

**ASSESSMENT OF THE FACTORS CONTRIBUTING TO THE LOW PREVALENCE
OF SAFE MALE CIRCUMCISION IN BUWOYA VILLAGE UGANDA.**

BY

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DECLARATION

I, NAKISUYI JOANITOR declare that my research dissertation submitted for the award of the Bachelor of Medicine and Bachelor of Surgery is a result of my original work and has never been submitted in any form for any academic award.

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DEDICATION

I dedicate this research study to my father, my mother and my grandmother.

ACKNOWLEDGEMENT

I thank my dear lord for the courage I had in this study. I thank all the participants in this study and all those who contributed to development of this study especially my uncle and mother. I extend my sincere gratitude to;

To my supervisor DR. WACHAYA DAVID without you this study could not be accomplished.

Special thanks go to MY DADDY for the financial and academic support .

Lastly I acknowledge The Kampala International University administration [School of Clinical Medicine and Dentistry] for the knowledge and skills I have gained in the 5 and half years while in this institution.

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ABBREVIATIONS.

KIUTH - Kampala International University-Teaching hospital.

SMC - Safe Male circumcision

UNICEF - United Nations International Children's Education Fund

WHO - World Health Organization

HIV - Human immune deficiency Virus

MOH - Ministry of Health

STI - Sexually Transmitted Infections

STD - sexually transmitted Diseases.

UDHS - Uganda Demographic and Health Survey.

UNPFA - United Nations Population fund

USAID - United States Agency for International Development

PEPFAR - United States President's Emergency Plan for AIDS Relief,

UNAIDS - Joint United Nations Programme on HIV/AIDS.

VMMC - voluntary medical male circumcision.

AMA - American Medical Association.

HCP - Health Communication Partnership.

MCP - Male Circumcision Policy.

ABC - "Abstain" "Be faithful" and always use a "Condom" strategy.

NHP - National Health Policy.

STAR-SW - Strengthening TB and HIV/AIDS Response in –South Western Uganda

Abstract

It has been proven in several randomized clinical trials that safe male circumcision reduces the risk of HIV transmission from female to male by 60%. The national target for Uganda by 2015 is to circumcise 4.2 million adults' men. There is need for a pragmatic approach and effective model to achieve this target.

The objective of the study was to determine the factors hindering the scaling up of circumcision numbers in men above 18 years in Buwoya village in Iganga district, Uganda.

A prospective cross-sectional study was carried out with a catchment population of 72 men above 18 years. Enrollment was voluntary and all respondents consented.

Out of a total of 72 respondents, only 19 (26%) men were circumcised and (74%) 53 men were uncircumcised. Out of the 53 men 14 were planning to be circumcised and 39 reported to never circumcise. The most reported factor hindering the uptake of safe male circumcision by men above 18 years in Buwoya village were pain, failure to secure time for the service and the long duration for healing.

However the study was carried out successfully.

1.1 BACK GROUND INFORMATION OF SAFE MALE CIRCUMCISION.**Introduction.**

Safe male circumcision is the removal of the foreskin of the penis. Worldwide male circumcision is undertaken for religious, cultural, social and medical reasons. Several studies have found significant association between male circumcision and HIV infection. Based on the results from three clinical trials and other accumulated evidence showing that male circumcision reduces the risks of HIV acquisition by 60%, **WHO, UNAIDS** in 2007 and **CDC** in 2008 issued a recommendation that male circumcision should be considered as part of a comprehensive prevention package. But also state that circumcision only provides minimal protection and should not replace other interventions to prevent transmission of HIV (**WHO, 2007 and Auvert et al 2005**).

Unlike some other HIV prevention interventions, safe male circumcision is a one-time, short procedure that confers a lifetime of reduced HIV infection risk for heterosexual men. But its protective effects extend beyond men: safe male circumcision also reduces the risk for human papillomavirus (or HPV), cervical cancer, and other sexually transmitted infections among female sexual partners of circumcised males. It should be remembered that female circumcision is genital mutilation and would increase the risk of HIV further. Brilliant scientists and researchers suggest that if eight of 10 adult men become circumcised within just five years in 14 priority countries in eastern and southern Africa, approximately 3.5 million new HIV infections could be prevented within 15 years, averting as much as \$16.5 billion in HIV care and treatment costs. And almost half of these new infections that would be averted are among women, because women's probabilities of encountering HIV-infected sex partners decrease as HIV-prevalence in men decreases due to circumcision. In turn, this indirect protective effect against HIV extends beyond those women to their uncircumcised male partners, and ultimately to the whole population. This indirect protection increases in relation to the breadth of coverage and the speed at which coverage is achieved (**Ambassador Scot, 2012**).

Uganda has been lauded as a success story in the fight against HIV/AIDS, when the prevalence reduced from over 18% (in rural areas) and 25-30% (in urban areas) in the early 1990s to current

national estimates of 6.5% (**UNAIDS 2010**). This has been largely attributed to the government's "Abstain, Be faithful, Use Condoms" (ABC) campaign, which was rigorously implemented in both rural and urban areas (**Edgar et al, 2002**).

However, this rapid decline phase was followed by stagnation of the prevalence between 6.1% and 6.5% and has remained here since 2000 (**UNAIDS, 2010**), highlighting the limitations of the ABC strategy in decreasing prevalence. This stall in the decline of HIV prevalence led to calls for a broader and more comprehensive prevention strategy that integrates different empirically proven prevention approaches with the ABC campaign (**Piot et al, 2009**). And that approach is safe male circumcision (SMC), which has been proven by different studies to decrease risk of HIV transmission by 60% (**Weiss et al, 2008**).

Uganda endorsed the SMC recommendation and developed her male circumcision policy. The development of Safe Male circumcision policy was conducted through participatory and consultative processes and informed by the draft NHPII and the 2008/2012 National HIV/AIDS strategic plan (**MCP, 2010**). This involved campaigns like "Stand Proud, Get Circumcised" and "We are the Pride of our Tribe", to motivate Ugandans and increase on the uptake of the practice (SMC) by the Ugandans (**Toolkit, 2013**). SMC in Uganda has been supported by many organizations including PEPFAR since April 2010 to reach Uganda's national target of 4.2 million eligible men undergoing the procedure by 2015 (**Ambassador scot, 2012**).

But the program has encountered scaling-up challenges, When compared across sub-Saharan Africa Uganda lags woefully behind other countries in the effort to scale up the number of male circumcisions and leads in the wrong category in the rise of the rate of HIV infections particularly troubling, approximately half of the new infections in Uganda, some 650000, have occurred in just the past five years (Ambassador Scot, 2013). There is also stiff opposition from influential politicians such as one who said that "Ugandans should return to morality and sexual discipline if HIV\Aids is to be fought effectively, adding that HIV/Aids is not a medical but a moral problem that should be treated as such. (**Uganda university, 2013**).

1.2 Problem statement.

The global prevalence of Circumcision is 33% with almost 70% of these being Muslim,(probably because circumcision is mandatory). The procedure is most prevalent in the United States 75% and parts of Southeast Asia and Africa. It is relatively rare in Europe, Latin America, parts of Southern Africa and most of Asia. Prevalence in Africa varies from less than 20% in some southern African countries to near universal in North and West Africa. Prevalence in Central and East Africa varies from approximately 15% in Burundi and Rwanda to 70% in the United Republic of Tanzania, 84% in Kenya and Only 25% in Uganda. **(WHO, 2007)**.According to Uganda MCP, 2010, only 10% of south westerns men are circumcised.

Because of the low prevalence of circumcision in Uganda, organizations such as PREFAR, STAR-WEST, have financially supported SMC with the intention to provide quality services. The Ugandan government has also taken the initiative to make the service affordable and accessible by making the service free, subsidizing the fee and by supporting out reaches (MCP, 2010). To motivate Ugandans to do SMC, the government has also put up projects such as “stand proud and get circumcised”, and “We are the pride” for cultures such as the Bagishu and Bakonjo which consider circumcision an obligation(Toolkit,2013) . In addition to this, there are religions in Uganda that take circumcision mandatory such as some Christians and Islam but the followers are not many in Uganda.

Despite all this, Uganda has challenges in scaling-up its male circumcision numbers in comparison to other countries in sub-Saharan Africa.**(Ambassadors cot, Uganda university,2013)**.

The failure to circumcise has increased the risk of transmission of STDs such as HIV/AIDS as a result of organisms that thrive in the prepuce. HIV/AIDS is responsible for more than 50% death each year in East Africa. **(Mhalu and lyamya, 2012)**.

1.3 Objectives of the study

1.3.1 General objective.

To determine the factors contributing to the low prevalence of safe male circumcision in Buwoya village.

1.3.1 Specific objective

- To determine the availability and affordability of the service in Buwoya village.
- To determine knowledge and beliefs of respondents on safe male circumcision.
- To determine the prevalence of circumcised men in Buwoya village.

1.4 Study justification.

By carrying out the study factors hindering the practice of circumcision will be identified and this will help in developing counteracting measures to augment the implementation of safe male circumcision by the government. The results from the study will be used by the government to develop strategies that will increase the uptake of SMC by the people.

According to the studies carried out, Some of the factors contributing to the low prevalence of Circumcision in Uganda are; some influential leaders are against the practice, few cultural and religious group that consider circumcision mandatory, illiteracy, and education level. But there is need to find out other factors contributing to the low rate of practice of SMC.

The findings of the study will be used by the health workers to design a way to promote and improve the practice and this will in turn help the community.

Apart from serving as a learning experience to the researcher, the community of Buwoya will also benefit from the information and also the students of KIUWC will get information since the research book will be disseminated to the University Library and it will act as a reference in the future research.

2.0 Literature review .

2.10 History of male circumcision.

The word “circumcision” comes from Latin circum (meaning “around”) and cædere (meaning “to cut”). (Wrana, 1939).

Medical male circumcision is the full removal of the penis fore skin, fully exposing the glans penis. Medical Male Circumcision is performed at a Medical facility by a qualified medical professional. All men have the right to safe and hygienic medical male circumcision services.

