FACTORS AFFECTING THE UPTAKE OF VOLUNTARY MEDICAL MALE CIRCUMCISION SERVICES AMONG THE YOUTH IN KISUMU COUNTY

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2012
DECLARATION

I declare that this is my original work and has not been presented for an award of a degree in any other university.

Signature _______________ Date _______________

Margaret Akinyi Egessa

This project has been submitted for examination with my approval as the University Supervisor

Signature _______________ Date _______________

Dr. Charles Owuor-Olungah

(i)
DEDICATION

This work is dedicated to my mother Petronala O. Anam for having taken the risk of taking me to school.
ACKNOWLEDGEMENTS

I would like to acknowledge and appreciate the valuable support of my supervisor Dr. Charles Owuor-Olungah for the time he put into this work, his valuable advice and guidance, the valuable recommendations and suggestions, without which I would not have completed this piece. I would also like to acknowledge all my lectures who took me through the Gender and Development course, for the insight, effort and time they dedicated to me. Gratitude to my colleagues and friends for all the support they accorded me during this course.

I also wish to thank my family for their constant encouragement that enabled me to overcome the difficult times during the course. I am therefore, deeply and sincerely indebted to them for the advice, patience, understanding and all the support they gave me during my course.

I would also like to thank my valuable respondents and informants for the time they accorded me during the period of data collection and without whom this research would not have been possible. Thank you all.
ABBREVIATIONS

ABC  Abstinence, Being Faithful and Consistent Condom Use

ART  Antiretroviral Therapy

FGD  Focus Group Discussion

FGM  Female Genital Mutilation

HIV  Human Immune Deficiency Virus

HTC  Home Testing and Counselling

IAGAS  The Institute of Anthropology, Gender and African Studies

KDHS  Kenya Demographic and Health Survey

JPHIEGO  John Hopkins Program for International Education in Gynaecology and Obstetrics

MC  Male Circumcision

MOH  Ministry of Health, Kenya

NASCOP  National HIV/STD Control Program

NRHS  Nyanza Reproductive Health Society

PEPFAR  President’s Emergency Plan for AIDS Relief
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<th>Acronym</th>
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<tr>
<td>PITC</td>
<td>Provider-Initiated Testing and Counselling</td>
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<tr>
<td>RCT</td>
<td>Random Controlled Trials</td>
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<tr>
<td>RH</td>
<td>Reproductive Health</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>TPB</td>
<td>Theory of Planned Behaviour</td>
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<tr>
<td>TRA</td>
<td>Theory of Reasoned Action</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Program on HIV and AIDS</td>
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<td>USAID</td>
<td>The United States Agency for International Development</td>
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<tr>
<td>VMMC</td>
<td>Voluntary Medical Male Circumcision</td>
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<tr>
<td>VCT</td>
<td>Voluntary Testing and Counselling</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>YPs</td>
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This study investigated the factors that affect the uptake of voluntary medical male circumcision services among the youth in Kisumu County. The research intended to contribute to the body of knowledge on VMMC. At policy level, the research sought to prompt a more acceptable approach towards implementation of VMMC in Luo land. In particular, the research sought to investigate the extent to which awareness of VMMC procedures, the socio-cultural norms and beliefs and the attitude of the service providers affect the uptake of VMMC services among the youth.

The study applied the Theory of Planned Behaviour which questions the classical model of Belief, Attitude, and Behaviour. It operates from the premise that, behaviour is determined by one’s intention, and intention is determined by the person’s attitude toward the behaviour and the influence of the person’s social environment or norms attitude towards behaviour; and that specific behaviour will have concrete consequence.

The data were collected using a survey questionnaire, key informant guide and FGD guide. A total of 100 respondents, 2 key informants and 2 focus group discussions among the trainees in YPs,

The finding of the study indicates that a majority of the respondents had knowledge on the procedures of VMMC however; the uptake is still low among the youth. Non-circumcision was mentioned by most participants as a significant cultural characteristic that distinguished the Luo from other communities, and some expressed
fear that introducing circumcision could cause loss of this cultural identity. In as far as service providers attitude and service provision are concerned, the barrier to MC uptake was the long distance to the health facilities. The study recommends that the government carries out door to door campaigns to popularize circumcision as a tool for lowering the rate of HIV transmission.

There is also need mass counseling for both men and women on the advantages of MC and the health care providers should demystify the belief that circumcision results in loss of virility or otherwise and properly educate the people on the link between MC and HIV transmission. Finally, there is need for a change of attitude among the Luos that MC is an alien culture and practicing it will make them slaves of other people’s culture.
CHAPTER 1: BACKGROUND TO THE STUDY

1.1. Introduction

Male circumcision (MC), the surgical removal of the foreskin of the penis, is a common surgical procedure worldwide that is performed for a variety of cultural, religious, social, and medical reasons (Gichocki, 2008). On one hand, there are communities that do not traditionally circumcise and who see such campaigns to take up MC as an affront on their culture. Research has shown that, under the proper circumstances, MC can help men avoid HIV infection but it cannot, however, eliminate the risk entirely. In light of these findings, the United States Agency for International Development (USAID), in accordance with the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), promotes a particular type of MC – Voluntary Medical Male Circumcision (VMMC) -- as part of a larger combination HIV-prevention portfolio. The Joint United Nations Program on HIV and AIDS (UNAIDS) and the World Health Organization (WHO) recommend safe, voluntary male circumcision as an additional, important strategy for the prevention of heterosexually acquired human immunodeficiency virus (HIV) infection in men in areas with high HIV prevalence and low levels of male circumcision (WHO/UNAIDS, 2007).

However, male circumcision can have deep symbolic meaning that could pose barriers to implementation. In some parts of the world, male circumcision is a traditional practice with religious or cultural significance; in others, it is a common hygiene intervention; and in yet others, it is unfamiliar or foreign. Consequently, the proportion of men who are circumcised varies by country from less than 5% to more than 80%, with an estimated 30% to 40% of adult
men circumcised worldwide (Rizvi et al., 1999). There is no comparable evidence demonstrating that male circumcision protects against male-to-female transmission or male-to-male HIV transmission (Marks et al., 2008). Male circumcision is a relatively simple, inexpensive one time surgical procedure that is cost effective, but raises a host of ethical, legal, and human rights challenges. There are also concerns on how to package the MC information to avoid misconceptions, false sense of security, safety, ethics and need for continual engagement at the community level. In such situations, the campaign is affected by lack of proper information leading to rumors, fears, misinterpretation of facts and sometimes political interference (UNAIDS, 2008).

The VMMC service delivery package supported through PEPFAR includes screening and treatment of sexually transmitted infections (STIs); HIV counseling and testing; risk reduction counseling focused on increasing the correct and consistent use of both male and female condoms, decreasing the number of multiple and concurrent sexual partnerships, and promoting other positive behavior changes relevant to HIV prevention; and ensuring active referrals of HIV-positive men to care and treatment programs (UNAIDS, 2007).

The benefits of male circumcision show that the practice has health and social benefits to society. Male circumcision is the latest addition to the proven strategies that people can use to protect themselves from HIV infection. Three conclusive studies, conducted in Kenya, Uganda, and South Africa, showed that male circumcision reduces a man’s chances of getting infected with HIV by about 60 percent (Auvert et al., 2005). This means that being circumcised can dramatically reduce a man’s risk of HIV infection, but it also means that male circumcision does
not provide complete protection against the virus. That is why it is critical to ensure that male circumcision is perceived as an addition to, and not a replacement for other effective HIV prevention measures. To ensure that they are protected against HIV infection, circumcised men and their partners must continue to practice the “ABCs” of safe sex; abstinence, being faithful to one uninfected partner, and correct and consistent use of condoms (WHO/UNAIDS/JPHIEGO, 2008). That is why health services in Kenya and other countries are offering male circumcision not as a stand-alone surgical procedure, but as an integral part of a comprehensive package of HIV prevention services (Binagwaho, 2010).

This approach follows the recommendation of the World Health Organization. The WHO’s *Male Circumcision Quality Assurance: a Guide to Enhancing the Safety and Quality of Services* states that a minimum package of HIV prevention services should be offered, and that male circumcision is not just the surgical procedure.

The Government of Kenya adopted Male Circumcision (MC) as part of the comprehensive strategies to reduce risks of HIV infection in line with the goals of the Political Declaration on AIDS and the Declaration of Commitment on HIV to make available to the public HIV related goods, services and information. Because its protective effect is partial, it is to be provided as part of a minimum package of the comprehensive HIV prevention and risk reduction strategies and as part of a broader male sexual and reproductive health promotion program (WHO/UNAIDS, 2007). This includes making available all effective sexual and reproductive health options accessible to all communities and individuals in an acceptable manner. The service providers will ensure that the process of providing male circumcision services is safe and
voluntary. Also, they will ensure the principles of informed consent, including accurate and sufficient information that is understandable to the client; assessment of capacity of the clients and the audience to understand given information; confidentiality; assurance of non-coercion and assisting those categorized in law as children to make informed decisions (WHO/UNAIDS, 2007).

