Situation Analysis to Determine the Acceptability and Feasibility of Male Circumcision Promotion in Uganda

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### ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>FGD</td>
<td>Focus group discussion</td>
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<tr>
<td>FHI</td>
<td>Family Health International</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>HCIV</td>
<td>Health Centre IV</td>
</tr>
<tr>
<td>MC</td>
<td>Male circumcision</td>
</tr>
<tr>
<td>MMC</td>
<td>Medical male circumcision</td>
</tr>
<tr>
<td>MUSPH</td>
<td>Makerere University School of Public Health</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>PSU</td>
<td>Primary sampling unit</td>
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<tr>
<td>SSU</td>
<td>Secondary sampling unit</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>SWOT</td>
<td>Strengths, weaknesses, opportunities, threats</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>The Joint United Nations Program on HIV/AIDS</td>
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<td>WHO</td>
<td>World Health Organization</td>
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1.0 INTRODUCTION

Results from three randomised trials in South Africa, Kenya, and Uganda provide evidence that male circumcision reduces the sexual transmission of HIV from women to men by at least 50%. Based on this compelling data, the WHO and UNAIDS have issued a set of recommendations for the use of male circumcision (MC) in HIV prevention efforts (WHO/UNAIDS, 2007). These recommendations are particularly applicable to Uganda, where the prevalence of heterosexually transmitted HIV infection is high, and prevalence of MC is low.

The WHO guidelines state that because MC does not provide complete protection against HIV, it should be considered only as one part of a comprehensive package to prevent HIV. MMC should be encouraged along with the delay of onset of sex, abstinence, mutual faithfulness, reduction in the number of sexual partners, consistent condom use, HIV counselling and testing, and treatment of other sexually transmitted infections. Furthermore, the guidelines acknowledge that there are potentially harmful effects of MMC promotion, such as men and women who receive false information that MC is some type of ‘magic bullet,’ or that MC provides complete protection against HIV transmission. Therefore, local strategies need to be developed to communicate essential, factual information in a way that is culturally sensitive, ethically appropriate, and medically relevant.

Because of the necessity of safe, aseptic conditions for performing male circumcisions, it is also imperative to assess the capacity of health care facilities and traditional health care providers (where applicable) to support increased provision of MC services. Furthermore, in order to provide policy-makers with information on the (1) cultural acceptability and (2) medical feasibility of promoting MC as an additional strategy for reducing the spread of HIV, WHO developed a Male Circumcision Situation Analysis Toolkit (Schmid and Budge-Reid, draft 2007). The study described in this report was prepared according to the recommendations of the WHO Toolkit.

2.0 GOAL AND OBJECTIVES

The purpose of this study was to assess the current state of MC in Uganda in order to provide Ugandan decision makers with adequate information to decide whether to pursue the promotion of MMC as an additional HIV prevention strategy, and which approaches should be used for scale-up. Based on the interests, concerns, and information needs expressed at preliminary stakeholders’ meetings, the specific objectives of this assessment were to describe:

- The degree of support for MC among key political, ethnic, and religious leaders at national and local levels;
- The acceptability of MC among men and women, including in their roles as parents;
• The themes and issues that should be taken into account in developing messages that will be most appropriate and acceptable for promoting MC as an HIV prevention strategy;
• Mechanisms for integrating MC into other health programs; and
• The availability of required human resources and infrastructure at hospitals and health centres for providing high quality MC services.

3.0 METHODS

3.1 Overview
Data collection methodologies and tools such as discussion guides, SWOT (strengths, weaknesses, opportunities, threats) analysis outlines, and survey instruments were provided in the WHO Male Circumcision Situation Analysis Toolkit and were adapted for use in this assessment. Following the WHO guidelines, the assessment included three activities at the national level: (1) a desk review; (2) a stakeholders’ meeting; and (3) informant interviews with key national-level leaders. Based on the WHO Toolkit recommendations, four activities at the district level also were carried out: (1) stakeholders’ workshops at the local level; (2) a household survey of men and women; (3) focus group discussions; and (4) a health facility service availability study.

In countries with populations of circumcised and uncircumcised men, the WHO Toolkit recommended conducting needs assessments in four districts: 1) the district with the largest population/capital city; 2) a large city in a non-MC area; 3) a rural district in a non-MC area that is near a district that practices MC; and 4) a non-MC area that is geographically distant from the second and third areas. Taking this into account as well as HIV prevalence rates, the districts of Kampala, Gulu, Kumi, and Rukungiri were chosen for the district-level situation analysis (see Table 1 for details):

Table 1: **Districts selected for the situation analysis, and the percentage circumcised and HIV-positive in each region**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Region</th>
<th>District</th>
<th>% circumcised</th>
<th>% HIV+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Capital</td>
<td>Kampala</td>
<td>Kampala</td>
<td>37.9</td>
<td>4.5</td>
</tr>
<tr>
<td>2 Large city, non-circumcision area</td>
<td>North Central</td>
<td>Gulu</td>
<td>2.4</td>
<td>7.1</td>
</tr>
<tr>
<td>3 Rural, non-circumcision area, but near circumcising area</td>
<td>Eastern</td>
<td>Kumi</td>
<td>4.9</td>
<td>3.2</td>
</tr>
<tr>
<td>4 Non-circumcision area, distant from numbers 2 and 3</td>
<td>Southwest</td>
<td>Rukungiri</td>
<td>7.6</td>
<td>4.4</td>
</tr>
</tbody>
</table>

Source: Uganda HIV/AIDS Sero-behavioural Survey 2004-2005, conducted by the Uganda Ministry of Health

More detailed information about each district is provided in Appendix 1.

3.2 National Level Data
(1) Desk review: The desk review was concluded in August 2007. The purpose was to document current knowledge about the prevalence and determinants of MC in Uganda, acceptability of MC, and provision of MC services. Sources of data for the desk review
included the Uganda HIV/AIDS Sero-behavioural Survey 2004-2005, conducted by the Uganda Ministry of Health (Table 1), published manuscripts and research reports, and public statements and media reports.

(2) Stakeholders’ meeting: The national stakeholders meeting was held in Kampala on Dec. 11, 2007, and included 31 representatives from the Ministry of Health (MOH), development partners, representatives from cultural and faith-based organizations, hospital administrators and clinicians, and selected NGOs. The purpose of the meeting was to inform the stakeholders of the scientific results on MC, encourage their participation in planning the situation analysis, elicit information, and increase their ownership in the project. During the one-day meeting, stakeholders were provided with an overview of MC as an HIV prevention method, and with recommendations from the WHO/UNAIDS. This was followed by a Q&A session, during which meeting attendees participated in a SWOT analysis about the MC project, then discussed the situation analysis.

(3) Key informant interviews: Individual interviews were conducted in December 2007 and January 2008 with 13 key informants. Participants were purposively drawn from organizations including the Ministry of Health, President’s Office, the Ugandan AIDS Commission, the Uganda Muslim Supreme Council, Parliamentary Committee on HIV/AIDS, Uganda People’s Defense Forces, THETA, and two national newspapers (New Vision and Monitor). The semi-structured interview guide that was used included 12 questions designed to obtain ideas and concerns of key stakeholders about the acceptability and feasibility of MMC in Uganda.

3.3 District Level Data

(1) District-level workshops: Meetings at the district level were conducted in February 2008 and involved a total of 91 participants. Participants were selected from the district political and civic leadership, health facility representatives, religious groups, mass media, and NGOs that provide health care services. The objectives of the workshops were to sensitize district leaders to MMC, brief district leaders on the planned situation analysis for MC, and solicit the views of district leaders on MMC. The activities undertaken during the district workshops with stakeholders were similar to the stakeholders’ national meeting activities.

(2) Household survey of men and women: A total of 1,675 men and women were interviewed in March and April 2008. The purpose of the survey was to explore the knowledge and personal preferences of men and women with regard to MC, both for themselves and their male children. The interviewer-administered survey instrument was brief, focused, and translated into the local language.

To obtain a sample that was representative of the population of each district, separate, two-stage cluster sampling strategy was used in each of the four selected districts. The Primary Sampling Unit (PSU) was the 2001 population census enumeration areas and the Secondary Sampling Unit (SSU) was households. Thirty PSUs were randomly selected within each district, and 14 SSUs were randomly selected within each PSU for sampling.
(seven each for men and women). One participant from each selected household was eligible if they were at least 18 years old and a parent. Permission from the local council in each town or village was obtained prior to conducting the survey.

A total of 833 men and 842 women completed interviews. The mean age of respondents ranged between 31 and 39 years in the four districts (Table 2). The average number of children was between four and five. Most respondents were Catholic or Protestant, although one-quarter of Kampala district residents was Muslim. Most residents in Kampala district lived in the city, while most residents in Gulu, Kumi, and Rukungiri districts were rural.

