

**FACTORS INFLUENCING UPTAKE OF SAFE MEDICAL MALE CIRCUMCISION
AMONG MEN AGED 18-38 YEARS IN RWETA VILLAGE,
PALLISA DISTRICT**

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DECLARATION

I declare that this research report has never been submitted for any academic or professional award of Bachelors in Nursing. It is out of my own research and is original.

NAISANGA FARIDA

Signature 

Date.....

APPROVAL

This research report has been prepared under my supervision, right from the start up to this stage and submitted with my approval.

MR. AFAYO ROBERT

Signature

Date.....

DEDICATION

This work is dedicated to my beloved mother Mrs Babirye Zubeda, my lovely daughters Mariam Nalubega and Fartiha Nalubega and lastly my great friend/ husband Mr. Lubega Jibril.

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My sincere thanks go to the University supervisor, Mr. Afayo Robert who read and critiqued my earlier drafts of this report and for guidance during the course of the study

TABLE OF CONTENTS

Declaration.....	i
Approval.....	ii
Dedication.....	iii
Acknowledgement.....	iv
Table of contents.....	v
List of figures.....	ix
List of tables.....	x
Definition of terms.....	xi
List of abbreviations.....	xii
Abstract.....	xiii

CHAPTER ONE: INTRODUCTION

1.1 Background of the study.....	1
1.2 Problem statement.....	2
1.3 General objective.....	2
1.3.1 Specific Objectives.....	2
1.4 Research Question.....	3
1.5 Justification of the Study.....	3
1.6 Conceptual frame work.....	4

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction.....	6
2.1 Level of uptake of safe medical male circumcision among men aged 18-38 years	6
2.2 Socio-demographic factors influencing uptake of safe medical male circumcision among men aged 18-38 years	8
2.3 The client related factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta Village	10
2.4 The health facility factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta Village	11

CHAPTER THREE: METHODOLOGY

3.1 Introduction.....	14
3.2 Study Design.....	14
3.3 Study setting.....	14
3.4 Study population	14
3.5 Sample size	14
3.6 Sampling procedure	15
3.7 Inclusion criteria	16
3.8 Exclusion criteria	16
3.9 Sources of data.....	16
3.10 Definition of variables	16
3.11 Research instrument.....	16

3.12 Data collection, storing and analysis description.....	17
3.13 Reliability and validity of the tool (Steps to minimize errors/Bias)	17
3.14 Ethical issues.....	17

CHAPTER FOUR: PRESENTATION OF RESULTS

4.1 Introduction.....	18
4.2 Socio-demographic characteristics of respondents.....	18
4.3 Level of uptake of safe medical male circumcision.....	19
4.4 Relationship between socio-demographic factors and uptake of safe medical male circumcision	20
4.5 Client related factors influencing uptake of safe medical male circumcision	21
4.6 Health facility related factors influencing uptake of safe medical male circumcision	21

CHAPTER FIVE: DISCUSSION

5.0 Introduction.....	23
5.1 Uptake of safe medical male circumcision	23
5.2 Socio-demographic factors influencing uptake of safe medical male circumcision.....	24
5.3 The client related factors influencing uptake of safe medical male circumcision.....	25
5.4 The health facility factors influencing uptake of safe medical male circumcision.....	26
5.5 Methodology Issues (Shortcomings)	27
5.6 Conclusions and Recommendations	28

REFERENCES	29
APPENDIX I: Consent	32
APPENDIX II: Questionnaire.....	33
APPENDIX III: Introductory Letter	39
APPENDIX IV: Correspondence	40

LIST OF FIGURES

Figure 1: Conceptual frame work	4
Figure 2: Level of uptake of Safe medical male circumcision among 243 men in Rweta village.....	19

LIST OF TABLES

Table 1: Socio-demographic characteristics of 243 men aged 18-38 years in Rweta Village, Pallisa.....	18
Table 2: Socio-demographic factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta village	20
Table 3: Client related factors influencing uptake of safe medical male circumcision among men aged 18-38 years Rweta village	21
Table 4: Health facility factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta village	22

DEFINITION OF TERMS

- Male circumcision: - Is the removal of the foreskin from the human penis.
- Adolescent - Describes the teenage years between 13 and 19 and can be considered the transitional stage from childhood to adulthood.
- Pre-pubertal circumcision: - Refers to circumcision before adolescent age.

LIST OF ABBREVIATIONS

VMMC	-	Voluntary Medical Male Circumcision
WHO	-	World Health Organization
MOH	-	Ministry Of Health
UNAIDS	-	United States Agency for International Development.
HIV	-	Human acquired Immune Virus
SMMC	-	Safe Medical Male Circumcision
AIDS	-	Acquired Immune Deficiency Syndrome
CBS	-	Central Bureau of Statistics
MC	-	Male Circumcision
CI	-	Confidence Interval
STI	-	Sexually Transmitted Infections
STDS	-	Sexually Transmitted Diseases
RCT	-	Routine Counselling and Testing
MOHSS	-	Ministry of Health and Social services
DHS	-	Demographic and Health Surveys

ABSTRACT

Introduction:

The topic of the study was Factors influencing uptake of safe medical male circumcision among male aged 18-38 years in Rweta village Pallisa district.

Objective: Asses factors influencing the uptake of safe medical male circumcision among male aged 18-53years in Rweta village Pallisa district.

Methodology:

Crosses sectional study was done and correspondents conveniently selected questionnaires were used to obtain data.

Results:

client related factors found to influenced uptake of safe medical male circumcision (importance of male circumcision X^2 71.578, $p < 0.001$, would like to be circumcised X^2 16.285, $p < 0.001$, knew importance of safe medical male circumcision X^2 52.187, $p < 0.001$, ever heard of medical circumcision (X^2 7.925, $p = 0.005$, ever heard of male circumcision reducing HIV infection X^2 12.138, $p < 0.001$ medical circumcision increases sexual feeling X^2 32.114, $p < 0.001$, fear of losing sexual time during recovery X^2 18.984, $p < 0.001$, male circumcision is painful X^2 43.675, $p < 0.001$) and only two health facility factors were found to influence uptake of safe medical male circumcision (welcoming health worker X^2 7.644, $p = 0.006$, and waiting time X^2 9.479, $p = 0.002$). The socio-demographic factors that influenced uptake of medical male circumcision (level of education X^2 13.007, $p = 0.005$, marital status X^2 8.202, $p = 0.042$, tribe X^2 8.576, $p = 0.036$, religion X^2 35.952, $p < 0.001$, occupation X^2 13.809, $p = 0.003$).

Conclusion:

It was concluded that majorities of people knew the advantage of safe medical male circumcision informally and thus have fears in taking up medical male circumcision.

Recommendation:

It was recommended that more emphasis should be put in health educating the community on advantages of safe medical male circumcision and bring services to where people work.

CHAPTER ONE: INTRODUCTION

This chapter presents the background of the study, problem statement, purpose of the study, specific objectives, research questions, justification of the study and conceptual framework.

1.1 Background of the study

Voluntary medical male circumcision (VMMC) is removal of fore skin of the penis surgically by trained professional. According to WHO (2014), this procedure was found to be effective in the prevention of HIV transmission because the fore skin creates a moist delicate part of the penis and the inner surface of the fore skin contains cells that are especially vulnerable to infection by HIV. Therefore removal of fore skin of the penis makes it tougher and resistant to infection. It was also noted that minor tears in fore skin makes it easy for HIV virus to penetrate in to the body (Rob, 2008).