According to studies, achieving 80% of male circumcision coverage by 2015 and maintaining it thereafter would avert more than 20% of projected new HIV infections in Botswana, Lesotho, Malawi, Namibia, Rwanda, Swaziland, Uganda, Zambia and Zimbabwe. Achieving this benchmark will meet 80 percent of the estimated demand for medical male circumcision (Hankins et al., 2011).

Kenya’s strategy proposes a phased approach, with the initial phase (three to five years) aiming to increase the proportion of Kenyan boys and men ages 15 to 49 who are circumcised from 84 percent to 94 percent by 2013. These goals are based on mathematical modeling studies suggesting that the impact of male circumcision on Kenya’s epidemic will be greatest if most of the eligible men can be reached as quickly and safely as possible. The focus will be on expanding access to male circumcision where the percentage of men who are circumcised is low and the prevalence of HIV is high. This will be primarily in selected districts of Nyanza, Western, Rift Valley, and Nairobi provinces. Reaching 80 percent of uncircumcised boys and men aged 15 to 49 in Nyanza by 2013 would prevent an estimated 900,000 infections among men and women over 20 years (Male Circumcision Consortium, 2009).
The formal adoption of male circumcision as a medical intervention against HIV infection by the government of Kenya initially met with resistance mainly from elders in traditionally non-circumcising communities. In Nyanza, the Luo Council of Elders initially came out strongly in condemnation of the promotion of male circumcision considering it to be an affront on the Luo culture. But they were also concerned with the potential for risk compensation and how best the messages would be packaged to avoid chances of misconceptions. Subsequently, after discussions and proper presentation of facts, the Council supported the initiative. There has been an upsurge of young men willing to undergo male circumcision in government and private hospitals and clinics although others still feel that it is not necessary (Nyanza Communication Guide, 2001). It is against this background that the study to assess the factors that affect the uptake of Voluntary Medical Male Circumcision (VMMC) services among the youth in Kisumu County was undertaken.

1.2. Problem Statement

MC is an emerging technology for primary intervention in HIV prevention that has been conclusively shown to proffer significant effectiveness in reducing heterosexual HIV-1 and HIV-2 acquisition to men, particularly among the high risk groups. Randomized Controlled Trials having confirmed that MC reduces the chances of HIV infection by about 60%, it would be important that communities that have low circumcision rates and high HIV prevalence take up this practice for prevention measures. However, as the study title suggests, these have been random and done across the general population and there has never been a study in Kisumu County mainly narrowing down to the youth and especially those that are in institutions of learning. This study was carried out specifically among the youth who are trainees in Youth
Polytechnics. The need to pay special attention to the youth arises from the fact that it has been found out that despite much progress in male circumcision in Nyanza, majority of the targeted youth remain uncircumcised. According to the National Male Circumcision Task Force, the primary target group of sexually active group, especially those in their 20s, is becoming a hindrance to the operation as they cite loss of income during the recuperation period as the reason for not being circumcised. In a statement attributed to the task force chairman, Dr Kioko, most of the men aged 25 years are shying away from the cut for numerous reasons such as loss of income and demands by their partners as well as possible complications. It has been observed that most of those defying the cut were basing their argument on misinformation about the voluntary medical male circumcision. Values—as expressed in social, cultural and gender norms, attitudes, and beliefs crosscut the entire socio-ecological approach and anchor individual and social behavior. For MC, these relate to notions of masculinity, sexuality, attitudes to risk, culturally rooted meanings around circumcision and the male body, and issues relating to gender.

This study therefore, sought to establish the factors that affect the uptake of VMMC services among the youth in Kisumu County given that this is one of the sites where the initiative is being carried out. It is however, of great concern that despite the availability of the VMMC services in this region, the uptake is rather low and the set targets may not be met (Otieno, 2012). To this end the study was guided by the following research questions:-
1.3. Research Questions

i) How does the awareness of what VMMC involves affect the uptake of the service?

ii) Which socio-cultural norms and belief systems affect the uptake of VMMC services among the trainees?

iii) How does the attitude of the service providers affect the uptake of VMMC services by the trainees?

1.4 Objectives of the Study

1.4.1 General Objective

The main objective of the study was to examine the factors affecting the uptake of VMMC services among the trainees in YPs in Kisumu County.

1.4.2 Specific Objectives

i) To find out how awareness of the procedure involved in MC affect the uptake of VMMC services.

ii) To establish the link between socio-cultural norms and belief systems to the uptake of VMMC services.

iii) To assess how the attitude of service provider is affecting the uptake of VMMC services.
1.5. Justification of the Study

This study sought to identify and further understand the key factors that may affect the willingness of the trainees in Youth Polytechnics (YPs) in Kisumu County to take up VMMC services. The findings of this study plays a pivotal role in assisting the policy makers put in place measures that will increase the number of youth who are going to take up VMMC services. Since this group is in the sexually active age and forms a bigger target group for VMMC services, an increase in the number that go for MC will result in significant reduction in the rate of HIV infections. The study brings more insight into the factors that hinder the uptake of VMMC services among the youth in Kisumu County. It also plays an important role in informing the service providers on how to improve and expand the VMMC services to make them more accessible to the youth who are one of the target groups. This is because despite the efforts that are already in place for the provision of VMMC services, the uptake is slow and the target may not be realized by the stipulated year of 2015. Generally, the findings of the study has the potential to assist VMMC service providers put in place measures to enable the realization of the MC targets set for 2013.

1.6. Scope and Limitations of the Study

This study was conducted in selected Youth Polytechnics in Kisumu County, Nyanza and was limited to knowledge and factors influencing attitude towards the uptake of voluntary medical male circumcision services. As a result of limited funding, this was a qualitative and quantitative cross-sectional study on a small sample focusing on reasons for or against uptake of VMMC services, looking at knowledge and attitude of the trainees who were undertaking different trades in the Youth Polytechnics in the County. This limitation of the study to youth who were trainees
in the Youth Polytechnics had potential bias because there were other youths outside these institutions who had issues regarding the uptake of VMMC services. In addition, the small sample size was not representative or sufficient enough to allow for the findings to be generalized to Kisumu population or the Luo community. Another limitation was the sensitivity of the topic which inhibited open discussion with the respondents who were not willing to make full disclosure on whether they had undergone MC or not to a female researcher. However, this problem was dealt with by involving a male research assistant.

1.7. Assumptions

i) The trainees’ awareness of the procedure of VMMC affects the uptake of the services.

ii) Socio-cultural norms and belief systems affect the uptake of VMMC services.

iii) The attitude of the service providers affects the uptake of VMMC services.

1.8. Definition of Key Terms and Concepts

Youth: The Kenya National Youth Policy, 2009, defines a Kenyan youth as one aged between 15 and 30 years. This takes into consideration the physical, psychological, cultural, social, biological and political definitions of the term.

Male Circumcision: the surgical removal of the foreskin of the penis; a common surgical procedure worldwide that is performed for a variety of cultural, religious, social, and medical reasons.
Voluntary Medical Male Circumcision: part of a larger combination HIV-prevention portfolio that recommends safe, voluntary male circumcision as an additional, important strategy for the prevention of heterosexually acquired human immunodeficiency virus (HIV) infection in men in areas with high HIV prevalence and low levels of male circumcision.
CHAPTER 2: LITERATURE REVIEW

2.1. Background of Male Circumcision

Male circumcision (MC) is a surgical procedure during which all or part of the foreskin (the fold of skin covering the head of the penis) is removed by making a surgical cut around the head of the penis (Gichocki, 2008). Globally, there are different types of MC. However, the most common type is where the foreskin of the penis is completely removed, exposing the entire glans of the penis (Doyle, 2005). Voluntary Medical Male Circumcision (VMMC) is the surgical removal of the foreskin from the head of the penis that is performed by trained medical providers under local anesthesia to prevent pain. Historically, MC has been associated with religious and cultural identity. Worldwide, the primary determinant of MC is religion, with almost all Muslim and Jewish males, being circumcised because of the belief that a covenant was made between Abraham and God (Rizvi et al., 1999). In some societies, MC has been associated with health benefits such as prevention of local foreskin problems, cancer of the penis, urinary tract infections, STIs and genital hygiene enhancement. Female partners of circumcised males have also reported a lower risk of acquiring Human Papilloma Virus (HPV) and cervical cancer. Recently male circumcision has been shown to be associated with lower transmission of STIs including HIV (Bailey et al., 2007).

Approximately 30% of the world’s males aged 15 years or older are circumcised. Of these, around two thirds are Muslims living mainly in Asia, the Middle East and North Africa, 0.8% are Jewish, and 13% are non-Muslim and non-Jewish men living in the United States of America. In Southern Africa, the prevalence of adult MC is rather low and is estimated to be around 15% in
countries like Swaziland, Zambia and Zimbabwe (WHO & UNAIDS, 2007b). However, the prevalence of adult MC is higher in other countries such as Malawi (21%), Botswana (25%), South Africa (35%), Lesotho (48%), Mozambique (60%), Angola (66%) and Madagascar (80%). Nevertheless, in each country, the proportion of circumcised men varies with provinces and ethnicities (WHO & UNAIDS, 2007b).

