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Issuance Date:	March 21, 2014
Deadline for Questions:	April 9, 2014
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Subject: USAID/Mali Request for Application (RFA) No. 688-14-000005, for implementing the Mali High Impact Health Services II Activity

The United States Agency for International Development Mission in Mali (USAID/Mali) is seeking applications from all eligible organizations, for an Assistance award to implement the "Mali High Impact Health Services II" Activity as fully described in Section 1 of this Request for Application.

This is a full and open competition RFA. Subject to the availability of funds**,** USAID anticipates awarding one (1) five-year Cooperative Agreement with an anticipated Total Estimated Amount not to exceed $45,000,000.

The authority for this Request for Application (RFA) is found in the Foreign Assistance Act of 1961, as amended. This RFA consists of this cover letter and the following:

Section 1 – Funding Opportunity Description
Section 2 – Eligibility Information
Section 3 – Application Format and Submission Instructions
Section 4 – Evaluation Criteria
Section 5 – Award and Administration Information
Section 6 – Required Certifications, Assurances, Other Statements of Applicant

Applications and questions shall be submitted by email not later than the due date specified above to the following: bamakoaao@usaid.gov.

USAID reserves the right to fund any or none of the applications submitted. Issuance of this RFA does not constitute an award commitment on the part of the US Government, nor does it commit the Government to pay for costs incurred in the preparation and submission of an application. Applications are submitted at the risk of the applicant and all preparations and submission costs are at its expense. In addition, award of the agreement contemplated by this RFA cannot be made until funds have been appropriated, allocated and committed through internal USAID procedures.

Answers to questions and any additional information regarding this RFA will be provided through an amendment to this RFA and posted on http://www.grants.gov.

Sincerely,

/s/

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ACRONYMS/ABBREVIATIONS

ACT	Artemisinin-combination therapies
AIDS	Acquired Immune Deficiency Syndrome
AMTSL	Active Management of Third Stage of Labor
ANC	Antenatal Care
AQ/PM	Amodiaquine/sulfadoxine-pyrimethamine
ART	Antiretroviral Therapy for HIV
ARVs	Antiretrovirals
ASACO	Association de Santé Communautaire
ASC	Agent de Santé Communautaire
ATN	Assistance Technique Nationale
BCC	Behavior Change Communication
BCC/SM	Behavior Change Communication/Social Marketing
CCDS	Centre Communal de Développement Sociale et Economique
CSCOM	Centre de Santé Communautaire
CSREF	*Centre de Santé de Référence*
CHV	Community Health Volunteer
CHW	Community Health Worker
DHS	Demographic and Health Survey
ENC	Essential Newborn Care
EDSM-V	Enquête Démographique et de Santé du Mali 2012-2013
FAM	Fertility Awareness Method
FANC	Focused Antenatal Care
FP	Family Planning
FSW	Female Sex Workers
FtF	Feed the Future
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
GHI	Global Health Initiative
GOM	Government of Mali
HCI	Health Care Improvement
HIHS	High Impact Health Services
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPP	Health Policy Project
IEC	Information Education Communication
IHP	International Health Partnership
IPTp	Intermittent Preventive Treatment of Malaria for Pregnant Women
IRS	Indoor Residual Spraying
LAM	Lactational Amenorrhea Method
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Activity
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MIYCN	Maternal, Infant and Young Child Nutrition
MOH	Ministry of Health
MRTC	Malaria Research and Training Center
MSM	Men who have Sex with Men
NGO	Non-Governmental Organization
NTD	Neglected Tropical Disease
PE/E	Pre-eclampsia/eclampsia
PHDP	Positive Health, Dignity and Prevention
PKC	Project Kènèya Ciwara
PMI	President's Malaria Initiative
PMP	Project Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission of HIV

PNPs	Policies, Norms, and Procedures
PRODESS	Health and Social Development Program
RFA	Request for Applications
SBCC	Social and Behavior Change Communications
SDM	Standard Days Method
SEC	Soins Essentiels dans la Communauté
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SM	Social Marketing
SMART	Standardized Monitoring and Assessment of Relief and Transition
SMC	Seasonal malaria chemoprevention
SPS	Strengthening Pharmaceutical Systems
STI	Sexually Transmitted Infection
SWAP	Sector Wide Assistance Program
TFR	Total Fertility Rate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Fund for Population Assistance
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Testing and Counseling for HIV
WASH	Water, Sanitation, and Hygiene
WB	World Bank
WHO	World Health Organization

SECTION 1 – FUNDING OPPORTUNITY DESCRIPTION

USAID/Mali's new comprehensive five-year (2014-2018) health sector program aims to assist the Government of Mali (GOM) Ministry of Health (MOH) to improve health outcomes and ending preventable child and maternal deaths by providing support to strengthen three critical health sector components: behavior change communication, health services delivery, and health systems strengthening. For the past decade, USAID support has been channeled through several different awards. Over the next five years (2014-2018), USAID will continue to focus on improving these essential, complementary components by consolidating and concentrating support in key awards.

Under its new health program, USAID's principal support for health service delivery in Mali will be provided through the "Mali High Impact Health Services II (MHIHS) Activity" (referred to as the "Activity" in this RFA). Other awards will be forthcoming in CY2014 and will focus on social and behavior change communication and social marketing (SBCC/SM) and on health systems strengthening (HSS) activities. All USAID awardees are expected to work very closely with each other and coordinate their respective activities and implementation plans.

The Activity is expected to employ a number of technical approaches that have proven to be effective in Mali, build on these successes and accelerate gains by incorporating new ideas and innovations to increase access to and improve the quality of a package of High Impact Health Services (HIHS). To achieve results, the MHIHS Activity will also employ strategies to strengthen community participation in and ownership of health matters, working with both private and public sector health care entities, in four regions of Mali and the district of Bamako. Moreover, while other USAID awards will focus more exclusively on SBCC/SM and HSS interventions, the present Activity is expected to contribute to the implementation of SBCC and HSS strategies and interventions especially in regard to their implementation at the district and community levels in target regions.

1.1 BACKGROUND/CONTEXT

The political situation in Mali was unstable for 18 months following the March 2012 *coup d'état* that resulted, *inter alia*, in economic sanctions by the Economic Community of West African States (ECOWAS) and suspension of donor funding to Mali. Nearly half a million people fled their homes when armed groups took over major northern cities by force. By early 2014, the number of internally displaced people (IDPs) was estimated at less than 200,000 as IDPs began returning to their homes in the north in large part due to the political stabilization and improved security following the September 2013 presidential elections. Most schools and health centers in the north, however, remain closed.

In its reconstruction plan, the post-coup interim government stated that GOM resources had decreased by 30 percent after the coup. The plan spoke of the fragility of government institutions, poor governance and pervasive corruption. A new president was democratically elected in September 2013, and legislative elections were held in December 2013. There is much hope that open acknowledgement of past mistakes and abuses will translate into effective reforms and serious nation building in the months and years to come as the needs are immense in every sector.

- **Mali Development Indicators**

Mali remains near the bottom of the United Nations Human Development Index, ranked 178th of 182 countries.[1] Approximately half of the population lives on less than U.S. $1 a day. The 2009 census showed the population of Mali is 14,517,176 with a growth rate of 3.6% per year - nearly double the population of 20 years ago (1987: 7,696,348 and 2.4% growth rate). Half of Mali's population is under the age of fifteen, and two-thirds are below twenty-five years of age.

Ninety percent of the population lives in the southern third of the country. Over 50% of the population lives in three regions - Sikasso (18.1%), Koulikoro (16.7%) and Segou (16.1%), and a

[1] UNDP 2009. Human Development Report 2009 -Mali.

quarter of the population resides in the capital city, Bamako, and surroundings areas. The least populated areas are concentrated in the vast northern regions of Gao (3.7%), Timbuktu, (4.7%) and Kidal (0.5%). These population factors stress the country's development plans in the areas of food security, economic growth, and attainment of Millennium Development Goals (MDGs).

Education levels are quite low; only 17% of women and 37% of men are literate. Agriculture is an essential component of the Malian economy, providing nearly 40 percent of the GDP in 2005.[2] The agricultural sector remains a major source of income and primary livelihood for an estimated 8.9 million people, nearly 80% of the population. There have been improvements in access to safe drinking water for much of the population, but progress in sanitation has lagged behind.

- **Mali's Health Administrative and Service Delivery Structure**

The MOH's administrative structure includes a national level represented by the cabinet of the Minister of Health and more than 20 National Directorates that report directly to the MOH Secretary General.[3] There are nine health directorates, one in each health administrative region (Gao, Kayes, Kidal, Koulikoro, Mopti, Ségou, Sikasso, Timbuktu) plus the capital of Bamako. The regions are subdivided into 49 administrative *cercles*, comprised of 54 health districts, while Bamako is divided into six administrative communes that correspond to six health districts, for a total of 60 districts nation-wide. The governance of the system is assured by 703 communes, each one administered by an elected local council headed by a mayor.

The health system is based on the principles of decentralization of health services and community participation to expand access to and quality of health services. The service delivery system is three-tiered with i) five national reference hospitals and a maternal and child hospital at the tertiary level in Bamako; ii) seven second-tier regional referral hospitals located in Kayes, Kati, Sikasso, Ségou, Mopti, Timbuktu and Gao; iii) 60 first-tier referral health centers (CSREFs or *Centre de Santé de Référence*) at the district level; and 1,094 community health centers (CSCOMs or *Centres de Santé Communautaire*) as well as parastatal, faith-based, military and other private health centers at the community level. CSCOMs are established and managed by community health associations (*ASACOs or Associations de Santé Communautaire*). In theory, CSCOMs are staffed by a physician, nurse, trained birth attendants, community health volunteers (CHVs), or *relais* in French, and, in some CSCOMs, community health workers (CHW or *Agent de Santé Communautaire/ASC).* Larger urban CSCOMs are typically more fully staffed than small rural centers.

The MOH provides CSCOMs with an initial supply of essential materials, equipment, and medications, as well as in-service training and supervision of technical staff. ASACOs recruit staff, including CHWs and CHVs*,* and manage income generated by the CSCOM to pay staff salaries, renew the stocks of medications and supplies, and maintain the facility. ASACOs also oversee the day-to-day management of the CSCOMs and ensure links with the community. The CHWs and CHVs are supervised by CSCOM technical teams.

In 2010, the MOH approved the strategy of *Soins essentiels dans la communauté* or SEC (essential care at the community level) and henceforth CSCOMs were allowed to provide, through CHWs, these essential services which include the integrated community case management of childhood illnesses (malaria, pneumonia, diarrhea), community management of acute malnutrition, family planning, essential newborn care, and hygiene and sanitation. CHWs are currently present in a relatively small number of CSCOMs, and are funded mostly by donors. (See Table 3 under Sub-Result 2.1 below for list of SEC interventions). There are also approximately 20,000 CHVs (*relais)* throughout Mali, who conduct promotional activities including, but not limited to, hand washing with soap, household hygiene, diarrhea treatment with oral rehydration salts (ORS), antenatal care (ANC), family planning (FP), and the prevention of malnutrition and malaria.

[2] FAO (2010) Profil Nutritionnel de Pays: République du Mali. Systèmes d'Information et de Cartographie sur l'Insécurité Alimentaire et la Vulnérabilité.
[3] See *Decret No.09-168/PM-RM,* April 29, 2009.

- **Key Health Sector Indicators**[4]

Despite recent improvements, Mali's health indicators remain among the worst in the world. Maternal and under-five child mortality rates are estimated at 464 maternal deaths per 100,000 live births[5] and 98 child deaths per 1,000 live births, respectively. Infant mortality fell from 96 infant deaths per 1,000 live births[6] to 58 infant deaths per 1,000 live births between 2006 and 2012. In the 2006 DHS, infant deaths represented 50% of child deaths, while in the 2012 DHS, infant deaths represented 59% of child deaths. Nearly half (46%) of all newborns begin breastfeeding immediately, but only one third (37%) are exclusively breastfed for six months. Vaccination rates for children (12-23 months) made a significant improvement between 2001 and 2006: diphtheria, tetanus and pertussis (DTP3) increased from 40% to 68%; Polio3 from 39% to 62%, and complete immunization from 29% to 48%. However, preliminary data from the 2012 DHS indicates that DTP3 has fallen to 63.1%.

Postpartum hemorrhage is the major cause of maternal mortality. While 74% of women receive at least one antenatal visit, only 59% of births are delivered with a skilled attendant. Malnutrition is a major contributor to maternal and child death and disability, as 38% of children suffer from chronic under-nutrition and 81% are anemic. Disparities between urban and rural areas can be seen for all health categories. In addition, mothers' education levels are closely connected to health service indicators, with, for example, 70% vaccination rates for children of mothers with secondary education or higher compared to 46% for children whose mothers have no formal instruction, underscoring the link between education of girls and child health status. Mali's fertility rate is 6.1 births per woman, with a modern contraceptive prevalence rate of 9.9%. There is a 31% unmet need for family planning (FP), increasing to 70% among postpartum women in the first year after giving birth.

Endemic malaria threatens the entire population and is the leading cause of morbidity and mortality. Malaria largely affects pregnant women and children under five, who suffer over two episodes per year on average. The rates of household ownership (84%) of long-lasting insecticide treated bed net and use among pregnant women (75%) and children under the age of five (70%) are improving, but malaria prevalence remains high with 52% of children carrying the malaria parasite during the high transmission period. Malaria case confirmation is also improving with more than 70% of malaria cases being confirmed before administration of malaria treatment, and IPTp (Intermittent Treatment of Malaria for Pregnant Women) increased from 4% in 2006[7] to 20% in 2012. USAID currently implements Indoor Residual Spraying (IRS) in three districts (Baraoueli, Bla and Koulikoro).

Mali's HIV prevalence rate is low (est. 1.3%) compared with other sub-Saharan countries, with pockets of higher prevalence among certain population groups, particularly female sex workers (FSW) and men who have sex with men (MSM). In 2009, HIV prevalence among FSW was 24.2%.[8] In Mali, program data shows rates of HIV prevalence among MSM at 17-35%. The total number of HIV-positive people is estimated at about 70,000, of whom 29,260 currently receive anti-retrovirals (ARVs). The Mali DHS 2006 found that only 12% of HIV positive individuals knew they were HIV positive. In 2010, 33% of pregnant women who received antenatal care (ANC) failed to be tested for HIV. Of those testing positive, 36% did not receive Antiretroviral Therapy (ART) to prevent transmission to the infant, and 26% of infants failed to receive ART.[9]

[4] Unless otherwise noted, health statistics in this RFA are from the *Enquête Démographique et de Santé du Mali EDSM-V 2012-2013 Rapport Préliminaire* (Demographic and Health Survey [DHS] 2012-2013 Preliminary Report). May 2013.
[5] *Mali Enquête Démographique et de Santé (EDSM-IV) (*Demographic and Health Survey [DHS] 2006). December 2007.
[6] Ibid.
[7] Ibid.
[8] Ministry of Health, Mali, Centers for Disease Control and Prevention, USAID. (2010) *Mali Integrated STI Prevalence and Behavior Survey (ISBS) Final report 2009*. Bamako: Ministry of Health Publications.
[9] *Système Local d'Information Sanitaire (*SLIS). Report 2010.

Nearly 12 million people are at risk of contracting an endemic neglected tropical disease (NTD) in Mali. These include lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiasis and trachoma. USAID support has been and will continue to be provided through USAID centrally-funded interventions that provide medications to treat NTDs. Mass drug distribution is done during national campaigns; one distribution channel is the CSCOMs with which this activity will work.

- **Health Sector Challenges and Opportunities**

The following list is not exhaustive of the challenges in implementing this activity: i) high population growth and a large youth bulge; ii) rapid urbanization - 25% of the population lives in Bamako and Kati Districts; iii) shortage of and uneven distribution of health workers, gaps in knowledge and training, and provider biases; iv) lack of equipment, materials and supplies for quality care; v) insufficient health financing through the cost recovery system and widespread inability to pay; vi) gender inequalities that prevent women from making family health decisions; vii) fragmented commodity supply chain management; viii) weak health management information system.

Nevertheless, there are positive signs that through focused concerted efforts, these challenges can be addressed. The MOH is committed to attaining all of the health-related Millennium Development Goals (MDGs): nutrition (No. 1), child health (No. 4), maternal and reproductive health (No. 5), and malaria and HIV (No. 6). Mali's health system benefits from the strong participation of civil society in both the management and the provision of services. Women, men, youth, and community groups organize themselves to support the health needs of their members through savings/credit clubs and professional organizations, and often work as community health volunteers. The MOH is also very supportive of research and innovation in all health areas. For example, under a USAID Activity, Active Management of Third Stage of Labor (AMTSL) was introduced and scaled-up through training of *matrones* (traditional birth attendants) who now are able to offer this service to women in under-served communities and in rural areas. Donor support for and interest in FP has recently increased. FP funders now include the World Bank, the Dutch, a Spanish-Tunisian partnership, and others; and UNFPA has designated Mali a first-tier priority country. Additionally, a study is underway for task-shifting of FP implant insertion by *matrones* as the front-line providers at CSCOMs.

- **Critical Assumptions**

Presidential and legislative elections took place toward the end of CY 2013. The new administration is currently in the process of elaborating new policies and development plans in consultation with a host of national and international partners. In the health sector, USAID has collaborated with MOH counterparts and the sector donor community on the development of the GOM ten-year and five-year health sector development plans – the former was approved and validated in January 2014 and the latter is under review at the present. The likelihood of the Activity success will be much higher as the development plans and other important national health strategies and policies are promulgated, understood, and implemented by all health sector partners. USAID's MHIHS II Activity will complement and reinforce other health sector donor programs and will be affected by donors' decisions regarding political developments in Mali. Furthermore, with continued sporadic military actions in the north, there are lingering concerns about physical security and travel to the field is restricted for safety reasons.

- **USAID/Mali's Activities in Health**

Since 2003, USAID/Mali has provided support for a "package" of HIHS that has evolved and expanded over the years. Services supported covered: i) family planning and reproductive health; ii) maternal health; iii) essential newborn care; iv) infant and child health; v) malaria control and prevention; vi) HIV/AIDS prevention, treatment and care; vii) water supply and sanitation; viii) neglected tropical diseases; and, ix) nutrition. The MHIHS II Activity will have primary responsibility for results related to the first five HIHS services mentioned above, and will also be responsible for

nutrition and water supply and sanitation activities which are a part of the MOH package of basic services delivered through CSCOMs. USAID/Mali's support for HIV, NTDs, and other targeted services (e.g., fistula care) has been and will continue to be provided through other USAID partners. Intensive nutrition and water supply and sanitation services will also be provided by other USAID partners in targeted high-risk geographic areas. The recipient of the MHIHS II award will be expected to collaborate closely with these USAID partners in implementing this activity. At a minimum, this will strengthen target communities' and providers' ability to recognize the need for and make timely referrals to these specialized services.

The MHIHS II Activity will build on the successful approaches and interventions of predecessor health activities, both bilateral and field support, including, but not limited to, *Assistance Technique Nationale Plus (*ATN Plus), Project Kènèya Ciwara (PKC II), Pathways to Health, Save the Children's Sikasso Community Health Activity, the Maternal and Child Health Integrated Program (MCHIP), the Health Care Improvement (HCI) Activity, the Fertility Awareness Method (FAM) Activity, the Health Policy Project (HPP), Systems for Improved Access to Pharmaceuticals and Services (SIAPS), Capacity Plus, and Measure Evaluation (see Annex 1 for additional details).

Over the years, USAID has supported a wide variety of interventions through these activities. USAID partners have developed and/or updated policies, norms, and procedures (PNPs) for health interventions in HIHS; trained clinical providers and community health workers in HIHS prevention and treatment interventions; introduced, tested and expanded approaches for reaching postpartum women with a wide range of contraceptive methods; strengthened ASACO management practices; improved the quality of health services; strengthened systems for supply chain/logistics, health information/data, and human resources; and engaged the private sector through social marketing and franchised providers.

During the first five years (2004-2008) of HIHS programming in Mali, USAID provided support to eleven districts throughout the country (one to three districts in all regions except Kayes) plus the district of Bamako. In the second five years (2009-2013), with the inclusion of the President's Malaria Initiative (PMI), the USAID program expanded to 35 districts across all of Mali's eight regions, plus Bamako. Under this activity (2014-2018), USAID will concentrate efforts in all districts of four regions – Kayes, Koulikoro, Gao, Sikasso – plus Bamako (with a focus on underserved peri-urban areas within Bamako). See Section 1.2.2 of this RFA.

- **Other Donor Support for Health**

As an International Health Partnership Country[10], Mali's many development partners provide financial and technical support for health care activities. Multilateral organizations include the World Bank, WHO, UNICEF, UNFPA, World Food Program (WFP), the European Union (EU), and the African Development Bank (AFDB). Several countries have bilateral relationships with the GOM: Belgium, Canada, France, Luxembourg, the Netherlands, Norway, Switzerland, Spain, and Sweden. The Global Fund for AIDS, Tuberculosis, and Malaria (GFATM) is also an active partner. During 2003-2010 period, Mali received eight GFATM awards totaling $127 million - three awards for HIV/AIDS, three for malaria, and two for tuberculosis (TB). Although three awards have been suspended for the past two years, Mali recently received new GFATM grants in 2012/2013 for HIV, malaria and TB.

[10] The **International Health Partnership** (**IHP+**) began in 2007 with 27 developing country governments, international development partners, civil society organizations and other non-state actors in order to accelerate progress towards the Millennium Development Goals. IHP+ is administered by the WHO and the World Bank and mobilizes partners to support comprehensive, country-led health strategies in a well-coordinated way.

- **USAID/Mission program in Mali**

The USAID/Mali Health Office makes a concerted effort to coordinate health sector interventions with activities managed by other USAID Offices. USAID's economic growth activities are designed to reinforce the development, transfer, and application of innovative technologies to improve agricultural productivity. Beginning in 2014 the Health Office will undertake a joint nutrition-agriculture project in Feed the Future zones with the Accelerated Economic Growth Office. The education program seeks to improve reading skills of Malian children in primary grades and increase equitable access to education in crisis and conflict environments. Also in 2014, the Health Office plans to support Education Office health education and gender initiatives. The Health Office has also collaborated with the Governance and Communication Office in the past and is likely to do so in the future to build local governance capacities of communes in targeted regions. See http://www.usaid.gov/where-we-work/africa/mali for further information.

1.2 ACTIVITY OBJECTIVE AND ANTICIPATED RESULTS

The "Mali High Impact Health Services II" Activity is designed to assist the GOM MOH to improve and expand select high impact health services and ending preventable child and maternal deaths by focusing on three critical health system components ***as they intersect at the community level***: health service delivery, social and behavior change, and health systems strengthening. The Activity objective is "Increased and Sustained Use of High Impact Health Services and Healthy Behaviors." The selected applicant is expected to employ a number of technical approaches that have already proven to be effective in Mali, build on these successes and incorporate new ideas and approaches to accelerate gains.

Taking into account the information provided in this RFA, the applicant must formulate and discuss its overall vision and operational strategies to achieve the following expected results (see Table 1 below).

Table 1. MHIMS II Activity Objective: Increased and Sustained Use of High Impact Health Services and Healthy Behaviors

Result 1: Improved demand for quality health services and products and adoption of healthy behaviors at the individual, household, and community levels.	**Result 2:** Improved access to and quality of integrated HIHS at the community level and appropriate referrals.	**Result 3:** Improved health systems management, functioning and accountability at the community and district levels, and coordination at the regional level.
Sub-Result 1.1 Improved knowledge, attitudes, and practices among target populations.	**Sub-Result 2.1** Service delivery points consistently deliver priority HIHS according to MOH standards.	**Sub-Result 3.1** Improved planning, management and accountability systems at the CSCOM/ASACO, district and regional levels.
Sub-Result 1.2 Community social norms support the use of healthy behaviors and health services.	**Sub-Result 2.2** Effective service delivery approaches for various HIHS applied and scaled up.	**Sub-Result 3.2** Data analyzed and used to plan, monitor and respond to health needs.
Sub-Result 1.3 Community advocacy strengthens service provision, management and accountability processes.	**Sub-Result 2.3** Referrals and follow-up strengthened between household, community, and facility for selected services.	**Sub-Result 3.3** Improved management processes to increase access, availability, and affordability of health care products and commodities.

In addition to achieving the above objective and anticipated results, the activity is expected to contribute substantially to the following national-level indicators (baseline is DHS 2012-2013):

- Reduce maternal mortality by 30%
- Reduce under-five mortality by 30%.
- Reduce newborn mortality by 25%.
- Increase modern method contraceptive prevalence rate by 5 percentage points.
- Reduce prevalence of underweight children under five by 30%.
- Reduce prevalence of stunted children under five by 30%.
- Reduce prevalence of wasted children under five by 50%.
- Reduce prevalence of underweight women by 20%.

1.2.1 ILLUSTRATIVE ACTIVITIES/INTERVENTIONS BY RESULT

Result 1: Improved demand for quality health services and products, and adoption of healthy behaviors at the individual, household, and community levels.

Interventions designed to achieve Result 1 may include targeted local-level actions in health promotion, community mobilization, inter-personal communications, media (e.g., community radio), advocacy and individual and institutional capacity building. The Activity's primary focus will be on community-level improvements in targeted districts, working with CSCOMs, ASACOs, CHWs, CHVs, CSREFs, communal health teams (*Equipes de Santé Communale*), Communal Social and Economic Development Centers (*Centres Communal de Développement Social et Economique* [CCDS]), traditional communicators such as *griots*, heads of households, influential individuals and/or other appropriate actors. The Activity is expected to strengthen regional and district health teams in social and behavior change communications (SBCC), building the teams' technical capacity to implement, manage, and evaluate the effectiveness of health promotion activities and institutionalize approaches for health communications at the community level. Linkages between communities, districts and regions, including the federations of ASACOs known as FERASCOM (regional) and FELASCOM (local), will be strengthened.

Communication interventions implemented under this Activity must reflect best practices from Mali and other countries in Africa using a combination of approaches including traditional communication channels. The interventions must be solidly grounded in formative research, be delivered with sufficient intensity and duration, address the needs of specific target populations and incorporate clear behavior change objectives and outcomes. Message content will address the multiple determinants and levels of human behavior, including individual knowledge, attitudes and motivations, social and cultural norms, interpersonal relationships, and structural factors that encourage or hinder healthy behaviors. Given the distinct issues in each region, messages and activities may vary from region to region, and possibly from district to district.

To ensure complementarity, efficiency and maximum impact of USAID resources, the selected applicant for the present "Mali High Impact Health Services II" award is expected to collaborate and coordinate with USAID's anticipated "Social Behavior Change Communication and Social Marketing for Improved Health Outcomes in Mali (SBCC/SM) Activity" which will also be awarded in CY2014. At the national level, the SBCC/SM activity will focus on policy, planning, design and coordination of SBCC/SM initiatives, activities, materials and tools for use at the national, regional and local levels. The SBCC/SM Activity may conduct national-level SBCC campaigns, and will develop messages and provide tools and materials to replicate these campaigns at the local levels. This will ensure coherent, coordinated SBCC campaigns from the national to the local level. It is expected that MHIHS II will provide input and feedback into SBCC messaging and interventions as the two USAID Activities collaborate and coordinate their respective work plans.

Materials and tools, developed by USAID's SBCC/SM partner will be made available to GOM MOH, civil society, and USAID implementing partners, including the awardee of the present "Mali High Impact Health Services II Activity" who, in turn, will be responsible for their use at the district and

community levels. Although the primary focus of the "Mali High Impact Health Services II Activity" is not the development of SBCC messages or materials, the MHIHS II selected applicant may be responsible for adapting messages, tools, and materials developed by USAID's SBCC/SM Activity for use at the local level, and/or for designing and implementing additional SBCC interventions as appropriate based on the specific needs of different target groups in the HIHS Activity's designated regions.

Sub-Result 1.1: Improved knowledge, attitudes, and practice among target populations

Social and behavior change communication (SBCC) interventions must be designed to effect behavioral changes in specific audiences including service providers at the facility and community levels (e.g., CSCOMs, private sector service providers, etc.). Illustrative interventions include individual-level messaging, small group interventions, use of local media, and community-level interactive methodologies. The applicant will describe plans to: i) empower and increase active involvement and participation of individuals, groups and communities in healthy behavior interventions at the district and community levels; ii) utilize multi-sectorial and multi-disciplinary approaches to promote healthy behaviors; iii) coordinate and implement harmonized health communication interventions; and, iv) make use of traditional communicators (e.g., *Réseau des Communicateurs Traditionnels pour le Développement).*

This activity is expected to build on successful activities and approaches implemented in Mali and elsewhere in similar environments. The recipient will be responsible for improving the quality of interpersonal communications for priority health areas as well as for carrying out campaigns targeting specific health issues and behaviors. Communications will incorporate cross-cutting themes, including gender equity and equality, roles and responsibilities of community members and locally elected leaders, good governance and accountability, and will pay particular attention to increasing the use of high impact health services and encouraging the adoption of healthy behaviors. Examples of subjects that may need to be addressed include, but are not limited to: i) nutrition (maternal, infant, and young child nutrition, use of local and diversified foods); ii) water, hygiene and sanitation (hand washing with soap, treatment and safe storage of drinking water, use of sanitation facilities); iii) maternal health: (pre-and post-natal care, birth spacing, FP, HIV testing, prevention/treatment of malaria, delayed marriage); and iv) child health (immunization, treatment of fever, prevention/treatment of malaria). The applicant's proposed communications interventions are expected to clearly reflect Mali's particular health sector issues and the socio-cultural context.

Sub-Result 1.2: Community social and cultural norms support the use of healthy behaviors and services

Local Non-Governmental Organizations (NGOs), civil society groups, and other community actors can be very effective implementers and partners in advocacy, communication and mobilization activities. They have local credibility, grassroots networks, and a clear social welfare agenda. By virtue of their deep involvement at the grassroots levels, these local partners have the potential to play an important role in reducing barriers to the use of high impact health services.

To achieve this sub-result, the activity aims at strengthening the capacity of civil society, local NGOs, and other actors to promote healthy behaviors and the use of HIHS. To be effective, SBCC interventions need to be evidence-based and well-grounded in a thorough understanding of community beliefs, perceptions, and practices in order to effectively address individual needs, gender and sociocultural norms, and structural issues that promote or impede healthy behaviors and lifestyles. Communications content must be focused and tailored to the prevailing socio-cultural contexts in each region and district, particularly with regards to gender, nutrition, and reproductive health practices. It is USAID/Mali's understanding that enlisting the support of key community and religious leaders will be critical to the success of the sub-result.

Sub-Result 1.3: Community advocacy strengthens service delivery, management and accountability processes

Interventions to achieve this sub-result will be designed to build the capacity of civil society, local NGOs, and other actors to: i) advocate for increased budget transparency at the local level, increased allocations for health, and increased use of HIHS and adoption of healthy behaviors; and ii) demand accountability and transparency in health service provision, promotion, and financing from ASACOs, CSCOMs, and other health structure managers, and from locally elected leaders (e.g., district mayors).

At the core of sub-results 1.2 and 1.3 is a strong emphasis on community commitment to and ownership of health service provision and behavior change. This entails increased local engagement in identifying problems and in determining and carrying out appropriate community-level actions. To be effective, community mobilization will be planned and implemented in partnership with a wide range of actors at the district and community levels.
The applicant should describe strategies and actions to strengthen relationships among local groups which may include but are not limited to NGOs, civil society organizations, particularly women's groups, FENASCOM, FERASCOM, FELASCOM, ASACOs, CSCOMs, traditional leaders, and faith-based organizations.

Audience Targeting

The Activity will target populations that are most impacted by the specific health issues being addressed, as well as those who can influence behavior, and those who provide health services at the facility and community levels. Table 2 below presents examples of target populations for Result 1. The application is expected to prioritize the target audiences and strategies, as well as the anticipated outcomes for each audience. The proposed priorities must be supported with clear convincing rationale.

Table 2. Target Audiences (depending on health intervention)
• Women and men of reproductive age (14-49) • Pregnant women • Mothers/caretakers of children • Neonates; infants under age one; children under age five • Fathers/heads of households • Community associations/groups (e.g., Women's groups, *Tontins*) • Community and religious leaders, traditional healers, marabous • Locally elected officials • Public and private sector service providers • Community members (TBAs, Grandmothers, mothers- in-law) • Adolescents and youth (males and females 10-24 years of age)

Result 2: Improved access to and quality of integrated HIHS and appropriate referrals

Significant gains have been made over the past ten years to increase access to and improve quality of health services and products at the community, CSCOM and CSREF levels, as well as in the private sector. Policies, norms and procedures (PNPs) have been developed and updated based on the latest evidence for HIHS and essential community care interventions. Novel service delivery approaches have been introduced and tested including a new cadre of community health workers (*agents de santé communautaires)*, community-based distribution and outreach, campaigns, social marketing, mobile outreach, integrated FP/MCH/nutrition services, task shifting, public-private partnerships, franchised private clinics, and others. Quality improvement approaches have been

initiated through training and facilitative supervision, improvement "collaboratives"[11] and the Ciwara d'Or accreditation that promotes greater use of quality health services at community and household levels through accreditation of the best CSCOMs.

This activity is expected to build on the success of these previous approaches and scale up those that have been most effective for improving quality and expanding services at different levels of the health structure and in different settings (e.g., urban, peri-urban, rural). The applicant may propose additional quality improvement and service expansion strategies and processes that the applicant believes are promising for Mali. The greatest emphasis must be placed on implementation and Activity results at the community level, through work with the CSCOMs, CHWs and CHVs, community-based for-profit and non-profit providers, pharmacies and drug shops, and/or other mechanisms as appropriate.

Over the life of this Activity, it is expected that service delivery, referral and follow-up strategies will be adapted, monitored, strengthened, scaled-up, documented and evaluated. Lessons learned will be widely shared. Improved service delivery will be linked with reinforced management systems, especially those that involve health workers' duties (e.g., recording and reporting on use of services and products). Local communities will be heavily involved in improving the quality of and access to HIHS. The applicant must describe the strategies, processes, and actions that will be employed to achieve these anticipated end of the Activity outcomes.

Sub-Result 2.1: Service delivery points consistently deliver priority HIHS according to MOH standards

Policies, Norms and Procedures (PNPs) have been developed and updated for each of the major high impact health services to be supported. The norms represent the minimum standard of care for services. PNPs have also been developed for the Essential Community Care (SEC) package of interventions for implementation by the CHWs at the community level. During the five years of this activity, PNPs may need to be updated periodically. A minimum level of effort is anticipated under this activity for work at the national level to update PNPs and for related policy advocacy**.** These types of interventions are expected only when they will contribute directly and substantially to the results desired under this award and need to be coordinated with USAID before beginning design.

The Activity will ensure that an integrated package of HIHS is delivered at the community, CSCOM, and CSREF levels throughout targeted geographic areas. The applicant should describe its approach to ensuring the implementation of PNPs and propose how it will build on the knowledge, skills development, and quality improvement efforts of predecessor activities, and further enhance and sustain the delivery of services according to minimum standards of care. Moreover, the Applicant should describe its approach to improving quality in the for-profit and non-profit (non-CSCOM NGO) private sectors.

The table below represents the package of HIHS at the CSCOM and CSREF levels and Essential Community Services to be supported under this activity (community health workers will refer clients to higher-level facilities for services listed in *italics*). The applicant may propose support for select referral centers, depending on need or may propose additional HIHS interventions and service delivery strategies in either, or both, public and private sector programs as appropriate (e.g., the provision of neonatal survival interventions by CHWs and/or CHVs).

[11] See http://www.hciproject.org/node/419

Table 3. Health Services to be Supported Under the Activity		
Health Intervention Areas	High Impact Health Services at CSCOMs and CSREFs	Essential Community Services by Community Health Workers (CHW/ASC)
Family Planning and Reproductive Health	- *Long-acting methods , IUD, Implants* - Short-acting methods, *Injectables*, Pills, condoms - Natural methods, Lactational Amenorrhea Method (LAM), Standard Days Method (SDM) - All women of reproductive age, postpartum women, youth - *Fistula repair*	- Refer for *long-acting methods* - Short-acting methods, Injectables, Pills, Condoms - Natural methods, LAM, SDM - All women of reproductive age, postpartum women, youth
Maternal and Newborn Health	- *Focused Antenatal Care (FANC) 3 visits, Tetanus Toxoid (TT), sulfadoxine-pyrimethamine (SP), Iron (Fe), birth plan* - *HIV Testing at Voluntary Counseling and Testing (VCT) / Prevention of Mother-to-Child Transmission (PMTCT) centers* - Clean and Safe Birth, Active Management of Third Stage of Labor (AMTSL), Pre-eclampsia/eclampsia (PE/E) - Essential Newborn Care (ENC) Breathing, drying, warming, cord care, early & exclusive breastfeeding	- *Essential Newborn Care (ENC) Breathing, drying, warming, cord care, early & exclusive breastfeeding*
Infant and Child Health	- Immunization - Integrated management of childhood illness (IMCI): malaria, diarrhea, pneumonia - Rapid diagnostic test for malaria - Artemisin-combination therapies (ACTs) - standard treatment worldwide for P. falciparum malaria. - Oral rehydration salts (ORS) +Zinc for diarrhea; Vitamin A supplementation - Antibiotics for pneumonia	- Integrated community case management of simple malaria, diarrhea, pneumonia - Malaria rapid diagnostic test - Treatment with ACT - ORS +Zinc for diarrhea - Vitamin A supplementation - Referrals to CSCOM - Follow up at household
Malaria Control and Prevention	- Bed net distribution - IPTp (during FANC) – at least three doses SP - Diagnose and treat with ACTs using Rapid Diagnostic Tests (RDTs) and microscopy and correct use of ACTs - Seasonal Malaria Chemoprevention (SMC) (starting in Kayes region per previous agreement with MOH)	- Promotion of bed net use - Diagnose and treat simple cases of malaria with RDT and ACTs - Refer severe malaria cases - Distribution of AQ/SP (amodiaquine + sulfadoxine-pyrimethamine) for SMC (pilot in Kayes per previous agreement with MOH)
HIV/AIDS Prevention, Treatment and Care	- HIV testing of pregnant women at VCT and PMTCT centers - Active referral to treatment for HIV positive women - HIV testing in VCT centers	
Water Supply and Sanitation (WASH)	- Promote hand washing with soap, hygiene, water treatment and storage	- Promote hand washing with soap, water treatment and storage

Table 3. Health Services to be Supported Under the Activity		
Health Intervention Areas	High Impact Health Services at CSCOMs and CSREFs	Essential Community Services by Community Health Workers (CHW/ASC)
	- Promotion of Community-led total sanitation	- Community-led total sanitation
Neglected Tropical Diseases*	- Refer for treatment ; distribute drugs during national treatment campaigns	
Nutrition	- Promotion of breastfeeding - Promotion of 1,000 days actions - Nutrition of pregnant women and children under 2 years - Management of acute malnutrition - Micronutrient supplementation - Deworming	- Promotion of breastfeeding - Promotion of 1,000 days actions - Nutrition of pregnant women and children under 2 years - Micronutrient Supplementation - Deworming - Community management of acute malnutrition
* Recipient is expected to collaborate with the other USAID partners that will take the lead on this activity. MHIHS II community partners will be responsible for referrals and key promotional activities.		

