

**MALE CIRCUMCISION MANAGERS' ATTITUDES TOWARD SAFE MALE  
CIRCUMCISION PROGRAM IMPLEMENTATION AND SCALE UP IN BOTSWANA**

by

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degree of Master of Philosophy (HIV/AIDS Management) in the Faculty  
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## **Declaration**

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: March 2013

## **Abstract**

**Background:** Safe Male circumcision (SMC) divides people for or against it, depending upon their attitudes. The Ministry of health (MOH) has built capacity in the country for rapid scale up of the program since 2009. However, despite the efforts, the number of men circumcised is lagging behind set targets. We do not know to what extent attitudes of the managers at national and district levels do influence this underperformance? The effectiveness of the managers at workplace at large will depend on their attitudes towards SMC. Managers with positive attitudes bring at workplace energy, creativity and momentum to fulfill the work objectives and goals.

**Objectives:** The objectives of the study were to;

- 1) establish the current situation of SMC implementation in Botswana,
- 2) establish the required attitudes for managers towards SMC program,
- 3) establish the attitudes of SMC managers at all levels toward SMC program,
- 4) determine the gap between the required attitudes and SMC managers' current attitudes toward SMC, and
- 5) Provide recommendation for reinforcing positive attitudes toward SMC program.

**Methods:** The study used an explorative qualitative design. It was carried out at the Ministry of health headquarters and in ten districts in Botswana. A total of 26 SMC program managers were interviewed using a semi-structured interview guide.

**Results:** The study found that the managers were confirming to positive attitudes toward the program as prescribed by the MOH's standards. Data revealed a positive trend in scaling up of the program albeit lagging behind set targets.

**Conclusion:** This study looked at the desired attitudes of SMC managers should possess and the level of attitudes currently have towards the program. It was not easy to link attitude and

performance of individuals. High turnover rate of SMC officers was a worrisome finding that calls for further study.

## Opsomming

**Agtergrond:** Na gelang van hul houdings, is die meeste mense hetsy sterk ten gunste van of heftig gekant teen veilige manlike besnydenis (VMB). Die Ministerie van Gesondheid is reeds sedert 2009 besig met vermoëbou-inisiatie we om die VMB-program vinnig uit te brei. Ondanks hierdie pogings, is die aantal mans wat ingevolge dié program besny word egter veel minder as die vasgestelde teikens. Dit is nie bekend in watter mate die houdings van VMB-programbestuurders op nasionale en distriksvlak hierdie onderprestasie beïnvloed nie. Die algehele doeltreffendheid waarmee dié bestuurders die program in werking stel, sal immers grootliks afhang van hul houdings jeens VMB. Bestuurders met 'n positiewe houding sal energie, kreatiwiteit en stukrag aan die werkplek verleen ten einde die programoogmerke en -doelwitte te verwesenlik.

**Oogmerke:** Die oogmerke van die studie was:

- 1) om die huidige stand van VMB-inwerkingstelling in Botswana te bepaal;
- 2) om te bepaal watter houdings bestuurders behóórt te hê jeens die VMB-program;
- 3) om te bepaal watter houdings bestuurders op alle vlakke wél het jeens die VMB-program;
- 4) om vas te stel in watter mate bestuurders se vereiste houdings en huidige houdings jeens VMB verskil; en
- 5) om aanbevelings te doen vir die versterking van positiewe houdings jeens die VMB-program.

**Metode:** Die studie het van 'n verkennende kwalitatiewe ontwerp gebruik gemaak. Dit is by die hoofkantoor van die Ministerie van Gesondheid sowel as in tien gesondheidsdistrikte in Botswana onderneem. Onderhoude aan die hand van 'n semigestruktureerde onderhoudsgids is met altesaam 26 VMB-programbestuurders gevoer.

**Resultate:** Die studie bevind dat die bestuurders wél positiewe houdings jeens die program toon soos wat die standaard van die Ministerie van Gesondheid vereis. Data dui op 'n positiewe tendens in die uitbreiding van die program, al word die vasgestelde teikens nie bereik nie.

**Gevolgtrekking:** Hierdie studie het ondersoek ingestel na die houdings waaroor VMB-programbestuurders behoort te beskik en die houdings wat hulle tans jeens die program openbaar. Dit was uitdagend om 'n verband tussen individuele houdings en prestasie te lê. Die hoë omsetsyfer onder VMB-beamptes is ook 'n kommerwekkende bevinding, wat verdere studie noodsaak.

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I would also like to extend my gratitude to Dr. Thozamile Qubuda my research leader for his professional leadership and guidance.

## **Dedication**

I would like to dedicate this assignment to

My beloved wife (Lydia J Zungufya)

My beautiful daughters (Nasrat, Gheda and Raya) for their patience, understanding and encouragement during the time I was working on this assignment.



## Abbreviations

AAP	American Association of pediatrics
ACHAP	African Comprehensive HIV/AIDS Partnership
AIDS	Acquired Immune Deficiency Syndrome
AMA	American Medical Association
BCIC	Behavior Change Information Communication
BUFF	Brothers United for Future Foreskin,
CSO	Central Statistic Office
DHMTs	District Health Management Teams
DOC	Doctors Opposing Circumcision.
HIV	Human Immune-deficiency Virus
I-TECH	International Training Education for Health
JHPIEGO	John Hopkins International Education for Gynecology and Obstetrics
MC	Male Circumcision
MOH	Ministry of Health
MOVE	Model of Optimizing Volume and Efficiency
NACA	National AIDS Coordinating Agency
NOCIRC	National Organization of Circumcision Information Resource Centers
NOHARRM	National Organization to Halt the Abuse and Routine Mutilation of Males,
PEPFAR	Presidential Emergency Program for AIDS Relief
PSI	Population Service International
RCT	Randomized Control Trial
RECAP	Recovery of a Penis
SMC	Safe Male Circumcision
SSI	Semi Structured Interview
UNAIDS	Joint United Nation program for HIV/AIDS
WHO	World Health Organization

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## **Chapter 1: Introduction, Research Problem and Objectives of the study**

### ***1.1. Introduction***

Male circumcision is the removal of the foreskin. It is one of the oldest and commonest surgical procedures worldwide (Weiss, Quigley & Hayes, 2000, p. 2361), undertaken for many reasons including religious, cultural, social and medical (Drain, Halperin, Hughes, Klausner & Bailey, 2006, p.172). In adult men, a four to six weeks period is required to fully heal the wound. Healing is usually complete after a week when circumcision is performed in babies (Plank & Makhema, 2009). Research has shown that removing the foreskin is associated with a number of health benefits that include better penile hygiene, prevention of balanitis and prosthitis, lower risk of sexually transmitted diseases especially ulcerative diseases such as chancroid and syphilis, reduced risk of penile cancer and reduced risk of cervical cancer in female partners of circumcised men (Drain et al, 2006).

Studies have shown that SMC reduces the risk of HIV transmission by 40-60% (WHO, 2011). The Southern Africa Orange Farm trial, which enrolled 3274 uncircumcised men, aged 18 to 24 years showed a 61% protection against HIV acquisition (Auvert, Taljaard & Lagaarde, 2005). The trial in Kisumu, Kenya, of 2784 HIV-negative men aged 18 to 24 years shows a 53% reduction of HIV acquisition in circumcised men relative to uncircumcised men (Bailey, Moses & Parker, 2007, p. 643-56). The trial of 4996 HIV-negative men aged 15 to 49 years in Rakai, Uganda showed that HIV acquisition was reduced by 51% in circumcised men (Gray, Kigozi & Serwadda, 2007, p.657-66).

The most plausible biological explanation for the higher levels of sexually transmitted infections, including HIV seen in uncircumcised men is that the inner mucosal surface of the foreskin is only thinly keratinized and therefore susceptible to minor trauma and abrasions that facilitate entry of pathogens (Hussain & Lehner, 1995, p. 475-484). The area under the foreskin is moist and warm, providing a microenvironment that facilitates the multiplication of pathogens, especially when penile hygiene is poor (Hussain & Lehner, 1995, p. 475-484). Further, the increased risk of HIV infection in uncircumcised men is believed to be due to increased risk of

genital ulcer diseases as well as the superficial location of HIV – 1 target cells (CD4+ T cells, macrophages and Langerhans cells) in the inner mucosal surface of the foreskin. In contrast, in circumcised men, the penile shaft is covered with a thickly keratinized epithelium that provides some protection to infection (Weiss, et al, 2006, p.101-109).

It must be recognized that male circumcision, as with any surgical procedure is not without risk. There is possibility for post-operative infection, and in inexperienced hands penile mutilation and even death can occur. The surgery can lead to excessive bleeding, hematoma and other complications in initial months after the procedure. In addition adverse reactions to the anesthetic used during the circumcision may occur. Thus trained personnel and correct equipment and aseptic conditions are necessary for proper circumcision (Rain-Taljaard, Lagarde, Taljaard, Campbell, MacPhail, Williams & Auvert, 2003, p. 315–327).

Following recommendation by UNAIDS and WHO in 2007, the government of Botswana has put measures in place to implement and scale up SMC in the country. The government aims to increase the prevalence of male circumcision (MC) from the current 11% (Central Statistics Office, 2008, p. 14) to 80% (National AIDS Coordinating Agency (NACA), 2009, p. 26) in 2016 which translates to about 470,000 circumcisions.

To-date after three years of implementation only about 20,000 men have been circumcised. There are several reasons for this underachievement relating to issues of management, human resource, supplies and infrastructures (Ministry of health (MOH), 2010).

MC, because of its controversial nature divides health professionals and the general public into proponents and opponents depending on individual socio-cultural background and the level of the understanding of different components of MC (Weiss et al, 2006, p. 101-109).

For the program to succeed, it must be led by managers with positive attitudes who are going to drive the objectives and reach the set target. Dickson, Tran, Samuelson, Njehmelu and Cherutich in 2011 showed that it is not enough for the country to adopt MC policy but it is necessary to put in place all factors that will support implementation and scale up of programs

including building positive attitudes towards it. Health practitioners and program managers must be committed to the goal.

Some of the managers were recruited specifically for SMC program but majority are managing it by default. Their attitudes towards SMC were never ascertained. It must be remembered that MC practices are largely culturally and religiously determined and as a result there are strong beliefs and opinions surrounding its practice. It is important to acknowledge that individuals' personal biases and the dominant circumcision practices of their respective communities may influence their interpretation of findings of existing body of MC knowledge. This can also apply to SMC managers who are leading and coordinating these programs (Mills & Siegfried, 2006, p.1236). The attitudes of managers towards male circumcision could work negatively or positively in achieving country's SMC set targets.

