

**KNOWLEDGE, ATTITUDE AND PRACTICES OF MALES 10-49
YEARS ATTENDING ISHAKA ADVENTIST HOSPITAL
ON SAFE MALE CIRCUMCISION**

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**A RESERCH REPORT SUBMITTED TO UGANDA NURSES AND
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ABSTRACT

Uganda Demographic and Health Survey conducted in 2016 asserted that only 26% of adults males in Uganda were circumcised and HIV prevalence among uncircumcised males was higher (6.7%) than in circumcised males (4.5%). Safe male circumcision could reduce the risk of new infections of HIV among males by 60% (WHO 2010)

A quantitative cross-sectional descriptive study among males involved 44 males aged 10-49 that were selected through convenient sampling method focused on knowledge, attitudes and practices towards safe male circumcision among males 10-49 years attending Ishaka Adventist hospital in Ishaka-bushenyi municipality.

Most males were Banyankole single aged 10-19(36.9%), with low formal education (54.4%) primary and (11.3%) none. 100% had heard about SMC, from radios (56.8%) and few from health workers (11.4%). They knew SMC for increasing sexual pleasure, and avoiding other STIs but not HIV. 68.2% did not know where they could get SMC services from.

Males agreed (65.5%) and strongly agreed (31.8%) that Post SMC wound take long to heal, while 43.3 and 36.6 agreed and strongly agreed that circumcised males perform better sexually. Majority of males were comfortable with local anesthesia (79.5%), whereas as stitching and bandaging were opposes (29.5%) and (36.3%). 20.4% of males were circumcised,

Majority of having been circumcised below 10 years (44.4%) by majorly religious leaders (55.5%). Those circumcised receive pain management (66.6%) education on wound care (55.5%) and STIs screening (22.2%) while HIV screening by only 11.1%.

There is considerably low knowledge on SMC where by those that know about SMC know it for other purposes like sexual pleasure and sexual performance but not HIV prevention, while envy a few that know about SMC do not know where they can access SMC services from.

Negative attitudes being basically on wound healing that they fear that it takes long and HIV risk reduction that they disagree with. While stitching and bandaging post SMC wound were opposed, local anesthesia and pain management had strong support of males.

Government move of SMC campaign for all males has low support of males 10-49 years it targets from ground. While those that are circumcised do it at younger age <10 for other reasons mostly being religious that HIV control.

APPROVAL

I hereby accept this report for above research study and approve it for submission to UNIMEB for marking.

Supervisor MR THEMBO KALENDE

DCN, DHSM, BME, MEAP

Signature..... Date

Signature Date

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DECLARATION

I Kaddu Yusufu, do hereby declare that this study is entirely the result of my own independent investigations. The various sources of information to which I am indebted are indicated in the text and references.

Signed

Date

DEDICATION

This research work is dedicated to My supervisor Mr. Kalende Thembo for the advice he has given me, my parents for the financial support, my brothers , my sisters especially Nanyanzi Hadija, Bukirwa Lukia ,Aminsi Nyanzi Nakalyowa Yudaya my classmate especially Gabula John Cosmas Atwebembire Grace, Dr Emma and Dr Mathew for their encouragement and support.

May almighty Allah bless you abundantly

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DEFINITION OF KEY TERMS

Male circumcision:	Surgical removal of the fore skin on male's penis
Attitude;	Refers to males' perception towards safe male circumcision as a practice, as well as its goals.
Practice:	Refers to male's involvement in male circumcision practices, including when, where and from whom.
Knowledge.	Refers to what males 10-49 years know about male circumcision, purpose, where and when they can get the service.

LIST OF ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
FDGs:	Focused Group Discussions
HIV:	Human Immune Deficiency Virus
MC:	Male Circumcision
MOH	Ministry of Health
SMC:	Safe Male Circumcision
STDs:	Sexually Transmitted Diseases.
UDHS:	Uganda Demographic Health Survey
UNICEF:	United Nations Children Fund.
VMMC:	Voluntary Medical Male Circumcision
WHO:	World Health Organization

CHAPTER ONE

1.0 INTRODUCTION

This chapter will contain the introduction, problem statement, purpose of the study, specific objectives, research questions and justification of study.

1.1 Back ground of the study

Male circumcision is the removal of the foreskin from the human penis. (WHO 2010)

In the most common procedure, the foreskin is opened, adhesions are removed, and the foreskin is separated from the glans. After that, a circumcision device may be placed then the foreskin is cut off. (Globally, Approximately 30% of males are estimated to be circumcised globally, of whom an estimated two thirds are Muslim. (WHO 2009)

Male circumcision has been shown to reduce the risk of heterosexual transmission of HIV infection in men by up to 60% in three randomized controlled trials. (WHO 2010)

The results from three large randomized clinical trials that were already confirmed in Kenya, Uganda and South Africa in 2007 which were published, showing that medically performed circumcision is safe and can reduce men's risk of HIV infection by 60% (Jonathan et al 2011). Based on this evidence, the World Health Organization (WHO) and UNAIDS recommend medical male circumcision as an essential part of HIV prevention programming. (WHO 2007)

While the majority of men in Uganda are not circumcised—according to the 2011 UDHS, only 24% of men are circumcised. There were already circumcising communities like the Bagisu, sabiny who practice circumcision for their cultural reasons, and Muslims who practice male circumcision for religious reasons. Traditional circumcision ceremonies involve many practices that increase the circumcision candidate's risk of acquiring HIV, including the practice of circumcision by untrained circumcisers in unhygienic settings. So, the Ministry of Health, with assistance from HCP and the STAR-E Project, worked with a group of concerned citizens in the Bugisu region to develop a HIV prevention campaign entitled “We are the Pride of our Tribe” (UDHS 2011)

In 2010, the Uganda Ministry of Health adopted the National Safe Male Circumcision Policy, which recommends voluntary safe male circumcision for all men, and makes it available through the public health system. among men 10-49 years by Ministry of Health, with assistance from Health Communication Partnership, these designed and executed a national SMC demand creation campaign entitled “Stand Proud, Get Circumcised”.(MOH 2010)

This was an effort to reduce HIV transmission among the males; however, it can also be done to treat certain conditions like phimosis, swelling of fore skin of the penis, foreskin tears and frenulum in addition to reducing HIV transmission. (USAID 2016).

There were other circumcising communities and groups in Uganda, like Gishu, Muslims, and Sabiny for cultural and religious reasons. (Nikel Alasu 2009).

1.2 Problem statement

Globally, 30% of males are estimated to be circumcised, of whom an estimated two thirds are Muslim. (WHO 2009)

The World Health Organization and the United Nations Program on HIV/ AIDS recommend SMC for countries with a high prevalence of HIV and low prevalence of male circumcision. Unfortunately, these are basically African countries, which carry 88% of world's HIV prevalence (WHO 2009)

In Africa, carry 88% of world's HIV prevalence east and sub-Saharan African countries namely: Ethiopia Kenya Tanzania Uganda south Africa south Sudan, Rwanda Burundi and Somalia carry 77% of world's HIV prevalence.(WHO 2014)

Uganda Demographic and Health Survey conducted in 2016 asserted that only 26% of adults males in Uganda were circumcised and HIV prevalence among uncircumcised males was higher (6.7%) than in circumcised males (4.5%). (WHO 2010)

Uganda is one of 14 priority countries identified for high-level SMC scale-up by the World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS). National estimates from 2011 indicate that 26% of men ages 10–49 are circumcised, with the largest proportions of circumcised men reporting having been circumcised during infancy (24.8%) or between the ages of 10 and 19 (23.9%). There is considerable geographic variation in MC (male circumcision) prevalence, ranging from 2% in western, and the Mid Northern region to 53% in the Mid-Eastern region. The proportion of men circumcised also differs significantly by religious status (97% of Muslim men vs. 10% of Christian religion),

ethnicity (2% of Langi and Acholi, Bakiga and Banyankole ethnic men vs. 81% of Bagisu, Jopadora and Sabin men), and economic status (35% of men living in wealthy households vs. 17% of men in poor households (Katherine et al 2014).

Being considerate to HIV transmission among males which knows no region, tribe and religion, the disproportionate prevalence of male circumcision practices showing that western region and its tribes have not embraced MALE CIRCUMCISION beginning from their historical and cultural values, to modern day where male circumcision is no longer for cultural values or religious act but to curb the rate of HIV transmission among males calls for an investigation. If males in this region are to enjoy 60% safety from contraction of incurable HIV through safe male circumcision, will depend on their knowledge, attitudes and practices on safe male circumcision.

