



DRAFT

Performance Management in the Health Sector

A Guide to Developing and Implementing Performance
Management Plans for USAID Health Programs



Foreword

This Toolkit was developed by IBM Business Consulting Services under the Integrated Managing for Results (IMR) contract in response to a request from the Monitoring and Evaluation (M&E) subcommittee of the USAID Health Sector Council. The primary authors were Shiro Gnanaselvam (Team Leader) and Elizabeth Sunindyo. It is based on the general Performance Management Toolkit that was developed by IBM (then PricewaterhouseCoopers LLP) in January 2001, but it has been customized and streamlined to meet the specific needs of USAID staff operating in the health sector. This Toolkit takes into account feedback provided by USAID Health Officers in the field and incorporates lessons learned by the IMR team while providing performance management technical assistance to numerous USAID Operating Units and delivering more than 35 workshops on Performance Management to USAID staff and partners worldwide.

The team acknowledges the technical support provided by the M&E subcommittee of the Health Sector Council, especially Subhi Mehdi of AFR/DP and Vathani Amirthanayagam of GH/RCS, who provided leadership and guidance throughout the development process.

We also thank Jacob Adetunji for his work on DHS and data quality as well as Mark Austin, Dick Cornelius, Karen Kasan, Nancy McCharen, Peggy Meites, William Murphy, Nahoko Nakayama, and Francisco Zamora (all of USAID) and Gustavo Angeles of the MEASURE project whose contributions during various iterations of this Toolkit have been significant. Our thanks also go to Macro International for providing the cover photograph for this report.

Finally, we thank all of the Operating Units in the field and in Washington who shared their time, knowledge and experience during the development of their Performance Management Plans.

We sincerely hope that this version of the Performance Management Plan (PMP) Toolkit will further the Agency's Managing for Results efforts and lead to more sustainable and effective health programs that improve the lives of the people that USAID staff work so hard to serve.

David Eckerson

Director, Office of Strategic and Performance Planning
Bureau for Policy and Program Coordination
United States Agency for International Development



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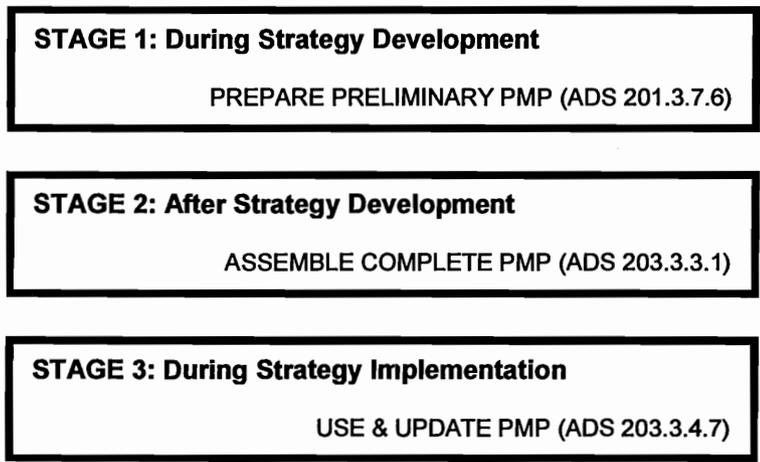
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Introduction to This Toolkit

The purpose of this Toolkit is to provide USAID staff and partners operating in the health sector with practical resources for a critical aspect of managing for results: developing and using a **performance management plan (PMP)**.

The primary target audience for this Toolkit is Health Strategic Objective (SO) teams who are responsible for developing the PMP for their SO. The Toolkit describes key performance management processes, suggests tools and techniques for developing a PMP, provides examples, and refers to additional helpful resources.

The Toolkit is divided into three sections, to mirror the following three stages of developing and using a PMP:



Before beginning Stage 1, it is helpful to consider what performance management is and what role a performance management plan plays in the management process.

What is Performance Management?

Performance management is the systematic process of

- Planning to monitor results of activities,
- Collecting and analyzing performance information to track progress toward planned results,
- Using performance information to influence program decision making and resource allocation and make midcourse corrections, and
- Communicating results achieved or not attained to advance organizational learning and tell the organization's story.

Performance management is not a one-time event; rather, it is an ongoing effort to improve program management and achieve better results with greater accountability.

What is a performance management plan (PMP)?

A PMP is a critical tool that allows effective performance management. A PMP should

- Plan for all performance management activities and tasks (from indicator data collection to conducting evaluations and assessments to portfolio reviews) that will be carried out over the life of the Strategic Objective;
- Define the specific performance indicators that will be used to assess progress over the life of the SO, determine baselines, and set targets;
- Plan and manage the data collection process needed to track progress; and
- Describe known data limitations and the data quality assessment procedures that will be used to verify and validate data used for external reporting.

What should be contained in a PMP?

The following table summarizes the contents of a preliminary PMP and a complete PMP, as provided in ADS 201.3.7.6 and 203.3.3. This table also refers to a series of worksheets that are included in the Toolkit to help your team quickly develop your PMP and document your results.

Summary of Mandatory and Non-Mandatory Elements of a Performance Management Plan (PMP)		Worksheet 6	Worksheet 7	Worksheet 8	Worksheet 9
Preliminary PMP	MANDATORY: A preliminary PMP				
	<ul style="list-style-type: none"> MUST propose performance indicators for the SO-level result (with baseline data and ultimate targets). 	√		√	
	<ul style="list-style-type: none"> SHOULD include performance indicators for the Intermediate Results (with baseline data and ultimate targets). 	√		√	
Complete PMP	MANDATORY: A complete PMP must include				
	<ul style="list-style-type: none"> At least one performance indicator at the SO level, with baseline and ultimate target levels. 	√		√	
	<ul style="list-style-type: none"> At least one performance indicator for each IR, with baseline and ultimate target levels. 	√		√	
	HIGHLY RECOMMENDED: A complete PMP should include				
	<ul style="list-style-type: none"> Calendar of performance management tasks. 				√
	<ul style="list-style-type: none"> Statement of the set of performance indicators to be used over the life of the SO; Information on appropriate disaggregation of indicators, such as by gender; and Justification of the selection of indicators. 	√			
	<ul style="list-style-type: none"> Baseline values and targeted values for <i>all</i> indicators in the PMP. 	√		√	
	<ul style="list-style-type: none"> Source of data and method for data collection. 	√			
	<ul style="list-style-type: none"> Schedule for data collection. 				√
	<ul style="list-style-type: none"> Known data limitations. 	√			
	<ul style="list-style-type: none"> Data quality assessment procedures. 	√			
	OPTIONAL: A complete PMP may				
	<ul style="list-style-type: none"> Describe plans for reviewing, using, and reporting on performance indicators. 	√			
	<ul style="list-style-type: none"> Identify data collection requirements that can be incorporated into activities and obligation agreements with partner organizations. 	√			
	<ul style="list-style-type: none"> Identify possible evaluation efforts to complement the performance management effort and identify circumstances requiring evaluations or other special studies. 				√
<ul style="list-style-type: none"> Estimate the costs of collecting, analyzing, and reporting performance data and plan how these will be financed. 	√				
<ul style="list-style-type: none"> Plan for process of collecting data for Agency reporting purposes. 				√	
<ul style="list-style-type: none"> Discuss plans for monitoring the development hypothesis, critical assumptions, and context indicators affecting the Results Framework. 	√				

Good practice suggests that all indicators—whether they be performance indicators used to track progress toward an Operating Unit’s SO or Agency common indicators used to track country-level performance and tell the Agency’s story—be maintained in a PMP format. While not required by the ADS, it makes good operational sense to plan for data collection, analysis, data quality assessment, and reporting of *all* indicators in a single PMP.

Appendix G – Annotated Outline for a Health Sector PMP can help an SO team structure its PMP to meet the above requirements. In addition, the CD accompanying this Toolkit contains several sample PMPs and the full series of worksheets.

How should a PMP be developed?

To be most useful for management, the development of a PMP should be a collaborative process involving implementing partners and others who have an interest in the outcomes of USAID programs. By involving these stakeholders, USAID staff can build a performance monitoring system that is more effective, integrated, and useful at all levels of program management.

Stage 1: Develop a Preliminary PMP

As provided in ADS Chapters 201 and 203, USAID uses two kinds of PMPs—preliminary (at time of strategy submission) and complete (within one year of strategy approval). The preliminary PMP should help readers of the Strategic Plan understand the scope and magnitude of change that is expected as a result of the proposed Strategic Objective(s).

The selection of indicators for the preliminary PMP should complement and reflect the strategy of the proposed SO. Within the health sector, the preliminary PMP can be particularly helpful at demonstrating basic elements of the proposed strategy. Specifically, by describing baseline and end-of-strategy targets, the preliminary PMP can communicate the magnitude of change that the proposed program is expected to have. It can also illustrate whether impacts are expected within a specific targeted population or at the level of the general population. In addition, a preliminary PMP can help specify whether the changes expected are at the outcome level (use of services and behavior change) or the impact level (improvement of health status).

As provided in ADS 201.3.7.6, a preliminary PMP

- *Must propose performance indicators for the Strategic Objective-level result (with baseline data and ultimate targets) and*
- *Should propose, if possible, performance indicators for the Intermediate Results (with baseline data and ultimate targets).*

Development of the preliminary PMP goes hand in hand with strategy development. As the SO team makes choices about which health sector problem(s) to address with the resources available, and formulates the SO-level results statement, ask the following two questions:

- How does USAID know this is a problem? What are the indicators of the problem?
- To what extent can USAID alleviate the problem, given the time and resources available? What would it look like if the problem were solved?

The answers to these two questions should provide you with the information you need for your preliminary PMP. The answer to the first question will provide you with the performance measure and baseline level of performance, while the answer to the second question will provide you with your end-of-strategy targets.

Helpful Resources to Learn More About Developing Health Sector Strategies and Preliminary PMPs (see also Appendix C – Resources on the Internet and Toolkit CD)

- ADS Chapter 201 – Planning, www.usaid.gov/pubs/ads/200/200.pdf
- TIPS 13: Building a Results Framework, www.dec.org/pdf_docs/PNACA947.pdf
- *Health and Family Planning Indicators: A Tool for Results Frameworks*, Vol. 1, www.dec.org/pdf_docs/PNACM806.pdf
- A Collaborative Approach to Reviewing HIV/AIDS Strategies, ADS 201 Mandatory reference, www.usaid.gov/policy/ads/200/200max.pdf.

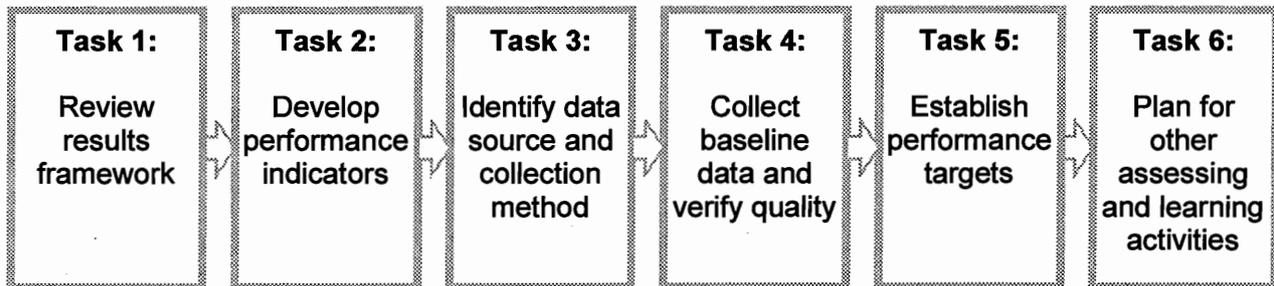
Stage 2: Develop a Complete PMP

Within one year of approval for a new Strategic Plan or Strategic Objective, teams must develop a complete PMP to monitor, evaluate, analyze, review, and report performance data throughout the life of the Strategic Objective.

This section of the Toolkit presents a six-task methodology for developing a comprehensive PMP. Each task is broken out into steps and is supported by worksheets that can help the team develop and document a complete PMP.

As provided in ADS 203.3.3.1, a **complete PMP**

- Must define at least one SO-level indicator (with baseline and final targets) and
- Must define at least one indicator for each IR (with baseline and final targets).



While the PMP development process is presented sequentially in order to simplify and clarify a complex set of tasks and sub-tasks, in reality the process is often either iterative or requires completing some tasks simultaneously. For example, you may get to task 3 (identify data source and collection method) and realize that one of the indicators you developed in task 2 is not appropriate because a reliable data source doesn't exist or the data collection method associated with that indicator is too costly. The SO team should then go back to task 2 to rethink that particular indicator and either revise it or select another indicator that is more appropriate.

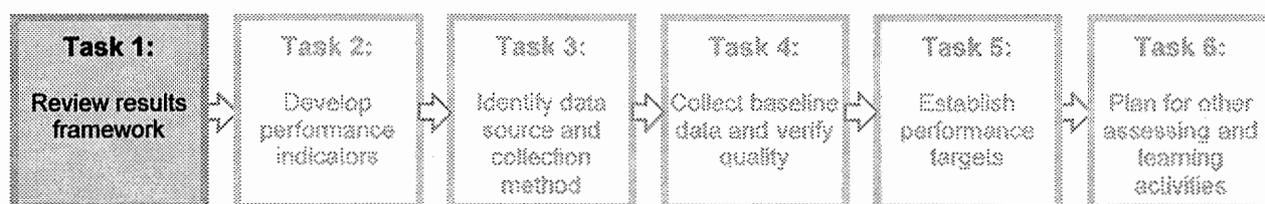
Getting Started

As your team is getting ready to develop a PMP, keep the following guiding principles in mind in order to streamline the process:

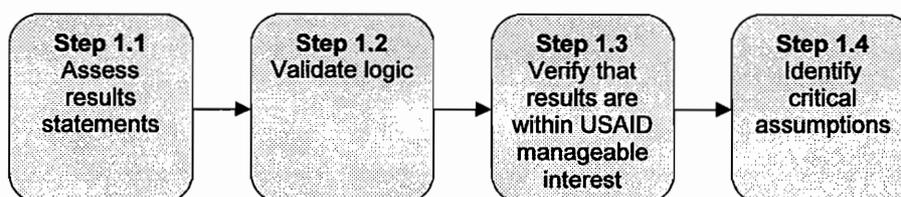
- *Employ a team approach to PMP development.* Involving the right group of people from the beginning ensures a better product at the end. A team approach also increases ownership of the document and thereby reinforces the importance of using the PMP once it has been completed. Keep in mind that the team should include not only USAID staff but implementers and other stakeholders as well.
- *Make sure that you have the right skills needed to develop the best PMP.* Assess whether your team currently has all the skills necessary to develop a PMP. Use **Worksheet 1 – PMP Development Team Skills Matrix** to help assemble a PMP development team that has a mix of the right skills.

- *Gather and review background materials.* At a minimum, review the approved Strategic Plan; strategy approval cable; most recent Annual Report; and relevant studies, assessments, or evaluations related to the SO.
- *Establish a work plan and stick to it.* With the burdens of day-to-day program management, tasks like developing a PMP can drag on endlessly and never come to closure. Starting with a work plan and making every effort to stick to it will ensure that you get the job done. Use **Worksheet 2 – PMP Development Workplan** as a template for developing the work plan.

Task 1 – Review Results Framework



The purpose of this task is not to develop a Results Framework from scratch or to repeat the strategy development. In preparation for a PMP, however, it is often useful to conduct a quick review of the Results Framework to validate the implied cause-effect relationships and ensure that all results are within USAID’s manageable interest. The process of reviewing results statements can be broken down into the following four steps:



Step 1.1 Assess results statements

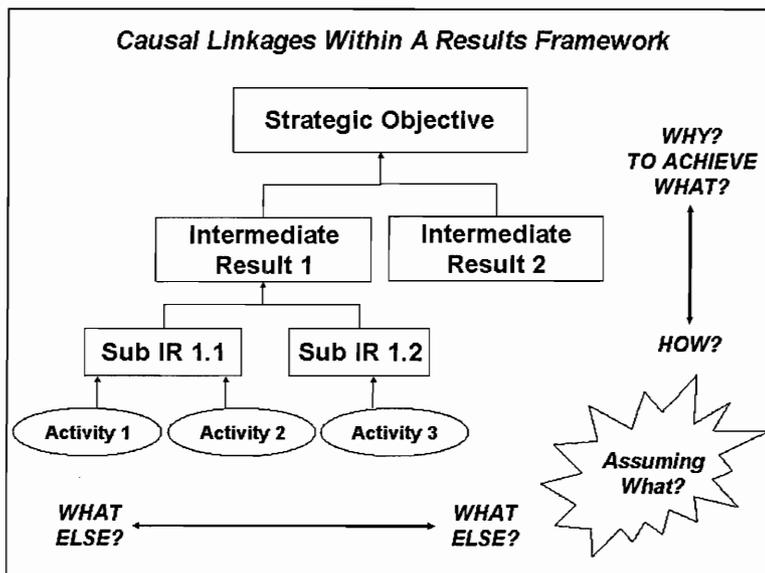
Good performance indicators start with good results statements that people can understand and agree on. Therefore, begin the PMP development process by reviewing SOs and IRs to make sure that each individual results statement is of good quality. Using **Worksheet 3 – Results Statement Assessment**, teams can verify whether the results statement is

- Measurable and objectively verifiable;
- Meaningful and realistic;
- Focused on USAID’s strategic commitments;
- Customer- or stakeholder-driven;
- Can be materially affected by the Operating Unit and its partners (within manageable interest);
- A statement of results – not an activity, process, or output; and
- Uni-dimensional – not a combination of results.

Step 1.2 Validate logic

Causality

The linkages within a Results Framework should be *causal*; the achievement of one Intermediate Result (IR) should contribute to the achievement of a higher level result in the framework. The causal linkages within a Results Framework should also be *direct*; there should not be too many assumptions that link a lower level result with a higher level result in the framework. The following figure illustrates these logical requirements.



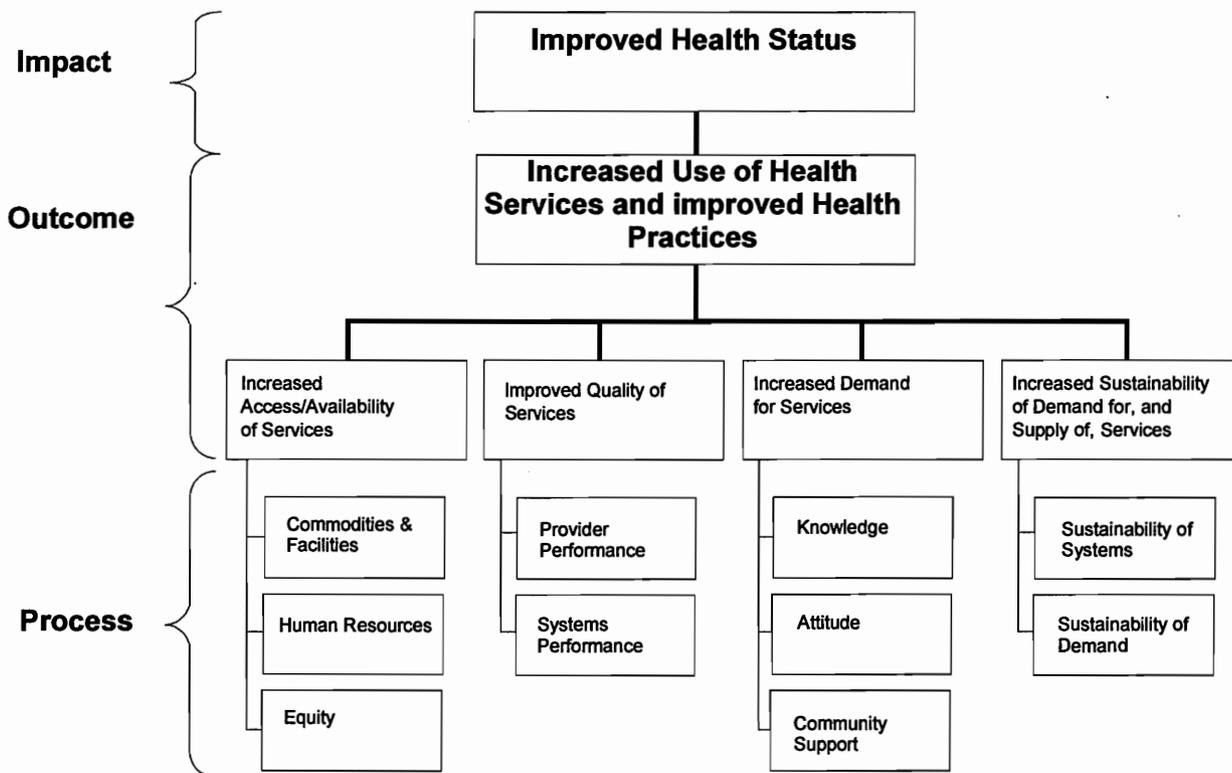
Moving across the Intermediate Results and sub-IRs of the framework should answer the question, “*What else* is required to achieve the above result?” Keep in mind that the logic of the Results Framework may be strengthened if the results of other development partners contributing to the sector are also considered.

Moving up the framework should answer the questions, “*Why* does this matter?” and “*So what* if we do this?” The highest level result on a Results Framework that a SO Team can be held materially responsible for should be the Strategic Objective level results statement.

Moving down the framework should answer the question, “*How* do we cause this effect?” (This question does not refer to the activities needed to achieve the result, but to other Intermediate Results needed to achieve the higher-level result.)

A model of this hierarchy of results for the family planning and health sector appears below. The various levels of this model are not identified as “SO” or “IR-level” because each Operating Unit should interpret what lies within its own manageable interest, or what it can be held materially accountable for. For example, the Strategic Plan for one mission may propose that the mission can affect total fertility, while the mission in the neighboring country may only intend to change the use of services (such as contraceptive prevalence) or the access to services. Several factors affect the decision about which “level” is most appropriate, including prior achievements in the health sector, timeframe of the approved Strategic Objective, resources

available, and country situation and political context. While the level chosen for the SO may differ from one Operating Unit to the next, the hierarchy of results and the causal relationships within the hierarchy remain much the same.



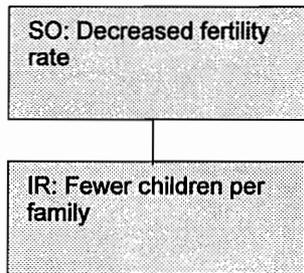
Source: Adapted from *Health and Family Planning Indicators: A Tool for Results Frameworks*, Vol. 1, page 4, Office of Sustainable Development, Bureau for Africa, USAID, www.dec.org/pdf_docs/PNACM806.pdf.

Common Problems with Causality

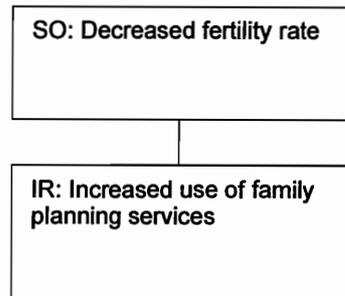
The following examples illustrate four common logical flaws that occur in Results Frameworks, and show how they can be improved.

- a. **The relationship is definitional, instead of causal.** If a result at one level of the framework is a restatement or a clarification of a result at another level, then there is a *definitional* problem in the framework. Instead, the lower-level result(s) should cause the achievement of the higher-level result. A quick way to determine if there is a definitional problem is to ask how the result can be measured. If the indicator(s) are the same for both results, then the lower level result is not causing the higher level result.

POOR
Example of a “definitional” relationship

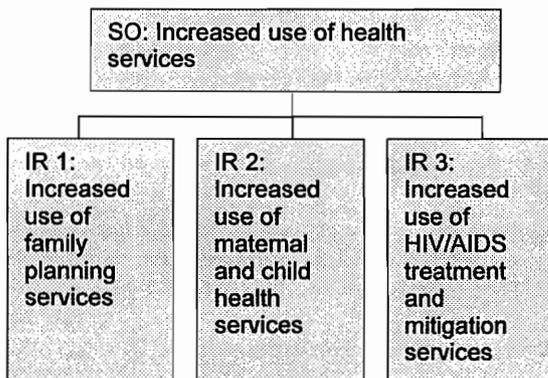


BETTER
Example of a stronger causal relationship

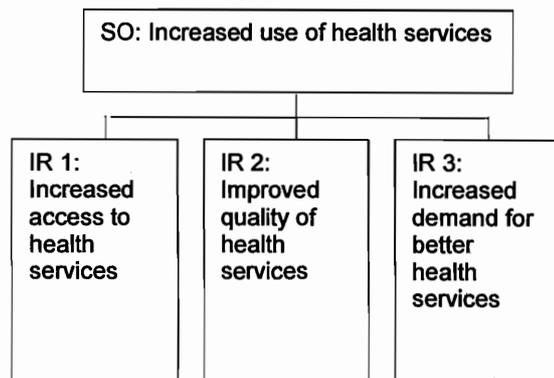


- b. **The relationship is categorical, instead of causal.** In the example below, the lower-level results are simply *categories* of the higher-level result. A quick way to test for a weak categorical relationship is to ask how each of the results can be measured. If the indicators for the lower-level result are simply categories of the indicator for the higher-level result, then the lower level results are not causing the higher level result.

