**FACTORS AFFECTING THE UPTAKE OF VOLUNTARY MEDICAL MALE CIRCUMCISION AMONG YOUTHS AGED 19-32 YEARS IN KISUMU NORTH**

**BY**

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**H121/0775/2016**

**A RESEARCH PROPOSAL SUBMITTED IN PARTIAL FULFILMENT FOR THE AWARD OF DIPLOMA IN COMMUNITY HEALTH AND DEVELOPMENT**

# Declaration

This research proposal is my original work and has not been presented to any university for the award of any diploma or any other award

Signature……………………………………………..Date……………………………………..

WENDY ATIENO OLUOKO

H121/0775/2016

The project has been submitted for review under my approval as the university supervisor

Signature…………………………………………Date………………………………..

DR.ERICK OGOLA

# 

# DEDICATION

I dedicate this work to my parents and siblings, for their love and support during the period of study.

# Acknowledgement

I am thankful to the almighty God for enabling me to accomplish this work, may all the glory, honour and blessing be unto him.

My special thanks go to my supervisor Dr. Erick Ogola for his support, advice and overall supervision.

Special mention goes to madam Veronica Knight for her assistance and guidance during the course of designing and selecting secondary data. Her pieces of advice and guidance enabled me to remain on course even though the work was so taxing.

To my parents, siblings. I owe you a lot due to you full support and utmost support and endurance to me during the crucial moment in my study pursuit.

To you all God bless you

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# LIST OF ACRONYMS

WHO World Health Organization

UNAIDS Joint United Nation Programme on AIDS

VMMC Voluntary Medical Male Circumcision

MMC Medical Male Circumcision

MC Male Circumcision

SSA Sub-Saharan Africa

VMC Voluntary Male Circumcision

NACC National AIDS control Council

CDC Centre for Disease Control

CHW Community Health Worker

HPV Human Papilloma Virus

ART Antireviral Therapy

HPTN HIV Prevention Trial Nations

JPIEGO Johns Hopkins Program for international education on Gynaecology and

Obstetrics

# ABSTRACT

Randomized controlled trials have demonstrated that medical male circumcision offers up to 60% efficacy in the prevention of heterosexual HIV transmission. The luo community of Kenya do not practise Traditional male circumcision and have been reporting the highest HIV prevalence rates in Kenya despite the concerted efforts to reach as many eligible male as possible, the response has been below expectation particularly adults. The study seeks to determine cultural factors affecting the uptake of voluntary medical male circumcision (VMMC) and people’s perception of VMMC on the spread of HIV/AIDS among youths age 19-32 years of Kisumu North of Luo Nyanza.

The study method will be a cross-sectional study which will target youths age 19-32 years, health providers and the care givers who will assist the researcher on getting the information since some of the youths will not fully open up to give the appropriate answers. Youths will be interviewed using open ended and closed ended question. The study will be done in Kisumu North in Luo Nyanza

# 1.0. CHAPTER 1: INTRODUCTION

## **1.1. Background**

Voluntary medical male circumcision VMMC mainly came up as a strategy to control the rapid spread of HIV and AIDS which had become a global pandemic .By 1997 an estimated 3.4 million people were already infected (WHO/UNAIDS/UNICEF/2011).There are interventions that had been put in place to control the spread of disease .in 2007 WHO and UNAIDS recommended that VMMC be applied alongside other HIV prevention strategies such as HIV testing and counselling ;provision and correct use of male and female condoms ;screening and testing for STIs and provision antiretral treatment for people living with HIV .The VMMC recommendation was based on three randomized trials undertaken from 2005 to 2007 ,and Rakai District ,Uganda (2007)which showed that medical male circumcision (MMC) lowers the risk of HIV transmission in heterosexual relationship by approximately 60% (Avert B el al,2005,Brailey Rc el al 2007,Gray R et al 2007 and Weiss HA.et-al 2010 WHO/UNAIDS 2011/UNAIDS 2012) The other reason was that in Africa trials voluntary male circumcision was found to effectively reduce new HIV infections because the transmission was mainly through heterosexual relationship unlike the American case and other western countries where HIV transmission was mainly through men having sex with men (MSM).however Buchbinder el al 2005 conducted a study among 3257MSM in sex US cities and his finding were that circumcised men were almost likely to transmit disease than circumcised men