Taking a look at Bushenyi district where Ishaka Adventist hospital is located, there is no evidence of any SMC study that has been done therefore this study is to be carried out in addition to some other researches that might have been done and were not published.

1.3 Purpose of the Study

To assess knowledge, attitudes and practices of males 10-49 years attending Ishaka Adventist hospital on safe male circumcision.

1.4 Specific Objectives.

- i. To assess knowledge of males 10-49 years attending Ishaka Adventists hospital on SMC.

- ii. To assess attitudes of male 10-49 years attending Ishaka Adventist hospital towards SMC
- iii. To assess practices on SMC among males 10-49 years attending Ishaka Adventist hospital.

1.5 Research questions

1. What is the knowledge of males 10-49 years attending Ishaka Adventists hospital on safe male circumcision?
2. What are attitudes of males 10-49 years attending Ishaka Adventists hospital towards safe male circumcision?
3. What are the circumcision practices among males 10-49 years attending Ishaka Adventists hospital?

1.6 Justification of the study.

Ishaka Adventist hospital is one of health units offering safe male circumcision services to males 10-49 years on both outreaches to community, and facility static service basis for free to all males as to reduce HIV transmission among males.

There is no restriction on who should be circumcised in as far as age is concerned, but the government of Uganda prioritize males 10-49 years, this being because is a sexually active age bracket of males, hence at a higher risk of contracting the infection through un protected sexual intercourse. Uganda targets to circumcise 4.6million males in this age bracket before 2020 (USAID 2016) Hence to meet this target, males have to efficiently utilize safe male circumcision services in facilities' where they are provided, Ishaka Adventists hospital included. This will directly

help circumcised men from contracting HIV by 60%, and indirectly reduce the rate of transmission of HIV in general population of Uganda by 9%. However the achievement will bases greatly on knowledge and practices on males targeted that will influence their safe male circumcision practices.

CHAPTER TWO:

LITERATURE REVIEW

2.0 introduction

This chapter will include literature review based on my specific objectives which include the following; Knowledge of males towards SMC, Attitudes of

Males towards SMC, Practices of males towards SMC, Knowledge of males towards safe male circumcision

On whether community views SMC as important practice; a research in South Africa that involved Focus group discussions showed that circumcision is still important to many people, and is seen as an essential part of the transition into adulthood. Reluctance to be circumcised was mainly related to the possibility of adverse outcomes of circumcision performed in non-medical settings, although initiation schools remain attractive for education and transmission of cultural values. (Rain-taljaard et al 2010)

2.1 knowledge of males on safe male circumcision

Knowledge on SMCs risk reduction on HIV contraction; some misconceptions remain, however, especially about the preventative nature of circumcision for STD transmission. Among 467 uncircumcised adult men, 59% said that they would be circumcised if circumcision reduced the chances of getting HIV and STDs. (Rain-taljaard et al 2010)

Knowledge of SMC in other parts of Uganda; a study conducted in IHK Kampala in 2012 indicated that there was sufficient knowledge and demand for SMC despite minimal mobilization effort by health teams (Moses et al 2012).

Factors influencing knowledge on SMC in Uganda; a study in East and Central Uganda on Determinants for awareness of MC for HIV prevention was examined with multiple logistic regression models. Out of all adults, 52.1% were male (mean \pm SD age 39.8 \pm 11 years), of whom 39.1% reported to be circumcised. Out of all youths, 58.4% were male (18.4 \pm 2.5), 35.0% circumcised. Adults were more aware of MC for HIV prevention than youths (87.1% vs. 76.5%; $p = 0.004$). In adults, awareness was increased with higher educational level compared to no school: primary school (adjusted OR 9.32; 95%CI 1.80-48.11), secondary (5.04; 1.01-25.25), tertiary (9.91; 0.76-129.18), university education (8.03; 0.59-109.95). Younger age and male sex were further significant determinants of increased awareness, but not marital status, religion, district, ethnicity, employment status, and circumcision status. In youths, we found a borderline statistically significant decrease of awareness of MC for HIV prevention with higher educational level, but not with any other socio-demographic factors. (Wilken et al 2010)

A study in university of Botswana on knowledge and attitudes towards MMC indicated that 95.4% had heard about MMC, 55.4% being for reduction of risks for infections, 43.5 for reduction of risk for other STIs, while 21.1% knew VMMC for improving genital hygiene. AEs known were improper procedure, delayed wound healing, interference with sexual activities, excessive blood loss, by 27%. 19.7%, 18.3%, 10.2% respectively. 100% of participants knew that VMMC is not 100% sure deal on HIV prevention, although only 91.1% believed that there was a necessity to abstain or use condom even after MMC. (S L .Meoble and G A. Tegegn 2014)

2.2. Attitudes of males towards safe male circumcision

Baseline standard by WHO on SMC; Safe male circumcision (SMC; also known as voluntary medical male circumcision [VMMC]) is a scientifically proven biomedical intervention that substantially reduces the risk of female-to-male transmission of HIV (Jonathan et al 2011)

Confidence in SMCs effectiveness in HIV prevention; Findings in study from Swaziland confirmed the existence of risk compensation behaviors like indulgence into unprotected sexual intercourse following circumcision; however, this study adds important contextual insight about precisely when and why such risk-taking occurs. Nevertheless this study suggests that male circumcision scale-up as an HIV prevention strategy is likely to foster protective behavior change among men. (Jonathan & Monique 2012)

Women's perception on SMC; a qualitative study by Erica and colleagues in Tanzania to assess women's perceptions of male circumcision in Iringa, Women in this study had strong preferences for circumcised men because of the low risk perception of HIV with circumcised men, social norms favoring circumcised men, and perceived increased sexual desirability of circumcised men.

The health benefits of male circumcision were generally overstated; many respondents falsely believed that women are also directly protected against HIV and that the risk of all STIs including cervical cancer is greatly reduced or eliminated in circumcised men. Participants reported a very strong social pressure for men to be circumcised. Uncircumcised men were described as being dirty, uneducated and "out of fashion." One woman described uncircumcised men as stated and said could

not accept sex with them or marry them, Some participants also stated that the only way women could protect themselves against HIV disease was for their sexual partners to be circumcised, Another recurrent theme was the shame associated with being uncircumcised. One woman discussed how embarrassed she would be if someone found out that her husband was uncircumcised (Erica et al 2013).

Attitudes towards SMC by originally non circumcising communities; despite the solidity of evidence on its benefits, opposition to MC by groups or individuals in non-circumcising societies remains. Since their claims are not supported by quality research and fail to withstand scrutiny by academic and medical experts, the opposition appears motivated by ideological like fear for pain and discomfort following circumcision or other reasons. Such opposition has failed spectacularly: in Germany, politicians last year voted four to one that infant circumcision does not violate children's rights or endanger their welfare. Thus, while evoking strong sentiments – perhaps because it targets a vital sexual organ – circumcision for men and infant boys is not harmful. Dissatisfied men wish they had a choice and report anger, feelings of loss, sadness, sexual anxieties, and reduced emotional expression. Psychological factors affect every aspect. Circumcised men often have difficulty acknowledging the harm and generally accept information favoring circumcision (Richard and Goodman 2013)

Some of community misconceptions on SMC; a study in Kenya through FGD participants indicated exposure to sensitization efforts and reported knowledge of the existence of SMC services in the community. Additionally, it was universally understood by participants that circumcision only provides partial protection from

HIV. In every FGD, participants correctly identified the 60% reduction in transmission of HIV to heterosexual men (Kulin et al., 2013).

However, participants in all four of the older (25+) FGDs also expressed concern that other community members misunderstood the level of protection provided by SMC and that this led to increased risky sexual practices. Only one of the younger (18–24) FGDs conveyed this worry. The perception that SMC is actually increasing the number of HIV infections in the community is exemplified by a response in one of the older male FGDs. There was universal knowledge of the availability of SMC services, but males reported high uptake in the community while females indicated that it is low. Improved hygiene, disease prevention, and improved sexual performance and desirability were reported facilitators. Barriers included a perceived increase in SMC recipients' physiological libido, post-surgical abstinence, lost income during convalescence, and lengthier recovery due to occupational hazards. Both males and females reported concerns about spousal fidelity during post-SMC abstinence. Reported misconceptions and community-held cultural beliefs include fear that foreskins are sold after their removal, the belief that a SMC recipient's first sexual partner after the procedure should not be his spouse, and the belief that vaginal fluids aid circumcision wound healing. (Paul E 2015).

