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Influential Factors Affecting the Acceptance of Safe Male Circumcision among Male Clients Aged 15-49 at Kaberamaido District Hospital, Kaberamaido District

Okello Godfrey

Department of Clinical Medicine and Dentistry Kampala International University Western Campus Uganda

ABSTRACT

The study aimed to identify factors influencing the uptake of Safe Male Circumcision (SMC) among males aged 15-49 years in the outpatient clinic at Kaberamaido District Hospital in Uganda. A cross-sectional study was conducted among 384 male respondents aged 15-49 years. Data was collected using researcher-administered questionnaires and analyzed using Graph Pad Prism 7 software and Pearson chi-square tests. 159 participants (41.4%) reported undergoing SMC, with all socio-demographic factors having a statistically significant relationship with SMC uptake, except religion. Personal factors, such as perception and awareness about SMC, significantly affected SMC uptake. Distance from the health facility had no impact on SMC uptake. The study concluded that the uptake of SMC among male clients was relatively low. To increase perception, community outreach, and village health teams' assistance, it is recommended that male clients recommend and increase awareness about SMC through community outreach and village health teams.

Keywords: Safe male circumcision, HIV prevalence, Voluntary medical male circumcision, Health facility, Village health teams.

INTRODUCTION

Male circumcision (MC) is where all or part of the foreskin is removed surgically [1]. According to [2], the most common type of male circumcision is one in which the foreskin of the penis is completely removed, exposing the entire glands of the penis. Safe male Circumcision (SMC) is the surgical removal of the foreskin from the head of the penis which is carried out by professionally trained Health Care Workers under local anaesthesia to prevent pain [1]. According to history, MC was mainly associated with religious practice but of current SMC is increasingly embraced in many parts of the world. It's of estimated that 38% of the world‟ 's males aged 15 years or older are circumcised of which about 62% are Muslims residing mainly in Asia, the Middle East and North Africa, 0.8% are Jewish and 3% are non-Muslim and non-Jewish men living in the USA [3]. Male circumcision was already a cultural tradition prior to the arrival of Islam as seen among the Poro in West Africa, and in Timor in South-East Asia [4]; while in Kenya, this cultural practice is observed mainly among the Baluya ethnic group. According to [5], in Africa, mostly in countries of Northern and Western regions, MC is almost universal; however, its uptake in other parts varies considerably with low uptake reported in the African countries of Botswana, Namibia, Swaziland, Zambia and Zimbabwe (World Health Organization [5]. The prevalence of MC is reported to be 21% in Malawi, 35% in South Africa 48% in Lesotho, 20% in Mozambique and more than 80% in Angola and Madagascar. In East and Central Africa, the prevalence varies from almost 15% in Burundi and Rwanda to 70% in Tanzania and 93% in Ethiopia [5]. In Uganda, MC is viewed as a sign of maturity among males in preparation for marriage among ethnic groups of Bamasaba and Sabiny from Eastern Uganda [6]. As per other studies, MC has been associated with health benefits such as prevention of local foreskin problems, cancer of the penis, urinary tract Infections, STIs including 60% reduction of HIV heterosexual transmission and genital hygiene

enhancement, Human Papilloma Virus (HPV) and cervical cancer [7]-[9] Following the successful three randomized controlled trials that showed 60% reduction in HIV heterosexual transmission among circumcised males [8]; [9] Safe male circumcision (SMC) programs was rolled out in several sub-Saharan African countries with high HIV prevalence and low prevalence of male circumcision by WHO and international bodies [10], however it was estimated that nine million SMCs have been undertaken since 2007 in eastern and southern Africa (The AIDS Vaccine Advocacy Coalition (AVAC) & Family Health International[10];[11] while it is estimated that 20 million SMCs are needed to achieve 80% coverage of SMC by 2025 [12].