POOR
Example of a “categorical” relationship

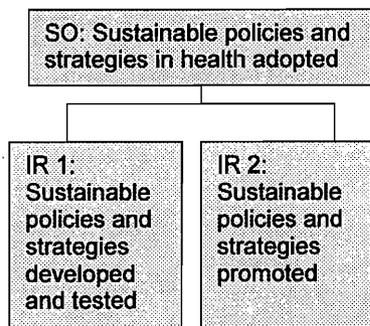


BETTER
Example of a stronger causal relationship

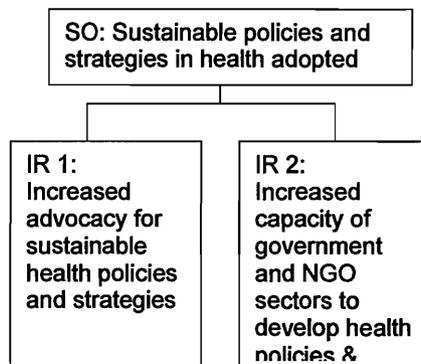


c. **The relationship is chronological, instead of causal.** The chronological problem occurs when the lower-level results simply identify the sequence or series of tasks that need to be completed, without identifying the causal linkages between the results. In the following example, the Intermediate Results are important steps in the process of arriving at the Strategic Objective, but they do not describe results that *cause* the SO level result.

POOR
Example of a “chronological” relationship

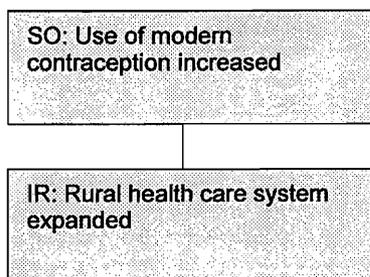


BETTER
Example of a stronger causal relationship

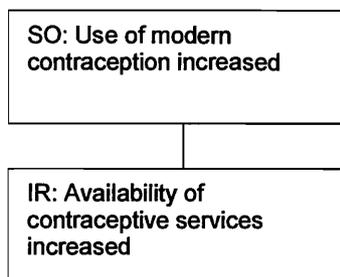


d. **The relationship is causal, but indirect.** The logical “jump” between two levels of results should not be too large. The problem of indirectness arises when several Intermediate Results would have to be assumed in order to achieve the higher-level result.

POOR
Example of an “indirect” relationship



BETTER
Example of a stronger causal relationship



Step 1.3 Verify that results are within USAID’s manageable interest

All results in an Operating Unit’s Results Framework should be within its manageable interest. In particular, the Strategic Objective level result should be the highest level result for which the Operating Unit can be held materially accountable for. A result is within USAID’s manageable interest if the following concepts are true:

To determine if a result is within USAID’s manageable interest, ask:

- *Would the result have been achieved if USAID had not been involved?*
- *Did USAID significantly and critically influence achievement of the result?*

- USAID is confident that its ability to influence, organize, and support others around commonly shared goals can lead to the achievement of results.
- The probability of success is high enough to warrant expending program and staff resources.

Step 1.4 Identify critical assumptions

Assumptions complete the “if/then” logic by describing the conditions that must hold between each level. Determine the assumptions by asking the question, “What general conditions must exist in order for the lower-level result to cause the higher-level result?” Critical assumptions can be found at every level within the Results Framework, and they should be continuously monitored.

*A **critical assumption** is a general condition under which the development hypothesis or strategy for achieving the Strategic Objective will hold true.*

Identifying critical assumptions is an important part of developing a PMP because the assumptions can:

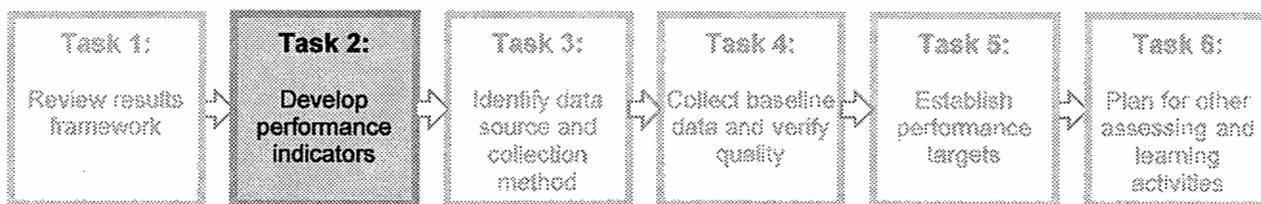
- Identify what is beyond the program/activity manager’s control;
- Provide shared judgment of the probability of success;
- Promote realistic program and activity design;
- Promote realistic program monitoring (tracking the status of assumptions might help to inform why intended results are/are not being achieved); and
- Improve communication between the program/activity manager and the SO team.

Use **Worksheet 4 – Results Framework Assessment** to facilitate your review of the entire Results Framework—confirm logic, manageable interest, and existence of assumptions.

Helpful Resources to Learn More About Results Statements and Results Frameworks

- ADS Chapter 201 – Planning, www.usaid.gov/pubs/ads/200/201.pdf
- TIPS 13: Building a Results Framework, www.dec.org/pdf_docs/PNACA947.pdf
- *Health and Family Planning Indicators: A Tool for Results Frameworks*, Vol. 1, www.dec.org/pdf_docs/PNACM806.pdf

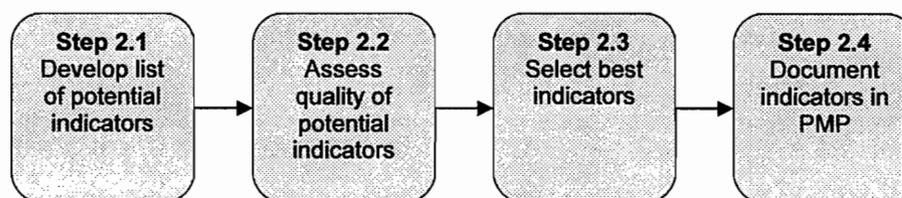
Task 2 – Develop Performance Indicators



Performance indicators are at the core of a performance management plan because they

- Help to measure progress toward each of the results in the Results Framework;
- Orient and motivate Operating Unit staff toward achieving results;
- Help to better communicate USAID achievements to host country counterparts, other partners, and customers; and
- Clearly and consistently report results achieved to USAID stakeholders, including Congress, Office of Management and Budget, and citizens.

Start with a list of potential indicators, and then narrow down the list to a final set based on the Agency's criteria for indicator quality. The process of developing performance indicators can be broken down into the following four steps.



Step 2.1 Develop list of potential indicators

Many different indicators could be used to describe and track the phenomena behind each result in a Results Framework, but some indicators will be more appropriate and useful than others. Potential indicators can come from sources such as

- Portfolio of activities and indicators used by implementing partners,
- Agency common indicators for the health sector (see Annual Report Guidance for each FY),
- Handbooks of sector indicators (see resources section at the end of this Toolkit),
- USAID sector expertise (Pillar and Regional Bureaus),
- Experience of other Operating Units with similar indicators,
- USAID Annual Report Database (www.dec.org/partners/ardb/),
- Internal brainstorming by SO team,
- External sector/regional experts, and
- The Internet (for indicators used by other organizations).

Try to use a participatory approach in brainstorming the list of performance indicators. Collaboration with partners has many benefits, and it makes good sense to draw on the experience of others and obtain their consensus throughout the process.

Step 2.2 Assess quality of potential indicators

Once the list of potential indicators is developed, assess each indicator against the USAID criteria for quality indicators. **Worksheet 5 – Performance Indicator Quality Assessment** is designed around the Agency criteria and is a convenient tool for documenting the strengths and weaknesses of each potential indicator.

The following section describes the Agency’s criteria for good indicators and provides examples, both strong and weak, to illustrate the criteria.

- 1. DIRECT:** The performance indicator should closely track the result it is intended to measure.

Poor Example (Direct)	Better Example (Direct)
<p>Result: Use of HIV/AIDS preventive services increased</p> <p>Poor Indicator: Number of condoms distributed in antenatal clinics</p> <p>Why this is a poor indicator: The number of condoms <i>distributed</i> is not a measure of condoms <i>used</i> (i.e., HIV/AIDS prevention services).</p>	<p>Result: Use of HIV/AIDS preventive services increased</p> <p>Indicator: Percentage of interviewees reporting condom use at last risky sexual encounter</p> <p>Why this is a better indicator: The number of individuals who report using a condom during their last risky sex encounter is direct evidence of increased use of an HIV/AIDS preventive measure.</p>

If direct indicators are not feasible, then use credible proxy measures. **Proxy indicators** are indirect measures of a given result that are linked to the result by one or more assumptions.

Poor Example (Proxy Indicator)	Better Example (Proxy Indicator)
<p>Result: Increased use of modern family planning practices</p> <p>Direct Indicator: Contraceptive prevalence rate</p> <p>Poor Proxy Indicator: Percentage of targeted providers trained in modern contraceptive methods</p> <p>Why this is a poor proxy indicator: A proxy indicator is by definition indirect and involves assumptions. However, in the above example, too many steps have to be assumed to link increases in trained providers (the proxy measure) to increased use of modern methods (the result). The relationship between the proxy and the result is neither well documented nor solid.</p>	<p>Result: Increased use of modern family planning practices</p> <p>Direct Indicator: Contraceptive prevalence rate</p> <p>Better Proxy Indicator: Couple years of protection (CYP)</p> <p>Why this is a better proxy indicator: Although CYP measures distribution of contraceptives—not use of contraceptives—the relationship between distribution and use of condoms is well documented and solid. Thus it is a credible proxy.</p>

2. OBJECTIVE: Performance indicators should be unambiguous about what is being measured; therefore, they should be uni-dimensional (measure only *one* phenomenon at a time) and be precisely defined in the PMP.

Poor Example – Precisely Defined	Better Example – Precisely Defined
<p>Result: Increased preparedness of health facilities</p> <p>Indicator: Percentage of products ordered and received</p> <p>Why this is a poor (imprecise) indicator: It is not very clear what is being measured: products ordered, or products received, or perhaps a combination of the two. Without an objective description of what is being measured, the indicator could be calculated differently each time, resulting in data that are not comparable over time.</p>	<p>Result: Increased preparedness of health facilities</p> <p>Indicator: Percentage of targeted health facilities experiencing contraceptive stock out</p> <p>Why this is a better (precisely defined) indicator: This indicator objectively states what should be counted (health facilities) and how it should be represented (percentage).</p>

Poor Example – Uni-dimensional	Better Example – Uni-dimensional
<p>Result: Improved skills of service providers</p> <p>Indicator: Percentage of targeted providers trained and counseling appropriately on the use of modern family planning methods</p> <p>Why this is a poor (multi-dimensional) indicator: This is a multi-dimensional measure because it attempts to measure of numbers of providers trained and also measure of numbers of providers actually counseling on the topic. Combining the two elements introduces ambiguity and complexity, which dilute the usefulness of the indicator. For example, if a provider is trained, but not providing counseling about the method, should he or she be counted? What about the reverse? How about someone who didn't received training, but is counseling appropriately?</p>	<p>Result: Improved skills of service providers</p> <p>Indicator: Percentage of targeted providers who counsel appropriately on the use of modern family planning methods.</p> <p>Why this is a better (uni-dimensional) indicator: This is a uni-dimensional indicator because it measures only one phenomenon: number of providers who provide the counseling. The SO Team should think through additional questions, however, such as how to determine "appropriate" counseling, and also how to actually observe or measure the providers. See Indicator Reference Sheet (Worksheet 6) for these questions on definition and data collection.</p>

3. USEFUL FOR MANAGEMENT: Performance indicators should be useful for the relevant level of decision making (at the SO team, Operating Unit, or Agency level). Avoid collecting and reporting information that is not used to support program management decisions. Operating Units usually have varying information needs for decision making, depending on where the Operating Unit is in implementing a particular SO. As such, determining which indicators are useful for management depends on the particular context, the decisions that need to be made, and the funding sources that are available.

4. PRACTICAL: Data collection costs, in terms of human and financial resources, are an important consideration. Operating Units should select performance indicators for which data can be obtained at reasonable cost and in a timely fashion. In general, the cost of collecting data for an indicator should not exceed the management utility of the data. A good rule of thumb is that costs to an Operating Unit for performance monitoring and evaluations should

normally range between 3 to 10 percent of the total budget for the Strategic Objective (see ADS 203.3.2.2).

5. ATTRIBUTABLE TO USAID AND ITS DEVELOPMENT PARTNERS: Performance indicators should measure changes that are clearly and reasonably attributable—at least in part—to USAID efforts. Attribution exists when the outputs produced by USAID-financed activities have a logical and causal effect on the results being measured by the performance indicator. A quick way to test for attribution is to ask, “If there had been no USAID activity, would this result (or level of result) have been achieved?” If the answer is “NO,” then the result is attributable to USAID. If the answer is “YES,” then likely there are attribution issues, and you may need to consider a different indicator and/or result.

6. TIMELY: Performance information should be available when it is needed to make management decisions. Relevant data should be available more frequently for decisions that occur frequently.

7. ADEQUATE: Each Strategic Objective and Intermediate Result should have a set of indicators which adequately describes the dimensions of change intended by the result. Most results will need more than one indicator to adequately track progress. For example, the result “increased use of child health services” would need indicators of multiple child health interventions (DPT3 vaccination rate, ORT use rate, and acute respiratory infection case management rate).

A general rule of thumb is two to three indicators per result, but this may depend on the complexity of the result being measured, the level of resources available for monitoring performance, and the amount of information needed to make reasonably confident decisions about the program. Having too few indicators may be insufficient to describe progress. Having too many indicators may increase the cost of collecting and analyzing the data.

Reflecting Gender Considerations in Performance Indicators

Men and women have different access to, and are affected differently by, development programs. USAID seeks to understand these differences, improve the efficiency and overall impact of its programs, and ensure that both women and men have equitable access to development activities.

Agency guidance (ADS 203.3.4.3) states that performance management systems and evaluations at the SO and IR levels should include gender-sensitive indicators and sex-disaggregated data when the technical analyses supporting the SO, the IRs, or the activities demonstrate that:

- The activities or their anticipated results involve or affect women and men differently.
- This difference is potentially significant for managing toward sustainable program impact.

The literature identifies four major elements of gender-sensitive programming. Illustrative performance indicators related to each of these four areas are provided in the following table:

Gender Aspect	Illustrative Indicators
Participation	<ul style="list-style-type: none"> • Number of women participants in RH policy process • Percentage of board members who are women's health advocates
Empowerment	<ul style="list-style-type: none"> • Percentage change in women's and men's knowledge of RH and HIV/AIDS/STIs • Percentage of women and men who are aware of medical needs during pregnancy
Equity	<ul style="list-style-type: none"> • Absence of requirements that clients have permission of husband or mother-in-law (for married women) or parents (for adolescents) • Percentage of women who say that they are given equal treatment (e.g., waiting time, courtesy, privacy, information given) as male clients.
Human Rights	<ul style="list-style-type: none"> • Percentage of policy makers who are knowledgeable about human rights approaches • Number of services that are available to all who seek them (including adolescents, single women, widows, and homosexuals)
<p>Sources: <i>A Framework To Identify Gender Indicators for Reproductive Health and Nutrition Programming</i>, October 2002, Interagency Gender Working Group, Subcommittee on Research and Indicators; and <i>Compendium of Indicators for Evaluating Reproductive Health Programs</i>, Vol. 1, MEASURE Evaluation Manual Series, No. 6, August 2002.</p>	

Operating Units should also consider gender when determining how data will be collected. For example, using only men to collect data may not yield an accurate data set if societal norms restrict social relations between the sexes.

Quantitative and Qualitative Indicators

Agency guidance (ADS 203.3.4.1) states that indicators may be quantitative or qualitative. Quantitative indicators can be directly observed and objectively counted, such as: number of condoms distributed, percentage of children who are vaccinated, etc. Qualitative indicators are subjective in nature, measuring things like perception, attitudes, and opinions (for example, percentage of women attending a health clinic who say that they are satisfied with the service they received). When compiling the PMP, the SO Team should decide which type of indicator is most appropriate for the result being measured.

Sometimes the distinction between quantitative and qualitative indicators is less clear; some subjective phenomena can be quantified in order to communicate the result more easily. For example, the result "use of health sector resources for primary health care increased" can be directly measured using the quantitative indicator "percentage of total health expenditures in targeted districts spent on primary health care." However, results like policy reform, capacity building, and legislative reform are more difficult to measure quantitatively. The result "legislative, regulatory, and policy framework for the health care sector improved" is best measured using qualitative techniques such as employing a panel of experts to conduct a policy environment review and rate critical elements of the policy environment.

If you decide to use qualitative indicators, keep the following in mind:

- Take steps to limit subjectivity, by trying the following:
 - Use the same raters/experts over time, wherever possible
 - Ensure that the raters are trained and have a common understanding of definitions, values in the rating scale, etc.
 - Define each term in the indicator clearly and precisely
- Consider using devices like rating scales, indexes, and scorecards to quantify your qualitative measures. While the quantification per se is not that important, using this technique adds structure to your indicator and makes it more useful for performance monitoring over time. See the following example:

Transforming Qualitative Data into Quantitative Performance Measures

To measure the IR “quality of maternal and child health services improved,” the following scale transforms qualitative information about services into a rating system:

- 0 point = Service not offered
- 1 point = Offers routine antenatal care
- 1 point = Offers recognition and appropriate management of high-risk pregnancies
- 1 point = Offers routine deliveries
- 1 point = Offers appropriate management of complicated deliveries
- 1 point = Offers postpartum care
- 1 point = Offers neonatal care

Score: $\frac{\text{Total actual service delivery points}}{\text{Total possible service delivery points}}$

Adapted from TIPS 8 – Establishing Performance Targets (www.dec.org/pdf_docs/PNABY226.pdf)

Step 2.3 Select best indicators

The next step is to narrow the list of potential indicators to the final indicators that will be included in the PMP. Be selective. Remember the costs associated with data collection and analysis. Limit the number of indicators used to track each objective or result. Select only the indicators that represent the most basic and important dimensions of your program at a reasonable cost.

Keep in mind that it may be difficult to find indicators that meet all the criteria (see Step 2.2) for good indicators. In fact, often there are trade-offs among the criteria. For example, the most direct measure may not be practical to collect on a regular basis. Your role as a manager is to weigh the pros and cons that have emerged through your assessment of the indicator and select the indicators that make the most sense for your program, given the realities you face.

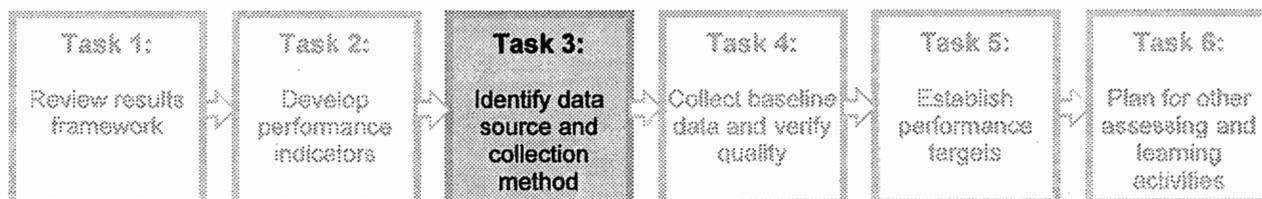
Step 2.4 Document indicators in the PMP

Proper documentation will facilitate the maintenance of quality performance indicators and data. Use **Worksheet 6 – Performance Indicator Reference Sheet** to document the indicators chosen and the rationale the team used to make the selection.

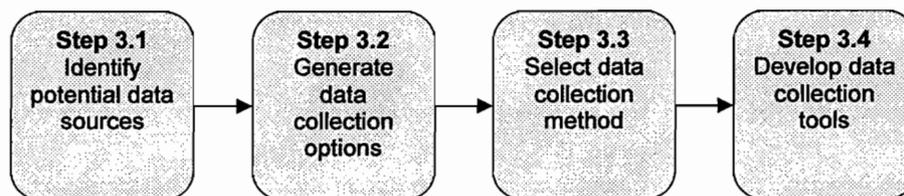
Helpful Resources to Learn More about Developing Performance Indicators (also see Appendix C – Resources on Internet and Toolkit CD)

- ADS Chapter 203, www.usaid.gov/pubs/ads/200/200.pdf
- TIPS 6: Selecting Performance Indicators, www.dec.org/pdf_docs/pnaby214.pdf
- TIPS 12: Guidelines for Indicator and Data Quality, www.dec.org/pdf_docs/pnaca927.pdf
- TIPS 14: Monitoring the Policy Reform Process, www.dec.org/pdf_docs/pnaca949.pdf
- TIPS 15: Measuring Institutional Capacity, www.dec.org/pdf_docs/pnacg612.pdf and www.dec.org/pdf_docs/pnacg624.pdf
- Health indicator handbooks

Task 3 – Identify Data Source and Collection Method



Data can be gathered and collected from a variety of sources, using a variety of methods. Some methods are hands-on and highly participatory, while others are more exclusive and rely on the opinion of one or two specialists. In most cases, it is best to use more than one data collection method per SO. The process of identifying quality data sources and developing data collection methods can be broken down into the following four steps:



Step 3.1 Identify potential data sources

For each selected performance indicator, SO teams should explore what data sources are available (or might be available if the indicators are conceptualized in different ways). Only indicators for which it is feasible to collect data in a given country should be used.

Determining appropriate potential sources of data will require conversations with people knowledgeable about various data sources (e.g., partners, government statistical or service agencies, public opinion survey organizations, and university social science research centers). These contacts will help you to understand

- What data are already being collected,
- Whether existing data would be appropriate for any of your indicators,
- Whether your indicators are relevant and feasible for the situation, and
- What alternatives may work.

If no feasible or reliable sources are available, then consider changing your indicator or using a proxy indicator for which good data will be available.

Step 3.2 Generate data collection options

A number of data collection methods are available to you, ranging from rigorous surveys that are costly (and therefore conducted less frequently) to rapid, low-cost methods that can provide more frequent data, but that may not be of such good quality. At this stage, identify all possible options for data collection for the selected indicators, so that at the next stage you can weigh the pros and cons of each approach and select the data collection method that is most appropriate. Some commonly used data collection methods include the following:

- **Formal survey:** Provides a rigorous and detailed sample survey method of gathering information from stakeholders and others by directly questioning them. A survey can be nationally representative or focus on a representative sample of the population of interest (e.g., DHS, BSS).
- **Informal survey:** Differs from a formal or sample survey in that it focuses on few variables, uses a small sample size, uses non-probability sampling, and thus typically permits more flexibility to interviewers in the field. An informal survey is also significantly lower in cost to administer. Some project-level surveys fit in this category.
- **File/document review:** Reviews data that have been previously collected and are present in the files or other documentation. This type of review offers a relatively quick method to discover what data have already been collected, with an eye toward minimizing the need for additional data collection and the costs associated with that data collection effort (e.g., review of service statistics, such as admission records and clinic registries; review of program records, such as personnel rosters, financial data, and logistics data; review of government documents and other official records).
- **Direct observation:** Intensive and systematic observation of a phenomenon or process in its natural setting; may also include interviews with key informants (e.g., observation of client-provider interactions; observation of trainers).
- **Peer review/expert panel review:** Involves review and assessment of program results by those with expertise in the field (e.g., review of policy and legislative environment to assess progress).
- **Content analysis:** Refers to the codification and analysis of qualitative data. By coding and classifying qualitative information, this method attempts to develop an understanding of large volumes of qualitative data (e.g., analysis of print media to determine frequency of communication or level of detail of public health messages in the newspapers).
- **Case study:** A research method that uses extensive description and analysis of a complex situation studied in its context to answer questions about the efficiency and effectiveness of current programs (e.g., case studies based on patient histories—used in training programs for service providers).

- **Focus group interview:** Small-group, facilitated session designed to quickly gather in-depth information while offering stakeholders a forum for direct participation (e.g., session with women sex workers to understand barriers to their use of condoms).
- **Key informant interview:** In-depth discussion with person who is knowledgeable on a specific topic (e.g., interview to determine existence of comprehensive HIV/AIDS care and support policies or interview to determine whether strategies and guidelines are in line with current WHO or international standards).
- **Community interview:** Meeting conducted on a specific topic that is open to all members of a village/community (e.g., community discussion about a proposed cost-recovery plan for basic services).

Step 3.3 Select data collection method

The best data collection systems are designed to be as simple as possible, not too time-consuming, not unreasonably costly, and also able to provide good information at a frequency that meets your management needs. In a resource-constrained environment, be practical when selecting data collection methods and tools. The following table lists some of the factors and related questions to consider in selecting an appropriate method:

Factors to Consider in Selecting a Data Collection Method

Factor	Questions to Consider
Cost	What is a reasonable cost for the team to incur for collecting the data? Some low-cost data collection methods limit the type of information that can be collected
Speed	How much time is available and reasonable for data collection and processing? How will shorter collection times impact other data characteristics, such as accuracy/level of detail?
Geographic Diversity	What is the geographic area impacted by the program? How can data be effectively collected in hard-to-reach or widely dispersed geographic areas?
Demographic Diversity	How much diversity is present in the target audience (e.g., income, size of organization, ethnicity)? A diverse population whose target audience is non-homogeneous on one or more factors may require a bigger sample size to capture impact accurately. Similarly, if valid estimates are required for large numbers of subpopulations (e.g., every state/province or every ethnic group), a larger sample is required, which significantly increases survey costs.
Level of Accuracy	How accurate should the data be? How accurate are the local government statistics? How do you balance level of accuracy against the cost of collecting data?
Reliability	Can comparable data be collected using this same method in the future?
Frequency	How often are the data to be collected? How does this frequency impact data collection in terms of staff/partner resources and costs associated with collecting the data?