2.3. Practices of males towards safe male circumcision

Male circumcision practices in other parts of Africa; a qualitative study conducted on male circumcision using focus group discussions and in-depth interview among men in South Africa, men aged 25-59 years, 36% reported being circumcised. The

median reported age at circumcision was 20. A total of 42% of 14-24-year-old circumcised men reported having been circumcised in a medical setting. (Raintaljaard 2010)

SMC practices in other east African countries; to assess cultural issues associated with circumcision in a traditionally circumcising population in northern Tanzania, of the 359 interviewees, 170 (47.4%) were males. Of the males, 168 (98.8%) were circumcised. Sixty one (36.3%) of the circumcised males had their procedure done in medical settings while 107 (63.7%) were circumcised in the traditional settings. The age at circumcision varied significantly with the provider of the procedure

Of those circumcised in the medical setting, 16/61 (26.2%) were circumcised by age 10 years, whilst only 6/107 (5.6%) were circumcised by the age of 10 years in traditional settings. Males circumcised in the medical setting were circumcised at a younger age compared to those circumcised in the traditional setting (log Rank test for equality of survival functions = 9.5, $P = 0.002$). Cost for circumcision procedures done in the medical setting was higher compared to the cost for procedures done in the traditional setting (Buweh et al., 2013)

SMC practice among health workers; while assessment of circumcisers in US (United States), the respondents, 956 (54%) perform at least one circumcision per month (35% of PEDs; 60% of FPs; 70% of OBs). Of the physicians performing circumcisions, 45% use anesthesia (71% of PEDs; 56% of FPs; 25% of OBs). Of physicians using anesthesia, 85% use dorsal penile nerve block (Futho et al., 2013).

A significantly higher percentage of male physicians (57%) are performing circumcisions than are a female (45%), but there was no difference in the percent

using anesthesia. Recently trained PEDs and FPs were more likely to use anesthetics than were their older colleagues, but OB use of pain relief was independent of their practice longevity. Physicians in the western states were significantly more likely to use anesthesia than were other physicians from the rest of the United States. (World Bank report 2014)

SMC practice and HIV prevalence; it has been observed in ecological studies that in populations where the male circumcision prevalence is over 80%, the HIV prevalence is less than 5% and where the male circumcision prevalence is low the HIV prevalence is high. (WHO 2010, MOH Uganda 2014, UNICEF 2012)

Prevalence of SMC practice in Uganda; The average Uganda male circumcision prevalence is 25% With an HIV prevalence estimated at 7.3% (Moses et al 2012)

Uganda is one of 14 priority countries identified for high-level SMC scale-up by the World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS). National estimates from 2011 indicate that 26% of men ages 10–49 are circumcised, with the largest proportions of circumcised men reporting having been circumcised during infancy (24.8%) or between the ages of 15 and 19 (23.9%). There is considerable geographic variation in MC prevalence, ranging from 2% in the Mid Northern region to 53% in the Mid-Eastern region. The proportion of men circumcised also differs significantly by religious status (97% of Muslim men vs. 10% of Catholic men), ethnicity (2% of Langi and Acholi, Bakiga and Banyankole men vs. 81% of Bagisu/Sabin men), and economic status (35% of men living in wealthy households vs. 17% of men in poor households (Katherine et al 2014).

SMC and specific communities in Uganda; in Ugandan fishing communities, a quantitative study in Masaka, Mpigi, Rakai, The estimated prevalence of reported circumcision at the baseline survey varied from 41.4% to 66.3% These data were collected from all men who participated in the survey, not only those. Who were later included in our sample. (Martin M 2016)

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter described the study design, study area, study population, sample size and sampling procedure, inclusion and exclusion criteria, definition of variables, research instruments, data collection procedures, data management and quality control, data processing and analysis , ethical considerations limitations and dissemination of findings.

3.1 Study Design and rationale

A descriptive cross sectional study was used involving quantitative methods of data collection. A cross-sectional study is the one that is carried out at appoint in a time or over a short period of time. The study design was selected because it aids in rapid data collection and allows a snap short interaction with a small group of respondents at a certain point in time thus allowing conclusions about phenomena across a wide population to be drawn. This method is also relatively inexpensive for the researcher as it takes a little time to conduct. The study design was used to examine knowledge, attitudes and practices on safe male circumcision among males 10-49 years attending health care in Ishaka Adventists hospital.

A quantitative method was chosen because of the nature of the research under study where numerical data is required.

3.2 Study setting and rationale

The study was conducted at Ishaka Adventist Hospital located in Ishaka-Bushenyi Municipality, Bushenyi District. Bushenyi is a district found in the South Western region of Uganda. It's located approximately 65kms by road from Mbarara town, the largest town in the region and 360kms from Kampala the Capital City of Uganda. The main language spoken in Bushenyi district is Runyankole as Banyankole people are the main occupants of this area. Bushenyi is mostly an agricultural district, with adequate well distributed rains and fertile soils with which it is blessed.

Ishaka Adventist Hospital is non-government health facility under missionary foundation by Seventh day Adventists union of Uganda but with other surrounding health facilities, serving Bushenyi district population of 241,500 people and as well as the surrounding districts. This area was purposely chosen because of the high youth population density from mother town Ishaka-Kizinda towns that are largely inhabited by youth who are direct benefice of 60% risk reduction from contracting HIV among sexually active 10-49 year males.

3.3 Study Population

The study was conducted on males 10-49 years attending health care services from Ishaka Adventist hospital. Ishaka Adventist hospital an average of 200 outpatient clients per day from Bushenyi and surrounding districts, and about 3500 admissions per year.

3.3.1 Sample size determination and rationale

The sample was determined using the formula for simple random sampling using single proportion given by: (Kish Leslie, 1965)

$$\textbf{Equation 1: Kish and Leslie Formula}; n = \left(\frac{Z^2 p q}{d^2} \right)$$

Where;

Where n = sample size,

Z = value corresponding to 95% level of significance=1.96

p = expected proportion of males affected 50%=0.5

$q = (1-p) = (1-0.5) = 0.5$, d =absolute precision 5%=0.05,

N =Total number of clients in Ishaka Adventist hospital at the time of survey =50

Therefore, from the above formula,

$$n = \left(\frac{1.96^2 * 0.5 * 0.5}{0.05^2} \right)$$

$$n = 384$$

Since my sample population N was less than 10,000

Equation2: Target population of $< 10,000$;

$$nf = \left(\frac{n}{1 + \frac{n}{N}} \right); \quad nf = \left(\frac{384}{1 + \frac{384}{50}} \right); \quad nf = 44.23 \text{ respondents}$$

Where no is sample size for N , population less than 10,000

The sample size therefore was 44 respondents.

3.3.2 Sampling Procedure and rationale

Convenience sampling was employed to select males of age 10-49 years who came to health facility from services at time of data collection,. This method involves giving all members equal chances to be recruited into the study basing on the members availability at the time of data collection. This method was preferred because of its simplicity in limited number of respondents since all males that utilize services in Ishaka Adventist hospital cannot easily be gathered, characteristic nature of targeted members, time saving and economical nature of sampling method.

3.4 Inclusion and exclusion criteria

3.4.1 Inclusion criteria

Males who consented include;

Males of age 10-49 years who were attending health services in Ishaka hospital outpatient department..

3.4.2 Exclusion criteria

Males below 10 years, and those above 49 years were not considered from this study, as they were not in the primary targeted population by Uganda ministry of health for SMC for risk reduction of contracting HIV.

3.5 Definition of variables

Assessment of knowledge, attitudes and practices on safe male circumcision is composed independent and the dependent factors or variables.

3.5.1 Dependent variables;

Male circumcision practices among males 10-49 years.

3.5.2 Independent variables;

Knowledge, Attitudes, demographic and other social cultural and economic characteristics that is Age, Education, marital status, occupation, religion and others that directly or indirectly affecting SMC.

3.6 Research instruments

A semi-structured questionnaire with leading questions was used to gather information from the respondents. Data was collected through researcher administered questionnaire to those unable to read and write in order to collect data from them, and self administered to those able to read and write to reduce bias from researcher's presence.

3.6.1 Pretesting of the Research Instrument

Questionnaire was pre-tested at Bushenyi health Centre IV one week before data collection for validity and reliability. Any observed inconsistency of the questions was corrected to meet the intended objectives before data was collected.

3.7 Data collection procedure

The questionnaires were administered to all respondents who met the inclusion criteria while at convenience place. Responses through researcher administered questionnaires were recorded in the questionnaires following the interviews, while the able to read and write respondents were given self-administered questionnaires which they answered secretly to avoid bias from researcher's presence. Then all questionnaires both researchers administered and self-administered were checked for completeness, and clarity on answers given, and then collectively withdrawn from respondents.

