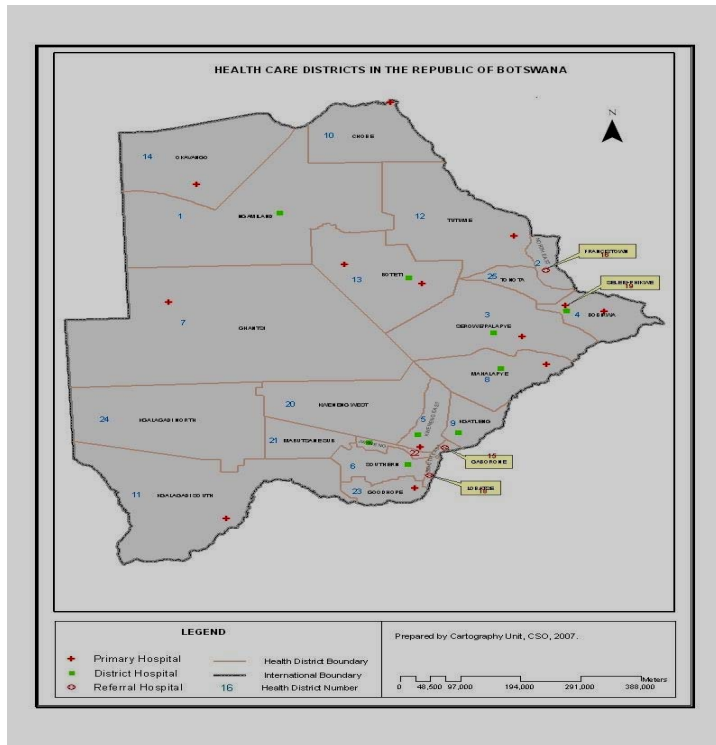




Republic of Botswana

SAFE MALE CIRCUMCISION ADDITIONAL STRATEGY FOR HIV PREVENTION



A NATIONAL STRATEGY



FOREWORD



The Botswana National Safe Male Circumcision Strategy is a first of its kind aiming to aggressively scale up male circumcision as part of a National Prevention Strategy against HIV/AIDS spread in Botswana. This strategy is to complement already existing strategies in order to achieve the national Vision of no new HIV Infections by the year 2016

The need for the national strategy to scale up Male Circumcision (MC) is imperative and has become clear in light of recent research findings in South Africa, Kenya and Uganda that demonstrated reduction of HIV infections among circumcised males by 50 - 60%.

Botswana among other countries with low prevalence of MC and high prevalence of HIV has adapted the UNAIDS/WHO recommendations to implement male circumcision as an additional strategy to reduce HIV transmission without delay.

The Botswana Male Circumcision Strategy focuses on increasing the prevalence of male circumcision among HIV Negative males of 0-49 years from 20% to 80%. The strategy will address issues pertaining to MC capacity building including skill building in clinical management of safe MC Services, Behavior Change Interventions Communication, Monitoring and Evaluation.

The strategy is also intended to guide planning, design implementation and monitoring of safe male circumcision activities. The roll out approach will be used to scale up the MC strategy in all Referral, District and Primary hospitals and finally some clinics at a later stage to increase accessibility of the service to the general population.

I am therefore pleased to endorse this strategy and offer my personal support to the work that will be done during its implementation.

Ms Lesego Motsumi MP
Minister of Health

PREFACE



Botswana has been severely affected by the HIV Epidemic with approximately 17.1 % HIV prevalence among the general population and highest prevalence (40.2%) among the 30-45 year age group (BAIS II). Considering this high prevalence, it is necessary for the Ministry of Health to look for other additional means to prevent further HIV transmission in the country.

Prior to developing this document a substantial amount of information on safe male circumcision has been gathered locally and internationally, and broad consultation has taken place to shape and guide this strategy. However, further research and consultations are needed for to further strengthen our strategies to ensure the standardization of the MC services.

A comprehensive training program, BCIC strategy and M&E frame work have been developed to support, safe MC scale up. The success of safe male circumcision as a prevention strategy will largely depend on how effectively we can be able to facilitate positive behavior changes among circumcised men so that the effect of MC can be optimized.

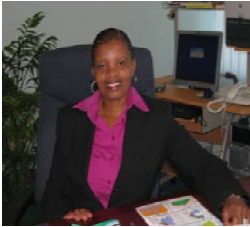
This MC strategic document is primarily meant to serve as a guide to all stakeholders in the public and private sectors and it is meant to be implemented as a joint effort between these sectors to prevent further transmission of HIV. The Botswana National Safe Male Circumcision Strategy is an intervention that will complement existing HIV prevention strategies.

I hope this strategic document will equally serve as a tool not only for the Ministry of Health and the Ministry of Local Government alone; but all other stakeholders and development partners, and that together we will join efforts in its implementation.

Finally I take this opportunity to congratulate everyone involved in the process of development of the Botswana Safe Male Circumcision strategy and support the urgency of its implementation.

**Mr Newman Kahiya
Permanent Secretary,
Ministry of Health.**

ACKNOWLEDGEMENTS



The Department of HIV/AIDS Prevention and Care of the Ministry of Health would like to extend its sincere appreciation and thanks to all those who have directly or indirectly contributed to the creation, development and preparation of this important complimentary HIV Prevention strategy.

Special acknowledgments go to UNAIDS/WHO for the timely response to provide Technical support in the development of the Botswana Safe Male Circumcision strategy. Special thanks go to UNAIDS/WHO consultants in particular for the technical expertise provided and commitment shown in the whole process of the development of this important document.

We recognize the contribution of our development partners ACHAP and BOTUSA in particular for the technical and financial support provided during the development of this strategy.

