

Strengthening Leading Mozambican NGOs and Networks

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PERFORMANCE MONITORING PLAN (PMP)

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Strengthening Leading Mozambican NGOs and Networks (CAP Mozambique)

Illustrative Performance Monitoring Plan (PMP)

The FHI 360 Performance Monitoring Plan (PMP) for the Strengthening Leading Mozambican NGOs and Networks project (CAP Mozambique) has four primary components:

- CAP Mozambique Development Hypothesis
- The narrative description of the results framework (2a), PMP (2b), explanation of the targets presented in the PMP, and description of the changes introduced since the most recent approval of this document (June 2013).
- A graphic presentation of the results framework.
- The PMP matrix which covers indicators; definitions, data collection methods, responsibility, and frequency; data sources; and baselines/targets.

1. CAP Mozambique Development Hypothesis

The CAP Mozambique development hypothesis asserts that quality service delivery of HIV/AIDS treatment, care, and prevention activities is dependent upon civil society organizations' technical and institutional capacity, and that the provision of grant financing to these organizations must be accompanied by appropriate training and technical assistance. In order to implement quality activities, organizations must have adequate technical capacity in the given programmatic area they are targeting, but the effectiveness of these interventions depends on the commitment and leadership of the organizations' governance structures, its financial and administrative capacity, its relationships with stakeholders, and other elements which contribute to the organizations' overall institutional strength.

CAP's approach is to provide training and technical assistance in multiple areas to support holistic organizational growth, thereby increasing the effectiveness of programmatic interventions. The CAP approach does not depend on training as the key mechanism for improving institutional capacity, but rather using training as one of many tools to support organizations. Organizations that receive grants from CAP are provided with targeted technical assistance specifically linked to project performance, as well as broader assistance through the organizational development department that concentrates on each organization's overall institutional goals. With this dual approach, CAP is strengthening the quality of CAP-funded interventions as well as contributing to the sustainability of each organization.

2. Narrative Description of Results Framework and PMP

The purpose of the CAP Mozambique project is to scale up service delivery of HIV/AIDS treatment, care, and prevention activities by strengthening the technical capacity and institutional development of Mozambican non-governmental organizations (NGOs), community-based organizations (CBOs), faith-based organizations (FBOs), networks, and associations, thereby moving towards "Mozambicanizing" the response to the HIV/AIDS epidemic.

(a) Results Framework

The CAP Mozambique project will include a wide range of activities that contribute toward the overall program goal, as well as to the specific objectives, expected results, and outcomes as set forth in the request for proposals (RFP). The results of CAP Mozambique will be:

1. Increased capacity of Mozambican CBOs, FBOs, NGOs, networks, and associations increase capacity to develop and manage effective programs that improve the quality and coverage of HIV/AIDS prevention, treatment, and care services;
2. Expanded HIV/AIDS prevention behaviors among key populations (most-at-risk groups) through NGOs and partners programs;
3. Increased numbers of youth, young adults, and adults in sexual relationships avoiding high-risk behaviors that make them vulnerable to HIV/AIDS infections;
4. Increased numbers of orphans and vulnerable children (OVC) receiving quality, comprehensive care in their respective target areas;
5. Increased quality and coverage of home-based health care (HBC) to people living with AIDS (PLWHA) and their families; and
6. Increased number of organizations that graduate from the first level to the advanced level of grants under CAP, and to direct USAID funding.

In addition to the results described above, CAP Mozambique captures results linked to USAID Gender and Health results. These indicators are captured in the PMP matrix.

(b) Program Performance Management Plan (PMP)

The project will use a number of monitoring and evaluation tools and approaches specifically adapted for the program and the country context to effectively capture results. The following are a few examples:

1. Monitoring of Output/Outcome Indicators

CAP Mozambique will monitor output and outcome indicator progress on a quarterly basis. Grantees will be trained on data collection for indicators specific to their projects at the initiation of grant activities and will report on these to FHI 360.

2. Baseline, Midterm, and Final Surveys

CAP Mozambique conducted a baseline survey to support the design and development of project activities, as well as provide the project with key baseline data for evaluation purposes. The baseline survey focused on measuring the outcome of the activities implemented by CAP Mozambique grant recipients within their target communities. The baseline focused on measuring the outcome of CAP Mozambique's prevention work in its target provinces. An endline survey was conducted in target communities to measure change on these key interventions. The results of the endline will be shared when finalized. A midterm survey was conducted to focus only on CAP's capacity building interventions with its partners, and did not specifically address any of the indicators in this PMP, but the findings support indicators covered in Result 1 of the results framework.

3. Capacity-Building Assessment Tools

CAP Mozambique will conduct a number of assessments to measure the increased technical and institutional capacity of its grant recipients and other organizations targeted with capacity-building support.

- a) **Participatory Organizational Assessment Process (POAP)** – Baseline and follow-up participatory self-assessments will be facilitated with each participating organization to assess improvement in institutional capacity.
- b) **Financial Health Check** – This questionnaire assesses each organization's financial reporting and management health, focusing on financial systems. FHI 360 will facilitate the Health Check at 12-18 month intervals to gauge organizational improvement in systems.
- c) **OVC Care Assessment** – This tool measures the capacity of CAP grant recipients to deliver quality OVC care. A baseline and follow-up assessments will be conducted to measure change and determine TA needs in this technical capacity for grant recipients.

- d) **Social Behavior Change (Prevention Programming) Assessment** – This tool measures the capacity of CAP Mozambique grant recipients to develop and deliver effective HIV/AIDS behavior change programming. A baseline and follow-up assessments will be conducted to measure change and TA needs in this technical capacity for grant recipients.
- e) **Report Writing Assessment** – This tool measures the capacity of the CSOs to report accurately and holistically on their quarterly activities and results.
- f) **Subgrant Management Capacity Assessment** – This assessment will be conducted with CAP Mozambique grant recipients that manage subgrants, and will capture their capacity to solicit, select, award, manage, and monitor these subgrants.

4. Focus Groups

Focus groups are conducted to support the design of CAP Mozambique grant recipient interventions, as well as are used as qualitative data to support quantitative data collection. Focus groups will be facilitated with recipients of CAP Mozambique training and technical assistance (TA), CSO representatives, members of CAP Mozambique grantee target communities, and others.

3. PMP Revisions

Since the last approval of the CAP Mozambique PMP in June 2013, a number of changes have been introduced into the CAP Mozambique project that triggered subsequent revision of the PMP. The key changes are summarized here to help facilitate review of this document. To begin, there were changes in the indicators themselves – most of which were directed by PEPFAR or USAID.

- PEPFAR introduced changes to Prevention and OVC indicators, dis-aggregations, and definitions that changed how CAP reports on activities
 - P.SBRP.03 was revised from MARP (most-at-risk populations) to KP (Key Populations). The dis-aggregation no longer includes truck driver, a key target population for one CAP Partner. Truck Drivers are now reported under a new prevention indicator (P.SBRP.07).
 - P.SBRP.01 (prevention for general populations) was eliminated.
 - P.SBRP.07 was added for prevention activities targeting priority populations.
 - C.CCC.02 was revised to include individuals over age 18, which means that partners could report on adults that receive services as a part of their family-centered OVC approach.
 - It is expected that USAID/PEPFAR will add a new OVC indicator “Number of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services” for FY15, although no formal guidance has yet been provided.
- PEPFAR introduced changes to GBV indicator definitions, and added new GBV indicators
 - P.GBV.06.01 - # of people screened for GBV (community)
 - P.GBV.04 (GBV focused on norms about masculinity) is to be removed for FY15 and beyond.
 - P.GBV.01 (GBV general) is to be removed for FY15 and beyond. However, CAP has elected to maintain this indicator to track individuals reached through GBV activities over the life of the project.
- PEPFAR introduced new defaulter tracing indicators for community partners
 - T.ARV.17.01 - # of ART defaulters or lost to follow-up actively sought during reporting period
 - T.ARV.18.01 - # of ART defaulters or lost to follow-up found during reporting period
 - T.ARV.19.01 - # of ART defaulters or lost to follow-up who returned to treatment
- CAP added a new indicator to link the activity of locating defaulters to the return to treatment.

- Number of individuals referred to ART
- CAP added a new GBV indicator to complement the GBV Screening indicator
 - Number of individuals referred to GBV services

In 2013, PEPFAR Mozambique priorities shifted towards a more clinical focus. Partners began reporting on their HIV Counseling and Testing, Referral to Health Services, defaulter tracing, and other activities. These services contribute to multiple results and all partners engage them in, so the related indicators appear under multiple results. These leads to some repetition in the PMP that was necessary to follow the existing results framework.

There was also a change in how targets were generated. Initially, CAP Mozambique determined its own targets; in 2012 USAID began providing targets to CAP Mozambique. The table in Annex 1 summarizes the differences between CAP Mozambique generated targets and USAID generated targets for the past two years. USAID-directed targets are included in this PMP where we have them. In many cases, where some targets drop after year 4, it is because of changing PEPFAR priorities; either resources have been shifted to other priorities (e.g. counseling and testing or GBV), or we have reduced the number of partners contributing to a target because of budget cuts. We note that CAP Mozambique is not a direct implementer, so all progress on targets for Results 2-5 is based on the activities of sub-partners.

CAP Mozambique reduced the number of assessments used to generate data for the indicator “Number of organizations demonstrating increased capacity in 2 or more areas” under Result 1. For the project design and budget assessments, it was extremely difficult to generate comparable data because CAP Mozambique stopped asking for full initial proposals with budgets from applicants, and only requested a concept paper. This change was made in recognition of the intense TA required to produce a viable proposal. It was not valid to compare proposals generated with TA with those generated without it. Also comparing proposals with those submitted to other donors provided inconclusive as other donors had different criteria and standards. The same applies to budgeting.