3.7.1 Data management and quality control

One day training was given to research assistants the objectives and procedures of the data collection by the investigators.

Data completeness and consistency was checked by the researcher and his research assistants. Data cleaning and editing took place; missed values were statistically handled at the time of data collection to help address concerns caused by incomplete data.

Data obtained was kept in safe custody and treated with respect and confidentiality. Coding and sorting at the end of data collection process was done to ensure adequacy, completeness and correctness of information collected.

3.7.2 Data analysis

Data entry, coding and analysis was done using SPSS version 20 software package. To explain the study population in relation to relevant variables, frequencies, percents and summery statistics were used. Associations between dependent and independent variables was assessed and presented using tables, graphs, and pie charts.

3.8 Ethical consideration

Informed consent and confidentiality

Authorities of Ishaka Adventist hospital where the study was conducted were presented with a recommendation letter from the Kampala International University School of nursing seeking approval to undertake the study. The respondents were also asked to consent before being interviewed. Interviews were conducted in a manner that enabled every respondent to responds freely and openly in the absence

of any other tension raising persons for confidentiality. Names of the respondents were not included in the data to ensure confidentiality.

3.9 Dissemination of results.

Five Copies of the study findings were produced and given to;

- i) The Uganda nurses and midwives examination board.
- ii) Kampala international university western campus library.
- iii) The researcher stayed with the copy
- iv) Ishaka Adventist hospital where the research shall be carried out,
- v) Bushenyi district health department.

CHAPTER FOUR:

STUDY FINDINGS AND INTERPRETATION

4.0 Introduction

This study investigated the “**knowledge, attitudes and practices of males 10-49 years attending Ishaka Adventist hospital towards safe male circumcision**”.

This chapter basically presents the findings of the study analyzed using Microsoft excel and presented in graphs, charts, and tables following the demographic characteristics of the respondents and specific objectives of the study.

4.2 Demographic characteristics of the participants.

Table 1 table showing demographic characteristics

demographic parameter	range	frequency	percentage
Age	10-19	17	38.6%
	20-29	13	29.5%
	30-39	09	20.4%
	40-49	5	11.3%
level of formal education	None	5	11.3%
	Primary	24	54.5%
	Secondary	13	29.5%
	Tertiary	2	4.5%
Marital Status	Married	10	22.7%
	Single	33	75.0%
	Divorced	1	2.3%
Religion	Protestant	12	27.3%

	Catholic	13	29.5%
	Muslim	4	9.1%
	Pentecostal	9	20.4%
	Others	6	13.6%
Tribe	Muganda	1	2.3%
	Mukiiga	6	13.6%
	Muhima	3	6.8%
	Munyankole	32	72.7%
	Others	2	4.5%

Majority of the participants were aged 10-19 followed by 20-29 with 38.6% and 29.5% respectively, while least being 10-49 years with 13.3%.

There was a significant low level of education with where 11.3% and 54.5% didn't have any formal education and only primary level of formal education, while only 29.5 and 4.5 percentages of participants had had secondary and tertiary levels of formal education respectively.

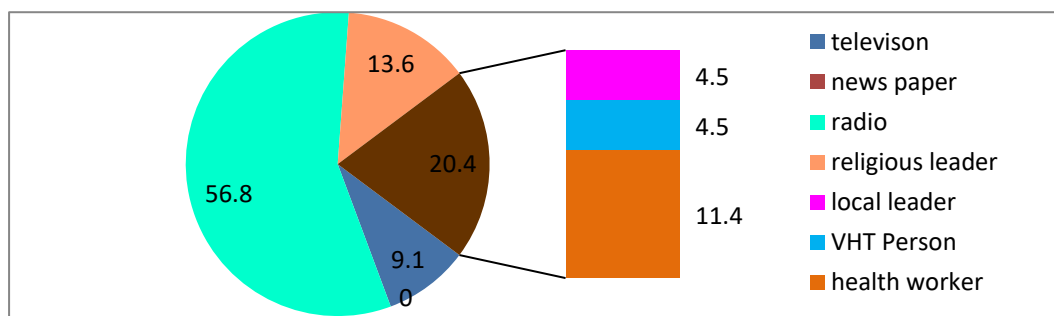
Single men were majority with 75.0% of participants. Christian faith formed the majority of participants with Catholics, Protestants and Pentecostals having percentages of 29.5, 27.3 and 20.4 percentages respectively.

Banyankole formed the majority of participants with 72.7%, followed by Mukiiga with 13.6%, while the rest being other tribes.

4.3 Knowledge of males 10-49 on SMC

Knowledge of participants were assessed based on whether they had heard about SMC, Who taught them about SMC, Knowledge on what are the reasons for SMC, and whether they had knowledge on where SMC can be freely accessed within their locality. The results from participants were as presented below.

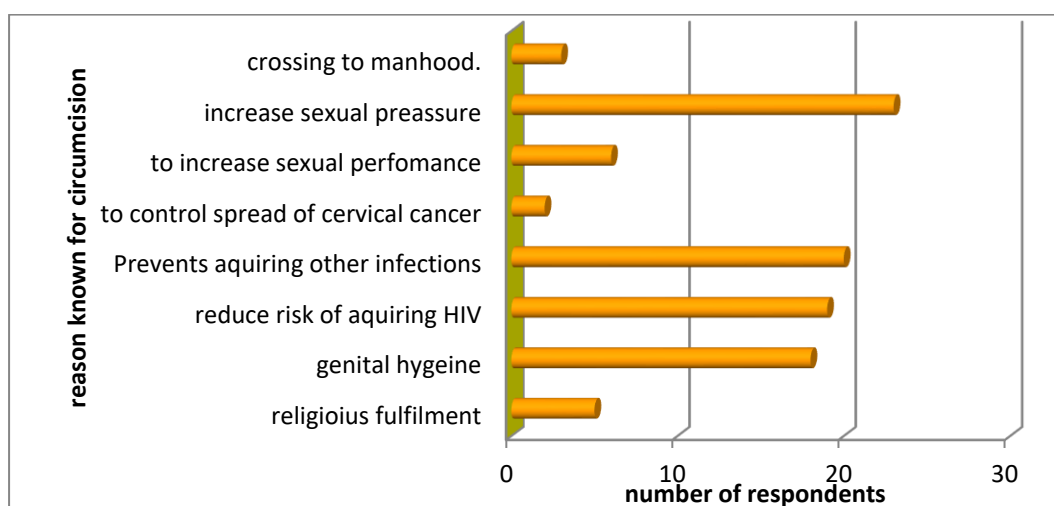
Figure 1: males that heard about SMC and source of information about SMC



All participants (100%) had heard about safe male circumcision.

Majority of the participants had heard about SMC from radios by 56.8%, those from health workers being 11.4%. While least source of knowledge was VHT with 4.5%

Figure 2: Knowledge on reasons for circumcision.



Increasing sexual pleasure and avoiding acquiring other infections were major known reason for circumcision, while only 43.1% were aware of HIV contraction risk reduction by 60% and least were those that knew controlling spread of cervical cancer to females as (4.5%)of the study population.

Table 2 knowledge on where SMC services can be freely accessed.

Heard about SMC?	frequency	percentage
YES	14	31.8%
NO	30	68.2%

Majority of participants 68.2% of participants did not know where they can freely access SMC within their locality while only 31.8 knew where they could get the service freely.

4.4 Attitudes of males 10-49 towards SMC

Attitudes of participants were assessed using scale parameter, where various parameters regarding SMC, they either **disagreed, agreed or strongly disagreed** to whatever is said about each specific parameter. While regarding some common packages and methods used in SMC, the participants perceived them as **being not good, good or very good.**

Table 3: attitudes towards SMC

scale	Do not agree	Agree	Strongly agree
SMC reduce risk of acquiring HIV by 60%	50%	38.6%	11.3
SMC improves genital hygiene	9.1%	45.4%	45.4%

Circumcised men performs better sexually	18.2%	43.2%	38.6%
SMC reduces transmission of cervical cancer	65.9%	22.7%	11.3
circumcised males are liked by most women	22.7%	36.3%	40.9%
On the other hand			
SMC reduces the length of the penis	61.3%	22.7%	15.9%
circumcision reduces glans sensitivity	18.1%	43.1%	38.6%
SMC reduces fertility and sexual pleasure	59.1%	22.7%	18.2%
SMC increases sexual promiscuity	15.9%	63.6%	20.4%
SMC is very painful	4.5%	77.3%	18.2%
post SMC wound take long to heal	2.7%	65.9%	31.8%

Only 2.7% disagreed to post SMC wound healing taking long, while 98.3 agreed (65.5%) or strongly agreed (31.8%) of to post SMC wound taking long to heal .