In Kenya, male circumcision is widely practiced and often serves as a rite of passage to adulthood. According to the 2008-09 Kenya Demographic and Health Survey (KDHS) it is indicated that the majority of Kenyan men (86%) were circumcised. Young men at age 15-19 years are the least likely to be circumcised. Men in urban areas (91%) are more likely to have been circumcised than their rural counterparts (84%). At least 90% of men are circumcised in all provinces except Nyanza province, where less than half the men (45%) are circumcised and among the Luo ethnic group (22%) (Central Bureau of Statistics [CBS], Ministry of Health [MOH] & ORC Macro, 2004). This variation in MC prevalence in most African countries and as noted in Kenya, is partly due to some groups who are traditionally non-circumcising, and also due to different ethnicities living in various parts of Africa (WHO & UNAIDS, 2007b).

Evidence from a study among the Sukuma ethnic group in North-west Tanzania, revealed that MC is becoming a popular practice in traditionally non-circumcising groups because of the HIV prevention programs implemented in those areas (Nnko et al., 2001). The study further revealed that perceived health-related reasons such as enhanced penile hygiene and reduced STI risk among those communities popularize the MC practice. In some sub-Saharan African countries, there is an indication that a high socio-economic status is associated with higher rates of
circumcision in traditionally non-circumcising communities. For instance, the rate of circumcision is higher among men with higher levels of education and those who live in urban areas. It was pointed out that, higher levels of education may imply social contact with a broader mix of different ethnic and religious groups. This in turn increases the likelihood of circumcision given such socio-behavioral interactions (Halperin, et al. 2005, Nnko et al., 2001).

2.1.1. Research on MC

Three randomized controlled trials conducted in South Africa, Kenya, and Uganda examined the impact of male circumcision on the transmission of HIV from women to men. The trial in Orange Farm, South Africa enrolled 3274 uncircumcised, HIV-negative men aged 18–24 years, and showed a 61% protective effect against HIV acquisition (Auvert et al., 2005). The trial in Kisumu, Kenya involved 2784 HIV-negative men, and showed a 53% reduction in HIV acquisition in men who became circumcised, compared with those who remained uncircumcised (Bailey et al., 2007). The trial in Rakai District, Uganda involved 4996 HIV-negative men, and showed that HIV acquisition was reduced by 51% in men who became circumcised compared with men who remained uncircumcised (Gray et al., 2007).

The trials involved adult, HIV-negative heterosexual male volunteers assigned at random to either undergo circumcision by trained medical professionals in a clinic setting, or wait until after the end of the trial to be circumcised. All participants were extensively counseled in HIV prevention and risk-reduction techniques, and were provided with condoms. Although the results of these trials are highly significant, it is essential to emphasize that male circumcision does not provide complete protection against HIV. Furthermore, HIV-infected circumcised men can still
transmit HIV to female and male sexual partners. There is no strong evidence that male circumcision reduces the risk of HIV transmission to a female partner, or that male circumcision reduces the risk of HIV transmission during anal sex to the receptive partner, whether male or female. Because the protective effect of male circumcision is only partial, male circumcision must be promoted in combination with other methods to reduce the risk of sexual transmission of HIV, including: correct and consistent condom use, delayed sexual debut, reduced numbers of sexual partners, avoidance of penetrative sex and voluntary HIV testing and counseling (Auvert et al., 2005).

2.1.2. MC in Kenya
Male circumcision is practiced by many communities in Kenya. In addition to religious reasons, circumcision often serves as a rite of passage. Data from the (2008-09) Kenya Demographic and Health Survey shows that 84% of Kenyan men are circumcised. A lower proportion of men age 15 to 19 are circumcised (72%) than those at older ages (minimum 84%). This could indicate a decline in the practice; however, it is more likely that some men do not go through the circumcision process until after age 20. More than 90% of men are circumcised in North Eastern, Eastern, Coast, and Central Provinces; more than 80% in Nairobi, Rift Valley and Western Provinces. In Nyanza, the prevalence of male circumcision overall is 46%, although there is wide variation within districts ranging from 17% to 99%. Nationally, HIV prevalence among adults is estimated at 5.1% with a significant proportion of new infections occurring among sexually active young adults. HIV prevalence exhibits similar regional variations with circumcision in that regions with high circumcision rates such as North Eastern, the prevalence rate is a low
of<1% while Nyanza with a low circumcision rate the prevalence of is peaking at 18% (KDHS, 2008-09).

The Government of Kenya has facilitated the development of the Kenya National HIV/AIDS Strategic Plan, the National Health Sector Strategic Plan II and other strategic documents jointly agreed upon by stakeholders within Government, civil society, the private sector and development partners. These documents form the basis for the scaling up of HIV prevention, care and treatment and the strengthening of health care delivery in Kenya (NASCOP, 2009).

2.1.3 Male circumcision among the Luo

Precisely and in its broadest sense, circumcision can be defined as 'the ritual mutilation of the genital organ'. In the case of men, this rendered the tip of the male organ uncovered. It involved the cutting of the foreskin among most Bantu peoples of Africa, but among the Southern Luo, it involved the cutting of the connective tissue joining the foreskin and the male organ at the back. The Luo people had their own methods of observing the ritual of circumcision which was only different in method. Ruth Benedict, in a discussion of rites that mark the passage of individuals to adult status recognizes that "what we need to know about such rites is what is identified in different cultures with the beginning of adulthood and what are their methods of admitting novitiates into the new status" (Benedict, 1939, pg 161).

There has also been a misconception that the removal of the lower teeth was the equivalent of circumcision among the Southern Luo. This is wrong since even among the Kipsigis, Teso, Maasai, etc., the removal of the teeth did not replace ritual circumcision among them. The
removal of the lower teeth among the Southern Luo, and others could therefore not replace ritual circumcision whatsoever, it had its own purpose (Benedict, 1939).

The Luo mode of circumcision has been eclipsed from the knowledge of most people. This has been accentuated by the fact that details such as festivious preparations and pomp after the operations which characterized most Bantu circumcision ceremonies were not practiced in Luo land. The ‘seclusion period’ was also non-existent in the concept of Luo circumcision, the operations were instead extempore. The absence of the seclusion period in the Luo concept of circumcision was due partly because, the Luo initiates had a short ‘healing period’ or convalescence. The nonexistence of the seclusion period in the concept of Luo circumcision was also partly due to their nomadic tradition of pastoralism and fish hunting which could not allow them to stay secluded in one place. All these reasons rendered the seclusion period unnecessary among the Luo people (K’Aoko, 1986).

2.1.4 Methods of circumcision in Luo

The Luo methods of circumcision differed from the Bantu method in that, it was a simple operation on younger boys of over twelve years by older ones who had qualified through the painful ordeal. The convenient places that the operation took place were the grazing fields where the young herds’ boys opted to carry out the operation. The operations were supervised by the older ones, who only reported to the elders on what they had done and the progress of the initiates. The young boys who had not gone through the operation were teased, and called dirty little ones. In some cases, when someone had come of age but had not braced up to suffer the ordeal, even girls would not want to shake hands with him (K’Aoko, 1986).
One method which the initiates had to brace up to involved the use of Okoko, which is the male soldier ant. The boy to undergo the operation had to sit with his legs apart. The male soldier ant would then be caught and its incisor like proboscis placed squarely on the connective tissue that joins the penile foreskin to the male organ. The male soldier ant would then tighten its grip onto this area to sever through the connective tissue. The result of this would be that the penile foreskin would shrink or recoil back and remain leaving the part of the male organ permanently uncovered (K’Aoko, 1986).

During this process, exceptional endurance among the candidates was their pride, since it earned them considerable respect among age groups. It also earned the candidates respectful names like Thwon or Thwondi in plural, meaning the brave ones. The fresh initiates, according to traditional Luo norms, were no longer expected to sleep in their parents hut. They were expected to sleep in hut known as Simba, which was shared by the age groups before each built a hut of his own (K’Aoko, 1986).

The other mode of circumcision was The Wino method (Flywhisk Method) which seems to have been very popular among the Southern Luo. In this flywhisk strand method, the operation procedure involved the presence of a thorn known as Kuth Alak Tar (the acacia tree thorn) and one long strand from a flywhisk known as Wino. The initiate was held down by a number of older ones with his legs apart. The thorn is first used to pierce through the connective tissue joining the foreskin to the male organ. As the thorn pierces further, blood drips from the mutilated part. The Wino is then passed through the opening made by the thorn, and knotted.
tightly round the circumference of the tissue. The hanging portion of the Wino is trimmed short by the use of an arrow blade or just a knife (K’Aoko, 1986).

The operation had no official preparation but was extempore just as the other methods of Luo circumcision. The knotted strand would slowly cut through the tissue overnight after two days, or more, depending on the individuals. The result was that the foreskin would shrink or recoil after the connective tissue had been circumcised by the strand of the flywhisk. The black strand from the flywhisk was supposed to be removed from particularly a black bull. It was not to be got from a heifer or a dairy cow. The symbolism behind this was that it was to depict the initiate’s maturity and manhood that the concept of initiation sought to fulfill (K’Aoko, 1986).