### ***1.2. Research problem***

The number of men circumcised remains very low despite all the resources that have been allocated to the program. Adequate staff for SMC has been recruited and capacitated. About 22 Doctors, 80 Nurses and 30 supporting staff were recruited and dedicated to MC at high volume MC sites (MOH, 2012). Infrastructure has been improved, more space at health facilities availed to MC equipment such as diathermy machines, and forceps etc. have been purchased. In some facilities specialized tents for MC have been erected. Mobile clinic and clinic in box have been purchased, lastly adequate supplies have been purchased, and 40,000 disposable MC kits have been purchased and distributed throughout the country (MOH, 2012).

Management for SMC is in place at all levels. At national level the responsibility for running MC program is National SMC coordinator. Other SMC managers at national level are SMC technical advisor, SMC MOVE project manager, North and South SMC Coordinators, North and south SMC mentors, SMC demand creation manager and SMC logistician. At lower district level, all District Health Management Teams (DHMTs) have SMC coordinator/focal person coordinating MC through district SMC task forces (MOH, 2012).

However, despite all these inputs the number of men circumcised is lagging behind set targets, we do not know to what extent the attitudes of SMC managers at national and district levels influence the implementation and scale up of SMC services. The research question therefore, was to what extent the attitudes of SMC managers at national and district levels does influence the implementation and scale up of the SMC program?

### ***1.3. Study aim***

The aim of the study was to establish the extent to which the attitudes of SMC managers at national and district levels influence the implementation and scale up of SMC program.

### ***1.4. Study objectives***

The objectives of the study were to;

- 1) establish the current situation of SMC implementation in Botswana,
- 2) establish the required attitudes for managers towards SMC program,
- 3) establish the attitudes of SMC managers at all levels toward SMC program,
- 4) determine the gap between the required attitudes and SMC managers' current attitudes toward SMC, and
- 5) provide recommendation for reinforcing positive attitudes toward SMC program.



## **Chapter 2: Literature review:**

### ***2.1. Introduction***

MC brought more arguments and disagreements than any surgical procedure in the history of mankind. The gap is widening since MC shown to reduce risk of HIV transmission (Alanis & Lucidi, 2004, p. 389). The controversies also touch areas of health benefits and risks of the procedure, ethical issues, and legal considerations and human rights principles to the practice (Alanis & Lucidi, 2004:379-95).

### ***2.2. Background of male circumcision in Botswana***

MC prevalence in Botswana is 11% (CSO, 2008, p. 17). The country in general is a non-circumcising country and only a handful of tribes are circumcising communities such as Xhosa, Xorera and Bakgatla (Neil, 2002). Also the majority of Batswana are Christians who are not practicing MC as a religious ritual (Neil, 2002).

MC was practiced in Botswana from time in memorial until it was stopped by British protectorate as barbaric and unchristian practice in 1917 (Mosothwane, 1999) but recently deceased paramount Chief of Bakgatla tribe, Kgosi Linchwe II, revived MC in Mochudi in 1975 as part of the traditional rite of passage ceremony called “bogwera” (Gungqisa, 2008, p. 8-12).

In December 2007, National AIDS Commission considered UNAIDS and WHO recommendations for countries with high HIV/AIDS prevalence and low MC prevalence to implement male circumcision. From April 2009 the country officially started to implement and scale up SMC in the country (WHO, 2011).

Management of SMC is provided by managers/officers from the department of HIV/AIDS Prevention and Care and the department of Clinical Services at national levels. At district level SMC coordinators at District Health Management Team and site SMC coordinators at health facilities manage SMC.

### **2.3. *Organizations that are supporting and opposing male circumcision***

While WHO, UNAIDS, PEPFAR, Global Fund for HIV, TB and Malaria actively sensitize countries over the use of male circumcision as HIV prevention measure, the anti-circumcision movements also have intensified their fights. There are several anti-circumcision organizations that are currently working in several countries such as NOHARRM: the National Organization to Halt the Abuse and Routine Mutilation of Males, NOCIRC: the National Organization of Circumcision Information Resource Centers, BUFF: Brothers United for Future Foreskin, RECAP: Recovery of a Penis, and DOC: Doctors Opposing Circumcision. Also there are many websites and journals, dedicated to anti-circumcisions activities (Kirsten, 2005, p. 135).

Not all medical professionals agreed on the benefit of male circumcision, for example the American Academy of Pediatrics (AAP) in March 1999, produced a policy statement that did not recommend male circumcision for infant to be done routinely, it can be performed only when it is medically indicated. The same opinion was made by other medical professional bodies like Canadian Pediatric Society in March 15, 1996, American Medical Association (AMA) in July 6, 2000 and American Academy of Family Physicians in February 14, 2002.

Debate on male circumcision is further confusing when the same organization keeps changing its position from time to time. For example, the same American Academy of Pediatrics was pro male circumcision in 50's, then changed its stance in 60's and changed again its position to neutral in 80's (AAP, 1989, p.390) and again turned against it in 1999 (AAP, 1999) and currently back to neutral position (AAP, 2005). It acknowledges issues of pain relief and the role of good hygiene (Anand & Hickey, 1987, p.1321-1329). It recognizes that male circumcision has both benefits and potential risks like any other surgical procedure (AAP, 2005)

### **2.4. *Male circumcision managers and how they were recruited in relation to their attitudes towards male circumcision***

Some of the managers/officers in-charge of male circumcision in the country was recruited specifically for SMC programs but majority are managing SMC programs by default. Their

attitudes towards SMC were never ascertained. It must be remembered that male ccircumcision practices are largely culturally and religiously determined and as a result there are strong beliefs and opinions surrounding its practice. It is important to acknowledge that individuals' personal biases and the dominant circumcision practices of their respective communities may influence their interpretation of findings of existing body of male circumcision knowledge. These can also apply to SMC managers who are leading and coordinating these programs (Wilson, Lindsey, Samuel, Schooler & Tonya, 2000). The attitudes of managers towards male circumcision could work negatively or positively in achieving country's SMC set targets.

### **2.5. *Attitudes and working behavior***

Wilson et al (2000) define attitude as an evaluation of individuals in their environment about anything e.g. events, activities, ideas etc. Results of evaluation can be either positive or negative. Attitude in other words is the behavior of the person that determines his status. The activity is the engine that drives a human being to a particular behavior.

Attitude changes during the life of an individual depending on the experience gain. Hereditary and other non-modifiable factors like personality can affect attitude but by large attitude remains the product of experience and it is expressed as behavior of a person (Tesser & Abraham, 1993, p.129-142).

The effectiveness of SMC managers at workplace by large will depend on their attitudes towards SMC (Eagly & Chaiken, 1995). Managers with positive attitudes bring at workplace energy, creativity and momentum to fulfill the work objectives and goals. The available body of evidence suggested that attitude can be changed to be either positive or negative depending on the individual exposure to environment (experience) or through complex process as a response to effective communication (Fazio, 1986, p. 204-400).

### **2.6. *Cultural-traditional male circumcision***

Traditional MC is currently performed in many countries in Africa. It is part of culture of many societies. The ritual is performed at specific periods in life with the main purpose of integrating

the male child into the society according to cultural norms (Mshana & Wambura, 2011, p. 239). In Botswana, it is carried out for cultural reasons as an initiation ritual and a rite of passage into manhood by few tribes known as "go rupa" or "Bogwera," (Mosothwane, 1999).

Traditionally, male circumcision was performed in a non-clinical setting by a traditional provider with no formal medical training (Mosothwane, 1999). But currently, most male circumcisions are performed in health facility settings by trained medical staff. Very few cases though of male circumcision performed outside of health facility settings do occur (Ali, 2008). The prevalence of traditional male circumcision in the country is not known (Ali, 2008).

Traditional male circumcision is associated with serious complications and even death (Peltzer & Kanta, 2009). Majority of un-circumcising communities viewed these complications as unnecessary, the fact that was refuted by circumcising communities and built the foundation for dispute whether male circumcision as a whole is beneficial or not. For circumcising communities traditional male circumcision is regarded very highly as it is perceived as keeping alive cultural practice and identity. It also portrays a sense of bravery. A circumcision state of a male can be a source of stigma depending in which society an individual male finds himself in (Mshana & Wambura, 2011, p. 239).

Despite initial fears, many studies conducted among traditionally circumcising and non-circumcising communities, SMC was accepted as a HIV prevention intervention (Kebaabetswe, 2003, p. 217). However, little is known on how public health practitioners from traditionally circumcising and non-circumcising communities where MC carries considerable social meaning and significance would respond to country-wide fully fledged SMC program. For the success of nation-wide SMC program, there is need to strengthen positive attitudes of all managers and clinicians toward SMC (Maughan-Brown, 2011, p. 499–505).

## 2.7. *Male circumcision for HIV prevention*

Helen Weiss and her group in 2000 noticed that the prevalence of MC varies between countries and also within a country and observed that countries that have a high rate of MC show lower rates of HIV prevalence and vice-versa (Weiss et al, 2000).

Majority of male circumcision observational studies that looked in to the evidence of male circumcision in reduction of risk of HIV transmission among heterosexual male have compared participants from various ethnic groups in which the prevalence of other risk factors might have varied. Agot, Ndinya-Achola, Kreiss and Weiss (2004, p. 157-163) conducted a study among men within a single ethnic community where circumcision was done for religious reasons and was able to show that male circumcision was associated with a reduced risk of HIV-1 infection.

UNAIDS and WHO commissioned Randomized Control Trials (RCT) to prove indeed MC could reduce risk of HIV infection. Three RCTs conducted in South Africa (Auvert et al, 2005), Uganda (Gray et al, 2007:657-66.) and Kenya (Bailey et al 2007: 643-56) showed MC can reduce risk of HIV transmission by 40 to 60 %. Even after Randomized Control Trials that are used as a gold standard and litmus paper to confirm causal-effect relation of a hypothesis in evidence based world (Schulz, Chalmers, Haynes & Altman, 1995, p. 408-12) Mills and Siegfried (2006), and Dowsett and Couch (2007) pointed out that all three RCTs found that MC reduces risk of HIV transmission because after circumcision all circumcised-men required some period of abstinence while non-circumcised-men continue to engage in risk behaviors. They argued that if the studies had continued for their scheduled time, it is probable that there would have been little difference between the circumcised group and the non-circumcised group (Mills & Siegfried, 2006, p.1236). But proponents of MC pointed out in all three RCTs the circumcised and non-circumcised men were required to abstain for six weeks and were matched for all other parameters except for MC. In that sense the arguments above are null and void (Auvert et al, 2005; Gray et al, 2007; Bailey et al 2007).

