

THE FACTORS AFFECTING THE UTILISATION OF SAFE MALE
CIRCUMCISSION AS HIV PREVENTIVE STRATEGY IN MITOOMA
DISTRICT, WESTERN UGANDA.

By

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BMS/0064/112/DU

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MEDECINE AND DENTISTRY IN PARTIAL FULFILMENT OF THE
REQUIREMENT OF THE AWARD OF BACHELOR OF MEDECINE AND
BACHELOR OF SURGERY OF KAMAPLA INETRNNATIONAL UNIVERSITY


DECEMBER 2014.

Declaration

This is to declare that this research proposal is my own work and has never been presented anywhere to any academic institution for any award other than the one for which it is now being submitted for.

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Approval

This is to approve this study which has been designed under my direct support and supervision and is now ready to be submitted to the faculty of clinical medicine and dentistry of Kampala International University in partial fulfillment of requirement of the award of bachelor of medicine and bachelor of surgery of Kampala International University.

Sign..........Date.....12/12/14.....

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Dedication:

I humbly dedicate this research work to my dear parents (Mr. NIM ODUR and Ms. MARY ODUR) for their lovely support throughout my education; secondly to my supervisor Dr. QASIM BUTT for his guidance through the research process and lastly to my friends

(B .DEREK,OBURA R, SEBASTIAN, BAHATI,to mention few)

ACKNOWLEDGEMENT.

I with great gratitude acknowledge the generous contribution of our family for supporting and allowing me to attain this educational level.

I acknowledge the effort of state house for the sponsorship that they accorded me to attain this paramount bachelor degree.

My sincere thanks goes to my supervisor Dr.M QASIM BUTT who tirelessly worked hard with me to ensure this research work a success.

I must thank the in-charge of bitereko health centre III for his authority to carry out this research at the unit.

Not forgetting my beloved daughter Aceng Racheal in whom i was motivated to go back to school and study this course.

I also extend my gratitude to the all my friends for support, encouragement and guidance they gave me during the course.

LIST OF ABBREVIATION

UNIADS - United Nations Agency for International Development.

SMC - Safe Male Circumcision.

HIV - Human Immunodeficiency Virus.

WHO - World Health Organization.

FGD- Focused Group Discussion.

LQAS - Lot Quality Assurance Survey.

MoH - Ministry of Health

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ABSTRACT.

This research was a descriptive cross sectional study on factors affecting the SMC utilization among both circumcised and none circumcised attending health services at bitereko health centre III.

The study population consisted of males aged between 15->50 years of age attending health services at above facility. Sample sizes of 201 respondents were selected randomly and interviewed using pre tested questionnaire.

The study constituted mainly young male of age bracket (15-49) with 77.11% and middle aged taking 16.92% ,majority of this age group were either married (44.3%) or single(43.4%) and very few participants aged above 50 with a percentage of 1.99%.

Most of the participants were mainly Christians (85%) and few Muslim with (15%) participation, and they had attained moderate educational level of either secondary (33%) or primary (23%) and modest number at extreme of none formal education (15%) and tertiary (11.08%).

Of the total respondents, majority were circumcised (88%) only (12%) uncircumcised, and they knew SMC has advantages over disadvantages with (88.09%) and (24%) respectively and this showed good utilization of SMC at (75%).

The above good percentages seen is mainly attributed to cultural acceptance of SMC as HIV preventive strategy with (89.06%) and the remaining percentage is due to fear for surgery, pain, concerns about safety, long time before the resumption of sexual activity and cost of the procedure ,a study conducted in Uganda by (Herman-Roloff, Otieno, Agot, Ndinya-Achola, & Bailey, 2011; Westercamp et al., 2011)

CONCLUSION

Both married and unmarried men of middle age were main participants whom most were safely circumcised, Education and religion appeared to have no influence on SMC as the research found no major barriers to SMC service.

Culture seem to have wholly accepted SMC which eventually seen high utilization.

CHAPTER ONE:

INTRODUCTION.

1.1 Background.

World Health Organization and UNAIDS recommended urgent roll out of Safe male circumcision to 13 priority countries in Sub-Saharan Africa, countries with low male circumcision prevalence and generalized epidemics with high HIV prevalence (UNAIDS, 2009 and WHO, 2012)

The recommendation came after three randomized controlled trials successfully demonstrated the partial protective effect of male circumcision against HIV during heterosexual sex. In Kenya the protective effect was 53%. In Uganda it was 51% while the South African trial showed a protective effect of 61% (Auvert, et al, 2005, Gray & Wawer, 2007)).

Other observational studies assessing the protective effect of male circumcision from HIV infection confirmed the significant association between being uncircumcised and HIV risk; the risk for circumcised men was found to be half that of uncircumcised men. (Gebremedhin, 2012).

A model-based study by Anderson et al (2010) examined the influence of male circumcision on heterosexual transmission of HIV transmission in Southern Africa and found that circumcision programs could prevent a substantial number of new infections in Africa targeting 10-20% of uncircumcised men each year.

1.2 Problem Statement

In most parts of the world, SMC is accepted for medical, religious and cultural values. In 2010, the UNAIDS and WHO reported that the practices of SMC protects the male by over 60% chance of acquiring HIV virus, recommending SMC as another standard HIV prevention strategy. Uganda adapted this policy and designed the national SMC program which has

mobilized the community, provided technical training to health staff and enabled logistics for the SMC services in Uganda.

Despite these interventions, SMC coverage continues to be low, as of 2013 only 48% of males in Uganda ages 15-59 with some districts like Mitoma having very low coverage according to the district LQAS 2013.