Safe male circumcision is believed to be associated with a reduction in HIV heterosexual transmission. If well adopted widely, SMC can prevent the acquisition of new HIV infections by 60% [5]. It is estimated that 20 million SMCs are needed to achieve 80% coverage of SMC by 2025 [12]. If this coverage is achieved and maintained, about 3.4 million new HIV infections could be averted, reducing the number of people needing HIV treatment and care, as well as saving considerable sums of money in future treatment costs [13]; [14]. As far as Uganda is concerned, the Uganda MOH started a voluntary safe male circumcision program as an HIV prevention strategy to improve the access of hard-to-reach, high risk and poor populations to SMC services at free cost with a target to circumcise 80% of males aged 15-49 years by the end of 2015 (Uganda National HIV Prevention Strategy, 2011-2015). Despite rolling out SMC services both in hospitalsand community outreaches, the uptake of SMC is still low. Between 2013 and 2017, only 188,512 males were reported to have been circumcised at the national level [15]. According to a study by [16] only two million men had received SMC the 4.2million men required while a geographic variation in male circumcision prevalence exists, ranging from 2% in the Mid-Northern region to 53% in the Mid-Eastern region of Uganda [17]. In some districts, such as Kaberamaido, there is no published data regarding the uptake of voluntary medical circumcision services or the factors that could influence voluntary medical circumcision utilization. Therefore, if this study is conducted it will help identify the factors that influence the uptake of safe male circumcision among males aged 15-49 years attending outpatient clinics in Kaberamaido District Hospital, Kaberamaido district.

METHODOLOGY

This chapter gives the descriptions of the research methods. It includes study designs, study setting, study population, how they will be selected for inclusion in the study sample size determination, sampling method, definition of study variables, data collection method and tools, quality control for data, data presentation and analysis, ethical issues, limitation of the study, and plan for dissemination of the study results.

Study design

The research design was a cross-sectional study design as it is the most suitable design for prevalence studies in which data is collected at one point in time with exposure and outcome being assessed at once within a short period [18]. Data gathered will represent the population. This study will be conducted between January and February 2022.

Sources of data

The study used primary data from the participants by means of researcher-administered questionnaires in which the information was derived directly from the respondents.

Area of Study

Kaberamaido District Hospital was a government-based health facility It is located in Kaberamaido district within Kaberamaido town. Its population coverage is about 27,100 people by 2017/2018. The health center is a very important institution that serves as a governmental referral health facility for the areas bordering it and it has the following departments: Medicine, surgery, paediatrics", obstetrics & gynaecology, dental, laboratory, and ophthalmology. Other departments include radiology, accounts, medical records, maintenance, human resource and anaesthesia. The study area was chosen because it has a low uptake of safe male circumcision reported in the community.

Study population

The study population included male

participants aged between 15-49 years attending Kaberamaido district hospital, kaberamaido district.

Inclusion criteria

All male participants of 15-49 years that consented or had assent signed by the parent or guardian and resident at Kaberamaido district for minimally 4 months prior to commencement of the study were included.

Exclusion criteria

All consenting/assenting male participants found to be very ill or whose mental status was found to be compromised at the time of the study were excluded.

Sample size determination

The sample size of the proposed study was determined using Kish and Leslie sample size formula (Kish and Leslie, 1965) as detailed below:

$n = (Z^2_{\alpha}pq)/e^2$

Where by:

n is the sample size required,

Z_{α} is the Z-value at $\alpha = 0.05$ whose value is 1.96 (from the distribution curve).

P = the proportion of circumcised participants expected among the respondents in the study

(By convention p =0.5 if there is no literature about such proportion as it is in thiscase)

Since p + q =1

Therefore,

q =1- p

q = 1-0.5

q =0.5 for this case

The estimated precision (e) of the study was estimated to be 0.05

Thus;

n =(Z2αpq)/e2

n= (1.96*1.96*0.5*0.5)/ (0.05*0.05)

Therefore, by substitution, the sample size n = (4*0.5*0.5)/ (0.05*0.05) = 384

n=384

Therefore, a minimum of 384 participants were considered for this study.

Sampling Techniques

The study used consecutive and purposive sampling methods which are common non- probability sampling methods used in Hospital setting. Consecutive enrolment method were used where by the respondents were selected as they were be received in the out patients department at Kaberamaido district hospital. Men were be selected purposively to give information related to the study if they were found eligible.

Study variables

The dependent variable for the study was uptake of SMC among the male clients attending Kaberamaido district hospital. The independent variables of the study were the factors associated with the uptake of SMC among clients attending Kaberamaido district hospital and these were socio-demographic and personal factors.

Data collection methods and tools

In this study, quantitative data was collected using a researcher administered questionnaire. A standardized questionnaire contains both closed (structured) and open ended (semi structured) questions on socio-demographic and personal factors associated with the uptake of SMC among clients attending Outpatients clinic in Kaberamaido district hospital, in Kaberamaido District is developed. The questionnaire uses both closed and open-ended questions.