## **1.2. Problem of the statement**

The prevalence uptake of VMMC in Kisumu is approximately 48.5% in Kisumu, (Avert B, taljaard D,lagarde E,et al,ANRS 1265trial.Plos med 2005;2 e298).despite the known medical benefits of circumcision in sub Saharan Africa (SSA).the uptake of VMMC is low among youths aged 19-32 years of age by 22% in sub Saharan Africa especially in Luo Nyanza who do not culturally practise male circumcision .however limited research studies have investigated the factors responsible for the low uptake of VMC

## **1.3. General objectives**

To investigate the factors responsible for the low uptake of VMMC

## **1.4 Specific objectives**

1. To determine the perception and attitude s of men towards VMMC

2. To investigate the cultural factors contributing to the uptake of VMMC

## **1.5 Research questions**

1. How is perception and attitudes of men towards VMMC?

2. How do cultural factors affect the uptake of VMMC?

## **1.6. Significance of study**

To inform on the factors hindering the uptake of VMMC which will assist in improving the uptake of the services?

## **1.7** Justification **of the study**

This study seeks to identify and understand the specific factors that affect the willingness of youths who are 19-32 years and to embrace VMMC .since this target group is the sexually active age and forms a bigger target group for VMMC ,as an increase of the number taking the service are, will result in a reduction of new HIV infections .The study will bring more insight into the barriers that hinder uptake of the service among men 19 -32years in Kisumu North ,Nyanza region .Thus there is a need to explore the barriers to uptake among this age group has informed the decision to undertake the research ,study findings will help policy makers put in place more measures that will enhance service uptake .it also plays an important role in informing Non-governmental organization and Public health facilities providing VMMC services now on how to improve and expand the VMMC services to make them more accessible to the youths who form a big bulk of the target group .this is because despite the effort that are already in place and besides cost effectiveness and analysis that have been done ,their uptake is low and the national targets and benefits out of VMMC may not be realized as projected by 2015(UNAIDS,2007)

# 2.0 CHAPTER 2: LITERATURE REVIEW

This is a discussion of literature on VMMC as a strategy for the prevention of HIV transmission.

## **2.1 Background of male circumcision**

Different countries have registered low uptake of VMMC services among the target population some regions have registered much lower uptake levels than others especially among youths aged 19-32 years old.

In 2007 it was estimated that that 33.2 million people were living with human immunodeficiency virus (HIV) and that there were 2.5 million new infections during the year. Discovering ways to prevent the transmission of HIV is of primary concern to healthcare authorities worldwide (UNAIDS 2007).

UNAIDS Kenya country page, www.unaids.org/en/geographical+area/by+country Kenya asp downloaded on March 22, 2012 providers that Kenya has more than one million people estimated to be living with HIV/AIDS (1.2 million as of end of 2003). Kenya’s HIV/AIDS prevalence rate (the percent of people living with the disease) is just below that of the Sub-Saharan –African region overall (6.7compared to 7.5)

Recent data indicates that the country’s HIV prevalence rate may be on the decline in some areas (ef UNAIDS, African fact sheet’ ’March 2005).However, the HIV epidemic poses significant challenges to the low income country. The government of Kenya first established a national AIDS control (NACC) in 1999 and has a national strategic framework for 2005-2010.

Between 1983 and 1985 26 cases of AIDS were reported in Kenya .sex workers were the first group affected .a study from 1985 reported that an HIV prevalence of 59% among youths. Towards the end of 1986 there was an average of four new cases of AIDS cases being reported to the World Health Organization (WHO).each month .this total 286 cases by beginning of 1987 38 of which had been fatal

By 1987 HIV appeared to be spreading more rapidly among the population –an estimated 1%to2% of youths were infected with the virus

However with high HIV infection prevalence in the priority nations VMMC has simply saved many lives over the years. And of course in combinations with the other preventive package.