Table 2: Demographic characteristics of household survey respondents (N=1675)

<table>
<thead>
<tr>
<th></th>
<th>Kampala District (N=418)</th>
<th>Gulu District (N=421)</th>
<th>Kumi District (N=416)</th>
<th>Rukungiri District (N=420)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (range)</td>
<td>31 (16-67)</td>
<td>35 (17-77)</td>
<td>36 (19-71)</td>
<td>39 (18-80)</td>
</tr>
<tr>
<td>Mean number of sons (range)</td>
<td>2.2 (1-20)</td>
<td>2.5 (1-8)</td>
<td>2.9 (1-13)</td>
<td>2.5 (1-15)</td>
</tr>
<tr>
<td>Mean number of daughters (range)</td>
<td>2.2 (1-15)</td>
<td>2.5 (1-9)</td>
<td>2.7 (1-8)</td>
<td>2.5 (1-11)</td>
</tr>
<tr>
<td>Religion (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Catholic</td>
<td>34</td>
<td>76</td>
<td>43</td>
<td>37</td>
</tr>
<tr>
<td>Protestant</td>
<td>32</td>
<td>18</td>
<td>49</td>
<td>54</td>
</tr>
<tr>
<td>Muslim</td>
<td>25</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>3</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Residence (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>--</td>
<td>70</td>
<td>96</td>
<td>99</td>
</tr>
<tr>
<td>Urban</td>
<td>100</td>
<td>30</td>
<td>4</td>
<td>1</td>
</tr>
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</table>

EPI DATA 3.1, STATA V10, and SAS V9.1 were used for data entry and verification, cleaning, and analysis. Analyses followed a pre-specified plan. It should be noted that no data detailing non-response rates to the household survey are available and, in a few cases, the selected primary or secondary sampling units were unreachable despite diligent efforts. Thus, these units were replaced with new sampling units. Also, in some instances, skip patterns prescribed in the survey were not followed during survey administration. Such cases were programmatically corrected at the time of analysis. Detailed data reports are presented in Appendix 2.

(3) Focus groups: Focus group discussions (FGDs) were conducted with men and women in each of the four districts in March and April 2008. The purpose was to explore any socio-cultural or ethical barriers, including potential for stigma that may inhibit or facilitate the implementation of MC in Uganda. The interview guide focused on reasons why males are circumcised or not circumcised in the community, opinions about MC, perceptions of who is qualified to carry out MC, perceived risks related to MC, and feelings about one’s male children being circumcised.

FGD participants were recruited from households not selected for the household survey. Between 28 and 31 focus groups were conducted in each district (Table 3). Group size ranged from three to 18 participants, with an average of 10 participants per group, and the discussions lasted between 1.5 and 2.5 hours. FGDs were conducted in the local language, and interviews were transcribed and translated by the focus group moderator or
notetaker. Because circumcision was common in only one district (Kampala), the large majority of focus groups was conducted with uncircumcised men. In Kampala district, however, 12 of the 31 focus groups included a majority of circumcised men or women who had circumcised partners.

Table 3: **Focus Group Discussions (FGDs), by males and females, in four districts in Uganda**

<table>
<thead>
<tr>
<th>District</th>
<th>Male FGDs</th>
<th>Female FGDs</th>
</tr>
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<tbody>
<tr>
<td>Kampala</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Gulu</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>Kumi</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>Rukungiri</td>
<td>14</td>
<td>14</td>
</tr>
</tbody>
</table>

* A Although a total of 30 focus group discussions were held in Kumi, only 27 focus group transcripts were available for analysis.

B Although a total of 28 focus group discussions were held in Rukungiri, only 19 focus group transcripts were available for analysis.

The focus group transcripts were coded using Nudist N6 qualitative software (QSR International, Doncaster, Australia), a qualitative data analysis program that facilitates analysis of textual data. The coded transcripts were then analyzed using NVivo, another qualitative software program. An initial coding tree was developed that followed the structure of the discussion guide. Next, the codes were applied to each transcript by one of two research assistants. Inter-coder reliability checks were conducted to ensure consistency between coders. The coded transcripts were then imported into Nvivo for analysis. Using the study objectives as a guide, coding reports were generated and analyzed for key themes across focus groups. Finally, summary memos, including key quotes and frequency tables, were prepared for each of the focus group study objectives.

(4) Service availability study: Two main data collection activities were conducted to identify gaps in service delivery infrastructure, staffing, and commodity needs that will need to be addressed prior to the implementation of a large-scale MMC intervention. The service availability study included data collection from public and private health facilities and staff in each of the four districts. Staffs were surveyed to assess their current practices in MC, as well as their overall attitudes towards the practice.

Health Facility Survey: A total of 26 health facilities were surveyed, including 17 public or private hospitals, and nine HCIVs. In most cases, health facility data were provided by the Medical Superintendent or In-charge, although three Medical Officers and one Clinical Officer provided the information in four facilities.

Health Provider Survey: A total of 59 health practitioners were surveyed across the four focal districts, with Kampala providing the majority of data (42 interviews), followed by Rukungiri (10 interviews), Gulu (five interviews), and Kumi (two interviews). Two-thirds of all interviews were conducted with hospital staff, but staff from health centres IVs and IIIIs, a nursing home, and an AIDS information centre were also interviewed. A
range of government, faith-based, non-faith-based NGOs, and private for-profit facilities were represented.

The study was approved by the Scientific and Ethical Committee (Institutional Review Board) at the Makerere University School of Public Health. Local leaders of the four districts gave administrative clearance.

4.0 RESULTS

Results are presented to address the five objectives of the situation analysis.

Objective 1: To describe the degree of support for MC among key political, ethnic, and religious leaders at national and local levels. Information addressing this objective was informed by the stakeholders’ meetings and key informant interviews.

4.1 Stakeholder Support for MMC

All national and local leaders interviewed knew about the association between MMC and the reduced risk of HIV infection. Stakeholders mentioned other benefits of MC as well, including better hygiene, reduced risk of cancer of the penis and cervix, reduced STIs, and enhanced sexual performance and pleasure. Some excerpts from the interviews include:

- “[Male circumcision] is a scientific measure against HIV/AIDS, and has the benefits of reducing other health conditions like carcinoma of the penis.”
- “It is a good intervention, which plays an important role in general health, as it is seen to be associated with reduced prevalence of carcinoma of the penis, which usually starts from the prepuce and carcinoma cervix, and also in the prevention of HIV/AIDS.”
- “Male circumcision improves hygiene and guards against STDS; excretions (smegma) accommodate germs, which cause infection. Sexual intercourse is associated with cuts to the penile tip, which is soft and likely to have cuts, leading to sexually transmitted diseases. MC removes these secretions and the lining of the penis head hardens.”

Stakeholders emphasized the need to continue Uganda’s focus on the ‘ABC’ strategy for HIV prevention, and to incorporate MMC into the comprehensive HIV prevention package. Many recognized that even if the contribution to HIV reduction is small, it remains an important prevention strategy.

- “People may think that they are protected, and preventive HIV programs may fail; yet, MMC is not 100% protective. MMC should be part of the ABC approach and not an alternative to the ABC strategy.”
• “There is need to continue emphasising ABC strategy as the mainstay in the prevention against HIV/AIDS.”

• “The association [between MMC and prevention of HIV infection] is very clear, especially to us in the Ministry of Health. It is positive in the fight against HIV/AIDS. Even if it contributed 5% to the prevention, it is good.”

Some stakeholders still expressed doubt that increased circumcision will lead to lower HIV infection rates. This underscores the need for a good communication strategy and public education program to accompany the introduction and implementation of MMC. Among other points, the strategy should emphasize that MMC provides partial protection and will not be a stand alone intervention. Instead, it will be part and parcel of a comprehensive HIV prevention strategy. There should be messages to address risk compensation. Some excerpts from interviews include:

• “… Still, there is no consensus on MMC, even among the doctors. Why is there low prevalence of HIV in the West Nile region and lowest prevalence in Karamoja where they do not circumcise? Answer this! The prevalence of HIV among the Bagisu tribe, who circumcise as a culture, is no different from the Bakiga tribe, who do not. Actually, it is higher among the Bagisu. The Minister for the Presidency recently lost a brother to HIV/AIDS; yet, a Mugisu. MMC may work in a controlled study, but not in a real life situation.”

• “The president is extremely unconvinced, and even some doctors are not convinced, too. His Excellency the President is strongly opposed to male circumcision. His worry is that we are likely to confuse his people and abandon the ABC strategy which is taking root, and increase risky sex behaviour because of the false sense of being protected from the HIV/AIDS infection by circumcision.”

Many leaders expressed fears that a MMC program would promote promiscuity and stigma against men seeking circumcision. Several also mentioned that circumcision is associated with the Muslim religion.

• “A non-circumcised man may think that those who have been circumcised are becoming promiscuous, want to start changing partners, want to increase sexual pleasure, and do it for fear of contracting HIV/AIDS.”

• “Some women might think that male circumcision is for those men who intend to engage in infidelity, change female partners, and yet fear to get infected.”

• “You know, sex is so important to peoples’ lives, and they want to enjoy it to the maximum. When ARVs came into existence, it caused less fear for HIV/AIDS, and so MMC is likely to relieve people of the fear of HIV/AIDS, and this may be problematic.”
• “Stigmatization may occur if MMC is associated with promiscuity and HIV/AIDS.”

• “A stigma may be attached if the circumcision is not done for religious and cultural purposes, but as a prevention measure against HIV/AIDS. It may imply that he is having multiple sexual partners and fears acquisition of HIV/AIDS.”

• “Men seeking circumcision are promiscuous and fear getting infected, and/or are converting to Islam.”

• “The main factor likely to influence the rate of MMC in this country is a feeling of being converted to Islam; yet, the majority of the population are Christians.”

Affordability and accessibility of the MMC procedure were also frequently mentioned as potential barriers for promotion, especially among poorer citizens. Subsidizing the cost of the procedure for poor residents by charging more to wealthier citizens was suggested as a solution by several stakeholders.