Circumcision is the world’s oldest planned surgical procedure, suggested by anatomist and hyper diffusions historian Grafton Elliot Smith to be over 15,000 years old. There is no firm consensus as to how it came to be practiced worldwide. In the history of circumcision, it is suggested that it began as a less severe form of emasculating a captured enemy: penectomy or castration would likely have been fatal, while some form of circumcision would permanently mark the defeated yet leave him alive to serve as a slave. (Peter Charles and Remondino, 1891)

2.11 Cultures and religions.

The history of the migration and evolution of the practice of circumcision is followed mainly through the cultures and people in two separate regions. In the lands south and east of the Mediterranean, starting with Sudan and Ethiopia, the procedure was practiced by the ancient Egyptians and the Semites, and then by the Jews and Muslims, with whom the practice traveled to and was adopted by the Bantu Africans. In Oceania, circumcision is practiced by the Australian Aborigines and Polynesians. There is also evidence that it was practiced in America, but little detail is available about its history. The Greek disliked circumcision (they regarded a man as truly “naked” only if his prepuce was retracted) leading to a decline in its incidence among many people that had previously practiced it. Jewish law states that “circumcision is a positive commandment to perform an act”, and is obligatory for Jewish-born males and for non-circumcised Jewish male converts. It is only postponed or abrogated in the case of threat to the life or health of the child.

In Islam, circumcision is mentioned in some hadith, but not in the Qur'an. Some Fiqh scholars state that circumcision is recommended, others that it is obligatory. Some have quoted the hadith to argue that the requirement of circumcision is based on the covenant with Abraham. While endorsing circumcision for males, Islamic scholars note that it is not a requirement for converting to Islam **(Rizvi, 1999)**.

The Catholic Church condemned the observance of circumcision as a mortal sin and ordered against its practice in the Ecumenical Council of Basel-Florence in 1442. Circumcision is customary among the Coptic, Ethiopian, and Eritrean Orthodox Churches, and also some other African churches. Some Christian churches in South Africa oppose circumcision, viewing it as a pagan ritual, while others, including the Nomiya church in Kenya, require circumcision for membership. Some Christian churches celebrate the Circumcision of Christ. But it should be noted that the vast majority of Christians do not practice circumcision as a religious requirement **(Wrana, 1989)**.

It is possible that circumcision arose independently in different cultures for different reasons **(Milos, 1992)**.

Circumcision in sub-equatorial Africa is performed on adolescent boys to symbolize their transition to warrior status or adulthood. In some cultures, males must be circumcised shortly after birth, during childhood, or around puberty as part of a rite of passage. Among some West African groups, such as the Dogon and Dowayo, circumcision is taken to represent a removal of "feminine" aspects of the male, turning boys into fully masculine males. Among the Urhobo of southern Nigeria and Bagisu in eastern Uganda Circumcision is symbolic of a boy entering into manhood. The ritual expression, OmoteOshare ("the boy is now man"), constitutes a rite of passage from one age set to another. For Nilotic peoples, such as the Kalenjin and Maasai, circumcision is a rite of passage observed collectively by a number of boys every few years, and boys circumcised at the same time are taken to be members of a single age set **(Wrana, 1939)**.

2.2 Prevalence of circumcision

Estimates of the proportion of males that are circumcised worldwide vary from one-sixth to a third. The WHO has estimated that 664,500,000 males aged 15 and over are circumcised (30% global prevalence), with almost 70% of these being Muslim. Prevalence in Africa varies from less than 20% in some southern African countries to near universal in North and West Africa. In

Uganda 25% of the men are circumcised. (WHO, 2007). The data further shows that male circumcision is more among the urban than the rural. Specifically, circumcision was much more common in eastern region(54.7%) as well as in Kampala(37.8%) and east central region(34.7%).Less than (10%) of men in men in north central ,northeast, and south western regions were circumcised. Prevalence of male circumcision was lowest among Catholics (10%) and highest among Muslims(97%) (**Uganda safe male circumcision policy, 2010**)

2.3 Sexual effects of circumcision

The sexual effects of circumcision are the subject of much debate. The American Academy of Pediatrics suggested that there are more varied sexual practice and less sexual dysfunction in circumcised adult men. There are anecdotal reports that penile sensation and sexual satisfaction are decreased for circumcised males. According to a study carried out in South Africa this may be due to removal of the nerve endings in the fore skin and subsequent thickening of the epithelium of the glans however there is little evidence for these studies and its inconsistent. In one of their studies, out of 1131HIV-1negative men reported mild to moderate erectile dysfunction 21 months after the surgery in the orange Farm intervention trial but it's still unclear whether it was a pre-existing problem.

The anecdotal also noted that there is no difference in exteroceptive and light tactile discrimination on the ventral or dorsal surfaces of the glans penis between circumcised and uncircumcised men. Conversely, it was stated that “the genitally intact male has thousands of fine touch receptors and other highly erogenous nerve endings many of which are lost to circumcision, with an inevitable reduction in sexual sensation experienced by circumcised males.” (Boyle et al , 2002), They concluded, “...Evidence has also started to accumulate that male circumcision may result in lifelong physical, sexual, and sometimes psychological harm as well. (Rizvi, 1999).

2.4 Epidemiology of HIV.

Today there are 34 million people living with HIV/AIDS worldwide (UNAIDS,2012). Eastern Africa is the second most affected region with HIV/AIDS after southern Africa. In Uganda the HIV prevalence amongst adults aged 15-49 years was estimated at 6.4% (Uganda National HIV

sero-behavioral survey, 2004-5).The prevalence rate has increased from 7.5%to 8.3% among women compared to 5-6% among men. Over 130000 new infections are recorded in the country each year (**UAIS,2011**).

2.5 Benefits from circumcision.

Evidence shows that the inner skin of the foreskin is more likely to absorb HIV than any other skin as it is more prone to small tears during sex. Within the fore skin are Langerhans cells and other receptors cells that attract the HIV virus. With circumcision the cells that attract HIV are removed reducing on the risk of HIV infection by 60% although there is still a 40% chance that the circumcised men can get HIV. It's also suggested that circumcised men are 8 times less likely to contract the HIV virus but condoms and safe sex must be used this also applies to preventing cancer of the cervix in women since it involves removal of reservoir for HPV, the major cause of the cancer of the cervix.(WHO,2007). At least 20% of cancer of the cervix would be avoided if all men were circumcised. (**British Medical Journal, 2002**).

After circumcision, the penis is easier to keep clean. It eliminates bruising and tearing during exit is odor-free, it feels cleaner, and this is an important factor in building self –confidence.

Circumcision in infancy makes cancer of the penis 10 times less likely (**WHO, 2007**).

However SMC is not as effective as condom use as an intervention strategy for HIV prevention. Other services provided at safe male circumcision are; promotion of ABC strategy, provision and promotion of correct and consistent use of male condoms, HIV testing and counseling services ,referrals to appropriate care and treatment if necessary for other STDs and full surgical removal of the fore skin (**MCP,2010**).

2.6 Complications of circumcision.

The reported rates of complication are likely to depend on age at circumcision, experience of the surgeon, reason for the circumcision and the method used. The potential complication is greater in adults as the procedure is more complex, requiring suturing of skin edges. Neonatal circumcision complication rates are between 1 in 500 and 2in 100 and are usually minor.

From different surveys different complication rates are reported about; 2%-4% (WHO, 2007), 2-10% (Williams and Kapilla,1993). Blood loss and infection are the most common complications. The complication rate of bleeding is between 0.1% and 35% (Kaplan, 1983).

These complications are worse in the traditional set up because circumcisions is carried out under non-clinical conditions on addition to their beliefs posing significant complications risks. The Eastern Cape Provincial Department of Health recorded 2 262 hospital admissions, 115 deaths and 208 cases of genital amputations for traditional male circumcisions between 2001 and 2006.

Another survey on complications of traditional male circumcision from a 1999 study of 48 boys in Nigeria revealed that hemorrhage occurred in 52% of the boys, infection in 21% and one child had his penis amputated (Schmid, 2008).

2.7 Ethical considerations.

For a minor the physician is bound under the ethical principles of beneficence and non-maleficence. With respect for autonomy and consent, Parents are assumed to have the child's best interests in mind. Ethically, it is imperative that the medical practitioner inform the parents about the benefits and risks of the procedure and obtain informed consent before performing the procedure. In the adults the decision is very easy by the patient with guidance under a professional health worker (WHO, 2007; Caga et al, 20011 and Pinto, 2012).

2.8 Economic considerations.

Circumcision for the prevention of HIV transmission in adults was found to be cost-effective in South Africa, Kenya and Uganda, with cost savings estimated in the billions of US dollars over 20 years. It was estimated that a \$1.5 billion investment in circumcision for adults in 13 high-priority African countries would yield \$16.5 billion in savings (Hankins et al, 2011).

It was also reported that the cost of the procedure is more expensive for an older male than a newborn (uthman et al, 2010 andHay, 2012)).

However SMC is free of charge in government health facilities of Uganda.(Uganda safe male circumcision policy,2010).

2.9 Factors influencing the acceptability of circumcision.

There are three most common salient barriers to the acceptability of male circumcision that is, fear of pain, concerns for safety and cost of the procedure.

The factors affecting the acceptability of the procedure in addition to the benefits of the procedure as already mentioned are; religion, ethnicity, and education level. Many myths and misunderstandings surround circumcision, which make it difficult for health care providers to reach the people who need it (**Ambassador Scot, 2013**).

According to a study done in central Uganda, it was reported that circumcision rates decreased with increase in the education level. It was also observed that the rate was higher in those with better economic status but also inconsistent in the different areas of the study (**Edgar et al, 2002 and WHO 2007**).

According to the Uganda safe male circumcision policy, 2010, almost all existing health service infrastructures perform the MMC procedure but need improvements to scale up the services and meet anticipated demand. Also more resources including staff capable of performing the circumcision procedure, better equipment and enhanced facilities are needed to provide increased SMC services.

METHODOLOGY**3.0.1 Study design**

A prospective cross sectional study was used to determine the factors contributing to the low prevalence of circumcision in Buwoya village.

3.0.2 Study Area/study population.

This study was carried out in Buwoya village, a class-p place with a population of 24154 people. Buwoya village is located in Iganga district which is bordered by Kaliro district to the north, Mayuge district to the south, Luuka district to the west and Bugirir district to the east. As of 2010 population census the district has an estimated population of 481700 people with a growth rate of 2.8%. According to the population census and housing policy of 2002, There are 3020 males in Buwoya village (UPC, 2002).

3.0.3 Sample size estimation.

Researcher used Kish and Leslie formula to calculate the sample size.

$$N = \frac{Z^2 \times P(1-P)}{D^2} =$$

Where N= desired sample size

Z= standard deviation scored at =1.96

P= proportion of the target population estimated to have same characteristics. For this study the known prevalence rate is 25%, so P = 25% or 0.25.

D= is the level of the error acceptable (assumed accuracy) 0.1 or 10%

$$N = \frac{1.96^2 \times 0.25(1-0.25)}{0.1^2} =$$

From the formula 72 respondents will be interviewed during the study.