Reliability and validity

Quality control measures is put in place to ensure validity and reliability of collected data in the following ways: The questionnaires were written in English and translated to kumam which is the local language comprehended by majority of the respondents in Kaberamaido District. Thirty (30) questionnaires were presented at Alwa health facility. Questions that did not yield the desired meaning were edited accordingly before starting the study. Questionnaires of the research were administered under supervision by the principal researcher and help from well-trained research assistants working at the health facility. Before closure, all interview questionnaires where double checked for completeness and approved for storage by the principal investigator. Questionnaires were be kept in safety and were only be accessed by the principal investigator.

Data presentation and analysis

Data was cleaned, coded and entered into Microsoft office Excel windows seven. Descriptive statistics (univariate) will be carried using graph pad prism software version 7 and presented as frequency tables or graphs. Bivariate analysis will be done using Pearson Chi-square tests to determine the relationship between the

dependent and independent variables in the study. P-values and their corresponding confidence intervals was calculated. For all statistical tests, P-values less than 0.05 were considered significant.

Ethical considerations

Permission was sought from the administration of Kampala International University's western campus and the Kaberamaido General Hospital Supretender Written informed consent was sought from all study participants before enrolment into the study after explaining the purpose of the study to each attending study participant. For all collected data, confidentiality was maintained by not revealing the participants' identities but using only codes.

RESULTS

Socio-Demographic Information of the Study Population

The study population was composed of 384 respondents with the majority (41.4%) in the age brackets of 15-25years, (62.5%) were single, (32.7%) were married, (41.4%) were humans, (16.4%) were Langis. Of the 384 participants, 359 (93.5%) were Christians; only 25 (6.5%) were Muslim. More details of socio-demographic information are given in Table 1.

Table 1: Socio-demography of the study population.

Variable	Frequency (n=384)	Percentage (%)
Age		
15-25years26-35years36-45years	158 125 58	41.1 32.6 15.1
46-49years	43	11.2
Tribe		
Kumams	159	41.4
Langi	63	16.4
Itesots	42	10.9
Acholi	18	4.7
Others	102	26.6
Marital Status		
Single	240	62.5
Married	141	32.7
Widowed	3	0.8
Highest Level of Formal education attained		
Primary	123	32.0
Secondary	136	35.4
Tertiary	76	19.8
Others	59	15.4
No formal education	21	5.5
Occupation		
Formal employment	87	22.7
Self-employed	44	11.5
Peasant	156	40.6
Student	58	15.0
Not employed	16	4.2
Religion		
Christian	359	93.5
Moslem	25	6.5
Cultural requirement of circumcision		
Yes	04	1.0
No	380	99.0

Uptake of safe male circumcision among the male clients attending the outpatient clinic at Kaberamaido District Hospital

According to this study, 159 (41.41%) of participants reported to have taken up SMC whereas 225 (58.59%) participants reported to have not taken up SMC. Figure 1 below is the summary of the results.