• “Affordability, availability, and accessibility to MMC are important concerns. Even insurance companies consider MMC as cosmetic and cannot cover the costs of MMC procedure.”

• “The price of male circumcision must be affordable to the potential beneficiaries or subsidize male circumcision to affordable levels.”

• “The price paid for male circumcision operation … includes both the operation and post-operative care. Is MMC paid for, or free of cost? Is it cheap or expensive, and can those who wish to circumcise afford it? All these questions need to be addressed, as some individuals may not afford the cost of medical male circumcision. Also remember that there are competing demands for the meagre family resources. If we consider massive intervention at US$50-60 each circumcision, how cost effective will MMC be?”

• “Make MMC services easily accessible. Decrease the distance, time, or delays, and make it free.”

Stakeholders mentioned other potential barriers to the promotion of MMC. These included men’s fears of removing a sensitive part from an important organ that could lead to medical problems or decreased sexual enjoyment, and perceptions of pain during the procedure. To address these fears, pre- and post-surgery MMC counselling programmes will be required.
4.2 Promoting MMC

National and local stakeholders expressed the need for well packaged information to enable potential beneficiaries to make informed decisions about MC. A good information, education, and communication package is essential to address circumcision myths. Stakeholders urged for clarification that MMC is not 100% protective and, therefore, the ABC strategy remains the cornerstone for the prevention of HIV infection. In addition, leaders suggested that promotional messages could be delivered through testimonies by individuals and couples who have already undergone MMC for HIV prevention, and that communication channels such as radio, newspapers, churches, and other social institutions be engaged for message delivery.

- “A well packaged message and marketing strategy to support MMC that indicates other good aspects of MMC, such as hygiene, reduced chances of acquiring cervical and penile cancer. It must also acknowledge that male circumcision contributes to the prevention of HIV/AIDS and cannot stand alone but must go along with the ABC strategy,”
- “Clear understanding of MMC by the community will help to avoid stigmatization of those who circumcise.”
- “Give a clear explanation of the process of male circumcision to the masses, and underscore the fact that male circumcision is not fully protective on its own and must follow the ABC rules.”
- “A success story of male circumcision by a community member may allay anxiety among the non-circumcised communities and increased demand for male circumcision.”

Mobilisation of the leadership (i.e., political, church, policy makers, opinion leaders), civil society organisations involved in HIV/AIDS related activities, planners, and the community are all important for promoting the MMC intervention. Most stakeholders felt that support is currently available at the national and district level, with community leaders already embracing support for the promotion of MMC to reduce the spread of HIV in Uganda. Support and funding are also currently available from development partners who are encouraging the promotion of MMC programs to reduce HIV transmission.

- “Political, religious, cultural, and opinion leaders have the most influence on people, and can publicly support our project only if they clearly understand MMC and are sure it will not lead to immorality, and even worsen the HIV/AIDS and other sexual transmitted infections.”
- “Sensitization [can be done] through opinion leaders, especially religious, cultural, and political leaders. Where there is stigma, a deliberate campaign to popularize MMC ought to be done. Involve the communities in the sensitization before and during implementation, and give feedback on what the public thinks. Involve the clergy in workshops, press releases, press conferences, and radio/television shows. Work with the local press,
to cover and inform the communities so that you can adjust and avoid conflict between the MMC project and press.”

The age at which MMC should be done remained a topic for debate. Data suggested that the procedure should be conducted before boys become sexually active. This was based on the premise that it would provide an opportunity for the scar to heal properly before a young man engages in sexual relations.

4.3 Service Delivery Needs
Stakeholders mentioned that one advantage to promoting MMC in Uganda is that there are existing health centres where increased MC services could be provided, including hospitals and HCIVs. On the other hand, there was also widespread concern that there is currently a lack of skilled medical personnel and well-equipped health facilities to carry out a large MMC program.

National and local leaders felt the most important factors in increasing the provision of health facility-based MMC are equipping health facilities and staffing them with appropriately trained health workers. Staffing capacity could be improved through either training of new health workers or additional training to the existing staff, and task shifting to involve clinical officers and nurses after a short orientation course. Most stakeholders felt MMC is a minor procedure, and staff easily could be trained to learn how to conduct MMC.

- “Medical male circumcision is a minor operation, and forms about 40% of the minor operations. It can be done by health cadres other than a doctor. Therefore, ensure safety, improve aseptic techniques and availability of equipment, and sensitize the public about MMC through the existing services.”
- “Most trained health staff available are capable of performing the MMC, but their numbers need to be increased by either recruiting more staff, or giving further education to the existing staff that are currently unable to do MMC so that they can do it.”
- “Address the issue of capacity to provide medical male circumcision services. Now there is no capacity to circumcise everyone that may come for MMC. Either train more health workers to carry out the procedure, or there should be task shifting to Clinical Officers.”
- “Use [HCIVs], which are almost well equipped to conduct surgery; equip them and train health personnel in those HCIVs. These are entry points to improve surgical services.”
- “Ensure availability of enough equipment and supplies — equipping health workers with skills, especially clinical officers, who can do male circumcision — and infrastructure development. [I am] reserved on the involvement of nurses, as the law of Uganda does not allow nurses to carry out surgical procedures.”
Objective 2: To describe the acceptability of MC among men and women, including in their roles as parents. Information addressing this objective was informed by household surveys of men and women.

4.4 Circumcision Status of Male Respondents in Four Districts
A large majority of male household survey respondents in Gulu, Kumi, and Rukungiri were uncircumcised. In Kampala, which has a sizeable proportion of Muslims, 40% of male respondents reported they were circumcised (Table 4). Compared to the data collected in the 2004-5 Uganda HIV/AIDS Sero-behavioural Survey, presented above, levels of circumcision reported in the current household survey were very similar, although circumcision rates in Gulu district were higher in the current survey (12%) than that of the North-central region in the 2004-5 Sero-behavioural survey (7.1%).

Table 4: Circumcision status of male household survey respondents (N=833)

<table>
<thead>
<tr>
<th></th>
<th>Kampala District (N=208)</th>
<th>Gulu District (N=210)</th>
<th>Kumi District (N=205)</th>
<th>Rukungiri District (N=210)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>% (95% CI)</td>
<td>n</td>
<td>% (95% CI)</td>
</tr>
<tr>
<td>Circumcised</td>
<td>84</td>
<td>40 (34, 46)</td>
<td>26</td>
<td>12 (8, 17)</td>
</tr>
<tr>
<td>Uncircumcised</td>
<td>124</td>
<td>60 (54, 66)</td>
<td>184</td>
<td>88 (83, 92)</td>
</tr>
</tbody>
</table>

4.5 Circumcision of Sons: Acceptability, Age, and Cost
All household survey respondents (N=1,675) were asked whether they would support circumcision of their male children. Following this initial query, respondents were provided with a health message linking MC and reduced HIV infection. The message read, “Recent studies show that male circumcision reduces the risk of being infected with HIV. Being circumcised is not enough on its own to protect from HIV and circumcised men MUST continue using other forms of protection.” After provision of this health message, respondents were asked if they would now consider circumcision of their sons.

After exposure to the health message, uncircumcised men in Kampala District were the most likely to support circumcision for their male children (79% support), and uncircumcised men in Kumi District were least likely to support it (59% support – Table 5).
Table 5: Acceptability of circumcision for sons among uncircumcised men in four districts after exposure to the health message (N=689)

<table>
<thead>
<tr>
<th>District</th>
<th>Kampala (N=124)</th>
<th>Gulu (N=175)</th>
<th>Kumi (N=196)</th>
<th>Rukungiri (N=194)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>% (95% CI)</td>
<td>n</td>
<td>% (95% CI)</td>
</tr>
<tr>
<td>Acceptable</td>
<td>98</td>
<td>79 (71, 87)</td>
<td>121</td>
<td>69 (62, 76)</td>
</tr>
<tr>
<td>Unsure or</td>
<td>26</td>
<td>21 (13, 29)</td>
<td>54</td>
<td>31 (24, 38)</td>
</tr>
<tr>
<td>Unacceptable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The acceptability of circumcision for sons among uncircumcised men did not vary by place of birth, current residence, or religion (Table 6).

Table 6: Acceptability of circumcision for sons among uncircumcised men by place of birth/current residence, and religion after exposure to the health message (N=689)

<table>
<thead>
<tr>
<th>District</th>
<th>Kampala (N=124)</th>
<th>Gulu (N=175)</th>
<th>Kumi (N=196)</th>
<th>Rukungiri (N=194)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Place of birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>84</td>
<td>79</td>
<td>144</td>
<td>69</td>
</tr>
<tr>
<td>Urban</td>
<td>40</td>
<td>80</td>
<td>31</td>
<td>68</td>
</tr>
<tr>
<td>Current Residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>0</td>
<td>---</td>
<td>116</td>
<td>67</td>
</tr>
<tr>
<td>Urban</td>
<td>124</td>
<td>79</td>
<td>58</td>
<td>72</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>60</td>
<td>80</td>
<td>138</td>
<td>69</td>
</tr>
<tr>
<td>Protestant</td>
<td>54</td>
<td>81</td>
<td>34</td>
<td>68</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>67</td>
<td>2</td>
<td>100</td>
</tr>
</tbody>
</table>

Data presented as number of respondents within each subcategory (n) and, of those, percent accepting circumcision for sons (%).