Many theories explain this but of great inference has been the cultural barriers to SMC and yet male aged 15-59 continues to lead new HIV incidences in Uganda. This study has therefore been designed to find out the utilization of SMC in Mitoma district.

1.3 Study Justification

Although there have been substantial researches on factors influencing the acceptance of safe male circumcision for HIV prevention worldwide, there has never been any previous attempts on this matter in Mitoma district, yet this study is vital in laying strategies for SMC in order to increase its acceptability.

The research is important to policy makers, program designers and implementers whose in laying strategies for intervention, monitoring and evaluation of SMC related programmes. On the other hand, the study findings will add onto existing literature that may be used by nurse researchers as well as recommendations providing a basis for research. With such desire to understand the barriers to SMC, the understanding of cultural barriers is thereby justified

1.4 Study Objectives

1. To determine the proportion of men aged 15 -59 years who have under gone safe male circumcision in Bitereko Sub County, Mitoma District
2. To assess demographic factors affecting SMC service utilization among male 15-59 years in Bitereko Sub County, Mitoma District
3. To identify cultural factors that influence utilization of safe medical circumcision among male 15-59 years in Bitereko Sub County, Mitoma District

1.5 Research Questions

1. What is the proportion of men aged 15-59 years who have undergone SMC in Bitereko Sub County, Mitoma District?
2. What are the geographic factors affecting the SMC service utilization by men 15-59 years in Bitereko Sub County, Mitoma District?
3. What are the cultural factors influencing the utilization of SMC among men 15-59 years in Bitereko Sub County, Mitoma District?

1.6 Study Scope

Geographical scope

The study shall be conducted in Bitereko Sub County, Mitoma District, which is one of the twelve sub counties in Mitoma district. The researcher has chosen this location purposefully due to the nature of its population, being one of the largest sub county with a total population of 33,200 people; and convenience of access.

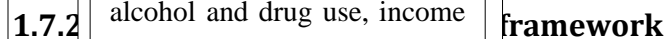
Time scope

The study time scope will cover a period of two month between 1st October 2014 and November 2014. Proposal preparation, research data collection, and report writing is expected to take a period of 2 months.

Content scope

The content scope for this study will be restricted to assessing the socio demographic, cultural and proportion of male 15-59 utilizing SMC at Mitooma district.

Figure 1: Conceptual Diagram



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and social linkage. The framework postulates that socio-demographic characteristics, social structures and health attitudes and beliefs affect the knowledge, attitudes and acceptability of SMC.

However, this relationship may be modified by environment, political set up and health facility factors from where one lives

CHAPTER TWO:

LITERATURE REVIEW.

Population factors that affect the utilization of SMC vary from one community to another. Studies have revealed that socio economic and cultural factors bare the major players in the utilization of SMC in various parts of the world.

Andersen and Newman (1990) showed that these factors can be the classified as the predisposing factor, enabling factors and need factors. Predisposing factors are the social and cultural characteristic of individuals that make an individual susceptible to utilize a health service.

The Jews and Muslims practice circumcision even at a tender age as part of their religious tradition and beliefs. To them, circumcision is perceived as a confirmation of people's relation to God(UNAIDS, 2007).

In one study in South Africa, Rain-Taljaard found out that some Christian communities view circumcision as a curse and an act of paganism while in Kenya, studies have shown that some Christian sects view circumcision as a rite of passage to be part of their belief(Mattson, Bailey, Muga, Poulussen, & Onyango, 2005; Rain-Taljaard et al., 2003).

In Eastern Uganda a traditionally circumcising community noted that circumcision was practiced as a test of bravery and endurance among men and masculinity , bravery and social cohesion with boys of the same age group being circumcised around the same time to improve social identity and spirituality(Bailey, Neema, & Othieno, 1999).

In Nigeria one study showed that most of the men in Bender State in the southern part of Nigerian enroll for circumcision as a motivation so as to maintain their culture(Myers, Omorodion, Isenalumhe, & Akenzua, 1985).

In a study done in Kenya, Nyanza province, Bailey found out that uncircumcised men in traditionally circumcising communities are discriminated against. In South Africa among the

Xhosa it is unacceptable to remain uncircumcised to an extent that forced circumcisions, discrimination, intimidation and violence are common (Mavundla, Netswera, Toth, Bottoman, & Tenge, 2010; Westercamp, Agot, Ndinya-Achola, & Bailey, 2011).

In Philippines where circumcision is almost universal and performed between the ages of 10-14 years, a survey among boys found strong evidence of social determinants where many boys choose to be circumcised in order to conform to tradition (Lee, 2005).

In Ghana and Uganda uptake of circumcision has been attributed to social conformity, improved hygiene, disease prevention, sexual enhancement and to attract women for sexual relation for it was found out in these two countries that women associate sexual pressure to circumcision (Albert et al., 2011; Mensch, Bagah, Clark, & Binka, 1999).

A similar study in South Africa showed that sexual reasons for circumcising may be more influential than other reasons, noting that “men were 8 times more likely to accept male circumcision if they believed that circumcised men enjoyed sex more and 6 times more likely to accept circumcision if they believed women enjoyed sex more with circumcised men.” The South African study also found that older men were more likely to be motivated to circumcise in order to give a woman sexual pleasure. (Scott et al., 2010).

Studies done in Tanzania have attributed the utilization of SMC with men of higher education status, higher socioeconomic status and those living in urban areas. However in Lesotho, utilization of medical circumcision is common among men with low socio economic status and having limited education. It was also common among men in the lowest wealth quartile and those living in rural areas. These findings associating SMC to education and social economic status was also in line with research findings in Ethiopia (USAID, 2006).

