

MONITORING, EVALUATION AND LEARNING POLICY



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OVERVIEW OF POLICY

The Agency For Health and Food Security (AHEFS) stands as a critical actor in Ghana's one health landscape. To solidify its role as a leader in evidence-based advocacy and service delivery, AHEFS requires a standardized Monitoring, Evaluation, and Learning (MEL) Policy. This policy is designed to systematically track progress, demonstrate accountability to donors and beneficiaries, and, most importantly, foster a culture of continuous learning to maximize the impact of its interventions. It directly supports AHEFS's strategic objectives, especially improving collaboration, empowering communities, and promoting sustainable health development.

Alignment with Current Strategic Programs

This MEL Policy is critically informed by and designed to support AHEFS's active portfolio, including:

- **Future Global and Other Fund Initiatives:** Anticipating involvement in Global Fund projects, this policy establishes a ready-made, rigorous system for reporting on disease-specific indicators (e.g., Sexual reproductive health, HIV/AIDS, TB, Malaria, Environment, and Agriculture), ensuring AHEFS can meet the stringent M&E requirements of such grants from the outset.
- **Advocacy Initiatives:** The policy includes mechanisms to monitor advocacy outcomes, such as tracking government budget allocations and disbursements to the health, environment and agriculture sectors, a key objective of AHEFS.

Core Principles of the MEL Policy

The AHEFS MEL Policy is guided by the organization's core values and will be:

- **Utilization-Focused:** All MEL activities are designed to be practical and provide actionable information for decision-making by AHEFS management, and the Board.
- **Accountable and Transparent:** It ensures robust data collection and reporting to demonstrate results to donors, government partners (MOH/GHS), and the communities served.
- **Participatory and Empowering:** The policy promotes the active involvement of community volunteers, and beneficiaries in M&E processes, such as through community feedback mechanisms, to strengthen local ownership and capacity.
- **Ethical:** It commits to the highest standards of data privacy, confidentiality, and ethical conduct in all MEL activities, ensuring 'do no harm' principles are upheld.
- **Adaptive and Learning-Oriented:** The system is designed not just to monitor but to systematically analyse data and generate lessons learned, enabling AHEFS to adapt strategies in real-time for greater effectiveness.

Key Components of the MEL Framework

The policy outlines the following essential components:

- **MEL Structure and Roles:** Defines clear MEL responsibilities for the AHEFS Secretariat (oversight, quality assurance), Supervision, and Implementing communities (data collection and reporting).
- **Program Logic Models and Frameworks:** Mandates the development of Theory of Change models and

logical frameworks for all projects to clarify the pathway from activities to impact.

- **Standardized Indicators and Tools:** Establishes a core set of standardized indicators (aligned with Donors, and MOH/GHS requirements) and data collection tools for consistency across all projects.
- **Data Management and Flow:** Creates a clear protocol for data flow from community volunteers → AHEFS → Donors, including timelines and quality checks.
- **Evaluation and Learning Cycle:** Schedules regular data review meetings, baseline/endline assessments, and after-action reviews to translate data into actionable insights and programmatic adaptations.
- **Capacity Building:** Includes a commitment to ongoing training for AHEFS staff and communities volunteers on MEL techniques, data analysis, and reporting.

Expected Benefits

Implementing this MEL Policy will enable AHEFS to:

- **Enhance Evidence-Based Decision-Making:** Provide management with timely, reliable data to guide strategic planning and resource allocation.
- **Demonstrate Tangible Impact:** Clearly communicate achievements and value for money to donors, partners, and stakeholders, strengthening AHEFS's reputation and fundraising potential.
- **Improve Program Quality:** Identify successes and challenges early, allowing for timely adjustments to improve service delivery and advocacy outcomes.
- **Strengthen AHEFS Capacity:** Build a unified and skilled network of AHEFS Staff and volunteers capable of meeting high M&E standards, increasing the collective impact of the Ahefs.
- **Fulfill Strategic Objectives:** Directly contribute to achieving AHEFS's mission and objectives, particularly in fostering collaboration, empowerment, and sustainable health development.
- This MEL Policy provides a comprehensive and practical framework to systematize AHEFS's approach to monitoring, evaluation, and learning. By adopting this policy, AHEFS will not only meet the accountability demands of its key donors and partners but will also significantly enhance its organizational effectiveness, ensuring its vital work continues to lead to a healthier, more equitable Ghana.

ACRONYMES

MEL:	Monitoring, Evaluation, and Learning
M&E:	Monitoring and Evaluation (the traditional term, often expanded to MEL)
MELP:	Monitoring, Evaluation, and Learning Plan
PMEL:	Planning, Monitoring, Evaluation, and Learning
KPI:	Key Performance Indicator
PO:	Performance Objective
LO:	Learning Objective
RBM:	Results-Based Management
ToC:	Theory of Change
LoA:	Logical Framework (LogFrame) / Level of Effort (context-dependent)
IM:	Impact Measurement
OM:	Outcome Mapping
SoP:	Standard Operating Procedure
DLM:	Developmental Leadership Model / Data Lifecycle Management
QA/QI:	Quality Assurance / Quality Improvement
DQAF:	Data Quality Assessment Framework
NDPC:	National Development Planning Commission
MDA:	Ministries, Departments, and Agencies
MMDA:	Metropolitan, Municipal, and District Assemblies
SDG:	Sustainable Development Goals (UN)
UN:	United Nations
UNDP:	United Nations Development Programme
UNICEF:	United Nations Children's Fund
WB:	World Bank
IMF:	International Monetary Fund
USAID:	United States Agency for International Development
GIZ:	Deutsche Gesellschaft für Internationale Zusammenarbeit (Germany)
DANIDA:	Danish International Development Agency
JICA:	Japan International Cooperation Agency
EU:	European Union

1.0 INTRODUCTION

1.1 PREAMBLE

The Monitoring and Evaluation (M&E) Manual for Agency For Health and Food Security (AHEFS) provides a structured approach to tracking performance, measuring outcomes, and ensuring accountability across the Ahefs's programs and initiatives. This manual is intended to guide all levels of M&E implementation from national to community levels ensuring coherence, consistency, and effectiveness in assessing AHEFS's contributions to Ghana's health sector.