Special thanks go to the members of the Technical Working Group for sharing their experiences, support and technical guidance towards the development of this strategy.

We extend our sincere gratitude to the Ministry of Local Government, Department of Clinical Services, Department of Public Health, District Health Teams, Hospital managers, as without them this strategy document would not have been complete.

Finally, I wish to recognize the effort and contribution of all individuals whom in one way or another have made this strategy development process a success.

To you all I say thank you.

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ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
ACHAP	African Comprehensive HIV/AIDS Partnerships
ANC	Antenatal care clinic
ARV	Antiretroviral
BCIC	Behaviour Change Interventions and Communication
BHP	Botswana Harvard Partnership
CDC	Centers for Disease Control and Prevention
DCS	Department of Clinical Services
DHAPC	Department of HIV/AIDS Prevention and Care
DPH	Department of Public Health
FGD	Focus group discussion
HIV	Human Immunodeficiency Virus
IEC	Information, Education Communication
KITSO	Knowledge, Innovation and Training Shall Overcome (AIDS)
MC	Male circumcision
MCH	Maternal and Child Health
MOH	Ministry of Health
MLG	Ministry of Local Government
MOE	Ministry of Education
MTP	Medium Term Plan
NAC	National AIDS Council
NSF	National Strategic Framework
PEPFAR	President's Plan for Emergency AIDS Relief
PMTCT	Prevention of Mother to Child Transmission
RHT	Routine HIV Testing
SOPs	Standard operating procedures
STI	Sexually transmitted infection
TWG	Technical working group
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

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I. BACKGROUND

HIV situation

Sub-Saharan Africa has been the hardest hit by the HIV/AIDS epidemic. Even though there has been a reduction in new infections since 2001, the region is still severely affected¹. Within this region, Southern Africa is the worst affected with national adult HIV prevalence exceeding 15% in eight countries in southern Africa. These countries are Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

Botswana is a Southern African country with an estimated population of 1.7 million people², with close to 90% of the population below the age of 49 years³. The country is divided into 24 health districts. There are currently 26 Government hospitals plus 3 hospitals that are run by the Botswana Defence Force, and 3 that are run by the mining industry. There are also 272 clinics through out the country.

The first case of AIDS was diagnosed in Botswana in 1985, and since that the HIV epidemic has spread rapidly², to the extent that it became the leading health and developmental challenge of the nation. HIV surveillance in pregnant women indicates that prevalence peaked around 2000 to 2001 and thereafter stabilized and began to show signs of declining. Figure 1 shows the trends in HIV prevalence from 1992 to 2007 based in on antenatal surveillance data. The overall HIV prevalence among pregnant women declined significantly from 36.2% in 2001 to 33.7% in 2007.

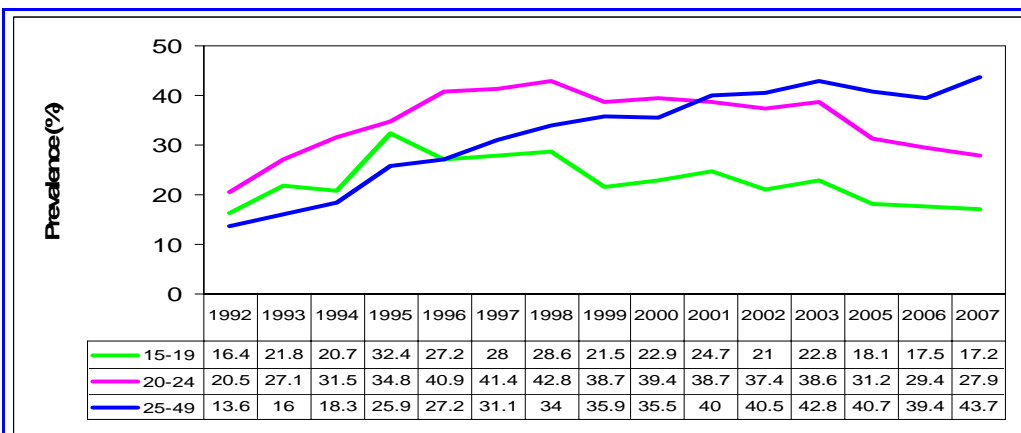
In terms of age groups, there was a significant decline in HIV prevalence in young pregnant women aged 15-19, 20 - 24 and those aged 25 – 29. However there was no significant decrease in HIV prevalence in women 30 – 49. In fact since 2001 the age group 25 - 39 has consistently had very high HIV prevalence of above 40% (fig 1). The decrease in HIV prevalence in younger women would probably indicate that HIV incidence is also falling, however the HIV prevalence in these young age groups still remains unacceptably high.

¹ AIDS Epidemic Update. 2007 UNAIDS

² Botswana Second Generation HIV/AIDS Surveillance. Technical Report 2007

³ CSO- Central Statistics Office, Population Projections for Botswana 2001-2031, September 2005

Figure 1: Trends in age-specific HIV prevalence rate among pregnant women 1992- 2007, Botswana Sentinel Surveillance.



In 2004, the Botswana AIDS Impact Survey estimated the national prevalence to be 17.1%. This survey also showed a similar pattern to that of the sentinel surveillance results in that HIV prevalence is markedly higher in older age groups above 25 years of age. Overall there is a higher prevalence among girls and women nationwide. Among males, the least affected age group is those above 50 years with a prevalence rate of 13.6%. The HIV prevalence among males aged 15 – 49 years is 20.0%. The most affected male age groups are from ages 25 – 54 years, which have an HIV prevalence of between 22.9% and 36.2% (BAIS II).

An estimated 300,000 people are living with HIV/AIDS and of these it was estimated in 2001 that about 110,000 were in need of ART.