About 25 circumcisions are performed worldwide in a minute with over 25% circumcised for religious, cultural, social or medical reasons (Moses, 2008). In a research done in 2014 in 14 African priority countries 3,240,977 males were circumcised; a 22% increase from 2013 and a 75% increase from the annual number of circumcisions performed just five years ago in 2010. The potential rise was due to recommendation by WHO and UNAIDS based on the 20.8 million VMMCs that are needed to achieve 80% coverage. The recommendation was adopted after three randomized controlled trials carried out from 2005 to 2007 in Orange Farm, South Africa (2005), Kisumu, Kenya (2007), and Rakai District, Uganda which revealed that medical MC lowers the risk of HIV transmission in heterosexual relationships by 60% (WHO, 2012).

WHO and UNAIDS recommended VMMC in Fourteen priority countries with Uganda included. These countries have high HIV prevalence, but with lower levels of male circumcision implementation. The target was to circumcise 80% of men between 15-49 years by 2015 (WHO-UNAIDS 2007 and Weiss *et al.*, 2008). The services were also to be provided to infants as well as adolescents for long term benefits. According to Njehumeli et al. (2011), Uganda target was at 12.7%. In Uganda MOH recommended SMMC for all men and made it available through the public health system. It also mobilized the public and promoted the uptake of SMMC services

among men 15 years with assistance from Health Communication Partnership (WHO, 2015). The policy was adopted in National Safe Medical Male Circumcision (SMMC) Policy in 2010.

1.2 Problem statement

Globally 36.7 million people are living with HIV, with sub-Saharan Africa having two-thirds and 46% of new cases reported in Eastern and Southern Africa. The ages 15-24, account for 35% of new HIV infections. In sub-Saharan Africa, this is linked not having access to prevention, care, and treatment of people living with HIV or at risk for HIV in a global (HIV/AIDS Epidemic, 2016).

Ugandan HIV burden is still high and this has resulted in continued spread of HIV, with estimated increasing number of people living with HIV of 1.4million in 2011 to 1.6M in 2013. (UGA narrative report 2014). Scaling up circumcision programs in 13 priority countries to 80% of uncircumcised men within 5 years requires a total of 20.3 million circumcisions performed. A further 8.4 million performed between 2016 and 2025, averting an estimated 3.4 million new HIV infections and 386,000 AIDS deaths through 2025 (Njeuhmeli *et al.*, 2011). Poor SMMC result into poor protection against female to male HIV transmission (Byakika-Tusiime, 2008).

The research intends to explore the factors that may have hindered the adoption of SMMC policies and strategies. If the study is not carried out there is a likely increase in the chances of HIV infection as circumcision reduces the chances HIV. The study will concentrate on men aged 18-38 years in Rweta village, Pallisa District as they are highly vulnerable to HIV infection due to low adoption progress.

1.3 General objective

To assess the factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta village so as to promote this strategy in reducing HIV/AIDS.

1.3.1 Specific Objectives

1. Determine the level of uptake of safe medical male circumcision among men aged 18-38 years in Rweta village.
2. To determine the socio-demographic factors influencing uptake of safe medical male

circumcision among men aged 18-38 years in Rweta village.

3. To establish the client related factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta village.
4. To establish the health facility factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta village.

1.4 Research Question

1. What is the level of uptake of safe medical male circumcision among men aged 18-38 years Rweta Village.
2. What are the socio-demographic factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta Village.
3. What are the client related factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta Village.
4. What are the health facility factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta Village.

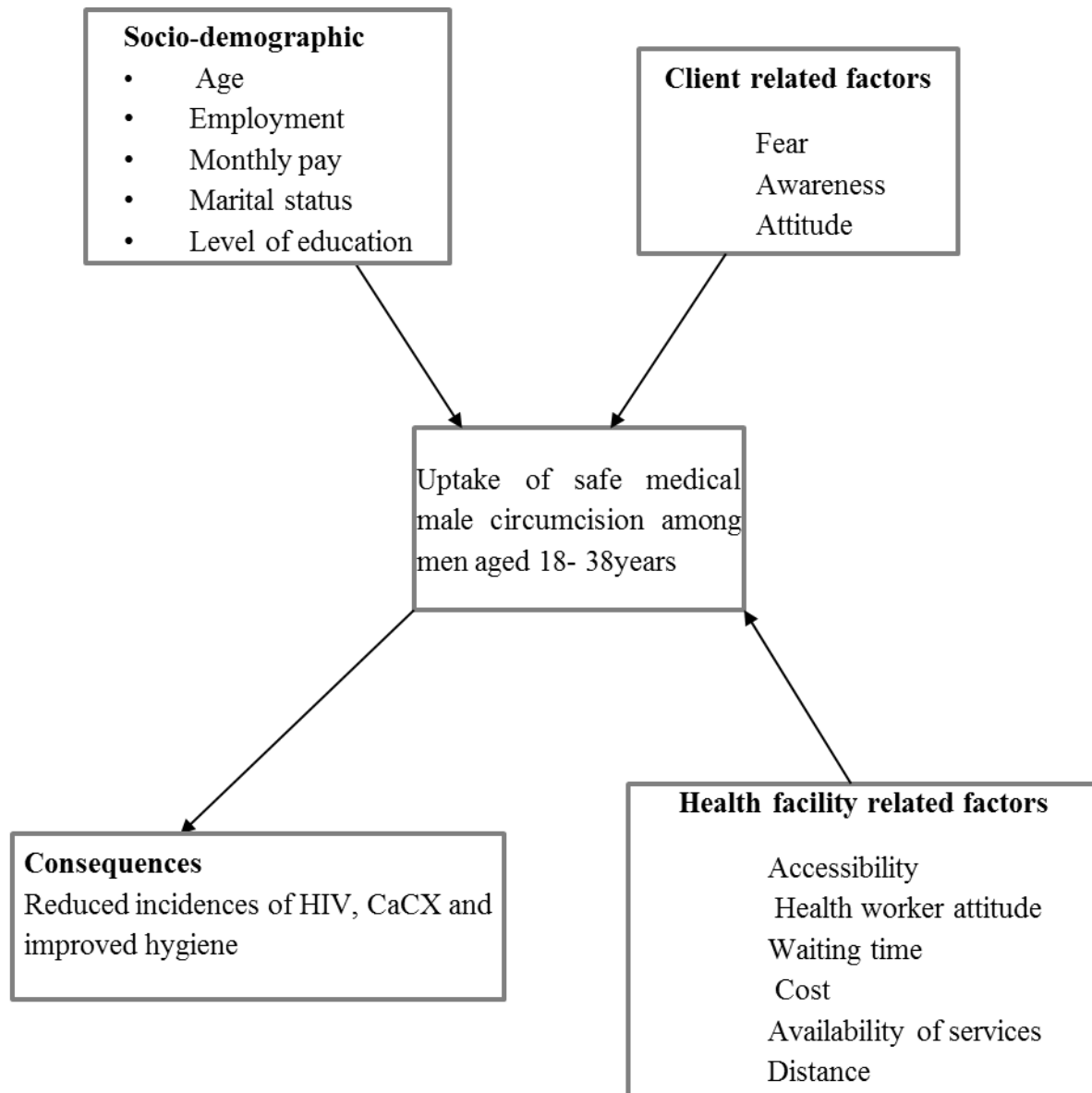
1.5 Justification of the Study

The study is expected to be useful to these categories of people in the following ways;

- i. It is hoped that this study will generate information that will be useful to policy makers and Ministry of Health to understand why uptake of safe male circumcision is still low among the males especially in rural areas. Thus a basis for formulating solutions that will improve the uptake of SMMC among males.
- ii. To the nursing education, the results from this study will again serve as an academic purpose to other researcher who will be interested in a study concerning safe medical male circumcision.
- iii. To the researcher, the study will work as a partial fulfillment of the requirement for the award of Degree in Nursing Science.