Sub-Result 2.2: Effective service delivery approaches for various HIHS applied and scaled up

Over the past five years, a variety of proactive service delivery approaches have been employed to increase use of services and adoption of healthy behaviors. Examples of such approaches include the introduction of the ASC as a new cadre of CHW able to provide simple curative care for childhood illnesses; mobile outreach and private providers offering long-acting contraceptive methods on immunization days; the provision of quality birthing services including Active Management of Third Stage of Labor (AMTSL) and Essential Newborn Care (ENC); social marketing (SM) and sales of aquatabs for point of use water treatment and ORS+Zinc for treatment of diarrhea; community mobilization for national campaigns such as Vitamin A supplementation or mass drug distribution for NTDs; a network of trained and functional *relais* who provide a vital link for promoting and influencing community, family and individual behavior changes and social norms; and task shifting of contraceptive implant provision to *matrones* at the CSCOM level.

The applicant will build on the base of the most effective service delivery approaches, adapt or introduce new approaches as needed, and take them to scale within each of the focus regions to achieve real and sustained impact for each of the high impact health services, products and healthy behaviors. The application must describe how it will expand the provision of HIHS to more Malians in order to have impact on national-level health indicators and activity objectives. Over the life of the activity, the recipient shall strive toward sustainability of interventions and results. As the activity is implemented, the recipient will analyze and document the process for attaining adaptation, scale up and sustainability of interventions in Mali.

Sub-Result 2.3: Referrals and follow up strengthened between household, community and facility for selected services

Barriers to access result in delays in seeking health care services. This is especially true for conditions that require referral to a higher level of care. Of particular interest under this sub-result are maternity and newborn care, childhood illness related to malaria, diarrhea, pneumonia and malnutrition, and insertion and removal of long-acting contraceptive methods.

This activity intends to strengthen the referral process from household to the front-line community health workers and CSCOMs, and between CSCOMs and CSREFs. Therefore, the applicant must describe its approach to achieve this objective and ensure the availability of quality care at, and

patient adherence to follow-up care prescribed by, referral facilities. Similarly, the applicant should describe how it will address identified referral system issues related to management processes (Result 3) and the community participation processes (Result 1).

In addition, the applicant must describe its proposed approach to including non-profit and for-profit private sector facilities in the referral system as feasible.

Result 3: Improved health systems management, functioning and accountability at the community, district and regional levels

It is expected that interventions designed to achieve this result will focus on strengthening the performance, management, and accountability of health facilities and personnel at the community and district levels, and facilitate coordination with regional health referral centers which, in turn, may also benefit, as needed, from direct interventions designed to enhance their capacity to coordinate and manage health issues.

The successful applicant will be expected to coordinate closely with USAID's national health systems strengthening (HSS) activities (which will be the subject of separate USAID awards), especially in the areas of: Health management information systems (HMIS), commodity logistics systems, human resources for health, and health financing. USAID's national-level health systems strengthening activities will work with MOH national authorities to strengthen critical health sector operational systems from the national to community level. When this is the case, as it currently is for the MOH health management information system (HMIS) and commodity logistics, USAID's systems strengthening partners will take the lead and coordinate systems-related work with all implicated USAID partners, while the HIHS activity will generally take the lead among USAID partners at the regional level and lower, especially in coordinating with local health officials and other local actors.

Within this context, it is anticipated that the Activity will: i) provide input and local-level perspective for USAID-supported national HSS activities; ii) implement HSS reforms at the local level, based on policy, PNPs, etc. developed with the MOH at the national level by other USAID partners and/or other donors; iii) supplement national HSS activities with local-level interventions that fill gaps in implementation and reinforce the work of USAID's national HSS partners; iv) other interventions as appropriate, which will contribute to the results and objective of this activity without duplicating the work of other implementing partners.

Sub-Result 3.1: Improved planning, management and accountability systems at the CSCOM/ASACO, district and regional levels

Interventions leading to the realization of this sub-result must be designed to improve transparency, accountability, planning and management within Mali's decentralized health system. Particular emphasis should be placed on ensuring effective implementation of improved systems and practices at the community and district levels, and improved coordination with the regional level.

The applicant must identify and discuss appropriate strategies and plans for improved transparency and accountability (including financial) in community, district and regional-level health centers; strengthened management at the CSCOM/ASACO, district and regional levels; and heightened private sector and civil society engagement in health matters.

Sub-Result 3.2: Data analyzed and used to plan, monitor and respond to health needs

The HMIS in Mali currently entails multiple monitoring and reporting systems, with different registers and processes for capturing and reporting service delivery statistics. Monthly reports are not systematically processed and forwarded up the system, nor is data systematically used at community, district or regional facilities for internal reviews and decision-making. There are critical

gaps in reporting, including routine reporting of services and activities provided by CHWs and CHVs. Additionally, data from private sector providers are not included in the national HMIS.
Proposed interventions to attain this sub-result will strengthen data collection, analysis and use for decision making, management, planning, budgeting, monitoring and reporting at the district and community levels. The information needs and reporting requirements for both public and private sector health care entities will be a consideration of interventions supporting this sub-result. It is anticipated that this sub-result will support opportunities for demand-side participation through better reporting and information dissemination to stakeholders, and more informed engagement by civil society and the private sector. The awardee will be expected to coordinate closely with USAID's other HMIS partners who will work with the MOH to strengthen the entire HMIS from the national to the community level.

Sub-Result 3.3: Improved management processes to increase access, availability and affordability of health care products and commodities

The national commodity logistics system is fraught with challenges such as limited capacity in drug procurement, management, and forecasting; lack of reliable commodity transportation to and storage at the community level; and weak logistics information reporting. As a result, stock outs of life-saving commodities are frequent at all health service delivery points.

To achieve the sub-result, the applicant will propose interventions that can be carried out at the community, district and regional levels to ensure the availability of affordable medicines, commodities and other critical health care products. Proposed approaches should address the challenges discussed above. Moreover, since the movement of commodities through the entire system is also affected by financial considerations, including the current cost recovery system, the applicant must address critical finance-related barriers to an effective commodity logistics system. Attention will also be given to the coordination of health information data and commodities logistics information to ensure that drug consumption corresponds to epidemiological data and that distribution of supplies are based on actual needs. For commodity logistics management work, the applicant is expected to coordinate closely with USAID's commodity logistics Activity, "Systems for Improved Access to Pharmaceuticals and Services" (SIAPS) (or future partner) which is currently USAID's lead partner working with the MOH to strengthen the commodity logistics system from the national to the community level.

1.2.2 GEOGRAPHIC COVERAGE

USAID/Mali has identified all districts of Koulikoro, Kayes, and Sikasso, as well as Bamako with a focus on underserved peri-urban areas of Bamako as this activity's desired geographic focus. In addition, the activity is expected to expand to cover Gao as soon as the situation permits. Approximately 65 percent of the total population of Mali lives in these target geographic areas and they each have serious health-related concerns. Sikasso, while growing much of the country's food, has among Mali's worst indicators for malnutrition and malaria. The Kayes region, with its difficult terrain, has significant challenges in reducing maternal and newborn mortality. The Koulikoro region has seen a large influx of population migrating to the areas surrounding Bamako, one of the fastest urbanizing cities in Africa over the past decade. As the population in Bamako's outlying communes and peri-urban areas continues to grow, so does the need for quality health services in these areas.

The Applicant will provide a sound plan for rolling out interventions, district by district and CSCOM by CSCOM, in the target regions, in Years 1 and 2 so that by the beginning of Year 3 all districts in Koulikoro, Kayes, Sikasso, and the communes of Bamako are benefitting from USAID HIHS assistance that has been tailored to address the specific needs of each district. The plan must also reflect the rollout of activities to Gao some time in Year 2.

Much work has already been done to strengthen CSCOMs under previous USAID Activities. The Applicant should take this into account and propose appropriate interventions for each CSCOMs, particularly in Bamako, depending on their current levels of performance and unique needs. Some

CSCOMs are presently functioning well and may require minimal assistance. Others, such as those that provide services for Bamako's impoverished peri-urban areas that became the destination for the thousands of people who fled the insecurity in northern Mali, will necessitate more substantial inputs. Additionally, the applicant will propose criteria for phasing down from a full package of support to a "lighter" more targeted package of support, and then to the cessation of assistance, if applicable, as districts and CSCOMs become more technical and financially sustainable. The timetable for the roll-out of interventions will be submitted with the workplan.

USAID envisions a coordinated approach among all USAID-supported health partners working in the same geographic area at the regional level and below in Mali. The Activity will play the lead role, in consultation with the USAID/Mali Office of Health, in coordinating the efforts of all USAID health partners in the Activity target regions, districts, and communities. As the major USAID partner at these levels, the recipient of this award will provide the structure and logistics necessary to maximize efficiency and increase the effectiveness of the health portfolio. It is anticipated that the recipient will work, with other USAID-supported partners to develop, where appropriate, joint approaches for decentralized planning, monitoring and evaluation. These processes may include, for example, annual joint planning and review sessions that engage appropriate regional and district representatives, so that USAID inputs are coordinated, complementary, and support overall achievement of the regional and district goals. This is important not only to ensure good use of USAID funds, but also to provide coherent support for regional, district, and community health authorities, rather than disparate, confusing and duplicative approaches.

The applicant will establish a headquarter in Bamako with field offices in the target regions where most of the interventions, activities and staff will be concentrated to facilitate collaboration with local government and health authorities, with CSCOMs, ASACOs and local for-profit and other nonprofit health care entities as well as other USAID partners. From its regional vantage points, the selected applicant will contribute vital local perspectives, based on operations research and firsthand implementation experience, on what constitutes appropriate and effective interventions in different communities. The applicant is expected to work with regional health authorities and with other USAID partners. As feasible and to save on operating costs, the applicant may choose to co-locate in the regions with other USAID partners that are already present in the region. Under USAID's new five-year program (2014-2018) the major new awards are MHIHS II, an SBCC/SM Activity (anticipated for award in 2014), and HSS Activities to be identified. USAID realizes that because of the timing of individual awards, co-locating might not be feasible in all cases. Nonetheless, to the extent possible, the applicant will actively seek and identify ways to share office space with other USAID partners that may already have established, or plan to establish, regional offices. The application must include a plan and timetable for setting up regional offices (one in each target region) from which to implement MHIHS II. The plan for establishing regional offices will be submitted with a timetable along with the first year workplan. Note that the applicant may choose to co-locate the Bamako headquarters/Koulikoro offices if desired.

Table 4 below presents information on the population size, and the number of districts, CSREFs, and CSCOMs in each USAID target region.

Table 4. MHIHS II Activity Target Areas

Region	Total Population	No. of Health Districts (communes for Bamako)	No. of CSREFs	No. of functional CSCOMs (in 2012)
Kayes	1,933,615	7	7	199
Koulikoro	2,422,108	9	9	182
Bamako	1,810,336	6	6	58
Sikasso	2,643,179	9	9	207
SUB- TOTAL	**8,709,238**	**31**	**31**	**646**
Gao	542,304	1	1	24
TOTAL	**9,251,542**	**32**	**32**	**670**

1.3 GUIDING PRINCIPLES

USAID/Mali's health sector activities are designed to contribute directly to the goals, objectives, and results outlined in several USG policy frameworks and initiatives. The implementation of this activity will contribute to achievement of the USG goals and objectives as articulated in the initiatives, strategies and guidance discussed below.

The Global Health Initiative (GHI)

GHI combines the skills of USG agencies under seven guiding principles to help partner countries improve health outcomes, with a particular focus on improving the health of women, newborns and children.[12] The primary goal of the GHI in Mali is to support the GOM in its efforts to attain Millennium Development Goals (MDG) 1 (Nutrition), 4 (Child Health), 5 (Maternal Health) and 6 (HIV/AIDS, Malaria, and other Infectious Diseases). Mali's GHI strategy[13] included several successful pilots of technical interventions and delivery approaches, which have been incorporated into the overarching Mali Health Program. These include: work with CHWs, integrated post-partum family planning to address the 70% unmet need among women who have recently given birth, a collaborative approach to improve the quality of services at CSCOMs, and the integration of the provision of long-term family planning methods at immunization days. USAID/Mali's health sector activities will continue to contribute to attainment of GHI Objective, indicators, and anticipated results (see Annex 3).

USAID Forward

The USAID Policy Framework 2011-2015 lays out the agenda for institutional reform known as USAID Forward,[14] which prepares the Agency to respond to the development challenges of the coming decades. Areas of focus include capacity building of local partners and systems, use of local country systems, developing new partnerships, an emphasis on innovation, and a renewed focus on results.

The President's Malaria Initiative (PMI)

PMI focuses on evidence-based interventions which, when scaled up, reduce the burden of child morbidity and mortality caused by malaria. PMI also serves as a platform through which to improve the delivery of integrated primary health care services while remaining focused on its core goal of reducing malaria-related mortality by 70% by the end of 2015 through 85% national coverage of pregnant women and children under five with malaria services.

USAID Water and Development Strategy (2013-2018)

The USAID Water and Development Strategy aims to save lives and advance development through improvements in water and sanitation (WASH) activities, and through sound management and use of water for food security.

Gender

In addition to adhering to the guiding principles encapsulated in the USAID Policy Framework 2011-2015, USAID Forward, and the Global Health Initiative (GHI), the activity will take into account the new USAID Gender Policy[15] to advance equality between females and males, and empower women and girls to participate fully in and benefit from development activities. Gender concerns shall be integrated into the entire activity cycle, from design and implementation to monitoring and evaluation. The recipient's approach will incorporate strategies for: i) reducing gender disparities in

[12] http://www.ghi.gov/
[13] http://www.ghi.gov/country/mali
[14] http://forward.usaid.gov/
[15] http://www.usaid.gov/what-we-do/gender-equality-and-womens-empowerment/addressing-gender-programming

access to, control over and benefit from resources, wealth, opportunities, and services; ii) reducing gender-based harmful traditional practices and mitigating their harmful effects on individuals and communities; and, iii) increasing the capability of women and girls to realize their rights, determine their life outcomes, and influence decision-making in households, communities, and societies.

Inclusive Development

USAID is committed to the inclusion of people who have physical and cognitive disabilities in line with the USAID Disability Policy. The objectives of the USAID Disability Policy are (1) to enhance the attainment of United States foreign assistance program goals by promoting the participation and equalization of opportunities of individuals with disabilities in USAID policy, country and sector strategies, activity designs and implementation; (2) to increase awareness of issues of people with disabilities both within USAID programs and in host countries; (3) to engage other U.S. government agencies, host country counterparts, governments, implementing organizations and other donors in fostering a climate of nondiscrimination against people with disabilities; and (4) to support international advocacy for people with disabilities. The full text of the policy paper can be found at the following website:

http://www.usaid.gov/about/disability/DISABPOL.FIN.html.

USAID therefore requires that the recipient not discriminate against people with disabilities in the implementation of USAID funded programs and that it makes every effort to comply with the objectives of the USAID Disability Policy in performing the activity under this award. To that end and to the extent it can accomplish this goal within the scope of the activity objectives, the recipient must demonstrate a comprehensive and consistent approach for including men, women and children with disabilities.

Innovation

Innovation is a fundamental principle under the Global Health Initiative and USAID Forward. Over the past five years a variety of innovative service delivery approaches have been tried in Mali to achieve greater utilization of services and products, and adoption of healthy behaviors. USAID's priority under this present activity is the scale up of known successful approaches. The applicant is encouraged to propose innovations that will further improve the efficiency and effectiveness of interventions being scaled up.

Resilience

For USAID, resilience is the ability of people, households, communities, countries, and systems to mitigate, adapt to, and recover from shocks and stresses in a manner that reduces chronic vulnerability and facilitates inclusive growth.[16] The guidance focuses specifically on areas where chronic poverty intersects with shocks and stresses to produce recurrent crises and undermine development gains. In these places, USAID aims to increase adaptive capacity (i.e., the ability to respond quickly and effectively to new circumstances) and improve the ability to address and reduce risk.

Partnership and Synergy

Collaboration and coordination are critical to ensure maximum impact. The recipient is expected to collaborate closely and create synergies between MHIHS activities and other development partners implementing at the local level in geographic areas covered by MHIHS. These include: i) other USAID/Mali Health activities (e.g., social and behavior change communication, social marketing, systems strengthening activities, etc.); ii) other USAID supported interventions in other sectors, such as agriculture and economic growth (e.g., Feed the Future), governance, and education; and, iii) other donors and actors in the health sector.

[16] http://www.usaid.gov/sites/default/files/documents/1870/USAIDResiliencePolicyGuidanceDocument.pdf

Human and Institutional Capacity Development (HICD)

HICD is an important function of this activity. HICD covers a wide range of subject areas and needs such as technical knowledge and skills, management and leadership, planning, budgeting, reporting, etc. The applicant will clarify in its application its HICD plan which will identify and describe the different training needs, by target group, that will be addressed, either through formal or non-formal learning strategies, under the activity. The plan will include a discussion of how the recipient intends to build the capacity of local organizations and groups such as the ASACOs, CSCOMs, CSREFs, CHWs and other local groups to improve the health status of their respective communities.

Sustainability

USAID considers sustainability to be achieved when host country partners and beneficiaries take ownership of development processes and maintain results beyond the life of an activity. Elements of sustainability include, but are not limited to:

- Health outcomes, such as the long-term ability of individuals, families, and households to adopt and maintain healthy behaviors and use of services.
- Health service characteristics, such as maintained improvements in quality, accessibility, and equity of use.
- Institutional and workforce capacity, such as maintained improvements in performance levels to achieve results or the increased effectiveness of institutions to manage, implement and evaluate activities.
- Capacity of recipient communities to design, implement and evaluate activities, or increased community ownership of and engagement in public health matters.
- Diversified and sustainable funding of health services provided by local entities.

The applicant must describe how its proposed activity will contribute to increased sustainability of intended health outcomes, characteristics of health services (e.g., quality, accessibility, equity), institutional and workforce capacity, and capacity of recipient communities.

1.4 OTHER CONSIDERATIONS

Environment Compliance

The applicant must address potential hazards to the environment in regards to the activity and interventions. **The application shall contain an environmental mitigation and monitoring plan which will address the environmental concerns especially with respect to waste management and as per instructions below.**

a) The Foreign Assistance Act of 1961, as amended, Section 117 requires that the impact of USAID's activities on the environment be considered and that USAID include environmental sustainability as a central consideration in designing and carrying out its development programs. This mandate is codified in Federal Regulations (22 CFR 216) and in USAID's Automated Directives System (ADS) Parts 201.5.10g and 204 (*http://www.usaid.gov/policy/ads/200/*), which, in part, require that the potential environmental impacts of USAID-financed activities are identified prior to a final decision to proceed and that appropriate environmental safeguards are adopted for all activities. Applicants' environmental compliance obligations under these regulations and procedures are specified in the following paragraphs of this RFA.

b) In addition, the contractor/recipient must comply with host country environmental regulations unless otherwise directed in writing by USAID. In case of conflict between host country and USAID regulations, the latter shall govern.

c) No activity funded under this assistance award will be implemented unless an environmental threshold determination, as defined by 22 CFR 216, has been reached for that activity, as documented in a Request for Categorical Exclusion (RCE), Initial Environmental Examination (IEE), or Environmental Assessment (EA) duly signed by the Bureau Environmental Officer (BEO). (Hereinafter, such documents are described as "approved Regulation 216 environmental documentation.")

d) An Initial Environmental Examination (IEE) has been approved for the program funding this RFA and can be found in the attached Annex 2 of this RFA, under component 2. The IEE covers activities expected to be implemented under this grant. USAID has determined that a categorical exclusion applies to some of the activities to be implemented under the MHIHS Activity, with no anticipated impact on the physical environment. However, USAID also determined that a **Negative Determination with conditions** applies to one or more of the activities. This indicates that if these activities are implemented subject to the specified conditions, they are expected to have no significant adverse effect on the environment. The recipient shall be responsible for implementing all IEE conditions pertaining to activities to be funded under this RFA.

e) As part of its initial Work Plan, and all Annual Work Plans thereafter, the recipient, in collaboration with the USAID Agreement Officer's Representative and Mission Environmental Officer or Bureau Environmental Officer, as appropriate, shall review all ongoing and planned activities under this award to determine if they are within the scope of the approved Regulation 216 environmental documentation.

f) If the recipient plans any new activities outside the scope of the approved Regulation 216 environmental documentation, it shall prepare an amendment to the documentation for USAID review and approval. No such new activities shall be undertaken prior to receiving written USAID approval of environmental documentation amendments.

g) Any ongoing activities found to be outside the scope of the approved Regulation 216 environmental documentation shall be halted until an amendment to the documentation is submitted and written approval is received from USAID.

h) Unless the approved Regulation 216 documentation contains a complete environmental mitigation and monitoring plan (EMMP) or a project mitigation and monitoring (M&M) plan, the recipient shall prepare an EMMP or M&M Plan describing how the recipient will, in specific terms, implement all IEE and/or EA conditions that apply to proposed project activities within the scope of the award and report on the EMMP implementation as an element of regular project performance reporting. The EMMP or M&M Plan shall include monitoring the implementation of the conditions and their effectiveness.

i) The recipient shall integrate a completed **EMMP or M&M Plan** into the initial work plan as well into subsequent annual work plans**,** making any necessary adjustments to activity implementation in order to minimize adverse impacts to the environment.

For an **exhaustive environmental compliance monitoring requirements**, refer to the IEE in Annex 2.

Cost and technical applications must reflect implementing the environmental compliance activities.

USAID's general launching point for information relating to environmental assessments and guidelines are available at: http://www.usaid.gov/our_work/environment/compliance

Branding Strategy

a. Applicants recommended for an assistance award must submit and negotiate a "Branding Strategy," describing how the program, project, or activity is named and positioned, and how it is promoted and communicated to beneficiaries and host country citizens.

b. The request for a Branding Strategy, by the Agreement Officer from the applicant, confers no rights to the applicant and constitutes no USAID commitment to an award.

c. Failure to submit and negotiate a Branding Strategy within the time frame specified by the Agreement Officer will make the applicant ineligible for an award.

d. The applicant must include all estimated costs associated with branding and marking USAID programs, such as plaques, stickers, banners, press events, materials, and so forth, in the budget portion of the application. These costs are subject to the revision and negotiation with the Agreement Officer and will be incorporated into the Total Estimated Amount of the grant, cooperative agreement or other assistance instrument.

e. The Branding Strategy must include, at a minimum, all of the following:

(1) All estimated costs associated with branding and marking USAID programs, such as plaques, stickers, banners, press events, materials, and so forth.

(2) The intended name of the program, project, or activity:

(i) USAID prefers to have the "USAID Identity," comprised of the USAID logo and brandmark, with the tagline "from the American people" as found on the USAID Web site at transition.usaid.gov/branding, included as part of the program or project name.

(ii) USAID prefers local language translations of the phrase "made possible by (or with) the generous support of the American People" next to the USAID Identity when acknowledging contributions.

(iii) It is acceptable to cobrand the title with the USAID Identity and the applicant's identity.

(iv) If branding in the above manner is inappropriate or not possible, the applicant must explain how USAID's involvement will be showcased during publicity for the program or project.

(v) USAID prefers to fund projects that do not have a separate logo or identity that competes with the USAID Identity. If there is a plan to develop a separate logo to consistently identify this program, the applicant must attach a copy of the proposed logos.

(3) The intended primary and secondary audiences for this project or program, including direct beneficiaries and any special target segments.

(4) Planned communication or program materials used to explain or market the program to beneficiaries.

(i) Describe the main program message.
(ii) Provide plans for training materials, posters, pamphlets, public service announcement, billboards, websites, and so forth, as appropriate.
(iii) Provide any plans to announce and promote publicly this program or project to host country citizens, such as media releases, press conferences, public events, and so forth. Applicant must incorporate the USAID Identity and the message, "USAID from the American People."
(iv) Provide any additional ideas to increase awareness that the American people support this project or program.

(5) Information on any direct involvement from host-country government or ministry, including any planned acknowledgement of the host-country government.

(6) Any other groups whose logo or identity the applicant will use on program materials and related materials. Indicate if they are a donor or why they will be visibly acknowledged, and if they will receive the same prominence as USAID.

f. The Agreement Officer will consider the Branding Strategy's adequacy in the award criteria. The Branding Strategy will be reviewed to ensure the above information is adequately included and consistent with the stated objectives of the award, the applicant's cost data submissions, and the performance plan.

g. If the applicant receives an assistance award, the Branding Strategy will be included in and made part of the resulting grant or cooperative agreement.

Marking Plan

a. Applicants recommended for an assistance award must submit and negotiate a "Marking Plan," detailing the public communications, commodities, and program materials, and other items that will visibly bear the "USAID Identity," which comprises of the USAID logo and brandmark, with the tagline "from the American people." The USAID Identity is the official marking for the Agency, and is found on the USAID Web site at http://transition.usaid.gov/branding.

b. The request for a Marking Plan, by the Agreement Officer from the applicant, confers no rights to the applicant and constitutes no USAID commitment to an award.

c. Failure to submit and negotiate a Marking Plan within the time frame specified by the Agreement Officer will make the applicant ineligible for an award.

d. The applicant must include all estimated costs associated with branding and marking USAID programs, such as plaques, stickers, banners, press events, materials, and so forth, in the budget portion of the application. These costs are subject to the revision and negotiation with the Agreement Officer and will be incorporated into the Total Estimated Amount of the grant, cooperative agreement or other assistance instrument.

e. The Marking Plan must include all of the following:

(1) A description of the public communications, commodities, and program materials that the applicant plans to produce and which will bear the USAID Identity as part of the award, including:

(i) Program, project, or activity sites funded by USAID, including visible infrastructure projects or other sites physical in nature;

(ii) Technical assistance, studies, reports, papers, publications, audio-visual productions, public service announcements, Web sites/Internet activities, promotional, informational, media, or communications products funded by USAID;

(iii) Commodities, equipment, supplies, and other materials funded by USAID, including commodities or equipment provided under humanitarian assistance or disaster relief programs; and

(iv) It is acceptable to cobrand the title with the USAID Identity and the applicant's identity.

(v) Events financed by USAID, such as training courses, conferences, seminars, exhibitions, fairs, workshops, press conferences and other public activities. If the USAID Identity cannot be displayed, the recipient is encouraged to otherwise acknowledge USAID and the support of the American people.

(2) A table on the program deliverables with the following details:
   (i) The program deliverables that the applicant plans to mark with the USAID Identity;
   (ii) The type of marking and what materials the applicant will use to mark the program deliverables;
   (iii) When in the performance period the applicant will mark the program deliverables, and where the applicant will place the marking;
   (iv) What program deliverables the applicant does not plan to mark with the USAID Identity , and
   (v) The rationale for not marking program deliverables.

(3) Any requests for an exemption from USAID marking requirements, and an explanation of why the exemption would apply. The applicant may request an exemption if USAID marking requirements would:

   (i) Compromise the intrinsic independence or neutrality of a program or materials where independence or neutrality is an inherent aspect of the program and materials. The applicant must identify the USAID Strategic Objective, Interim Result, or program goal furthered by an appearance of neutrality, or state why an aspect of the award is presumptively neutral. Identify by category or deliverable item, examples of material for which an exemption is sought.
   (ii) Diminish the credibility of audits, reports, analyses, studies, or policy recommendations whose data or findings must be seen as independent. The applicant must explain why each particular deliverable must be seen as credible.
   (iii) Undercut host-country government "ownership" of constitutions, laws, regulations, policies, studies, assessments, reports, publications, surveys or audits, public service announcements, or other communications. The applicant must explain why each particular item or product is better positioned as host-country government item or product.
   (iv) Impair the functionality of an item. The applicant must explain how marking the item or commodity would impair its functionality.
   (v) Incur substantial costs or be impractical. The applicant must explain why marking would not be cost beneficial or practical.
   (vi) Offend local cultural or social norms, or be considered inappropriate. The applicant must identify the relevant norm, and explain why marking would violate that norm or otherwise be inappropriate.
   (vii) Conflict with international law. The applicant must identify the applicable international law violated by the marking.

f. The Agreement Officer will consider the Marking Plan's adequacy and reasonableness in the award criteria, and will approve and disapprove any exemption requests. The Marking Plan will be reviewed to ensure the above information is adequately included and consistent with the stated objectives of the award, the applicant's cost data submissions, and the performance plan.

g. If the applicant receives an assistance award, the Marking Plan, including any approved exemptions, will be included in and made part of the resulting grant or cooperative agreement, and will apply for the term of the award unless provided otherwise.

1.5 STAFFING

The applicant is expected to provide/describe positions that are **Key** to the successful implementation and accomplishment of the Activity goals and objectives. USAID's policy limits the number of key position to no more than five positions or five percent of recipient employees working under the award, whichever is greater.

USAID/Mali views the following as illustrative profiles for possible key positions for this Activity:

Chief of Party and Deputy

Given the complexity of this project's desired results, it is anticipated that the Chief of Party (COP) and Deputy Chief of Party (DCOP) must have at least 10-15 years' experience each in managing and implementing complex public health programs. Their background and skills will complement each other. Each candidate should have at a minimum a Master's Degree in a health-related field, social services, management, international development or business administration. They should have strategic vision for the health sector, leadership qualities, professional reputation, strong interpersonal skills, and written and oral presentation skills to be able to fulfill the diverse technical and managerial requirements of the job.

Illustrative qualifications considered as significant skills increasing the likelihood of success include:

- Strong management skills and experience in running large complex public health programs.
- At least one of the candidates should have experience in program administration, financial oversight, award contractual compliance, sub-award management.
- Candidates' combined experience should include past work as a mid-level or senior staff in at least five of the following technical areas and good knowledge of the salient issues in the other areas: i) reproductive health and family planning; ii) maternal health, newborn and infant care; iii) child health; iv) nutrition, water and sanitation; v) malaria prevention and treatment; vi) HIV/AIDS prevention and testing; vii) health systems strengthening; viii) quality improvement/quality assurance; ix) procurement and supply chain management; x) public sector and civil society capacity building; xi) behavior change interventions; xii) monitoring and evaluation and/or operations research.
- Each candidate should have demonstrated skills in English and French at minimum FSI-III level.

Senior Technical Advisor, Behavioral Interventions and Communications

Minimum of seven years of experience in implementing behavior change interventions and communications activities in developing or middle income countries. S/he must have at a minimum a Master's Degree in health or social sciences, or a related advanced degree relevant to the field of public health. The Senior Technical Advisor, Behavioral Interventions and Communications will have at least five years demonstrated state-of-the-art experience in at least four of the following areas: the design of behavioral interventions/social and behavior change communications messages and interventions; the application of the behavioral sciences in program design, implementation, monitoring, and evaluation; SBCC programs targeting the general population; SBCC programs targeting key or vulnerable populations; community-based SBCC program development and implementation; work on gender issues, e.g., gender equity, gender-based violence; the use of epidemiological and other health-related data in SBCC program design, implementation, monitoring, and evaluation; SBCC-related qualitative research. S/he must have at least three years' experience in managing and supervising a team. S/he should have language skills in English and French at minimum FSI-III level or equivalent.

Senior Technical Advisor, Integrated Health Services

Minimum seven years of experience in implementing national, multi-disease health activities in developing or middle income countries. S/he must have at a minimum a Master's Degree in health

or social sciences, or a related advanced degree relevant to the field of public health. S/he will have at least five years demonstrated state-or-the-art experience in at least four of the following areas: clinical malaria programs; community malaria/family planning/maternal and child health programs; testing and counseling for HIV and/or prevention of mother to child transmission of HIV; quality improvement/quality assurance; gender; and the use of epidemiological and other health-related data in program design, implementation, monitoring, and evaluation. At least three years demonstrated experience in managing and supervising a team. S/he should have demonstrated skills in English and French at minimum FSI-III level.

Senior Technical Advisor, Monitoring and Evaluation

An advanced degree in a relevant discipline, and at least seven years of experience designing and implementing monitoring and evaluating activities and special studies for complex programs in developing countries. S/he must have a firm command of monitoring and evaluation methodologies and very knowledgeable about issues related to integrated health services and support programs. S/he must have experience in setting up and managing monitoring and evaluation systems that track performance as sub-results/results and by funding stream. S/he must have demonstrable analytical skills to measure program outcomes and support program supervision. S/he must have strong writing and organizational skills for monitoring and reporting on program and study results. S/he should have language skills in English and French at minimum FSI-III level or the equivalent.

The applicant has the discretion to determine the proper number and mix of additional personnel, short-term technical staff and others to meet program requirements to be described in the application. Engagement of qualified Malian professionals is encouraged whenever possible. It is critical that staff skills and roles complement each other since teamwork is essential to the successful implementation of this activity.

1.6 MONITORING & EVALUATION AND RESEARCH

Monitoring of results is a key element of USAID programs. USAID seeks data and information to improve performance and effectiveness as well as to inform planning and management decisions. Accurate and timely monitoring will enable this Activity to improve approaches, adapt to changing conditions and make mid-course corrections as necessary.

Monitoring and Evaluation (M&E)

The application will provide a monitoring and evaluation plan that covers the life of the activity with clear benchmarks and indicators that would permit tracking, evaluating, and reporting on progress and achievement of the results. It will also include a methodology for monitoring gender impact, including incorporation of gender-sensitive indicators. The M&E plan shall use data from the DHS 2012-2013 as baseline for indicators. Sources used to set baseline for other indicators (not included in DHS) shall be cited.

Indicators and annual targets in the M&E Plan will directly relate to the technical assistance, material support and capacity-building envisioned under the Activity, and will be designed to feed directly into USAID's overall Performance Management Plan (PMP) for Strategic Objective 6, "Increased Use of High-Impact Health Services." The M&E Plan shall present: i) measurable, achievable and time-phased benchmarks and indicators with clear links to the national-level indicators specified in Section 1.3 of this RFA and in USAID/Mali's overall Performance Management Plan (PMP)[17] (see Annex 3); ii) expected programmatic outcomes and outputs; iii) methodologies to be employed in collecting, analyzing and reporting on different types of data (quantitative and qualitative); iv) a timetable for routine data collection as well as for any proposed ad hoc studies or surveys; v) a discussion of how results of routine M&E will be used to improve Activity implementation, and to inform future plans and strategies; and, vi) clearly link to the relevant indicators in USAID/Mali's overall Health Program PMP.

[17] USAID's PMP will be updated when the final version of the 2012-2013 DHS is available

If the activity involves untested hypotheses or aims to demonstrate new approaches that are anticipated to be expanded in scale or scope, an impact evaluation must be planned as per USAID's Evaluation Policy.[18] And, while the applicant may wish to conduct its own mid-term and final evaluations, it should be noted that USAID/Mali intends to contract separately with an external entity to conduct both a mid-term and final evaluation of the USAID/Mali health portfolio, including the MHIHS II activity.

Special Studies

This activity presents an excellent opportunity to study different aspects of integrated service delivery at the community level. USAID anticipates that the recipient will conduct three to five studies over the life of the program. The applicant will propose and discuss study topics to be conducted. Topics must be practical, solution-oriented and clearly linked to critical aspects of the program.

The proposed studies, including plans for the dissemination of results, will be included in the applicant's workplan/implementation plan. Potential topics include but are not limited to the study of: the role and effects of private community-based health providers on the use and cost recovery of CSCOMs; incentives for community health workers; the role of mobile technology for improving quality of care and/or changing health behaviors; and the introduction of expanded neonatal care (or another new high-impact health service) into the integrated package of care. It is expected that at least one study activity will fit the definition of "impact evaluation" as defined in the USAID Evaluation Policy.[19]

[18] www.usaid.gov/evaluation/policy
[19] www.usaid.gov/evaluation/policy

SECTION 2 – ELIGIBILITY INFORMATION

2.1 ELIGIBLE APPLICANTS

USAID policy encourages competition in the award of grants and cooperative agreements. In response to this RFA, any U.S. or international organization, private voluntary organization, non-profit, or for-profit entity (willing to forego profit) is eligible to apply.

Pursuant to 22 CFR 226.81, it is USAID policy not to award profit under assistance instruments. Therefore, no fee is allowed. However, all reasonable, allocable, and allowable expenses, both direct and indirect, which are related to the grant program and are in accordance with applicable cost standards, may be paid under the grant. In the absence of a properly supported indirect cost rate (i.e. by a valid audit), all costs shall be direct charges.

In addition, the successful applicant must receive a positive responsibility determination from the USAID Agreement Officer prior to receiving an award. Details on USAID's pre-award responsibility determination policy and procedure can be found on the agency website, in its automated directive system (ADS) chapter 303: http://www.usaid.gov/policy/ads/300/303.pdf.

2.2 COST SHARING AND LEVERAGING RESOURCES

There is **no** requirement of cost share under this RFA. However, cost share is strongly encouraged as stated in section 4.2. Any cost share commitment must be included in the budget.

Applicants are also encouraged to identify other third parties' resources to complement the activity and explain in their application the added value they bring. Such funding may come from many sources including privately generated funds, commodities, or other resources made available by other bilateral donors, private foundations, or multilateral donors.

SECTION 3 – APPLICATION FORMAT AND SUBMISSION INSTRUCTIONS

All applications shall be submitted electronically to the address and by the deadline specified on the cover page. Applications will be reviewed for responsiveness to the above Funding Opportunity, in accordance with the guidelines below and the evaluation criteria defined in Section 4.