The perception among different communities that SMC results into improved penile hygiene and lowering the risk of infection has been attributed to increasing utilization of SMC. Studies conducted in different African countries found out that circumcised men were most likely to maintain penile hygiene (Lukobo & Bailey, 2007; Mattson et al., 2005; Ngalande, Levy, Kapondo, & Bailey, 2006; Nnko, Washija, Urassa, & Boerma, 2001).

A study in rural Ugandan districts found that enhanced sexual pleasure was considered a reason to get circumcised significantly more often by uncircumcised than circumcised men (18.9%

versus 2.4%). Further, men considered enhanced sexual pleasure twice as often a reason to circumcise than females (4.8% versus 9.2%). In one study in neighboring Kenya, acceptability was at 60% among men and 68% among women (Mattson et al., 2005,).

In a similar study in Uganda, participants also perceived circumcision as increasing men's sex drive and a woman's pleasure, something that was viewed as an important benefit by many. A study in Tanzania found perceptions that confirm the importance of enhanced sexual performance and sexual pleasure for the man and the woman, as being motivating factors for getting circumcised (Albert et al., 2011)..

The most salient barriers to the utilization of SMC have been identified to include study fear for surgery, pain, concerns about safety, long time before the resumption of sexual activity and cost of the procedure (Herman-Roloff, Otieno, Agot, Ndinya-Achola, & Bailey, 2011; Westercamp et al., 2011) .

In traditionally non circumcising populations, SMC by a trained health professional was deemed safe. In Rakai district in a study done in Rakai Health sciences program to evaluate the effectiveness of SMC done by clinical officers and medical officers, it was noted that there was no difference in complication occurrence among the two different categories of health workers. This was found to be necessary for the scale up of SMC services even in health centres that did not have medical Officers (Buwembo et al., 2011).

Studies done elsewhere in Africa have found out that infection, excessive bleeding, excessive pain and possible mutilation was common in the hands of traditional circumcisers. On the other hand, wound healing and infection after SMC was slower among HIV infected men compared to circumcised men and this could also be seen as a barrier to the utilization of SMC (Kebaabetswe et al., 2003; Kigozi et al., 2008; Lagarde et al., 2003).

Fear of pain was based largely on the experience and knowledge of traditional circumcision in which case pain is viewed as an integral part as the rite of passage to adulthood. It was also found out that complication rates were more in the tradition circumcision compared to SMC because the traditional surgeons lacked adequate knowledge in infection control, wound care and pain control.

However, in SMC analgesia is provided and this has been found to reduce the fear factors and this in turn is expected to lead more men utilize SMC for HIV prevention(Bailey, Egesah, & Rosenberg, 2008; Kigozi et al., 2008; Kim & Goldstein, 2009; Lagarde et al., 2003).

Cost has also been identified as a barrier to the utilization of SMC. Studies done in Malawi and Kenya found out that some of the communities prefer SMC to be provided in public institutions where no user fees exist, while other proposed that even in cases of paying for SMC, the user fees would be less than that charged in private settings.

In 1998 after the removal of user fees for SMC, the number of men enrolling for SMC increased and this was seen as a major factor in the utilization of SMC(Bailey, Muga, Poulussen, & Abicht, 2002; Ngalande et al., 2006).

A study done in Uganda in 2004 to assess the Access to and utilization of health services among the poor communities in Uganda, Kiwanuka found out that the poor and the vulnerable are less likely to utilize health services due to the long distance from their homes to service centers, lack of medicines at health facilities and perceived poor quality of care in many public facilities. It was also noted that cost of both transportation and cost of medicines were also cited by these communities as potential barriers that would stop them from utilizing health services (Kiwanuka et al., 2008).

CHAPTER THREE:

STUDY METHODOLOGY.

3.1 Introduction.

This chapter discusses the blue print of this study that is the methods that shall be used in the study. This include the study design, study site, study population,, sample size, sampling methods, pretesting, Data collection Data analysis, quality control, study limitation, ethical considerations and dissemination of results.

3.2 Study design and rationale

The studies will be a cross- sectional descriptive; majorly employing quantitative design. This design was chosen by the researcher since it is known to provide numeric description of the part of the population, describes and explain events as they were as they will be, cheap and enables rapid data collection and ability to understand a population from a part of it(Oso, 1991)

3.3 Study Area

The study will be conducted in Bitereko Sub County, Mitoma District. The sub county makes up one of the twelve sub counties of mitoma with a total population of 33,200 people of whom male of 15-59 years old makes about 9,000

3.4 Study Population

The target population will consist of 200 males of 15-59 years of age within the two sub counties of kanyabwanga, and bitereko..... These sub counties represent the accessible population of the district in Mitoma district since one is close to the source of services (close to Health Center) and another population that is far from the health unit. Access to health services has been documented as the most influential factor that promotes the utilization of SMC.

3.5 Sampling methods.

The study shall employ cluster and stratified sampling techniques to select sub groups of population in their proportions and select from each group a sub group of samples. This will ensure that sub groups like the self-employed men, the unemployed and the rural groups are all included in the study. The clustering will be used to identify and study a group of men who are

not able to provide independent opinions on the subject of study. These sampling methods aim at proportionate representations with a view of accounting for the difference in sub groups characteristics.

The researcher is convinced that target is not uniform. This is because of the differences in residence and economic activities; as such the target population cannot be considered as homogenous, stratified sampling will ensure that the target population is divided into homogenous strata for the purpose of this study.