3.0.4 Sampling procedure.

A simple random sampling technique will be used to obtain the required sample size of the study. The researcher interviewed respondents from every after 2 households until the sample size was attained. The interview was open to anyone who qualified for the study.

3.0.5 Data collection tools.

The method of collecting the data entailed the use of questionnaire, clip board and a pen

A questionnaire was administered to each study participants; this questionnaire contained all the necessary information concerning the objective of the study

The questionnaire contains closed ended questions. A serial number was used to ensure confidentiality and comfort of the respondents. The questions were simple, short in English and for those with difficulties in the language were assisted.

3.0.6 Quality control.

This was ensured by holding meetings with my assistants before and after collection of data from the community. This enabled corrections where necessary.

3.0.7 Pre-testing

The questionnaire was pre-tested on ten respondents from the village that share the same social, cultural and economic status as of the study area.

This was meant to identify possible source of errors that may be encountered during data collection by the data collection tool (questionnaire).

3.0.8 Selection criteria

3.0.81 Inclusion criteria

- ✓ Residents
- ✓ Above 18 years
- ✓ Male sex

3.0.82 Exclusion criteria

- ✓ Non Residents
- ✓ Below 18 Years
- ✓ Female sex
- ✓ Muslims and circumcising groups/cultures

3.0.9 Data analysis

The study finding was analyzed using excel 12.0 for windows. The results were presented in form of pie chart, histogram, bar graph and line graphs and figures for accuracy of processing the data and a Statistician will be consulted during data analysis.

3.1 Ethical considerations

An introductory letter was obtained from the university Faculty of biomedical to introduce the researcher to the area of the study.

An informed consent was ensured to all the subjects willing to participate in the study.

Despite the economic and social status of the respondent, politeness humbleness and friendliness was adhered. The participants were not forced to answer question when not willing due to ethical inclinations

3.2 limitations of the study

- ✓ Financial constraints.
- ✓ Difficulty in accessing distant villages
- ✓ Some respondents asked for money

4.0

CHAPTER FOUR

4.01 AGE OF RESPONDENTS

Out of the 72 respondents who were interviewed, 33.33% of them were between the age of 18 and 29 years, 33.33% of them were between 30 and 41 years, 33.33% of the respondents were of the age above 42 years.

4.01 A pie chart showing percentage in age groups of respondents

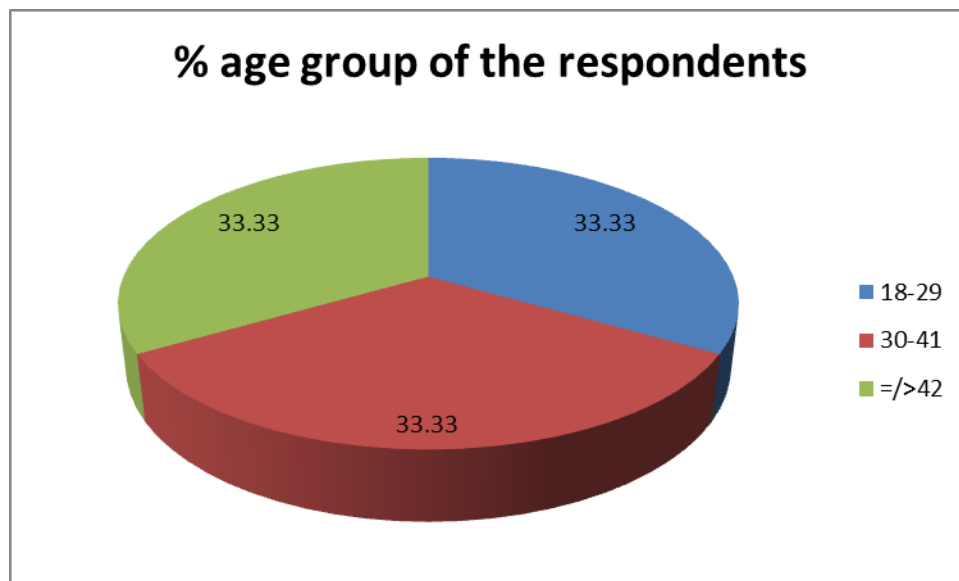
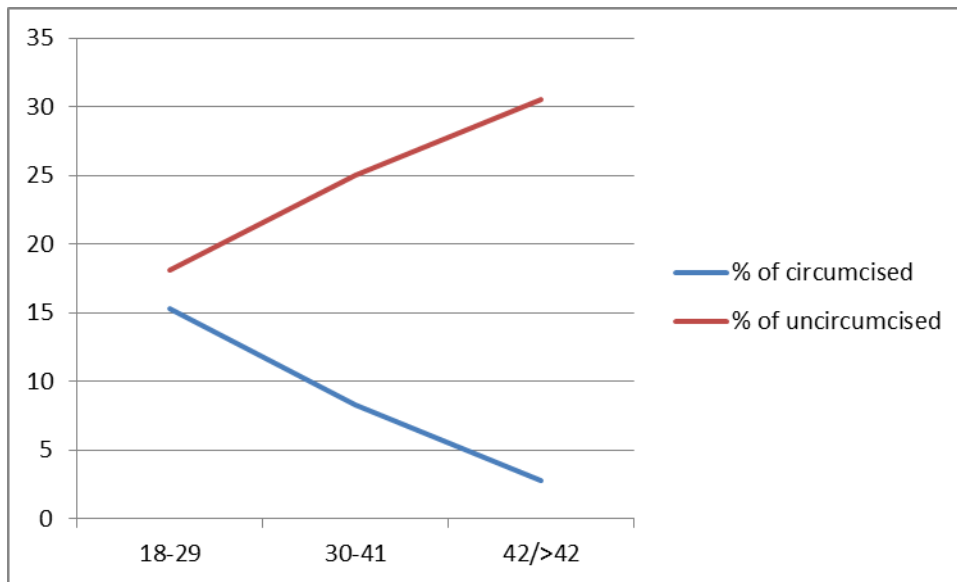


Table to show circumcision status of the corresponding age groups.

	Number of circumcised	% of circumcised	Number of uncircumcised	% of uncircumcised
18-29	11	15.28	13	18.06
30-41	6	8.33	18	25
42/>42	2	2.78	22	30.56

The most circumcised age group was between 18-29

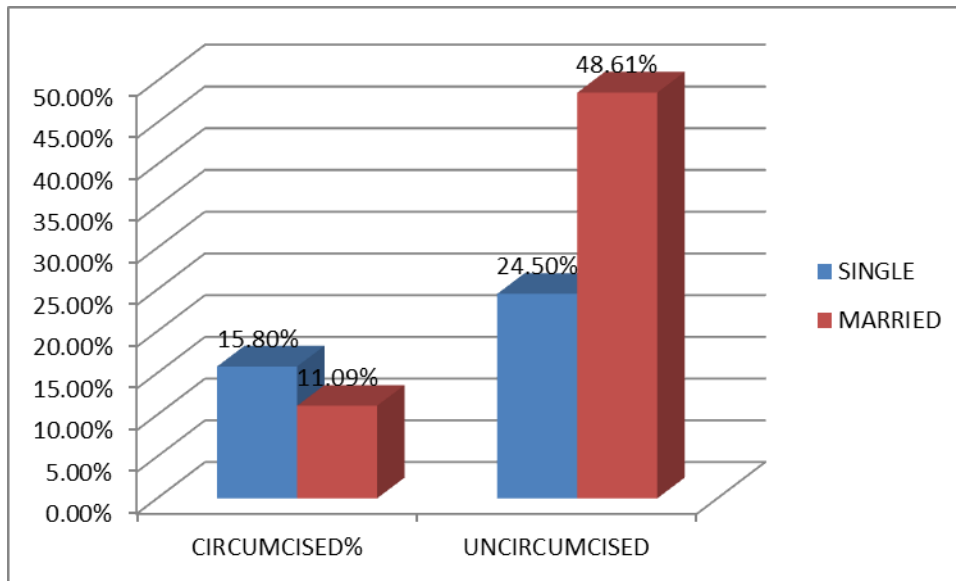
A line graph to show the trend in circumcision status of the corresponding age group.



The older the age the more less the rate of circumcision practice and the younger the more great the circumcision uptake.

4.02 MARITAL STATUS OF RESPONDENTS

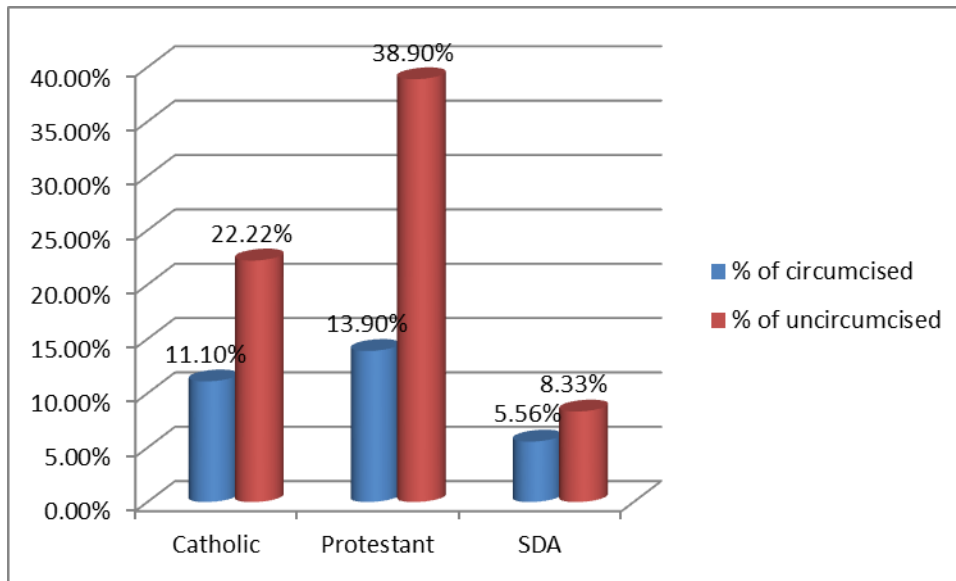
A bar graph showing the marital status of the respondents with their circumcision status



43(59.7%) of the respondents were married and 29 (40.27%) were single. The single were more circumcised compared to the married ones.