Once you have weighed all the factors and considered all the data collection options, you should select the one that makes the most sense for you. The following chart may be helpful in that process:

Type of Phenomena Being Measured	Possible Data Collection Approach
Indicator refers to populations' approval, attitudes, behavior, etc.	<ul style="list-style-type: none"> • Consider a sample survey: <ul style="list-style-type: none"> - Collaborate with an organization that is already implementing a survey or poll. - Develop a new survey. - Conduct focus group discussions.
Indicator refers to services/outcomes provided by grantees, contractors, or government agencies.	<ul style="list-style-type: none"> • Consider <ul style="list-style-type: none"> - Agency records or logs, - Panel of beneficiaries or experts, - Direct observation, - Facility-based surveys, and - Client surveys.
Indicator refers to the quality of a complex process (e.g., institutional development).	<ul style="list-style-type: none"> • Consider <ul style="list-style-type: none"> - Expert panel with milestone scale and - Case studies.
Indicator refers to the contents or quality of multiple documents (e.g., local government budgets).	<ul style="list-style-type: none"> • Consider using content analysis.
Indicator refers to the quality of service provided or a government operation in multiple locations.	<ul style="list-style-type: none"> • Consider <ul style="list-style-type: none"> - Direct observation, - Focus groups or key informant interviews, and - Mystery client studies.

After completing Tasks 3.1 through 3.3, refer to the copies of **Worksheet 6 – Performance Indicator Reference Sheet**, which you completed in Task 2. Update the section called “Plan for Data Acquisition by USAID.”

Step 3.4 Develop data collection tools

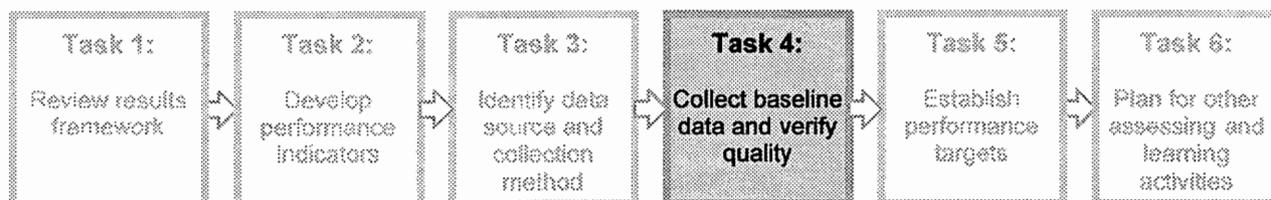
Once data collection methods are chosen, whoever is responsible for data collection may need to develop tools to collect the data. As a USAID staff member, you will probably not need to do this yourself; however, you should be aware of the methods and protocols that will be involved in data collection because these will have an impact on data quality—something that should be documented in the PMP. See **Appendix F – Guidelines for Developing and Using Data Collection Tools**.

Helpful Resources to Learn More about Data Collection (also see Appendix C – Resources on the Internet and Toolkit CD)

- ADS Chapter 203, www.usaid.gov/pubs/ads/200/203.pdf
- TIPS 1: Conducting a Participatory Evaluation, www.dec.org/pdf_docs/pnabs539.pdf
- TIPS 2: Conducting Key Informant Interviews, www.dec.org/pdf_docs/pnabs541.pdf
- TIPS 3: Preparing an Evaluation Scope of Work, www.dec.org/pdf_docs/pnaby207.pdf
- TIPS 4: Using Direct Observation Techniques, www.dec.org/pdf_docs/pnaby208.pdf
- TIPS 5: Using Rapid Appraisal Methods, www.dec.org/pdf_docs/pnaby209.pdf

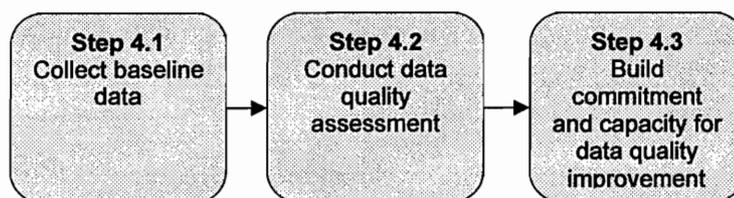
- TIPS 10: Conducting Focus Group Interviews, www.dec.org/pdf_docs/pnaby233.pdf
- TIPS 11: The Role of Evaluation in USAID, www.dec.org/pdf_docs/pnaby239.pdf
- TIPS 12: Guidelines for Indicator and Data Quality, www.dec.org/pdf_docs/pnaca927.pdf
- TIPS 14: Monitoring the Policy Reform Process, www.dec.org/pdf_docs/pnaca949.pdf
- TIPS 15 Annexes: Measuring Institutional Capacity, www.dec.org/pdf_docs/pnacg612.pdf and www.dec.org/pdf_docs/pnacg624.pdf
- Department of Energy, "The Performance-Based Management Handbook, Vol. 4: Collecting Data to Assess Performance," www.ora.gov/pbm/pbmhandbook/pbmhandbook.html
- Kumar, Krishna, "Rapid, Low-Cost Data Collection Methods for A.I.D.," December 1987, www.dec.org/pdf_docs/PNAAL100.pdf
- CDIE Resource Book on Strategic Planning and Performance Monitoring Under Reengineering, "Common Problems/Issues with Using Secondary Data," April 1997 [DEXS Document #PN-ACH-632]
- Health Indicator Handbooks

Task 4 – Collect Baseline Data and Verify Quality



In order to manage for results, you should gather and analyze data that meets the Agency’s data quality standards. This is important because poor-quality data can lead to incorrect inferences (e.g., USAID interventions had a given impact when they did not or vice versa). In addition, in an era of increasing accountability and shrinking budgets, demonstrating strong performance on the basis of reliable data helps to justify programs and their costs.

The process of collecting baseline data and verifying its quality can be broken down into the following three steps:



Step 4.1 Collect baseline data

Completing Task 3 led your team through the process of determining what data to collect and the method and tools that should be used to collect data. Now is the time to execute your data collection plan and begin collecting the initial data for each indicator.

The baseline measure establishes the reference point for the start of the program period. Ideally, the baseline should immediately precede the start of a new Strategic Plan; however, in some cases, planners may need to go back several years to correctly portray the context in which progress will be made. In addition, it may not always be possible to secure baseline data for the chosen year. For example, your baseline data may come from a DHS that was conducted before the new strategy begins. In such instances, the baseline may be the most recent past year for which the relevant information exists or can be acquired. Also, examine the trends of prior-year data when selecting a baseline year. There could be unexpected spikes or dips in the trend, and a year in which one or the other occurs would be a poor year to select as the baseline year.

Step 4.2 Conduct a data quality assessment

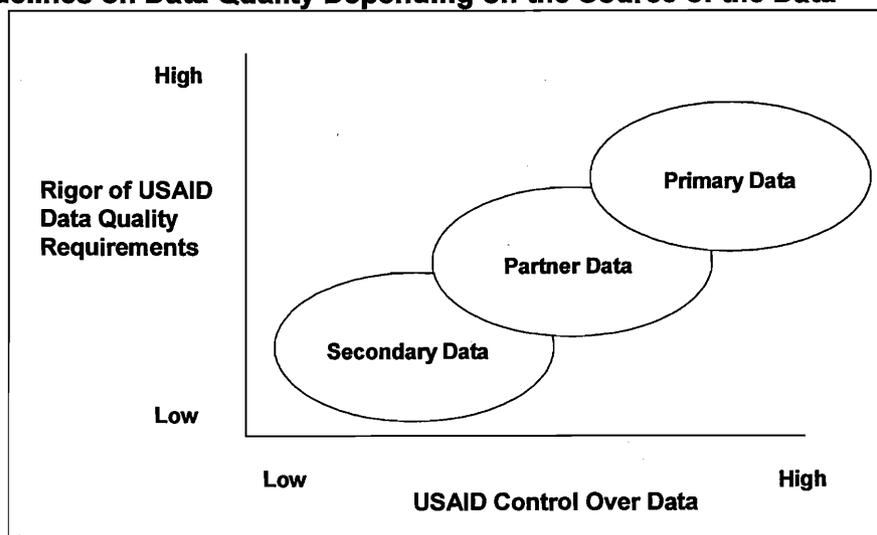
SO Teams should know whether they can trust data to use in making decisions. Performance data should be as complete, accurate, and consistent as management needs and resources permit. A data quality assessment of each selected performance indicator will help verify the usefulness of data.

MANDATORY: Data reported to USAID/Washington for Government Performance and Results Act (GPRA) reporting purposes or for reporting externally on Agency performance must have had a data quality assessment at some time within the three years before submission. (ADS 203.3.5.2)

In all data quality assessments, the data are verified by examining the extent to which they meet the following Agency standards for good-quality data:

- **Validity.** Do the data clearly and directly measure what we intend to measure?
- **Integrity.** Are mechanisms in place to reduce the possibility that data are manipulated for political or personal reasons?
- **Precision.** Are the data at the appropriate level of detail? Is the margin of error acceptable, given the management decisions to be affected?
- **Reliability.** Would you come to the same findings if the data collection and analytical process were repeated?
- **Timeliness.** Are data available frequently enough to inform decisions? Are data current enough when they are available?

Agency Guidelines on Data Quality Depending on the Source of the Data



According to the ADS, the level of quality expected and how you conduct a data quality assessment depend on the source of the data. As the previous diagram illustrates, USAID recognizes three categories of data sources: (1) *primary data* (i.e., data that are collected by USAID or where collection is funded directly by USAID), (2) *partner data* (i.e., data that are gathered by USAID implementing partners), and (3) data from *other secondary sources* (i.e., data from government agencies, other development organizations). Because USAID has the most control over primary data, the Agency's requirements for data quality are most rigorous for any data (e.g., DHS data) that fall into this category. The data quality requirements for secondary source data are least rigorous because USAID has little control over data collected

and analyzed by other organizations. Data from implementing partners fall somewhere in between because the Agency has a reasonable level of control over the data and thus quality requirements are also at a medium level.

Suggestions on Conducting Quality Assessments of Data from Different Sources

The following table presents a practical approach for assessing data from each of these data sources:

Data Source	Steps in Conducting a Data Quality Assessment
<p>USAID (e.g., data from USAID-funded surveys such as the DHS and BSS)</p>	<ol style="list-style-type: none"> 1. Ensure that data quality requirements are written into any solicitations (e.g., SOW, RFP, and RFA) for data collection. 2. Obtain a copy of the methodology for data collection, transcription, and analysis, and determine whether it is rigorous enough to meet the five data quality standards. Make this determination by focusing on the following: <ul style="list-style-type: none"> • Are written procedures in place for data collection? • Is the data collection process consistent from year to year? • Are data collected using methods to address and minimize sampling and non-sampling errors, and are sampling errors reported for key indicators? • Are data collected by qualified personnel, and are personnel properly supervised? • Are there mechanisms to detect duplicate data? • Are safeguards in place to prevent unauthorized changes to the data? • Are source documents maintained and readily available? 3. Ensure that the methodology was in fact followed during the data collection process and that the quality assurance mechanisms were used. Do this by interviewing individuals responsible for data collection (e.g., representatives of the contractor responsible for data collection), conducting spot checks, and/or reviewing the methodology section of the final report. 4. Document your findings in a short memo-to-file, and save it in your data quality files, together with all necessary supporting documentation (e.g., methodology for data collection, survey instrument).
<p>Implementing Partner (e.g., training records and program reports from implementing partners)</p>	<ol style="list-style-type: none"> 1. Interview the appropriate individual within the partner organization (remember, this may not be the Chief of Party) to obtain an understanding of the data collection, analysis, and maintenance process with your implementing partner. 2. Review partner reports to determine whether they are sufficiently consistent to be reliable. 3. Periodically sample and review data for completeness, accuracy, and consistency. This includes ensuring that <ul style="list-style-type: none"> • The indicator definitions being used by the partner are consistent with the definitions contained in your PMP. • The data collection process is consistent from year to year. • The data are complete in coverage. • The formula used to calculate the indicator (if any) is applied correctly. 4. Conduct field visits to compare central office records with field site records; try to visit a broad range of sites. You don't need to make a separate trip for "data quality" purposes. Simply build it into field visits you make for other purposes. 5. Arrange for an audit of financial information if any of your performance indicators use financial information. 6. Document your findings in a short memo-to-file, and save it in your data quality files, together with any supporting documentation.

Data Source	Steps in Conducting a Data Quality Assessment
<p>Other Secondary Source (e.g., data from the ministry of health; government budget data; census data)</p>	<p>The focus of the assessment is primarily to understand the strengths and weaknesses in the data. To do this,</p> <ol style="list-style-type: none"> 1. Arrange for a briefing with someone affiliated with the source of the data (government ministry; other donor organization) who is knowledgeable about the data to gain a better understanding of the data collection and analysis process. This should help you determine whether the data can be trusted. 2. Arrange for briefings with other development partners to obtain their view of the accuracy and credibility of the data. 3. Periodically sample and review data for completeness, accuracy, and consistency. 4. Document your findings in a short memo-to-file, and save it in your data quality files, together with any supporting documentation. <p><i>Some special considerations:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> USAID usually does not have the right to audit or investigate data quality in depth. <input type="checkbox"/> If USAID provides technical assistance to a government ministry to improve data collection and analysis, it may be easier to assess the data and to make suggestions about improving its quality.

When you conduct the data quality assessment, recognize that no data are perfect, but they should be good enough to document performance and support decision making. Use your professional judgment, and back it up by documenting your decisions and supporting information. Judgments about sufficient quality levels should reflect

- Uses of the data,
- Management judgments about what level of quality is needed for confident decisions,
- Technical assessments about what degree of quality is possible (e.g., professional judgment about acceptable levels of error; implications of data collection methodology, sampling strategy), and
- Practical considerations: trade-off between accuracy and cost or between dimensions of quality (e.g., timeliness and completeness).

As you conduct data quality assessments, use **Worksheet 7: Data Quality Assessment Tool** as a guide for each indicator or each data source. The worksheet can also be used to document the findings of the assessment.

Data Quality Challenges by Data Source

Because health indicators rely on a variety of data sources and data collection methods, data quality issues vary widely. The following tables are organized by the source of health data and present practical tips on how an Operating Unit can assess the quality of the data¹. These tables provide examples of data quality limitations that Operating Units often find during the data quality assessment of this kind of data (but not all challenges are present in all programs). There are also practical steps that an Operating Unit can take to address those data quality limitations.

¹ Note data source in this instance refers not to the three USAID data source categories (primary, implementing partner, other secondary) referred to earlier, but rather to a more detailed level of sources that are specific to health data.

Data Quality Challenges with Official Health Records

Source of Data	<p>Official health records, such as</p> <ul style="list-style-type: none"> - Central HMIS or health statistics, - Registry of births, and - Registry of deaths.
Steps to Assess Quality of the Data	<ul style="list-style-type: none"> - Ask for a briefing with ministry staff to obtain the data collection methodology and protocols, especially for mobile or vulnerable populations. Ask whether mobile/satellite clinics are reporting (or what proportion of them is reporting). - Interview staff to understand whether data collection methodology was followed. - Determine whether data cover USAID focus areas (geographic focus, demographic focus, etc.). - Determine when the raw data were collected and what time period they represent. - Ask to see electronic copy and hard copy of the database or data records.
Possible Data Quality Limitations	<ul style="list-style-type: none"> - Validity: The reported data do not accurately represent the populations targeted by USAID programs. - Timeliness: The data represent health conditions several years ago, which were covered by previous USAID reporting years. - Integrity: The data could be manipulated for a variety of reasons.
Actions That Can Be Taken to Address Data Quality Limitations	<ul style="list-style-type: none"> - Triangulate the data by interpreting them with other sources of data (such as results of local studies or partner data reported from implementation sites). - Compare centrally reported data with records at field sites. - Because USAID has little control over the data, you may not be in a position to take any actions to address data limitations. If this is the case, at a minimum, document the limitations that you do find.

Data Quality Challenges with Surveys

<p>Source of Data</p>	<p>Surveys – population-based and funded and administered by an entity other than USAID (e.g., national government):</p> <ul style="list-style-type: none"> - Census 	<p>Surveys – local or project scale:</p> <ul style="list-style-type: none"> - Baseline and follow-up surveys - Behavioral surveillance - Antenatal testing 	<p>Surveys – population-based that are funded/managed by USAID:</p> <ul style="list-style-type: none"> - DHS - RHS
<p>Steps to Assess Quality of the Data</p>	<p>For all surveys:</p> <ul style="list-style-type: none"> - Obtain and review survey/data collection and processing methodology and protocols. - Interview staff to understand whether data collection and processing methodology was followed. - Interview staff and review records to determine what population is represented in the survey. Determine whether the survey contains a representative sample of the USAID-assisted population. - Talk to other donors and other users of the data to obtain their perspective of data quality. - Determine when the raw data were collected and what time period they represent. 		
<p>Possible Data Quality Limitations</p>	<p>For all surveys, the following challenges may be relevant:</p> <ul style="list-style-type: none"> - Validity: The survey may not adequately represent the intended population because of design flaws, sampling errors, or bias. - Integrity: The data may have been manipulated—in design, collection, or analysis phases—for personal or political gain. Have certain subpopulations been deliberately underrepresented? - Precision: The data are not sufficiently precise to determine whether the reported change represents change in the population or just “noise” in the data. - Timeliness: The data are not available frequently enough to inform USAID’s decision points, or the data are not current enough to measure recent changes. 		
<p>Actions That Can Be Taken to Address Data Quality Limitations</p>	<p>For surveys with low or medium USAID control over data collection and analysis:</p> <ul style="list-style-type: none"> - Because these are secondary source data, and USAID has little or no control, there is not much that USAID can do to address data quality limitations. Most important, DOCUMENT any identified weaknesses. - Consider (if resources permit) providing technical assistance to the census bureau to build its data collection capacity. - Look for trends in the data, rather than interpreting one data point. (Assuming that the data quality challenges of these data have been similar over time, then the bias in the data is likely to be similar year to year.) - Triangulate the data by interpreting them with other sources of data (such as results of local studies or partner data reported from implementation sites). - Schedule program reviews to coincide with future surveys. - Be clear in reporting. 	<p>For surveys with high USAID control over data collection and analysis, all of the steps at the left may still be relevant.</p> <p>Conduct a full data quality assessment, using Worksheet 7.</p>	

Data Quality Challenges with Other Government Documents

<p>Source of Data</p>	<p>Other government documents, such as</p> <ul style="list-style-type: none"> - Official policies, procedures; - Health laws, codes; - National and local budgets and financial records; - Service delivery standards; - Job descriptions; - Training and certification materials; and - Lists of training participants.
<p>Steps to Assess Quality of the Data</p>	<ul style="list-style-type: none"> - Compare policies with results of client satisfaction interviews. - Compare centrally reported data with records at field sites. - Conduct spot checks, or ask implementing partners to.
<p>Possible Data Quality Limitations</p>	<ul style="list-style-type: none"> - Validity: Written procedures do not match behavior. - Precision: Documentation is not detailed enough.
<p>Actions That Can Be Taken to Address Data Quality Limitations</p>	<ul style="list-style-type: none"> - Because these are data over which USAID has low/no control, USAID may not be in a position to address the limitations. If this is the case, at a minimum, document the limitations that you identified. - If possible, provide technical assistance to the entity that collects the data to help it improve its data collection systems. - Compare procedure documents over time.

Data Quality Challenges with Facility and Service Statistics

Source of Data	<p>Facility and service statistics, such as</p> <ul style="list-style-type: none"> - Commodities and logistics records (commodity procurement plans, product lists), - Facility audit of equipment and supplies, - Admission records, - Lab records, - Clinic records for specific services, and - Client records.
Steps to Assess Quality of the Data	<ul style="list-style-type: none"> - Spot-check records. - Conduct site visits. - Ask other development partners whether reported data are reliable.
Possible Data Quality Limitations	<ul style="list-style-type: none"> - Integrity: Records have been manipulated. - Validity and Reliability: Incomplete coverage/reporting or some data have been entered incorrectly.
Actions That Can Be Taken to Address Data Quality Limitations	<ul style="list-style-type: none"> - If the level of USAID control over the data is low, USAID may not be able to take any actions to address the data quality limitations. If this is the case, at a minimum, document the limitations that are identified. - If the level of control that USAID has over the data is medium, consider the following types of actions: <ul style="list-style-type: none"> - Standardize forms for tracking logistics. - Provide training for service providers on data collection protocols and quality controls.

Common Data Quality Challenges with Assessments of Providers and Services

Source of Data	<p>Assessments of providers and services</p> <ul style="list-style-type: none"> - client satisfaction surveys - client exit interviews - observation of provider behavior - competency tests for providers - providers self-assessments - performance ratings
Steps to Assess Quality of the Data	<ul style="list-style-type: none"> - Interview implementers to determine how assessments are conducted. Are there written guidelines? Is the process consistent from year to year? Is there potential for bias or manipulation? Are there any quality control mechanisms in place?
Possible Data Quality Limitations	<ul style="list-style-type: none"> - Validity: Failure to use consistent definitions/terms or objective evaluation criteria; Potential for different types of bias (e.g., in a self-rating instrument, the rater might tend toward higher ratings) - Reliability: Changing definitions/terms/evaluation criteria over time
Actions That Can Be Taken to Address Data Quality Limitations	<ul style="list-style-type: none"> - If the level of control over the data is medium, consider the following actions to address data quality limitations: <ul style="list-style-type: none"> - Help those gathering the data—usually implementing partners—understand USAID’s standards for data quality. - Take steps to build the capacity of those responsible for data collection (usually implementing partners) to develop solid data collection protocols and quality control mechanisms. - If the level of control that USAID has over the data is low (e.g., the data are collected by a secondary source over which USAID has no influence), then there might not be much that the Agency can do to address the data limitations. At a minimum, document the limitations (if any) that you do find.

Data Quality Challenges with Partner Data

Source of Data	Partner data Training statistics Financial data
Steps to Assess Quality of the Data	<ul style="list-style-type: none"> - Review partner reports carefully. - Periodically spot-check the source data, and compare them with the data that are reported to you. - Understand how the data are collected and processed. Determine whether there is potential in the process for data quality to be compromised. - Periodically conduct third-party surveys and assessments to validate data reported by partners.
Possible Data Quality Limitations	<ul style="list-style-type: none"> - Validity: Because the data are self-reported, there is a potential for bias. - Reliability: Data collection, transcription, and analysis methods change over time. More likely to occur if partners lack strong monitoring and evaluation capacity. - Timeliness: Data are not current or frequent enough for USAID decision making. More likely if the partner is a government agency than if it is a USAID contractor. - Integrity: Manipulation of data (e.g., training statistics) to present a more positive picture.
Actions That Can Be Taken to Address Data Quality Limitations	<ul style="list-style-type: none"> - Address the problem before it occurs. Therefore, include data quality and reporting requirements in contracting documents and recognize the financial implications of better-quality data. As much as possible, develop standard approaches (format, contents, and timing) early on. - When problems are identified, assist those responsible for data collection to understand USAID standards for data quality and build their capacity to improve data quality.

Step 4.3 Build commitment to and capacity for quality

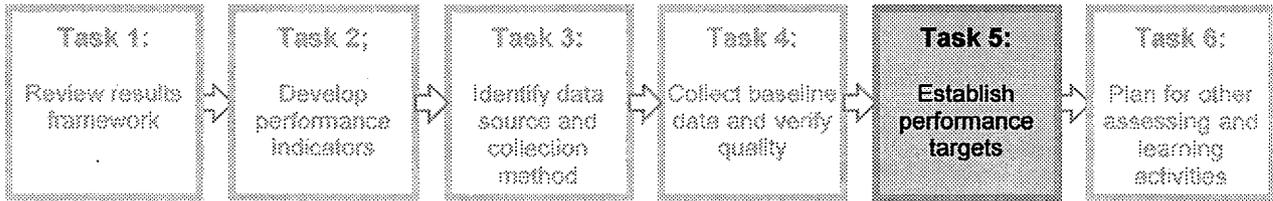
Managers of health programs should create a climate that encourages coordination, resource allocation, and attention to data quality issues that enable improvements in data quality. This means that activity managers should reinforce the importance of data quality with implementing partners. Similarly, SO team leaders and Mission Directors should reinforce the same point with their staff. The first step in building commitment for data quality is to start using the data.