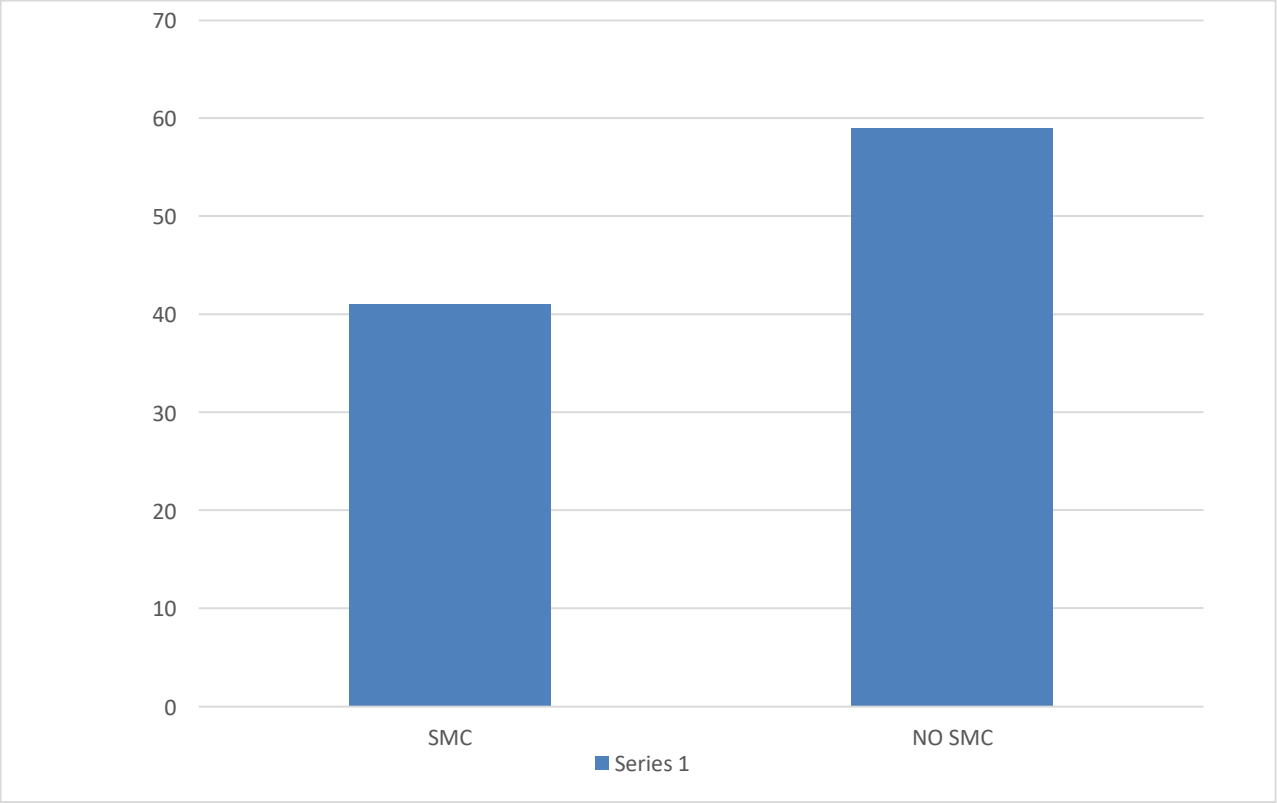

Figure 1: shows the percentage of the participants who undertook safe male circumcision.
***Percentages in the figure are rounded off to a single figure**.

Socio-Demographic Factors Influencing Uptake of Smc among the Male Clients Attending the Outpatient Clinic Kaberamaido District Hospital.

A bivariate analysis was done to determine the association between the socio- demographic factors and SMC uptake. As shown in table 2, tribe, age, occupation, level of education were the socio-demographic factors associated with uptake of SMC ($p < 0.05$). There wasn‟t any difference in uptake of Safe Male Circumcision among the various religious denominations ($p=0.5752$). Greater number of Participants who reported to have undertaken Safe male circumcision was in the age group of 15-25 years. More single (64.2%), married men (35.8%) had undertaken SMC. Of the 159 respondents who reported having undertaken Safe male circumcision, the greater portion attended tertiary level of education (37.4%) and were self-employed (34.0%). Bivariate details analysis was given in Table 2 below showing more details.

Table 2: Association between the socio-demographic factors and uptake of SMC in the studypopulation

			χ^2	df	P Value
Variable	**Uptake of Safe MaleCircumcision**				
	Yes (%)	**No (%)**			
	(n=159)	**(n = 225)**			
Age					
15-25years	88(55.3)	36 (16)	71.4	3	**0.0001***
26-35years	39(24.5)	127 (56.4)			
36-45years	18(11.3)	42(18.7)			
46-49years	15(9.4)	22(9.8)			
Tribe					
kumams	61(38.3)	98(43.5)	13.7	4	**0.0083***
Langi	18(11.3)	49(21.8)			
Itesots	22(13.8)	23 (10.2)			
Acholi	13 (8.2)	12(4.7)			
Others	45 (28.3)	43 (19.1)			
Marital status					
Single	102 (64.2)	43 (19.1)	ND	NA	
Married	57 (35.8)	179 (79.6)			-
Widowed	0 (0)	3 (1.3%)			
Education level Primary	23(14.5%)	52(23.1%)			
Secondary	52(32.7%)	75(33.4%)	26.4	5	**0.0001***
Tertiary	60(37.4%)	40(15.7%)			
Others	13(8.2%)	46(18.0%)			
No formal Education	11(6.9%)	12 (5.3%)			
Occupation					
Formal	33(20.7%)	77(34.2%)	43.2	4	**0.0001***
Self-employed Peasant	54(34.0%)	79(35.1%)			
Student	15 (9.4%)	45(20.0%)			
Non- employed	46 (28.9%)	16 (7.1%)			
	11 (6.9%)	8 (3.6%)			
Religion					
Christians	146 (91.8%)	210 (93.2%)	0.3	2	**0.5753**
Moslems	13 (8.2%)	15 (6.7%)			
Cultural requirement Yes	30(18.9%)	12(5.3%)	24.4	1	**0.0001***
No	129(81.1%)	213(94.7%)			