## **2.2. People’s perception and attitude of VMMC on the spread of HIV**

**A case of the Luo community**

Male circumcision is the surgical removal of part of the foreskin of the male reproductive organ (penis). It has been practised by mankind from early days and it is not clear when and how it started. The early Egyptian mummies (2300BC) bear the marks of circumcision, and wall painting in Egypt show that it was customary several thousand years still. Many reasons for this practise have been ranging from obeying the law of God to promoting public health (Bhimji 2000). Male circumcision has been believed to be treatment for a number of health problems/disorders. According to winkle (2000) ,the American medical establishment has promoted male circumcision as a preventive measure for an astonishing array of pathologies ,ranging from masturbatory insanity ,moral laxity ,aesthetic and hygiene to headache tuberculosis ,rheumatism ,hydrocephalus ,epilepsy ,paralysis , near-sightedness ,rectal prolapse urinary tract infection and cancer of the penis, cancer of the cervix ,syphilis and AIDS. On medical grounds, male circumcision can be recommended if one has injury or anomalies of the foreskin and if one continuous to suffer from infections.

The age to circumcise varies across societies and across individuals within societies. In most developed countries and in communities like Islam and some minority Christian sector, circumcision is normally done within days or weeks after birth while in many African tribal groups men are circumcise usually in late child hood or early adolescence. In some parts of Africa and in the world, male circumcision is observed as a rite of passage into manhood. Adolescent boys undergo an initiation ceremony where they are circumcised and taught the basic of married life. Up until this stage, they will not be expected to be sexual active hence the need to initiate them.

According to WHO Bulletin, 84%out of 2006, around 20% globally and 35% in developing countries are circumcised for religious, cultural, medical and other reasons. In Africa the practise varies from country to country. Researchers have noted significant variation in HIV prevalence in certain Africa and Asian countries that seems to be associated with levels of male circumcision in the community (LA Porte and Aggleton, 1998; Leclerc madlala, 2004). In areas where circumcision is common, HIV prevalence tends to be lower, conversely, higher areas of HIV prevalence overlapped with region where male circumcision is not commonly practised (NIAD/NH 2006).

Countries in west Africa ,where male circumcision is common ,have HIV prevalence levels well below those of countries in eastern and southern Africa for example according to UNAIDS (2007)in 2005 ,Benin had a HIV prevalence of 1.8% while Cameroon had 5.4% in countries of southern and eastern Africa with the highest HIV prevalence ,male circumcision rates are generally under 20%.most countries in southern Africa have low levels of male circumcision and coincidentally have the highest burden of HIV/AIDS in the world

Male circumcision is conducted at varying cost from country and from institution to institution depending on where the procedure is conducted and who performs it and other various factors. According to Bailey et al (2005), data from Nyanza, Kenya suggest that circumcision can be done in medical facilities for about US$25 per procedure. In South Africa on the orange free study, each circumcision was conducted for about US$45(jewkes, 2006, Hang rove and mahatma, 2005). According to population service international (2008), in Zimbabwe the cost of male circumcision is between US$150 according to information gathered from some practitioners.

Striking is that, the acceptability of male circumcision is affected by socio-cultural backgrounds. Some cultures put a lot of emphasis on it, while others are silent about it. Jews are one of the tribes that have been practising male circumcision since long back and the procedure is acceptable among them.in their culture, practising male circumcision is regarded as obeying God. The basis of the practise is found in genesis (17 verses 11) where Abraham was instructed to circumcise every male new born from that day onwards and never to stop the practise as a covenant with God

In certain cultures genital cutting is an integral part of initiation practises from boyhood to socially recognized manhood .in many African societies initiation affirms age and gender as two major principles of social organization. Local understanding often links MC with improved hygiene and a lower risk of HIV and STIs and this has culminated in a growing preference for VMMC in many African countries. VMMC is unique in that it targets men exclusively to reduce the risk of sexually transmitted HIV. Successfully VMMC programs will use existing cultural platforms and leverage the support of relevant tradition authorities to promote male norms that encourage sexual health and risk reduction.