AHEFS is a leading civil society organisation working to influence health policy, mobilize resources, and coordinate community-based health interventions across Ghana. With key grants from development partners, and donors. Ahefs operates within a framework of accountability, learning, and evidence-based advocacy. This M&E Manual is developed in alignment with AHEFS's strategic focus areas: Partnership and Coordination, Capacity Building, Advocacy and Resource Mobilization, Monitoring and Evaluation, and Governance and Leadership.

This Manual presents a comprehensive framework for Monitoring and Evaluation (M&E), designed to institutionalize a culture of evidence-based practice across the entire Ahefs.

1.2 PURPOSE AND SCOPE OF THE M&E&L MANUAL

This Monitoring and Evaluation (M&E) Manual provides a standardized, structured, and practical approach for tracking the performance and measuring the outcomes of all programmes, projects, and initiatives undertaken by AHEFS. Its primary purpose is to ensure that Ahefs's contributions to Ghana's health sector are not only visible but are also accurately assessed for their effectiveness, efficiency, and sustainability.

The manual is designed to be an essential operational tool, guiding M&E implementation at every level of the Ahefs's work from national-level policy advocacy and coordination down to community-based health interventions. By establishing common indicators, reporting formats, and evaluation protocols, this manual ensures **coherence and consistency** in how data is collected, analysed, and used. This, in turn, strengthens the comparability of results across different projects and enhances the overall **accountability** of Ahefs to its beneficiaries, government partners, and donors.

1.3 THE STRATEGIC CONTEXT OF AHEFS

AHEFS operates as a leading civil society organisation with a strategic mandate to influence health policy, mobilize resources, and coordinate community-based health interventions across the country. This work is executed within a robust framework that prioritizes accountability, continuous learning, and evidence-based advocacy. The development of this M&E Manual is a direct response to and is intricately aligned with AHEFS's core strategic focus areas:

- **Partnership and Coordination:** The M&E system facilitates collaborative data collection and joint analysis, strengthening partnerships and ensuring coordinated action.
- **Capacity Building:** The manual serves as a key resource for building the M&E capacities of Ahefs staff, empowering them to manage their projects more effectively.
- **Advocacy and Resource Mobilization:** Robust M&E data generates the compelling evidence required to advocate for policy change and to demonstrate results to current and potential donors, thereby securing

vital funding.

- **Monitoring and Evaluation:** This manual operationalizes this strategic pillar itself, providing the concrete "how-to" for fulfilling this critical function.
- **Governance and Leadership:** Strong M&E practices support transparent reporting and informed decision-making by the Ahefs's leadership, reinforcing good governance.

1.4 GUIDING PRINCIPLES

The M&E system outlined in this manual is founded on key principles that will guide its implementation:

- **Utility:** The system is designed to provide practical, timely, and relevant information that meets the needs of its users for decision-making and learning.
- **Feasibility:** The procedures and indicators are realistic, prudent, and cost-effective to implement, considering the capacity and resources of Ahefs staff.
- **Ethicality:** The system upholds the highest ethical standards, ensuring the confidentiality and rights of all participants and promoting a "do no harm" approach.
- **Accuracy:** The system is committed to generating technically accurate information that adequately reflects the realities on the ground.

1.5 INTENDED AUDIENCE

This manual is intended for all stakeholders involved in the work of AHEFS. This includes the Ahefs Secretariat, and technical staff responsible for programme implementation and M&E. It is a living document that will be periodically reviewed and updated to reflect evolving strategic priorities and lessons learned from its application.

By adopting and diligently applying the frameworks contained in this manual, AHEFS reaffirms its commitment to excellence, transparency, and maximizing its positive impact on the health and well-being of the people of Ghana.

2.0 M&E FRAMEWORK

AHEFS's M&E Framework is built on the theory of change that links activities to outputs, outcomes, and ultimately impact. It describes how the actions lead to results and provides a structure for measuring these results effectively.

2.1 THEORY OF CHANGE

The theory of change outlines the logical sequence through which AHEFS's interventions are expected to lead to desired outcomes and impact in health improvement. For instance, training community volunteers on one health will increase knowledge (output), enhance community practices (outcome), and contribute to reduced disease burden (impact).

2.2 RESULT CHAIN FRAMEWORK

Results Chain framework, a cornerstone of the Monitoring, Evaluation, and Learning (MEL) system for the Agency For Health and Food Security (AHEFS). The Results Chain (also known as a Logic Model or Theory of Change) is a visual and narrative representation of how our programs are designed to achieve their intended impact. It illustrates the logical sequence from the resources we invest to the ultimate changes we seek in the health status

of Ghanaians.

Understanding and applying this framework is essential for all Ahefs staff. It ensures we share a common language for planning, monitoring, and reporting, and it helps us demonstrate our collective accountability and effectiveness to stakeholders, including communities, government partners, and donors.

2.3 DEFINITION OF THE RESULTS CHAIN COMPONENTS

The Results Chain is composed of five interconnected levels. Each level is dependent on the successful implementation of the previous one. The table below defines each component with examples specific to the health sector in Ghana.

COMPONENT	DEFINITION	GHANA-SPECIFIC EXAMPLES FOR AHEFS MEMBERS
1. Inputs	The financial, human, material, and organizational resources dedicated to the program. These are what we invest .	- Financial Resources: Grants from donors. - Human Capital: Program managers, community health nurses, field officers, volunteers, technical experts. - Infrastructure: Office space, vehicles, motorbikes, ICT equipment, training materials. - Partnerships: Collaboration with Ghana Health Service (GHS), CHAG, District Health Directorates, traditional authorities, community-based Organizations and ministry of environment and science and technology.
2. Activities	The key actions, tasks, and events undertaken using the inputs to produce the desired outputs. These are what we do .	- Trainings: Workshops on malaria case management for Community Health Volunteers (CHVs); sensitization on HIV/AIDS stigma reduction for health workers. - Advocacy Campaigns: Engaging parliamentarians on increased health budget allocation; media campaigns on the importance of one health. - Community Mobilizations: Organizing health screening days (e.g., for BP, diabetes); forming Mother Support Groups for maternal health. - Service Delivery: Direct provision of services, such as distributing insecticide treated nets (ITNs), conducting family planning counseling, or supporting ART adherence.