3.1. TECHNICAL APPLICATION

The technical application is the most important item of consideration and must be specific, complete and presented concisely. It shall be submitted in English and be a maximum of 25 pages, single space on standard A4 or letter and in standard font and size. The application shall demonstrate the applicant's capabilities and expertise with respect to achieving the goals of this Activity and fully respond to the technical evaluation criteria.

The following items are not included in the above page limitation:

- Cover Page;
- Executive Summary
- Table of Contents;
- Acronym list;
- Dividers;
- Resumes and references per section
- Management structure, charts (such as organizational charts), or labor distribution chart;
- Past Performance Report;
- Work Plan, Implementation or Monitoring Plans;
- Branding and Marking Plans.

The application will contain the following sections, as more fully explained below.

1. Cover Page (1 page maximum – not included in the page limit)

A single page that includes project title, RFA number, the name of the organization(s) submitting application, contact person, telephone and fax numbers, e-mail, and address. Any proposed sub-grantees (or implementing partners) must be listed separately. If applicable, the TIN (Tax Identification Number) and DUNS (Data Universal Numbering System) must also be listed on the cover page.

2. Executive Summary (3 pages maximum – not included in the page limit)

The applicant will briefly describe the technical approach, activities, goals, purposes, and anticipated results. The Executive Summary will also briefly describe the technical and managerial resources of the applicant’s organization and describe how the overall activity will be managed.

3. Technical Approach (included in the page limit)

The application will provide a clear overall vision and operational strategy to achieve the expected results of the activity. This will include the applicant’s analysis of the important challenges in the health sector in Mali, the complexity of the current situation and the challenges of programming and/or service provision in the target regions. USAID expects the applicant to utilize its expertise and experience in designing evidence-based approaches and interventions for addressing the challenges at the regional, district and community levels. The Applicant will not only propose activities to be performed, but also explain the rationale for prioritizing, sequencing, and scaling-up different activities by region and district over time.

Coordination with other USAID and other partners funded activities is important. The applicant should clearly demonstrate its approach for building on the successes and lessons learned from

previous approaches including past and current USAID and other donor health programs and scale up those that have been most effective for improving quality and expanding services at different levels of the health structure and in different settings.

The application must demonstrate a sophisticated understanding of gender and how potential imbalance with regards to gender can best be addressed in programming and propose meaningful approaches to address gender, girls' and women empowerment, as well as constructive engagement of men.

The applicant will include in an annex a draft illustrative implementation plan (including a narrative) which details activities towards achieving the results, a timeline, partners and resources (including human resources) required for implementing the activity and consistent with the applicant's technical approach. The plan shall also be clear on how the applicant will ensure a rapid-start-up and cost-effective operations. The expectation is that the activity will be operational within 60 days of the award. The proposed implementation plan will cover the life of the activity and include a more detailed first-year annual workplan. The workplan will include the plan for the roll-out of interventions. Furthermore, in accordance with the Environmental compliance section of the RFA, the applicant shall provide as part of its initial workplan and all subsequent annual workplans a completed Environmental Mitigation and Monitoring Plan describing how it will implement all Initial Environmental Examination (IEE) conditions that apply to the proposed activities.

In addition, the applicant is expected to provide an illustrative monitoring and evaluation plan that will demonstrate how the applicant will establish baselines and targets, and measure progress towards the stated targets and objectives. The final work plan and M&E plan will be completed within 30 days of award.

The application shall also provide a sustainability plan which will be clear on how the activity will build on and expand existing platforms to foster stronger systems and sustainable results. The technical discussion should include arrangements for effective and complimentary operations among partner organizations and the Government of Mali, including linkages to existing networks, structures, and resources. USAID/Mali strongly encourages the applicant to fully integrate the local skills, capabilities and expertise in a substantive way.

4. Organizational Capacity, Management Plan, and Staffing (included in the page limit)

The applicant will provide evidence of its organization's technical resources, expertise and capacity for implementing similar programs. In addition, it will provide as part of its application a Management Plan that provides assurance that the activity will be managed in a professional, efficient and collaborative manner to achieve the stated objectives and results. The Management Plan will describe how the applicant will employ streamlined management strategies and procedures to reduce overall operational costs, ensure adequate controls over the activity commodities, equipment and supplies, and respond appropriately and in a timely manner to both programmatic and operational demands. The Management plan will specify the organizational structure and composition of the Activity team (including home office support and other long and short term technical assistance – STTA) and describe the roles and responsibilities of proposed staff members. It will include: i) Staffing Plan for Bamako headquarters and field offices, complete with an organizational chart depicting relationships between headquarters and regional offices, and between staff positions; ii) a description of US-based home office staff roles and responsibilities (for prime and partners), lines of authority and communication with Mali-based team; iii) management and communication modalities between prime and partner organizations (US and local) and staff; iv) HR plans/procedures for managing multi-partner staff; v) envisioned interactions between Bamako headquarters and field offices, including measures and procedures to ensure that management is always up-to-date on activities and issues at all sites; and vi) the strategy for establishing and supporting regional offices. The Management Plan will also describe how the applicant will handle relationships with the respective MOH Regional Offices and with the other partners which will be using the same office space as the recipient.

The applicant must include resumes and full job descriptions of proposed Key Personnel and other important managerial and technical personnel to be assigned to this activity, including a minimum of three (3) references with email addresses. Proposed personnel not yet identified may be shown as "TBD" (to be determined).

The applicant is expected to include as part of its application a letter of commitment signed by each person proposed as key personnel confirming their present intention to serve in the stated position immediately upon award and their availability to serve for the term of the proposed award.

CVs or resumes, Letters of Commitment of proposed Key Personnel and other important managerial and technical personnel to be assigned to this activity, including a minimum of three (3) references with email addresses will be provided as attachments and not count toward the 25 page limit.

5. Past performance (included in the page limit except as noted below)

This section will provide a description of the applicant's and prospective sub-partners' previous work and experience with respect to the proposed activity especially in regards to the following areas:

- Strengthening the delivery of community-based integrated services and behavior change communication interventions;
- Improving quality of care and motivation of community and facility-based health workers and volunteers;
- Partnering with and building the capacity of local authorities, associations, community organizations and groups;
- Strengthening governance and accountability at the decentralized level.

The applicant will also provide record of relevant past performance for up to five projects implemented over the past three years which best illustrate the applicant's (and any partners') performance and include the performance location, award number (if available), a brief description of the work performed, and a point of contact list with current telephone numbers. This information can be provided as part of the attachments and will not count towards the page limitation.

It is recommended that the applicant alert the contacts that their names have been submitted and that they are authorized to provide past performance information when requested.

In addition to the technical quality of the applicant's performance, the assessment of past performance will include project management, customer satisfaction, cost control and quality of home office support.

USAID may contact references and use the past performance data, along with other information, to determine the applicant's responsibility. The Government reserves the right to obtain information for use in the evaluation of past performance from sources inside or outside the Government.

3.2. COST APPLICATION

The Cost Application is to be submitted as a separate document from the technical application and shall be formatted in Microsoft Excel and be in US dollars ($). The Cost Application shall include a summary budget by year for the proposed activity and a detailed budget. The budget shall provide uses of USAID funds and the proposed cost share.

The detailed budget with an accompanying budget narrative in MS Word shall facilitate USAID's determination that costs are allowable, allocable and reasonable. While there is no page limit, applicants are encouraged to be as concise as possible. Budget notes and supporting narratives must provide further clarification to the proposed budget. The budget must be also submitted using

Standard Form 424 and 424A which can be downloaded from the USAID web site: http://www.usaid.gov/procurement_bus_opp/procurement/forms/sf424/

The budget shall include:

(a) The breakdown of all costs associated with the activity according to costs of, if applicable, headquarters, regional and/or country offices;
(b) The breakdown of all costs according to each partner organization or sub-recipient/sub-grantee involved in the activity;
(c) The costs associated with external, expatriate technical assistance and those associated with local in-country technical assistance;
(d) The breakdown of the financial and in-kind contributions of all organizations involved in implementing the proposed program;
(e) Potential contributions of non-USAID or private commercial donors to the activity;
(f) A procurement plan for commodities.

Usually, the cost application contains the following budget categories and supporting notes:

(a) Salary and Wages: Direct salaries and wages will be proposed in accordance with the Applicant's personnel policies. Budget narrative must explain how daily rates are calculated and whether based on established written policies of the organization or market surveys.
(b) Fringe Benefits: If the applicant has a fringe benefit rate that has been approved by an agency of the U.S. Government, such rate will be used and evidence of its approval should be provided (e.g. copy of NICRA). If a fringe benefit rate has not been so approved, the application may propose a rate and explain how the rate was determined. If the latter is used, the narrative must include a detailed breakdown comprised of all items of fringe benefits (e.g., unemployment insurance, workers compensation, health and life insurance, retirement, FICA, etc.) and the costs of each, expressed in dollars and as a percentage of salaries.
(c) Travel and Transportation: The application will indicate the number of trips, domestic, regional, and international, and the estimated costs. Specify the origin and destination for proposed trips, duration of travel, and number of individuals traveling. Per Diem must be based on the applicant's normal travel policies and will be assessed as part of cost effectiveness.
(d) Equipment: The application must justify the need, type, the number and price of equipment items to be procured.
(e) Supplies: The application must justify the need and quantities of supply items related to this activity.
(f) Sub-grants: The application must be clear about any sub-grants to be used.
(g) Other Direct Costs: This includes communications, report preparation costs, passports, visas, medical exams and inoculations, insurance (other than insurance included in the applicant's fringe benefits), office rent, etc. The narrative must provide a breakdown and support for all other direct costs;
(h) Indirect Costs: The Applicant must support the proposed indirect cost rate with a letter from a cognizant U.S. Government audit agency, a Negotiated Indirect Cost Agreement (NICRA), or with sufficient information (e.g. audited financial statements) for USAID to determine the reasonableness of the rates (For example, a breakdown of labor bases and overhead pools, the method of determining the rate, etc.). In the absence of adequate supporting documentations, all costs shall be direct.

Cost Sharing: The proposed cost share shall be reflected in the cost application. Cost sharing plan will be discussed in the Budget Notes to the extent necessary to determine its feasibility and realistic access to the sources and funds.

Required Certifications and Representation: All Certifications and Representations found under Section 6 must be completed and submitted with the cost application.

SECTION 4 – EVALUATION CRITERIA

The criteria found in this section are the criteria by which all applications will be individually evaluated. The criteria are listed in descending order of importance. For the purpose of this RFA, technical considerations are more important than cost.

The application must contain the Applicant's best terms from both technical and cost standpoints. USAID reserves the right, but is not under obligation, to enter into discussions with one or more applicants in order to obtain clarifications, additional details, or to suggest refinements in the proposed Activity, budget, or other aspects of an application, if doing so is determined to be in the best interest of the U.S. Government.

4.1 TECHNICAL EVALUATION CRITERIA

Technical Approach

The technical approach will be evaluated on the overall merit (creativity, clarity, analytical depth, state-of-the-art technical knowledge and responsiveness) and feasibility of the approach and strategies proposed to achieve the activity's objective and results based on the following:

Overall Technical Approach

- Overall technical approach is innovative, appropriate to the culture and context of Mali and builds on USAID's current and past accomplishments. The approach conveys a deep understanding of how to work effectively at the community level in Mali with a large number of different entities and likelihood that proposed activities will help achieve the overall objectives and results expected for this activity.

- The extent to which the approach reflects a good understanding of GOM/MOH applicable regulations, policies, norms and procedures as well as USAID's guiding principles in the design and execution of activities (gender, partnerships and synergies, human and institutional capacity building and sustainability).

- Application presents appropriate strategies and plans for addressing gender disparities and for achieving behavior changes, improved integrated service delivery, and systems strengthening results in the five different target regions based on the unique and specific health concerns and needs of each target region.

- Application plans include appropriate capacity building-strategies for local systems, individuals and institutions, including those at the regional, district, and community levels.

Implementation, workplans and M&E Plan

- Application presents an ambitious and realistic implementation plan and schedule for coordinating and phasing in service quality improvement activities and systems strengthening interventions, district by district in each of the target regions. A sound mobilization schedule that demonstrates ability and commitment to mobilize activities rapidly after award execution.

- The soundness of the M&E Plan; the plan should encompass all MHIHS II activities/interventions and presents (i) relevant, measurable indicators and appropriate benchmarks to gauge activity progress in a timely manner and iii) appropriate plans for reporting and dissemination of results.

Organizational capacity, Management Plan and Staffing

Evaluation under this factor will focus on the quality of overall staffing plan, the proposed key personnel as well as the management approach, which together support the activity's ability to achieve desired outcomes.

- Demonstrated capacity to manage a complex program.

- A solid, streamlined management plan that provides a clear statement of organizational structure, mission and objectives contributing to achievement of the proposed activities. The plan must be clear on how a decentralized management approach (small headquarters office based in Bamako and three to four regional offices) will work efficiently and effectively to maximize both programmatic and operations resources and minimize costs. A proposed organizational structure that addresses all required technical assistance areas and maximizes the comparative advantage of key partners and staff.

- A clear description of roles and responsibilities, internal and external communication arrangements (i.e., within the local office as well as with home office backstops, if applicable).

- Strengths and qualifications of the candidates proposed for Key Personnel positions. Responsiveness of overall staffing pattern to ensure that all technical and management requirements are covered by appropriately skilled and adequate number of staff or STTA as the case may be. A staffing mix (including key and non-key personnel and short-term technical assistance) that creatively optimizes the use of resources to successfully undertake the proposed approach.

Past Performance

- Demonstrated relevant technical and field experience
- Quality of performance in programs of similar technical content and scope in West Africa.

4.2 COST AND OTHER FACTORS

Cost Effectiveness and Cost Realism

Cost will be evaluated on the basis of reasonableness, and realism. Cost realism will be based on the following considerations:

a) Are proposed costs realistic for the work to be performed under this award?
b) Do the costs reflect a clear understanding of the Activity requirements?
c) Are the costs consistent with the various elements of the applicant's technical application?

Cost Share

Non-Federal cost sharing/leveraging will be considered in relation to the added value it represents to the overall Activity and sustainability and may be recognized as a factor that results in a higher level of quality of performance.

Branding Strategy and Marking Plan

USAID will request and evaluate a branding strategy and marking plan from apparently successful applicants only. This evaluation will not be part of the competitive evaluation set forth in this section and will aim to ensure that applicants have a reasonable strategy for Branding and Marking for the Activity.

4.3 EVALUATION SYSTEM

The following adjectival scoring system will be used by the technical evaluation committee to assess each of the technical criteria and sub-criteria as well as the technical application as a whole:

"Outstanding"	**O**	Very significantly exceeds most or all solicitation requirements. Response exceeds a "Better" rating. The applicant has clearly demonstrated an understanding of all aspects of the requirements to the extent that timely and highest quality performance is anticipated.
"Better"	**B**	Fully meets all solicitation requirements and significantly exceeds many of the solicitation requirements. Response exceeds an "Acceptable" rating. The areas in which the applicant exceeds the requirements are anticipated to result in a high level of efficiency or productivity or quality.
"Acceptable"	**A**	Meets all solicitation requirements. Complete, comprehensive, and exemplifies an understanding of the scope and depth of the solicitation requirements.
"Marginal"	**M**	Less than "Acceptable." There are some deficiencies in the technical application. However, given the opportunity for discussions, it has a reasonable chance of becoming at least "Acceptable." (Areas of an application which remain to be "Marginal" after "Final application Revision" shall not be subject to further discussion or revision.) If award is made on the initial applications, there will not be an opportunity for discussions nor a chance to become at least "Acceptable."
"Unacceptable"	**U**	Application has many deficiencies and/or gross omissions: failure to provide a reasonable, logical approach to fulfilling much of the expected results and solicitation requirements; failure to come up with an adequate management /staffing plan. When applying this adjective to the technical application as a whole, the technical application must be so unacceptable in one or several areas that it would have to be significantly revised to attempt to make it other than acceptable.

SECTION 5 – AWARD AND ADMINISTRATION INFORMATION

5.1 EXPECTED FUNDING LEVEL AND PERIOD OF PERFORMANCE

USAID expects to award one (1) Cooperative Agreement not exceeding $45,000,000, as the result of this RFA. The anticipated period of performance is five (5) year with implementation expected to begin o/a October 01, 2014.

5.2 MANAGEMENT AND ADMINISTRATION OF AWARDS

Depending on the type of recipient, the award resulting from this RFA may be administered in accordance with Standard provisions for U.S. Nongovernmental organizations found at http://www.usaid.gov/pubs/ads/300/303maa.pdf or in accordance with the Standard provisions for Non-U.S. Nongovernmental organizations available at: http://www.usaid.gov/pubs/ads/300/303mab.pdf.

The Agreement Officer is the only individual who may legally commit the Government. No costs chargeable to the proposed award may be incurred before receipt of either a fully executed award or a specific written authorization from the Agreement Officer. An Agreement Officer's Representative (AOR) will be designated to serve as the primary contact between USAID and the recipient. S/He will monitor activities to ensure that defined objectives and results are met.

5.3 SUBSTANTIAL INVOLVEMENT

USAID may be substantially involved in the following areas with a cooperative agreement:

- USAID approval of the recipient's Annual Work/Implementation Plans
- USAID approval of key personnel funded under the agreement (limited to five positions) or five percent of the recipient's total team size (whichever is greater)
- USAID approval of the Activity's Monitoring and Evaluation (M&E) Plans
- Approval of sub-award recipients, and concurrence on the substantive provisions of the sub-awards; and coordination with other cooperating agencies.
- Agency and recipient joint participation including selection of advisory committee members.

5.4 REPORTING

Financial Reporting

The recipient shall account for expenditures for activities carried out under this project to ensure funds are used for their intended purposes. Financial reports shall be in accordance with 22 CFR226.52.

(a) Quarterly Report: The recipient must submit an SF 425, the Federal Financial Report, via electronic format to the U.S. Department of Health and Human Services (http://www.dpm.psc.gov) within 30 calendar days following the end of each quarter. A copy of this form shall be simultaneously submitted to the Agreement Officer's Representative (AOR) and the USAID/Mali Financial Management Office.

(b) Final Report: The recipient must submit within 90 calendar days following the estimated completion date of this award and, in accordance with 22 CFR 226.70 – 72, the original and three (3) copies of the final Federal Financial Reports (SF-425) to: (a) USAID/Washington, M/CFO/CMP-LOC Unit; (b) the Agreement Officer (bamakoaao@usaid.gov); (c) the Agreement Officer's Representative (AOR). The electronic version of the final SF 425 must be submitted to the U.S. Department of Health and Human Services (http://www.dpm.psc.gov) in accordance with paragraph (a) above.

In case, the recipient does not have a Letter of Credit (LOC), reporting will be done using SF 1034 at a frequency to be defined at award time.

Periodic Performance Reporting

- **Quarterly Progress Reports**

  The implementing partner will prepare and submit to the Agreement Officer Representative (AOR) a quarterly report within 30 days after the end of each USG fiscal quarter with the exception of the quarter ending September 30 of each year, when an Annual Report will be required.

  Over the life of the activity, the recipient will be requested to provide at least three "success stories" per year based on results to date as well as ad hoc reports on activities as USAID may require from time to time (e.g., in response to requests from USAID/W or other interested parties). USAID will also require the recipient's assistance in compiling the annual Family Planning Compliance Report.

- **Annual Workplan**

  Annual Workplans shall be required of the recipient that will detail the work to be accomplished during the upcoming year. The first year draft workplan is due with the application and will be finalized 30 days after start of Agreement. Annual workplans thereafter are due one month prior to the start of the following year of implementation and will be approved by the AOR.

  The environment monitoring and mitigation plan shall be submitted along with the workplan.

- **Activity Monitoring and Evaluation Plan**

  The applicant shall submit a draft M&E plan with the application which will be finalized within 30 days after the award. Updates to the M&E Plan can be made annually in collaboration with USAID.

- **Final Report**

  Pursuant to 22 CFR 226.51(b), a final performance report will be required under this award within ninety (90) days following the estimated completion date of the Agreement.

- **Close-out Plan**

  Three months prior to the completion date of the Cooperative Agreement, the recipient shall submit a Close-out Plan to the Agreement Officer and AOR. The close-out plan shall include, at a minimum, an illustrative property disposition plan; a plan for phase out of in-country operations; a delivery schedule for all reports or other deliverables required under the Agreement; and a timeline for completing all required actions in the Plan.

SECTION 6 – REQUIRED CERTIFICATIONS, ASSURANCES, OTHER STATEMENTS OF APPLICANT

PART I CERTIFICATIONS AND ASSURANCES

1. Certification Regarding Lobbying

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal Cooperative Agreement, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, United States Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

2. Statement for Loan Guarantees and Loan Insurance

“The undersigned states, to the best of his or her knowledge and belief, that: If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.”

3. Prohibition on Assistance to Drug Traffickers for Covered Countries and Individuals (ADS 206)

USAID reserves the right to terminate this Agreement, to demand a refund or take other appropriate measures if the Grantee is found to have been convicted of a narcotics offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140. The undersigned shall review USAID ADS 206 to determine if any certifications are required for Key Individuals or Covered Participants.

If there are COVERED PARTICIPANTS: USAID reserves the right to terminate assistance to or take other appropriate measures with respect to, any participant approved by USAID who is found to have been convicted of a narcotics offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140.

4. Certification Regarding Terrorist Financing, Implementing Executive Order 13224

By signing and submitting this application, the prospective recipient provides the certification set out below:

1. The Recipient, to the best of its current knowledge, did not provide, within the previous ten years, and will take all reasonable steps to ensure that it does not and will not knowingly provide, material support or resources to any individual or entity that commits, attempts to commit, advocates, facilitates, or participates in terrorist acts, or has committed, attempted to commit, facilitated, or participated in terrorist acts, as that term is defined in paragraph 3.

2. The following steps may enable the Recipient to comply with its obligations under paragraph 1:

a. Before providing any material support or resources to an individual or entity, the Recipient will verify that the individual or entity does not (i) appear on the master list of **Specially Designated Nationals and Blocked Persons**, which is maintained by the U.S. Treasury's Office of Foreign Assets Control (OFAC), or (ii) is not included in any supplementary information concerning prohibited individuals or entities that may be provided by USAID to the Recipient.

b. Before providing any material support or resources to an individual or entity, the Recipient also will verify that the individual or entity has not been designated by the United Nations Security (UNSC) sanctions committee established under UNSC Resolution 1267 (1999) (the "1267 Committee") [individuals and entities linked to the Taliban, Usama bin Laden, or the Al Qaida Organization]. To determine whether there has been a published designation of an individual or entity by the 1267 Committee, the Recipient should refer to the consolidated list available online at the Committee's website: **http://www.un.org/Docs/sc/committees/1267/1267ListEng.htm**.

c. Before providing any material support or resources to an individual or entity, the Recipient will consider all information about that individual or entity of which it is aware and all public information that is reasonably available to it or of which it should be aware.

d. The Recipient also will implement reasonable monitoring and oversight procedures to safeguard against assistance being diverted to support terrorist activity.

3. For purposes of this Certification:

a. "Material support and resources" means currency or monetary instruments or financial securities, financial services, lodging, training, expert advice or assistance, safehouses, false documentation or identification, communications equipment, facilities, weapons, lethal substances, explosives, personnel, transportation, and other physical assets, except medicine or religious materials."

b. "Terrorist act" means-

(i) an act prohibited pursuant to one of the 12 United Nations Conventions and Protocols related to terrorism (see UN terrorism conventions Internet site: **http://untreaty.un.org/English/Terrorism.asp**); or

(ii) an act of premeditated, politically motivated violence perpetrated against noncombatant targets by subnational groups or clandestine agents; or

(iii) any other act intended to cause death or serious bodily injury to a civilian, or to any other person not taking an active part in hostilities in a situation of armed conflict, when the purpose of such act, by its nature or context, is to intimidate a population, or to compel a government or an international organization to do or to abstain from doing any act.

c. "Entity" means a partnership, association, corporation, or other organization, group or subgroup.

d. References in this Certification to the provision of material support and resources shall not be deemed to include the furnishing of USAID funds or USAID-financed commodities to the ultimate beneficiaries of USAID assistance, such as recipients of food, medical care, micro-enterprise loans, shelter, etc., unless the Recipient has reason to believe that one or more of these beneficiaries commits, attempts to commit, advocates, facilitates, or participates in terrorist acts, or has committed, attempted to commit, facilitated or participated in terrorist acts.

e. The Recipient's obligations under paragraph 1 are not applicable to the procurement of goods and/or services by the Recipient that are acquired in the ordinary course of business through contract or purchase, e.g., utilities, rents, office supplies, gasoline, etc., unless the Recipient has reason to believe that a vendor or supplier of such goods and services commits, attempts to commit, advocates, facilitates, or participates in terrorist acts, or has committed, attempted to commit, facilitated or participated in terrorist acts.

This Certification is an express term and condition of any agreement issued as a result of this application, and any violation of it shall be grounds for unilateral termination of the agreement by USAID prior to the end of its term.

5. Certification of Recipient

By signing below the recipient provides certifications and assurances for (1) the Certification Regarding Lobbying, (2) the Prohibition on Assistance to Drug Traffickers for Covered Countries and Individuals (ADS 206) and (3) the Certification Regarding Terrorist Financing Implementing Executive Order 13224 above.

These certifications and assurances are given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts, or other Federal financial assistance extended after the date hereof to the recipient by the Agency, including installment payments after such date on account of applications for Federal financial assistance which was approved before such date. The recipient recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in these assurances, and that the United States will have the right to seek judicial enforcement of these assurances. These assurances are binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign these assurances on behalf of the recipient.

RFA/APS No. _____

Application No. _____

Date of Application _____

Name of Recipient _____

Typed Name and Title _____

Signature _____

Date _____

PART II – KEY INDIVIDUAL CERTIFICATION NARCOTICS OFFENSES AND DRUG TRAFFICKING

I hereby certify that within the last ten years:

1. I have not been convicted of a violation of, or a conspiracy to violate, any law or regulation of the United States or any other country concerning narcotic or psychotropic drugs or other controlled substances.

2. I am not and have not been an illicit trafficker in any such drug or controlled substance.

3. I am not and have not been a knowing assistor, abettor, conspirator, or colluder with others in the illicit trafficking in any such drug or substance.

Signature: _____

Date: _____

Name: _____

Title/Position: _____

Organization: _____

Address: _____

_____

Date of Birth: _____

NOTICE:

1. You are required to sign this Certification under the provisions of 22 CFR Part 140, Prohibition on Assistance to Drug Traffickers. These regulations were issued by the Department of State and require that certain key individuals of organizations must sign this Certification.

2. If you make a false Certification you are subject to U.S. criminal prosecution under 18 U.S.C. 1001.

PART III – PARTICIPANT CERTIFICATION NARCOTICS OFFENSES AND DRUG TRAFFICKING

1. I hereby certify that within the last ten years:

a. I have not been convicted of a violation of, or a conspiracy to violate, any law or regulation of the United States or any other country concerning narcotic or psychotropic drugs or other controlled substances.

b. I am not and have not been an illicit trafficker in any such drug or controlled substance.

c. I am not or have not been a knowing assistor, abettor, conspirator, or colluder with others in the illicit trafficking in any such drug or substance.

2. I understand that USAID may terminate my training if it is determined that I engaged in the above conduct during the last ten years or during my USAID training.

Signature: _____

Name: _____

Date: _____

Address: _____

_____

Date of Birth: _____

NOTICE:

1. You are required to sign this Certification under the provisions of 22 CFR Part 140, Prohibition on Assistance to Drug Traffickers. These regulations were issued by the Department of State and require that certain participants must sign this Certification.

2. If you make a false Certification you are subject to U.S. criminal prosecution under 18 U.S.C. 1001.

Part IV – SURVEY ON ENSURING EQUAL OPPORTUNITY FOR APPLICANTS

Applicability: All RFA's must include the attached Survey on Ensuring Equal Opportunity for Applicants as an attachment to the RFA package. Applicants under unsolicited applications are also to be provided the survey. (While inclusion of the survey by Agreement Officers in RFA packages is required, the applicant's completion of the survey is voluntary, and must not be a requirement of the RFA. The absence of a completed survey in an application may not be a basis upon which the application is determined incomplete or non-responsive. Applicants who volunteer to complete and submit the survey under a competitive or non-competitive action are instructed within the text of the survey to submit it as part of the application process.)

Survey on Ensuring Equal Opportunity for Applicants

PART V – OTHER STATEMENTS OF RECIPIENT

1. Authorized Individuals

The recipient represents that the following persons are authorized to negotiate on its behalf with the Government and to bind the recipient in connection with this application or grant:

Name Title Telephone No. Facsimile No.

_____

_____

2. Taxpayer Identification Number (TIN)

If the recipient is a U.S. organization, or a foreign organization which has income effectively connected with the conduct of activities in the U.S. or has an office or a place of business or a fiscal paying agent in the U.S., please indicate the recipient's TIN:

TIN: _____

3. Data Universal Numbering System (DUNS) Number

(a) Unless otherwise specified in the solicitation using an applicable exemption, in the space provided at the end of this provision, the recipient should supply the Data Universal Numbering System (DUNS) number applicable to that name and address. Recipients should take care to report the number that identifies the recipient's name and address exactly as stated in the proposal.

(b) The DUNS is a 9-digit number assigned by Dun and Bradstreet Information Services. If the recipient does not have a DUNS number, the recipient should call Dun and Bradstreet directly at 1-800-333-0505. A DUNS number will be provided immediately by telephone at no charge to the recipient. The recipient should be prepared to provide the following information:

(1) Recipient's name.
(2) Recipient's address.
(3) Recipient's telephone number.
(4) Line of business.
(5) Chief executive officer/key manager.
(6) Date the organization was started.
(7) Number of people employed by the recipient.
(8) Company affiliation.

(c) Recipients located outside the United States may e-mail Dun and Bradstreet at globalinfo@dbisma.com to obtain the location and phone number of the local Dun and Bradstreet Information Services office.

The DUNS system is distinct from the Federal Taxpayer Identification Number (TIN) system.

DUNS: _____

4. Letter of Credit (LOC) Number

If the recipient has an existing Letter of Credit (LOC) with USAID, please indicate the LOC number:

LOC: _____

5. Procurement Information

(a) Applicability. This applies to the procurement of goods and services planned by the recipient (i.e., contracts, purchase orders, etc.) from a supplier of goods or services for the direct use or benefit of the recipient in conducting the program supported by the grant, and not to assistance provided by the recipient (i.e., a subgrant or subagreement) to a subgrantee or subrecipient in support of the subgrantee's or subrecipient's program. Provision by the recipient of the requested information does not, in and of itself, constitute USAID approval.

(b) Amount of Procurement. Please indicate the total estimated dollar amount of goods and services which the recipient plans to purchase under the grant:

$_____

(c) Nonexpendable Property. If the recipient plans to purchase nonexpendable equipment which would require the approval of the Agreement Officer, please indicate below (using a continuation page, as necessary) the types, quantities of each, and estimated unit costs. Nonexpendable equipment for which the Agreement Officer's approval to purchase is required is any article of nonexpendable tangible personal property charged directly to the grant, having a useful life of more than one year and an acquisition cost of $5,000 or more per unit.

TYPE/DESCRIPTION (Generic) _____
QUANTITY _____
ESTIMATED UNIT COST _____

(d) Source. If the recipient plans to purchase any goods/commodities which are not in accordance with the Standard Provision “USAID Eligibility Rules for Procurement of Commodities and Services,” indicate below (using a continuation page, as necessary) the types and quantities of each, estimated unit costs of each, and probable source. “Source” means the country from which a commodity is shipped to the cooperating country or the cooperating country itself if the commodity is located in the cooperating country at the time of purchase. However, where a commodity is shipped from a free port or bonded warehouse in the form in which received, “source” means the country from which the commodity was shipped to the free port or bonded warehouse. Additionally, “available for purchase” includes “offered for sale at the time of purchase” if the commodity is listed in a vendor’s catalog or other statement of inventory, kept as part of the vendor’s customary business practices and regularly offered for sale, even if the commodities are not physically on the vendors’ shelves or even in the source country at the time of the order. In such cases, the recipient must document that the commodity was listed in the vendor’s catalog or other statement of inventory; that the vendor has a regular and customary business practice of selling the commodity through “just in time” or other similar inventory practices; and the recipient did not engage the vendor to list the commodity in its catalog or other statement of inventory just to fulfill the recipient’s request for the commodity.

TYPE/DESCRIPTION _____
QUANTITY _____
ESTIMATED GOODS _____
PROBABLE GOODS _____
PROBABLE (Generic) _____
UNIT COST _____
SOURCE _____

(e) Restricted Goods. If the recipient plans to purchase any restricted goods, please indicate below (using a continuation page, as necessary) the types and quantities of each, estimated unit costs of each, intended use, and probable source. Restricted goods are Agricultural Commodities, Motor

Vehicles, Pharmaceuticals, Pesticides, Rubber Compounding Chemicals and Plasticizers, Used Equipment, U.S. Government-Owned Excess Property, and Fertilizer.

TYPE/DESCRIPTION _____
QUANTITY _____
ESTIMATED _____
PROBABLE _____
INTENDED USE (Generic) _____
UNIT COST _____
SOURCE _____

(f) Supplier Nationality. If the recipient plans to purchase any goods or services from suppliers of goods and services whose nationality is not in accordance with the Standard Provision "USAID Eligibility Rules for Procurement of Commodities and Services," indicate below (using a continuation page, as necessary) the types and quantities of each good or service, estimated costs of each, probable nationality of each non-U.S. supplier of each good or service, and the rationale for purchasing from a non-U.S. supplier.

TYPE/DESCRIPTION _____
QUANTITY _____
ESTIMATED _____
PROBABLE SUPPLIER _____
NATIONALITY _____
RATIONALE (Generic) _____
UNIT COST (Non-US Only) _____
FOR NON-US _____

6. Past Performance References

On a continuation page, please provide past performance information requested in Section 2.1.5 of this RFA.

7. Type of Organization

The recipient, by checking the applicable box, represents that -

(a) If the recipient is a U.S. entity, it operates as [ ] a corporation incorporated under the laws of the State of, [ ] an individual, [ ] a partnership, [ ] a nongovernmental nonprofit organization, [ ] a state or local governmental organization, [ ] a private college or university, [ ] a public college or university, [ ] an international organization, or [ ] a joint venture; or

(b) If the recipient is a non-U.S. entity, it operates as [ ] a corporation organized under the laws of _____ (country), [ ] an individual, [ ] a partnership, [ ] a nongovernmental nonprofit organization, [ ] a nongovernmental educational institution, [ ] a governmental organization, [ ] an international organization, or [ ] a joint venture.

8. Estimated Costs of Communications Products

The following are the estimate(s) of the cost of each separate communications product (i.e., any printed material [other than non-color photocopy material], photographic services, or video production services) which is anticipated under the grant. Each estimate must include all the costs associated with preparation and execution of the product. Use a continuation page as necessary.

- End of RFA -

ANNEX 1 – USAID/MALI HEALTH SECTOR - ACTIVITIES *

HEALTH FIELD SUPPORT - Prime Partner	MAJOR FIELD SUPPORT ACTIVITIES
Africa Indoor Residual Spraying (IRS) - Abt Associates	This Activity provides support to the National Malaria Program and the conduct of household spraying to kill mosquitoes and prevent malaria transmission in 3 districts In 2012 (Bla, Koulikoro, Baroueli districts). IRS manages all aspects of the annual spraying operations, including hiring, training and supervising seasonal spray operating teams from target districts.
Capacity Plus - Intrahealth	CapacityPlus was originally conceived to work in partnership with the MOH, local training institutions, and others on a comprehensive human resources for health (HRH) program to address Mali's health workforce crisis. In mid-2013 Activity focus shifted to the northern region of Gao where the health system had been seriously compromised by the 2012 armed conflict. The Activity will assess and support the rehabilitation and continuing functioning of the Gao Nursing School, as well as undertake a rapid health sector assessment in the Gao District to evaluate the status of the health facilities, service provision, and human resources for health.
Central Contraceptive Procurement (CCP) - JSI	Through CCP, USAID/Mali procures family planning, other essential maternal health commodities and nutritional supplements.
DELIVER PROJECT: Malaria - JSI	DELIVER supports the procurement and distribution of life-saving antimalarial commodities for the prevention and treatment of malaria. The points of distribution are Mali's privately owned and operated community-based health centers.
Health Care Improvement (HCI) Project - URC	HCI aims to achieve and document measurable improvements in the quality of care and health workforce management. HCI targets reductions in maternal and neonatal mortality and morbidity in the Kayes, Segou and Sikasso regions, working closely with regional MOH directorates and partners, utilizing high impact interventions that apply modern methods of quality improvement. In Kayes and Segou HCI works at regional, district and community-level facilities. In Sikasso, HCI is also addressing the high rates of anemia in children <5 years.

Maternal and Child Health Integrated Program (MCHIP) - Save the Children	MCHIP contributes to USAID Mali efforts to reduce maternal, newborn and child mortality. It works to ensure increased access to integrated, evidence-based packages of MNCH-FP interventions at both the community and facility levels in select districts of Mali. Through MCHIP, support is also provided for BCC/SM work in the areas of FP/RH, MCH, HIV, Nutrition, and WASH. (Note that several aspects of MCHIP were incorporated into USAID's Mali High Impact Health Services II Activity and the SBCC/SM Activity.)
Measure DHS III - IFC International	Through this mechanism, Mali's fifth Demographic and Health Survey (DHS) was undertaken in 2012, preliminary partial report was distributed in May 2013, and the final report is due in April or May 2014.
Measure Evaluation III - CPC UNC	Measure Evaluation III provides assistance to strengthen the HMIS in Mali. Measure also assists the USAID/Mali Health Team with its robust health portfolio M&E data base, analyses and PMP.
Promoting the Quality of Medicines in Developing Countries (PQM) - USP	PQM focus is on the quality, safety, and efficacy of medicines essential to USAID priority diseases, particularly malaria, HIV/AIDS, and tuberculosis. PQM works with Mali's medicine regulatory agency to strengthen the country's quality assurance systems. Interventions range from assessing QA/QC systems and capacity, establishing a marketing quality management (MQM) program as part of post marketing surveillance, establishing or strengthening a pharmaco vigilance program, and building capacity of the Official Medicines Control Laboratory (OMCL).
Supply Chain Management Systems (SCMS) Project - PfSCM	Through SCMS, USAID/Mali procures commodities for HIV/AIDS activities.
System for Improved Access to Pharmaceuticals and Services (SIAPS) - MSH	SIAPS works to assure the availability of quality pharmaceutical products and effective pharmaceutical services to achieve desired health outcomes. The program promotes and uses a systems-strengthening approach consistent with the Global Health Initiative (GHI) and designed to improve and sustain health impact. SIAPS' technical approach emphasizes GHI principles, especially improving metrics, monitoring, and evaluation; capacitating local governments and organizations; and increasing country ownership.
UNICEF Umbrella Grant	USAID provides support to UNICEF's program in Mopti (resilience zone).