National response to HIV/AIDS epidemic

In response to the enormous challenge of HIV/AIDS, Botswana developed and implemented a series of response plans. A short-term plan (STP) was developed soon after the identification of the first case and the focus was on HIV diagnosis and IEC. Botswana has mounted a broad multi-sectoral response to HIV/AIDS encompassing both health sector based and non-health sector based HIV/AIDS interventions. The programmes were implemented in line with the MTP1 (1989 - 1993), MTP 2 (1997 - 2002), the NSF (2003 – 2009) and the Health Sector HIV/AIDS strategy (2003 – 9).

There is very high political and leadership commitment that provides an enabling environment for the response. The National AIDS Council chaired by the Former President Mr. Mogae provides oversight of the national response through its secretariat, the National AIDS Coordinating Agency. The Ministry of Health coordinates the health sector response, while the Ministry of Local Government coordinates district-based responses. Key partners in the national effort to fight HIV/AIDS include the UN family, US Centers for Disease Control and Prevention (BOTUSA)/President's Plan for Emergency AIDS Relief (PEPFAR), the African Comprehensive HIV/AIDS Partnership (ACHAP), Botswana Harvard Partnership and various NGOs and CBOs. The Government of Botswana finances the bulk of the National response (about 80%) with PEPFAR and ACHAP providing substantial additional resources.

With these efforts, a number of HIV interventions have been scaled up and very high coverage rates attained. For example, ART has been scaled up from an initial 4 sites in 2002 in Gaborone, Francistown, Maun and Serowe to 32 ART sites by December 2004 with at least 1 site in each of the 24 health districts. To date provision of ART has been scaled up to an additional 43 clinics. By the end of December 2007, over 90,000 patients were on ART representing about 82% of all estimated patients in need of ART.

Routine testing and counseling is functional in all health facilities with around 150,000 patients tested annually. VCT is offered in 16 stand-alone Tebelopele sites, 5 BOFWA and 11 BOCAIP sites and 6 additional NGOs have been identified to further scale up VCT. PMTCT services have been scaled up to all (634) health facilities with ANC and maternity in the country, the uptake of PMTCT is over 85%. Mother to child transmission of HIV has been reduced from an estimated 40% without PMTCT to about 4.8%. All donated blood units are screened for HIV before transfusion and syndromic management of STIs has been rolled out to all health facilities.

Clearly these commendable efforts together with other prevention efforts have contributed to the reduction of HIV infection rates in the country. However, the HIV infection rates are still very high, and if the national goal of zero HIV infections by 2016 is to be attained more needs to be done and all potential HIV prevention interventions explored. Thus having reviewed all the available information and evidence on Male Circumcision as an HIV intervention, the National AIDS Council recommended MC as an additional HIV prevention strategy in the Country.

Male circumcision and HIV Prevention

In 2005, a randomized controlled trial conducted among uncircumcised men aged 18-24 years in South Africa showed that male circumcision reduced the risk of acquiring HIV infection by 60%⁴. Two further studies conducted in Uganda⁵ and Kenya⁶ showed similar results. These 3 studies provide new, compelling evidence that male circumcision offers some protection against acquiring HIV infection. These findings confirm those from previous observational studies and that of a meta-analysis of 28 published studies conducted in 2000⁷.

The prevalence of male circumcision varies between countries and also within countries. Countries that have a high rate of male circumcision also show apparently lower rates of HIV prevalence. Botswana is one of the countries with very low prevalence of MC.

A mathematical model was used to calculate the public health impact of large scale male circumcision for HIV prevention⁸. One of the scenarios developed calculated HIV transmission and prevalence in a context similar to that of Botswana (low MC, high HIV prevalence), using antenatal clinic (ANC) surveillance data.

The results showed that a programme with high MC uptake (80%) of susceptible (HIV negative) males over a period of 10 years would reduce male HIV prevalence from 30% to around 10%; and reduce that among the females from 40% to about 20%. In a scenario of low MC uptake (50%), the HIV prevalence among females decreased from 40% to about 30%, while male HIV prevalence decreased from about 30% to 20%.

⁴ Auvert B, Taljaard D, Lagaarde E, *et al.* Randomized, controlled intervention of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. *PLoS Med* 2005; 2(11):e298.

⁵ Gray H, Kigozi G, Serwadda D, *et al.* Male circumcision for HIV prevention in young men in Rakai, Uganda: a randomized, controlled trial. *Lancet* 2007; 369:657-66.

⁶ Bailey C, Moses S, Parker CB, *et al.* Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized, controlled trial. *Lancet* 2007; 369: 643-56.

⁷ Weiss HA, Quigley M, Hayes R. Male circumcision and risk of HIV infection in sub-Saharan Africa: a systematic review and meta-analysis. *AIDS* 2000; 14:2361 -70

⁸ [Nagelkerke NJ, Moses S, de Vlas SJ, et al.](#) Modelling the public health impact of male circumcision for HIV prevention in high prevalence areas in Africa. *BMC Infect Dis.* 2007 Mar;7:16.

History of Male Circumcision in Botswana

Male circumcision is one of the oldest and commonest surgical procedures and has been practiced worldwide for reasons, which include religious, cultural, social and medical.

The history of male circumcision in Botswana is documented as far back as 1874. In the article from 1917, there is one description of the “surgical” procedure. A person who is chosen by the chief is usually one who is acknowledged to have the skill to perform the operation on the whole regiment of boys.⁹ This individual “uses an ordinary knife which he has sharpened specially for the purpose. The thumb of the operator is inserted in the foreskin and a circular cut is made right around. There is no attempt to stop the bleeding; nothing is done with the blood; and the amputated foreskin is simply thrown away”. The document goes on to describe frequent bathing, and use of white clay and fat on the body. However, it is not readily apparent if any one of these is a measure used to stop infection of the wound.