In response to research findings, the government of Kenya developed a national strategy to scale up VMMC through a phased approach. Between 2009 and 2013, Kenya aimed at to deliver the comprehensive package of VMMC services to 860000 boys and men aged (19-32) years (NASCOP, 2010a). By mid-2010, Nairobi province and begun performing male circumcision, and preparatory efforts were underway in western province. According to Kenya demographic and health survey (2003), the coastal province (at 97.2%) and North Eastern province ranked lowest at 17% and Kisii communities rates at 99%

In Nyanza province therefore the where male circumcision are substantially lower than the national average, Kenya performed more than 230000 VMMC procedure from 2008 to December 2010,that is more than 60% of previously uncircumcised adult males (NACC and NASCOP2012). Delivery of this program also offers an opportunity to deliver and reinforce sexual reduction risks reduction messages ,screen and treat for STIs, provide free condoms as well as offer male sexual and reproductive health services (NASCOP,2010a). All this is towards achieving the national and global HIV goal of ensuring universal access to HIV prevention and treatment, care and support as well as national goal of a healthy vibrant and productive population 2030

## **2.3 Perception on adverse effects of circumcision**

Majority of both respondents who have undergone and those who have not undergone VMMC (64.6%) think that VMMC has adverse effects z-test (p-value=.996) indicates that knowledge of VMMC adverse effects absence was similar among circumcised and uncircumcised respondents. Poor wound healing and wound complications are the most cited (38.2%) adverse effects of VMMC.

## **2.4 Cultural factors affecting uptake of VMMC**

**Cost and accessibility**

Both components of data identified access to VMMC and cost as a major hindrance to uptake of VMMC .many participants stated that the cost in form of either transport to access free VMMC services or payment for the procedure in private health facilities was beyond their means.

## **2.5 Cultural influence**

Culture is another contributing factor to the lower uptake of VMMC by 19%.

In Sub Saharan Africa and other traditional communities of the world, MC has been practised for reasons other than religion in any one country prevalence of MC can vary dramatically by ethnicity (Merck 1997). In Kenya for example although 84%of all men are circumcised the prevalence is much lower among the Luo and the Turkana (14% and 40% respectively). No history of traditional male circumcision has ever been documented to exist though men had their six lower teeth removed (UNAIDS, 2007). In many culture the practise is a rite of passage to manhood, though sometimes is a sign of endurance and bravery. More often than not it is associated with masculinity, self-identity spirituality and social cohesion as boys of the same age group get circumcised at the same time. The Luo’s in Kenya have reported that they are continuously discriminated against because of their circumcision status WHO (UNAIDS, 2010)

## **2.6 Fear of pain and bleeding**

Some participants indicated that fear of complications associated with VMMC kept away some men from undergoing some procedure. Indicating that it was an operation that involves cutting of the foreskin. Fear of pain associated with undergoing circumcision was a concern stated quite often (60%) while 31% identified bleeding as another factor preventing men from accessing VMMC services as some believed could lead to death.

Fear for pain was attributed for injection given before the procedure cutting off the foreskin and post-operative healing

## **2.7 Lack of secrecy and female providers**

The study found the hospital environment to be a source of humiliation because of lack of privacy as well as the presence of female providers. Most participants pointed out that lack of special rooms to keep circumcised men out of sight of relatives and other villagers who visit the hospital was perceived shameful. Similarly many older participants expressed that being attended to by female health providers was embarrassing, particularly considering the fact that one was not sick.

Major reasons given were that some youths would erect as a female provider prepares them for circumcision. Male circumcision was valued as a sensitive issue carried out in a male only setting in many traditionally circumcising communities. This finding concurs with others which found that many youths were not comfortable with women clinicians being part of the circumcising team for fear of being exposed as youths who had not been circumcised and the potential of sexual arousal

## **2.8 Socio-economic status**

It has been shown that socio economic factors influence the uptake of male circumcision especially in the countries with more recent uptake of the practise ,especially the English speaking industrialized nations (UNAIDS ,2007)between the 19th and 20th century ,MC was mostly practised among the rich about 74%and 57% in private and non-private health facility by the year 1953. This has recently been seen among the poor immigrants (UNAIDS 2007).

