
# PEPFAR Guide to Monitoring & Reporting Voluntary Medical Male Circumcision (VMMC) Indicators

## APPENDICES

**July 2013**

**February 2013**

# Prevention
## Male Circumcision

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| **Indicator:**<br>**P5.1D**<br>Essential/Reported | **Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program within the reporting period** |
| **Type of Indicator:** | Direct |
| **Numerator:** | Number of males provided with voluntary medical circumcisision. Services are provided as part of a minimum package of MC for HIV prevention services per national standards and in accordance with the WHO/UNAIDS/Jhpiego *Manual for Male Circumcision Under Local Anesthesia.*[1] This number is comprised of those circumcised within the reporting period and disaggregated by age (required), HIV status (recommended), and service delivery location setting (recommended). |
| **Denominator:** | N/A |
| **Disaggregation:** | <table><tr><td>Required for HQ reporting and aggregation to program summary level</td><td><1</td></tr><tr><td>Required for HQ reporting and aggregation to program summary level</td><td>1-9</td></tr><tr><td>Required for HQ reporting and aggregation to program summary level</td><td>10-14</td></tr><tr><td>Required for HQ reporting and aggregation to program summary level</td><td>15-19</td></tr><tr><td>Required for HQ reporting and aggregation to program summary level</td><td>20-24</td></tr><tr><td>Required for HQ reporting and aggregation to program summary level</td><td>25-49</td></tr><tr><td>Required for HQ reporting and aggregation to program summary level</td><td>50+</td></tr></table><br>Recommended for in country partner level tracking<br>HIV positive by test(s) on site<br>HIV negative by test(s) on site<br>HIV indeterminate result by test(s) on site<br>Documented HIV positive result from other HTC provider<br>Documented HIV negative result from other HTC provider<br>Unknown HIV status/refused HIV test<br>Self-reported HIV negative and declined re-test (HIV status not verifiable)<br>Self-reported HIV positive and declined re-test (HIV status not verifiable)<br><br>Recommended for in country partner level tracking<br>Fixed/permanent location<br>Temporary (including mobile) location |
| **Purpose:** | Three randomized controlled clinical trials in sub-Saharan Africa demonstrated a 60% reduction in risk of female-to-male HIV transmission among men randomized to receive circumcision (compared to uncircumcised controls).[2,3,4] This evidence is supported by long-standing ecologic and observational data. Elective surgical male circumcision confers a partially protective effect against HIV acquisition for HIV-negative men at risk for acquiring HIV from HIV-positive |

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| | female sexual partners, and may be particularly beneficial in populations where HIV prevalence is high and male circumcision prevalence is low. **For maximal population impact, uptake of male circumcision should be as high and as rapid as safely possible and aligned with national policy**. The total number of males circumcised indicates a change in the supply of and/or demand for VMMC services. Additionally, disaggregated information may be useful to evaluate whether prioritized services have been successful at reaching the intended population (by age), set targets have been achieved, and modeling inputs should be adjusted. |
| **Applicability:** | All countries with PEPFAR-funded partners providing VMMC for HIV prevention services as part of the WHO-defined minimum package of services should report on this indicator. |
| **Data collection frequency:** | Data should be collected continuously at the program/site level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. monthly or quarterly, for the purposes of program management and review. |
| **Measurement tool:** | VMMC Registry or client medical records maintained by each program/site |
| **Method of measurement:** | The sum of clients documented as having received VMMC within the reporting period in VMMC Registries or clients' medical records maintained by programs.<br><br>Explanation: Males who are provided with circumcision as part of the VMMC for HIV prevention program and in accordance with the WHO/UNAIDS/Jhpiego *Manual for Male Circumcision Under Local Anesthesia*[1] and per national standards by funded programs/sites in the reporting period meet the definition for the numerator.<br><br>PEPFAR does not provide funding to perform male circumcision under general anesthesia or sedation, and cases of MC under general anesthesia/sedation should not be paid for by PEPFAR and should not be counted in the indicator. Children may receive PEPFAR-funded VMMC as long as the procedure is performed using local anesthesia and in accordance with the WHO/UNAIDS/Jhpiego *Manual for Male Circumcision Under Local Anesthesia*.[1] VMMC using local anesthesia should be deferred if the maturity level of the child precludes use of local anesthesia.<br><br>Programs should focus on compiling data for the numerator from MC Registers or client medical records maintained by funded programs/sites. A program site is a fixed or mobile facility that is able to provide all components of the minimum package of MC for HIV prevention services. The **VMMC minimum package of services** must include elective surgical male circumcision using local anesthesia provided after education and consent and delivered in the context of comprehensive HIV prevention messages/services that include the following age-appropriate services: on-site pre-operative HIV counseling and testing (offer of); active exclusion of symptomatic STIs and syndromic treatment when indicated; post-operative wound care and abstinence instructions; counseling on risk reduction, reducing number and concurrency of sexual partners, and delaying/abstaining from sex; and, provision and promotion of correct and consistent use of male and/or female condoms.<br><br>It is anticipated that some programs may establish formal referral relationships with voluntary counseling and testing (VCT) services to provide the HIV testing components of the MC minimum package of services. In these cases, a repeat HIV test 'on-site' may not be necessary, if the VMMC program and VCT service have agreed upon what constitutes 'certifiable results.' Though it is not possible |

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| | to mandate a specific length of time before the MC surgery that an HIV test must have been done, it is suggested that the HIV test be done within the prior 3 months.<br><br>Clients who present without a 'certifiable result' and wishing to defer HIV testing are should be encouraged to re-test for HIV at the MC site. Those who decline re-testing and insist on self-reporting should have their information recorded in the appropriate 'HIV status not verifiable' disaggregation category; however, self-reported results equate to an unknown HIV status.<br><br>Clients circumcised in a fixed/permanent location, such as a hospital or clinic, should be counted in the 'fixed/permanent location' recommended disaggregation category. Those circumcised in a school, tent, mobile facility, or in any location intended for use as another purpose but temporarily established for MC, should be counted in the 'temporary (including mobile) location' recommended disaggregation category. |
| **Interpretation:** | Programs are required to report on the actual number of males circumcised in accordance with the WHO/UNAIDS/Jhpiego *Manual for Male Circumcision Under Local Anesthesia*[1] so that the overall uptake and delivery of the PEPFAR-funded VMMC for HIV prevention services in the country can be monitored, outcomes evaluated, and impact of male circumcision on HIV incidence at a population level can be modeled. Comparing current and previous values of this indicator may reflect newly implemented service delivery or changes in volume of supply and/or demand. When the number of male circumcisions is disaggregated by age and HIV status, it will be possible to adjust inputs used in models to determine impact of male circumcision programs on HIV incidence. Disaggregation by age may be particularly helpful in determining whether age-specific communication strategies are working to create demand. Disaggregation by service delivery location/setting may allow for evaluation of resource allocations. Non-PEPFAR funded providers also performing MCs within the reporting period will not be captured by this indicator, and any broader evaluations of population-level uptake will need to be interpreted accordingly. |

# Prevention
## Male Circumcision

<table>
<tr><td>Indicator: #P5.2.D<br>Essential/ Reported</td><td>Number of circumcised clients experiencing at least one moderate or severe adverse event (AE) during or following surgery, within the reporting period</td></tr>
<tr><td>Type of Indicator:</td><td>Direct</td></tr>
<tr><td>Numerator:<br>Essential/Reported</td><td>Number of clients circumcised that experience (reporting back to the respective circumcising program) one or more moderate or severe AE(s) during the reporting period, according to the date of MC surgery.</td></tr>
<tr><td>Denominator:</td><td>N/A</td></tr>
<tr><td>Disaggregation:</td><td>
<table>
<tr><td>Recommended for</td><td>Severe AE(s) (number of clients with at least one (or more) severe AE(s) reported)</td></tr>
<tr><td>Recommended for</td><td>Moderate AE(s) (number of clients with at least one (or more) moderate AE(s) reported, no AE(s) qualify as severe)</td></tr>
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<table>
<tr><td>Recommended for</td><td>First AE(s) onset day 0, intra-operative/prior to discharge from the facility</td></tr>
<tr><td>Recommended for</td><td>First AE(s) onset day 0, following discharge from the facility</td></tr>
<tr><td>Recommended for</td><td>First AE(s) onset post-operative days 1-6</td></tr>
<tr><td>Recommended for</td><td>First AE(s) onset post-operative day $\geq$ 7</td></tr>
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<table>
<tr><td>Recommended for</td><td>Moderate/Severe anesthesia reaction</td></tr>
<tr><td>Recommended for</td><td>Moderate/Severe bleeding</td></tr>
<tr><td>Recommended for</td><td>Moderate/Severe infection</td></tr>
<tr><td>Recommended for</td><td>Moderate/Severe pain</td></tr>
<tr><td>Recommended for</td><td>Moderate/Severe wound disruption</td></tr>
<tr><td>Recommended for</td><td>Moderate/Severe sexual dysfunction/undesirable sensory change</td></tr>
<tr><td>Recommended for</td><td>Moderate/Severe scarring/disfigurement/poor cosmetic result; excess skin removal; injury to glans/shaft of penis</td></tr>
<tr><td>Recommended for</td><td>Occupational exposure to blood/body fluids</td></tr>
<tr><td>Recommended for</td><td>Moderate/Severe other AE(s): excess swelling of penis/scrotum (including hematoma); difficulty urinating; other</td></tr>
</table>
</td></tr>
<tr><td>Purpose:</td><td>3 randomized controlled clinical trials in sub-Saharan Africa demonstrated a 60% reduction in risk of female-to-male HIV transmission among men randomized to receive circumcision (compared to uncircumcised controls). This evidence is supported by long-standing ecologic and observational data. Elective surgical male circumcision confers a partially protective effect against HIV acquisition for HIV-negative men at risk for acquiring HIV from HIV-infected female sexual partners, and may be particularly beneficial in generalized HIV epidemics and where HIV</td></tr>
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| | prevalence is high and male circumcision prevalence is low. **Like all surgeries, male circumcision is not without risk, and the performance and reporting of safe MC services depends in part upon skill and quality of surgery, effectiveness of post-operative instructions, willingness or ability of the patient to follow post-operative instructions, suitability of the surgical candidate, level of CD4 count if HIV-positive, and the judgment of the healthcare personnel assessing AEs. Intra- and post-operative complications must be monitored to ensure maximization of the provision of safe, quality MC services**, and in turn engender trust in communities and foster high demand for MC services. |
| **Applicability:** | All countries with PEPFAR-funded partners providing the VMMC minimum package of services should report on this indicator. |
| **Data collection frequency:** | Data should be collected continuously at the program/site level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. monthly or quarterly, for the purposes of program management and review. |
| **Measurement tool:** | VMMC Register, Adverse Event Register, or client medical records maintained by each service provider |
| **Method of measurement:** | Sum of clients experiencing moderate and severe adverse events documented in Adverse Event Monitoring Logs or client medical records maintained by programs.<br><br>Explanation: Clients who have documentation in the facility record that they experienced one or more moderate or severe AEs (AEs would necessarily have to be reported back to the respective circumcising program) during or following MC surgery meet the definition for the numerator. It is the date of surgery, not the date of AE(s), that must fall within the reporting period. For instance, if the reporting period is October 1, 2009, through December 31, 2009, and a client was circumcised December 29, 2009 and had a moderate adverse event on January 2, 2010, then this client would meet the definition and be included in the numerator (since his surgery was performed within the reporting period, even though his adverse event occurred after the reporting period). Adverse events must be documented in a client's clinic record or registry by the facility that performed the surgery. For this reason, it is anticipated that the indicator reporting may reflect fewer adverse events than actually occurred (as clients experiencing AE(s) may not return to the facility at all, seek care for AE(s) elsewhere, or the facility may fail to document occurrence of the AE(s) in the appropriate record). For reporting purposes, AEs include MC cases involving an occupational exposure to blood/body fluids. Occupational exposure to blood/body fluids (splash, sharps injuries) are based upon guidelines set forth in the WHO/ILO *Post-exposure Prophylaxis to Prevent HIV Infection* (http://www.who.int/hiv/pub/guidelines/PEP/en/index.html)<br><br>For the specific moderate/severe AEs listed in the disaggregation above, the following guidance for distinguishing between moderate and severe is offered. Routine reporting of moderate and severe AEs is all that is recommended. AEs of seriousness less than moderate should not be reported.<br><br>ANESTHESIA REACTION:<br><br>**Moderate:** Reaction to anesthetic including lightheadedness, nervousness, dizziness that resolves spontaneously and **not** requiring use of medicines or equipment from the emergency cart/kit/list of emergency commodities at MC site and no transfer to another facility or admission to hospital (localized itching at the injection site would not qualify as a moderate AE). |