Communication written in 1888 describes an occasion of the ‘bogwera’ ceremony among the Bakwena tribe taking place with the consequent death of more than 50 of the initiates¹⁰. No explanation is given as to the cause of these deaths.

As these practices were found to be cruel, barbaric and unhygienic, the High Commissioner passed a proclamation on 19 December 1917 to prohibit initiation ceremonies in the Bechuanaland Protectorate¹¹. Persons under the age of 16 were not to be initiated without the consent of their parents or guardians. The document also outlines the punishment for contravening this prohibition.

No information on neonatal circumcision was found in the documentation from this period.

Currently MC is performed in both private and public hospitals although at a fairly low rate.

⁹ Willoughby W C. Notes on the initiation ceremonies of Becwana. 1909. Botswana National Archives and Records Number - BNB370

¹⁰ Letter to Sir S G A Shippard. Dated Sept 21st 1888. Botswana National Archives and Records - Number HC24/24

¹¹ Mosothwane M N. An ethnographic study of initiation schools among the Bakgatla bag a Kgafela at Mochudi (1874 – 1988). Pula:Botswana Journal of African Studies. Date unknown. 15(1) 144- 165.

MC acceptability in Botswana

A study published in 2002 on acceptability of male circumcision in Botswana found that circumcision of a male child was highly acceptable among both male and female respondents provided the procedure was offered at no cost to the patient and in a hospital setting¹². The acceptability rose even further (to nearly 90%) after a brief information session on the procedure. A similar response pattern was seen among uncircumcised males with regards to undergoing the procedure themselves, reaching to 81% after informational briefing sessions.

In further analysis of all participants, individuals with children were more likely to favour circumcision than those without, with most feeling that the ideal age for circumcision is before 6 years. The majority of participants (90%) felt that circumcision should be performed in the hospital setting.

These findings were not without their detractors. Some argued that the introduction of male circumcision, particularly among neonates, into a non-circumcising society would be more difficult¹³. The reasons given are medical, psychological, sexual, and human rights and ethical, among others. Apart from this study and related comments, information on neonatal circumcision on Botswana was not found. However, one paper made reference to a policy decision taken in Botswana to offer male circumcision as part of routine antenatal care at all health facilities¹⁴. This has not been implemented and no other reference to this policy was found.

¹² [Kebaabetswe P, Lockman S, Mogwe S, et al.](#) Male circumcision: an acceptable strategy for HIV prevention in Botswana. *Sex Transm Infect.* 2003 Jun; 79(3):214-9.

¹³ [Boyle GJ.](#) Issues associated with the introduction of circumcision into a non-circumcising society. *Sex Transm Infect.* 2003 Oct; 79(5):427-8.

¹⁴ Wilson D, de Beyer J. Male circumcision: Evidence and Implications. 2006 .World Bank Paper

http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1132695455908/M&EGR_MaleCircumcision_Mar31.pdf

Accessed 01Dec07

II. RATIONALE FOR SAFE MALE CIRCUMCISION

Botswana needs to implement Safe Male Circumcision as an additional HIV prevention intervention because:

The country has a high HIV prevalence and there is evidence that incidence though declining could still be very high. Overall HIV prevalence in the general population from 18 months of age and above is 17.1%¹⁵.

Although the country has put in place preventive measures including an effective PMTCT program, BCIC programs, HIV testing and counseling, blood safety program and STI management and control, there is still a high rate of HIV transmission in the country. Therefore, MC is essential in adding to the existing strategies in preventing the spread of HIV infection.

The combination of recent research findings in South Africa, Kenya and Uganda, and the WHO/UNAIDS recommendations that male circumcision is efficacious in reducing HIV infection has prompted many countries in Africa to scale up this component of HIV prevention and develop national policies, strategies and implementation plans. Botswana is one such country.

III. OPPORTUNITIES

The following opportunities exist and they provide a conducive environment for scaling up MC:

- 1 Strong political will and support to MC by government and development partners.
- 2 High acceptance of MC in the population
- 3 Existence of good infrastructure and health systems that could enable scaling up of MC services
- 4 All hospitals are already performing MC albeit at a small scale
- 5 Availability of strong programs at facility (e.g. RHT, ANC) and community levels.

¹⁵ Botswana AIDS Impact Survey II. 2004

IV. CHALLENGES

The MC strategy faces following challenges:

- 1) Setting ground for Safe Male Circumcision to be performed with the utmost respect for human rights.
- 2) Maintaining a sustainable and long-term effort.
- 3) Ensuring availability of the adequate, qualified, skilled and motivated doctors and nurses capable of conducting high quality MCs.
- 4) Ensuring the population gets the right messages about MC and does not lead to behavior disinhibition.
- 5) Ensuring access to the hard to reach populations.
- 6) Ensuring a transparent, coordinated and collaborated effort from all partners.
- 7) Reducing stigma associated with HIV testing and male circumcision status.

VI. GUIDING PRINCIPLES ON SAFE MALE CIRCUMCISION

The following principles will guide the implementation of safe male circumcision for HIV prevention. These principles take into account the WHO/UNAID recommendations as well as the socio-cultural and service delivery context in Botswana.

- 1) **Male Circumcision does not provide complete protection against HIV**
Male circumcision should never replace other known methods of HIV prevention and should always be considered as part of a comprehensive HIV prevention package, which includes: promoting delay in the onset of sexual relations, abstinence from sex and reduction in the number of sexual partners; providing and promoting correct and consistent use of male and female condoms; providing HIV testing and counseling services; and providing services for the treatment of sexually transmitted infections.