In the Sub Saharan Africa, MC is not consistent with socio economic status with some countries such as Tanzania and Ethiopia showing consistency with this association whereas Lesotho is contradictory. (UNAIDS 2007)

## **2.9 Level of education.**

Lack of awareness of the importance of circumcision as an intervention strategy against HIV transmission has been one of the major challenge to its adoption in many African communities. A Christian tribal chief in Lusaka, Zambia decided to become a campaigner of circumcision after reading about the medical benefits of circumcision such as hygiene and reduction of HIV infection rates.

He supported his decision with biblical practise of the Old Testament. Tanzania launched her VMMC programme in areas where they don’t practise as part of their religion or as a rite of passage during infancy puberty or adolescence stages.

### **2.9.0 Knowledge that circumcision helps prevent HIV burden in the community.**

In the year 2012, UNAIDS estimated that a total of 35.3 million people were living with HIV globally. It shows that more people are receiving anti-retroviral therapy. New HIV infection declined from 3.4million in 2001 to 2.3million. The total number of HIV/AIDS related deaths was 1.6 million. The number of people receiving ARVs was 9.7million among the low and middle income countries (WHO/UNICEF/UNAIDS 2003).

According to 2013 UNICEF statistics, South Africa for example has one of the highest HIV prevalence in the world with heterosexual transmission of virus. VMMC is therefore one of the main strategies adopted in reducing HIV transmission in the sub Saharan Africa (Scott, Weiss and viljoen 2005)

### **2.9.1 Perceived health and sexual benefits beyond HIV**

Different surveys have shown that among the English speaking industrialized nations and traditionally non-circumcising SSA, MC is associated with improved penile hygiene and reduced risk for infection. Similar studies in the USA, Ghana, Kenya ,Botswana ,Zimbabwe ,Zambia and republic of Korea confirm the same association as the driving force behind seeking MC(UNAIDS,2007). Another study in Nyanza showed that 55%of the uncircumcised men believed that women enjoyed sex more with circumcised men and this association is a stronger predictor for VMMC than other determinants. Similar studies that yielded similar observations have been conducted in Uganda (Wilken et al, 2010), North West Tanzania, Westonaria, South Africa and southern Nigeria (UNAIDS, 2007)

### **2.9.2 The direct and indirect benefits of VMMC**

Voluntary medical male circumcision (VMMC) is indirectly beneficial for the women, said Cindra fever. If HIV rate is lowered in the community then women also benefit from VMMC indirectly, because it only directly protects transmission from female to male partner it doesn’t protect against HIV transmission from male to female partner(WHO/UNAIDS,2012)

Voluntary medical male circumcision also reduces transmission of human papilloma virus (HPV) and herpes. If a man is circumcised he is less likely to transmit HPV and herpes to the woman.HPV is the biological agent causing penile cancer in men and cervical cancer in women. Herpes and HPV can also facilitate HIV infection.it is a great benefit to reduce this risks of HIV,HPV and herpes by VMMC(JPIEGO,2009)VMMC has been found to reduce the risks of herpes simplex virus-2,human papilloma virus in men and their female partners. And is associated with a reduction in the risk of genital cancer in both men and women. (Njehumeli et al, 2011). A man is expected to abstain from sex for six weeks after circumcision. This allows for full healing to occur thereby reducing further risks of infection during this period (Jpiego, 2009) on another study on ecological analysis of religion male circumcision and infection disease in 118 developing countries MC was also strongly associated with lower HIV prevalence among countries with primarily heterosexual HIV transmission but not among countries with primarily homosexual or injection drug use HIV transmission. These findings strengthen the reported biological link between MC and some sexually transmitted infections disease including HIV and cervical cancer (Drain halperin Hughes, Klaussner and bailey 2006).

Another major turning point in HIV prevention research was when HPTN 052 study results were announced in the year 2011. The HPTN 052 study found that early initiation of antiviral therapy (ART) substantially reduced the risk of HIV transmission within serodicordant couples (Boileym, desar k gumel 2012.

