

**NATIONAL SEXUAL AND REPRODUCTIVE HEALTH SERVICE PACKAGES FOR
MEN AND ADOLESCENT BOYS**

“Men health is a societal community and family matter”

#MenMatterToo

April 2025



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LIST OF ABBREVIATIONS AND ACRONYMS

ACRONYM	LISTING
AAT	Nucleic Acid Amplification Test
ABYM	Adolescent Boys and Young Men
AIDS	Acquired Immuno Deficiency Syndrome.
ANC	Antenatal care
ARV	Anti-Retro Viral
APC	Advancing Partnership in Communities
BAIS	Botswana AIDS Impact Survey
BMI	Body Mass Index
BOFWA	Botswana Family Welfare Association
BONELA	Botswana Network on Ethics, Law and HIV/AIDS
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality
CBOs	Community-based organizations
COVID-19	Corona Virus Disease of 2019
CSE	Comprehensive Sexuality Education
CSOs	Civil Society Organizations
DHIS	District Health Information System
DHMT	District Health Management Team
DRA	Digital Rectal Examination
DV	Domestic Violence
EHSP	Essential Health Services Package
ESA	Eastern Southern Africa
GBV	Gender-based violence
HAART	Highly Active Anti Retro- Viral Therapy
HIV	Human Immunodeficiency Virus
HPV	HPV Human Papillomavirus
HTC	HIV Testing and Counseling.
HTS	HTS HIV testing services
ICPD	International Conference on Population and Development
IEC	Information, education and communication
IHSP	Integrated Health Services Plan

HPV	Human Papilloma Virus
IPV	Intimate Partner Violence
KII	Key Informant Interview
LAM	Lactational Amenorrhea Method
LGBTQ	Lesbians Gays, Bisexual, Transgender and Queer
LMIC	Low Middle Income Countries
M&E	Monitoring and Evaluation.
MOH	Ministry of Health
MSM	Men Sex Men
NAHPA	National AIDS and Health Promotion Agency
NDP	National Development Plan
NACP	National AIDS Control Program
NCD	Non-Communicable Diseases
NPC	Support Appreciate Learn Transfer
PAC	Post-abortion care
PCR	Polymerase Chain Reaction
PEP	Post-exposure prophylaxis
PHC	Primary health care
PMTCT	Prevention of mother-to-child transmission
PNC	Pre/postnatal care PTA Parent teacher association
PSA	Prostate Specific Antigen
RMNCAH+N	Reproductive, Maternal, Neonatal, Child and Adolescent Health + Nutrition
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
SMC	Safe Male Circumcision
SRH	Sexual and Reproductive Health and Rights
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TWG	Technical Working Group.
UHC	Universal Health Coverage
UN	United Nations.

UNAIDS	Joint United Nations Programme on HIV/AIDS.
UNDP	United Nations Development Program.
USAID	United States Agency for International Development
UTI	Urinary Tract Infections
VAW	Violence Against Women
VLS	Viral Load Suppression
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
YWCA	Young Women Christian Association

PREFACE

Botswana continues to face high new HIV infections, particularly among adolescent girls; high gender-based violence perpetuated by deep-rooted negative social norms and harmful practices, reinforcing inequalities, patriarchal attitudes, and gender stereotypes that promote negative masculinity and normalize GBV. While progress has been made, persistent negative SRHR indicators continue to be recorded. The National Relationships study (2018), reports that 37% of women experienced GBV at least once in their lifetime including intimate partner and non-partner violence; 30% of men reported having perpetrated GBV in their lifetime; and women of reproductive age were more likely to experience intimate partner violence than older women with 15% of women experiencing GBV during pregnancy; 45% of men believed in any rape case, there was need to ask whether the victim was promiscuous; 34% affirmed that in some rape cases, women wanted it to happen; and 41% believed if a woman does not fight back, it is not rape; 17% of women of reproductive age had an unmet need for family planning evidenced through differential fertility rate by rural/urban divide and education level attainment.

Botswana is committed to leaving no one behind in health and scaling up the provision of client-centered, integrated healthcare services. This is in line with global, regional, and national policy frameworks. The government is successfully scaling up the delivery of integrated services across the country following the implementation of the 2gether 4 SRHR programme. It focused on;

- a) Creating an enabling legal and policy environment that empowers all people to exercise their SRH rights and access quality integrated SRHR, HIV and SGBV services.
- b) Scaling up the provision of client-centred, quality assured, integrated, and sustainable SRHR, HIV and SGBV services which meets the needs of all people.
- c) Empowering all people to exercise their SRH rights, adopt protective and promotive behaviours, and access quality integrated services.

While the programme was a success, among others, ensuring access to integrated SRH, HIV and SGBV services, facilitating men and boys to fully access integrated SRH and HIV services

tailored to their needs remains limited. Low utilization and adherence to prevention services are often due to poor health-seeking behaviors among men and boys; unlike females, men and boys were less likely to obtain ART or be virally suppressed (95.88.87).

Delivering quality tailor-made interventions that are responsive to the unique needs of men and boys, including facilitating their active participation in challenging negative social and gender norms is critical, for the attainment of sexual and reproductive health and rights (SRHR).

Male involvement in SRH is prioritized in several national documents such as the RMNACH+N strategy, and national strategy for male involvement in SRHR/HIV/GBV (2007-2012) among others. These strategies defined a package of services for this cohort. This was followed by the 2010 Essential Health Service Package (ESHP) which further defined service packages for children, adolescents, women, and broadly everyone in Botswana, albeit with no specific service packages tailored for men and boys. With both guiding documents overdue for revision and requiring to be aligned with national, regional and global strategic direction on SRHR, therefore defining a national package of SRHR services aligned with the global package of SRHR services for men and boys is therefore required.

The service packages will provide a clear guidance to health care providers to deliver quality integrated gender-sensitive SRH clinical services for men and boys, using tailored approaches to lead to better health outcomes, contribute to ending GBV and ultimately promote gender equality by encouraging positive masculinity.

ACKNOWLEDGEMENTS

Delivering quality tailor-made interventions that are responsive to the unique needs of men and boys including facilitating their active participation in challenging negative social and gender norms is critical for the attainment of Sexual and Reproductive Health and Rights (SRHR).

This service package is meant to guide all health care workers from the public sector to the private sector on the provision of health care for men and boys. By working together we will be able to deliver on the Ministry of Health's targets for ensuring the attainment of health by all by 2030.

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1.0 INTRODUCTION, RATIONALE AND OVERVIEW

1.1 PURPOSE OF THIS SERVICE PACKAGE

The Botswana Sexual and Reproductive Health Service Packages for Men and Adolescent Boys has been developed to support providers of Sexual and Reproductive Health (SRH) services to increase the range and quality of services that meet the specific and diverse needs of men and adolescent boys. This package of services complements the national guidelines on health services Integration of SRH services within clinical and non-clinical contexts of Botswana and follows a gender-transformative approach. In doing so, this service package contributes to efforts to ensure universal access to Sexual and Reproductive Health and Rights (SRHR) as prioritized in the Sustainable Development Goals **IPPF and UNFPA (2017)**. The specific objectives of the services package are to;

- Contribute to reducing the STIs infections among men and boys in particular HIV
- Encourage Shared Responsibility in Family Planning
- Address Social and Cultural Barriers to accessing SRHR services by men and adolescent boys.
- Reduce the Risk of Gender-Based Violence (GBV)
- Address the Needs of Vulnerable Groups of men, and adolescent boys.
- Improve access to health care services and eventually Universal Health Coverage and health outcomes

1.2 RATIONALE FOR A SERVICE PACKAGE FOR ADOLESCENT BOYS AND MEN IN BOTSWANA

Global, continental and regional commitments, such as the International Conference on Population and Development (ICPD) Programme of Action, the Maputo Plan of Action, and the SADC Regional Strategy on Sexual Reproductive Health and Rights (SRHR), all emphasize the

importance of engaging men and boys to achieve gender equality and foster women empowerment. Despite these commitments, the current body of work from the East and Southern Africa (ESA) region indicates that the initiatives to engage men and boys as clients, supportive partners and advocates in SRHR, remain small in scale. Men have substantial sexual and reproductive health needs, including the need for contraception, prevention and treatment of HIV and other sexually transmitted infections (STIs), sexual dysfunction, infertility and male cancers.

TABLE 1: UNMET SRHR NEEDS FOR MEN & BOYS

Men`s unmet SRH needs	Situation
Men and Contraception & FP	<ul style="list-style-type: none"> ● Male condoms and Vasectomy, accounts for 25% of contraceptive use globally. ● No improvement since 1994 <p><i>*current FP use, are based on data from women only, creating knowledge gaps on men`s preferences and behaviours.</i></p>
HIV and AIDS	<ul style="list-style-type: none"> ● 54% of new infections in 2022 were among men and boys ● 100 00 more in than women contracted HIV I 2022 ● Risk of HIV among MSM globally is 26 times higher than in the general population. ● AIDS-related mortality has declined for both men was 47% compared to 55% in women from 2010-2023.
Sexual Dysfunction	<ul style="list-style-type: none"> ● 50% of men aged 40-70 years reported an experience of Erectile Dysfunction (ED) in Europe. ● 36% of men in Germany using online pharmacies for ED treatment report doing so due to shame and confidentiality.
Men and fertility	<ul style="list-style-type: none"> ● Globally, sperm counts fell by 52% between 1971 and 2011. <p>Male infertility contributes to around 50% of infertility in couples.</p>
Men and reproductive cancers	<ul style="list-style-type: none"> ● The prevalence of male cancers has climbed globally since the 1980s. ● There is limited research on supportive care needs for men with reproductive cancers, affecting clinical intervention effectiveness.

Source: (Shand. T., and Evoy, C., 2024)

It is important to note that national policies and strategies pay insufficient attention to the male engagement on SRHR, the delivery of SRHR services to meet the needs of men and boys, and the promotion of gender-equitable attitudes and behaviours, hence the need to package SRHR services for men and adolescent boys.

1.3 WHO ARE THE USERS OF SERVICE PACKAGE?

As outlined in the global package of services for men and boys, the primary audience includes all levels of staff and service providers in facility and community based settings that offer, or would like to offer, SRHR services for men, from adolescence through to adulthood. Programme managers, policy makers and advocates working in this area will also find it useful **(IPPF and UNFPA, 2017)**. The package can be used by Civil Society Organizations (CSOs) providing SRHR services to men and adolescent boys or by those intending to develop their work in this area within Botswana.

1.4 HOW TO USE THE SERVICE PACKAGE

This service packages provide an overview of the SRHR services that need to be provided for men and adolescent boys and links to existing tools, policies, service delivery guidelines and resources utilizing a gender-transformative approach.

The service package may be used in the following ways:

- To learn about the importance of addressing men and adolescent boys' SRHR and the principles for this work;
- To understand the components of an organized approach to providing a package of SRHR services for men and adolescent boys;
- To determine what SRHR services for men and adolescent boys should be provided by an organization or where existing services should be improved;
- To scale-up and strengthen SRHR service provision and programming for men and adolescent boys, through key building blocks and strategies to operationalize this package; **(IPPF and UNFPA, 2017)**.

1.5 How this service package is organized

Section one of the package provides a background and overview of the male involvement in SRHR services within a global, regional and national perspective and why it is important to use a

gender-transformative approach to provide SRHR services for men and adolescent boys. The section point out gaps on the provision of SRHR services for men and boys in Botswana. **Section two** outlines a situational analysis on the building blocks critical to scaling-up work on men and adolescent boys and SRHR that should be considered prior to operationalizing the service package. The building blocks are discussed within the context of Botswana as informed by the situational analysis. An intervention mapping was conducted through a stakeholder’s workshop, review of policy documents and literature, and interviews with key informants in order to obtain contextually relevant information pertaining to the service packages.

Section three outlines the SRHR package for men and adolescent boys, including an overview of the key service components. **Section four** outlines each of the elements of the SRHR package in greater detail and provides a list of relevant guidelines, tools and resources to refer to. **Section Five** discusses specific health and service delivery considerations related to adolescence, sexual orientation and gender identity. **Section Six** provides key steps for operationalizing the framework, including assessing the current situation, building capacity and commitment, programme design, implementation, and monitoring and evaluation. **Section Seven** provides a list of associated resources for additional information and guidance on scaling-up work on men and adolescent boys’ SRHR.

SECTION 1: BACKGROUND AND FRAMING ON

MEN AND BOYS' SRHR

1.0 SECTION 1: BACKGROUND AND FRAMING ON MEN AND BOYS' SRHR

Only nine years ago, all UN Member States adopted the 2030 Agenda for Sustainable Development that included a specific target for achieving universal access to SRHR (Gender Equality Goal 5). Despite these important pronouncements, steps to secure universal access and coverage of SRHR services, and the promise of adolescent girls' and boys' SRH and rights remains unrealized. Gender-Based Violence (GBV), Violence Against Women (VAW), Intimate Partner Violence (IPV), or Domestic Violence (DV) is deep-rooted in African societies (Petrina, 2023) and its negative impact on the attainment of SDG 5 cannot be ignored. Globally, Gender-Based Violence accounts for nearly one quarter of all recorded crimes (Petrina, 2023). The World Health Organisation (WHO) estimates that 30% of women worldwide have experienced physical and/or sexual intimate partner violence, and 7% have experienced non-partner sexual violence, in their lifetime (World Health Organization, 2021). Among ever-partnered young women aged 15–24, the prevalence of intimate partner violence is 29%. Prevalence of combined intimate partner and non-partner violence ranges from 27% in the WHO European Region to 46% in the African Region (García-Moreno et al., 2013). While progress has been made to push SRH, HIV, and GBV indicators downwards, Botswana continues to face high new HIV infections, particularly among adolescent girls; high gender-based violence perpetuated by deep-rooted negative social norms and harmful practices, reinforcing inequalities, patriarchal attitudes, and gender stereotypes that promote negative masculinity and normalize GBV. Persistent negative SRHR indicators continue to be recorded. According to a National Relationships study of Botswana in 2018, 37% of women reported experiencing GBV at least once in their lifetime including intimate partner and non-partner violence; 30% of men reported having perpetrated GBV in their lifetime; and women of reproductive age were more likely to experience intimate partner violence than older women with 15% of women experiencing GBV during pregnancy (Chiramba, Musariri and Rasesigo, 2018). The situation regarding access to SRHR services is that; 17% of women of reproductive age have an unmet need for family planning evidenced through differential fertility rate by rural/urban divide and education level attainment. According to the Botswana AIDS Impact survey V (2023) HIV prevalence was 26.2% among females and 15.2% among males. 96.4% of females and 93.0% of males living

with HIV of adults living with HIV were aware of their HIV-positive status. 82.3% of young females and 89.1% young males of young people living with HIV were aware of their HIV-positive status. Among all young people living with HIV in Botswana, 80.5% were young females and 89.1% were young males. Regarding viral load suppression, among those who were aware of their HIV-positive status and on treatment, 73.7% young females and 81.8% young males had VLS. Regarding HIV testing among adults aged 15-64 years, 88.0% reported that they had ever received an HIV test, with a higher percentage among females: 89.4% than males: 86.5%.

Cancers remains an offending ailment among the male population of Botswana. The global cancer observatory register for 2022 by [Bray, \(2024\)](#), reported that the top five (5) most frequent cancers which constituted 941 new cases of male cancers in Botswana were prostate; 159 (16.9%), Kaposi Sarcoma 134 (14.2%), esophageal 92 (9.8%), lip and oral cavity 61 (6.5%), NHL 52 (5.5%), and, other cancers at 443 cases (47%). In Botswana, while contraceptive prevalence is high, male participation in contraceptive use is primarily through condoms (64.2%), ([Rakereng, 2024](#)) with a lower percentage using vasectomy. While specific, recent data on male sexual dysfunction rates in Botswana is limited, studies suggest that a significant portion of men experience some form of sexual dysfunction, with erectile dysfunction being the most common ([Rosen, 2000](#)).

A notable gap and gender disparities is found in the HIV care continuum from prevention to treatment of ailments related to HIV ([DiCarlo et al., 2014](#), [Gari et al., 2014](#), [Staveteig et al., 2017](#)). In their study [Mashumba and colleagues \(2024\)](#) reported victimizations (beating, removal of condoms during anal sex) discrimination and limited of access to HIV services by Men who have Sex with Men (MSM) and Men Sex Workers (MSW) in Botswana ([Matlapeng, 2023](#)).

Adolescent Boys and Young Men (ABYM) continue to be left behind ([Cornell and Dovel, 2018](#)). It is worth noting that even though the SRH programme has been successful in Botswana, among others, ensuring access to integrated SRH, HIV and SGBV services, facilitating men and boys to fully access integrated SRH and HIV services tailored to their needs remained limited. Low utilization and adherence to prevention services are often due to poorer health-seeking

behaviours among men and boys. Unlike females, men and boys were less likely to obtain ART or be virally suppressed (95.88.87) as depicted by the indicators in the captured above.

Despite the observations made by the authors above, and in line with global, regional, and national policy frameworks, Botswana is committed to leaving no one behind in health and scaling up the provision of client-centered, integrated healthcare services. Under the leadership of the Ministry of Health, the government successfully is scaling up the delivery of integrated services across the country following the implementation of the 2gether 4 SRHR programme. The programme focused on; a) Creating an enabling legal and policy environment that empowers all people to exercise their SRH rights and access quality integrated SRHR, HIV and SGBV services; b) Scaling up the provision of client-centered, quality assured, integrated, and sustainable SRHR, HIV and SGBV services which meets the needs of all people; c) Empowering all people to exercise their SRH rights, adopt protective and promotive behaviours, and access quality integrated services.

It is against this brief background that Ministry of Health (MoH) developed a national package of SRHR services aligned to the global package of SRHR services for men and boys.

SECTION 2: SITUATIONAL ANALYSIS OF THE BUILDING BLOCKS FOR WORKING ON

MEN & BOYS' SRHR

SECTION 2: SITUATIONAL ANALYSIS ON THE BUILDING BLOCKS FOR WORKING ON MEN & BOYS' SRHR

The **IPPF and UNFPA, (2017)** proposes seven essential and interlinked building blocks to support the efforts of organizations to operationalize a greater focus on men and adolescent boys' SRHR. This section presents the seven building blocks in the context of Botswana. The contextualization of these building block was achieved and informed by desk review of policy documents, workshop held on the 7th November with key stakeholders and interviews with key eleven informants from various sectors which were providing SRH services.

2.1 Methodology for The Situational Analysis

A situational analysis of an intervention, requires the use of rigorous and robust techniques to capture the state of affairs on the ground as accurately as possible in order to inform its planning. A combination of qualitative approaches to data collection, analysis and interpretation was used. The reasons for the triangulation of methods for the gap analysis for men and boys' SRHR services was to decrease the deficiencies and biases that could stem from a single method. Moreover, a mixed methods approach was essential to allow for stakeholder engagement. Triangulation provided an opportunity to include men and adolescent boys' in all their diversity and facilitated an application and bench marking of approaches from different part of the world to the development of packages for SRHR services for men and adolescent boys. A mapping of Intervention involving evidence synthesis and engagement with local stakeholders, guided the adaptation and development packages for SRHR services for men and adolescent boys. The technical approach therefore included;

2.2 Verifying the needs for the service Packages through

2.2.1 DESK REVIEW

The consultant reviewed literature on the SRHR programs globally, regionally and locally. The desk review aimed at collecting evidence which was used to inform the SRHR service packages for men and boys in Botswana. A review of documents within Botswana was undertaken in an effort to contextual the envisaged packages. *Table 2* below depicts the documents which were reviewed from global, regional and local perspectives.