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| | **Severe**: Symptoms of severe allergic reaction to local anesthetic including rash, urticaria, angioedema and shortness of breath, or symptoms of overdosage of local anesthetic including lightheadedness, nervousness, confusion, dizziness, drowsiness, ringing of ears, blurred or double vision, sensations of heat, cold or numbness, twitching, tremors, convulsions, unconsciousness, respiratory depression, bradycardia, hypotension requiring use of medicines or equipment from the emergency cart/kit/list of emergency commodities or hospitalization to manage the reaction.<br><br>BLEEDING:<br>Moderate: Intra-operative bleeding that requires a pressure dressing to control; or post-operative bleeding that requires a special return to the clinic for a pressure dressing or additional skin sutures without surgical re-exploration of the wound. (Intra-operative bleeding that is easily controlled or post-operative spotting of the bandage with blood would not qualify as a moderate AE).<br>Severe: Intra-operative bleeding requiring blood transfusion, transfer to another facility, or hospitalization; or post-operative bleeding that requires surgical re-exploration, hospitalization, or transfer to another facility.<br><br>INFECTION:<br>Moderate: Discharge from the wound, painful swelling with erythema or elevated temperature or use of oral antibiotics (Erythema around the incision line, by itself, would not be serious enough to qualify as a moderate AE)<br>Severe: Cellulitis or abscess of the wound, or infection severe enough to require surgical intervention, hospitalization or intravenous or intramuscular antibiotic therapy.<br><br>PAIN (INTRA- AND POST-OPERATIVE):<br>Moderate: Pain serious enough to result in disability (as evidenced by loss of work or cancellation of normal activities) that lasting for at least 1 day after surgery. Pain that results in early termination of surgery would also be considered a moderate pain AE.<br>Severe: Pain serious enough to result in disability (as evidenced by loss of work or cancellation of normal activities) more than one day after surgery.<br><br>WOUND DISRUPTION:<br>Moderate: Wound disruption that is extensive enough to require suturing or other clinical intervention (but not surgery).<br>Severe: Surgical re-exploration is required, or referral/transfer to another facility or hospitalization is required.<br><br>SEXUAL DYSFUNCTION/UNDESIRABLE SENSORY CHANGES:<br>Moderate: Post-operative changes that impair or preclude sexual function for between 3 and 6 months after the date of surgery that were not present prior to surgery (sexual dysfunction for a shorter period would not qualify as a moderate AE)<br>Severe: Post-operative changes that impair or preclude sexual function for greater than 6 months after the date of surgery and were not present prior to surgery<br><br>SCARRING/DISFIGUREMENT/POOR COSMETIC RESULT; EXCESS SKIN REMOVAL; INJURY TO GLANS:<br><br>Scarring/disfigurement/poor cosmetic result |

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| | Moderate: Scarring/disfigurement is discernible but re-operation not required (absence of discernible scarring/disfigurement, despite a client's complaint about the surgical outcome, would not be considered a moderate AE).<br>Excess skin removal<br>Moderate: Tightening of the skin is discernible but re-operation not required (absence of discernible tightening of skin, despite a client's complaint about the surgical outcome, would not be considered a moderate AE).<br><br>Injury to glans/shaft Moderate: Abrasion of the glans or shaft requiring pressure dressing, but surgical repair is not required.<br>Scarring/disfigurement/poor cosmetic result Severe: Requires re-operation or referral/transfer to another facility<br>Excess skin removal Severe: Requires re-operation or referral/transfer to another facility<br>Injury to glans/shaft Severe: Injury that requires additional surgical intervention to stop bleeding or to repair, including additional surgical intervention at the time of the initial surgery. Severing of the glans or shaft is also considered a severe AE.<br><br>OCCUPATIONAL EXPOSURE:<br>Moderate: All occupational exposures are moderate (none are mild or severe)<br><br>OTHER: EXCESS SWELLING OF PENIS/SCROTUM (INCLUDING HEMATOMA); DIFFICULTY URINATING; OTHER:<br>Excess swelling of penis/scrotum (including hematoma) Moderate: Symptoms /signs that require clinical intervention (not surgery).<br>Difficulty urinating Moderate: Partial obstruction requiring a special return to the clinic but not surgical intervention nor placement of a catheter (transient difficulty urinating that resolves on its own would not be considered a moderate AE).<br>Other Moderate: Other adverse events related to the surgery that result in disability (as evidenced by loss of work or cancellation of normal activities) lasting for at least 4 days after surgery but not more than 7 days.<br>Excess swelling of penis/scrotum (including hematoma) Severe: Surgical re-exploration required or symptoms /signs so extraordinary as to cause disability (as evidenced by loss of work or cancellation of normal activities) lasting for at least 8 days after surgery<br>Difficulty urinating Severe: Complete obstruction and/or requires placement of a catheter, referral for treatment or surgery to correct.<br>Other Severe: Other AE(s) related to the surgery that result in disability (as evidenced by loss of work or cancellation of normal activities) lasting for at least 8 days after surgery, or result in hospitalization or referral/transfer to another facility.<br><br>It is anticipated that some programs may establish formal referral relationships with voluntary counseling and testing (VCT) services to provide the HIV testing components of the VMMC minimum package of services. In these cases, a repeat HIV test 'on-site' may not be necessary, if the VMMC program and VCT service have agreed upon what constitutes 'certifiable results.' Though it is not possible to mandate a specific length of time before the MC surgery that an HIV test must have been done, it is suggested that the HIV test be done within the prior 3 months. Clients who present without a 'certifiable result' and wishing to defer HIV testing are not able to self-report their result. Such clients should be counted in the 'unknown/refused HIV test' recommended disaggregation category.<br><br>Clients circumcised in a fixed/permanent location, such as a hospital or clinic, should be counted in the 'fixed/permanent location' recommended disaggregation category. |

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| | Those circumcised in a school, tent, mobile facility, or in any location intended for use as another purpose but temporarily established for VMMC, should be counted in the 'temporary (including mobile) location' recommended disaggregation category. |
| **Interpretation:** | Programs are recommended to report the number clients experiencing moderate or severe adverse events to allow for monitoring of safe, quality service provision. Frequency, and frequency of severity, of AEs above 'an acceptable level' is an indication of the need for investigation into causes and possible interventions. Further, disaggregation by timing of adverse event may inform planning of post-operative care considerations, particularly from mobile/remote services that may have limited availability following surgery. Disaggregation by specific type of AE may help determine the need for additional training to prevent or manage certain complications. |

# VMMC Indicator (P5.3D): Facilities

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| **Indicator:** Recommended | **Number of locations providing MC surgery as part of the minimum package of MC for HIV prevention services within the reporting period** |
| **Type of Indicator:** | Direct |
| **Numerator:** | Number of separate locations providing MC surgery as part of the minimum package of MC for HIV prevention services per national standards and in accordance with the WHO/UNAIDS/Jhpiego *Manual for Male Circumcision Under Local Anesthesia*[1] within the reporting period and disaggregated by services delivery location setting (recommended). |
| **Denominator:** | N/A |
| **Disaggregation:** | Recommended for in country partner level tracking<br>Fixed/permanent location(s)<br>Temporary (including mobile) location(s) |
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| **Purpose:** | Three randomized controlled clinical trials in sub-Saharan Africa demonstrated a 60% reduction in risk of female-to-male HIV transmission among men randomized to receive circumcision (compared to uncircumcised controls).[2,3,4] This evidence is supported by long-standing ecologic and observational data. Elective surgical male circumcision confers a partially protective effect against HIV acquisition for HIV-negative men at risk for acquiring HIV from HIV-positive female sexual partners, and may be particularly beneficial in populations where HIV prevalence is high and male circumcision prevalence is low. **Sufficient number and strategic placement of locations are necessary in order to meet demand with supply of human and material resources.** The number and type of location setting will be monitored to ensure adequacy and efficiency of resource allocation, and in turn provide the highest level of service as safely possible. |
| **Applicability:** | All countries with PEPFAR-funded partners providing the MC minimum package of services should report on this indicator. |
| **Data collection frequency:** | Data should be collected continuously at the program/site level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. monthly or quarterly, for the purposes of program management and review. |
| **Measurement tool:** | Program administrative records |
| **Method of measurement:** | The sum of separate locations providing MC surgery as part of the minimum package of MC for HIV prevention services within the reporting period.<br><br>Explanation: A location that provides MC surgery as part of the minimum package of MC for HIV prevention services in accordance with the WHO/UNAIDS/Jhpiego *Manual for Male Circumcision Under Local Anesthesia*[1] and per national standards by funded programs/sites in the reporting period meets the definition for the numerator. |
| | Static structures (constructed foundation, walls, roof) used to provide medical care services, such hospitals or clinics, should be counted in the 'fixed/permanent location' recommended disaggregation category. Non-permanent structures (such as tents or temporary facilities), mobile services units, and structures typically used for non-medical purposes (such as schools, churches, etc.) should be counted in the 'temporary (including mobile) location' recommended disaggregation category. |