The pattern of acceptability of circumcision for sons among women was similar to that of uncircumcised men: Female Kampala district respondents were highly likely to support circumcision of their sons (95% support), while women in the Kumi district were the least supportive (49% support – Table 7).
Table 7: Acceptability of circumcision for sons among women in four districts after exposure to the health message (N=842)

<table>
<thead>
<tr>
<th>District</th>
<th>Kampala (N=210)</th>
<th>Gulu (N=211)</th>
<th>Kumi (N=211)</th>
<th>Rukungiri (N=210)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>% (95% CI)</td>
<td>n</td>
<td>% (95% CI)</td>
</tr>
<tr>
<td>Acceptable</td>
<td>199</td>
<td>95 (90, 99)</td>
<td>161</td>
<td>76 (70, 83)</td>
</tr>
<tr>
<td>Unsure or</td>
<td>11</td>
<td>5 (1, 10)</td>
<td>50</td>
<td>24 (17, 30)</td>
</tr>
<tr>
<td>Unacceptable</td>
<td></td>
<td></td>
<td>51</td>
<td>24 (17, 31)</td>
</tr>
</tbody>
</table>

The acceptability of circumcision of sons among women generally did not vary by place of birth or current residence (Table 8). However, in Gulu district, women currently living in urban areas were more supportive of circumcision for their sons than women currently residing in rural areas. There was also a trend for Protestant women to be slightly more supportive of circumcision for their sons than Catholic women, and all Muslim women believed their sons should be circumcised.

Table 8: Acceptability of circumcision of sons among women by place of birth, current residence, and religion after exposure to the health message (N=842)

<table>
<thead>
<tr>
<th>District</th>
<th>Kampala (N=210)</th>
<th>Gulu (N=211)</th>
<th>Kumi (N=211)</th>
<th>Rukungiri (N=210)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Place of birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>162</td>
<td>96</td>
<td>183</td>
<td>76</td>
</tr>
<tr>
<td>Urban</td>
<td>47</td>
<td>91</td>
<td>26</td>
<td>77</td>
</tr>
<tr>
<td>Current residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>0</td>
<td>--</td>
<td>153</td>
<td>73</td>
</tr>
<tr>
<td>Urban</td>
<td>210</td>
<td>95</td>
<td>58</td>
<td>84</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>59</td>
<td>93</td>
<td>160</td>
<td>76</td>
</tr>
<tr>
<td>Protestant</td>
<td>65</td>
<td>97</td>
<td>36</td>
<td>78</td>
</tr>
<tr>
<td>Muslim</td>
<td>60</td>
<td>100</td>
<td>5</td>
<td>100</td>
</tr>
<tr>
<td>Other</td>
<td>25</td>
<td>80</td>
<td>9</td>
<td>67</td>
</tr>
</tbody>
</table>

Data presented as number of respondents within each subcategory (n) and, of those, percent accepting circumcision for sons (%).

In general, acceptability was higher among women than among uncircumcised men following exposure to the HIV health message, and was highest among Kampala residents (Figure 1). Kumi residents were the least likely to support circumcision for their male children.
Among circumcised men, there was almost complete acceptance of circumcision for their male children. Of the 134 circumcised male respondents, only three respondents said that they were unsure or would not circumcise their sons following exposure to the message.

Some respondents did change their opinion about circumcising their sons after provision of the health message. Overall, women were more likely to increase their level of support than men (Table 9). About half of the women in Kampala, Gulu, and Rukungiri districts increased their support after hearing the health message, while about one-third of the uncircumcised men in Gulu and Kumi districts did the same.

Table 9: Proportion of uncircumcised male and female respondents who initially did not support circumcision of their sons, but increased their support after provision of the health message

<table>
<thead>
<tr>
<th>District</th>
<th>Kampala</th>
<th>Gulu</th>
<th>Kumi</th>
<th>Rukungiri</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males (N=26)</td>
<td>4</td>
<td>32</td>
<td>34</td>
<td>19</td>
</tr>
<tr>
<td>Females (N=18)</td>
<td>44</td>
<td>51</td>
<td>11</td>
<td>49</td>
</tr>
<tr>
<td>Males (N=78)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females (N=101)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males (N=118)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females (N=118)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males (N=77)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females (N=96)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased support (%)</td>
<td>96</td>
<td>56</td>
<td>68</td>
<td>49</td>
</tr>
<tr>
<td>Did not increase support (%)</td>
<td>4</td>
<td>44</td>
<td>51</td>
<td>34</td>
</tr>
</tbody>
</table>
4.6 Adult Circumcision

The large majority of respondents thought circumcision of sons should occur prior to adulthood, but there were some regional differences. In Kampala district, most respondents believed that infancy (0-1 years) was the best age for circumcision, followed by childhood (2-9 years). Circumcised men and women in Rukungiri district felt the same, although many uncircumcised men in Rukungiri thought childhood was also one of the best times for circumcision. In Gulu and Kumi districts, adolescence (10-17 years) was also thought to be a good age for circumcision, with about one-quarter of uncircumcised male and female respondents recommending this time period. Male Gulu district respondents were the least likely to recommend infancy for circumcision, with fewer than 15% of respondents supporting infant circumcision.

There was wide variation in how much respondents would be willing to pay for circumcising their sons. Five thousand Uganda shillings was most often mentioned as the maximum that a respondent would pay for circumcision, although this cost ranged from 200 shillings up to 200,000 shillings (US $1=1650 USH). In general, respondents in Kampala District were willing to pay more than respondents in other districts, and uncircumcised men were less willing to pay than circumcised men and female respondents.

After provision of the health message in the survey instrument, uncircumcised men were asked if they would consider being circumcised. Men in Kampala district were most willing to support circumcision for themselves (62%), and men in Rukungiri district were least likely to support it (40% – Table 10).

Table 10: Acceptability of adult circumcision among uncircumcised men in four districts after exposure to the health message (N=699)

<table>
<thead>
<tr>
<th>District</th>
<th>Kampala (N=124)</th>
<th>Gulu (N=174)</th>
<th>Kumi (N=196)</th>
<th>Rukungiri (N=194)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>% (95% CI)</td>
<td>n</td>
<td>% (95% CI)</td>
</tr>
<tr>
<td>Acceptable</td>
<td>77</td>
<td>62 (53, 71)</td>
<td>96</td>
<td>55 (47, 63)</td>
</tr>
<tr>
<td>Unsure or</td>
<td>47</td>
<td>38 (29, 47)</td>
<td>78</td>
<td>45 (37, 53)</td>
</tr>
<tr>
<td>Unacceptable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Objective 3: To describe the themes and issues that should be taken into account in developing messages that will be most appropriate and acceptable for promoting MC as an HIV prevention strategy. The main data source for key information addressing this objective was the focus group discussions with men and women.
4.7 Positive and Negative Aspects of MMC

Circumcision was believed to have many positive health benefits. Reduction in STIs and HIV/AIDS transmission, and increased hygiene were mentioned in more than half of the focus group discussions.

- “I hear that when circumcised, HIV and other sexual diseases can hardly affect you.” (Male, Rukungiri district)
- “I survived all the diseases of our youthful days (syphilis and gonorrhoea) because I was circumcised.” (Male, Gulu district)
- “When one is circumcised, simple disease like candidiasis, syphilis can fail to catch a circumcised man, but such diseases can easily catch uncircumcised ones.” (Male, Rukungiri district)
- “Male circumcision makes the penis firm and not easily prone to cuts and bruises, thus reducing the chances of contracting sexually transmitted infections.” (Female, Gulu district)
- “I think circumcision helps keep the penis clean, that even when you travel far from home and don’t bathe for long, you don’t feel dirty. We hear on radio that when one gets circumcised, he cannot easily contract infection from a woman, since the germs have nowhere to hide.” (Male, Gulu district)

Circumcision was also perceived by many to provide a variety of benefits during sexual intercourse, although a number of participants also thought that circumcision resulted in a less attractive penis.

- “I hear women say that circumcised men satisfy them sexually, and you know if there is no satisfaction in the house, then the woman might look for another man and get infected.” (Male, Gulu district)
- “The skin of a circumcised person feels better compared to the uncircumcised one. Once you test a circumcised man, you wouldn’t go in for an uncircumcised one.” (Female, Kampala district)
- “I think the circumcised man looks ugly…one [is] changing what God had originally created.” (Female, Kumi district)
- “Circumcision reduces the size and strength of the penis.” (Male, Kumi district)
- “Circumcised men have large and ugly penises that hurt women.” (Female, Gulu district)
Promiscuity was mentioned as the key concern following MC. Men and women believed that circumcised men in particular enjoyed sex, and they expressed concern that circumcised men might feel free to have sex with multiple women. This perception was not shared by women in Kampala district. In Kumi district there was a widespread belief that, following circumcision, the first woman a man had sex with would become a “harlot” or promiscuous.