Majority of participants disagreed with the fact that SMC reduce chances of acquiring HIV (50.0%) While 38.6 and 11.3 percentages agreed or strongly agreed to HIV acquiring risk reduction.

43.3% of males and 38.6% of males agreed and strongly disagreed that circumcised males perform better sexually. While 36.3% of males and 40.9% of the participants agreed and strongly agreed that circumcised males are more liked by women compared to their uncircumcised counterparts.

On the other hand, men disagreed that SMC reduces the length of penis (61.3%), while (15.9%) strongly agreed that SMC reduce the lengths of penis.

Males (59.1%) disagreed that SMC reduce sexual pleasure, while 63.6 believed that SMC increases sexual promiscuity among circumcised males. 77.3% of

participant agreed that SMC is very painful, while only 4.5% disagreed to SMC being very painful.

Table 4 Attitudes towards some common SMC practices

SMC PRACTICE.	not good	Good	very good
circumcising under local anesthesia	2.3%	18.2%	79.5%
stitching post SMC wound	29.5%	40.9%	29.5%
bandaging post SMC wound	36.3%	45.4%	18.2%
post SMC pain management using panadol	2.3%	65.9%	31.8%
post SMC wound by open dressing with saline water	4.5%	88.6%	6.8%

Majority of males (79.5%) said that SMC under local anesthesia is very good, while only 2.3% believed that it is not good. Opposed to stitching and strong support to stitching SMC wound was equal by 29.5% in both. 65.9% of Males said that post SMC pain control using panadol is good while 2.3% said that it is not good.

Table 5: showing those that would consider being circumcised, and these that support government policy of circumcising males 10-49.

Parameter	frequency		%		parameter	percentage	%
would be circumcised	31		56.8		Its good	31	43.4
would not be circumcised	36		43.2		Not good	36	56.8

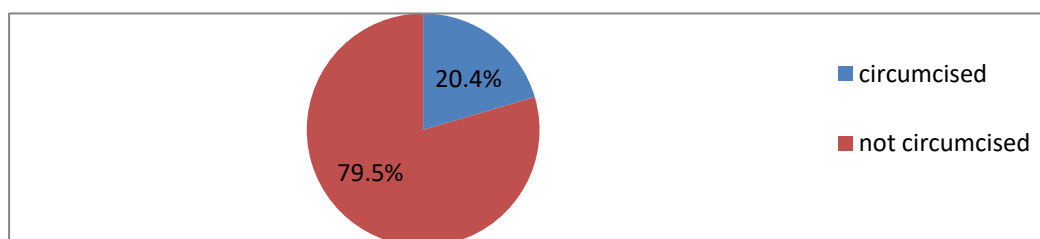
Majority of males (56.8%) said that they would not accept to be circumcised if a chance availed its self provided that they were not circumcised, while only 43.2% still said that they would take the chance and be circumcised.

Majority of males said that implementing SMC for all males 10-49 as HIV control strategy is a not a good idea, while only 43.4% were in support for mass mobilization for SMC of males 10-49 years nationwide as HIV control strategy.

4.5 Circumcision practices among males 10-49.

Practices were assessed based on whether the participant was circumcised, age at which he was circumcised and circumcision practitioner that circumcised individual participant.

Figure 3: Prevalence of SMC



Majority of males were not circumcised (79.5%) while only 20.4% of males were circumcised.

Table 6 age and person that circumcised. n=9

Parameter	Range	Frequency	Percentage
age when circumcised	below 10	4	44.4%
	10-19	2	22.2%
	20-29	3	33.3%
	30-39	0	00.0%
	40-49	0	00.0%
who circumcised	health worker	3	33.3%
	cultural leader	0	00.0%
	religious leader	5	55.5%
	parent/relative	0	00.0%
	don't know	1	11.1%

Majority of participants (44.4%) were circumcised when they were below 10 years.

Males circumcised by religious leaders were the majority (55.5%) followed by 33.3% circumcised by health workers, while parents/relatives and cultural leaders were not involved in circumcising any member in their study population as studied.

Table 7: table showing package received on SMC by circumcised members.

s/n	SMC Package	frequency	percentage
1	TT immunization	1	11.1%
2	screening of STIs	0	0.0%

3	jigger screening	0	0.0%
4	HIV counseling and test	1	11.1%
5	supportive care on STIs infection prevention	2	22.2%
6	pain management with Pain killer	6	66.6%
7	health education on post SMC wound care	5	55.5%
8	health support in form of follow up and adverse event management	1	11.1%

Only 11.1% of all circumcised clients had received TT immunization, Follow up and adverse event management, and HIV screening and testing on SMC, while screening of other STIs and jiggers were not received on SMC at all. However, pain management using painkillers and education on post SMC wound care was most accessed packages on SMC by most clients with 66.6 and 55.5 percentages respectively.

CHAPTER FIVE: DISCUSSION OF STUDY FINDINGS, CONCLUSION, AND RECOMMENDATIONS.

5.0 Introduction

This chapter deals with discussion of the study findings, conclusion from study findings and recommendation from study findings of research titled “**knowledge, attitudes and practices of males 10-49 years attending Ishaka Adventist hospital towards safe male circumcision.**” The study also compares the findings from this particular study to findings from other study areas by other researchers, and gold line standards set by national and international organizations regarding circumcision and safe male circumcision.

5.2: Discussion of the study findings.

The findings from the research study titled “knowledge, attitudes and practices of males 10-49 years attending Ishaka Adventist hospital on SMC”. Is discussed following the demographic characteristics of study population and objectives. The findings are discussed on bi-directional view that is, researchers’ view on the finding, and finding in relation to previous studies from other areas by other researchers.

5.2.1 Social demographic characteristics of the study population

Most of the respondents were aged 10-19 years followed by those 20-29 years. This could be simply because these being composed of youth that makes largest percentage of Uganda’s population utilizing health services. Hence if SMC services can be offered at Ishaka Adventist hospital, these may benefit most than other age

groups. Uganda has since times registered new infections of HIV among the youth; where by new acquired infections among the youth has doubled by 50%

Hence their knowledge, attitudes and practices directly affects government's target of reducing new infections.

Most respondents had had a level of formal education, including primary level (54.5%), secondary (29.5%) and tertiary (4.5%). This implies that they are able to retrieve knowledge from various sources like news papers, magazines and others, hence expected to have adequate knowledge and negative attitudes towards SMC as was also found out By Wilken et al that In youths, were found a borderline statistically significant decrease of awareness of MC for HIV prevention with higher educational level, but not with any other socio-demographic factors. (Wilken et al 2010)

Single men were majority with 75.0% of participants. This could be possibly because, the study involved adolescents of 10-19 and young youth in twenties. These being school and early post school ages are not yet married. Cultural and social pressure has been proven to have positive influence on male circumcision. For example to assess women's perceptions of male circumcision in Iringa, by Erica et al (2013) Women in this study had strong preferences for circumcised men because of the low risk perception of HIV with circumcised men, social norms favoring circumcised men, and perceived increased sexual desirability of circumcised men. Hence these are expected to have good circumcision practices to increase desirability form opposite sex there by effecting 60% HIV risk reduction in these age groups.

Christian faith formed the majority of participants with Catholics, Protestants and Pentecostals having percentages of 29.5, 27.3 and 20.4 percentages respectively. Religious affiliation has direct impact on SMC practices, teachings on SMC has great impact on followers attitudes towards SMC. Of recent, circumcision has not been mandatory in most of Christian faith, however, it has not been illegal either thereby leaving the decision of whether to be circumcised or not to an individual however, circumcision had been previously stood out being more prevalent in some religions than others. For example, **WHO** found out that of 30% global circumcised male population, two thirds are Muslim. (WHO 2009)

Banyankole formed the majority of participants with 72.7%, followed by Bakiga with 13.6%, while the rest being other tribes. Ishaka Adventist hospital is located in Ankole where most of population is Banyankole hence a reason for dominance. Culture and ethnicity has impact on circumcision practices, Ankole culture has not had circumcision as its core cultural values, and hence circumcision in this community is expected to be low as found by Catherine et al (2014) that There is considerable geographic variation in MC (male circumcision) prevalence, ranging from 2% in western, and the Mid Northern region to 53% in the Mid-Eastern region. **(Katherine et al 2014).**

5.2.2 Knowledge of males 10-49 years on SMC.

All participants (100%) had heard about SMC, hence with positive reaction, are expected to have good knowledge and attitudes towards safe male circumcision. Knowledge on SMC is higher compared to Meoble and Tegegn et al (2014) findings

in their study on knowledge and attitudes of males in university of Botswana where only 95.4% of males had heard about SMC

Participants that had heard about SMC had majorly heard from radios (56.8%). religious leaders and health workers were other sources of information to bigger numbers by 13.6% and 11.4% respectively. This could be basically because radios are affordable to most members of community, both literates and illiterates. Hence these could be having good knowledge on SMC however with no clarity on some puzzling issues regarding SMC since this source gives less interpersonal interaction during announcements and advertisement.