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| **Interpretation:** | Programs are recommended to report on the number of locations providing MC surgery as part of the minimum package of MC for HIV prevention services umber of males circumcised in accordance with the WHO/UNAIDS/Jhpiego *Manual for Male Circumcision Under Local Anesthesia*[1] so that the total number of locations and location settings can be monitored and evaluated. Comparing current and previous values may indicate newly opened or closed locations in response to changes in demand, or need for opening of new or closing or moderating of existing locations (when compared with levels of services provision). When disaggregated by location setting, resource allocation may be guided to areas underserved areas. In addition, if service location data is mapped, geographic coverage may be evaluated. |

# VMMC Indicator (P5.4D): Follow-up Rates

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| **Indicator:** Recommended | **Number of males circumcised within the reporting period who return at least once for post-operative follow-up care (routine or emergent) within 14 days of surgery** |
| **Type of Indicator:** | Direct |
| **Numerator:** | Number of clients circumcised within the reporting period who return to the MC surgery location (or designated alternate location) at least once for post-operative follow-up care within 14 (?) days of surgery |
| **Denominator:** | N/A |
| **Disaggregation:** | None |
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| **Purpose:** | Three randomized controlled clinical trials in sub-Saharan Africa demonstrated a 60% reduction in risk of female-to-male HIV transmission among men randomized to receive circumcision (compared to uncircumcised controls).[2,3,4] This evidence is supported by long-standing ecologic and observational data. Elective surgical male circumcision confers a partially protective effect against HIV acquisition for HIV-negative men at risk for acquiring HIV from HIV-positive female sexual partners, and may be particularly beneficial in populations where HIV prevalence is high and male circumcision prevalence is low. **After MC surgery, follow-up care is important for assessment of potential surgical complications and reinforcement of HIV prevention counseling messages (abstinence during wound healing and lifelong sexual risk reduction strategies).** Follow-up rates will be monitored to ensure sufficient number of clients are returning to MC locations for assessment, care, and counseling. |
| **Applicability:** | All countries with PEPFAR-funded partners providing the MC minimum package of services should report on this indicator. |
| **Data collection frequency:** | Data should be collected continuously at the program/site level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. monthly or quarterly, for the purposes of program management and review. |
| **Measurement tool:** | MC Register or client medical records maintained by each service provider |
| **Method of measurement:** | The sum of clients returning to the MC surgery location for post-operative follow-up care within the reporting period (by date of surgery).<br><br>Explanation: Clients who have documentation in the facility record that they returned to the location (or designated alternate location) at least once for post-operative care within 14 (?) days of surgery meet the definition for the numerator. Follow-up care may be either routine or emergent. It is the date of surgery, not the date of follow-up care, that must fall within the reporting period. |

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| | For instance, if the reporting period is October 1, 2009, through December 31, 2009, and a client was circumcised December 29, 2009 and returned to the location for follow-up on January 2, 2010, then this client would meet the definition and be included in the numerator (since his surgery was performed within the reporting period, even though his follow-up occurred after the reporting period). Follow-up must be documented in a client's clinic record or registry by the facility that performed the surgery. For this reason, it is anticipated that the indicator reporting may reflect a lower rate of post-operative care than actually occurred (as clients may seek follow-up care elsewhere). |
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| **Interpretation:** | Programs are recommended to report on the number of clients returning to the location of MC surgery for post-operative care so that follow-up rates can be monitored and evaluated. Low follow-up rates may indicate a problem with education and counseling on the need for post-operative care and/or barriers to accessing post-operative care. Follow-up rates may also help interpret adverse event data which are collected at the time of follow-up. If both rates of follow-up and adverse events are low, for example, the true adverse event rates may be either higher or lower than reflected by the data. Clients lost to follow-up not only fail to receive clinical assessment, they also fail to receive reinforcement of counseling and risk reduction messages. |

# NATIONAL-LEVEL INDICATORS

## VMMC Indicator: Number Performed

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| **Indicator:** Essential/Reported | **Number of males circumcised per national standards within the reporting period (regardless of funding source)** |

## VMMC Indicator: Percentage Circumcised

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| **Indicator:** Essential/Reported | **Percentage of males in the population circumcised** |

# Health System Strengthening
## HRH - in-Service Training

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| **Indicator #H2.3.D** Essential/Reported | **Number of health care workers who successfully completed an in-service training program within the reporting period** |
| **Type of Indicator:** | Direct |
| **Numerator:** Essential/Reported | The number of health care workers who successfully completed an in-service training program |
| **Denominator:** | N/A |
| **Disaggregation:** | Essential/Reported: Male Circumcision and Pediatric Treatment Training<br>Essential/Not Reported: All program areas |
| **Purpose:** | It is widely acknowledged that the lack of trained health workers is a major barrier to scaling up HIV/AIDS services. The lack of a sufficient workforce in the PEPFAR countries presents a serious challenge not only to HIV/AIDS programs but to every area of health.<br><br>The data will tell us the number of health care workers who are available to support the mitigation of the HIV/AIDS epidemic each year as a result of full or partial PEPFAR support.<br><br>This indicator will not be collected at OGAC by cadre of health care worker; however, if the data are available by cadre in country and reviewed along with survey or other human resources data, country teams could gain some understanding about whether the participants completing in-service training programs represent the correct ratio of health care worker cadres and whether the 'mix' of health care workers is the correct 'mix' to meet the human resource demands of the health system, according to each country's epidemiological profile and other factors. Based on this data, countries can determine how to prioritize investments in the education and on-going training of health care workers to maximize workforce expansion and capacity building within the cadres of professionals that are most needed. |
| **Applicability:** | All countries with PEPFAR-funded partners with a focus on expanding the quality and capacity of the workforce through the provision of in-service training should report on this indicator. |
| **Data collection frequency:** | Data should be collected continuously from training facilities and aggregated in time for PEPFAR reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation from partners, i.e. quarterly, for the purposes of program management and review. |
| **Measurement tool:** | Program reports, Human Resource Information Systems, educational institutions, professional associations, Ministry of Education, Labor or Health. Note: these data were collected under PEPFAR I, however, it was done so by program area. Now, it will all be collected under one indicator, but will be disaggregated by program area, so that no new data forms need to be developed. |
| **Method of measurement:** | The number is the sum of health care workers who successfully completed an in-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. In the absence of international or national standards, the minimum requirement will be determined by the PEPFAR country team.<br><br>Any individual involved in safeguarding and contributing to the prevention, |

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| | promotion, and protection of the health of the population may be counted in this in-service training indicator. Refer to the pre-service training indicators #H2.1.D and #H2.2.D for illustrative, but not exhaustive, examples of the types of workers one might include. This in-service training indicator includes health workers as illustrated in indicator #H2.1.D and community health and para-social workers as illustrated in #H2.2.D. There are no specific exclusions to this in-service training indicator #H2.3.D.<br><br>Explanation:<br>Training is a learning activity taking place in in-country, 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.<br><br>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 clinical mentoring or structured supervision so long as the following three criteria are met:<br><br>1) Training objectives are clearly defined and documented<br>2) Participation in training is documented (e.g. through sign-in sheets or some other type of auditable training)<br>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.)<br><br>The unit of measure is the number of persons trained or retrained. A person is counted as having been trained if he or she participates in a workshop or course, sponsored with USG support (in whole or in part), with a specific training subject, area, theme or topic. Some examples of training domains are: (1) Delivering home-based care to HIV infected persons; (2) New methods for ensuring financial accountability; (3) Treatment of resistant HIV Infection; (4) Provincial M&E training. If a person attended all four of the above courses, for example, that person should be counted four times. If a person repeats the same training course, he/she should not be counted twice. Please count the staff/volunteers of your organization who were trained, as well as any additional individuals (e.g. from a different organization) that you may have trained in a USG-supported training course that your organization implemented. Only participants who complete the full training course should be counted.<br><br>An individual should only be counted once they have completed the training. Individuals that are mid-way through a training course should be counted in the next reporting period. Individuals attending more than one training in a particular program area during a reporting period should only be counted once. Individuals participating in training that covers more than one program area may be counted in each of the respective areas.<br><br>If two partners are providing different aspects of training to the same individuals in the same program area (e.g. one partner provides classroom training, another provides clinical mentoring), each partner should report the number of persons uniquely trained by their respective organization, but should note which partner is |

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| | providing the complementary training role and estimate the number of persons counted by both partners.<br><br>In the specific case where USG-supported partners conduct training events that include the staff of sub-grantees, then the prime partner should report all the persons trained, in order to avoid double counting.<br><br>In-service 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. In-service training may update existing knowledge and skills, or add new ones. Care should be taken to base trainee selection on content and skill needs. It requires a shorter, more focused period of time than pre-service education, and is often more "hands-on." It can be a workplace activity (led by staff, peers or guest lecturers) or an external event.<br><br>In-service training can occur through structured learning and follow-up activities, or through less structured means, to solve problems or fill identified performance gaps. In-service training can consist of short non-degree technical courses in academic or in other settings, non-academic seminars, workshops, on-the-job learning experiences, observational study tours, or distance learning exercises or interventions.<br><br>An in-service training program must meet national or international standards and have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion. The duration and intensity of training will vary by cadre; however, all training programs should have at a minimum the criteria listed above.<br><br>This indicator is distinct and separate from the indicator for pre-service training and education – a health care worker may be counted under both indicators ONLY if that worker has completed pre-service training and education distinct and separate from their in-service training in the same reporting period.<br><br>Types of In-service Training:<br>1. Continuing education: Education/training offered to current providers to either update or add new knowledge and skills. While in-service training is often limited to practitioners in the public sector and/or managed by the Ministry of Health (or similar entity), continuing education is often used to describe education/training that is provided by other sources, such as professional associations, that reaches private sector practitioners and which can be linked to re- licensure and/or certification.<br>2. On-the-job training: Instruction in a specific task or skill is provided via mentoring by a practitioner using explanations, demonstration, practice and feedback. On-the-job training may be combined with academic or technical training to provide a practical experience component.<br>3. Computer based training: An interactive learning experience in which the computer provides most of the stimuli, the learner responds, and the computer analyzes the responses and provides feedback to the learner. Components most often consist of drill-and practice, tutorial, or simulation activities offered alone or as supplements to traditional instruction. CBT is sometimes also used as a component of a pre-service education course.<br>4. Distance learning: Distance learning is characterized by a geographic |

