

Socio-Demographic Factors Influencing Women Involvement in Voluntary Medical Male Circumcision in Maziba Sub-County Ndorwa East, Kabale District

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ABSTRACT

Voluntary medical male circumcision is being scaled up at a slow pace in Uganda. Individuals' awareness must be increased in order for them to develop good attitudes toward male circumcision as an HIV prevention technique. A cross-sectional study design was adopted, with parishes selected using a cluster selection method and the number of homes selected using a probability proportionate to size method. Households were chosen for study using systematic random sampling, and a total of 358 adult female respondents took part in the study. Data was collected using a semi-structured questionnaire. STATA version 14.2 was used to analyze the data. Women who were medical workers and teachers were more likely to support their male partners towards circumcision (aPR=1.8, 95%CI 1.3-2.3 & aPR=1.5, 95%CI 1.1-2.1) respectively. Majority of women who had negative attitude towards male circumcision thought it was a painful procedure. In order to improve attitude towards Voluntary medical circumcision, it is necessary to inform the community of its benefits, and that it is done under local anesthesia and is not a painful procedure.

Keywords: Socio-demographic factors, women, male circumcision

INTRODUCTION

Male circumcision is the surgical removal of the penis' foreskin, and it is one of the world's oldest and most prevalent procedures [1,2,3,4,5,6]. It is usually done for social, cultural, religious, or medicinal purposes [1,2,7,8,9]. A qualified health care professional or doctor performs the medical male circumcision procedure in a medical facility. When performed in a professional setting under sterile conditions by a competent practitioner using correct instrumentation, medical male circumcision is a rapid and safe procedure [3,10,11].

According to randomized clinical trials that were conducted in Sub-Saharan Africa; South Africa [4]; Kenya [5] and Uganda [6] male circumcision protects against HIV and reduces the incidence of other sexually transmitted infections (STIs), such as genital ulcers, human papillomavirus (HPV), and chlamydia in female partners of circumcised men. Circumcision lowered the probability of heterosexual HIV transmission from an infected woman to a circumcised man by

more than 60%, according to these studies. Because of this, WHO/UNAIDS advised male circumcision as part of a comprehensive strategy to prevent heterosexually-acquired HIV infection in countries with high HIV incidence and low male circumcision rates in 2007 [3,12,13,14]. In 2010, Uganda implemented a safe male circumcision (SMC) policy as part of a comprehensive HIV prevention approach that included abstinence, faithfulness to one partner, and condom usage (ABC). Male circumcision was primarily done for socio-cultural reasons as a rite of passage from childhood to manhood among the Bagisu and Bakonjo ethnic groups, as well as a religious ceremony among Moslems, prior to the implementation of this policy. The SMC policy's purpose was to help reduce HIV and other STIs by providing safe male circumcision services [7,15,16].

The study was done to identify the socio-demographic factors influencing women involvement in voluntary medical male circumcision in the study area.

METHODOLOGY

Study design

A cross-sectional study design was employed among women living in Maziba sub-county, Kabale South western Uganda.

Study area

Maziba sub-county is in South East part of Kabale district, and the major economic activity is crop husbandry especially pineapple growing for cash.

Study population

The research participants were chosen based on inclusion and exclusion criteria.

Inclusion criteria

Adult women who had been living with a male partner for at least 6 months in the Maziba sub-count and had given their agreement to participate in the study were included.

Exclusion criteria

Women with Muslim male partners, and those who were found with mental illness or critical illness were not included in the study.

Sampling techniques

To pick parishes, a cluster sampling approach was utilized, followed by a probability proportionate to size method to determine the number of homes. A household was chosen for study using systematic random sampling. A collection of random numbers was used to generate a random start. If a home was empty at the time of a visit, it was returned later that day or the next day. If the house was permanently vacant, the inhabitant lady changed her mind about participating in

Women aged below 30 years were 33% less likely to be involved in Voluntary medical male circumcision of their male partners compared to those aged 31 years and above, aPR=0.7, 95%CI (0.5-0.9). Women who were medical workers were 1.8 times more likely to support their male partners compared to their counterparts who were peasants, aPR=1.8,95%CI 1.4-2.3. Also, women who were teachers were 1.5 times

the study, or an adult woman who fit the inclusion criteria was not available for interview after several tries, the next nearest family was visited.

Data collection instruments

A pre-tested standardized semi-structured questionnaire was used to collect data.