TABLE 2: DOCUMENT REVIEWED FOR THE DESK REVIEW

Level	Document	Relevance to the SRHR service packages for men and Boys
Global	The Global Sexual and Reproductive Health Service Package for Men and Adolescent Boys: 2017	<ul style="list-style-type: none"> • All packages were deemed applicable to Botswana. However, the naming was modified to facility and community based packages of services.
	The International Conference on Population and Development (ICPD), 1994	<ul style="list-style-type: none"> • Calls countries to commit policies to the principles of equitable representation of both sexes. • Chapter vii; elaborates on issues of reproductive rights and health, FP, STIs and HIV, Sexuality and gender and adolescent health.
Regional	Strategy for Sexual and Reproductive Health and Rights in the SADC Region 2019-2030	<ul style="list-style-type: none"> • The strategy is inclusive of Men and Boys, Key populations sex workers, people who inject and use drugs, prisoners, MSM and LGBTQI, Migrants, Refugees, Mobile Populations, People living with Disabilities and victims of sexual exploitation. • Calls countries to transform –expand enabling environments, which includes eradicating poverty, and eliminating all harmful practices

		<p>and all discrimination and violence against women and girls.</p> <ul style="list-style-type: none"> • The ten strategic SRHR outcomes by 2030 are relevant especially the one on removal of all barriers, including policy, cultural, social and economic, that serve as an impediment to the realization of SRHR in the region.
	<p>Regional Strategy and Framework of Action for Addressing Gender Based Violence 2018-2030</p>	<ul style="list-style-type: none"> • The focal area on the engagement of men and boys in the prevention of GBV. • Identified limited male involvement in the prevention and response to GBV.
	<p>Agenda 2063 Maputo Plan of Action (2016-2030)</p>	<ul style="list-style-type: none"> • The plan intended to improve and accelerates SRH and rights efforts for the effective implementation of the continental policy framework on SRHR. • The plan focused mostly on ending preventable maternal, newborn, child and adolescent deaths by expanding contraceptive use, reducing levels of unsafe abortion, ending child marriage, • Eradicating harmful traditional practices including female genital mutilation and eliminating all forms of violence and discrimination against women and girls and ensuring access of adolescents and youth to SRHR by 2030 in all countries in Africa. • Little intensions to focus on men and boys' SRHR issues is noted in this document.
	<p>Minimum Standards for the Integration of HIV and Sexual</p>	<ul style="list-style-type: none"> • Made important pronouncements on the standards; i) on Policy review or development

	and Reproductive Health in the in the SADC Region (2015) and national policy frameworks	to create a conducive environment for integrated HIV and SRH service delivery, ii) Identifying strategies for addressing negative cultural practices which hinder access to and utilization of SRH and HIV services, and iii) inclusion of key populations and gender-based violence in SRH programming.
	A Policy Brief A Framework For Voluntary Medical Male Circumcision: Effective HIV Prevention And A Gateway To Improved Adolescent Boys' & Men's Health In Eastern And Southern Africa By 2021	<ul style="list-style-type: none"> ● Offers ; ● an approach to packaging of SRH services for men and Adolescent boys in accordance to their needs; ● i) Young adolescent boys (10–14 years) ● develop referral linkages with age-appropriate, CSE, vaccinations, ● ii) Older adolescents (15–19 years) ● The need for education and counselling on HIV risk and related gender norms, and a positive notions of masculinity. ● iii) Young adult men (20–29 years) ● Life course and needs for FP education; tuberculosis and HIV diagnosis and linkage to treatment; and alcohol and drug use disorder prevention.
	Documents on Local Perspective	
National	Botswana Integrated Health Services Plan (2010-2020),	<ul style="list-style-type: none"> ● Health services that are most needed and most efficient, and incorporates the views of both health professionals and the general public.

		<ul style="list-style-type: none"> • The services reflect best international practice, hence aligns with global 	
	Essential Health Service Package for Botswana (EHSP) (2010),	<ul style="list-style-type: none"> • Provide a packaging of health services according to the levels of the health facilities. • The SRH services were not packaged according to men and women but in general terms and delivered mostly in PHC facilities. 	
	Botswana Integrated Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH+N) Strategy (2018–22),	<ul style="list-style-type: none"> □ Provide direction, key actions and specific activities for each RMNCAH+N programme area. More focus is on maternal and newborn their framework is complimented by the integration of services, which includes a broader spectrum. 	
	National Guidelines on Health Services Integration (2021)	<ul style="list-style-type: none"> • Offers a packaging format for health services (client and provider-initiated approaches). • The three models of service delivery follow, the kiosk, supermarket and mall models. The three are integrated approaches which follow facility-based service delivery points. In this regard, the SRHR service packages for men and boys complimented this approach. 	

2.2.2 WORKSHOP WITH TECHNICAL WORKING GROUP

The consultant held a meeting with stakeholders at the MOH, WHO UNAIDS and UNFPA country offices. The purpose of the meeting was to obtain information on the sexual and reproductive health needs for men and boys in Botswana, and clarified their contextually relevant determinants. A face-to face workshop was held on the 7th November, 2024. The workshop was

facilitated by the consultant assisted by the expert from MOH, UNFPA and other relevant stakeholders. A standardized *facilitator's guiding* tool was used during the workshop. The findings of the workshop were captured as *Appendix 1*

2.2.3 VIRTUAL INTERVIEW WITH KEY INFORMANT

In order to build national consensus on strategies and interventions to be included in the packages of SRHR services for men and boys, the consultant gathered opinions through interviews with key stakeholders who played the role of key informants. Key informant were selected purposively using the criteria of being involved with men and boys programs (HIV, SGBV) in Botswana. A key informant guide comprising semi-structured questions was used to engage key informants in the discussions. The guide comprised questions on how programs; i) could have a focus on men and boys, ii) could deliver quality gender sensitive SRH clinical services, iii) could meet the context and local SRHR needs for men and boys`, iv) could have organization and workforce commitment to providing SRHR services for men and, v) could address the primary prevention and integrated approach, (refer *to appendix 2*:informant interview guide) drawn from chapter 2 of the global sexual and reproductive health service package for men and adolescent boys, (IPPF and UNFPA 2017).

The interviews gathered the informants` views on the implementation processes, relevance and effectiveness of the implemented initiatives of men and boys SRHR programs within Botswana. Furthermore the interviews solicited for lessons learnt and best practices to be continued within the programs available in Botswana. The interviews were conducted through virtual platforms of telephonic and what-up calls. Information gathered during the interviews was recorded on the phone and latter typed to produce transcriptions which were summarized into a code book *see appendix 3*.

2.2.4 DATA SYNTHESIS

Data generated from the desk review and the workshops and interviews with informant were collated and synthesised to identify emerging views and common themes. Themes were

summarised into concise information reflected in the contextualization of the seven building blocks used for programming SRHR packages for men and adolescent boys. See *appendix 3*

2.3 Intervention Mapping According To The Building Blocks To Working On Men & Boys` SRHR

2.3.1 USING A GENDER-TRANSFORMATIVE APPROACH

Global health organisations advocate gender-transformative programming (which challenges gender inequalities) with men and boys to improve sexual and reproductive health and rights (SRHR) for all. A gender transformative approach is described in the *text box 1 below*,

Box 1: Gender Transformative Approach

Gender transformative approaches actively strive to examine, question and change rigid gender norms and imbalances of power as a means of reaching health as well as gender equity objectives.

Gender transformative approaches encourage critical awareness among men and women of gender roles and norms; promote the position of women; challenge the distribution of resources and allocation of duties between men and women; and/or address the power relationships between women and others in the community, such as service providers and traditional leaders. Health programs with a “gender transformative” approach, or an explicit focus on questioning gender norms and expectations, show promise in achieving GBV prevention outcomes. **IPPF and UNFPA, (2017)**

The desk review and informant interviews identified specific positive programming mechanisms of gender-transformative interventions to guide the package of services for men and boys SRHR in Botswana. The policy documents on SRH such as the 2gether 4 SRHR programme which is a Joint United Nations (UN) Regional Programme combining efforts from UNFPA, UNAIDS, UNICEF, and WHO, focused on strengthening the provision of integrated services, targeting adolescent girls and young people as well as key populations. In Botswana, since 2011, UNFPA collaborated with the Ministry of Health to scale-up the integration of Sexual and Reproductive

Health and Rights (SRHR), implemented HIV and Sexual Gender-based Violence (SGBV) services in thirteen (13) health districts under the 2gether 4SRHR programme since 2018. Since then, Botswana adopted the integration of SRHR, HIV, and SGBV services as a national strategy which has managed to enhance the transformative approach to SRHR in Botswana. Key transformation as noted when the country reviewed Laws and policies; and developed strategic plans and guidelines that link SRHR, HIV and SGBV and committed to the provision of comprehensive integrated services. A very important milestone to note is the capacity building which was conducted at the thirteen targeted districts. The voice of the key informants echoed the need for community based approaches in order to reach men who could be reluctant to visit health facilities. The other important themes which ran from transcriptions of the interviews community mobilisation, community involvement and participation and health education noted as key strategies for achieving a gender transformative programmatic approach. Similar to most African countries few gender-transformative interventions in Botswana addressed unequal power relations at the structural level (LaRocco, 2024, Ruane-McAteer et al., 2020).

It is worth noting that even though the SRH programming has been successful in Botswana in ensuring access to integrated SRH, HIV and SGBV services, the transformation has not been fully extended to men and boys. Facilitating men and boys to fully access integrated SRH and HIV services tailored to their needs remained limited. A workshop on held the 07th November, 2024 with the national stakeholders revealed that lack of access and coverage of men's health needs within the country. Moreover, interviews with key informants indicated that Botswana lags behind its regional neighbors in terms of transforming negative gender norms for example only 11.1% of seats in parliament were held by women. The informant echoed that gender-oriented civil society (like all civil society in Botswana) has been impacted by a lack of donor funding since the COVID-19 pandemic. The middle income status of Botswana led to reluctance of donors to fund SRH programs and the gender transformative movement and efforts. There has been limited resources allocated to the SRHR programs for men and boys in the country.

2.3.2 DELIVERING QUALITY GENDER-SENSITIVE SRH CLINICAL SERVICES

Upper-Middle-Income countries (UMIC) such as Botswana, present with a high aversion to the utilization of Sexual and Reproductive Health (SRH) services by men mainly due to men's poor

Health Seeking Behaviour (HSB) and concerns about the quality of services delivered to them. This is evident despite several international conventions, adopted programmes and policies that seek to educate men and boys on reproductive health services. The review of literature found that there was an apparent lack of focus on men's SRH by international programmes such as Sustainable Development Goals (SDGs) and Family Planning 2020 (FP2020), and a larger focus on women and youth, which ultimately contributes to the quality of SRH services for men (**Baker and Shand, 2017**). Furthermore, the review revealed that SRH service provision is often disjointed and unstructured for men's health needs and is mostly needlessly expensive (**De Silva, 2016**). It is worth-noting the Global Sexual and Reproductive Health Service Package for Men and Adolescent Boys warns that providing quality care to men and adolescent boys should not impact or weaken the quality of care provided to women and adolescent girls.

Box 2: Dimensions for achieving high-quality health care

Dimensions For Achieving high-Quality	
<input type="checkbox"/>	Care must be safe, effective and reliable, acceptable/client-centred, timely, efficient and equitable;
<input type="checkbox"/>	Services must be available, accessible and acceptable.
<input type="checkbox"/>	Clients have the right to information, choice, privacy and confidentiality, dignity and comfort, and continuity of services and consistent professional medical opinion;
<input type="checkbox"/>	The needs of service providers must be met to fulfil clients' needs. IPPF and UNFPA, (2017)

The informant interviews conducted with stakeholder revealed that men and boys face many challenges when they seek reproductive health services. Some of the themes which emerged from the interviews included policy constraints and discrimination (e.g. the ministry of Education advocates for abstinence and no condom distribution in schools while girls counter-parts who were initiated on FP methods receive FP services at school based facilities) operational barriers (operational hours), lack of information and a feeling of discomfort or embarrassment, and stigma and discrimination. The interviews also found that men and boys do not have access to male-friendly services compared to women. Furthermore the stakeholders for the workshop complained that even where attention has been given to the service-delivery needs of men and boys, the services were often delivered in a cursory manner that simply adds to

existing services tailored to women, rather than sufficiently addressing gaps in SRH care for men. Men clinics which are run by the private sector, are located mostly in urban areas and the cost of them was a barrier to accessing them. Informants who were clinical practitioners complained about the lack of male screening and other essential equipment necessary for the provision of service for men and boys seeking SRH services in the exception of those used in the SMC services. Most of the informants lamented about the lack of skills and knowledge for the practitioners to render SRH services for men and boys. One informant echoed that the mentality of “one size fits all, is not appropriate in the delivery of services for men. The informant emphasized that there is diversity even among men, hence the need for training and acquisition of tailor made skills for rendering services to men and boys. Moreover, informants stated that SRH services were mostly provided by female providers who out-number their male counterparts. This implies that men presenting at SRH clinics are more likely to be attended to by female providers. A workshop held with the stakeholders, some of whom were practitioners also pointed out that Botswana men were often uncomfortable discussing sexual issues with female providers. The experiences articulated above called the country to provide male friendly services described in *text box 3*.

Box 3: Male Youth Friendly Services

<p>What are Male Friendly Services</p> <ul style="list-style-type: none"><input type="checkbox"/> Care must be safe, SRH health services and programmes should better reflect the health needs of men and adolescent boys and encourage their appropriate use of services.<input type="checkbox"/> Such services should encompass coordinated and multidisciplinary SRH care, addressing both primary prevention and disease management.<input type="checkbox"/> Services should be provided to men by qualified staff in line with agreed quality of care standards. The range of barriers that men face when accessing and engaging with SRH services should also be appropriately considered, including whether the infrastructure of the health facility is male friendly, i.e. bathrooms for men and neutral decor.<input type="checkbox"/> Section 6 supports the operationalization of this service package in a male friendly manner (IPPF and UNFPA, 2017).
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2.3.3 TAKING A PRIMARY PREVENTION AND INTEGRATED APPROACH

In Botswana both the Ministry of Health (MOH) and the Ministry of Local Government are responsible for providing health care at different levels of the health system. The country has a

six-tiered health care delivery system: mobile stops, health posts, clinics, primary hospitals, district hospitals and referral hospitals. Strategic partnerships with Civil Society Organizations (CSOs) including the Botswana Family Welfare Association (BOFWA), the Botswana Network on Law and Ethics (BONELA), and Stepping Stones, have strengthened the provision of youth-friendly services, and promoted male involvement and gender mainstreaming. The BOFWA and the Young Women's Christian Association (YWCA) have been providing information and services about sexual reproductive health to young people in Botswana. While Botswana has an impressive network of reproductive health services and facilities widely available throughout the country, male-oriented reproductive health programs are out-numbered by those serving females. CSOs providing male services were few in the country and specialized male clinics were mostly located in urban areas.

Botswana has successfully managed to focus her attention on primary prevention and integration as part of the approach to SRH. Many lessons have been learned from providing quality SRH services to women and girls that should be built upon as part of improving SRH provision for men and adolescent boys. Such lessons include ensuring confidentiality and quality of care, appropriately training service providers, building organizational commitment and strengthening community-based health service delivery. Interviews with key informants captured the following themes on how services could have a more primary health focus; the need to integrate SRHR for boys into the school health program; a greater need for comprehensive sexuality education both in schools and at home; and the integration of health education and promotion activities at community gatherings such as Sunday soccer games, competitions on traditional music and songs and community gatherings called by traditional authorities.

2.3.4 MEETING MEN'S DIVERSE SRH NEEDS OFTEN REQUIRES A DIFFERENT APPROACH

Sexual and Reproductive Health (SRH) rights emphasize on the equality of men and women in the possession of healthcare. Despite this fact, only women have been considered the target group for the SRH programs. Achieving the SDG involves more than encouraging men to take responsible sexual behaviors, but a careful understanding of their concerns about the SRH. Men need a wide range of SRH services especially education and counseling that are influenced by social and demographic factors. One of the issues that came up during the meeting with stakeholders was that, based on evidence, the sexual and reproductive health needs of adolescent

boys and young men were not well addressed in Botswana, and that ABYM are severely affected by HIV and STIs as their female counterparts because of lack of information on their bodies. A key informant mentioned that men are dying from reproductive cancers such as prostate and testicular cancer as they lack information. Data on these cancers show high incidence rates of 23.9 and 12.4 per 100 000 per year for prostate and esophageal cancers respectively. It is also worth noting that, healthcare policies (e.g. Male involvement,) for men have mostly focused on their role in women's health about STIs including HIV and unwanted pregnancies. This revealed that, less attention was paid to men's SRH care needs. The most important reason for such a negligence is the lack of appreciation of the diversities of men and boy's SHR needs. It must be born in mind that dealing with men's SRH is different from providing services for women (as is the case vice-versa). It often requires a different way of speaking to men. For example, a key informant working at a center providing SRH to male, mentioned that men often present to their center with psychological symptoms requiring counselling services. Upon skillful assessment and history taking, these men disclose their actual STI concerns as opposed to the psychological complaint they reported initially. Moreover, the [\(IPPF and UNFPA, 2017\)](#) acknowledges that existing sex differences in health-care utilization, where many men do not access services, men's knowledge of SRH issues may also be low and they may feel embarrassed being seen at a health centre or discussing concerns about sex and sexuality.

In the context of Botswana, a key informant who is also a clinician, based at the Ministry of Health shared that a lot of men fear stigma and discrimination from family partner and community, and as such they often avoid seeking medical attention. The pressures to provide financial support for one's family or stress relating to their economic situation where men are the "bread winners" and feel inadequate. Informants reported that multiple visitation to health facilities may not be seen as the best use of one's time compared to seeking paid work.

Health systems factors such as encountering shortage of skilled staff, lack of medical equipment needed for delivery of services to men and boys or experiencing a breach of confidentiality/privacy may further discourage men from seeking medical treatment. A key informant who provided services to diverse group such as MSM reported to shortage of trained personnel, limited access to HIV information, condoms, treatment and instances of verbal abuse by service providers and other healthcare users.

Botswana, like other countries comprises of various men groups who have additional or slightly different sexual and reproductive health issues and needs, e.g. young men and adolescent boys, gay and bisexual men and other men who have sex with men, men and adolescent boys living with HIV, men who sell sex, men who inject drugs, and people identifying as men. The participants at the workshop held with stakeholders lamented about the lack of skilled manpower to provide services to the aforementioned groups. The second workshop captured unmet SRH needs for Men Sex Workers and Men having. These included victimizations (beating, removal of condoms during anal sex, receiving unethical services from health workers) discrimination and limited of access to HIV services which was also reported by (Matlapeng, 2023). The recommendation was that health care providers need to be trained to accommodate diverse needs and ensure access to stigma-free services.