3.5.1 Inclusion criteria

Respondent who accepted to consent to participate in the study voluntarily were enrolled in this study. Respondents aged 15 years and 59 were be enrolled in this study.

3.5.2 Exclusion Criteria

Respondents who declined to participate in this study were excluded from the study. Those who were found to be very sick. The deaf, those below 15 years of age and the dumb were excluded in the study.

3.6: sample size determination.

Two methods of sample size determination will be employed in this study

1. Convenience sampling methods that shall be employed to determine the respondents at the discretion of the research for the youth will be identified by stratified sampling techniques.
2. The sample size for the male within(near the health unit) will calculated using Sloven's formula (1962), given by:

$$n = \frac{N}{1 + N(e)^2}$$

Equation 1: Sloven Formula

Where n= sample size

e= confidence interval

N= total Population of the target population

N= 7000, e= 0.07

$$n = \frac{9000}{1 + 9000(0.07)^2}$$

$$n = 200$$

Therefore: n= 200 respondents

3.7. Data collection methods.

Primary data will be got directly from the interviews with different respondents through a self-administered questionnaire that shall be printed in English. Those who may not know how to read and write, focused group discussion (FGD) will be arranged in two different parishes for them, each FGD will consist of 5-10 participants per parish.

3.8. Quality control.

Quality of information obtained will assured through: Pre testing the data collection tool within another area apart from where the research will be conducted. The researcher due to convenience will pretest the questionnaire in 2 randomly selected households in Bassajja town three days before data collection will be started. This will allow for adjustment of language used in the construction of the questionnaire and improved its overall clarity. Data collation will be done in 4 days to allowed space for onsite checking for any error or incomplete response by the respondents. This ensured that all the information captured will be complete

3.9 Data management.

Data will be entered on a computer using Epi data package version 3.1. It will subsequently be exported into a statistical program SPSS version 21 for analysis. Graphs and tables will be produced in SPSS. Binary Logistic regression will be done to calculate how each of the factors mention in the questionnaire by the respondents affects the utilization of SMC in Mitoma district

3.10 Data analysis and Presentations

Data will be presented in the form tables, graphs and charts. Continuous variables will be summarized by using means, medians, and Standard deviations. The analyzed data will be presented in the form of tables, graphs and charts.

3.11. Ethical consideration.

Approval for this study will sought from the faculty of Clinical Medicine and Dentistry of Kampala International University office of the dean. A formal letter of introduction will be got that will introduce the student to the community through the local council officers and the District Health officer. All the information and data collected from the respondents will be coded to avoid disclosure of personal identity and information. This will be meant to ensure confidentiality of the data collected.

3.12: Study limitation and Mitigation Strategies.

The researcher believes the greatest limitation of this study will be time given that the program has only been condensed in two months which will not allow the researcher to explore the factors in details and present them adequately. Besides, the researcher believes for convinces, a high margin of error will be used in this study (7%). This will make the statistical power to conclude the findings from this study limited.

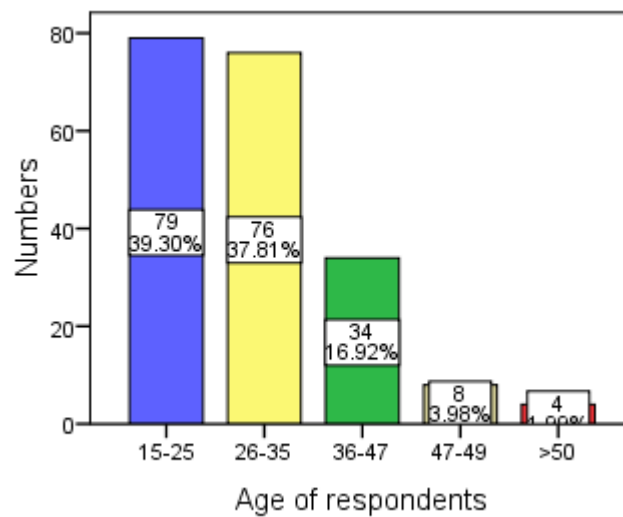
CHAPTER FOUR:

STUDY FINDINGS

This chapter presents the findings and the results of the study according the specific objectives of the study. The findings and results are represented in form of graphs, pie charts and tables with the accompanying descriptive statements immediately after every presentation.

4.1 Socio demographic data

Figure 1: Distribution of respondents by age.



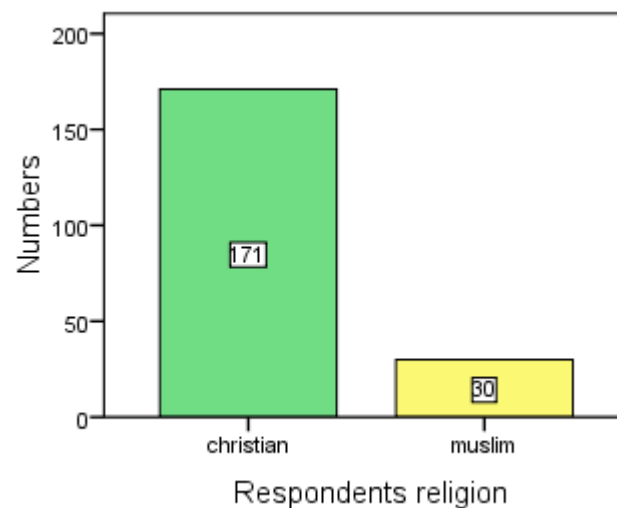
The figure above shows majority of respondents are between the ages of 15-25 and 26-35 with 39.3% and 37.81% respectively, moderate numbers of respondent were aged between 36-47 representing 16.92% and very few were aged between 47-49 and >50 with 3.98% and 1.99% respectively.