3. Outputs	The direct, tangible products or deliverables resulting from the activities. These are what we produce or deliver. They are typically quantitative.	Management (iCCM). - Policy briefs developed: 5 policy briefs on Non-Communicable Diseases (NCDs) developed and disseminated to the Ministry of - Communities Health reached: 50 communities in the Ashanti Region mobilized for sanitation drives. - Follow-ups conducted: 1,200 post natal care visits completed for new mothers. - Number of ITNs distributed: 10,000 nets distributed in a high-risk district.
4. Outcomes	The specific changes in knowledge, behaviours, practices, or policies that occur among the target population or systems as a result of the program's outputs. These are the short term and results. medium-term	- Improved Knowledge: Increased awareness among adolescents about Sexual and reproductive health, HIV prevention attitudes and methods ,environment and health . - Behaviour Change: Higher uptake of skilled delivery services; improved household water treatment and storage practices. - Policy Influence: Adoption of a new national guideline on mental health that the advocated - Systems for Strengthening: Improved data collection and reporting by health facilities in a target district.
5. Impact	The long-term, sustainable, and fundamental improvement in the health or social conditions of the target population. This is the ultimate goal of our work. Impact is often achieved by the combined efforts of multiple actors over time.	- Improved Health Outcomes: Reduced prevalence of malaria in children under five in. - Reduced the operational Mortality: Decline zones in maternal mortality ratio (MMR) or under five mortality rate (U5MR) in targeted regions. - Reduced Morbidity: Lower incidence of tuberculosis or new HIV infections. - Sustainable Development: A healthier, more productive population contributing to Ghana's development goals.

2.4 APPLICATION IN THE AHEFS MEL SYSTEM

The Results Chain framework is not just a planning tool; it is actively used throughout the program cycle:

- **Planning:** It is the basis for developing log frames and MEL plans.
- **Monitoring:** We track indicators primarily at the Input, Activity, and Output levels (e.g., Are activities on

schedule? Are we reaching our target numbers?).

- **Evaluation:** We assess the achievement of Outcomes and contribution to Impact through specific studies, surveys, and evaluations.
- **Reporting:** It provides a clear structure for reporting progress to stakeholders, showing how activities are logically linked to higher-level results.
- **Learning:** When results are not achieved, the chain helps us pinpoint where the theory may have broken down, facilitating adaptive management and organizational learning.

By consistently using the Results Chain framework, the Agency for Health and Food Security and its members can enhance the strategic focus, coherence, and demonstrable impact of our collective efforts to improve the health of all Ghanaians. This shared understanding is key to our credibility, accountability, and ultimate success.

3.0 INDICATOR FRAMEWORK

AHEFS uses a mix of standard and custom indicators to monitor progress. These indicators are aligned with programmatic goals and donor requirements.

3.1 TYPES OF INDICATORS

- **Input Indicators:** Resources allocated (e.g., budget disbursed for health campaigns)
- **Process Indicators:** Implementation status (e.g., training sessions conducted)
- **Output Indicators:** Immediate results (e.g., number of participants trained)
- **Outcome Indicators:** Short/medium-term effects (e.g., % of communities adopting preventive health practices)
- **Impact Indicators:** Long-term effects (e.g., reduction in malaria prevalence)

3.2 DISAGGREGATION

Indicators should be disaggregated by sex, age, region, and target group to promote equity and inclusion. Disaggregation in AHEFS MEL policy is the deliberate practice of collecting, analysing, and reporting data broken down by specific population subgroups. For AHEFS, it is not just a technical exercise; it is a core ethical and strategic imperative. This allows AHEFS to identify and address hidden inequalities, target resources more effectively, and advocate for health equity with powerful, evidence-based data.

AHEFS mission inherently revolves around reaching the most vulnerable and marginalized. Disaggregated data is the tool that makes this mission measurable.

Reason	Explanation & Relevance to Agency For Health and Food Security
1. Unmasking Health Inequalities	Ghana faces significant health disparities based on geography (North vs. South, urban vs. rural), economic status, gender, age, and disability. Aggregated data can mask the fact that improvements are only happening for easier-to-reach groups, while the most vulnerable are stagnating or being left further behind.
2. Ensuring Equity,	Equality means giving everyone the same thing. Equity means giving people what they

Not Just Equality	need to achieve similar outcomes. Disaggregated data is the evidence base for equity-focused programming. It helps you advocate for redistributing resources to the districts or groups with the greatest need.
3. Improving Program Targeting & Design	By understanding which subgroups are not benefiting from a health intervention (e.g., adolescent girls not accessing SRHR services, or poor households not utilizing NHIS), you can redesign your programs to be more inclusive and effective for those specific groups.
4. Strengthening Advocacy	Data broken down by region, income quintile, or gender provides irrefutable evidence for policy advocacy. You can powerfully demonstrate to the Ghana Health Service (GHS), Ministry of Health (MoH), and donors that specific policies are failing certain populations and need to be changed.
5. Accountability to Beneficiaries	It demonstrates a commitment to accountability towards all Ghanaians, not just the majority or the easiest to reach. It shows you are genuinely tracking whether you are fulfilling your mission for everyone.
6. Meeting Donor & SDG Requirements	Major donors and the Sustainable Development Goals (SDGs) explicitly mandate "leaving no one behind." A robust disaggregation plan in your MEL system is often a prerequisite for funding and is essential for reporting on SDG indicators like 3.8 (Universal Health Coverage).

AHEFS Monitoring and Evaluation Manager will decide on a standard set of variables to disaggregate by. This list should be guided by Ghana's specific demographic and health landscape.

Core Variables (Essential for All Programs):

1. Geographic Location:

- ❖ **Region:** (e.g., Greater Accra, Northern, Volta, Ashanti) ❖ **District:** Essential for district-level health planning.
- ❖ **Urban/Rural:** A critical divider for access to health services in Ghana.
- 2. **Sex and Age:**
- ❖ **Sex:** Male, Female.
- ❖ **Age:** Use life-cycle groups (e.g., <1, 1-4, 5-14, 15-19, 20-34, 35-49, 50+). **Adolescents (10-19)** should be a key group for SRHR and HIV programs.

3. Socio-Economic Status:

- ❖ **Wealth Quintile:** (Poorest, Poor, Middle, Richer, Richest) using a proxy means test (e.g., type of housing, assets). This is vital for assessing equity in health financing and NHIS enrolment.

AHEFS embracing disaggregation is about aligning our MEL practice with our core value of **health for all**. It transforms Ahefs from a collection of service providers into a powerful, evidence-driven force for health equity in Ghana. By systematically asking "Who is being left behind?" we ensure that our collective work truly contributes to a Ghana where every citizen, regardless of who they are or where they live, has the opportunity to lead a healthy life.