- “For us people in villages, when we hear something on the radio, we think it’s the truth. And we normally hear that if a man is circumcised, he will not get HIV. So after circumcision, men will know that they cannot get HIV, so they will not protect themselves, since they know they are circumcised.” (Female, Rukungiri district)
- “I think circumcision increases promiscuity. Sitting at the market here daily, I observe many young men get circumcised and nursed at the mosque across from here, but as soon as they get better, I see them go after every girl around.” (Female, Gulu district)
- “Circumcision will increase promiscuity just like condoms — better to teach the youth about morality.” (Female, Gulu district)
- “It also promotes promiscuity among men, because they will think they are now safe to have live sex with anyone, which means they may end up getting HIV.” (Male, Kumi district)
- “Circumcision makes a man become too sexy, and if he begins with any woman after circumcision, that woman becomes a harlot.” (Male, Kumi district)

Many focus group participants also were worried that circumcision could lead to adverse events such as pain, infection, disfigurement, death, or even contracting HIV during the procedure. Also, some participants were concerned about the healing time necessary following circumcision. Men from every area indicated they would need financial assistance during the immediate post-operative and recovery period to help maintain their family income.

- “There is a possibility of becoming disabled, that is to say, the male organ is full of veins around it, which might easily be cut, and this can cause permanent paralysis of the penis.” (Male, Kampala district)
- “After circumcision, if one is not properly treated, one may end up getting other infections like cancer or secondary infections (e.g., tetanus).” (Male, Kumi district)
- “There is danger of contracting HIV during circumcision in case people share the circumcision knife at a traditional circumcision ceremony.” (Male, Gulu district)
• “There is death. For example, one old person was circumcised, and he could not heal and later died. There is another man who lost a penis because of circumcision; he had sex before he healed.” (Male, Rukungiri district)

• “If the man who is a bread winner gets sick, you the woman alone may not manage, so how does the family survive?” (Female, Kumi district)

• “You should appreciate that we are farmers and busy people who are physically active. The pain and duration needed to heal completely is too long to bear, and the body part to be circumcised is also a busy place. Who will compensate us for time lost?” (Male, Gulu district)

• “Other men would like to circumcise, but they think of the amount of time they will stay without working, and ask, ‘Who will feed his family?’” (Female, Kampala district)

Although not widespread, a few participants voiced concerns that circumcision would weaken their “manhood” or contradict their religious beliefs.

• “There are certain things God has created and are not supposed to be tempered with; there are others that can be removed, like hair in the armpits, and pubic hair, but when you suggest circumcision, you feel you are spoiling something.” (Male, Kampala district)

• “Religiously, it will be like you are abusing God’s creation, because the foreskin is meant to protect the penis. Any thing can hurt the penis, since it is exposed.” (Male, Kumi district)

• “If they circumcise and they tell them to covert to Islam religion, there will be a problem.” (Female, Rukungiri district)

• “It will look like I am changing religion — crossing over to Islam, even other Christians will wonder what I am doing.” (Male, Kumi district)

4.8 Performance of MC

Most participants believed that circumcision should be performed by medical personnel in a hospital setting or HCIVs. In Kampala and Rukungiri, the most frequently mentioned location was hospitals, whereas in Gulu and Kumi, HCIV health facilities were more often endorsed. Participants indicated a wide range of options for HCIV settings, including mobile care clinics, local/regional health centres, and parish/religious temporary clinics. Those that preferred medical facilities cited reduced risks during the circumcision procedure due to cleanliness and well-trained health care providers, as illustrated by the quotes below:

• “There is proper care and cleanliness in the hospital, and in case of any complication, they will handle it.” (Female, Kumi district)
• “If these people are to be circumcised, let them stay in the hospitals and get healed from there … otherwise, if they are to heal from home, some will not wait to have sex with their wives.” (Male, Rukungiri district)

• “The health personnel are the most perfect people to do it … when it is done at the health centre, it makes it not religious.” (Male, Kumi district)

• “Trained people in hospitals have qualifications, and this will encourage parents to take their male kids there, unlike in Mosques and among the Bagishu, who circumcise without qualifications.” (Female, Kampala district)

• “Make it available in many places, like the current HIV mobile clinics.” (Female, Gulu district)

• “The health facility should be near the community, and health personnel [should be] available.” (Female, Kumi district)

• “The health facility reduces risks through accidents, like accidentally cutting off the penis completely. At the health facility they first sterilize that part, so you don’t feel pain during circumcision. At the health facility they maintain cleanliness, use gloves, et cetera, so it is safe. Traditionalists pass on diseases from one person to another, because they may use the same pair of gloves for all the people being circumcised, therefore passing on diseases.” (Male, Kumi district)

A minority of participants, mostly in Kampala and Kumi, endorsed traditional circumcision settings.

• “I do not agree with [circumcision at health facilities], because it’s like interfering with existing cultures. They have always done it without any complaints. I plus my brothers were circumcised when we were two weeks old. My suggestion is that things should continue as they are … because they may bring a medical person who may cause complications, and every accusing finger will be pointing at him.” (Male, Kampala district)

• “We have seen people from [hospitals] circumcised. They fall sick very often, and even take long to heal, and the way it is done is not good. It is a disorganized shape, and not round, as it is supposed to be.” (Male, Kampala district)

• “It should be done by our Islamic doctor. If the medical personnel is not a Muslim, he will not follow the right Islamic traditions.” (Male, Kumi district)

• “In Bugisu it will be useless if someone is circumcised by a technical person, since there are rituals performed. If you do it from the hospital, you have to repeat it traditionally.” (Male, Kampala district)
In addition, some participants stated that traditional circumcisers should be trained by the government and allowed to conduct religious circumcisions, either in a traditional or health care setting.

- “Let the government train people based on their culture. For example, train a Mugisu to circumcise a Gisu, a Mukonjo to circumcise the Bakonjo, and the Muslims to circumcise the Muslims.” (Male, Kampala district)
- “It should be like the home-based counselling and testing (HBCT), which was done in the homes, because if we have to go to hospital, will the government give us the transport? They should be circumcised at home by medically trained personnel.” (Female, Kumi district)

4.9 Attitudes Toward Circumcising Sons

The most commonly cited reason for circumcising a son across all focus groups was the prevention of HIV/AIDS, or to provide a “healthier future” in general. This was particularly salient for mothers. A few participants mentioned their support for circumcising their children because they believed the pain would be worse if circumcised as an adult.

- “With this new [HIV reduction] information, to say ‘no’ to the circumcision of our children is to deliberately destroy their future.” (Male, Gulu district)
- “Since there is no known cure for HIV, the government is behaving desperately, like a woman with a sick child, who tries a health facility, pastors for prayers, and consults a native doctor. In the end, she might not know what has healed the child, but at least the child is healed. For the health of my child, I consider him getting circumcised.” (Female, Gulu district)
- “For me, I have heard several views from the newspapers and radio stations that it reduces the risk of catching HIV. So, circumcising them when they are young safeguards their future. More so, they heal fast when they are young, unlike the adults, because they have responsibilities which will stop them from being circumcised.” (Male, Kumi district)
- “Given that HIV is destroying our homes, and since I hear that circumcision can reduce the risk of contraction of the virus, I have no problem with the operation. One would rather lose a small part of his body than the entire life.” (Male, Gulu district)
- “I have no problem with my son getting circumcised, especially when he is young; even Jesus was circumcised when he was only eight days old.” (Male, Gulu district)
- “When you circumcise your child when he is still young, he grows when he is clean, and nothing disturbs him. He will not get disturbed to think of
circumcising when he is already old. He is circumcised when he is still young, the pain is not too much, like on an old person. The pain is bearable for a young boy.” (Female, Rukungiri district)

Additional information about the health benefits of circumcision would encourage many parents to circumcise their sons, especially if circumcision was linked to a proven reduction in HIV/AIDS. A small number of male groups also indicated that they would want to speak with survivors of the circumcision procedure to ensure that there were no adverse events or side effects.

- “We need more information about circumcision before we can decide to do so. For instance, my grandfather never rode nor sat on a bicycle simply because, at times, people fell from it even though he knew several advantages of the bicycle. Likewise is circumcision: There [should] be more sensitization to counter the disadvantages.” (Male, Gulu district)
- “I don’t trust anything from the government anymore. This might be a political agenda against us, and circumcision might be used against us, as happened in some people’s history. We have just gone through a war, now there is a problem with our land they have failed to grab through the constitution. I think they might try to use circumcision to weaken us. We need full understanding on the idea behind this circumcision.” (Female, Gulu district)

Parents who were opposed to circumcision of their sons typically mentioned their belief that it would signify a religious conversion, their reluctance to subject their children to the pain of circumcision, that sons should make the decision for themselves, that the operation is too expensive, and that it would encourage their children to engage in sexual activity. Some participants in Gulu and Kumi indicated that they would not circumcise their sons because HIV/AIDS was a modern problem, and that a traditional practice would not solve the current problem.

- “I reject MMC because it is the same as turning my children into Muslims.” (Male, Kumi district)
- “I would accept it, but it will be like pushing him to have sex, since he knows he is circumcised and he will not get infected. It’s like packing condoms for your son when he is going to school.” (Female, Rukungiri district)
- “When a child becomes promiscuous, I cannot be happy for him, and this is due to circumcision. They should use something else to circumcise men, not a razor blade. Because I think it’s the razor blade which makes them [have?] more sexual pleasure. They should use … like, a pair of scissors, or what they use in hospitals.” (Female, Rukungiri district)
- “For me, I would want my son to be circumcised when he is still young, because he grows knowing that you did it for hygienic purposes, but not
knowing that it’s one way of preventing HIV/AIDS. It will be like pushing the child to have sex, since he knows he is safe.” (Female, Gulu district)

• “For me, I would not support his circumcision for the reason of preventing HIV, because we do not get HIV/AIDS through having sex only, and it will push them to have more sex, and be sexy. But it may be preventing other STDs like syphilis. Whether circumcised or not, we all get HIV.” (Female, Rukungiri district)

• “Is it true that this disease will have no cure for a long time? Because why should we subject the future generation to something that does not exist in our tradition just because we want we to solve a current problem?” (Male, Gulu district)

Participants in every district indicated that a lower cost — or free operation, or some gift for participation — would encourage them to get circumcised or circumcise their child. A number of participants in Gulu district indicated they would need better access to local and regional health centres in order to be able to get their son circumcised. Finally, several participants suggested that MMC would be accepted if government policy mandated it.