Nagelkerke, Moses & De Vlas (2007, p. 16) conducted a mathematical model to calculate the public health impact of large scale male circumcision for HIV prevention and found out that if prevalence of male circumcision could be increased to 80% over a period of 10 years would

reduce male HIV prevalence from 30% to around 10%; and females from 40% to about 20% (Nagelkerke et al, 2007).

Potential explanation given to the preventive effect of male circumcision is that there are large numbers of Langerhans cells (Primary target cells for HIV because they contain large amount of CD4 molecules) present in the epithelium of inner foreskin and are closer to the skin due to a thinner layer of keratin (Hussain & Lehner, 1995, p. 475-484).

Other factor to facilitate the entry of the virus is the presence of ulcerative STIs, such as HSV-2, chancroid and syphilis, which are more common in uncircumcised man (Weiss et al, 2006).

Lastly, Estrada and Patterson in 2002 independently to each other did in vitro study to ascertain speed of viral uptake by various body mucosa. The mucosal surface of the foreskin was 7 times more efficient than mucosa lining female cervix in uptake of HIV.

### **2.8. *Male circumcision for religious purpose***

MC done for religious purpose has existed throughout the history of mankind (DeMeo, 1990, p. 99-110). MC in religious settings serves spiritual purposes and does not have justifications for promoting health practices (DeMeo, 1990). MC for religious purposes is usually performed shortly after birth, during early childhood or around puberty (Drain, Halperin, Hughes, Klausner & Bailey, 2006, p.172) . Religious MC is most established in Muslim world and Israel. It is most practiced by men of the Jewish and Muslim faiths (Drain et al, 2006). Further discussion of religious MC is beyond the scope of this study. What is important is the role of association of MC with particular faiths might have a repercussion on the attitudes of the managers who are tasked to implement it at national scale.

### **2.9. *Acceptability of SMC***

The important factor in the implementation of Safe Male Circumcision for HIV prevention in the country is its acceptability by community. In the situation of existing controversies in the world it is a big challenge. That is the reason why UNAIDS and WHO proposed and implementing countries agreed to start with acceptability studies. Several acceptability studies were conducted

in Africa and elsewhere since early 90's to measure acceptability of adult and child male circumcision at health facilities under aseptic conditions by qualified medical practitioners to inform policies regarding whether and how to promote SMC as an additional strategy for HIV prevention.

Westercamp & Bailey (2007) compiled MC acceptability studies conducted in East and Southern Africa from 1998 to 2006. They comprehensively reviewed 13 acceptability studies among traditionally uncircumcised society and concluded that MC is very well accepted. The data revealed that; uncircumcised men willing to be circumcised were 65%, women favoring circumcision for their partners were 69%, men willing to circumcise their son were 71% and women willing to circumcise their son were 81%.

In Botswana the male circumcision acceptability studies were done several times and found to be acceptable in 2003 in general public (Kebaabetswe, 2003), in 2007 among Health Care Providers (Ali, 2008) and again in 2010 by Jhpiego (MOH, 2010) and 2009 among expecting mothers by Botswana Harvard Partnership (MOH, 2009).

Even recent studies in sub-Saharan Africa show high acceptability for male circumcision for example a recent study in Uganda revealed between 60% and 86% of fathers and 49% and 95% of mothers were supportive of male circumcision for their sons (Albert, Akol, L'engle, Tolley & Ramirez, 2011, p. 1578-85).

Although acceptability to Safe Male Circumcision is high in the region, those studies that also measure knowledge and attitudes have shed doubt on the validity of the information. It was not clear what components of male circumcision were accepting? For example multicounty study that was conducted in Botswana, Namibia and Swaziland, asking about socio-economic characteristics, knowledge and attitudes about HIV and MC and MC history by Anderson and Cockcroft in 2011. Although acceptance was very high; 50% of the uncircumcised young men planned to be circumcised, 75% of young men and women planned to have their sons circumcised. "But some respondents had inaccurate beliefs and unhelpful views about male circumcision and HIV. Between 9 and 15% believed a circumcised man is fully protected

against HIV; 20-26% believed men need not be tested for HIV before male circumcision; 14-26% believed HIV-positive men who are circumcised cannot transmit the virus; and 8-34% thought it was okay for a circumcised man to expect sex without a condom" (Anderson & Cockcroft, 2011, p. 189–198).

In Dominican Republic although male circumcision acceptance was very high among clinicians, but only 23% had experience with male circumcision (Brito, Luna, & Bailey, 2010, p. 1530–1535). It is also common for young people to be shy discussing issues of sexuality; it is thought this could also affect actual acceptability levels in real life (Feng, Lu, Zeng, Nan, Wang & Xu, 2010, p. 281–285). Lastly the study of Mugwanya, beaten, Nakku-Joloba, Katabiri, Celum, Tisch and Whalen in Uganda in 2010 among HIV-1 serodiscordant couples have shown high level of understanding on the importance of male circumcision for HIV prevention especially among uncircumcised HIV-1 negative serodiscordant males but only half of them expressed interest in the procedure.

### ***2.10. Risk compensation after male circumcision procedure.***

Anti-circumcisions groups advocate that MC will eventually lead to Risk compensation/behavior disinhibition and erode all gains brought by SMC. If circumcised men increase number of sexual partners and contacts by an average of more than 25%, this will offset any beneficial effect of MC (Gray et al, 2003). This is because the risk of HIV infection increases tenfold immediately after MC when the wound is not healed completely. Usually wound heals completely after six weeks (Gray et al, 2003). This is being collaborated by the study of Bridges, Gray, McIntyre, and Martinson in 2011 that was conducted in Johannesburg in South Africa that showed that white men are likely to stop using condoms consistently after undergoing MC. But the same study showed opposite finding for black men and colored.

Another study in Zambia has shown an increase in risk behavior after MC; 46% of circumcised men reported resuming sex before three weeks, 82% reported at least one unprotected sex act, and 37% reported sex with two or more partners (Hewett, Hallett, Mensch, Dzikedzeke, Zimba-Tembo, Garnett & Todd, 2012). But Grund and Hennink working in Swaziland in 2011 found a



different scenario where majority of men after circumcision, portrayed more responsible positive sexual behavior including increase in condom use and reduction of sexual partners.

Several recent behavioral studies conducted in Sub-Saharan Africa could not see increase in risk behavior after MC for example Agot, Kiarie, Nguyen, Odhiambo, Onyango and Weiss (2007) and Westercamp, Bailey, Bukusi, Montandon, Kwena and Cohen (2010).

In conclusion studies are divided on this issue but majority of studies did not show significant increase of risk compensation behavior among circumcised men after one year than uncircumcised men, suggesting that any protective effect of male circumcision on HIV acquisition is unlikely to be offset by an adverse behavioral impact (Agot et al, 2007, p. 66–70) and those few men who showed increase in risky behavior after circumcision are likely to report risky sexual behavior at base line (Hewett et al 2012).

### ***2.11. Cost of male circumcision strategy for HIV prevention***

Another bone of contention is centered on the overall cost of implementation of SMC program. Opponents of MC argued that the cost of surgical procedure, administrative cost for the program and cost due to loss of productivity of circumcised men during the period of recuperation is extremely high. The relative cost of MC is even high if you compare with cost spent on other HIV prevention programs (Anderson, Wilson, Grulich, Carter & Kaldor, 2009). For example US\$1,500,000,000 will be needed between 2011 and 2015 to achieve 80% coverage in 13 priority countries in southern and eastern Africa (Hankins, Forsythe & Njehumeli, 2011).

The proponents of MC citing that, MC for HIV prevention is cost saving and cost effective. They argued that by preventing HIV infection today it will save governments in terms of cost many of years of treatment and care of individuals living with HIV/AIDS for life. For example investments of US\$1,500,000,000 result in net savings of US\$16,500,000,000 for the region in the next 20 years (Hankins et al, 2011).

According to the Botswana Safe Male Circumcision implementation plan of 2009 the cost of five years male circumcision program in the country is about BWP 145,471,288 (MOH, 2010).

## ***2.12. Complications of male circumcision procedure including sexual dysfunction***

Possibilities of adverse events are another area of arguments. Like any surgical procedure adverse events can happen during or after MC. The complication of procedure can range from mild for example a mild infection (Sotolongo, Hoffman & Gribetz, 1985, p. 102-3) to severe for example excessive bleeding and penile mutilation or even death (Gluckman, Stoller, Jacobs & Kogan, 1995, p.778-779). Complications of male circumcision are less if the procedures are done in health facilities under aseptic conditions by qualified clinicians (Hankins et al, 2011).

There is lot of dispute on the true rate of complications of male circumcision procedures. The rate range from 1.7% (Williams & Kapila, 1993, p. 1231-6) through 9% (Peltzer & Kanta, 2009, p. 83–97) or even 48% (Kim & Pang, 2006).

In all areas of complications brought by MC, serious debate going on for centuries is the effect of MC on sexuality and sexual pleasure. Controversy over the sexual consequences of MC has been fuelled by a lack of objective way of measuring sexual pleasure and other parameters of sexual functions (Morris, Sorrells, James, Snyder, Mark, Reiss, Eded, Milos, Wilcox & Van Howe, 2006).

Some studies find that MC enhance fine touch perception of glans of circumcised men and increase sexual pleasure (Bleustein, forgaty, Eckholdt, Arezzo & Melman, 2005; Fink, Carlson & De Vellis, 2002) but other studies find sexual pleasure is reduced (Collins, Upshaw, Rutchik, Ohannessian, Ortenberg & Albertsen, 2002; Senkul, Iseri, Sen, Karademir, Saracoglu & Erden 2004), while some studies claim there is no difference in terms of sexual pleasure between circumcised and uncircumcised men (Shen , Chen, Zhu, Wan, & Chen, 2004; O’Hara, 1999).

There is a possibility that negative attitudes and reluctance to be circumcised or assisting others to be circumcised is related to the fear on possibility of adverse outcomes of circumcision (Rain-Taljaard, R. C., Lagarde, E., Taljaard, D. J., Campbell, C., MacPhail, C., Williams, B., & Auvert, 2003, p. 315–327). For the program to be successful there is a need to identify managers who have these negative attitudes and correct them through training and counseling programs.

