indicators. For each level: what would prove this exists?

Step 3: Build your MEAL Framework Table. Nine columns: what to measure, how to calculate it, data sources, frequency, responsibility, and accountability.

Step 4: Set up your Monthly Learning Meeting. Schedule it now. If you're already in an ongoing project, schedule your first meeting in four weeks. Use the 4-part agenda.

Step 5: Document as you go. Successes, challenges, accountability, and actions. Your meeting notes become your donor reports.

Key Messages to Remember

- MEAL is not four separate systems — it is one integrated approach
- Know the difference between impact (what your project contributes towards), outcomes (what your project will deliver), and outputs (the change states you need to achieve your outcomes)
- Focus on measuring what matters. Do not collect data simply because it would be nice to know. Collect data that would influence your decision-making. If nothing would change as a result of collecting it, you are probably wasting your efforts.
- Accountability goes three ways: to donors, to your team, and — possibly most importantly — to your communities
- Learning does not happen automatically. Learning only happens when you schedule it and plan for it, through monthly review meetings.



Sita began with questions. She built a results chain, then a MEAL plan that would answer those questions throughout her 12-month project. By Month 12, she had evidence of what worked, what didn't, and why — to share with her program director, donors, and communities, and most importantly, to improve her own work.

You can do exactly what Sita did. Not just because donors need it, but because you need it — to understand and improve the impact of what you do.



Lesson 11

Reflection & Action Planning

Integration and Implementation

Key Learning Integration: What are the three most important insights from this course that will change how you approach MEAL planning in your work?

Implementation Priorities: Of all the areas covered, which two need the most attention in your current work — framework design, indicator development, data collection planning, accountability mechanisms, or learning systems?

Organizational Reality Check: What organizational barriers will you need to address to implement improved MEAL practices? Who needs to support these changes for them to succeed?

Practical Next Steps: What specific action will you take in the next 30 days to begin applying these MEAL planning concepts? How will you share these tools with your team?

Action Item: Schedule a meeting with your supervisor or team within one week to discuss implementing improved MEAL practices. Come prepared with specific examples of how this could strengthen monitoring, learning, and accountability in your current projects.

Your goal: become more effective at demonstrating impact and learning from your work in complex environments where communities depend on your success.

Feel free to share your reflections and feedback on this course below.