**3.1 CHAPTER 3: RESEARCH METHODOLOGY**

This chapter discusses the research methods that would be employed in this research. Areas to be discussed in this chapter include the research design, study population and determination of the sample size and sampling procedures. The research also looks at the collection, presentation of data and it concludes by discussing data.

## **3.2. Study area**

The study will be conducted in Kisumu North Sub County an administrative division of Kisumu County. The area is divided into a number of villages, including usare,korando B, Rota.

Rota having a warm climate and temperature varying from 640 F to 880F and is rarely below 610 F or above 930 F

## **3.3. Research design**

Researcher will use a cross-sectional study to conduct the research at Lumumba hospital among youths on the low uptake of VMMC.

## **3.4. Study population**

The target group for the study will be health providers and the care givers who will assist the researcher on getting the information on the uptake of VMMC since they are the immediate people who get the information from the community members.

Unit of analysis will be the health providers and care givers, because the aim of the study is to capture the low uptake of VMMC according individual youth.

Caregivers will be involved since they have the adequate information on the low uptake of VMMC while participants may not be able to give adequate information some may go as far as giving inaccurate information, therefore generalization of the results from such information may not be as precise but rather relative, equally in some instances participants may disclose only information they are confortable disclosing.

## 

## **3.5. Sampling procedure**

Data will be collected using simple random techniques to administer the questionnaire the method is designed that the individuals will be chosen randomly. This will be done by developing a list of all possible participants that can be surveyed and then selecting a sub-group that represents a whole.

## **3.6 Data collection instrument**

Self-administered questionnaire will be used to collect information from study participants. According to leedy and ormand (2005) a questionnaire is an instrument with open or closed questions or statement, to which a respondent must react.it, will be used as a primary source of data collection. Each questionnaire will be accompanied by a covering letter explaining then purpose of study to the prospective respondents. General instruction on completing the questionnaire and importance of completing the questions will be included. The covering letter will explain why it is important that that the potential respondent personally completes the questionnaire by providing accurate and objective response to all questions apart from establishing a rapport, it also aims at gathering as much information as possible on their demographic characteristics, their knowledge and perceptions of male circumcision and their acceptability of the procedure. They will be asked to state how they would want circumcision to be performed, female youths will also be asked if it matters to them to have a circumcised partner or not, weather circumcision would be of any importance to them and whether they would accept to circumcise their male children.

## **3.7 DATA COLLECTION PROCEDURE**

Questionnaire will be used to collect data per scheduled respondents. Questions will be both open and closed ended and given to caregivers and health providers allowing them to fill.

## **3.8 ETHICAL CONSIDERATIONS**

The researcher will extensively explain the purpose and objectives of the study to all participants and gives them opportunity to ask questions on issues that will need clarification.

Verbal informed consent will be sought from all the study subjects before allowing their participants into the study, this is because some participants might misinterpret the information, some may not know how to read and some may not be able to write. The study subjects will be assured that the study is anonymous and that the information they supply will be treated with utmost confidentiality and is only going to be used for the purpose of the study as explained. Access to the study participant’s information will be limited to people with something to do with the study and no one else, and is limited to the institution sponsoring the study only for the purpose of exams administration by institution in question.

However, the participants will be notified that the processed information (study reports) would be made available to anyone interested in the study with the direct consent of the researcher

Participants will be assured that their names would not appear anywhere in the study instruments .participants will be informed that they can withdraw from the study at any time without providing reasons and without any disadvantages

## **3.9 DATA ANALYSIS PROCEDURE**

All questionnaires will be arranged and other records for easier processing and analysis, questions will be numbered and arranged in order and the circumcised groups will be compared to uncircumcised group to see their characteristics.s

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## **Appendixes**

**Appendix 1: Consent form**

I am a student at Jaramogi Oginga Odinga University of Science and Technology pursuing course in community health and development. As part of my academic requirement for the award of diploma, I am required to carry out a field study leading to write a research paper. To this end, I hereby submit a humble request to you to help me achieve my study objectives by way of voluntarily filling this questionnaire. Each response will be treated with utmost confidentiality and will only be used for the academic purposes mentioned. Your support is hereby appreciated in advance

**Appendix 2: RESEARCH QUESTIONS FOR INDIVIDUAL**

**INSTRUCTIONS:**

1. Do not write your name nor contact in this question paper
2. Fill in the write answers to each questions by either ticking in the box or writing your response as required.
3. Answer all questions to facilitate accurate data analysis and interpretation.