The IPPF and UNFPA, (2017) advocates for services which reflect the health needs of men and adolescent boys which encompass coordinated and multidisciplinary SRH care, addressing both primary prevention and disease management. The services package also recommends that services should be provided to men by qualified staff in line with agreed quality of care standards. The range of barriers that men face when accessing and engaging with SRH services should also be appropriately considered, including whether the infrastructure of the health facility is male-friendly, i.e. bathrooms for men and neutral decor.

2.3.5 INCLUDING A FOCUS ON YOUNG MEN AND COUPLES

The East and Southern African region, has a young demographic profile, hence the key regional commitments on sexual and reproductive health and rights (SRHR) have begun to more intentionally consider the needs of adolescent boys and young men. A desk review revealed that the Southern African Development Community (SADC) Regional Strategy for SRHR (2019–2030) calls for Member States to engage men and boys as partners, and as individuals with their own SRHR needs. Furthermore, the Botswana draft services package for Reproductive, Maternal, Newborn, Child and Adolescent Health (Botswana RMNCAH Strategy 2018-2022) is more explicit on the needs of adolescent boys and men.

Adolescence is a stage where gender and sexual norms are usually established. A typical characteristic of this stage is role confusion which can influence the sexual and reproductive health needs of young boys. Adolescence is also a time often marked by a lack of knowledge about changes in their own and that of the female body, and concerns about sex, masturbation and sexual dysfunction issues. It is also worth noting that adolescence and emerging adulthood are specific periods in which an individual is characterized as risk-taking, irresponsible and lacking control in relation to their own health. A stakeholder at the meeting echoed that, these behavioural traits are mostly prevalent in school environment. These young men may fear accessing reproductive services outside school due to embarrassment and to stigma from their community or peers, and too often when they do access such services and information they face prejudice from service providers. The [IPPF and UNFPA \(2017\)](#) warns that providing accurate SRH information to adolescent boys and young men can help them adopt safer sexual practices, and more openly discuss their feelings and concerns. It can also help this group approach sexual relationships in a more healthy, supportive and respectful manner. As part of this approach, improving parent-child communication around SRH issues is also very important.

Working with young couples, provides a critical window of opportunity to reaching men (of any sexual orientation), particularly given men's lower engagement with the health system. In Botswana, women too often bear the burden of responsibility for accessing SRH services and the maintenance of SRH within their families, a couples approach also provides opportunities to challenge this gender inequality. Key informants appreciated the positive impact the couples HIV testing approach used by HIV testing centers had in reducing the transmission of HIV from mother to the child in Botswana, and lamented on the need for programs to be inclusive of the MSM and Male Sex Workers. Given that most of the interventions for SRH generally require support from both partners, creating safe spaces where men and women can be provided with services and information together is essential.

2.3.6 ADAPTING TO THE CONTEXT AND LOCAL NEEDS AMONG MEN

The provision of SRH services takes place across many different contexts. In Botswana these contexts include; the six tier hierarchical network of public facility PHC settings, private facilities

found in urban areas and few male clinics. In order to focus on men's SRHR, key informants who were also assigned to be members of a TWG for the development of services packages were engaged. The informants identified the following barriers in the community to men accessing SRHR services.

- Lack of access to specialised men and boys clinics
- Work commitment and the pressure to provide for the family interferes with finding time for SRH services needs
- Men and adolescent boys living in hard to reach places like the cattle post do not have access to SRHR services
- Cultural norms, whereby men fear lack of confidentiality; “ga ba batle dikgang tsa bone di utlwa ke batho”
- Lack of laws advancing men and adolescent boys' SRH and uncoordinated efforts of implementing policies on men and boys SRH.

When asked about the components of service package best-suited to men's needs in Botswana, key informants emphasised on the need for community based approaches. A recurring theme for preference of community based services was the low seeking behavior prevalent amongst men. An informant working with men and boys emphasised the need for psychological services package within the community settings. The informant further highlighted on the issues of; passion killings, the prevalent practices of failure to disclose symptoms of STIs, and reluctance of men in seeking medical services.

2.3.7 BUILDING A COMMITTED ORGANIZATION AND WORKFORCE

The ICPD advocates for partnership between men and women so that men can better understand and participate in SRH issues. Botswana has demonstrated commitment to improving the health status of men and women across the age spectrum. The country has addressed gender equality in a number of policy documents including National Population Policy, Revised National Policy of Education, National Policy on HIV and AIDS, and National Policy on Culture. The Ministry of Health in Botswana has undertaken an initiative to integrate the HIV/TB and SRH into various policy documents. The recent development is the integration of TB/HIV/RMNCAH/GBV training curricula which targets the clinical and the community cadre.

The consultant assessed the availability of SRH policies for men and boys using the IPPF policy on men and SRH template. The finding of the mini assessment are presented in **table 3 below**; show that good country progress in developing relevant policies to respond to male SRHR concerns.

TABLE 3: AVAILABILITY OF SRHR POLICIES & GUIDELINES FOR MEN & BOYS

Key Elements of the Policy	Available		Elaborate Your Response
	Yes	No	
Men and sexual and reproductive health (IPPF Policy)			
Men's role in promoting gender equity in health	X		Prevention and management of GBV, a guide for health care workers
Reaching boys and young men	X		VMMC and Men's health strategy Coaching boys into young men
Men as partners in preventing HIV & other STIs	X		STI guidelines HIV clinical guidelines
Men as partners in the provision of safe abortion services	X		There is none
Men as partners in improving access to services	X		PMTCT School health policy
Strategy on adolescents and youth (UNFPA 2013)			
Promote comprehensive sexuality education	X		ASRH strategy FP 2030
Promote youth leadership and participation	X		National Youth policy DREAMS project
Gender equality (IPPF Policy 1.3)			
	x		Prevention and management of GBV, a guide for health care workers

It is also worth noting that Botswana has not provided specialist training to make staff feel more comfortable providing SRHR services to men in all their diversity, building their understanding of the common SRHR issues that men have, and empowering them to provide non-judgemental services ([Mashumba and colleagues 2024](#); [Matlapeng, 2023](#)). The key themes on this are were lack of skills and capacity on the part of the service providers, an indifferent mind set of some providers in attending to key populations. The latter was reported as religious or cultural clash between the belief systems of the provider and the client (see *code book*)

SECTION 3: SRHR SERVICE FOR MEN AND BOYS

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In recent years, there has been a growing recognition of the need to address the SRH needs of men and boys. In 2017, UNFPA and IPPF issued the Global Sexual and Reproductive Health Service Package for Men and Adolescent Boys to help standardize male SRH care (Aantjes, 2024). A combination of SRH services are required to respond effectively to the needs of men and adolescent boys in all their diversity. This combination comprises of two sets of packages 1. Facility-Based and 2. Community-Based SRH services for men and boys. The provision of the above packages follows a gender-transformative approach whereby whether it is done in the health facility, at school, workplace or in the community it must actively integrates information on gender norms and roles, and the importance of men to take responsibility for their own, and their partner's and family health and wellbeing (UNFPA and IPPF, 2017). In an attempt to align with these policy and programming efforts, signatories of the International Conference on Population and Development (ICPD) Programme of Action committed to crafting policies and strategies that would more actively involve men in sexual and reproductive health programmes and family life (Aantjes, 2024). Botswana as a signatory to ICPD adopted and contextualized the recommended components of the 12 categories of facility and community-based services. Figure 1 shows the component headings plus three community-based services.

3.1 Facility-Based Services



FIGURE 1: COMPONENT HEADINGS FOR FACILITY BASED SRHR SERVICES

3.2 Community-Based Services

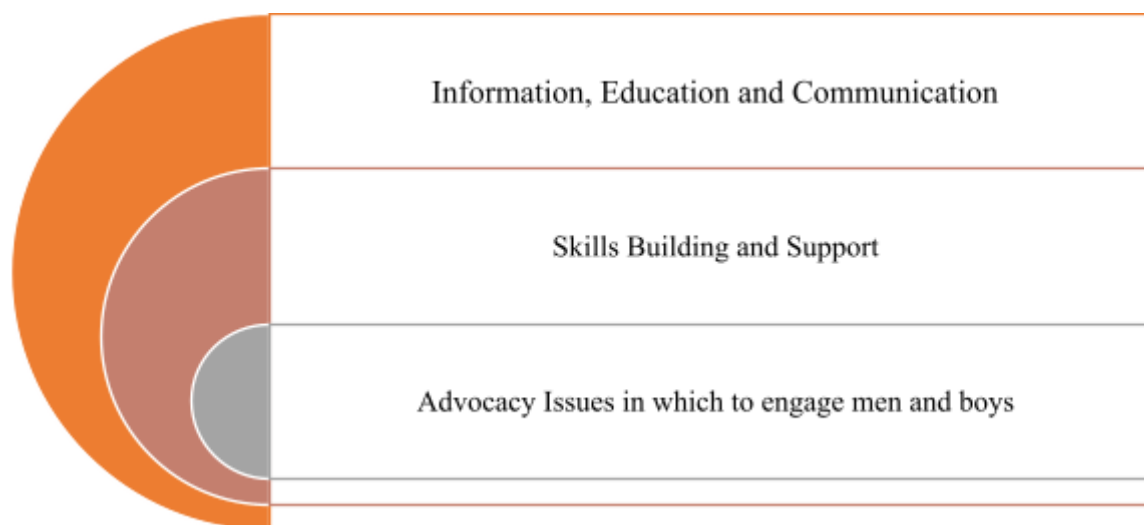


FIGURE 2: COMPONENT HEADINGS FOR COMMUNITY BASED SRHR SERVICES

TABLE 4: ADDITIONAL DETAILS OF FACILITY BASED SRHR SERVICES

Facility-Based SRH services for men and adolescent boys	Detailed Components
1. History Taking	a. Take a standard medical history
	b. Take a detailed sexual health assessment (including sexual function and satisfaction)
	c. Assess for fertility intentions
	d. Take a cancer evaluation (as appropriate)
	e. Assess for experience of sexual and gender-based violence, including intimate partner violence (initial assessment questions)
	f. Assess for alcohol, tobacco and other substance use
	g. Assess for mental health including depression
	h. Assess for nutrition, food availability, diet and exercise
	i. Assess for immunizations/vaccinations
	j. Take a history for sexual and reproductive-related male cancers
	k. Refer for any abnormalities

2. Physical Examination	a. Measure height and weight, and calculate Body-Mass Index (BMI)
	b. Measure blood pressure
	c. Conduct external genital and perianal exam
	d. Conduct other physical exam relevant to men and adolescent boys from history using clinical judgement
	e. Refer for any abnormalities
3. Family Planning	a. Counsel client (if not undertaking couple counselling) and provide information on all available contraceptive options, his role in this, and how to be supportive and communicate with his partner in choosing the contraceptive option that works for them.
	b. Counsel a couple (if partner agrees) and provide information on all available FP methods.
	c. Provide condoms and condom-compatible lubricant, and other contraceptive methods including emergency contraception
	d. Provide vasectomy services (or referral)
4. Sexually Transmitted Infections (STIs)	a. Counsel client and provide information on STIs, including couple counselling (if partner agrees)
	b. Conduct external genital and perianal exam (as part of syndromic management)
	c. Use the syndromic approach to diagnose STIs. Provide etiological diagnosis of STIs (diagnostic testing as per flowchart).
	d. Treat STIs following syndromic management or etiological diagnosis as per the guidelines
	e. Counsel client and provide support for partner(s) notification for STIs (give a contact slip) and facilitated treatment (where applicable)
	f. Provide condoms and condom-compatible lubricant
	g. Provide HPV and Hepatitis B vaccinations as per guidelines
	h. Provide viral hepatitis services including prevention, screening and treatment per the guidelines.
5. HIV and AIDS	a. Provide HIV testing services (including education and counselling)
	b. Provide condom and condom-compatible lubricant
	c. Provide antiretroviral treatment for HIV (or referral) including initiation, monitoring and adherence support
	d. Provide pre-exposure prophylaxis (PrEP) for HIV
	e. Provide post-exposure prophylaxis (PEP) for HIV
	f. Provide voluntary medical male circumcision (VMMC)
	g. Counsel client on how to support partner in preventing mother-to-child transmission of HIV (if partner wants)
	h. Diagnose, manage and prevent HIV-related coinfections and co-morbidities
	i. Provide care and support for men and adolescent boys living with HIV
6. Disorders of the male reproductive	a. Diagnose and counsel client on sexual dysfunctions (erectile dysfunction, delayed ejaculation, premature ejaculation), and provide referral

system, & sexual dysfunction	b. Treat or refer for sexual dysfunctions (erectile dysfunction, delayed ejaculation, premature ejaculation)
	c. Treat or refer for other disorders of the male reproductive system (warts, varicoceles, urological disease, etc.)
	d. Screen and treat urinary tract infections (or refer)
7. Male cancers	a. Counsel client on sexual and reproductive-related male cancers (prostate, testicular, penile, anal, breast)
	b. Take a history for sexual and reproductive-related male cancers
	c. Refer for further investigation and management as necessary.
	d. Counsel client on how to support partner during treatment and care (if partner wants)
8. Fertility and infertility	a. Counsel client on basic fertility awareness including preconception health
	b. Counsel couples for conception (if the partner agrees)
	c. Counsel client on infertility
	d. Provide basic infertility care for men, including semen analysis
	e. Treat for infertility/provide assisted reproduction or refer
	f. Counsel client (and partner) on adoption or refer
9. Supporting prenatal and postnatal care, including safe motherhood	a. Counsel client on preconception, support during pre-and post-natal period and care-giving.
	b. Provide links to a support group for expectant and new fathers / classes on parenting/ fatherhood skills
	c. Paternity leave
10. Supporting Pregnancy loss	a. Counsel clients who are partners in pregnancy loss care on the role they can play as a source of support
	b. Support client to be a supportive partner and to participate in pre- and post-abortion care counselling sessions (if the partner wants)
11. Sexual and gender-based violence (SGBV) support	a. Screen for experience of SGBV, including intimate partner violence
	b. Counsel and support clients affected by violence and refer for clinical, psychosocial and protection services
	c. Refer clients who have a history of perpetrating SGBV to a relevant programme/support group
12. Information and counselling	a. Provide information and counsel client on sex, sexuality and sexual health, including pleasure (for man and partner)
	b. Provide information and counsel client on self-confidence and self-esteem.
	c. Provide information and counsel client on relationships and non-violent sex communication and negotiation
	d. Provide information on comprehensive sexuality education (CSE), values and gender equality, with specific focus on role of men, to reach in and out-of-school youth.

	e. Provide information on genital/anal health and hygiene
	f. Counsel client and provide information on stigma reduction, particularly in the context of HIV and other STIs

The service packages in **table 4** above are based on the standard set-up of SRH services in Botswana; and tend to include both a static “first level” clinic and outreach SRH services to communities. It is important to note that the client has the right to refuse any service offered (except in the case of being suicidal and/or homicidal, which can be grounds for detainment in accordance with the medical practice of Botswana) (**Mental Disorders Act, 1971**). There is no expectation that every service in the table above should be provided in a single facility or a single client encounter. The service mix needs to be based on the expertise and resources available in the facility and an understanding of the needs of the community which the facility serves. For the healthcare providers, taking a detailed history of a new client is particularly important. The provider then offers the required services based on current national service standards or refers as necessary, either within the facility or to another facility. For services that are not provided, effective referrals systems should be set up that include mechanisms to ensure a client receives the service referred for and any necessary follow up.

Community-Based Services

Community based services shown on **table 5** below follows that integrated health services package. The service package in this section will be delivered mostly by community workers, peer to peer program and men`s health organizations deployed at local CSOs.

TABLE 5: COMPONENTS OF COMMUNITY BASED SRH SERVICES

SRH Services	Community Based	Components
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INFORMATION, EDUCATION
AND COMMUNICATION

- a. Basic sex and SRH education, including sexuality and sexual orientation, pleasure and anatomy, libido, masturbation and related myths
- b. Genital health and penile hygiene (e.g. reduction)
- c. Contraception choices and men's supportive role in making a contraceptive choice with their partner
- d. Infertility
- e. Prevention and treatment of STIs and HIV
- f. Supportive involvement in prenatal and postnatal care, materials on fatherhood/men's role as a parent
- g. Mental health and psychosocial support
- h. Stigma reduction, particularly for HIV and other STIs
- i. Awareness and prevention of SRH-related male cancers
- j. Drug and alcohol dependence or overuse
- k. Tobacco dependence



SKILLS BUILDING AND
GROUP SUPPORT

- a. Pregnancy and STI prevention (including HIV)
- b. Fatherhood and maternal health, newborn and child health and development skills
- c. Non-violent communication and negotiation in relationships (between couples/other caregivers, on shared caregiving and domestic responsibilities, and with children)
- d. Awareness of risk-taking behaviour and the effect this can have on their own and their partners sexual and reproductive health
- e. Engaging men in SGBV prevention
- f. Comprehensive sexuality education, values and gender equality, support for women and girls' rights including reproductive rights, with specific focus on role of men and to provide positive images of more gender-equitable men
- g. Support groups for men (such as groups for men living with HIV), and Treatment retention



ENGAGEMENT
IN ADVOCACY

- a. Greater focus on men and adolescent boys within national SRH & HIV laws and policies
- b. Comprehensive abortion care services and stigma-free environment.
- c. Increasing and promoting shared parental leave
- d. Engaging men in SGBV prevention
- e. Engaging men as partners in supporting prenatal and postnatal care, including safe motherhood
- f. Creating an enabling policy environment that addresses discrimination and violence against men, for example men who have sex with men, and transgender men and other gender-nonconforming individuals, male sex workers, men who inject drugs, male prisoners

g. Acceptance of adolescent sexuality and SRH and creating an enabling policy and legal environment that aims to dismantle barriers to adolescent SRH
Funding for SRHR men and boys programs

** Not all components need to be provided for each client. The components provided will depend on the specific needs of each client.*

SECTION 4:

DETAILED SUMMARY OF SRHR FACILITY-BASED SERVICE COMPONENTS

SECTION 4: DETAILED SUMMARY OF SRH FACILITY-BASED SERVICE COMPONENTS

This section describes the 12 facility-based service components introduced in section 3 above. Specifically, further explanation and key activities for each component are listed, as well as resources to consult for additional information (for example, on considerations of commodities and medical equipment). Please note that the implementation of these services should be in line with global (e.g. UNFPA and IPPF, 2017) regional (e.g. Agenda 2063 Maputo Plan of Action (2016-2030) Strategy for SRHR in the SADC Region 2019-2030, Revised SADC Protocol on Gender and Development (2016) , Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the in the SADC Region (2015) and national policy frameworks (Botswana Integrated Health Services Plan (2010), Essential Health Service Package for Botswana (EHSP) (2010), Botswana Integrated Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH+N) Strategy (2018–22), Botswana SRHR and HIV and AIDS Linkages Integration Strategy and Implementation Plan). It is of paramount importance to note that the document driving the delivery of the packaged services in this policy shall be the National Guidelines on Health Service Integration (2021).