1.6 Conceptual frame work

Figure 1: Conceptual frame work



The conceptual frame work shows that the level of uptake of medical male safe circumcision is influenced by socio-demographic, client and health facility related factors.

On the socio-demographic factors, it is thought that male circumcision is determined by age, employment, monthly pay, marital status and level of education.

On the client related factors, the conceptual framework shows, fear, level of awareness' and attitude determines the level of utilization of safe medical male circumcision among men aged 18-38 years.

Lastly, the health facility related factors too like Accessibility, health worker attitude, waiting time, cost, availability of services and distance also influence uptake of safe medical male circumcision among men aged 18-38 years.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This chapter presents the literature review as obtained from books and journals by other scholars about the factors influencing uptake of safe medical male circumcision. The chapter is arranged according to the study objective following subheadings:-patient, social-economic and health facility related factors respectively.

2.1 Level of uptake of safe medical male circumcision among men aged 18-38 years

According to Rizvi et al. (2009) in a study conducted on 150 participants about Religious Circumcision. It was revealed that worldwide there quite a plethora of male circumcision. The most noted one commonly practiced involves the complete excavation of the foreskin of the penis to expose the entire glans of the penis (Doyle, 2005). The study also revealed that historically male circumcision has been largely based on religious and cultural identity. For instance almost entirely Muslim and Jewish males undergo circumcision based on the belief that a covenant was made between Abraham and God (Rizvi et al., 1999).

Reports indicate that about 30% of the world's males population of the age of 15 years or older are circumcised. Two thirds of these populations making about 69% are majorly Muslims occupying parts of Asia or Middle East and North Africa). The rest are Jewish making 0.8% and non-Muslim and non-Jewish men residing in the United States of America making 13% (WHO and UNAIDS, 2007).

The trend of adult male circumcision in countries occupying the Southern part of Africa varies tremendously. The prevalence rates in countries like Zimbabwe, Zambia and Swaziland are rather low making about 15% (WHO and UNAIDS, 2007). On the other hand, other countries like Malawi (21%), Botswana (25%), South Africa (35%), Lesotho (48%), Mozambique (60%), Angola (66%) and Madagascar (80%) have a higher prevalence rate of adult male circumcision (WHO and UNAIDS, 2007). In Southern Africa and generally in the rest of Africa the proportion of circumcised men tend vary in relation to provinces and ethnicities (WHO and UNAIDS, 2007). For instance in Kenya, Demographic and Health Survey (DHS) conducted in 2013 documented that a total of 84% Kenyan's were circumcised. The trend was generally low

in Nyanza Province (46.4%) to about (100%) in Eastern province and also low within the Luo ethnic group (17%) (CBS et al., 2014). In Namibia the Demographic and Health Survey studies conducted on males aged 15-59 years (n=3,915) indicated a 21% men under went circumcision (MOHSS, 2014). The survey further revealed that the observed prevalence rates varied with regions. In centrally located regions occupied by Himba and Herero ethnics the rates ranged from 41% to 57 %. On the other hand in the Northern regions occupied by Oshiwambo ethnics the rates were lower estimated at 14% (MOHSS, 2008). As observed in Namibia the trend in male circumcision does not differ significantly in the rest of Africa attributed to difference in ethnicities and culture of people residing in the areas (WHO and UNAIDS, 2007).

Nnko et al. (2011) conducted a study on factory workers in the North-west Tanzania and noted originally non-circumcising groups were increasingly adopting male circumcision. The study attributed this to population started perceiving MC as a way to prevent HIV. In addition the practice was believed to enhance penile hygiene, reduce the incidence of other sexually transmitted diseases, and enhanced cure rates for STDs.

The majority MC programs have placed emphasis on adult male circumcision an approach that has yielded some level of success. One noted instance involved the circumcision of more than 90,000 as of January 2010 (Dickenson and WHO, 2010). On the other hand children male circumcision has lagged behind due to less attention given to it from public health professionals. This is probably because public health benefit obtained from young male circumcision tend accrue over time or not immediate and that also infant circumcision is safer and yields less adverse events (WHO and UNAIDS, 2007).

Two meta-analyses of observational studies conducted in sub-Sahara Africa published in 1999 and 2000 reported a decline in HIV infection risks among circumcised men in comparison to their uncircumcised counter parts. The studies reported the decline in risk amounted to as high as half that of uncircumcised men (crude Relative risk (RR) 0.52, 95% CI 0.46-0.68) (VanHowe, 1999; Weiss et al., 2000). Auvert et al. (2005) carried out voluntary HIV counselling and testing study involving 3,274 uncircumcised men in a range of 18 – 24 years. The rate of incidence of the infection was around 0.85 per 100 person-years in the intervention/test group and the control group about 13 and 2.1 per 100 person-years representing a RR of 0.40 (95%CI:

0.24% – 0.68%; $p= 0.001$). Additional studies involving voluntary counselling and testing were conducted in 2007 in Kenya (Kisumu) and Uganda (Rakai) among individual participants of 2784 (18 – 24 years) and 4996 (15-49 years) HIV negative uncircumcised males respectively (Bailey et al., 2007; Gray et al., 2007). In these studies it was found MC reduced the risk of HIV infection to about 53% in the Kenyans (Bailey et al., 2007) and 51% in Ugandans (Gray et al., 2007). Following these studies, in 2010 the Ministry of Health in Uganda opted for a National Safe Male Circumcision Policy that emphasized voluntary safe medical male circumcision for all men and made it publically accessible in all health systems.

2.2 Socio-demographic factors influencing uptake of safe medical male circumcision among men aged 18-38 years

In originally non-circumcising communities there is indication that increased high socio-economic status has resulted into increased rates of circumcision. The data was availed based on a study conducted on uncircumcised men in sub-Sahara African countries involving purposively individuals divided into 12 focus group discussions (Roloff et al., 2011). In this study it was found out that high level of education and urban settings were associated with high rate of circumcision. The higher levels of education may imply social contact with a wide range of ethnic and religious categories thus increases the chances of circumcision given such socio-behavioural interactions.

A cross sectional study was conducted in Lesotho to elucidate the motivation and barriers to Safe VMMC involving 161 participants. The study revealed that health was the major driving motivation for circumcision. Many men noted the need to protect against HIV infection (73%) and other STDs (62%) while others noted improved penile hygiene (47%) (Skolnik et al., 2014). In another study separately conducted in South Africa it was revealed sexual reasons as a motivating factor for circumcision. Men were 8 times more likely to uptake circumcision if believed that circumcised men enjoyed sex more, and 6 times more likely to uptake circumcision if believed women enjoyed sex more with circumcised men. The study also noted that old men accept with enthusiasm if believed that circumcision will increase their ability to satisfy their partners (Scott et al., 2010). The study did not differ from what was observed in rural Uganda

where enhanced sexual pleasure was a motivational factor for circumcision (Miir-Nakayima et al., 2010).