4.03 RELIGION OF RESPONDENTS

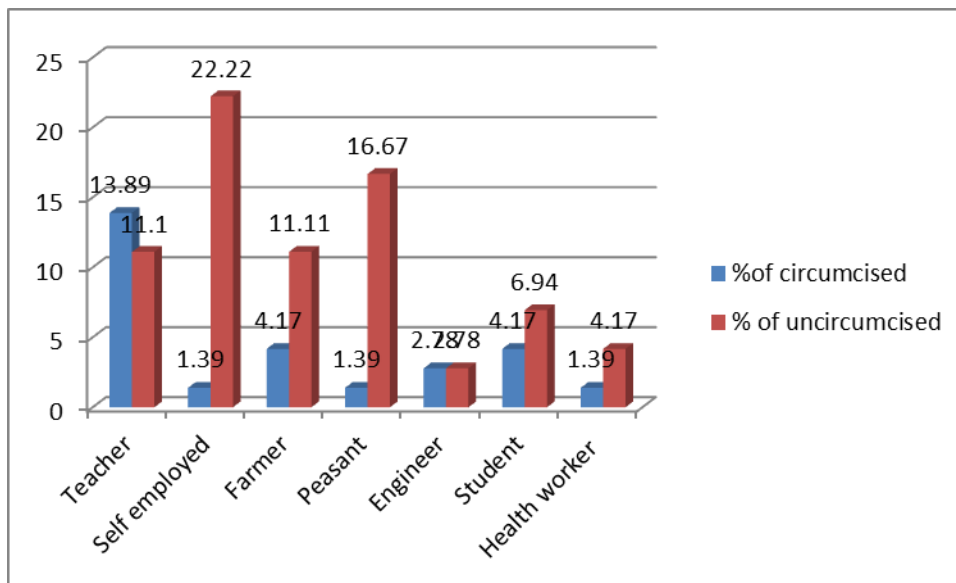
A column graph showing the religion of the respondents as per circumcision status



24 (33.3%) of the respondents were Catholics, 10 (13.9%) were SDA and 38 (52.78%) of the respondents were Protestants. The Catholics were more circumcised compared to the other two religions.

4.04 OCCUPATION OF THE RESPONDENTS

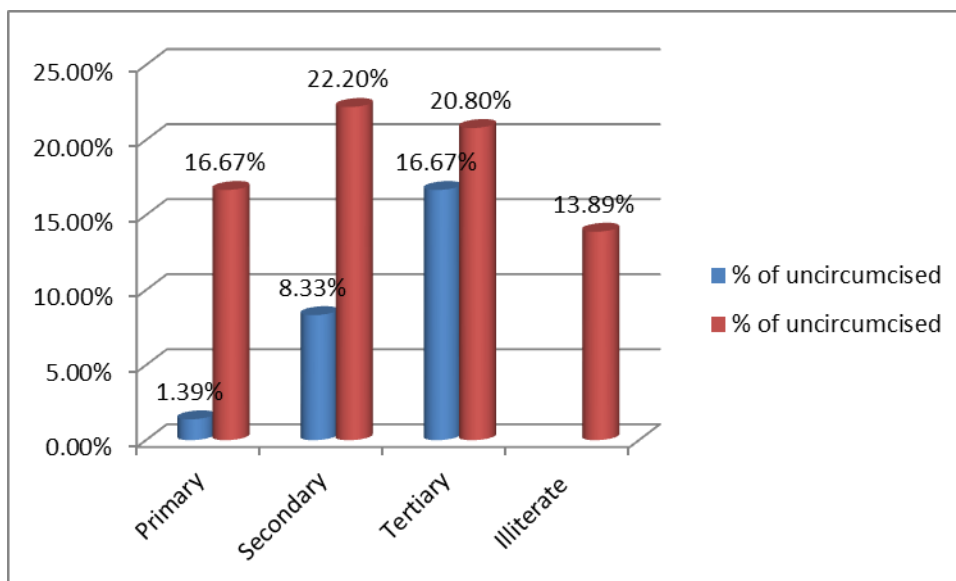
A bar graph showing the occupation of the respondents and their circumcision status.



Out of the 72 respondents, 18(25%) were teachers, 17 (23.6%) were self-employed, 12(15.2%) were farmers, 4(5.56%) were health workers, 4 (5.56%) were engineers, 13 (18.05%) were peasants and 8 (11.1%) were students. Teachers were the most circumcised in comparison to the rest.

4.05 Education level of the respondents

4.05 A column graph showing the education level of the respondents and corresponding circumcision status.

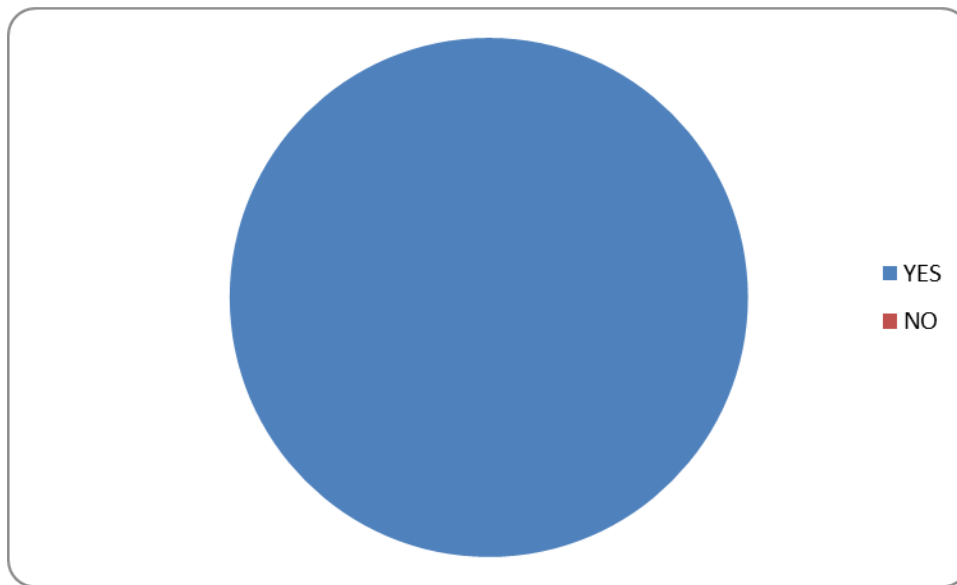


Out of the 72(100%) respondents, 13 (18.05%) were of primary school level, (30.56%)22 were of secondary school level,27(37.5%) were of tertiary level and 10 were illiterate.

The most circumcised respondents were of tertiary level

4.06 KNOWLEDGE ON CIRCUMCISION

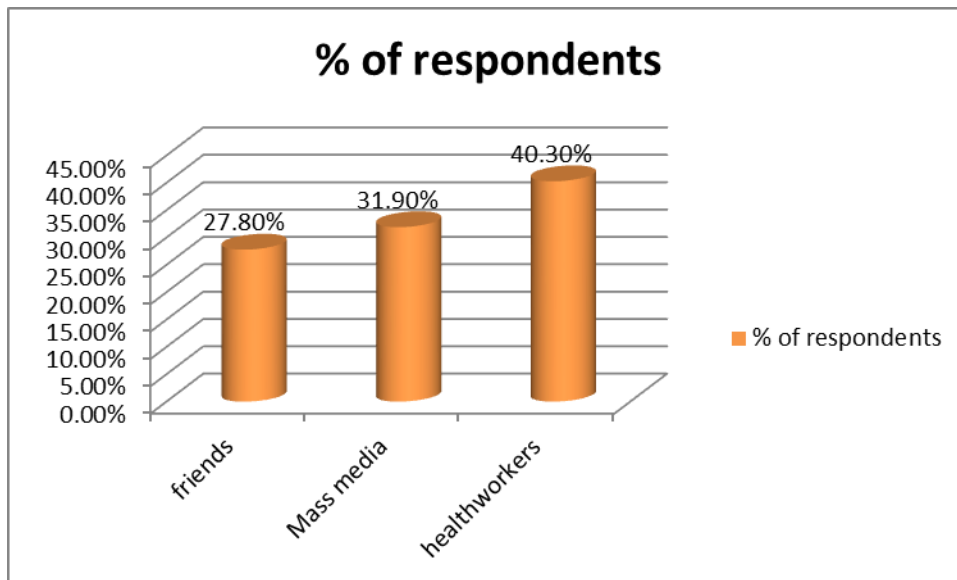
A pie chart showing number of respondents who were aware of safe male circumcision.



All of the 72 (100%) respondents were aware of the existence of safe male circumcision

4.07 source of information on safe male circumcision.

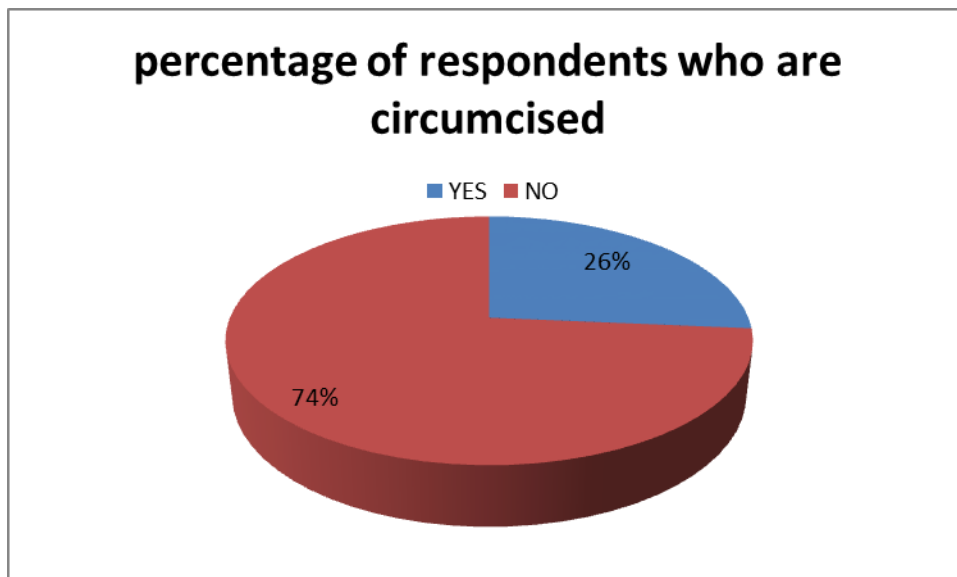
4.07 A column graph showing the means by which the respondents got informed about safe male circumcision.



Most of the respondents were informed via health workers and mass media.

4.08 PRACTICE OF CIRCUMCISION

A pie chart showing the number of respondents who are circumcised and uncircumcised.



53(74%) of the respondents were not circumcised and 19 (26%) of the respondents were circumcised.