Several indicators are PEPFAR indicators. Rather than repeating the definitions in this document, we refer to the PEPFAR Indicator guidance. It will be important to consult *PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014* when reviewing this PMP.

4. CAP Mozambique Targets

Targets for Year 6 correspond to FY15 (October 1, 2014 – September 30, 2015). Targets for Year 7 (FY16) also are included, and capture the targets for the remainder of the project (ending July 2016).

Strengthening Leading Mozambican NGOs and Networks (CAP Mozambique) Results Framework

AO: Scale up service delivery of HIV/AIDS treatment, care, and prevention activities by strengthening the technical capacity and institutional development of Mozambican non-governmental organizations (NGOs), community-based organizations (CBOs), faith-based organizations (FBOs), networks, and associations.

Critical Assumptions

- Mozambican organizations have sufficient systems to manage USAID-financed projects.

IR1: Increased capacity of Mozambican CBOs, FBOs, NGOs, networks, and associations increase capacity to develop and manage effective programs that improve the quality and coverage of HIV/AIDS prevention, treatment, and care services.

- Number of Civil Society Organizations using USG assistance to improve internal organizational capacity
- Number of Mozambican civil society organizations using USG assistance to contribute to the health system
- Dollar value of program funds obligated to local organizations
- Number of individuals trained in institutional capacity building
- Number of organizations demonstrating increased capacity in 2 or more areas
- Number of meetings facilitated to share experiences and lessons learned with CBOs/FBOs/NGOs
- Number of indicators assessed by a data quality audit

IR2: Expanded HIV/AIDS prevention behaviors among most-at-risk groups through NGOs and partners programs.

- Number of Key Populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards
- Number of community health and social workers (CHSW) who successfully completed a pre-service training program
- Number of individuals trained in institutional capacity building
- Number of targeted condom service outlets
- Number of people referred to health services by community-based organizations
- Number of referrals from community-based organizations known to be completed
- Number of individuals who received Counseling and Testing (C&T) services for HIV and received their test

IR4: Increased numbers of orphans and vulnerable children (OVC) receiving quality, comprehensive care in their respective target areas

- Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
- Number of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services
- Number of community health and social workers (CHSW) who successfully completed a pre-service training program
- Number of individuals trained in institutional capacity building
- Number of people referred to health services by community-based organizations
- Number of referrals from a community-based organization known to be completed
- Number of direct participants in savings and loans groups supported by PEPFAR
- Number of individuals who received Counseling and Testing (C&T) services for HIV and received their test results
- Number of ART defaulters or lost to follow-up actively sought during reporting period
- Number of ART defaulters or lost to follow-up found during reporting period
- Number of individuals referred to ART
- Number of ART defaulters or lost to follow-up who returned to treatment during the reporting period

USAID Health and GBV Indicators

- Number of individuals reached through USG-funded community health activities
- Number of people completing an intervention pertaining to gender norms, that meets minimum criteria
- Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion (GBV)
- Number of individuals screened for GBV (community partners)
- Number of individuals referred to GBV services

IR3: Increased numbers of youth, young adults, and adults in sexual relationships avoiding high-risk behaviors that make them vulnerable to HIV/AIDS infections.

- Number of each priority population reached who completed a standardized HIV prevention intervention including the specified minimum components during the reporting period
- Number of intended target population reached with individual- and/or small group-level interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards
- Number of community health and social workers (CHSW) who successfully completed a pre-service training program
- Number of people referred to health services by community-based organizations
- Number of referrals from community-based organizations known to be completed
- Number of mass media spots delivered
- Number of targeted condom service outlets
- Increased number of individuals reporting reduction of engagement risk behaviors associated with HIV
- Increased number of individuals who have sought counseling and testing
- Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission
- Percentage of individuals reporting increased dialogue about high-risk behaviors
- Percentage of individuals reporting increased dialogue about social norms that influence high-risk behaviors
- Number of individuals who received Counseling and Testing (C&T) services for HIV and received their test results
- Number of ART defaulters or lost to follow-up actively sought during reporting period
- Number of ART defaulters or lost to follow-up found during reporting period
- Number of individuals referred to ART
- Number of ART defaulters or lost to follow-up who returned to treatment during the reporting period

IR5: Increased quality and coverage of home-based health care (HBC) to people living with AIDS (PLWHA) and their families.

- Number of community health and para-social workers who successfully completed a pre-service training program
- Number of people referred to health services by community-based organizations
- Number of referrals from a community-based organization known to be completed

IR6: Increased number of organizations that graduate from the first level to the advanced level of grants under CAP, and to direct USAID funding.

- Increased number of organizations with strong enough systems to graduate from the first level of CAP grants to the advanced level.
- Increased number of organizations with strong enough systems to graduate from CAP to direct USAID funding.

Performance Monitoring Plan

Result 1: Increased capacity of Mozambican CBOs, FBOs, NGOs, networks, and associations to develop and manage effective programs that improve the quality and coverage of HIV/AIDS prevention, treatment, and care services. Number of people referred to health services by community-based organizations			
Performance Indicator	Indicator Definition	Data Collection a) Method b) Responsibility c) Frequency	Baseline/Target Values
Number of Civil Society Organizations using USG assistance to improve internal organizational capacity	<p>CSOs include labor unions. Improved capacity refers to, inter alia: establishing transparent and accountable financial systems, establishing internal democratic mechanisms, and establishing better ability to represent constituent's interests.</p> <p>CAP CSOs counted under this indicator include those participating in financial management training, Intercambios, exchange visits, grant recipients and subgrant recipients under umbrella awards that receive institutional capacity building.</p>	<p>a) Project Records</p> <p>b) FHI 360</p> <p>c) Quarterly</p>	<p>Y1: 69 Y2: 76 Y3: 86 Y4: 91 Y5: 29 Y6: 30 Y7: 15</p> <p>Baseline Value: 0</p>
Number of Mozambican civil society organizations using USG assistance to contribute to the health system	<p>Civil society organizations include community-based organizations, labor unions, NGOs, associations, networks, and umbrella organizations. A contribution to the health system using USG assistance captures CSOs provided with funding through CAP Mozambique to improve the quality and coverage of prevention, treatment, and care services. This includes CAP grant recipients and subgrant recipients under umbrella awards (organizations providing grants, subcontracts, and transfer of goods).</p>	<p>a) Project Records</p> <p>b) FHI 360</p> <p>c) Quarterly</p>	<p>Y1: 49 Y2: 56 Y3: 44 Y4: 72 Y5: 20 Y6: 16 Y7: 11</p> <p>Baseline Value: 0</p>
Dollar value of program funds obligated to local organizations	<p>The dollar value of program funds obligated to local organizations refers to the amount CAP Mozambique has obligated to Mozambican organizations to implement their grants.</p> <p>A "local organization" must:</p> <ul style="list-style-type: none"> • Be organized under the laws of the recipient country; • Have its principal place of business in the recipient country; • Be majority owned by individuals who are citizens or lawful permanent residents of the recipient country or be managed by a governing body, the majority of whom are citizens or lawful permanent residents of a recipient country; and • Not be controlled by a foreign entity or by an individual or individuals who are not citizens or permanent residents of the recipient country. 	<p>a) Project Records</p> <p>b) FHI 360</p> <p>c) Semi-annually</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: \$7.7 million Y5: \$6.3 million Y6: \$5,640,540 Y7: \$800,000</p> <p>Baseline Value: 0</p>

	<p>The term “controlled by” means a majority ownership or beneficiary interest as defined above , or the power, either directly or indirectly, whether exercised or exercisable, to control the election, appointment, or tenure of the organization’s managers or a majority of the organization’s governing body by any means, e.g., ownership, contract, or operation of law.</p> <p>“Foreign entity” means an organization that fails to meet any part of the “local organization” definition. Government controlled and government owned organizations in which the recipient government owns a majority interest or in which the majority of a governing body are government employees, are included in the above definition of local organization.</p>		
<p>Number of individuals trained in institutional capacity building</p> <p><i>By individuals trained to promote HIV/AIDS prevention through behavior change</i></p> <p><i>By OVC Care</i></p> <p><i>By organizational capacity development</i></p> <p><i>By stigma/discrimination</i></p> <p><i>By project and budget development</i></p> <p><i>By individuals trained to provide training and technical assistance</i></p>	<p>Institutional capacity building is defined as training that supports an organization’s capacity to respond to the HIV/AIDS epidemic. This includes organizational development as well as HIV/AIDS technical skills. The aggregate indicator includes all individuals trained in subcategories. An individual trained in multiple areas is counted for each training received.</p> <p>Training is a learning activity taking place in-country, in a third country, or in the U.S. in a setting predominantly intended for teaching or facilitating the development of certain knowledge, skills, or attitudes of the participants with formally designated instructors or lead persons, learning objectives, and outcomes, conducted full-time or intermittently.</p> <p>Training refers to training or retraining of individuals and must follow a curriculum with stated (documented) objectives and/or expected competencies.</p> <p>Training may include traditional, class-room type approaches to training as well as on the job or “hands-on” training, such as mentoring or structured supervision, if the following three criteria are met:</p> <ol style="list-style-type: none"> 1) Training objectives are clearly defined and documented; 2) Participation in training is documented (e.g. sign-in sheets or some other type of auditable training); and 3) Program clearly defines what it means to complete training (e.g. attend at least four days of a five-day workshop, achieve stated key competencies, score XX% on post-test exam, etc.). <p>Training programs are for practicing providers to refresh skills and knowledge or add new material and examples of best practices needed to fulfill their current job responsibilities. Training may update existing knowledge and skills, or add new ones.</p> <p>Training Areas:</p> <ul style="list-style-type: none"> • <u>HIV/AIDS prevention through behavior change training</u> will support CSOs to implement formative research to thoroughly analyze the situation and target audience, and develop and deliver appropriate messages and mediums to affect behavior change. • <u>OVC care training</u> will help OVC caregivers provide one or more of the following services and support to children, families, and their communities to ensure that orphans and vulnerable children grow and develop as valued members of their communities: 	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: 325 Y2: 487 Y3: 574 Y4: 1,047 Y5: 709 Y6: 550 Y7: 116</p> <p>Baseline Value: 0</p>