Wambura et al. (2011) conducted cross-sectional study in Northern Tanzania to determine the level of acceptance of safe MMC in the traditionally circumcising communities. In the study questionnaires were administered to 170 males and 189 females that were randomly selected. In the study more preference was indicated for pre-pubertal circumcision in the medical setting and this was associated with above primary school education, non-Kurya tribe group residing in urban areas. The study further revealed that the proportion of males circumcised in clinical settings were generally. The study also showed that, males circumcised in the clinical settings were younger compared to those circumcised in the traditional settings. This was attributed to the believe that traditional circumcision prepares the boy into manhood to take up social responsibilities. In other settings like in the South African Eastern Cape region initiation into manhood after a medical circumcision still lacks acceptability as (70%) due to fear for stigmatization.

In Rwanda a cross-sectional study involving 200 respondents revealed acceptability of pre-pubertal circumcision in the medical setting. The respondents noted that pre-pubertal circumcision results in quick wound healing, less pain and bleeding and generally minimal loss of work time during wound healing period. Further pre-pubertal medical circumcision has no likely hood of increased sexual behavior following circumcision. The practice also provide enough time for wound healing and keratin development reducing the risk of acquiring HIV infection that tend to happen if sex resumed before wound healing (Binagwaho et al., 2010). Asimwe et al. (2013) conducted a qualitative study in Kampala Uganda involving 350 male participants in a group focus discussion. The study aimed at uncovering the social cultural factors impacting on HIV/AIDS. The study cited male circumcision was influenced by traditional practices and tends to be prevalent in the late teen to adult years rather than with infants. The study recommended that MC needs to analyze how best to accommodate such traditional practices.

Other socio-demographic factors like cost of circumcision impact significantly on the level of uptake of MC. A descriptive survey conducted in Kenya involving 130 males and 130 females

revealed that MMC was more costly in comparison to the traditional circumcision procedure. The greater populations of people especially living in rural settings are not able to pay for the procedure (Bailey et al., 2008). Other barriers included factors such as friendly service delivery encompassing considerations like proper communications, women participation for the purpose of encouraging their spouses, and counselling for postsurgical abstinence. These barriers were cited in a 16 focus group discussion conducted in Tanzania in districts of Iringa and Njombe (Marya, 2013).

2.3 The client related factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta Village

A descriptive study involving 50 traditional parishioners formed into discussion groups conducted in Tanzania noted that the uptake of MC was influenced by both women and men's perception in relation to region culture and social concepts. These factors were dimmed to vary depending on the region and country. The study revealed that up to 80% of the individuals were willing to opt MC if it would protect against HIV infections. In the study also more than half of the females would prefer circumcised males as sexual partners (Mboera et al., 2009). In a related study factors like bleeding and pain during surgical procedures were noted to about 39.3% (N=33) among the participants that would not prefer MC while 48.8% (N=41) of participants had surgical fears. The descriptive study involved 84 male adolescents participants from Nanogang community (Yewondwossen, 2012).

To investigate sexuality and sexual functioning as barriers to MC descriptive studies were conducted. The studies were based on prevailing information that removal of penis foreskin is associated with gradual reduction in sexual feelings and sensations. In one of the descriptive study it was reported that about two thirds of circumcised experienced difficulty during masturbation, about 20% noted worsening of their sexual lives while 6% reported improved sexual lives after circumcision (Chow et al., 2014).

In another descriptive and qualitative study conducted in Nyanza and Kenya about hindrances to the adoption of VMMC, it was reported that fear of pain during and post-surgical operation, sexual abstinence during the healing period and cost in terms of finances and time off work are significant hindrances towards the adoption of safe male circumcision at the individual level.

The concerns were more pronounced among uncircumcised men and women with uncircumcised sexual partners. Young adult men generally were less concerned, the concerns were more observed among men aged 25 and 35 years. A greater proportion of women about a half had no concerns about the financial situation of their partners during this period and were more willing to provide assistance. The financial earnings of more than half of the circumcised men were not compromised and basically those with financial concerns were based on misinformation. The period required off work (generally 2-3 days) and abstinence following the procedure (about 6 weeks) was confused by some men (Evens et al., 2014). Similarly the nature of employment also happened to be a blocking factor seeking MMC. Males engaged in transport sector like boda-boda riding, manual work and fishing were reluctant to obtain MMC services (Evens et al., 2014).

Even et al. (2014) further investigated the impact of abstinence on the uptake of VMMC. In focus group discussion about a third of men cited abstinence as a concern. The men mentioned that that they could not hold sexual urge during the period of healing and even their partners may not be able to accommodate it. The men who were less concerned about abstinence period mentioned the long term benefits and therefore were worthwhile. They also recommended talking to their sexual partners before the procedure.

Another study was conducted in Tanzania in regions of Iringa and Njombe intended to identify social and individual factors affecting the adoption of VMMC. The study contained 142 participants grouped into 16 divisions for discussion purposes stratified by sex and age. From the study it adult males reported shame associated with seeking VMMC in the same locations with younger males as a major social and personal hindrance. They also noted of inappropriateness of VMMC to be conducted after marriage when having children (Plotkin et al., 2013).

2.4 The health facility factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta Village

The major health barriers for the efficient uptake of SMMC included; Costs on transport, insufficient clinical settings, the quality of services, insufficient tools and supplies, lack of

qualified staffs to provide the services, and low level of experience in relation to how and when to provide fixed versus mobile services (Herman-Roloff et al., 2011 and Odeny et al., 2012).

Regarding quality assurance, a study was conducted by Kigozi et al. (2008) on 30 health facilities that were purposely selected. From the study it was found out that there was no male Circumcision Quality Assurance Standards being implemented in the facilities visited so as to assure quality of male circumcisions being performed. Therefore in such units men are unlikely to utilize services for SMMC due to fear of acquiring complications emanating from lack of quality assurance.

In an interview conducted on health workers in Zambia about the limitations to the adoption of SMMC, the health workers cited lack of adequate infrastructure and long waiting time before the procedure. The workers further mentioned that space in theatre would only be chanced for male circumcision and only three procedures could comfortably be done on a clinic day. From the findings, 60% of level two hospitals had adequate space compared to 22% for level one hospitals. The challenges were primarily with counseling areas, including waiting area, operating space, and recovery areas (MOH Zambia, 2009).

Health facilities has always had a challenge of surgical supplies meant for circumcision, this was cited by Lukobo and Bailey (2007) in their study, supply of consumables used in circumcision across the country has not been standardized. Major challenges being experienced in the facilities were stock outs of sutures (cut-gut), disinfectants for infection prevention and plastic aprons. Similarly, Muula (2007) reported health facilities using general medical surgical supplies not meant for circumcision being used to offer male circumcision.

Shortage of health workers dedicated to medical male circumcision and provision of services at certain times only were cited in a study carried out by Wilcken et al. (2010). In health facilities not oriented/trained in the male circumcision programme SMMC was done primarily by medical officers. Thus due to inadequate staff, safe male circumcision is hindered.