4.09 SITE FOR CIRCUMCISION

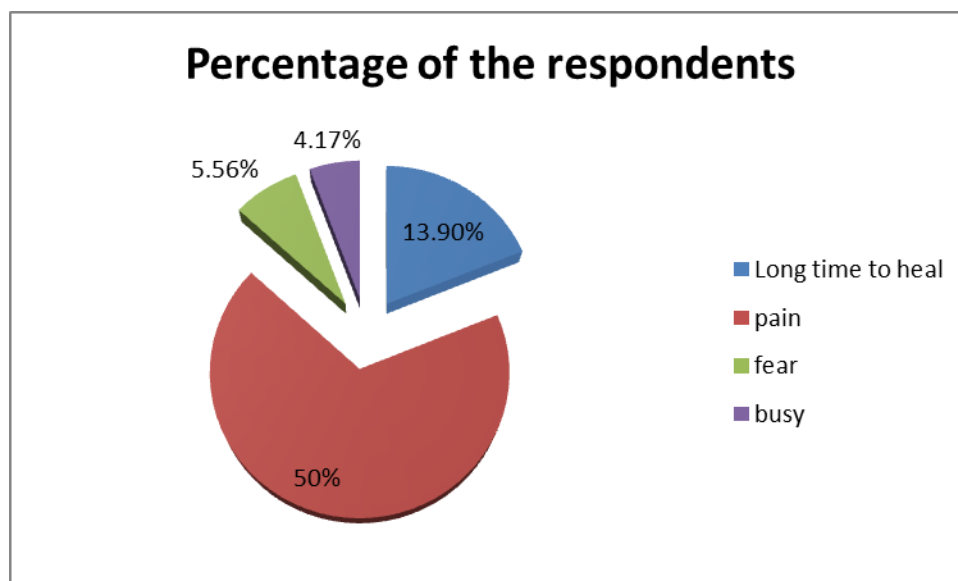
Table to show the circumcision site with the corresponding number of respondents that circumcised from the site.

Circumcision site	Number of. Circumcised respondents	Percentage of respondents
Health unit	14	73.7%
Home	03	15.8%
Others (schools outreach site)	02	10.53%

Most of the respondents circumcised from the health facilities.

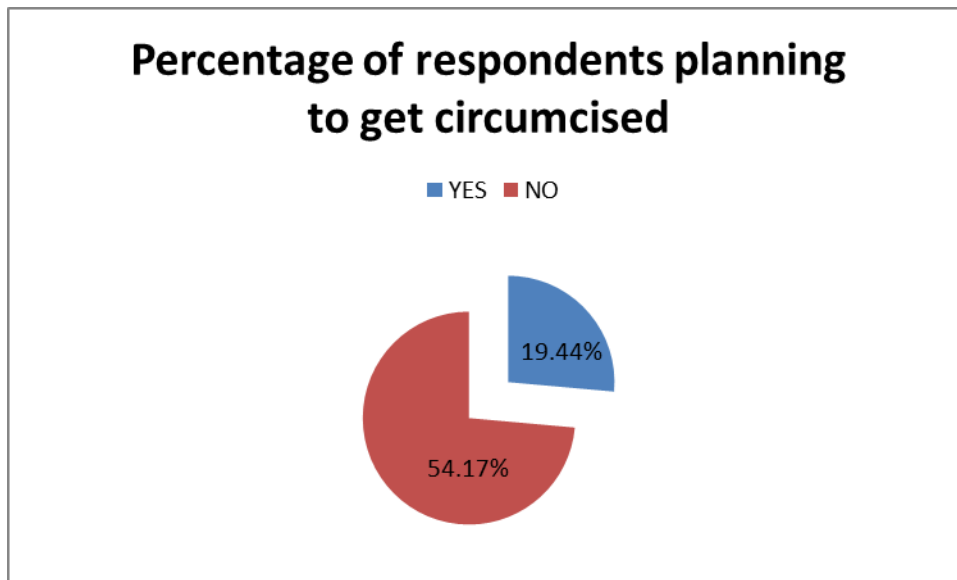
4.10 Reasons why some respondents are not circumcised.

4.10 A pie chart showing reasons why some respondents are not circumcised.



From the 73.6% respondents who were not circumcised, 50% reported pain as the reason, 13.9% reported the long time to heal, fear was reported by 5.56% and 4.17% said that they were busy.

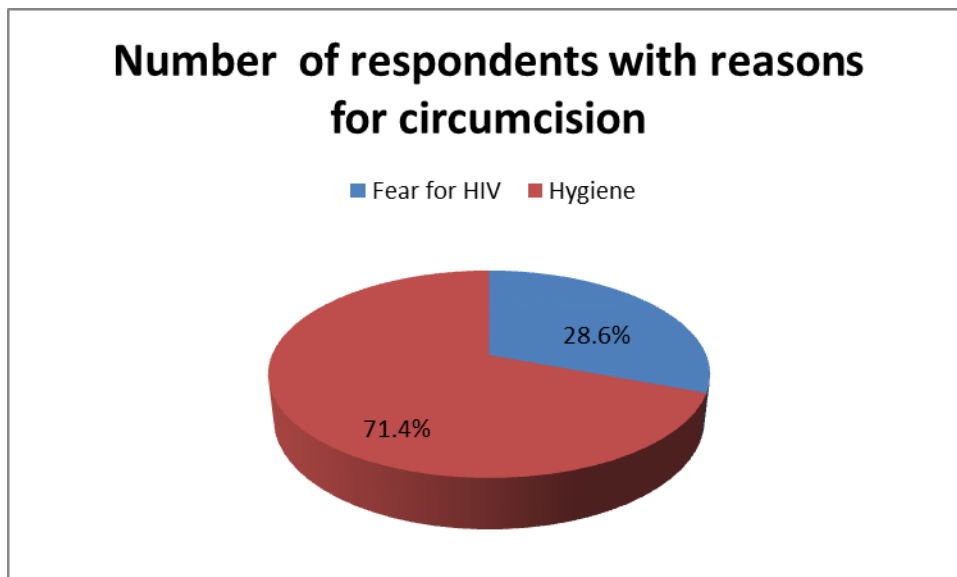
4.11 A pie chart below shows respondents who are planning to get circumcised and those who are not.



Out of the 74% respondents who were not circumcised, 14(19.44%)of the respondents were planning to get circumcised and 39(54.17%) of the respondents were not planning for circumcision.

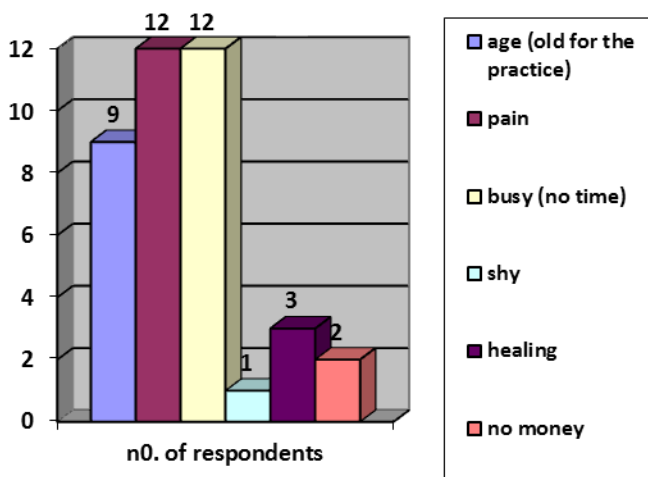
4.11 a .Reasons why some respondents are going for circumcision.

A pie chart showing reasons why some respondents are planning to get circumcised



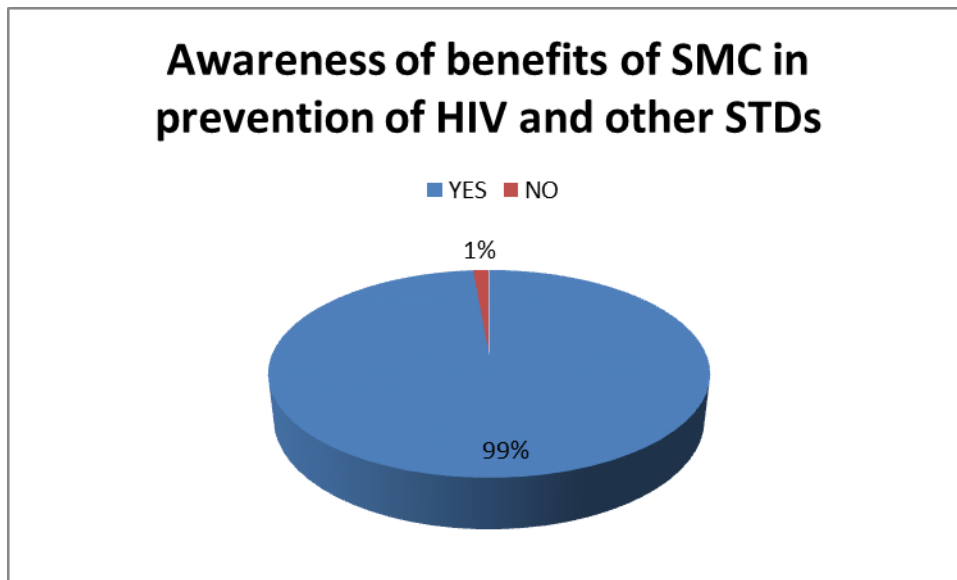
4 of the respondents were planning to get circumcised for the fear of contracting HIV and 10 of the respondents were planning for circumcision for the hygienic purposes.

4.11b A bar graph showing reasons why the uncircumcised are not planning to get circumcised.