HEALTH BILATERAL- Prime Partner	MAJOR BILATERAL ACTIVITIES
Association de Soutien et au Developpement des Activites de Population (ASDAP)	USAID provided a Grant to ASDAP to address malnutrition, water and sanitation issues in Sikasso, Kinya, Kadioula, and Koutiala. Funds are used to conduct nutrition and WASH activities (e.g., food diversification, behavior change communications for healthy diets, WASH).
Assistance Technique Nationale Plus (ATN Plus) - Abt Associates	ATN+ supported the MOH at the national, regional, district and community health center levels to improve the quality of and access to HIHS; to design and implement BCC activities to increase the demand for HIHS; and identify opportunities for public-private partnerships to further expand services. The Activity worked in all 8 regions plus Bamako. Through ATN+, USAID/Mali supported a comprehensive effort by the GOM to expand the delivery of HIHS to key Malian populations, particularly in rural areas, while promoting the use of services and behavior change. Improved HIHS covered maternal health, FP, essential newborn care, immunization, diarrheal disease, nutrition and malaria. (Note that several aspects of ATN+ were incorporated into USAID's RFA for Mali High Impact Health Services II Activity).
SBCC/SM	Support will be provided for behavior change and communications and broad social marketing program. Estimated start up is by end of FY2014.
Fistula Care	USAID's first fistula treatment and care project ended in 2013. A second project was awarded in March 2014. Support entails training of doctors, nurses, and midwives at hospitals. Also, providers at primary and secondary facilities will be trained in emergency obstetric care to prevent fistula incidence and to facilitate referrals. Efforts will be made to reintegrate women affected by fistula into their communities.
HIV Prevention	This Activity will provide support to local NGOs that work in HIV/AIDS prevention.
HIV Prevention - Soutoura	Grant to local NGO that carries out HIV and STI prevention activities designed to reduce the transmission of STIs and HIV, and to educate and improve the health status of sex workers in Bamako, Niono, Kati and Kayes.

Integrated Rural Program (IRP) to Improve Nutrition and Hygiene in Mali APS	IRP aims to improve nutritional status of women and children, with a focus on the prevention and treatment of undernutrition, targeting the first 1000 days of a child's life. Three categories of interventions are supported, namely those that: increase access to and consumption of diverse and quality foods; improve nutrition and hygiene-related behaviors; and increase utilization of high impact nutrition and WASH promotion and treatment services. Two awards were made under this mechanim in September 2013.
Malaria Research and Training Center (MRTC) FARA	USAID funds are used to support malaria-related research at MRTC.
Project Keneya Ciwara II (PKC II) - CARE	PKC II aims to increase the use of quality health services at the community level and improve health practices at the household level throughout Mali. PKC II focuses on strengthening good governance practices by community health associations to improve their management of community health issues. The Project strives to improve the relationships between local authorities and health associations so that together they can fully play their roles in addressing local health issues. In the area of HIV/AIDS, PKC II support focuses on high-risk groups. (Note that several aspects of PKC II were incorporated into USAID's RFA for the Mali High Impact Health Services II Activity)

* This list presents an overview of most of USAID's health sector activities, as of March 2014. It is not exhaustive, e.g., it does not include planned evaluations, staffing, mechanisms or activities under negotiation. Nor does it reflect joint endeavors with other USAID sector programs, with some donors, or potential agreements with GOM entities.

ANNEX 2 - INITIAL ENVIRONMENTAL EXAMINATION

PROGRAM/PROJECT DATA:

Program Number: Health Development Objective
Country/Region: Mali/Africa
Program/Project Title: Increased Use of High Impact Health Services and Healthy Behaviors

1. BACKGROUND AND ACTIVITY/PROJECT DESCRIPTION

1.1 PURPOSE AND SCOPE OF IEE

The purpose of this IEE, in accordance with 22CFR216, is to provide the first review of the reasonably foreseeable effects on the environment, and on this basis, recommend Threshold Decisions, and in some cases attendant conditions for activities undertaken under the Mali Health Project (MHP). This IEE also sets out program-level implementation procedures intended to assure that conditions in this IEE are translated into specific mitigation measures and actions and to ensure systematic compliance with this IEE during project implementation.

1.2 BACKGROUND

USAID/Mai's health program supports the goal of **sustained improvements in health** through **increased use of high impact health services and healthy behaviors.** This will be achieved through programming in three component areas: 1) delivery of an integrated package of high-impact health services at the community level, 2) social and behavior change communication (SBCC), and 3) health systems strengthening (HSS).

Based on the epidemiology and conditions in Mali, interventions will fall into the following technical areas:

- Maternal, Neonatal, and Child Health & Family Planning
- Malaria
- Infectious Disease (including HIV/AIDS)
- Nutrition, Water, and Sanitation

1.3 DESCRIPTION OF ACTIVITIES.

The program has the following sub-purposes/components and sub-components:

Component 1 - Social and Behavior Change Communication (SBCC)
This component includes: the research, development, production and dissemination of SBCC messages at the national and local levels through mass media, local level media, and interpersonal communications; national level coordination and capacity building for SBCC; formative research, monitoring, and evaluation for the development and dissemination of materials and tools; capacity building of local SBCC partners.

Component 2 - Integrated High Impact Health Services and Appropriate Referrals
This component will support the delivery of high-impact health services, primarily through the delivery of an integrated package of preventive and treatment services at the community level, including capacity building of health providers and local-level health systems. Services will be

delivered through community health clinics and the outreach workers associated with them, mobile outreach strategies, social marketing, peer networks, or other appropriate means of distribution. Additionally, activities will work with the private sector to improve the quality and quantity of high-impact health services provided by the private-sector, as well as improved referral of complicated cases from the private sector to appropriate public sector facilities and improved use of private sector service statistics in national health data. Activities will also work to improve referrals throughout the health system.

A sub-section of this component is the provision of services related to water and sanitation including:

Small-scale Construction Activities

- Construct or rehabilitate water storage facilities including cisterns, water tanks, reservoirs, etc.
- Construct or rehabilitate small rainwater diversion or infiltration structures (e.g., catchment dams, infiltration ditches, etc.)
- Construct or renovate boreholes
- Install mechanized or manual pump systems
- Construct or renovate hand dug wells
- Construct or rehabilitate water treatment facilities (e.g., install pipes, backwash sand filters, intakes, pumps, replacement/ rehabilitation of clarifiers, power supply, and/or generators)

Small-scale Water Supply and Sanitation Activities

Water Supply

- Construct or renovate boreholes
- Install mechanized or manual pump systems
- Construct or renovate hand dug wells
- Construct or renovate connection to or extensions of networked water supply distribution systems, including installation of tap stands
- Construct or renovate water storage tanks
- Construct or renovate rainwater harvesting systems
- Construct or renovate spill-water drainage facilities/structures
- Construct or renovate cattle troughs connected to potable water systems
- Construct or renovate spring boxes/surface water potable water supply systems
- Operate water supply systems, including water treatment, upkeep and maintenance of pumps, pipes, and other infrastructure, management of fee collection, etc.

Sanitation

- Construct or renovate sanitation facilities (latrines or other)
- Construct or renovate hand washing basins, laundry facilities and/or public showers
- Construct or renovate wastewater drainage or conveyance networks

Component 3 - Health Systems Strengthening and Management

This component will strengthen the Malian health systems needed to deliver high-impact health services. Activities will strengthen gaps in decentralized management at the community, district and regional levels, as well as selected support at the national level. Activities will include capacity building, coordination, training, advocacy, and policy work in the following areas: human resources management, health financing, health management and governance, and health information systems.

2. ENVIRONMENTAL BASELINE INFORMATION

2.1.Location

The MHP has nationwide coverage, though some activities will be more geographically focused.

2.2.Host Country Environmental Laws and Policies

The Malian constitution recognizes all citizens' "right to a healthy environment" and stipulates in article 15 that the "protection of the environment and the assurance of quality of life is the purpose and responsibility of the state". USAID and implementing partners will ensure that norms regarding environmental protection are respected.

Law 89-61/AN-RM of September 2, 1989 states that the importation of toxic waste will be prohibited. USAID will not be involved in the importation of toxic waste.

Law 01-20/AN-RM of April 26, 2001 stipulates that harmful chemical substances "which can pose a danger to man or his environment are subject to tight regulation and inspections by Ministries in charge of environment and public safety." USAID will not be involved in the use of harmful chemical substances.

Order 01-046/PRM of September 20, 2001 authorizes the ratification of the Communal Regulation of member states of the Inter-State Committee for Drought Control in the Sahel (CILSS) on the registration of pesticides signed in Djamena on December 16 1999. USAID does not anticipate importing and or procuring any pesticides under this IEE.

Law 02-006 of January 31, 2002 maintains that the conservation, protection and management of water resources is obligatory by the Ministry of Environment and must be respected by all. Article 14 states that it is strictly prohibited to spill and contaminate the water bodies and their flora and fauna. USAID and partners will respect this law.

Order 02-049/P-RM of March 29, 2002 on the Creation of the Niger Bassin Agency outlines the roles and responsibilities of the Niger River Basin Agency, which include the "preservation of the River, including the protection of terrestrial and aquatic ecosystems." USAID and implementing partners will respect and comply with the requirements of the River Niger Basin Agency, and will respect basin environments to ensure there is no contamination of their flora and fauna.

Law 02-14/AN-PR of June 3, 2002 institutes the registration and the management of pesticides in the Republic of Mali. It states overall general principles on matters surrounding their importation, their chemical composition, packaging, repackaging, and the storage of pesticides. USAID does not anticipate importing and or procuring any pesticides under this IEE.

Decree 03-594/PRM of December 31, 2003 refers to the, which outlines the rules, regulations and procedures for Environmental Impact Assessments, which must be conducted by private or public projects implemented in Mali, incluidng major industrial, agricultural, mining, artisanal, and commercial or transport developments. The MHP will not implement any activities that meet the definition above of a "project" under decree No. 03-594/P-RM.

Decree 02-305 concerns the protection of vegetables and crop production. USAID will respect the protection of agricultural practices in the areas where USAID-funded activities are conducted.

National Plan for the Promotion of High Impact Hygiene Practices in the Framework of Reducing Diarrheal Diseases (2011 – 2015). This strategy is dated april 2004 and and has the following objectives:

Ensure the healthiness of the living environment; protect the public health and the environment using a collection and disposal and treatment system of biomedical waste in Mali.	
Global objective 1: Improve very significantly the management of biomedical wastes in health centres in Mali	Specific objectives: - Provide the health centres with equipment for the collection and disposal of biomedical wastes; - Draft plans for managing biomedical waste in health centres
Global objective 2: Develop a strong and secured partnership in the field of biomedical waste management	Specific objectives: - Organize stakeholders into a more functional system with lower impact particularly in Bamako
Global objective 3 : Raise the awareness of stakeholders on the problem of biomedical waste management through IEC	Specific objectives - Increase the knowledge of direct and indirect stakeholders - Raise the awareness of direct and indirect stakeholders on the hazards associated with the bad management of biomedical wastes and the risk related to some attitudes and practices.
Global objective 4: Build and develop the skills of stakeholders using targeted training programs	Specific objectives - Improve stakeholder attitudes - Change practices - Strengthen knowledge on biomedical wastes
Global objective 5: Strengthen the institutional, legal and regulatory framework	Specific objectives - Provide Mali with a specific regulation on biomedical waste, - Create an implementation, discussion and monitoring framework

3. EVALUATION OF PROJECT ACTIVITIES WITH RESPECT TO ENVIRONMENTAL IMPACT POTENTIAL AND RECOMMENDED DETERMINATIONS

An evaluation of potential negative impacts of the program activities is shown in Table 2 below.

Table 2. Evaluation of project activities with respect to Potential Environmental Impacts and Recommended Determinations

Illustrative Activities	Potential Invironmental Impacts	Recommended Determinations
Component 1 Social and Behavior Change Communication: Sub-Purpose 1: Improved demand for quality health services and improved knowledge of preventive healthy behaviors at the individual, household, and community levels.		
• National strategy for SBCC developed, incorporating other relevant strategies already developed for malaria, nutrition, etc. • National strategy for SBCC implemented • Capacity of CNIECS and, as appropriate, other national entities, for strategic planning and coordination strengthened • Capacity of local partners developed for the conduct of SBCC-appropriate formative research, monitoring of dissemination, and evaluation of impact. • Formative research conducted for all high priority SBCC activities and campaigns • Impact assessments conducted of all high priority SBCC activities and campaigns • Messages developed and tested for a variety of media: mass media, local media, and for interpersonal communications support • Guidelines for use of SBCC materials and tools prepared to support use at all appropriate levels of local communities	These activities has no impact on the physical environment	A **Categorical Exclusion** is recommended pursuant to 22CFR 216.2(c)(1)(i) for action not having an effect on the environment, 22CFR 216.2(c)(2) (i) for education, technical assistance, or training activities , 22CFR 216.2(c)(2) (ii) for controlled experimentation exclusively for the purpose of research and field evaluation and 22CFR 216.2(c)(2) (iii) for analyses, studies, academic or research workshops and meetings and 22CFR 216.2(c)(1)(v) for Document and information transfer

Illustrative Activities	Potential Invironmental Impacts	Recommended Determinations
• Materials and tools adapted and produced for use at community level • Messages for mass media, including local, community radio, disseminated to mass media outlets • Capacity of local partners developed for all aspects of message development, testing and production. • High priority messages and related materials and tools disseminated at Health facilities, Community level, Mobile/outreach, Accredited private sector franchises, offices, etc. and Social marketing outlets • High priority messages disseminated through local, community radio and other local media • High priority messages provided through interpersonal communication, social networks, and other appropriate media.		
Component 2 Integrated High Impact Health Services and Appropriate Referrals: Sub-purpose 2: Improved availability of and access to integrated high impact health services and appropriate referrals.		
• Increased capacity of local organization(s) in marketing, distribution, and sales of socially marketed products and services • Improved sustainability (programmatic, organizational, and financial) of lead, local social marketing organization	These activities has no impact on the physical environment	A **Categorical Exclusion** is recommended pursuant to 22CFR 216.2(c)(1)(i) for action not having an effect on the environment, 22CFR 216.2(c)(2) (i) for education, technical assistance, or training activities, and 22CFR 216.2(c)(2)(v) for document and information transfer.

Illustrative Activities	Potential Invironmental Impacts	Recommended Determinations
• Improved and expanded contributions of social marketing outlets and organizations in developing and disseminating SBCC high priority messages and materials. • Clients referred for services to a higher level of service provider go for services • Referral sites provide feedback to referring site on services provided and follow up for the client that is required. • Monitoring of Epidemic Surveillance and Response (ESR) system for northern Mali		
• Facility and community health worker service sites expanded • Volunteer workers engaged in promoting use of high impact services • Expanded campaigns that include high impact health services to reach 90% of population at least two times per year • Increased mobile outreach from CSCOMs and other fixed facilities for priority services, such as long-acting family planning • Increased outlets for socially marketed products and services	These activities could lead to the generation of medical waste. They will involve the procurement, management and disposal of public health commodities including pharmaceutical drugs, laboratory supplies and reagents. If handled, treated, disposed incorrectly, medical waste and expired commodities can spread disease, poison people, livestock, wild animals, plants and whole ecosystems.	A **negative determination** is recommended pursuant to 22CFR 216.3(a)(3)(iii) subject to the **condition** that the USAID program makes reasonable effort to assure that adequate management strategies are available to the decentralized health services and that proper orientation in waste management is carried out with health authorities and workers. The USAID Bureau for Africa's Environmental Guidelines for Small Scale Activities in Africa (EGSSAA) Chapter 8, "Healthcare Waste: Generation, Handling, Treatment and Disposal" (http://www.encapafrica.org/sectors/medwaste.htm) contains guidance which should be used to promote proper disposal of medical waste. Other important references to consult in establishing a waste

Illustrative Activities	Potential Invironmental Impacts	Recommended Determinations
• Increased sales of socially marketed products and services • Expanded number of private clinical practices include provision of high quality, high impact health services • Expanded number of NGO and faith-based health service providers include provision of high quality, high impact health services • HIV/AIDS counseling and testing conducted • Expanded access to PMTCT for all women attending focused antenatal care • If pilot successful, scale up of seasonal malarial chemoprevention (SMC) tested in Kita District for over 100,000 children, 3-59 months of age.		management program are WHO's Safe Management from Health Care Activities: http://www.who.int/water_sanitation_health/healthcare_waste/en/ To the extent that Implementing partners assume responsibility for in-country storage for pharmaceuticals procured under USAID funding, these pharmaceuticals will be stored according to the information provided on the manufacturer's Materials Safety Data Sheet (MSDS). These are supplied by the manufacturer and can also be found on the internet by using the active ingredient and MSDS as search terms. If disposal of any of these pharmaceutical drugs is required, due to expiration date or other reasons, the preferred method of disposal is to return to the manufacturer. If this is not possible, then follow the guidelines in the WHO document for Safe Disposal of Unwanted Pharmaceuticals During and After Emergencies found at http://www.who.int/water_sanitation_health/medicalwaste/pharmaceuticals/en/
Component 3: Health systems strengthening and management: Sub-purpose 3:		
• Improved data use and reporting from private sector health providers • Evidence-based management and governance tools and approaches used at all levels • Policy gaps identified	These activities has no impact on the physical environment	A **Categorical Exclusion** is recommended pursuant to 22CFR 216.2(c)(1)(i) for action not having an effect on the environment, 22CFR 216.2(c)(2) (i) for education, technical assistance, or training activities, 22CFR 216.2(c)(2)(iii) for analyses, studies, academic or research workshops and meetings, and 22CFR 216.2(c)(2)(v) for document and information transfer

Illustrative Activities	Potential Invironmental Impacts	Recommended Determinations
• Improved planning, management and accountability systems at the CSCOM/ASACO, district, and regional level • Improved recruitment, retention and allocation of health care providers sufficient to meet geographic and technical need • Innovative financing options identified, developed and tested, as needed, at all levels • Evidence-based approaches for more efficient use of funds and improved transparency expanded • Reduced financial barriers and increased demand for quality services • Policy gaps addressed and process improved		
• Improved management processes to increase health care access, availability and affordability	If poorly managed, unused or expired health commodities including pharmaceutical drugs, laboratory supplies and reagents can spread disease by human and animal poisoning people, and cause harm to aquatic life	A **negative determination** is recommended pursuant to 22CFR 216.3(a)(3)(iii) subject to the **condition** that the USAID program makes reasonable effort to assure that adequate management strategies are available to the decentralized health services and that proper orientation in waste management is carried out with health authorities
• Increased number and quality of healthcare workers at health services sites that meet national standards in qualifications		A **negative determination** is recommended pursuant to 22CFR 216.3(a)(3)(iii) subject to the **condition** that training/TA in service delivery must incorporate best practice standards in proper waste management practices. The

Illustrative Activities	Potential Invironmental Impacts	Recommended Determinations
		content of the training and capacity building must be consistent with the good-practice guidance of Africa's Environmental Guidelines for Small Scale Activities in Africa (EGSSAA) Chapter 8, "Healthcare Waste: Generation, Handling, Treatment and Disposal" fount at (http://www.encapafrica.org/sectors/medwaste.htm)
Additional Nutrition, Water and Sanitation Activities		
Small-scale construction ▪ Construct or rehabilitate water storage facilities including cisterns, water tanks, reservoirs, etc. ▪ Construct or rehabilitate small rainwater diversion or infiltration structures (e.g., catchment dams, infiltration ditches, etc.) ▪ Construct or renovate boreholes ▪ Install mechanized or manual pump systems ▪ Construct or renovate hand dug wells ▪ Construct or rehabilitate water treatment facilities (e.g., install pipes, backwash sand filters, intakes, pumps, replacement/ rehabilitation of clarifiers, power supply, and/or generators)	Damage to sensitive or valuable ecosystems from construction of infrastructure, associated temporary worker dwelling, or construction storage units for personnel or equipment Removal of vegetation and/or compaction of the soil and grading of the site, altering drainage patterns and water tables, changing access to water by animals, people and vegetation, or degrading water resources Sedimentation of surface waters through removal of natural land cover, excavation, extraction of construction materials and other construction-related activities that result in soil erosion	A **negative determination** is recommended pursuant to 22CFR 216.3(a)(3)(iii) subject to the **condition** that all small-scale construction activities will be conducted following best practices and principles provided in Chapter 3: Small Scale Construction of the USAID Environmental Guidelines for Small-scale Activities in Africa (complete set of guidelines found at www.encapafrica.org)
Small-scale Water Activities *Water Supply* • Construct or renovate boreholes • Install mechanized or manual pump systems • Construct or renovate hand dug wells • Construct or renovate connection to or extensions	Improper siting of facilities that damages or destroys natural ecosystems (within wetlands, protected areas, or other sensitive habitats, etc.) Depletion of freshwater resources (surface and groundwater) Conflict over water resource allocation	A **negative determination** is recommended pursuant to 22CFR 216.3(a)(3)(iii) subject to the **condition** that all water supply activities should be conducted in a manner consistent with the good design and implementation practices described in Chapter 16: Water Supply and Sanitation of the USAID Environmental Guidelines for Small-scale Activities in Africa

Illustrative Activities	Potential Invironmental Impacts	Recommended Determinations
of networked water supply distribution systems, including installation of tap stands • Construct or renovate water storage tanks • Construct or renovate rainwater harvesting systems • Construct or renovate spill-water drainage facilities/structures • Construct or renovate cattle troughs connected to potable water systems • Construct or renovate spring boxes/surface water potable water supply systems • Operate water supply systems, including water treatment, upkeep and maintenance of pumps, pipes, and other infrastructure, management of fee collection, etc.		(complete set of guidelines found at www.encapafrica.org)
Sanitation activities ▪ Construct or renovate sanitation facilities (latrines or other) ▪ Construct or renovate hand washing basins, laundry facilities and/or public showers ▪ Construct or renovate wastewater drainage or conveyance networks	Increased human health risks from contamination of surface water, groundwater, soil, and food by human waste and disease pathogens Degradation of stream, lake, estuarine and marine water quality and degradation of land habitats, or negative impacts to surface or groundwater quality due to inappropriate siting or construction of latrines or wastewater collection systems, or release of human waste from sanitation facilities Defecation around and not in latrines or other sanitation facilities, potentially contaminating	A **negative determination** is recommended pursuant to 22CFR 216.3(a)(3)(iii) subject to the **condition** that all sanitation activities should be conducted in a manner consistent with the good design, siting, and implementation practices described in Chapter 16: Water Supply and Sanitation of the USAID Environmental Guidelines for Small-scale Activities in Africa (complete set of guidelines found at www.encapafrica.org)

Illustrative Activities	Potential Invironmental Impacts	Recommended Determinations
	surface water and/or shallow groundwater sources, adversely affecting both human and ecosystem health	

4. MONITORING AND REPORTING FOR ENVIRONMENTAL COMPLIANCE

This examination does not cover pesticides, including their procurement, use, transport, storage or disposal. Any pesticide activity proposed under this program would necessitate an amended IEE, including all elements of analysis required by 22CFR216.3 (b) under USAID Pesticide Procedures.

In addition to the specific conditions enumerated in Section 3, the negative determinations recommended in this IEE are contingent on full implementation of the following general monitoring and implementation requirements:

1. **Review of New Procurements.** As a normal part of the pre-procurement process, the Mission will analyze the activities under each new health procurement to determine whether they are covered by this IEE. Procurements which are covered by this IEE will be certified as such by the Mission Environmental Officer. If the activities under a new procurement are determined not to fall under this IEE, an amendment to this IEE will be prepared.

2. **IP Briefings on Environmental Compliance Responsibilities.** The Health team shall provide each Health Implementing Partner (hereinafter IP), with a copy of this IEE; Each IP shall be briefed on their environmental compliance responsibilities by their cognizant C/AOR. During this briefing, the IEE conditions applicable to the IP's activities will be identified. When possible, this IEE will be included in solicitations.

3. **Development of EMMP.** Each IP whose activities are subject to one or more conditions set out in Section 3 of this IEE shall develop and provide for C/AOR review and approval an Environmental Mitigation and Monitoring Plan (EMMP) documenting how their project will implement and verify all IEE conditions that apply to their activities.
   These EMMPs shall identify how the IP shall assure that IEE conditions that apply to activities supported under subcontracts and sub-grant are implemented. (In the case of large sub-grants or subcontracts, the IP may elect to require the sub-grantee/subcontractor to develop their own EMMP.)

   ***(Note:** refer to the AFR EMMP Factsheet, available at www.encapafrica.org.)*

4. **Integration and implementation of EMMP.** Each IP shall integrate their EMMP into their project work plan and budgets, implement the EMMP, and report on its implementation as an element of regular project performance reporting.

   IPs shall assure that sub-contractors and sub-grantees integrate implementation of IEE conditions, where applicable, into their own project work plans and budgets and report on their implementation as an element of sub-contract or grant performance reporting.

5. **Integration of compliance responsibilities in prime and sub-contracts and grant agreements.**

   a. The Health team shall assure that contracts or agreements for implementation of the project, and/or significant modification to current contracts/agreements shall reference and require compliance with the conditions set out in this IEE, as required by ADS 204.3.4.a.6 and ADS 303.3.6.3.e.
   b. IPs shall assure that sub-contracts and sub-grant agreements reference and require compliance with relevant elements of these conditions.

6. **Assurance of sub-grantee and sub-contractor capacity and compliance.** IPs shall assure that sub-grantees and subcontractors have the capability to implement the relevant requirements of this IEE. The IP shall, as and if appropriate, provide training to sub-grantees and subcontractors in their environmental compliance responsibilities and in environmentally sound design and management (ESDM) of their activities.

7. **Health Team monitoring responsibility.** As required by ADS 204.5.4, the Health team will actively monitor and evaluate whether the conditions of this IEE are being implemented effectively and whether there are new or unforeseen consequences arising during implementation that were not identified and reviewed in this IEE. If new or unforeseen consequences arise during implementation, the team will suspend the activity and initiate appropriate, further review in accordance with 22 CFR 216. USAID Monitoring shall include regular site visits.

8. **New or modified activities.** As part of its initial Work Plan, and all Annual Work Plans thereafter, IPs, in collaboration with their C/AOR, shall review all planned and on-going activities to determine if they are within the scope of this IEE.
   If any IP activities are planned that would be outside the scope of this IEE, an amendment to this IEE addressing these activities shall be prepared for USAID review and approval. No such new activities shall be undertaken prior to formal approval of this amendment.
   Any ongoing activities found to be outside the scope of the approved Regulation 216 environmental documentation shall be halted until an amendment to the documentation is submitted and written approval is received from USAID. This includes activities that were previously within the scope of the IEE, but were substantively modified in such a way that they move outside the scope.

9. **Compliance with Host Country Requirements.** Nothing in this IEE substitutes for or supersedes IP, sub-grantee and subcontractor responsibility for compliance with all applicable host country laws and regulations. The IP, sub-grantees and subcontractor must comply with host country environmental regulations unless otherwise directed in writing by USAID. However, in case of conflict between host country and USAID regulations, the latter shall govern.

10. **Government-to-government (G2G) assistance.** In keeping with USAID Forward, investment in government-to-government assistance is an important development objective. In order to pursue such opportunities USAID/Mali will need to obtain Authorization for Use of Partner Country Systems (AUPCS)—a new requirement for G2G assistance specified in ADS 220 - Use of Reliable Partner Country Systems for Direct Management and Implementation of Assistance. This will include certification of the effectiveness of Mali's environmental assessment procedures, policies, and

legal/regulatory frameworkas well as their actual implementation. This certification likely will require that a capacity assessment be implemented to assure that host government systems are capable of ensuring sound environmental compliance and where gaps are identified appropriate capacity building measures will be recommended as conditionalities to the final approval of an AUPCS. This also should be harmonized with the expectations of other sector donors (World Bank, EU, etc.), in line with the Paris Declaration of Aid Effectiveness

PERFORMANCE MANAGEMENT PLAN FISCAL YEAR 2013

Strategic Objective 6: Increased Use of High-Impact Health Services and Healthy Behaviors

June 2013

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Appendices

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B. Data Quality Checklist
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ACRONYMS

ACT	Artemisinin-Based Combined Therapy
ADS	Automated Directives System
AID	Agency for International Development (United States)
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
AOTR	Agreement Officer's Technical Representative
APS	Anemia and Parasitemia Survey
ASC	Agent de Santé Communautaire
ASDAP	Association pour le Soutien du Développement des Activités de Population
BCC	Behavior Change Communication
CCM	Community Case Management
CHW	Community Health Worker
COTR	Contracting Officer's Technical Representative
CSW	Commercial Sex Workers
CYP	Couple-Years Protection
DHS	Demographic and Health Survey
DPM	Directorate of Pharmacy and Medicines
ENC	Essential Newborn Care
EPI	Expanded Program for Immunization
FP	Family Planning
FtF	Feed the Future
FY	Fiscal Year
GHI	Global Health Initiative
GOM	Government of the Republic of Mali
HBMF	Home-Based Management of Fever
HHS	Household Hunger Scale
HIHS	High-Impact Health Services
HKI	Helen Keller International
ICCM	Integrated Community Case Management
IP	Implementing Partner
IPR	Implementing Procurement Reform
IPTp	Intermittent Preventive Treatment During Pregnancy
IR	Intermediate Results
IRS	Indoor Residual Spraying
ITN	Insecticide-Treated Net
IUD	Intrauterine Device
JMP	Joint Monitoring Programme
MAD	Minimum Acceptable Diet
MARP	Most At-Risk Population
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Program
MCPR	Modern Contraceptive Prevalence Rate
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MIS	Malaria Indicator Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal, and Child Health
MOH	Ministry of Health

MSM	Men Who Have Sex With Men
NGO	Nongovernmental Organization
NMR	Neonatal Mortality Rate
NOA	New Obligating Authority
PEPFAR	President's Emergency Plan for AIDS Relief (United States)
PIR	Portfolio Implementation Review
PKCII	Project Kénéya Ciwara II
PLHIV	People Living With HIV
PO	Program Office
PMI	President's Malaria Initiative (United States)
PMP	Performance Management Plan
PPR	Performance Plan and Report
PRODESS	Health and Social Development Program
PSI	Population Services International
PwP	Prevention With PLHIV
RAMOS	Reproductive-Age Mortality Survey
RDT	Rapid Diagnostic Test
RH	Reproductive Health
SEC	Community-Based Essential Health Services
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SLIS	Système Local d'Information Sanitaire
SO6	Strategic Objective (sixth)
SP	Sulfadoxyne-Pyrimethamine
STI	Sexually Transmitted Infection
TBD	To Be Determined
T&C	Testing and Counseling
U5M	Under 5 Mortality
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	U.S. Government
WHO	World Health Organization

SECTION I. INTRODUCTION

Background

Since 2003, USAID/Mali has been implementing its 10-year High-Impact Health Services(HIHS) program to increase the use of and integrated package of effective services proven to decrease child and maternal morbidity and mortality. The main focus of this strategy is to increase access, availability, and quality of key health services in Mali and to promote adherence to positive health behaviors in Malian households that improve child survival and maternal health.

In 2010, Mali became a Global Health Initiative Plus country (www.ghi.gov/) and a Feed the Future country (www.feedthefuture.gov/). In Fiscal Year (FY) 2010, the United States Agency for International Development (USAID or the Agency) Mission in Mali decided to systematically restructure its health program in response to changing needs and budgetary circumstances. The Mission and implementing partners reviewed the Mission's strategic priorities, and decided to make a number of programmatic changes, and reduce the geographic coverage to 36 districts (Appendix A) for a number of key interventions. As a result, the performance management plan (PMP) also underwent substantial revision.

In addition, the March 2012 coup and the war against the extremist Muslims in the North affected the implementation of many activities. The current PMP has been revised, taking those events into consideration. This PMP provides a monitoring framework for program activities and results that are anticipated for 2013 through 2015. The document outlines a Results Framework for organizing the portfolio of activities managed by the Mission and identifies a monitoring plan, including relevant indicators for program management.

USAID/Mali's sixth strategic objective for health (SO6), which remains unchanged, is to "increase use of high-impact health services and healthy behaviors." The purpose of SO6 is to expand the use of proven, effective health services and promote health practices to address underweight prevalence rates, neonatal mortality, under 5 mortality (U5M) and maternal mortality, persistent high fertility, and threats of HIV/AIDS in Mali.

The SO6 aims to increase the use of HIHS and healthy behaviors through five intermediate results (IRs):

IR1. Increased use of quality family planning (FP); reproductive health (RH); maternal, neonatal, and child health (MNCH) services

IR2. Increased coverage and use of key malaria interventions

IR3. Increased coverage of HIV/AIDS and sexually transmitted infection (STI) prevention services among selected most at-risk populations (MARPs)

IR4. Improved nutritional status, water supply, hygiene, and sanitation

IR5. Improved national, regional, district, and community management and health systems

The Performance Management Plan document is organized as follows:

Section I introduces the PMP and provides background information.

Section II presents the Results Framework, indicators, logical consistency of the framework, and the critical assumptions underpinning it.

Section III describes how the SO6 team manages its program for results and covers issues such as responsibilities for various performance management tasks (e.g., data collection, reporting, analysis).

Section IV contains performance indicator reference sheets for all results-level indicators.

Guiding Principles of the Performance Management Plan

The PMP is an important tool for managing and documenting portfolio performance. It enables timely and consistent collection of comparable performance data to make informed program management decisions. The principles governing this PMP are based on the Agency's guidelines for assessing and learning (ADS 203.3.2.2).

A tool for self-assessment: This PMP has been developed to enable the SO6 team to actively and systematically assess its contribution to USAID/Mali's program results and take corrective action when necessary. At its core are practical tools, such as indicator reference sheets and a performance management task schedule.

Performance-informed decision making: The PMP is designed to inform management decisions. The indicators chosen, when analyzed in combination, will provide data to demonstrate or disprove the basic development hypothesis.

Transparency: To increase transparency, indicator and data quality assessments have been or will be conducted, and any known limitations documented in the PMP.

Economy of effort: When selecting indicators, efforts were also made to streamline and minimize the burden of data collection and reporting. Data collection for each of the indicators will be reviewed with partners to eliminate duplication to the extent possible. In addition, the principle of "management usefulness" was applied to ensure that only data that would be useful for making decisions would be collected.

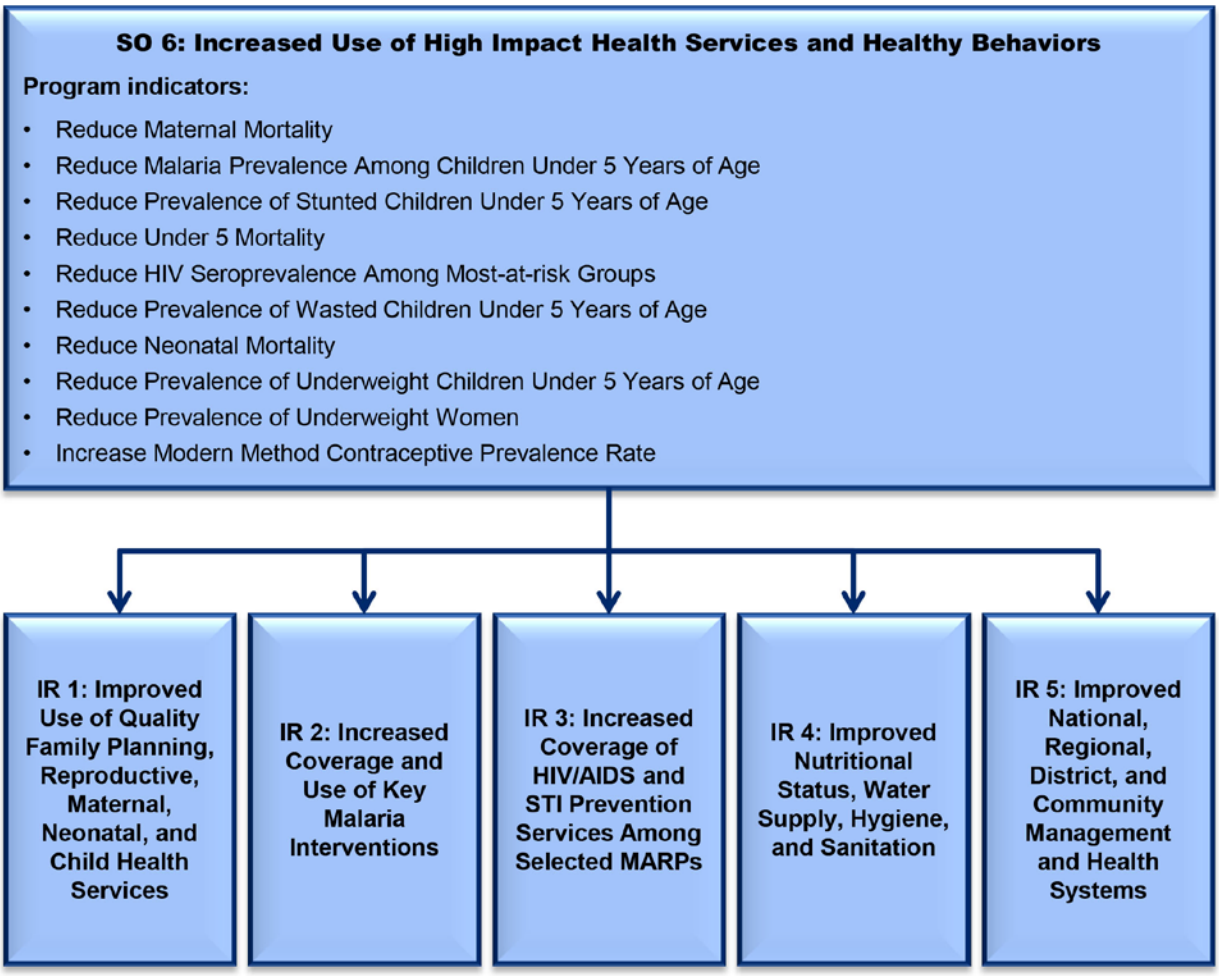
Participation: Finally, the PMP has been developed in a participatory manner. Implementing partners actively contributed to developing the Results Framework, selecting indicators and completing performance indicator sheets.