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| | separation of instructor and learner where learners work on their own. It uses a range of mechanisms such as self-guided lesson plans, mailings, radio, and computer based activities. Usually it is tied to an educational facility and uses sequential instructional material that is corrected by the instructor. Regardless of methodologies chosen, it requires motivation on the part of the learner and regular feedback on the part of the learning institution. It can also be used for pre-service education.<br><br>Explanation of Subsets:<br><br>MALE CIRCUMCISION TRAINING: CIRCUMCISION TRAINING: Persons who receive in-service training in one or more of the following functions in the delivery of MC for HIV prevention services should be counted in this sub-set: 1) MC provider/surgeon (persons who surgically remove the foreskin, regardless of whether they are a physician, nurse, clinical officer, etc.); 2) surgical assistant; 3) counselor (persons who provide education and counseling of clients on MC); and/or 4) ancillary staff (persons who perform sterilization and preparation of surgical instruments/equipment). Training may be for infant or adolescent/adult MC surgical methods. Persons who receive training to perform multiple functions (i.e., as both counselor and surgical assistant), and persons trained in multiple methods (infant and adolescent/adult methods) should only be counted once.<br><br>Programs should focus on compiling data on male circumcision training from Training Registers maintained by funded programs. MC for HIV prevention services in adolescents/adults is comprised of a minimum package of components that includes elective surgical male circumcision using local anesthesia provided after education and consent and delivered in the context of comprehensive pre-operative HIV counseling and testing (offer of), pre-operative STI assessment (and treatment when indicated), post-operative HIV risk reduction counseling and abstinence/healing instructions, and provision of condoms.<br><br>PEDIATRIC TREATMENT TRAINING: Persons who receive in-service training to perform a key function in the pediatric treatment should be counted in this sub-set. Pediatric treatment in-service training will fall into the following categories for this indicator:<br>- Nurse<br>- Counselor<br>- Clinical Officer<br>- Physician<br>- Health Surveillance Advisor (HSA)<br>- Pharmacist<br>In-service training for the purposes of this indicator includes the following modalities in addition to traditional classroom training and workshops:<br>- Issues in pediatric treatment<br>- Dosing for children<br>- Adherence counseling for children<br>- Appropriate clinical monitoring of therapy<br><br>Definition of PEPFAR support: PEPFAR support includes funding for full or partial support of an in-service training activity, including course development, training materials, trainer salaries, training site rental or renovation, participant per diem and travel costs. |

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| | When unclear about the level of PEPFAR support, refer to the principles of the Direct definition. You will need to apply these principles to what you are counting. |
| **Interpretation:** | This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator does not measure the placement or retention in the health workforce of trained individuals.<br><br>Although training is an essential component of human resources for health, programs should plan it in the context of effective human resources management and an overall HRH strategy. |

# Prevention

## Sexual and other Risk Prevention for General Population

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| **Indicator #P8.1.D** Essential/Reported | **Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required** |
| **Type of Indicator:** | Direct |
| **Numerator:** Essential/Reported | Number of the **target population** reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required |
| **Denominator:** Recommended | Total number of intended target population in the catchment area<br>*Recommended at partner level only |
| **Disaggregation:** Recommended | By Sex: Male, Female<br>By Age: 10-14, 15+ |
| **Purpose:** | Individual and small-group level prevention interventions have been shown to be effective in reducing HIV transmission risk behaviors. Delivering these interventions with fidelity (including intended number of sessions) to the appropriate populations is an important component of comprehensive HIV prevention strategies.<br><br>It is important to know how many people complete an intervention in order to monitor how well programs are reaching the intended audience with HIV prevention programming.<br><br>This information can be used to plan and make decisions on how well a certain audience is being reached with individual and/or small group level interventions. If a small percentage of the intended audience is being reached with either one intervention, then it would be recommended that activities are adjusted to improve reach. If a large percentage of the intended audience is being reached, then headquarter staff would want to take these lessons learned and disseminate them to other countries. The country can use the information to improve upon the quality of the program as well as scale-up successful models. |
| **Applicability:** | All countries with PEPFAR-funded partners who implement individual and/or small group level prevention interventions that seek to modify behaviors that lead to HIV transmission among general populations, including adult and youth (both in and out of school youth). |
| **Data collection frequency:** | Data should be collected continuously at the organization level. Data should be aggregated in time for PEPFAR annual reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review |
| **Measurement tool:** | Data can be obtained from program monitoring tools. |
| **Method of measurement:** | This indicator is intended to capture programs targeting **general populations**. Programs that specifically target MARP or PLWHA populations should **not** be counted under this here. Instead count these populations under indicators #P8.3.D and #P7.1.D respectively.<br><br>Explanation of Numerator<br>The numerator can be generated by counting the number of de-duplicated individuals from an activity defined target population who are reached with and complete the defined prevention intervention. |

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| | *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.*<br><br>In order to be counted, an individual should complete the intended number of sessions that were implemented with fidelity to the intervention.<br><br>*Number reached:* Number of individuals in the target population who are reached with and complete individual and/or small group level HIV Prevention interventions that are based on evidence and/or meet the minimum standards required.<br><br>*Intended Target Population*: The specific target population around which a prevention intervention was intentionally designed. Populations to be counted in this indicator are general population adult and/or youth, including both in school and out of school youth. For this indicator, populations that participate in a variety of behavioral risks could be counted, including but not limited to the following illustrative examples: individuals who engage in: transactional sex (giving or receiving a gift in exchange for sex); sex under the influence of alcohol; other behaviors that could place them at risk of transmission.<br><br>Only individuals representing the specific 'intended audience' will count under this indicator. For example: If a program activity is designed to target youth (ages 10-15) and individuals who are much older or much younger than the intended target population participate in the activity, then these individuals should not be counted. Only the 10-15 year olds for which the program was designed should be counted.<br><br>*Individual-level interventions (ILI):* Interventions that are provided to one individual at a time (e.g., individual counseling). The intervention assists clients in making plans for individual behavior change and ongoing appraisals of their own behavior. Counseling associated with testing and counseling should not be counted here.<br><br>*Small group level interventions (GLI):* Interventions that are delivered in small group setting (less than 25 people) and that assist clients in making plans for behavior change and appraisals of their own behavior. Small group can include a family or couple.<br><br>*Evidence-based interventions*: Interventions based on the country's epidemic, the drivers of that epidemic, and the most current understanding of behavioral and/or social science. Evidence based HIV behavioral interventions have been rigorously evaluated and have been shown to have significant and positive evidence of efficacy (e.g. elimination or reduction of risky sexual or drug taking behaviors). These interventions are considered to be scientifically sound, provide sufficient evidence of efficacy in other contexts and/or target populations, and address HIV prevention needs of the communities by targeting |

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| | the specific target population.<br><br>Comprehensive prevention programs must be based on evidence and/or meet the minimum standards required.<br><br>*Minimum Standards Required:* In the absence of evidence-based interventions, other interventions that could be considered for implementation are those who meet the minimum standards required. These interventions are based on sound behavioral science theory and do have some empirical evidence in the form of being based on formative assessment results. They can also be based on a past successful program. All programs should use process monitoring data to continually gage the appropriateness of the intervention and plan to collect outcome monitoring data to determine effectiveness.<br>In order to count persons reached, the interventions must:<br>– have a clearly defined audience<br>– have clearly defined goals and objectives<br>– be based on sound behavioral and social science theory<br>– be focused on reducing specific risk behaviors<br>– have activities that address the targeted risk behaviors<br>– employ instructionally sound teaching methods<br>– provide opportunities' to practice relevant risk reduction skills<br><br>*Intended number of sessions:* The number of sessions defined in the program description and as prescribed in the intervention. One component linked to the effectiveness of curriculum-based programs is completing the intended number of sessions of that curriculum. If fewer sessions are conducted, then that program is not following one of the criteria for effective curriculum based sessions. Activity narratives or partner plans should define the number of sessions that are planned and how many (percent of) sessions that must be attended/completed by an individual in order to "count." This may be done activity by activity with oversight from PEPFAR in-country team or the in-country team may wish to set a standard for all partners working in the area of prevention.<br><br>*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.<br><br>Comprehensive prevention programs include interventions at multiple levels (e.g., mass media, community-based, workplace, small group, and 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 and counseling and testing, 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 |

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| | 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.<br><br>*Explanation of Denominator (recommended at partner level):*<br>Catchment area: Geographic region from which persons come to receive HIV prevention services, or from which persons are being recruited into HIV prevention services. The size and population of this area can vary, depending on organization or agency and the services provided. For the general population, depending on the target sites, there may be a registration available of individuals between the ages of 25 and 49. Population estimates for sub-districts/districts/regions can also be used if available.<br><br>The percent coverage can be determined if both the numerator and denominator are included. Country teams can encourage their partners to consider ways to estimate denominators, using similar methods used in estimating targets. |
| **Interpretation:** | This indicator provides information on the total number of unduplicated individuals that received individual-level and/or small-group level interventions. |
| **Additional Information** | Refer to the PEPFAR Behavior Based Prevention Indicator TWG with further inquiries. |