2) Correct Communication and messages on male circumcision are critical

- Communication strategies shall ensure that clear and consistent messages are disseminated and that male circumcision is promoted within the context of comprehensive HIV prevention strategies.
- Messages shall be developed to ensure that men opting for the procedure and their partners are counseled that male circumcision is only partially protective and therefore they need to continue to use other effective measures of HIV prevention.
- Messages and counseling shall stress that resumption of sexual relations before complete wound healing may increase the risk of acquisition of HIV infection among recently circumcised HIV-negative men and may increase the risk of HIV transmission to female partners of recently circumcised HIV-positive men.
- Men who undergo circumcision should abstain from sexual activity for at least six weeks after the operation. Thereafter, other HIV prevention strategies, including the correct and consistent use of male and female condoms, should be promoted and adhered to, as for uncircumcised men.
- Messages shall be carefully tailored and culturally sensitive.
- Messages should address both men and women.

3) The socio-cultural context should inform male circumcision programming.

- The socio-cultural implications of male circumcision shall be taken into account in the design and implementation of policies and programmes.
- Human rights, legal and ethical principles must guide service delivery
- Safe male circumcision shall be provided with full adherence to medical ethics and human rights principles. Informed consent, confidentiality and absence of coercion should be assured.
- Parents and guardians who are responsible for providing consent, including for the circumcision of male infants, should be given sufficient information regarding the benefits and risks of the procedure in order to determine what is in the best interests of the child.
- Safe Male Circumcision services shall be accessible, provided safely and without discrimination.

4) The gender implications of male circumcision as an HIV prevention method must be addressed

- Safe Male Circumcision services shall take the opportunity that male circumcision programmes afford for education and behaviour change communication, promoting shared sexual decision-making, gender equality, and improved health of both women and men.
- The scale-up of male circumcision services shall include the goals of changing gender norms and roles and promoting gender equality. The programme shall monitor and minimize potential negative gender-related impacts of male circumcision programmes.
- Male circumcision service provision shall be used to address the sexual health needs of men; actively counsel and promote safer and responsible sexual behavior.

5) Programmes should be targeted to maximize the public health benefit

- Scaling up access to male circumcision services shall be promoted as a priority for adolescents and young men. In addition, since neonatal circumcision is a less complicated and risky procedure it shall also be promoted. Safe circumcision shall be performed in a safe, culturally acceptable and sustainable manner. The Safe Male Circumcision services shall be promoted to HIV-negative men aged 0 – 49 years.
- MC service delivery shall be monitored and evaluated for possible untoward effects such as increases in unsafe and unprotected sex and increases in sexual violence.
- MC services shall not be delivered in isolation, but as part of a recommended minimum package which includes information about the risks and benefits of the procedure, counseling about the need to adopt and maintain safer sex practices, access to HIV testing, condom promotion and provision, and the management of sexually transmitted infections.

6) Health services need to be strengthened to increase access to safe male circumcision services

- Needs assessments should be undertaken to describe and map out the anticipated scope of male circumcision scale-up, human resource and training needs, infrastructure, commodities and logistic requirements, costs and funding, and systems for monitoring, evaluation and follow-up.

- Training and certification of providers shall be rapidly implemented to increase the safety and quality of services in the public and private sectors.
- Supervision systems for quality assurance shall be established along with referral systems for the management of adverse events and complications.
- A clear strategy shall be developed to ensure that MC services are integrated into strengthened health systems as soon as it is feasible.
- Additional resources shall be mobilized to finance the expansion of safe male circumcision
- Implementation of safe MC services shall not take away resources from other essential health programmes.

7) Promoting circumcision for HIV positive men is not recommended

- Based on the current available evidence, MC is not to be promoted for HIV-positive men.
- If medically indicated, MC shall be provided to all men irrespective of HIV status.
- If male circumcision is requested by men with HIV infection; following in-depth counseling on the known risks and benefits, it should not be withheld unless it is medically contraindicated.
- HIV testing should be recommended for all men seeking male circumcision, but should not be mandatory.

8) Research is needed to guide program implementation

- Baseline studies shall be conducted for monitoring purposes and for the evaluation of impact.
- Operational research shall be conducted as MC services are scaled up.

V. OVERALL OBJECTIVE

The overall objective of this strategy is to contribute to the reduction of HIV infection rates by **scaling up safe MC through out the country to reach MC prevalence rate of 80% among 0-49 years old HIV-negative males by 2012.**

VI. SPECIFIC OBJECTIVES

The following are the specific objectives for safe MC services:

- 1) To strengthen the capacity of health services for scaling up safe MC (Training, HR, outsourcing, augment infrastructure, standard setting, mentorship, linkages and referrals)
- 2) To offer a comprehensive safe MC service package to all men consenting to undergo MC
- 3) To strengthen BCIC on MC for all segments of the population (Circumcised males, addressing gender issues, women, parents, stakeholders, uncircumcised males – community mobilization)
- 4) To systematically monitor and evaluate MC (acceptance, performance, coverage, safety and impact of safe MC services.)

OBJECTIVE 1. To strengthen the capacity of health services for scaling up safe MC

Even though the scaling up of safe male circumcision will be integrated within the context of existing health services, it will nonetheless require additional capacity strengthening of health systems. This includes increasing the number of health workers, training, equipment and supplies, and developing linkages and referral systems between MC and other essential interventions such as HIV testing and counselling, ANC, and BCIC programmes. Thus, the following strategic approaches will be adopted in order to attain this specific objective:

1.1 Increasing human resource capacity

This will be done through the recruitment of extra-health workers and exploring other innovating approaches such as outsourcing MC services to the public private sector.

Main Activities

- **Recruiting additional Health workers**

In order to scale up MC and reach the targets stipulated in the general objective, it is envisaged to recruit 26 doctors to work at the hospitals on a full-time basis. These doctors will conduct MC in their hospitals and coordinate all MC related activities in their respective catchment areas. In addition staff will be recruited for the DHAPC to coordinate MC activities.