Table1: Distribution of respondents by marital status.

Marital status	Frequency	Percent
not married	92	43.4%
married	94	44.3%
separated	15	7.15%
Total	201	100%

The table above shows frequency of respondents according to marital status; most of respondents were married representing 44.3%, followed by un married with 43.4% and the least respondents were separated with 7.15%. However there were no respondents who are either divorced or widowed.

Figure 2: Distribution of respondents by religion.



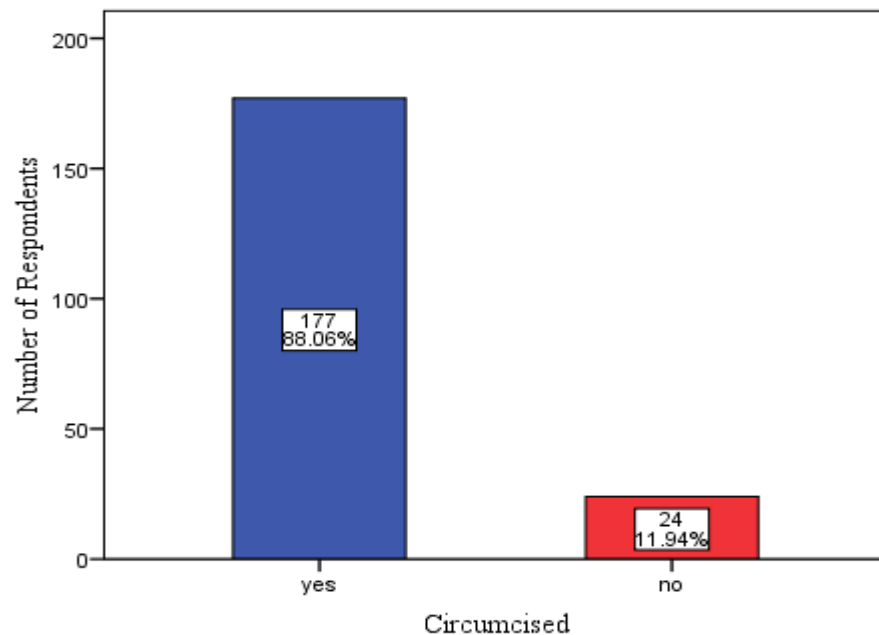
The above figure shows majority of the respondents were Christian (171) , Muslim were least respondents (30)

Table 2: **Distribution of respondents by educational level.**

Education al. level	Frequency	Percent
no formal education	32	15.1%
primary	49	23.1%
secondary	70	33.0%
collage	26	12.3%
university	24	11.3%
Total	201	100.0%

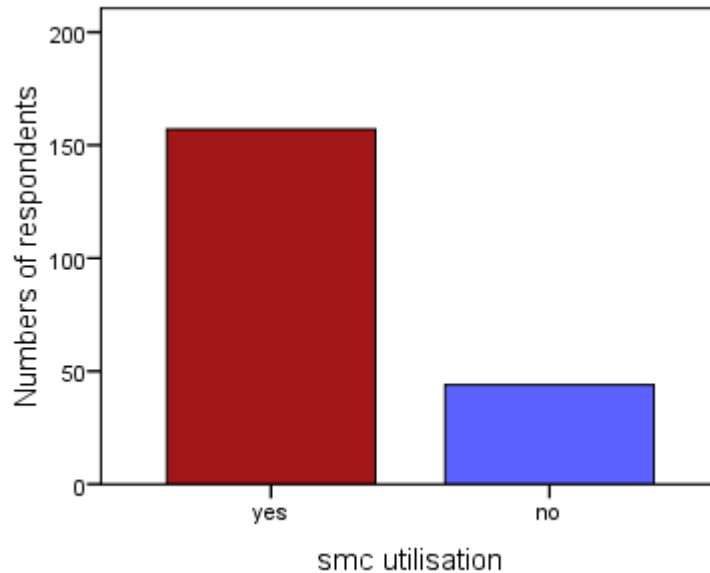
The table above shows majority of respondent has attained secondary education represented by 33.0% ; followed by those who at least attained primary level; Moderate percentage (15%) had no formal education and least numbers of respondents who has reached college and university with 12.3% and 11.3% respectively.

Figure 3: **Distribution of circumcised respondents**



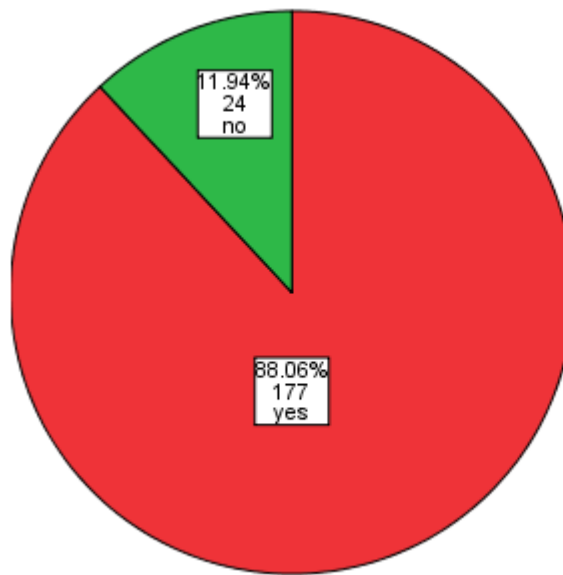
The above figure shows that most of the respondents were circumcised 177 (88.06%) compared to un circumcised respondents 24 (11.94%)