SECTION II. STRATEGIC OBJECTIVE 6 RESULTS FRAMEWORK

Graphical Representation

The following graphical representation of the results framework illustrates how activities, indicators, and intermediate results relate to the strategic objective.

Figure 1: Results Framework for SO6



Logical Consistency of the Results Framework

The main hypothesis of this framework is that increased availability and coverage of quality preventive and curative health services and interventions promoting healthy practices will cause people to change behaviors and to use health services more appropriately. Increased use of quality health services will in turn contribute to the Malian population's improved health status.

SO6 team's strategic objective is to "increase use of high-impact health services and improved healthy behaviors." It is expected that progress toward this objective will result in reductions in child and maternal mortality, as noted in the top box of the Results Framework in Figure 1.

Five intermediate results will contribute to meeting the strategic objective. Four of the five intermediate results represent the health areas in which HIHS and improved healthy behaviors are most likely to impact the overall health status of the Malian population. The health areas include maternal and child health, family planning, malaria, nutrition, water and sanitation, and HIV/AIDS. The results will be achieved by increasing access, availability, and quality of health services; working with communities to increase awareness about health issues; and empowering individuals to protect their own health. Examples of the HIHS that the program aims to improve include antenatal, delivery, and neonatal care; childhood vaccinations; malaria prevention and treatment; family planning; voluntary testing and counseling for HIV; and the control of diarrheal diseases.

Critical Assumptions

The following fundamental assumptions underpin the activities that will be implemented by the SO6 team:

- Household revenues will remain steady or increase.
- General elections will be conducted peacefully in July 2013, and political and social stability will return to normal in the coming years, especially in the northern provinces.
- The Government of the Republic of Mali (GOM) will make reasonable progress in implementing the Health and Social Development Program (PRODESS, in French).
- GOM commitment in the promotion of family planning will be adequate to sustain the program.
- Funding levels will be available at target levels or higher, if the need is demonstrated, for the next 3 years.
- There are no major stock-outs of key medicines, contraceptives, or other essential equipment.
- Support from other donors in the health sector will continue.

SECTION III. MANAGING SO6 FOR RESULTS

USAID/Mali staff and partners have specific roles and responsibilities in the overall performance management system. The USAID monitoring and evaluation (M&E) officer is responsible for the overall implementation of this plan. The USAID team will collect, analyze, and report on these data. Table 1 outlines the responsibilities for each of the major steps in the monitoring process, which are further discussed in detail in this section.

Table 1: Major Steps and Responsibilities in the Management of the SO6 Results

Major Step	Responsibility
Collecting performance data	USAID partners; SO6 team
Reviewing performance and portfolio	USAID partners; SO6 team
Reporting performance results (annual report)	SO6 team
Assessing data quality	SO6 team
Conducting evaluations and special studies	USAID partners; SO6 team
Budgeting for performance management	SO6 team; USAID partners
Reviewing and updating the PMP	SO6 team

Collecting Performance Data

Data Collection: The majority of the data in this PMP stem from partner program-monitoring tools and from the Mali health information system. Implementing partners are responsible for acquiring and transferring the data to the Mission, as specified in the performance indicator reference sheets. Several indicators will be collected and reported on separately for each of the 36 focus districts.

The SO-level indicators will be collected through population-based surveys (Demographic and Health Survey [DHS], Malaria Indicator Survey [MIS], Multiple Indicator Cluster Surveys [MICS] or special studies).

Data Analysis: When necessary, data analysis will be done by the contractor, cooperating agency, or national/international partner responsible for carrying out the data collection. Appropriate health, population, and nutrition staff will also be involved in the review, analysis, and validation of the data compiled and presented to the Mission. Should there be any discrepancies in the data provided by surveys, service statistics, or other sources, the SO6 M&E team will perform triangulation of data to better understand the dynamics of data disparity. Activities carried out to ensure data accuracy will be captured in the data quality assessment sheets.

Reporting to USAID/Mali: The implementing partners will submit data quarterly, semiannually, or annually, depending on the reporting schedule defined in the agreement they signed with the USAID/Mali. Reporting will be done via a Web-based data entry system set up for this purpose. Data will automatically be aggregated across partners, and charted against established targets and against past performance.

Reviewing Performance Plan and Report and Portfolio

Activity managers, working on an individual basis, and the SO6 team, working together, will monitor performance data during the year. Depending on the results of these reviews, the SO team may need to adjust its programming and activities. Quarterly meetings will be held with all implementing partners to share the evolution of activity implementation among the implementing team, and examine the completion of milestones and the achievement of performance results. The Mission will also sponsor an annual portfolio review to evaluate the overall progression of the SO.

The revised Automated Directives System (ADS) 200 guidance requires each SO team to conduct an annual portfolio review. The portfolio review is defined as a "required systematic analysis of the progress of an SO by the SO team and its operating unit. It focuses on both operational and strategic issues and examines the robustness of the underlying development hypothesis and the impact of activities on results. It is intended to bring together various expertise and points of view to arrive at a conclusion as to whether the program is "on track" or if new actions are needed to improve the chances of achieving results (ADS 203.3.3). At a minimum, a portfolio review must examine the following.

Progress toward SO achievement and expectations regarding future results achievement.

Evidence that outputs of activities are adequately supporting the relevant IRs and ultimately contributing to the achievement of the SO

Adequacy of inputs for producing activity outputs and efficiency of processes leading to outputs

Status and timeliness of input mobilization efforts

Status of critical assumptions and causal relationships defined in the Results Framework, along with the related implications for performance toward SOs and IRs

Status of related partner efforts that contribute to the achievement of IRs and SOs

Status of the operating unit's management agreement and the need for any changes to the approved strategic plan

Pipeline levels and future resource requirements

SO team effectiveness and staffing adequacy

Vulnerability issues and related corrective efforts

The SO6 team should consult ADS Tables 203 A, 203 B, and 203 C for ideas on how to improve the portfolio review process.

Table 2: Schedule of SO6 Team Performance Reviews

Type of Review	When	Purpose
Quarterly partner coordination meeting	Quarterly when Semiannual meeting is not held (January, April, July, October)	Review evolution of project activities, share select major accomplishments, review progress toward milestone achievement, performance targets
Annual portfolio review and strategy meeting	October	Following the portfolio review, this meeting will address revisions and plans for strategy implementation for the upcoming year

Reporting Performance Results: The Annual Report

USAID uses performance information not only to assess operating unit progress, but also as the basis of its resource request for subsequent years and to share knowledge and enhance learning throughout the organization. Like other operating units, USAID/Mali submits an annual report on its performance against expected results, including both its successes and areas identified for improvement.

The annual report is prepared in accordance with the specific guidance for that year issued by the Agency. The report uses two main sources of information: (1) SO and IR performance indicator data, and (2) the portfolio review process described earlier. The PMP is a key document in preparing for the report, since it contains information on all SO and IR performance indicators, including indicator and data quality assessments, responsibilities for data collection and analysis, and the management utility of each indicator. Agency guidance requires that all indicators meet Agency standards for indicator quality and data quality if data are used to support assertions in the report. These standards are described in ADS 203.3.6.5.

Assessing Data Quality

Data Quality Assessment Procedures: The SO6 team will undertake periodic data quality assessments for each indicator. When conducting data quality assessments, team members use the Data Quality Checklist as a guide (Appendix B). Findings are written up in a short memo (as part of the trip report form) and filed in the team's performance management files. If the SO team determines any data limitations exist for performance indicators (either during initial or periodic assessments), further investigations will be undertaken to improve estimates. The SO team documents any actions taken to address data quality problems in the appropriate performance indicator reference sheet(s), and in the annual report. If data limitations prove too intractable and damaging to data quality, the SO team seeks alternative data sources or develops alternative indicators.

Date of Future Data Quality Assessments: At a minimum, data quality assessments will be performed at an interval of 3 years from the date of the most recent data assessment for all indicators to be reported to USAID/Mali, as per the ADS. The years in which data quality assessments are due have been noted in the indicator reference sheets.

Procedures for Future Data Quality Assessments: The SO6 M&E Officer, along with the activity manager, will perform site visits, monitor databases and Health Management Information Systems (HMIS), and evaluate—using different tools such as data checklists, interviews with providers and clients, as well as semiannual meetings with contractors—cooperating agencies and national/international partners.

Known Data Limitations and Significance (if any): While indicator-specific data limitations have been identified in the performance indicator reference sheets, this section seeks to identify general limitations relating to data collection, and detail the actions taken or planned to address these limitations.

Table 3: Data Limitations and Corrective Actions

Data Collection Limitation	Action Planned to Address Data Limitation
Validity and reliability of data, especially those provided by the ministry of health (MOH) HMIS	Completeness and timeliness are major limitations with HMIS data. When possible, implementing partners (IPs) should note the percent of facilities reporting. Any training activities at the facility level should emphasize the importance and protocols for data capture. When possible, provide technical assistance to improve HMIS system, encourage close collaboration between contracting agency partner and local-level reporting units to improve and verify data quality.
Lack of consistent terms	Workshops were held in 2011 with implementing partners to insure consistent definitions and terms. Indicator reference sheets need to be revisited at time of data collection.
Lack of objective evaluation criteria	If possible, conduct retreat with implementing partners to discuss and determine evaluation criteria.
Integrity as data or records might have been manipulated	If possible, perform spot checks and independent evaluation to validate data provided by partner agencies.
Self-reported data may under- or overreport socially desirable results	This bias is an inherent limitation of most survey research methodologies. While it is difficult to counteract, triangulation with other sources of data will provide points of reference for the estimation of over/underreporting, and it would be expected that levels of bias introduced will not vary greatly over time, thus allowing for less biased trend analysis.

Budgeting for Performance Management

The SO6 team has allocated resources for monitoring and evaluation in all funding mechanisms negotiated to date. There is almost always a trade-off between cost and data quality. This trade-off was taken into consideration when selecting indicators and methods for data collection, and efforts were made to select the most cost-effective yet appropriate approaches. As such, most indicators draw on ongoing data collection efforts by partners and impose only minimal or no additional data collection requirements. Implementing partners and the Mission should consider data collection requirements when determining annual budgets.

Further planning needs be undertaken with regards to primary data collection, through surveys at the population level. Population-level data will be needed to assess progress toward intermediate results, and for assessing reductions in morbidity and mortality. A DHS is planned for 2012, but additional surveys targeted at specific subpopulations and geographical coverage areas are needed. An evaluation plan is proposed for the next 5 years (for details see Section V: Evaluation and Learning).

Reviewing and Updating the PMP

The PMP serves as a "living" document that the health team uses to guide its performance management efforts. As such, it is updated as necessary to reflect changes in strategy and/or activities. PMP development is therefore not a one-time occurrence, but rather an ongoing process of review, revision, and reimplementation. The PMP is reviewed and revised at least annually and as necessary. When reviewing the PMP, the SO team considers the following issues:

Are the performance indicators measuring the intended result?

Are the performance indicators providing the information needed?

How can the PMP be improved?

If the SO team makes major changes to the PMP regarding indicators or data sources, then the rationale for adjustments are documented. For changes in minor PMP elements, such as indicator definition or responsible individual, the PMP is updated to reflect the changes, but without the rationale.

SECTION IV. PERFORMANCE INDICATOR REFERENCE SHEETS

The following section contains detailed performance indicator reference sheets for each results-level indicator.

List of Health Indicators

During the current revision, the Mission will report on the following required (standards) and custom indicators. These indicators are described using the performance indicator reference sheet.

SO6: Increased Use of High-Impact Health Services and Healthy Behaviors

1. Maternal mortality ratio [standard]
2. Neonatal mortality rate [standard]
3. Modern Contraceptive Prevalence Rate (MCPR) [standard]
4. Under 5 mortality rate [standard]
5. Malaria prevalence among children under 5 years of age [custom]
6. Prevalence of underweight children under 5 years of age [standard]
7. Prevalence of stunted children under 5 years of age [standard]
8. Prevalence of wasted children under 5 years of age [standard]
9. Prevalence of underweight women [standard]

IR1: Increased Use of Quality FP, RH, MNCH Services

1. Couple-years protection (CYP) in USG-supported programs
2. Percent of births attended by a skilled doctor, nurse, or midwife (3.1.6-40)
3. Percent of births receiving at least four antenatal care (ANC) visits during pregnancy (3.1.6-48)
4. Percent of deliveries in health facilities using active management of the third stage of labor (AMTSL) and essential newborn care (ENC)
5. Percent of children 12–23 months of age who have received measles vaccine by 12 months of age [standard]
6. Percent of USG-assisted service delivery sites providing FP counseling and/or services.
7. Number of health care providers trained in FP/RH with U.S. Government (USG) fund
8. Number of ASCs (Agent de Santé Communautaire) trained in FP/RH with USG funds
9. Number of “relais” trained in FP/RH with USG funds

IR2: Increased Coverage and Use of Key Malaria Interventions

1. Number of health workers trained in case management with artemisinin-based combined therapies (ACTs) with USG funds
2. Number of ACT treatments purchased by other partners that were distributed with USG funds
3. Number of ACT treatments purchased with USG funds
4. Number of artemisinin-based combination therapy (ACT) treatments purchased in any fiscal year with USG funds that were distributed in this reported fiscal year (3.1.3-2)
5. Number of health workers trained in malaria laboratory diagnostics (rapid diagnostic tests [RDTs] or microscopy) with USG funds
6. Number of malaria RDTs purchased with USG funds
7. Number of RDTs purchased in any fiscal year with USG funds that were distributed to health facilities in this reported fiscal year
8. Number of insecticide-treated nets (ITNs) purchased by other partners that were distributed with USG funds
9. Number of ITNs purchased with USG funds
10. Number of ITNs purchased in any fiscal year with USG funds that were distributed in this reported fiscal year
11. Number of people trained with USG funds to deliver indoor residual spraying (IRS)
12. Number of houses targeted for spraying with USG funds
13. Number of houses sprayed with IRS with USG funds
14. Total number of residents of sprayed houses
15. Number of health workers trained in intermittent preventive treatment in pregnancy (IPTp) with USG funds
16. Number of sulfadoxine-pyrimethamine (SP) tablets purchased with USG funds
17. Number of SP tablets purchased with USG funds that were distributed to health facilities
18. Proportion of women who received intermittent preventive treatment (IPT) during ANC visits during their last pregnancy

IR3: Increased Coverage of HIV/AIDS and STI Prevention Services Among Selected MARPs

1. Number of individuals who received testing and counseling (T&C) services for HIV and received their test results (President's Emergency Plan for AIDS Relief [PEPFAR] output—#P11.1.D)

2. Number of people living with HIV/AIDS (PLHIV) reached with a minimum package of prevention with PLHIV (PwP) interventions (PEPFAR output - #P7.1.D)
3. Number of the targeted population reached with individual and/or small group–level HIV prevention interventions that are based on evidence and/or meet the minimum required standards (PEPFAR output—#P8.1D)
4. Number of MARP reached with individual and/or small group–level preventive interventions that are based on evidence and/or meet the minimum required standards
5. Number of condoms distributed

IR4: Improved Nutritional Status, Water Supply, Hygiene, and Sanitation

1. Number of people trained in child health and nutrition through USG-supported program
2. Number of children under 5 reached by USG-supported nutrition programs
3. Number of children under 5 who received vitamin A from USG-supported programs
4. Prevalence of children 6–23 months receiving a minimum acceptable diet
5. Prevalence of households with moderate or severe hunger
6. Percent of households with soap and water at a handwashing station commonly used by family members (3.1.6-51)
7. Number of communities certified as “open defecation free” (ODF) as a result of USG assistance
8. Percent of population using an improved sanitation facility
9. Number of Aquatabs tablets sold as result of USG assistance
10. Prevalence of exclusive breastfeeding of children under 6 months of age

IR5: Improved National, Regional, District, and Community Management and Health Systems

1. Number of awards made directly to local organizations
2. Percentage of operating unit program funds obligated through partner country systems
3. Percentage of operating unit program funds obligated to local organizations
4. Number of policies or guidelines documents developed or updated with USG assistance to improve access to and use of HIHS
5. Percent of facilities that had all tracer medicines and commodities in stock in the last 3 months

Performance Indicator Reference Sheets

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health

Indicator: Maternal mortality ratio (MMR) [standard]
Name of Strategic Objective/Development Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-1:** Increased Use of Quality Family Planning, Reproductive, Maternal, Neonatal, and Child Health Services
Geographic Focus: National
Description
Precise Definition: Maternal deaths in women aged 15-49 years that occurred during pregnancy, delivery, or within 2 months of delivery. **Numerator:** Maternal deaths in women aged 15–49 years that occurred during pregnancy, delivery, or within 2 months of delivery **Denominator:** The number of live births. The number of live births is used in the denominator as an approximation of the population of all pregnant women who are at risk of a maternal death.
Unit of Measure: Per 100,000 live births
Disaggregated by: No
Justification and Management Utility: This indicator used to measure progress toward Millenium Development Goal (MDG) 5. The indicator will be used for program planning and adjustments and to decide whether budget allocation needs to change for the desired impacts. Policymakers, program managers, and development partners will use this indicator.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Population-based surveys
Data Source(s): DHS, Reproductive-Age Mortality Survey (RAMOS) studies, where available (preferred when conducted over total population or representative sample)
Method of Data Acquisition by USAID: ICF International
Frequency and Timing of Data Acquisition by USAID: Every 5 years. A DHS is planned in 2011.
Estimated Cost of Data Acquisition: To be determined (TBD)
Individual(s) Responsible at USAID: Mariama Bah, Madina Sangare, Souleymane Sogoba, and Salif Coulibaly
Location of Data Storage: ICF International Web site. Hard-bound copies of the DHS report are available in the health team offices. The DHS report will also be stored both in electronic and hard-copy version by the Mission M&E Specialist.

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: MMR [standard] (continued)
Data Quality Issues
Date of Initial Data Quality Assessment: The DHS has built-in data quality control procedures. A DHS is planned in 2012. In addition, the health team will carry out ad hoc quality assessment to ensure the USG data quality standards are met.
Known Data Limitations and Significance (if any): Ideally, data are retrieved through a vital registration system. In the vast majority of countries with high maternal mortality, this is not possible and surveys are used. Maternal mortality rates and ratios are subject to high levels of relative sampling error due to their relatively rare occurrence. Given that maternal deaths are relatively rare events, obtaining MMRs with reasonably good precision requires extremely large samples, particularly where fertility is not exceptionally high. Except where sample sizes are extremely large, MMRs calculated from large DHS-type surveys relate to a time up to 10 years prior to the survey date, meaning that the "current" ratio will in fact be several years old, a potential drawback in using MMR as a measure of recent change. Maternal mortality is also affected by nonhealth social determinants. Nevertheless, maternal mortality ratios are more robust, easier to measure, and better reflect obstetric risk than maternal mortality rates. Conventionally, the ratios have been tracked longitudinally for longer periods of time, approximately 5 years. While RAMOS studies can be considered more accurate, they tend to be extrapolated from studies on subnational populations. DHS provides trend data, though with less accuracy.
Actions Taken or Planned to Address Data Limitations: Collaboration between USAID and the implementing partner, ICF International, during all stages of the survey, is recommended to ensure high-quality data.
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis: ICF International and GOM will conduct the initial analysis of survey data. Data will be analyzed to conduct a comparison in maternal mortality rates between years, to show progress in reducing maternal mortality rates. Findings of the DHS will be reviewed and analyzed by the health team.
Presentation of Data: Data will be presented in the form of graphs and tables.
Review of Data: Data will be reviewed in conjunction with the Performance Implementation Review (PIR) and the Performance Plan and Report, as well as other relevant reports. Contracting Officer's Technical Representatives (COTRs)/Agreement Officer's Technical Representatives (AOTRs), activity managers, the team leader, M&E focal persons, and the Program Office (PO) are responsible for reviewing data.
Reporting of Data: Data will be reported in the Performance Implementation Review and the Performance Plan and Report, as well as relevant SO6 reports.
Other Notes
Notes on Baselines/Targets: DHS 2006
Data Issues/Questions to Be Addressed: DHS provides national estimates that may not accurately measure the impact of USG's investments in the focused districts.

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: MMR [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009 Baseline		464 per 100,000 live births	DHS 2006 for the period 2000 to 2006; MMR was 582 per 100,000 live births for the period 1999 to 2001
2010	388		Assuming a steady decrease of 48.4 per year from 2001 (582) to reach the goal of 146 by the 2015 roadmap (Feuille de Route) to accelerate the decrease of MMR
2011	340		Assuming a steady decrease of 48.4 per year from 2001 (582) to reach the goal of 146 by the 2015 roadmap (Feuille de Route) to accelerate the decrease of MMR
2012	292		Assuming a steady decrease of 48.4 per year from 2001 (582) to reach the goal of 146 by the 2015 roadmap (Feuille de Route) to accelerate the decrease of MMR
2013	243		Assuming a steady decrease of 48.4 of the 2012 target
2014	195		Assuming a steady decrease of 48.4 of the 2013 target
2015	146		Assuming a steady decrease of 48.4 of the 2014 target; 4 per year from 2012

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: U5M rate [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-1:** Increased Use of Quality Family Planning, Reproductive, Maternal, Neonatal, and Child Health Services
Geographic Focus: National
Description
Precise Definition(s): **Numerator:** Number of deaths among children under age 5 in a given year **Denominator:** Number of live births in the same year/1,000
Unit of Measure: Per 1,000 live births
Disaggregated by: Sex
Justification and Management Utility: To evaluate the impact of the four proven malaria interventions. Bureau-level planners, Congress, partner governments, and other stakeholders would use this information. U5M rate is a leading indicator of the level of child health/survival and overall development in countries. It is a key indicator for the GHI, as well as being the indicator to measure MDG 4: reduction of child mortality.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Household surveys
Data Source(s): DHS, MICS, and MIS
Method of Data Acquisition by USAID: When surveys are available
Frequency and Timing of Data Acquisition by USAID: The timeframe for these surveys in any given country will be different. The DHS is implemented every 5 years and the MICS every 3 years. The MIS is primarily a coverage survey, so it does not always include mortality data. These surveys are not conducted on an annual basis in any given country, so reporting on this indicator can only be done when the above surveys are scheduled, which could be every 3 to 5 years.
Budget Mechanism:
Individual Responsible at USAID: Aboubacar Sadou and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any): These surveys are not conducted annually, so data may not be available at the optimal intervals for evaluation. U5M rate is, strictly speaking, not a rate (i.e., the number of deaths divided by the number of population at-risk during a certain period of time), but a probability of death derived from a life table and expressed as a rate per 1,000 live births. Often disaggregated U5M rates are presented for 10-year periods because of the rapid increase in sampling error if multiple categories are used. Censuses and surveys provide such detail; vital registration data usually do not include socioeconomic variables, but can provide other disaggregation. However, in most of the developing world vital registration is of little or no value in looking at child mortality because of incomplete numerators and denominators. Age-specific mortality rates are calculated from data on births and deaths in vital statistics registries, censuses, and household surveys in developing countries. Estimates based on household survey data are obtained directly (using birth history, as in Demographic and Health Surveys) or indirectly (Brass method, as in Multiple Indicator Cluster Surveys). The data are then summed for children under 5 and the results are expressed as a rate per 1,000 live births. Because rates calculated from DHS-type surveys relate to a time several years prior to the survey date, the "current" ratio may in fact be several years old, a potential drawback in using U5M rate as a measure of recent change.

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: U5M rate [standard] (continued)			
Data Quality Issues (continued)			
Actions Taken or Planned to Address Data Limitations:			
Date of Future Data Quality Assessments: TBD			
Procedures for Future Data Quality Assessments:			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009 Baseline		191 per 1,000 births	DHS 2006
2011			
2012	95		Assuming 50% of reduction in 2012, to reach the President's Malaria Initiative's (PMI's) goal of near zero death due to malaria by 2015.
2013			
2014			

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Neonatal mortality rate [standard]
Name of Strategic Objective/Development Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-1:** Use of Quality Family Planning, Reproductive, Maternal, Neonatal, and Child Health Services Increased
Geographic Focus: National
Description
Precise Definition: **Numerator:** Number of deaths among infants in the first 28 days of life in a given year **Denominator:** Number of live births in that year/1,000
Unit of Measure: Per 1,000 live births
Disaggregated by: Sex
Justification and Management Utility: Reducing the neonatal mortality rate (NMR) directly contributes to MDG 4, to reduce U5M by two-thirds between 1990 and 2015. Mortality among children in the first month of life is responsible for 37% of U5M (World Health Organization [WHO], 2008). The indicator will be used for program planning and adjustments and to decide whether budget allocation needs to change for the desired impacts. Policymakers, program managers, and development partners will use this indicator.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Household survey
Data Source(s): DHS or MICS
Method of Data Acquisition by USAID: ICF International
Frequency and Timing of Data Acquisition by USAID: Varies. Every 5 years for DHS.
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: Mariama Bah, Madina Sangare, Souleymane Sogoba, and Salif Coulibaly
Location of Data Storage: ICF International Web site. Hard-bound copies of the DHS report are available in the health team offices. The DHS report will also be stored both in electronic and hard-copy version by the Mission's M&E Specialist.
Data Quality Issues
Date of Initial Data Quality Assessment: The DHS has built-in quality control procedures.
Known Data Limitations and Significance (if any): Often disaggregated neonatal mortality rates are presented for 10-year periods because of the rapid increase in sampling error if multiple categories are used. Censuses and surveys provide such detail; vital registration data usually do not include socioeconomic variables, but can provide the other disaggregation. However, in most of the developing world, vital registration is of little or no value in looking at child mortality because of incomplete numerators and denominators. Age-specific mortality rates are calculated from data on births and deaths in vital statistics registries, censuses, and household surveys in developing countries. Estimates based on household survey data are obtained directly (using birth history, as in Demographic and Health Surveys) or indirectly (Brass method, as in Multiple Indicator Cluster Surveys). The data are then summed for neonates, and the results are expressed as a rate per 1,000 live births. Because rates calculated from DHS-type surveys relate to a time several years prior to the survey date, the "current" ratio may in fact be several years old, a potential drawback in using NMR as a measure of recent change.

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Neonatal mortality rate [standard] (continued)			
Data Quality Issues (continued)			
Actions Taken or Planned to Address Data Limitations:			
Date of Future Data Quality Assessment:			
Procedures for Future Data Quality Assessments:			
Plan for Data Analysis, Review, and Reporting			
Data Analysis: ICF International and GOM will conduct the initial analysis of survey data. Data will be analyzed to conduct a comparison in maternal mortality rates between years, to show progress in reducing maternal mortality rates. Findings of the DHS will be reviewed and analyzed by the health team.			
Presentation of Data: Data will be presented in the form of graphs and tables.			
Review of Data: Data will be reviewed in conjunction with the PIR and the PPR, as well as other relevant reports. COTRs/AOTRs, activity managers, the team leader, M&E focal persons, and the PO are responsible for reviewing data.			
Reporting of Data: Data will be reported in the PIR and the PPR, as well as relevant SO6 reports.			
Other Notes			
Notes on Baselines/Targets: DHS 2006			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		46	DHS 2006
2010	34		Assuming a steady decrease of 2.89 per year from the 2006 DHS estimate of 46 to reach the goal of 20 by the 2015 roadmap (Feuille de Route) to accelerate the decrease of MMR. The decrease of 2.89 was calculated by subtracting 20 from 46 and dividing by 9 (the 9-year gap between 2006 and 2015).
2011	32		Assuming a steady decrease of 2.89 of the 2010 target
2012	29		Assuming a steady decrease of 2.89 of the 2011 target
2013	26		Assuming a steady decrease of 2.89 of the 2012 target
2014	23		Assuming a steady decrease of 2.89 of the 2013 target
2015	20		Assuming a steady decrease of 2.89 of the 2014 target

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Modern contraceptive prevalence rate [standard]
Name of Strategic Objective/Development Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-1:** Increased Use of Quality Family Planning, Reproductive, Maternal, Neonatal, and Child Health Services
Geographic Focus: National
Description
Precise Definition: Percentage of reproductive-age women (aged15–49) who are currently using a modern method of contraception **Numerator:** Number of women (aged15–49) of reproductive age currently using a modern method of contraception **Denominator:** Total number of women (aged15–49) of reproductive age
Unit of Measure: Percentage
Disaggregated by: Numerator/denominator
Justification and Management Utility: MCPR is a direct measure of the desired outcome of FP/RH programs. It is directly linked to reductions in unintended pregnancies. Data (which are typically available every 5 years) are used for assessing longer-term program impact and regional and rural-urban differences, reviewing the reach of various program components, and developing new strategies and program directions.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Household survey
Data Source: DHS
Method of Data Acquisition by USAID: ICF International
Frequency and Timing of Data Acquisition by USAID: Every 5 years. Next DHS planned in 2012.
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: Madina Sangare, Madiou Yattara, and Souleymane Sogoba
Location of Data Storage: ICF International Web site. Hard-bound copies of the DHS report are available in the health team offices. The DHS report will also be stored both in electronic and hard-copy version by the Mission's M&E Specialist.
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any): Measures of the prevalence of contraceptive use are usually derived from interviews with representative samples of women of reproductive age. These interviews are affected by recall bias.
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Modern contraceptive prevalence rate [standard] (continued)			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009 Baseline		6.9%	DHS 2006
2010	13		Assuming a steady increase by 1.45 per year from 2006 (6.9%) to reach the goal of 20 by the 2015 roadmap (Feuille de Route) to accelerate the decrease of MMR
2011	14		Assuming a steady decrease of 1.45 of the 2010 target
2012	16		Assuming a steady decrease of 1.45 of the 2011 target
2013	17		Assuming a steady decrease of 1.45 of the 2012 target
2014	19		Assuming a steady decrease of 1.45 of the 2013 target
2015	20		Assuming a steady decrease of 1.45 of the 2014 target

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

<table>
<tr><th colspan="2">Indicator: Couple-years protection in USG-supported programs [standard]</th></tr>
<tr><td colspan="2">Name of Strategic Objective/Development Objective: Increased Use of High-Impact Health Services and Healthy Behaviors</td></tr>
<tr><td colspan="2">Name of Intermediate Result:
IR-1: Use of Quality Family Planning, Reproductive, Maternal, Neonatal, and Child Health Services Increased</td></tr>
<tr><td colspan="2">Geographic Focus: National</td></tr>
<tr><th colspan="2">Description</th></tr>
<tr><td colspan="2">Precise Definition: CYP is the estimated protection provided by contraceptive methods during a 1-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period.
The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYPs for each method are then summed over all methods to obtain a total CYP figure.
USAID conversion factors for CYP follow:</td></tr>
<tr><th>Method</th><th>CYP per Unit</th></tr>
<tr><td>Copper-T 380-A intrauterine device (IUD)</td><td>4.6 CYP per IUD inserted (3.3 for 5-year IUD; e.g., LNG-IUS)</td></tr>
<tr><td>3-year implant (e.g., Implanon)</td><td>2.5 CYP per implant</td></tr>
<tr><td>4-year implant (e.g., Sino-Implant)</td><td>3.2 CYP per implant</td></tr>
<tr><td>5-year implant (e.g., Jadelle)</td><td>3.8 CYP per implant</td></tr>
<tr><td>Emergency contraception</td><td>20 doses per CYP</td></tr>
<tr><td>Fertility awareness methods</td><td>1.5 CYP per trained adopter</td></tr>
<tr><td>Standard days method</td><td>1.5 CYP per trained adopter</td></tr>
<tr><td>Lactational amenorrhea method</td><td>4 active users per CYP (or .25 CYP per user)</td></tr>
<tr><td>Sterilization</td><td>10</td></tr>
<tr><td>Oral contraceptives</td><td>15 cycles per CYP</td></tr>
<tr><td>Condoms (male and female)</td><td>120 units per CYP</td></tr>
<tr><td>Vaginal foaming tablets</td><td>120 units per CYP</td></tr>
<tr><td>Depo-Provera injectable</td><td>4 doses per CYP</td></tr>
<tr><td>Noristerat (NET-En) injectable</td><td>6 doses per CYP</td></tr>
<tr><td>Cyclofem monthly injectable</td><td>13 doses per CYP</td></tr>
<tr><td>Monthly vaginal ring/patch</td><td>15 units</td></tr>
<tr><td colspan="2">Unit of Measure: CYP</td></tr>
<tr><td colspan="2">Disaggregated by: None</td></tr>
<tr><td colspan="2">Justification and Management Utility: The term CYP reflects distribution and is a way to estimate coverage and not actual use or impact. The CYP calculation provides an immediate indication of the volume of program activity. CYP can also allow programs to compare the contraceptive coverage provided by different family planning methods. CYP is easy to calculate from data that programs routinely collect; these data can come from a variety of sources and are relatively easy to track.</td></tr>
<tr><td colspan="2">Indicator's Relevance to Gender: Both male and female data will contribute in the calculation of this indicator.</td></tr>
</table>

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Couple-years protection in USG-supported programs [standard] (continued)			
Plan for Data Acquisition by USAID			
Data Collection Method: Systems for improved access to pharmaceuticals and services (SIAPS) obtains national CYP data from the Directorate of Pharmacy and Medicines (DPM).			
Data Source(s): DPM records and HMIS			
Method of Data Acquisition by USAID: SIAPS			
Frequency and Timing of Data Acquisition by USAID: Quarterly			
Estimated Cost of Data Acquisition:			
Individual(s) Responsible at USAID: Madina Sangare, Madiou Yattara, and Souleymane Sogoba			
Location of Data Storage:			
Data Quality Issues			
Date of Initial Data Quality Assessment: April 2011			
Known Data Limitations and Significance (if any):			
Actions Taken or Planned to Address Data Limitations:			
Date of Future Data Quality Assessment: April 2014			
Procedures for Future Data Quality Assessments:			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed: CYP conversion factors are based on how a method is used, how often it fails, how often there is wastage, and how many units of the method are typically needed to provide 1 year of contraceptive protection for a couple. The calculation takes into account that some methods, for example condoms and oral contraceptives, may be used incorrectly and then discarded, or that IUDs and implants may be removed before their lifespan is realized.			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009 Baseline		440,362	
2010	400,000	444,928	
2011	460,000		15% of the 2010 target
2012	552,000		20% of the 2011 target
2013	717,600		30% of the 2012 target
2014	717,600		Same as 2013 target because of probable stable use of long-acting modern contraceptive methods

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Percent of births attended by a skilled doctor, nurse, or midwife (3.1.6-40)
Name of Strategic Objective/Development Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-1:** Increased Use of Quality Family Planning, Reproductive, Maternal, Neonatal, and Child Health Services
Geographic Focus: 36 districts
Description
Precise Definition: **Numerator:** Births in a given year attended by a skilled birth attendant, such as a doctor, nurse, or midwife. A doctor, midwife or nurse is a person who, having been regularly admitted to a professional educational program, is duly recognized in the country in which he or she is located, has successfully completed the prescribed course of studies, and has acquired the requisite qualifications to be registered and/or legally licensed to practice. **Denominator:** Live births in the same year/100.
Unit of Measure: Percentage
Disaggregated by: Numerator, denominator
Justification and Management Utility: This indicator is used by planners and managers to identify and target geographic areas for care, when disaggregated subnationally, and to indicate areas of need in relation to preparation, deployment, and retention of personnel. It can be used for policy discussion to develop context-specific strategies to improve care for childbearing women during labor and birth. This indicator in and of itself does not measure quality of care, and so it should be assessed along with other indicators.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: USAID/Mali will use both DHS 2012 and Système Local d'Information Sanitaire (SLIS) routine data.
Data Source(s): DHS 2012 and SLIS
Method of Data Acquisition by USAID: ATN Plus
Frequency and Timing of Data Acquisition by USAID: Quarterly
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: Madina Sangare, Mariama Bah, Madiou Yattara, and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any): There may not be consistency in identifying trained personnel by survey respondents. They may not know the basic credential of the provider in some cases. Surveys such as the DHS do not identify doctors and nurses with midwifery training/skills. Some surveys identify assistance from a skilled provider but do not specify their actual qualifications. The SLIS routine data will affected by underreporting and completeness.