Section A: Bio data

Age of respondent………………………………………………………………………

Location…………………………………………………………………………………

Sub location…………………………………………………………………………….

Religion…………………………………………………………………………………..

Level of education………………………………………………………………………

Age when circumcised………………………………………………………………….

Marital status………………………………………………………………………….

**Section B: FACTORS AFFECTING THE UPTAKE OF VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC)**

Put a tick in the appropriate box or fill the spaces provided appropriately and correctly

1. How many children do you have?
2. None
3. 1-2
4. 3-5
5. More than 5
6. What is you religion?
7. Catholic
8. Protestant
9. Muslim

Others specify…………………………………..

1. What is your level of education
2. None
3. Primary
4. Secondary
5. College/tertiary
6. If married, what is your spouse level of education
7. None
8. Primary
9. Secondary
10. college/tertiary
11. What is your occupation?
12. Unemployed
13. Self-employment
14. Employed (salaried)

Others specify………………………………………………………………

1. What is the occupation of your spouse?
2. Unemployed
3. Self-employment
4. Employed (salaried)

Others specify………………………………………………………

**PART 3: KNOWLEDGE, ATTITUDE, BELIEFS AND WILLINGNESS TO CIRCUMCIZE**

**Knowledge and practise of circumcision**

1. Have you had about voluntary medical male circumcision (VMMC)?

Yes

No

1. Does it have any benefits?

Yes

No

**If yes, tick which of the following you believe are the potential benefits**

Offers up-to 100% protection from HIV for men

Offers up-to 60% protection from HIV for men

Improves penile hygiene

**Does VMMC have adverse effects on the circumcised person?**

Yes

No

If yes, state briefly adverse effects

……………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………..

**Have you undergone VMMC?**

Yes

No

1. **If yes,** **1)** how old were you circumcised?

More than 19 years old

Less than 19 years old

1. What motivated you to circumcise, state briefly

……………………………………………………………………………………………….

……………………………………………………………………………………………………..

1. Would you allow your son to circumcise?

Yes

No

Explain your response

…………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………….

**Part 4: men’s understanding of the VMMC procedure/service delivery**

Briefly explain what happens;

1. Before one gets circumcised…………………………………………………………………….

………………………………………………………………………………………………………………….

1. During circumcision ……………………………………………………………………………………………………………………….
2. After circumcision………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Why in your opinion do many men hesitate to circumcise

State briefly…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

Should VMMC service be offered by (tick appropriately);

NGO’s

Why………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..

The government

Why…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

THANK YOU AND GOD BLESS YOU

**Appendix 3 Work plan**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | October 2017 | November 2017 | December 2017 | January 2018 | FEB March 2018 | April 2018 |
| Topic section |  |  |  |  |  |  |
| Proposal writing |  |  |  |  |  |  |
| Proposal presentation |  |  |  |  |  |  |
| Data collection |  |  |  |  |  |  |
| Project writing, oral presentation and final project report |  |  |  |  |  |  |

**Appendix 4:**  **Budgeting**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| NO | ITEM | QUANTITY | NO.OF PEOPLE | COST EACH (KSH) | TOTAL COST(KSH) |
| 1  2  3  4  5  6  7  8  9  10  11 | Research assistant training  Secretary  Printing papers  Printer  Ball pens  Hb pencils  Rubber  Transport  Photocopying  Binding  Lunch  **Total** | 3 days  5 months  3 reams  1  10  10  5  60 days  1000 pages  2 copies  60 days | 3  1  2 | 1000  5000  500  24000  20  15  2o  200  2  100  200 | 9000  15000  1500  24000  200  150  100  24000  2000  200  12000  **88,150** |