Since the Luo type of circumcision was carried out extempore, there was therefore, no fixed season in which the candidate could undergo the ritual ordeal in the pasture fields. The tacit approval of the elder’s attitude towards the ritual operations encouraged the older ones who had undergone the operation to recruit eligible candidates for the painful ordeal. To mark and also to remind one of the good performances during the endurance test, the exceptionally successful circumcision graduate (or *Thuon*) was likely to be designated to important strategic positions during ancestral pre-colonial wars among other warriors.

The *Tuchruok*, (The Piercing Method) is another method of circumcision that was used. In this procedure, the older boys who had undergone the operation got hold of the boys to be operated, setting them ready for the ordeal. The acacia tree thorn is used to pierce through to the connective tissue joining the foreskin to the inner dermis of the male genital. Since the hind part
of the thorn is generally larger than the fore part, the sharp part is pushed further, thereby widening the ‘opening’. The widening process continues until the connective tissue joining the foreskin to the inner dermis of the male genital is finally severed. Here too, like in the previous cases, the foreskin shrinks backwards, leaving the forepart of the male organ permanently uncovered (K’Aoko, 1986).

The last method of the Luo genre of circumcision that was also popular was the Ridhruok (Peeling Method). In this type of operation, the foreskin of the male organ is the part that was mutilated by the peeling process. In this method the penile connective tissue is not mutilated like the other four methods, but, the older boys after getting hold of the boy to be initiated would force back his foreskin continuously until the tip of the male genital organ remained uncovered. However, brave ones could perform the ordeal themselves without help from anywhere. Some preferred to perform the operation bit by bit for a few days until finally the tip of the penis remained uncovered. This is the method that did not require great courage, and therefore the least painful. There was not much bleeding either, particularly for those who opted to carry out the operation gradually. Since this method was the least painful, it was dubbed the method of cowards. In Luo mode of circumcision, there were no specialists to act as “Craftsmen” for the rituals. It was the reliable accomplished firsthand experience of the older boys who had gone through the rituals that rendered them ‘experts’ to perform the ritual on the candidates (K’Aoko, 1986).
2.1.5. Significance and Meaning of Luo Circumcision

The significance of circumcision custom among the Luos was that it marked radical changes for the individual. During that period, a person went through physical, emotional and psychological changes, which took him from childhood through adolescence to adulthood. One physical importance of the circumcision was that this operation helped in adulthood because in most cases people were known to bleed if they indulged in copulation before undergoing the ritual ordeal (K’Aoko, 1986).

Another physical importance of the custom according to the Luo people was that it marked the acceptance of youth into adulthood, it was thus a transitional rite marked by the cutting of the connective tissue as symbol of getting rid of the period childhood, and getting ready for adulthood. It also had the physical importance of bridging youth and adulthood; initiation was therefore, a central bridge in life. It was initiation that also bridged the male and the female, fatherhood and motherhood, since it signified the official permission for marriage and the subsequent bearing of children. Also, a person could perform sacred rituals after initiation. As seen in the fact that the boys who had undergone the ritual could be allowed to perform it on younger ones (K’Aoko, 1986).

In the Luo mode of circumcision, the graduates who successfully underwent the pains of the ordeal were then considered responsible enough to be able to have the right to inherit the property from their parents. The initiates could also be able to inherit the widow of a deceased elder brother or relative, to discourage widowhood. The emotional dimension of the change undergone was manifested in the bloodshed during the painful operation. The shedding of this
blood onto the ancestral land was intended to bind the initiate to the departed members of the community including ancestors, who are in the intermediaries with the sacral deities of Luo spiritual life. This was an important rite which emphasized the relationship of the initiate and the sacred dimension of life, that is, the physical and the spiritual (K’Aoko, 1986).

Returning home was a psychological change on the initiate like a new birth. The graduates went home from the pasture field as new people and responsible. Another psychological change on the initiate was that it was believed to be a mark of solemn unity and identification. The Luo genre of circumcision identified the initiates as members of Luo people. The psychological changes that an initiate underwent included the significance of the pains during the operation. The tolerance of the pangs of the ordeal was token of the endurance test and prowess of the initiate. Betrayal of pain was a sign of cowardice, an attribute that was not respected among the male circles in Luo land. The initiates considered themselves as a batch of an incumbent age-set, made up of young men who had undergone initiation at the same time (K’Aoko, 1986).

It is noteworthy that this concept of Luo circumcision ensured that the need for genital hygiene was observed as a concomitant factor, it is also worth noting that in the Luo mode of circumcision there was no, equivalence of Bantu traditional education during the seclusion period. Since there was no seclusion period in Luo circumcision, the traditional schooling among the Luo took place mostly at the Duol, or bonfire. An elder would often be present at the Duol to inculcate ancestral Luo values to the young adults and the young adults could advice each other at the Simba (K’Aoko, 1986).
2.1.6. The Prevalence of Luo Circumcision Rite in Contemporary Luo Life

It is noteworthy that the practice of Luo ritual circumcision is still operational in some parts of Luo land such as parts of South Nyanza, Siaya and the vicinities of Lake Victoria regions. This persistence can be experienced in the areas of Luo land mentioned above, but not equally true of the urbanized Luo. Only those who underwent the operation before migrating to the urban areas can be considered to know about the painful ordeal. The gradual marginalization of the ancestral Luo circumcision from the secular ways of life has been accelerated by the rapid economic and social changes of the modernization process (K’Aoko, 1986).

The survival of this Luo ritual has been manifested in contemporary life by the prevalent existence and practice of the peeling method. This method has managed to survive considerably better than the other methods because of the fact that it was the most simple and least painful besides it is a method that one could easily perform himself. The result of this preference of the Ridhruko method, nowadays, is that ancestral methods are not very much thought of now, yet it was one of the methods that every Luo boy was supposed to undergo before becoming a man (K’Aoko, 1986).

However, even though the Luo mode of circumcision has been affected by some aspects of social, the revival for the survival of Luo circumcision need more enthusiastic practitioners in present Luo life. Therefore it is noteworthy that quite a number of people from Luo land have undergone the operation, but a large number of the young generation, especially the urbanized, have not heard of the ritual ordeal (K’Aoko, 1986).
2.1.7. The Future and Effects of Contemporary Change on Luo Circumcision

The wave of contemporary change and westernization has threatened to affect Luo ancestral circumcision in several ways. The new factors which affect the Luo custom include the concept of urbanization which has resulted into rural urban mobility, forcing the modern Luo to search for jobs in towns and dwell there. Some of them have settled in these towns with their families, resulting into the eclipse of the customary practice among the Luo youths. This is because they no longer hold cattle in the grazing fields where the customary ritual was practiced. The modern moneyed economy forces the parents to hire herdsmen to graze the cattle back at the countryside. Western education has also aggravated the modern Luo youth’s ignorance in the traditional initiation rite. The post-colonial school as an institution of learning has encouraged the teaching of western cultural values and beliefs in the educational system.

The ancestral norm that every eligible age-group had to go through the rite of passage, in order to be considered an initiate who had graduated, has nowadays been relaxed by contemporary permissiveness of the social order. This has been made worse by the influence of modern affluence in present society. The future of the concept of Luo circumcision is partly uncertain because of the present violation of the virginity cult, yet it is noteworthy that the breaking of the hymen in marriage provided a necessary pre condition for observing the ritual. Despite temporary changes in Luo, cultural practices the Ridhruok method’s future in the concept of Luo circumcision may keep persisting deriving this persistence to its simplicity. The ignorance of some urbanized Luo youth about the ritual practice has forced some of them to resort to the hospital for the observation of the ritual. But in the modern hospitals the youth have ended up surgically cutting the male foreskin of the genital organ, instead of the connective tissue joining
the male organ and the foreskin as was the case of the Luo ancestral circumcision (K’Aoko, 1986).

In the hospital, anesthesia is applied to render the male organ insensitive to pain during the operation. This is opposed to the significance of the endurance test, which was meant to gauge the manly prowess of the individual undergoing the operation. The Luo type of circumcision has nowadays moved out of its age old practice of carrying out the ordeal, and has acquired the designation of a surgical operation in modern medical clinics. The modern medical clinics have made use of the surgical blade or the pair of scissors, to cut the foreskin of the male organ. In retrospect, Luo ancestral circumcision should adjust with contemporary change. This fact that the Luo community had always been undergoing their own unique methods of ancestral circumcision has been clouded from the awareness of most Kenyans. This is evident from the very fact that various ethnic groups in Kenya have coined words in their different vernacular, to refer to the uncircumcised ones, particularly beamed at the Luo people (K’Aoko, 1986).

2.1.8. Beliefs about Health Benefits of Male Circumcision

In Kenya, a study conducted in Nyanza province among 107 men and 110 women found that 91% of men in Nyanza province associated MC with better penile hygiene, even among those who preferred to remain uncircumcised. The same study found that the majority of women, irrespective of their partners' circumcision status, believed that uncircumcised men are more likely to contract STIs and even HIV (Mattson et al., 2005).
Generally, penile hygiene was believed to be a major facilitator of MC in both traditionally circumcising and non-circumcising communities (Kebaabetswe et al., 2003). In fact, in some societies, being uncircumcised is unacceptable and it is believed to cause diseases. For instance, in a qualitative study to analyze the cultural concepts, practices and social relations associated with MC in two West African countries, Senegal and Guinea-Bissau, the foreskin was believed to be dirty, a source of bad smell and disease, and even evil. The study further showed that sexual relations between a man who is not circumcised and a woman who is a virgin is perceived to cause a terrible disease whose symptoms are similar to those of AIDS (Niang & Boiro, 2007).