Helpful Resources to Learn More about Data Quality (also see Appendix C – Resources on the Internet and Toolkit CD)

- ADS Chapter 203 – Assessing and Learning, www.usaid.gov/pubs/ads/200/203.pdf
- TIPS 12: Guidelines for Indicator and Data Quality, www.dec.org/pdf_docs/pnaca927.pdf
- Handbook of Democracy and Governance Program Indicators, www.dec.org/pdf_docs/PNACC390.pdf
- U.S. General Accounting Office, “The Results Act: An Evaluator’s Guide to Assessing Agency Performance Plans,” www.whitehouse.gov/OMB/mgmt-gpra/gplaw2m.html

- U.S. General Accounting Office, "Performance Plans: Selected Approaches for Verification and Validation of Agency Performance Information"
- U.S. General Accounting Office, Standards for Internal Controls, www.gao.gov/

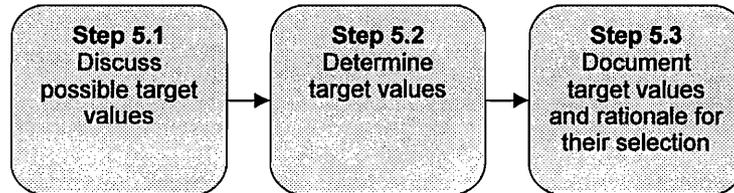
Task 5 – Establish Performance Targets



The approved Strategic Plan included a theory (or development hypothesis) about *what kind of change or improvement* could be achieved with USAID effort during the timeframe of the Strategic Objective. Setting performance targets translates the Strategic Plan into measurable increments and goals, showing *how much change or improvement* can be achieved. Without targeting a level of intended achievement, it is very difficult to take credit for achievements!

A performance target is a "specific, planned level of result to be achieved within an explicit timeframe." ADS 200.6

The process of establishing performance targets can be broken down into the following three steps:



Step 5.1 Discuss possible target values

In earlier tasks of this Toolkit, you selected performance indicators and collected baseline data. Now your team should establish final targets (usually end of SO) and interim targets (usually annual) for those performance indicators. Collaborating with others who are knowledgeable about the local situation, and who understand what level of accomplishment can be expected, is key to setting targets that are ambitious *and* achievable. A **target-setting meeting** to discuss potential performance targets is a good way to do this. Involve your implementing partners in the meetings, when ever possible. In your discussions, consider the following:

- **Look at past trends, and project those trends into the future.** Think about how USAID interventions will change or affect the projection for the next decade. If the data are disaggregated (e.g., by gender, geography, or age), you may have to start by setting targets at the disaggregated level in order to arrive at the consolidated target for your overall indicator.

- **Look at empirical evidence:** Unlike many other sectors, the health sector has the advantage of vast amounts of empirical data and research to draw on. As you develop your targets, consult experts and/or the literature to determine appropriate target levels, such as the example with CPR and TFR.² (For more guidance on target setting for other Health and Family Planning indicators, see *Health and Family Planning Indicators: A Tool for Results Frameworks*, Vol. 1, www.dec.org/pdf_docs/PNACM806.pdf.)

*Example of using technical expertise to set appropriate targets for **contraceptive prevalence rate (CPR)** and **total fertility rate (TFR)**:*

- *In most developing countries, a 1–2 percent increase in CPR per year is generally considered significant progress. Most developing countries are far from the 65 percent associated with “replacement level” fertility. Experience shows that countries starting with very low contraceptive prevalence (less than 10 percent) have been able to report a doubling of CPR within five years.*
 - *TFR of 2.1–2.2 children per woman represents “replacement level” fertility. A one-child decrease in TFR requires an approximately 15 percent increase in CPR.*
- **Consider the timing or sequencing of interventions.** Think about other events or external conditions that may affect indicator values over time. For example, imagine that you are tracking “percentage of births attended by personnel trained by Ministry of Health.” Your team is also providing most of the support for the MOH training program, and you know that it will take two years for personnel in rural areas to be trained. Your team sets the targets for years 1 and 2 very low, but the targeted values for years 3 and 4 are higher.
 - **Consider how long it takes to see change.** When are program activities expected to have an impact on indicator values? For example, imagine that you are tracking “percentage of at-risk population using a condom during last sexual encounter.” You know that there is a cycle of awareness—behavior change—impact on seroprevalence. In your particular country, how long will it take for your education and awareness programs to affect the sexual behaviors of the targeted at-risk population?
 - **Differentiate between long-term development goals and results that are possible given the time and resources available.** For example, an 85 percent immunization rate is necessary for measles vaccination to provide herd immunity; however, if you are starting with a very low baseline rate (say 10 percent), achieving a rate of 85 percent is probably unreasonable, even over a five-year strategy period. At the same time, you may find it difficult to set a rate lower than 85 percent, knowing that the lower rate will not have a significant public health impact. In order to be realistic and set targets that are achievable with the resources available and within the timeframe of the strategy, it may be helpful if you think of your current target as a milestone toward achieving a longer-term goal.
 - **Determine how much change is likely within each year.** Is the same level of change expected for each year of the program? Why or why not? Are the data likely to spike

² The example in the box is based on the following resources: John Ross, John Stover, Amy Willard. 1999. *Profiles for Family Planning and Reproductive Health Programs: 116 Countries*. The Futures Group, International: Glastonbury; C. F. Westoff (1990), “Reproductive Intentions and Fertility Rates,” *International Family Planning Perspectives*, Vol. 16, No. 3; and J. A. Ross and E. Frankenberg (1993), “Prevalence of Contraceptive Use and Fertility Patterns,” Ch. 1 in *Findings from Two Decades of Family Planning Research*, Population Council, NY.

(one data point is much higher or lower than the rest) or plateau (the trend stops changing)? Is the use of ORT likely to spike following the rainy season or a rainy year? Is the demand for bed nets likely to plateau when every household has a bed net?

Step 5.2 Determine target values

A good target value is ambitious and optimistic, but also achievable. A common practice is to set targets that will encourage the team to “stretch” and exceed past performance. However, a target that is too high or that allows zero tolerance for human error can undermine morale and make targets unattainable. Once you have considered all the possibilities, select a target level that can generate team members’ and partners’ interest and elicit their commitment.

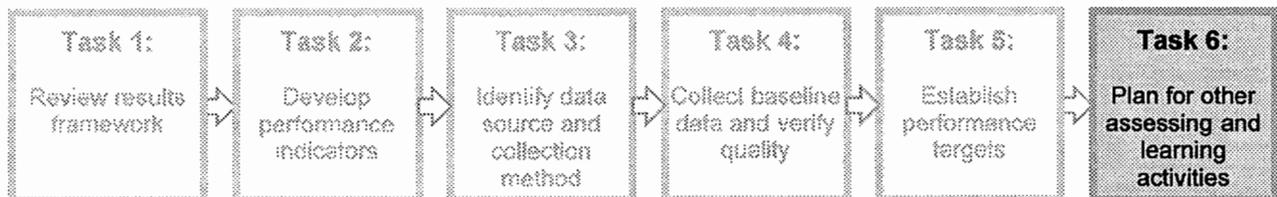
Step 5.3 Document target values and rationale for their selection

Once you have selected a target value, make sure that you document it in your PMP. Equally important is documenting the rationale for the targets so that you can refer to this reasoning when trying to analyze or interpret actual performance data later. Use two worksheets for documentation. **Worksheet 6 – Performance Indicator Reference Sheet** includes a section for documenting baseline data and targets. Also, describe the rationale that was used in setting targets under “Notes on Baselines/Targets.” Many teams like to input their baseline and target information into **Worksheet 8 – Summary Performance Data Table** as well, because this table allows teams to consolidate all their PMP data (baselines, targets, and actuals) in one place.

Helpful Resources to Learn More about Establishing Targets (see also Appendix C – Resources on the Internet and Toolkit CD)

- TIPS 8, “Establishing Performance Targets,” www.dec.org/pdf_docs/pnaby226.pdf
- www.dec.org/pdf_docs/PNACC390.pdf
- *Health and Family Planning Indicators: A Tool for Results Frameworks*, Vol. 1, www.dec.org/pdf_docs/PNACM806.pdf

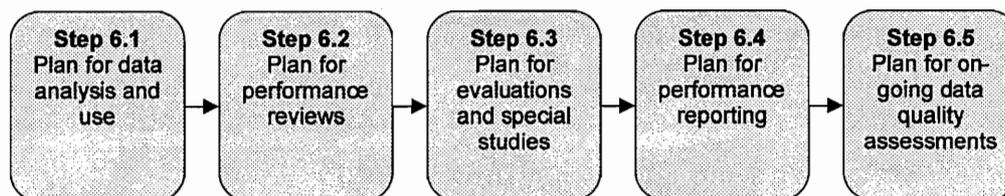
Task 6 – Plan for Other Assessing and Learning Activities



Assessing and learning is the process of systematically obtaining useful feedback and applying it to move programs forward and report progress to others. Therefore, think about supplementing performance monitoring with planned evaluations, special studies, and other formal and informal information sources, as needed. This comprehensive approach to planning for assessment and learning will yield useful performance information that will help the SO Team

- Make informed management decisions regarding the best use of resources to achieve desired objectives over time;
- Improve the performance, effectiveness, and design of existing development assistance; and
- Document findings on the impact of development assistance.

The process of planning for these other elements can be broken down into the following five steps:



In general, use **Worksheet 9 – Performance Management Task Schedule** for a way to schedule all your team's assessing and learning activities: data acquisition and analysis, portfolio reviews, performance reporting, data quality assessment, evaluation plans, etc.

Step 6.1 Plan for data analysis and use

Although everyone needs information, it can be challenging to process and synthesize raw data before reporting and using. Sound analysis of performance data will provide useful information about what happened (against expected results). It may also give an indication of why progress is or is not on track generally, although additional data points gathered through evaluations and/or special studies will be needed to fully answer *why* the observed level of performance is occurring. Properly planning how performance data will be analyzed, used, and presented is at the heart of performance management. To plan for this, ask these key questions:

- How will the data be analyzed?
- Who will be involved in the analysis?
- Who will use the data and for what purpose?
- How will the data be presented?

Document your overall plan for data analysis and presentation in your PMP. For data that will be gathered and analyzed by others (e.g., implementing partners), make sure that your partners understand the level and type of analysis and presentation formats that you expect.

Step 6.2 Plan for performance reviews

ADS Chapter 203 requires two types of performance reviews of Operating Unit performance: the *portfolio review*, conducted annually within the Operating Unit, and the *intensive program review*, conducted approximately every three years by the responsible Bureau.

Portfolio reviews: Find out when portfolio reviews are likely to be conducted and include it in the schedule of performance

A **portfolio review** is a required annual review conducted by the Operating Unit. Its purpose is to systematically analyze the progress of each SO by examining both strategic and operational issues and to determine whether a program is "on track." (ADS 203.3.7)

management tasks for the SO. Determine what information will help assess progress of the SO at the portfolio review and when that information will be collected or analyzed.

Intensive program reviews: As provided in ADS 203.3.10, intensive program reviews are mandatory reviews conducted every three years by Pillar or Regional Bureaus of each Operating Unit or program. The purpose of the review is to provide Washington Offices the opportunity to examine thoroughly how each program is proceeding relative to the Results Framework and performance management plan for each SO and to review resource requirements. Procedures for conducting an intensive program review is left up to each Bureau, but the process must include other Bureaus and Offices. Find out when the intensive program review is likely to be conducted and include it in the schedule of performance management tasks for the SO. Determine what information will help assess progress of the SO at the portfolio review and when that information will be collected or analyzed.

Step 6.3 Plan for evaluations and special studies

Evaluation is a relatively structured analytical effort undertaken selectively to answer specific management questions regarding USAID-funded assistance programs or activities. Evaluation is also a management tool that plays a vital role in Agency decision making, accountability reporting, and learning. It is an important source of information about the performance of USAID activities, programs, and strategies.

At the beginning of a Strategic Objective, identify any known studies that are scheduled (such as DHS) or any evaluation issues that can be predicted. At annual portfolio reviews, determine whether there are performance deviations (positive or negative) that show need for evaluations or studies. Near the end of the SO life, determine whether something happened that requires a study to better understand the results.

Use two worksheets in this Toolkit to help you plan for evaluations and special studies. **Worksheet 10 – Evaluations and Special Studies Planning** can be used to document the set of evaluations and special studies that you plan to complement your regular performance monitoring efforts. This worksheet will help you identify the subject, timing, and any special research considerations associated with each planned evaluation or special study. As you get closer to carrying out an evaluation, use **Worksheet 11 – Evaluation Scope of Work Planning** to develop the scope of work for the evaluation.

Step 6.4 Plan for performance reporting

To enhance learning opportunities within the Agency and among partners and other stakeholders, plan to report and share progress toward expected results. Base reporting upon quantitative and qualitative performance information gathered through performance monitoring systems, evaluations, and other relevant sources. Make every effort to be open and direct and to share both successes and failures.

Since the Annual Report serves as the primary document for reporting performance information for each Operating Unit, it makes sense to identify ahead of time which indicators and assessment results will be included in the analysis leading up to the Annual Report. The SO Team may also have other internal management decisions that require reporting, separate from the Annual Report.

Step 6.5 Plan for ongoing data quality assessments

Make sure that you plan for ongoing data quality assessments. At a minimum, you should meet the ADS requirement that any data reported to Washington for Government Performance and Results Act (GPRA) or other reporting purposes should have had a data quality assessment during the three years prior to reporting. Equally important is ensuring that you can trust the data you are collecting and can confidently use them for decision-making purposes. A good practice is to set up a **data quality file**. Use this file to store copies of data collection instruments, source documents, raw figures, or worksheets used to calculate indicators, data quality assessment memos and reports, etc.

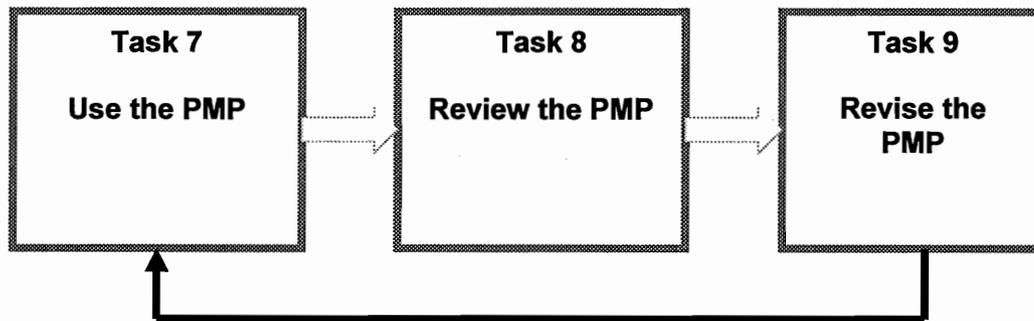
See **Appendix D – Data Quality Limitations of Frequently Used Indicators** for examples of commonly occurring data quality issues and steps that can be taken to address them. Also see earlier Step 4.2 for suggestions on how to conduct data quality assessments, and common data quality challenges by source of data.

Helpful Resources to Learn More about Analysis and Evaluation (see also Appendix C – Resources on the Internet and Toolkit CD)

- ADS Chapter 203, www.usaid.gov/pubs/ads/200/203.pdf
- TIPS 1: Conducting a Participatory Evaluation, www.dec.org/pdf_docs/pnabs539.pdf
- TIPS 2: Conducting Key Informant Interviews, www.dec.org/pdf_docs/pnabs541.pdf
- TIPS 3: Preparing an Evaluation Scope of Work, www.dec.org/pdf_docs/pnaby207.pdf
- TIPS 4: Using Direct Observation Techniques, www.dec.org/pdf_docs/pnaby208.pdf
- TIPS 5: Using Rapid Appraisal Methods, www.dec.org/pdf_docs/pnaby209.pdf
- TIPS 10: Conducting Focus Group Interviews, www.dec.org/pdf_docs/pnaby233.pdf
- TIPS 11: The Role of Evaluation in USAID, www.dec.org/pdf_docs/pnaby239.pdf

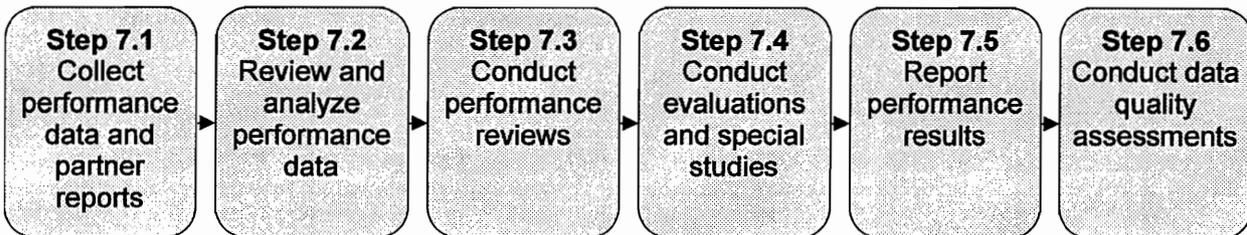
Stage 3: Use, Review, and Revise the PMP

Having developed a performance management plan, you have taken an important step toward managing your health program for results. Using the data in the PMP will help you track and communicate the progress of your SO. Use your PMP regularly to make informed management decisions, improve tactics and organizational processes, identify performance gaps, and set goals for improvements.



Task 7 – Use the PMP

Once you have developed your PMP, start using it by implementing the performance management tasks, such as the following, that you identified in your PMP:



Step 7.1 Collect performance data and partner reports

In your PMP, you identified a schedule for data collection for each of your performance indicators. While implementing the program, ensure that the data are collected and reported to you in the format that is most helpful for your management purposes. If you choose to maintain your PMP data in a Summary Performance Data Table (see **Worksheet 8**), enter the data from partner reports into the summary table on a regular basis. The advantage of using a summary format is that it provides the data for all your indicators—including baseline, target, and actual—in a single table, allowing a complete picture of performance across your Results Framework that enables you to see patterns and relationships easily.

As implementing partners submit periodic reports to USAID, make sure that you review them. Schedule a meeting to discuss the contents of the report with the partner. In the meeting, ask

any question that you might have, including those that will support the data quality assessment that you may have to conduct at a future date. As you review the reports, if you find that the format or analysis does not support your needs, discuss alternative approaches with your counterparts.

Step 7.2 Review and analyze performance data

Consider the following ways of analyzing the data:

Analysis Approach	Analysis Technique	Questions to Consider
<p>Analyze data for a single result</p>	<ul style="list-style-type: none"> • Compare actual performance against targets. • Compare current performance with prior year's performance. • Compare current performance to baseline. • Analyze trends in performance. 	<ul style="list-style-type: none"> • Did we meet our targets? Why or why not? • How does this period's performance compare with the last period's? Are we on track for our ultimate target?
<p>Analyze data across the Results Framework</p>	<ul style="list-style-type: none"> • Examine performance of lower results in relation to higher results. • Examine data from critical assumptions to help interpret results. 	<ul style="list-style-type: none"> • Did our critical assumptions hold during the performance period? • What happened that we did not expect?
<p>Analyze the contribution of USAID's activities to the achievement of results</p>	<ul style="list-style-type: none"> • Examine timing of results in relation to timing of USAID program efforts. • Compare movement in results trends to movement in level of USAID program efforts. • Compare performance with that of a control group in similar environment. 	<ul style="list-style-type: none"> • What improvements are needed? • Are new results statements, indicators, or targets needed?

Step 7.3 Conduct performance reviews

As provided in ADS 203, two kinds of performance reviews are required during program implementation: annual portfolio reviews and the (triennial) intensive program review. In developing your PMP, you planned for when these reviews would take place and what information you needed to be informed.

- There is no one prescribed structure or process for conducting portfolio reviews, and each Operating Unit or SO Team may define standard procedures that are judged useful for their programs. Many Operating Units conduct a portfolio review as part of the preparation process for Annual Reports.
- Some Operating Units conduct portfolio reviews in two parts, each with a different focus. For example, one part might be focused on program results (such as progress toward SOs, status of crosscutting themes, and status of critical assumptions), while the other is focused on internal mission management issues such as procurement, pipeline, and staffing.
- Another common approach is for designated staff to analyze a variety of program-related information and prepare issues for discussion in a larger group forum that may include SO team members, other members of the Operating Unit, and partners.

- See ADS 203.3.7 for more on portfolio reviews and ADS 203.3.7.2, in particular, on illustrative questions to guide a portfolio review.

Step 7.4 Conduct evaluations and specials studies

As you review the data and manage your portfolio, you may find it necessary to conduct an evaluation or special study to gain a more in-depth understanding of a situation. Remember, performance monitoring tells you only *what* is going on. Evaluation is a tool that can be used to complement performance monitoring and tell *why* and *how* a certain phenomenon is occurring.

Step 7.5 Report performance results

Each year, SO teams have to generate reports describing their performance for a variety of reasons and audiences. Chief among these reports is the Annual Report, which forms the basis for the Agency's reporting to Congress in compliance with the Government Performance and Results Act (GPRA). As you write your Annual Report section and other reports, keep in mind that the key to presenting data and information effectively is to tell a compelling story. Be candid. Users of performance information will want to know how you plan to address performance problems and limitations. Visual displays such as tables, boxes, and figures can condense information, present it in a clear format, and highlight underlying relationships and trends, and communicating findings to decision makers quickly and effectively.

Step 7.6 Conduct data quality assessments

As mentioned before, ADS 203.3.5.2 provides that data sent to Washington for reporting externally on Agency performance must have had a data quality assessment within the last three years before submission. This means that data quality assessment should be an ongoing element of performance management activities for each SO. The previous section of the Toolkit (see Task 4) emphasized the importance of planning for data quality assessments. Now that you are implementing your program and using your PMP, conduct the data quality assessments according to schedule and update the PMP and/or data quality files with the findings. This need not be excessively onerous if you build data quality assessment into your normal work processes. For example, conduct a data quality assessment while doing a routine site visit, instead of making it a separate activity. Use **Worksheet 7 – Data Quality Assessment Checklist** to document your assessments of reported data.

Why Is All This Important?

Actually executing the performance management tasks outlined in your PMP will enable you to truly manage for results. Having a PMP is but the first step in this ongoing process. More specifically, implementing the above tasks will allow you to

- Determine whether your development hypothesis is valid;
- Determine whether the critical assumptions continue to hold;
- Make informed decisions on whether to abandon or modify Agency programs, Strategic Objectives, or activities that are not achieving intended results;

- Plan new programs, Strategic Objectives, and/or activities; and
- Communicate progress to USAID/Washington, the U.S Congress, and other stakeholders.

Documentation Is Key

As you begin the implementation process, you must ensure that the team is maintaining adequate documentation to support the performance management process. Not only will this limit your vulnerability should you ever be audited, it will also serve as an important repository of the process by which your program and your PMP has evolved.

Task 8 – Review the PMP

As a good rule of thumb, plan to review and revise the PMP at least twice a year, while preparing for the portfolio review or Annual Report. In your review, consider the following questions:

- Are our indicators working?
- Are we getting the information that we need?
- How can we improve the PMP?

Through the review of PMP data, you may find that you need to make changes to your PMP. For example, you may realize that you should disaggregate data differently or that you should collect data more or less frequently. Or you may find that you need to understand a particular trend in the data in more depth, possibly through an evaluation. If you need to conduct an evaluation, this will be a new performance management task that you will have to add to your calendar of tasks and plan for at the appropriate time. In any event, your review of the PMP may result in your having to update your PMP to accurately reflect current needs.

Task 9 – Revise the PMP

In the normal process of implementing a Strategic Objective, it is common that some elements of the PMP need to be revised. For example, the responsible staff person has changed, or the operational definition of an indicator needs to be updated. Make these changes as frequently as is useful.

The calendar of tasks in the performance management task schedule is also likely to change regularly, based on evolving circumstances. Maintain an up-to-date calendar and share it across the team.

More significant changes such as changing, adding, or dropping an indicator should only be done if there is a compelling need. The team should weigh the advantages of making the change against problems that could occur as a result of the change. For example, data collected before an indicator or data collection method was changed may not be comparable to data collected after the change. In some cases the Operating Unit has the authority to approve changes to performance indicators without Bureau or Agency approval. As provided in ADS 203.3.4.7, however, “significant” changes to a previously approved SO need additional discussion and formal approval from the responsible Bureau.

Document the rationale for changes, especially changes in target values and the selection of indicators. Having a brief but accurate historical record helps all who use the PMP, but is particularly important for any staff who join the SO later in time. In addition, documenting the rationale for changes over time prepares the team to answer questions from other stakeholders who want to know why changes were made and to what degree performance indicators and data were reviewed.