Muula (2007) study revealed insufficient knowledge on male circumcision services offered in first, second and health center facilities as hindrances to seeking medical male circumcision. It was found that the Health Management Information System (HMIS) officers have not been

involved in male circumcision work. This implies that male circumcision services may be hindered.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter explains the various methods and procedures that were used and followed while conducting the study. This include the research design, study setting, study population, sampling procedure, source of data, study variables, research instruments, data collection procedures, reliability and validity of the tool (Steps to minimize errors/bias), ethical issues and limitations of the study.

3.2 Study Design

The study design that was a cross sectional and descriptive, employing both quantitative and qualitative data collection methods. It crossed sectional type of design because a number of variables like age, gender, level of education, occupation, marital status, will be studied at a single point in time. It was descriptive because it gave study different factors hindering uptake of safe male circumcision.

3.3 Study setting

The study was carried out in Rweta village the people in this village participate in trade activities. The common languages spoken are Lugwere, Lusoga, Ateso and Luganda since the majority of the people in the area of Bantu speaking group.

3.4 Study population

The study population was male while the target group was male aged between 18-35years of age.

3.5 Sample size

The total sample size was (241) respondents because of limited time and other limited resources.

In this study, the sample size will be calculated using a sample size formula by Kish Leslie (1996);

I.e. $n = \frac{Z^2 p (1-p)}{Q^2}$

Q^2

Where,

n is the sample size from N= general population

Z= standard normal variance =1.96

P= prevalence= 26%

Q= error which is allowed = 0.05

Therefore,

$$n = \frac{[(1.96)^2 \times 0.11(1-0.11)]}{0.05^2}$$

$$n = \frac{3.8416 \times (0.11 \times 0.89)}{0.05^2}$$

$$n = \frac{(3.8416 \times 0.0979)}{0.0025}$$

$$n = \frac{0.37609264}{0.0025}$$

$$= 241$$

Therefore, the size was 241 respondents.

3.6 Sampling procedure

With the assistance of LC 1 and village health team, all men aged 18-38 years and were willing to participate were enrolled in the study from Monday to Friday.

3.7 Inclusion criteria

- Males aged 18-38 years
- Being able and willing to give informed consent and to participate in the study

3.8 Exclusion criteria

- Those who were busy and not willing to participate in the study.

3.9 Sources of data

Data was gathered from two sources, the primary and secondary source.

Primary source:

This involved moving to the field aimed at gathering data, related to the research objectives. This was done in this way because the study required obtaining first-hand information from the respondents to be circumcised. This kind of data was obtained using an interview guide.

Secondary source:

This data was collected from secondary sources and published literature on the topic under study. This was done so as to back up the primary data and it was to be obtained from newspapers, published research, catalogues, pamphlets and text books, magazines, internet/websites and several other sources.

3.10 Definition of variables

The study variables in the study were independent and dependent variables. The independent variables were demographic data such as age, religion, tribe, marital status occupation, patients, social-cultural and institutional related factors. Then the dependent variables in the study were uptake of safe male circumcision services.

3.11 Research instrument

The study used pre-tested interview guide because some people were illiterate to fill the questionnaire. The interview guide comprised of both open and close ended questions.

3.12 Data collection, storing and analysis description

Pretested questionnaires with both open and close ended questions were used in the study. The researcher student trained two (2) research assistants who helped her in data collection. Questionnaires and interview guides were distributed and given out over a total of five days. Respondents who were able to read and understand got self administered questionnaire, as the researcher plus the two research assistants assisted the illiterate to read, interpret and fill in the responses correctly. Anonymity was maintained; the questionnaires were placed in a sealed manila folder and kept in safe custody at the end of each session. Only the researcher handled filled in questionnaires and kept them under key and lock. The data was coded first, cleaned manually then later entered and analyzed using Statistical Package for Social Science (SPSS). Descriptive statistics including percentages, pie charts and graphs were generated using this programme then data was to be backed up on a disc to avoid virus corrupting all the work.

3.13 Reliability and validity of the tool (Steps to minimize errors/Bias)

The data collection instruments were pre-tested among the males at the circumcision center in Kibuli Hospital to determine their validity. Corrections were made before the final administration of the instrument to the respondents. The reliability of data collection instrument were achieved by designing the instruments according to study objectives. Data was managed by the researcher herself to ensure confidentiality, security and accuracy. Data were completed and stored in the computer to avoid losses.

3.14 Ethical issues

Upon approval of the proposal by the supervisor an introductory letter from the administration of the Academic Registrar was obtained by the researcher. This was used to obtain permission from the authorities of the village(L.C) who introduced the researcher to the village health team. The researcher also got informed consent from the respondents before data collection. The respondents were assured of confidentiality regarding the release of information but not indicating their names.

CHAPTER FOUR: PRESENTATION OF RESULTS

4.1 Introduction

This chapter presents the findings of the study from a total of 243 correspondents who were male aged 18-38 years in Rweta village Pallisa district. The results were presented according to the objective of the study.

4.2 Socio-demographic characteristics of respondents

Table 1: Socio-demographic characteristics of 243 men aged 18-38 years in Rweta Village Pallisa

Variable	Category	N	Frequency
Age	18-22	117	48.1
	23-28	76	31.3
	29-38	50	20.6
Level of education	None	26	10.7
	Primary	31	12.8
	Secondary	183	75.3
	Tertiary	3	1.2
Marital status	Married	56	23.0
	Single	155	63.8
	Divorced	7	2.9
	Cohabiting	25	10.3
Tribe	Itesots	67	27.9
	Langi	34	14.2
	Others ^{x1}	50	20.6
	Bagwere	89	37.1
Religion	Christian	154	63.4
	Moslem	38	15.6
	Others ^{x2}	51	21.0
Occupation	Businessman	68	28.0
	Civil servant	14	5.8
	Peasant	50	20.6
	Others ^{x3}	111	45.7

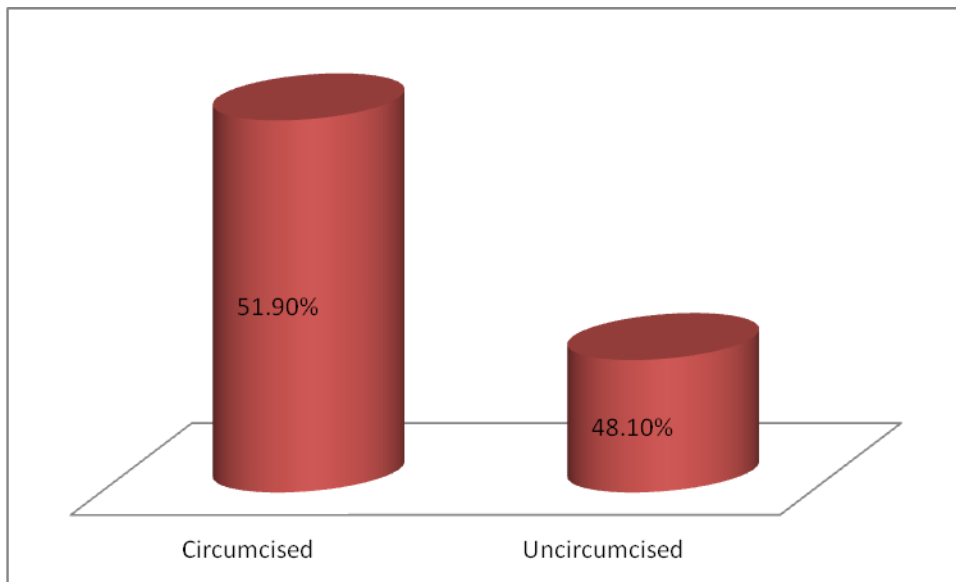
X¹=bagisu, basoga, baganda, X²=protestants, born again, X³=students.