	<p>psych-social/spiritual support, nutrition support, shelter, protection, and access to health care – including HTC and ART, education/vocational training, and economic strengthening.</p> <ul style="list-style-type: none"> • <u>Organizational capacity-development training</u> will support CSOs to develop the capacities which enable them to function as a sustainable CSO, including governance, management, human resources, financial resources, external relations, and technical capacity. • <u>Stigma/discrimination training</u> is defined as training for health care professionals (including CSO and government health officials) on how to reduce their own behaviors that may lead to stigma and discrimination against people living with HIV/AIDS and to challenge others in examining and rebuking behaviors that create or support stigma or discrimination. • <u>Project and budget development training</u> will support CSOs to a) generate a project design through a proposal and/or workplan and b) develop a realistic budget to support project implementation. This includes revising project descriptions and budgets for grant modifications. • <u>Individuals trained to provide training and technical assistance to support CSOs</u> are defined as recipients of CAP Mozambique training that intend to provide TA or training in organizational or technical skills to other CBOs/FBOs/NGOs. 		
<p>Number of organizations demonstrating increased capacity in 2 or more areas</p> <p><i>By improvement in organizational development areas (by self-assessment)</i></p> <p><i>By improvement in financial management capacity</i></p> <p><i>By improvement in quality of OVC care</i></p> <p><i>By improvement in quality of prevention programming</i></p> <p><i>By improvement in reporting</i></p> <p><i>By improvement in</i></p>	<p>Capacity is defined as the skills, approaches, and resources drawn upon to implement project activities. The aggregate indicator includes all organizations demonstrating improvement in 2 or more subcategories.</p> <p><u>Organizational development</u> includes: governance, management, human resources, financial resources, external relations, and technical capacity. Baseline and follow-up ratings in each organizational development area are reached through a process of self-assessment.</p> <p><u>Financial management capacity</u> is defined as the capacities required to effectively manage grant funds, including a) adequate internal controls; b) an accounting system that accurately records all financial transactions and ensures that these transactions are supported by invoices, timesheets, and other documentation; c) adequate processes to control grant funds, d) evidence of receiving audits as appropriate, e) evidence of adequate administrative systems to facilitate procurement processes, filing of documentation, and appropriately allocated personnel.</p> <p><u>OVC care</u> is defined as providing one or more of the following services and support to children, families, and their communities to ensure that orphans and vulnerable children grow and develop as valued members of their communities: psych-social/spiritual support, nutrition support, shelter, protection, and access to health care – including HTC and ART, education/vocational training, and economic strengthening. Included in this assessment are core project management skills such as M and E and HR Management.</p> <p><u>Prevention programming</u> is defined as the process of a) developing a solid analysis of the problem, b) conducting formative research with the target audience to understand the problem and potential barriers to behavior change, c) knowing about other interventions in the target area, d) determining the objectives of the project, e) determining the appropriate medium for messages, f) determining</p>	<p>a) Capacity-Building Assessment Tools</p> <p>b) FHI 360</p> <p>c) Annually</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: 8 Y5: 8 Y6: 7 Y7: 4</p> <p>Baseline Value: 0</p>

<i>subgrant management capacity</i>	<p>the appropriate language for the messages, g) validating the selected medium and messages, and h) evaluating the impact of the prevention program. Included in this assessment are core project management skills such as M and E and HR Management.</p> <p><u>Reporting</u> is required of grant recipients each quarter. The content of the reports are assessed on the accuracy of reporting on grant targets, the analysis that complements these targets, and information on how the organization will feed the M&E data into program implementation.</p> <p><u>Subgrant management</u> is defined as the process of soliciting, selecting, awarding, managing, and monitoring subgrants.</p>		
Number of meetings facilitated to share experiences and lessons learned with CBOs/FBOs/NGOs	Meetings are defined as formally scheduled quarterly meetings for grant recipients, Intercambios, exchange visits, and other training events as well as less formal gatherings and events where CBOs/FBOs/NGOs share experiences and lessons learned with each other.	<p>a) Project Records</p> <p>b) FHI 360</p> <p>c) Semi-annually</p>	<p>Y1: 9</p> <p>Y2: 9</p> <p>Y3: 7</p> <p>Y4: 11</p> <p>Y5: 10</p> <p>Y6: 8</p> <p>Y7: 1</p> <p>Baseline Value: 0</p>
Number of indicators assessed by a data quality audit	CAP Mozambique conducts data verification exercises with its grant recipients at least once during the life of each grant award. During this data quality audit, data is tracked from the source document through to the final output (report to USAID) to identify potential gaps in the data collection/reporting process. Since the primary focus of these data quality audits is on the chain of data from source to USAID, priority is placed on verifying the data linked to PEPFAR and CAP indicators required by the CAP Mozambique project. 'Indicators' assessed would be defined as PEPFAR and/or CAP indicators included in this PMP that are included in one or more data quality audits conducted by the CAP team of its grant recipients.	<p>a) Project Records</p> <p>b) FHI 360</p> <p>c) Semi-annually</p>	<p>Y1: N/A</p> <p>Y2: N/A</p> <p>Y3: N/A</p> <p>Y4: 4</p> <p>Y5: 5</p> <p>Y6: 5</p> <p>Y7: 0</p> <p>Baseline Value: 0</p>
Result 2: Expanded HIV/AIDS prevention behaviors among key populations (most-at-risk groups) through NGOs and partners programs			
Performance Indicator	Indicator Definition	Data Collection a) Method b) Responsibility c) Frequency	Baseline/Target values
Number of Key Populations reached with individual and/or small group level HIV preventive interventions that are based on	<p>Number of individuals in the intended population (CSW, IDU, and MSM) who are reached with individual- and/or small group- level interventions that are based on evidence and/or meet the minimum standards required.</p> <p>This is PEPFAR indicator P.SBRP.03. The full definition referred to in this document is found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: N/A</p> <p>Y2: N/A</p> <p>Y3: N/A</p> <p>Y4: N/A</p> <p>Y5: N/A</p>

<p>evidence and/or meet the minimum standards</p> <p><i>By KP Type: CSW, male IDU, female IDU, and MSM</i></p> <p><i>By Sex: Male and Female</i></p>			<p>Y6: 135 Y7: 0</p> <p>Baseline Value: 0</p>
<p>Number of community health and social workers (CHSW) who successfully completed a pre-service training program</p> <p><i>Cadre: APE; Community Health Activists; Para-social workers</i></p> <p><i>By Sex: Male, Female</i></p>	<p>The number is the sum of community health and social workers who successfully completed a pre-service training program within the reporting period with full or partial PEPFAR support. Individuals will not count as having successfully completed their training unless they meet the minimum requirements as defined by international or national standards. “Pre-service” training comprises training that equips community health and social workers (CHSWs) to provide services for the first time. Oftentimes, CHSWs are given pre-service training once they have been hired but before they begin providing services to the community – these individuals would count towards this indicator. Individuals that receive a ‘refresher’ course that also includes an agenda, curriculum, participant list, and criteria for counting successful completion of the course also will be counted for this indicator.</p> <p>This is PEPFAR indicator SS.HRH.02. The full definition can be found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>	<p>a) Project Records</p> <p>b) FHI 360</p> <p>c) Quarterly</p>	<p>Y1: 295 Y2: 15 Y3: 0 Y4: 15 Y5: 0 Y6: 0 Y7: 0</p> <p>Baseline Value: 0</p>
<p>Number of individuals trained in institutional capacity building</p> <p><i>By individuals trained to promote HIV/AIDS prevention through behavior change</i></p>	<p>Institutional capacity building is defined as training that supports an organization’s capacity to respond to the HIV/AIDS epidemic. This includes organizational development as well as HIV/AIDS technical skills.</p> <p>Training is a learning activity taking place in-country, in a third country, or in the U.S. in a setting predominantly intended for teaching or facilitating the development of certain knowledge, skills or attitudes of the participants with formally designated instructors or lead persons, learning objectives, and outcomes, conducted full-time or intermittently.</p> <p>Training refers to training or retraining of individuals and must follow a curriculum with stated (documented) objectives and/or expected competencies. Training may include traditional, classroom type approaches to training as well as on the job or “hands-on” training, such as mentoring or structured supervision, if the following three criteria are met:</p> <ol style="list-style-type: none"> 1) Training objectives are clearly defined and documented; 2) Participation in training is documented (e.g. sign-in sheets or some other type of auditable training); and 3) The program clearly defines what it means to complete training (e.g. attend at least four days of a five-day workshop, achieve stated key competencies, score XX% on post-test exam, etc.) <p>Training programs are for practicing providers to refresh skills and knowledge or add new material</p>	<p>a) Project Records</p> <p>b) FHI 360</p> <p>c) Quarterly</p>	<p>Y1: 0* Y2: 0 Y3: 0 Y4: 0 Y5: 0 Y6: 0 Y7: 0</p> <p>Baseline Value: 0</p> <p>*Targets for Y1-Y5 are included within the general prevention (Result 3) targets.</p>