# Prevention
## Testing and Counseling

<table>
<tr><td>Indicator #P11.1.D<br>Essential/Reported</td><td>Number of individuals who received HIV Testing and Counseling (HTC) services for HIV and received their test results</td></tr>
<tr><td>Type of Indicator:</td><td>Direct</td></tr>
<tr><td>Numerator:<br>Essential/Reported</td><td>Number of individuals who received HTC services and received their test results during the past 12 months</td></tr>
<tr><td>Denominator:</td><td>N/A</td></tr>
<tr><td>Disaggregation:</td><td>
<table>
<tr><td>Essential/Reported</td><td>By Age/Sex: <15 Male</td></tr>
<tr><td>Essential/Reported</td><td>By Age/Sex: <15 Female, 15+</td></tr>
<tr><td>Essential/Reported</td><td>By Age/Sex: 15+ Male</td></tr>
<tr><td>Essential/Reported</td><td>By Age/Sex: 15+ Female</td></tr>
<tr><td>Essential/Reported</td><td>By test result: Positive, Negative</td></tr>
<tr><td>Recommended</td><td>By type of counseling: Individual, Couples*</td></tr>
<tr><td>Recommended</td><td>By MARP type: CSW, IDU, MSM</td></tr>
</table>
</td></tr>
<tr><td>Purpose:</td><td>This indicator is intended to monitor trends in the uptake of HTC services within a country, regardless of the type of HTC setting type or strategy. Further the disaggregation by serotype provide information about the overall % HIV-positive yields of persons tested and contribute to an understanding of linkage through proxy (new diagnoses to new care/treatment enrollments).<br><br>The recommended levels of disaggregation are intended to monitor access to and uptake of HTC by specific populations that are most affected by the epidemic. Data could also be useful for projecting programmatic needs such as test kits and other staffing resources, although individuals are counted.</td></tr>
<tr><td>Applicability:</td><td>All countries with PEPFAR-funded partners directly supporting HTC services regardless of where the service is being delivered and the population groups receiving the services, including TB patients, pregnant women, HIV-exposed infants, and circumcised males.</td></tr>
<tr><td>Data collection frequency:</td><td>Data collection at the PEPFAR funded site should be ongoing. Data analysis and review should be done quarterly to monitor progress towards achieving the targets, and to identify and correct any data quality issue. . Data should be collected, analyzed, and aggregated in time for PEPFAR reporting cycles.</td></tr>
<tr><td>Measurement tool:</td><td>Existing HTC registers and reporting forms that are already being used to capture HTC encounters could be revised to include the disaggregation categories.<br><br>Examples of data collection forms include client intake forms, activity report forms, or health registers such as STI registers, HMIS registers and NGO records.</td></tr>
<tr><td>Method of measurement:</td><td>Data for the numerator should be generated by counting the total number of individuals who received HTC from any service delivery point. Service delivery points could include fixed health care facilities such as, hospitals, public and private clinics, VCT, ANC, L&D, PMTCT, or TB sites; standalone sites such as free standing sites not associated with medical institutions; and, mobile testing such as, HTC services offered in a specific location for a limited period of time, e.g. outreach, door-to-door services and workplace testing events.</td></tr>
</table>

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| | All individuals receiving HTC should be counted in this indicator regardless of where the service is provided. These individuals will include TB patients, pregnant women, men receiving circumcision, and HIV-exposed infants.<br><br>To adequately collect data for this indicator, a minimum provision of the following services is required: counseling, testing, return and receipt of test results.<br><br>*Couples counseling describe those sessions where two or more people in a relationship come together for HTC services. If a couple comes for services together, they should be counseled together and receive their test results together, where possible. When this happens data should be collected for each individual and it should be indicated on the form that this was a couple session as opposed to an individual session. |
| **Interpretation:** | This indicator is intended to monitor individuals and the trends in the uptake of testing and counseling over time. However, in some cases, data for this indicator might include repeat testers. If data on persons who retest are not available, this indicator will give information on the number of times HTC services were delivered, rather than the number of individuals who received HTC services. Repeat testing is common practice among most HTC programs and it is important to recognize this and interpret the aggregated data with caution.<br><br>Over time, the number of people who are expected to be tested and counseled within a country will vary depending on numerous factors such as, the numbers of people with previously confirmed positive status, or the number of people who may be at perceived risk of HIV infection, and hence this indicator should be interpreted accordingly.<br><br>In addition, the type and focus of a HTC program for each respective country has an impact on its interpretation. For example, a program that targets high-risk groups or areas of highest prevalence, may have smaller numbers tested, and yet higher yield in HIV infection identification than a program providing general HTC services.<br><br>Given that this indicator is intended to count individuals and not tests, data produced through this indicator would need further interpretation for use in commodities planning.<br><br>Finally, this indicator does not provide information on whether those who were tested were adequately referred and linked to and are receiving follow up services (e.g., HIV care, VMMC) to benefit from knowing their HIV status. |
| **Additional Information:** | - Partially harmonized with #7, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf<br>• Partially harmonized with Prevention indicator (HIV-P8b), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf |

## Appendix 2. Sample Paper Data Collection Forms

**Education Attendance Sheet** **Page ___ of ___**

Date of Education Session: D D / M M / Y Y Y Y Topic:

Location/Venue: Organization:

Educator Name: Educator Unique ID:

| | Surname | First Name | Unique ID | Gender | | Age, in years (check one) | | | | | | | Civilian | Active Duty |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Male | Female | 1-9 | 10-14 | 15-19 | 20-24 | 25-34 | 35-49 | 50+ | | |
| 1 | | | | M | F | | | | | | | | Civ | Sol |
| 2 | | | | M | F | | | | | | | | Civ | Sol |
| 3 | | | | M | F | | | | | | | | Civ | Sol |
| 4 | | | | M | F | | | | | | | | Civ | Sol |
| 5 | | | | M | F | | | | | | | | Civ | Sol |
| 6 | | | | M | F | | | | | | | | Civ | Sol |
| 7 | | | | M | F | | | | | | | | Civ | Sol |
| 8 | | | | M | F | | | | | | | | Civ | Sol |
| 9 | | | | M | F | | | | | | | | Civ | Sol |
| 10 | | | | M | F | | | | | | | | Civ | Sol |
| 11 | | | | M | F | | | | | | | | Civ | Sol |
| 12 | | | | M | F | | | | | | | | Civ | Sol |
| 13 | | | | M | F | | | | | | | | Civ | Sol |
| 14 | | | | M | F | | | | | | | | Civ | Sol |
| 15 | | | | M | F | | | | | | | | Civ | Sol |
| 16 | | | | M | F | | | | | | | | Civ | Sol |
| 17 | | | | M | F | | | | | | | | Civ | Sol |
| 18 | | | | M | F | | | | | | | | Civ | Sol |
| 19 | | | | M | F | | | | | | | | Civ | Sol |
| 20 | | | | M | F | | | | | | | | Civ | Sol |
| 21 | | | | M | F | | | | | | | | Civ | Sol |
| 22 | | | | M | F | | | | | | | | Civ | Sol |
| 23 | | | | M | F | | | | | | | | Civ | Sol |
| 24 | | | | M | F | | | | | | | | Civ | Sol |
| 25 | | | | M | F | | | | | | | | Civ | Sol |

Educator Signature _____ Military Rep/HIV Coordination Office Signature: _____

Print Name _____ Print Name _____

# Education Event Summary Report

Date of Education Session: D D / M M / Y Y Y Y  Start Time:

Location/Venue:  End Time:

## Educator Information

First Name  Unique ID:

Middle Name  Phone No.

Surname

Role: Drama Group  Peer Educator  Counselor  Non-Military  Commanding Officer

## Education Session Information

Topic(s) of Session

Number of Promotional Materials Distributed

- Condoms
- Educational brochures
- Posters
- Other, specify

Types of Methodologies Used (check all that apply)

- Drama
- Lecture
- Condom demonstration
- Other, specify
- Educational Games
- Sports Activities
- Social Event

## Participant Information

Using the below table, fill in the number of participants who attended the session by type, gender and age.

| | | Civilians | | Active Duty | |
|---|---|---|---|---|---|
| | | Male | Female | Male | Female |
| Age (in years) | 1-9 | | | | |
| | 10-14 | | | | |
| | 15-19 | | | | |
| | 20-24 | | | | |
| | 25-34 | | | | |
| | 35-49 | | | | |
| | 50+ | | | | |
| **Totals** | | | | | |

Overall total number of participants who attended session:

**Educator's Notes:**

Logistics (How was it planned, resources used?)

Views on the event (planning, implementation)

Specific Challenges

Team's comments for improvement

# Registration Form

Date: D D / M M / Y Y Y Y  Unique ID:

Registration Location:

## Client Details

First Name  Date of Birth: D D / M M / Y Y Y Y

Middle Name  Gender: ☐ Male ☐ Female

Surname  Phone No.

Home Address:

Current Physical Address (*Military*):

## Next-Of-Kin

First Name  Home Address:

Middle Name  Relationship:

Surname  Phone No:

## Marital Status

☐ Currently Married
☐ Currently cohabitating
☐ Single, previously married or previously cohabitated
☐ Single, never married or never cohabitated

## Education

☐ Primary
☐ College/University
☐ Secondary
☐ Did not attend school
☐ High School

## Military Status

**Is client a civilian?** ☐ Yes ☐ No

If yes, is client: ☐ Dependent ☐ Civilian employee ☐ Community member/not related to active duty

If no, fill out below.

**Military ID Number:**  **Unit:**

**Current Base Location:**

**Military Status:**

☐ Active Duty
☐ Volunteer
☐ Retired

**Command:**

☐ Ground Forces Command
☐ Signals
☐ Defence Logistic Command
☐ Air Arm Command
☐ Corps of Engineers
☐ Other Units:

**Current Rank:**

☐ Private
☐ Junior NCO
☐ Warrant Officer/Sr NCO
☐ Junior Officer
☐ Senior Officer
☐ General Officer

**Date of Entry into Military:** D D / M M / Y Y Y Y

## Commanding Officer:

First Name  Unit:

Middle Name  CO Rank:

Surname  Phone No:

Command:

☐ Ground Forces Command
☐ Air Arm Command
☐ Signals
☐ Defence Logistic Command
☐ Corps of Engineers
☐ Other Units:

Name of Person Responsible for Data Entry on this Form:

Print:

Signature of Person Responsible for Data Entry on this Form:

Sign:

## HIV Testing & Counseling Form

Client Surname: | | | | | | | | | | | | | Client First Name: | | | | | | | | | | | | |

Client Date of Birth: D D / M M / Y Y Y Y Client Unique ID: | | | | | | | | | | | | |

Date: D D / M M / Y Y Y Y Location of this Counseling session: | | | | | | | | | | | | |

### Sexual Risk Assessment

Has the patient ever had sex? ☐ Yes ☐ No

If yes, did the patient use a condom at last sex? ☐ Yes ☐ No ☐ Don't Know

### HIV Testing History

Has the patient ever received an HIV test? ☐ Yes ☐ No

If yes:

Date of most recent test D D / M M / Y Y Y Y

Test result

- ☐ Documented HIV positive result from other HTC provider
- ☐ Documented HIV negative result from other HTC provider
- ☐ Self-reported HIV negative and declined re-test (HIV status not verifiable)
- ☐ Self-reported HIV positive and declined re-test (HIV status not verifiable)
- ☐ Did not receive results

Test location | | | | | | | | | | | | | | | | | | | | | | | | |

### New HIV Test

Was the patient offered an HIV test? ☐ Yes ☐ No If no, reason why not: | | | | | | | | | | | | |

Did patient receive an HIV test as part of the MC minimum package of HIV prevention services? ☐ Yes ☐ No

If yes:

Date of Test: D D / M M / Y Y Y Y

Test result

- ☐ HIV positive by test(s) on site
- ☐ HIV negative by test(s) on site
- ☐ HIV indeterminate result by test(s) on site

If HIV positive, does patient still want MC? ☐ Yes ☐ No

Was patient referred for MC services? ☐ Yes ☐ No

### CD4 Testing

If HIV positive, did the patient receive a CD4 test within the past 6 months? ☐ Yes ☐ No

If yes, fill out below:

Date of most recent test D D / M M / Y Y Y Y

CD4 result | | | |

Test location | | | | | | | | | | | | | | | | | | | | | | | | |

**Counselor's Comments:**

Name of Person Responsible for Data Entry on this Form: Signature of Person Responsible for Data Entry on this Form:

Print: Sign:

## SMC Counseling Form

**COUNSELOR'S DECLARATION**

I am the **counselor/surgeon** and the above client has been given information at this center about:

- what is circumcision and its potential as part of the HIV comprehensive prevention package;
- the benefits of circumcision and other information on sexual reproductive health including STIs;
- the importance of HIV testing and counseling before male circumcision
- administration of the anesthetic and how circumcision is done;
- the possible adverse effects of circumcision;
- what to do before circumcision;
- what to do after circumcision;
- what to do if there are any complications or problems after circumcision;
- an emergency contact number and information about where to go in an emergency;
- why it is important to use condoms and other prevention methods after circumcision;

I have given the person to be circumcised and their parent/guardian an opportunity to ask me questions about all the above and believe that the client understands the information given. To the best of my knowledge the client and their parent/guardian is capable of giving consent and has enough information to make a proper decision about whether to proceed with the operation of circumcision (removal of the foreskin).