Socio-demographic characteristics of respondents assessed included; age, marital status, tribe, level of education and occupation. Majority 117 (48.1) of the respondents were between ages of 18-22, most of them had attended school up to secondary level 183(75.3%) and few had attended tertiary 3 (1.2%). Majority of respondents were Bagwere 89(37.1) and few 34(14.2%) were langi. The highest number of respondents were single 155(63.8) while only 7(2.9%) had divorced. Most of the correspondents were Christians 154(63.4%) with lowest being Muslims 38(15.6%). Most of them were students 111(45.7%) and least were civil servants at 14(5.8%) as shown in Table 1.

4.3 Level of uptake of safe medical male circumcision

Among the correspondents it was revealed that (51.90%) were circumcised and (48.10%) were uncircumcised as shown in figure 1.

Figure 2: Level of uptake of Safe medical male circumcision among 243 men in Rweta village



4.4 Relationship between socio-demographic factors and uptake of safe medical male circumcision

Among all the socio-demographic factors studied, age ($\chi^2=3.692$, $p=0.158$) was found not to influence uptake of safe medical make circumcision among men in Rweta village Pallisa district as shown in table 2.

Table 2: Socio-demographic factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta village

Variable	Uptake	No uptake	Chi square	P-value
Age				
18-22	65(52.0)	51(44.0)	3.692	0.158
23-28	40(32.0)	35(30.2)		
29-38	20(16.0)	30(25.9)		
Level of education				
None	6(4.8)	20(17.2)	13.007	0.005
Primary	13(10.4)	18(15.5)		
Secondary	105(84.0)	76(65.5)		
Tertiary	1(0.8)	2(13.8)		
Marital status				
Married	24(19.2)	31(26.7)	8.202	0.042
Single	90(72.0)	64(55.2)		
Divorced	2(1.6)	5(4.3)		
Cohabiting	9(7.2)	16(13.8)		
Tribe				
Acholi	25(20.3)	41(35.3)	8.576	0.036
Langi	16(13.0)	18(15.5)		
Itesot	28(22.8)	22(19.0)		
Others	54(43.9)	35(30.2)		
Religion				
Christian	62(49.6)	91(78.4)	35.952	<0.001
Moslem	36(28.8)	2(1.7)		
Others	27(21.6)	23(19.8)		
Occupation				
Businessman	40(32.0)	27(23.3)	13.809	0.003
Civil servant	7(5.6)	7(6.0)		
Peasant	14(11.2)	35(30.2)		
Others	64(51.2)	47(40.5)		

4.5 Client related factors influencing uptake of safe medical male circumcision

All client related factors were found to influence uptake of safe medical male circumcision significantly among men in Rweta village Pallisa district as shown in table 3.

Table 3: Client related factors influencing uptake of safe medical male circumcision among men aged 18-38 years Rweta village

Variable	Uptake	No uptake	Chi-square	P-value
MC is important				
Yes	120(97.6)	56(49.6)	71.578	<0.001
No	3(2.4)	57(50.4)		
Would like to be circumcised				
Yes	38(55.9)	29(25.9)	16.285	<0.001
No	30(44.1)	83(74.1)		
Aware of importance of circumcision				
Yes	117(97.5)	67(58.8)	52.187	<0.001
No	3(2.5)	47(41.2)		
Ever heard about MC				
Yes	115(95.8)	97(90.6)	7.925	0.005
No	5(4.20)	17(14.9)		
Ever heard MC reduces HIV infection				
Yes	111(88.8)	80(70.8)	12.138	<0.001
No	14(11.2)	33(29.2)		
MC increases sexual feeling				
Agree	51(41.5)	34(30.4)	32.114	<0.001
Disagree	38(30.9)	48(41.7)		
I don't know	34(27.6)	56(48.7)		
Fear of losing sexual time				
Agree	10(9.1)	34(30.4)	18.984	<0.001
Disagree	73(66.4)	47(42.0)		
I don't know	27(24.5)	31(27.7)		
MC is painful				
Agree	20(17.4)	63(55.8)	43.675	<0.001
Disagree	82(71.3)	33(29.2)		
I don't know	13(11.3)	17(15.0)		
My religion does not support				
Yes	9(7.4)	21(18.6)	6.616	0.010
No	113(92.6)	92(81.4)		

4.6 Health facility related factors influencing uptake of safe medical male circumcision

In table 4, the health workers attitude such as welcoming, (not being rude) ($x^2=7.644$, $P=0.006$) and waiting time before seeing any health worker at health facility ($x^2=9.479$, $P=0.002$) were the

health facility factors found to be associated significantly with uptake of safe medical male circumcision among men in Rweta village.

Table 4: Health facility factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta village

Variable	Uptake	No uptake	Chi-square	P-value
Availability of health workers				
Yes	86(69.9)	72(65.5)	0.530	0.467
No	37(30.1)	38(34.5)		
Health workers are welcoming				
Yes	69(71.9)	47(52.2)	7.644	0.006
No	27(28.1)	43(47.8)		
Distance from health facility				
<2km	59(48.4)	51(44.7)	3.555	0.169
2-5km	41(33.6)	31(27.2)		
>5km	22(18.0)	32(28.1)		
Transport to health facility				
Not affordable	16(13.1)	19(16.8)	1.250	0.535
Affordable	86(70.5)	72(63.7)		
Very expensive	20(16.4)	22(19.8)		
Waiting time				
30 min or less	49(39.8)	23(21.1)	9.479	0.002
More than 30 min	74(60.2)	86(78.9)		

CHAPTER FIVE: DISCUSSION

5.0 Introduction

This chapter presents the discussion of the results in relation to literature review and study findings.

5.1 Uptake of safe medical male circumcision

The study showed that almost half of the population had taken up safe medical male circumcision. However, the uptake was probably linked to cultural practice of the Bagishu found in eastern district of Uganda. In a Uganda Demographic and Health Survey conducted in 2006, only 25% of adults were circumcised. Therefore MOH (2010) developed a National Policy on Safe Male Circumcision, with aim of circumcising 80% (4.2 million) of all uncircumcised men of age 15-49 years by 2025. The study established that the level of uptake of VMMC was 52%. This proportion is slightly lower than the reported median acceptability rate (62%) in sub-Saharan Africa (Roloff, 2011). Associated factors noted were education level, medical and hygiene as key elements in uptake.

Educating the public to promote the uptake of SMMC services among men 15 years and older and make services available through the public health system are the policies developed by Uganda Ministry of Health (2010), with assistance from Health Communication Partnership. That was designed and executed as a national SMMC demand creation campaign entitled “Stand Proud, Get Circumcised”.

According to the Uganda Demographic and Health Survey (UDHS), 2014 only 24% of men are circumcised in Uganda. This is not in line with our study probably because the UDHS study was not limited to Rweta village where cultural groups also do practice traditional circumcision to a large extent.

In conclusion MC uptake of up to about 52% of men in Rweta village was circumcised hence improved health and reducing on chances of acquiring HIV infection.