	and examples of best practices needed to fulfill their current job responsibilities. Training may update existing knowledge and skills, or add new ones.		
Number of targeted condom service outlets	<p>This indicator refers to a fixed distribution point or a mobile unit with a fixed schedule that provides condoms for free or for sale to a given community as an important part of a comprehensive HIV prevention message. The numerator can be generated by summing the number of condom service outlets with fixed distribution points or mobile units with fixed schedules providing condoms for free or for sale. Community distribution outlets that include condoms can also be included. Condom outlets should be counted so long as USG support is provided in a way that enables or increases the availability of condoms, even if the program is not funded as an activity under condoms and other prevention. For example, if USG is directly supporting a counseling and testing site that also provides condoms, this can be counted as a USG-supported condom service outlet so long as USG support is contributing to the increased availability of condoms at the site.</p> <p>Condom outlets should only be counted at the end distribution point, such as a health facility, a community venue, etc. This does not include supply chain distribution or distribution at the provincial or district level. Condom outlets should be counted where a unique program is being implemented and/or a unique population served. If a facility has multiple places where condoms are available but each of these places serve essentially the same population (multiple stalls in a bathroom), this location can only be counted once. If USG support contributes to the increased availability of condoms within multiple places or programs within one facility (e.g. Within the counseling and testing program, antenatal program, and TB clinic in one health facility), each of the different locations where a different population is being served can be counted as a unique condom service outlet. Individuals (e.g. peer educators) can count as condom distribution outlets only if they are in a fixed location on a fixed and predictable schedule. They do not count for this indicator if they are roving and/or do not have a predictable schedule. This is PEPFAR indicator P.SBRP.05. This is the full definition for this indicator.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: 4</p> <p>Y2: 30</p> <p>Y3: 4</p> <p>Y4: 125</p> <p>Y5: 85</p> <p>Y6: 5</p> <p>Y7: 0</p> <p>Baseline Value: 0</p>
<p>Number of people referred to health services by community-based organizations</p> <p><i>By Type of Health Referral: HCT, pre-TARV/TARV, Sexual Reproductive Health, GBV, Suspected Malaria, Suspected TB, Other</i></p>	<p>Community based organization is defined as any civil society organization that works in the community. A referral is defined as providing information about where a particular health service can be accessed. As appropriate, information may also be provided about the particular health concern (i.e. testing and counseling, sexual reproductive health, etc.) to support an individual's decision to act upon the referral. Referrals might be provided in a one-on-one situation with an activista, or may take place in the context of a prevention session. The referral will include content on that topic, information on where to access services, and will cite the service.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: N/A</p> <p>Y2: N/A</p> <p>Y3: N/A</p> <p>Y4: N/A</p> <p>Y5: 0</p> <p>Y6: 70</p> <p>Y7: 0</p> <p>Baseline Value: 0</p>
Number of referrals from community-based organizations known to	<p>Community based organization is defined as any civil society organization that works in the community. This indicator counts the number of individuals that were referred to a service provider who then received services and therefore counts as a "completed" referral.</p>	<p>a) Project Records</p>	<p>Y1: N/A</p> <p>Y2: N/A</p>

<p>be completed</p> <p><i>By Type of Completed Referral: Health, Other</i></p>		<p>b) FHI 360, Grantees</p> <p>c) Semi-Annually</p>	<p>Y3: N/A Y4: N/A Y5: 0 Y6: 0 Y7: 0</p> <p>Baseline Value: 0</p>
<p>Number of individuals who received Counseling and Testing (C&T) services for HIV and received their test results</p> <p><i>By CT Setting: ATS, ATS-Community, Clinical</i></p> <p><i>By Sex: Male, Female</i></p> <p><i>By Age: 0-14 years, 15+ years</i></p> <p><i>By Test Result: Positive, Negative, Undetermined</i></p> <p><i>By Type of Counseling: Individual, Couples, Family</i></p> <p><i>By Subset of Persons Tested: Persons with documented referral</i></p> <p><i>By Subset of Positive: Persons enrolled into HIV care</i></p>	<p>Community-based counseling and Testing in Health (Community) – Counseling and testing for HIV also including screening and referral for hypertension, sexually transmitted infections, and tuberculosis, but taking place in a community (non-health facility).</p> <p>This is PEPFAR indicator P.CT.01. The full definition can be found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: 0 Y2: 0 Y3: 0 Y4: 0 Y5: 2,178 Y6: 300 Y7: 0</p> <p>Baseline Value: 0</p>

Result 3: Increased numbers of youth, young adults, and adults in sexual relationships avoiding high-risk behaviors that make them vulnerable to HIV/AIDS infections			
Performance Indicator	Indicator Definition	Data Collection a) Method b) Responsibility c) Frequency	Baseline/Target Values
<p>Number of each priority population reached who completed a standardized HIV prevention intervention including the specified minimum components during the reporting period</p> <p><i>By Sex: Male, Female</i></p> <p><i>By Age: 10-11 years old; 12-14 years old; 15-24 years old/ 25+ years old</i></p> <p><i>By Priority Population: young girls, truck drivers, prisoners, clients of sex workers, other</i></p> <p><i>By Intervention Duration: single session, multiple session</i></p>	<p>The indicator is intended to capture programs targeting priority populations. Delivery of prevention packages for all priority populations will be tracked with this indicator, with the exception of packages for key populations as defined by UNAIDS and WHO: sex workers, men who have sex with men/transgender, and people who inject drugs. The method of measurement can be from program monitoring logs that collect the number of persons reached within the comprehensive prevention intervention package. Program monitoring logs must be auditable, that is, they must contain enough information on individual beneficiaries to stand an audit or recount (e.g. crowd estimates are not auditable). In order to be counted, an individual should complete the intended number of session that were implemented with fidelity to the intervention.</p> <p>This is PEPFAR indicator P.SBRP.07/08. The full definition can be found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: N/A Y5: N/A Y6: 10,510 Y7: 0</p> <p>Baseline Value: 0</p>

<p>Number of intended target population reached with individual- and/or small group- level interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards</p> <p><i>By Sex: Male, Female</i></p> <p><i>By Age: 10-11 years old; 12-14 years old; 15-24 years old; 25+ years old</i></p> <p><i>By OVC</i></p>	<p>Primarily focused: The messages and content of the activities spend the majority of their time discussing; increasing individual and group’s self-risk assessments; building the skills; and other supportive behavioral, cognitive and social components to increase the AB behaviors.</p> <p>Abstinence and/or being faithful: AB interventions can include programs, services, and messages which encourage sexual abstinence, delay of sexual debut and secondary abstinence, mutual fidelity, mutual knowledge of HIV status, and social and gender norms which promote mutual respect and open communication about sexuality. AB interventions can also include programs, services, and messages which discourage multiple and/or concurrent partnerships, cross-generational and transactional sex, sexual violence, stigma, and other harmful gender norms and practices. AB interventions targeting youth should support skills-based sexuality and AIDS education as well as involve parents and guardians to improve communication with children and parenting skills.</p> <p>Comprehensive Prevention Programs: Implementing a comprehensive prevention program at the country level involves multiple components, such as setting epidemiologically sound priorities, developing a strategic prevention portfolio, employing effective program models, supporting a coordinated and sustainable national response, establishing quality assurance/monitoring/evaluation mechanisms, and expanding and strengthening PEPFAR prevention staff.</p> <p>Comprehensive prevention programs include interventions at multiple levels (e.g., mass media, community-based, workplace, small group, individual) as well as providing a range of messages that are appropriate for the country’s epidemic and the specific target group. Prevention programs should appropriately link to services, such as male circumcision, counseling and testing and HIV care and treatment, address stigma and discrimination, and increase awareness of social norms that affect behaviors. Effective ABC messages are also a goal. The ABC paradigm includes abstinence, delay of sexual debut, mutual faithfulness, partner reduction, and correct and consistent use of condoms by those whose behavior places them at risk for transmitting or becoming infected with HIV. The most appropriate mix of programs and messages will depend on the country’s epidemic, what populations are being focused on, the circumstances they face, and behaviors within those populations that are targeted for change. Comprehensive prevention programs must be based on evidence and/or meet the minimum standards required.</p> <p>This indicator only counts those interventions at the individual- and/or small-group level. Individual- and small group-level interventions are components of a comprehensive program but are not by themselves defined as a comprehensive program. Partners do not have to implement comprehensive prevention programs to utilize this indicator, but should work with other partners and stakeholders to ensure that comprehensive prevention programs are implemented in the communities that they work in.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: 28,473 Y2: 32,744 Y3: 3,426 Y4: 2,987* Y5: 4,600 Y6: 3,150 Y7: 0</p> <p>Baseline Value: 0</p> <p>* This target was provided by USAID to CAP on April 25, 2013.</p>
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<p>Number of community health and social workers (CHSW) who successfully completed a pre-service training program</p> <p><i>Cadre: APE; Community Health Activists; Para-social workers</i></p> <p><i>By Sex: Male, Female</i></p>	<p>The number is the sum of community health and social workers who successfully completed a pre-service training program within the reporting period with full or partial PEPFAR support. Individuals will not count as having successfully completed their training unless they meet the minimum requirements as defined by international or national standards. “Pre-service” training comprises training that equips community health and social workers (CHSWs) to provide services for the first time. Oftentimes, CHSWs are given pre-service training once they have been hired but before they begin providing services to the community – these individuals would count towards this indicator. Individuals that receive a ‘refresher’ course that also includes an agenda, curriculum, participant list, and criteria for counting successful completion of the course also will be counted for this indicator.</p> <p>This is PEPFAR indicator SS.HRH.02. The full definition can be found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>	<p>a) Project Records</p> <p>b) FHI 360</p> <p>c) Quarterly</p>	<p>Y1: 323 Y2: 242 Y3: 420 Y4: 1,563 Y5: 705 Y6: 0 Y7: 0</p> <p>Baseline Value: 0</p>
<p>Number of people referred to health services by community-based organizations</p> <p><i>By Type of Health Referral: HCT, pre-TARV/TARV, Sexual Reproductive Health, GBV, Suspected Malaria, Suspected TB, Other</i></p>	<p>Community based organization is defined as any civil society organization that works in the community. A referral is defined as providing information about where a particular health service can be accessed. As appropriate, information may also be provided about the particular health concern (i.e. testing and counseling, sexual reproductive health, etc.) to support an individual’s decision to act upon the referral. Referrals might be provided in a one-on-one situation with an activista, or may take place in the context of a prevention session. The referral will include content on that topic, information on where to access services, and will cite the service.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: N/A Y5: 3,369 Y6: 8,600 Y7: 0</p> <p>Baseline Value: 0</p>
<p>Number of referrals from community-based organizations known to be completed</p> <p><i>By Type of Completed Referral: Health, Other</i></p>	<p>Community based organization is defined as any civil society organization that works in the community. This indicator counts the number of individuals that were referred to a service provider who then received services and therefore counts as a “completed” referral.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Semi-Annually</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: N/A Y5: 2,231 Y6: 200 Y7: 0</p> <p>Baseline Value: 0</p>