4.0 ROUTINE DATA COLLECTION– CADRE OUTPUT DATA

This section outlines the routine data collected and reported by community-based actors engaged by AHEFS under its one health programs. These actors operate across various districts and regions, supporting both facility-linked and purely community-based service delivery efforts.

At the program management level, AHEFS also tracks process and performance indicators to monitor implementation progress, guide decision-making, and fulfill reporting obligations.

4.1 DATA COLLECTION AND REPORTING TOOLS

AHEFS employs a mixed-methods approach to data collection, utilizing both quantitative and qualitative tools. This ensures a holistic understanding of program performance, capturing not only what has been achieved (the numbers) but also how and why results have occurred (the context, stories, and perceptions). This rigorous and systematic process is fundamental to evidence-based decision-making and programmatic learning.

Data collection tools are selected based on their suitability for measuring specific **indicators** as defined in the program's **Performance Measurement Framework (PMF)**. The following are the primary tools and methods utilized by AHEFS:

- **Routine Health Information Systems (RHIS):** These are structured systems for the regular collection of aggregated data from health facilities and community-level activities. RHIS data provides quantitative information on service delivery outputs (e.g., number of antenatal care visits, vaccinations administered,

community health worker . This data is crucial for tracking trends and performance against targets on a frequent basis.

- **Beneficiary Surveys:** Standardized questionnaires administered to a representative sample of the target population. Surveys are used to collect quantitative data on knowledge, attitudes, practices (KAP), coverage, and satisfaction levels. Surveys may be conducted at baseline, mid-term, and endline to measure change over time.
- **Focus Group Discussions (FGDs):** Facilitated group discussions with 6-10 homogenous participants (e.g., mothers of children under-five, male community leaders). FGDs are a qualitative method used to explore group norms, collective experiences, and the reasons behind certain behaviors or survey results. They provide rich, contextual data on community perceptions.
- **Key Informant Interviews (KIIs):** Semi-structured, in-depth interviews with individuals who have specific expertise or a unique perspective on the program (e.g., government officials, head clinicians, respected community elders). KIIs provide qualitative insights into institutional processes, policy environments, and high-level challenges and successes.
- **Observational Checklists:** Structured tools used to directly observe and record conditions, behaviors, or processes against a predefined set of criteria. This method is often used for assessing facility readiness (e.g., availability of equipment, supplies), quality of service delivery, and adherence to protocols, providing objective data that may not be captured through self-reporting. AHEFS ensures that all relevant routine data is captured using standardized data collection tools. Daily and weekly activities are initially recorded in field notebooks and later transcribed onto paper-based registers. These registers are subsequently digitized using electronic data collection systems such as REDCap, Kobo Toolbox, or other approved platforms, depending on the project. Data entry may be completed by community cadres, field volunteers, case managers, or data focal persons at the facility or district level. The timing of data collection is deliberately aligned with the measurement needs of each indicator to ensure data is timely, relevant, and cost-effective.
- **Monthly:** Data from Routine Health Information Systems (RHIS) is typically collated and reported monthly. This high frequency allows for rapid identification of issues and near- real-time program management.
- **Quarterly:** Aggregated data from community volunteers reports and specific output-level indicators are often compiled and analysed quarterly. This supports regular reporting to donors and internal quarterly program reviews.
- **Annually:** Broader outcome-level data, often collected through beneficiary surveys or in-depth qualitative studies, is typically gathered on an annual basis. This allows sufficient time for changes to occur and provides a strategic overview of program
- progress towards its goals. Specific evaluations (mid-term, final) will also have their own data collection timelines as outlined in their respective terms of reference.
- The specific frequency for each indicator is detailed in the program's PMF and MEL Plan.

4.2 REPORTING AND FEEDBACK MECHANISMS

AHEFS maintains a structured data reporting and feedback system to support timely, complete, and quality-assured

data transmission from the community level to program management. The process varies slightly between programs but is coordinated under a unified data governance structure.

5.0 HIV PROGRAM DATA FLOW

The purpose here is to establish a standardized procedure for the consistent collection, flow, verification, storage, analysis, and reporting of all data generated by AHEFS Program. This ensures data quality, integrity, confidentiality, and timely availability for decision-making, reporting to donors, and program improvement.

5.1. SCOPE

This policy applies to all AHEFS staff, partners, and volunteers involved in the implementation, monitoring, and evaluation of all Programs. This includes, but is not limited to, Community Health Workers, Counsellors, Clinicians, Data Clerks, M&E Officers, and Program Managers.

5.2 KEY DEFINITIONS

- **Data Source:** The original point of data generation (e.g., patient file, client intake form, counselling session register).
- **Data Collection Tools:** Standardized instruments used to capture data (e.g., HTS register, ART patient card, reporting forms).
- **Data Entry Point:** The location (health facility, office) and level where data is first digitized.
- **Primary Data:** Data collected directly from clients/beneficiaries (e.g., test results, patient demographics).
- **Aggregate Data:** Data that has been summarized (e.g., total number of clients tested in a month).
- **Data Flow:** The movement of data from its source through various levels to its final use and storage.

5.3 HIV PROGRAM DATA FLOW: STEP-BY-STEP PROCEDURE

The data flow for the HIV Program follows a structured pathway from the service delivery point to national and donor reporting. The step-by-step description below provides an overview, followed by a detailed description of each step.

DETAILED STAGES OF DATA FLOW

Stage 1: Data Collection and Recording at Service Delivery Point

- **Activity:** Service providers (counsellors, clinicians, outreach workers) deliver services (HTS, ART initiation, condom distribution) and record data **immediately and accurately** in the prescribed, standardized tools.
- **Key Tools:** HTS Register, Pre-ART/ART Register, Patient Monitoring Card, Condom Distribution Log, GBV Screening Form.
- **Responsibility:** Service Providers, Community Health Workers.

Stage 2: Data Compilation and Verification at Facility Level

- Activity: A designated Data Clerk or M&E Focal Person compiles data from all primary tools into a facility-level monthly aggregate report (e.g., using a template like the PEPFAR HFR). The facility-in-charge must **verify and sign off** on the report before submission.
- Frequency: By the 3rd of every month for the previous month's data.
- Responsibility: Data Clerk, M&E Focal Person, Facility Manager.