2.1.9. Service delivery approaches

VMMC services are provided at static, outreach, and mobile sites. Static sites are health facilities that are equipped and staffed to provide services on a routine basis. The outreach approach entails provision of services on an ad hoc and one-off basis by mobile teams in response to sharp increases in demand at lower level facilities, which do not have the capacity (human or infrastructural) to offer routine VMMC services. Outreach teams use such nonclinical facilities as schools, churches, and other community centers. Before service provision is allowed to proceed (and usually for only a limited number of visits), facilities identified as potential outreach sites are assessed to ensure that they could be supported to offer the minimum infrastructure required for safe VMMC services (MOH/NASCOP, 2008).
2.1.10 Voluntary Medical Male Circumcision Procedures

Each client seeking VMMC is registered and given a card with a unique identification number. The client's age and other demographic data are recorded at registration. Then Community mobilizers and peer educators provide basic public information about HIV and male circumcision to clients waiting for services. This includes demonstration of the use of condoms and other reproductive health (RH) commodities and the MC procedure. At some sites, entertainment education is also provided through video clips and songs that are used to prompt dialogue and question-and-answer sessions (Nyanza Provincial Task Force on Male Circumcision, 2009).

For the purpose of consent, VMMC clients are divided into three groups, which are handled differently. The first group is made up of 18 year olds and older (adults) who are self-consenting adults and would then give informed consent; the next group is of 15 to 18 year olds (mature minors) who would require consent at home or at VMMC sites endorsed by parents, legal guardian, or a person with recognized parental responsibility. The parent and mature minor are counseled at VMMC site and endorse consent form before surgery. The mature minor may be circumcised in the absence of parent as long as the client presents consent form signed by parent in the presence of a trained VMMC counselor. The last group is made of those who are younger than 15 years (minors) and for this category, consent is given at VMMC sites by parents, legal guardians, or a person with recognized parental responsibility. The parent and minor are then counseled at VMMC sites since the parent or legal guardian must accompany minor to the site. The minor is only circumcised if accompanied by parent (MOH/NASCOP, 2008).
Counseling for VMMC involves detailed education about the risks and benefits of MC; reinforcement of safer sex practices; education about male sexual and RH issues; information about the partial protection from HIV and other STIs offered by the procedure; instructions on postoperative wound care and abstinence; and home testing and counseling (HTC). This is done by MC-trained HTC counselors. At the facility, a provider-initiated testing and counseling (PITC) approach is used. Linkages are also enhanced with existing VCT services for referral of eligible male clients for circumcision. HIV-positive clients receive post-test counseling and are referred to designated antiretroviral therapy (ART) sites (MOH/NASCOP, 2008).

Medical history and physical examination is done before circumcision in order to detect contraindications to the procedure and conditions that need treatment or referral. This is then followed by surgical excision of foreskin done under local anesthesia using the forceps guided method which is the most common method of performing medical circumcision in the public sector. Less common, but also safe and effective, methods of surgical circumcision are the dorsal slit and the sleeve resection. To perform a forceps guided circumcision pain killer is administered, then the foreskin is pulled over the head of the penis with a pair of forceps and the foreskin is then snipped using the forceps as a guide. Sutures are then done around the penis to hold the skin in place and a dressing is applied. Medical male circumcision is one of the most common procedures performed worldwide and complications are very rare and usually easily resolved (MOH/NASCOP, 2008).

Client record forms are completed immediately after surgery and postoperative instructions are given during a brief period of postoperative observation. Clients are instructed on how to remove
their dressings at home on the third postoperative day and given an appointment for postoperative review on the seventh day after the surgery (MOH/NASCOP, 2008).

2.2. Theoretical Framework

The study was informed and guided by the Theory of Planned Behaviour (TPB). The proponent of this theory is Ajzen. It is an extension of the earlier Theory of Reasoned Action (TRA), (Fishbein & Ajzen 1975), TPB states that individual behaviour is driven by behavioural intentions where behavioural intentions are a function of an individual's attitude toward the behaviour, the subjective norms surrounding the performance of the behaviour, and the individual's perception of the ease with which the behaviour can be performed (behavioural control). This perceived behavioural control is presumed to not only affect actual behaviour directly, but also affect it indirectly through behavioural intention (Zimmerman et al., 2005). Attitude towards the behaviour is defined as the individual's positive or negative feelings about performing the behaviour. It is determined through an assessment of one's beliefs regarding the consequences arising from a behavior and an evaluation of the desirability of this consequence. The centrality of behavioural intention questions the classical model of Belief, Attitude and Behaviour (Conner & Sparks, 1995). Behavioral control is defined as one's perception of the difficulty of performing a behavior. TPB views the control that people have over their behavior as lying on a continuum from behaviors that are easily performed to those requiring considerable effort, resources, etc.
In TPB, behavioural intention is determined by several factors. To begin with, attitudes towards
behaviour are determined by the belief that a specific behaviour will have a concrete
consequence and the evaluation of this consequence. Secondly, are the subjective norms or the
belief in whether other relevant persons will approve one’s behaviour, plus the personal
motivation to fit in with the expectations of others. Another factor is the Perceived Behavioural
Control, determined by the belief about access to the resources needed in order to act
successfully, plus the perceived success of these resources (information, abilities, skills,
dependence or independence from others, barriers, opportunities etc). And lastly, are the socio-
demographic variables and personality traits which condition attitudes, subjective norms and
perceived behavioural control.

2.2.1 Relevance of the Theory to the Study

Theory of Planned Behaviour is important to this study because it specifies the nature of
relationships between beliefs and attitudes. Since the form of MC promoted under VMMC is
not a cultural practice of this community, the choice to undergo it for an individual often
involves a lot of effort as one may be considered an outcast or be rejected after undergoing the
procedure. Those who undergo this in some areas in the region may be considered to be defying
the cultural norms and therefore, have to be prepared to be ridiculed and called names. The
model is thus a very powerful and predictive model for explaining human behaviour. According
to this model, people’s evaluations of, or attitudes toward behaviour are determined by their
accessible beliefs about the behaviour, where a belief is defined as the subjective probability that
the behaviour will produce a certain outcome. In some cases, the youth may be reluctant to
undergo MC because of the outcome and its implication in the future. These attitudes men have,
determine whether they will accept or reject MC as an HIV prevention method as influenced by
the social environment, that is, the community or society in which one lives or regards as
important.

To understand why the youth are not taking up the VMMMC services requires knowledge of their
socio-cultural background, their socialization and how their attitudes have formed. This makes
TPB relevant because of its encouragement of feelings of self-control which would be useful in
the case of the youth making a decision to go for MC as the theory promotes feelings of control
and self-efficacy in negotiating with partners.

Theory of Planned Behaviour is therefore, important to understanding the entire process of
decision making in either to adopt or not adopt MC as an option in the prevention of HIV
infection. The planned behaviour view of health has a bearing in the process of choosing
methods and by extension, the perception of the success and safety of the said method of disease
prevention.
CHAPTER 3: METHODOLOGY

3.1. Introduction

This section describes the research site, research design, sampling, methods of data collection, methods of data analysis and ethical concerns.

3.2. Research Site

This study was conducted in five randomly selected Youth Polytechnics in Kisumu County. The County has 11 youth polytechnics that are administered by the Ministry of Youth Affairs and Sports. The trainee population in these YPs was 440 with 141 females and 299 males. Total enrolment in YPs for the year 2009 was 18,122 trainees. This shows the critical role played by these institutions towards transforming Kenya into a medium income country by the year 2030. The YPs empower youth through provision of accessible, appropriate and quality training in technical, vocational, industrial, entrepreneurship and life skills.

Kisumu is one of the counties in Nyanza Region, which is predominantly populated by the Luo ethnic group. This is an ethnic group to which male circumcision is not a cultural practice. The districts that make up Kisumu County are Nyando, Kisumu East and West, Muhoroni and Nyakach. The county derives its name from Kisumu which is a port city in western Kenya.

Kisumu has gradually developed to an industrial town and the hub of political, industrial and economic activities in Western Kenya. It currently hosts some of the major industrial enterprises in Kenya as well as the regional headquarters of Nyanza Region. A good number of international and local NGOs also have their bases in Kisumu. This has lead to an increase in rural-urban migration in search of employment, mainly in the informal sectors. As a result of this and other
economic factors, Kisumu, currently experiences the highest average urban poverty levels at 48% against a national average of 29% (UN Habitat, 2009).

Kisumu is Kenya’s third largest city with a population of approximately 400,000 residents. The majority of Kisumu’s population belongs to the Luo ethnic group, one of Kenya’s largest and the only major group that currently does not practice circumcision even though they had various forms of MC performed in the past (K’Aoko, 1986). The Luhya, the Kisii and the Asian community form the other considerably present tribes in Kisumu with the Asians forming a large business enterprise block. Its cosmopolitan nature has attracted other ethnic groups who ply their trade in the Town. This has made Kisumu a cultural melting pot as a result of the interaction between different communities that have settled within Kisumu and its environs.