- **Involving Private Practitioners**

MOH will explore all possible ways of maximizing the involvement of private practitioners in order to tap into the capacity in the private sector. The private practitioners will be included in training sessions for safe MC and Safe MC documents including guidelines and SOPs will be shared with them. In addition the MOH will advocate for favourable terms for safe MC with Medical AID Schemes and feasibility for outsourcing to the private sector will be considered

1.2 Training Health Workers

Safe Male Circumcision is part of the pre-service training in Medical schools; however MC is not routinely done in all health facilities in Botswana. Therefore in-service training is needed to ensure Health Care Providers (in both public and private sector) are skilled in the provision of safe MC and the quality of the services is maintained. Hands on training will be provided to doctors and theatre nurses and the rest of the health care workers (Nurses, pharmacists, pharmacy technicians, laboratory technicians etc) will receive training aimed at improving their education/knowledge on safe MC.

Main Activities

- Development of a comprehensive training curriculum for doctors, theatre nurses and educational materials for other health workers
- Provide basic training and regular refresher courses to health care providers implementing Safe Male Circumcision.
- Develop an effective, comprehensive training plan for Safe Male Circumcision annually.
- Establish Safe Male Circumcision base of Master trainers at Princess Marina and Nyangabwe referral hospitals for basic trainings and mentoring.
- Integrate Safe Male Circumcision trainings with others DHAPC trainings (KITSO, STI, BCIC training courses).
- Develop modalities for accreditation
- Establish a monitoring and evaluation process to identify training needs and ensure effective training is provided

1.3 Augmenting equipment and supplies

The rapid assessment of MC in health facilities revealed a need to augment equipment and supplies (surgical kits, HIV testing kits etc) if safe MC was to be scaled up to meet the overall objective. Ensuring that there is adequate equipment and supplies is thus an important strategic action.

Main Activities

- Assessing the equipment and supplies needs of facilities
- Procuring and distribution of the surgical equipment and other supplies
- Assessing facilities for readiness for MC scale up

1.4 Establishing Referral System for HIV-negative male individuals for safe MC

All HIV negative male individuals, from all Voluntary Counseling and Testing sites (VCT), Reproductive and Child Health clinics, PMTCT (Early Infant Diagnosis), and from health facilities after routine HIV testing (RHT) shall be referred for safe MC. Issues related to safe male circumcision will be incorporated into post-test counseling for all HIV negative individuals.

Main Activities

- Develop and disseminate SOP to establish these referrals for infant, adolescent and adult male circumcision.
- Incorporate MC issues into post-test counseling for HIV negative individuals in all site (public, private and NGOs) offering HIV testing

1.5 Setting Standards and quality assurance for MC

Male circumcision when not performed properly can result in serious complications, which can be detrimental to the ultimate goal of reducing risk for HIV infection. Therefore it is important that the standards for safe male circumcision are set and systems for quality assurance established.

Main Activities

The following main activities will be implemented to improve quality assurance:

- Revise and disseminate standards for safe MC.
- Develop supervisory and mentoring guidelines to ensure quality of services and accountability
- Supervises and mentor safe MC (BHP-Master Trainers program and STI mentors shall be used)
- Strengthen surgical outreach programs

OBJECTIVE 2. To offer a compressive safe MC Service package to all males consenting to under go MC

All clients for safe male circumcision as an HIV prevention intervention (infants, adolescents and adults) should receive counseling, HIV testing, a safe surgical procedure, and follow up support

The following **main activities** will be done:

Counseling

Counseling is the most important aspect of safe MC. It should be provided several times along the course of safe MC. The counseling should focus on the surgical procedure itself and behavior change. The risk reduction counseling shall be provided at the time of booking, pre-MC and post-MC and at six weeks post-MC. Safe MC counseling guidelines will be developed and disseminated to all health facilities. In addition, counseling of parents on safe male circumcision of infants will be incorporated into the ANC, MCH and early infant diagnosis services.

HIV testing

HIV test will be offered immediately before MC. If the result is HIV-negative, MC will be performed but if the result is HIV-positive, the client will be referred for counseling. After thorough counseling and the client still wants to go ahead with the procedure, circumcision will be performed.

HIV test will be repeated after three months and annually after that. HIV test will be repeated any time if the client had an exposure to HIV infection.

Safe MC Procedure

It has been agreed that only a standard MC procedure using surgical instruments will be promoted and included into the training curriculum for hands-on MC training courses in the country.

Follow up

The client will be seen after a week if there is no complication or earlier if there is complication. During this visit, counseling will be repeated to reinforce the need to stay negative and to clarify and answer any question during this period. The need to abstain from sex for six weeks after MC and to follow safer sex practices will be recommended.

The next follow up visits shall be after 6 weeks and 3 months. At the 6 week follow up further counseling will be provided. At 3 months, further counseling and a repeat HIV test will be offered.

OBJECTIVE 3. To Strengthen BCIC on MC for all segments of the Population

Because MC only offers partial protection from HIV infection in males and that there is no immediate benefit to women, it is important that the public is provided with accurate information on MC including the benefits and limitations of this intervention for HIV prevention. BCIC is therefore an important strategy in scaling up MC and realizing its benefits. In addition, BCIC will assist in mobilizing the public for MC and increasing demand for MC from the target groups (i.e infants, adolescents and adult males).

Main Activities

The following activities will be conducted:

- Develop an IEC strategy for MC as part of the overall health sector BCIC strategy
- Solicit support for MC from political and civic leaders at all levels.
- Disseminate regularly specific and targeted information to the various audiences (general public, uncircumcised men, adolescent boys, circumcised men, implementers, other stakeholders)
- Ensure that gender and human rights considerations are addressed as MC is scaled up.