4.1 Details of Facility Based SRHR Services for Men & Boys

A number of these service components are already required to be provided to men as part of existing national guidelines in Botswana, and the health sector organizations should ensure their compliance with such commitments. In addition, many of the service components depicted in *table 7* are also relevant for women and are currently being provided to women within many service provision contexts. Therefore, they should continue to be provided to women, and extended to men, where that is not currently the case.

TABLE 6: DETAILS OF FACILITY SRHR SERVICES

SRH Facility-Based components by Category	Key details and activities	Related guidelines and resources for further information
1. History Taking questions on male client		
a. Take a standard medical history	Assess for medical and surgical history, current medical conditions and medications and allergies reason for visit, and current/impending fatherhood status.	Ministry of Health (2010) The Essential Health Service Package for Botswana
b. Take a detailed sexual health assessment (including sexual function and satisfaction)	<p>Ask the male client about their sexual history including:</p> <ol style="list-style-type: none"> 1) Sexual practices/behaviour 2) Sexual partners, current and recent 3) Sexual function and satisfaction, including level of interest in sex, change in libido, regularity, erectile dysfunction, any difficulties during sexual intercourse, and level of satisfaction. Refer to category 6 for further details. 4) Current and future pregnancy prevention/family planning as appropriate 5) Current use of SRH and HIV medicines and commodities 6) STI/HIV protection 7) Past STI/HIV history <p>Ask if the client has any questions about sex. Note that it is particularly important to ask men about sex, given stigma in such areas.</p>	<p>Ministry of Health (2010) The Essential Health Service Package for Botswana.</p> <p>Ministry of Health (2012) Sexual and Reproductive Health Policy Guidelines and Service Standards</p> <p>Strategy for Sexual and Reproductive Health and Rights in the SADC Region 2019-2030</p>
c. Assess for fertility intentions	Determine fertility intentions and whether there are any known difficulties with fertility. If the intention is not to have children at present – ensure there is knowledge about contraceptive options available. Refer to category 3 for more details.	Ministry of Health (2012) Sexual and Reproductive Health Policy Guidelines and Service Standards
d. Take a cancer evaluation (as appropriate)	<p>Ask about family history of prostate, testicular and breast cancer.</p> <p>Depending on the age of the client, assess whether the client has ever had a prostate exam, or conducted a self-testicular exam. Provide age-appropriate follow-up testing and treatment for cancer, as needed.⁵⁴</p> <p>Note that there is no internationally-agreed standard or routine screening method for prostate and testicular cancer. In the US, routine examination of the testicles for testicular cancer is not recommended in asymptomatic adolescent and adult men, and advice differs on the use of</p>	<p>Ministry of Health (2010) The Essential Health Service Package for Botswana.</p> <p>Ministry of Health (2012) Sexual and Reproductive</p>

	<p>prostate-specific antigen (PSA)-based screening for prostate cancer. However, it is important that clinicians and health providers are aware of its signs and symptoms, and can provide appropriate information to clients, where applicable. Moreover, the male genital examination still remains an important part of the male physical examination (beyond the need to screen for testicular cancer). See category 7 below, and resources for further information</p>	<p>Health Policy Guidelines and Service Standards</p> <p>Strategy for Sexual and Reproductive Health and Rights in the SADC Region 2019-2030</p>
<p>e. Assess for experience of sexual and gender-based violence including intimate partner violence (initial assessment questions)</p>	<p>Conduct initial assessment for history of incidences of all forms of violence and abuse, physical, emotional/mental, including sexual violence and domestic violence. It is important to remember that some men may be apprehensive about discussing violence, such as rape and partner abuse. This should include assessing both experience and perpetration of violence, as well as a history of exposure to childhood family violence (given links between childhood experience of violence and future perpetration in men).⁵⁶ If there is an indicator of any of the above conduct a fuller assessment and provide counselling and referrals, as appropriate, as outlined in category.</p>	<p>Prevention and of Gender-Based Violence; A guide for Health care workers, 2021.</p>
<p>f. Assess for alcohol, tobacco and other substance use</p>	<p>Assess for alcohol use, other substance use and smoking habits/use of other tobacco products, and whether use is having deleterious consequences for the client or others. Counselling should then be provided based on assessment, with referral to behavioural interventions to reduce alcohol/other substance use and smoking cessation, as appropriate, acceptable and available.</p>	
<p>g. Assess for mental health including depression</p>	<p>Assess for signs of depression, anxiety, stress and other mental health issues, including risk of suicide, homicide and other forms of violence. This is important given the high reported global rates of male depression and links to SRH and HIV, risk-taking behaviour specific for SRHR, as well as high levels of male suicide.⁵⁷ If positive findings, probe in accordance with relevant national standards and refer as appropriate.</p>	<p>Mental health Act</p>
<p>h. Assess for nutrition, food availability, diet and exercise</p>	<p>Assess nutritional status, food availability, diet and level of exercise. This is important given benefits of a healthy diet and regular exercise, and links between poor diet/insufficient exercise and male SRH problems, such as decreased fertility and libido. Provide counselling and referrals as appropriate</p>	

i. Assess for immunizations/vaccinations	<p>Assess past receipt of SRH immunizations or care. Offer (or refer) all clients for:</p> <ul style="list-style-type: none"> • Routine vaccination recommended for at risk men and adolescent boys, particularly MSM and those living with HIV. • Hepatitis B (HBV) vaccination among boys aged below 19 years and for all at risk men, particularly MSM, people who inject drugs, and people living with HIV. HBV vaccination is recommended as standard during infant immunization. • Hepatitis A, recommended for MSM (in some contexts). 	
2. Physical exam of male client		
a. Measure height and weight, and calculate Body Mass Index (BMI)	<p>Assess all men and adolescent boys for obesity, including measuring their weight, height and calculating body mass index (BMI). Obese men should be referred for counselling and behavioural interventions.</p>	
b. Measure blood pressure	<p>Measure blood pressure. This should be every two years if normal (blood pressure <120/80), every year for young people, and every year for those with pre-hypertension (blood pressure 120-139/80-89)</p>	
c. Conduct external genital and perianal exam	<p>Perform examination of the external genital and perianal (around the anus, the opening of the rectum). Document developmental stage, and other genital findings including discharge, phimosis, lesions/ulcers, etc. Examine skin and hair, inguinal nodes, scrotal contents, penis and the perianal area.</p> <p>In addition, a physical examination should be conducted as part of an evaluation for male infertility with particular focus given to:</p> <ol style="list-style-type: none"> 1) examination of the penis, including the location of the urethral meatus 2) palpation of the testes and measurement of their size 3) presence and consistency of both the vas deferens and epididymis 4) presence of a varicocele and hydroceles 5) secondary sex characteristics 6) a Digital Rectal Exam (DRA) 7) Proctoscopy (when required) 	
d. Conduct other physical exam(s) relevant from history using clinical judgement	<p>Based on the history information provided in section 1, any other physical exam should be provided following standard medical practice and clinical judgement.</p>	

3. Family Planning		
<p>a. Counsel client (if not undertaking couple counselling) and provide information on all available contraceptive options, his role in this, and how to be supportive and communicate with his partner in choosing the right contraceptive option that works for them both</p>	<p>In addition to the above, provide information on the role men can play in supporting, and being involved in, pregnancy prevention/family planning. This can include men doing the following:</p> <ul style="list-style-type: none"> • Use male contraceptive methods, such as condoms and vasectomy. • If female controlled method, help with this method if female partner so desires (e.g. by helping insert the spermicide, if needed, or reminding her when to use it), and if the partner is not using a female condom, then consider also simultaneously using a male condom for dual method use as a back-up and to prevent HIV and other STIs. • Support by using an alternative method (such as withdrawal or condoms) in case the female partner forgets to use or has an unexpected problem with her chosen method. • Provide financial support (e.g. by helping his partner pay for the method). • Provide emotional support (e.g., by accompanying his partner to the clinic, discussing the reasons for choosing one method over another, and/or supporting her choice of method). <p>See resources section for strategies on involving men in family planning</p>	<p>Ministry of Health (2010) The Essential Health Service Package for Botswana.</p> <p>Ministry of Health (2012) Sexual and Reproductive Health Policy Guidelines and Service Standards</p> <p>Strategy for Sexual and Reproductive Health and Rights in the SADC Region 2019-2030</p>
<p>b. Counsel a couple (if partner agrees) and provide information on contraception including promotion of dual protection</p>	<p>Offer couple counselling to male and female partners during family planning visits and provide only if female partner consents to this. Provide information (individually or with couples) on the various types of contraceptive methods, and their effectiveness, merits, and side effects, and help the couple/individual client choose a method and explain its use. As most methods are female-controlled, encouraging couple communication around family planning, and that men provide support to their partners in this area, is essential (including the lactational amenorrhea method (LAM) and fertility awareness methods) and the man's role in supporting his partner in effectively following these methods. Highlight the importance of triple protection from HIV, other STIs, and unintended pregnancy, and that family planning can help women and men plan and space births and prevent unintended pregnancy. Couple counselling should ideally be linked to the provision of skills development on equitable and safe negotiation around sex (see resources section)</p>	

<p>c. Provide condoms and condom compatible lubricant and other contraceptive methods, including emergency contraception</p>	<p>Condoms (male and female) should be readily available for men women, and widely distributed to men in various community settings. Provide condoms along with instructions about correct and consistent use as well as condom-compatible lubricant. Other contraceptive methods, particularly emergency contraception, should be made available to men on behalf of their partners.</p> <p>Condom demonstration models should be availed for educating on correct use.</p>	
<p>d. Provide vasectomy services (or referral)</p>	<p>Vasectomy is one of the few male-only methods of contraception, and clients should be informed about and given access to the procedure along with the entire range of contraception available. It is a male sterilization procedure that prevents the passage of sperm into the ejaculation fluid by blocking the spermatic cords (vasa deferentia). Men can either receive conventional (incisional) vasectomy or noscalpel vasectomy (NSV). NSV has a number of advantages.</p> <p>Provide pre-vasectomy counselling. Inform men about the effectiveness of vasectomy, potential side effects/complications, and degree of permanency. Highlight that this method does not provide protection from HIV and other STIs. Undertake the procedure. Undertake a post-vasectomy semen analysis.</p>	
<p>4. Sexually transmitted infections (STIs)</p>		
<p>a. Counsel client and provide information on STIs, including couple counselling (if partner agrees)</p>	<p>Provide information on the various types of STIs, including transmission, symptoms, and prevention techniques for all STIs, including HIV (see category 5 below), and how STIs can be detected and treated. Emphasize harm reduction, safer sex and dual protection.</p> <p>Following a diagnosis, recommend that the client notify their sexual partners, so that they, too, can be tested and treated. See category 4c below.</p> <p>Counselling should ideally be linked to the provision of skills development, including how to correctly and consistently use condoms, and equitable and safe negotiation around sex (see resources section).</p> <p>Job aids/IEC should be freely and easily accessible</p>	<p>EHSP</p> <p>National Guidelines on Health Services Integration (2021)</p>
<p>b. Conduct external genital and perianal exam (as part of syndromic management)</p>	<p>The specific approach to syndromic management for STIs for men should be based on national guidelines for the diagnosis and treatment of STIs and local/national prevalence. The general approach is outlined below.</p>	

	<p>STIs are often easier to detect with men rather than women, as men as it is easier to detect specific signs and symptoms such as urethral discharge and genital ulcers. As such, syndromic management of STIs (Treatment of STIs based on signs and symptoms) can be very effective with men. By performing genital and anorectal examination, it is possible to look for symptoms of STIs, including urethral discharge (often gonococcal or chlamydial infection) and genital ulcers (often syphilis, chancroid or genital herpes).</p> <p>It may also be important to look for anorectal infections, as ulcers can also appear in this area, as well as anorectal discharge (often gonococcal or chlamydial infection). Other syndromes can also be managed, but it is important to recognize the limitations of syndromic management.</p>	
<p>c. Provide etiological diagnosis of STIs (diagnostic testing), i.e. laboratory and microscopy</p>	<p>The specific approach to etiological diagnosis of STIs for men should be based on national guidelines for the diagnosis and treatment of STIs and local/national prevalence. The general approach is outlined below.</p> <p>Serological tests are available for the laboratory diagnosis of syphilis, Hepatitis B and Hepatitis C. Similar to HIV, rapid point-of-care diagnostic tests are available for serological syphilis diagnosis.</p> <p>Diagnosis of chlamydia and gonorrhea requires laboratory diagnosis through microscopy or AAT/PCR (Nucleic Acid Amplification Test/Polymerase Chain Reaction) of either a urine sample or urethral/anorectal/pharyngeal swab.</p> <p>Etiological diagnosis of STIs (or diagnostic testing) is problematic in many settings due to the length of time it takes, the need for trained laboratory staff, resources required and costs</p>	
<p>d. Treat STIs following syndromic management or etiological diagnosis</p>	<p>The specific approach to STI treatment for men should be based on national guidelines for the diagnosis and treatment of STIs. The general Approach includes providing treatment for STIs based on syndromic management or etiological diagnosis. Where treatment is not available, clients must be referred.</p>	<p>Syndromic management of STI</p>
<p>e. Counsel client and provide support for partner notification for STIs and facilitated treatment (where applicable)</p>	<p>Partner notification for STIs is encouraged, where possible. Notification can be active (where the facility makes contact with the partner) or passive (where the facility asks the clients to inform or bring their partners). This should be discussed with the client during post-test counselling, and support provided. The specific approach should be based on national guidelines for the diagnosis and treatment of STIs.</p>	

<p>f. Provide condoms and condom compatible lubricant</p>	<p>Consistent and correct use of male condoms reduces sexual transmission of many STIs, including HIV. Condoms (male and female) should be readily available, affordable, accessible and of quality, and widely distributed to men in various community settings.</p> <p>Condom-compatible lubricants (i.e. water- or silicone-based) should also be available, as can decrease risk of condom failure, especially for anal intercourse.</p> <p>Always demonstrate condom use.</p>	
<p>g. Provide HPV and Hepatitis B vaccinations</p>	<p>HPV is mainly transmitted through sexual contact and can lead to cancers of anus and penis in men. Non-cancerous types can cause genital warts, which are very common and infectious, and respiratory papillomatosis. HPV vaccines have been approved in many countries and are recommended for boys before the onset of sexual activity to prevent genital cancers and genital warts. Hepatitis B attacks the liver, which can cause acute and chronic disease, such as cirrhosis of liver or liver cancer and is spread by blood, semen and other bodily fluids. Hepatitis B vaccine is recommended for infants to prevent infection.</p>	
<p>Provide viral hepatitis services including prevention, screening and treatment</p>	<p>Hepatitis B and C are blood-borne viruses and hepatitis B is also spread by semen and other body fluids. It is recommended that screening be offered to individuals belonging to a population with high Hepatitis Virus prevalence or risk/exposure behaviour, in particular, injecting drug use through the sharing of injection equipment.</p> <p>Hepatitis B attacks the liver, which can cause acute and chronic disease, such as cirrhosis of liver or liver cancer. Oral treatments are recommended (tenofovir, entecavir) since they are the most potent at suppressing the hepatitis B virus. Antiviral drugs, called direct antiviral agents (DAA) are the newest, more effective therapies. There is no vaccine for hepatitis C.</p>	
<p>5. HIV and AIDS</p>		
<p>a. Provide HIV testing services (including information and counselling)</p>	<p>HIV testing services (HTS) are key for men to know their status. It must always be voluntary and free from coercion. The HIV testing process should be guided by the WHO's "5 Cs" of HTS: Consent; Confidentiality; Counselling; Correct results; and linkage to Care.</p> <p>Provide male clients who test positive with HIV prevention, treatment and care services. Those clients who test negative should be provided with prevention programmes and encouraged to undertake retesting at a later stage. HTS must be part of a comprehensive programme, with clear</p>	<p>National Guidelines on Health Service integration (2021)</p> <p>Hand book of the Botswana 2016 integrated HIV Clinical Care Guidelines</p>

	<p>links between testing and HIV prevention, treatment and care services. Counselling remains an essential component of HIV testing services with pre-test information and post-test counselling. Pre-test information can be provided in a group setting, but everyone should have the opportunity to ask questions in a private setting if they request it. All HIV testing must be accompanied by appropriate and high-quality post-test counselling, based on the specific HIV test result and HIV status reported. Post-test counselling offers a valuable opportunity to provide accurate information about safer sex and harm reduction that is relevant to the person being tested, as well as other SRH-related care.</p> <p>Provide couples HTS, where possible and there is no risk of resulting violence. This will support couples to test together and mutually disclose their HIV status, and make informed decisions about HIV prevention and offer each other support for obtaining and adhering to ART. HTS for couples or partners should be offered to anyone, regardless of how they define their relationships. Provide alternative HIV testing methods such as through mobile clinics, workplace testing, door-to-door testing and self-testing, including the use of rapid, point-of-care HIV diagnostic tests. Further details on HTS are provided in the resources section.</p>	<p>PEP Guidelines</p> <p>Guidelines on pre-exposure prophylaxis (PrEP) guidelines</p> <p>Ministry of Health (2010) The Essential Health Service Package for Botswana.</p> <p>Ministry of Health (2012) Sexual and Reproductive Health Policy Guidelines and Service Standards</p>
<p>b. Provide condoms and condom compatible lubricant NB: also under contraceptives & STIs</p>	<p>Consistent and correct use of male condoms prevents sexual transmission of many STIs, including HIV. Condoms (male and female) should be readily and cheaply available for men and widely distributed to men in various community settings. Condom-compatible lubricants (i.e. water- or silicone-based) should also be available, as can decrease risk of condom failure, especially for anal intercourse. The provision of condom and condom-compatible lubricant should therefore be a key part of HIV prevention strategies.</p> <p>Use condom models to demonstrate correct condom use</p>	<p>STI guidelines</p>
<p>c. Provide antiretroviral treatment for HIV (or referral) including initiation, monitoring and adherence support</p>	<p>Evidence highlighting the potential of HIV antiretroviral treatment (ART) to reduce HIV transmission by suppression of viral load, supports the early initiation of ART. It is important to also be aware of the current lower rates of ART access among men compared to women, especially in sub-Saharan Africa, men's challenges associated with ART adherence, and men's greater likelihood to be lost to follow-up or to die while on ART</p> <p>Provide ART to those testing positive with a CD4 count of ≤ 500 cells/mm³, or refer the client to another ART provider. ART should be</p>	<p>Handbook of the Botswana 2016 integrated HIV clinical care guidelines</p>