3.3. Study Design

The study design was cross-sectional, combining both quantitative and qualitative methods of data collection. It involved quantitative data; this included, free listing within the survey questionnaire to find out knowledge and ranking of MC as a method of HIV prevention among the trainees. The questionnaire explored emerging issues of knowledge and factors influencing attitude towards acceptance or rejection of MC among the youth. The second phase involved a Focus Group Discussions (FGD) to obtain qualitative data and explore some of the issues pertaining to MC that emerged in the questionnaire. The exclusion – inclusion criteria for the subjects was age and this was verified from the class registers so as to leave out those who are still minors.
3.4. Study Population and Unit of Analysis

The target group for study was male trainees in selected YPs in Kisumu County. Using convenient and random sampling, I sampled male trainees present in the institutions and administered the questionnaire to find out why the youth would accept or reject MC. I also carried out a focus group discussion with a few respondents to explore some of the issues pertaining to MC. The individual was the unit of analysis. This was because the aim of this study was to capture the attitude of men towards VMMC as HIV prevention method and factors which influence their uptake of VMMC services.

3.5. Sampling, Sample Size and Procedures

The sample size was a group of 100 male trainees. The researcher randomly selected trainees from selected YPs within Kisumu County. Five YPs were selected in the county and the researcher identified twenty students from each of the institutions. Specifically ten students were selected from each year of study and the class registers were used to randomly select the research subjects. The FGD involved 10-12 males Youth Polytechnic trainees who were randomly chosen from one urban YP and one rural YP.

Key Informant Interviews were conducted with a counselor in charge of a VMMC site and the Secretary to the Nyanza Reproductive Health Society (NRHS). The interviews elicited in-depth information on pertinent issues relating to MC as an HIV preventive measure through face-to-face interviews. The counselor was interviewed to explore emergent issues regarding up-take of MC services, healing practices, forms of resistance and piggybacking MC on other HIV preventive measures. The secretary to the NRHS was interviewed to explore wide issues such as
the VMMC strategy, the need for socio-cultural change, the attitude of the service providers and service provision models. Since the secretary has a lot of influence on the programming of the VMMC activity, exploring his views and concerns relating to MC as an HIV preventive measure is essential for identifying critical points for the envisaged service provision on MC.

3.6. Data Collection Methods

3.6.1. Survey

This technique was instrumental in collecting quantitative data. A standard questionnaire was administered to 100 trainees selected through random selection. The questionnaire comprised of both closed and open-ended questions to allow for probing as well as precision and efficiency during coding (Bernard, 2000). The information collected using this method included the demographic information of the respondents, their knowledge of the health benefits of MC, their willingness to undergo MC and what they considered as barriers to MC.

3.6.2. Focus Group Discussion

This method was used to provide qualitative data on major themes, which helped to contextualize the uptake of VMMC as a HIV infection prevention strategy. Such themes included acceptance and rejection of MC, social cultural influence on the uptake of VMMC services, peer pressure and acceptance of MC, masculinity stereotyping, communication and sharing of information and coping mechanism in the society after undergoing MC. This was important considering that the community does not circumcise and actually have a derogative name for those who have undergone it. There were two FGDs with 12 participants each and one
was at a Youth Polytechnic within Kisumu Municipality while the other one was in a YP in Nyando District.

3.6.3 Key Informant Interviews

Two key informants were interviewed. The first one, who is the secretary to the Nyanza Reproductive Health Society was considered specialist, articulate, knowledgeable and experienced in issues of voluntary medical male circumcision. He was used to provide additional information to that obtained through survey and Focus Group Discussions. The key informant provided in-depth information on the VMMC service coverage, service provision models, service providers training and the effect of socio-cultural belief system on the uptake of MC in the community. This took the form of conversation between the informant and the researcher.

The second informant was the counselor in charge of Lumumba VMMC site was interviewed to explore emergent issues regarding up-take of MC services, healing practices, forms of resistance and piggybacking MC on other HIV preventive measures.

3.7. Data Analysis

The data was analyzed using qualitative and quantitative techniques. It was prepared for analysis through editing, coding and cleaning. Quantitative data was analyzed using SPSS and Microsoft Excel then presented using tables, bar charts and pie charts. Qualitative data was subjected to content analysis. This was done by identifying emerging themes in the data, relating the themes to the study objectives to find out how they contribute to answering the study problem. This
brought out the perspective of the people. Direct quotes and comments from the key informants and FGD participants also helped in understanding the perception of the youth under study.

3.8. Ethical Considerations

Data collection always carries with it the possibility of doing harm, to others and these risks must always be minimized (Simmons and McCall, 1985). Given that this study was on a sensitive and controversial topic, being culturally unacceptable and having the HIV link, the principle of informed consent was always upheld throughout the recruitment process and data collection. Explanations on the study were continuously done; giving all the necessary information and permission was from the study subjects beforehand. The data collected was not be used in any way that was likely to cause embarrassment to the participants, as the data was kept secret and where in doubt of this the respondents were encouraged to be anonymous by not writing their names on the questionnaire and also using pseudonyms when attributing direct quotes to the informants. Whenever some people were not willing to give certain information they had, they were informed from the onset of the interview that they were not obliged to answer all the questions. They were also assured of privacy and confidentiality, security and ownership of the information and were free to withdraw from the study at any point.

In accordance with the principles governing research involving human participants, this study ensured the following were done to uphold respondents’ ethical rights; approval was given by the Institute of Anthropology, Gender and African Studies (IAGAS), a permit was applied for from the National Council of Science and Technology (NCST), Ministry of Higher Education, all participants were required to give informed consent prior to participating in the study, and all reasonable efforts to ensure that confidentiality was maintained were made. To ensure exclusion
of minors the ages were verified from the class registers. As concerns matters of compensation, since the study was not incisive, this did not arise.
CHAPTER 4: DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1. Introduction

This chapter discusses the research findings, interprets and presents the information on the factors affecting the uptake of voluntary medical male circumcision (VMMC) services among the youth in Kisumu County. The findings of this study are presented on the following themes based on the research objectives which included how the awareness of VMMC procedures affect the uptake of the services, the socio-cultural norms and belief system affecting the uptake of VMMC services and the effect of the attitude of service providers on the uptake of the services.

4.2. Demographic Information of Respondents

The general information of the study population is described in terms of age, marital status, ethnic group, religion and educational level. All the above mentioned aspects were considered to be important for the study since they provided general characteristics of the group that is targeted for male circumcision. A total of 100 respondents were surveyed during data collection process. In the sample, the largest age group interviewed was the cohort of 18-25 years old, at 90.8% followed by the cohort of 26-30 years old at 9.2%. Age is a demographic factor that affects people’s opinions and daily operations due to experience, knowledge and their position in the society.

All the respondents were however males since they are the target for male circumcision. This group being the youth who are still in training institutions, a large number of the respondents (83.7%) were single and had never been married, 9.2% were living together but not married,
5.1% were married while 2% were divorced. However, education level plays a very important role in the integration of an individual and how they are able to adapt to new ideas and interact with others. From the findings, the majority of the respondents (46%) had primary education and given that this level of education is usually localized, it is likely that they have never had any interactions with people from circumcising communities and it is likely also that they may not know what male circumcision is all about. The trainees had different qualifications prior to joining the youth polytechnics. Thirty percent had acquired secondary school education while 18% had tertiary education. The level of education was deemed to have an influence on respondents' abilities to access information as well as effectively make decisions regarding their health.

4.3 Awareness of VMMC Procedures

4.3.1 Perception and Knowledge of VMMC

One of the things that the study sought to find out was if the target population was aware of the procedures of VMMC. When asked whether they had heard about MC, a large percentage 84.5% of those interviewed indicated that they had heard about the practice of male circumcision while only 15.3% responded to the contrary. This is a big percentage of those who have not heard considering that these are people who are in a learning institution, mixing freely with others and having a better access to information. The fact that there existed this lack of knowledge about MC in such an environment despite the fact that Male Circumcision is an issue which is widely talked in this region is a cause for concern. There must be a serious effort on disseminating of information concerning male circumcision. Majority of the respondents were
aware of the various benefits of male circumcision such as its ability to reduce the rates of HIV and STI infections and chances of getting penile cancer. The respondents also affirmed the belief that male circumcision makes it easier for one to maintain penile hygiene.

From the study, it also emerged that the respondents were not only aware of the procedure but there were some of them who had undergone MC. From their responses, 59.4% of the respondents had already undergone the cut. For the respondents who had undergone the process of Male Circumcision, 61.5% indicated that they did it for medical reasons as their main motivation. The medical reasons which were mentioned by the respondents included reduction of infections such as STD and HIV, easy maintenance of penile hygiene and reduction in the occurrence of penile cancer. The other reasons that were given for increased uptake of VMMC included the widespread campaigns by the various groups that offer the services, the cosmopolitan nature of the study site that has enabled interaction between different ethnic communities and inter marriages. Those who had not undergone it were mainly afraid of the experiences they heard from those who had undergone it.