Where there are significant associations between dependent and independent variables Chi-square for marital status ND-not done for cells below 5.

Personal Factors Influencing Uptake of Safe Male Circumcision among Male Clients Attending Outpatient's Clinic at Kaberamaido District Hospital.

Participants were asked questions regarding factors influencing uptake of safe male circumcision and the details of the study results are summarised as below in Table 3.

Table 3: Personal factors influencing uptake of Safe Male Circumcision among male clientsattending the outpatient clinic at Kaberamaido District Hospital (n=384).

Personal factors	Reason	Frequency	Percentage (%)
Awareness about SMC	Yes	280	72.9
	No	104	27.1
Information source on SMC	Relative/Parents	33	8.6
	Teacher[school]	15	3.9
	Health workers'/Health facilities	157	40.9
	Religious leaders	36	9.4
	Educational program-Radio	38	9.9
	Newspaper	35	9.1
	Friends[peers]	72	18.8
Have been you influenced	Yes	196	96.1
into SMC? (n=204)	No	8	3.9
	Spouse	27	13.2
Influential sources	Parental	76	37.3
	Self	22	10.8
	Peer	82	40.2
Reasons for having	Health or hygiene	74	36.3
circumcision(n=204)	Sexual satisfaction	21	10.3
	STI/HIV protection	38	18.6
	Religious beliefs	30	14.7
Reason for not	Pain fear	74	36.3
having-circumcision(n=180)	Fear of costs involved	5	2.8
	Reduction of sexual	13	7.2
	Pleasure	18	10
	Fear of going against my traditional beliefs	9	5
	Fear of hurting my wife/ girlfriend preference for uncircumcised penis	40	22.2
	delayed wound healing fear	21	11.7
	Others		
Distance to the nearest health	<10KM	176	45.8
facility	>10KM	208	54.2
Opinion on safe male circumcision	Very good	106	27.6
	Good	199	51.8
	Poor	**89**	**23.2**

According to Table 3 above, 280 (72.9%) of the participants had information about safe male circumcision while 104 (27.1%) never heard any information concerning safe male circumcision. Out of the 384 participants, (43.8%) said the nearest

health centre was less than 10 kilometres 74 (36.3%) got circumcised because of health/hygiene purposes as the main reason. Other reasons for getting circumcised included being protected from STIs/HIV (10.3%), religious reasons 30 (14.7%) and sexual satisfaction 24 (10.3%). According to this study, 196 (96.1%) who got circumcised were influenced and this forms a major portion and just 8 of them (3.9%) were self-motivated. The greater number was influenced by peers (40.2%) and parents (37.2%). Pain (36.3%) was reported by most of the respondents as the primary barrier and (7.2%) stated fear of reduction of sexual pleasure as another barrier and they have been summarised in Table 3 above.

Personal Factors Influencing Uptake of Smc

To determine the association between personal factors and SMC uptake, bivariate analysis was carried out and the results are shown in table 4 below.

Table 4: Association between the personal factors and uptake of SMC in the study population

Variable	Response	SMC uptake (n=384)		$\chi 2$	df	P- Value
		Yes (n=159)	No (n=225)			
Awareness about SMC Opinion about Circumcision and Distances	Yes	100(62.9%)	179(79.6%)			
	No	58(36.5%)	47(20.8%)	21	1	**0.0001***
	Very good	47(29.6%)	50(22.2%)			
	Good	50(31.4%)	150(66.7%	56.2	2	**0.0001***
	Poor	62(39.0%)	25(11.1%)			
	<10km	91(57.2%)	115(51.1%)			
	≥10km	67(42.1%)	111(49.3%)	1.3	1	**0.2360**

Awareness concerning SMC and its perception were the personal factors that significantly influenced SMC uptake among the male patients (P<0.05), whereas the distance to the health facility did not influence SMC uptake (P=0.236). The greater number (62.9%) had awareness about SMC. A greater number who reported having been circumcised medically had a very poor opinion regarding SMC as shown in the results included in Table 4 above.