	<p>used in combination with other interventions, such as the provision of condoms.</p> <p>The current HIV treatment guidelines for Botswana, recommend initiation of ART regardless of CD4 count for the HIV-positives. Sero-discordant couples are offered PrEP. For HIV prevention. Early ART initiation is also recommended for clinical reasons for people co-infected with HIV and hepatitis B virus with severe hepatic disease and/or active TB. Provide follow-up support for drug adherence among men initiated on to ART.</p>	<p>Botswana HIV Prevention Road Map 2023-2025</p>
<p>d. Provide pre-exposure prophylaxis (PrEP) for HIV</p>	<p>Oral pre-exposure prophylaxis (PrEP) of HIV is the use of ARV drugs by people who are not living with HIV to prevent the acquisition of HIV. Studies have demonstrated the effectiveness of PrEP in reducing HIV transmission among sero-discordant heterosexual couples and MSM, among others. Where sero-discordant couples can be identified and where additional HIV prevention choices for them are required, particularly among MSM, daily oral PrEP (specifically tenofovir or the combination of tenofovir and emtricitabine) may be considered as a possible additional intervention for the uninfected partner.</p>	<p>Accelerating HIV prevention to end AIDS in Botswana Strategy for Sexual and Reproductive Health and Rights in the SADC Region 2019-2030</p>
<p>e. Provide Post-Exposure Prophylaxis (PEP) for HIV</p>	<p>Post-exposure prophylaxis (PEP) is given to reduce the likelihood of acquiring HIV infection after possible exposure. PEP is currently the only way to reduce the risk of HIV infection in an individual who has been exposed to HIV, such as through sexual assault, possible sexual exposure or medical exposure. As such, it is widely considered an integral part of an overall HIV prevention strategy. The current recommended duration of PEP is 28 days; the first dose should be taken as soon as possible and within 72 hours after exposure.</p>	<p>2021 Botswana HIV Case Surveillance Implementation Guide</p>
<p>f. Provide voluntary medical male circumcision (VMMC)</p>	<p>Voluntary medical male circumcision (VMMC) is recommended as an important strategy for the prevention of heterosexually acquired HIV infection in men in countries with a high HIV prevalence and low levels of male circumcision.</p> <p>Where provided, VMMC should be a part of a comprehensive prevention package, and seen as an opportunity to provide a broader range of SRH/HIV services to men and adolescent boys. This is particularly important given the lack of engagement with health systems among men and adolescent boys, and the opportunity that VMMC provides to bring this group into that system. As such, VMMC should never be set-up as a stand-alone intervention. VMMC should be complemented with HIV</p>	

	<p>testing and counselling services, screening and treatment for STIs, the promotion of safer sex practices, and the provision of family planning services and male and female condoms.</p> <p>Evidence is lacking in terms of effectiveness of VMMC during anal intercourse. VMMC must be performed by well-trained health practitioners in hygienic settings. Free and informed consent must be obtained from the client, and confidential and risk-reduction counselling should be provided. Information should be provided on both the possible benefits and harms of VMMC. Where possible, related health messages within the context of VMMC should address both men and women</p>	
<p>g. Counsel client on how to support partner in preventing vertical transmission of HIV (if partner wants)</p>	<p>Men’s involvement in preventing vertical transmission of HIV – sometimes referred to as Prevention of Mother-to-Child Transmission of HIV (PMTCT), or Prevention of Parent-to-Child Transmission (PPTCT) – can have an important beneficial effect on improving health outcomes for both the mother and the baby.</p> <p>Provide men with information on the prevention of vertical transmission process, and offer active referral for male partners. Provide HIV couple counselling and testing to men (see category 5a above), within a family-centred approach. Acknowledge and address men’s associated needs, such as to access HIV treatment if they test positive.</p> <p>Men’s involvement should also be encouraged within the context of Option B+ (Option B+ recommends providing lifelong ART to all pregnant and breastfeeding women living with HIV regardless of CD4 count or WHO clinical stage). This would include acknowledging and addressing men’s associated needs, such as to access HIV treatment if they test positive.</p>	
<p>h. Diagnose, manage and prevent HIV-related coinfections and co-morbidities</p>	<p>For men living with HIV , an essential part of HIV treatment and care is the management of Addressing HIV effectively also requires addressing other comorbidities such as other sexually transmitted blood-borne infections, mental health disorder and opportunistic infections such as pneumonia, tuberculosis, viral hepatitis, persistent diarrhoea, oral thrush and skin infections. The medical history will provide initial indicators for possible opportunity infections that need to be screened for. Prophylaxis and treatment should be provided (or referred for) as appropriate.</p> <p>Existing recommendations cover initiation of CPT among adults, adolescents, pregnant women and children for prevention of Pneumocystis pneumonia, toxoplasmosis and bacterial infections, as well</p>	

	<p>as benefits for malaria prophylaxis and discontinuation of CPT. Among people living with HIV, TB is the most frequent life-threatening Opportunistic infection and a leading cause of death. ART should be provided to all people with HIV with active TB disease. Implement the WHO maintenance regimens, monitoring and managing toxicities, timing of ART and discontinuing maintenance regimens.</p> <p>People living with HIV are at increased risk of developing a range of non-communicable diseases (NCDs), including cardiovascular disease, diabetes, chronic lung disease and some types of cancer. Chronic HIV care provides the opportunity for screening, monitoring and managing NCDs, especially through primary care. Integrating interventions such as nutrition assessment, dietary counselling and support, smoking cessation, promoting exercise, monitoring blood pressure and where available cholesterol as part of HIV care provide opportunities for reducing the risks of NCDs among people living with HIV.</p>	
<p>i. Provide care and support for men and adolescent boys living with HIV</p>	<p>Address the SRH and positive health, dignity and prevention (see note below) needs of men living with HIV, their partners and family members, including providing support for men in sero-discordant relationships.</p> <p>Provide referrals to support groups for men living with HIV, where necessary and feasible.</p> <p>Role models of men living with HIV can play an important role in encouraging other men and adolescent boys to get tested for HIV, to access treatment and to take protective measures, such as going for VMMC and using condoms.</p> <p>Note that positive health, dignity and prevention for and with people living with HIV, encompasses a set of actions that help people living with HIV protect their sexual health, prevent other STIs, delay HIV disease progression, and avoid transmitting HIV infection to others. People living with HIV play an essential role in preventing new HIV infections. Strategies include individual health promotion, scaling-up of HIV and SRH services, community participation, and advocacy and policy change.</p>	<p>Handbook of the Botswana 2016 integrated HIV clinical care guidelines</p> <p>Botswana HIV Prevention Road Map 2023-2025 Accelerating HIV prevention to end AIDS in Botswana</p>
<p>6. Disorders of the male reproductive system, including sexual dysfunction</p>		
<p>a. Diagnose and counsel client on sexual dysfunctions (erectile dysfunction,</p>	<p>Ask about concerns men may have on sexual dysfunction. Provide counselling for low sexual desire, erectile dysfunction (impotence), delayed ejaculation, premature ejaculation and pain during sexual activity. See resources section for further information.</p>	<p>Botswana Policy Guidelines and Service Standards</p>

<p>delayed ejaculation, premature ejaculation), and provide referral</p>	<p>Provide referrals to address the psychological aspects of these issues, where necessary.</p>	
<p>b. Treat (or refer) for sexual dysfunctions (erectile dysfunction, delayed ejaculation, premature ejaculation)</p>	<p>After assessment, provide treatment or referral for:</p> <ul style="list-style-type: none"> • Erectile dysfunction (impotence) • Premature ejaculation • Delayed ejaculation • Problems with libido <p>See resources section for further information</p>	
<p>c. Treat (or refer) for other disorders of the male reproductive system (warts, varicoceles, urological disease, etc.</p>	<p>After assessment, provide treatment or referral for disorders such as:</p> <ul style="list-style-type: none"> • Acne and skin lesions of the genital tract (including colposcopy for warts) • Hernias • Varicoceles • Urological disease (e.g. benign prostate hyperplasia) • Pain during sexual activity <p>See resources section for further information</p>	
<p>d. Screen and treat urinary tract infections (or refer)</p>	<p>Urinary tract infections (UTIs) are rare among adult men but are more common if a man has an abnormal genitourinary tract. It is important to consider STIs that may have symptoms similar to a UTI and should be considered in the differential diagnosis. UTIs may be addressed through the syndromic management approach in category 4a above.</p> <p>Nevertheless, awareness of UTIs is important. UTIs can involve the urethra (urethritis), bladder (cystitis), or kidneys (pyelonephritis). When the kidneys are involved, UTIs can be life threatening.</p> <p>Where possible, diagnose the UTI using a urine specimen/sample.</p> <p>Treat the UTI with antibiotics, or refer the client where testing and treatment are not available.</p>	
<p>7. Male cancers</p>		
<p>a. Counsel client on sexual and reproductive health-related male cancers (prostate, testicular, penile, anal, breast)</p>	<p>SRH-related male cancers include prostate, testicular, penile, anal, and breast cancers. While it is not expected that a primary healthcare clinic will provide cancer treatment, it is important that clinicians and health providers are aware of the signs and symptoms and can provide appropriate information to clients, where applicable. This includes information how the client can conduct a self-exam to identify male</p>	<p>Botswana Cancer Registry</p> <p>Ministry of Health (2010)</p> <p>The Essential Health Service Package for Botswana.</p>

	genital structures (e.g. penis, testicles, epididymis, spermatic cord, vessels) and understand what's normal or not.	Ministry of Health (2012) Sexual and Reproductive Health Policy Guidelines and Service Standards
b. Take a history for sexual and reproductive related male cancers	<p>It is important to note that there are no internationally-agreed standard for routine screening methods for most sexual and reproductive-related male cancers. However, an assessment of each of the cancers is possible and should be based on the signs and symptoms highlighted in the client's medical history. Males presenting with STIs, cancers form part of the differential diagnosis.</p> <p>Prostate cancer: Prostate cancer is an adenocarcinoma (malignant tumour) of the prostate gland. Its incidence rises steadily with age - prostate cancer is rare in men under 40 years. As such, screening is advised mainly for men aged 40 years and over. Undertake a digital rectal examination and check whether the client is showing signs and symptoms (including pain in pelvic area, and urinary retention).</p> <p>Diagnosis is assisted by a needle biopsy of the prostate gland, a trans-rectal ultrasound and an elevated prostate-specific antigen (PSA).</p> <p>Testicular cancer: Testicular cancer is a malignant tumour of the testicle. This cancer is rare, but is one of the most common cancers in men under. It is most commonly misdiagnosed as epididymitis. Undertake a physical examination, particularly of the testicle, and check whether the client is showing signs and symptoms (scrotal pain, pain during sleep, etc.).</p> <p>Penile cancer: Penile cancer, also known as squamous cell carcinoma of the penis, while rare, is mostly seen in older uncircumcised men, and is associated with poor hygiene. Most penile cancers originate near the corona of the glands. Undertake a physical examination, and check whether the client is showing signs and symptoms (such as prolonged painful erections). This cancer can often have a wart-like appearance.</p> <p>Penile cancer has a low mortality rate if diagnosed quickly, and a high mortality rate if not.</p> <p>Anal cancer: Anal cancer, cancer of the anus, is rare, with anal cancer being slightly more common in women. Anal cancer is typically an anal squamous cell carcinoma, and is often linked to human papillomavirus (HPV) infection. Take anal pap smears (similar to those used in cervical cancer screening) only when anal colposcopy is available, for early detection of anal cancer in high-risk individuals. Symptoms of anal</p>	

	<p>cancer can include pain or pressure in the anus or rectum, a change in bowel habits, a lump near the anus, rectal bleeding, itching or discharge.</p> <p>Breast cancer: Men with breast cancer typically have lumps detectable by touch. Clinical breast exams are used to detect and diagnose it and, if found, a biopsy is necessary to check for signs of cancer. Ultrasounds and MRIs can also be used to detect breast cancer.</p> <p>Radiation exposure, high estrogen levels and family history increase men’s risk of breast cancer</p>	
c. Refer for further investigation and management as necessary	For all the cancers refer the client for further investigation, management or treatment as necessary.	
8. Fertility and infertility		
a. Counsel client on basic fertility awareness for men including preconception health	<p>Provide information to men and women on how to have children when they are desired. This information should include helping couples identify the days of the month when the female partner is most likely to get pregnant and pre-conception information such as the importance of folic acid to prevent neural tube and other defects.</p>	<p>EHSP National Guidelines on Health Service Integration (2021) Policy Guidance to Male Involvement in SRH, HIV & AIDS and GBV Prevention & management Addendum</p>
b. Counsel couples for conception (if the partner agrees)	<p>Involve men in pre-conception counselling and partner’s pregnancy testing and counselling services, offered as part of family planning services, where appropriate. Such services should be provided in accordance with national family planning guidelines.</p> <p>It is of fundamental importance that any approach to working with male partners within the context of pregnancy testing is underpinned by support for a women’s right to choose, including whether or not to involve her partner. Such male engagement should never produce unnecessary barriers to women accessing pregnancy testing and counselling services.</p>	
c. Counsel client on infertility	Provide counselling guided by the information elicited from the client during the medical and history and physical exam findings (categories 1 and 2 above). Where there is no apparent cause of infertility, the client should be educated about how to maximize fertility. Attention should be	

	paid to the emotional and educational needs of the client, with referrals for appropriate support, where necessary.	
d. Provide basic infertility care for men, including semen analysis	<p>Infertility is commonly defined as the failure of a couple to achieve pregnancy after 12 months or longer of regular unprotected intercourse. An earlier evaluation may be warranted where known risk factors/questions of male infertility are present. It is recommended that an infertility evaluation of both partners is undertaken simultaneously.</p> <p>Refer to results on screening and history (see category 1 above). The physical examination (category 2c above) should be conducted.</p> <p>Male clients concerned about their fertility should have a semen analysis. The semen analysis is the first and most simple way to screen for male fertility. If this test is abnormal, they should be referred for further diagnosis (i.e. second semen analysis, endocrine evaluation, post-ejaculate urinalysis or others deemed necessary) and treatment (category 8f).</p> <p>Referral to specialist care following the result of the infertility evaluation, if necessary</p>	
e. Treat for infertility/ provide assisted reproduction (or refer)	Provide infertility services to diagnose and treat the underlying condition, consider referral to a sperm bank, or refer the male client to specialist care for a full infertility workup and treatment, where possible.	
f. Counsel client (and partner) on adoption (or refer)	Provide counselling, education and support on adoption or refer to an adoption agency or the relevant health/social services.	
9. Supporting pregnancy loss		
a. Counsel client on preconception, support during prenatal and postnatal period and care-giving	<p>Provide information on the role and responsibilities of parents, particularly the father, during prenatal health, childbirth, newborn care, child development, and child care.</p> <p>Provide information on the positive role men can play in supporting safe motherhood, including:</p> <ul style="list-style-type: none"> • Reducing the delay in women getting treatment by learning to recognize complications of pregnancy and delivery and the ways to respond to them • Being supportive of her decision to seek medical attention, despite possible resistance from others including family members • Paying for her transport • Allocating family and community resources for transportation and delivery <p>Counselling should ideally be linked to the provision of skills</p>	<p>EHSP</p> <p>National Guidelines on Health Services Integration</p> <p>PMTCT Guidelines</p>

	development for men as positive parents, such as through men's involvement in fathers groups (see category 9b below).	
b. Provide link to a support group for expectant and new fathers, classes on parenting, fatherhood skills	Provide support groups for expectant and new fathers. These groups should include a skills development component on parenting and communication skills, which contribute to stronger parent-child and father-mother relationships. See resources section for further information	Ministry of Health (2010) The Essential Health Service Package for Botswana. Ministry of Health (2012) Sexual and Reproductive Health Policy Guidelines and Service Standards

10. Supporting safe abortion care

a. Counsel clients who are partners in safe abortion care on the role they can play as a source of support	<p>Acknowledge that men have a role to play in increasing their partner's access to safe abortion services, thus contributing to a decline in maternal morbidity and mortality related to unsafe abortion.</p> <p>Provide specific information and education for men on abortion and how to support interventions to increase access to safe abortion.</p> <p>It is of fundamental importance that any approach to working with male partners within the context of safe abortion services are underpinned by support for a women's right to choose, including whether or not to involve her partner. Such male engagement should never produce unnecessary barriers to women accessing safe abortion services.</p>	<p>Ministry of Health (2010) The Essential Health Service Package for Botswana.</p> <p>Ministry of Health (2012) Sexual and Reproductive Health Policy Guidelines and Service Standards</p> <p>Ministry of Health (2021) National Guidelines on Health Services Integration</p>
b. Support client to be a supportive partner and participate in pre and post-abortion care counselling sessions (if the partner wants)	Enable and encourage men and adolescent boys to participate in pre and post-abortion care counselling sessions, if a woman so desires. Some women want their partner, husband or other support person present for such counselling. And likewise, many male partners express the desire for more information about their partner's condition during post-abortion care and about family planning.	

11. Sexual and gender-based violence (SGBV) support

<p>a. Screen for experience of SGBV, including intimate partner violence</p>	<p>The health service plays a crucial role in responding to sexual and gender-based violence, through breaking the silence around such violence and preventing violence from happening (through detection and referral services) and offering care. Also, for many survivors of violence, visiting a health care facility may be one of the only opportunities (and potentially a lost opportunity) for detecting and stopping abuse, and providing them with the necessary medical and counselling services. Globally, women and girls have been found to report lifetime experiences of physical and sexual violence at between 10-70% (with most estimates falling between 30-60%). Emerging data is also finding that adolescent boys and men, particularly in high-violence settings, may experience concerning levels of physical and sexual violence, including during childhood. Given that violence violates human rights and the evidence that adolescent boys who experience SGBV are more likely to go on to perpetrate violence in later life, it is important to intervene, where possible, to stop this cycle of violence. There is also stigma associated with men and adolescent boys acknowledging that they have been the victims of SGBV.</p> <p>This may already have been covered in 1f, above. If not, assess for history of incidences of violence and abuse, including sexual violence and domestic violence. This should include assessing both experience and perpetration of violence, as well as a history of exposure to childhood family violence (given links between childhood experience of violence and future perpetration in men).⁸³ Screening can either be done in response to situations where signs of abuse are present or routine screening for all clients of a particular service. Provide counselling and referrals, as is appropriate, for survivors and perpetrators of sexual abuse and domestic violence.</p> <p>Note that routine screening of men as survivors of SGBV may not necessarily be the most effective way of detecting this hidden population. Screening tools should be validated, precise and safe.</p>	<p>Regional Strategy and Framework of Action for Addressing Gender Based Violence 2018-2030</p> <p>Botswana Policy Guidance to Male Involvement in SRH, HIV & AIDS and GBV Prevention and Management</p>
<p>b. Counsel and support clients affected by violence and refer for clinical, psychosocial and</p>	<p>Provide counselling and support to those affected by sexual and gender-based violence. Beyond immediate medical attention, survivors of violence may need additional clinical tests, psychological support and other protection services. Refer the client to these medical, social and legal services for assistance</p>	

protection services		
c. Refer clients who have a history of perpetrating GBV to a relevant programme or support group	Provide support groups (or referrals) for men dealing with violence. These programmes have been shown, in some contexts, to be effective, though there are important pre-conditions, methodological considerations and areas for caution before initiating such work (or referring men to such support groups). ⁸⁴ See resources section for additional details.	
12. Information and counselling		
a. Provide information and counsel client on sex, sexuality and sexual health, including pleasure (for man and partner)	Provide counselling and information to men and adolescent boys in the following areas: <ul style="list-style-type: none"> • Basic sexuality and fertility • Changes in sexual functioning during reproductive life span, including male and female puberty • Penis size • Masturbation • Male and female anatomy and physiology • Social and emotional development • Sexuality, sexual orientation, and gender identity • Pleasure (for men and adolescent boys, and women and girls) and libido • Accessing clinical care regularly for testing and screening and treatment • Sexual myths and cultural barriers 	
b. Provide information and counsel client on self-confidence and self-esteem	Provide information and counsel men and adolescent boys on self-esteem, self-respect, positive masculinity and male role identity, personal potential, confidence in the future, and promoting a sense of control over one's life and decisions	
c. Provide information and counsel client on relationships and non-violent communication and negotiation	Provide information and counsel men and adolescent boys on effective communication and equitable sexual decision-making within relationships. Information should also be included on when sexual involvement is appropriate, forms of sexual expression, sexual coercion, abuse and violence, domestic violence, rape awareness, and the influence of alcohol and other drugs on sexual behaviour. This information should ideally be linked to a skills development component.	
d. Provide information on	Provide information to men and adolescent boys about the importance of gender equality and benefits for men and women as a result of more	

<p>comprehensive sexuality education (CSE), values and gender equality, with specific focus on role of men to reach in- and out-of-school youth</p>	<p>equitable relationships and communities. Positive values can include respect for others, positive manhood and responsible fatherhood. See resources section for further information.</p>	
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4.2 Detailed Summary of Community Based SRHR Services

This section outlines complementary and comprehensive services for men and adolescent boys that are needed to respond to their health needs at the community level. The development of the service package follows similar principles as noted for SRH facility-based services.