<p>Number of mass media spots delivered</p>	<p>Mass media is defined as the dissemination of prevention messages through media specifically envisioned and designed to reach a very large audience, such as the national, provincial, or district population, or specific target populations (e.g. Women, youth, high risk groups.) Mass media typically includes radio networks, mass-circulation newspapers and magazines, television, and digital media. There is typically little focus on interpersonal interaction in mass-media and community mobilization messages/programs.</p> <p>The indicator can be generated by summing the number of mass media spots for each category for the reporting period. This indicator measure the number of media spots delivered, not the number of persons reached through the indicator. Each time a media spot is delivered/presented should be counted as one number regardless of the size of the audience receiving message. For print publications, depending on the time of media being used should be counted as the number of times a public service advertisement is run in a local newspaper or journal. The flyers of leaflets, the number should reflect the number of times that the print document was distributed en masse for public consumption. This is PEPFAR indicator P.SBRP.04. This is the full definition for this indicator.</p>	<p>a) Project Records b) FHI 360, Grantees c) Quarterly</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: N/A Y5: N/A Y6: 9 Y7: 0 Baseline Value: 0</p>
<p>Number of targeted condom service outlets</p>	<p>This indicator refers to a fixed distribution point or a mobile unit with a fixed schedule that provides condoms for free or for sale to a given community as an important part of a comprehensive HIV prevention message. The numerator can be generated by summing the number of condom service outlets with fixed distribution points or mobile units with fixed schedules providing condoms for free or for sale. Community distribution outlets that include condoms can also be included. Condom outlets should be counted so long as USG support is provided in a way that enables or increases the availability of condoms, even if the program is not funded as an activity under condoms and other prevention. For example, if USG is directly supporting a counseling and testing site that also provides condoms, this can be counted as a USG-supported condom service outlet so long as USG support is contributing to the increased availability of condoms at the site.</p> <p>Condom outlets should only be counted at the end distribution point, such as a health facility, a community venue, etc. This does not include supply chain distribution or distribution at the provincial or district level. Condom outlets should be counted where a unique program is being implemented and/or a unique population served. If a facility has multiple places where condoms are available but each of these places serve essentially the same population (multiple stalls in a bathroom), this location can only be counted once. If USG support contributes to the increased availability of condoms within multiple places or programs within one facility (e.g. Within the counseling and testing program, antenatal program, and TB clinic in one health facility), each of the different locations where a different population is being served can be counted as a unique condom service outlet. Individuals (e.g. peer educators) can count as condom distribution outlets only if they are in a fixed location on a fixed and predictable schedule. They do not count for this indicator if they are roving and/or do not have a predictable schedule. This is PEPFAR indicator P.SBRP.05. This is the full definition for this indicator.</p>	<p>a) Project Records b) FHI 360, Grantees c) Quarterly</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: N/A Y5: N/A Y6: 30 Y7: 0 Baseline Value: 0</p>
<p>Increased number of individuals reporting</p>	<p>Risk behaviors include: engaging in sexual activity with multiple partners, sharing needles, and engaging in unprotected sex. Individuals are counted when they report a reduction in frequency of</p>	<p>a) Survey</p>	<p>Baseline Value:</p>

<p>reduction of engagement risk behaviors associated with HIV</p> <p><i>By Sex: Male, Female</i></p> <p><i>By Age: 10-11 years old; 12-14 years old; 15-24 years old; 25+ years old</i></p>	<p>engaging in these behaviors.</p>	<p>b) FHI 360</p> <p>c) Baseline, Final</p>	<p>Multiple Partners: Female 15-24: 28% Female 25+: 18% Male 15-24: 44% Males 25+: 42%</p> <p>Sharing Needles: Always share: Females 25+: 39% Males 25+: 8%</p> <p>Never share: Female 15-24 yrs: 66% Female 25+: 29% Male 15-24 yrs: 0% Male 25+: 39%</p> <p>Unprotected sex: Female 15-24 yrs: 85% Female 25+: 92% Male 15-24 yrs: 69% Male 25+: 84%</p> <p>No condom at last sex: Female: 15-19 yrs: 81% Female 20-24 yrs: 83% Female 25+ yrs: 92% Male 15-19 yrs: 63% Male 20-24 yrs: 75% Male 25+ yrs: 82%</p>
<p>Increased number of individuals who have sought counseling and testing</p> <p><i>By Sex: Male and Female</i></p>	<p>Individuals are counted if they have attempted to seek counseling and testing regarding their HIV/AIDS status.</p>	<p>a) Survey</p> <p>b) FHI 360</p> <p>c) Baseline, Final</p>	<p>Baseline Value: Females: 35% Males: 28%</p>
<p>Percentage of young women and men aged 15-24 who both correctly identify ways of</p>	<p>This indicator is constructed from responses to the following set of prompted questions:</p> <ol style="list-style-type: none"> 1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? 2. Can a person reduce the risk of getting HIV by using a condom every time they have sex? 	<p>a) Survey</p> <p>b) FHI 360</p>	<p>Baseline Value: Female 15-19: 44% Female 20-24: 47%</p>

<p>preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission</p> <p><i>By Sex: Male and Female</i></p> <p><i>By Age: 15-19, 20-24</i></p>	<p>3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing food with someone who is infected?</p> <p>The first three questions should not be altered. Questions 4 and 5 ask about local misconceptions and may be replaced by the most common misconceptions in your country. Examples include: “Can a person get HIV by hugging or shaking hands with a person who is infected?” and “Can a person get HIV through supernatural means?” Those who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator. An answer of “don’t know” should be recorded as an incorrect answer. The indicator should be presented as separate percentages for males and females and should be disaggregated by the age groups 15-19 and 20–24 years. Scores for each of the individual questions (based on the same denominator) are required as well as the score for the composite indicator.</p>	<p>c) Baseline, Final</p>	<p>Male 15-19: 52% Male 20-24: 40%</p>
<p>Percentage of individuals reporting increased dialogue about high-risk behaviors</p> <p><i>By Sex: Male and Female</i></p>	<p>Dialogue about high-risk behaviors includes any conversations between individuals or within small groups about high-risk behaviors for HIV/AIDS. High-risk behaviors include: engaging in sexual activity with multiple partners, sharing needles, engaging in unprotected sex.</p>	<p>a) Survey b) FHI 360 c) Baseline, Final</p>	<p>Baseline Value: With partner/spouse: No dialogue: Male – 18%, Female – 23%</p> <p>With family/friend: No dialogue: Male – 18%, Female – 22%</p> <p>With peer educator: No dialogue: Male – 35%, Female – 38%</p>
<p>Percentage of individuals reporting increased dialogue about social norms that influence high-risk behaviors</p> <p><i>By Sex: Male and Female</i></p> <p><i>By Age: 10-11 years old; 12-14 years old; 15-24 years old; 25+ years old</i></p>	<p>Dialogue about high-risk behaviors includes any conversations between individuals or within small groups about high-risk behaviors for HIV/AIDS. Social norms are defined as individual or group perceptions, opinions, or norms. These can include perspectives about men and women roles, perceptions that it is acceptable for teachers to have sex with their students, perceptions about local youth initiation rites, and others.</p>	<p>a) Survey b) FHI 360, Grantees c) Baseline, Final</p>	<p>Baseline Value: With partner/spouse: No dialogue: Male – 29%, Female – 44%</p> <p>With family/friend: No dialogue: Male – 27%, Female – 38%</p> <p>With peer educator: No dialogue: Male – 45%, Female – 47%</p>