DISCUSSION

Prevalence of Uptake of Safe Male Circumcision among Male Clients Attending Outpatient's Clinic at Kaberamaido District Hospital.

In this study, less than half of the respondents (41.4%) reported to have been circumcised medically which is less than the 80% target set by the Ministry of Health of men aged 15-49years who should be circumcised [15] despite massive campaigns by the Uganda Ministry of Health. This therefore calls for more various approaches by Kaberamaido district authorities to sensitize communities and schools about the benefits of SMC. This can be done through community mobilization by the help of village health teams, radio talk shows, presentations in gathering concerning male circumcision, school visiting programs to educate pupils and students on importance of SMC Observably, the prevalence of SMC in this study is little greater compared to the prevalence of 34% that was reported by TASO in a study that was done in Masaka district [19]; Uganda narrative report), but its lower than the 58.3% prevalance in the study done in Makerere university[20]. However, when compared with uptake of SMC in some African, the uptake of circumcision in the Kaberamaido community is much lower compared to the prevalence of SMC that was reported in some communities of Kenya of 91% and Tanzania (70%); while higher than that

report of the study done in Zimbabwe among men aged 18-19years,prevalence of self-reported voluntary medical male circumcision was 15.3%[21] another study conducted in Zambia among youth voluntary medical male circumcision prevalence was 16.5% Different factors could help explain variations in uptake of safe male circumcision in the different communities among which could be the extent of community sensitization on uptake of safe male circumcision, availability of health facilities and human resource to carry out safe male circumcision, the strong influence by religion, as well as the cultural and traditional beliefs but the community sensitization is known to improve uptake of safe male circumcision. In this study, uptake of safe male circumcision among the male clients was significantly influenced by age, level of education, parents and peers. The majority of the males who had undertaken SMC were youths under 25 years old. This can explain how the youth are influenced by their peers and would not likely feel stigmatized upon acceptance of SMC uptake as would the adults. The results obtained in this study were quite similar to the study that was carried out in Kampala and Kayunga districts which reported greater uptake of SMC among younger adults mostly due to peer influence. This is because some young men would feel more accepted, and respected and would enjoy the company and support of their peers if they were circumcised [21]. Other studies done in Zambia and elsewhere also confirm the significant impact of peer involvement in increasing the uptake of SMC among the youth [22]; [23]. This is because youth always share information"s together both in social media and their social gatherings and encourage each other hence higher numbers among the youth. In other studies, older men felt like they had passed the age for circumcision and they could not see any need to uptake it while some were not willing to be circumcised because they thought they were "okay" the way they were [24]. Others feel shamed upon seeking services at an older age together with younger boys or they fear that their partners would engage in sexual infidelity while they are healing [25]. The current results suggest SMC programs would achieve more success if they targeted males at a younger age as acceptance is likely greater among the younger ones as compared to older males. Various studies show that the level of education increases awareness about circumcision as it plays a vital role in risk reduction of HIV/AIDS and other STIs thus, sufficient knowledge may bring about long-lasting behaviour change [26]. This is similar to previous studies in Uganda which showed that a higher number of circumcised men were associated with a higher level of education [27]. The results of the study by Mbusa et al also indicated that a lack of in-depth knowledge about the benefits and limitations of MMC made people reluctant and sceptical about it. According to the study, it showed that more educated males had better knowledge about safe male circumcision and its benefits in reducing chances of acquiring STIs. In this study, more single than married men reported to have undertaken SMC, having fewer married men undertaking SMC reflects minimal spousal support towards circumcision. Somefear that their spouses would engage in extramarital sexual relationships while they are healing, while other studies reported the fear of losing of sexual urge when one is circumcised explained the non- uptake of SMC by some men [15]. Basing on the results it reflected the need for community sensation, spouse support and dealing with the fear of marriage dissolution after undergoing male circumcision by some men. The observation regarding the influence of marital status is however not consistent with the results of Uganda Demographic and Health Survey, (2010) in which a slight difference in uptake of SMC among the married and single men was seen. The differences in the study findings could be explained by variations in beliefs about Safe Male Circumcision since the studies were carried out in different ethnic populations. In some societies, it is believed that male circumcision is a developmental milestone for a man and also perceived to protect one from sexually transmitted diseases [26] therefore such results in the acceptance of SMC. There was a higher number of circumcised males amongst self-employed than those employed by other people this could be because of the possibility of staying away from the