• “Give people incentives like nets, beddings to encourage them, because it is difficult to convince a lay person, so they would like to be made happy with the blankets or a bed sheet. Like Blood Bank when people are donating blood, they give them sodas and biscuits and that encourages many people to donate and remain happy.” (Male, Kumi district)

• “To circumcise them: Youth are so used to money, if the government can ‘bribe’ them with some projects and even T-shirts like we received for action against landmines.” (Male, Gulu district)

• “You should also do it like Muslims, give daughters, so the government needs to give some gifts too as motivation. Consider also the period one takes to heal, which is so long he needs to be supported.” (Male, Kampala district)

• “As we know, it is mainly Muslims who get circumcised, and this area is mostly habited by Christians who do not circumcise, so to get more youth circumcised without them feeling like they are becoming Muslims, the government should emphasize that the operation is done at a health facility.” (Female, Gulu district)

• “It should be made mandatory that a child be circumcised at birth. If it’s made a policy inclusive of procedure, and our parliamentary representatives [accept it], then we will also accept.” (Male, Kampala district)
4.10 Decision-making about MC

Regarding circumcision of adult men, most focus group participants stated that it is the man’s decision whether to circumcise. A few people thought it should be a joint decision between the husband and wife, because their sex life might change as a result of circumcision.

- “The man should decide whether to circumcise or not. What do the women have to circumcise?” (Male, Rukungiri district)
- “Since you are the man, you know the risks to men, so you can decide, because in most cases we have experienced men’s diseases.” (Female, Kampala district)
- “Father, because he is the head and has more right than a woman.” (Male, Kumi district)
- “If I am to get circumcised, I and my wife have to agree on it. Supposing the operation goes wrong … then how will she support me if she did not know what I was doing? (Male, Gulu district)
- “I think I have to discuss it with my partner, because circumcision is not just about my physical health, but also about my sexuality. She has to accept the likely changes that might occur in our sex life.” (Male, Gulu district)

Regarding the circumcision of male children, most participants stated that parents should decide this together. Others felt that the decision belongs solely to the mother, or solely to the father, and some people in each district thought it should be the son’s decision to make for himself, or to make together with his family.

- “It is about agreeing, because if my wife goes to the village with my children and circumcises them without my notice, I will declare that they are no longer my children, but if we both agree, then it is okay. Both of us have to discuss about it, most especially if the couple is a non-Muslim.” (Male, Kampala district)
- “This decision is made between the man and wife for the husband and young children to get circumcised. For the older children, we talk to them, and if they accept, we support and nurse them.” (Female, Gulu district)
- “Health matters cannot be left to one parent alone, so both father and mother and the children have to dialogue so that they can support each other during the healing process. We have dialogued before as we did with condom use with the youth.” (Male, Gulu district)
- “Now always it’s the man who is the head of the family, so he is the one who comes with that decision and you agree. Even if it’s the women who come up with the decision, it’s the man who actually decides. The women
have no power to make a decision unless you do not have a man.”
(Female, Rukungiri district)

- “There is nothing, because I am not the owner of the child. If the husband refuses, then you have no alternative but to let the child decide for himself when he is an adult.” (Female, Kampala district)

- “As a mother, I suggest, but my husband has the final decision, because if I insist on the circumcision, he might accuse me of having got the child with a Muslim.” (Female, Gulu district)

- “These days, mothers are looking after children without any help from the man, so such women decide what is good for their children.” (Female, Kampala district)

- “I and my husband cannot make decisions for my adolescent sons. I don’t even see them during the day. They no longer eat at home anymore, but they spend the whole day with their friends. This is what the camps have done to us, and we are parents in name, not authority. We will advise them and leave the decision to the child.” (Female, Gulu district)

4.11 Perceptions of Cost for Male Circumcision

Many participants stated that circumcision should be a free, government-subsidized initiative. Since HIV/AIDS was a national problem, the government should be responsible for covering the cost of MMC if it was to be used as a prevention tool. Participants cited large families, low wages, and high drug costs as reasons for having a free circumcision program.

- “This being a life-saving initiative, it should be totally free, so that both poor and rich can access it equally.” (Male, Gulu district)

- “If it becomes policy, government has to accomplish its duty of making sure people are circumcised freely.” (Male, Kumi district)

- “The government has seen that HIV/AIDS has spread so much, and saw that, after circumcision, the disease will reduce. So, they should do it for free. Some will refuse to circumcise, and again, if you ask money for those who have accepted to circumcise, they will also decide not to circumcise, so I would say it should be free.” (Female, Rukungiri district)

- “It should be free because a family of six boys plus their father will not afford the cost if it is not free. It is the government programme. It’s the one that knows benefits of circumcision, so let it meet the costs on behalf of its people.” (Male, Rukungiri district)

- “I think the health centre at the camp cannot carry out the operation, and one has to go all the way to Gulu hospital. You have to factor in the cost of transport and upkeep in case the operation is not carried out on the appointed day, and the hospital bills, like medicine. This is very expensive
for us; moreover, some one is not sick. To motivate someone who decides
to bear all that cost, it should be free.” (Female, Gulu district)

• “It should be free to remove all the excuses that the youth would normally
make. In this village the young boys would rather use their money to drink
than circumcision, and any payment makes the decision not to circumcise
very easy. So I think 1000 [shillings] is reasonable.” (Male, Gulu district)

• “I have always wanted to be circumcised but was constrained by the
cost…. I would prefer that the government just helps, because there are
many people who want but cannot afford.” (Male, Kampala district)

Half of the participants that did not agree that MMC should be a free program thought
that it should cost somewhere between 1,000 and 10,000 Uganda shillings (Ush). Most
often, participants cited 5,000 USh as a fair price. Participants that did not agree with free
circumcision cited doctors’ salaries, fees for hospitals, and lack of quality of free
procedures as the main reasons for charging for the procedure. Participants indicated that
if procedures were free, that doctors and health care workers would have no incentive of
offering proper care and treatment.

• “I think 3000 USh for the operation, since I still need some money to
‘bribe’ the health worker so that he takes good care of the child.” (Male,
Gulu district)

• “Free things are not the best because they do not do as good a job …
because whatever is used, ranging from equipment, drugs, and even a
pen, costs money. So they should ask for a moderate fee of about 2,000 to
3,000 USh.” (Female, Kampala district)

• “It should not be for free in hospitals, or even culturally, because people
will not heal, and free things are not good, most especially in government
hospitals.” (Female, Kampala district)

• “I would suggest like 5000 USh, and this money should be asked only for
drugs, but the real cutting of the skin should be free.” (Male, Rukungiri
district)

• “It should be done in hospitals and charge like 2000-5000 USh to motivate
doctors to work effectively.” (Male, Rukungiri district)

4.12 Women’s Perceptions of Men Who Are Circumcised
In two-thirds of all female focus groups, participants stated that circumcised men are
more hygienic and free from disease, and about half of all groups mentioned that
circumcised men are protected from HIV/AIDS and STIs.

• “According to a Muslim neighbour in town before I came to the camp,
circumcised men are clean. That is why they can marry many women and
yet not suffer from STIs, so it might mean the same for me. It means that
my husband has reduced chances of suffering infections on the penis, since it is always clean.” (Female, Gulu district)

- “Others say that circumcision helps in prevention of AIDS/STDs, like for Bagisu, it is good to prevent germs, so good for their hygiene.” (Female, Kampala district)

- “You enjoy [a circumcised man] because you are free, because you know the man is clean, because with an uncircumcised man, you have some fear that he is going to leave something like sickness in you. You develop some fears.” (Female, Kampala district)

- “Some men take a week without bathing, but if that foreskin is removed, it improves the hygiene and reduces some diseases that women may get.” (Female, Rukungiri district)

- “When men go out to have sex with other women and he is not circumcised, when he comes to have sex with you, both get the disease. But if he is circumcised, you cannot get the disease. Even if he goes to have sex with other women, the risk of getting diseases is reduced.” (Female, Rukungiri district)

In about half of the female focus groups, some women also felt that circumcised men are sexually and aesthetically pleasing to their partners. However, a number of women believed that circumcised men are more promiscuous, or sex is more difficult with these men, and many women in Kumi believed that circumcised men make their female partners promiscuous.