5.2 Socio-demographic factors influencing uptake of safe medical male circumcision

The socio-demographic factors that influenced the uptake of medical male circumcision are level of education (X^2 13.007, $p=0.005$), marital status (X^2 8.202, $p=0.042$), tribe (X^2 8.576, $p=0.036$), religion (X^2 35.952, $p<0.001$), occupation (X^2 13.809, $p=0.003$) and age (X^2 3.692, $p=0.15$).

SMMC uptake was highly influenced by education level of the correspondents. The high level of education improves one's way of reasoning and thus people get to understand the merits of SMMC such as reduced incidences of acquiring STDs. A similar study was carried out by Roloff et al. (2011) noted high socio-economic status being associated with higher rates of circumcision in traditionally non-circumcising communities, higher among men with higher levels of education and living in urban areas. The study was among uncircumcised men that were purposively selected and involved in 12 focus group discussion in some sub-Saharan African countries.

Age is cited as a positive factor determining the uptake of SMMC. In Rweta the uptake of MC was not influenced statistically by age, but the percentages of participation followed the general trend observed in Uganda. In Uganda male circumcision prevalent seems higher in late teen to adult years, rather than with infants according to the study done in Kampala among 350 correspondents by Asiimwe et al. (2013). On the other hand this population has a lot of peer influence thus improving on uptake as every one doesn't want to be left behind this is in line with a focused group study carried out by USAID (2010) where peers made a group decision to get circumcised.

Religion statistically appeared to affect the uptake of MC positively. About (63%) of participants were Christians (46%), this indicates that religion has no influence in uptake of SMMC as most people used to think circumcision is for Muslims. The results reflect that people know the importances of safe medical male circumcision such as improved male hygiene, reduce chances of acquiring HIV/STIs. A study conducted by Rizvi et al. (2009) found MC to be highly associated with religious and cultural identities. Other factors like occupation, tribe and marital status all were significantly important in determining the level of uptake of MC.

5.3 The client related factors influencing uptake of safe medical male circumcision

All client related factors influenced uptake of safe medical male circumcision of men in Rweta village (importance of male circumcision (X^2 , 71.578, $p < 0.001$, would like to be circumcised X^2 , 16.285, $p < 0.001$, knew importance of safe medical male circumcision X^2 , 52.187, $p < 0.001$, ever heard of medical circumcision X^2 , 7.925, $p = 0.005$, ever heard of male circumcision reducing HIV infection X^2 , 12.138, $p < 0.001$ medical circumcision increases sexual feeling chi square 32.114, $p < 0.001$, fear of losing sexual time during recovery (X^2 , 18.984, $p < 0.001$, male circumcision is painful (X^2 , 43.675, $p < 0.001$).

Majority of correspondents knew the importance of safe medical male circumcision and were able to state them such as, improved hygiene, reduces chances of acquiring STDS and HIV infection, this explains why uptake is high hence achieving the MOH target of 80% by 2025. These findings are in line with a focused group discussion by Tsui et al. (2014) conducted on 161 participants. Health was the main reason why men sought VMMC in order to reduce risks of contracting HIV and STIs. Many men expressed a sense of individual responsibility to reduce one's risk of acquiring HIV and STIs and a communal responsibility to reduce the rates of HIV in Lesotho. Similar findings were noted by Wilcken et al. (2010) in a quantitative, descriptive survey design conducted where the majority (89.9%) of the respondents had high level of awareness such as hygienic benefit of safe male circumcision.

Fear of pain was not among the hindrances to seek medical male circumcision. This could be to the fact that the study involved mostly young men who fear nothing once they need to achieve certain objective in life. However, this appears not to be universal. Yewondwossen (2012) carried out a quantitative and descriptive type of study design, where he noted fear of surgical complications, like pain, bleeding, and infection by 39.3% (N=33) of the participants as factors hindering uptake of SMMC as also noted by Brooks et al. (2010).

Increased sexual feeling was noted among reasons as to why male involved in male circumcision and being that the age bracket 18-35 is sexually active. This explains why uptake is relatively high thus enabling the MOH reach its target of 80% circumcised men by 2025. This is in line with Scott et al. (2010) in quantitative descriptive study. The study noted MC was highly

influenced by sexual desire than other reasons. As men were 8 times more likely to accept male circumcision with a believe that circumcised men enjoyed sex more. Similar study was done in rural Uganda by Miiro-Nakayima et al. (2010) in quantitative descriptive study, sexual pleasure was a major a reason to get circumcised significantly more often by uncircumcised than circumcised men (18.9% versus 2.4%).

5.4 The health facility factors influencing uptake of safe medical male circumcision

Availability of health care workers positively influenced clients to seek medical male circumcision as they had services anytime. In a study done by Wilcken et al. (2010) in a quantitative, descriptive survey design showed unavailability of staffs and those trained only provided services at fixed times only low after hour services. VMMC would increase with time if it is made available at all time this was house hold survey conducted by Kenya's national VMMC (2013) access to VMCC appeared to increase over time if VMMC was available to most men who wanted it.

Good attitude such as welcoming, not being rude was noted as negatively influenced uptake of safe medical male circumcision. However, this is in line with a study carried by Nyaga (2015) where majority of the men who took part in the study reported that their greatest misgiving about circumcision was related to fear of pain and long waiting time to be worked on at health facility. However, it noted health facility related factors that influenced positively the uptake of safe medical male circumcision were availability of health workers and health workers attitude. The only factors that influenced negatively was the waiting time, this calls for employment of more professionals to offer the services in time. Though in our study the distance to the health facility was reasonable and affordable and generally waiting time was acceptable.

George, Strauss, Chirawu, Rhodes, Frohlich, Montague and Govender¹⁸⁴ are given support to deal with their HIV positive result during the disclosure process with the counsellor. The location where testing is undertaken, including ensuring that the service providers are not known community members and are trusted by the learners is crucial, because where learners feel compromised, uptake will be jeopardized. This calls for adequate HCT counselling and a good referral system.

for young people seeking VMMC (Mavhu et al. 2011). Implementers of scale-up programmes for VMMC targeting adolescents must be cognisant of the fears, stigmas and possible discrimination relating to HCT and STI screening. Ensuring VMMC is offered within a comprehensive health (including sexual and reproductive health) package that includes initiatives aimed at increasing awareness and education surrounding VMMC as well as decreasing stigma and fear relating to HIV, HCT and VMMC will be useful in increasing uptake among high school learners. Another key finding at the individual level concerns models of service delivery. This includes issues relating to timing, location and pain management regarding the VMMC procedure. Respondents in this study were largely in favor of mobile high-volume VMMC sites, where boys could be circumcised and have time to heal without having to contend with the pressures of normal life including attending school, sports and other day-to-day activities. Boys indicated that these mobile camps created an environment where they felt supported by their peers and were able to ask questions and receive information and individual attention without fear of discrimination. Mobile high-volume sites may also help service providers to optimize their own processes and ensure high coverage (Montague et al. 2014). VMMC programmes targeting young people should consider offering both mobile and fixed-site VMMC to accommodate the preferences of a wider range of individuals in order to maximize uptake. Regardless of whether mobile or fixed-site VMMC is offered, programme designers and implementers must be aware of the timing of activities and be sensitive to the possible conflicts of interest between wanting to undergo circumcision and other responsibilities they may have.