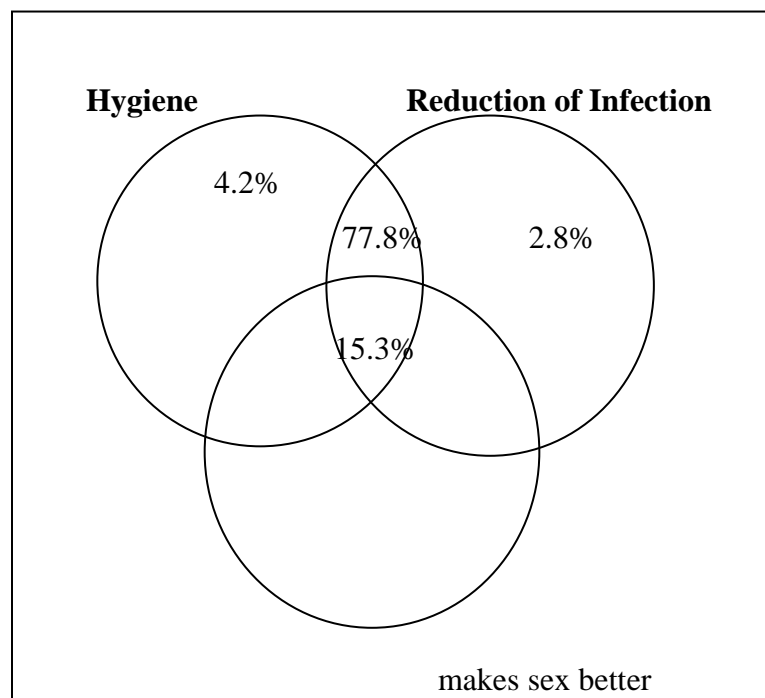
12(16.67%) of the respondents were not planning for circumcision because of pain for the practice, 12(16.67%) reported to be busy, 9(12.5%) said they were old for the practice, 3(4.17%) were worried of the healing time, 2(2.7%) had no money required for the service and 1(1.38%) reported shyness as the reason why he could not circumcise.

4.12 A pie chart below shows respondents who are aware of the benefit of safe male circumcision in relation to reduction of risk of HIV and other STDs.



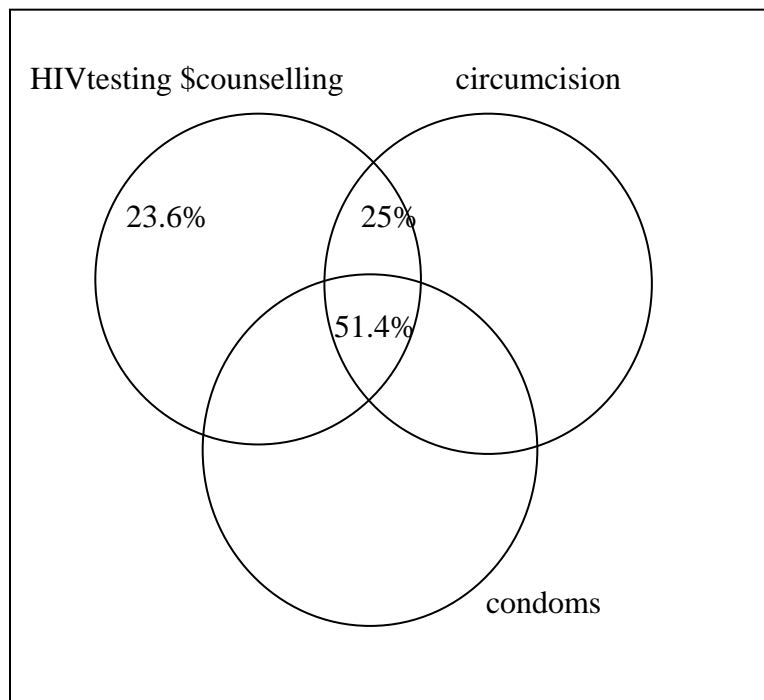
71(99%) of the respondents were aware of the benefit of safe male circumcision in relation to the reduction of HIV risk and only 1(1%) was not aware.

4.13A Venn diagram showing the number of respondents aware on other benefits of safe male circumcision



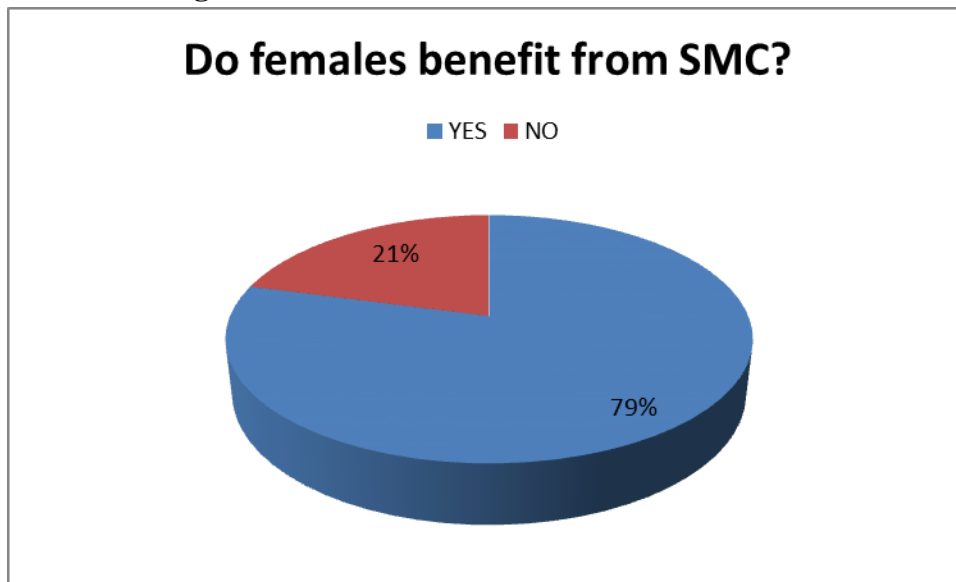
Most (77.8%) of the respondents were aware of the hygiene and reduction of risk of infection as the benefit of circumcision and 11(15.3%) were aware of three benefits of circumcision.

4.14 A venn graph showing the known services offered at safemale circumcisio site.



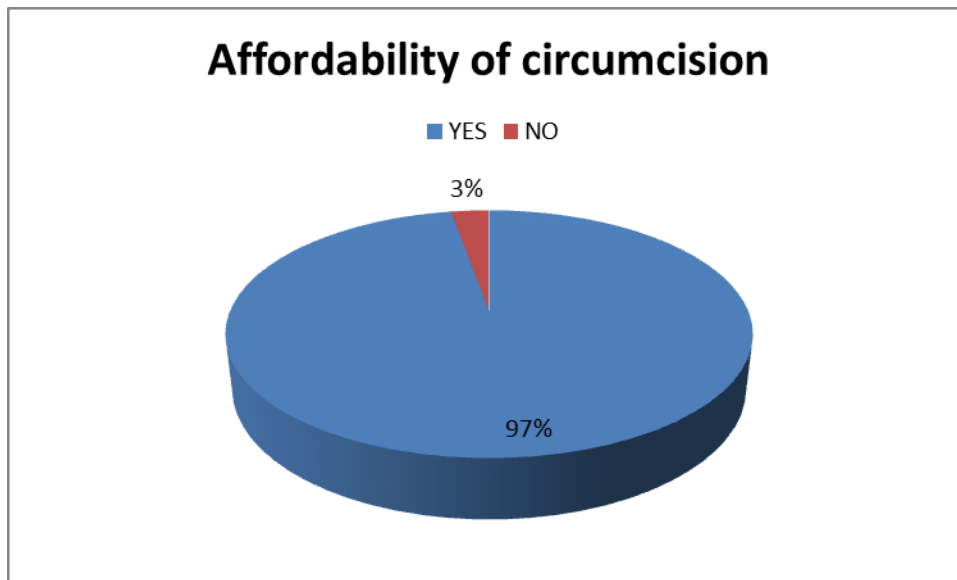
Most of the respondents were aware of the sevicees offered at the safe male circumcision site.

4.15 Knowledge that women benefit from safe male circumcision.



57(79%) of the respondents agreed that women benefit from safe male circumcision and 15(21%) are not aware of the benefit of safe male circumcision to women.

4.16 A pie chart showing the respondents who can afford safe male circumcision and those who can not.



97% of the respondents could afford the service and 3% could not afford the service.

4.17 Availadility of the SMC service

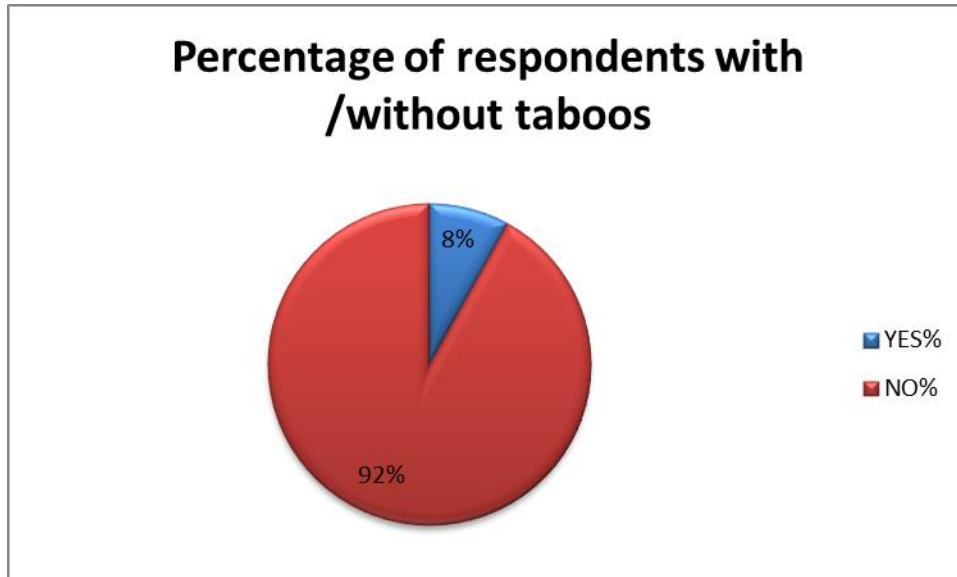
100% of the respondents reported that the circumcision service was available.

4.18 Accessibility of SMCservice.

Most ,98% of the respondents agreed that the health facilities were accessible

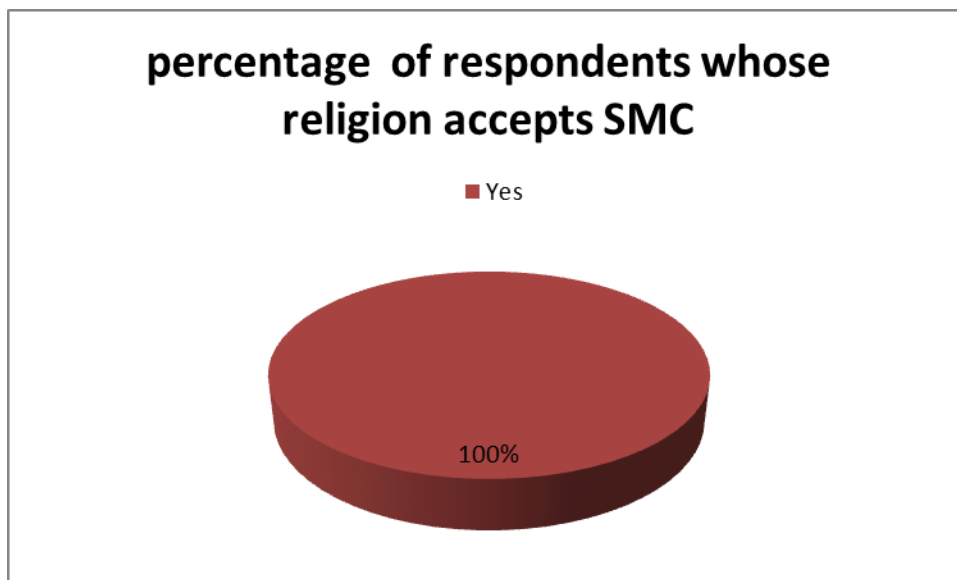
4.19 Taboos on safe male circumcision

A bar graph showing the number of respondents who have taboos against safe male circumcision.