Signed _____ Date D D / M M / Y Y Y Y

**(Circumcision counselor/surgeon )**

Client's reason for accepting SMC:

☐ HIV prevention ☐ STI prevention ☐ Improved hygiene ☐ Partner's preference

☐ Cultural acceptance ☐ Increased sexual performance

Client's reason to declining or deferring SMC:

☐ Fear of pain ☐ Fear of safety ☐ Not culturally appropriate ☐ Not allowed by religion

☐ Deployed otherwise ☐ Partner influence ☐ Schedule conflict

Type of counseling: ☐ Individual ☐ Couple ☐ Follow-up

Permission to call patient to follow up? ☐ Yes ☐ No

Comments:

# Booking Form

Date: D D / M M / Y Y Y Y  Unique ID:

Name of Scheduler:

## Client Demographics

First Name  Date of Birth: D D / M M / Y Y Y Y

Middle Name  Gender: ☐ Male ☐ Female

Surname  Phone No.

Home Address:

Current Physical Address (*Military* ):

## Emergency Contact

First Name  Home Address:

Middle Name  Relationship:

Surname  Phone No:

## If minor, name of Parent/Guardian:

First Name  Home Address:

Middle Name  Relationship:

Surname  Phone No:

## Commanding Officer

First Name  Unit:

Middle Name  Rank:

Surname  Phone No:

Command: ☐ Ground Forces Command ☐ Air Arm Command ☐ Defence Logistic Command

☐ Signals ☐ Corps of Engineers ☐ Other Units:

## MC Booking

Date of MC: D D / M M / Y Y Y Y  Time of Appointment: ☐ AM (Morning) ☐ PM (Afternoon)

Booking Status: ☐ Attended ☐ Rebooked ☐ Cancelled, Reason why:

☐ Defaulted

Referred from: ☐ Care & Treatment Center ☐ STI Clinic ☐ Education Session

☐ HIV Testing & Counseling ☐ Self-Referral ☐ Family Planning Services

Other:

Did patient receive an MC education session? ☐ Yes ☐ No

Name of Person Responsible for Data Entry on this Form:

Print:

Signature of Person Responsible for Data Entry on this Form:

Sign:

# Medical History Form

Client Surname: | Client First Name:

Client Date of Birth: D D / M M / Y Y Y Y | Client Unique ID:

Date: D D / M M / Y Y Y Y | Name of Provider:

| Does the patient have any of the following conditions? | | | If yes, is patient currently taking treatment? | | |
|---|---|---|---|---|---|
| Haemophilia or bleeding disorders | Yes | No | Haemophilia or bleeding disorders | Yes | No |
| Diabetes | Yes | No | Diabetes | Yes | No |
| HIV/AIDS | Yes | No | HIV/AIDS | Yes | No |

**Is the patient currently taking any medications?** Yes No

If yes, specify medication(s):

**Has the patient been treated for an STI in the last 3 months?** Yes No

**Is the patient currently being treated for any other condition?** Yes No

If yes, specify condition(s):

**Does patient have any known allergy to medications?** Yes No

If yes, specify medication(s):

**Has patient ever had a surgical operation?** Yes No

If yes, fill out below:

Date of Procedure: D D / M M / Y Y Y Y | Type of procedure:

List complications, if any:

Does the patient have a metal implant? Yes No

**Does the patient have any of the following complaints?**

- Urethral discharge
- Painful urination
- Genital sore/ulcer
- Difficulty retracting foreskin
- Painful erection
- Concern about erection or sexual function
- Swelling of the scrotum

Other:

Notes:

Name of Person Responsible for Data Entry on this Form: | Signature of Person Responsible for Data Entry on this Form:

Print: | Sign:

## Physical Examination Form

Client Surname: Client First Name:

Client Date of Birth: D D / M M / Y Y Y Y Client Unique ID:

Date: D D / M M / Y Y Y Y Name of Provider:

Blood pressure: / Pulse: Weight (kg): Temperature:

Pallor ☐ Yes ☐ No Lymphadenopathy ☐ Yes ☐ No Wasting ☐ Yes ☐ No

**Genital Examination** Examination of penis: ☐ Normal ☐ Abnormal

If abnormal, specify below:

- ☐ Phimosis
- ☐ Paraphimosis
- ☐ Epispadias
- ☐ Hypospadias
- ☐ Ulcers
- ☐ Balanitis
- ☐ Torsion
- ☐ Irretractable foreskin
- ☐ Penile discharge
- ☐ Other, specify:

Any medications prescribed? ☐ Yes ☐ No If yes, list medication & dosage: _____

**Did patient have previous circumicision?** ☐ Yes ☐ No If yes, specify grade below.

- ☐ 1 Foreskin covers one-half or more of the glans; completely uncircumcised
- ☐ 2 Foreskin is past the sulcus, but covers less than one-half of the glans
- ☐ 3 Foreskin is not past the sulcus, but can be extended past the sulcus to cover one-half of the glans without compressing the glans
- ☐ 4 Foreskin is completely absent; completely circumcised

**Is patient fit to receive MC?** ☐ Yes ☐ No ☐ Defer If no, reason why: _____

Notes:

Name of Person Responsible for Data Entry on this Form:

Print:

Signature of Person Responsible for Data Entry on this Form:

Sign:

# Surgery and Immediate Post-Operative Form

Client Surname: | | | | | | | | | | | | | Client First Name: | | | | | | | | | | | | |

Client Date of Birth: D D / M M / Y Y Y Y Client Unique ID: | | | | | | | | | | | | |

Date of MC: D D / M M / Y Y Y Y

## Surgery Notes

Location of Surgery: | | | | | | | | | | | | |

Start Time: H H : M M AM/PM

Anesthesia:
- ☐ Marcaine 0.5% | | | . | mL
- ☐ Lignocaine 1% | | | . | mL
- ☐ Lignocaine 2% | | | . | mL

DBNP ☐ DBNP + ring block ☐

Procedure used:
- ☐ Sleeve
- ☐ Dorsal Slit
- ☐ Forceps Guided

If other, specify: | | | | | | | | | | | | |

Suture:
- ☐ Chromic ☐ Vicryl rayoide
- ☐ Plain Gut ☐ Not applicable

Diathermy used: ☐ Yes ☐ No

MC Surgeon: | | | | | | | | | | | | |

Anesthesiologist: | | | | | | | | | | | | |

Assistant: | | | | | | | | | | | | |

Surgeon's signature: _____

End Time: H H : M M AM/PM

Notes:

## Immediate Post-Op Notes

Blood pressure: | | | / | |

Pulse: | | | Temperature: | | |

Adverse events observed? ☐ Yes ☐ No

If yes, specify type and degree of severity below:

| Adverse Event | | Mild | Moderate | Severe |
|---|---|---|---|---|
| AN | Anaesthesia reaction | ☐ | ☐ | ☐ |
| BL | Bleeding | ☐ | ☐ | ☐ |
| DP | Damage to Penis | ☐ | ☐ | ☐ |
| ES | Excessive Skin Removed | N/A | ☐ | ☐ |
| PA | Pain | ☐ | ☐ | ☐ |
| OE | Occupational Exposure | N/A | ☐ | N/A |

*(Healthcare worker; moderate severity only)*

Was patient referred to another facility for care?

☐ No ☐ Yes, location: | | | | | | | | | |

Disposition*:

☐ Hold in recovery & monitor for 20 min; discharge home with standard instructions; follow-up within 2 days

☐ Hold in recovery & monitor for ___ min; discharge home with standard instructions; follow-up within ___ days

☐ Other, specify: | | | | | | | | | | | |

Blood pressure: | | | / | |

Pulse: | | | Temperature: | | |

Post-operative medications prescribed:

Name | | | | | | | | | | Dosage | | | | | |

Name | | | | | | | | | | Dosage | | | | | |

Name of Pharmacy | | | | | | | | | |

Post-MC counseling provided? ☐ Yes ☐ No

Name of Person Responsible for Data Entry on this Form:

Print:

Signature of Person Responsible for Data Entry on this Form:

Sign:

***If there is more than one disposition within the immediate post-op time period, please use another page to capture additional clinical findings & notes on medical condition of the patient**

# Post-Operative Follow-Up Visit

Client Surname: | | | | | | | | | | | |  Client First Name: | | | | | | | | | | | |

Client Date of Birth: D D / M M / Y Y Y Y  Client Unique ID: | | | | | | | | | | | |

Clinic Name: | | | | | | | | | | | |  Date: D D / M M / Y Y Y Y

Form completed by: | | | | | | | | | | | |

## Patient Background

Patient First Name: | | | | | | | | | | | |  Middle Name: | | | | | | | | | | | |

Patient Surname: | | | | | | | | | | | |  Date of MC: D D / M M / Y Y Y Y

Clinic/location where surgery took place | | | | | | | | | | | | | | | | | | | | |

Name of Doctor/Surgeon (who removed foreskin) | | | | | | | | | | | | | | | | | | | | |

Name of Nurse | | | | | | | | | | | | | | | | | | | | |

## Adverse Events (AE)

Adverse events observed? ☐ Yes ☐ No  If yes, complete rest of form.