Unfortunately, only 11.4% of population heard about SMC from health workers similarly to finding by moses et al (2012) in his study on Knowledge of SMC in other parts of Uganda; a study conducted in IHK Kampala in 2012 indicated that there was sufficient knowledge and demand for SMC despite minimal mobilization effort by health teams (Moses et al 2012). This implies that health education on SMC has not been thorough on the ground; hence the members likely to have a gap on knowledge on health related reasons of circumcision.

Increasing sexual pleasure and avoiding acquiring other infections were major known reason for circumcision by 52.2% and 45.45 respectively, while only 43.1% were aware of HIV contraction risk reduction by 60% and controlling spread of cervical cancer to females was known by only 4.5% of the participants. This is similar to a finding from university of Botswana By Meoble and Tegegn (2014) where 55.4% of males that knew SMC being for reduction of risks for infections,

43.5 for reduction of risk for other STIs, while 21.1% knew VMMC for improving genital hygiene.

There is a gap on knowledge for reasons of carrying out SMC. Participants that knew about SMC knew it for sexual reasons than disease prevention purposes. This implies that, given the availability of the service, its utilizability may be high, however may be accompanied by compensatory risk behaviors in more than 50% of study population that do not know about disease prevention in SMC. This may be similarly to findings in Swaziland that confirmed the existence of risk compensation behaviors like indulgence into unprotected sexual intercourse following circumcision; however, this study adds important contextual insight about precisely when and why such risk-taking occurs. Nevertheless this study suggests that male circumcision scale-up as an HIV prevention strategy is likely to foster protective behavior change among men. (Jonathan & Monique 2012)

Majority (68.2%) of participants did not know where they can freely access SMC within their locality while only 31.8% knew where they could get the service freely. This could be because of non interactive sources of knowledge on SMC as seen above that radios were major sources of knowledge. This implies that even with good knowledge on SMC, members did not know where to access SMC services from hence directly negatively affecting SMC practice among participants as opposed to findings by Kulin et al (2013) in Kenya where participants indicated exposure to sensitization efforts and reported knowledge of the existence of SMC services in the community.

5.2.3 Attitudes of males towards SMC.

Only 11.3% of participants strongly agreed that SMC reduces risk of acquiring HIV by 60%, while 50% disagreed on SMC reducing risk of acquiring HIV. This implies that the role of SMC in HIV spreading control is undermined contrary to finding by Jonathan et al (2010) through randomized clinical trials in Kenya, Uganda and South Africa and WHO 2010 that Male circumcision has been shown to reduce the risk of heterosexual transmission of HIV infection in men by up to 60% (WHO 2010) This implies that compensatory risk behaviors are less likely since there are negative attitudes on risk reduction on spread of HIV.

However, majority of participants agreed (45.4%) and strongly agreed (45.4%) that SMC improves on genital hygiene. Hence to improve on SMC practices in this particular community, hygiene should be incorporated in talk package since people have strong confidence in SMC to improve hygiene. This is contrary to finding in Botswana by Meoble and Tegegn (2014) where only 21.1% of males knew circumcision for hygiene, the rest being for diseases prevention.

There is a belief that circumcised males performs better sexually (agree 43.2% + strongly agree 38.6%) than those uncircumcised. Hence males in this community likely to practice SMC for sexual reasons since every man would like to be sexually strong. However, there is no scientific proof on this that circumcised males are more sexually active than those uncircumcised. However, a study in Tanzania by Erica et al (2013) in her study on female perception on SMC that they proffered circumcised males than their uncircumcised counterparts due to better sexual performance,

where they described Uncircumcised men were described as being dirty, uneducated and “out of fashion.”

Majority of Males (65.9%) disagreed with SMC reducing transmission of cervical cancer while only 22.7% agreed and 11.3% strongly agreed that SMC reduces risk of transmission of cervical cancer. This is contrary to findings in Tanzania by Erica et al (2013) where the health benefits of male circumcision were generally overstated and many respondents falsely believed that women are also directly protected against HIV and that the risk of all STIs like cervical cancer is greatly reduced or eliminated in circumcised men.

This implies that cervical cancer is either not understood by majority of this population, or the role of prepuce in harboring the Herpes virus is greatly undermined. To improve SMC practices, more awareness on HERPES virus transmission should be emphasized. Much as it is not good for the undermined role of SMC on disease prevention, compensatory risk behaviors are less likely since majority believes not in complete protection against STIs.

However, there is a belief that SMC reduces sensitivity of the glans penis among 43.1 and 38.6 percentages of males who agreed or strongly agreed respectively that SMC reduces the glans sensitivity. This is contrary to Erica et al(2013) finding in his study on community perception on male circumcision where social pressure was piled on uncircumcised males, females sexually proffering circumcised that uncircumcised which implies that they functioned better and normally without any impairment. There is no scientific and health related proof of this as a fact though

its believed in by the majority. Hence it can act as a hindrance to SMC among men in fear that their sensitivity during sex will reduce.

While other men agreed (22.7%) or strongly agreed that SMC reduces fertility and sexual pleasure, majority (59.1%) Disagreed that SMC reduce fertility and sexual pleasure. This implies that though some men ay boycott being circumcised due to fearing loosing fertility or sexual pleasure, these fears has less effect on this community because the majority disagrees with this misconception on SMC.

Only 4.5% of males 10-49 disagreed on SMC being very painful while the rest 77.3% and 18.2% agreed or strongly agreed that SMC is very painful. This is similar to Goodman's findings that despite the solidity of evidence on its benefits, opposition to MC by groups or individuals in non-circumcising societies remains. Since their claims are not supported by quality research and fail to withstand scrutiny by academic and medical experts, the opposition appears motivated by ideological like fears of pain, discomfort following circumcision or other reasons. Such opposition has failed spectacularly: (Richard and Goodman 2013)

Pain has no measure to call it "Very painful"; it depends on only what each individual person perceives as very painful. There is no man that would like to be subjected to pain he considers to be very, hence with this intense fear of pain that may have to be endured to undergo SMC, most males are likely to shun voluntary medical male circumcision due to this unknown pain anticipation. However, with good education on procedure of medical male circumcision under local anesthesia

and post SMC pain management using paracetamol, has no so called very much pain as perceived by majority.

Adding on fear for pain, still majority agreed (65.9%) or strongly agreed (31.8%) that post SMC wound takes long to heal. This is potentially dangerous as it can cause indulgence into risky behaviors following circumcision as was found by Paul (2015) about Reported misconceptions and community-held cultural beliefs include fear that first sexual partner after the procedure should not be his spouse, and the belief that vaginal fluids aid circumcision wound healing hence likely to read to promiscuity, and early sex that can lead to bleeding following circumcision. (Paul E 2015).

Under normal circumstances however, this wound heals between 1-2 weeks, and up to 6 weeks for even formed scar to heal. This doesn't necessarily sound long period to nurse a wound in good condition compared to lifelong benefits of the practice there after.

To assess attitudes towards some common practices during SMC, on use of anesthesia, 79.5% of males said that it's good, while only 2.3% said that it not. In USA, 45% of circumciser use anesthesia for pain control (Buweh et al 2013). Since this is routine method used in SMC, if emphasized on in mobilization for SMC, may attract more men to circumcision as it was found out in Tanzania by Paul(2015) that worry of pain and wound healing were among major hindrances to circumcision in Tanzania.

Stitching is not greatly opposed as only 29.5% of males were opposed to stitching post SMC wound opposed to 40.9 +29.5% who believes that it is good and very good to stitch post SMC wound. This being done reduces risk of wound infection and reduces time of healing there by making SMC more convenient.