### **2.13. Ethics, law, human rights and male circumcision**

Another area of debate is the whole issues of ethics, law and human rights. MC is not addressed directly in any international declarations on human rights. Yet its implications can be found in declarations for example the United Nations Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the United Nations Convention on the Rights of the Child etc. (<http://www.circumstitions.com/Rights.html>).

The government of Botswana in 2009 developed guiding principles that are aligned with UNAIDS and WHO values that govern the implementation of SMC as an additional strategy for HIV prevention. The following human rights principles apply directly to SMC and should be adhered to by all individuals who provide MC services and all clients should be informed about them; the right to informed consent before a medical procedure is carried out, the right to information for making choices about one's health and wellbeing, the right to confidentiality and privacy, the right to non-discrimination, equal protection and equality before the law and the right to access the highest quality of health care services.

Concerning promoting SMC for HIV positive men again there are different opinions. One camp advocates for promotion of SMC to every uncircumcised men irrespective of their HIV status, the reason being HIV prevention is only one benefit of MC among many. The other camp opposes the idea and advocates promoting SMC to HIV negative uncircumcised men only.

The guiding principle governing implementation of SMC in the country does not recommend promoting circumcision to HIV positive men based its decision on the fact that the current available data does not provide evidence on the reduction on the risk of HIV transmission from circumcised HIV positive males to HIV negative females. At the same time guiding principles allow HIV positive men to be circumcised if they wish after in-depth counseling.

HIV testing is the prerequisite for all SMC programs for HIV prevention. There are potentially negative social consequences of counseling and testing when the positive HIV statuses become disclosed in the community; the consequences including family and relationship disruption, sexual violence, stigma and discrimination (van der Straten, King, Grinstead, Serufilila & Allen,

1995, p. 936). Attitudes of individuals are different towards HIV counseling and testing. A person with negative attitudes might not offer clients HIV test as requested by program.

## **Chapter 3: Research methodology and results**

### ***3.1. Introduction***

The study was an explorative qualitative study research design that was used to investigate what attitudes SMC managers have and how they influence implementation and scale up of the SMC program in the country.

### ***3.2. Study Sites***

The study was carried out at the Ministry of health headquarters (National SMC program) and in ten districts in Botswana; Greater Gaborone, Mahalapye, Palapye, Serowe, Greater Francistown, Maun, Molepolole, Kgatleng, Kanye and Ramotswa. The districts were chosen because they are implementing the SMC strategy called “Method of Optimization Volume and Efficiency” (MOVE), where more than 80% of men targeted to be circumcised envisaged coming from these sites. These sites have dedicated MC teams and space to provide services.

### ***3.3. Target audience and sample size***

A total of 26 SMC program managers at national and district levels were targeted in ten districts. There were 6 managers at national level and 20 managers at district level. The letters of intent for the study was sent to the Director of the Department of HIV/AIDS Prevention and Care and respective heads of DHMTs where SMC managers were supervised. The letters were followed by telephone calls to arrange for interviews’ appointments.

The inclusion criteria were whether the participant is an SMC program manager at national or SMC MOVE district/site and if he/she was willing to participate. If the answer for any of the question was “no” then, the manager was excluded from the study.

### ***3.4. Interviews and study instrument***

Each subject was interviewed using a semi-structured interview guide as data collecting tool. Each interview recorded and transcribed afterwards by interviewer. The interviews took approximately one and half to two hours.

### **3.5. *Data analysis***

Data analysis was done by coding texts. Codes were then categorized to themes before analysis was done. Themes were used to write the report. A total of 24 managers were interviewed in ten selected districts, out of 26. The average age was 41 years; ranging from 26 to 61 years old. There were 11 males and 13 females. All 24 participants were of Christian faith and 20 out of them have at least one son. Four have grandson. Nine of them are from circumcising and 15 from non-circumcising communities. Nine have diploma, 15 have first degrees and 5 have master degrees. Three applied for the SMC managerial job but 21 were recruited before SMC program was started in the country and the program found them on the job; this was the group that SMC program was an additional responsibility to other duties assigned to them by the Ministry of Health.

### **3.6. *Ethical consideration***

The study was not envisaged to raise any ethical questions. However, considerations were taken to prevent privacy of the participants. Only the researcher had access to data that are stored in a safe place in a locked cupboard.

All participants were asked and provided written consent to participate in the study. Care was taken not to collect and/or record information that will identify the respondents. Participants were assigned unique ID number from 1 to 24.

## **Chapter 4: Result of the study**

### ***4.1. Introduction***

In this chapter the findings of the study will be elaborated in terms of the progress of SMC program to date, capacity and attitudes of the managers.

### ***4.2. Progress of SMC Program***

The SMC program started from April 2009. The goal of the program was “to contribute to reduction of HIV transmission by scaling up Safe MC throughout the country”. The objective of the program was “to increase the prevalence of SMC among HIV Negative males of 0-49 years from 11.2% to 80%”. The program target is 385,000 men to be circumcised by 2016 (MOH, 2010, p. 5-18).

### ***4.3. Coordination teams at National and district levels***

SMC program has recruited managers to provide management and coordination at national level; 10 officers including National SMC coordinator, SMC MOVE Project manager, 2 regional Coordinators, M&E manager, BCIC manager, logistician etc. At district level the program has recruited at each district three managers including District SMC Coordinators, SMC Behavior Change Information Communication (BCIC) Coordinators and Site administrators. At National level SMC Coordination teams meet three times a week to discuss and evaluate progress of the program on the ground (MOH, 2012, p.14 -18).

### ***4.4. Service Delivery teams***

The Ministry of Health has put in place 15 dedicated SMC teams in place in identified high volume districts where number of un-circumcised men is believed to be high. The rest of the country SMC services are provided in more than 36 hospitals and 15 public clinics (MOH, 2012, p.14 -18).

*Table 1. SMC MOVE Dedicated Sites*

<b>CDC SUPPORTED (MOVE)</b>	<b>ACHAP SUPPORTED (MOVE)</b>
Gaborone - Bontleng Clinic	Francistown- Area W clinic
Gaborone- Nkoyaphiri Clinic	Serowe - Sekgoma Memorial Hospital
Maun – Old General Hospital	Gaborone - Block 8 Clinic
Kweneng East - SLH	Kgatleng- Boseja II Clinic
Mahalapye	Palapye Primary Hospital
Phikwe	Kanye Main clinic
	Ntshe clinic – Francistown
	Souh East -Emmanuel Youth Center
	Serowe - Sekgoma
	Kweneng East - Thamaga

Source: Ministry of Health Botswana.

Table 1 above, shows SMC sites that are placed in high volume districts. These sites are dedicated in providing SMC services only using MOVE model. There are 6 sites that are supported by CDC through I-TECH and Jhpiego and 10 sites supported by ACHAP.

#### ***4.5. Number of HIV Negative men circumcised since SMC program inception***

The table 2 below shows the number of HIV negative men circumcised annually. The fiscal year in Botswana is from 1<sup>st</sup> April to 31<sup>st</sup> March. In Fiscal year 2009/2010 (year 1) 6,231 men were circumcised (62% of target), 2010/2011 (year 2) 6,660 men were circumcised (55% of target) and 2011/2012 (year 3) 19,574 men were circumcised (32.6%). Cumulatively there were 36, 527 males circumcised by April 2012. Note that the target is increasing annually (MOH, 2012, p. 20 - 36).

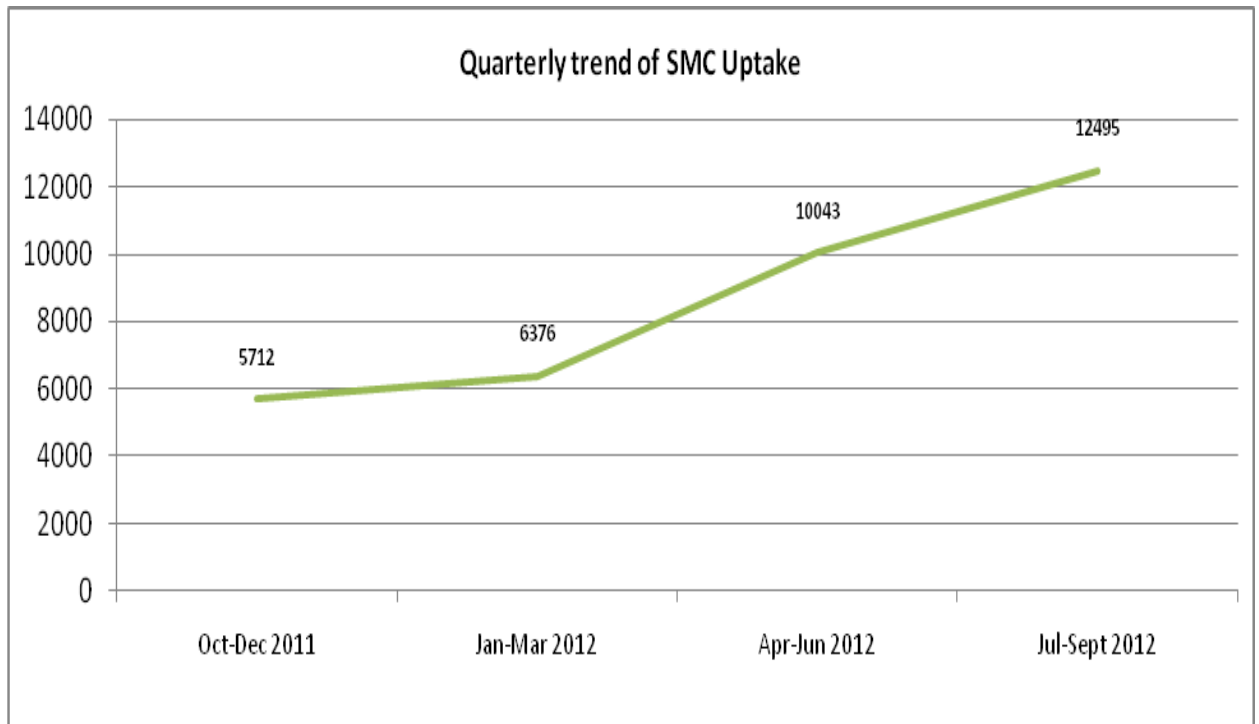


Table 2. SMC Program achievement from April 2009 to March 2012(3 years implementation)

Time of Implementation	Target for the financial Year	Number of HIV negative Men circumcised	% Uptake
April 2009-March 2010	10 000	6,231	62%
April 2010- March 2011	12 000	6,660	55%
April 2011 –March 2012	60 000	19,574	32.6%

Source: Ministry of Health, Botswana.