Figure 4: **Distribution of SMC utilization by respondents.**



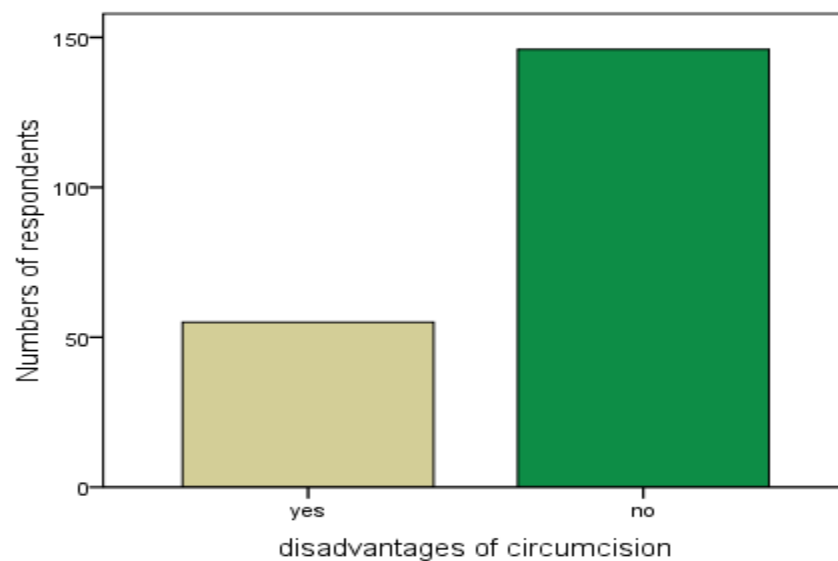
The above figure shows majority (152) of respondents think people are utilizing safe male circumcision as a strategy for HIV prevention compared to (49) respondents who think people are not utilizing Safe male circumcision as HIV preventive strategy.

Figure 5: **Distribution of respondents who knows advantages of circumcision.**



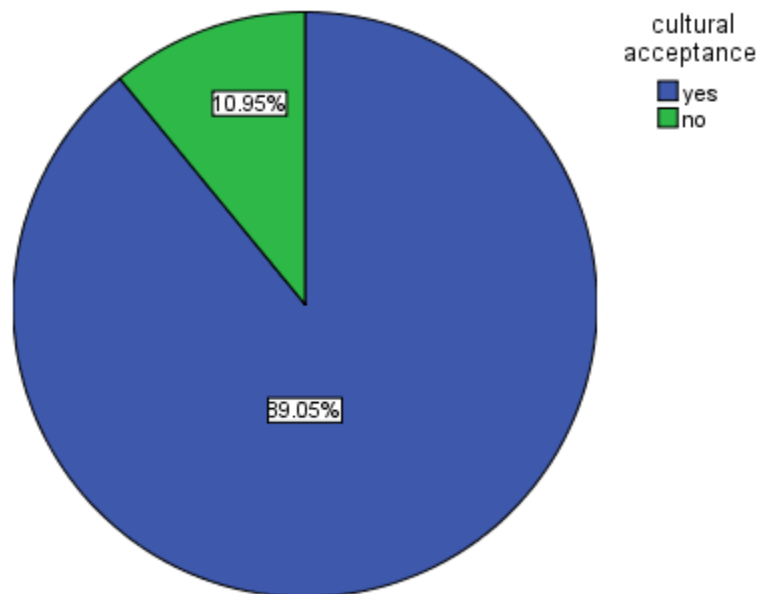
The above figure shows majority of the respondents 88.06 % (177) knows advantages of safe male circumcision and only 11.94% (24) respondents who said safe male circumcision has no advantages

Figure 6: **Distribution of respondents by disadvantage of circumcision.**



The above figure shows majority of respondents (151) 75.2% who believes circumcision have no disadvantages and (50) 24.8% respondents believe circumcision has disadvantages.

Figure 7: **Distribution of respondents by cultural acceptance of circumcision.**



The above figure shows majority of respondents 89.06% their culture do accept circumcision and only 10.95% of respondents whose culture does not accept circumcision.

CHAPTER FIVE:

DISCUSSION

5.1 Demographic Characteristics.

5.1.1 Age

From figure 1, it showed most of the respondents are aged from 15-35 years (77.11%) followed by age group 36-47 (16.92%) and the least respondents were aged from >47(5.52%) .This percentage figure are in line with sexual activeness of the different age groups as those in age range of 15-47 are more sexually active than those above 47 years of age.

This means HIV risk of transmission would be high among this sexually active group if no preventive strategy is put in place thus safe male circumcision is the major risk reduction in HIV transmission being taken by this age group compared to those who know they are not sexually active though few are also taking SMC as HIV preventive strategy.

This tally with 2010, the UNAIDS and WHO reports that the practices of SMC protects the male by over 60% chance of acquiring HIV virus, recommending SMC as another standard HIV prevention strategy. Uganda adapted this policy and designed the national SMC program which has mobilized the community, provided technical training to health staff and enabled logistics for the SMC services in Uganda hence increased number of sexually active age group enrolment for SMC seen in this study.

5.1.2: Marital Status.