Data Analysis

The socio-demographic features of research participants were described using univariate analysis. Mean, SD, percentage and frequencies were used to summarize data. Stratification was done over marital status to detect any differences.

Ethical Considerations

Informed consent

The study's primary investigator (Tumwesigye Ronard) presented himself to the participants and discussed all of the procedures involved, as well as the study's aim, participant selection criteria, risks, and benefits. Participants were also told that their participation was completely voluntary, that they could stop at any time during the interview, and that if they had any questions, they could contact the appropriate person. Before participating in the data collecting method, individuals who accepted that they had understood were asked to sign or place a thumbprint on a written informed consent statement.

Confidentiality and privacy

All completed questionnaires were kept under lock and key by the lead investigator.

RESULTS

more likely to support their partners towards medical male circumcision compared to peasant women, aPR=1.5, 95%CI 1.1-2.1. Women who were self-employed were 50% less likely to support their spouses towards medical male circumcision compared women who were government employed, cPR=0.5, 95%CI 0.4-0.6.

Table 1: Socio-demographic factors influencing women involvement in voluntary medical male circumcision in Maziba Sub-county, Kabale district

Variable	Involvement in MMC (No)	Involvement in MMC (yes)	cPR (95% CI), p-value	aPR(95%CI), P-value
Age in years				
≥ 31	16 (30.8)	36 (69.2)	1.00	1.0
< 31	32 (56.1)	25 (43.9)	0.63 (0.45-0.90), 0.01	0.67 (0.48-0.94), 0.02
Occupation n(%)				
Peasant	27 (45.8)	32 (54.2)	1.00	1.0
Business	14 (56.0)	11 (44.0)	0.81 (0.49-1.34), 0.42	0.78 (0.48-1.29), 0.34
Medical worker	0 (0.0)	7 (100.0)	1.84 (1.46-2.33), < 0.001	1.78 (1.36-2.31), < 0.001
Teacher	2 (18.2)	9 (81.8)	1.51 (1.05-2.17), 0.028	1.47 (1.05-2.05), 0.025
Other	5 (71.4)	2 (28.6)	0.5 (0.16-1.73), 0.295	0.65 (0.19-2.20), 0.49
Employment n(%)				
Government	0 (0.0)	10 (100.0)	1.00	
Self employed	44 (50.0)	44 (50.0)	0.5 (0.41-0.62), < 0.001	
Employed by NGO	2 (25.0)	6 (75.0)	0.75 (0.50-1.12), 0.16	
Other	1 (50.0)	1 (50.0)	0.5 (0.12-2.01), 0.33	
Education n(%)				
None	5 (55.6)	4 (44.4)	1.00	
Primary	22 (48.9)	23 (51.1)	1.15 (0.52-2.53), 0.73	
Secondary	16 (48.5)	17 (51.5)	1.16 (0.52-2.59), 0.72	
Tertiary	5 (22.7)	17 (77.3)	1.74 (0.81-3.75), 0.16	
Tribe n(%)				
Mukiga	41 (43.2)	54 (56.8)	1.00	
Munyankole	3 (42.9)	4 (57.1)	1.0 (0.52-0.96), 0.98	
Mufumbira	1 (33.3)	2 (66.7)	1.17 (0.52-2.67), 0.70	
Others	3 (75.0)	1 (25.0)	0.44 (0.08-2.44), 0.35	

DISCUSSION

Women aged below 31 years were 33% less likely to be involved in VMMC of their male partners compared to those aged 31 years and above. This is perhaps due to; older women are likely to have knowledge of the benefits regarding male circumcision. Also it is presumed that older women can easily convince their male partners towards circumcision as compared to younger women who might possess low self-esteem. There are no similar documented studies regarding influence of a woman's age on male partner circumcision. Occupation of a woman was also significantly affecting her involvement in male circumcision. Women who were medical workers were 1.8 times more

likely to support their male partners towards VMMC as compared to peasant women. This is so because women who are medical workers are much exposed to continuous medical education regarding all possible benefits of male circumcision. Similarly, women who are teachers were 1.5times more likely to support their male partners towards male circumcision compared to peasant women and this is so because such women are educated about the benefits of male circumcision. Women who were self-employed were 50% less likely to be involved in circumcision of their male partners compared to government workers. This is attributed to their busy schedules that disallow them to

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discuss benefits of circumcision with their male partners.

CONCLUSION

Factors such as age, occupation and employment status of women were significant predictors of women

involvement in Voluntary Medical Circumcision of their male partners.

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