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Percent of births attended by a skilled doctor, nurse, or midwife (3.1.6-40) (continued)			
Actions Taken or Planned to Address Data Limitations: Strengthening SLIS to improve quality, timeliness, and completeness of its data.			
Date of Future Data Quality Assessment: TBD			
Procedures for Future Data Quality Assessments:			
Plan for Data Analysis, Review, and Reporting			
Data Analysis: Trend analysis, comparison between districts			
Presentation of Data: Data will be presented in tables, graphs, and maps.			
Review of Data: Data will be reviewed in conjunction with the PIR and the PPR, as well as other relevant reports. COTRs/AOTRs, activity managers, the team leader, M&E focal persons, and the PO are responsible for reviewing data.			
Reporting of Data: Data will be reported in the PIR and the PPR, as well as relevant SO6 reports.			
Other Notes			
Notes on Baselines/Targets: 2009 baseline data was not available. 2010 targets are based on assumption of 10% increase each year for 2009 and 2010.			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		50	2010 SLIS annual report
2010		51	2011 SLIS annual report
2011	55		
2012	60		
2013	65		
2014	80		

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Percent of births receiving at least four ANC visits during pregnancy (3.1.6-48)
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-1:** Increased Use of Quality Family Planning, Reproductive, Maternal, Neonatal, and Child Health Services
Geographic Focus: 36 districts
Description
Precise Definition(s): Number of pregnant women who completed at least three antenatal care visits provided by skilled providers from USG-assisted facilities in the last 12 months. All Centre de Santé Communautaire, or community health centers, and Centres de Santé de Référence, or district-level health referral centers, within the USAID focus districts are to be considered USG-assisted facilities.
Unit of Measure: Number of women
Disaggregated by: Numerator/denominator
Justification and Management Utility: Information used both for program planning and adjustments. Data are used by program managers, policymakers, and development partners.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: SLIS quarterly reports
Data Source: SLIS
Method of Data Acquisition by USAID: ATN Plus will collect data and send to USAID
Frequency and Timing of Data Acquisition by USAID: Quarterly
Budget Mechanism: To be reflected in the ATN Plus budget
Individual Responsible at USAID: Mariama Bah and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any): This indicator tells us the volume of ANC at facilities but not the coverage of ANC (i.e., the percentage of pregnant women who use ANC services). Also, quality, timeliness, and completeness of SLIS data are an issue.
Actions Taken or Planned to Address Data Limitations: Completeness of data is to be reported, along with indicators.
Date of Future Data Quality Assessments: 2015
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis: Data will be analyzed quarterly by the COTR/AOTR and the M&E team, along with the pipeline analyses to ensure adequate implementation of the activities.
Presentation of Data: Maps, tables, and graphs.
Review of Data: The COTR/AOTR will report any discrepancies in the report data to the health team. If needed, meetings will be arranged with the implementing partners for clarification.
Reporting Data: TBD

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Percent of births receiving at least four ANC visits during pregnancy (3.1.6-48) (continued)			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009 Baseline		NA	
2010	NA	NA	
2011	NA	NA	New indicator
2012	400,000		Anticipated number of ANCs visits in 2012
2013	440,000		10% increase in 2013
2014	484,000		10% increase in 2014

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Percent of deliveries in health facilities using active management of the third stage of labor and essential newborn care [custom]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR1:** Increased Use of Quality Family Planning, Reproductive, Maternal, Neonatal, and Child Health Services
Geographic Focus: 36 districts
Description
Precise Definition(s): Percent of deliveries in health facilities using active management of the third stage of labor AND essential newborn care. **Numerator:** Number of deliveries in health facilities using AMTSL and ENC in the 36 districts. **Denominator:** Total number of deliveries in health facilities in the 36 districts. The criteria for meeting AMTSL and ENC standard follow: The presence of at least one trained provider and at least one trained midwife at the facility. The existence of registries for recording deliveries with AMTSL and births with ENC. The presence of oxytocin in the facility stored in refrigerator or cooler and the existence of a notebook for monitoring its use.
Unit of Measure: Percent
Disaggregated by: Numerator/denominator
Justification and Management Utility: The active management of the third stage of labor is a combination of actions to speed the delivery of the placenta and prevent postpartum hemorrhage. These deliveries are almost exclusively vaginal in nature. Through these simple actions, trained providers can play a vital role in saving women's lives. Likewise, ENC can greatly decrease neonatal deaths.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Supervisory visit reports
Data Source: Program reports from ATN Plus
Method of Data Acquisition by USAID: ATN will collect data and send to USAID
Frequency and Timing of Data Acquisition by USAID: Quarterly
Budget Mechanism: To be reflected in ATN Plus budget
Individual Responsible at USAID: Madina Sangare, Mariama Bah, and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any): This indicator assesses the service delivery point's capacity to provide AMTSL and ENC at a given point in time. This capacity is susceptible to stock-outs and rapid provider turnover.
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessments: 2015
Procedures for Future Data Quality Assessments:

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Percent of deliveries in health facilities using active management of the third stage of labor and essential newborn care [custom] (continued)			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009 Baseline		50	
2010	60	60	
2011	70	78	
2012	82		5% increase from the actual of 2011, because of GHI, the BEST action plan, and the new behavior change communication (BCC) project
2013	86		5% increase from the actual of 2011, because of GHI, the BEST action plan, and the new BCC project
2014	90		5% increase from the actual of 2011, because of GHI, the BEST action plan, and the new BCC project

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Percent of children 12–23 months of age who have received measles vaccine by 12 months of age [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-1:** Increased Use of Quality Family Planning, Reproductive, Maternal, Neonatal, and Child Health Services
Geographic Focus: National
Description
Precise Definition(s): **Numerator:** Children aged 12–23 months who received measles vaccine by the time they were 12 months of age **Denominator:** Number of living children aged 12–23 months/100 during the same period
Unit of Measure: Percent
Disaggregated by: Sex
Justification and Management Utility: Indicator will be used for program planning and adjustments, to decide whether budget allocation needs to change for the desired impacts. Used by policymakers, program managers, and development partners.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: DHS/MICS/RH surveys and other population-based surveys
Data Source(s): DHS, MICS, and RH surveys
Method of Data Acquisition by USAID: ICF International, United Nations Children's Fund (UNICEF), and ATN Plus
Frequency and Timing of Data Acquisition by USAID: Every 5 years for DHS
Budget Mechanism:
Individual(s) Responsible at USAID: Madina Sangare, Mariama Bah, and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any): Data quality depends on recall by respondents (since almost half of respondents were unable to produce the immunization record cards at the time of the survey).
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessments: 2015
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting Data:

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Percent of children 12–23 months of age who have received measles vaccine by 12 months of age [standard] (continued)			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009 Baseline		NA	
2010	NA	NA	
2011	NA	NA	New indicator
2012	91%		Assuming steady increase in routine immunization coverage
2013	93%		
2014	95%		

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Percentage of USG-assisted service delivery sites providing family planning counseling and/or services (Standard)
Name of Strategic Objective/Development Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-1:** Increased Use of Quality Family Planning, Reproductive, Maternal, Neonatal, and Child Health Services
Geographic Focus: National
Description
Precise Definition: USG-Assisted: Funded with congressionally earmarked FP funds for any kind of assistance. Service Delivery Sites: Clinics, hospitals, facilities (government, private or nongovernmental organization (NGO)/faith-based organization), pharmacies, and/or social marketing sales points. Does not include community health workers (CHWs). FP Counseling: FP information and/or FP counseling provided in the context of a visit with an FP service provider. FP Services: Provision of FP methods and or FP referrals. **Numerator:** Number of USG-assisted service delivery sites providing FP information and/or services. **Denominator:** Number of service delivery points planned to receive USG assistance.
Unit of Measure: Percentage
Disaggregated by: Numerator/denominator
Justification and Management Utility: This indicator is used to assess the longer-term program output and impact and to develop new strategies and program directions and interventions.
Indicator's Relevance to Gender: No
Plan for Data Acquisition by USAID
Data Collection Method: Routine service statistics data
Data Source: SLIS
Method of Data Acquisition by USAID: ATN Plus
Frequency and Timing of Data Acquisition by USAID: Quarterly
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: Madina Sangare, Salif Coulibaly, and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan For Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Percentage of USG-assisted service delivery sites providing family planning counseling and/or services [standard] (continued)			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010			
2011		85	Steady increase
2012	90		Steady increase
2013	92		Steady increase
2014	95		Steady increase

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Number of health care providers trained in FP/RH with USG funds [custom]
Name of Strategic Objective/Development Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-1:** Increased Use of Quality Family Planning, Reproductive, Maternal, Neonatal, and Child Health Services
Geographic Focus: National
Description
Precise Definition: Number of health care providers (physicians, midwives, nurses, and other medical personnel) trained to deliver FP and RH services. Definition of training: Training refers to the new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A training session must have specific learning objectives, a course outline and a curriculum, and expected knowledge, skills, and/or competencies to be gained by participants. Only participants who complete the full training course should be counted. If a training course is conducted in several sessions or covers more than one topic, individuals should be counted once for this training course. If training spans more than one programmatic area with separate and specific objectives and curricula for each program, individuals should be counted for each program area. Individuals trained in training courses cofunded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period.
Unit of Measure: Number
Disaggregated by: Health care provider categories, sex
Justification and Management Utility: This indicator measures the USG investment in capacity building in FP/RH programs.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Routine reporting
Data Source: Partner reports
Method of Data Acquisition by USAID: ATN Plus
Frequency and Timing of Data Acquisition by USAID: Quarterly
Estimated Cost of Data Acquisition:
Individual(s) responsible at USAID: Mariama Bath, Madina Sangare, Salif Coulibaly, and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: TBD
Known Data Limitations and Significance (if any): Completeness of partner reports
Actions Taken or Planned to Address Data Limitations: Each USAID partner involved in training should design a database to capture this indicator.
Date of Future Data Quality Assessment: TBD
Procedures for Future Data Quality Assessments: Site visits

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Number of health care providers trained in FP/RH with USG funds [custom] (continued)			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data: Tables, maps			
Review of Data: Data will be reviewed in conjunction with the PIR and the PPR, as well as other relevant reports. COTRs/AOTRs, activity managers, the team leader, M&E focal persons, and the PO are responsible for reviewing data.			
Reporting of Data: Data will be reported in the PIR and the PPR, as well as relevant SO reports.			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010			
2011	1,196	1,259	
2012	100		Devolution stage, only new staff will be trained
2013	100		
2014	100		

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Number of ASCs trained in FP/RH with USG funds [custom]
Name of Strategic Objective/Development Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-1:** Increased Use of Quality Family Planning, Reproductive, Maternal, Neonatal, and Child Health Services
Geographic Focus: National
Description
Precise Definition: Number of ASCs (agent de santé communautaire) trained
Unit of Measure: Number
Disaggregated by: Sex, district
Justification and Management Utility: This indicator measures the USG investment in capacity building in FP/RH programs at community level.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Routine reporting
Data Source: Partner reports
Method of Data Acquisition by USAID: ATN Plus
Frequency and Timing of Data Acquisition by USAID: Quarterly
Estimated Cost of Data Acquisition:
Individual(s) responsible at USAID: Mariama Bath, Madina Sangare, Salif Coulibaly, and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: TBD
Known Data Limitations and Significance (if any): Completeness of partner reports
Actions Taken or Planned to Address Data Limitations: Each USAID partner involved in training should design a database to capture this indicator.
Date of Future Data Quality Assessment: TBD
Procedures for Future Data Quality Assessments: Site visits
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data: Tables, maps
Review of Data: Data will be reviewed in conjunction with the PIR and the PPR, as well as other relevant reports. COTRs/AOTRs, activity managers, the team leader, M&E focal persons, and the PO are responsible for reviewing data.
Reporting of Data: Data will be reported in the PIR and the PPR, as well as relevant SO6 reports.

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Number of ASCs trained in FP/RH with USG funds [custom] (continued)			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010			
2011	681	521	
2012	400		New ASCs to be trained
2013	200		To take into account sustainably of this activity; partners pay ASCs' salaries
2014	70		To take into account sustainably of this activity; partners pay ASCs' salaries

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Number of "relais" trained in FP/RH with USG funds (custom)
Name of Strategic Objective/Development Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-1:** Increased Use of Quality Family Planning, Reproductive, Maternal, Neonatal, and Child Health Services
Geographic Focus: National
Description
Precise Definition: Number of relais trained
Unit of Measure: Number
Disaggregated by: Sex, district
Justification and Management Utility: This indicator measures the USG investment in capacity building in FP/RH programs at community level.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Routine reporting
Data Source(s): Partner reports
Method of Data Acquisition by USAID: ATN Plus
Frequency and Timing of Data Acquisition by USAID: Quarterly
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: Mariama Bath, Madina Sangare, Salif Coulibaly, and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: TBD
Known Data Limitations and Significance (if any): Completeness of partner reports
Actions Taken or Planned to Address Data Limitations: Each USAID partner involved in training should design a database to capture this indicator.
Date of Future Data Quality Assessment: TBD
Procedures for Future Data Quality Assessments: Site visits
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data: Tables, maps
Review of Data: Data will be reviewed in conjunction with the PIR and the PPR, as well as other relevant reports. COTRs/AOTRs, activity managers, the team leader, M&E focal persons, and the PO are responsible for reviewing data.
Reporting of Data: Data will be reported in the PIR and the PPR, as well as relevant SO6 reports.

Maternal Neonatal and Child Health, Family Planning, and Reproductive Health (continued)

Indicator: Number of “relais” trained in FP/RH with USG funds [custom] (continued)			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2010			
2011			
2012			
2013			
2014			

Malaria

Indicator: U5M [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Increased Coverage and Use of Key Malaria Interventions
Geographic Focus: National
Description
Precise Definition(s): **Numerator:** Number of deaths among children under age 5 in a given year **Denominator:** Number of live births in the same year/1,000
Unit of Measure: Per 1,000 live births
Disaggregated by: Sex
Justification and Management Utility: To evaluate the impact of the four proven malaria interventions. Bureau-level planners, Congress, partner governments, and other stakeholders would use this information. U5M rate is a leading indicator of the level of child health/survival and overall development in countries. It is a key indicator for the GHI, as well as being the indicator to measure MDG 4: reduction of child mortality.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Household surveys
Data Source(s): DHS, MICS, and MIS
Method of Data Acquisition by USAID: ICF International
Frequency and Timing of Data Acquisition by USAID: The timeframe for these surveys in any given country will be different. The DHS is implemented every 5 years and the MICS every 3 years. The MIS is primarily a coverage survey, so it does not always include mortality data. These surveys are not conducted on an annual basis in any given country, so reporting on this indicator can only be done when the above surveys are scheduled, which could be every 3 to 5 years.
Budget Mechanism:
Individual Responsible at USAID: Aboubacar Sadou and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any): These surveys are not conducted annually, so data may not be available at the optimal intervals for evaluation. U5M rate is, strictly speaking, not a rate (i.e., the number of deaths divided by the number of population at-risk during a certain period of time), but a probability of death derived from a life table and expressed as a rate per 1,000 live births. Often disaggregated U5M rates are presented for 10-year periods because of the rapid increase in sampling error if multiple categories are used. Censuses and surveys provide such detail; vital registration data usually do not include socioeconomic variables, but can provide other disaggregation. However, in most of the developing world vital registration is of little or no value in looking at child mortality because of incomplete numerators and denominators.

Malaria (continued)

Indicator: U5M [standard] (continued)			
Data Quality Issues			
Age-specific mortality rates are calculated from data on births and deaths in vital statistics registries, censuses, and household surveys in developing countries. Estimates based on household survey data are obtained directly (using birth history, as in Demographic and Health Surveys) or indirectly (Brass method, as in Multiple Indicator Cluster Surveys). The data are then summed for children under five and the results are expressed as a rate per 1,000 live births. Because rates calculated from DHS-type surveys relate to a time several years prior to the survey date, the "current" ratio may in fact be several years old, a potential drawback in using U5M rates as a measure of recent change.			
Actions Taken or Planned to Address Data Limitations:			
Date of Future Data Quality Assessments: TBD			
Procedures for Future Data Quality Assessments:			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009 Baseline		191 per 1,000 births	DHS 2006
2010			
2011			
2012	95		Assuming 50% of reduction in 2012, to reach the PMI's goal of near zero death due to malaria by 2015.
2013			
2014			

Malaria (continued)

Indicator: Malaria prevalence among children under 5 years of age (custom)
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Coverage and Use of Key Malaria Interventions Increased
Geographic Focus: National
Description
Precise Definition: The indicator is calculated by dividing the total number of children with malaria infection (detected by microscopy) by the total number of children under 5 tested for parasites by microscopy.
Unit of Measure: Percentage
Disaggregated by: Sex
Justification and Management Utility: Critical in assessing the overall impact of the National Malaria Control Program effort in implementing the four proven malaria interventions: ACT; ITNs, IPTp, and IRS.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Household surveys
Data Source(s): MIS or Anemia and Parasitemia Survey (APS)
Method of Data Acquisition by USAID: ICF International
Frequency and Timing of Data Acquisition by USAID: APS was carried out in 2010, and a malaria module was included in the DHS 2012.
Estimated Cost of Data Acquisition:
Individual(s) responsible at USAID: PMI and Souleymane Sogoba
Location of Data Storage: PMI
Data Quality Issues
Date of Initial Data Quality Assessment: 2010
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: 2013 (MIS is planned in 2013)
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Malaria prevalence among children under 5 years of age [custom] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2010 Baseline		38% by microscopy	Range: 16 to 45% Male: 38.6%; female: 36.4% Urban: 4.8%; rural: 44.6%
2011	NA		
2012	NA		
2013	15%		Assuming 60% reduction to reach the PMI goal of reducing malaria cases by 75% in 2015
2014	NA		

Malaria (continued)

Indicator: Number of health workers trained in case management with ACTs with USG funds [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Coverage and Use of Key Malaria Interventions Increased
Geographic Focus: National
Description
Precise Definition: Number of health workers trained in case management with ACTs with USG funds
Unit of Measure: Number of people
Disaggregated by: Sex, facility/community
Justification and Management Utility: Health providers' skills in case management are crucial in reducing malaria morbidity and mortality.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Routine collection
Data Source(s): Implementing partners and GOM
Method of Data Acquisition by USAID: ATN Plus
Frequency and Timing of Data Acquisition by USAID: Quarterly
Estimated Cost of Data Acquisition:
Individual(s) responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any): The indicator does not reflect on the quality of the training provided, nor on the quality of the outcome of the training.
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of health workers trained in case management with ACTs with USG funds [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		412	
2010	1,229	1,277	
2011	NA	1,957	
2012	1,500		Continued refresher trainings
2013	1,500		Continued refresher trainings
2014	1,500		Continued refresher trainings

Malaria (continued)

Indicator: Number of ACT treatments purchased by other partners that were distributed with USG funds [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Increased Coverage and Use of Key Malaria Interventions
Geographic Focus: National
Description
Precise Definition: Number of ACT treatments purchased by other partners (not USG) but distributed with USG funds.
Unit of Measure: Number of treatments
Disaggregated by: None
Justification and Management Utility: The indicator takes into account the number of ACT treatments that are procured by other partners and distributed using USG funds. Also, it measures the degree of collaboration between USG, the GOM, and its partners that invest in the malaria supply chain.
Indicator's Relevance to Gender: No
Plan for Data Acquisition by USAID
Data Collection Method: Routine collection
Data Source: GOM
Method of Data Acquisition by USAID: SIAPS, PMI
Frequency and Timing of Data Acquisition by USAID: Annually
Estimated Cost of Data Acquisition:
Individual(s) responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of ACT treatments purchased by other partners that were distributed with USG funds [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010			
2011			
2012	TBD		
2013	TBD		
2014	TBD		

Malaria (continued)

Indicator: Number of ACT treatments purchased with USG funds [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Coverage and Use of Key Malaria Interventions Increased
Geographic Focus: National
Description
Precise Definition: Number of ACT treatments purchased with USG funds and received in Mali
Unit of Measure: Number of treatments
Disaggregated by: No
Justification and Management Utility: The indicator measures the number of ACTs purchased with USG funds, received in country, and not yet distributed.
Indicator's Relevance to Gender: No
Plan for Data Acquisition by USAID
Data Collection Method: Routine collection
Data Source: PMI
Method of Data Acquisition by USAID: PMI
Frequency and Timing of Data Acquisition by USAID: Annually
Estimated Cost of Data Acquisition:
Individual(s) responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of ACT treatments purchased with USG funds [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		330,589	
2010		739,200	Based on the PMI fourth report (calendar year results)
2011	500,000	1,289,190	To fill the gap for the Global Fund to fight AIDS, Tuberculosis and Malaria (GFAM) suspension
2012	1,550,000		To fill the gap for the GFAM suspension
2013	1,000,000		Assuming correct implementation of community-based essential health services (SEC), renewal of GFAM, and decrease of malaria cases due to increase in effective malaria diagnoses and treatment.
2014	1,000,000		Assuming correct implementation of SEC, renewal of GFAM, and decrease of malaria cases due to increase in effective malaria diagnoses and treatment.

Malaria (continued)

Indicator: Number of ACT treatments purchased in any fiscal year with USG funds that were distributed in the reported fiscal year [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Coverage and Use of Key Malaria Interventions Increased
Geographic Focus: National
Description
Precise Definition: Number of ACT treatments purchased in any fiscal year with USG funds that were distributed in this reporting fiscal year (1) to health facilities, (2) to CHWs (home-based management of fever [HBMF], community case management [CCM])
Unit of Measure: Number of ACT treatments
Disaggregated by: Type of distribution: facility/CHW (HBMF, CCM)
Justification and Management Utility: This indicator is directly related to the impact of the USG's investment in malaria control activities. The indicator is used for program planning, budgeting, and reporting. Country managers and partners use the indicator.
Indicator's Relevance to Gender: No
Plan for Data Acquisition by USAID
Data Collection Method: Routine collection
Data Source: SIAPS
Method of Data Acquisition by USAID: PMI/SIAPS
Frequency and Timing of Data Acquisition by USAID: Annually
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment: June 2010
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: June 2013
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of ACT treatments purchased in any fiscal year with USG funds that were distributed in the reported fiscal year [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009 Baseline		330,589	
2010	400,000	500,000	
2011	1,289,190	789,190	
2012	2,050,000		1,550,000 ACTs will be purchased, in addition to the remaining 500,000 purchased in 2011 but not distributed
2013	1,500,000		
2014	1,500,000		

Malaria (continued)

Indicator: Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Increased Coverage and Use of Key Malaria Interventions
Geographic Focus: National
Description
Precise Definition: Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds. Training refers to the new training or retraining of individuals in malaria diagnostics (RTDs or microscopy) according to the national standards.
Unit of Measure: Number of people
Disaggregated by: Sex, facility/community
Justification and Management Utility: The indicator measures the number of health workers who are trained in diagnostics that lead to more appropriate treatment.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Routine collection
Data Source(s): Implementing partners' reports
Method of Data Acquisition by USAID: ATN plus
Frequency and Timing of Data Acquisition by USAID: Quarterly
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		412	
2010	1,289	587	
2011	800		
2012	1,620		Same as ACTs + 120 laboratory technicians
2013	1,620		Same as ACTs + 120 laboratory technicians
2014	1,620		Same as ACTs + 120 laboratory technicians

Malaria (continued)

Indicator: Number of RDTs purchased with USG funds [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Coverage and Use of Key Malaria Interventions Increased
Geographic Focus: National
Description
Precise Definition: Number of RDTs purchased with USG funds.
Unit of Measure: Number of RDTs
Disaggregated by: None
Justification and Management Utility: The availability of RDTs in country is important for appropriate malaria case management.
Indicator's Relevance to Gender: No
Plan for Data Acquisition by USAID
Data Collection Method: Routine collection
Data Source: PMI
Method of Data Acquisition by USAID: PMI
Frequency and Timing of Data Acquisition by USAID: Annually
Estimated Cost of Data Acquisition:
Individual(s) responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of RDTs purchased with USG funds [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		31,380	
2010	30,000	500,000	
2011	500,000	500,000	
2012	2,000,000		To fill the gap of the GFAM suspension and apply the case management guidelines
2013	1,000,000		Assuming renewal of GFAM
2014	1,000,000		Assuming renewal of GFAM

Malaria (continued)

Indicator: Number of RDTs purchased in any fiscal year with USG funds that were distributed to health facilities in this reported fiscal year [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Increased Coverage and Use of Key Malaria Interventions
Geographic Focus: National
Description
Precise Definition: Number of RDTs purchased in fiscal year with USG funds that were distributed to health facilities in this reported fiscal year.
Unit of Measure: Number of RDTs
Disaggregated by: None
Justification and Management Utility: The availability of RDTs in country is important for appropriate malaria case management.
Indicator's Relevance to Gender: No
Plan for Data Acquisition by USAID
Data Collection Method: Routine collection
Data Source(s): Implementing partners and MOH
Method of Data Acquisition by USAID: PMI/SIAPS
Frequency and Timing of Data Acquisition by USAID: Quarterly
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of RDTs purchased in any fiscal year with USG funds that were distributed to health facilities in this reported fiscal year [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010		530,000	PMI fourth report
2011	500,000	TBD	
2012	TBD		
2013	TBD		
2014	TBD		

Malaria (continued)

Indicator: Number of ITNs purchased by other partners that were distributed with USG funds [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Increased Coverage and Use of Key Malaria Interventions
Geographic Focus: National
Description
Precise Definition: Number of ITNs purchased by other partners that were distributed with USG funds
Unit of Measure: Number of ITNs
Disaggregated by: None
Justification and Management Utility: The indicator provides the number of ITNs purchased by other partners and distributed with USG funds.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition By USAID
Data Collection Method: Routine collection
Data Source(s): DPM, PMI
Method of Data Acquisition by USAID: PMI/DELIVER
Frequency and Timing of Data Acquisition by USAID: Annually
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of ITNs purchased by other partners that were distributed with USG funds [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010			
2011			
2012	320,000		Planned distribution of ITNs purchased by UNICEF and GFAM
2013			
2014			

Malaria (continued)

Indicator: Number of ITNs purchased with USG funds [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Coverage and Use of Key Malaria Interventions Increased
Geographic Focus: National
Description
Precise Definition: Number of ITNs purchased with USG funds
Unit of Measure: Number of ITNs
Disaggregated by: No
Justification and Management Utility: The indicator provides linkage to the outcome indicator on household ownership of ITNs, as well as the use of ITNs.
Indicator's Relevance to Gender: None
Plan for Data Acquisition by USAID
Data Collection Method: Routine collection
Data Source(s): DPM, PMI
Method of Data Acquisition by USAID: PMI
Frequency and Timing of Data Acquisition by USAID: Annually
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of ITNs purchased with USG funds [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		600,000	
2010	1,240,000	2,110,000	
2011	1,500,000	3,037,150	
2012	0		
2013	1,300,000		
2014	1,300,000		

Malaria (continued)

Indicator: Number of ITNs purchased in any fiscal year with USG funds that were distributed in this reported fiscal year [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Increased Coverage and Use of Key Malaria Interventions
Geographic Focus: National
Description
Precise Definition: Number of ITNs purchased in any fiscal year with USG funds that were distributed in this reported fiscal year (1) through campaigns, (2) through health facilities (ANC or child health clinics), (3) through the private/commercial sector, (4) through other distribution channels.
Unit of Measure: Number of ITNs
Disaggregated by: Method of distribution: campaigns/facilities
Justification and Management Utility: The indicator is used for program planning, budgeting, and reporting. Country managers and partners use the indicator.
Indicator's Relevance to Gender: No
Plan for Data Acquisition by USAID
Data Collection Method: Routine data collection
Data Source(s): DELIVER
Method of Data Acquisition by USAID: PMI/DELIVER
Frequency and Timing of Data Acquisition by USAID: Quarterly
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment: June 2010
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: June 2013
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of ITNs purchased in any fiscal year with USG funds that were distributed in this reported fiscal year [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		600,000	
2010	1,240,000	660,790	
2011	3,610,000	2,040,964	
2012	996,186		Among a total of 3,037,150 ITNs purchased in 2011, a sum of 2,04,964 were distributed. The remaining 996,186 will be distributed in 2012.
2013	1,300,000		PMI's contribution to routine ITNs (ANC and the Expanded Program for Immunization [EPI])
2014	1,000,000		PMI's contribution to routine ITNs (ANC and EPI)

Malaria (continued)

Indicator: Number of people trained with USG funds to deliver IRS [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Increased Coverage and Use of Key Malaria Interventions
Geographic Focus: Target areas
Description
Precise Definition: Number of people trained with USG funds to deliver IRS—only include spray personnel such as spray operators, supervisors, clinicians, and ancillary personnel. EXCLUDE drivers, washers, and security guards from this number.
Unit of Measure: Number of people
Disaggregated by: Sex
Justification and Management Utility: The indicator contributes to build local capacity to deliver IRS to reduce malaria transmission.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Routine collection during the spray season
Data Source(s): Abt Africa Indoor Residual Spraying (AIRS)
Method of Data Acquisition by USAID: Abt AIRS
Frequency and Timing of Data Acquisition by USAID: Spray season
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of people trained with USG funds to deliver IRS [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		424	
2010	424	549	
2011	730	816	
2012	816		
2013	816		
2014	816		

Malaria (continued)

Indicator: Number of houses targeted for spraying with USG funds [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Coverage and Use of Key Malaria Interventions Increased
Geographic Focus: Target areas
Description
Precise Definition: Number of houses targeted for spraying with USG funds—report the number of houses that were located in the geographic area to be sprayed. This should NOT be an estimate; it should be an actual count of the structures found in the spray area that were eligible for spraying (i.e., defined as structures in which people sleep).
Unit of Measure: Number of houses
Disaggregated by: None
Justification and Management Utility: The indicator contributes to build local capacity to deliver IRS to reduce malaria transmission.
Indicator's Relevance to Gender: No
Plan for Data Acquisition by USAID
Data Collection Method: Routine collection during the spray season
Data Source(s): Abt AIRS
Method of Data Acquisition by USAID: Abt AIRS
Frequency and Timing of Data Acquisition by USAID: Spray season
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of houses targeted for spraying with USG funds [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010		130,842	
2011	180,000	208,998	Based on Malaria Operational Plan (MOP) FY11
2012	180,000		Based on MOP FY12
2013	208,998		Based on IRS annual report 2011
2014	208,998		Based on IRS annual report 2011

Malaria (continued)

Indicator: Number of houses sprayed with IRS with USG funds [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Increased Coverage and Use of Key Malaria Interventions
Geographic Focus: Target areas
Description
Precise Definition: Number of houses sprayed with IRS with USG funds—report the actual number of houses that were sprayed. This should NOT be an estimate; this should be a subset of all structures found that were eligible for spraying.
Unit of Measure: Number of houses
Disaggregated by: None
Justification and Management Utility: The indicator contributes to deliver IRS to reduce malaria transmission.
Indicator's Relevance to Gender: No
Plan for Data Acquisition by USAID
Data Collection Method: Routine collection during the spray season
Data Source(s): Abt AIRS
Method of Data Acquisition by USAID: Abt AIRS
Frequency and Timing of Data Acquisition by USAID: Spray season
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of houses sprayed with IRS with USG funds [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		126,922	
2010	170,000	127,273	
2011	208,998	202,821	
2012	202,821		Assuming no extension of IRS areas
2013	202,821		
2014	202,821		

Malaria (continued)

Indicator: Total number of residents of sprayed houses [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Coverage and Use of Key Malaria Interventions Increased
Geographic Focus: Target areas
Description
Precise Definition: Total number of residents of sprayed houses—report the number of residents living in the houses that were sprayed. This should NOT be an estimate; it should be an actual count of the persons residing in the sprayed houses.
Unit of Measure: Number of people
Disaggregated by: Sex
Justification and Management Utility: The indicator is used for program planning, budgeting, and reporting. Country managers and partners use the indicator.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Routine data collection during the spray period
Data Source(s): Abt AIRS
Method of Data Acquisition by USAID:
Frequency and Timing of Data Acquisition by USAID: Annual
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment: June 2010
Known Data Limitations and Significance (if any): The indicator provides a yearly account of the number residents in the sprayed houses. Mechanisms are in place to reduce possible manipulation of the data.
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: June 2013
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Total number of residents of sprayed houses [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009 Baseline		457,374	
2010	580,000	440,815	
2011	600,000	697,512	
2012	697,512		Assuming similar estimates in IRS-targeted areas
2013	697,512		
2014	697,512		

Malaria (continued)

Indicator: Number of health workers trained in IPTp with USG funds [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Increased Coverage and Use of Key Malaria Interventions
Geographic Focus: National
Description
Precise Definition: Number of health workers trained in IPTp with USG funds
Unit of Measure: Number of people
Disaggregated by: Sex, category of health provider
Justification and Management Utility: Linkage to outcome indicator on percentage of women receiving IPTp. The indicator is used for program planning, budgeting, and reporting. Country managers and partners use the indicator.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Routine
Data Source(s): ATN Plus
Method of Data Acquisition by USAID: ATN Plus
Frequency and Timing of Data Acquisition by USAID: Quarterly
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of health workers trained in IPTp with USG funds [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		60	
2010	1,229	1,173	
2011	510	1,983	
2012	1,620		Same as training in case management, plus 120 focus antenatal care staff
2013	1,620		Same as training in case management, plus 120 focus antenatal care staff
2014	1,620		Same as training in case management, plus 120 focus antenatal care staff

Malaria (continued)

Indicator: Number of SP tablets purchased [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Coverage and Use of Key Malaria Interventions Increased
Geographic Focus: Target areas
Description
Precise Definition: Number of SP tablets purchased with USG funds
Unit of Measure: Number of tablets
Disaggregated by: None
Justification and Management Utility: SP tablets are needed to give to women for IPTp. IPTp decreases malaria infections in women. This leads to decreased number of women with anemia and placental malaria, decreased prevalence of low birth weight, and decreased infant deaths associated with low birth weights. The indicator is used for program planning, budgeting, and reporting. The indicator is used by country managers and partners.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Routine
Data Source(s): Primary data source is a purchase order/invoice
Method of Data Acquisition by USAID: PMI
Frequency and Timing of Data Acquisition by USAID: Yearly
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of SP tablets purchased [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		3,000,000	
2010			
2011	0		There was enough SP to cover the needs.
2012	3,186,000		To cover the needs of at least 2 doses of IPTp among pregnant women, assuming 5% of general population.
2013	3,500,000		
2014	4,000,000		

Malaria (continued)

Indicator: Number of SP tablets purchased with USG funds that were distributed to health facilities [standard]
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2:** Increased Coverage and Use of Key Malaria Interventions
Geographic Focus: Target areas
Description
Precise Definition: Number of SP tablets purchased with USG funds that were distributed to health facilities. This is the number of SP tablets, NOT IPTp doses.
Unit of Measure: Number of tablets
Disaggregated by: None
Justification and Management Utility: Linkage to outcome indicator on percentage of women receiving IPTp. The indicator is used for program planning, budgeting, and reporting. Country managers and partners use the indicator.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Routine
Data Source(s): SIAPS
Method of Data Acquisition by USAID: PMI, SIAPS
Frequency and Timing of Data Acquisition by USAID: Quarterly
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Malaria (continued)

Indicator: Number of SP tablets purchased with USG funds that were distributed to health facilities [standard] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		3,000,000	
2010			
2011	0		There was enough SP to cover the needs
2012	3,186,000		To cover the needs of at least 2 doses of IPTp among pregnant women assuming 5% of general population.
2013	3,500,000		
2014	4,000,000		

Malaria (continued)

Indicator: Proportion of women who received IPT during ANC throughout their last pregnancy
Name of Strategic Objective: Increased Use of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-2**: Coverage and Use of Key Malaria Interventions Increased
Geographic Focus: National
Description
Precise Definition: **Numerator:** Number of women who received two or more doses of a recommended antimalarial drug during ANC visits to prevent malaria during their last pregnancy that led to a live birth within the last 2 years. **Denominator:** Total number of women surveyed who delivered a live baby within the last 2 years.
Unit of Measure: Percent
Disaggregated by: No
Justification and Management Utility: Linkage to overall impact of the program, since the use of IPT prevents malaria during pregnancy among women. The indicator is used for program planning, budgeting, and reporting. The indicator is used by country managers and partners. This indicator helps track progress toward program targets and goals.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Household surveys (DHS, MICS, MIS)
Data Source(s): DHS 2012
Method of Data Acquisition by USAID: ICF International
Frequency and Timing of Data Acquisition by USAID: When surveys are available
Estimated Cost of Data Acquisition:
Individual(s) Responsible at USAID: PMI team and Souleymane Sogoba
Location of Data Storage:
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:

Malaria (continued)

Indicator: Proportion of women who received IPT during ANC throughout their last pregnancy			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010		40	
2011	60		
2012	70		
2013	85		
2014	85		

HIV/AIDS and STI Prevention Among Selected MARPs

Indicator: Number of individuals who received T&C services for HIV and received their test results [standard]
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-3:** Increased Coverage of HIV/AIDS and STI Prevention Among Selected MARPs
Geographic Focus: Target areas
Description
Precise Definition(s): Number of persons who received T&C services for HIV and received their test results during the past 12 months from USG-funded testing teams. To adequately collect data for this indicator, a minimum provision of the following services is required: counseling, testing, return, and receipt of test results.
Unit of Measure: Number of persons
Disaggregated by: Sex: male/female, age: <15, 15+
Justification and Management Utility: This indicator intended to monitor access to and uptake of HIV T&C by specific populations that are most affected by the epidemic. Data could also be useful for projecting programmatic needs, such as test kits and other staffing resources, although individuals are counted.
Indicator's Relevance to Gender: In Mali, women have higher rates of HIV than men, and commercial sex workers (CSWs) and men who have sex with men (MSM) are highly vulnerable to the disease. Women's lower levels of education impair their income opportunities, and gender-based stigma against CSWs and MSM increases their vulnerability.
Plan for Data Acquisition by Usaid
Data Collection Method: Monitoring forms
Data Source: T&C registers and reporting forms
Method of Data Acquisition by USAID: Project Kénéya Ciwara II (PKCII), SOUTOURA, Population Services International (PSI), and ARCAD Sida send to USAID through a Web-based tool.
Frequency and Timing of Data Acquisition by USAID: Data reported to USAID quarterly. Data should be collected, reviewed, and cleaned continuously at the facility level.
Budget Mechanism: Cost of data collection needs to be considered in IP contracts
Individual(s) Responsible at USAID: Clinton Trout and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: April 2011
Known Data Limitations and Significance (if any): Repeat testing is common practice among most HIV T&C programs, and it is important to recognize this and interpret the aggregated data with caution.
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: April 2014
Procedures for Future Data Quality Assessments:

HIV/AIDS and STI Prevention Among Selected MARPs (continued)

Indicator: Number of individuals who received T&C services for HIV and received their test results [standard] (continued)			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets: Baselines and targets based on previous programmatic targets.			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010		41,518	Baseline
2011		37,930	
2012	35,000		The general population has been supported previously. The focus is on MARPs with the expectation of increased detection of HIV-positive persons.
2013	35,000		The general population has been supported previously. The focus is on MARPs with the expectation of increased detection of HIV-positive persons.
2014	35,000		The general population has been supported previously. The focus is on MARPs with the expectation of increased detection of HIV-positive persons.