Table 1 has shown that majority of respondents were married 44.3% followed by those who are not yet married 43.4% , few were separated men 7.1% none of the respondents were either divorced or widower who declined to participate in the study .The results findings confirms statement released by Uganda Aids commission in October 2014 singling married people as having highest HIV prevalence in the country and also it confer with the New vision publication of 30th November 2014 which showed more HIV prevalence among the Banyankore and Bakiga men with prevalence rate of 9.7% and 9.6% respectively thus not surprising to see more married and none married enrolling for the SMC as HIV preventive strategy in the study area dominated

by banyankore and bakiga tribes. The possible reasons as to why divorced and widower declined to participate in the study is because of sexual in-activeness or no partner thus no need for preventive strategy.

5.1.3 Religion.

From figure 2, it's seen that majority of the respondents were Christians (171) this is because the study area is highly populated with Christians who has some bias on some HIV preventive methods like condom use in which Catholics does not believe in hence opting for SMC as preventive method without defiling their Christian belief hence their high numbers during the study and few Muslim (30) turned up for study, because circumcision is the requirement by Muslim all of them were circumcised prior to study and since they believe in polygamy SMC would be the strategy to reduce the risk of HIV among them.

5.1.4 Educational Level

From table 2, majority of the respondents had attained secondary level with a percentage of 33%, because this is an age group when most people are sexually active as well as most had been well sensitized about safe male circumcision.

It was closely followed by primary school level at 23% which was attributed to many more people being able to access the services brought near to them. Very few of the respondents had attained college and university because of absence of such institutions in the area. Meanwhile those who had non-formal education were a percentage of 15%, which was of a greater proportion meaning few would not go for SMC services due to ignorance as much as the services would be available.

5.2.0 Proportion of Circumcised Men.

5.2.1 Distribution of Circumcised Respondents

From figure 3, a large percentage of 88% of the respondents were circumcised which was attributed to SMC services being brought nearer to the people meaning the services were accessible to the people and also more people were sensitized.

Meaning people are now believing in the WHO 2010 statement released which suggests that SMC confer risk reduction by 60% hence many people getting the services This large percentage

were asked why they were circumcised and they gave a range of reasons ranging from their cultural acceptances to numerous medical benefits that SMC gave them. A small group of 18% was not circumcised due to disbelief in SMC and fear for unknown complications.

5.2.2 Distribution of Respondents Utilizing SMC.

Figure four showed that majority of respondents (152) 75% are utilizing the SMC as HIV prevention strategy. This could be attributed to cultural acceptance and benefits that SMC confer in HIV transmission risk and because the men in study area has higher HIV prevalence ie banyankore and bakiga with (9.7%) and (9.6%) respectively this would call for a preventive strategy which is dually accepted in the community in junction with the other medical benefits thus utilizing the SMC services.

The few respondents (49) were not utilizing the services could be attributed to ignorance about SMC as a good percentage(15%) of respondents had no formal education so it would be hard for this group to understand the concepts of SMC and this also confirm a study done in Uganda in 2004 to assess the Access to and utilization of health services among the poor communities in Uganda, Kiwanuka found out that the poor and the vulnerable are less likely to utilize health services due to the long distance from their homes to service centers, lack of medicines at health facilities and perceived poor quality of care in many public facilities.

It was also noted that cost of both transportation and cost of medicines were also cited by these communities as potential barriers that would stop them from utilizing health services.

This research finding contradicts the low national coverage which is at 48% thus probably there could be high utilization in other areas both at national and district level, and there would be need to scale up the services to even lowest health facilities such that the service utilization increases

5.3.0 Barriers to SMC

5.3.1 Distribution of Respondents by SMC Advantages.

From figure 5, majority of the respondents 88.06% whom all were circumcised has confirmed that the SMC does not have disadvantages this is because circumcision has been made safe for people by training all medical cadres involved in the program and this confirms the research trial conducted in Rakai district by(Buwembo et al 2011)prior at the beginning of the enrolment of

SMC in which both Medical officers and clinical officer allowed to do the procedure and later an assessment were made to determine the complications that would arise from the procedure done by both cadres and it was found that in both cadres there were negligible complications hence circumcision if done safely does not have any disadvantages. this also highlights the study done by Albert et al 2011 citing sexual pleasure and drive among women after a man been circumcised.

The few respondents 11.94% who agreed that SMC has disadvantages confirms the study conducted by otieno-Achola& bailey et al 2011 which include fear for surgery, pain, concerns about safety, long time before the resumption of sexual activity and cost of the procedure.

5.3.2 Distribution of Respondents by SMC Disadvantages.

From figure 6, few of the respondents 24.8% agreed with the finding in figure 5 and confirming the few respondents 11.94% who belief SMC still has some disadvantages as Fear of pain was based largely on the experience and knowledge of traditional circumcision in which case pain is viewed as an integral part as the rite of passage to adulthood. It was also found out that complication rates were more in the tradition circumcision compared to SMC because the traditional surgeons lacked adequate knowledge in infection control, wound care and pain control.

However, in SMC analgesia is provided and this has been found to reduce the fear factors and this in turn is expected to lead more men utilize SMC for HIV prevention

5.3.3 Distribution of Respondents by Cultural Acceptance.

From figure 7, majority of the respondents 89.06% agreed their culture do accept SMC and this confirm the following studies done:

In Eastern Uganda a traditionally circumcising community noted that circumcision was practiced as a test of bravery and endurance among men and masculinity, bravery and social cohesion with boys of the same age group being circumcised around the same time to improve social identity and spirituality.

In Nigeria one study showed that most of the men in Bender State in the southern part of Nigerian enroll for circumcision as a motivation so as to maintain their culture.