Majority (56.8%) said that they could not be circumcised while only 43.2% of males could. This implies that though males knew about circumcision, had not incorporated its practice into their minds and still see it unnecessary. This could be due to knowledge deficit on role of circumcision in HIV prevention as a study in South Africa on factors that may promote circumcision found out that 59% of males 10-49 said that they would be circumcised if circumcision reduced the chances of getting HIV and STDs. (Rain-taljaard et al 2010)

Also, most males (56.8%) say that it's not a good policy by the government of Uganda to massive SMC to all males 10-49 years contrary to Uganda targets to circumcise 4.6million males in this age bracket before 2020 (USAID 2016) Hence to meet this target, males have to efficiently utilize safe male circumcision services in facilities' where they are provided, Ishaka Adventists hospital included. There is no evidence to why most males think that it's not good move by the government to emphasize SMC, however it may be due to knowledge gaps on reasons for this emphasis. Hence for males to embrace this program gracefully there is a need to emphasize on reasons for than practice for SMC. This will in turn improve SMC service utilization.

5.2.4 Practices of males 10-49 on SMC.

Only 20.4% of males were circumcised, while the rest 79.6% were not circumcised. This is abnormally low compared to average circumcision prevalence of approximately 30% of males are estimated to be circumcised globally, (WHO 2009) and 24% of men are circumcised in Uganda according to the 2011 UDHS.

There are no clear reasons for this low prevalence among these males, but being located in Ankole where male circumcision has not been part of native culture, hence circumcision in this area may entirely be motivated by health and religious reasons only.

To assess the kind of male circumcision, age at which client was circumcised and person that circumcised a person were considered. Majority of males (44.4%) were circumcised while they were below 10 years, followed by those circumcised when 20-29 years. This implies that most males are circumcised while still young, hence motivated by parents' knowledge on SMC or Religion, culture and religion that medical and health reasons. As found out that of East Africa's circumcised population, Thirty six (36.3%) of the circumcised males had their procedure done in medical settings while 107 (63.7%) were circumcised in the traditional and religious setting settings. The age at circumcision varied significantly with the provider of the procedure (Buweh et al 2013)

Of the circumcised, majority (**55.5%**) of males was circumcised by religious leaders, followed by **33.3%** circumcised by health workers. health workers played a low role of community male circumcision compared to 36.3% of east Africa's circumcised male population in medical setting. This could be motivated by other

factors like cost as also found out by Buweh et al (2013) that Cost for circumcision procedures done in the medical setting was higher compared to the cost for procedures done in the traditional and religious setting (Buweh et al., 2013)

Parents/relatives and cultural leaders had not circumcised any of the circumcised males. This could be because, majority of males having been circumcised at young ages than 10. Could have been circumcised for religious purpose that fulfils purity, than culture that considers circumcising in puberty to crossing to manhood or health reasons that focuses on sexually active ages 10-49 that are considered most at risk ages and therefore priority for disease prevention and health promotion.

To assess the package during SMC practices by males, screening of STIs and Jigger screening were least involved in MC packages by circumcised males. This sounds normal since most clients were circumcised at young age hence STIs least expected. However, to adults, it's very important practice to screen other STIs among males. This is because in sexually active males, compensatory risk behaviors likely since less awareness prevail regarding other STIs. This is similarly to what was found out in a qualitative study of sexual behavior change and risk compensation following adult male circumcision in urban Swaziland (Jonathan et al 2011) Findings in study from Swaziland confirmed the existence of risk compensation behaviors following circumcision; however, this study adds important contextual insight about precisely when and why such risk-taking occurs. Nevertheless this study suggests that male circumcision scale-up as an HIV prevention strategy is likely to foster protective behavior change among men. (Jonathan & Monique 2012)

Others practices like HIV testing and STI infection prevention supportive care were also least involved during client circumcision.

Pain management and wound care which seem to be immediately affecting the client are the most availed at 66.6% and 55.5% respectively during SMC to achieve pain control and wound healing similarly to findings in USA by Futhon et al (2013) where 45% of all circumcisers used anesthesia. While those with long term effect to client like STIs screening, supportive care to prevent other STIs being least involved. This could be possibly because, most of clients circumcised are due to non health related reasons hence role of SMC in HIV and other disease prevention being undermined.

5.3: conclusion from the study findings.

The study population composed of mostly by natives of Ankole the Banyankole from the study area, with majority being Christians, who are single men, adolescents and youth 10-19 and 20-28 years; with at least a level of formal education, hence their circumcision practices valid in HIV control strategy.

Participants had heard about SMC hence good knowledge, most sources of knowledge on SMC being radios, religious leaders and health workers respectively. Males knew SMC for increasing sexual pleasure, preventing other STIs but not HIV and cervical cancer spreading. SMC was known for hygiene reasons, religious reasons but not health promotion reasons Like 60% risk reduction for acquiring HIV, Males mostly did not know where they can freely acquire SMC services within their locality.

There low positive attitude on SMC towards reducing HIV acquisition risk by 60%. While there was a strong positive attitude that SMC increases genital hygiene and sexual pleasure, and circumcised males performing better than uncircumcised. Negative attitudes were basically on SMC reducing spread of cervical cancer, and controlling HIV. Others were on SMC being painful, and wound healing taking a very long time. Positive attitudes were on use of anesthesia during circumcision, and pain control using panadol following SMC. Males also were proposed to stitching than leaving wound unstitched following SMC. However, males still would not consider being circumcised given that an opportunity was availed to them and still remain adamant towards government policy on SMC for HIV control saying that it's not a good move implying no support to the policy.

Circumcision prevalence is very low compare to global and national statistics. Of the few circumcised, Most males are circumcised when below 10 years, by religious leaders than by health workers, while parents and cultural leaders did not play a part directly in circumcising. There is an increasing trend with decrease in age in SMC. Those elderly by 30 and above showed little involvements in SMC, than young 10-19, and 20-29 implying that the trend of utilization of Circumcision services is increasing at accelerating phase.

5.4: Recommendations from the study findings.

To bushenyi district community

I recommend the general population of bushenyi district to utilize safe male circumcision services from health workers and health facilities within their locality in order to achieve this 60% risk reduction, and avoid unsafe events associated with circumcision outside health facility like non use of anesthesia which cause a lot of pain, sepsis associated to non aseptic techniques and other adverse reactions related to circumcision that usually go un managed if it's done by cultural or religious leaders.

To Ishaka Adventist hospital authorities

I recommend that talk about circumcision and its availability in facility to its clients in order to increase on service demand by its clients there by indirectly contributing to HIV control in bushenyi and Uganda at large.

To Bushenyi district health department:

I recommend community based approach and community health staffing increment in bushenyi district to avail advice and health education to people in community regarding HIV and its control measures including safe male circumcision.

More massive informative advertisements to be intensified in order to inform the population on circumcision services and where it can be easily and freely accessed by general population it order to increase its utilizability.

5.5 IMPLICATION TO NURSING PRACTICE

5.5.1 To nursing practice.

More problem focused community health education on relationship between safe male circumcision and HIV prevention to create knowledge facts based awareness in community so as to value its role in disease prevention.

I recommend practicing nurses to intensify health talks on SMC and reasons why it is important for health than what is basically known like increasing sexual performance and sexual pleasure there by eliminating their associated risks like compensatory risk behaviors like unsafe sex and sexual promiscuity following SMC.

5.5.2 To nursing education

More precise and mathematical way of mechanism under which SMC contribute the theoretical 60% HIV risk reduction be designed in order to make it more presentable to members of community to instill this practice of SMC in members of community.

5.5.3 To nursing research

I recommend future researchers to study about factors affecting utilization of SMC services in Bushenyi district so as to come up with factors promoting or hindering circumcision in this population.

5.6 Areas for further research.

Factors affecting circumcision practices among males 10-49 years in Bushenyi district.

Trend of HIV and STIs Prevalence in relation to incorporated safe male
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journal on post SMC health care to prevent complication.

APPENDICES

Appendix I:

Data collection material

Consent Form

Good morning/afternoon? My name is Kaddu Yusufu, I am conducting a research titled “**knowledge, attitudes and practices on males 10-49 years attending Ishaka Adventist hospital on SMC**” The purpose of this study is to establish knowledge attitude of males 10-49 years on safe male circumcision. The study will involve asking you some questions concerning you. All the information collected

will be treated in confidence and used only for purposes of this study; the dissemination of results will be by way of summarized information that will have no reference to any particular individual.

You are free to choose whether to take part in the study or not, and feel free to Withdraw at any time during the interview. For any questions concerning the study please contact the chief Investigator through the following contact address:

Mobile. Number: 0751404453,0788822485

I hereby invite you to take part in the interview on the above subject. The interview will take approximately 5 minutes.

Statement of informed consent

The above information has been clearly explained to me and I have read/understood it. I do here by voluntarily agree to participate in this study.

Respondents signature/thumb
print.....

Name of research assistant eliciting
consent.....

Signature.....

Date.....