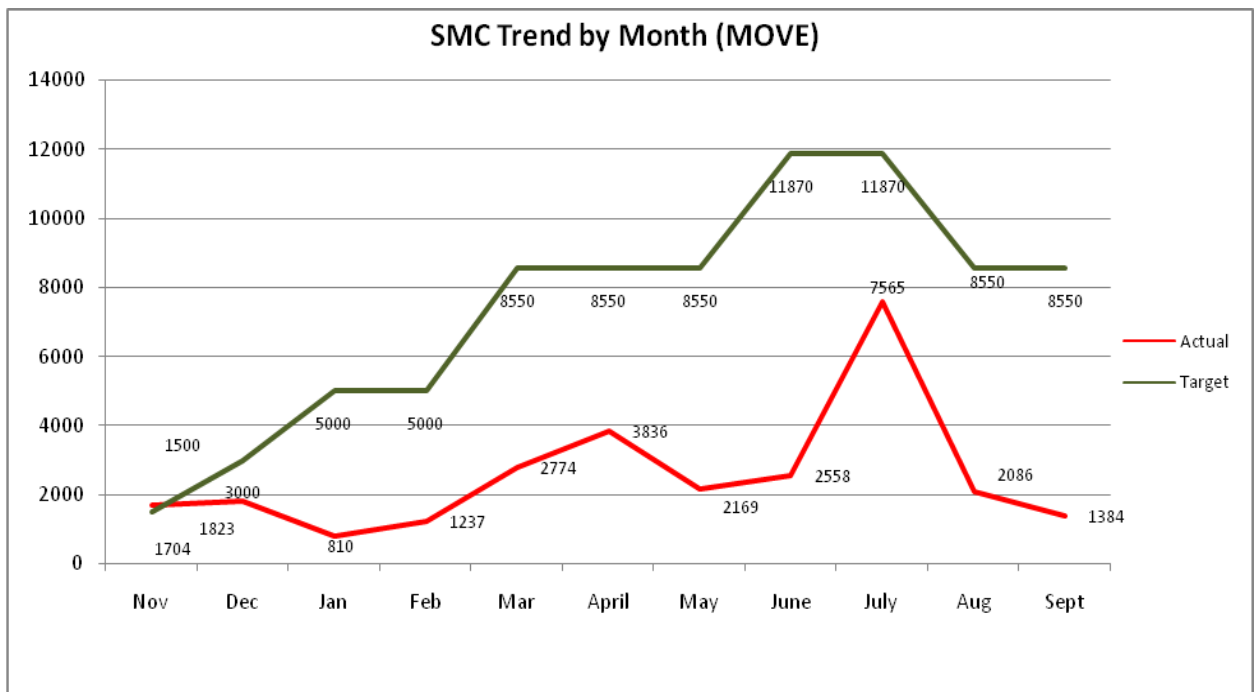
Figure 1. Quarterly trend of SMC uptake Oct 2011 –Sept 2012



Source: Ministry of Health.

Figure 1 above shows the trend of number of men circumcised at dedicated SMC sites. The trend was a steady increase in the number of men circumcised every quarter. The increase was alluded to the establishment and implementation of MOVE strategy in the country. In an effort to increase SMC uptake the ministry recruited SMC-focused teams, conducted focused SMC trainings and strategic/ targeted SMC community mobilization (MOH, 2012, p. 20 - 36).

Figure 2. SMC trend by MOVE sites monthly from November 2011 to September 2012.



Source: Ministry of Health, Botswana.

Figure 2 above shows the trend of men circumcised from November 2011 to September 2012 versus target during the same period.

If you take the period on the figure above from November 2011 to September 2012 there were 32, 887 SMCs cumulatively done by all SMC sites (MOVE and Integrated) reflecting 40.6% of the 80, 990 target; out of that 27, 946 SMCs done by MOVE sites.

If you add cumulatively the number of men circumcised from inception (1<sup>st</sup> April 2009) to 30<sup>th</sup> September 2012 is 55 003 which translates to 14.3% of the 385 000 program target (MOH, 2012).

*Table 3. Adverse Events*

<b>Reaction to Anaesthesia</b>	<b>Bleeding (all types)</b>	<b>Haematoma (all types)</b>	<b>Infection (all types)</b>
17	133	110	93
1.08% AEs for SMC cases done since program inception			

Source: Ministry of Health, Botswana.

Table 3 above shows the cumulative adverse events rate for SMC program since inception is 1.08%. This is below the cutoff point of less than 2% of WHO/UNAIDS (WHO, 2011).

#### **4.6. Required attitudes by SMC manager**

The attitudes of all health care workers in the country is governed by the Ministry of Health Vision “The Ministry shall excel in providing customer focused services consistent with global standards”, mission “The Ministry of Health exists to provide comprehensive quality health care services to the nation” and the following values;

- Botho: The Ministry of Health pledges to serve customers with compassion, courtesy and consideration
- Customer Focus: The Ministry pledges to serve its customers in an efficient and effective manner guided by the principle of Botho.

- Integrity: The Ministry of Health is committed to accuracy, transparency and forthright in its dealing with the public.
- Timeliness: The Ministry pledges commitment to provide timely services.
- Equity: The Ministry of Health shall make health services accessible to all Batswana.

Managers that were interviewed see themselves as hard working, serious, sympathetic, open minded, reliable and responsible officers. Minority of the managers see other managers in some districts were not working hard and own the program as they should be.

All managers attributed that they are prescribing to the ministry of Health's values and hence their attitudes are drawn from them.

#### ***4.7. Recruitment and job satisfaction***

The majority of the respondents (21) did not apply to work for SMC. It was by default that when the SMC program was established, additional responsibilities were added to their already busy schedules. The respondent acknowledged that they had to learn about SMC on the job. Although deficit in knowledge was not appreciated but majority of them alluded that they needed further increase in their SMC knowledge in the form of institutional training and benchmarking trips to Kenya, Tanzania and Zimbabwe.

The remaining three managers were specifically recruited for SMC program. They applied for the position and they had prior knowledge of SMC management. But still, they felt like they need further training in SMC specifically in research designing and SMC social marketing.

All managers supported SMC but felt it is a very hard work, stressful and their principals are not appreciative of their efforts. Few of managers felt that their colleagues are not working as hard as themselves.

All managers were happy working for the program. Few alluded that, the program focuses on a small area of operation; that they are losing out in advancing themselves and denied getting broader experience in the provision of health services. It was observed that there is a high

turnover of the SMC managers especially at National level where, since inception in 2009 the program it has been led by 4 different National Coordinators.

#### ***4.8. Benefits and Risks of male circumcision***

Majority of the managers who were interviewed mentioned that SMC has both benefits and risks but, benefits outweigh risks. The crucial benefit of SMC mentioned by managers was HIV prevention followed by increase of penile hygiene and prevention of cervical cancer for the partners of the circumcised men. No one mentioned adherence to religious norms as reason or benefit of SMC.

On the risks of SMC all respondents cited bleeding, hematoma and infection being the main risks of undergoing SMC. When asked about change in sexual pleasure and performance, majority were in agreement that SMC increases sexual pleasure and enhance sexual performance. Few reported that sexual pleasure and performance were reduced after SMC. Majority felt the procedure is painful but they are willing to promote and defend it.

All managers had no problem to allow their sons and close relatives to undergo SMC. The reason for this was alluded due to belief that SMC will reduce the risks of acquiring HIV infection by 40 - 60%.

#### ***4.9. Barrier to SMC***

All managers interviewed agreed that there are many barriers that prevent men to be circumcised. The major barriers according to all respondents were men have high fear of pain, afraid of HIV testing and unable to abstain from sex for 6 weeks. Other barriers were attributed to religious and cultural reasons

None of the managers, related barrier to access of SMC services was due to inadequate management or coordination of the program. Surprisingly none of the managers shared concern about adverse events and quality improvement of SMC services.

#### ***4.10. Achieving SMC program goal and targets***

All managers at national level were of the opinion that the set target of MOH to circumcise 385,000 men aged 13 -49 years by 2016 is achievable. The sentiment that was not shared by the majority of managers at district level, majority of them thought the target is very ambitious and it will never be reached.

All managers in agreement thought that SMC as HIV prevention strategy were worth pursuing although; it is labour and financial intensive program.

#### ***4.11. Way forward***

Moving forward managers proposed the following;

- The program should hire more managers to share work load.
- Managers should be trained in management and leadership skills and sent for benchmarking trips to other Sub-Saharan countries implementing SMC.
- The country should focus on Infant Early Male Circumcision as it is sustainable and easy to implement.
- To increase advocacy and community mobilization activities for SMC.
- Minority of the managers suggested for the program to be redesigned and that the whole SMC program should be implemented by dedicated staff in dedicated facilities that will be run entirely by partners such as ACHAP, ITECH, PSI, Jhpiego and others.

## **Chapter 5: Conclusion and recommendations**

### ***5.1. Introduction***

In this chapter, the findings of this study will be discussed in the context of the existing literature, findings from evaluation of SMC program in Botswana, National SMC database and SMC weekly updates reports. The aim is to link the desired attitudes that the employees of MOH should possess and the levels of attitudes that program managers have toward the SMC program. The discussion will also focus on the environment where SMC program was implemented and whether this has an impact on the effectiveness and efficiency of managers and outcome of the program.

### ***5.2. Progress of SMC Program***

The country has made appreciable progress in implementing SMC program. The program started officially in 1<sup>st</sup> April 2009. At the time capacity in terms of service delivery was relatively low. For two years the integrated model was used based on using existing health facilities that provide combined general health services to provide SMC services; in addition to other already existing health services. During those two years needed equipment and consumables for SMC were not enough. But, despite all those challenges the program managed to perform 6,231 (62%) male circumcision in the first year and 6,660 (55%) in second year of implementation (see table 2).

The rapid evaluation of the SMC program progress after two years of implementation revealed that integrated approach would not yield anticipated results therefore, the country adopted WHO/UNAIDS SMC MOVE model which entails sharing tasks, optimally use of space and techniques to make surgical procedure more efficient. After embracing the MOVE model the numbers of men circumcised have been increasing steadily. In just 3 months (October – December 2011) the program managed to circumcise 5,712 men nearly the total amount of men circumcised in the whole first year of implementation. The following quarter the number of men circumcised increased from 6,376 to 10,043 by the next quarter and finally July to September 2012 number of men circumcised were 1,495 in that quarter (see figure 1).