Stage 3: Data Submission, Aggregation, and Quality Assurance at Partner Level

- Activity: The facility-level monthly reports are submitted to the central AHEFS M&E Unit.
 - The M&E Officer conducts a **routine Data Quality Audit (DQA)** by cross-checking a sample of entries in the reports against the primary source registers.
 - Data from all facilities are aggregated into a central database (e.g., Excel, SQL, DHIS2).
- Frequency: Submission by the 5th of the month; DQA conducted quarterly.
- Responsibility: M&E Officer, Program Manager.

Stage 4: Data Analysis, Reporting, and Utilization

- Activity:
 - Analysis: The M&E team analyses the aggregated data to track performance against indicators, identify trends, and generate insights.
 - Internal Reporting: Findings are presented in **monthly/quarterly program review meetings** to inform management decisions and adaptive programming.
 - External Reporting: Cleaned and validated data is used to prepare and submit reports to donors (e.g., quarterly PEPFAR reports) and national health management information systems (HMIS) as required.
- Responsibility: M&E Officer, Program Manager.

Stage 5: Data Storage and Archiving

- Activity: All hardcopy primary tools and reports are stored in locked, secure cabinets at the facility/organization office. Electronic data is stored on secure, password-protected servers with regular backups. Data is archived according to the organization's **Data Retention Policy** (typically a minimum of 5-7 years post-project closure, in line with national regulations).
- Responsibility: All staff, with oversight from the M&E Manager.

5.4 ROLES AND RESPONSIBILITIES (CSS/HIV)

Role	Key Data-Related Responsibilities
	M&E Officer (Head Office)
	Program Manager
Service Provider	
Data Clerk / M&E Focal Person (Facility)	IT Officer

Accurately record data in primary tools during/after service delivery; ensure client confidentiality.

Compile facility-level aggregate reports; perform basic data checks; submit reports on time.

Aggregate data; conduct DQAs; analysed data; prepare internal and donor reports; build capacity of field staff.

Use data for decision-making; ensure resources are available for M&E activities; review and approve reports.

Ensure security and functionality of electronic database.

7.0 DATA QUALITY ASSURANCE (DQA)

The credibility of AHEFS's work depends on the accuracy and reliability of its data. Routine Data Quality Assessments (DQAs) are integral to our MEL system, ensuring that data used for decision-making is of the highest possible quality.

7.1 DQA COMPONENTS

DQA is an ongoing process that involves the following key activities:

- **Verification:** This involves physically cross-checking reported data against original source documents (e.g., training attendance lists, beneficiary registration forms, payment records). The goal is to confirm that data has been transcribed and aggregated correctly at each level of reporting.
- **Validation:** This step checks the data itself for intrinsic qualities. It includes:
 - **Accuracy:** Is the data correct and a true reflection of the facts?
 - **Completeness:** Is all required data present, with no missing values or reports?
 - **Consistency:** Is the data consistent over time and across different reporting tools?
 - **Timeliness:** Was the data collected and reported within the scheduled timeframe?
- **Supervision and Coaching:** Regular supervisory visits by M&E and program staff to implementation sites are conducted. These visits serve to observe data collection processes firsthand, provide on-the-job coaching to field staff, address challenges in real-time, and reinforce the importance of data quality.

7.2 DQA SCHEDULE

- **Routine Checks:** Initial data verification and validation are performed monthly by district and regional staff during the data aggregation process.
- **Spot Checks:** Unscheduled data audits will be conducted by the National M&E Unit on a quarterly basis for a sample of sites.
- **Comprehensive DQA:** A formal, in-depth DQA will be conducted annually for each major project, assessing a representative sample of indicators and data sources.

7.3 USE OF M&E DATA

The ultimate purpose of investing in a robust MEL system is to generate and utilize evidence. AHEFS is committed to ensuring that M&E data is not merely collected for reporting purposes but is actively used to improve programs, demonstrate impact, and influence broader change.

7.4 KEY APPLICATIONS OF M&E DATA

M&E data will be systematically used for the following purposes:

- **Informing Program Design and Adaptation:** Data on what is working and what is not will directly inform strategic planning, activity redesign, and resource allocation. This ensures our programs remain relevant, effective, and responsive to beneficiary needs.
- **Tracking Progress and Demonstrating Impact:** Data will be used to regularly track performance against logframe indicators and strategic objectives. This allows us to measure efficiency, effectiveness, and overall impact for accountability to stakeholders, including beneficiaries, donors, and the public.

- **Advocating for Policy Change and Funding:** Robust, evidence-based findings are powerful tools for advocacy. We will use our data to make a compelling case for policy reforms, secure continued or new funding, and engage in public discourse on critical issues.
- **Building an Evidence Base for Scaling Interventions:** By systematically documenting outcomes and lessons learned, we create a strong evidence base that can justify the scaling up of successful pilot interventions or the adaptation of effective models in new contexts.

FEEDBACK AND LEARNING MECHANISMS

To institutionalize the use of data, AHEFS will establish regular feedback loops, including quarterly review meetings, annual learning workshops, and the dissemination of simplified findings to community stakeholders to ensure transparency and collaborative learning.

8.0 EVALUATION PROCEDURES 8.1 INTRODUCTION AND PURPOSE

Evaluations are systematic and impartial assessments of the design, implementation, and results of ongoing or completed interventions. The primary purpose of evaluation within the Agency For Health and Food Security is to determine the relevance, efficiency, effectiveness, impact, and sustainability of our projects and programs. This process provides evidence-based information that is credible and reliable, enabling management and stakeholders to incorporate lessons learned into decision-making processes. Evaluations are fundamental for accountability to donors, beneficiaries, and partners, and for generating knowledge to improve future health interventions in Ghana.

8.2 TYPES OF EVALUATIONS

Evaluations are conducted at critical points in the project lifecycle to answer specific questions. Member NGOs are encouraged to plan and budget for these evaluations from the inception of any project.

8.2.1 BASELINE STUDIES

- **Timing:** Conducted before the start of project implementation or immediately after.
- **Purpose:** To establish a benchmark by measuring the initial situation, including key indicators and contextual factors. The baseline provides a reference point against which progress, and impact can be measured at mid-term and end-line.
- **Key Questions:** What is the current status of the health issue we are addressing? What is the prevailing knowledge, attitudes, and practices of the target community?