Appendix ii

Questionnaire Schedule

SECTION (A)

- 1) Demographic characteristics of study population.

Age	10-19	
	20-29	
	30-39	
	40-49	

level of formal education	None	
	Primary	
	Secondary	
	Tertiary	
Marital Status	Married	
	Single	
	Divorced	
Religion	Protestant	
	Catholic	
	Muslim	
	Pentecostal	
	Others	
Tribe	Muganda	
	Mukiiga	
	Muhima	
	Munyankole	
	Others	

SECTION (B)

KNOWLEDGE OF MALES ON SMC (SAFE MALE CIRCUMCISION)

1. (a) Have you ever heard of SMC (Safe male circumcision)?

Yes ☐

No ☐

(b) If yes, from whom did you hear about SMC?

Health worker ☐

VHT ☐

Local leader ☐

Religious leader ☐

Radio ☐

News papers. ☐

(c) What were the reasons that you were told as reasons for circumcision? **Multiple answers**

Religious fulfillment ☐

Promoting genital hygiene ☐

Prevention of acquiring HIV ☐

Prevention of acquiring other STIs ☐

Avoiding transmission of cervical cancer ☐

For increasing sexual performance and pressure

For crossing to man hood ☐

(c) Do you know where SMC services can be accessed from within Bushenyi district?

Yes ☐

No ☐

SECTION C:

Attitudes of males towards safe male circumcision

3. (A) why do you think about the following regarding SMC? (Tick a single box right in the table)

No.	scale	Do not agree	Agree	Strongly agree
1	SMC reduce risk of acquiring HIV by 60%			
2	SMC improves genital hygiene			
3	Circumcised men performs better sexually			
4	SMC reduces transmission of cervical cancer			
5	circumcised males are liked by most women			
	On the other hand			
6	SMC reduces the length of the penis			
7	circumcision reduces glans sensitivity			
8	SMC reduces fertility and sexual pleasure			
9	SMC increases sexual promiscuity			
10	SMC is very painful			
11	post SMC wound take long to heal			

(B)What is your view on use of the following during SMC?

SMC PRACTICE.	not good	Good	very good
circumcising under local anesthesia			
stitching post SMC wound			
bandaging post SMC wound			
post SMC pain management using paracetamol			
post SMC wound by open dressing with saline water			

(C) If you are/ you were not circumcised today, would you go for the service given that it is availed?

Yes ☐

No. ☐

(d). Recently the government, incorporated SMC as one of strategies to reduce HIV Transmission to males. What is your opinion about it?

.....

SECTION D:

PRACTICES OF MALES ON SAFE MALE CIRCUMCISION

4 (a) what is your current status regarding male circumcision?

Circumcised ☐

Not circumcised. ☐

(b) At what age and by who were you circumcised? **(Tick on right)**

age when circumcised	below 10	
	10-19	
	20-29	
	30-39	
	40-49	
	above 49	
who circumcised	health worker	
	cultural leader	
	religious leader	
	parent/relative	
	don't know	

(c) Which of the following was part of your package when you were circumcised?

1	TT immunization		7	health education on post SMC wound care	
2	screening of STIs		8	health support in form of follow up and adverse event management	
3	jigger screening		9	wound care	
4	HIV counseling and test				
5	supportive care on STIs infection prevention				
6	pain management with Panadol				

Thank You for Your Cooperation

**Appendix iii SCANNED LETTER OF AUTHORIZATION TO CARRY OUT
RESEARCH IN AREA OF THE STUDY.**

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RESEARCH IN AREA OF THE STUDY.**



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Office of the Dean - School of Nursing Sciences

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

RE: KADDU YUSUFU - DNS/0003/143/DU

The above mentioned is a student of Kampala International University - School of Nursing Sciences undertaking Diploma in Nursing Science and he is in his final academic year.

He is recommended to carry out his data collection as a partial fulfillment for the award of the Diploma in Nursing Science.

His topic is **KNOWLEDGE, ATTITUDE AND PRACTICES OF MALES 10-49 YEARS ATTENDING ISHAKA ADVENTIST HOSPITAL ON SAFE MALE CIRCUMCISION.**

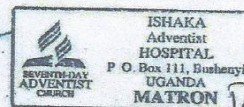
Any assistance rendered to him will be highly appreciated.

Thank you in advance for the positive response.



Musoke, Ishaka
RESEARCH COORDINATOR

*Received and accepted
to collect data at Ishaka Adv.
Hospital in HIV/AIDS department.*

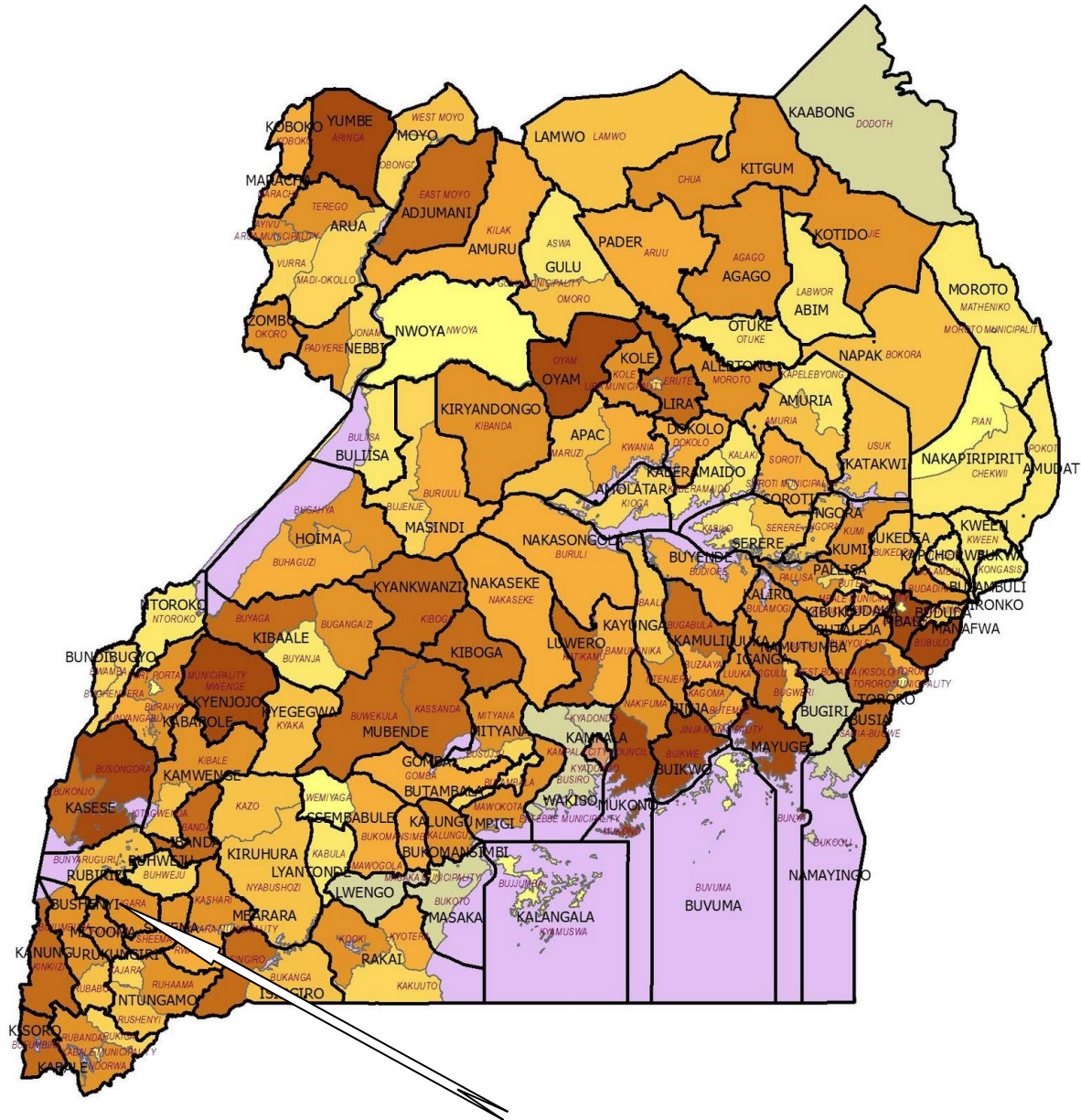


20/8/2017

"Exploring the Heights"

APPENDIX IV:

A MAP OF UGANDA SHOWING LOCATION OF BUSHENYI DISTRICT WHERE ISHAKA ADVENTIST HOSPITAL IS LOCATED.



LOCATION OF BUSHENYI DISTRICT

[illegible]