If you add cumulatively the number of men circumcised from inception (1<sup>st</sup> April 2009) to 30<sup>th</sup> September 2012 is 55 003 which translates to 14.3% of the 385 000 program target by 2016(MOH, 2012).

Botswana just like other 14 countries that were implementing SMC, the largest proportion of number of men circumcised was achieved after adopting MOVE strategy. Fourfold increase was noted.

Hypothetical speculation that this study tried to address in that the SMC program is not achieving its target may be due to low performance of its program managers as a reflection of the negative attitudes by some of the managers towards the program could not be supported by available SMC data.

The number of men circumcised is steadily increasing every quarter for more than 4 quarters now. It can be seen that the targets are also increasing quarter by quarter that made it very difficult to reach target percentagewise (Moving target effect - see figure 2)

The country is not doing badly even when compared with other 14 countries that are implementing SMC program (see table 3 below). Cumulatively, by September 2012 all countries performed 1,451,505 male circumcisions about 7.0% of 2015 target. Botswana achieved 14.3% of its 2016 target (UNAIDS, 2012; MOH, 2012).



Table 3. Number of SMCs Performed in 14 Priority Countries: 2008 - 2012

## Number of male circumcisions performed in the 14 priority countries: 2008-2012

Country	Number of MCs carried out per year						% achieved of estimated number of MCs needed to reach 80% prevalence by end of 2011
	2008	2009	2010	2011	2012 (end August)	Total by end of 2011	
Botswana	0	5,424	5,773	14,661	26,423	25,858	7.5
Ethiopia	0	769	2,689	7,542	9,600	11,000	27.5
Kenya	11,663	80,719	139,905	159,196	118,517	391,483	45.5
Lesotho**	No data	No data	No data	No data	5,953	No data	N/A
Malawi	589	1,234	1,296	11,881	No data	15,000	0.7
Mozambique	0	100	7,633	29,592	69,249	37,325	3.5
Namibia	0	224	1,763	6,123	3,607 (July)	8,110	2.5
Rwanda	0	0	1,694	25,000	33,100	26,694	1.5
South Africa	5,190	9,168	131,117	296,726	No data	442,201	10.2
Swaziland	1,110	4,336	18,869	13,791	8,728	38,106	20.8
Tanzania	0	1,033	18,026	120,261	116,673 ( July)	139,320	10.1
Uganda	0	0	21,072	77,756	104,721 ( March)	98,828	2.3
Zambia	2,758	17,180	61,911	85,151	No data	167,000	8.6
Zimbabwe	0	2,801	11,176	36,603	25,700	50,580	2.6
<b>Total</b>	<b>21,310</b>	<b>122,988</b>	<b>422,924</b>	<b>884,283</b>	<b>(522,271)</b>	<b>1,451,505</b>	<b>7.0</b>

Source: Ministries of Health  
No data available for Lesotho

Source: WHO/UNAIDS

Table 3 above, shows number of male circumcisions done from 2008 to 2012 by 14 priority countries in Eastern and Southern Africa.

### 5.3. Managers' attitudes towards SMC program

Attitudes may determine managers' behaviour at work place and influence product positively or negatively depending on the type of attitudes (Hale, Householder & Greene, 2003, p. 259-286). That is why it was imperative to explore the attitudes of managers towards their work.

Ministry of Health prescribes to the set of attitudes that are called "values" in this instance and mandate its entire staff to live them. The major ones are "Botho" or humanity and "customer focus". The SMC managers must serve customers with compassion, courtesy and consideration in an efficient and effective manner guided.

The SMC managers must also observe “integrity, “timeliness” and “equity” when performing their duties. In dealing with the public the managers must be accurate and transparent. The SMC services should be rendered to all Batswana throughout the country in a timely manner (as and required).

SMC managers portrayed to be hard working, serious, sympathetic, open minded, reliable and responsible officers. Even those who commented about other SMC managers they know from other districts that their attitudes were less positive; they attributed them to being over worked and lack of appreciation from the supervisors. These findings were not supported by two customer surveys that were conducted in 2008 and 2010 among other things was to measure the attitudes of Health Services managers’ attitudes throughout the country. The surveys showed very low customer satisfaction rate of 27% and 45% respectively.

The managers attributed that they are in compliance with the prescribed Ministry of Health’s values and that define their attitudes and behaviour. The same comments were made by the Health Service Managers during customer satisfaction surveys in 2008 and 2010(Botswana’s National e-Government Strategy 2011-2016).

The attitude is refined by the environment where the managers find themselves operating. One of the crucial environments that shape the attitude and productivity of the manager is the recruitment process (Raymond, Hollenbeck, Gerhart & Wright, 2010, p.168 -181).

When the SMC program started the program architecture did not take into consideration the notions of job analysis and design to inform institutional audit and the management of Human Resource including selection, placement and recruitment of the managers. As a result the majority of the respondents (21) did not apply to work for SMC. It was by default that when the SMC program was established, additional responsibilities were added to their already busy schedules.

Job analysis and design is crucial because it helps to create job employee fit (right job for the right person), predetermine training needs and in conducting performance rewarding scheme objectively. In short the system will be able to provide conducive environment for the

development and strengthening of positive attitudes towards SMC program (Raymond et al, 2010). This is supported by the respondent desire to learn more about SMC on the job and also through institutional training and benchmarking trips to Kenya, Tanzania and Zimbabwe.

Job dissatisfaction is an indirect indicator of negative attitudes toward work (Ajzen & Fishbein, 1980, p. 286 -300). All managers interviewed, although positive on their job, they felt it is a very hard work, stressful and their principals are not appreciative of their efforts. They also explained that SMC is focusing on a small specific area of operations that, they felt that they are losing in advancing themselves or acquiring broader skill sets that are going to make them more competitive in the job market once the program comes to an end.

Job dissatisfaction can also be observed from the high rate of turnover of the SMC managers especially at National level where, since inception in 2009 the program has been led by 4 different National Coordinators. It can be speculated that a dissatisfied manager has intentions of acting on his/her negative attitudes. This is supported by industrial psychologists Fishbein and Ajzen I in 1975 and 1980 in their “Theory of Reasoned Action” (TRA). It is not always intentions to manifest into action. It depends on the environment prevailing at the time (Ajzen & Fishbein, 1980, p. 286 -300).

Attitudes towards SMC determine if a manager believes SMC benefits outweigh risks (Ajzen & Fishbein, 1980). If the risks outweigh benefits then likely his/her attitudes towards SMC might be negative. Majority of the managers who were interviewed mentioned that SMC benefits outweigh risks. It will be difficult for the managers to advocate for SMC if they do not believe in the benefits of SMC. The crucial benefit of SMC mentioned by managers was HIV prevention followed by increase of penile hygiene and prevention of cervical cancer for the partners of the circumcised men. The findings were similar with the results of the study that evaluated the effectiveness of short-term communication strategy in the country in 2011 where “Reducing the chance of a Man getting HIV” was the most cited benefit of SMC (65%).The second most cited benefit was “protection against STI” at 50.9% and “circumcised penis is hygienic” at 26.8% (PSI & ACHAP, 2011, p. 24).

The main risks of the SMC that might be a barrier for clients accessing SMC services according to SMC Managers interviewed were; bleeding, hematoma and infection. Changes in sexual pleasure and performance after SMC was the major debate in the media (Payne, Thaler , Kukkonen , Carrier & Binik , 2007, p. 667) where majority of the SMC bad publicity is coming from the claim that it reduces sexual pleasure and performance (Payne K et al, 2007). Few of SMC managers interviewed agreed with the negative press, that sexual pleasure and performance were reduced after SMC procedure. Majority of the respondents explained that SMC increases sexual pleasure and enhances sexual performance. There was none who said that there is no change in sexual pleasure and performance after SMC procedure. This is supported by many studies in Africa (Kigozi, Watya, Polis, Buwembo, Kiggundu & Wawer, 2008; Krieger, Mehta, Bailey & Agot, 2008). Majority felt the procedure is painful but they are willing to promote and defend it.

Positive attitudes towards SMC were portrayed by managers where all agreed to allow their sons and close relatives to undergo SMC. The reason put forward by the respondents was that they believe SMC reduces the risks of acquiring HIV infection by 60%. That is supported by randomized trials in Orange farm, Kisumu and Rakai (Bailey et al, 2007; Gray et al, 2007).

Attitudes positive or negative can be informed by the perceived reality in achieving task at hand (Raymond et al, 2010). All managers at national level were of the opinion that the set target of MOH to circumcise 385,000 men aged 13 -49 years by 2016 is achievable. The sentiment that is not shared by the majority of managers at district level, where majority of them thought the target is very ambitious and it will never be reached.

#### ***5.4. Challenges facing SMC program***

Challenges in the implementation of the SMC program form part of the environment that influence managers' attitudes towards the program (Payne et al, 2007). All managers interviewed agreed that there are many challenges that prevent men to be circumcised. The major challenges or barriers according to all respondents were men being afraid of pain and HIV testing. They are also unable to abstain from sex for 6 weeks. The same findings were recorded from evaluation of

SMC short term communication strategy in 2011 by PSI and ACHAP; fear of pain 66% and fear of HIV testing 52%.

Other challenges that were mentioned by Managers were attributed to religious and cultural barrier that prevent men accessing SMC. In the PSI and ACHAP study (2011) 93% of uncircumcised men who said they do not have immediate plans to be circumcised mentioned this as one of their main reasons for not accessing the SMC procedure.

None of the manager's related challenges that led to barrier to access of SMC services were due to inadequate management or coordination of the program. This may be an indication that during induction and recruitment management and leadership skills were not emphasized (Raymond et al, 2010). It is interesting to pursue further on this angle.

Surprisingly none of the managers shared concerns about adverse events and quality improvement of SMC services. This may be due to the emphasis on scaling up of the program and getting more number of men to be circumcised.

Limited demand for SMC services is the main challenge facing SMC program. The number of men reached with messages is very high but this does not translated to the number of men actually circumcised.

Space for performing various SMC activities; STI screening, HIV testing and counselling and surgical procedure is limited in most of the health facilities. Additional space is needed to be created. This will allow smooth integration of SMC into routine services, especially early infant male circumcision and adolescent services. Integration of the service will allow for the SMC services to be sustainable in a long run (MOH, 2012).