Date of AE diagnosis D D / M M / Y Y Y Y

Number of days since MC Procedure was performed (compare Date of MC to Date of AE diagnosis)

| | | | Days

Name of Doctor/Nurse | | | | | | | | | | | | | | | | |

## Check all that apply, then fill out section entitled "Treatment Outcome."

| | Mild | Moderate | Severe |
|---|---|---|---|
| **Anaesthesia Reaction/Complication (AN)** | 1 | 2 | 3 |
| **Bleeding (BL)** | 1 | 2 | 3 |
| **Damage to Penis (DP)** | 1 | 2 | 3 |
| **Excessive Skin Removed (ES)** | N/A | 2 | 3 |
| **Infection (IN)** | 1 | 2 | 3 |

*If wound necrosis observed, also report Scarring/Disfiguration (SD) - Severe

*If severe wound disruption observed, also report Wound Disruption (WD) - Severe

| | | | |
|---|---|---|---|
| **Pain (PA)** | 1 | 2 | 3 |
| **Sexual Complications (SC)** | 1 | 2 | 3 |
| **Scarring and/or Disfigurement (SD)** | 1 | 2 | 3 |

*If severe wound necrosis is observed, also report Infection (IN) - Severe

| | | | |
|---|---|---|---|
| **Swelling of penis/scrotum, including haematoma (SH)** | 1 | 2 | 3 |
| **Torsion of Penis - new onset (TO)** | 1 | 2 | 3 |
| **Wound Dehiscence &/or Disruption (WD)** | 1 | 2 | 3 |

*If checked, also report Infection (IN) - Severe

| | | | |
|---|---|---|---|
| **Voiding problems, difficulty urinating (VO)** | 1 | 2 | 3 |

**Occupational Exposure to HIV (OE) - Health care worker**

2 Moderate  Specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Other**

1 Mild  Specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | |

2 Moderate  Specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | |

3 Severe  Specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| **Treatment Outcome** | **Treatment Outcome (if more than one AE observed)** |
|---|---|
| Type of AE: | Type of AE: |
| ☐ Resolved (no further action) | ☐ Resolved (no further action) |
| ☐ Referred | ☐ Referred |
| To where: | To where: |
| and when: D D / M M / Y Y Y Y | and when: D D / M M / Y Y Y Y |
| ☐ Repeat Visit on D D / M M / Y Y Y Y | ☐ Repeat Visit on D D / M M / Y Y Y Y |
| In your clinical judgement, was the AE … | In your clinical judgement, was the AE … |
| ☐ MC-related or ☐ non-MC-related? | ☐ MC-related or ☐ non-MC-related? |
| Additional Comments/Notes: | Additional Comments/Notes: |
| Name of Person Responsible for Data Entry on this Form: | Signature of Person Responsible for Data Entry on this Form: |
| Print: | Sign: |

# Post-Operative Follow-Up Visit

Client Surname: | | | | | | | | | | | |  Client First Name: | | | | | | | | | | | |

Client Date of Birth: D D / M M / Y Y Y Y  Client Unique ID: | | | | | | | | | | | |

Clinic Name: | | | | | | | | | | | |  Date: D D / M M / Y Y Y Y

Form completed by: | | | | | | | | | | | |

## Patient Background

Patient First Name: | | | | | | | | | | | |  Middle Name: | | | | | | | | | | | |

Patient Surname: | | | | | | | | | | | |  Date of MC: D D / M M / Y Y Y Y

Clinic/location where surgery took place | | | | | | | | | | | | | | | | | | | | |

Name of Doctor/Surgeon (who removed foreskin) | | | | | | | | | | | | | | | | | | | | |

Name of Nurse | | | | | | | | | | | | | | | | | | | | |

## Adverse Events (AE)

Adverse events observed? ☐ Yes ☐ No  If yes, complete rest of form.

Date of AE diagnosis D D / M M / Y Y Y Y

Number of days since MC Procedure was performed (compare Date of MC to Date of AE diagnosis)

| | | | Days

Name of Doctor/Nurse | | | | | | | | | | | | | | | | |

## Check all that apply, then fill out section entitled "Treatment Outcome."

| | Mild | Moderate | Severe |
|---|---|---|---|
| **Anaesthesia Reaction/Complication (AN)** | 1 | 2 | 3 |
| **Bleeding (BL)** | 1 | 2 | 3 |
| **Damage to Penis (DP)** | 1 | 2 | 3 |
| **Excessive Skin Removed (ES)** | N/A | 2 | 3 |
| **Infection (IN)** | 1 | 2 | 3 |

*If wound necrosis observed, also report Scarring/Disfiguration (SD) - Severe

*If severe wound disruption observed, also report Wound Disruption (WD) - Severe

| | | | |
|---|---|---|---|
| **Pain (PA)** | 1 | 2 | 3 |
| **Sexual Complications (SC)** | 1 | 2 | 3 |
| **Scarring and/or Disfigurement (SD)** | 1 | 2 | 3 |

*If severe wound necrosis is observed, also report Infection (IN) - Severe

| | | | |
|---|---|---|---|
| **Swelling of penis/scrotum, including haematoma (SH)** | 1 | 2 | 3 |
| **Torsion of Penis - new onset (TO)** | 1 | 2 | 3 |
| **Wound Dehiscence &/or Disruption (WD)** | 1 | 2 | 3 |

*If checked, also report Infection (IN) - Severe

| | | | |
|---|---|---|---|
| **Voiding problems, difficulty urinating (VO)** | 1 | 2 | 3 |

**Occupational Exposure to HIV (OE) - Health care worker**

2 Moderate  Specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Other**

1 Mild  Specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | |

2 Moderate  Specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | |

3 Severe  Specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| **Treatment Outcome** | **Treatment Outcome (if more than one AE observed)** |
|---|---|
| Type of AE: | Type of AE: |
| ☐ Resolved (no further action) | ☐ Resolved (no further action) |
| ☐ Referred | ☐ Referred |
| To where: | To where: |
| and when: D D / M M / Y Y Y Y | and when: D D / M M / Y Y Y Y |
| ☐ Repeat Visit on D D / M M / Y Y Y Y | ☐ Repeat Visit on D D / M M / Y Y Y Y |
| In your clinical judgement, was the AE … | In your clinical judgement, was the AE … |
| ☐ MC-related or ☐ non-MC-related? | ☐ MC-related or ☐ non-MC-related? |
| Additional Comments/Notes: | Additional Comments/Notes: |
| Name of Person Responsible for Data Entry on this Form: | Signature of Person Responsible for Data Entry on this Form: |
| Print: | Sign: |

# Post-Operative Follow-Up Visit

Client Surname: | Client First Name:

Client Date of Birth: D D / M M / Y Y Y Y | Client Unique ID:

Clinic Name: | Date: D D / M M / Y Y Y Y

Form completed by:

## Patient Background

Patient First Name: | Middle Name:

Patient Surname: | Date of MC: D D / M M / Y Y Y Y

Clinic/location where surgery took place

Name of Doctor/Surgeon (who removed foreskin)

Name of Nurse

## Adverse Events (AE)

Adverse events observed? ☐ Yes ☐ No If yes, complete rest of form.

Date of AE diagnosis D D / M M / Y Y Y Y

Number of days since MC Procedure was performed (compare Date of MC to Date of AE diagnosis)

☐☐☐ Days

Name of Doctor/Nurse

## Check all that apply, then fill out section entitled "Treatment Outcome."

| | Mild | Moderate | Severe |
|---|---|---|---|
| **Anaesthesia Reaction/Complication (AN)** | 1 | 2 | 3 |
| **Bleeding (BL)** | 1 | 2 | 3 |
| **Damage to Penis (DP)** | 1 | 2 | 3 |
| **Excessive Skin Removed (ES)** | N/A | 2 | 3 |
| **Infection (IN)** | 1 | 2 | 3 |

*If wound necrosis observed, also report Scarring/Disfiguration (SD) - Severe

*If severe wound disruption observed, also report Wound Disruption (WD) - Severe

| | | | |
|---|---|---|---|
| **Pain (PA)** | 1 | 2 | 3 |
| **Sexual Complications (SC)** | 1 | 2 | 3 |
| **Scarring and/or Disfigurement (SD)** | 1 | 2 | 3 |

*If severe wound necrosis is observed, also report Infection (IN) - Severe

| | | | |
|---|---|---|---|
| **Swelling of penis/scrotum, including haematoma (SH)** | 1 | 2 | 3 |
| **Torsion of Penis - new onset (TO)** | 1 | 2 | 3 |
| **Wound Dehiscence &/or Disruption (WD)** | 1 | 2 | 3 |

*If checked, also report Infection (IN) - Severe

| | | | |
|---|---|---|---|
| **Voiding problems, difficulty urinating (VO)** | 1 | 2 | 3 |

**Occupational Exposure to HIV (OE) - Health care worker**

2 Moderate Specify:

**Other**

1 Mild Specify:

2 Moderate Specify:

3 Severe Specify:

| **Treatment Outcome** | **Treatment Outcome (if more than one AE observed)** |
|---|---|
| Type of AE: | Type of AE: |
| ☐ Resolved (no further action) | ☐ Resolved (no further action) |
| ☐ Referred | ☐ Referred |
| To where: | To where: |
| and when: D D / M M / Y Y Y Y | and when: D D / M M / Y Y Y Y |
| ☐ Repeat Visit on D D / M M / Y Y Y Y | ☐ Repeat Visit on D D / M M / Y Y Y Y |
| In your clinical judgement, was the AE … | In your clinical judgement, was the AE … |
| ☐ MC-related or ☐ non-MC-related? | ☐ MC-related or ☐ non-MC-related? |
| Additional Comments/Notes: | Additional Comments/Notes: |
| Name of Person Responsible for Data Entry on this Form: | Signature of Person Responsible for Data Entry on this Form: |
| Print: | Sign: |

# Adverse Event Reference Guide

**Anaesthesia Reaction or Complication (AN)**

| | |
|---|---|
| 1 Mild | Mild palpitations, vaso-vagal reaction (light-headedness/dizziness) or nausea requiring monitoring at clinic<br>Resolved spontaneously without medical treatment |
| 2 Moderate | Significant palpitations, vaso-vagal reaction or emesis (vomiting)<br>Required medical intervention at clinic |
| 3 Severe | Severe allergic reaction or other reaction to anaesthetic<br>Transferred/referred to another facility<br>Hospitalized for anaphylaxis or other anaesthetic reaction |