HIV/AIDS and STI Prevention Among Selected MARPs (continued)

Indicator: Number of PLHIV reached with a minimum package of PwP interventions [standard]
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-3:** Increased Coverage of HIV/AIDS and STI Prevention Among Selected MARPs
Geographic Focus: Target areas
Description
Precise Definition(s): Number of PLHIV reached with a minimum package of PwP interventions. Notes: The number of PLHIV who are reached with a minimum package of PwP interventions (see definition below). The sexual partner(s) or family members of a PLHIV may also receive a service as part of the PwP intervention. While these services may contribute to the minimum standards that are required to count the PLHIV, only the PLHIV should be counted under this indicator. Do not additionally count the partner or family member. Minimum package of PwP interventions required for the indicator: In order to count under this indicator, PLHIV must have received at last visit (in a clinic-/facility-based or community-/home-based program) the following interventions that constitute the minimum package of PwP: Assessment of sexual activity and provision of condoms (and lubricant) and risk-reduction counseling (if indicated) Assessment of partner status and provision of partner testing or referral for partner testing Assessment for STIs and (if indicated) provision of or referral for STI treatment and partner treatment Assessment of family planning needs and (if indicated) provision of contraception or safer pregnancy counseling or referral for family planning services Assessment of adherence and (if indicated) support or referral for adherence counseling Assessment of need and (if indicated) referrals or enrollment of PLHIV in community-based programs, such as home-based care, support groups, posttest clubs, and so forth
Unit of Measure: Number of persons
Disaggregated by: None
Justification and Management Utility: PwP efforts are part of a comprehensive prevention strategy and include both behavioral and biomedical interventions. The purpose of this indicator is to measure how well clinic-/facility-based and community-based programs are reaching PLHIV with a minimum package of prevention interventions and services, including evidenced-based behavioral and biomedical interventions designed to protect the health of the infected person and reduce the spread of HIV to their sex partners and children.
Indicator's Relevance to Gender: In Mali, women have higher rates of HIV than men, and CSWs and MSM are highly vulnerable to the disease. Women's lower levels of education impair their income opportunities, and gender-based stigma against CSWs and MSM increases their vulnerability.
Plan for Data Acquisition by USAID
Data Collection Method: Monitoring forms
Data Source: T&C registers and reporting forms
Method of Data Acquisition by USAID: ARCAD Sida through quarterly reporting to a Web-based tool
Frequency and Timing of Data Acquisition by USAID: Data reported to USAID annually. Data should be collected, reviewed, and cleaned continuously at the facility level.
Budget Mechanism: Cost of data collection needs to be considered in ARCAD Sida contract
Individual Responsible at USAID: Clinton Trout and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office

HIV/AIDS and STI Prevention Among Selected MARPs (continued)

Indicator: Number of PLHIV reached with a minimum package of PwP interventions [standard] (continued)			
Data Quality Issues			
Date of Initial Data Quality Assessment: 2012			
Known Data Limitations and Significance (if any):			
Actions Taken or Planned to Address Data Limitations:			
Date of Future Data Quality Assessment: 2015			
Procedures for Future Data Quality Assessments:			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets: This is the first year USAID is conducting this program. Targets were estimated based on the level of effort in a similar program in Ghana and estimations from USAID/Mali partners.			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009	NA	NA	New program in 2012
2010	NA	NA	New program in 2012
2011	NA	NA	New program in 2012
2012	5,000		Scale-up of activities
2013	7,500		Scale-up of activities
2014	10,000		Scale-up of activities

HIV/AIDS and STI Prevention Among Selected MARPs (continued)

Indicator: Number of the targeted population reached with individual and/or small group–level HIV prevention interventions that are based on evidence and/or meet the minimum standards required [standard]
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-3:** Increased Coverage of HIV/AIDS and STI Prevention Among Selected MARPs
Geographic Focus: Target areas
Description
Precise Definition(s): Number of the target population reached with individual and/or small group–level HIV prevention interventions that are based on evidence and/or meet the minimum standards required. Counting the number of de-duplicated individuals in a defined target population who are reached with and complete the defined prevention intervention can generate this number. This indicator only counts those interventions at the individual and/or small group level. Individual and small group–level interventions are components of a comprehensive program, but are not by themselves defined as a comprehensive program. Partners do not have to implement comprehensive prevention programs to use this indicator, but should work with other partners and stakeholders to ensure that comprehensive prevention programs are implemented in the communities in which they work. (See: The next generation PEPFAR indicator guide for complete definition: Version 1.1, August 2009, pp. 62-63) Notes: This indicator is intended to capture programs targeting general populations. Programs that specifically target MARPs or PLWHA should not be counted here. However, non-MARPs, such as clients of sex workers, truckers, partners of HIV-positive persons are included in this indicator.
Unit of Measure: Number of persons
Disaggregated by: None
Justification and Management Utility: Individual and small group–level prevention interventions have been shown to be effective in reducing HIV transmission risk behaviors. Delivering these interventions with fidelity (including intended number of sessions) to the appropriate populations is an important component of comprehensive HIV prevention strategies. It is important to know how many people complete an intervention in order to monitor how well programs are reaching the intended audience with HIV prevention programming. This information can be used to plan and make decisions on how well a certain audience is being reached with individual and/or small group–level interventions. If a small percentage of the intended audience is being reached with either intervention, then it would be recommended that activities be adjusted to improve reach. The information can be used to improve the quality of the program, as well as the scale-up of successful models.
Indicator's Relevance to Gender: In Mali, women have higher rates of HIV than men, and CSWs and MSM are highly vulnerable to the disease. Women's lower levels of education impair their income opportunities, and gender-based stigma against CSWs and MSM increases their vulnerability.

HIV/AIDS and STI Prevention Among Selected MARPs (continued)

Indicator: Number of the targeted population reached with individual and/or small group–level HIV prevention interventions that are based on evidence and/or meet the minimum standards required [standard] (continued)			
Plan for Data Acquisition by USAID			
Data Collection Method: Monitoring forms			
Data Source: T&C registers and reporting forms			
Method of Data Acquisition by USAID: PKCII, SOUTOURA, ARCAD Sida			
Frequency and Timing of Data Acquisition by USAID: Quarterly			
Budget Mechanism: Cost of data collection needs to be considered in IP contracts			
Individual(s) Responsible at USAID: Clinton Trout and Souleymane Sogoba			
Location of Data Storage: SO6 M&E Officer's office			
Data Quality Issues			
Date of Initial Data Quality Assessment:			
Known Data Limitations and Significance (if any):			
Actions Taken or Planned to Address Data Limitations:			
Date of Future Data Quality Assessment:			
Procedures for Future Data Quality Assessments:			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets: Targets for this indicator will be set based on activities in 2012.			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009	NA		
2010	NA		
2011	NA		
2012	TBD		
2013	TBD		
2014	TBD		

HIV/AIDS and STI Prevention Among Selected MARPs (continued)

Indicator: Number of MARPs reached with individual and/or small group–level HIV preventive interventions that are based on evidence and/or meet the minimum standards required [standard]
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-3:** Increased Coverage of HIV/AIDS and STI Prevention Among Selected MARPs
Geographic Focus: Target areas
Description
Precise Definition(s): Number of MARPs reached with individual and/or small group–level preventive interventions that are based on evidence and/or meet the minimum standards required. Notes: This indicator only counts those interventions at the individual and/or small group level. Individual and small group–level interventions are components of a comprehensive program, but are not by themselves defined as a comprehensive program. Partners do not have to implement comprehensive prevention programs to use this indicator, but should work with other partners and stakeholders to ensure that comprehensive prevention programs are implemented in the communities in which they work.
Unit of Measure: Number of persons
Disaggregated by: MARP type: MSM and CSWs, sex: male/female
Justification and Management Utility: Individual and small group–level prevention interventions have been shown to be effective in reducing HIV transmission risk behaviors. It is important to know how many people complete an intervention in order to monitor how well programs reach intended target populations with HIV prevention programming.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Monitoring data
Data Source: SOUTOURA, ARCAD Sida program reports
Method of Data Acquisition by USAID: SOUTOURA, PKCII, and ARCAD Sida send to USAID
Frequency and Timing of Data Acquisition by USAID: Sent to USAID quarterly. Data should be collected continuously at the organization level.
Budget Mechanism: Cost of tracking clients and differentiating between new and past users' needs to be considered in IP contracts.
Individual(s) Responsible at USAID: Clinton Trout and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: April 2011
Known Data Limitations and Significance (if any): Double counting of clients is an issue with these types of data.
Actions Taken or Planned to Address Data Limitations: IPs should develop appropriate monitoring tools to differentiate between new and repeat clients.
Date of Future Data Quality Assessment: April 2014
Procedures for Future Data Quality Assessments:

HIV/AIDS and STI Prevention Among Selected MARPs (continued)

Indicator: Number of MARPs reached with individual and/or small group–level HIV preventive interventions that are based on evidence and/or meet the minimum standards required [standard] (continued)			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		NA	
2010	NA	NA	
2011	8,916		CSWs: 6,900; MSM: 2,016
2012	14,000		CSWs: 10,000; MSM: 4,000
2013	16,000		CSWs: 11,000; MSM: 5,000
2014	18,000		CSWs: 12,000; MSM: 6,000

HIV/AIDS and STI Prevention Among Selected MARPs (continued)

Indicator: Number of condoms distributed [custom]
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-3:** Increased Coverage of HIV/AIDS and STI Prevention Among Selected MARPs
Geographic Focus: National
Description
Precise Definition(s): Number of condoms distributed with USG funds
Unit of Measure: Number of condoms
Disaggregated by: None
Justification and Management Utility: This indicator measures the availability of condoms among high-risk groups.
Indicator's Relevance to Gender: In Mali, women have higher rates of HIV than men, and CSWs and MSM are highly vulnerable to the disease. Women's lower levels of education impair their income opportunities, and gender-based stigma against CSWs and MSM increases their vulnerability.
Plan for Data Acquisition by USAID
Data Collection Method: Monitoring forms
Data Source: Implementing partners' reports
Method of Data Acquisition by USAID: PKCII, SOUTOURA, ARCAD Sida, and PSI
Frequency and Timing of Data Acquisition by USAID: Quarterly
Budget Mechanism:
Individual(s) Responsible at USAID: Clinton Trout and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment:
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets: Targets based on previous years' baselines
Data Issues/Questions to Be Addressed:
Other Notes:

HIV/AIDS and STI Prevention Among Selected MARPs (continued)

Indicator: Number of condoms distributed [custom] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		10,618,419	
2010	10,618,419	10,891,543	
2011	11,653,951	11,529,735	
2012	12,000,000		Estimates based on past performance on condom distribution
2013	13,000,000		Estimates based on past performance on condom distribution
2014	14,000,000		Estimates based on past performance on condom distribution

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation

Indicator: Prevalence of underweight children under 5 years of age [standard]
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-4:** Improved Nutritional Status, Water Supply, Hygiene, and Sanitation
Geographic Focus: Feed the Future (FtF) "zones of influence" targeted by the USG intervention
Description
Precise Definition(s): Underweight is defined as a weight-for-age anthropometric measurement. Underweight is a reflection of acute and/or chronic undernutrition. This indicator measures the percentage of children 0–59 months of age who are underweight, as defined by a weight for age Z score < -2. **Numerator:** The total number of children 0–59 months with a weight for age Z score < -2. **Denominator:** The total number of children 0–59 months in the sample with weight for age Z score data.
Unit of Measure: Percentage
Disaggregated by: Sex: male/female
Justification and Management Utility: Reducing the prevalence of underweight children under age 5 is the goal of the FtF Initiative. The prevalence of underweight is also an indicator to monitor the Millennium Development Goal 1c8: "Halving the number of people who are hungry." Monitoring the prevalence of underweight children 0–59 months therefore allows USAID and its partners to show the contribution of FtF programs to the Millennium Development Goal.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Household survey
Data Source: Population-based survey
Method of Data Acquisition by USAID: FEEDBACK project, ICF International
Frequency and Timing of Data Acquisition by USAID: Data should be collected in the zones of influence for baseline, midterm, and final reporting. Ideally, data would be collected approximately every 2 years (2012, 2014, and 2016).
Budget Mechanism: M&E contract (FEEDBACK) and ICF International
Individual(s) Responsible at USAID: Fatimata Ouattara and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: 2014 and 2016
Procedures for Future Data Quality Assessments:

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Prevalence of underweight children under 5 years of age [standard] (continued)			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		NA	
2010		26.7%	DHS 2006
2011	NA	NA	The implementation mechanism of the President's FtF Initiative is being processed
2012	22.7%		Expected change -15% of the DHS 2006 baseline value in FtF zones of influence
2013	TBD		Will be available in the annual workplan of the implementing mechanism based on FEEDBACK baseline data
2014	TBD		Will be available in the annual workplan of the implementing mechanism based on FEEDBACK baseline data
2015	18.7%		Expected change -30% of the DHS 2006 baseline value in FtF zones of influence

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Prevalence of stunted children under 5 years of age (standard)
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-4:** Improved Nutritional Status, Water Supply, Hygiene, and Sanitation
Geographic Focus: FtF zones of influence targeted by the USG intervention
Description
Precise Definition(s): Stunting is a height-for-age measurement that is a reflection of chronic nutrition. This indicator measures the percentage of children 0–59 months (i.e., under 5 years) who are stunted, as defined by a height for age Z score < -2. Children with a height for age Z score < -2 and ≥ -3 are classified as moderately stunted. Children with a height for age Z score < -3 are classified as severely stunted. This indicator will be a measurement of any stunting (i.e., both moderate and severe stunting combined). While stunting is difficult to measure in children 0–6 months, and most stunting occurs in the -9–23 month range (1,000 days), this indicator data will still be reported for all children under 5 to align with DHS data and to capture the impact of interventions over time. **Numerator:** The total number of children 0–59 months with a height for age Z score < -2. **Denominator:** The total number of children 0–59 months in the sample with height for age Z score data.
Unit of Measure: Percentage
Disaggregated by: Sex: male/female
Justification and Management Utility: Stunted, wasted, and underweight conditions in children under 5 years of age are the three major nutritional indicators. Stunting is an indicator of linear growth retardation, most often due to prolonged exposure to an inadequate diet and poor health. Reducing the prevalence of stunting among children, particularly 0–23 months, is important because linear growth deficits accrued early in life are associated with cognitive impairments, poor educational performance, and decreased work productivity among adults. Better nutrition leads to increased cognitive and physical abilities, thus improving individual productivity in general, including improved agricultural productivity.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Household survey
Data Source: Population-based survey
Method of Data Acquisition by USAID: FEEDBACK project and ICF International
Frequency and Timing of Data Acquisition by USAID: Data should be collected in the zones of influence for baseline, midterm, and final reporting. Ideally, data would be collected approximately every 2 years (2012, 2014, and 2016).
Budget Mechanism: M&E contract (FEEDBACK) and ICF International
Individual(s) Responsible at USAID: Fatimata Ouattara and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: 2014 and 2016
Procedures for Future Data Quality Assessments:

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Prevalence of stunted children under 5 years of age (standard) (continued)			
Plan for Data Analysis, Review, & Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		NA	
2010		37.7%	DHS 2006
2011	NA	NA	
2012	33%		Expected change -12.5% of the DHS 2006 baseline value in FtF zones of influence
2013	TBD		Will be available in the annual workplan of the implementing mechanism based on FEEDBACK baseline data
2014	TBD		Will be available in the annual workplan of the implementing mechanism based on FEEDBACK baseline data
2015	28.3%		Expected change -25% of the DHS 2006 baseline value in FtF zones of influence

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Prevalence of wasted children under 5 years of age [standard]
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-4:** Improved Nutritional Status, Water Supply, Hygiene, and Sanitation
Geographic Focus: FtF zones of influence targeted by the USG intervention
Description
Precise Definition(s): This indicator measures the percentage of children 0–59 months who are acutely malnourished, as defined by a weight for height Z score < -2. Although different levels of severity of wasting can be measured, this indicator measures the prevalence of all wasting (i.e., both moderate and severe wasting combined). The numerator for the indicator is the total number of children 0–59 months with a weight for height Z score < -2. The denominator is the total number of children 0–59 months in the sample with weight for height Z score data.
Unit of Measure: Percentage
Disaggregated by: Sex: male/female
Justification and Management Utility: Stunted, wasted, and underweight conditions in children under 5 years of age are the three major nutritional indicators. Wasting is an indicator of acute malnutrition. Children who are wasted are too thin for their height and have a much greater risk of dying than children who are not wasted.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Household survey
Data Source: Population-based survey
Method of Data Acquisition by USAID: FEEDBACK project and ICF International
Frequency and Timing of Data Acquisition by USAID: Data should be collected in the zones of Influence for baseline, midterm, and final reporting. Ideally, data would be collected approximately every 2 years (2012, 2014, and 2016).
Budget Mechanism: M&E contract (FEEDBACK) and ICF International
Individual(s) Responsible at USAID: Fatimata Ouattara and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: 2014 and 2016
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Prevalence of wasted children under 5 years of age [standard] (continued)			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		NA	
2010		15.2%	DHS 2006
2011	NA	NA	
2012	12.9%		Expected change -15% of the DHS 2006 baseline value in FtF zones of influence
2013	TBD	TBD	Will be available in the annual workplan of the implementing mechanism based on FEEDBACK baseline data
2014			Will be available in the annual workplan of the implementing mechanism based on FEEDBACK baseline data
2015	10.6%		Expected change -30% of the DHS 2006 baseline value in FtF zones of influence

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Prevalence of underweight women [standard]
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-4:** Nutritional status, water supply, hygiene, and sanitation improved
Geographic Focus: FtF zones of influence targeted by the USG intervention
Description
Precise Definition(s): This indicator measures the percentage of nonpregnant women of reproductive age (15–49 years) who are underweight, as defined by a body mass index (BMI) < 18.5. To calculate an individual's BMI, weight and height data are needed: BMI = weight (in kg)/height (in meters). The numerator for this indicator is the number of nonpregnant women 15–49 years with a BMI < 18.5. The denominator for this indicator is the number of nonpregnant women 15–49 years in the sample with BMI data.
Unit of Measure: Percentage
Disaggregated by: None
Justification and Management Utility: This indicator provides information about the extent to which women's diets meet their caloric requirements. Adequate energy in the diet is necessary to support the continuing growth of adolescent girls and the ability of women to provide optimal care for their children and participate fully in income-generating activities for their families. Undernutrition among women of reproductive age is associated with increased morbidity, poor food security, and adverse birth outcomes in future pregnancies. Improvements in women's nutritional status are expected to improve women's work productivity, which may also benefit agricultural production, linking the two strategic objectives of FtF.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Household survey
Data Source: Population-based survey
Method of Data Acquisition by USAID: FEEDBACK project and ICF International
Frequency and Timing of Data Acquisition by USAID: Data should be collected in the zones of Influence for baseline, midterm, and final reporting. Ideally, data would be collected approximately every 2 years (2012, 2014, and 2016).
Budget Mechanism: M&E contract (FEEDBACK) and ICF International
Individual(s) Responsible at USAID: Fatimata Ouattara and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: 2014 and 2016
Procedures for Future Data Quality Assessments:

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Prevalence of underweight women [standard] (continued)			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		NA	
2010		13.5%	DHS 2006
2011	NA	NA	
2012	12.2%		Expected change -10% of the DHS 2006 baseline value in FtF zones of influence
2013	TBD	TBD	Will be available in the annual workplan of the implementing mechanism based on FEEDBACK baseline data
2014	TBD	TBD	Will be available in the annual workplan of the implementing mechanism based on FEEDBACK baseline data
2015	10.8%		Expected change -20% of the DHS 2006 baseline value in FtF zones of influence

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Number of people trained in child health and nutrition through USG-supported programs
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-4:** Improved Nutritional Status, Water Supply, Hygiene, and Sanitation
Geographic Focus: FtF zones of influence targeted by the USG intervention
Description
Precise Definition(s): Number of people (health professionals, primary health care workers, community health workers, volunteers, nonhealth personnel) trained in child health care and child nutrition through USG-supported programs during the reporting year. For this indicator, please simply count the training attendance numbers without distinguishing whether the same person received multiple trainings. In such a case, that person would be counted several times, which is acceptable for this indicator.
Unit of Measure: Number
Disaggregated by: Sex: male/female, district, categories of providers
Justification and Management Utility: Development of human capacity through training is a major component of USG-supported health area programs in this element.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Activity records/program data
Data Source: Implementing partners; service statistics from USAID projects
Method of Data Acquisition by USAID: AVRDC (The World Vegetable Center), ACDI/VOCA, ATN Plus, Helen Keller International (HKI), Wash Plus, UNICEF, and Association pour le Soutien du Développement des Activités de Population (ASDAP)
Frequency and Timing of Data Acquisition by USAID: Quarterly
Budget Mechanism:
Individual(s) Responsible at USAID: Fatimata Ouattara and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: 2014 and 2016
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Number of people trained in child health and nutrition through USG-supported programs (continued)			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		NA	New initiative
2010	NA		New initiative
2011	NA		New initiative
2012	500		Estimated value, subject to change during implementation of FtF in Mali
2013	500		Estimated value, subject to change during implementation of FtF in Mali
2014	500		Estimated value, subject to change during implementation of FtF in Mali
2015	500		Estimated value, subject to change during implementation of FtF in Mali

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Number of children under 5 reached by USG-supported nutrition programs
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-4:** Improved Nutritional Status, Water Supply, Hygiene, and Sanitation
Geographic Focus: FtF zones of influence targeted by the USG intervention
Description
Precise Definition(s): Number of children under 5 years of age reached during the reporting year by programs with nutrition objectives, which can include behavior change communication activities, home or community gardens, micronutrient fortification or supplementation, anemia reduction packages, growth monitoring and promotion, and management of acute malnutrition.
Unit of Measure: Number
Disaggregated by: Sex
Justification and Management Utility: Good coverage of nutrition programs is essential to prevent and treat malnutrition and improve child survival.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Activity reports, program data
Data Source: Implementing partners
Method of Data Acquisition by USAID: FEEDBACK and ICF International
Frequency and Timing of Data Acquisition by USAID: Quarterly
Budget Mechanism:
Individual(s) Responsible at USAID: Fatimata Ouattara and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: 2014 and 2016
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Number of children under 5 reached by USG-supported nutrition programs (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009	NA		
2010	NA		
2011	NA		New program
2012	2,976,698		Same assumptions as for vitamin A
2013	3,065,999		Same assumptions as for vitamin A
2014	3,157,979		Same assumptions as for vitamin A

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Number of children under 5 who received vitamin A from USG-supported programs
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-4:** Improved Nutritional Status, Water Supply, Hygiene, and Sanitation
Geographic Focus: National
Description
Precise Definition(s): Number of children under 5 years of age who received vitamin A from USG-supported programs in the last 6 months from the time this data was collected. In order to reduce vitamin-A deficiency most effectively, children need two rounds of coverage in 1 year. In order to not double count children, please only report the number of rounds in the last 6 months.
Unit of Measure: Number
Disaggregated by: Sex: male/female
Justification and Management Utility: Good coverage of nutrition programs is essential to prevent and treat malnutrition and improve child survival.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Routine
Data Source: SLIS, ATN Plus
Method of Data Acquisition by USAID: FEEDBACK, ICF International, ATN Plus
Frequency and Timing of Data Acquisition by USAID: Quarterly
Budget Mechanism:
Individual(s) Responsible at USAID: Fatimata Ouattara and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: August 2010
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: August 2013
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Number of children under 5 who received vitamin A from USG-supported programs (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		2,729,761	Data source: Government of Mali Health Information System (SLIS)
2010	2,805,823	2,805,823	Data source: Government of Mali Health Information System (SLIS)
2011	2,889,998		Estimation based on 3% population growth, assuming 100% of children under 5 will receive vitamin A
2012	2,976,698		Estimation based 3% population growth, assuming 100% of children under 5 will receive vitamin A
2013	3,065,999		Estimation based 3% population growth, assuming 100% of children under 5 will receive vitamin A
2014	3,157,979		Estimation based 3% population growth, assuming 100% of children under 5 will receive vitamin A
2015	3,252,718		Estimation based 3% population growth, assuming 100% of children under 5 will receive vitamin A

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Prevalence of children 6–23 months receiving a minimum acceptable diet [standard]
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-4:** Improved Nutritional Status, Water Supply, Hygiene, and Sanitation
Geographic Focus: FtF zones of influence targeted by the USG intervention
Description
Precise Definition(s): This indicator measures the proportion of children 6–23 months of age who receive a minimum acceptable diet (MAD), apart from breast milk. The MAD indicator measures both the minimum feeding frequency and the minimum dietary diversity, as appropriate for various age groups. If a child meets the minimum feeding frequency and the minimum dietary diversity for their age group and breastfeeding status, then he or she is considered to have received a minimum acceptable diet. Tabulation of the indicator requires that data on breastfeeding, dietary diversity, number of semisolid/solid feeds, and number of milk feeds be collected for children 6–23 months the day preceding the survey. The indicator is calculated from the following two fractions: 1. Breastfed children 6–23 months of age who had at least the minimum dietary diversity and the minimum meal frequency during the previous day/Breastfed children 6–23 months of age 2. Nonbreastfed children 6–23 months of age who received at least two milk feedings and had at least the minimum dietary diversity, not including milk feeds and the minimum meal frequency during the previous day/Nonbreastfed children 6–23 months of age Minimum dietary diversity for breastfed children 6–23 months is defined as having four or more of the following seven food groups (refer to the WHO Infant and Young Child Feeding IYCF operational guidance document cited below): 1. Grains, roots, and tubers 2. Legumes and nuts 3. Dairy products (milk, yogurt, cheese) 4. Flesh foods (meat, fish, poultry, and liver/organ meats) 5. Eggs 6. Vitamin A–rich fruits and vegetables 7. Other fruits and vegetables Minimum meal frequency for breastfed children is defined as having two or more feedings of solid, semisolid, or soft food for children 6–8 months and three or more feedings of solid, semisolid, or soft food for children 9–23 months. Minimum dietary diversity for nonbreastfed children is defined as having four or more of the following six food groups: 1. Grains, roots, and tubers 2. Legumes and nuts 3. Flesh foods (meat, fish, poultry and liver/organ meats) 4. Eggs 5. Vitamin A–rich fruits and vegetables 6. Other fruits and vegetables Minimum meal frequency for nonbreastfed children is defined as four or more feedings of solid, semisolid, soft food, or milk feeds for children 6–23 months, with at least two of these feedings being milk feeds.
Unit of Measure: Percentage
Disaggregated by: Sex
Justification and Management Utility: Measurement of household hunger provides a tool to monitor global progress of USG-supported food security initiatives. A decrease in household hunger is also a reflection of improved household resilience. The indicator has been validated to be meaningful for cross-cultural use employing data sets from seven diverse sites.
Indicator's Relevance to Gender: Yes

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Prevalence of children 6–23 months receiving a minimum acceptable diet [standard] (continued)			
Plan for Data Acquisition by USAID			
Data Collection Method: Household survey			
Data Source: Population-based survey			
Method of Data Acquisition by USAID: FEEDBACK project and ICF International			
Frequency and Timing of Data Acquisition by USAID: Data should be collected in the zones of influence for baseline, midterm, and final reporting. Ideally, data would be collected approximately every 2 years (2012, 2014, and 2016).			
Budget Mechanism: M&E contract (FEEDBACK) and ICF International			
Individual(s) Responsible at USAID: Fatimata Ouattara and Souleymane Sogoba			
Location of Data Storage: SO6 M&E Officer's office			
Data Quality Issues			
Date of Initial Data Quality Assessment: 2012			
Known Data Limitations and Significance (if any):			
Actions Taken or Planned to Address Data Limitations:			
Date of Future Data Quality Assessment: 2014 and 2016			
Procedures for Future Data Quality Assessments:			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed: For detailed guidance on how to collect and tabulate this indicator, refer to the WHO document: Indicators for Assessing Infant and Young Child Feeding Practices, Part 2, Measurement, available at http://whqlibdoc.who.int/publications/2010/9789241599290_eng.pdf			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		NA	
2010		6.7%	DHS 2006
2011	NA	NA	New Initiative
2012	16%		Expected change +136.5% of the DHS 2006 baseline value in FtF zones of influence
2013	TBD	TBD	Will be available in the annual workplan of the implementing mechanism based on FEEDBACK baseline data
2014	TBD	TBD	Will be available in the annual workplan of the implementing mechanism based on FEEDBACK baseline data
2015	25%		Expected change +273% of the DHS 2006 baseline value in FtF zones of influence

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Prevalence of households with moderate or severe hunger
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-4:** Improved Nutritional Status, Water Supply, Hygiene, and Sanitation
Geographic Focus: FtF zones of influence targeted by the USG intervention
Description
Precise Definition(s): This indicator measures the percentage of households experiencing moderate or severe hunger, as indicated by a score of two or more on the household hunger scale (HHS). To collect data for this indicator, respondents are asked about the frequency with which three events were experienced by household members in the last 4 weeks: (1) had no food at all in the house; (2) went to bed hungry, (3) went all day and night without eating. For each question, the following responses are possible: never (value = 0), rarely or sometimes (value = 1), often (value = 2). Values for the three questions are summed for each household, producing an HHS score ranging from 0 to 6. Numerator: The total number of households with a score of two or more on the HHS. Denominator: The total number of households in the sample with HHS data.
Unit of Measure: Percentage
Disaggregated by: Gendered household type: female, no male; male, no female; male and female
Justification and Management Utility: Measurement of household hunger provides a tool to monitor global progress of USG-supported food security initiatives. A decrease in household hunger is also a reflection of improved household resilience. The indicator has been validated to be meaningful for cross-cultural use, using data sets from seven diverse sites.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Household survey
Data Source: Population-based survey
Method of Data Acquisition by USAID: FEEDBACK project and ICF International
Frequency and Timing of Data Acquisition by USAID: Data should be collected in the zones of influence for baseline, midterm, and final reporting. Ideally, data would be collected approximately every 2 years (2012, 2014, and 2016).
Budget Mechanism: M&E contract (FEEDBACK) and ICF International
Individual(s) Responsible at USAID: Fatimata Ouattara and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: 2014 and 2016
Procedures for Future Data Quality Assessments:

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Prevalence of households with moderate or severe hunger (continued)			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed: This indicator should always be measured at the same time each year, at the most vulnerable part of the year (e.g., right before harvest, during the dry season). Although this indicator will be collected in the zone of influence by the centrally funded FtF M&E contractor, USAID/Washington is also working with Headquarters and Missions to have the HHS added as a module to the DHS, which is usually conducted every 5 years. Missions direct which modules the DHS should add to the default set of survey questions, and all focus countries should request that the HHS module be added to any upcoming DHS for collection of the national-level data. For more information on the HHS, including guidance for collection and tabulation of the prevalence of households with moderate or severe hunger, refer to the FANTA Web site: www.fanta-2.org.			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010		NA	No baseline data are currently available for this indicator. However, this indicator is among the required FtF indicators.
2011	NA	NA	The Household Hunger Index module has been included in the 2012 DHS.
2012	TBD	TBD	The FtF M&E contractor will conduct the population-based survey in FtF zones of influence in early 2012, and targets will be revised accordingly.
2013	TBD	TBD	
2014	TBD	TBD	
2015	TBD	TBD	

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Percent of households with soap and water at handwashing station commonly used by family members
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-4:** Nutritional status, water supply, hygiene, and sanitation improved
Geographic Focus: Targeted areas
Description
Precise Definition(s): A handwashing station is a location where family members go to wash their hands. In some instances, these are fixed locations where handwashing devices are built in and are permanently placed. However, they may also be movable devices that may be placed in a convenient spot for family members to use. The measurement takes place via observation by an enumerator during the household visit. The enumerator must see the soap and water at this station. The soap may be in bar, powder, or liquid form. Shampoo will be considered liquid soap. The cleansing product must be at the handwashing station or reachable by hand when standing in front of it. A "commonly used" handwashing station, including water and soap, is one that can be readily observed by the enumerator during the household visit, and where study participants indicate that family members generally wash their hands. **Numerator:** Number of households where both water and soap are found at the commonly used handwashing station **Denominator:** Total number of household
Unit of Measure: Percent
Disaggregated by: Numerator, denominator
Justification and Management Utility: Information to be used by cooperating agencies and contractors implementing programs to report on project performance. Data may be used to modify interventions to increase effectiveness.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Household survey
Data Source: Round 4 of MICS conducted by UNICEF (http://www.childinfo.org/mics4_surveys.html) and ICF International's DHS (http://www.measuredhs.com/countries/) and household surveys, which may be conducted in project areas at least twice during USG-funded interventions.
Method of Data Acquisition by USAID: FEEDBACK project
Frequency and Timing of Data Acquisition by USAID: Data should be collected in the zones of influence for baseline, midterm, and final reporting. Ideally, data would be collected approximately every 2 years (2012, 2014, and 2016).
Budget Mechanism: M&E contract (FEEDBACK) and ICF International
Individual(s) Responsible at USAID: Fatimata Ouattara and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Percent of households with soap and water at handwashing station commonly used by family members (continued)			
Data Quality Issues			
Date of Initial Data Quality Assessment: 2012			
Known Data Limitations and Significance (if any):			
Actions Taken or Planned to Address Data Limitations:			
Date of Future Data Quality Assessment: 2014 and 2016			
Procedures for Future Data Quality Assessments:			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed: The measurement of handwashing is difficult and should preferably be conducted by objective measures that do not rely on self-reports. Spot checks required to obtain information are an objective proxy for measuring handwashing.			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		NA	Not available at this time. However, this indicator is among the required FtF indicators.
2010	NA		Not available at this time. However, this indicator is among the required FtF indicators.
2011	NA		Not available at this time. However, this indicator is among the required FtF indicators.
2012	NA		
2013	NA		
2014	NA		
2015	NA		

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Number of communities certified as ODF as result of USG assistance
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-4:** Nutritional status, water supply, hygiene and sanitation improved
Geographic Focus: Targeted areas
Description
Precise Definition(s): *The Handbook on Community-Led Total Sanitation* produced by Kamal Kar and Robert Chambers in 2008 suggests a qualitative approach to determining ODF status. This may include visiting former open defecation sites at dawn and dusk; determining whether open/hanging latrines are being used, as well as paths to installed latrines; and observing existing community sanctions for infringements to ODF rules, and so forth. To facilitate inspection and safeguard against fraud when rewards to communities are used as incentives, verification of ODF may require involving a committee of inspectors made up of government officials, NGO staff, community residents, and residents from neighboring towns that have achieved ODF status. Kar and Chambers even suggest withholding certification of ODF status for a 6-month period to ensure that sanitation coverage has been sustained. Qualitative methods, such as those mentioned above, may also be combined with quantitative measures. Households in a village labeled as ODF may be visited to count how many households in the village have a latrine. This may also be achieved through a mapping exercise.
Unit of Measure: Number
Disaggregated by: No
Justification and Management Utility: Information to be used by cooperating agencies and contractors implementing programs to report on project performance. Data may be used to modify interventions to increase effectiveness.
Indicator's Relevance to Gender: No
Plan for Data Acquisition by USAID
Data Collection Method: Data collected by the Government of Mali and implementing partners on USG-assisted communities.
Data Source: Wash Plus, ASDAP, UNICEF
Method of Data Acquisition by USAID: Wash Plus, ASDAP, UNICEF
Frequency and Timing of Data Acquisition by USAID: Data should be collected in the zones of influence for baseline, midterm, and final reporting. Ideally, data would be collected approximately every 2 years (2012, 2014, and 2016).
Budget Mechanism:
Individual(s) Responsible at USAID: Fatimata Ouattara and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: 2014 and 2016
Procedures for Future Data Quality Assessments:

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Number of communities certified as ODF as result of USG assistance (continued)			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed: Program managers may be interested in using a community-led total sanitation approach to increase sanitation coverage. Given the rewards that are offered for achieving ODF status, communities may find it easier to achieve ODF status than to maintain it over time.			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010			
2011			
2012			
2013			
2014			
2015			

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Percent of population using improved an improved sanitation facility
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-4:** Improved Nutritional Status, Water Supply, Hygiene, and Sanitation
Geographic Focus: Targeted areas
Description
Precise Definition(s): **Numerator:** Number of persons within households in a population representative sample where the head of household or designated adult answers the question "What kind of toilet facility do members of your household usually use?" with one of the following: flush or pour/flush facilities connected to a piped sewer system, septic system, or pit latrine; pit latrines with a slab; composting toilets; and ventilated improved pit latrines. **Denominator:** All persons in population representative sample. An improved sanitation facility, defined according to the Joint Monitoring Programme (JMP), is one that hygienically separates human excreta from human contact; this includes flush or pour/flush facility connected to a piped sewer system, a septic system or a pit latrine, pit latrines with a slab, composting toilets, or ventilated improved pit latrines. Any other sanitation facilities are considered "unimproved." Unimproved sanitation includes flush or pour/flush toilets without a sewer connection, pit latrines without slab/open pit, bucket latrines, or hanging toilets/latrines. Households that use a facility shared with other households are also not counted as using an improved sanitation facility. The wording and definition of this indicator follows international guidelines in order to facilitate discussion about sanitation coverage issues with the donor community.
Unit of Measure: Percent
Disaggregated by: Numerator, denominator
Justification and Management Utility: Use of an improved sanitation facility by households is strongly linked to decreases in the incidence of waterborne disease among household members, especially among children under age 5. Diarrhea remains the second leading cause of child deaths worldwide. Useful in tracking the contribution of USG-funded activities to the MDGs.
Indicator's Relevance to Gender: No
Plan for Data Acquisition by USAID
Data Collection Method: DHS and the WHO/UNICEF JMP for Water Supply and Sanitation (http://www.wssinfo.org/data-estimates/introduction).
Data Source: DHS 2012 and FEEDBACK
Method of Data Acquisition by USAID: ICF International and FEEDBACK
Frequency and Timing of Data Acquisition by USAID:
Budget Mechanism:
Individual(s) Responsible at USAID: Fatimata Ouattara and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Percent of population using improved an improved sanitation facility (continued)			
Data Quality Issues			
Date of Initial Data Quality Assessment: 2012			
Known Data Limitations and Significance (if any): Not all household members may regularly use the noted improved sanitation facility. In particular, in many cultures young children are often left to defecate in the open and create health risks for all household members, including themselves. The above question asked to measure this indicator does not capture such detrimental, uneven sanitation behavior within a household. If the JMP changes the definition of improved sanitation facilities to include certain types of shared sanitation facilities, the calculation of the indicator proposed here would have to be modified accordingly.			
Actions Taken or Planned to Address Data Limitations:			
Date of Future Data Quality Assessment: 2014 and 2016			
Procedures for Future Data Quality Assessments:			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010			
2011			
2012			
2013			
2014			
2015			

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Number of Aquatabs tablets sold as result of USG assistance [custom]
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-4:** Improved Nutritional Status, Water Supply, Hygiene, and Sanitation
Geographic Focus: National
Description
Precise Definition(s): Number of Aquatabs sold as result of USG assistance
Unit of Measure: Number
Disaggregated by: None
Justification and Management Utility: Clean water is essential to prevent and treat malnutrition and improve child survival.
Indicator's Relevance to Gender: NA
Plan for Data Acquisition by USAID
Data Collection Method: Routine
Data Source: PSI sales data
Method of Data Acquisition by USAID: PSI
Frequency and Timing of Data Acquisition by USAID: Annually
Budget Mechanism:
Individual(s) Responsible at USAID: Fatimata Ouattara and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment:
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:
Other Notes
Notes on Baselines/Targets:
Data Issues/Questions to Be Addressed:
Other Notes:

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Number of Aquatabs tablets sold as result of USG assistance [custom] (continued)			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		NA	
2010		4,500,000	
2011		7,041,590	
2012	800,000		
2013	840,000		
2014	880,000		

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Prevalence of exclusive breastfeeding of children under 6 months of age [standard]
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-4:** Improved Nutritional Status, Water Supply, Hygiene, and Sanitation
Geographic Focus: FtF zones of influence targeted by the USG intervention
Description
Precise Definition(s): This indicator measures the percent of children 0–5 months of age who were exclusively breastfed during the day preceding the survey. Exclusive breastfeeding means that the infant received breast milk (including milk expressed or from a wet nurse) and may have received oral rehydration salts, vitamins, minerals, and/or medicines, but did not receive any other food or liquid. **Numerator:** The total number of children 0–5 months surveyed exclusively breastfed in the day preceding the survey. **Denominator:** The total number of children 0–5 months surveyed.
Unit of Measure: Percent
Disaggregated by: Sex; numerator, denominator
Justification and Management Utility: Exclusive breastfeeding for 6 months provides children with significant health and nutrition benefits, including protection from gastrointestinal infections and reduced risk of mortality due to infectious disease.
Indicator's Relevance to Gender: Yes
Plan for Data Acquisition by USAID
Data Collection Method: Household survey
Data Source: Population-based survey
Method of Data Acquisition by USAID: UNICEF
Frequency and Timing of Data Acquisition by USAID: Data should be collected in the zones of influence for baseline, midterm, and final reporting. Ideally, data would be collected approximately every 2 years (2012, 2014, and 2016).
Budget Mechanism: UNICEF
Individual(s) Responsible at USAID: Fatimata Ouattara and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: 2014 and 2016
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:

Improved Nutritional Status, Water Supply, Hygiene, and Sanitation (continued)

Indicator: Prevalence of exclusive breastfeeding of children under 6 months of age [standard] (continued)			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed: For detailed guidance on how to collect and tabulate this indicator, refer to the WHO document, Indicators for Assessing Infant and Young Child Feeding Practices, Part 2, Measurement, available at http://whqlibdoc.who.int/publications/2010/9789241599290_eng.pdf			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010		37.8%	DHS 2006
2011	NA	NA	
2012	47%		Expected change -25% of the DHS 2006 baseline value in FtF zones of influence
2013	TBD	TBD	Will be available in the annual workplan of the implementing mechanism based on FEEDBACK baseline data
2014	TBD	TBD	Will be available in the annual workplan of the implementing mechanism based on FEEDBACK baseline data
2015	57%		Expected change -50% of the DHS 2006 baseline value in FtF zones of influence

National, Regional, District, and Community Management and Health Systems

Indicator: Number of wards made directly to local organizations
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-5:** Improved National, Regional, District, and Community Management and Health Systems
Geographic Focus: National
Description
Precise Definition(s): This indicator counts the number of awards made directly by the USG (not through intermediaries) to local organizations each fiscal year. It excludes awards made to public sector institutions but can include awards made to parastatals or universities. Awards can be either acquisition or assistance. For purposes of indicator reporting, at the time of the award, a local organization must be organized under the laws of the recipient country; have its principal place of business in the recipient country; be majority-owned by individuals who are citizens or lawful permanent residents of the recipient country or be managed by a governing body, the majority of whom are citizens or lawful permanent residents of a recipient country; not be controlled by a foreign entity or by an individual or individuals who are not citizens or permanent residents of the recipient country; be majority-owned by individuals who are citizens or lawful permanent residents of the region or be managed by a governing body, the majority of whom are citizens or lawful permanent residents of the region; not be controlled by a foreign entity or by an individual or individuals who are not citizens or permanent residents of the region.
Unit of Measure: Number of awards to local organizations in the past fiscal year
Disaggregated by: Numerator, denominator
Justification and Management Utility: This indicator tracks operating unit progress toward meeting an objective of USAID Forward's Implementing Procurement Reform (IPR) objective to diversify the USG's partner base. It is a direct measure of the increase in the number of USG local partners. This indicator measures progress toward the targets set under IPR Objective 2. It will be used by senior staff, bureau-level planners, and country-level managers to assess progress in achieving USAID Forward's Objective 2 Local Capacity Development (LCD) of IPR and to plan for improvements in LCD programming.
Indicator's Relevance to Gender: No
Plan for Data Acquisition by USAID
Data Collection Method: Data will be collected by each operating unit annually from acquisition and assistance records kept in the operating unit.
Data Source: USAID: health office and Office of Financial Management (OFM)
Method of Data Acquisition by USAID: USAID: Financial Information System
Frequency and Timing of Data Acquisition by USAID: Annually
Budget Mechanism:
Individual(s) Responsible at USAID: Madiou Yattara and Souleymane Sogoba
Location of Data Storage:

National, Regional, District, and Community Management and Health Systems (continued)

Indicator: Number of wards made directly to local organizations (continued)			
Data Quality Issues			
Date of Initial Data Quality Assessment:			
Known Data Limitations and Significance (if any):			
Actions Taken or Planned to Address Data Limitations:			
Date of Future Data Quality Assessment:			
Procedures for Future Data Quality Assessments:			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010			
2011			
2012			
2013			
2014			

National, Regional, District, and Community Management and Health Systems (continued)

Indicator: Percentage of operating unit program funds obligated through partner country systems
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-5:** Improved National, Regional, District, and Community Management and Health Systems
Geographic Focus: National
Description
Precise Definition(s): Operating units should enter the percentage in the results field and provide the numerator and denominator values where specified as disaggregates. The result entered for this indicator is calculated using the following numerator and denominator. **Numerator:** The dollar value of an operating unit's annual program allocation obligated (or subobligated via a bilateral agreement) through partner country systems during the fiscal year. The term "partner country system" is defined in ADS 220.1. **Denominator:** The total value of the current year program allocation for the Operating Unit. An operating unit's annual program allocation includes new obligating authority (NOA), carryover funds, and transfers from other USG agencies. Missions that obligate funds into a Strategic Objective Grant Agreement/Development Objective Grant Agreement (SOAG/DOAG) and subobligate funds into awards the year following the appropriation should treat these funds as if they were carryover funds. For example, the full amount of funds obligated into a SOAG/DOAG in FY11 should be included in the denominator for FY12, and any funds that are subobligated through local systems should be counted in the numerator for FY12. Partner country systems can be at the sovereign and subsovereign level. Funds obligated through regional governmental organizations are not included.
Unit of Measure: Percent
Disaggregated by: Numerator, Denominator
Justification and Management Utility: This indicator tracks operating unit progress toward meeting the stated target of USAID Forward's IPR Objective 1: "Strengthen partner country capacity to improve aid effectiveness and sustainability." It is a direct measure of the objective to "Increase obligations of program funds through partner country systems." This indicator measures progress toward the targets set under IPR objective 1: "Strengthen partner country capacity to improve aid effectiveness and sustainability by increasing use of reliable partner country systems and institutions to provide support to partner countries." It will be used by senior staff, bureau-level planners, and country-level managers to assess progress in achieving USAID Forward's Objective 1 of IPR and to plan for improvements in programming directly with public sector institutions.
Indicator's Relevance to Gender: No

National, Regional, District, and Community Management and Health Systems (continued)

Indicator: Percentage of operating unit program funds obligated through partner country systems (continued)			
Plan for Data Acquisition by USAID			
Data Collection Method: This indicator is a proxy for improved capacity of financial management systems. Without appropriate controls and proactive monitoring/capacity building efforts, increasing funds through partner country systems could, in fact, have the reverse of the intended effect. (Increasing funds to an institution not yet ready to manage those funds could make the institution vulnerable to corruption, mission-drift, etc.) Therefore, it is essential that operating unit staff monitor implementation for unintended consequences.			
Data Source: Budget, acquisition, and assistance records at USAID			
Method of Data Acquisition by USAID: USAID: health team and OFM			
Frequency and Timing of Data Acquisition by USAID: Annually			
Budget Mechanism:			
Individual(s) Responsible at USAID: Madiou Yattara, Salif Coulibaly, and Souleymane Sogoba			
Location of Data Storage:			
Data Quality Issues			
Date of Initial Data Quality Assessment:			
Known Data Limitations and Significance (if any):			
Actions Taken or Planned to Address Data Limitations:			
Date of Future Data Quality Assessment:			
Procedures for Future Data Quality Assessments:			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010			
2011			
2012			
2013			
2014			

National, Regional, District, and Community Management and Health Systems (continued)

Indicator: Percentage of operating unit program funds obligated to local organizations
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-5:** Improved National, Regional, District, and Community Management and Health Systems
Geographic Focus: National
Description
Precise Definition(s): **Numerator:** The dollar value of operating unit program funds obligated or subobligated directly by the USG (not through intermediaries) to local organizations during the fiscal year. **Denominator:** The total value of the annual program allocation for the Operating Unit. An operating unit's annual program allocation includes NOA, carryover funds, and transfers from other USG agencies. Missions that obligate funds into a SOAG/DOAG and subobligate funds into awards the year following the appropriation should treat these funds as if they were carryover funds. For example, the full amount of funds obligated into a SOAG/DOAG in FY11 should be included in the denominator for FY12, and any funds that are subobligated to local organizations should be counted in the numerator for FY12. For purposes of indicator reporting, at the time of the award a local organization must be organized under the laws of the recipient country; have its principal place of business in the recipient country; be majority-owned by individuals who are citizens or lawful permanent residents of the recipient country or be managed by a governing body, the majority of whom are citizens or lawful permanent residents of a recipient country; not be controlled by a foreign entity or by an individual or individuals who are not citizens or permanent residents of the recipient country. The term "controlled by", means a majority ownership or beneficiary interest as defined above, or the power—either directly or indirectly, whether exercised or exercisable—to control the election, appointment, or tenure of the organization's managers or a majority of the organization's governing body by any means (e.g., ownership, contract, or operation of law).
Unit of Measure: Percentage
Disaggregated by: Numerator, denominator
Justification and Management Utility: This indicator tracks operating unit progress toward meeting the stated target of USAID Forward's IPR Objective 2: "Increase the value of direct grants and contracts to local organizations." It is a proxy measure of the outcome of Objective 2: "Strengthen local civil society and private sector capacity to improve aid effectiveness and sustainability." The assumption is that increased percentage of funds obligated to local organizations is directly correlated to higher capacity of these organizations, because the USG can only give funds to organizations capable of managing those funds; thus, an increased percentage in funds indicates higher capacity and organizations that have organizational weaknesses will be required to include capacity building targets in their activities as a requirement for ongoing receipt of funds. This indicator measures progress toward the targets set under IPR Objective 2. It will be used by senior staff, bureau-level planners, and country-level managers to assess progress in achieving USAID Forward's Local Capacity Development Objectives and to plan for improvements in LCD programming.
Indicator's Relevance to Gender: No

National, Regional, District, and Community Management and Health Systems (continued)

Indicator: Percentage of operating unit program funds obligated to local organizations (continued)			
Plan for Data Acquisition by USAID			
Data Collection Method: Budget, acquisition, and assistance records			
Data Source: USAID: health team and OFM			
Method of Data Acquisition by USAID: USAID			
Frequency and Timing of Data Acquisition by USAID: Annually			
Budget Mechanism:			
Individual(s) Responsible at USAID: Madiou Yattara, Salif Coulibaly, and Souleymane Sogoba			
Location of Data Storage:			
Data Quality Issues			
Date of Initial Data Quality Assessment:			
Known Data Limitations and Significance (if any):			
Actions Taken or Planned to Address Data Limitations:			
Date of Future Data Quality Assessment:			
Procedures for Future Data Quality Assessments:			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009			
2010			
2011			
2012			
2013			
2014			

National, Regional, District, and Community Management and Health Systems (continued)

Indicator: Number of policies or guidelines developed or updated with USG assistance to improve access to and use of high impact health services [custom]
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-5:** Improved National, Regional, District, and Community Management and Health Systems
Geographic Focus: National
Description
Precise Definition(s): Number of national policies or guidelines developed or updated with USG assistance to improve access and use of high-impact health services. Number of improvements to laws, policies, regulations, or guidelines related to improving access to and use of health services drafted with USG support. Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society. An explicit health policy can achieve several things: it defines a vision for the future which, in turn, helps to establish targets and points of reference for the short and medium term; it outlines priorities and the expected roles of different groups; and it builds consensus and informs people (http://www.who.int/topics/health_policy/en/). According to the WHO definition, a guideline is any document, whatever its title, that contains recommendations about health interventions, whether they are related to clinical practice, public health, or policy. A recommendation provides information about what policymakers, health care providers, or patients should do (WHO handbook for Guideline Development). In general, policies and guidelines are developed at the national level, at the highest level of the health system. High-impact services are those related to FP, RH, MNCH, immunization, malaria, HIV/AIDS, nutrition, water supply, sanitation, and hygiene, including health system strengthening.
Unit of Measure: Number
Disaggregated by: Program areas: FP, RH, MNCH, immunization, malaria, HIV/AIDS, nutrition, water supply, sanitation, and cross-cutting.
Justification and Management Utility: Appropriate policies and guidelines are necessary for good governance in health and help the health system function more effectively and efficiently.
Indicator's Relevance to Gender: None
Plan for Data Acquisition by USAID
Data Collection Method: Routine monitoring
Data Source: Program reports
Method of Data Acquisition by USAID: ATN Plus, Health Care Improvement Project, PKCII, Health Policy Project, HKI, SIAPS, Maternal and Child Health Integrated Program (MCHIP), PSI, UNICEF, and Save The Children.
Frequency and Timing of Data Acquisition by USAID: Annually
Budget Mechanism:
Individual(s) Responsible at USAID: Salif Coulibaly and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office

National, Regional, District, and Community Management and Health Systems (continued)

Indicator: Number of policies or guidelines developed or updated with USG assistance to improve access to and use of high impact health services [custom] (continued)			
Data Quality Issues			
Date of Initial Data Quality Assessment: 2012			
Known Data Limitations and Significance (if any):			
Actions Taken or Planned to Address Data Limitations:			
Date of Future Data Quality Assessment: 2015			
Procedures for Future Data Quality Assessments:			
Plan for Data Analysis, Review, and Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Notes on Baselines/Targets: Targets are based on the needs of the MOH and are not dependent on prior achievements. Targets are not very precise as needs may not necessarily be identified in advance.			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		25	
2010	13	28	Although targets are proposed herein, in reality they are based on needs of the MOH, and are not dependent on prior achievements.
2011	13		Indicative figures, awaiting confirmation from MOH
2012	20		Indicative figures, awaiting confirmation of MOH
2013	20		Indicative figures, awaiting confirmation of MOH
2014	20		Indicative figures, awaiting confirmation of MOH

National, Regional, District, and Community Management and Health Systems (continued)

Indicator: Percentage of facilities that had all tracer medicines and commodities in stock in the last 3 months [custom]
Name of Strategic Objective: Increased Utilization of High-Impact Health Services and Healthy Behaviors
Name of Intermediate Result: **IR-5:** Improved National, Regional, District, and Community Management and Health Systems
Geographic Focus: National
Description
Precise Definition(s): **Numerator:** Number of facilities that had in stock all tracer medicines and commodities in the last 3 months of the visit or survey. **Denominator:** Total number of facilities visited or surveyed. An unexpired tracer medicine or commodity (e.g., ACT, SP, oral contraceptive pills, injectables, ocytocin, and condoms) is in stock at a health facility. USAID, the GOM, and its partners will define a list of tracer medicines and commodities.
Unit of Measure: Percentage
Disaggregated by: District
Justification and Management Utility: The availability of medicines and commodities is a critical determinant of the success of most of USG health programs. This indicator measures the ability of a supply system to maintain a constant supply of products and supplies at health facility level.
Indicator's Relevance to Gender: NA
Plan for Data Acquisition by USAID
Data Collection Method: Routine monitoring
Data Source: Program reports
Method of Data Acquisition by USAID: SIAPS
Frequency and Timing of Data Acquisition by USAID: Quarterly
Budget Mechanism:
Individual(s) Responsible at USAID: Aboubacar Sadou, Madiou Yattara, Madina Sangare, and Souleymane Sogoba
Location of Data Storage: SO6 M&E Officer's office
Data Quality Issues
Date of Initial Data Quality Assessment: 2012
Known Data Limitations and Significance (if any):
Actions Taken or Planned to Address Data Limitations:
Date of Future Data Quality Assessment: 2015
Procedures for Future Data Quality Assessments:
Plan for Data Analysis, Review, and Reporting
Data Analysis:
Presentation of Data:
Review of Data:
Reporting of Data:

National, Regional, District, and Community Management and Health Systems (continued)

Indicator: Percentage of facilities that had all tracer medicines and commodities in stock in the last 3 months [custom] (continued)			
Other Notes			
Notes on Baselines/Targets:			
Data Issues/Questions to Be Addressed:			
Other Notes:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
2009		NA	
2010	NA	NA	
2011	NA	NA	New indicator
2012	60		Guess estimated
2013	72		Assuming 20% increase from 2012
2014	86		Assuming 20% increase from 2013

SECTION V. EVALUATION AND LEARNING

The SO team will ensure the active involvement in the evaluation process of all stakeholders in the program: providers, partners, customers (beneficiaries), and any other interested parties. Participation typically takes place throughout all phases of the evaluation: planning and design; gathering and analyzing the data; identifying the evaluation findings, conclusions, and recommendations; disseminating results; and preparing an action plan to improve program performance.

Planned Evaluation Activities

The Health Portfolio Assessment:

The purpose of the assessment is to measure the performance of the current health portfolio, including an understanding of the effectiveness of USAID health interventions on improvements in Malian health status. The assessment will use available data: Mission PMPs and annual performance reports, GOM HMIS, IP routine monitoring data, DHS (2006, 2012), MICS, Anemia and Parasitemia Survey, Integrated Sexually Transmitted Disease Prevalence and Behavior Surveillance (2000, 2003, 2006, and 2009), and other pertinent background documents. The assessment will inform/contribute to the establishment of baselines for a future impact evaluation of the USAID/Mali health portfolio.

Prevention for Positives HIV Knowledge, Attitudes, and Behavior Baseline Survey:

The purpose of the study is to establish baseline data, key gaps in information, and attitudes about sexuality issues, high-risk behaviors, and treatment at the health facilities. It will also highlight service needs of PLHIV.

Final Evaluation of HIV Prevention Activities with High-Risk Groups (2000–2010):

The aim is to evaluate the impact of USAID/Mali HIV prevention activities for high- and medium-risk groups, and their effects on HIV and STI prevalence, HIV-related knowledge, and behavior. The contractor is asked to perform the research, analysis, and presentations regarding medium-

risk groups (truckers, ticket touts, ambulatory vendors, and household maids) and to verify and include research, analysis, and presentation for CSWs carried out by the USAID HIV/AIDS Technical Advisor (through 15 additional key informant interviews).This study will provide rich information to guide USAID and CDC and other national and international organizations in the design of future programming for key populations in Mali and in Africa.

Roles and Responsibilities of the SO Team (adapted from the USAID Evaluation Policy)

Develop, as needed, the guidance, tools, and contractual mechanisms to access technical support specific to the types of evaluations.

Develop, through the PO (as defined in ADS 100), a budget estimate for the evaluations to be undertaken during the following fiscal year.

Ensure that final scopes of work for external evaluations adhere to the standards described by the USAID Evaluation Policy.

Ensure, through the PO, that evaluation draft reports are assessed for quality by management and through an in-house peer technical review, and that comments are provided to the evaluation teams.

Ensure, through the PO, that evaluation data are warehoused for future use.

Integrate evaluation findings into decisions about strategies, program priorities, and project design.

Appendix A

List of 36 Focus Districts for FP, Maternal and Child Health (MCH), and Water and Sanitation Activities

List of 36 Focus Districts for FP, Maternal and Child Health (MCH), and Water and Sanitation Activities

Region	District
Kayes	Kayes Kita Djema
Koulikoro	Koulikoro Kati Ouéléssébougou Dioila Fana
Sikasso	Sikasso Koutiala Bougouni Kadiolo Kignan
Segou	Ségou Markala Niono San
Mopti	Mopti Tenenkou Bankass Bandiagara
Tomboctou	Tombouctou Niafunké Goundam Diré Gourma-Rharouss
Gao	Gao Ansongo
Kidal	Kidal Tessalit
Bamako	Commune I Commune II Commune III Commune IV Commune V Commune VI

Appendix B

Data Quality Checklist

DATA QUALITY CHECKLIST

The SO team will use the following checklist to assess the quality of performance data, specifically in terms of validity, reliability, timeliness, precision, and integrity:

Data Quality Assessment Checklist

Strategic objective:

Intermediate result (if applicable):

Data source(s):

Survey/Knowledge, Attitudes, and Practice

Service statistics

Health Facility Assessment

Other

Partner or contractor who provided the data (if applicable):

Year or period for which the data are being reported:

Is this indicator reported in the annual report? (Circle one) YES NO

Date(s) of assessment:

Location(s) of assessment:

Assessment team members:

For Office Use Only
SO team leader approval: _____ Date_____
PO approval: _____ Date_____
Copies to: _____
Comments:

Category	Yes	No	Comments
Validity			
Is there a solid logical relation between the program activity and what is being measured?			
Are the people collecting data qualified and properly supervised?			
Were known data collection problems appropriately assessed?			
Are steps being taken to limit transcription error?			
Are steps taken to correct known data errors?			
Reliability			
Is a consistent data collection process used from year to year, location to location, data source to data source?			
Are there procedures in place for periodic review of data collection, maintenance, and processing?			
Are data collection, cleaning, analysis, reporting, and quality assessment procedures documented in writing?			
Are data quality problems clearly described in final reports?			
Timeliness			
Is regularly scheduled data collection in place to meet program management needs?			
Is data properly stored and readily available?			
Precision			
Is there a method for detecting duplicate data?			
Is there a method for detecting missing data?			

Category	Yes	No	Comments
Integrity			
Are there proper safe guards in place to prevent unauthorized changes to the data?			
Has there been or is there planned an independent review of results reported?			

Appendix C

Summary Matrix of PMP Indicators

SUMMARY MATRIX OF PMP INDICATORS

USAID/MALI PPR Indicators and Targets

Program Element	Indicator	IP Reporting	Geographic Focus	Disaggregated by	FY09 Base	FY10 Targets	FY10 Results	FY11 Targets	FY11 Results	FY12 Targets	FY13 Targets	FY14 Targets
MCH/FP/RH	Maternal mortality ratio (S)	ICF	National	No	464	388	NA	340	NA	292	243	195
	Under 5 mortality rate (S)	ICF	National	Sex	191	NA	NA	NA	NA	95	NA	NA
	Neonatal mortality rate (S)	ICF	National	Sex	46	34	NA	32	NA	29	26	23
	Modern contraceptive prevalence rate (S)	ICF	National	Numerator, denominator	6.9	13	NA	14	NA	16	17	19
	Couple-years of protection in USG-supported programs (S)	SIAPS	National	No	440,362	400,000	444,928	460,000	NA	552,000	717,600	717,600
	Percent of births attended by skilled doctor, nurse, or midwife (S)	ATN Plus	36 districts	Sex, district	61	63	61	62	57	63	65	67
	Number of births receiving at least four ANC visits during pregnancy (S)	ATN Plus	36 districts	District	NA	NA	NA	NA	NA	400,000	440,000	484,000
	Percentage of deliveries in health facilities using active management of the third stage of labor and essential newborn care (C)	ATN Pius	36 districts	District	50	60	60	70	78	82	86	90
	Percentage of children 12–23 months of age who have received the measles vaccine by 12 months of age (S)	ATN Plus	National	Sex, district	NA	NA	NA	NA	NA	91	93	95

C: Custom indicator
S: Standard indicator
NA: Not available
TBD: To be determined

USAID/MALI PPR Indicators and Targets (continued)

Program Element	Indicator	IP Reporting	Geographic Focus	Disaggregated by	FY09 Base	FY10 Targets	FY10 Results	FY11 Targets	FY11 Results	FY12 Targets	FY13 Targets	FY14 Targets
MCH/FP/RH (continued)	Percentage of USG-assisted service delivery sites providing family planning counseling and/or services (S)	ATN Plus	National	District	NA	NA	NA	NA	85	90	92	95
	Number of health care providers trained in FP/RH with USG funds (C)	ATN Plus	National	Sex, type of health provider	NA	NA	NA	NA	1,196	100	100	100
	Number of ASCs trained in FP/RH with USG funds (C)	ATN Plus	National	Sex, district	NA	NA	NA	681	521	400	200	70
	Number of "relais" trained in FP/RH with USG funds (C)	ATN Plus	National	Sex, district								

C: Custom indicator
S: Standard indicator
NA: Not available
TBD: To be determined

USAID/MALI PPR Indicators and Targets (continued)

Program Element	Indicator	IP Reporting	Geographic Focus	Disaggregated by	FY09 Base	FY10 Targets	FY10 Results	FY11 Targets	FY11 Results	FY12 Targets	FY13 Targets	FY14 Targets
Malaria	Under 5 mortality rate (S)	ICF	National	Sex	191	NA	NA	NA	NA	95	NA	NA
	Malaria prevalence among children under 5 years of age (C)	TBD	National	Sex	38	NA	NA	NA	NA	NA	15	TBD
	Number of health workers trained in case management with ACTs with USG funds	ATN Plus, MCHIP	National	Sex, facility/ community	412	1,229	1,277	NA	1,957	1,500	1,500	1,500
	Number of ACT treatments purchased by other partners that were distributed with USG funds	PMI, SIAPS	National	No	NA	NA	NA	NA	NA	TBD	TBD	TBD
	Number of ACT treatments purchased with USG funds	PMI	National	No	330,589	NA	739,200	500,000	1,289,190	1,550,000	1,000,000	1,000,000
	Number of ACT treatments purchased in any fiscal year with USG funds that were distributed in this reported fiscal year	PMI, SIAPS	National	Facilities/CHW (HBMF, CCM)	330,589	400,000	500,000	1,289,190	739,190	2,100,000	1,500,000	1,500,000

C: Custom indicator
S: Standard indicator
NA: Not available
TBD: To be determined

USAID/MALI PPR Indicators and Targets (continued)

Program Element	Indicator	IP Reporting	Geographic Focus	Disaggregated by	FY09 Base	FY10 Targets	FY10 Results	FY11 Targets	FY11 Results	FY12 Targets	FY13 Targets	FY14 Targets
Malaria (continued)	Number of health workers trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds	ATN Plus	National	Sex, facility/ community	412	1,289	587	800	NA	1,620	1,620	1,620
	Number of RDTs purchased with USG funds	DELIVER	National	No	31,380	30,000	500,000	500,000	500,000	2,000,000	1,000,000	1,000,000
	Number of RDTs purchased in any fiscal year with USG funds that were distributed to health facilities in this reported fiscal year	PMI, SIAPS	National	No	NA	NA	530,000	500,000	TBD	TBD	TBD	TBD
	Number of ITNs purchased by other partners that were distributed with USG funds	PMI/ DELIVER	National	No	NA	NA	NA	NA	NA	320,000	TBD	TBD
	Number of ITNs purchased with USG funds	PMI	National	No	600,000	1,240,000	2,110,000	1,500,000	3,037,150	0	1,300,000	1,300,000
	Number of ITNs purchased in any fiscal year with USG funds that were distributed in this reported fiscal year	PMI/ DELIVER	National	Campaigns, facilities, private/ commercial sector	600,000	1,240,000	660,790	3,610,000	996,186	TBD	1,300,000	1,000,000

C: Custom indicator
S: Standard indicator
NA: Not available
TBD: To be determined

USAID/MALI PPR Indicators and Targets (continued)

Program Element	Indicator	IP Reporting	Geographic Focus	Disaggregated by	FY09 Base	FY10 Targets	FY10 Results	FY11 Targets	FY11 Results	FY12 Targets	FY13 Targets	FY14 Targets
Malaria (continued)	Number of people trained with USG funds to deliver IRS	Abt AIRS	Target areas	Sex	424	424	1,549	730	NA	816	816	816
	Number of houses targeted for spraying with USG funds	Abt AIRS	Target areas	No	130,842	180,000	180,000	208,998	NA	180,00	208,998	208,998
	Number of houses sprayed with IRS with USG funds	Abt AIRS	Target areas	No	126,922	170,000	127,273	208,998	202,821	202,821	202,821	202,821
	Total number of residents of sprayed houses	Abt AIRS	Target areas	Sex	457,374	580,000	440,815	600,000	697,512	697,512	697,512	697,512
	Number of health workers trained in IPTp with USG funds	ATN Plus	National	Sex	60	1,229	1,173	510	1,983	1,620	1,620	1,620
	Number of SP tablets purchased with USG funds	PMI	National	No	3,000,000	NA	NA			3,000,000	3,500,000	4,000,000
	Number of SP tablets purchased with USG funds that were distributed to health facilities	PMI, SIAPS	National	District	3,000,000	NA	NA	0	0	3,186,000	3,500,000	4,000,000
	Proportion of women who received IPTp during ANC visits during their last pregnancy	ICF	National	No	NA	NA	40	60	NA	70	85	85

C: Custom indicator
S: Standard indicator
NA: Not available
TBD: To be determined

USAID/MALI PPR Indicators and Targets (continued)

Program Element	Indicator	IP Reporting	Geographic Focus	Disaggregated by	FY09 Base	FY10 Targets	FY10 Results	FY11 Targets	FY11 Results	FY12 Targets	FY13 Targets	FY14 Targets
HIV/AIDS	Number of individuals who received testing and counseling services for HIV and received their test results	SOUTOURA ARCAD Sida, PKCII, PSI	National	Sex, MARP type (MSM, CSM, other)	41,518	NA	41,518	NA	37,930	35,000	35,000	35,000
	Number of people living with HIV/AIDS reached with a minimum package of prevention with PLHIV interventions	ARCAD/Sida	Target areas	No	NA	NA	NA	NA	NA	5,000	7,500	10,000
	Number of the targeted population reached with individual- and/or small group-level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	SOUTOURA ARCAD Sida, PKCII	Target areas	No	NA	NA	NA	TBD	TBD	TBD	TBD	TBD
	Number of MARPs reached with individual- and/or small group-level HIV preventive interventions that are based on evidence and/or meet the minimum standards required (S)	SOUTOURA ARCAD Sida, PKCII	Target areas	Sex, MARP type (MSM, CSM, other)	NA	NA	NA	NA	8,916	14,000	16,000	18,000
	Number of condoms distributed (C)	SOUTOURA, PKCII, ARCAD Sida, PSI	National	No	10,618,419	10,618,419	10,891,543	11,653,951	11,529,735	12,000,000	13,000,000	14,000,000

C: Custom indicator
S: Standard indicator
NA: Not available
TBD: To be determined

USAID/MALI PPR Indicators and Targets (continued)

Program Element	Indicator	IP Reporting	Geographic Focus	Disaggregated by	FY09 Base	FY10 Targets	FY10 Results	FY11 Targets	FY11 Results	FY12 Targets	FY13 Targets	FY14 Targets
Nutrition and Wash	Prevalence of underweight children under 5 years of age	ICF, FEEDBACK	FtF zones of influence	Sex	26.7	NA	NA	NA	NA	22.7	NA	18.7
	Prevalence of stunted children under 5 years of age	ICF, FEEDBACK	FtF zones of influence	Sex	37.7	NA	NA	NA	NA	33.0	NA	28.3*
	Prevalence of wasted children under 5 years of age	ICF, FEEDBACK	FtF zones of influence	Sex	15.2	NA	NA	NA	NA	12.9	NA	10.6*
	Prevalence of underweight women	ICF, FEEDBACK	FtF zones of influence	No	13.5	NA	NA	NA	NA	12.2	NA	10.8*
	Number of people trained in child health and nutrition through USG-supported programs	AVDRC, ACDI, HKI, ATN Plus, Wash Plus, UNICEF ASDAP	National	Sex	NA	NA	NA	NA	NA	500	500	500
	Number of children under 5 reached by USG-supported nutrition programs	ICF, FEEDBACK	National	Sex	NA	NA	NA	NA	NA	2,976,698	3,065,999	3,157,979
	Number of children under 5 who received vitamin A from USG-supported programs	ICF, FEEDBACK	National	Sex	2,729,761	2,805,823	2,805,823	2,889,998	NA	2,976,698	3,065,999	3,157,979
	Prevalence of children 6–23 months receiving a minimum acceptable diet	ICF, FEEDBACK	FtF zones of influence	Sex	6.7	NA	NA	NA	NA	16	NA	25*
	Prevalence of households with moderate or severe hunger (S)	ICF, FEEDBACK	FtF zones of influence	Gendered household type, child no adult	NA	NA	NA	NA	NA	TBD	TBD	TBD

C: Custom indicator
S: Standard indicator
NA: Not available
TBD: To be determined

USAID/MALI PPR Indicators and Targets (continued)

Program Element	Indicator	IP Reporting	Geographic Focus	Disaggregated by	FY09 Base	FY10 Targets	FY10 Results	FY11 Targets	FY11 Results	FY12 Targets	FY13 Targets	FY14 Targets
Nutrition and Wash (continued)	Percent of households with soap and water and a handwashing station commonly used by family members	ICF, FEEDBACK	National	Numerator, denominator	NA	NA	NA	NA	NA	TBD	TBD	TBD
	Number of communities certified as "open defecation free" as a result of USG assistance	Wash Plus, ASDAP, UNICEF	National	No	NA	NA	NA	NA	NA	TBD	TBD	TBD
	Proportion of population using an improved sanitation facility	ICF, FEEDBACK	National	Numerator, denominator	NA	NA	NA	NA	NA	TBD	TBD	TBD
	Number of Aquatabs tablets sold with USG assistance (C)	PSI, UNICEF	National	No	NA	NA	4,500,000	NA	7,041,590	800,000	840,000	880,000
	Prevalence of exclusive breastfeeding of children under 6 months of age (S)	UNICEF	FtF zones of influence	Sex	37.8	NA	NA	NA	NA	47	NA	57

C: Custom indicator
S: Standard indicator
NA: Not available
TBD: To be determined

USAID/MALI PPR Indicators and Targets (continued)

Program Element	Indicator	IP Reporting	Geographic Focus	Disaggregated by	FY09 Base	FY10 Targets	FY10 Results	FY11 Targets	FY11 Results	FY12 Targets	FY13 Targets	FY14 Targets
Cross Cutting	Number of awards made directly to local organizations	USAID	For-profit, not-for-profit	No	NA	NA	NA	NA	NA	TBD	TBD	TBD
	Percentage of operating unit program funds obligated through partner country systems	USAID	Numerator, denominator	No	NA	NA	NA	NA	NA	TBD	TBD	TBD
	Percentage of operating unit program funds obligated to local organizations	USAID	Numerator, denominator	No	NA	NA	NA	NA	NA	TBD	TBD	TBD
	Number of policies or guidelines developed or updated with USG assistance to improve access to and use of high-impact health services (C)	ATN Plus, UNICEF, SIAPS, PCKII	National	Program area	25	13	28	13	20	20	20	20
	Percentage of facilities that had all tracer medicines and commodities in stock in the last 3 months (c)	SIAPS	National	District	NA	NA	NA	NA	NA	60	72	86

C: Custom indicator
S: Standard indicator
NA: Not available
TBD: To be determined

Appendix D

USAID/MALI RESULT FRAMEWORK

USAID/MALI RESULT FRAMEWORK

SO6: Increased Use of High Impact Health Services and Healthy Behaviors

Program indicators:

- **Reduce Maternal Mortality**
- **Reduce Under Five Mortality**
- **Reduce Newborn Mortality**
- **Increase Modern Method Contraceptive Prevalence Rate**
- **Reduce Malaria Prevalence among children under five years of age**
- **Reduce HIV Sero-prevalence among Most At Risk Groups**
- **Reduce Prevalence of underweight children under five years of age**
- **Reduce Prevalence of Stunted children under 5 years of age**
- **Reduce Prevalence of wasted children under five years of age**
- **Reduce Prevalence of underweight women**

IR 1: Use of Quality Family Planning, Reproductive, Maternal, Neonatal, and Child Health Services Improved

PPR Indicators

1. Couple-Years Protection (CYP) in USG-supported programs (standard)
2. Number of pregnant women who completed at least 3 antenatal care (ANC) visits during pregnancy (custom)
3. Percent of deliveries in health facilities using active management of the third stage of labor (AMSTL) and essential newborn care (custom)
4. Percent of children 12-23 months of age who have received measles vaccine by 12 months of age (standard)

IR 2: Coverage and Use of Key Malaria Interventions Increased

PPR Indicators

1. Total Number of residents of sprayed houses (standard)
2. Number of ITNs purchased with USG funds that were distributed (standard)
3. Number of ACT treatments purchased with USG funds that were distributed (standard)

IR 3: Coverage of HIV/AIDS and STI Prevention among selected MARP Increased

PPR Indicators

1. Number of individuals who received testing and counseling services for HIV and received their result (standard)
2. Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required (standard)
3. Number of people living with HIV/AIDS reached with a minimum package of Prevention with PLHIV (PwP) interventions (standard)

IR 4: Nutritional Status, Water Supply, Hygiene, and Sanitation Improved

PPR Indicators

1. Number of children (6 to 59 months) who received a dose of *vitamin A* from USG-supported programs (standard)
2. Prevalence of households with moderate or severe hunger (standard)
3. Prevalence of children 6-23 months receiving a minimum acceptable diet (Standard)
4. Women's Dietary Diversity: Mean number of food groups consumed by women of reproductive age (Standard)
5. Prevalence of exclusive breastfeeding of children under six months of age (Standard)
6. Number of people trained in child health and nutrition through USG-supported programs (Standard)
7. Prevalence of anemia among women of reproductive age (Standard)
8. Prevalence of anemia among children 6-59 months (Standard)
9. Number of children under five reached by USG-supported nutrition programs
10. Number of Aquatabs tablets sold with USG assistance (custom)

IR 5: National, Regional, District, and Community Management and Health Systems Improved

PPR Indicators

1. Number of policies or guidelines documents developed or updated with USG assistance to improve access to and use of high impact health services (custom)
2. Percent of facilities that had all tracer medicines and commodities in stock in the last three months (standard)
3. Number of people trained with USG assistance (custom)