Appendix A: Acronyms and Definitions

List of Acronyms

ADS	Automated Directives System
BSS	Behavioral Surveillance Survey
CDIE	USAID Center for Development Information and Evaluation
CIWG	Common Indicators Working Group
CPR	Contraceptive Prevalence Rate
CSP	Country Strategic Plan
CTO	Cognizant Technical Officer
CYP	Couple Years of Protection
DHS	Demographic and Health Survey
DPT	Diphtheria Polio Tetanus
GH	Bureau for Global Health
GIS	Geographic Information System
GPRA	Government Performance and Results Act
HMIS	Health Management Information System
IP	Implementing Partner
IR	Intermediate Result
M&E	Monitoring and Evaluation
MFR	Managing for Results
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
NGO	Non-Governmental Organization
ORT	Oral Rehydration Therapy
PMP	Performance Management Plan
PPC	USAID Bureau for Policy and Program Coordination
PVO	Private Voluntary Organization
RFP	Request for Proposals
RH	Reproductive Health
RHS	Reproductive Health Survey
SO	Strategic Objective
SOW	Scope of Work
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
U5MR	Under Five Mortality Rate
UNICEF	United Nations International Children's Emergency Fund
WFA	Weight for Age
WHO	World Health Organization

Definitions

(From ADS 200.6)

Accountability for Results (or Results Accountability)

The establishment of clear responsibility and expectation related to achieving formally approved results. Expectations concerning accountability vary with the degree of control that an individual or Operating Unit has over the results they are managing. (ADS Chapters 200–203)

Accrual

The estimated cost of goods and/or services or other performance received by the Agency, but not yet paid for. Accruals are calculated for specific agreements and help provide current information on the financial status of an activity (or group of activities), agreement, or program. In the case of construction, they may be based on percentage completed. [See ADS Series 600 (<http://www.usaid.gov/policy/ads/600/>) for a more technical discussion of this term.] (ADS Chapters 200–203)

Activity

A set of actions through which inputs, such as commodities, technical assistance, training, or resource transfers, are mobilized to produce specific outputs, such as vaccinations given, schools built, micro-enterprise loans issued, or policies changed. Activities are undertaken to achieve Strategic or Special Objectives that have been formally approved and notified to Congress. (ADS Chapters 200–203)

Activity Approval Document (AAD)

A document that approves one or more activities for implementation. (ADS Chapters 200–203)

Activity Manager

Member of a Strategic Objective (SO) team or sub-team who is responsible for the day-to-day management of one or more specific activities. The Activity Manager is selected by the SO team and may or may not also have the delegated authorities of a Cognizant Technical Officer (CTO), whose authority to carry out contract management functions are designated by a Contracting or Agreement Officer. [See “Cognizant Technical Officer (CTO).”] (ADS Chapters 200–203)

Agency Goal

A long-term development result in a specific area to which USAID programs contribute. An Agency goal has been identified as a specific goal in the Agency Strategic Plan (ASP). (ADS Chapters 200–203)

Agency Mission Statement

The ultimate purpose of Agency programs; it is the unique contribution of USAID to U.S. national interests. There is one Agency Mission, and it is described in the Agency Strategic Plan. (ADS Chapters 200–203)

Agency Objective

A development result that contributes to the achievement of an Agency goal as defined in the Agency Strategic Plan. Agency Objectives generally denote preferred approaches or areas of emphasis for programs that support specific goals. They should not be confused with Strategic or Special Objectives. Agency Objectives provide a general framework for more detailed planning that occurs for specific country and regional programs. (ADS Chapters 200–203)

Agency Program Approach

A tactic commonly used to achieve a particular Agency Objective. Several program approaches are associated with each Agency Objective. These are identified in the Agency Strategic Plan. (ADS Chapters 200–203)

Agency Strategic Plan (ASP)

An overall Agency plan for providing development and humanitarian assistance, which articulates the Agency mission, goals, objectives, and program approaches. The Agency Strategic Plan is coordinated with and reflects U.S. Government foreign policy priorities, as described in the International Affairs Strategic Plan (IASP). (ADS Chapters 200–203)

Agent

Term no longer used. See “Partner.”

Annual Report

An annual document produced by each Operating Unit and submitted to the responsible Bureau to report on past performance, future resources needed, and data needed for Agency-wide management, budget decisions, and external reporting. Annual Reports began in 2001 and replaced the Results Review and Resource Request (R4). (ADS Chapters 200–203)

Attribution

The extent to which a result is caused by USAID activities. (ADS Chapters 200–203)

Baseline

See “Performance Baseline.”

Bureau Planning Framework

A description of the goals and priorities for a sector or region (in some cases a country). It serves to guide Operating Unit Strategic Plans within that Bureau.

Cognizant Technical Officer (CTO)

The individual who performs functions that are designated by the Contracting or Agreement Officer, or are specifically designated by policy or regulation as part of contract or assistance administration. In other parts of the U.S. Government, the synonymous term is usually “Contracting Officer’s Technical Representative (COTR).” (See “Activity Manager” and ADS Series 300.) (ADS Chapters 200–203)

Conditions Precedent (CP)

A condition or set of conditions that must be met before USAID will agree to disburse funding. [For example, if the host country laws require legislative approval of the Strategic Objective Agreement (SOAG), then USAID must receive evidence of that approval before funds disbursement.]

Core Member

A member of a Strategic Objective (SO) team carrying out a specific U.S. Governmental function for that SO. (ADS Chapters 200–203)

Core Team

Term no longer used. See “Core Member” and “Strategic Objective (SO) Team.”

Covenant

A condition that must be met during the performance of the Strategic Objective Agreement (SOAG) (such as after disbursement of USAID funding).

Critical Assumption

A general condition under which the development hypothesis or strategy for achieving the objective will hold true. Critical assumptions are outside the control or influence of USAID and its partners (in other words, they are not results), but they reflect conditions likely to affect the achievement of results in the Results Framework, such as the level of world prices or the openness of export markets. (ADS Chapters 200–203)

Customer

The person or group who is receiving a service, or who is considered the recipient or beneficiary of a given result or output. There are several different types of USAID customers:

Ultimate Customers: Those host country individuals, especially the socially and economically disadvantaged, who are beneficiaries of USAID assistance and whose participation is essential to achieving sustainable development results.

Intermediate Customers: Those organizations, including host country governments, that receive USAID services to implement programs that are designed to benefit the ultimate customer. This includes private voluntary organizations (PVOs), contractors, and host country entities.

Internal/Process Customers: Bureaus, Offices, Operating Units, and individuals within USAID that benefit from, and participate in, the activities undertaken by other Bureaus, Offices, Operating Units, and individuals within the Agency.

Washington and U.S.-Based Customers: U.S. Government entities, or individuals representing such an entity, at whose behest USAID carries out its programs and who have a stake in the program results that USAID produces. Examples include Congress, the Office of Management and Budget (OMB), and the Department of State. Congress represents U.S. taxpayers. (ADS Chapters 200–203)

Customer Service Plan

A planning document previously required for every individual Operating Unit. The plan is no longer required. This term is no longer used. (ADS Chapters 200–203)

Delegation of Authority (DOA)

A document that officially recognizes when an official, vested with certain powers (authorities), extends that power (authority) to another individual or position within the chain of command. (ADS Chapters 201–202)

Deobligation

The process of removing unneeded funds from an obligating instrument. This step is typically done upon completion of activities when unliquidated obligations might have become excessive or might no longer be needed for their original purpose. (ADS Chapters 200–203)

Development Actors

USAID has recently expanded its concept of development actors to include the full range of organizations—both public and private—who seek to achieve improvements in society. These groups can include private-sector companies, foundations, universities, philanthropic leaders, multilateral organizations, faith-based membership organizations, and ethnic diaspora sending money home to their country of origin. (ADS Chapters 200–203)

Development Alliance

See “Public-Private Alliance.”

Development Hypothesis

A narrative description of the specific causal linkages between Intermediate Results (IRs) and a Strategic Objective (SO) that are expected to lead to the achievement of the SO. The hypothesis is based on sound development theory, knowledge, and experience within the context of a specific SO. Generally, the term refers to plausible linkages and not statistically accurate relationships. (ADS Chapters 200–203)

Disbursement

Payments made by the Agency to other parties, using cash, check, or electronic transfer. (ADS Chapters 200–203)

Due Diligence

The technical term for the necessary assessment of the past performance, reputation, and future plans of a prospective alliance partner, private sector, or other entity, with regard to various business practices and principles. This assessment of a prospective alliance partner would normally involve, at a minimum, examining its social, environmental, and financial track records. (ADS Chapters 200–203)

Environmental Impact Statement

A detailed study of the reasonably foreseeable positive and negative environmental impacts of a proposed USAID action and its reasonable alternatives on the United States, the global environment, or areas outside the jurisdiction of any nation. [See [ADS Chapter 204](#) (<http://www.usaid.gov/policy/ads/200/204.pdf>) and Mandatory Reference, 22 CFR 216.] (ADS Chapters 200–203)

Evaluation

A relatively structured, analytical effort undertaken selectively to answer specific management questions regarding USAID-funded assistance programs or activities. (ADS Chapters 200–203)

Expanded Team

Term no longer used. See “Strategic Objective (SO) Team.”

Expenditures

The sum total of disbursements and accruals in a given time period. These are typically calculated for specific agreements, activities, and programs. Expenditures are estimates of the total cost incurred by the Agency for a given agreement, activity, or program. Also referred to as “Accrued Expenditure.” [See [ADS Series 600 for a more technical discussion of this term](#) (<http://www.usaid.gov/policy/ads/600/>).] (ADS Chapters 200–203)

Framework Goal

A higher-level development result to which a Strategic Objective (SO) contributes. Framework goals are beyond the manageable interest of an Operating Unit, either because of the timeframe necessary to achieve them or because they address very broad objectives. (ADS Chapters 200–203)

Gender

The economic, political, and cultural attributes and opportunities associated with being male or

female. The social definitions of what it means to be male or female vary among cultures and change over time. (ADS Chapters 200–203)

Global Development Alliance

The Agency's new business model promoting public-private alliances as a central element of USAID's strategic assessment, planning, and programming efforts. This initiative involves recognition of a changed role for USAID in development assistance, outreach to an expanded range of potential partners, and organizational changes within the Agency. (ADS Chapters 200–203)

Host Country

The country in which a USAID-funded activity takes place. (ADS Chapters 200–203)

Implementation Letters

Formal correspondence between USAID and another party following a formal agreement that obligates funding. Implementation letters serve several functions, including providing more-detailed implementation procedures, providing details on terms of an agreement, recording the completion of conditions precedent to disbursements, and approving funding commitments and mutually agreed-upon modifications to program descriptions. Formerly known as "Project Implementation Letters (PIL)." (ADS Chapters 200–203)

Indicator

See "Performance Indicator."

Initial Environmental Examination

The first review of the reasonably foreseeable effects of a proposed action on the environment. Its function is to provide a brief statement of the factual basis for a Threshold Decision as to whether an Environmental Assessment or an Environmental Impact Statement will be required. [See ADS Chapter 204 (<http://www.usaid.gov/policy/ads/200/204.pdf>).] (ADS Chapters 200–203)

Input

A resource, such as technical assistance, commodities, training, or provision of USAID staff, either Operating Expenses (OE) - or program-funded, that is used to create an output. (ADS Chapters 200–203)

Instrument

A contract, grant, bilateral agreement, or other mechanism that obligates or subobligates program or Operating Expenses (OE) funds. (ADS Chapters 200–203)

Intermediate Customer

See "Customer."

Intermediate Result (IR)

An important result that is seen as an essential step to achieving a Strategic Objective (SO). IRs are measurable results that may capture a number of discrete and more specific results. IRs may also help to achieve other IRs. (ADS Chapters 200–203)

Internal/Process Customer

See "Customer."

International Affairs Strategic Plan (IASP)

An overarching framework for the international affairs goals of the executive branch of the Federal Government and is prepared by the Secretary of State. (ADS Chapters 200–203)

Leveraging

Significant resource mobilization. In the case of public-private alliances, USAID seeks the mobilization of resources of other actors on a 1:1 (or greater) basis. Resources may include funds, in-kind contributions, and intellectual property.

Manageable Interest

The concept of manageable interest recognizes that achievement of results requires joint action on the part of many other actors, such as host country governments, institutions, other donors, civil society, and the private sector. When an objective is within USAID's manageable interest, it means that we have reason to believe that our ability to influence, organize, and support others around commonly shared goals can lead to the achievement of desired results and that the probability of success is high enough to warrant expending program and staff resources. A result is within an entity's manageable interest when there is sufficient reason to believe that its achievement can be significantly and critically influenced by interventions of that entity. (ADS Chapters 200–203)

Management Agreement

An agreement between an Operating Unit and its Bureau that provides approval to implement a proposed Strategic Plan. The Management Agreement provides a summary of agreements on a set of strategic and other objectives, confirmation of estimated resources over the Strategic Plan timeframe, SO start and end dates, and additional guidance on any special management concerns. Formerly called "Management Contract." (ADS Chapters 200–203)

Management Contract

Term no longer used. See "Management Agreement."

Memorandum of Understanding (MOU)

A document that sets forth an agreement between parties. A Memorandum of Understanding may be used to cover a range of topics, including results to be achieved, activities to be implemented, and the respective roles and responsibilities of each party. An MOU is not used for obligating funds; however, an MOU may be used to confirm an agreement with a host government on a program that USAID will fund directly through an obligating instrument signed with other parties. (ADS Chapters 200–203)

Mortgage

A claim on future resources that has been authorized in the Operating Unit's Management Agreement; the difference between the total authorized level of funding and the cumulative total amount of funds obligated to a particular Strategic Objective, Intermediate Result, or activity. (ADS Chapters 202, 602)

National Security Strategy (NSS)

An overarching U.S. Government policy document that covers the national security principles underlying U.S. foreign policy. As published in September 2002, its main themes include promoting "human dignity" through political and economic freedom, providing security against terrorism and weapons of mass destruction, working with others to defuse regional conflicts, and strengthening America's national security institutions. Objectives of development

assistance are central to the document, which was prepared by the National Security Council. (ADS Chapters 200–203)

Non-Project Assistance (NPA)

Also known as “Program Assistance.” Its distinguishing feature is the manner in which USAID resources are provided. Under this mode, USAID provides a generalized resource transfer, in the form of foreign exchange or commodities, to the recipient government. This is in contrast to other types of assistance in which USAID finances specific inputs, such as technical assistance, training, equipment, vehicles, or capital construction. (This distinction parallels distinctions in law and previous USAID usage between Project and Non-Project Assistance.) (ADS Chapters 200–203)

Operating Units

USAID field Missions, regional entities, and USAID/Washington Offices that expend program funds to achieve approved Strategic Objectives (including Special Objectives and Program Support Objectives). (ADS Chapters 200–203)

Operating Expenses (OE)

Costs related to personnel, other administration costs, rental, and depreciation of fixed assets. (ADS Chapters 200–203)

Operations Policy

Program procedures, rules, and regulations affecting the management of USAID internal systems, including budget, financial management, personnel, procurement, and program operations. (ADS Chapters 200–203)

Outcome

A result sought by USAID. In ADS Chapters 200–203, the term “outcome” is equivalent to “result.” (See “result” in ADS Chapters 200–203.)

Output

A tangible, immediate, and intended product or consequence of an activity within USAID’s control. Examples of outputs include people fed, personnel trained, better technologies developed, and new construction. Deliverables included in contracts will generally be considered outputs, as will tangible products and consequences of USAID grantees. (ADS Chapters 200–203)

Parameter Setting

See “Planning Parameters.”

Partner

An organization or individual with which/whom the Agency collaborates to achieve mutually agreed-upon objectives and to secure participation of ultimate customers. Partners include host country governments, private voluntary organizations, indigenous and international non-governmental organizations (NGOs), universities, other U.S. Government agencies, United Nations and other multilateral organizations, professional and business associations, and private businesses and individuals. (ADS Chapters 200–203)

Performance Baseline

The value of a performance indicator before the implementation of USAID-supported activities that contribute to the achievement of the relevant result. (ADS Chapters 200–203)

Performance Indicator

A particular characteristic or dimension used to measure intended changes defined by a Results Framework. Performance indicators are used to observe progress and to measure actual results compared with expected results. Performance indicators help answer how or whether an Operating Unit or SO team is progressing toward its objective, rather than why such progress is or is not being made. Performance indicators may measure performance at any level of a Results Framework (Strategic Objective level or Intermediate Results level). (ADS Chapters 200–203)

Performance Management

The systematic process of monitoring the results of activities; collecting and analyzing performance information to track progress toward planned results; using performance information to influence program decision making and resource allocation; and communicating results achieved, or not attained, to advance organizational learning and tell the Agency's story. (ADS Chapters 200–203)

Performance Management Plan

A tool used by an Operating Unit and SO team to plan and manage the process of assessing and reporting progress toward achieving a Strategic Objective. Known as a "Performance Monitoring Plan" until 2002. (ADS Chapters 201–203)

Performance Monitoring Plan

See "Performance Management Plan."

Performance Target

Specific, planned level of result to be achieved within an explicit timeframe. (ADS Chapters 200–203)

Pillars

USAID's four Pillars are its new strategic orientation, encompassing all USAID-managed programs regardless of account. The Pillars are the Global Development Alliance; Economic Growth, Agriculture, and Trade; Global Health; and Democracy, Conflict, and Humanitarian Assistance.

Pillar Bureaus

Provide leadership and innovation in their respective fields. The three Pillar Bureaus are Economic Growth, Agriculture, and Trade (EGAT); Democracy, Conflict, and Humanitarian Assistance (DCHA); and Global Health (GH). The activities funded by the Pillar Bureaus are primarily intended to maximize program dollars available to Operating Units in the field. Pillar Bureaus concentrate on program activities that support Operating Units in the field. (ADS Chapters 200–203)

Planning Parameters

The limits, constraints, and options within which decision making and planning take place, especially for the development of Strategic Plans. (ADS Chapters 200–203)

Portfolio Review

A periodic review of all aspects of an Operating Unit or Strategic Objective (SO) team's programs, often held in preparation for submission of the Annual Report. (ADS Chapters 200–203)

Program Assistance

Also known as “Non-Project Assistance.” Its distinguishing feature is the manner in which USAID resources are provided. Under this mode, USAID provides a generalized resource transfer, in the form of foreign exchange or commodities, to the recipient government. This is in contrast to other types of assistance in which USAID finances specific inputs, such as technical assistance, training, equipment, vehicles, or capital construction. (This distinction parallels distinctions in law and previous USAID usage between Project and Non-Project Assistance.) (ADS Chapters 200–203)

Program Assistance Approval Document (PAAD)

An internal USAID document, used before 1994, approving non-project assistance. Term no longer used. (ADS Chapters 200–203)

Program Assistance Initial Proposal (PAIP)

An internal USAID document, used before 1994, used to initiate and identify proposed non-project assistance, including commodity import programs. It was analogous to the former Project Identification Document (PID). Term no longer used. (ADS Chapters 200–203)

Program Development and Learning (PD&L) Objectives

Used by Bureaus to finance program development, program assessments, and learning efforts that do not fit within the scope of existing Strategic Objectives (SOs). They are intended to fund studies, analyses, pilots, pre-implementation, and evaluative work for developing future SOs, for assessing completed SOs, or for disseminating lessons learned. (ADS Chapters 200–203)

Program Support Objective (PSO)

A Program Support Objective contains activities being implemented exclusively to support achievement of other Strategic or Special Objectives in one or multiple Operating Units. The results of the activities under a PSO should be visible through, and attributed to, another Strategic or Special Objective. (ADS Chapters 200–203)

Project

Considered one of several possible types of activities that contribute to a given result or set of results. It is a structured undertaking (often involving considerable money, personnel and equipment) of limited duration that is developed through various administrative, analytical, and approval processes in order to achieve a tangible objective (such as a school construction project or an adult literacy project). (ADS Chapters 200–203) Note: The current term is defined differently than before 1995.

Project Identification Document (PID)

An internal USAID document, used before 1995, that initially identifies and describes a proposed project. Term no longer used. (ADS Chapters 200–203)

Project Paper (PP)

An internal USAID document, used before 1995, that provides a description and appraisal of a project and the plan for implementation. The project paper was used to obtain formal approval. Term no longer used. (ADS Chapters 200–203)

Public-Private Alliance (PPA)

An agreement between two or more parties involving joint definition of a development problem and shared contributions to its solution. Alliances are characterized by a shared understanding

of the development problem or issue; a shared belief that an alliance will be more effective than any approach taken by a single actor; a shared commitment of resources; significant use of limited resources; and perhaps most important, a willingness to share risks. (ADS Chapters 200–203)

Result

A significant, intended, and measurable change in the condition of a customer or a change in the host country, institutions, or other entities that will affect the customer directly or indirectly. Results are typically broader than USAID-funded outputs and require support from other donors and partners not within USAID's control. (ADS Chapters 200–203)

Results Framework

A planning, communications, and management tool that conveys the development hypothesis implicit in the strategy and the cause-and-effect linkages between the Intermediate Results (IR) and the Strategic Objective (SO). A Results Framework includes the SO and the IRs necessary to achieve the SO, whether funded by USAID or its partners. It includes any critical assumptions that must hold for the development hypothesis to lead to achieving the relevant objective. Typically, it is laid out in graphic form, supplemented by narrative. (ADS Chapters 200–203)

Results Package

A shorthand designation for items that contribute to achieving a particular result. Some Operating Units have used the term as a name for documentation used to obtain approval for a set of activities and to define SO subteams that concentrate on a particular new set of activities. The term is no longer "officially" used. Documentation to approve activities is called "Activity Approval Documentation." (ADS Chapters 200–203)

Special Objective (SpO)

An objective that is difficult to define and measure or that is not directly linked to a goal in the Agency Strategic Plan. Special Objectives are expected to be small in scope, relative to the total portfolio of any Bureau. Special Objectives should meet at least one of the following criteria:

- Represents a response to a legislated earmark or special foreign policy interest that is beyond what is described in the Agency Strategic Plan or that does not contribute directly to an Operating Unit's Strategic Objectives
- Is exploratory or experimental in nature, such as development of a new program area
- Is research and contributes to the achievement of an Agency goal
- Responds to an emergency or short-term postcrisis stabilization effort, such as when an interim Strategic Plan is indicated (ADS Chapters 200–203)

Stakeholders

Those who are affected by a development outcome or have an interest in a development outcome. Stakeholders include customers (including internal, intermediate, and ultimate customers), but can include more broadly all those who might be affected adversely or indirectly by a USAID activity and who might not be identified as a "customer." (ADS Chapters 200–203)

Strategic Budgeting

USAID's programming policy, which closely links resource allocation with strategic priorities and performance. It is a core element of results-based management.

Strategic Objective (SO)

The most ambitious result that a USAID Operating Unit, along with its partners, can materially affect and for which it is willing to be held accountable. SOs can be designed for an Operating Unit to provide analytic, technical, logistical, or other types of support to the SOs of other Operating Units (whether bilateral, multicountry, or global in nature). (ADS Chapters 200–203)

Strategic Objective Agreement (SOAG)

A formal agreement that obligates funds between USAID and the host government or other parties, such as, in certain cases, regional organizations created by governments. It sets forth a mutually agreed-upon understanding of the timeframe; results expected to be achieved; means of measuring those results; and resources, responsibilities, and contributions of participating entities for achieving a clearly defined Strategic Objective. (ADS Chapters 200–203)

Strategic Objective (SO) Team

A group of people with complementary skills who are empowered to achieve a specific USAID development objective for which they are willing to be held accountable. The primary responsibility of SO teams is to make decisions and implement activities related to accomplishing the objective. Another essential function is to ensure open communication and collaboration across organizational boundaries at all phases of the development process. SO teams may decide to organize subteams if they wish to manage complex SOs more efficiently. SO teams comprise USAID employees and those partners and customers considered to be essential for achieving the SO. (ADS Chapters 200–203)

Strategic Plan

A document used to describe and obtain approval for one or more Strategic Objectives or Special Objectives to be implemented by an Operating Unit. Approved Operating Unit Strategic Plans represent an Agency-wide commitment to a set of objectives and Intermediate Results (IRs) to be accomplished by an Operating Unit. (ADS Chapters 200–203)

Strategic Plan Timeframe

The time period in which USAID plans to make funds available for a given set of Strategic, Special, or Program Support Objectives. The Strategic Plan sets the overall vision and strategic directions for this timeframe.

Strategic Support Objective (SSO)

Term no longer used. See “Strategic Objective (SO).”

Target

See “Performance Target.”

Ultimate Customer

See “Customer.”

Washington Customer

See “Customer.”

Appendix B: Worksheets

Electronic versions of the following worksheets in Microsoft Word are included in the Toolkit CD.

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Worksheet 1: PMP Development Team Skills Matrix

Use this worksheet to list all of the proposed team members of the PMP development team and their proposed roles. Checkmark each skill that the team members have. Use this worksheet to ensure that you have a good cross section of skills represented on the team.

Name	Knows USAID MFR approach	Has sector experience	Has sector training or education	Knows local conditions in depth	Knows USAID structure, processes, culture	Knows PM methods and best practices	Has facilitation, analytical, and report-writing skills	Proposed Role
1.								
2.								
3.								
4.								
5.								

Worksheet 2: PMP Development Workplan

Use this worksheet to list all of the major tasks and subtasks needed to prepare the PMP. Expand the worksheet by including additional rows or columns in the table, as needed. Another approach is to use Microsoft Project or other project planning software to develop the workplan if someone on the team is familiar with the software.