<p>Number of individuals who received Counseling and Testing (C&T) services for HIV and received their test results</p> <p><i>By CT Setting: ATS, ATS-Community, Clinical</i></p> <p><i>By Sex: Male, Female</i></p> <p><i>By Age: 0-14 years, 15+ years</i></p> <p><i>By Test Result: Positive, Negative, Undetermined</i></p> <p><i>By Type of Counseling: Individual, Couples, Family</i></p> <p><i>By Subset of Persons Tested: Persons with documented referral</i></p> <p><i>By Subset of Positive: Persons enrolled into HIV care</i></p>	<p>Community-based counseling and Testing in Health (Community) – Counseling and testing for HIV also including screening and referral for hypertension, sexually transmitted infections, and tuberculosis, but taking place in a community (non-health facility).</p> <p>This is PEPFAR indicator P.CT.01. The full definition can be found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: 0 Y2: 0 Y3: 0 Y4: 0 Y5: 0 Y6: 1,000 Y7: 0</p> <p>Baseline Value: 0</p>
<p>Number of ART defaulters or lost to follow-up actively sought during reporting period</p> <p><i>By Sex: Male, Female</i></p> <p><i>By Age: 0-14 years, 15+ years</i></p> <p><i>By Status: Defaulter and Lost to Follow-up</i></p> <p><i>By Treatment Modality: ART, PMTCT-ANC, and TB-HIV</i></p>	<p>This is a subset indicator to PEPFAR Indicator T.ARV.16.01. As a Community Partner, CAP does not report on Indicator T.ARV.16.01, but does on subset indicators T.ARV.17.01, 18.01, and 19.01.</p> <p>Community partners begin with the number of patients identified as defaulters or lost to follow-up based on the list received from a clinical site for actively sought as a subgroup of the total identified at site. They report conducted and its outcome must be reported by the partner who performed the activity to avoid double counting.</p> <p>This is PEPFAR indicator T.ARV.17.01. The full definition can be found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: N/A Y5: N/A Y6: 650 Y7: 0</p> <p>Baseline Value: 0</p>

<p>Number of ART defaulters or lost to follow-up found during reporting period</p> <p><i>By Sex: Male, Female</i></p> <p><i>By Age: 0-14 years, 15+ years</i></p> <p><i>By Status: Defaulter and Lost to Follow-up</i></p> <p><i>By Treatment Modality: ART, PMTCT-ANC, and TB-HIV</i></p>	<p>This is a subset indicator to PEPFAR Indicator T.ARV.16.01. As a Community Partner, CAP does not report on Indicator T.ARV.16.01, but does on subset indicators T.ARV.17.01, 18.01, and 19.01.</p> <p>Community partners begin in the number of patients identified as defaulters or last to follow-up based on the list received from the site for actively sought as a subgroup of the total identified at site. The report conducted and its outcome must be reported by the partner who performed the activity to avoid double counting.</p> <p>This is PEPFAR indicator T.ARV.18.01. The full definition can be found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: N/A Y5: N/A Y6: 440 Y7: 0</p> <p>Baseline Value: 0</p>
<p>Number of individuals referred to ART</p> <p><i>By Sex: Male, Female</i></p>	<p>These are individuals referred to ART once they have been found through defaulter tracing. The individuals counted here are also counted under “Number of people referred to health services by community-based organizations.”</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: N/A Y5: N/A Y6: 290 Y7: 0</p> <p>Baseline Value: 0</p>
<p>Number of ART defaulters or lost to follow-up who returned to treatment during the reporting period</p> <p><i>By Sex: Male, Female</i></p> <p><i>By Age: 0-14 years, 15+ years</i></p> <p><i>By Status: Defaulter and Lost to Follow-up</i></p>	<p>This is a subset indicator to PEPFAR Indicator T.ARV.16.01. As a Community Partner, CAP does not report on Indicator T.ARV.16.01, but does on subset indicators T.ARV.17.01, 18.01, and 19.01.</p> <p>Community partners begin in the number of patients identified as defaulters or last to follow-up based on the list received from the site for actively sought as a subgroup of the total identified at site. The report conducted and its outcome must be reported by the partner who performed the activity to avoid double counting.</p> <p>This is PEPFAR indicator T.ARV.19.01. The full definition can be found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: N/A Y5: N/A Y6: 200 Y7: 0</p> <p>Baseline Value: 0</p>

By Treatment Modality: ART, PMTCT-ANC, and TB-HIV			
Result 4: Increased numbers of orphans and vulnerable children (OVC) receiving quality, comprehensive care in their respective target areas			
Performance Indicator	Indicator Definition	Data Collection a) Method b) Responsibility c) Frequency	Baseline/Target Values
<p>Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS</p> <p>By Sex: Male; Female</p> <p>By age: <18, 18+</p> <p>By Type of service: Economic Strengthening, Food and Nutrition, Shelter and Care, Education and/or vocational training, Health care, Psychosocial, social, and/or spiritual support, and Protection</p>	<p>The number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS. The number should reflect active beneficiaries (children or caregivers) who received at least one OVC funded service from facilities and/or community-based organizations. Active beneficiary is defined as an individual who has received program services in the last three months and who is scheduled to receive program services at least once every three months, as outlined in program guidelines or standards of practice. New beneficiaries who only registered in the last quarter will be counted as active, even if they have not yet received services. Partners will report on the number of beneficiaries on their “active” registries. Partners will not be required to count the number of individuals receiving services at each reporting period. Rather, the number reported will reflect active beneficiaries as defined in the paragraph above.</p> <p>The disaggregation by type of service indicator will count all OVCs or OVC caregivers receiving services by that service area. If an OVC or OVC caregiver received multiple types of services, then they should be counted once for the overall (aggregate) indicator. This means that the sum of the dis-aggregations by type of service may exceed the value of the indicator.</p> <p>This is PEPFAR indicator C.CCC.02. The full definition can be found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly and Annually</p>	<p>Y1: 1,520 Y2: 1,474 Y3: 1,200 Y4: 4,050 Y5: 5,470* Y6: 6,990 Y7: 6,285</p> <p>Baseline Value: 0</p> <p>* This target was provided to CAP by USAID.</p>
<p>Number of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services</p>	<p>This is a new PEPFAR indicator brought to CAP’s attention in November 2014. No formal guidance, definitions, or dis-aggregation requirements have yet been provided to implementing partners. As such, no targets have been set.</p> <p>CAP defines this as any beneficiary from an OVC program that has completed referrals in the</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: N/A</p>

<p><i>By Sex: Male; Female</i></p>	<p>following areas: HTC, pre-TARV, and TARV. It also includes any individuals tested directly by a CAP OVC Partner. This includes OVC and their caregivers, as well as any individual that is reached through activities implemented in the community.</p>	<p>c) Quarterly and Annually</p>	<p>Y5: N/A Y6: 0 Y7: 0</p> <p>Baseline Value: 0</p>
<p>Number of community health and social workers (CHSW) who successfully completed a pre-service training program</p> <p><i>Cadre: APE; Community Health Activists; Para-social workers</i></p> <p><i>By Sex: Male; Female</i></p>	<p>The number is the sum of community health and social workers who successfully completed a pre-service training program within the reporting period with full or partial PEPFAR support. Individuals will not count as having successfully completed their training unless they meet the minimum requirements as defined by international or national standards. “Pre-service” training comprises training that equips community health and social workers (CHSWs) to provide services for the first time. Oftentimes, CHSWs are given pre-service training once they have been hired but before they begin providing services to the community – these individuals would count towards this indicator. Individuals that receive a ‘refresher’ course that also includes an agenda, curriculum, participant list, and criteria for counting successful completion of the course also will be counted for this indicator.</p> <p>This is PEPFAR indicator SS.HRH.02. The full definition can be found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>	<p>a) Project Records b) FHI 360, Grantees c) Quarterly and Annually</p>	<p>Y1: 306 Y2: 80 Y3: 173 Y4: 287 Y5: 175 Y6: 300 Y7: 86</p> <p>Baseline Value: 0</p>
<p>Number of individuals trained in institutional capacity building</p> <p><i>By OVC care</i></p>	<p>Institutional capacity building is defined as training that supports an organization’s capacity to respond to the HIV/AIDS epidemic. This includes organizational development as well as HIV/AIDS technical skills. OVC care is the provision of one or more of the following services and support to children, families, and their communities to ensure that OVC grow and develop as valued members of their communities: psychological, spiritual, preventative, food support, shelter, protection, access to health care, education/vocational training, and economic strengthening.</p> <p>Training is a learning activity taking place in-country, in a third country, or in the U.S. in a setting predominantly intended for teaching or facilitating the development of certain knowledge, skills or attitudes of the participants with formally designated instructors or lead persons, learning objectives, and outcomes, conducted full-time or intermittently.</p> <p>Training refers to training or retraining of individuals and must follow a curriculum with stated (documented) objectives and/or expected competencies. Training may include traditional, class-room type approaches to training as well as on the job or “hands-on” training, such as mentoring or structured supervision, if the following three criteria are met: 1) Training objectives are clearly defined and documented; 2) Participation in training is documented (e.g. through sign-in sheets or some other type of auditable training); and 3) The program clearly defines what it means to complete training (e.g. attend at least four days of a five-day workshop, achieve stated key competencies, score XX% on post-test exam, etc.).</p> <p>Training programs are for practicing providers to refresh skills and knowledge or add new material</p>	<p>a) Project Records b) FHI 360, Grantees c) Quarterly and Annually</p>	<p>Y1: 72 Y2: 74 Y3: 10 Y4: 29 Y5: 0 Y6: 86 Y7: 0</p> <p>Baseline Value: 0</p>