In a study done in Kenya, Nyanza province, Bailey found out that uncircumcised men in traditionally circumcising communities are discriminated against. In South Africa among the Xhosa it is unacceptable to remain uncircumcised to an extent that forced circumcisions; discrimination, intimidation and violence are common

In Philippines where circumcision is almost universal and performed between the ages of 10-14 years, a survey among boys found strong evidence of social determinants where many boys choose to be circumcised in order to conform to tradition.

The few respondents 10.95% whose culture does not accept the SMC could be attributed to the most salient barriers to the SMC acceptance have been identified to include fear for surgery, pain, concerns about safety, long time before the resumption of sexual activity and cost of the procedure.

CHAPTER SIX: CONCLUSION AND RECOMMENDATION.

6.1 Conclusion

From the study findings, the following can be concluded.

The target age group were the ones turning up for SMC and most of them were either married or not married hence SMC as HIV preventive strategy among sexually active group is being taken up.

Most of the respondents were circumcised through SMC that were being conducted periodically at the Health centre thus utilization of SMC is good.

Majority of the respondents were Christians and few Muslim whose educational level ranged mainly from non-formal to secondary hence education does not affects the SMC utilization.

It's now known that SMC predominantly has more advantages compared to the disadvantages .because of this it has increased the SMC service utilization in the study area.

SMC has been generally accepted among the culture and it acceptance made utilization to increase in the study area.

6.2 Recommendations.

At the Community Level.

- Community leaders should get involved in the programme to increase awareness and acceptance.
- Cultural institutions should also get involved to widen the acceptance.
- Both younger and older age group should actively participate in the SMC program as HIV preventive strategy.

At district level.

- District should intensify awareness about the SMC by educating the general public.

- SMC should be made routine activities at the programme sites to capture those that come after the scheduled program time frame.
- Sex education should be conducted at schools to create awareness among the school children and community as well.
- District should work with both cultural and political leaders to enhance acceptance and awareness among people.

At national level.

- MOH should extend SMC service delivery to even lower Health facilities to increase coverage.
- Government should ensure constant supply of the circumcision kits.
- More cadres of health workers should be trained on SMC.
- Government should also formulate the policy on SMC to widen utilization.

Appendices

Appendix I: Data Collection Tool

Part A: Socio Demographic Data

Age of the respondents

- a) 15-25
- b) 26-35
- c) 36-47
- d) 47-49
- e) Above 50

Marital status

- a. Not-married
- b. Married
- c. Separated
- d. Widow/widower
- e. divorced

Religion

- a. Christians
- b. Muslims

Education level

- a. No formal education
- b. Primary (elementary)
- c. Secondary (high school)
- d. College
- e. University

Part B: Proportion of Circumcised Men

Are you circumcised?

- a. Yes
- b. No

In your view, why were you circumcised?.....

.....

Do you think many people are utilizing SMC as a HIV prevention strategy?

- a. Yes
- b. No

Part C: Barriers to SMC

Are there any advantages of being circumcised?

- a. Yes
- b. No

If yes, please mention.....

Are there any disadvantages of being circumcised?

- a. Yes
- b. No

If yes, please mention.....

Does your culture accept male circumcision?

- a. Yes
- b. No

If no why?.....

THANKS FOR YOUR TIME

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Appendix II: Work Plan

Activity	Duration	Percentage Finished	Responsible Person
Topic Formulation	2 weeks	100%	Patrick
Approval of Topic	one week	100%	Faculty
Assignment of Supervisor	one week	100%	Faculty
Preparing the proposal	2 weeks	50%	Patrick
Approval of the proposal	1 week	0%	Supervisor

Correction of Proposal	1 <i>week</i>	0%	Patrick
Approval of Proposal	2 <i>days</i>	0%	Supervisor

Research Item	Title	Qty	Unit cost (Ug sh)	Total (Ugsh)
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Data Collection	2 <i>weeks</i>	0%	Patrick
Data Analysis	2 <i>weeks</i>	0%	Patrick
Report Writing	3 <i>weeks</i>	0%	Patrick
Correction of Report	1 <i>week</i>	0%	Patrick
Submission of report	1 <i>week</i>	0%	Patrick/supervisor

Research assistants	2	100000 x 2	200,000	Data collection and data entry
Stationery	Ream of paper	1	20000 x 1	20,000
	Black pens	1	15000	15000
	Box of Pencils	1	10000	10000
Remuneration	FGD stipend	1	1 x 2000	40,000
Communication.	Airtime	2	10000 x 2	20000
Data analysis /report writing	Statistician	1	100,000	100,000
Binding	Binding	4	2000	4,000
Meals	Refreshments	20	2000 x 20	40,000
Total			449,000	

MAP OF MITOOMA DISTRICT





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**OFFICE OF THE DEAN,
FACULTY OF CLINICAL MEDICINE & DENTISTRY**

21/11/2014

TO WHOM IT MAY CONCERN

RE: OLOYA PATRICK (BMS/0064/112/DU)

The above named is a student of fourth year at Kampala International University pursuing a Bachelor of Medicine, Bachelor of Surgery (MBChB) programme.

He wishes to conduct his research project in your hospital.

Topic: Factors affecting the utilization of safe Male circumcision as HIV prevention strategy in Mitooma district, Western Uganda.

S/O
Dr. Akib Surat
Asso. Dean, FCM &D



You have been granted permission to carry-out your research work at the health centre

**BITEREKO
HEALTH CENTRE III
RUHINDA - BUSHENYI
DATE 25.11.2014**

for KC