6(8%) of the respondents had taboos against circumcision and 66(92%) of the respondents did not have any taboos against circumcision.

4.20 A pie chart showing the number of respondents whose religion accepts circumcision.



72(100%) of the respondents agreed that circumcision was allowed in their religion.

5.1 DISCUSSION OF THE STUDY FINDINGS.

5.11 Socio demographic data

On average the participants were evenly distributed , about 33.33% distribution in each age group. Most of the circumcised age range was between 18-29 with a percentage of 15.28% .The most circumcised age group was 24-29 with a percentage of 43.8%. The most uncircumcised age group was 42 and above with a percentage of 30.56%. This concurs with other studies where circumcision as an adult /post puberty was reported to be undesirable due to higher risk of complications (Ngalande et al ,2006;Rain and Taijaard et al ,2003).The younger were more positive to the practice compared to the older ones, the older one gets the less likely he is to be circumcised.

From the study the single were more circumcised compared with the married probably because they are more curious about their health. Most of the married were uncircumcised.

Generally the uptake of circumcision by the Christian faith was low and almost had no influence on circumcision. This study concurs with the several studies which show that circumcision numbers are higher in the circumcising cultures and religions where circumcision is mandatory (WHO, 2007).

Out of the 25% teachers 13.9% were circumcised and 11.1% were uncircumcised. Only 1.38% of the self-employed was circumcised out of 24.16%.out of 16.67% farmers 4.17% were circumcised and 11.11% were uncircumcised.1.38% out of 5.6% health workers was circumcised and the engineers were equally circumcised and uncircumcised. Only 1.38% peasant out of the 22.2% peasants was circumcised and 4.17% students out of 11.11% were circumcised. All of the respondents could afford the service because it is offered free of charge. Even those who paid for the service said that the service was affordable (3000/=) apart from a few.

Only 1.38% respondent of primary school level out of the 18.1% was circumcised.

8.33% respondents out of the 30.6% respondents of secondary school level were circumcised.

16.7% out of the 37.5% respondents of tertiary level was circumcised and none of the illiterate was circumcised. The biggest group of the study was not illiterate. This could have contributed

to the awareness of safe male circumcision because illiteracy could be a hindering factor to the awareness on SMC. However none of the illiterate was unaware of the existence of safe male circumcision. This study contradicts the several studies done which show that awareness would increase on the uptake of the service because only one health worker was circumcised out of the four that were recruited in this study. Just like other studies the higher the education attainment the lower the rates of circumcision. This concurs with a study which demonstrated that education attainment had a negative relationship with circumcision although in this study the tertiary group was the most circumcised compared to the illiterate and primary school level. **(Edgar et al, 2002, Wilcken et al, 2010)**

5.12 Knowledge of the respondents on safe male circumcision

All of the 72 (100%) respondents were aware of the existence of safe male circumcision. This concurs with a study done in 2010 (USAID and HCP, 2010). However 26% of men were circumcised and 74% were uncircumcised. Most of the respondents 40.3% were informed through health workers and 31.9% via mass media and the rest 27.7% through friends. This study showed that health workers had done most of the job of disseminating the information about safe male circumcision but since the percentage of circumcised men in this area is low with only 26% circumcised men just higher than the national prevalence, probably these men have insufficient knowledge on safe male circumcision. This study concurs with other studies where it has been shown that the level of circumcision was directly related to the level of awareness. **(Edgar et al, 2002).**

Out of the 72 men, (53)74% men were uncircumcised and (19)26% were circumcised. Out of 26% respondents who were circumcised, 19.4 % of the respondents circumcised from health facilities, 4.16% from home and 2.78% from mass circumcision at school.

From the 73.6% respondents who were not circumcised, 50% reported pain as the reason, 13.8% reported the long time to heal, fear was reported by 5.56% and 4.17% said that they were busy .

Out of the 53 respondents who were not circumcised, 14(19.44%) of the respondents were planning to get circumcised and 39(54.1%) of the respondents were not planning for circumcision.

Out of the 26% respondents who were planning to circumcise, 5.56% of the respondents were planning to get circumcised for the fear of contracting HIV and 13.9% of the respondents were planning to circumcise for the hygienic purposes. From other studies carried out hygiene and reduction of the risk of HIV spread after circumcision were recognized universally as extremely important and viewed as major benefits of circumcision. (**Bailey et al, 2002; Halperin et al, 2005; Kebaabetswe et al, 2003**). This means these people are aware of the benefits of safe male circumcision although the rate of uptake of the circumcision is low.

Out of the 74% respondents who were not circumcised, 16.7% of the respondents were not planning for circumcision because of pain. Pain has been reported as a major barrier to acceptability of circumcision from various studies (**WHO, 2007; Bailey et al, 2002; Scot et al, 2005**). 16.7% reported to be busy. From a study done at Kampala international hospital, the commonest reason for those who did not turn up for the service at mass circumcision was being busy/ failure to secure time for the practice (**Moses Galukandel et al, 2002**). 12.5% said they were old for the practice; Many studies have found that young are more likely to view circumcision more favorably than their elders for many reasons like faster healing and reduced sensitivity. 4.17% were worried of the long healing time. There has been fear of the unknown and healing time from the different studies (**Alfred khehlar Wayne Adams, 2012; USAID and HCP, 2010; Alfred F.X.O et al, 2009**). 2.8% had no money required for the service and 1.39% reported shyness as the hindering factor to circumcise.

Out of 72 respondents, 71(99%) of the respondents were aware of the benefit of safe male circumcision in relation to the reduction of HIV risk and only 1(1%) was not aware. This concurs with a study where most of the respondents were aware of the relationship between HIV and circumcision (**USAID and HCP, 2010**).

About the other benefits of circumcision, 77.8% of the respondents were aware that circumcision improves on the hygiene and reduces on the risk of contracting other infections other than HIV, 15.3% agreed that circumcision improves hygiene, reduction of infection and makes sex better, 2.8% were for hygiene only and 3 were in favor of reduction of infections only. This concurs with other studies of (**WHO, 2007; USAID and HCP, 2010**).

Most of the respondents were aware of the services offered at the SMC site such as removal of the foreskin, HIV testing and counseling, promotion of condom usage and ABC strategy. But none of the respondents mentioned about pain killers offered at the safe male circumcision site, not even the health workers and yet analgesics is the first service offered after circumcision.

Most 57(79%) of the respondents agreed that women benefit from safe male circumcision and 15(21%) were not aware of benefit of safe male circumcision to women. Circumcision reduces the risk of HIV infection in women from their partners and cancer of the cervix. At least 20% of cancer of the cervix would be avoided if all men were circumcised (**British Medical Journal , 2002**).

5.13 Affordability of safe male circumcision

97% of the respondents could afford the service because SMC service was provided free of charge and 3% could not afford the service because of the payments required at some health facilities for the service. The charge was 3000/=, implying that some people are too poor to afford the service even after subsidization. They could not go for the freely offered service because of the belief that free services are of poor or low quality. Several studies show that free services are viewed as poor quality services (**Ngalande et al, 2006**).

5.14 Accessibility of the respondents on safe male circumcision

70(97.2%) of the respondents agreed that circumcision was accessible and 2.8% disagreed because of the poor roads and also complained of the long distance to the health center but all of them agreed that safe male circumcision was available in all the health facilities. This study concurs with the safe male circumcision policy, 2010, where it was reported that almost all the health facilities in Uganda offer safe male circumcision.

5.15 Culture and taboos on safe male circumcision

6(8%) of the respondents had taboos against circumcision and 66(92%) of the respondents did not have any taboos against circumcision. Taboos influence culture and culture influences religion and vice versa. Taboos are hindering factor in the uptake of safe male circumcision. According to other studies, disapproval of circumcision is evident in the existence of a derogatory term for a circumcised man or a man with a congenitally shortened prepuce (**Bailey et al ,20002;Tsela and Haperin,2006**).

5.16 Religion.

All (100%) of the respondents agreed that circumcision was allowed in their religions. From the other studies carried out, it has been reported that Christians should circumcise and practice male circumcision since Jesus was circumcised and the bible teaches of the practice (**Lukobo and Bailey, 2003**).

5.2 CONCLUSIONS.

According to this study which was carried out aiming at finding the factors contributing to the low prevalence of safe male circumcision among men in Buwoya village that were above 18 years, the Ugandan government plus the ministry of health have done their work although they should strategize on changing the negative attitude the people have towards circumcision, these people have a perception that circumcision is painful and that's why pain is the major revealed factor hindering the uptake of the practice in this age category. The knowledge on how safe, safe male circumcision is among these residents is lacking and this is a major challenge to the dream of reaching 80% target of circumcised men in Uganda.

The following was revealed from the study;

- ✓ Most of the respondents were not illiterate
- ✓ Most of the respondents agreed that circumcision was affordable, available and accessible.
- ✓ 100% of the respondents are aware of the existence of safe male circumcision.
- ✓ Most of the respondents were aware of the benefits of circumcision in relation to the reduction of the risk of HIV transmission.
- ✓ Most of the respondents were aware of the benefit of circumcision to women
- ✓ Most of the respondents were aware of the services offered at the safe male circumcision site
- ✓ Most of the respondents had no taboos against circumcision and therefore their cultures accepted it.
- ✓ Although the respondents belonged to non-Muslim faith they all accepted that circumcision was not prohibited in their faith and cultures.

- ✓ Some respondents were unaware of the benefit of male circumcision to women.
- ✓ All the respondents were unaware that analgesics are used in the safe male circumcision.
- ✓ Pain, the 6weeks period required for the wound to heal after circumcision, lack of time/being busy and old age for the practice were the most reported reasons by the respondents as to why they are not circumcised and are not willing to circumcise. The others were taboos, shyness, and lack of money for quality services, inaccessible health facilities and fear.
- ✓ From the study, the men in this village have insufficient knowledge on safe male circumcision because safe male circumcision is painless.