Sub-Saharan Africa is faced with a challenge of inadequate human resource for health. Botswana is faced with constrain in qualified and skilled human resource for health in both numbers and skills. MOVE strategy provide part of the solution but the possibility of task shifting provision of SMC procedure needs to be explored (MOH, 2012).

Effective management of the SMC program at all level is another challenge. Coordination of resources and various stockholders that support Ministry of Health is complex and it has many facets. Different partners have different planning and fiscal year period, for example CDC September to August, ACHAP January to December and Ministry of Health Botswana is April to March. Managers have inadequate skills in management and leadership especially at district level.

Logistic management for SMC program is another challenge facing the program. Process of procurement of supplies and equipment is lengthy and time consuming. Maintenance of infrastructure and waste disposal is not adequately done.

Transport is another challenge facing the program across the board. Transport is needed for demand creation, outreach services and waste management.

Negative media on SMC recently has become a challenge and threat to the scale up of the program in the country (MOH, 2012).

### ***5.5. Study limitations***

This study did have several limitations that needed to be considered when reading this manuscript. Firstly descriptive cross-sectional research designed was used. While descriptive research design is a valid method for social case study like this, there is always a concern over the validity of the findings, replication of the study and various interpretations of the results (Christensen, Johnson & Turner, 2011, p. 226).

Secondly, cross-sectional designs study the events at one-point moment that is not suitable to study a phenomenon such as attitude that is affected by time, environment and other complex psychological parameters like intentional behavior and subjective norms (Ajzen & Fishbein, 1980).

Thirdly, managers were expected to have positive attitudes towards SMC since it is the job they are employed to do. It is not known how this affects the overall findings of the study.

Fourthly, the study measured performance of volitional behavior to determine attitudes of SMC managers towards SMC against MOH set of positive attitudes, while the study served profound purpose of setting a base for further studies, earlier researches found weak correlation between the two (Ajzen & Fishbein, 1980; Hale et al, 2003).

### ***5.6. Recommendations for future research***

This study showed that SMC managers have positive attitudes towards SMC programs according to the Ministry of Health prescribed values, but left many questions unanswered that future studies should try to address. As it has been described earlier, attitudes, negative or positive need certain environmental condition to manifest. The environment will allow managers to weigh pro or against certain attitudes depending on the weight/importance the manager put on the importance of that attitudes relating to his/her performance at work. Future studies should be able to observe and study these dynamics.

This study looked at very few variables and this limited the author in making wider inferences. Future studies should look into the managers' knowledge and skills on SMC services, management and leadership. This approach will provide wider understanding of the ability of SMC managers to coordinate and manage the program.

From this study, readers will learn that there was a high turnover of the senior managers who run the program but the study did not provide explanation on the reasons why this happened neither did it explain the effect that high turnover rate had on the attitudes of the remaining managers and program progress as a whole. Future studies should add this component. Job satisfaction of the managers could be also added to this list.

Lastly SMC program is far from reaching its target. This performance should not be attributed to one component of the business plan. The findings suggested that human resource component of the business plan was not developed optimally. In-depth human resource situational analysis is recommended to be done in understanding of developing human resource management plan.

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## Appendices

### *Appendix no. 1. Participant Consent form.*



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jou kennisvennoot • your knowledge partner

## **STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH**

### ***SAFE MALE CIRCUMCISION MANAGERS' ATTITUDES TOWARD MALE CIRCUMCISION PROGRAM IMPLEMENTATION AND SCALE UP IN BOTSWANA***

You are asked to participate in a research study conducted by Dr. Ali S Ali. MD, MMED, PgD HIV/AIDS, from the Department of HIV/AIDS Prevention and Care. He is a student at Stellenbosch University pursuing Mphil degree in HIV/AIDS management. *The results of this study will be contributed to his thesis.* You were selected as a possible participant in this study because you are Safe Male Circumcision program manager at national/district level.

#### **1. PURPOSE OF THE STUDY**

Studies have shown that Safe Male Circumcision (SMC) reduces the risk of HIV transmission by 40-60%. Following recommendation by UNAIDS and WHO in 2007, the government of Botswana has put measures in place to implement and scale up SMC in the country. The government aims to increase the prevalence of male circumcision (MC) from the current 11% to 80% in 2016 which translates to about 470,000 circumcisions.

To-date after three years of implementation the number of men circumcised remains very low about 20,000 despite all the resources that have been allocated to the program. Adequate staff for SMC has been recruited and capacitated, infrastructure has been improved and adequate supplies have been purchased<sup>1</sup>.

Male circumcision practices are largely culturally and religiously determined and as a result there are strong beliefs and opinions surrounding its practice. For the program to succeed, it must be led by managers with positive attitude who are going to drive the objectives and reach the set target. Some of the managers were recruited specifically for SMC program but majority are managing it by default. Their attitudes towards SMC were never ascertained. It is not known to what extent the attitude of SMC managers influence the implementation and scale up of SMC services.

The study will measure types and level of attitudes program managers have toward the program. It will also suggest strategies for the strengthening of positive attitudes.

## **2. PROCEDURES**

If you volunteer to participate in this study, we would ask you to do the following things:

Interviewers will explain the study to you over the phone. If you agree we will follow you to your office. You will be asked to sign this informed consent form and then you will be interviewed in private. However, if you choose, the interview can also be conducted at another place of your choice.

The whole interview will take approximately 30 to 45 minutes but not more than an hour.

## **3. POTENTIAL RISKS AND DISCOMFORTS**

The interview should not raise any *foreseeable risks, discomforts, inconveniences, to you. However, we will ask permission to conduct interview from your supervisor and arrange time that is suitable to you.*

## **4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

You will not benefit directly from your participation in this study. However, the attitudes of people who are managing SMC program will be known. There will be an opportunity for strengthening positive attitudes and for correction of negative attitudes. This will increase efficiency in the program and optimization of the resources including time.

## **5. PAYMENT FOR PARTICIPATION**

You will receive no payment for participating in to this study.

## **6. CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of not recording your name or any identify in the documents including recording tapes. You will be allocated serial number. The data will be kept with the principal investigator in a metallic cupboard and locked all the time. Only principal investigator and study leader at University of Stellenbosch will have access to raw data. Study leader is more experience researcher, he is going to guide principal investigator to conduct good ethical and credible study. All data will be destroyed after the thesis has been marked probably by January 2013.

## **7. PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

## **8. IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact Dr. Ali S Ali by telephone +26772776689 or Dr. Thozamile Qubuda on (021) 808 3999.

## **9. RIGHTS OF RESEARCH SUBJECTS**

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

**SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE**

The information above was described to me.....  
*The participant by.....in English and I am the participant is in command of this language. I the participant was given the opportunity to ask questions and these questions were answered to my satisfaction.*

*I hereby consent voluntarily to participate in this study. I have been given a copy of this form.*

\_\_\_\_\_

**Name of Subject/Participant**

\_\_\_\_\_

**Name of Legal Representative (if applicable)**

\_\_\_\_\_

**Signature of Subject/Participant or Legal Representative**

**Date**

**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to \_\_\_\_\_ [*name of the subject/participant*] and/or [his/her] representative \_\_\_\_\_ [*name of the representative*]. [*He/she*] was encouraged and given ample time to ask me any questions. This conversation was conducted in *English* and *no translator was used*.

\_\_\_\_\_

\_\_\_\_\_

***Signature of Investigator***

***Date***

**Appendix no. 2. Letter of Approval HRDC Ministry of Health Botswana.**

Telephone: (267) 363200  
FAX (267) 353100  
TELEGRAMS: RABONGAKA  
TELEX: 2818 CARE BD



MINISTRY OF HEALTH  
PRIVATE BAG 0038  
GABORONE

REPUBLIC OF BOTSWANA

REF NO: PPME-13/18/1 Vol VII (220)

01 June 2012

Health Research and Development Division

Notification of IRB Review: New application

Dr Ali Salim Ali  
P O BOX 81811  
Gaborone

**Protocol Title:** Safe Male Circumcision (SMC) Mangers  
Attitude Towards Male Circumcision Program  
Implementation And Scale Up In Botswana

HRDC Protocol Number: HRDC 00765

Sponsor: N/A  
HRDC Review Date: 01 June 2012  
HRDC Expiration Date: 01 June 2013  
HRDC Review Type: HRDC reviewed  
HRDC Review Determination: Approved  
Risk Determination: Minimal risk

Dear Dr Ali

Thank you for submitting a new application for the above referenced study.

This permit does not however give you authority to collect data from the selected sites without prior approval from the management. Consent from the identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health within 3 months of completion of the study. Copies should also be submitted to all other relevant authorities.

If you have any questions please do not hesitate to contact Mr. P. Khulumani at [pkhulumani@gov.bw](mailto:pkhulumani@gov.bw), Tel +267-3914467 or Lemphi Moremi at [lamoremi@gov.bw](mailto:lamoremi@gov.bw) or Tel: +267-3632464

### **Continuing Review**

In order to continue work on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for Approval at least three (3) months prior to the protocol's expiration date. The Continuing Review Form can be obtained from the Health Research Division Office (HRDD), Office No. 9A 10 or Ministry of Health website: [www.moh.gov.bw](http://www.moh.gov.bw) or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: [kgmmotlhanka@gov.bw](mailto:kgmmotlhanka@gov.bw). As a courtesy, the HRDD will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form.

### **Amendments**

During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek HRDC approval before implementing it. Please summarize the proposed change and the rationale for it in the amendment form available from the Health Research Division Office (HRDD), Office No. 9A 11 or Ministry of Health website: [www.moh.gov.bw](http://www.moh.gov.bw) or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: [kgmmotlhanka@gov.bw](mailto:kgmmotlhanka@gov.bw). In addition submit three copies of an updated version of your original protocol application showing all proposed changes in bold or "track changes".

### **Reporting**

Other events which must be reported promptly in writing to the HRDC include:

- Suspension or termination of the protocol by you or the grantor
- Unexpected problems involving risk to subjects or others
- Adverse events, including unanticipated or anticipated but severe physical harm to subjects.