DESCRIPTION	START DATE	END DATE	LEVEL OF EFFORT	STAFF
Task 1:				
Subtask 1:				
Subtask 2:				
Task 2:				
Subtask 1:				
Subtask 2:				
Task 1:				
Subtask 1:				
Subtask 2:				
Task 2:				
Subtask 1:				
Subtask 2:				

Worksheet 3: Results Statement Assessment

Sector:

Strategic Objective:

Results Statement (Name/Number):

CRITERIA FOR ASSESSING THE RESULTS STATEMENT	Yes	No	Un-sure	COMMENTS
Is the results statement MEASURABLE ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is the results statement MEANINGFUL ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is the results statement REALISTIC ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is the results statement focused on USAID STRATEGIC COMMITMENTS ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is the results statement CUSTOMER or STAKEHOLDER DRIVEN ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is the results statement within the MANAGEABLE INTEREST of the Operating Unit and its development partners?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is the results statement focused on RESULTS or outcomes of activities (such as impact, quality, cost/efficiency timeliness), rather than a description of activities themselves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is the statement UNIDIMENSIONAL (focused on one result, rather than a combination of results)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

OTHER COMMENTS:

RECOMMENDATION:

- Accept results statement
- Revise results statement, and then accept
- Reject results statement

Worksheet 4: Results Framework Assessment

Sector: _____

Name of Strategic Objective: _____

CRITERIA FOR ASSESSING THE RESULTS FRAMEWORK	Yes	No	Un- sure	COMMENTS
CAUSAL LINKAGE: At each level of the Results Framework, does achievement of one result cause the achievement of the other? Is the linkage direct?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CONTRIBUTIONS OF USAID PARTNERS: At each level of the Results Framework, have activities been identified (regardless of whether they will be conducted by USAID or its partners) to cause the result at the next level? [Note: Not all results from USAID partners have to be identified in the framework, but there may at least be mention of them in the narrative that accompanies the framework.]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MANAGEABLE INTEREST (A): Is the SO-level result one that the team, working with its partners, can materially affect?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MANAGEABLE INTEREST (B): Is the team willing to be held accountable for all results within the Results Framework, including the SO-level result?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CRITICAL ASSUMPTIONS: Have all the critical assumptions been identified at each level of the Results Framework?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

OTHER COMMENTS:

RECOMMENDATION:

- ___ Accept Results Framework
- ___ Revise Results Framework and then accept
- ___ Reject Results Framework

Worksheet 5: Performance Indicator Quality Assessment

Name of Indicator:

Name of Relevant Result:

CRITERIA	COMMENTS
<p><i>Is the indicator DIRECT?</i></p> <ul style="list-style-type: none"> • Does it closely measure the result it is intended to measure? • Is it grounded in theory and practice? • Does it represent an acceptable measure to both proponents and skeptics? • If it is a proxy, is it as directly related to the relevant result as possible? 	
<p><i>Is the indicator OBJECTIVE?</i></p> <ul style="list-style-type: none"> • Is it unambiguous about what is being measured? • Is there general agreement over the interpretation of the results? • Is it unidimensional (i.e., does it measure only one phenomenon at a time)? • Is it operationally precise (i.e., is there no ambiguity over what kind of data should be collected)? 	
<p><i>Is the indicator USEFUL for management?</i></p> <ul style="list-style-type: none"> • Useful at what level? (SO? Project? Agency?) • How will it be used? 	
<p><i>Is the indicator PRACTICAL?</i></p> <ul style="list-style-type: none"> • Are timely data available (i.e., are data current and available on regular basis)? • Can the data be collected frequently enough to inform management decisions? • Are data valid and reliable? • Are the costs of data collection reasonable? 	
<p><i>Is the indicator ATTRIBUTABLE to USAID effort?</i></p> <ul style="list-style-type: none"> • Are the links between USAID-supported activities and the result being measured clear and significant? • Can the result be attributed, at least in part, to USAID efforts? 	

CRITERIA	COMMENTS
<p><i>Is the indicator TIMELY?</i></p> <ul style="list-style-type: none"> • Are data available when needed for decision making? • Are data available frequently enough for decision making? 	
<p><i>Is the indicator ADEQUATE?</i></p> <ul style="list-style-type: none"> • Does it merely indicate progress, rather than attempt to fully describe everything an activity accomplishes? • Taken as a group, are the indicator and its companion indicators the minimum necessary to ensure that progress toward the given result is sufficiently captured? 	
<p><i>Should the indicator be DISAGGREGATED?</i></p> <ul style="list-style-type: none"> • Is disaggregation necessary and appropriate? 	
<p><i>Does the indicator reflect GENDER CONSIDERATIONS (if technical analysis demonstrates the need for this)?</i></p>	

OTHER COMMENTS:

RECOMMENDATION:

Worksheet 6: Performance Indicator Reference Sheet, Blank

Use this comprehensive reference sheet to record and update all relevant information for a particular indicator. Imagine that you are providing a new staff member with a quick—but complete—overview of this performance indicator, including where the raw data come from and how they can be analyzed. Edit the headings to make this worksheet more relevant to your situation, or modify the sheet to meet Operating Unit requirements, as needed. For suggestions on how to complete this form and an example of a completed form, see the following pages.

Performance Indicator Reference Sheet			
Name of Strategic Objective:			
Name of Intermediate Result:			
Name of Indicator:			
Geographic Focus:			
Is This an Annual Report Indicator? No ___ Yes ___, for Reporting Year(s) _____			
DESCRIPTION (Refer to Toolkit Stage 2, Task 2)			
Precise Definition(s):			
Unit of Measure:			
Disaggregated by:			
Justification & Management Utility:			
PLAN FOR DATA ACQUISITION BY USAID (Refer to Toolkit Stage 2, Task 3)			
Data Collection Method:			
Data Source(s):			
Method of Data Acquisition by USAID:			
Frequency and Timing of Data Acquisition by USAID:			
Budget Mechanism:			
Individual(s) Responsible at USAID:			
Individual(s) Responsible for Providing Data to USAID:			
Location of Data Storage:			
DATA QUALITY ISSUES (Refer to Toolkit Stage 2, Task 4)			
Date of Initial Data Quality Assessment:			
Known Data Limitations and Significance (if any):			
Actions Taken or Planned to Address Data Limitations:			
Date(s) of Future Data Quality Assessments:			
Procedures for Future Data Quality Assessments:			
OTHER NOTES (Refer to Toolkit Stage 2, Tasks 4 & 5)			
Notes on Baselines/Targets:			
Other Notes:			
PERFORMANCE INDICATOR VALUES			
Year	Target	Actual	Notes
THIS SHEET LAST UPDATED ON:			

Worksheet 6: Instructions

Instructions for Completing the Performance Indicator Reference Sheet
Name of Strategic Objective: Enter the number and full name of the SO.
Name of Intermediate Result: Enter the number and full name of the IR, if applicable.
Name of Indicator: Enter the full title of the indicator.
Geographic Focus: Describe specific geographic regions (if any) that will be the target of interventions affecting this indicator.
Is This an Annual Report Indicator? Enter yes or no, and clarify which reporting years(s).
DESCRIPTION (Refer to Toolkit Stage 2, Task 2)
Precise Definition(s): Define the specific words or elements used in the indicator.
Unit of Measure: Enter the unit of measure (e.g., <i>number of . . .</i> , <i>percentage of . . .</i> , or <i>U.S. dollars</i>). Clarify the minimum or maximum values, if needed (e.g., <i>minimum score is 1.0 and maximum score is 5.0</i>). Clarify whether the number is cumulative or specific to the year. Clarify numerator and denominator, if applicable.
Disaggregated by: List any planned ways of disaggregating the data (e.g., <i>male/female</i> , <i>youth/adult</i> , <i>urban/rural</i> , <i>region</i>), and justify why useful.
Justification & Management Utility: Briefly describe <i>why</i> this particular indicator was selected and <i>how</i> it will be useful for managing performance of the SO team's portfolio. If the value of this indicator changes, what does this indicate about the program?
PLAN FOR DATA ACQUISITION BY USAID (Refer to Toolkit Stage 2, Task 3)
Data Collection Method: Describe the <i>tools</i> and <i>methods</i> for collecting the raw data. Examples include ledger of patient names, document review, structured interviews, focus group interviews, written survey, direct observation, self-reported information, and so on. Who collects the raw data, and where is it stored before it gets to USAID?
Data Source(s): Identify the source(s) of data (e.g., DHS, ministry data, or partner records).
Method of Data Acquisition by USAID: How does USAID acquire the data or report? Describe the form in which the SO team will receive the data (such as periodic monitoring report or compiled survey analysis report).
Frequency and Timing of Data Acquisition: Describe <i>how often</i> data will be received by the SO team or Operating Unit, and <i>when</i> .
Budget Mechanism: Enter what funding mechanism (e.g., contract for project implementation, or grant) will be used to fund data acquisition.
Individual(s) Responsible at USAID: Identify the specific SO team member(s) who will be <i>directly responsible</i> for acquiring the data.
Individual(s) Responsible for Providing Data to USAID: Identify who is responsible for providing the data to USAID.
Location of Data Storage: Identify where the data will be maintained in the Operating Unit (e.g., specific file cabinet, or specific folder on shared computer).
DATA QUALITY ISSUES (Refer to Toolkit Stage 2, Task 4)
Date of Initial Data Quality Assessment: Enter the date of initial data quality assessment and the responsible party.
Known Data Limitations and Significance (if any): Describe any data limitations discovered during the initial data quality assessment. Discuss the significance of any data weakness that may affect conclusions about the extent to which performance goals have been achieved.
Actions Taken or Planned to Address Data Limitations: Describe how you have taken—or will take—corrective action, if possible, to address data quality issues.
Date(s) of Future Data Quality Assessments: Enter the planned date(s) for subsequent data quality assessments.
Procedures for Future Data Quality Assessments: Describe <i>how</i> the data will be assessed in the future (e.g., spot checks of partner data, financial audit, site visits, or software edit check).
OTHER NOTES (Refer to Toolkit Stage 2, Task 4&5)
Notes on Baselines/Targets: Explain how the baselines and targets were set, and identify any assumptions made. If baselines and targets have not been set, identify <i>when</i> and <i>how</i> this will be done.
Other Notes: Use this space as needed.
PERFORMANCE INDICATOR VALUES

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Year	Target	Actual	Notes

THIS SHEET LAST UPDATED ON: mm/dd/yy

To avoid version control problems, type the date of most recent revision or update to this reference sheet.

Worksheet 6: Example

Performance Indicator Reference Sheet			
Strategic Objective: Increased use of high impact health services and improved health practices			
Intermediate Result: N/A (this is a SO-level not IR-level indicator)			
Indicator: DPT3 coverage			
Geographic Focus: In four USAID target zones			
Is This an Annual Report Indicator? Yes, 2004, 2005, 2006			
A. Description			
Precise Definition(s): Percentage of children 12-23 months who received three complete doses of DPT (diphtheria, pertussis, and tetanus) vaccine before they reached the age of 12 months. The numerator is the number of children currently age 12-23 months who did receive three does of DPT vaccine before age 12. The denominator is the total number of children aged 12-23 months in the observation area.			
Unit of Measure: Percentage of children			
Disaggregated by: Geographic location			
Justification & Management Utility: DPT3 is the best measure of the use of services and also serves as a proxy for full immunization coverage. This indicator is helpful in validating the routine reporting system and is an important indicator to measure the incremental progress of the immunization program in-country.			
B. Plan for Data Acquisition by USAID			
Data Collection Method: Program statistics at service delivery sites			
Data Source(s): Implementing partner data (service statistics) for target zones for annual data collection. Compare with MOH data when available.			
Method of Data Acquisition by USAID: USAID will obtain semi-annual reports from implementing partner and annual reports from MOH			
Frequency and Timing of Data Collection: Every six months. December in Annual Report from implementing partner; June in a separate report			
Budget Mechanism: Cost included within the contract with the implementing partner.			
Individual(s) Responsible at USAID: J. Perez, Activity Manager			
Individual(s) Responsible for Providing Data to USAID: K. Lee, M&E specialist from implementing partner			
Location of Data Storage: C:/USAID/Health/PMP			
C. Data Quality Issues			
Date of Initial Data Quality Assessment: January 2001. Official government data from MOH were compared with project level service statistics to determine data quality.			
Known Data Limitations and Significance (if any): The data collection and analysis does not take into account the timeliness of the doses or the time interval between the doses.			
Actions Taken or Planned to Address Data Limitations:			
Date(s) of Future Data Quality Assessments: January 2004; January 2007			
Procedures for Future Data Quality Assessments:			
D. Performance Indicator Values			
Year	Target	Actual	Notes
2000 (Baseline)	-	15%	
2001	20%		
2002	25%		
2003	30%		
2004	35%		
2005	40%		

Worksheet 7: Data Quality Assessment Tool

Refer to this checklist when the SO team conducts both initial and periodic data quality assessments.

Name of Strategic Objective:	
Name of Intermediate Result (if applicable):	
Name of Performance Indicator:	
Data Source(s):	<input type="checkbox"/> Survey / KAP <input type="checkbox"/> Service Statistics <input type="checkbox"/> Health facility assessment (HFA) <input type="checkbox"/> Other
USAID Control Over Data:	<input type="checkbox"/> High (USAID is source and/or funds data collection) <input type="checkbox"/> Medium (Implementing partner is data source) <input type="checkbox"/> Low (Data are from a secondary source.)
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:	
<i>For Office Use Only</i>	
SO team leader approval: X _____ Date _____	
Mission director or delegate approval: X _____ 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 a regularized schedule of data collection in place to meet program management needs?			
Is data properly stored and readily available?			

CATEGORY	YES	NO	COMMENTS
PRECISION			
Is there a method for detecting duplicate data?			
Is there a method for detecting missing data?			
INTEGRITY			
Are there proper safeguards in place to prevent unauthorized changes to the data?			
Has there been or is there planned an independent review of results reported?			

IF NO RELEVANT DATA WERE AVAILABLE	COMMENTS
If no recent relevant data are available for this indicator, why not?	
What concrete actions are now being undertaken to collect and report these data as soon as possible?	
When will data be reported?	
SUMMARY	COMMENTS
Based on the assessment relative to the five standards, what is the overall conclusion regarding the quality of the data?	
Significance of limitations (if any):	
Actions needed to address limitations (given level of USAID control over data):	

Worksheet 8: Summary Performance Data Table

Use this worksheet to keep track of baseline values and target values for the life of the SO for each SO and IR indicator. Note that although this worksheet consolidates performance data about your whole portfolio in one place, the worksheet is missing several key components that are found on Worksheet 6, such as definition of indicator, unit of measure, rationale for determining targets, and explanation of actual performance. Modify this worksheet to include additional indicators and years, as needed.

SO or IR	Results Statement	Indicator	Unit of Measure	Disaggregation	Baseline Year	Baseline Value	2005 Target	2005 Actual	2006 Target	2006 Actual	2007 Target	2007 Actual
SO												
IR												
Sub-IR												

Worksheet 9: Performance Management Task Schedule

Use this worksheet to schedule all of the SO team's monitoring and reporting activities over the life of the SO. Modify the table to include additional indicators and years, as needed.

PERFORMANCE MANAGEMENT TASKS	FY 2004				FY 2005				FY 2006				FY 2007				Notes
	Q1	Q2	Q3	Q4													
COLLECT CONTEXT-LEVEL DATA																	
COLLECT SO-LEVEL PERFORMANCE DATA																	
COLLECT IR-LEVEL PERFORMANCE DATA																	
COLLECT ACTIVITY-LEVEL DATA																	
CONDUCT EVALUATIONS & SPECIAL STUDIES																	
REVIEW PERFORMANCE INFORMATION																	
REPORT PERFORMANCE RESULTS																	

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PERFORMANCE MANAGEMENT TASKS	FY 2004				FY 2005				FY 2006				FY 2007				Notes
	Q1	Q2	Q3	Q4													
ASSESS DATA QUALITY																	
REVIEW & UPDATE PMP																	

Worksheet 10: Evaluations and Special Studies Planning

Use this worksheet during a facilitated discussion with the PMP development team to determine whether and when evaluations and special studies might be conducted during the life of the SO. A completed version of this worksheet can be found in Part 2, Task 6.3 of the Toolkit.

Evaluation/Study Subject	When	Key Research Question(s)

Worksheet 11: Evaluation Scope of Work (SOW) Planning

Use this worksheet as soon as the SO team has determined that an evaluation should take place in the near future. Reviewing this list of questions will help formulate a well-developed SOW.

PLANNING ELEMENTS	DESCRIPTION
What is the activity or strategy being evaluated?	
Provide a brief background on the implementation.	
What are existing performance information sources?	
What is the purpose of the evaluation?	
Who is the audience for the evaluation?	
How will the evaluation be used?	
What are the key evaluation questions?	
What evaluation methods will be used to answer the evaluation questions?	
What is the proposed composition of the evaluation team?	
What customers, partners, or stakeholders will participate in the evaluation?	
What is the schedule for the evaluation?	
What logistics are necessary for the evaluation?	
What are requirements for reporting and dissemination of the evaluation?	
What is the budget for the evaluation?	

Appendix C: Resources on the Internet and Toolkit CD

Almost all of the following resources are available on the Toolkit CD. Direct website addresses are also provided for direct downloading and printing from the Internet.

General Performance Management

Title	Internet Location
1. ADS Chapter 200	www.usaid.gov/pubs/ads/200/200.pdf
2. ADS Chapter 201	www.usaid.gov/pubs/ads/200/201.pdf
3. ADS Chapter 202	www.usaid.gov/pubs/ads/200/202.pdf
4. ADS Chapter 203	www.usaid.gov/pubs/ads/200/203.pdf
5. Conducting Group Interviews in Developing Countries (USAID report #PN-AAL-088, 1987)	www.dec.org/pdf_docs/PNAAL088.pdf
6. Database of "Development Experience Clearinghouse"	www.dec.org (a website of resources, not a single document)
7. Database of R4s and Annual Reports	www.dec.org/partners/pmdb/ (a website of resources, not a single document)
8. Dialogue about ADS Programming Policies	www.USAIDResults.org (click on Town Hall) (a website of resources, not a single document)
9. Economic and Social Data Services	http://cdie.usaid.gov (internal USAID only) (a website of resources, not a single document)
10. Evaluation Manual – Evaluating Operations Research Utilization: Guidelines for Assessing Process and Impact (USAID report #PNACR627, 2001)	www.dec.org/pdf_docs/PNACR627.pdf
11. Evaluation Methods: Looking at Results in a Reengineered USAID. USAID Evaluation News, 1995, Washington, DC	Not available on the Internet
12. Legal and Policy Considerations When Involving Partners and Customers on Strategic Objective Teams and Other Consultations	www.usaid.gov/pubs/ads/200/2016s1.doc
13. Measuring Capacity Building. March 2001, MEASURE Evaluation	www.cpc.unc.edu/measure/publications/special/capacity_building.pdf
14. Monitoring & Evaluation: Some Tools, Methods & Approaches (World Bank report #24614, 2002)	http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2002/09/06/000094946_0208290405451/Rendered/PDF/multi0page.pdf
15. Performance Management Toolkit (including worksheets)	www.USAIDResults.org (click on Tools)

Title	Internet Location
16. Performance Monitoring Indicators Handbook (World Bank report #WTP334, 1996)	http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/1996/09/01/000009265_3961219094954/Rendered/PDF/multi_page.pdf
17. Rapid, Low-Cost Data Collection Methods for A.I.D. (USAID report #PNAAL100, 1987)	www.dec.org/pdf_docs/PNAAL100.pdf
18. Research and Reference Services	http://cdie.usaid.gov (internal USAID only) (a website of resources, not a single document)
19. TIPS No. 1: Conducting a Participatory Evaluation (1996)	www.dec.org/pdf_docs/PNABS539.pdf
20. TIPS No. 2: Conducting Key Informant Interviews	www.dec.org/pdf_docs/PNABS541.pdf
21. TIPS No. 3: Preparing an Evaluation Scope of Work (1996)	www.dec.org/pdf_docs/PNABY207.pdf
22. TIPS No. 4: Using Direct Observation Techniques	www.dec.org/pdf_docs/PNABY208.pdf
23. TIPS No. 5: Using Rapid Appraisal Methods (1996)	www.dec.org/pdf_docs/PNABY209.pdf
24. TIPS No. 6: Selecting Performance Indicators (1996)	www.dec.org/pdf_docs/PNABY214.pdf
25. TIPS No. 7: Preparing a Performance Monitoring Plan (1996)	www.dec.org/pdf_docs/PNABY215.pdf
26. TIPS No. 8: Establishing Performance Targets (1996)	www.dec.org/pdf_docs/PNABY226.pdf
27. TIPS No. 9: Conducting Customer Service Assessments (1996)	www.dec.org/pdf_docs/PNABY227.pdf
28. TIPS No. 10: Conducting Focus Group Interviews (1996)	www.dec.org/pdf_docs/PNABY233.pdf
29. TIPS No. 11: Role of Evaluation in USAID (1997)	www.dec.org/pdf_docs/PNABY239.pdf
30. TIPS No. 12: Guidelines for Indicator and Data Quality (1998)	www.dec.org/pdf_docs/PNACA927.pdf
31. TIPS No. 13: Building a Results Framework (2000)	www.dec.org/pdf_docs/PNACA947.pdf
32. TIPS No. 14: Monitoring the Policy Reform Process (2000)	www.dec.org/pdf_docs/PNACA949.pdf
33. TIPS No. 15: Measuring Institutional Capacity (2000)	www.dec.org/pdf_docs/PNACG612.pdf ; Annexes available at www.dec.org/pdf_docs/PNACG624.pdf
34. View from USAID [on Performance Measurement, Evaluation and Results-Based Management] (USAID report #PCAAB083)	www.dec.org/pdf_docs/PCAAB083.pdf

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Title	Internet Location
35. Health and Family Planning Indicators: A Tool for Results Frameworks, Vol. I (USAID report #PNACM806, 1999)	www.dec.org/pdf_docs/PNACM806.pdf
36. Health and Family Planning Indicators: Measuring Sustainability, Vol. II (USAID report #PNACE795, 1999)	www.dec.org/pdf_docs/PNACE795.pdf
37. Applications of GIS Technology to Disease Control. Gregory Glass et al. Baltimore: Johns Hopkins University, 1993	Not available on the Internet
38. Assessing the Health of the Poor: Towards a Pro-Poor Measurement Strategy. Ian Diamond, Zoe Matthews, and Rob Stephenson. London: DFID, 2001	Not available on the Internet
39. "Case Definitions for Public Health Surveillance," <i>Morbidity and Mortality Weekly</i> , Vol. 39, No. RR-13, Oct. 19, 1990	www.cdc.gov/mmwr/preview/mmwrhtml/00025629.htm
40. Evaluating Health Projects: Lessons from the Literature. Susan Stout, et al. Washington, DC: The World Bank, 1997	Not available on the Internet
41. "Guidelines for Evaluating Surveillance Systems," <i>Morbidity and Mortality Weekly</i> , Vol. 37, No. S-5, May 6, 1988	www.cdc.gov/mmwr/preview/mmwrhtml/00001769.htm
42. Health Manager's Guide: Monitoring the Quality of Primary Care. Bruno Bouchet. 2000. (USAID report #PNACK584)	www.dec.org/pdf_docs/PNACK584.pdf
43. Health Manager's Guide: Monitoring the Quality of Hospital Care. (USAID report #PNACL794)	www.dec.org/pdf_docs/PNACL794.pdf
44. Health Manager's Toolkit	http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=toolkit&language=English (a website of resources, not a single document)
45. Impact of Community Level Variables on Individual Level Outcomes: Theoretical Results and Demographic Applications (USAID report #PNACQ362, 2002)	www.dec.org/pdf_docs/PNACQ362.pdf
46. Malaria Control/Roll Bank Malaria Programme. A. Kabore, Y. Kassnakogno, and E. A. Afari. Harare: WHO/AFRO, December 2001	Not available on the Internet
47. Measuring Results of Health Sector Reform for System Performance: A Handbook of Indicators. Partnerships for Health Reform. Abt Associates, Bethesda, MD, 1997. (USAID report #PNACH329)	www.dec.org/pdf_docs/PNACH329.pdf

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Title	Internet Location
48. Monitoring Population and Health Program Efforts with Composite Indices (MEASURE <i>Evaluation Bulletin</i> , No. 3, USAID report #PNACN324, 2001)	www.dec.org/pdf_docs/PNACN324.pdf
49. "Performance Measurement: Problems and Solutions," David Eddy. <i>Health Affairs</i> , Vol. 17, #4, July/August, 1998	www.healthaffairs.org/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v17n4/s2.pdf
50. USAID Pillar Bureau for Global Health	www.usaid.gov/our_work/global_health/ (a website of resources, not a single document)
51. Workshop on Health Impact Evaluation: A Review of Methodological Approaches to Evaluating Health Programs (USAID report #PNABB440, 1986)	Not available on the Internet

Child Survival and Maternal Health

Title	Internet Location
52. Assessment of the Quality of National Child Immunization Coverage Estimates in Population-Based Surveys (USAID report #PNACQ365, 2002)	www.dec.org/pdf_docs/PNACQ365.pdf
53. Compendium of Child Survival Monitoring and Evaluation Tools	www.cpc.unc.edu/measure/techassist/tools_methods/inventory/inventory.html (a website of resources, not a single document)
54. Every Death Counts: Measurement of Maternal Mortality Via a Census (USAID report #PNACQ378, 2001)	www.dec.org/pdf_docs/PNACQ378.pdf
55. IMCI: An Integrated Approach to Child Health Within the Context of Early Child Care for Survival, Growth, and Development (ECC-SGD) Strategy: A Draft Framework for Discussion	Not available on the Internet
56. Is Estimating Maternal Mortality Useful? (USAID report #PNACQ379, 2001)	www.dec.org/pdf_docs/PNACQ379.pdf
57. Measuring Maternal Mortality from a Census: Guidelines for Potential Users (USAID report #PN-ACM-125, 2001)	www.dec.org/pdf_docs/PNACM125.pdf
58. Monitoring and Evaluation of Nutrition and Nutrition-Related Programmes: A Training Manual for Programme Managers and Implementers (USAID report #PNACK247, 2000)	www.dec.org/pdf_docs/PNACK247.pdf
59. "Monitoring and Evaluation: Tools for Improving Child Health and Survival," <i>BASICS Quarterly Technical Newsletter</i> , Spring 1998, #5	Not available on the Internet
60. Tool for the Assessment of Injection Safety. (USAID report #PNACN797)	www.dec.org/pdf_docs/PNACN797.pdf