8.2.2 Mid-Term Reviews (MTR)

- **Timing:** Conducted approximately at the midpoint of the project cycle.
- **Purpose:** To assess progress towards achieving planned objectives and results. The MTR is a formative evaluation, meaning its primary goal is to provide timely information to make necessary adjustments to the project's strategy, work plans, and resources to improve performance during the remaining period.
- **Key Questions:** Are we on track to achieve our objectives? What is working well? What challenges have emerged? What operational changes are needed?

8.2.3 End-Term Evaluations

- **Timing:** Conducted in the final stages of a project, after its primary activities have been completed.
- **Purpose:** To conduct a summative assessment of the project's overall performance. It measures the extent to which project goals and outcomes were achieved, assesses the intervention's effectiveness, efficiency, and relevance, and begins to analyze its potential sustainability and impact.
- **Key Questions:** To what extent were the project objectives achieved? What were the major factors influencing the achievement or non-achievement of the objectives? What is the likelihood of the benefits continuing?

8.2.4 Other Evaluation Types

- **Ex-Post Evaluations:** Conducted some time (e.g., 1-3 years) after project completion to assess long-term impact and sustainability.
- **Thematic/Cross-Cutting Evaluations:** Assess a specific theme (e.g., Gender Mainstreaming, Community Ownership) across multiple projects.
- **Impact Evaluations:** Rigorous studies designed to establish a causal relationship between the intervention and observed changes in outcomes.

8.3 EVALUATION GUIDELINES

The following guidelines must be adhered to by all member NGOs when planning and conducting

8.3.1 Develop a Comprehensive Terms of Reference (ToR)

Every evaluation must be guided by a clear and detailed Terms of Reference. The ToR serves as the primary agreement between the management and the evaluation team. It must include:

- **Purpose and Objectives:** Clearly state why the evaluation is being done and what it aims to achieve.
 - **Key Evaluation Questions:** Specific questions the evaluation must answer.
 - **Scope:** Define the geographical coverage, time period, and project components to be evaluated.
 - **Methodology:** Outline the proposed data collection and analysis methods.
 - **Deliverables:** Specify expected outputs (e.g., draft report, final report, presentation).
 - **Timeline and Work Plan.**
 - **Evaluation Team Composition and Required Expertise.**
 - **Roles and Responsibilities** of the evaluation team and the NGO staff.
- ### 8.3.2 Ensure Meaningful Participation of Stakeholders

Stakeholder participation is crucial for ownership, credibility, and the utility of evaluation findings. The process should be inclusive and engage:

- **Primary Stakeholders:** Project beneficiaries, community members, and local health workers.
- **Key Partners:** Ghana Health Service (GHS), district health directorates, community-based organizations, and other relevant government agencies.
- **Internal Stakeholders:** Project staff, management, and the secretariat.
- **Participation Mechanisms:** Involvement should occur throughout the evaluation process, including in the design (e.g., validating questions), data collection (e.g., as respondents), and dissemination of findings (e.g., validation workshops).

8.3.3 Use Mixed-Methods Approaches

Evaluations should employ a mixed-methods approach, combining quantitative and qualitative data collection techniques. This triangulation strengthens the validity and depth of the findings.

- **Quantitative Methods:** Used to measure the scale of change (e.g., surveys, routine data analysis, pre/post tests). This answers questions like "how much" or "how many."
- **Qualitative Methods:** Used to understand the reasons behind the change, perceptions, and contextual factors (e.g., Focus Group Discussions (FGDs), Key Informant Interviews (KIIs), case studies, and observation). This answers questions like "why" and "how."
- **Data Triangulation:** Findings from different sources and methods should be compared and contrasted to ensure consistency and reliability.

8.4 EVALUATION MANAGEMENT AND UTILIZATION

8.4.1 Management of the Evaluation Process

- **Independence:** The evaluation should be as independent as possible. While internal staff can conduct some reviews, major evaluations (especially end-term) should be conducted by external consultants to ensure objectivity.
- **Ethical Standards:** Evaluators must adhere to ethical guidelines, including informed consent, confidentiality, anonymity, and a "do no harm" principle, especially when dealing with vulnerable populations.

8.4.2 Learning and Dissemination

The primary value of an evaluation lies in its use. Therefore:

- **Draft Report Review:** A draft report shall be shared with key stakeholders for feedback.
- **Validation Workshop:** A workshop shall be held to present, discuss, and validate the findings, conclusions, and recommendations with stakeholders.
- **Final Report:** A concise, actionable final report must be produced and widely disseminated.
- **Management Response:** Project management is required to develop a formal "Management Response" document that outlines an action plan for addressing the evaluation's recommendations, specifying responsible persons and timelines.

8.4.3 Archiving

All final evaluation reports, ToRs, and management responses must be archived in the Ahefs's central knowledge management system for future reference and organizational learning.

9.0 ROLES AND RESPONSIBILITIES FOR M&E IMPLEMENTATION

9.1 PREAMBLE

Effective Monitoring and Evaluation (M&E) is fundamental to the success of the Agency For Health and Food Security. It ensures accountability, learning, and evidence-based decision-making across all levels of our operations. Successful M&E implementation is a collaborative effort, requiring clear definition of roles and responsibilities for all officers and part.

2. Documentation and Record Keeping:

- ❖ Maintain well-organized and secure records of all primary data collected, including raw datasets, completed questionnaires, and consent forms.
- ❖ Document success stories, case studies, and lessons learned that provide qualitative evidence of program impact.
- ❖ Keep accurate records of program activities, outputs, and beneficiaries reached.

3. **Data Validation and Entry:**

- ❖ Validate all collected data at the source for completeness and accuracy before submission.
- ❖ Enter data into agreed-upon organisations (e.g., designated templates, online forms) as per the reporting schedule.
- ❖ Designate an M&E Focal Person within the CSO responsible for overseeing these tasks.

4. **Reporting and Participation:**

- ❖ Submit complete and accurate M&E reports to the Regional Coordinator (or directly to the Secretariat where applicable) according to the agreed timelines (monthly, quarterly, etc.).
- ❖ Actively participate in M&E training, review meetings, and learning events organized by the Ahefs.
- ❖ Use M&E findings for internal programmatic decision-making and adaptive management to improve project effectiveness.

9.4 COORDINATION AND COMMUNICATION

To ensure seamless collaboration, the following mechanisms will be adhered to:

- **Regular Meetings:** Quarterly M&E coordination meetings will be held between the National Secretariat and Regional Coordinators. Regional Coordinators will hold bi-annual meetings with CSOs in their region.
- **Reporting Flow:** The standard reporting flow is from CSOs→Regional Coordinators→National Secretariat. Direct reporting from CSOs to the Secretariat may occur for specific, centrally managed projects.
- **Feedback Loops:** The National Secretariat commits to providing feedback on consolidated reports and analyses back to Regional Coordinators and CSOs to close the learning loop.