workplace unlike in formal employment. This is also in accordance with other studies in which respondents expressed the fear of staying away from work, especially if the man is the sole provider for the family [23]. Cultural tradition may improve acceptance of uptake, especially in communities where cultural influences are very strong. There was no statistically significant relationship between the religion and uptake of male circumcision. This is probably because many Muslims are circumcised culturally in childhood. The result from the present study suggests the need for Kaberamaido District Authorities like LCV, DHOs and DEOs to collaborate with religious and cultural leaders in organizing sensitization campaigns in churches, Mosques, schools and in ceremonies like weddings burials to sensitize the population about the relevance of SMC. Individual factors that significantly impacted the uptake of SMC in the study population included having awareness about SMC and the perception of SMC. However, distance to health facilities had no influence on SMC uptake. Among those who reported to have undertaken SMC, the greater number were aware of SMC. This may be due to an increase in educational campaigns about HIV prevention strategies in the Kaberamaido district and from the right sources as the majority of the respondents (41.1%) reported having obtained information about SMC programs from health workers/clinics, and radio talk shows among others. This means that with an increase in health awareness programs, the uptake of SMC in Kaberamaido community would be increased. The current findings were compared to the findings of a study that was carried out in Zimbabwe in which a good number of participants had knowledge of the benefits of SMC [28]; although not consistent with results of the study conducted in Nairobi among the Luo people of Kenya in which participants had less knowledge about male circumcision [29]-[36] this there explains also differences in the level if SMC uptake among different communities .Therefore, this calls for increased awareness about SMC as an HIV prevention strategy this is because it is believed that sufficient knowledge may facilitate positive attitude towards male circumcision. Whereas majority of the study participants had a very good opinion about SMC, greater number who reported to have been circumcised medically had a very poor opinion regarding SMC. A probable explanation to this finding is that it is possible for one to have a poor opinion of SMC, yet understand the benefits of undertaking SMC while those who have a good opinion of SMC may not have undertaken it for personal reasons. As observed in this study, a number of reasons for non-uptake of SMC were cited including the fear of pain, fear of delayed wound healing ear of delayed wound healing, wife/girlfriend preference for uncircumcised penis, fear of going against traditional beliefs, the fright that SMC would reduce sexual pleasure, as well as the fear of costs that may be involved. This corresponded with studies which highlighted the fear of pain, loss of sexual desire, and bleeding, additional costs of undertaking the procedure and possible cultural tradition as some of the barriers to male circumcision acceptability [30]; [8]; [15]; [31]; [28]. This indicates the increased need for awareness about the procedure and benefits of SMC by Local district authorities including LCV Chairmen, District Health Officer and DEO of Kaberamaido district should collaborate with other relevant stakeholders, village Health teams (VHTs) to further increase awareness on safe male circumcision thus increasing its uptake among the male. Also, health care professionals performing SMC need to have good pre and post counseling, to make the information on male circumcision and other HIV prevention methods available to increase knowledge and benefits of male circumcision in preventing HIV acquisition and transmission also by utilizing medically circumcised men in promoting uptake among individuals in their social networks this strategy there for will bring an increase in the uptake of voluntary medical male circumcision among male clients between 15-49 years attending kaberamaido District Hospital was 41.4%. The Socio-demographic factors that were significantly associated with the uptake of SMC among males aged 15-49 years attending kaberamaido district Hospital were age, and marital status, level of education, peers significantly influenced uptake of SMC.

The benefits of safe male circumcision were hygiene, reducing STI/ HIV transmission [37]-[41].

RECOMMENDATIONS

Local district authorities including LCV Chairmen, DHO and the DEO of kaberamaido district should collaborate with other relevant stakeholders HCWs, and village Health teams to increase awareness through various educational programs which in the long run will further enhance attitude and probably uptake of SMC.

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