Title	Internet Location
61. Toolkit for Monitoring and Evaluating Breastfeeding Practices and Programs (USAID report #PNABZ581, 1996)	Not available on the Internet

HIV/AIDS

Title	Internet Location
62. Collaborative Approach to Reviewing HIV/AIDS Strategies (ADS 201 Mandatory reference)	www.usaid.gov/policy/ads/200/200max.pdf
63. Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A Handbook for Program Managers and Decision Makers	www.fhi.org/en/aids/impact/impactpdfs/evaluationhandbook.pdf
64. Expanded Response Guide to Core Indicators for Monitoring and Reporting on HIV/AIDS Programs (USAID report # PN-ACS-452, 2003)	www.dec.org/pdf_docs/PNACS452.pdf
65. Handbook of Indicators for HIV/AIDS/STI Programs (USAID report #PNACK416, 2000)	www.dec.org/pdf_docs/PNACK416.pdf
66. Implementation of the Declaration of Commitment on HIV/AIDS: Core Indicators (UNAIDS pamphlet, 2001)	www.unaids.org/UNGASS/docs/JC895-LeafletCoreInd_en.pdf
67. Indicators for Monitoring and Evaluation of AIDS Programs. MEASURE <i>Evaluation</i> Bulletin, 2001, No. 2 (USAID report #PNACN335, 2001). Contains multiple articles, including the one listed below:	www.dec.org/pdf_docs/PNACN335.pdf and
68. Developing Survey-Based Indicators For National AIDS Programmes: UNAIDS/MEASURE Evaluation Indicator Field Test Group. MEASURE <i>Evaluation</i> Bulletin, 2001, No. 2 (USAID report #PNACM547, 2001)	www.dec.org/pdf_docs/PNACM547.pdf
69. List of Resources Available Through UNAIDS	www.unaids.org/publications/order.html (a website of resources, not a single document)
70. Monitoring the AIDS Epidemic Using HIV Prevalence Data Among Young Women Attending Antenatal Clinics: Prospects and Problems (USAID report #PNACJ195, 2000)	www.dec.org/pdf_docs/PNACJ195.pdf
71. Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators (UNAIDS report #02.51E, 2002)	www.unaids.org/UNGASS/docs/JC894-CoreIndicators_en.pdf
72. National AIDS Councils: Monitoring and Evaluation Operations Manual (UNAIDS report # 02.47E, revised report 2002)	www.unaids.org/publications/documents/epidemiology/surveillance/JC808-MonEval_en.pdf
73. National AIDS Programmes: A Guide to Monitoring and Evaluation (UNAIDS report #00.17E, 2000)	www.unaids.org/publications/documents/epidemiology/surveillance/JC427-Mon&Ev-Full-E.pdf

Title	Internet Location
74. Technical Notes on HIV/AIDS and Education: Africa Bureau Suggested Indicators for HIV/AIDS Mitigation and Prevention Activities in Education	Not available on the Internet
75. UN Agency for AIDS	www.unaids.org (a website of resources, not a single document)

Population and Reproductive Health

Title	Internet Location
76. Framework to Identify Gender Indicators for Reproductive Health and Nutrition Programming (USAID report #PNACR626, 2002)	www.dec.org/pdf_docs/PNACR626.pdf
77. Health, Nutrition, and Population Indicators: A Statistical Handbook (World Bank report #18772, 1998)	http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2000/02/24/000094946_9903040625509/Rendered/PDF/multi_page.pdf
78. Investing in Population, Health and Nutrition Monitoring and Evaluation: Lessons Learned (MEASURE <i>Evaluation</i> Bulletin, 2003, No. 5), in six separate articles	Article 2 = www.cpc.unc.edu/measure/publications/bulletins/bulletin5/article2.pdf Article 3 = www.cpc.unc.edu/measure/publications/bulletins/bulletin5/article3.pdf
79. Management and Organizational Sustainability Tool (MOST): A Guide for Users and Facilitators. (USAID report #PNACJ622)	www.dec.org/pdf_docs/PNACJ622.pdf
80. Measuring Family Planning Sustainability at the Outcome and Program Levels (USAID report #PNACQ366, 2002)	www.dec.org/pdf_docs/PNACQ366.pdf
81. Monitoring Quality of Care in Family Planning by the Quick Investigation of Quality (QIQ): Country Reports. Chapel Hill: MEASURE <i>Evaluation</i> Technical Report Series No. 5 (USAID Report #PNACM158, 2000)	www.dec.org/pdf_docs/PNACM158.pdf
82. Monitoring Quality of Care in Family Planning: A Comparison of Observation and Client Exit Interviews. Ruth E. Bessinger and Jane T. Bertrand. MEASURE <i>Evaluation</i> Working Paper Series No. WP-00-27, Dec. 2000. (USAID report #PNACM167)	www.dec.org/pdf_docs/PNACM167.pdf
83. Monitoring the Quality of Care In Family Planning (MEASURE <i>Evaluation</i> Bulletin, No. 1 (USAID report #PN-ACN-334, 2000)	www.dec.org/pdf_docs/PNACN334.pdf
84. More Evils of CYP. Commentary in Studies in Family Planning, Vol. 27, No. 4	Not available on the Internet

Title	Internet Location
85. Pocketbook of Family Planning and Reproductive Health Indicators for Program Design and Evaluation (USAID report #PNACG519, 1998)	www.dec.org/pdf_docs/PNACG519.pdf
86. Quick Investigation of Quality (QIQ): A User's Guide for Monitoring Quality of Care in Family Planning. MEASURE <i>Evaluation</i> Manual Series, No. 2, Feb. 2001 (USAID report #PNACM124, 2001)	www.dec.org/pdf_docs/PNACM124.pdf
87. Sampling Manual for Facility Surveys for Population, Maternal Health, Child Health and STD Programs in Developing Countries. MEASURE <i>Evaluation</i> Manual Series, No. 3, July 2001	www.cpc.unc.edu/measure/publications/manuals/facility.pdf
88. Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services (a handbook), Robert Miller et al. USAID and The Population Council. (USAID report # PN-ACA-451)	Not available on the Internet
89. Target-Cost: A Model for Projecting the Family Planning Service Requirements and Costs to Achieve Demographic Goals. Glastonbury: The Futures Group (1994)	Not available on the Internet
90. Training Workshop for Monitoring and Evaluation of Population, Health and Nutrition Programs.	www.cpc.unc.edu/measure/publications/manuals/training_manual/notes.pdf AND www.cpc.unc.edu/measure/publications/manuals/training_manual/appendix.pdf

Resources Included in Toolkit CD

The compact disk (CD) accompanying this Toolkit includes electronic copy of nearly all the reference documents listed above. The following resources are also included:

Title	Internet Location
91. Sample PMP A	Not available on the Internet
92. Sample PMP B	Not available on the Internet
93. Toolkit Worksheets	Not available on the Internet

Appendix D: Data Quality Limitations of Frequently Used Indicators

Total Fertility Rate (TFR)

DESCRIPTION
Precise Definition(s): The average number of children that would be born per woman if all women were to pass through the childbearing years bearing children according to the current schedule of age-specific fertility rates.
Unit of Measure: Number of children per 1,000 women
Disaggregated by: Not applicable
Justification & Management Utility: The TFR is the most widely used fertility measure in program impact evaluations because it provides an easily understandable measure of hypothetically completed fertility. These data can be presented to inform the Agency of the trends in the reproductive health sector and can place the country's health program in the development context of the region and the continent.
DATA QUALITY ISSUES
Known Data Limitations and Significance (if any): Data for this indicator is usually obtained from the population based Demographic and Health Surveys (DHS) or Reproductive Health Surveys (RHS, from the CDC). See Appendix D of this Toolkit for description of DHS approach to data quality.
Actions Taken or Planned to Address Data Limitations: Contractor will address and provide an analysis of the data quality issues faced in the current survey and will rectify these issues in the subsequent survey.

Under 5 Mortality Rate (U5MR)

DESCRIPTION
Precise Definition(s): Number of deaths among children under age 5 in a given year per 1,000 live births in that same year. U5MR refers to deaths by age 5 per 1,000 live births, whereas child mortality refers to deaths by age 5 per 1,000 children who survived the first year of life (i.e., mortality among children ages 1–4)
Numerator: The number of deaths among children under age 5 in that specified year
Denominator: Total number of children under age 5 in that specified year
Unit of Measure: Number of deaths per 1,000 live births
Disaggregated by:
Justification & Management Utility: U5MR may indicate program impact more comprehensively than infant mortality rate (IMR) because it reflects results of child survival interventions focused on reducing mortality among infants, as well as those that have the highest impact during the second and third year of life.
Notes on Target Setting: Generally speaking, the higher a country's U5MR, the more one can hope to reduce it. Targets should be set with consideration for the size of the program and the types of interventions to be supported.
DATA QUALITY ISSUES
Known Data Limitations and Significance (if any): Unlike TFR, U5MR is not a very precise measure of program impact because of the strong influence of other contributing factors such as economic conditions or food supply. If data is from DHS, see the description of the DHS approach to data quality in Appendix D of this Toolkit.
Actions Taken or Planned to Address Data Limitations: If the USAID program is not national, be careful in analyzing the relationship between program activities and national population-wide trends.

HIV Seroprevalence Rate

DESCRIPTION
<p>Precise Definition(s): The percentage of blood samples taken from young men and young women aged 15–24 years who test positive for HIV during household survey (DHS)</p> <p>Numerator: The number of blood samples taken from young men and young women aged 15–24 years who test positive for HIV</p> <p>Denominator: Total number of men and women aged 15–24 years surveyed and tested</p> <p>Unit of Measure: Percentage</p> <p>Disaggregated by: Urban/rural, male/female</p> <p>Justification & Management Utility: This indicator gives a good idea of relatively recent trends in HIV infection nationwide in countries where the epidemic is heterosexually driven. Confining this indicator to men and women under the age of 25 years aims to give a picture of recent trends in infection. Most infections in this group are relatively new, and data from these younger men and women are also less subject to bias than data from the whole reproductive age span.</p>
DATA QUALITY ISSUES
<p>Known Data Limitations and Significance (if any): Data for this indicator is usually obtained from the population based surveys such as the Demographic and Health Surveys (DHS), Reproductive Health Surveys (RHS, from the CDC), behavioral surveillance surveys, or the Integrated STD/HIV and Behavioral Survey (ISBS). See Appendix D of this Toolkit for description of DHS approach to data quality.</p> <p>Actions Taken or Planned to Address Data Limitations:</p>

Contraceptive Use

DESCRIPTION
<p>Precise Definition(s): Percentage of women of reproductive age (15–49 years) who are using (or whose partner is using) a modern method of contraception at the time of the survey</p> <p>Numerator: Number of women of reproductive age (15–49 years), married or in union, using a modern contraceptive method</p> <p>Denominator: Total number of women of reproductive age (15–49 years), married or in union, surveyed</p> <p>Unit of Measure: Percentage</p> <p>Disaggregated by: Type of method</p> <p>Justification & Management Utility: The contraceptive prevalence rate provides a measure of population coverage of contraceptive use, taking into account all sources of supply and all contraceptive methods. It is the most widely reported measure of outcome for family planning programs at the population level.</p>
DATA QUALITY ISSUES
<p>Known Data Limitations and Significance (if any): Data for this indicator is usually obtained from the population based Demographic and Health Surveys (DHS) or Reproductive Health Surveys (RHS, from the CDC). See Appendix D of this Toolkit for description of DHS approach to data quality.</p> <p>Actions Taken or Planned to Address Data Limitations: Triangulate data by interpreting them with other data sources, especially data pertaining to USAID-assisted subpopulations. Present trends in the data, rather than interpreting one data point. Contractor will address and provide an analysis of the data quality issues faced in the current survey and will address them in subsequent survey. CYP will be used as a proxy indicator in off years.</p>

Condom Use at Last Risky Sexual Encounter

DESCRIPTION
Precise Definition(s): The proportion of young people (15-24) who report using a condom at last sex with a non-marital, non-cohabiting partner in the past 12 months
Numerator: The number of respondents aged 15-24 who report that they used a condom the last time they had sex with a non-marital, non-cohabiting partner in the past 12 months
Denominator: Total number of respondents aged 15-24 who report that they had sex with a non-marital, non-cohabiting partner in the past 12 months
Unit of Measure: Percentage
Disaggregated by: male/female, by age grouping 15-19, and 20-24
Justification & Management Utility: If everyone used condoms every time he or she had sex with a non-marital, non-regular sex partner, a heterosexual HIV epidemic would be almost impossible to sustain. This indicator includes in the denominator all young people having sex with a non-marital, non-cohabiting partner, thus, it is able to capture the sexual behavior of younger people both in and out of what may be considered stable or regular relationships.
DATA QUALITY ISSUES
Known Data Limitations and Significance (if any): This indicator does not measure consistent use. Because this indicator is derived from self-reported data (such as BSS or ISBS), a bias might be introduced by respondents answering in the affirmative because of a desire to please the interviewer.
Actions Taken or Planned to Address Data Limitations: Present the trends in data (when available), rather than interpreting one data point.

Total Condom Sales

DESCRIPTION
Precise Definition(s): The total number of condoms sold by the social marketing program financed by your Mission
Unit of Measure: Number of condoms
Disaggregated by: Urban/rural
Justification & Management Utility: This indicator measures the sales trends of the social marketing program funded by USAID. Increased numbers indicate a positive trend.
DATA QUALITY ISSUES
Known Data Limitations and Significance (if any): It is assumed that sales of condoms will mean that the condoms are used and used correctly. Self-reported distribution data could be open to bias and misreporting.
Actions Taken or Planned to Address Data Limitations: Perform an independent assessment of the sales (in national, regional, and retail sites) to validate the sales numbers provided to USAID. Visit retail outlets supplied by the social marketing contractor and do spot-checks on stocks and sales data.

Couple Years of Protection (CYP)

DESCRIPTION
Indicator: Estimated couple years of protection against pregnancy provided by family planning services during a period of one year.
Precise Definition(s): <ul style="list-style-type: none"> • <i>Couple years of protection (CYP)</i> is based upon the volume of all contraceptives sold or distributed to clients during that year. CYP is calculated by applying a conversion factor to the quantity sold of each method, which yields the estimated overall protection (in couple years) from all methods combined. • <i>Family planning services</i> are defined in the CYP methodology each have conversion factors, as follows: oral contraceptives, 15 cycles per CYP; IUD, 3.5 per IUD inserted; Norplant implant, 3.5 per implant; condoms, 120 units per CYP; vaginal foaming tablets, 120 tablets per CYP; sterilization, 9 CYP per sterilization procedure; Depo-Provera (injectable), 4 "doses" (1 ml) per CYP.
Unit of Measure: Number of CYPs
Disaggregated by: Contraceptive Method
Justification & Management Utility: CYP measures the volume of program activity. Program managers use it to monitor progress in the delivery of contraceptives services. The advantage of this indicator is that it can be calculated from data routinely collected from all different service delivery mechanisms (clinics, community based distribution programs, social and commercial marketing).
DATA QUALITY ISSUES
Known Data Limitations and Significance (if any): When used as a proxy for CPR, CYP assumes that the contraceptives sold or distributed will be used. Additionally, one cannot ascertain the number of individuals represented by CYP. (For example, one woman could have 13 cycles of protection, or 13 women could each have one cycle of protection.)
Actions Taken or Planned to Address Data Limitations: To deal with the bias introduced because of self-reporting, the Mission could perform an independent assessment of the sales (in national, regional, and retail sites) to validate the sales numbers provided to USAID. The Mission could also visit retail outlets supplied by the social marketing contractor and do spot-checks on stocks and sales data.

Nutritional Status of Children

DESCRIPTION
Precise Definition(s): Percentage of children aged 12–23 months whose weight is more than two standard deviations below the median weight achieved by children of that age <ul style="list-style-type: none"> • Numerator: Number of children aged 12–23 months whose weight is more than two standard deviations below the median weight achieved by children of that age • Denominator: Total number of children aged 12–23 months surveyed
Unit of Measure: Percentage
Disaggregated by: male/female
Justification & Management Utility: Weight for age (WFA) is a measure of stunting and is generally accepted to be one of the best general indicators of the health status of a population. It is responsive to a number of factors, including the economy, food availability, and the quality and quantity of health service provision. It is generally the most commonly available indicator for national and international comparisons of nutritional status.
DATA QUALITY ISSUES
Known Data Limitations and Significance (if any): There may be some level of variability between interviewers performing the task of weighing. The validity of the indicator also depends on the accuracy of the weighing instruments and the caretaker's ability to report the correct age of the child. While the accepted standard worldwide is the use of weight-for-age as the long-term outcome of child nutrition and growth promotion programs, this indicator does measure growth faltering, an early sign of health and nutrition problems.
Actions Taken or Planned to Address Data Limitations: Variability in measurement can be reduced through quality training. The training program should include the weighing and measuring of real children.

DPT3 Coverage

DESCRIPTION
<p>Precise Definition(s): Proportion of children under one year of age who received three complete doses of DPT (diphtheria, pertussis, and tetanus) vaccine before age 12 months</p> <p>Numerator: Number of children aged 12–23 months who received three doses of DPT vaccine before age 12 months</p> <p>Denominator: Total number of children aged 12–23 months surveyed</p>
<p>Unit of Measure: Percentage</p>
<p>Disaggregated by: Male/female, Urban/rural;</p>
<p>Justification & Management Utility: This indicator is the best measure of use of services and also serves as a proxy for full immunization coverage. It is helpful in validating the routine reporting system and is an important indicator to measure the incremental progress of the immunization program in-country.</p>
DATA QUALITY ISSUES
<p>Known Data Limitations and Significance (if any): This indicator does not take into account the timeliness of each of the doses of DPT or the interval between the doses.</p>
<p>Actions Taken or Planned to Address Data Limitations: Often the USAID program cannot affect the data quality issues; be cautious in including this data in program reports.</p>

Oral Rehydration Therapy Use

DESCRIPTION
<p>Precise Definition(s): The proportion of children aged 0–59 months with diarrhea in the past two weeks who were treated with oral rehydration salts and/or recommended home fluids and/or increased fluids</p> <p>Numerator: Number of children aged 0–59 months with diarrhea in the past two weeks who received oral rehydration salts and/or recommended home fluids and/or increased fluids</p> <p>Denominator: Number of children aged 0–59 months surveyed who had diarrhea in the past two weeks</p> <p>The definition of diarrhea is three or more loose or watery stools during a 24-hour period. Oral rehydration salts (ORS) are a balanced mixture of glucose and electrolytes for use in treating and preventing dehydration, potassium depletion, and base deficit due to diarrhea. When ORS are dissolved in water, the mixture is called ORS solution. A government-recommended homemade fluid may be a cereal-based mixture, or it may include soups and other fluids, including plain water.</p>
<p>Unit of Measure: Percentage</p>
<p>Disaggregated by: Male/female, Urban/rural; type of treatment received</p>
<p>Justification & Management Utility: This indicator measures both behavior change and the program performance of the diarrheal disease control program. Diarrhea is the principal cause of death of many children in developing countries. Diarrhea-related deaths are caused by dehydration produced by acute watery diarrhea. The basic principle of home management of diarrhea is to prevent dehydration by increasing fluid intake with oral rehydration fluid or government-recommended fluids as soon as the episode of diarrhea starts.</p>
DATA QUALITY ISSUES
<p>Known Data Limitations and Significance (if any): The indicator does not capture timely treatment of diarrhea; that is, whether oral rehydration therapy was provided as soon as the episode of diarrhea started.</p>
<p>Actions Taken or Planned to Address Data Limitations: Ensure that the surveys are conducted at the same time every two years to avoid data variations due to the rainy season, when there might be a greater presentation of diarrhea cases.</p>

Vitamin A Supplementation

DESCRIPTION
<p>Precise Definition(s): Proportion of children aged 12–59 months who received a high dose of Vitamin A in the past 6 months</p> <p>Numerator: Number of children aged 12–59 months who received a high dose of Vitamin A in the past 6 months</p> <p>Denominator: Total number of children aged 12–59 months surveyed</p> <p>Doses are set by national MOH following the WHO guidelines. The average of the two Vitamin A campaigns carried out during the year will form the basis of this indicator.</p>
<p>Unit of Measure: Percentage</p>
<p>Disaggregated by: female/male</p>
<p>Justification & Management Utility: This indicator measures the coverage achieved through the national Vitamin A program effort in a specified period. Supplementation is the most immediate and direct approach in improving Vitamin A status and the most widely implemented. During the first six months of life, exclusively breast-fed infants can obtain adequate amounts of Vitamin A from the mother's breast milk, if the mother herself is not Vitamin A deficient. A high-dose supplement of Vitamin A (200,000 IU) protects against Vitamin A deficiency for 4–6 months; therefore, in order to receive full protection, children should receive Vitamin A supplementation twice a year. If not, they will again become subject to the risks of increased infection (especially measles and diarrhea), corneal scarring, and increased mortality.</p>
DATA QUALITY ISSUES
<p>Known Data Limitations and Significance (if any): This indicator is a coverage indicator and does not provide any information on the prevalence of Vitamin A deficiency. Because the quality of health statistics can vary among facilities, indicators calculated from service statistics may be less accurate than those based on survey data in places where the quality of routine data are poor.</p>
<p>Actions Taken or Planned to Address Data Limitations: Data for this indicator is usually obtained from the population based Demographic and Health Surveys (DHS) designed to adhere to the principles underlying the collection and processing of high-quality data and meet the ADS criteria for data quality. Should program data be used, data quality assessments should be carried out.</p>

Exclusive Breast-Feeding Rate

DESCRIPTION
<p>Precise Definition(s): Proportion of infants aged less than 6 months who were exclusively breast-fed in the past 24 hours</p> <p>Exclusive breast-feeding is the practice of giving only breast milk to the infant, with no other solids or liquids, including water. Infants are, however, allowed to have drops of vitamins/minerals/medicines.</p> <p>Numerator: Number of infants aged less than 6 months (less than 180 days) who were exclusively breast-fed in the past 24 hours</p> <p>Denominator: Total number of infants aged less than 6 months (less than 180 days) surveyed</p>
<p>Unit of Measure: Percentage</p>
<p>Disaggregated by: Gender. The rate of exclusive breast-feeding, if disaggregated by sex, can be an indication of whether gender bias exists in the country. In India, women more often discontinue breast-feeding of daughters in the first six months as compared with sons. Discontinuation of exclusive breast-feeding is one of several factors ultimately contributing to a lower female/male sex ratio in India as compared with countries where son preference is not evident.</p>
<p>Justification & Management Utility: This indicator gives an overall measure of the degree to which women have adopted behaviors consistent with the recommendation that infants aged 0–6 months should be breast-fed. Relative to infants who are exclusively breast-fed, infants not breast-fed at all have at least 14 times the risk of death due to diarrhea. The risk is greatest in the first two months of life (Murray et al., 1997). Even the introduction of herbal teas to water to infants who have been exclusively breast-fed increases the risks of diarrheal morbidity and death.</p>
DATA QUALITY ISSUES
<p>Known Data Limitations and Significance (if any): Indicators of current breast-feeding practices can be relatively easily measured and are sensitive to changes resulting from program activities. Because USAID, UNICEF, and WHO endorse 6 months as the recommended period for exclusive breast-feeding, a variation of this indicator that monitors the full 6-month period is recommended as a common indicator for USAID programs in both child survival and family planning. Monitoring use of exclusive breast-feeding 0–3 months, however, is far more sensitive to program impact because rates among children aged 4–6 months tend to remain very low, even in countries with very active promotion of breast-feeding.</p>
<p>Actions Taken or Planned to Address Data Limitations: Missions supporting breast-feeding promotion programs may also wish to monitor the proportion of children exclusively breast-fed at different age periods (e.g., 0–1 month, 2–3 months, 4–6 months).</p>

Pregnant Women Receiving Intermittent Presumptive Treatment of Malaria

DESCRIPTION
<p>Precise Definition(s): The percentage of women who were given or who purchased malaria medication, according to national policy, during their most recent pregnancy.</p> <p>Numerator: Number of pregnant women who received (given or purchased) intermittent treatment for malaria</p> <p>Denominator: All pregnant women surveyed</p> <p>Unit of Measure: Percentage</p> <p>Disaggregated by: Urban/rural, public/private, and trimester of pregnancy</p> <p>Justification & Management Utility: It measures a key preventive service for malaria (Intermittent Presumptive Treatment) that increases the risk of maternal anemia, prematurity, and low birth weight, especially during a woman's first pregnancy. Recent studies show that in highly endemic areas, intermittent treatment with an efficacious single-dose antimalarial medication is safe and effective and can be delivered in the context of existing antenatal care services.</p>
DATA QUALITY ISSUES
<p>Known Data Limitations and Significance (if any): The indicator does not address the completeness of the drug regimen taken during pregnancy. In addition to determining the type of malaria medication taken, information on the frequency and timing of drug administration is required to determine whether pregnant women are adequately protected against malaria. Facility records measure the proportion of women given or prescribed medication, but does not reflect the proportion of women who took the medication.</p> <p>Actions Taken or Planned to Address Data Limitations: Clinics should maintain records on the numbers of patients attending and on the number of women given first, second, and third courses of presumptive intermittent treatment or the number of packets of chloroquine dispensed.</p>