5.3 RECOMMENDATIONS

There is need to clearly communicate to the public that safe male circumcision is painless. The health workers should emphasize that safe male circumcision is painless if handled by professional health workers. People should be sensitized that strong painkillers are used through the operation and after the operation until one heals. If pain as a hindering factor is managed the fear towards circumcision will be averted, and excuses such as being busy and old for the practice as per the study findings will be eliminated and this could make the practice welcoming.

More emphasis should be put on the younger age group since they are more positive to the practice compared to the older age groups.

The health workers too need to act as role models for SMC. As per the study findings, health workers have a negative attitude towards circumcision.

Engagement of national and district political, cultural, religious leadership is very crucial in scaling up the SMC in communities. These would act as role models to the elderly groups of men who take old age and being busy as the hindering factor to circumcision.

Effective coordination and collaboration with partners at national and district level is key to ensure close monitoring and learning in SMC programs.

Civil society organization should program, mobilize communities, monitor and advocate for safe male circumcision scale-up in their communities.

Women involvement in safe male circumcision is very important in the mobilization of more men and also in supporting their spouses in adhering to abstinence during the 6 weeks after surgery and psychological support.

More focus should be emphasized on the young age group since they are more positive to the SMC practice compared to the old.

APPENDIX I:

REFERENCES

- 1 Alfred khehlar wyne adams,2012.Aqualitative study on the low utilization of male circumcision services in Kwaluseni Swaziland ,pg 20.
- 2 Alfred f.x.o.Obure ,2009.Psychosocial factors influencing promotion of male circumcision for HIV prevention in non circumcising community in rural western Kenya.
- 3 Auvert, B., Taljaard, D., Lagarde, E. et al (2005). Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 trial. PLoS Medicine, 2(11), 1–11.
- 4 Bailey, R. C., Muga, R., Poulussen, R., & Abicht, H. (2002). The acceptability of male circumcision to reduce HIV infections in Nyanza Province, Kenya. AIDS Care, 14(1), 27–40.
- 5 Bailey, R. C., Plummer, F. A., & Moses, S. (2001). Male circumcision and HIV prevention: Current knowledge and future research directions. The Lancet Infectious Diseases, 1(4), 223–231.
- 6 Caga-anan ECet al ,2011. Clinical Ethics in Pediatrics: A Case-Based Textbook. Cambridge University Press.p. 43.ISBN 978-0-521-17361-2.
- 7 Edgar asiimwe,2002 Personnal willingness to undergo safe male circumcision among young men in rural Uganda decreases with increased educational attainment
- 8 Gray, R. H., Kiwanuka, N., Quinn, T. C. et al (2000). Male circumcision and HIV acquisition and transmission: Cohort studies in Rakai, Uganda. AIDS, 14(15), 2371–238111
- 9 Hay W l, 2012,Current Diagnosis and Treatment Pediatrics 21/E. McGraw Hill Professional. pp. 18–19. ISBN 978-0-07-177971-5
- 10 Halperin, D. T., & Bailey, R. C. (1999). Male circumcision and HIV infection: Ten years and counting. Lancet, 354, 1813–1815.
- 11 Halperin, D. T., Fritz, K., McFarland, W., & Woelk, G. (2005). Acceptability of adult male circumcision for sexually transmitted disease and HIV prevention in Zimbabwe. Sexually

Transmitted Diseases, 32(4), 238–239. 8 Milos et al,1992. "Circumcision: A medical or a human rights issue?".

12 Kebaabetswe, P., Lockman, S., Mogwe, S. et al (2003). Male circumcision: An acceptable strategy for HIV prevention in Botswana. *Sexually Transmitted Infections*, 79(3), 214–21.

13 Lagarde, E., Dirk, T., Puren A., Reathe, R. T., & Bertran, A. (2003). Acceptability of male circumcision as a tool for preventing HIV infection in a highly infected community in South Africa. *AIDS*, 17(1), 89–95.

14 Mattson, C. L., Bailey, R. C., Muga, R., Poulussen, R., & Onyango, T. (2005). Acceptability of male circumcision and predictors of circumcision preference among men and women in Nyanza Province, Kenya. *AIDS Care*, 17(2), 182–194.

15 Male Circumcisions and Risk for HIV Transmission and Other Health Conditions: Implications for the United States". Centers for Disease Control and Prevention.2008.
<http://www.cdc.gov/hiv/resources/factsheets/circumcision.htm>

16 Moses galukandel,Denis Bbaale ,Kevin Duffs et al2012,Mass safe male circumcision :Early lessons from aUgandan site.

17 Ngalande, R., Levy, J., Kapondo, C., & Bailey, R. C. (2006). Acceptability of male circumcision for prevention of HIV infection in Malawi. *AIDS and Behavior*, 10(4), 377–385

18 National Center for Health Statistics, 2007. Trends in circumcisions among newborns".
National Hospital Discharge Survey
<http://www.cdc.gov/nchs/products/pubs/pubd/hestats/circumcisions/circumcisions.htm>.
Retrieved on 2008-08-19. 2

19 Pinto K ,2012. "Circumcision controversies". *Pediatric clinics of North America* 59 (4): 977–986.doi:10.1016/j.pcl.2012.05.015. PMID 228578446 Rizvi et al, 1999. "Religious circumcision: a Muslim view"

20 Rain-Taljaard, R. C., Lagarde, E., Taljaard, D. J.,et al (2003). Potential for an intervention based on male circumcision in a South African town with high levels of HIV infection. *AIDS Care*, 15(3), 315–327.

- 21 Rudolph C,et al (2011). Rudolph's Pediatrics, 22nd Edition. McGraw-Hill Companies, Incorporated. p. 188. ISBN 978-0-07-149723-7.
- 22 Scott, B. E., Weiss, H. A., & Viljoen, J. I. (2005). The acceptability of male circumcision as an HIV intervention among a rural Zulu population, Kwazulu-Natal, South Africa. *AIDS Care*, 17(3), 304–313.
- 23 Schmid GP, and Dick B. (2008). "Adolescent boys: who cares?".
- 24 Tsela, S., & Halperin, D. T. (2006). Knowledge, attitudes and practices regarding male circumcision in the Manzini (central) region of Swaziland. In *The XVI international AIDS conference*. Toronto, Canada.
- 25 Uthman OA et al (2010). "Economic evaluations of adult male circumcision for prevention of heterosexual acquisition of HIV in men in sub-Saharan Africa: a systematic review". In Van Baal, Pieter H. M. *PLoS ONE* 5 (3): e9628. doi:10.1371/journal.pone.0009628.PMC 2835757. USAID and HCP,2010,factors that influence ability to seek medical male circumcision service,pg6
- 26 Weiss, H. A., Quigley, M. A., & Hayes, R. J. (2000). Male circumcision and risk of HIV infection in sub-Saharan Africa: A systematic review and meta-analysis. *AIDS*, 14, 2261–2370.
- 27 WHO,2009,Male circumcision services ;quality assessment toolkit.http://www.who.int/hiv/pub.male_circumcision/qa_toolkit accessed 10 september 2012.
- 28 WHO,2010,Uganda safe male circumcision policy.
- 29 World Health Organization. (2005). UNAIDS statement on South African trial findings regarding male circumcision and HIV Statement developed by the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF) and the UNAIDS Secretariat, 26 July 2005. <http://www.who.int/mediacentre/news/releases/2005/pr32/en/>, Accessed on 15 March 2006.
- 30 World Health Organization, 2007,Male circumcision: Global trends and determinants of prevalence, safety and acceptability p9,16,17,20,23. 1.
- 31 Wrana, P. (1939). "Historical review: Circumcision". *Archives of Pediatrics* 56: 385–392.

APPENDIX II:
CONSENT FORM

QUESTIONNAIRE

This study is undertaken to establish the knowledge and attitude of the people of Buwoya village on safe male circumcision. Your participation is voluntary and the information given is confidential. And will be used for only study purposes. You may interrupt the interview and ask any question or even leave the study at any point for any reason.

You will not receive any benefits from the study however the information obtained will help in designing a policy and interventions promoting the uptake of the practice of circumcision.

If you agree to participate in the practice ,please sign here.....

Date.....Serial number.....

PART A: SOCIO DEMOGRAPHIC DATA

1. Age (years) of the respondents

a) 18-29 (b)30-41 (c) 42/>42

2. Marital status

(a)single (b) Married (c)Separated (d)Widow/widower (e)divorced

3 Religion

(a)protestant (b)catholic (d)SDA (e) Others(SPECIFY).....

4. Occupation

(a) Teacher (b) self-employed (c) farmer (d) health worker (e) engineer (f)
peasant (g)others.....

5. Education level.

(a) Primary school (b) secondary school (c) tertiary/university

(d)illiterate

PART B: KNOWLEDGE OF RESPONDENTS ON SAFE MALE CIRCUMCISION

6. Are you aware about existence of safe male circumcision(where its done and the person who carries it out?

YES

NO

7. What was your first source of information about safe male circumcision?

(a) health workers (b) Friends (c) Mass media (Radio, TV, Newspaper)

(d)Other (f) Never heard of any information

8 Are you circumcised? YES NO

9 If YES, where did you circumcise from?

(a)Hospital/health Centre/clinic (b) Home (c) others.....

10 If NO, why.....

11 Are you planning to get circumcised?

YES, why..... NO, why.....

12 Do you know that circumcision reduces the risk of acquiring HIV and other STDs?

YES NO

13 Are you aware of the other benefits of safe male circumcision?

a) Improves on the hygiene b) Reduction of infections and diseases c) makes sex more enjoyable d)others.....

14 Do you know the services offered at safe male circumcision site?

(a) HIV testing and counseling (b) Safe removal of the fore skin of the penis

(c)Condoms and promotion of ABC strategy (e) others.....

15 Are you aware that women benefit from safe male circumcision?

YES NO.....

AFFORDABILITY

16 Is safe male circumcision affordable?

YES, why NO, why (how much do you pay).....

AVAILABILITY

17 Are there health facilities that offer the service? YES NO

ACCESSIBILITY

18 Are the health facilities accessible? YES, why..... NO, why.....

RELLIGION AND CULTURE

19 Do you have any taboos against circumcision? YES NO

20 Does your religion accepts it? YES NO

APPENDIX III A GLOBAL MAP SHOWING THE CIRCUMCISION PREVALENCE