- “I hear that circumcised men love sex very much; I don’t know whether I have the energy to contain it daily.” (Female, Gulu district)

- “The first time I saw a circumcised penis, it was on two young, naked Muslim boys from the neighbourhood who had come to play with my children. The penis looked [so] ugly that I asked them to go back home and put on clothes, so how can I allow it for my husband?” (Female, Gulu district)

- “They say that a circumcised man is more sexually active. I would prefer one who is not circumcised, because a circumcised man may be like a bone. I would not handle his stiffness, maybe I will get hurt.” (Female, Kumi district)

- “There is no way we can compare the two [circumcised and uncircumcised men], because we cannot marry two at the same time. But I would say there is a problem with circumcised men, because a circumcised man may just want to penetrate you before your body is ready for sex, and you end up getting tears, because we hear that a circumcised penis is very rough.” (Female, Rukungiri district)
• “Some girls fear circumcised men … that they make you promiscuous; they make you want to sleep with men all the time and increase sexual desire.” (Female, Kumi district)

• “After my husband gets circumcised, he sleeps with me first. Then I become sexually wild. I end up getting HIV even if I didn’t have it in the first place, because I will look for every man available, and then I end up catching the virus.” (Female, Kumi district)

A few women in each district stated that circumcision was only for Muslim men, or that it would lead to religious conversion.

• “I thought people who circumcise get changed into another religion. This is because after circumcision, they start praying in the mosque.” (Female, Kumi district)

• “I used to think that male circumcision was done by Muslims. For me, I used to think it’s only people in the Muslim religion that circumcise. So this one of saying all people circumcise … I don’t understand it.” (Female, Rukungiri district)

**Objective 4: To describe potential mechanisms for improving access to reproductive health messages to young men through MC. Information addressing this objective was informed by the stakeholders’ meetings and key informant interviews.**

Although the goal of this objective was to investigate mechanisms that might be appropriate for integrating MMC with other health services, little data were collected that directly addressed this. The few comments obtained from stakeholders indicated a general level of support for integration, but simultaneously generated many concerns about the feasibility and resources required for successfully integrating MMC with existing health services, or including additional services along with the MMC intervention.

**4.13 MMC Integrated with HIV Testing**

Most key informants thought inclusion of Voluntary Counselling and Testing (VCT) for HIV in the MMC activity would provide a complementary health service that would be accepted by men.

• “Offering an HIV test, with referral to counselling and medical services is complementary. We (Ministry of Health) are encouraging an integrated approach to health service delivery. The policy of offering HIV testing will not [negatively] affect a programme to increase male circumcision.”

Several stakeholders supported integration of VCT for HIV and MMC services, but expressed some reservations, including the need for additional resources.
• “It is good, but timing and resources may cause it to go on slowly.”
• “It is a good idea, but care must be taken to ensure that we do not affect the little achievements that we have made or had.”
• “This is a good idea, but is bound to have many implementation difficulties. We have problems with VCT; what about when we add on MMC?”
• “… MMC should not be introduced as a ‘stand alone’ intervention. Resources should be allocated without compromising other interventions.”
• “… Let MMC be part of the broader approach/interventions and not a ‘stand alone,’ or elevate above other approaches (i.e., integrate MMC with other interventions).”

4.14 MMC Integrated with Family Planning Services
Stakeholders indicated that involvement of men in reproductive health services was a good idea. However, it was debatable as to how feasible it would be to implement it in a male-dominated society.

• “Adding sexual and reproductive health services is a good idea. Male involvement should be made prominent (i.e., males should be seen to actively participate in the programme).”
• “Yes, this is fine. MMC must not be seen in the context of HIV/AIDS prevention alone, but must be seen to offer multiple health benefits.”
• “This is a good idea, but I am not sure of the practicability of this.”
Objective 5: To describe the capacity of the health care system to provide high quality MC services. The main data source for key information addressing this objective was the service availability study.

4.15 MMC in Health Facilities

To achieve this objective, data were collected from 26 health facilities (17 hospitals and nine health centres). The assessment revealed that MMC was performed in all 17 of the hospitals, included in the health facility survey. The mean number of MCs performed in these hospitals in the last 12 months was 321 in Kampala, 10 in Kumi, 57 in Gulu, and 16 in Rukungiri. On the other hand, of the nine HCIVs, only one health facility in Gulu and two health facilities in Kampala performed MC. In the last 12 months, the Gulu facility had performed 89 MCs and the Kampala facilities did not provide data.

Of the 59 health practitioners surveyed, 34 practitioners (58%) had performed a male circumcision at least once. Practitioners in hospital settings were more likely to have performed MC than practitioners in HCIVs. Of those who had performed MC, three-quarters had performed MC in the last 12 months, averaging 68 MCs in hospitals and 19 in HCIVs. In addition to performing MC at the current health facility, many hospital-based providers had performed MC in another public health facility or in a private clinic. Practitioners in Kampala hospitals reported performing the most MCs of all district settings, averaging 83 per practitioner during the last year.

Among the facilities that performed MC, reasons that were cited by more than two-thirds of the facilities as indications for MMC included phimosis or paraphimosis, balanitis (inflammation of the glans penis), hygiene, and patients’ personal preferences. One-third reported circumcising patients for religious reasons and because the patient heard that MC reduces HIV.

Almost three-quarters of the practitioners surveyed had seen complications or adverse events result from the procedure of MC. Excessive bleeding, infection or sepsis, haematoma, and disfigurement were the most commonly mentioned adverse events. Practitioners reported seeing an average of seven MCs over seven years that resulted in adverse events.

Circumcisions were performed at every age group across the circumcising facilities. All practitioners who performed MC in the last 12 months had circumcised adults, and two-thirds had circumcised adolescents, children, and infants.

Cost information was collected from in-charges in 14 facilities. In the hospitals, the cost paid by the patient ranged from 2,000 USh in a government hospital in the Kumi district, to as much as 295,000 USh at a private for-profit hospital in Kampala district. The other 10 hospitals that provided cost data charged between 20,000 USh and 150,000 USh for the circumcision, depending on the age of the patient. In the two non-hospital government health facilities that provided cost data, the cost ranged from 1,000 to 30,000 USh paid by the patient for the circumcision.
Additional information about cost was collected from the practitioner survey. Practitioners reported a median cost to the patient of 50,000 USh, ranging from 15,000 to 300,000 USh. Patient costs in hospital settings were higher, with a median cost of 50,000 USh in hospitals, compared to 30,000 USh in HCIVs settings.

Almost all the health facilities surveyed were able to perform minor surgeries; almost two-thirds had done Caesarean Sections, and about one-third had performed vasectomies.

Most health facilities had a surgical theatre (21 out of 26), and in all but one hospital, the surgical theatres were in working condition. However, three HCIVs did not have a surgical theatre, and three additional HCIVs had a surgical theatre but it was not operational. All health facilities except one HCIV in Gulu had electricity. Sixteen facilities were connected to the grid, one used a generator, one used solar power, and seven facilities had two or more sources of electricity. More than three-quarters of the facilities surveyed had one or more autoclaves for sterilizing equipment, about half had a pressure cooker, and about one-third of facilities had other means to sterilize equipment.

### 4.16 Provider Attitudes toward MC

All practitioners believed there are advantages to MC. More than 90% of practitioners believed that MC improves hygiene and provides some protection against STDs and AIDS. In addition, 78% thought it reduced the risk of HIV infection, and 71% thought it reduced the risk of penile cancer.

A small proportion of practitioners believed that MC can enhance sexuality: 36% thought that women preferred men who were circumcised, and 19% thought circumcision increased sexual pleasure and sexual performance. However, 14% believed that circumcision encouraged adultery. Fewer than 10% believed that circumcised men can safely have sex with many women, that circumcised men do not need to use condoms, that the tip of the penis needs to be covered with a foreskin, or that MC is forbidden by religion.

The majority of practitioners felt that circumcision pain is bearable for a child, and that MMC is expensive. Practitioners also believed that death is more likely in traditional MC (88% said death could occur) than in MMC (29% said death could occur). Finally, three-quarters of practitioners acknowledged that one can get infected by HIV during MC.

When asked which ages are best for MC, approximately one-half (54%) of the practitioners believed that infancy is best, followed by childhood, or between two to nine years old (25%), adulthood (13%), and adolescence (6%).

When asked what patients should be charged for MMC, practitioners were about evenly split between thinking it should cost between 10,000 and 20,000 USh, and thinking it should cost more than 20,000 USh. Only a few thought it should cost less than 10,000 USh. Hospital staff believed patients should pay more for circumcision (median of 20,000 USh) than HCIVs staff (median of 15,000 USh).
4.17 MMC Scale-up

Of the 26 respondents who completed the health facility survey, the majority (89%) felt that their facilities were capable of doing MMC. On the other hand, three HCIV staff stated that their facilities would be unable to provide MC services during scale-up. To introduce or increase MMC services, facilities outside of Kampala would need, in order of priority, increased staff training, more equipment and instruments, medications, disposable equipment, and a surgical room. In Kampala, the biggest needs were for more equipment and a surgical room.

The majority of practitioners (59%) said they would need additional training to perform MMC. HCIV staff perceived a greater need for training than staff who worked in hospitals (84% versus 46%, respectively). Most practitioners needed comprehensive training that includes theoretical and practical content.

Almost all practitioners thought trained medical and clinical officers should be permitted to perform MMC. Practitioners had mixed feelings about nurses performing MMC. For example, only about 40% thought trained male or female nurses should be allowed to perform MMC. However, HCIV staff were more supportive of nurses performing MMC than hospital staff. Additionally, only one-quarter agreed that traditional and religious male circumcisers should be trained and allowed to perform MMC.
5.0 CONCLUSIONS AND RECOMMENDATIONS

The male circumcision intervention to reduce the spread of HIV is best referred to as medical male circumcision (MMC). The addition of the word “medical” to “male circumcision” clarifies that the MMC program refers to circumcision provided by medically trained personnel in medical settings, and helps to divorce the MMC intervention from religious or cultural meanings.