The provision of services is deliberately designed to empower men, and adolescent boys take an active and participatory role in improving their own health and that of their communities as expressed by key informants of. Community based SRHR services for men and adolescent boys also require a holistic and inclusive approach that can help promote healthy masculinity and foster gender equality towards improving SRH outcomes for all.

Adapted from the Global Sexual and Reproductive Health Service Package for Men and Adolescent Boys, the following complementary (to facility-based) services have been organized around three (3) broad categories: i) Information, education and communication materials; ii) Skills building and support and iii) Advocacy issues in which to engage men and adolescent boys (see *table 7*). It is expected that by focusing on and promoting education and awareness, men and adolescent boys empowerment, better health seeking behavior, effective communication and healthier masculinities can be attained. Furthermore, the supportive service package draws from the input of experts and other service providers working with men and adolescent boys, which highlight especially broader cultural issues for consideration. These supportive services must be cognizant of the context, expressed and non-expressed needs of men and adolescent boys in a given locality. Various key considerations have also been drawn from interviews with key

informants/experts and other relevant stakeholders to ensure appropriate adaptation of the UNFPA guidance on SRH package please refer to *appendix 3*.

TABLE 7: DETAILS OF THE COMMUNITY BASED SRHR SERVICES

SRH non-clinical services for men & adolescent boys	Components	Objective to guide key activities
1. Information, education and communication materials for men and adolescent boys.	Basic sex and SRHR education, including sexuality and sexual orientation, pleasure and anatomy, libido, masturbation and related myths.	1.1 To raise awareness and foster understanding of SRHR issues, gender roles, and the impact of gender norms on sexual and reproductive health
	Genital health and penile hygiene (e.g. circumcision reduction); infertility, erectile dysfunction, andro-pause	1.2 To inform & empower men to participate in SRHR decision-making processes, especially in relation to family planning, contraceptive use, and parenting.
	Contraception choices and men's supportive role in making a contraceptive choice with their partner	1.3 To promote emotional wellbeing, reduce stigma around mental health, and provide support for men experiencing mental health issues related to SRHR.
	Prevention and treatment of STIs and HIV	
	Supportive involvement in prenatal and postnatal care, materials on fatherhood/men's role as a parent	1.4 To educate men on the importance of non-violent relationships, consent, and respect, while providing support to those who may have been involved in or affected by gender-based violence.
	Mental health and psychosocial support – facts and myths; education on depression; living with someone with mental illness	1.5 To provide adolescent boys with the tools and knowledge to make informed decisions about their sexual health and relationships, and to equip them with the resources to challenge harmful gender norms.
	Stigma reduction, particularly for HIV and other STIs	
	Awareness and prevention of SRH-related male cancers	1.6 To provide comprehensive information and guidance to men and adolescent boys for

	<p>Messages on risks associated with drug, tobacco and alcohol dependence or overuse</p> <p>Awareness about availability of services for family planning, youth-friendly services, prostate & breast cancer screening & importance of health seeking behavior, safer-sex negotiation, and gender-based violence.</p>	<p>service referrals to promote access and uptake of available services.</p>
<p>2. Skills building and group support for men and adolescent boys.</p>	<p>Pregnancy and STI prevention (including HIV)</p> <p>Fatherhood and maternal health, newborn and child health and development skills</p> <p>Non-violent communication and negotiation in relationships (between couples/other caregivers, on shared caregiving and domestic responsibilities, and with children)</p> <p>Awareness of risk-taking behaviour and the effect this can have on their own and their partners sexual and reproductive health</p> <p>Engaging men in SGBV prevention</p> <p>Comprehensive sexuality education, values and gender equality, support for women and girls' rights including reproductive rights, with specific focus on role of men and to provide positive images of more gender-equitable men.</p>	<p>2.1 Gender-sensitive SHR education – SRH education should challenge stereotypes, promote respectful relationships, and focus on shared responsibilities. Topics should cover healthy masculinities, consent, healthy relationships, family planning, sexual rights, HIV prevention, and the importance of mental health in SRH.</p> <p>2.2 Demystify the role of men in family planning, especially preventing unintended pregnancy and effective use of contraception – issues of male contraception such as vasectomy and involve men in antenatal and postnatal classes.</p> <p>2.3 Promote fatherhood education that focuses on male involvement in pregnancy, childbirth and parenting – the nurturing role of a father, including young fathers.</p> <p>2.4 Couples' counselling should address sexual health, contraception, STI prevention, and emotional wellbeing – deconstruct harmful stereotypes and norms around masculinity</p> <p>2.5 Establish dedicated spaces where men can discuss emotional issues, particularly concerning relationships, masculinity, and stress – safe spaces for men to talk about anxiety, depression, and trauma, which may be linked to SRH, such as infertility, sexual</p>

	Support groups for men (such as groups for men living with HIV). School based SRH education focusing on the physical, emotional, and social aspects of puberty, healthy relationships, consent, and emotional regulation.	performance concerns, or experiences of sexual violence.
3. Advocacy issues in which to engage men and adolescent boys.	Greater focus on men and adolescent boys within national SRH & HIV laws and policies	3.1 Advocate for policy framework for the establishment of safe space for men to express their vulnerabilities and talk about sensitive SRH issues that affect them – sports and recreational activities 3.2 Promote community-based awareness campaigns to educate men on SRH issues, including safe abortion services available. 3.3 Advocate for the inclusion of men in workplace health policies that support SRH, such as paternity leave, family planning resources, and counseling services. 3.4 Promote national and sub-national campaigns to address health seeking behaviour, fear, ridicule and judgmental service provision for men. 3.5 Establish and promote paternity networks for men to share experiences, advice and challenges as well as resources for navigating fatherhood and societal expectations. 3.6 Men as allies in ending SGBV – campaigns to create awareness and help men address domestic violence, sexual harassment, abuse, recognize unhealthy relationships, toxic masculinity and bystander mentality – education programs to address conflict resolution skills.
	Safe abortion services and stigma-free environment	
	Increasing and promoting shared parental leave	
	Engaging men in SGBV prevention	
	Engaging men as partners in supporting prenatal and postnatal care, including safe motherhood	
	Creating an enabling policy environment that addresses discrimination and violence against men, for example men who have sex with men, and transgender men and other gender-nonconforming individuals, male sex workers, men who inject drugs, male prisoners	
	Acceptance of adolescent sexuality and SRH and creating an enabling policy and legal environment that aims to dismantle barriers to adolescent SRH	

SECTION 5:

CONSIDERATIONS FOR DELIVERY OF SRHR SERVICES PACKAGE FOR MEN & BOYS

**SECTION 5: CONSIDERATIONS FOR DELIVERY OF SRHR SERVICES PACKAGE
FOR MEN & BOYS**

Men's utilization of sexual and reproductive health products and services remains low in Botswana because lots of SRHR programs do not focus explicitly on men as end users and failure to acknowledge the diversity among male clients seeking services. Though the SRH needs of each man differs, there are particular groups of men that have specific health needs and the service delivery mechanisms required to reach these groups have some subtle differences. The adolescent boys, gay and bisexual men and other men who have sex with men, and transgender men and other gender-nonconforming individuals are often sidelined by the national attempt of leaving “no one behind”. This section looks at the specific service delivery and health considerations for each of the groups in turn. It builds on the SRH service package outlined in sections 3 and 4 above. **Table 8** identifies gaps in services delivery for the diverse group and propose possible recommendation to address them.

TABLE 8: CONSIDERATIONS FOR DELIVERING SERVICES TO DIVERSE GROUPS OF MALE CLIENTS

Factor To consider	Gap in Service Delivery	Recommendation
Adolescent Boys (10-19)		
Rapid physical and psychological development	Lack information on bodily changes	Intensify CSE in schools, home and health facilities or in other settings.
The social and peer pressure to conform to normative attitudes and behaviours which is at its peak	Lack of psychosocial services	Psycho social support services in schools to challenge dominant, inequitable and violent forms of masculinity.

Adolescent Men who have Sex with Men	Age-related restrictions to HIV and SRH services (e.g. HTS not under 16) and the limited availability of youth-friendly services.	<p>Botswana should</p> <ul style="list-style-type: none"> • Increase access to SRH services for men and boys in all parts of the country. • decentralize service delivery to rural setting of Botswana. • provide all adolescent clients with the right, comprehensive and affordable health services. <p>Service providers must;</p> <ul style="list-style-type: none"> • be non-judgmental • render discrete and confidential services • allow for client to choose a service provider (male or female) for clinical, counselling, educator and social work services • allow for participation and/or inclusion of community-led services, engagement of peer youth outreach workers and health system navigators • allow flexible opening hours
Increase in AIDS related deaths	Limited services to all adolescent groups	<ul style="list-style-type: none"> • Provide CSE in all areas of the country • Provide SRH services to all adolescents and young people irrespective of their age, marital status, HIV status, sexual orientation, gender identity, occupation, social status, geographical location or ability to pay • Access to condoms and condom-compatible lubricant • Challenge norms on gender, masculinity and sexuality • Adopt the 2017 Global Accelerated Action for the Health of Adolescents (AA-HA)
Men who have sex with Men		
Stigma and discrimination at service points	<p>Limited community based organizations (CBOs)</p> <p>Limited public health facilities providing KP friendly services</p>	<ul style="list-style-type: none"> • Create a welcoming environment. • Take an open, non-judgmental sexual and social history. • Avoid making assumptions and ask open-ended questions. • Be aware of the importance of confidentiality. Refer to other sources of support within the community (men and boys centers).

		<ul style="list-style-type: none"> • Training for HCW on human rights and KP competency.
Men who have Sex with Men are at higher risk of HIV and anal cancer due to sexual exposure to HPV	Lack of professionally trained service providers	<ul style="list-style-type: none"> • Training on provision of SRH services to men • Integrate provision of KP friendly services in SRH • Appropriate STI screening in relation to sexual activities (i.e. anorectal, pharyngeal) • Access to condoms and condom-compatible lubricant • HPV vaccine for young men • Test for HIV, Syphilis and Viral Hepatitis • HBV vaccine for young men • Cancer screening (i.e. anal, oropharyngeal)
Mental health issues, related to experiences of homophobia or social exclusion.	Limited access to appropriate mental health services within facility-based service centers	<ul style="list-style-type: none"> • Increase funding For CSOs providing SRH services to men and boys • Integrate mental health services into facility-based services for men. • Train health care workers on GBV.
Transgender Men		
Family rejection, police harassment, violence (including sexual violence), vulnerability to HIV and poor mental health because of social stigma. prejudice and discrimination	Lack of professionally trained service providers	<ul style="list-style-type: none"> • All staff must be provided with relevant training. • Train health care workers on KP competency • Advocacy • Be understanding and non-judgmental. A negative reaction can do serious harm. • Ensure intake form asks for “gender” and “assigned-sex-at-birth”. • Get names and pronouns correct (ask discreetly if necessary). • Be aware of the importance of confidentiality. • Refer to appropriate, specialist gender services and/or other sources of support. <p>Providers should deliver;</p> <ul style="list-style-type: none"> • Appropriate STI screening to current anatomy and sexual activities

		<ul style="list-style-type: none"> • Cancer screening (i.e. breast, cervical, anal, oropharyngeal) and offering pap smears, cervical, ovarian, uterine and breast cancer screenings
Specific considerations for transgender women		
Needs around lifelong oestrogen therapy and sex reassignment surgery	<p>Inadequate services for transgender women.</p> <p>Inadequate training of service providers</p>	<ul style="list-style-type: none"> • Appropriate STI screening to current anatomy and sexual activities • Cancer screening (i.e. prostate, anal, oropharyngeal)

SECTION 6:

OPERATIONALIZING THE SERVICE PACKAGE

SECTION 6: OPERATIONALIZING THE SERVICE PACKAGE

The service package is developed for the health system of Botswana which includes all institutions, and Organizations delivering health services to citizens and residents living within the country. In order to deliver on the mandate of this service packages, organizations will find it important to follow certain steps, each of which is explored in more detail in *figure 3* below (UNFPA and IPPF, 2017):

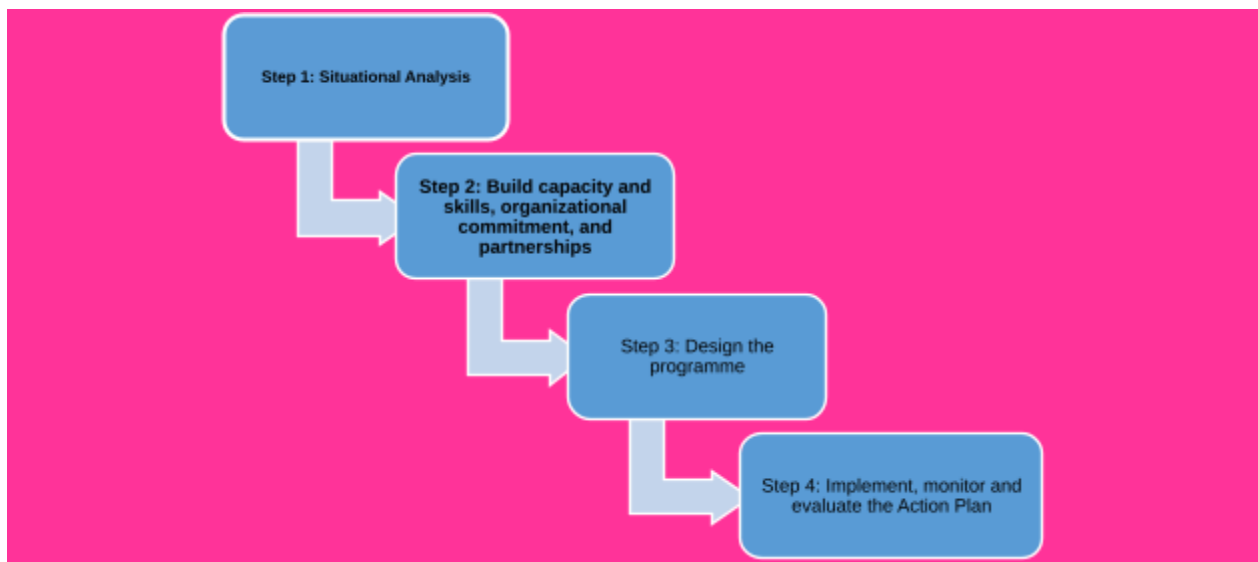


FIGURE 3: OPERATIONAL STEPS FOR IMPLEMENTATION OF SRHR SERVICE PACKAGES

Steps 1 through 3 are about developing an Operational Action Plan. Use the template provided in Appendix 4, which supports organizations in moving through these steps.

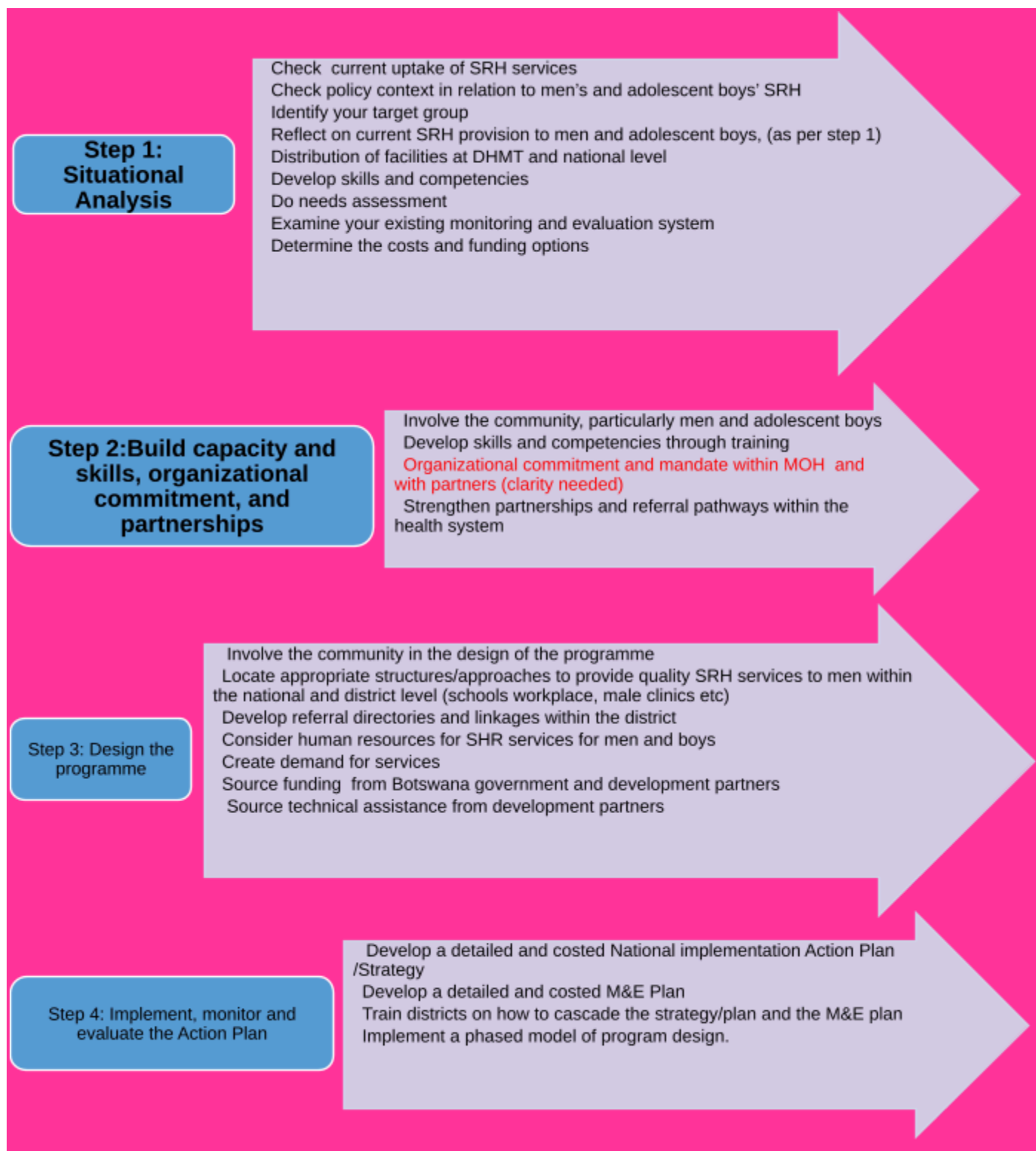


FIGURE 4: CONSIDERATIONS FOR THE IMPLEMENTATION OF SRHR SERVICE PACKAGES

SECTION 7:

MONITORING & EVALUATION COMPONENT OF SRH SERVICES FOR MEN

SECTION 7: MONITORING & EVALUATION COMPONENT OF SRH SERVICES FOR MEN & BOY

A key part of implementation is ongoing monitoring and evaluation, with a consistent focus on promoting gender-transformative practices and measuring the results. This should ideally be integrated within existing activities. **UNFPA and IPPF, (2017):** recommends that the M&E should, at a minimum, include the following:

- Monitoring effectiveness of implementation of male services (feasibility and acceptability)
- Indicators to measure the success of activities intended to reduce gender inequalities in access to SRH, such as increased knowledge, attitude change and behaviour change, from the individual to the state level
- Recording and reporting new service statistics
- Undertaking regular male client satisfaction of care surveys
- Assessing provider knowledge, attitudes and perceptions in working with men and adolescent boys (in all their diversity) as well as provider satisfaction
- Encompassing both quality assurance and quality improvement approaches.