This policy ensures that every officer and partner understand their vital role in building a culture of evidence and accountability within the Agency For Health and Food Security.

10.0 CAPACITY BUILDING AND ORGANIZATIONAL LEARNING

10.1 POLICY STATEMENT

The Agency For Health and Food Security (AHEFS) recognizes that robust Monitoring, Evaluation, and Learning (MEL) systems are fundamental to achieving its mission and the collective impact of its Ahefs staff. AHEFS is committed to a systematic and sustained investment in strengthening the MEL capacities of its Secretariat staff and all community Volunteers. This commitment is rooted in the belief that enhanced MEL capabilities lead to improved program quality, evidence-based decision-making, accountability to beneficiaries and donors, and ultimately, better health outcomes for the communities we serve. This policy

outlines the framework for continuous learning and capacity development.

10.2 CAPACITY BUILDING STRATEGIES

To achieve its capacity-building objectives, AHEFS will employ a multi-faceted approach tailored to the diverse needs of its network. The key strategies include:

a) Periodic Training Workshops for M&E Officers and Program Staff

- **Purpose:** To provide foundational and advanced knowledge on MEL concepts, tools, and methodologies.
- **Scope:** Workshops will be conducted regularly (e.g., semi-annually or annually) and will cover topics such as:
 - Developing MEL Frameworks (Logical Frameworks, Theory of Change)▪ Data Collection Methods (quantitative and qualitative)
 - Data Quality Assurance (DQA) techniques
 - Data Analysis, Visualization, and Interpretation using relevant software (e.g., Excel, KOBO Toolbox, SPSS)
 - Reporting for Donors and Stakeholders
 - Utilizing MEL data for adaptive management and learning.
- **Target Audience:** M&E Officers, Program Managers, Community Volunteers ,and relevant staff of AHEFS Secretariat.

b) Mentorship and Coaching Programs

- **Purpose:** To provide personalized, hands-on support for MEL practitioners, fostering professional growth and practical problem-solving skills.
- **Scope:** The program will pair less experienced M&E staff from AHEFS with MEL experts (either from within the network or external consultants). Mentorship will focus on:
 - ❖ Guidance on specific MEL challenges faced by the member .❖ Support in developing or refining MEL plans for specific projects.❖ Coaching on data analysis and reporting.
 - ❖ Career development advice for MEL professionals.

c) M&E Clinics and Peer Learning Exchanges

- **Purpose:** To create safe spaces for collaborative problem-solving, sharing of best practices, and learning from both successes and failures.
- **Scope:** These will be informal, focused sessions designed to address common challenges.
 - ❖ **M&E Clinics:** Themed sessions where members bring specific MEL problems (e.g., "how to track a difficult indicator," "dealing with low survey response rates") for collective brainstorming and solution-finding.
 - ❖ **Learning Exchanges:** Organized visits or virtual meetings between AHEFS STAFF and community volunteers to share successful MEL tools, processes, or innovations. This promotes cross-pollination of ideas and reduces duplication of effort.

10.3 KNOWLEDGE MANAGEMENT AND LEARNING

AHEFS will institutionalize learning by:

- Documenting and disseminating key lessons learned, best practices, and case studies from member programs through newsletters, reports, and an online knowledge portal.
- Conducting periodic reflection sessions after major project milestones or evaluations to discuss findings and implications for future programming.

11.0 ETHICS AND DATA PROTECTION 11.1 POLICY STATEMENT

The Agency For Health and Food Security (AHEFS) is committed to conducting all Monitoring, Evaluation, and Learning (MEL) activities according to the highest ethical standards and in full compliance with Ghana's Data Protection Act, 2012 (Act 843). The dignity, rights, safety, and privacy of all individuals participating in our data collection processes are of paramount importance. This policy ensures that all data collected by AHEFS, and its Ahefs staff is gathered, stored, analysed, and used responsibly, ethically, and lawfully.

11.2 GUIDING PRINCIPLES

All MEL activities must adhere to the following core principles:

a) Informed Consent

- **Requirement:** Voluntary, informed consent must be obtained from every individual (respondent) before their participation in any data collection activity (e.g., surveys, interviews, focus group discussions).
- **Procedure:** The consent process must be conducted in a language understandable to the participant. It must clearly explain:
 - ❖ What their participation will involve (time, procedures).
 - ❖ Any potential risks or discomforts.
 - ❖ The benefits of participation (if any).
 - ❖ That participation is entirely voluntary, and they can withdraw at any time without penalty.
 - ❖ How their data will be protected and used.
- **Documentation:** Consent should be documented, preferably in writing. For illiterate participants, a witnessed verbal consent process must be recorded audio-visually or meticulously documented by the data collector.

b) Confidentiality and Anonymity

- **Requirement:** AHEFS and its members have a duty to protect the identity and personal information of all participants.
- **Procedure:**
 - ❖ **Confidentiality:** Personally Identifiable Information (PII) such as names, contact details, and location data must be kept strictly confidential. It must be stored separately from the main survey/data responses using unique identification codes.
 - ❖ **Anonymity:** Where possible and scientifically sound, data should be collected and reported anonymously. In reports and presentations, data should be aggregated to prevent the identification of any individual.

❖ **Secure Storage:** All data, both physical (paper questionnaires) and digital, must be stored securely using password protection, encryption, and locked cabinets. Access is restricted to authorized MEL personnel only.

c) Data Use Agreements (DUA)

- **Requirement:** A formal Data Use Agreement (DUA) must govern the access, handling, sharing, and use of all MEL data, especially when multiple partners are involved.

- **Scope:** The DUA must be signed by all relevant parties (AHEFS Secretariat, member NGOs, external evaluators, donors) before data is shared. It shall specify:

- ❖ **Who can access the data:** A clear list of individuals or entities.

- ❖ **Permitted uses of the data:** The specific purposes for which the data can be used (e.g., for project reporting, advocacy, learning).

- ❖ **Prohibited uses:** Explicit restrictions on uses, such as commercialization or use for purposes that could harm participants.

- ❖ **Data security standards:** The minimum-security protocols that must be followed.