OBJECTIVE 4. To systematically monitor and evaluate Safe MC

A M&E system for MC will be developed in order to collect, collate, analyze and disseminate (including feedback) data/information on the MC programme. This will enable monitoring and evaluation of performance of MC programme and measurement of impact of MC in reducing the risk of acquisition of HIV in the population. The proposed instruments for data collection are in Annex 2.

Areas to be monitored

- Acceptance (demand/knowledge, attitude and use of services)
- Performance/coverage (access)
- Safety of MC (occurrence of adverse events)
- Impact (number of HIV infections averted)

1. Acceptance

Indicators

- Changes in MC demand rates/rates of use of service
- Changes in knowledge about MC, benefits of MC (& accompanying activities) and attitudes towards MC and use of services

Sources of data/information on MC

- Monitoring & evaluation of IEC/behavioral change, evaluation of impact of IEC on knowledge, attitudes and practices
- Changes in knowledge about benefits of MC (& accompanying activities), attitudes towards MC and use of service:
- Baseline and ongoing post implementation surveys - surveys to be carried out among individuals (men and women), parents of minors and service providers
- Baseline and on going post implementation FGDs among population groups (school children, parents, opinion leaders, service providers, etc)

2. Access

Indicators

- Coverage rates
- Demand rates

Sources of Data

- HIV negative population eligible to get MC vs those that use/utilize the service
- Routine information on numbers using/demanding MC service in health facilities (facility, area, age & HIV status of MC cases)

3. Safety

Indicators

- Rates of adverse events (complications) among cases in different age groups
- Rates of type of adverse events among all adverse events

Sources of Data

- HIV negative population eligible to get MC vs those that use/utilize the service
- Routine information on numbers using/demanding MC service in health facilities (facility, area, age & HIV status of MC cases)

4. Impact

- Infections averted in the sexually active population (particularly among groups of population responsible for most transmission/incidence)

Indicator

- Rates of new cases averted

Sources of Data

- Incidence rates of HIV surveys – on population
- Use of models that would use data/variables from routine health information to determine number of new infections averted
- Impact on incidence of HIV among women (long term)

5. Feedback Mechanisms

There will be monthly reporting of MC activities from districts. Reports from central data analysis indicating acceptance, access/demand, safety, impact of MC to:

- Reporting facilities
- Partners /Stakeholders
- General population
- Appropriate reports will be disseminated for surveys and FGD

VII. IMPLEMENTATION MODALITIES

Overall Coordination

The MOH through the DHAPC will be the lead agency in providing overall programmatic guidance for the safe MC services. The STI Control Program in the DHAPC will be administratively responsible for running the MC programme. MOH shall develop in consultation with stakeholders, an implementation plan based on this strategy and it will spearhead its execution.

Actual safe MC services will be run by the Department of Clinical services through hospitals at different levels and MLG will also be part of the effort through various clinics.

MOH will coordinate safe MC through Safe MC TWG for implementation issues and through Safe MC Reference Group for policy issues. This group will advise the Principal Secretary of MOH on all issues pertaining to safe MC. Membership of both groups will be revised when need arises.

The Reference Group and TWG shall be used to coordinate safe MC at national levels. At the district levels coordination shall be done through STI focal persons, who will be responsible to integrate safe MC activities among other routine STI activities at their levels. Guidelines to facilitate this coordination shall be developed and disseminated by the STI Control Program.

Coordination of Training

The following institutions will have responsibility of ensuring Safe Male Circumcision trainings are provided. The Department of HIV/AIDS Prevention and Control, Training-coordinating unit will provide coordination of the training program. The Unit will ensure that the curriculum is developed and there is harmonization and consistency in the messages provided with other HIV-focused training programs. The Department of HIV/AIDS Prevention and Control, STI control Program will be responsible for the management and implementation of the Botswana National Safe Male Circumcision Training Programme. The program will provide the leadership and logistical support for the training program. The STI unit will work together with the Training Coordinating unit to develop an annual training plan with budget. The Department of Clinical Services, Princess Marina and Nyangabwe Referral hospitals will provide hands-on training on Safe Male Circumcision and mentoring services.

Rollout of Safe MC Services

Safe Male Circumcision will be scaled up in a phased manner. The initial phase will concentrate on scaling up safe MC in the 26 hospitals and block 8 clinic in Gaborone that are currently performing male circumcision routinely. Following this, an additional 5 clinics Charles Hill clinic, Tonota clinic, Kang clinic, Serowe/Palapye Boipelelo clinic, and Jubilee clinic, which already have operating theatres will be assessed and improved to provide safe male circumcision. Gradually more clinics including private institutions will be assessed to start offering safe male circumcision. However all clinics will be expected to provide as a minimum essential component of safe MC, follow up support for uncomplicated cases.

Roles and Responsibilities

All stakeholders are expected to play important role in scaling up safe Mc as an additional HIV prevention strategy. It is expected that stakeholders will draw on this strategic document in planning and implementing activities for scaling up safe MC as an additional HIV prevention intervention.

Civil Society, NGOS

Civil society including NGOs CBOs, Faith Based Organizations and others will play a key role in the implementation of the BCIC component of the National Safe MC strategy and in the provision of VCT services as well as counseling for safe MC. Thus they will be key in educating the public about MC as well as in creating public support and demand for safe MC,

Ministry Of Health

The Ministry of health will provide strategic technical guidance to the planning implementation, monitoring and evaluation of safe MC as an HIV prevention strategy. In addition, MOH will coordinate all health sector related aspects of MC.