A 24 year old respondent who had undergone MC had this to say about his experience:-

“I went to a VMMC site which is within a health center. The process of waiting for registration took so long that I started feeling tired. Meanwhile the other people who were at the clinic kept looking at me and this made me feel shy. After the counseling and the testing, I was ushered into the surgery room. The person to operate on me did not talk to me or even explain to me what he intended to do to. Instead, I was asked to lie on the bed, my penis was clamped and anesthesia injected right into it. The needle he used was very big and the whole process was so scaring. I bled a lot and the pain after the operation was too much. I really struggled to get back home
since walking was so difficult. Later, I had to deal with the stigma from the other boys around
who gave me nicknames.”

Another 20 year old participant who has not gone for MC because of the pain and the stigma had
this to say:-

“I have often wondered if I should undergo this operation which I am told causes so much pain.
Furthermore, the penises of those who have undergone it in the village are viewed as objects of
curiosity as well as ridicule. Young men can be ruthless on other young men who are different.”

Majority of these respondents also indicated that the ideal persons to perform MC were the
medical personnel and the ideal places for performing it were the health facilities. This means
that a large number of the youth in this area have the proper information on what MC entails.
This clearly came out during the Focus Group Discussions where the participants were able to
graphically explain the process that they were taken through during their visits to the VMMC
sites.

A 19 year old respondent who had undergone MC in 2010 had this to say about the procedure:

“When you get to the clinic, you are first of all counseled on health issues such as HIV and STIs.
Then one is taken through counseling on what MC entails and its advantages. After the
counseling session and if one is ready to undergo MC, they are tested for HIV and other
infections. Those who are found to be unwell are then treated for their ailments while those
who are well are prepared for the surgery. After the cutting, one is stitched, bandaged and given
comfortable clothing that would not rub against the fresh wound before being discharged with painkillers and instructions on how to care for the wound”

4.3.2 Perceptions of MC and HIV/STI Prevention

The respondents were also asked about the health benefits of MC and among those that they mentioned were reduction of the rate of HIV and STIs infections, reduction of the occurrence of penile cancer and easy maintenance of penile hygiene.

Many participants expressed an awareness that MC could help reduce incidence of sexually transmitted infections (STIs) such as syphilis, genital ulcers, and HIV. A 21 year old discussant referred to an uncircumcised penis as “soft and fragile...more susceptible to cracks and scratches during in-and-out thrusting of penetrative sex”. The discussants explained that the cracks and scratches during penetrative sex were seen as providing easy gateways for entry of the HIV virus and other germs into the body. They understood that MC helps reduce STIs because germs causing infections hide under the foreskin; it accommodates many germs. Again, the foreskin is fragile and breaks easily and this makes the man to get AIDS from an infected woman. In contrast, another 26 year old participant described a circumcised penis as follows: “it is jua kali [weathered] and does not get cut easily by pubic hair”.

During the discussions, some participants noted that they already secretly sought circumcision services from the nearest health facility. This was done due to the fear of the stigma that is associated with circumcision in this region.
A 19 year old participant, who disclosed, during the group discussion, that he intends to get circumcised soon in the nearby hospital, described this situation as follows:

"To get circumcised or not is an individual's own decision. I don't have to wait for a trumpet to be blown by elders to start protecting myself. If it can at least protect us from these diseases, do I have to ask the village elder for permission? I don't even need to wait for the government to launch it. Some of us here are already getting circumcised. For example, I have an appointment tomorrow and my friends are waiting for the outcome of my operation for them to go for it too".

Overall, the respondents had a very high level of awareness of the protective effects of male circumcision such as reduction in the rates of HIV and STI infections and occurrence of penile cancer. Following this understanding of the benefits, there should be large numbers of the youth going for MC. It is therefore, a cause for concern that despite the respondents’ knowledge and understanding of the benefits of MC, some were still unwilling to undergo it. It was also interesting to note that there are those who still believe that circumcised men can have sex without a condom. This therefore, means that there is still need to give accurate information regarding the health benefits of MC as lack of it may be a hindrance to the achievement of the target.

From the discussions the low uptake of MC in Luoland has been due to the providers’ use of leaders to convince the people to embrace MC and therefore the Luo Council of Elders is seen as wanting to force the idea on the community. The respondents suggested that since the people understood the health benefits of MC, they should be left on their own to decide. There should
also be efforts to put up proper facilities for MC and budgetary allocations to cater for opportunity costs of MC for those who undergo it. Apart from that the other discouraging factors towards the uptake of MC among the youth are the hot temperatures in the region that results into a lot of sweating and thus affecting the wound and prolonging the healing process.

This is what a 24 year old participant who had undergone MC had to say about the effect of the heat on the wound:

“The heat makes one to continuously sweat and the wound is always wet therefore taking long to heal. The sweat also makes wound more painful when it trickles on it. But just like any other wound, the heat makes the pain unbearable”

4.3.3 Pain and Healing Complications

Apart from being aware of the health benefits of MC, the respondents were also aware of some of the complications that arise from this procedure. What were mentioned by the discussants included uncontrolled bleeding that may result into death, impotency, amputation of the penis, infection of the wound, loss of sexual drive, infertility, shortening of the penis and growth of keloids around the penis. From the discussions it was evident that the youth considered some of these complications a threat to their safety and affected the decision to undergo MC. It is therefore, crucial that the organizations dealing with MC in this region sets the record straight over the adverse effects in order to encourage more young people to go for the cut. There seems to be lack of accurate information on the comprehensive benefits of MC.

A 20 year old respondent had this to say about the information they get on MC:-
When they want you to go for the operation, they only tell you about the benefits of having it done. Hardly do they tell you about what may go wrong during and after the operation. I think they should be telling people about the benefits as well as the risks of undergoing the operation so that one can go for it knowing what to expect.

The complications that arise from MC have a big influence on its uptake as seen by the respondents’ willingness to get circumcised if they were assured that the process won’t have complications. Of those who had not undergone the procedure, 41.5% said that they would definitely get circumcised if they were assured that the process would be free of complications.

The respondents also had issues regarding the pain that comes with MC and when asked what they thought about it, 33% of the participants mentioned that fear of excessive pain during circumcision and healing complications could be a major obstacle to seeking the procedure. They indicated that the pain was unbearable. Many discussants held a perception that pain was a key characteristic of circumcision practices in neighboring tribes. The participants said that they had heard of circumcision ceremonies in these communities, in which endurance of pain was an indicator of being a man. This fact was also corroborated by the Secretary to the Nyanza Reproductive Health Society who said:-

“One thing that preoccupies those coming to seek MC is the pain that goes with it and not the person who will operate on them.”
Most participants mentioned that fear of excessive pain during circumcision and healing complications could be a major obstacle to seeking the procedure. Twenty five percent of the uncircumcised respondents gave the fear of pain as the primary reason why they are not yet circumcised while 9.8% said they feared complications that arise from the operation.

A 20 year old male discussant who had undergone the operation stated:

"What we really fear is the pain. For a man, the pain after being cut with a knife is unbearable. After that you walk with your legs apart like a child who has soiled himself. Walking is even more difficult when it is raining. You can hardly pull your feet off the mud. The pain is so much"

Some participants expressed the perception that time to heal and other social complications could also be barriers to men in the community seeking to circumcise. Some discussants expressed a perception that since men were socialized to tolerate pain, they would avoid incidences where they are seen as unable to bear it. A few participants proposed that circumcision be performed at a special place, where circumcised men heal before returning to the community. The participants suggested that this place would also allow men to “wear wrappers” as they heal without feeling humiliated. There was a belief among these discussants that wearing wrappers in public would debase masculinity.

A 22 year old participant who had undergone the operation had this to say about the wrappers the men wore after MC:-
"They need a place to stay until they get well and can put on trousers before being told to go home... so that even if people know that he went for MC, but not that he still covers himself with a wrapper like a woman here at home".

Participants suggested that more males would circumcise if the procedure was performed in a professional setting and with pain reduced through stronger anesthesia unlike the local one that is currently used. The respondents were also concerned about the fact that movement after the surgery is a problem because of the pain that arises from it. They are also required to put on attire that is not so male and this makes it obvious to those they encounter that they have undergone MC. This was because in this community, males who were circumcised or had congenitally shortened prepuces were stigmatized and experienced isolation.

4.3.4 HIV Testing, Abstinence and MC

Whereas the respondents were aware that one of the tests they needed to take before undergoing MC is the HIV one, the discussants had issues with the test and some admitted to having walked away from the VMMC sites after it was apparent that they had to take the test.

A 23 year old respondent who declined the mandatory HIV test prior to the operation had this to say:

"To take a HIV test requires preparation on the part of the individual beforehand. The fact that when you turn up to get the cut you must also take an HIV test keeps some of us away. It is also more complicated because when you test positive then you are not cut. This means that people
can easily tell your HIV status at that time. I was not ready for that and therefore left the clinic without undergoing the operation”.

This requirement that those who wish to undergo MC have to take an HIV test and then turning away those who test positive is considered discriminatory by the respondents and they also feel that it exposes them to ridicule.