- ❖ **Data destruction timeline:** The schedule for the secure destruction of data once its purpose has been fulfilled and the retention period has expired.

11.3 COMPLIANCE AND ACCOUNTABILITY

- All AHEFS staff and member organization personnel involved in MEL activities are required to undergo training on this Ethics and Data Protection policy.

- Breaches of this policy will be taken seriously and may result in disciplinary action, termination of partnership agreements, and legal consequences as per Ghanaian law.

- The AHEFS Secretariat bears the overall responsibility for ensuring compliance and will conduct periodic audits of MEL data practices across the network.

12.0 LEGAL AND POLICY FRAMEWORK LOCAL (GHANA SPECIFIC)

By grounding the MEL Policy Manual in this multi-layered framework, the Agency For Health and Food Security will ensure it is **legally compliant, nationally relevant, globally aligned, and ethically sound**. This enhances the credibility of the Ahefs and its members with the government, donors, and the communities they serve.

These are the most critical for day-to-day operations and ensure alignment with the Government of Ghana's systems.

A. Core Legal and Governance Frameworks:

1. The 1992 Constitution of Ghana:

- ❖ **Chapter 5: Fundamental Human Rights and Freedoms:** Guarantees rights to life, MEL system must measure the contribution of NGO work to realizing these rights.

- ❖ **Directive Principles of State Policy (Articles 34-41):** Mandates the state to provide basic healthcare, making the Ahefs's work a partner in fulfilling a

constitutional directive.

2. **Companies Act, 2019 (Act 992):** Governs the registration and operation of companies, including non-profit companies limited by guarantee (the typical legal form for NGOs in Ghana). It outlines governance, reporting, and accountability requirements.
3. **Public Financial Management Act, 2016 (Act 921):** While primarily for public institutions, its principles of transparency, accountability, and value for money are best practices that donors and the government expect NGOs to adhere to. The MEL manual should reflect these principles.
4. **Ghana Statistical Service Act, 2019 (Act 1003):** Establishes the GSS as the central authority for data collection, management, and dissemination. NGOs must ensure their data collection methods are sound and may need to seek permission or collaborate with GSS for large-scale surveys.

B. Health Sector-Specific Policies and Strategies:

1. **National Health Policy (2020):** Titled "Ensuring Healthy Lives for All," this is the overarching policy document. The Ahefs's MEL framework must explicitly link its goals and indicators to the objectives of this policy (e.g., Primary Health Care, Universal Health Coverage).
2. **National Health Financing Strategy (2015-2025):** Guides how health care is funded. MEL activities should track efficiency and equity in resource utilization, aligning with the strategy's goals.
3. **Ghana National Health Insurance Scheme Act, 2012 (Act 852):** As a key financing mechanism, NGO work often interfaces with the NHIS. MEL can track access to NHIS by marginalized populations the NGOs serve.
4. **Various Programme-Specific Policies:**
 - o *Reproductive Health Policy*
 - o *Adolescent Health Policy*
 - o *Non-Communicable Diseases Policy*
 - o *HIV and AIDS Policy and Anti-Stigma Strategy*
 - o The MEL manual should incorporate indicators from these specific policy areas relevant to the Ahefs.

C. Data Protection and Privacy:

1. **Data Protection Act, 2012 (Act 843):** This is critically important for MEL. It governs the collection, use, storage, and disclosure of personal data. The MEL manual **must** have a dedicated section on data privacy, informed consent, confidentiality, and security protocols that are fully compliant with this Act.

II. FOREIGN AND INTERNATIONAL CONVENTIONS AND FRAMEWORKS

These provide the global normative standards and commitments that Ghana has endorsed, which should guide the ethical and programmatic focus of the MEL system.

A. Core International Human Rights Instruments:

1. **Universal Declaration of Human Rights (UDHR, 1948):** Article 25 establishes the right to a standard of living adequate for health.
2. **International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966):** Article 12 recognizes the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Ghana is a

signatory. The MEL should assess progress towards realizing this right.

3. **Convention on the Elimination of All Forms of Discrimination against Women**

(CEDAW, 1979): Critical for health programs focused on women (maternal health, reproductive rights). Ghana is a state party.

4. **Convention on the Rights of the Child (CRC, 1989):** Guides work on child health. Ghana is a state party.

B. Key Health-Related International Agreements:

1. **Alma-Ata Declaration (1978) on Primary Health Care:** The foundation of modern primary health care, emphasizing community involvement—a core principle for NGOs.

2. **Sustainable Development Goals (SDGs, 2015-2030):** Specifically, **SDG 3: "Ensure healthy lives and promote well-being for all at all ages."** The MEL framework **must** use SDG indicators (e.g., 3.1, 3.2, 3.3, 3.8) as a standard reference point to demonstrate contribution to global goals.

3. **International Health Regulations (IHR, 2005):** Relevant for NGOs working on disease surveillance, outbreak response, and health security.

C. Aid and Development Effectiveness Principles:

1. **The Paris Declaration on Aid Effectiveness (2005) / Accra Agenda for Action (2008) / Busan Partnership Agreement (2011):** These emphasize:

- o **Ownership:** Aligning with Ghana's national strategies (hence the importance of local frameworks).
- o **Alignment:** Using Ghana's country systems where possible.
- o **Harmonization:** Reducing duplication (e.g., using standardized indicators across member NGOs).
- o **Managing for Results:** Focusing on sustainable outcomes, which is the core of MEL.
- o **Mutual Accountability:** Being transparent to stakeholders, including government and beneficiaries.

Data Generation

Weekly Records
(Notebooks)

Data collection
tools

Send data monthly

Using internet
enabled Tablets

HIV /CSS

- CATS
- MM
- MOH

GAVI

- Field volunteers
- NGO officers

Data Transmission and Quality Control

Data Verification
for

- Completeness
- Accuracy
- Reliability
- Integrity
- Timeliness

Database Management

(REDCap)

Data cleaning and
processing

Data Archiving

Data cleaning
protocol

Data sharing protocol

Data security protocol

Ensure quality data.

Data Analysis

(Excel, Power Bi,
Stata)

Data Analysis
*(for frequencies and
interdependency)*

Data Dissemination

Data Validation

- Periodic
monitoring
- OSDV
- Quarterly
reviews
- Semi-annual
- Annual

HIV Program

- NACP
- CCM
- Networks

GAVI PROGRAM

- EPI

Global Fund

LFA

Country Team