Do not hesitate to contact us if you have any questions. Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours sincerely



P. Khulumani  
**For Permanent Secretary**



*Appendix no. 3. Letter of Ethics Clearance University of Stellenbosch*



UNIVERSITEIT-STELLENBOSCH-UNIVERSITY  
jou kennisvenoot • your knowledge partner

10 August 2012

Tel.: 021 - 808-9003  
Enquiries: Mr. Winston A Beukes  
Email: [wabeukes@sun.ac.za](mailto:wabeukes@sun.ac.za)

**Reference No. DESC 62/2012**

Dr Ali Salim Ali  
Africa Centre for HIV and AIDS Management  
Stellenbosch University

Dr Ali

**LETTER OF ETHICS CLEARANCE**

With regard to your application, I would like to inform you that the project, *"Safe male circumcision (SMC) managers' attitude toward male circumcision program implementation and scale up in Botswana*, was approved on the following proviso's:

1. The researcher will remain within the procedures and protocols indicated in the proposal, particularly in terms of any undertakings made in terms of the confidentiality of the information gathered.
2. The research will again be submitted for ethical clearance if there is any substantial departure from the existing proposal.
3. The researcher will remain within the parameters of any applicable national legislation, institutional guidelines and scientific standards relevant to the specific field of research.
4. The researcher will consider and implement the foregoing suggestions to lower the ethical risk associated with the research.
5. This ethics clearance is valid for one year from 10 August 2012 to 09 August 2013.

We wish you success with your research activities.

Best regards

  
MR WA Beukes

REC Coordinator: Research Ethics Committee: Human Research  
Registered with the National Health Research Ethics Council (NHREC): REC-050411-032



**Afdeling Navorsingsontwikkeling • Division for Research Development**

Privaatsak/Private Bag X.I • Matieland 7602 • Suid-Afrika/South Africa  
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[www.sun.ac.za/research](http://www.sun.ac.za/research)

*Appendix no. 4. Semi-structured Interview guide.*

**SAFE MALE CIRCUMCISION MANAGERS' ATTITUDES TOWARDS MALE CIRCUMCISION**

**SEMI-STRUCTURED INTERVIEW GUIDE**

**NOTES**

Semi-Structured Interviews (SSI) will be conducted to explore the attitudes of SMC managers towards male circumcision.

**Outputs**

For each SSI:

- Completed consent form for participation in research, signed by participant.
- Recording of each interview (to be transcribed)
- File naming: please name file with ID number only, eg SSI: Name of district \_ serial no. (eg, SSI: Gaborone\_01)
- Interviewer notes – include in the header of each transcript:

---

ID no. SSI: -----\_-----

Interviewer name-----

District-----

Date of Interview-----

Time of interview:

Time interview started: -----



Time interview ended: -----

Any other general observations: -----

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-----

-----

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### **Selection criteria**

Participants will be eligible for inclusions in the semi-structured interviews if they are SMC managers and signed inform consent.

### **Recruitment procedures**

Interviewers will explain the study to SMC managers over the phone. Those agreeing will be followed at their offices. They will be asked to sign informed consent form and then they will be interviewed in private. However, if participants choose, the interview can also be conducted at another place at the client's choice.

### **Instructions to interviewer**

Check that:

- MC client has signed the informed consent form to participate in the SSI
- Study ID number has been noted
- Tape recorder works to record the voices of interviewer and participant.
- Ensure no other persons are present for the interview.

### **Introduction by interviewer**

“Thank you very much for joining me today, and for agreeing to participate in this interview.

My name is XXXX and I am here to interview you.

*If appropriate: This conversation will take place mainly in English.*

You have agreed to speak with me here today about Safe Male Circumcision the program you are working with.

Can you confirm what your designation is?

*(Confirm that he/she is SMC manager either at national or district level. Address any queries arising. If he/she is not an SMC manager at national or district level, thank him/her, and leave.)*

As we talked about when you signed the consent form, I would like to find out about your views regarding Safe Male Circumcision. We are also going to be talking about your fellow SMC managers their perceptions and attitudes towards Safe Male Circumcision in general and specific about a place of SMC in HIV prevention

Overall, the purpose of this interview is to find out your opinions about the ways SMC managers view male circumcision in relation to benefits and risks, reasons why men are circumcised, How religion and traditions influence male circumcision, feasibility of achieving targets of SMC in Botswana, advert events, sexual pleasure and sexual performance after male circumcision, also will want to find out your view and that of other SMC managers on neonatal and childhood male circumcision.

I expect that our conversation today should take up to an hour. If you want to leave at any point, then you are free to do so and we will end our conversation. However, I would appreciate it if you would try to stay all the way through to the end.

Everything that we talk about today will remain private, between you and me. I will not be recording your name. As I explained earlier when we went through the informed consent form, I will be using this tape recorder to record our discussion. I hope you will feel comfortable sharing your opinions openly and honestly with me. There is no right or wrong answers – I would really

appreciate hearing your views. If there are any questions that you don't want to answer, then simply say so and we will move on. Please speak up and speak clearly to make sure that your voice can be recorded.

Do you have any questions about anything that I have just said? (*Answer all questions.*)  
Any more questions? (*Keep asking until all questions have been answered.*)

Ok, let's begin the interview.

**Instructions to interviewer:** *Prior to starting your interview, please check to ensure that the tape recorder is working properly by recording a trial question and answer, and playing it back to confirm that it is audible. Inform the participant of what you are doing.*

**Interviewer Script:** "These are questions to test that the recorder is in working order. They will be erased once the interview starts."

- How far do you live from your office?
- How do you usually get here?

**Instructions to interviewer:** *Rewind/restart the tape recorder before starting the interview.*

Questions	Probes
<b>Background and demographics</b>	
First, I'd like to know a little about you – tell me about yourself. Instructions to interviewer, we need to capture the following: <ul style="list-style-type: none"> <li>• <i>Age</i></li> <li>• <i>Religion</i></li> <li>• <i>From traditional circumcising of non-circumcising tribe</i></li> </ul>	<ul style="list-style-type: none"> <li>• How old are you?</li> <li>• What is your religion</li> <li>• You are from traditional circumcising tribe or not?</li> <li>• What is the highest education you received?</li> <li>• Are you married/single/have a steady</li> </ul>

Questions	Probes
<ul style="list-style-type: none"> <li>• Education (Highest achieved) – <i>Diploma, First degree, second degree, PhD, other training</i></li> <li>• <i>Marital status</i></li> <li>• <i>Children</i></li> <li>• <i>Hobby</i></li> </ul>	<p>partner?</p> <ul style="list-style-type: none"> <li>• Do you have any children?</li> <li>• What is your hobby?</li> </ul>
<b>Workplace issues</b>	
<p>Can you please tell me about how you first learned about male circumcision?</p> <p>.</p> <p>Now tell me how you find yourself working for SMC program.</p> <p>Now I would like to talk about your colleagues, how they feel about working for SMC program</p> <p>Was there any information that you would have liked that you didn't have before making a decision to work for SMC?</p> <p>What is the general perception among your peers about male circumcision program?</p> <p>In general how your colleagues find MC procedure?</p>	<ul style="list-style-type: none"> <li>• Did you learned about SMC before or after you got employed?</li> <li>• Did you applied for SMC position or you were appointed to the position?</li> <li>• They are happy, unhappy or indifferent working for the program</li> <li>• Was there any information you could have received before you came to work for the program?</li> <li>• Your peers enjoying working for SMC program?</li> <li>• Is SMC procedure very traumatic?</li> </ul>
<b>Benefits and Risks of male circumcision</b>	

Questions	Probes
<p>Let now talk about benefits and risks of male circumcision:</p> <ul style="list-style-type: none"> <li>• What other managers think about benefits and risks of MC? What are more benefits or risks?</li> <li>• Which benefits were most important to you?</li> <li>• Would you allow your son and close relatives to be circumcised?</li> <li>• If the answer is yes how important were these benefits in making your decision to allow your son and close relatives to get circumcised?</li> </ul> <p>Now let discuss about risks of MC;</p> <ul style="list-style-type: none"> <li>• What were the risks of SMC?</li> <li>• Do you think people are taking into consideration any of the risks when they made decision to get circumcised?</li> </ul> <p>One of the controversies surrounding MC is its effect on sexual performance and sexual pleasure.</p> <p>How your colleagues think the effect of MC on</p>	

Questions	Probes
<p>sexual performance?</p> <p>How your colleagues think the effect of MC sexual pleasure?</p> <p>What clients say about the effect of MC on sexual performance and pleasure?</p>	
<b>Reasons why men get circumcised</b>	
<p>In your view what are the reasons make people wanted to be circumcised?</p> <p>Do you think religion and tradition believe has an effect of making men to accept or refuse to be circumcised?</p> <p>Please explain how your colleagues think about SMC and risk reduction of HIV transmission?</p> <p>How your colleagues think about testing clients for HIV before male circumcision procedure?</p>	<ul style="list-style-type: none"> <li>• Do religion/tradition/medical reason/HIV prevention is the commonest reason for people to be circumcised?</li> <li>• Did your colleagues think that SMC can actual reduces risk of HIV transmission?</li> <li>• How does MC reduce risk of a man getting HIV? <i>Removal of foreskin, target cells, etc</i></li> <li>• Is it 100% effective? <i>No, 60%.</i></li> <li>• Do you still need to use condoms? Reduce partners? Keep getting</li> <li>• Is HIV testing clients necessary or not?</li> </ul>
<b>Outcome of SMC procedure and program</b>	
<ul style="list-style-type: none"> <li>• What colleagues say about pain during and after circumcision?</li> <li>• What people say about the rate of adverse events after MC in Botswana?</li> <li>• How is the general feeling among SMC</li> </ul>	

Questions	Probes
<p>managers on achieving target of circumcising about half a million men by 2016?</p> <ul style="list-style-type: none"> <li>• How would you explain to a friend the amount of protection from HIV that MC gives to his female sex partner?</li> </ul>	
<b>Neonatal and childhood male circumcision</b>	
<p>What is the general opinion on circumcising new born baby boy among your peers?</p> <p>What is the general opinion on circumcising small boy of about 3 to 10 years of age among your peers?</p>	
<b>Recommendations/Looking ahead</b>	
<p>We are coming to the end of our discussion. Before we finish, I would like to hear your thoughts about how the SMC program could be improved in the future.</p> <p>If you had the opportunity to change something in the whole program of Safe Male Circumcision, what would you change? Why?</p> <p>What advice would you like to give to other SMC managers to improve the program?</p>	<p>Is there anything that the SMC managers could have done differently to better manage the program?</p>

**Concluding remarks**

That concludes our discussion. Is there anything else that you would like to share with me today?

*[Let client add anything else].*

Thank you very much for sharing your views with me today.

**Adopted from Zambia's Adult's SSI guide for Post male Circumcision Risk compensation study V3 – 15<sup>th</sup> January 2010.**