Some example indicators for programmes working with men and adolescent boys can be found in box 4 below;

Box 4: Sample indicators for programmes working with men and adolescent boys (UNFPA and IPPF, 2017)

- Men's knowledge about family planning; HIV and AIDS; STIs; reproductive rights; partners' attitudes about family planning
- Knowledge of and attitudes towards vasectomy by service providers, men and women; demand for vasectomies; level of technical skill to provide no-scalpel vasectomy
- Knowledge, attitudes and practices among young men about rights; violence; gender roles;

RH behaviours; age at first sexual experience or marriage; good parenting

- Provider awareness of signs of violence; referral systems; community attitudes; police attitudes and behaviours
- Decline in restrictions on services and information; access of adolescents to services
- Age and sex mix of clients; client satisfaction with services
- Policymakers' knowledge of and attitude towards human rights approach

Assessment of whether State-level RH rights enforcement mechanisms are in place and whether revised service delivery protocols include human rights language;

existence of clients' bills of rights

- Funds allocated for RH programmes
- Number of information, education and communication (IEC) activities and materials developed, pretested, and disseminated

Men's knowledge and attitudes about their sexual behaviour related to women's RH; increase in condom use; increase in demand for STI counselling services

- Number of visits by young men to SRH services tailored to them
- Percentage of pregnant women receiving prenatal services whose male partner was tested for HIV These indicators are examples and do not cover the full range of indicators that would be required.

NB: *The indicators table provide a few examples and do not cover the full range of indicators that would be required for the Botswana program. Development of a detailed M&E plan with indicators drawn from the Botswana context is recommended.*

8.0 LIST OF REFERENCES

- IPPF and UNFPA (2017). Global Sexual and Reproductive Health Service Package for Men and Adolescent Boys. London: IPPF and New York City: UNFPA.
- BAKER, P. & SHAND, T. 2017. Men's health: time for a new approach to policy and practice? *Journal of global health*, 7.
- BRAY, F., LAVERSANNE, M., SUNG, H., FERLAY, J., SIEGEL, R.L., SOERJOMATARAM, I. AND JEMAL, A., 2024. Global cancer statistics 2022: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA: a cancer journal for clinicians*, 74(3), pp.229-263.
- CORNELL, M. & DOVEL, K. 2018. Reaching key adolescent populations. *Current Opinion in HIV and AIDS*, 13, 274-280.
- DE SILVA, V. 2016. World book of family medicine: Sexual and reproductive health in primary care: Where do we go from here? vol. 26. *Wonca Europe: Iberoamericana Edition: Portugal*, 1-4.
- DICARLO, A. L., MANTELL, J. E., REMIEN, R. H., ZERBE, A., MORRIS, D., PITT, B., ABRAMS, E. J. & EL-SADR, W. M. 2014. 'Men usually say that HIV testing is for women': gender dynamics and perceptions of HIV testing in Lesotho. *Culture, health & sexuality*, 16, 867-882.
- MASHUMBA, L., 2024. 'Blowjobs are Jobs Too': An Exploratory Study into Victimization Experiences of Male Sex Workers in Botswana. *Sexuality & Culture*, 28(1), pp.54-70.
- MATLAPENG, K.M., BABATUNDE, G.B., GWELO, N.B. AND AKINTOLA, O., 2023. Accessing HIV services in Botswana: perspectives of men who have sex with men and other stakeholders. *Global Health Action*, 16(1), p.2262197.
- GARCÍA-MORENO, C., PALLITTO, C., DEVRIES, K., STÖCKL, H., WATTS, C. & ABRAHAMS, N. 2013. *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*, World Health Organization.
- GARI, S., MARTIN-HILBER, A., MALUNGO, J., MUSHEKE, M. & MERTEN, S. 2014. Sex differentials in the uptake of antiretroviral treatment in Zambia. *AIDS care*, 26, 1258-1262.

- LAROCCO, A. A. 2024. Women in Botswana. *Oxford Research Encyclopedia of African History*.
- WOERLD HEALTH ORGANIZATION. 2021. *Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women*, World Health Organization.
- PETRINA, G. E. 2023. An Evaluation of Community Attitudes Towards Gender-Based Violence in Partnership with the Community of Maunatlala, Botswana.
- RAKERENG, T.M., DIKGOLE, K.S., MARIBE, L.S., SPECIALE, A.M. AND LAVELANET, A., 2024. Assessment of unintended pregnancies, contraception, and abortion in Botswana. *International Journal of Gynecology & Obstetrics*, 164, pp.51-60.
- ROSEN, C. BROWN, J. HEIMAN, S. LEIBLUM, C. MESTON, R. SHABSIGH, D. FERGUSON, R. D'AGOSTINO, R., 2000. The Female Sexual Function Index (FSFI): a multidimensional self-report instrument for the assessment of female sexual function. *Journal of sex & marital therapy*, 26(2), pp.191-208.
- RUANE-MCATEER, E., GILLESPIE, K., AMIN, A., AVENTIN, Á., ROBINSON, M., HANRATTY, J., KHOSLA, R. & LOHAN, M. 2020. Gender-transformative programming with men and boys to improve sexual and reproductive health and rights: a systematic review of intervention studies. *BMJ global health*, 5, e002997.
- SHAND, T., AND CONOR EVOY, C., 2024. The representation of men in regional and global sexual and reproductive health policy, a report from Global Action on Men's Health, September, 2024)
- STAVETEIG, S., CROFT, T. N., KAMPA, K. T. & HEAD, S. K. 2017. Reaching the 'first 90': Gaps in coverage of HIV testing among people living with HIV in 16 African countries. *PloS one*, 12, e0186316.

Other References

The Fifth Botswana AIDS Impact Survey 2021(BAIS V) Report

National Policy on Mental Health Ministry of Health, Gaborone, July, 2003

Mental health Act; 1983

9.0 APPEDIX:

Appendix 1. Facilitators Tool For Workshop 1, Attendance Registers For The Workshops

Group 1: Focus on young men and couples

1. What are the needs for young men and couples?
 - *Probe for,*
 - Knowledge about their own and the female body,
 - Concerns about sexuality, and sexual dysfunction issues.
 - Stigma in accessing SRHR services
 - religious and cultural beliefs and practices, which may disapprove of young people's sexuality.
2. In your opinion, are there any areas where women bear the burden of responsibility for accessing SRH services? Which ones are these?
 - *Probe for*
 - contraceptive decision-making among couples
 - male partners support for female contraceptive methods
 - support for same sex couple
 -

Group 2: The context and local needs among men & boys

1. What are barriers in the community to men accessing SRH services?
 2. Which national and local laws and policies advance men and adolescent boys' SRH?
 3. Which national laws and policies hinder men and adolescent boys' SRH (e.g. criminalized relationships)?
 4. How (services provided) and where (settings for service provision) is best place to reach men?
- Probe for* SRHR service packages available to men in Botswana
5. Among the components of this service package mentioned above, what are best-suited to men's needs and which ones are suite for boy? (given the need for services will vary by age and population, etc.)?

Group 2: Organization and workforce commitment to providing SRHR services for men

Can we now move on to discuss the awareness staff in your organization have on issues pertaining to men's sexual and reproductive?

6. In your opinion do staff have the skills and confidence to deal with SRHR issues for men and boys?

Probe for

- Their commitment to doing so.
- Issues around confidentiality and anonymity.

7. Do you think staff in your organization need specialist training to make them feel more comfortable providing SRH services to men in all their diversity?

Probe for

- suggestions on content to help staff build a broader understanding of SRHR issues that men have (as identified through the assessment)

Group 2: Organization and workforce commitment to providing SRHR services for men

Can we now move on to discuss the awareness staff in your organization have on issues pertaining to men's sexual and reproductive?

6. In your opinion do staff have the skills and confidence to deal with SRHR issues for men and boys?

Probe for

- Their commitment to doing so.
- Issues around confidentiality and anonymity.

7. Do you think staff in your organization need specialist training to make them feel more comfortable providing SRH services to men in all their diversity?

Probe for

- suggestions on content to help staff build a broader understanding of SRHR issues that men have (as identified through the assessment)

Group 3: Primary prevention and integrated approach

8. Do you think Botswana is doing enough to encourage men and boys to report to SRH service delivery points on time?

Probe for

- increase men's knowledge at an earlier stage,
- change the harmful norm of low health-seeking behaviour,
- Men and boys engagement in SRHR issues pertaining to their health with the health system (clinical and non-clinical)

9. What models to decentralize health services and community-based responses should be adopted for men and boys SRHR services in Botswana?

10. Share with us some of the key recommendation you would like to make for the development for SRHR services package for men and boys the MoH could adopt?

SRH service package for men and adolescent boys

- A combination of SRH services are required to respond effectively to the needs of men and adolescent boys in all their diversity.

- Services relevant at the community level
- Services relevant at the clinic or first-level health facility

Appendix 2: Key Informant Interview Guide

KEY INFORMANT INTERVIEW: DEVELOPMENT OF A NATIONAL PACKAGES OF SRHR SERVICES ALIGNED TO THE GLOBAL PACKAGE OF SRHR SERVICES FOR MEN AND BOYS

BACKGROUND SHEET	
FIELD	ENTRY
Name of Consultant:	Gabaake KP
Organization: Name of Institution:	
Sex: Age: Position of the Interviewee: Start: End:	

Good day! My name is and I am with _____. We are here (on a call) on behalf of Ministry Of Health and UNAIDS, UNFPA, WHO conducting an assessment on SRHR needs for men and boys in Botswana in order to develop SRHR service packages.

Your organization have been to participate in this assessment. Your participation this exercise is voluntary, and all the information you share with us will be kept confidential and shall not be used against you and your organization. We will be asking you several questions about the SRHR needs for men and boys. The interview should take you approximately 30-45 minutes to complete.

Benefits: The information from our discussion will be used by the Ministry of Health to inform the development of a national packages of SRHR services for men and boys which aligns to the global package of SRHR services for men and boys.

Risk: Neither your name nor that of other health workers taking part in this discussion will be included in the information collected or in any report. Still, we are asking for your help by participating in this important assessment.

There is no penalty or loss of benefits for declining to participate. You may refuse to answer any question or choose to stop the interview at any time.

Do you have any questions about the assessment? If you have any additional questions about the assessment or your right as a participant in this assessment and need to contact a member of the team, you may do so at the contact information below:

For your questions you can contact the following local study team member:

For questions about the study _____ for questions about your right as a participant

Ms Goitseone Phatswane at the Ministry Of Health

Phone: 267 72 192 201

Email:

I agree to participate in this study.

A focus on young men and couples

Interviewee's signature _____ Date: _____

What are the needs for young men and couples?

Probe for;

- Knowledge about their own and the female body,
- Concerns about sexuality, and sexual dysfunction issues.
- Stigma in accessing SRHR services
- religious and cultural beliefs and practices, which may disapprove of young people's sexuality.

In your opinion, are there any areas where women bear the burden of responsibility for accessing SRH services? Which ones are these?

Probe for

- contraceptive decision-making among couples
- male partners support for female contraceptive methods
- support for same sex couple

Delivering quality gender-sensitive SRH clinical services

What are the challenges to delivering quality SRH clinical services to males?

Probe for issues around

- safety,

- effectiveness,
- acceptable/client-centred,
- timeliness,
- efficiency and equity
- access and acceptability;
- privacy and confidentiality,
- dignity and comfort,
- and continuity of services

In your opinion are SRHR services for men and boys male-friendly?

Men and boys friendly services

SRH health services and programmes should better reflect the health needs of men and adolescent boys and encourage their appropriate use of services. Such services should encompass coordinated and multidisciplinary SRH care, addressing both primary prevention and disease management. Services should be provided to men by qualified staff in line with agreed quality of care standards. The range of barriers that men face when accessing and engaging with SRH services should also be appropriately considered, including whether the infrastructure of the health facility is male-friendly, i.e. bathrooms for men and neutral decor. Section 6 supports the operationalization of this service package in a male-friendly manner

The context and local needs among men

1. What are barriers in the community to men accessing SRH services?
2. Which national and local laws and policies advance men and adolescent boys' SRH?
3. Which national laws and policies hinder men and adolescent boys' SRH (e.g. criminalized relationships)?
4. How (services provided) and where (settings for service provision) is best place to reach men?

Probe for SRHR service packages available to men in Botswana

5. Among the components of this service package mentioned above, what are best-suited to men's needs and which ones are suite for boy? (Given the need for services will vary by age and population, etc.)?

Organization and workforce commitment to providing SRHR services for men

Can we now move on to discuss the awareness staff in your organization have on issues pertaining to men's sexual and reproductive?

6. In your opinion do staff have the skills and confidence to deal with SRHR Issues for men and boys?

Probe for

- Their commitment to doing so.
- Issues around confidentiality and anonymity.

7. Do you think staff in your organization need specialist training to make them feel more comfortable providing SRH services to men in all their diversity?

Probe for

- suggestions on content to help staff build a broader understanding of SRHR issues that men have (as identified through the assessment)

Primary prevention and integrated approach

8. Do you think Botswana is doing enough to encouraged men and boys to report to SRH service delivery points on time?

Probe for

- increase men's knowledge at an earlier stage,
- change the harmful norm of low health-seeking behaviour,
- Men and boys engagement in SRHR issues pertaining to their health with the health system (clinical and non-clinical)

9. What models to decentralize health services and community-based responses should be adopted for men and boys SRHR services in Botswana?

10. Share with us some of the key recommendation you would like to make for the development for SRHR services package for men and boys the MoH could adopt?

Inform the participant that you have come to the end of this discussion and thank him/her for his/her participation. Once more inform the respondent that the information collected will be treated as confidential and shall not be used against their operation.

Appendix 3: Transcriptions and Code book

Organization for Informant	Thematic Area	Emerging Themes
BGBVC	<p align="center">Focus on Young Men & Couples</p> <p>Needs for young men & couples</p> <p>They need access to accurate knowledge. We need to take advantage of the digital space, however, there is need for them be careful of information they obtain from maranyane as it could present inaccurate info.</p> <p>Youth friendly SRH services where they could have confidential service especially when they receive STI, Contraceptive service</p> <p>Services should be comprehensive to include men and boys in their diversity. They need support from parents, community, teachers and health practitioners</p> <p>Legal frameworks</p> <p>To insure autonomy, independent decisions about their reproduction health issues and concerns, like to determine the number of children one want to have, there is need for laws to firmly support men and boys to do this. At the moment, the legal frameworks lack precision on the SRH issues for men.</p> <p>Couples needs</p> <p>Access to a variety of contraceptive options and guidance on how to use FP services are limited for men and boys. Men only play the supportive role of their female partners. There is an urgent need for education and information to men and boys on FP. The community still stigmatizes men who go to facilities to get condoms. The thinking is that one has multiple partners and wants to prevent STIs. Condoms are associated more with STI prevention than a FP method. Another method which is highly stigmatized in the morning after pill- the community views it as carelessness.</p> <p>Again, I note that women yes bear the burden of responsibility accessing SRH services because they are the ones who bear the physiological consequences of being pregnancy. The perception is that they are expected to do the right thing; pregnancy prevention if they don't want it. They even get questioned on why they would go on to have five children for instance. The community and men are harsh on women regarding the use of FP</p> <p>Men just play the supportive role or even no role at all.</p> <p>Support for same sex couples</p>	<p>Need education</p> <p>Services need to be friendlier.</p> <p>Teachers and the community need to pay attention to boy child.</p> <p>No legal support for men SRHR</p> <p>Men are only viewed as support for female partners</p> <p>No FP services for men</p> <p>FP seen as women's responsibility</p> <p>Community harsh on women who relegate FP to me</p> <p>Lack of YFS</p>

	<p>The health system in Botswana lack youth friendly services. Again there are no services tailor made for same sex couples. The society stigmatizes these couples and fail to advocate for services for them. There very limited guidelines, protocols and even training of health service providers in providing care to LGBTQ communities. Just a few advocacy organizations sensitizing people on acceptance and inclusivity of these couples, nothing on how to provide services to them.</p>	<p>No SRH services for LGBTQ</p> <p>Efforts are just on sensitization</p>
MOH-SRH Unit	<p>I feel gore young men have limited access to family planning services not because they are not available but it's because they are hindered by culture, religion and stigma. Stigma in a sense that an 18 year old boy will face stigma from the community , friends and parents if they are seen or caught in possession of family planning contraceptives.</p> <p>Same sex couples of African origin may still face cultural restrictions and limited exposure to sexual health education, preventing them from being at a stage where they can confidently teach or guide others on issues related to sexuality and relationships.</p> <p>They is lack of knowledge especially on the boy child, I belief the boy child has been left behind from the beginning may be it is because we have thought gore masculinity means social understanding of various things, which is totally different and incorrect. The girl child have an understanding of their bodies and their sexual dysfunction because of vulnerability their social issues surrounding rape and early sexual debut. They now about puberty from an early age, about breast and breast growth and what it means. On the other hand the boy child knows nothing about his boy, he is left to experiment and self-discovery. So due to lack of education as a child ill-prepares them for fatherhood, at the time they are called to fatherhood , they will not know what to do or intervene, or even teach their boy child social life. Young man have issue of access to family planning services due to culture , religion ,stigma and lack of knowledge</p>	<p>Boy child left behind from long</p> <p>SRH Programs have focused on girls because of their vulnerabilities</p> <p>Boy need education to understand their bodies</p> <p>Lack of education bred inadequate fatherhood</p>
MOH-SRH	<p>Women bear most of the burden for SRH services because societal and cultural norms often place the responsibility of family planning, pregnancy, childbirth, and child-rearing on them, and most SRH programs and services are traditionally designed to target women more than men.</p> <p>Young couples need comprehensive sexuality education in schools. Moreover, our health systems need to adjust and adapt to men`s expectations. Men and boys need to be taught to understand their bodies, similar to what we do for young girls.</p> <p>Need to be taught about male sexual dysfunctions (strength and weakness) Need to understand men` sexual problems?</p> <p>Need education on FP (vasectomy)</p> <p>Couples need education on fatherhood</p>	<p>CSE in schools</p> <p>Men and boys equally need to be taught about sex health</p> <p>Need to know sexual dysfunctions</p> <p>Fatherhood and FP</p>
Tebelopele	<p>Family planning commodities are often less accessible to young men and couples due to stigma, cultural taboos, limited male-friendly services, and challenges such as stock-outs, and fear of judgment when seeking these services.</p>	<p>Health systems bottlenecks</p>

Couples of the same sex frequently encounter cultural barriers, including social stigma, community rejection, and traditional beliefs that do not recognize or support their relationships, making it harder for them to access sexual and reproductive health services in a safe and supportive environment. Stigma and cultural barriers and restrictions

Couples of African origin may still face cultural restrictions and limited exposure to sexual health education, preventing them from being at a stage where they can confidently teach or guide others on issues related to sexuality and relationships.