In conclusion only two health facility factors were found to influence uptake of safe medical male circumcision welcoming health worker (X^2 7.644, $p=0.006$) and waiting time (X^2 9.479, $p=0.002$).

5.5 Methodology Issues (Shortcomings)

The study might have been bias because participants were selected randomly in the community, may be the ones selected were circumcised compared to those left out.

Information bias: the research assistants were trained for only one day due to limited time and resources, this did not allow me to assess them to know whether they had understood the objectives of the study as per the questionnaire and this could have affected underestimation either positively or negatively.

Ability to generalize findings to all men in Pallisa district may not be possible because of sample size being small and Rweta village may not generate all the men in Pallisa district.

5.6 Conclusions and Recommendations

The level of uptake of safe medical male circumcision was average.

The social demographic factor found to influence uptake of safe medical male circumcision were level of education, marital status, tribe, religion and occupation of men in Rweta village.

All client factors such as knowledge and attitude were found to significantly influence uptake of safe male circumcision.

This study found out that attitude of health workers and waiting time at health facility influence uptake of male circumcision.

It was recommended that more emphasis should be put in health educating the community on advantages of safe medical male circumcision and also bring services to where people work.

In order to increase uptake of safe medical male circumcision, creating more awareness through the use of all leaders at different levels and use of social media.

More circumcision points should be opened up including outreaches so as to avail people with the service more easily without waiting for so long to be worked upon.

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APPENDIX I: CONSENT

FACTORS INFLUENCING UPTAKE OF SAFE MEDICAL MALE CIRCUMCISION AMONG MEN AGED 18-38 YEARS IN RWETA VILLAGE PALLISA DISTRICT

Dear participant, you have been selected to participate in this study. The aim of the study is to assess factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta village Pallisa district.

The information given will be kept with confidentiality and it will be only used for the research purpose. The results of the study will be useful to the ministry of health and other health service providers in re-designing programs of safe medical male circumcision programmes to improve optimal health for men.

Accepting to participate in the study will not attract any benefits and refusal to participate will not have any penalties.

Your responses will be treated anonymous throughout the study and therefore your name is not needed. For any information about the study please feel free to contact the researcher on Telephone: 0700145208. Please indicate below with a tick

I agree to participate

don't agree to participate

APPENDIX II: QUESTIONNAIRE

Questionnaire

Questionnaire Number.....

Date of interview.....

My name is Naisanga Farida a student Nurse at IHSU. I am carrying out a study on factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta village. You are therefore requested to give the necessary response. All the information given will be accorded maximum confidentiality.

Instructions.

Please fill in the spaces provided or circle against the appropriate response.

Section A: Socio-demographic factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta village.

1. How old are you? Between

1) 18-22 []

2) 23-28 []

3) 29-38 []

2. What's your level of education?

1) None []

2) Primary. []

3) Secondary. []

3) Tertiary. []

3. What is your marital status?

- 1) Married []
- 2) Single []
- 3) Divorced []
- 4) Cohabiting []

4. What is your tribe?

- 1) Acholi []
- 2) Mugwere []
- 3) Itesot []
- 4) Others..... (specify) []

5. Please circle your religion.

- 1) Christian []
- 2) Moslem []
- 3) Other (specify)..... []

6. What is your occupation?

- 1) Business person []
- 2) Civil servant []
- 3) Peasant []
- 4) Others (Specify)..... []

Section B: Determine the level of uptake of safe medical male circumcision among men aged 18-38 years Rweta Village

7. Are you circumcised?

1) Yes []

2) No []

8. Is circumcision important?

1) Yes []

2) No []

9. If yes, what are they.....

Section C: Client related factors influencing uptake of safe medical male circumcision among men aged 18-38 years Rweta Village

10. Would you like to be circumcised?

1) Yes []

2) No []

11. If no, is pain the reason as to why you don't want to circumcise

1. Yes []

2. No []

12. If no what are other reasons please specify.....

13. Are you are aware of the importances of circumcision

1) Yes [] 2) No []

14. If yes how did you get informed?

1. Radio []

2. Health workers []

3. Relative []

15. Have you ever heard of MC?

1. Yes []

2. No []

16. Have you ever heard that MC reduces the risk of HIV infection?

1. Yes []

2. No []

17. Circumcised men have more sexual feelings than uncircumcised men

1. Agree []

2. Disagree []

3. Don't know []

18. I don't like to be circumcised for fear of losing sexual time during the time of healing

1. Agree []

2. Disagree []

3. Don't know []

19. The male circumcision procedure pain is unbearable and this prevent me from being circumcised

1. Agree []

2. Disagree []

3. Don't know []

20. My religion does not support male circumcision and this prevents men from getting circumcised?

1. Yes []

2. No []

21. Where do you prefer male circumcision to be performed from

1. Health facility []
2. Traditional circumciser []
3. Others (Specify) []

Section D: Health facility factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Rweta Village

22. Are health workers readily available to offer mmedical male circumcision?

- 1) Yes []
- 2) No []

23. Are the health workers welcoming and ready to serve you?

- 1) Yes []
- 2) No []

24. How far is your home to the health facility offering MMC?

- 1) Less that 2km []
- 2) 2-5km []
- 3) Over 5 km22 []

25. How much money do you pay on every visit for the service?

- 1) Between 2000-5000 []
- 2) 6000-10,000 []
- 3) More than 10,000 []

26. How do you rate the cost of transport to the facility?

- 1) Not affordable []

2) Affordable []

3) Very expensive []

27. How long do you take to be served at the facility

1) Less than 30 minutes []

2) More than 30minutes []

28. What causes this?

29. In your view how can medical male circumcision be promoted?

.....

Thanks for your cooperation

APPENDIX III: INTRODUCTORY LETTER



making a difference in health care

Office of the Dean, School of Nursing

Kampala, 22nd February 2016

To: CHAIRMAN INDUSTRIAL AREA
KAGWESE WARD, RULETA VILLAGE

Dear Sir/Madam,

RE: ASSISTANCE FOR RESEARCH

Greetings from International Health Sciences University.

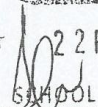
This is to introduce to you **Naisanga Faridah 2012-BNS-TU-050** who is a student of our University. As part of the requirements for the award of a Bachelors degree in Nursing of our University, the student is required to carry out research in partial fulfillment of her award.

Her topic of research is: **Factors influencing uptake of safe medical male circumcision among men aged 18-38 years in Ruleta Village, Pallisa District**

This therefore is to kindly request you to render the student assistance as may be necessary for her research.

I, and indeed the entire University are grateful in advance for all assistance that will be accorded to our student.

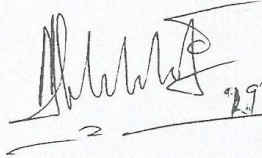
Sincerely Yours,


22 FEB 2016
SCHOOL OF NURSING
P.O. Box 7782, Kampala - Uganda
Ms. Agwang Agnes
Ag. Dean, School of Nursing

The International Health Sciences University
P.O. Box 7782 Kampala - Uganda
(+256) 0312 307400 email: aagwang@ihsu.ac.ug
web: www.ihsu.ac.ug

APPENDIX IV: CORRESPONDENCE

Accepted to do
research



P. U. L. C.
AIRMAN L. C. INDUSTRIAL AREA
WILSON AVENUE
WILSON, N. J.

0712215539