**Bleeding (BL)**

| | |
|---|---|
| 1 Mild | More significant bleeding than usually experienced, but easily controlled (intra-operative)<br>Stained underwear/dressing with no active bleeding **or** small amount of bleeding from minor clot disruption when changing dressing<br>Required 10 or less minutes of manual pressure to control |
| 2 Moderate | Bleeding difficult to control, requiring significant additional intra-operative time to control<br>Ongoing active bleeding and/or swelling that required a special return to the facility for medical attention<br>Required extra pressure dressing or extra couple of sutures to control<br>Observed patient for at least 1 hour and reviewed dressing before sending home or taking further action |
| 3 Severe | Unable to control bleeding adequately during operation<br>Required post-operative blood transfusion (significant blood loss and/or signs of shock present)<br>Surgical re-exploration for ligation or cauterization of bleeding vessels<br>Required hospitalization<br>Transferred to another facility |

**Damage to Penis (DP)**

| | |
|---|---|
| 1 Mild | Bruising or abrasion<br>Superficial burn or laceration to glans or shaft<br>Required extra dressings |
| 2 Moderate | Significant laceration or burn to glans or shaft<br>Required prolonged intra-operative attention to treat<br>Required extra pressure dressing<br>Requires additional clinic follow up care |
| 3 Severe | Severe injury including severed portion of glans, shaft laceration with ongoing bleeding or significant burn injury leading to tissue necrosis/death/loss or strangulation from too tight a dressing or device application.<br>Required additional surgery<br>Transferred to another facility<br>Required hospitalization |

**Excessive Skin Removed (ES)**

| | |
|---|---|
| 2 Moderate | Intra-operative excess removal noted requiring either:<br>mobilization of skin near wound margin, or placement of extra sutures for reinforcement<br>Post-operative tightening of the skin is discernible, but re-operation not required |
| 3 Severe | Provider was unable to adequately close the wound margins<br>Mobilization of skin to close the wound margin required<br>Discernable tightening requiring reoperation<br>Transferred to another facility<br>Required hospitalization |

**Infection (IN)**

| | |
|---|---|
| 1 Mild | Marked signs of erythema and minimal serous discharge or infective process noted at frenulum or suture margin |
| | Only topical antibiotics used |
| | Infected area less than 1 cm in length |
| 2 Moderate | Purulent discharge from wound |
| | Systematic (Oral or IV) antibiotics needed |
| | Infected area greater than 1 cm in length |
| 3 Severe | Abscess |
| | Severe cellulitis |
| | Wound necrosis *if observed, also report Scarring/Disfiguration (SD) - Severe |
| | Severe wound disruption *if observed, also report Wound Disruption (WD) - Severe |
| | Tissue loss |
| | Referral to specialist required for treatment or monitoring |

**Pain (PA)**

| | |
|---|---|
| 1 Mild | Mild discomfort (3-4 on pain scale) with client able to remain still and cooperate for duration of procedure |
| | No additional local anaesthetic required |
| 2 Moderate | Moderate discomfort (5 or 6 on pain scale), with client expressing pain clearly |
| | Required interruption of operation for additional local anaesthetic |
| | Patient unable to work or cancelled normal activities lasting for 4-7 days after surgery |
| 3 Severe | Severe discomfort (7 on pain scale), with client expressing pain and the addition of local anaesthesia having no effect |
| | Required early termination of MC or administration of general anaesthesia |
| | Patient unable to work or cancelled normal activities lasting for 7 or more days after surgery |

**Sexual Complications (SC)**

| | |
|---|---|
| 1 Mild | Transient occurrence impairing sexual function, lasting less than 3 months |
| 2 Moderate | Transient occurrence impairing sexual function, lasting between 3-5 months |
| 3 Severe | Permanent sexual dysfunction lasting more than 6 months |

**Scarring and/or Disfigurement (SD)**

| | |
|---|---|
| 1 Mild | Patient complains of disfigurement but physical exam normal |
| | Visible ridging which the client complains about or provider notices, but no distortion of the penile organ |
| | The affected portion of the suture line is more than a third of the circumference |
| 2 Moderate | Disfigurement noted on physical exam but no re-operation necessary |
| | Ridging is gross and either involving more than a third of the suture line or the suture line describes more than one circumferential line |
| | Penis looks like it will be able to remould during healing (sufficient penile skin left to permit moulding) |
| 3 Severe | Discernible scarring/disfigurement |
| | Such distortion that the client cannot tolerate the appearance |
| | Surgical intervention required |
| | Transferred to another facility |
| | *If severe wound necrosis is observed, also report Infection (IN) - Severe |

**Swelling of penis/scrotum, including haematoma (SH)**

| | | |
|---|---|---|
| 1 | Mild | Significant circumferential swelling along incision line (without bleeding) that resolves with time |
| 2 | Moderate | Localized swelling associated with some bleeding that resolves spontaneously (with or without pressure dressing) |
| 3 | Severe | Generalized haematoma causing significant discomfort and distress, with ongoing oozing of blood from suture margins<br>Surgical re-exploration for drainage of haematoma<br>Required that residual bleeder be cauterized or transfixed<br>Required hospitalization<br>Transferred to another facility<br>Required transfusion |

**Torsion of Penis - new onset (TO)**

| | | |
|---|---|---|
| 1 | Mild | Torsion is visible as misalignment of the two lines, causing a twisted/rotated appearance, but does not cause discomfort in all states of turgidity |
| 2 | Moderate | Flaccid penis appears rotated and is increasingly apparent at erection<br>Torsion causes mild pain or discomfort with erection but no surgery needed<br>Torsion less than 90 degrees |
| 3 | Severe | Distortion is apparent in the flaccid sate<br>Erections are painful and the client cannot tolerate the appearance, discomfort, or pain<br>Severe symptomatic torsion requiring re-operation<br>Torsion greater than 90 degrees |

**Wound Dehiscence &/or Disruption (WD)**

| | | |
|---|---|---|
| 1 | Mild | Disruption involving only one suture or less than 1 cm |
| 2 | Moderate | Disruption involving two or more sutures or 2 cm, but no surgical intervention<br>Systematic antibiotics needed |
| 3 | Severe | Wound disruption requiring additional surgery, e.g. re-suturing or debridement<br>Transferred to another facility<br>Required hospitalization<br>*If checked, also report Infection (IN) - Severe |

**Voiding problems, difficulty urinating (VO)**

| | | |
|---|---|---|
| 1 | Mild | Partial obstruction that is transient<br>Resolved spontaneously or with loosening of dressing |
| 2 | Moderate | Partial obstruction requiring special return to clinic outside of routine follow-up<br>Required treatment in clinic-- such as transient catheterization |
| 3 | Severe | Complete urinary retention/obstruction<br>Required surgical re-exploration for urethral injury or blockage<br>Required placement of supra-pubic tube<br>Transferred to another facility |

**Occupational Exposure to HIV (OE) - Health care worker**

| | | |
|---|---|---|
| 2 | Moderate | |

## Appendix 3. Sample Consent Form

**Safe Male Circumcision Consent Form for Adults and Adolescents**

I, _____ consent to be circumcised (removal of the foreskin) by the
*Name of Client (above)*
practitioner, _____ and the assistant(s) of his/her choice.
*Name of Practitioner (above)*

I understand that he/she will use additional surgery, investigation or treatment during the course of the procedure if this becomes, in their judgment, necessary. I understand that this is an irreversible surgical procedure and as with any medical or surgical procedure there are risks involved. The procedure and its possible outcomes, including complications such as bleeding, swelling, and infection, have been fully explained and discussed with me.

I therefore declare that:

- I have read and understood this informed consent.
- I have been given the opportunity to ask questions.
- All my questions regarding Male Circumcision have been answered satisfactorily.
- My signature below proves that I have freely given my consent to the male circumcision procedure.

Client's Signature or thumbprint:
_____Date: _____

Client ID Number: _____

Signature of health professional: _____

Category of health professional: _____

*If the patient is too young to give legal consent, that is,* ***under the age of 16****, the form should be countersigned by a parent or legal guardian.*

I _____(print in BLOCK LETTERS) being the parent/legal guardian of the above named minor and having received all the relevant information on male circumcision as part of a comprehensive HIV prevention program, hereby authorize you to perform the said operation on my child. I commit myself to assist him to attend to all the reviews as advised and throughout the healing period as required.

Signed …… Date …….
**Parent or guardian requesting circumcision on behalf of a minor**

# Appendix 5: Assessing USG Direct Support for Service Delivery

In order to count individuals as receiving a direct service, the USG supported activity must be directly connected to site-specific service delivery. Completing the below checklist can help to verify that a PEPFAR activity is producing a direct service and justification for counting that service as direct.

**Checklist: Assessing USG Direct Service Delivery Support**

| Assessment Criteria | YES | NO | DK |
|---|---|---|---|
| **PANEL ONE** | | | |
| 1. Compared to other donors/partners, the dollar value that we invest at the service delivery site(s) is substantial.[8] OR: | | | |
| 2. We have frequent (i.e. more than one day per week) contact with service delivery site personnel, patients, and/or clients. OR: | | | |
| 3. We regularly assist with essential M&E functions provided at the service delivery site(s). | | | |
| **AND:** | | | |
| **PANEL TWO** | | | |
| 4. Quality prevention, care and/or treatment services at the site(s) would not occur in the absence of our support. OR: | | | |
| 5. The quality of the services provided at the service delivery site(s) would be unacceptably low without our support. OR: | | | |
| 6. The support provided represents a substantial contribution toward sustainability of services at the service delivery site(s). | | | |

[8] It is difficult to derive an acceptable PEPFAR-wide definition of "substantial" given the varying sizes of country programs, the absolute numbers diagnosed with AIDS, HIV sero-prevalence rates, USG staffing, the nature of the Emergency Plan country assistance, etc. Consequently, using this checklist as a starting point, in each country the USG needs to justify and document its assessment of direct service delivery.

If “YES” is checked for any of the items in Panel One AND in Panel Two of Checklist, then USG direct support is assumed to be direct and likely providing sufficient impact to justify claiming 100% of the site-specific results for the program-level indicator under consideration.

If “NO” or “DK” (Don’t Know) is checked for all items in one or both panels, then the USG may not be directly supporting the service delivery activity or the support may be insufficient to claim 100% of the individuals at the site. The USG in-country team must determine if there is sufficient justification to claim direct results and justify a way to estimate the appropriate fraction of this total that is commensurate with USG support, and then document the estimation procedures that were used in order to create audit trail.

A frequent data quality challenge at the USG program level is the extent to which multiple partners are simultaneously reporting 100% of the individuals receiving services from the same service delivery site. USG PEPFAR in-country teams will need to account for double counting as a result of multiple partners working in the same service area when aggregating partner level results.

***Note: This checklist helps to make determinations about direct service delivery. However, the term "Direct" can also be applied more broadly to describe other direct outputs of PEPFAR-funded activities, such as a policy developed, a protocol revised, a laboratory updated, or a person trained. See page 11 for full definition of “Direct”.***