	and examples of best practices needed to fulfill their current job responsibilities. Training may update existing knowledge and skills, or add new ones.		
<p>Number of people referred to health services by community-based organizations</p> <p><i>By Type of Health Referral: HCT, pre-TARV/TARV, Sexual Reproductive Health, GBV, Suspected Malaria, Suspected TB, Other</i></p>	Community based organization is defined as any civil society organization that works in the community. A referral is defined as providing information about where a particular health service can be accessed. As appropriate, information may also be provided about the particular health concern (i.e. testing and counseling, sexual reproductive health, etc.) to support an individual's decision to act upon the referral. Referrals might be provided in a one-on-one situation with an activista, or may take place in the context of a prevention session. The referral will include content on that topic, information on where to access services, and will cite the service.	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Semi-Annually</p>	<p>Y1: N/A</p> <p>Y2: N/A</p> <p>Y3: N/A</p> <p>Y4: N/A</p> <p>Y5: 390</p> <p>Y6: 800</p> <p>Y7: 300</p> <p>Baseline Value: 0</p>
<p>Number of referrals from community-based organizations known to be completed</p> <p><i>By Type of Completed Referral: Health, Other</i></p>	Community based organization is defined as any civil society organization that works in the community. This indicator counts the number of individuals that were referred to a service provider who then received services and therefore counts as a "completed" referral.	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Semi-Annually</p>	<p>Y1: N/A</p> <p>Y2: N/A</p> <p>Y3: N/A</p> <p>Y4: N/A</p> <p>Y5: 2,751</p> <p>Y6: 1,550</p> <p>Y7: 350</p> <p>Baseline Value: 0</p>
<p>Number of direct participants in savings and loans groups supported by PEPFAR</p> <p><i>By Type of Participant: PLWHA, OVC Caregiver, OVC, Other (i.e. Adult Community Member)</i></p> <p><i>By Sex: Male; Female</i></p>	<p>Participants in savings and loan groups are individuals that join S&L groups organized by CAP partners. Participants can be direct project beneficiaries (i.e. OVC caregivers/OVC participating in OVC project activities) or be members of the target community invited to participate in the S&L groups. OVC are only counted if they are full participants in the activity as active savers – they are not counted if they indirectly receive benefits through the participation of a caregiver. Individuals participating in S&L group are counted again each fiscal year for this indicator.</p> <p>This indicator was provided to CAP by USAID yet a formal definition is not yet available. CAP has defined the indicator for reporting purposes.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: N/A</p> <p>Y2: N/A</p> <p>Y3: N/A</p> <p>Y4: N/A</p> <p>Y5: N/A</p> <p>Y6: 300</p> <p>Y7: 250</p> <p>Baseline Value: 0</p>
<p>Number of individuals who received Counseling and Testing (C&T) services for HIV and</p>	(Community) – Counseling and testing for HIV also including screening and referral for hypertension, sexually transmitted infections, and tuberculosis, but taking place in a community (non-health facility).	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p>	<p>Y1: 0</p> <p>Y2: 0</p> <p>Y3: 0</p> <p>Y4: 0</p>

<p>received their test results</p> <p><i>By CT Setting: ATS, ATS-Community, Clinical</i></p> <p><i>By Sex: Male, Female</i></p> <p><i>By Age: 0-14 years, 15+ years</i></p> <p><i>By Test Result: Positive, Negative, Undetermined</i></p> <p><i>By Type of Counseling: Individual, Couples, Family</i></p> <p><i>By Subset of Persons Tested: Persons with documented referral</i></p> <p><i>By Subset of Positive: Persons enrolled into HIV care</i></p>	<p>This is PEPFAR indicator P.CT.01. The full definition can be found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>	<p>c) Quarterly</p>	<p>Y5: 0 Y6: 300 Y7: 0</p> <p>Baseline Value: 0</p>
<p>Number of ART defaulters or lost to follow-up actively sought during reporting period</p> <p><i>By Sex: Male, Female</i></p> <p><i>By Age: 0-14 years, 15+ years</i></p> <p><i>By Status: Defaulter and Lost to Follow-up</i></p> <p><i>By Treatment Modality: ART, PMTCT-ANC, and TB-HIV</i></p>	<p>This is a subset indicator to PEPFAR Indicator T.ARV.16.01. As a Community Partner, CAP does not report on Indicator T.ARV.16.01, but does on subset indicators T.ARV.17.01, 18.01, and 19.01.</p> <p>Community partners begin in the number of patients identified as defaulters or last to follow-up based on the list received from the site for actively sought as a subgroup of the total identified at site. The report conducted and its outcome must be reported by the partner who performed the activity to avoid double counting.</p> <p>This is PEPFAR indicator T.ARV.17.01. The full definition can be found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: N/A Y5: N/A Y6: 690 Y7: 250</p> <p>Baseline Value: 0</p>

<p>Number of ART defaulters or lost to follow-up found during reporting period</p> <p><i>By Sex: Male, Female</i></p> <p><i>By Age: 0-14 years, 15+ years</i></p> <p><i>By Status: Defaulter and Lost to Follow-up</i></p> <p><i>By Treatment Modality: ART, PMTCT-ANC, and TB-HIV</i></p>	<p>This is a subset indicator to PEPFAR Indicator T.ARV.16.01. As a Community Partner, CAP does not report on Indicator T.ARV.16.01, but does on subset indicators T.ARV.17.01, 18.01, and 19.01.</p> <p>Community partners begin in the number of patients identified as defaulters or last to follow-up based on the list received from the site for actively sought as a subgroup of the total identified at site. The report conducted and its outcome must be reported by the partner who performed the activity to avoid double counting.</p> <p>This is PEPFAR indicator T.ARV.18.01. The full definition can be found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: N/A Y5: N/A Y6: 450 Y7: 110</p> <p>Baseline Value: 0</p>
<p>Number of individuals referred to ART</p> <p><i>By Sex: Male, Female</i></p>	<p>These are individuals referred to ART once they have been found through defaulter tracing. The individuals counted here are also counted under “Number of people referred to health services by community-based organizations.”</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: N/A Y5: N/A Y6: 340 Y7: 85</p> <p>Baseline Value: 0</p>
<p>Number of ART defaulters or lost to follow-up who returned to treatment during the reporting period</p> <p><i>By Sex: Male, Female</i></p> <p><i>By Age: 0-14 years, 15+ years</i></p> <p><i>By Status: Defaulter and Lost to Follow-up</i></p>	<p>This is a subset indicator to PEPFAR Indicator T.ARV.16.01. As a Community Partner, CAP does not report on Indicator T.ARV.16.01, but does on subset indicators T.ARV.17.01, 18.01, and 19.01.</p> <p>Community partners begin in the number of patients identified as defaulters or last to follow-up based on the list received from the site for actively sought as a subgroup of the total identified at site. The report conducted and its outcome must be reported by the partner who performed the activity to avoid double counting.</p> <p>This is PEPFAR indicator T.ARV.19.01. The full definition can be found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: N/A Y5: N/A Y6: 235 Y7: 60</p> <p>Baseline Value: 0</p>

<i>By Treatment Modality: ART, PMTCT-ANC, and TB-HIV</i>			
Result 5: Increased quality and coverage of home-based health care (HBC) to people living with AIDS (PLWHA) and their families.			
Performance Indicator	Indicator Definition	Data Collection a) Method b) Responsibility c) Frequency	Baseline/Target Values
<p>Number of people referred to health services by community-based organizations</p> <p><i>By Type of Health Referral: HCT, (pre)TARV, Family Planning, Sexual Reproductive Health, GBV, PMTCT, nutrition and child health services, and General Health</i></p>	<p>Community based organization is defined as any civil society organization that works in the community. Referrals can take place in a group setting (i.e. during a debate facilitated by an <i>activista</i> regarding HIV/AIDS prevention and care) or an individual basis.</p>	<p>a) Project Records b) FHI 360, Grantees c) Quarterly</p>	<p>Y1:0 Y2: 0 Y3: 0 Y4: 0 Y5: 0 Y6: 200 Y7: 0</p> <p>Baseline Value: 0</p>
<p>Number of people referred to health services by community-based organizations</p> <p><i>By Type of Health Referral: HCT, pre-TARV/TARV, Sexual Reproductive Health, GBV, Suspected Malaria, Suspected TB, Other</i></p>	<p>Community based organization is defined as any civil society organization that works in the community. A referral is defined as providing information about where a particular health service can be accessed. As appropriate, information may also be provided about the particular health concern (i.e. testing and counseling, sexual reproductive health, etc.) to support an individual's decision to act upon the referral. Referrals might be provided in a one-on-one situation with an <i>activista</i>, or may take place in the context of a prevention session. The referral will include content on that topic, information on where to access services, and will cite the service.</p>	<p>a) Project Records b) FHI 360, Grantees c) Quarterly</p>	<p>Y1:0 Y2: 0 Y3: 0 Y4: 0 Y5: 0 Y6: 100 Y7: 0</p> <p>Baseline Value: 0</p>