Barriers rooted in culture and myths often lead to misunderstandings about sexual and reproductive health, reinforcing stigma and discouraging men and couples from seeking services or making informed decisions about their sexual well-being.

Single parenthood can influence the development of a boy child’s understanding of sexuality, as limited parental guidance, absence of male role models, or lack of open discussions about sexual health may affect how boys form their attitudes, behaviors, and beliefs around sexuality. Limited parental guidance for boy children

Nutrition plays a key role in influencing sexuality, as a healthy, balanced diet supports proper hormonal function, sexual development, fertility, and energy levels, while poor nutrition can lead to delayed puberty, reduced libido, and reproductive health issues.

Men & Boys

Needs for young men & couples

There is a significant gap in knowledge about both male and female reproductive health. Many young men lack basic education on their bodies and those of their partners. Everything centers on stigma. Issue of sexuality and sexual dysfunctions are taboos. Men fail to come to clinics because of stigma. SRH services for men are not prioritized Knowledge and education of boy child lagging behind.

Religious and cultural beliefs often disapprove of open discussions on sexuality, as you know we live in a country that is religious and takes its culture serious this has made it difficult for young men to access necessary information and support looking at some teachings from some religions and cultural groups which are against the use of western medicines. Religious barriers
FP is conceived as a woman’s responsibility

Yes, women often bear the responsibility in areas like contraceptive decision-making and ensuring family planning, male partners show limited support for female contraceptive methods

Delivering Quality SRH services for men & boys

BONEPWA I don’t think they are challenges in delivering SRH services because the clinics in Botswana offer education on STIs, pregnancy and other SRH issues. The challenge I noticed is that topics on MSM, Transgender populations like commercial sex workers are never discussed. When it comes to gay men seeking services, they themselves do not know how to present their ailment at facilities. They shy away from presenting telling it all. They opt to complain of non-issues or falsely report their ailment, cannot talk about anal complaints. They also feel ashamed of complaining about STI symptoms because they fear to be ridiculed or failure to use condoms. Health workers lag behind on current and emerging issues,

Health workers are challenged by lack of skills, their challenge is that if they are not taught about current and emerging health issue or situations, they lag behind because the health challenges they learnt about

issues at IHS become updated and there may be issues which they were not taught about. Nurse and doctors need to be updated on current issues.

Lack of content issues on men's in health workers' basic training curriculum

BGBVC Issues of knowledge gap in the side of the health care providers. Dissemination of information on SRH issues for men is a problem.

Accessibility physical accessibility- services for men are mostly available in urban areas. Most services are available in towns and I think mobile clinics could work to bridge that gap especially in rural areas.

Another accessibility is that the services are not free or affordable at least they should be affordable.

Client centered approach is needed. We need to impose what we feel is good for the client. There is need to find out what the client needs and the help they need.

Another area is adhering to ethical codes of conduct. Clients need to give information so that they make informed decision- they are going to make decisions based on what they know.

It is important also to use evidence based services. I take that we can learn a lot from many protocols, like the WHO recommended and from other reputable bodies.

Males have little services readily available compared to women services. I am wondering if this is because we believe men seldom seek for health services.

Service providers need capacity building to strengthen their ability to maintain confidentiality and privacy, which is critical for encouraging men and boys to seek SRH services.

MOH –SRH-
Disease Control

Need client centered approaches; we should avoid the concept of one glove fits all

SRH services for men and boys should be client-centered, meaning they must be tailored to the individual needs, preferences, and circumstances of each client to ensure respectful, responsive, and effective care, essential equipment for men not always available. There is need to set up facilities in Botswana to cater for men and accord them the dignity they deserve

Many facilities lack proper equipment and private consulting rooms with screens or partitions, making it difficult to examine men comfortably and compromising their privacy and dignity during SRH consultations.

I note that essential equipment for men is not always available in health facilities except at SMC theaters and facilities. Check-up are therefore done OPDs of SMC facilities.

There is need to establish male friendly services.

Tebelopele

Men friendly services are often inadequate, with many health facilities lacking tailored spaces, trained staff, and approaches that address the specific sexual and reproductive health needs of men and boys.

There is a need to improve men's knowledge and awareness about sexual and reproductive health services to empower them to make informed decisions and increase service utilization.

Men require psychological support as part of sexual and reproductive health services to address issues like stress, anxiety, and emotional challenges related to their sexual and reproductive well-being.

Men-friendly services often lack confidentiality and do not create spaces where men feel free to express themselves; there is a need for services that ensure dignity, comfort, and privacy to encourage men to seek sexual and reproductive health care.

MOH SRH
Clinician

Men friendly services are often not enough, with many health facilities lacking tailored spaces, trained staff, and approaches that address the specific sexual and reproductive health needs of men and boys.

SRH services for men and boys should be client-centered, meaning they must target the individual needs, preferences, and circumstances of each client to ensure respectful, responsive, and effective care, essential equipment for men not always available.

There is no equity, to let me say equity is tilted in upper case. Women are the main focus, because of their physiological challenges like pregnancy for nine months, post-partum and delivery. It is also critical that men services be looked into otherwise it's a lost group.

SRHR services are inadequate in Botswana

Health system lacking; staff, infrastructure, interventions.

Not client centric

Not equitably distributed

Men & Boys

Barriers to men accessing SRH services in the community.

Stigma associated with seeking sexual and reproductive health support is still a barrier even at this time which we thought it would be things of the past but it's still there, this happens due to lack of knowledge about the importance of SRH by most men in our communities and also lack of that little push from their partners.

Cultural expectations of masculinity discourage men from openly discussing health issues, we know that in our cultures men are expected to show strength well must of our man ba swa because they don't want to give in and get help because they will feel like they have lost their masculinity which I believe isn't that important when compared to your health.

Most men lack of knowledge about available services for SRH because they don't even go to clinics they only go there when the situation is out of hand but most men don't know little about the SRH services in their health facilities which is very scary if I may say.

Lack of male friendly SRH services Compared to women, services are lacking.

Community barriers.

Stigma about health seeking

Culture expect men to be strong

Lack of knowledge

Lack of friendly services

The Context And Local Needs Among Men

BONEPWA

Community barriers to men accessing SRH services

Stigma and discrimination it's a barrier for us-men to access services. The other thing is brought about by the lack of programs for men's health. Teaching or health education which is intentional to teach people

Community barriers

<p>about the current situation isn't available. The health worker are now faced with problems of helping patients who do know about their issues.</p>	<p>There is stigma and discrimination</p>
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Policies And Laws That Advance Men And Adolescent Boys

Opinion

<p>Integration approach of SRH services to avoid or reduce stigma and discrimination in health facilities. Integration of clinical and non-clinical interventions. The primary health care is our daily things. When clinical services are integrated, health promotion and health education become an integral part. The health talks offered at clinics every morning before patients are seen, are crucial. We can do what we call community lead interventions so that our clients participate in their care as the primary health care (Alma-Atta declaration) dictates. PHC calls for states that without community involvement they is nothing that we can achieve so we have to package our services in a way that the community has an input so I don't think they is help In separating the services.</p>	<p>Integrated services Health promotion Community participation and involvement</p>
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<p>BGBVC</p>	<p>Socio cultural factors and perceptions which are available in communities need our attention. The notion of masculinity, that people will question the presence of male client at health facilities; like what is the problem with this man? That is stigma. I think that is lack of knowledge by men about their SRH needs and understanding of their roles in family planning, STIs, and their overall sexual reproductive health.</p>	<p>Communities still lag behind</p>
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Policies And Laws That Advance Men And Adolescent Boys

<p>They are not explicit and don't prioritize the SRH needs for men which then leads to a lack of targeted intervention and funding. Isn't it why we do not understand men's need, and policies are silent about men's health hence the gap.</p>	<p>Stigma and discrimination Policies are lacking</p>
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How To Reach Men & Boys

<p>Sport & recreational settings(Bars and social clubs)</p> <p>Workplace because men will tell you they are busy working for their families</p> <p>Tertiary schools- when they become men</p> <p>Churches, reach pastors and religious people</p>	<p>Outreach services</p>
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<p>Men & Boys</p>	<p>Community barriers to men accessing SRH services</p> <p>Lack of knowledge around Family Planning options. Most man don't have lack knowledge about the variety of methods they can use to plan or prevent pregnancies (such as contraceptive pills, condoms, implants, IUDs, injections).</p> <p>Many men prefer consulting traditional doctors or healers due to cultural beliefs or mistrust of modern healthcare systems, creating a barrier to accessing formal sexual and reproductive health services.</p>	<p>Communities still a barrier. Lack of knowledge Traditional medicine for men's reproductive health Poor mental health attributed by stigma</p>
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	<p>Poor mental health can reduce men’s confidence and self-esteem, increase feelings of stigma and fear of judgment, contribute to risky behaviors like substance abuse, and ultimately lower their motivation and willingness to access essential sexual and reproductive health services.</p>	that a men should be strong
	<p>Men are a diverse population, varying in culture, beliefs, socioeconomic status, and personal experiences, all of which shape their attitudes, behaviors, and access to sexual and reproductive health services.</p>	Male –male provider
	<p>Some men may have a preference for the gender or type of healthcare personnel they interact with, such as preferring male providers over female providers, which can affect their willingness to access sexual and reproductive health services.</p>	Men fear to take time off from jobs
	<p>Men often face workplace barriers like rigid schedules, fear of job insecurity, or inability to take time off, which limit their opportunities to seek timely sexual and reproductive health services, mines and farms.</p>	Stigma, intimidation
	<p>Some men may avoid sexual and reproductive health services due to fear of intimidation or judgment from healthcare providers, peers, or the community, making them reluctant to seek care.</p>	
MOH –Disease Control Unit	<p>The absence of targeted policies and laws leads to men’s sexual and reproductive health being overlooked in many programs and services, as most national frameworks tend to focus heavily on women and children. Without clear guidelines and supportive legal structures, men’s health needs such as fertility services, mental health related to SRH, STI prevention, and access to male-friendly clinics are often ignored. This gap contributes to low male engagement in SRH services, poor health-seeking behavior, and missed opportunities to promote shared responsibility between men and women in matters of sexual and reproductive health.</p>	Lack of targeted policies.
	<p>Non-clinical, community-based support plays a crucial role in reaching men where they are, offering SRH education, counseling, and services in familiar and comfortable environments such as workplaces, sports clubs, churches, and other community settings. This approach helps to reduce stigma, increase trust, and improve accessibility for men who might avoid formal health facilities.</p>	Focus on community based approaches because men don’t like going to facilities
	<p>Clinical support provides men with SRH services through formal health settings, but it is sometimes underutilized due to barriers like lack of privacy and male-friendly services.</p>	
Tebelopele	<p>We do not criminalize same sex marriage but it is not allowed. We however need to make some changes in the national identity cards to accommodate these minority groups.</p> <p>When it comes to our settings for service provision, a lot needs to be done, There is need to expand on male friendly clinics and pilot services provisions. There may be need to change, male clients to be cared for male providers and females by females.</p> <p>The settings for service provision could be clinical and non-clinical. We know that males are reluctant to attend clinical setting, This calls for an increase in community setting to accommodate men.</p>	
MOH- SRH Unit	<p>Policies are available but they are not explicit and don’t prioritize the SRH needs for men and boys. They are not man specific they are general to include all groups of people. Policies which are available are so general</p>	Policies lack focus on men

to issues of access and coverage of people, equity, regardless of gender and providers are also generalist. Moreover, policies available policy for SRH tend to focus on women only.

Pilot project on men SRR services.

I feel we can afford to develop a men sector in our health system. If this sector available it will create a platform where men's health issues can be learnt. My suggestion is to do this as a pilot or trail for may be a year and half, with a set of indicators to track, analyse and have recommendations of how to proceed. We will even learn how to make friendly for a men.

Organization And Workforce Commitment To Providing SRH Services For Men

BONEPWA	<p>Training to increase commitment to men's SRH. We need to upskill workers to increase their level of comfort to provide services. Some workers have never encountered SRH men clients, they need training so that train they accept men from diverse populations. Service providers may even need Psychosocial support to accept these populations.</p>	<p>Training to upskill provider with service provision to MSM</p>
	<p>Health workers since need to know about the WHO service packages s that when they meet diMSM at the clinics hey will know how to care for them and render provide appropriate care. You may find that one's religious beliefs are a barrier to service delivery, the battle with how to balance work and religion without violating the rights of clients and their personal rights. Health works need to be trained to offer services to these groups.</p>	<p>Religious clashes need to be avoided between client and provider</p>
	<p>The proposed package ya WHO should be introduced to the community to get the response from the communities so that they too can accept it these populations and if there is clash in rights something can be done to avoid a one sided situation.</p>	
Men & Boys	<p>I believe intensive training is necessary because many staff members lack the necessary training and confidence to deal with issues like MSM some stuff members don't know how to deal with such patients that is where we end up with confidentiality concerns. There is a need for specialist training to make SRHR services more inclusive for men, training should focus on better understanding SRHR challenges specific to men.</p>	<p>Training</p>
	<p>A community-based approach ensures that SRH services are delivered in familiar, trusted, and accessible spaces, helping to break down barriers such as stigma, distance, and lack of awareness that often prevent men and boys from seeking care.</p>	<p>Community based approaches</p>
Tebelopele	<p>There is need for capacity building because some healthcare providers may be influenced by cultural and religious beliefs that affect how they deliver sexual and reproductive health services to men, and these issues need to be confronted through continuous training and sensitization.</p>	<p>Capacity building across sectors</p>
	<p>Men's clinics are often not easily accessible due to factors such as high costs, remote geographical locations, and limited coverage, making it difficult for many men to seek sexual and reproductive health services.</p>	<p>Cost</p>
	<p>There is a need to develop specialized human resources with the skills and knowledge required to address the specific sexual and reproductive health needs of men and boys in a sensitive and effective manner.</p>	<p>Lack of geographical access</p>

		Develop skills
MOH Diseases control Unit	<p>The PHC model is effective because it supports both clinical and non-clinical approaches to SRH service delivery, but community health workers need capacity building and training to effectively engage men and deliver male-friendly services at the community level.</p> <p>There is a need to build capacity by training health workers on male SRH services, focusing on gender sensitivity, effective communication, male-specific SRH knowledge, psychological support, clinical skills for men's health, community outreach, and monitoring to improve service quality and male engagement</p>	Training of CHW
MOH-SRH Unit	<p>There is a need to develop specialized human resources with the skills and knowledge required to address the specific sexual and reproductive health needs of men and boys in a sensitive and effective manner.</p> <p>Men's clinics are often not easily accessible due to factors such as high costs (most of them are private clinics) and remote geographical locations, making it difficult for many men to seek sexual and reproductive health services.</p>	<p>Capacity building across sectors</p> <p>Specialized HR for SRH services for men & boys</p> <p>Lack of access due to cost</p>
Primary Prevention And Integrated Approach		
BONEPWA	To an extent the government is doing well. We will shift service provision to include men. Primary healthcare is good and it's non-discriminatory, it's a universal access to services by anybody. Content missed on men's health. Services should be accessible at any time, nothing like its 3pm you should come. We need integrated services at any time of the day.	Access all day
Tebelopele	<p>Although attempts are being made, there is a clear need for ongoing research to identify and implement up-to-date and effective approaches.</p> <p>Non-clinical settings, such as Sunday soccer matches or community choirs, are often more preferred than clinical settings because they provide a relaxed and familiar environment for engaging men in health education and services.</p> <p>Integrating boys and adolescents into school health programs helps especially secondary and boarding schools.</p>	<p>Ongoing research</p> <p>Community gatherings will be ideal for health education</p>
MOH-Disease Control Unit	<p>Both clinical for those with ailments, where treatment and interventions are rendered. These should be provided at all levels of care, hospitals, clinics</p> <p>The lower levels (clinics and mobile stops), we can render consultations, health education and promotion on men and boys sexuality. Special education in schools, integrated with sexuality education curriculum for schools.</p>	Both clinical and community based, CSE
MOH-SRH Unit	Non clinical setting will be helpful for us, since we already have an issues with men attendance to facility based services. Non clinical setting should spell out clearly the type of services and context at which they are provided. The service providers must be non-clinical as well.	Non- clinical settings most preferred.

<p>Integrating boys and adolescents into school health programs helps provide them with essential knowledge, skills, and access to sexual and reproductive health services, promoting healthier behaviors from a young age.</p>	<p>School health to include SRH services for boys,</p> <p>CSE</p>
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Recommendations

<p>MOH-Disease Control Unit</p>	<p>A needs assessment is essential to identify gaps in male-focused SRH services, understand men's unique health needs, and guide the development of targeted interventions and programs.</p> <p>The needs assessment process should be strengthened through collaboration with NGOs, as they have valuable community insights, resources, and experience in reaching men and boys with tailored SRH services.</p>	<p>Needs assessment for a deeper understanding of men and boys needs</p>
<p>Men & Boys</p>	<p>Creating strong partnerships with CBOs is key to extending SRH services to hard-to-reach men and boys, leveraging local trust and networks to enhance awareness, engagement, and service delivery in the community.</p> <p>Increase funding for Men's health</p>	<p>Partnerships with CBOs</p> <p>Funding</p>
<p>MOH SRH Unit</p>	<p>The guidelines, training manuals and policies for integrated GBV services are available at MOH.</p> <p>There need to train operationalize, roll out and engage with CSO in the implementation of these.</p> <p>Packaging of SRH services will only need to align with the already available minimum package of integration.</p>	<p>Training</p> <p>Packaging of services</p>
<p>BONEPWA</p>	<p>Review policies to include men and boys, because truly, we can't function with outdated policies which are 20 years old, reviewing health policies to know where are, and where the gaps are will help.</p> <p>We often advocate for community lead monitoring, community lead interventions what do we mean when we don't know anything about men and boys' health, how do we monitor them, how do we package our community interventions How do we model the , how do we teach them, we should listen to communities because they have the knowledge. We community workers we should have people within the communities to implement, lead and monitor interventions with our society.</p>	<p>Policy review to embrace men's health</p> <p>Community Involvement and community lead interventions</p>