Use of Insecticide-Treated Bed Nets

DESCRIPTION
<p>Name of Indicator: Percentage of vulnerable population who report having slept under an insecticide-treated bed net the previous night.</p> <p>Precise Definition(s):</p> <ul style="list-style-type: none"> • <i>Vulnerable population</i> means pregnant women and children under 5 years • Denominator: Total vulnerable population surveyed (or counted as part of the survey, in the case of children under five whose mothers were surveyed in their place) <p>Unit of Measure: Percentage</p> <p>Disaggregated by: Urban/rural; pregnant women and children under five</p> <p>Justification & Management Utility: This indicator measures the utilization of insecticide-treated bed nets—a key strategy for malaria prevention programs.</p>
DATA QUALITY ISSUES
<p>Known Data Limitations and Significance (if any): Because the prevalence of malaria-carrying mosquitoes varies seasonally, use of bed nets may follow a similar seasonal pattern. In evaluating trends in the use of insecticide-treated bed nets, attention should be paid to the time of the year in which the surveys were conducted in order to clarify whether estimates of bed net use reflect levels during the peak or low malaria season.</p> <p>Actions Taken or Planned to Address Data Limitations: Ensure that the surveys are conducted at the same time during the year to avoid data variations due to malarial seasonality. Household data (available every 2–3 years, but not for the entire geographic zone)</p>

Births Attended by Trained Medical Personnel

DESCRIPTION
Name of indicator: Percentage of births attended by trained health personnel
Precise Definition(s): <ul style="list-style-type: none"> • <i>Trained health personnel</i> include all persons with midwifery skills, including auxiliary health personnel/birth attendants, who can manage normal deliveries and diagnose and refer obstetric complications. Programs promoting delivery by trained TBAs may choose to include them; in such a case, it would be helpful to report two figures (with and without TBAs). • Numerator: Number of births attended by trained medical personnel during the reference period • Denominator: Total number of live births occurring within the reference period
Unit of Measure: Percentage
Disaggregated by:
Justification & Management Utility: Many argue that increasing the proportion of deliveries with a skilled attendant is the single most critical intervention for reducing maternal mortality and therefore improving maternal health status. Moreover, the proportion of births with a skilled attendant is a benchmark indicator for monitoring progress toward the International Conference on Population and Development (ICPD) goals.
DATA QUALITY ISSUES
Known Data Limitations and Significance (if any): In general, births with a skilled attendant are associated with lower rates of maternal mortality. However, confounding factors, such as the strong correlation between skilled attendant and institutional delivery, make assessing the impact of skilled attendant alone difficult to determine.
This indicator uses a birth-based analysis, and the sample will over-represent women with multiple births in the survey period. Women with more than one birth are also more likely to have other risk factors, such as high parity and lower rates of health services use. Delivery coverage may therefore be underestimated, although this underestimate is likely to be small.
Because the denominator includes only women with live births and excludes women with fetal deaths and stillbirths, the only valid association will be with neonatal mortality, and not with perinatal mortality.
Actions Taken or Planned to Address Data Limitations:

Appendix E: DHS Data Quality Assurance Methodology

QUALITY ASSURANCE PROCEDURE IN THE COLLECTION AND PROCESSING OF DEMOGRAPHIC AND HEALTH SURVEY (DHS) DATA

The Demographic and Health Surveys program was designed to adhere to the principles underlying the collection and processing of high quality data. The program has been ongoing for almost 20 years and has become one of the most valuable sources of survey data that are used in the population, health and nutrition (PNH) sector from less developed countries. Since 1984, about 150 nationally representative surveys have been collected in about 70 countries across Africa, Asia, Latin America and Eastern Europe. Although no survey data is completely error-free, over the years, DHS data are highly regarded and considered to be “as good as it gets” in precision and in aggregate reliability over time. The surveys are processed and data are released on a timely basis, the questionnaires are designed to show both content and face validity, and the collection of the data is handled by an independent contractor to ensure objectivity in the finding, and the generation of data that is not affected by political or programmatic preferences.

In the section that follows, the procedures that are followed to ensure that DHS data meet the ADS criteria for validity, integrity, precision, reliability and Timeliness is laid out, beginning with the design of the questionnaire.

1. Questionnaire Design

Extensive Multi-layer Vetting and Review: At the beginning of every five-year phase of the DHS project, the model questionnaires and questionnaire modules are extensively revised. This process is both comprehensive and inclusive, involving some of the leading experts in every key area covered by the survey, the USAID Strategic Objective Teams, HPN Cooperating Agencies, international agencies, MEASURE partners, DHS senior advisors, host country governments, and data users. During MEASURE DHS+, for example, DHS held more than 30 separate meetings on the design of the core questionnaires. The DHS international Technical Advisory Group also took part in the review of the questionnaires. This process helped to ensure not only that the important HPN topics and key indicators would be adequately covered, but that the questions would be understandable and meaningful. Results of qualitative studies of questions are also taken into account in the questionnaire design, when available. Although the DHS questionnaires are extensively redesigned every five years, most questions on DHS questionnaires do not change from one round to the next to facilitate the estimation of trends in key indicators over time.

Careful Pretests of Core Questionnaires: Once the core questionnaires have been revised, DHS conducts an extensive pretest in one country. At the end of the pretest, the interviewers and other field staff are debriefed on all aspects of their field experience. Particular emphasis is put on how well respondents understood the questions and whether they misinterpreted any questions or had difficulty in answering them. The core questionnaires are then revised and finalized based on the pretest findings.

Country-by-Country Pretests: A similar review and pretest take place in each country that is conducting a DHS. A local technical advisory committee is formed that typically includes representatives of USAID and other funding agencies, host country government organizations,

USAID Cooperating Agencies, international organizations, universities, and NGOs, including women's groups. Although the technical advisory committee usually meets frequently and makes recommendations on all aspects of the survey, particular emphasis is given to the questionnaire design.

Content Validity of Questions in Local Languages: To further ensure that the questions are well understood by respondents, the questionnaires are translated into all major local languages (including all languages spoken by more than 10 percent of respondents and occasionally other important languages). The translated versions of the questionnaire are independently back-translated by a person who has not seen the original questionnaire, and any differences between the original version and the back-translated version are reconciled. Finally, the questionnaire is pre-tested in all of these languages (in both urban and rural areas, with respondents from different groups and economic classes) and is revised on the basis of the pretest results, including the debriefing with the field staff.

2. Sample Design

Sample designs for DHS surveys are based on the general principles of National Coverage, Probability Sampling, Use of Preexisting Sampling Frames, and Simplicity of Design.

National Coverage: DHS surveys are nationally representative, except in a few cases where small proportions of the population are excluded due to extreme inaccessibility or security problems.

Scientific Sampling and Household Listing Procedure: All DHS surveys require scientific probability sampling (i.e., the units selected have known, non-zero probabilities of selection). Unscientific methods, such as purposive sampling or quota sampling, are never allowed. In the selected enumeration areas, a complete household listing and mapping operation is conducted, although in large enumeration areas these operations may be conducted only in selected segments. DHS surveys do not allow listing, sampling, and interviewing to be conducted in a single operation by interviewers, since experience shows that this type of arrangement can adversely affect the quality of the survey. In every survey, the sample design is carefully documented to allow for the computation of sampling errors, linkage with other data sources, and various kinds of checks and supplementary studies.

3. Field Operations

The quality and integrity of DHS data depend in large measure on the success of the fieldwork. Thus, special emphasis is placed in the DHS program on good fieldwork. The key elements of success are proper training of the field staff and careful monitoring of field operations.

Adequate Training of Fieldworkers: Interviewers and other field staff are trained for a minimum of three weeks. The training includes instruction in interviewing techniques and survey field procedures, a detailed review of each item in the questionnaires, guest lectures (from experts in areas such as family planning, reproductive health, and domestic violence), mock interviews between trainees in the classroom, and practice interviews in the field. DHS headquarters staff are heavily involved in all aspects of training and field operations. Health investigators who weigh and measure women and young children conduct anemia testing, and conduct tests for other biomarkers are extensively trained in their areas of responsibility. Reliability of the measurements they make is checked during the training by requiring the

investigators to conduct multiple tests on the same individual and to obtain consistent results. They are not allowed to begin fieldwork until they can consistently produce reliable results.

Existence of Standardized Training Tools: DHS produces several standard manuals that are used as training and capacity building tools to enhance field operations. They include the Interviewer's Manual, Supervisor's and Editor's Manual, Sampling Manual, Household Listing Manual, Training Manual, Data Processing Manual, and Operations Manual. They also help to ensure that uniform procedures are followed in all surveys.

Multi-layered Quality Control: A unique element of quality control is the requirement that a field editor be attached to each interviewing team. The editor is responsible for fully checking every completed questionnaire in the field, observing selected interviews with each interviewer, and reporting any problems to the field supervisor. The editor and the field supervisor are responsible for randomly making call-backs to make sure that the interviews have been conducted at the right households and to check the validity of the answers to key questions.

Another important component of the DHS quality-control program is the preparation of field-check tables shortly after completed questionnaires start arriving from the field, and approximately every two weeks throughout the course of the fieldwork. These tables are produced for each field team. They are designed to detect at an early stage any unexpected patterns in the data and to provide immediate feedback to the field staff so that improvements can be made quickly. In addition, monitoring of operations in the field is conducted frequently by central office staff of the implementing agency and DHS staff. Completed questionnaires go through several levels of checking in the field and the central office. First, the interviewer is required to check through the entire completed questionnaire before leaving the household to ensure that all answers are legible and that the skip pattern has been followed correctly. Next, the field editor checks the questionnaire while the team is still in the enumeration area so that it is still possible to return to the sample household to collect missed information or correct inconsistencies. Questionnaires are checked again by office editors in the central office before going for data processing.

4. Data Entry and Editing

One Hundred Percent Verification: All DHS data from the questionnaires go through double-entry and 100 percent verification in the central office. The data entry operation is set up by DHS data processing staff, who also monitor the early phases of the operation and ensure that the data quality tables are produced in a timely manner. If any common problems are found to occur at this stage, the information is fed back to the field teams so that errors do not persist.

Good Data Editing Process: The data editing program is designed to catch remaining errors. The program checks for structural errors, out of range values, improper following of the skip pattern on the questionnaire, and inconsistencies in the answers. Inconsistencies that reflect actual errors have to be resolved before proceeding. This is an iterative process that continues until there are no more errors in the data. The final check of the data is during the preparation of the tabulations.

Internal Consistency Checks and Secondary Validation: For all surveys, DHS examines the internal consistency of the data and also compares the results with similar estimates from other data sources.

Periodic Data Quality Assessment: DHS periodically conducts in-depth analyses of data quality. Some of these analyses are published in-house and widely distributed; some are published in peer-reviewed journals; and others are primarily used internally to inform decisions about possible improvements in the questionnaires or field procedures.

Periodic Formal Reliability Tests: DHS also periodically conducts formal reliability tests of the data and special in-depth or experimental surveys which are analyzed with an eye toward making further recommendations for improvements.

Public Data Availability and Transparency: A hallmark of the DHS program is the requirement that data sets from all surveys must be made publicly available. This provides a high degree of transparency, allows independent checks on data quality, and puts the implementing agency on notice that the quality and integrity of the data must be maintained. The various levels of checks described above, and the close monitoring of all survey operations by DHS staff, help to ensure that manipulation of the data does not occur.

5. Objectivity in Reporting

Independence of Source: In the entire history of the DHS program, we have not detected a single instance of manipulation of the data for political or personal reasons. Since DHS is not involved in action programs, DHS is widely viewed as an objective and reliable organization that demands high quality in all operations and has no reason to favor particular results. Data sets are usually available to the public soon after the publication of the national report. In some instances, countries request that data sets not be distributed for some time after the publication of the national report to level the playing field and give local scholars sufficient time to conduct research, or for other reasons. In a few cases, a country prefers to review all outside requests for data sets, but in most cases DHS can distribute data sets freely (and always free of charge) to bona fide users.

Publication of Sampling Errors: Sampling errors for key indicators are published in the appendix of every DHS report so that data users can easily gauge the precision of the estimates. The sampling errors vary, depending on the overall sample size, the sample size for each reporting domain, the size of the denominators for individual indicators, and the variance of the estimates. The precision of the estimates is greatest at the national level and for indicators based on all women or all children. Some of the indicators that typically have relatively high sampling errors are the maternal mortality rate and infant and child mortality rates. For example, for countries in sub-Saharan Africa, the relative sampling errors are about 2 percent for the number of children ever born and 7 percent for the infant mortality rate. The average design effect (deft) across all DHS surveys is about 1.5.

Publication of Sample Design: DHS reports also include detailed discussions of the sample design and all aspects of survey operations. Response rates at both the household and individual level have been consistently high since the beginning of the DHS program (95 percent on average at the household level and 93 percent on average for women), and any differential non-response for different geographical areas is partially offset by including non-response as one element in the calculation of sample weights. Non-response is certainly not large enough to have a substantial effect on the survey estimates or to alter the policy and program implications of the results.

Preliminary reports for DHS surveys are typically published within three months of the final day of fieldwork. Final reports are generally published 9-12 months after the end of fieldwork. The speed of publication compares very favorably with other large-scale, national-level surveys.

Appendix F: Guidelines for Developing and Using Data Collection Tools

Collection Method	Guidelines
Rapid, low-cost (focus groups, community interviews, informal surveys, etc.)	<ul style="list-style-type: none"> • Define the problem, and formulate the research question. • Identify the sample population for the study. • Carefully choose a facilitator. • Generate and pretest the interview guide. • Recruit the sample. • Conduct the interviews, meetings, focus groups, or survey • Analyze data, and share the results with stakeholders.
Case study	<ul style="list-style-type: none"> • Define the problem, and formulate the scope and objective of the query, with specific attention toward the nature and context of subject. • Identify samples to be used in the study. They should address the representational needs of the range of data being evaluated and show the relevance of the study. • Select the type of case most appropriate to the needs of the program. • Collect the data to be analyzed through a combination of sources. • Analyze the data, accounting for rival explanations, reproduction of findings, internal validity, plausibility, ability to generalize, and overall coherence. • Evaluate the results regarding ability to generalize and internal data validity. • Write the report, and share the findings.
Content analysis	<ul style="list-style-type: none"> • Determine the data source. • Establish the coding categories, and code the text. • Analyze category frequencies, correlation, and patterns. • Write the report, and share it as needed.
Peer review/ expert panel evaluation	<ul style="list-style-type: none"> • Use peer review in conjunction with other evaluation techniques. • Use peer review for research and development activities that are in the public domain. • Peers should be readily identifiable. • Avoid internal peers. • Guard against dysfunctional group dynamics. • If scales are used, test the validity and reliability of those scales. • Provide a bias statement for reviewers. • Ensure that all peers/experts have a common understanding of the task at hand and the ratings, if a scale is to be used. • Document findings of review in a report, and share as needed.
File review in evaluation	<ul style="list-style-type: none"> • Review file contents. • Analyze data. • Document findings in a report, and share as needed.
Surveys	<ul style="list-style-type: none"> • Define the areas of evaluation, and develop applicable questions. • Establish a survey plan. • Develop a sampling protocol that includes a well-thought-out method of data collection, sampling techniques, and method of analysis. • Develop the questionnaire. • Field test the questionnaire, individual questions, and the time it takes to administer the test.

	<ul style="list-style-type: none">• Distribute the questionnaire to respondents with a return date.• Provide a follow-up contact with non-respondents.• Analyze data, and share the results with stakeholders.
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Appendix G: Annotated Outline for a Health Sector PMP

(For examples of complete PMPs, please see the Toolkit CD)

SECTION TITLE	KEY ISSUES TO ADDRESS	OTHER COMMENTS
SECTION 1: INTRODUCTION		
Background	<ul style="list-style-type: none"> ▪ State the SO and IRs that will be covered by this PMP. ▪ Describe how PMP was developed (e.g., in collaboration with implementing partners, with the assistance of USAID/Washington). ▪ Describe briefly how the PMP is organized. 	<ul style="list-style-type: none"> ▪ Keep the section short. No longer than a half page. ▪ Though not required, this section is helpful to set context.
Guiding Principles	<ul style="list-style-type: none"> ▪ Describe the key principles (e.g., tool for self-assessment, economy of effort, participation) that govern(ed) the development/use of the PMP. 	<ul style="list-style-type: none"> ▪ Keep the section short. No longer than a half page. ▪ Not required, but is helpful to articulate the Operating Unit's performance management approach.
Budgeting for Performance Management	<ul style="list-style-type: none"> ▪ Describe how the SO team will cover costs associated with performance monitoring (e.g., Will it be built into project implementer contracts?). Is independent monitoring/evaluation capability necessary? If so, how will this be funded?). Provide an estimate of the overall budget envelope that will be dedicated to performance management. ADS Chapter 203 suggests that 3–10 percent of a program's resources should be allocated to performance management. 	<ul style="list-style-type: none"> ▪ Keep this short. No longer than a paragraph. ▪ Responds to ADS recommendation that budgeting issues be addressed in the PMP.
SECTION 2: RESULTS FRAMEWORK		
Graphical Representation	<ul style="list-style-type: none"> ▪ Provide a graphical representation of the Results Framework. Include all IRs and sub-IRs, as well as indicators and assumptions in the graphic. If possible, also include activities, and show which results are associated with each activity. 	<ul style="list-style-type: none"> ▪ The graphic should take only a page. ▪ Not required, but very important to any user of the PMP to quickly understand the logic of the framework and the activities and get an overview of the indicators.

SECTION TITLE	KEY ISSUES TO ADDRESS	OTHER COMMENTS
Framework Logic	<ul style="list-style-type: none"> ▪ Describe the logic of the framework in words. Alternatively, refer the reader to the description in the Strategic Plan (if this is adequately described there). 	<ul style="list-style-type: none"> ▪ Can be as short as a few sentences or up to a page long. ▪ Not required, but helpful to users of the PMP to understand the logic of the framework.
Critical Assumptions	<ul style="list-style-type: none"> ▪ Describe the fundamental assumptions that underpin the development hypothesis. It is important to include these in the PMP because they should be tracked as part of the performance management effort to help understand why results are/are not occurring. 	<ul style="list-style-type: none"> ▪ Keep this short. No longer than a half page. ▪ Responds to ADS Chapter 203 recommendation that a discussion of plans for monitoring critical assumptions be included in a PMP.
SECTION 3: MANAGING THE SO FOR RESULTS		
Collecting Performance Data: <ul style="list-style-type: none"> (a) Levels of performance data (b) Data collection responsibilities (c) Performance indicators vs. required indicators 	Describe <ul style="list-style-type: none"> • The <i>different levels</i> at which performance data will be collected for this PMP (e.g., contextual data, results-level data, activity-level data, and data to track critical assumptions). • High-level data collection responsibilities (e.g., if data collection will be embedded in implementing partner contracts, note this). • The Annual Reporting process requires OUs to report on a set of required/common indicators (which may or may not be the same measures the OU uses to assess performance), as well as a set of performance indicators selected by the OU. Both types of indicators should be maintained in the PMP. In this section of the PMP, you could provide a summary list of your performance indicators and the required indicators for your sector. 	<ul style="list-style-type: none"> ▪ Keep this short – a half to one page would be appropriate. ▪ Responds to ADS Chapter 203 recommendation that the PMP identify data collection responsibilities that will be incorporated into activities and obligations with partners.

SECTION TITLE	KEY ISSUES TO ADDRESS	OTHER COMMENTS
<p>Conducting Evaluations and Other Studies</p>	<ul style="list-style-type: none"> ▪ Describe any evaluations or special studies (e.g., DHS) that will be carried out over the life of the SO. The list will need to be updated over time. 	<ul style="list-style-type: none"> ▪ This could be as short as one paragraph or be described in a short table. ▪ Responds to ADS Chapter 203 recommendation that evaluations or special studies that complement the performance monitoring effort should be described in the PMP.
<p>Plan for Data Analysis</p>	<ul style="list-style-type: none"> ▪ Describe how data in the PMP will be analyzed. ▪ State who will be responsible for analysis (contractor)? USAID?). If triangulation of data will be necessary, state who will be responsible. 	<ul style="list-style-type: none"> ▪ Keep this section short. Generally a paragraph or two should suffice.
<p>Reviewing Performance Information – Ongoing Data Review, Portfolio Review, Other Reviews</p>	<ul style="list-style-type: none"> ▪ Describe how the SO team/individual activity managers will review performance on an ongoing basis (e.g., review partner reports, do site visits). ▪ Describe the process for the annual portfolio review. ▪ Describe any other performance reviews that your SO team/mission might perform. 	<ul style="list-style-type: none"> ▪ Can be brief – a half to one page. ▪ Responds to ADS Chapter 203 recommendation that the PMP should describe plans for reviewing and using performance information and for monitoring the development hypothesis, critical assumptions, and context indicators.
<p>Reporting Results – The Annual Report and Other Reports</p>	<ul style="list-style-type: none"> ▪ Briefly describe the performance reports (such as Annual Report) that the SO team will contribute to and how the PMP and PMP data will be used for those reports. If specific indicators have to be identified in advance for reporting purposes, they can be described here. 	<ul style="list-style-type: none"> ▪ Can be very brief. ▪ Responds to ADS Chapter 203 recommendation that the PMP should describe plans for reporting performance information.

SECTION TITLE	KEY ISSUES TO ADDRESS	OTHER COMMENTS
Procedures for Assessing Data Quality	<ul style="list-style-type: none"> ▪ Provide an overview of the procedures that the SO team will use to assess data quality. For example, will a data quality assessment instrument be used? If so, which one? How frequently will the assessments be done? What specific actions (e.g., site visits, spot-checks) will the assessment entail? ▪ Could also identify commonly occurring data quality limitations and actions that are planned to address them. Note: Indicator-specific limitations and response actions should be noted on each Performance Indicator Reference Sheet. 	<ul style="list-style-type: none"> ▪ The section need not be long, but should be covered adequately. ▪ Responds to an ADS Chapter 203 requirement that procedures for data quality assessment be documented. ▪ Use Worksheet 7.
Reviewing and Updating the PMP	<ul style="list-style-type: none"> ▪ State how frequently the PMP will be reviewed to determine whether updates are necessary. ▪ Describe the process for the review of the PMP. ▪ State how changes to the PMP (if any) will be documented. 	<ul style="list-style-type: none"> ▪ Can be short, but should be included because it helps to ensure that the PMP is up to date and thus a living document.
Performance Management Task Schedule	<ul style="list-style-type: none"> ▪ Fill out a summary schedule/ calendar that summarizes all the performance management tasks (as noted above) that the SO team will undertake and when they will occur. 	<ul style="list-style-type: none"> ▪ Responds to ADS recommendation that a PMP should contain a calendar of performance management tasks. ▪ Use Worksheet 9 in the Toolkit.
SECTION 4: INDICATOR REFERENCE SHEETS		

SECTION TITLE	KEY ISSUES TO ADDRESS	OTHER COMMENTS
SO- and IR (including sub-IR)-Level Indicators	<ul style="list-style-type: none"> ▪ Fill out a Performance Indicator Reference Sheet for each indicator included in the PMP. 	<ul style="list-style-type: none"> ▪ Responds to ADS requirements/ recommendations that PMPs contain <ul style="list-style-type: none"> ○ At least one indicator for each SO and IR, ○ The set of indicators that will be used for performance monitoring, ○ Baseline and target values for each indicator, ○ Source and data collection method for each indicator, ○ Schedule of data collection for each indicator, and ○ Description of known data limitations and steps to address them for each indicator. ▪ Use Worksheet 6 in the Toolkit.
Other Indicators	<ul style="list-style-type: none"> ▪ If your SO team is also using other indicators (e.g., activity-level indicators, indicators of critical assumptions, context indicators, and synergy indicators) for performance management, at a minimum include a list of those indicators in the PMP. You may want to go further and include indicator reference sheets for each indicator, as well; however, this is not necessary to meet ADS requirements. 	<ul style="list-style-type: none"> ▪ Responds to ADS suggestion that plans for monitoring critical assumptions and context indicators be included in the PMP.

SECTION TITLE	KEY ISSUES TO ADDRESS	OTHER COMMENTS
Summary Performance Data Table	<ul style="list-style-type: none"> ▪ Set up a Summary Performance Data Table that includes all your PMP indicators and their baseline, target, and actual values. 	<ul style="list-style-type: none"> ▪ Responds to ADS recommendation that a PMP contain baseline, target, and actual values for all indicators. Although baselines, targets, and actuals are captured for each indicator in each individual Performance Indicator Reference Sheet, that presentation doesn't allow you to review performance across the entire SO. Using a Summary Performance Data Table will allow you to do this. ▪ Use Worksheet 8.
SECTION 5: NEXT STEPS	<ul style="list-style-type: none"> ▪ Document next steps (if any), timing, and responsible individuals. Make sure that you provide the date when the next steps were generated so that a future user of the document can easily determine whether the next steps are still applicable. 	
SECTION 6: ANNEXES	<ul style="list-style-type: none"> ▪ Append as annexes anything that would be useful to users/ implementers of the PMP. For example, if a Data Quality Assessment Checklist is to be used to conduct data quality assessments, provide a copy of the checklist. 	