Result 6: Increased number of organizations that graduate from the first level to the advanced level of grants under CAP, and to direct USAID funding.			
Performance Indicator	Indicator Definition	Data Collection a) Method, b) Responsibility, c) Frequency	Baseline/Target Values
Increased number of organizations with strong enough systems to graduate from the first level of CAP grants to the advanced level	<p>CAP's first level (i.e. Up-and-Coming) of organizations are those classified by CAP Mozambique to have the basic management and technical capacities in place to effectively manage a subgrant. Advanced organizations are those that meet CAP Mozambique's eligibility criteria to be advanced – which include a history of managing multi-year awards, clear separation of roles between the board of directors and implementing staff, and documented policies and procedures for financial management, procurement, human resources, travel, and inventory management.</p> <p>This indicator was included in a contractual modification to CAP's cooperative agreement. However, since that time CAP has received guidance from USAID that organizations considered "advanced" by CAP could be recommended to graduate to direct USAID funding (see indicator below). Therefore, there are no targets for this indicator for Years 6 and 7.</p>	<p>a) Graduation process (desk review, site visit, internal evaluation meeting)</p> <p>b) FHI 360</p> <p>c) Semi-Annually</p>	<p>Y1: 0 Y2: 0 Y3: 0 Y4: 2 Y5: 1 Y6: 0 Y7: 0</p> <p>Baseline Value: 0</p>
Increased number of organizations with strong enough systems to graduate from CAP to direct USAID funding	<p>Advanced organizations are those that meet CAP Mozambique's eligibility criteria to be advanced – which include a history of managing multi-year awards, clear separation of roles between the board of directors and implementing staff, and documented policies and procedures for financial management, procurement, human resources, travel, and inventory management. Organizations are recommended to USAID for funding if they successfully pass CAP Mozambique's graduation process from the advanced category to eligible for USAID funding.</p>	<p>a) Graduation process (desk review, site visit, internal evaluation meeting)</p> <p>b) FHI 360</p> <p>c) Semi-Annually</p>	<p>Y1: 0 Y2: 0 Y3: 1 Y4: 1 Y5: 2 Y6: 1 Y7: 0</p> <p>Baseline Value: 0</p>
Additional USAID Health Indicators			
Performance Indicator	Indicator Definition	Data Collection a) Method b) Responsibility c) Frequency	Baseline/Target Values
Number of individuals reached through USG-funded community health activities	<p>Individuals reached through USG-funded community health activities include all individuals reached through CAP Mozambique prevention and OVC activities implemented through CSO partners.</p>	<p>a) Project Records</p> <p>b) FHI 360</p> <p>c) Quarterly</p>	<p>Y1: 51,081 Y2: 58,509 Y3: 16,232 Y4: 21,620* Y5: 33,000 Y6: 20,785</p>

			Y7: 7,005 Baseline Value: 0 *This target was revised based on the targets USAID provided to CAP on April 25, 2013.
PEPFAR Gender Indicators			
Number of people completing an intervention pertaining to gender norms, that meets minimum criteria <i>By Sex: Male; Female</i> <i>By Age: 0-4, 5-9, 10-14, 15-17, 18+</i>	This is a new PEPFAR indicator for FY15. Written guidance on this indicator has not yet been provided to implementing partners, but is expected in the PEPFAR Guidance for SAPR 2015. USAID provided guidance in a meeting on November 20, 2014, with implementing partners on the reporting dis-aggregations indicated in the column to the left.	a) Project Records b) FHI 360 c) Quarterly	Y1: N/A Y2: N/A Y3: N/A Y4: N/A Y5: N/A Y6: 11,650 Y7: 720 Baseline Value: 0

<p>Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion (GBV)</p> <p><i>By Sex; Male, Female</i></p> <p><i>By Age: 0-4, 5-9, 10-14, 15-17, 18-24 and 25+</i></p> <p><i>By District</i></p>	<p>The result can be generated by counting the number of adults and children who were reached by an individual, small group or community-level intervention or service that explicitly addressed GBV during the reporting period. These interventions or services are cross-cutting and contribute to results across a range of PEPFAR program areas. Individuals reached by mass media interventions are not counted in this indicator. Individuals counted under this indicator may also be captured under other relevant prevention indicators.</p> <p>Number of adults and children reached is the number of individuals who are provided with the intended intervention as defined in the program description and as prescribed in the intervention or service.</p> <p>Individual-level interventions or services are those that explicitly address GBV and are provided to one individual at a time, e.g. job skills training, tuition grants, etc.</p> <p>Small-group-level interventions or services are those that explicitly address GBV and are delivered in small group settings (less than 25 people), e.g. empowerment training for women in microfinance projects, men’s support groups addressing gender norms, information dissemination to women’s groups, etc.</p> <p>Community-level interventions or services that explicitly address GBV and are delivered in community-wide settings (25 or greater people), e.g., awareness raising forums, town hall meetings, large discussion groups, etc.</p> <p>To be able to count individuals reached for this indicator, individual, small group, or community-level interventions must address the following topics:</p> <ul style="list-style-type: none"> • Definition of Gender Based Violence • Description/Discussion of types of Gender Based Violence that exist • Information on where to seek support for GBV cases • Link between HIV&AIDS and GBV • Provide information about GBV legislation <p>This was a PEPFAR indicator through FY14 (Year 5 of this PMP). CAP continues to report on this indicator as CAP Partners continue to implement GBV activities that might not reach the 10-hour minimum requirement for the new GBV indicator (above), which came into effect in FY15.</p>	<p>a) Project Records</p> <p>b) FHI 360</p> <p>c) Quarterly</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: 13,913 Y5: 17,590 Y6: 9,950 Y7: 576</p> <p>Baseline Value: 0</p>
<p>Number of individuals screened for GBV (community partners)</p> <p><i>By Sex; Male, Female</i></p> <p><i>By Age: 0-4, 5-9, 10-14,</i></p>	<p>In order to be eligible, GBV screening must include appropriate referrals (for those screened positive) to at least one of the six GBV service component(s) that comprise the minimum package of services: a) PEP; b) EC; c) STI screening/Tx; d) HIV Testing and treatment; e) Psychosocial support; and e) Referrals (referrals could include a wide range of services, including psycho-social, legal, other counseling, pastoral care, emergency and other medical care, safe shelter, economic support and counseling etc.). The referral does not have to be completed in order to count someone as screened (i.e., the person does not have to follow-up with their</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly and Annually</p>	<p>Y1: N/A Y2: N/A Y3: N/A Y4: N/A Y5: N/A Y6: 295</p>

<p>15-17, 18-24, 25+</p> <p><i>By GBV Status: Positive, Negative</i></p>	<p>referrals in order to count as screened).</p> <p>Using checklists or other screening tools, and following nationally or regionally determined guidelines and plans, providers should screen for various forms of GBV. Screening should assess potential or actual experiences of emotional, physical, and sexual violence with and without force (e.g. coercion). Based on results of screening (e.g., threat of violence, experience of violence) provider should make and document referrals to relevant services. Referrals should include name of service organization or provider, as well as contact information (e.g. location, phone number, hours of service), though contact information need not be documented for purposes of this indicator.</p> <p>This is PEPFAR indicator P.GBV.06. The full definition can be found in the PEPFAR Indicators Reference Guide – PEPFAR Mozambique, Version 5.2, August, 2014.</p>		<p>Y7: 132</p> <p>Baseline Value: 0</p>
<p>Number of individuals referred to GBV services</p> <p><i>By Sex; Male, Female</i></p>	<p>These individuals are referred to a GBV service with the assistance of a community-based organization following screening. GBV services may include, but are not limited to, the following: health services and police.</p>	<p>a) Project Records</p> <p>b) FHI 360, Grantees</p> <p>c) Quarterly and Annually</p>	<p>Y1: N/A</p> <p>Y2: N/A</p> <p>Y3: N/A</p> <p>Y4: N/A</p> <p>Y5: N/A</p> <p>Y6: 82</p> <p>Y7: 26</p> <p>Baseline Value: 0</p>

Annex 1 – Changes to CAP Mozambique Targets

Fiscal Year 2013 (CAP Mozambique Project Year 4)

Summary of changes to CAP targets for FY13: CAP Mozambique first submitted targets for FY13 in September 2011. The team revised its FY13 targets in mid-2012 and included new provisional targets in its Annual Workplan (AWP) for FY13. These were further adjusted in January 2013 when CAP Mozambique responded to a COP-related request from the mission. On April 24, 2013, USAID communicated Mission-generated target revisions for CAP Mozambique for FY13. The table below shows the provisional targets CAP Mozambique proposed in its FY13 AWP, and those assigned by USAID on April 24, 2013.

Indicator	Targets submitted in September 2011	Targets in approved Workplan Sept 2012	Targets assigned by the Mission April 2013
P.SBRP.03.03: Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards	200	360	435
P.SBRP.01.03: Number of intended target population reached with individual and/or small group level preventative interventions that are based on evidence and/or meet the minimum standards	24,536	40,516	14,148
P.SBRP.02.03: Number of intended target population reached with individual and/or small group level HIV preventative interventions that are primarily focused on <u>abstinence and/or being faithful</u> , and are based on evidence and/or meet the minimum standards	13,564	8,500	2,987
SS-HRH.02: Number of health care workers who successfully completed an pre-service training program	276	1,906	2,028
P-SBRP.05: Number of targeted condom service outlets	4	125	
P-SBRP.04: Number of mass media spots delivered	-	30	
C-CCC.02: Number of OVC receiving OVC services	4,050	4,050	4,050
P.GBV.01.03: Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion (GBV)	n/a	n/a	13,913

Fiscal Year 2014 (CAP Mozambique Project Year 5)

The targets illustrated in the table below are those CAP presented in its AWP submitted September 2013, and the targets assigned to CAP Mozambique by the mission in March 2014.

Indicator	Targets in approved Workplan Sept 2013	Targets assigned by the Mission March 2014
P.SBRP.03.03: Number of Key Population reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards	500	N/A
P.SBRP.02.03: Number of intended target population reached with individual and/or small group level HIV preventative interventions that are primarily focused on <u>abstinence and/or being faithful</u> , and are based on evidence and/or meet the minimum standards	4,600	N/A
SS-HRH.02: Number of health care workers who successfully completed an pre-service training program	880	N/A
P-SBRP.05: Number of targeted condom service outlets	85	N/A
P-SBRP.04: Number of mass media spots delivered	9	N/A
P.SBRP.07: Number of each priority population reached who completed a standardized HIV prevention intervention including the specified minimum components during the reporting period	20,800	12,525*
C-CCC.02: Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS	5,200	5,470
C-CCC.03: Number of clients receiving home based care services	20	N/A
P.GBV.01 - Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion (GBV)	17,590	N/A
P-GBV.04 - Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS	7,700	N/A
P-GBV.06 - Number of people screened for GBV (community screening)	0	N/A
P-CT-01 – Number of individuals who received Counseling and Testing (C&T) services for HIV and received their test results	2,178	N/A