Ministry of Local Government

MLG will lead the role out of MC to clinics and will work with MOH to ensure that Minimum package of MC services for various clinics and health posts are defined and provided

NACA

NACA will provide overall coordination of safe MC scale up and ensure that it is being closely integrated with other HIV prevention efforts as defined in the National HIV prevention Plan.

Development Partners

Development partners will be expected to provide financial support and technical assistance in the planning, coordination, implementation, monitoring and evaluation of the scaling up of safe male circumcision.

VIII. FINANCING THE SCALING UP OF MALE CIRCUMCISION

Budget

The budgeting process took into account the following: the direct costs of performing the procedure and indirect costs of trainings, BCIC, M&E and administrative support. Activities falling within each group were itemized and costed. Personnel costs were also included. The five years budget of safe MC scale is **P 145,471,288 (Refer to Annex 3)**

Resource Mobilization

Safe male circumcision is to be implemented as an add-on strategy for HIV prevention to complement other existing interventions. Therefore financial resources earmarked for the scaling up of existing intervention should not be diverted to safe male circumcision. In this regard, the MOH shall mobilize resources from government and development partners operating within the country. In addition, aspects for which funding may not be available locally will be included in the Global Fund to fight AIDS Tuberculosis and Malaria Round 8 proposal on HIV/AIDS.

ANNEX – 1: Budget

80% coverage of eligible population:

- Number of MCs performed in five years 467,262
- Magnitude of demand in five years 584,077
- Number of eligible population unattended in five years 116,815
- Coverage after five years 80%
- Cost per MC performed P372.5
- HIV infections averted 70370
- Cost per HIV infection averted P2473.3

MC coverage of 80% in age group 0-49 years

5 Year Budget Summary for Male Circumcision Scale up in Botswana (BWP)

	Year 1	Year 2	Year 3	Year 4	Year 5	<u>Total</u>
<i>Direct surgery costs</i>	<i>22,742,087</i>	<i>23,361,688</i>	<i>24,190,954</i>	<i>24,961,237</i>	<i>25,811,629</i>	<i>121,067,595</i>
Supplies/ Equipment	15,871,291	15,871,291	15,871,291	15,871,291	15,871,291	79,356,455
HR	6,870,796	7,490,397	8,319,663	9,089,946	9,940,338	41,711,140
<i>Indirect costs</i>	<i>7,601,529</i>	<i>2,851,104</i>	<i>7,138,082</i>	<i>2,950,522</i>	<i>3,862,456</i>	<i>24,403,693</i>
Training/ workshops	1,178,920	1,108,920	1,108,920	1,108,920	1,108,920	5,614,600
IEC	4,985,022	1,485,289	4,883,519	1,525,030	1,546,158	14,425,018
M&E	918,817	66,422	931,477	80,398	946,906	2,944,020
Administrative	518,770	190,473	214,166	236,174	260,471	1,420,055
Total	30,343,616	26,212,792	31,329,036	27,911,759	29,674,085	145,471,288

Annex 2

Instruments for data collection

a) Routine health information from health facilities

Name of health facility _____

Name and designation of reporting staff _____

Date of Report _____

Case number	Date of MC	Area of residence	Age	Result of HIV test	Follow up(s)	Type of Adverse events (if any)

(b) Questionnaires for surveys

Appropriate survey questionnaires or FGDs guidance frame for:

- Baseline and *ongoing* post implementation surveys. Surveys to be carried out among individuals (men and women), parents of minors and service providers
- Baseline and *on going* post implementation FGDs among population groups (school children, parents, opinion leaders, service providers, etc

c) Routine feedback from MOH to health facilities

Name and designation of reporting staff _____

Date of Report _____

Month	Facility	District	MCS by age group	HIV status of cases	Complicated cases (adverse events)	Number of each type of complication	Comments
			<1yr 1-5yrs 6-14yrs 15-49yrs	Number +ve Number -ve			
			<1yr 1-5yrs 6-14yrs 15-49yrs	Number +ve Number -ve			
			<1yr 1-5yrs 6-14yrs 15-49yrs	Number +ve Number -ve			

Comment [t1]: This is too large and age group if we are to be able to monitor and have surveillance on what is happening in different age groups, the age related impact of the programme etc. I would seriously suggest that this is broken down into 5 or 10 year age groups; much routine health information from facilities is collected in this way (e.g. MH 1048 form)

			<1yr 1-5yrs 6-14yrs 15-49yrs	Number +ve Number -ve			
			<1yr 1-5yrs 6-14yrs 15-49yrs	Number +ve Number -ve			
			<1yr 1-5yrs 6-14yrs 15-49yrs	Number +ve Number -ve			
			<1yr 1-5yrs 6-14yrs 15-49yrs	Number +ve Number -ve			

ANNEX - 3

MEMBERS OF SAFE MALE CIRCUMCISION REFERENCE AND TECHNICAL WORKING GROUP

Reference Group	Technical Working Group
1) WHO	1) WHO
2) UNAIDS	2) DHAPC/ MOH - Secretariat
3) DHAPC/ MOH - Secretariat	3) DPH/MOH – Sexual and reproductive health
4) DPH/MOH – Sexual and reproductive health	4) CS/MOH
5) CS/MOH	5) MLG/PHC
6) MLG/PHC	6) NACA
7) NACA	
8) ACHAP	
9) BOTUSA	
10) Men's sector	
11) BONASO	
12) BONEPWA	
13) BOFWA	
14) PMD Association	
15) UB – sociology department	
16) PSI	
17) Representative of Medical Aid Schemes	
18) PEPFAR country office	
19) MOE	
20) BONELA	

BACK



Male circumcision has long been part of the Bakgatla tribe's history through coming of age ceremonies like this 1934 initiation in Mochudi. Photo courtesy of the Phuthadikobo Museum.