5.1 Support for MMC

There is presently a great deal of support for the MMC intervention. The large majority of national and local level leaders and key informants interviewed for this situation analysis supported the MMC intervention, as were health care practitioners and administrators. These stakeholders were aware of the link between MC and reduced HIV transmission, and they voiced strong support for the promotion of MMC as part of the ‘ABC+’ HIV prevention strategy.

The Kampala, Gulu, Kumi, and Rukungiri district residents interviewed for this situation analysis also demonstrated a substantial level of support for MMC to prevent HIV transmission. Interviewees were more supportive of circumcision for their sons than circumcision for adult males. However, they did express a number of barriers to MCC that must be addressed for the intervention to succeed.

Demand for the MMC procedure can be generated and increased through a supportive national policy, increased access to MMC services, and provision of well-packaged information to the Ugandan people. Health facilities must be prepared to provide the MMC procedure while ensuring that the supply of skilled medical personnel, sufficient medical equipment, and surgical facilities are available to meet demand.

Create a national policy on MMC: Stakeholders at the national and local levels want a policy on MMC to support them. Currently, there is no legal framework or policy to support MMC. There is still lack of consensus on certain aspects of the MMC program, so more discussion on the recommended age for MMC, the category of personnel who could provide the procedure at Ugandan health facilities, and the feasibility of integrating MMC with other health services need to occur among practitioners and policy-makers. Political leadership and donor support could be utilised to develop and implement a national MMC policy and MMC program. This formulation of a national MMC policy could begin with a roundtable discussion and then move into a working group at the Ministry of Health, and other stakeholders.
5.2 Preparation of Health Facilities for MMC Intervention

Health service infrastructure already exists in all districts included in the situation analysis, and all hospitals (but only three HCIVs) included in the assessment have been performing MMC. To provide increased MMC services and meet anticipated demand for the MMC intervention, more qualified health workers, and more and better equipment and facilities are needed. Hospitals are better equipped than HCIVs to handle increased demand for MMC. The presence of a supportive political environment at the local level and donor support are of paramount importance in the strengthening of the health system to meet the demand for MMC services.

Increase personnel: While all stakeholders and health practitioners agreed that additional personnel need to be trained to carry out the MMC procedure, disagreement was expressed regarding task shifting and the appropriate level of personnel to carry out the procedure. Many perceived MC to be a minor procedure, and thus could be performed by Clinical Officers or nurses with basic training, instead of surgeons or other medical doctors.

Integrate MMC with other services: Stakeholders also felt that MMC services should be integrated with HIV voluntary testing and counselling (VCT), reproductive health services, and other existing health services. However, the feasibility of these suggestions was uncertain, and raised questions about resource allocation and the need to maintain proven successes while simultaneously promoting new HIV prevention strategies.

Increase access at HCIVs: Health centre level fours (located at the health sub-district level) could be used as entry points for those seeking the MMC procedure. Since improved access to local and regional health centres is necessary for the MMC intervention to succeed, this is one way to increase access to MMC services. Many of these facilities already have the required surgical room and equipment needed for the MMC procedure.

Provide counselling: Counselling must also be an integral element of the MMC intervention. To prevent or decrease potential risk compensation, and address concerns of men and their female partners related to the procedure and the follow-up period, trained counsellors should be available in health facilities that offer MMC. Counselling should stress that MMC provides only partial protection against HIV, and that maintenance of other risk reduction strategies is necessary, provide a clear explanation of how the MMC procedure is carried out and typical side effects from the procedure, address concerns about changes in sexual activity or performance following the procedure, and provide information about wound care during the healing period.

Provide MMC for all age groups: Health facilities should provide training on the conduct of MMC for males of all ages, and be prepared to offer MMC to males of varying ages. Although health care practitioners felt infant circumcision was best, followed by circumcision during childhood, preferences for the age of circumcision varied across all data sources. Most stakeholders and district residents favoured MC before the onset of
sexual activity, but a substantial number of residents in two districts included in the situation analysis felt adolescence was the best age for MMC.

**Make MMC affordable:** The MMC procedure is currently expensive and unaffordable to many of the resident populations, especially to those living in rural areas. Most household respondents thought MMC should be subsidized by the government, and that it either should be provided free of charge, or at a cost of as much as 5,000 USh. This contrasts sharply to the median cost of 50,000 USh reported by the health practitioners for the cost of MC in the facilities where they are employed. Kampala residents were willing to pay slightly more than residents in the other districts surveyed. Several stakeholders suggested that the MMC procedure to the poor could be cross-subsidized by charging the wealthier households higher fees and poorer households lower fees.

### 5.3 Acceptability and Promotion of MMC to the Ugandan People

The situation analysis was designed to survey households in three areas where MC is uncommon. As a result, fewer than 12% of the male household respondents in three districts, which were overwhelming Christian, were circumcised. The fourth district, Kampala, has a sizeable proportion of Muslim residents, and 40% of men in this district were circumcised.

When uncircumcised men were asked if they would consider getting circumcised as adults, between 40% and 62% of men across the four districts included in the situation analysis said they would consider it. Support for circumcising sons was greater: Between 59% and 77% of uncircumcised men supported MMC of their sons, between 49% and 95% of women supported circumcision of their sons, and almost 100% of circumcised men supported circumcision of their male children. Residents in Kampala and female respondents were more supportive of MMC for their sons than other respondents.

**Target women:** Although women have not traditionally been targets of MMC promotional messages, they are an important target group for the MMC program. Women are frequently involved in the process of deciding whether to circumcise male children, and sometimes women are consulted by their male partners in decisions about adult MMC. Women were generally more supportive of MMC for their male children, somewhat more likely to support MMC after being provided with information about reduced transmission of HIV among circumcised men, and inclined to pay more for MMC than men would pay.

It is important to note that many women perceived that circumcised men were more sexually and aesthetically pleasing, but a smaller number were fearful that a circumcised partner would make sexual activity more difficult. Testimonials provided by women whose partners have undergone MMC and are satisfied with the results should be enlisted to address these concerns.

**Engage Communities:** Key opinion leaders should be mobilised to support the MMC intervention and promote it in their communities. There are many resources at the national and local levels that can be utilised to promote MMC: Radio stations,
newspapers, churches, schools, and community groups are available and can be used as channels for advocacy. Testimonials from men who have undergone MMC and their female partners should be incorporated as promotional aids.

**Develop appropriate communication strategies and create promotional materials:** To guide public education and information dissemination, educational and health promotion materials need to be developed that consider the following issues.

- **Call the procedure “medical male circumcision”:** Surprisingly, only a few people mentioned the perception that circumcision is for Muslims. Stakeholders believed this to be a major barrier to the uptake of MMC, and also a few men and women in the focus group discussions expressed this concern. Referring to the program as MMC will help to alleviate religious barriers to circumcision. In addition, community engagement to understand the rationale for MMC will help to assure the Ugandan people that MMC is appropriate for all citizens regardless of religious affiliation.

- **Explain why MC is associated with reduced HIV:** Many respondents at the district level knew about the link between MC and reduced HIV transmission. Others stated that more information would help them to make an informed decision about whether to pursue MMC. Promotional materials should be developed that present a clear explanation for why MC is associated with reduced HIV infection.

- **Highlight myriad health benefits of MMC, especially improved hygiene:** Household survey respondents, along with stakeholders and health practitioners, mentioned other benefits to MC, including better hygiene, reduced risk of STIs, and reduced risk of certain types of cancer. Better hygiene was frequently mentioned as one of the most advantageous aspects of MC, and respondents at all levels perceived that improved hygiene resulting from foreskin removal afforded some protection from STIs. Therefore, promotional materials should highlight the hygienic benefits of MMC and other potential health advantages resulting from the procedure.

- **Emphasize that MMC is not 100% effective:** Encourage continued use of ABC+ prevention strategies. All constituencies included in the situation analysis expressed concern that a MMC program would promote promiscuity due to the perception that circumcision enhances sexual activity and the potential for risk compensation by newly circumcised men. Promotional materials must emphasize that MMC is not 100% effective against HIV, and that existing HIV prevention strategies must continue to be used by circumcised men and their female partners. In addition, risk compensation has not been demonstrated in studies of MC and this finding should be mentioned in MMC promotional materials.

- **Minimize fears of MMC procedure, and highlight investment in MMC program:** Many people perceived that MC is a traumatic procedure that is very painful, often results in complications, and requires a long recovery period. In light of these findings, current MC practices in medical settings should be examined and improved where necessary, prior to and alongside the introduction of new MMC services. Promotional materials should provide a clear explanation of the procedure and presentation of what to expect during and after MMC to reduce
misperceptions and fear. Highlighting the substantial investment in preparing health facilities for MMC intervention will be helpful.

6.0 LIMITATIONS

The situation analysis included only a small sample of four districts, 26 health units, and 59 health care providers. In addition, of the 59 health care providers interviewed, 72% were from Kampala. Therefore, the data collected may not be representative of the entire country of Uganda. Nevertheless, the assessment provides important insights into people’s knowledge, attitudes, perception and practice of MMC, as well as the preparedness of health facilities to conduct MMC.

7.0 REFERENCES