On abstinence, 74.9% of the respondents felt that it was very difficult to observe this and suggested that the MC be carried out in camps where those who have undergone it would be kept in isolation and away from the attraction of their female partners in order to avoid the temptation of wanting to have sex before they are fully healed. In these secluded centers, they would also be able to dress comfortably and appropriately to allow faster healing of the wound.

As one of the discussants in the FGD who had undergone MC put it:

“When a man who is recently cut sees a woman, he thinks about sex and the penis erects, even if it has not healed well. This causes more pain. Men don’t want to be seen crying. They are taught from childhood that men never cry like women”.

Even though abstinence is an issue among the youth, the secretary of Nyanza Reproductive Health Society (NRHS) however, reported that the service providers have had no major cases of adverse effects resulting from the failure of those who have undergone the operation to abstain. The effect of this is usually measured through the adverse effects and these have been very
minimal. Rarely do they encounter those who come back to the clinic with complications arising out of early resumption of sex.

4.3.5 Cost Implications and Uptake of VMMC Services

A good number of the respondents were not aware of the fact that MC is carried out free of charge and they have always tagged a cost to it. When their knowledge about the cost of undergoing male circumcision was sought, it came out that there are those who still believe that MC is paid for because when asked how much they thought it cost to get circumcised, 15.4% of the respondents gave it a cost. For this category therefore, the monetary implications would be considered before one took the step towards MC. The organizations that are offering MC need to come out very clearly and make the target population understand that the service is offered for free. Even after the issue of cost was clarified to them that MC is actually free, 18% of the respondents still maintained that they would remain uncircumcised. This then rules out the issue of cost and probably the limiting factors are the socio-cultural issue.

Most discussants observed that apart from the actual cost of the procedure, there are a myriad of additional associated costs that could obstruct circumcision-seeking behavior in the community. These included expenses for wound dressing, medications, and transport costs to visit the health facility. Moreover, circumcision was least among household priorities and its long term effects In addition; there was fear that circumcision may temporarily immobilize economically productive males. Many discussants perceived that the time taken to heal would lead to loss of much needed daily household income.
A male participant opined as follows:

"If this man is the breadwinner of his house, and you want to put him down for 2 to 3 weeks, depending on how his body responds to the healing process, it would be very costly. He is both the driver and the conductor of his family's livelihood. Economically this family will be affected, starved, because the man got circumcised".

Economic activities for the youth seem to dictate very much the uptake of VMMC. According to the key informant, the men who are 18 years and above are not keen on going for MC as they regard it as something that would keep them out of work which they need to provide for their families. It has been noted that the boda boda riders especially were not willing to go for MC as this would keep them out of work for the length of time that they are recovering. In some cases the boda boda operators have been asking for a stipend to cater for their needs especially during the times that they are off work.

One of the key informants noted that the need to stay out of work for the recovery period has proved a hindrance to the uptake of MC among the boda boda riders specifically. They are not willing to leave work to undergo the surgery. From the focus group discussion, the discussants preferred that the MC should have a season when it is done in Luoland just as it happens in other communities. Their preference was that this be done during the harvesting period.

The discussants had this to say about the benefits of carrying out MC during this season:-
“During this time there is plenty of food and even if one does not work, they can get food as the people will be harvesting. The harvesting period is also usually dry and as one is recovering, they do not have to struggle with the mud which makes their movement difficult as is the case during the rainy season”.

The respondents in the training institutions preferred MC to be done during the school time since during the holidays, there are other issues to be dealt with. Their suggestion was that if possible those who offer services can set camp in the institutions because here the conditions are more favorable and the hygienic environment is cleaner makes the care of the wound easier. This would also enable those who have been cut to avoid walking for long distances and not subject themselves to hard labor as is the case when they recuperate in the homes.

4.4. Social-Cultural Norms and Belief System Affecting Uptake of VMMC

4.4.1 Cultural and Social Significance of MC to the Community

Non-circumcision was mentioned by most participants as a significant cultural characteristic that distinguished the Luo from other communities, and some expressed fear that introducing circumcision could cause loss of this cultural identity. A male participant in one of the FGDs described this perception as follows:

“By circumcising our men, we are officially joining the culture of the others. This community is going to lose its cultural identity as it is the non-circumcision that distinguished the Luos from their neighbors such as the Kisiis, Luhyas and Kalenjins. The call to have our men take up MC should be purely for the health benefits that this brings both to the men and the women”.

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On whether MC existed in Luoland, 66% of the respondents indicated that male circumcision was not an old cultural practice among the Luo. However, it has been noted that MC in this community was an old practice that took various forms. This therefore, means that a large percentage of the youth in this area do feel that this is a culture of other communities that is being imposed on them and up taking it is going to take a lot of convincing.

The discussants suggested that since MC was considered in other communities as a rite of passage, the Luos should not be compelled to embrace it because it means taking up other people’s culture. They argued that the Luos observed their own rite of passage and this is what they should stick to. However, they supported the fact that MC should continue to be performed because of the health benefits that it provides to both men and women.

The Luo Council of Elders and top Luo politicians initially put up resistance against MC in Luoland and its uptake became a political issue.

However, according to the secretary of the Nyanza Reproductive Health Society (NRHS), the situation has now changed with the idea being bought by the Luo Council of Elders and even the old people in the community have accepted it now. As a result of this, the cultural resistance that was initially there has ceased and the uptake is on course. This is can be confirmed by the fact that the target that the MC project set for Nyanza was 500,000 by the year 2013 but as at June 2012 about 360,000 had been circumcised and it was the hope of the NRHS that the remaining number would be achieved come the end of the target period.
4.4.2 Discrimination against Circumcised Men

Many discussants mentioned several labels that were associated with circumcised men or those with shortened prepuces. Terms like rayuom, apum, mwache, jomwa or kimirwa featured prominently. Further exploration of the meaning of these words revealed that they are derogatory terms, often used to refer to men who are circumcised, or whose prepuces are shortened.

One discussant stated:

"Once they (other boys and men) discover that you have been circumcised, they laugh at and make fun of you. In many circumstances you are given a nickname".

From the experiences of those respondents who had undergone circumcision, they are made fun of, laughed at and ridiculed. Some of the respondents who had not been cut were afraid of the experience especially when they are informed of the stigma attached to the cut.

On whether MC should be culturally integrated in Luoland, the discussants mentioned that already some men would choose to circumcise in order to be more acceptable to their neighboring, traditionally circumcising communities. A discussant observed:-

"Things are changing at a very high speed and time has really overtaken some of these cultural inhibitions about circumcision. As we intermarry and take their women, we are adopting some other cultures from them as they do so from us... it will change...some Luos in town are already secretly taking their kids for circumcision in hospitals...ethnic mix and match".
4.4.3 Sexual Satisfaction Barriers

On MC and sexual performance, 39% of the respondents agreed that the men who are circumcised have increased sexual desire while 38% felt that male circumcision lowered the sexual desire. The big percentage of respondents feeling that male circumcision interferes with sexual urge could be a deterrent to the uptake of MC. Men and their egos especially where sexual drive is a measure of masculinity, will not take up anything that interferes with this. However, from the focus group discussion those who had undergone MC reported increased sexual pleasure from their partners and they indicated that their partners were impressed by their performance especially after the circumcision.

Improved sexual performance and satisfaction, defined as male sexual satisfaction, female sexual satisfaction, and male sexual performance, were common facilitators to MC uptake, especially among young men. Additionally, participants reported that MC reduces cuts and bruising on the foreskin during sexual intercourse. Finally, participants believed that MC improves male sexual satisfaction by several other mechanisms, especially by reducing the worry of acquiring HIV or a STI during sex, by making condom use easier, and by making the penis more “rough” which increases friction during sex.

A 21 year old participant had this to say about increased performance

"Men can have sex several times in the same night; the time to ejaculation is increased; penetration is easier; and circumcised men have more “energy” for sex”.

Another discussant had the following to say:
"The girls are happy with you, they get excited when you are doing it and so they want to meet you more often. They tell others about you and therefore you are approached by more girls. Even you, as you do it, you feel that your performance has increased. This is because when you are circumcised, the rubber gets hardened, so it is not sensitive and you can go on for long and therefore satisfying your partner better. But when you are not circumcised, the rubber [prepuce] is sensitive and you get sexual satisfaction faster leaving your partner longing for more."

4.5 Effect of Attitude of Service Providers on Uptake of VMMC

4.5.1 Attitude of the Health Workers

The discussants reported that reaction of the health workers at the VMMC site on enquiry about MC is usually helpful and one is quickly referred to the place where they can get the services. Most of the group members had issues with the surgeon as they never seemed to take time to explain to the clients what exactly they would be doing. However, the counselors were friendly, positive and very encouraging to those who wanted to undergo MC. The support staff at the sites was also very welcoming but the surgeons were very rough.

However, on some occasions the experiences of those who wish to undergo MC is never that pleasant. During the focus group discussion in one of the institutions, it came out that the clients get mishandled and are on occasions not allowed to freely decide whether they want the circumcision or not. According to the discussants, the people offering MC would pick them up from the polytechnic for sensitization on MC but on reaching the sites, things changed as this discussant puts it:
A 23 year old participant in the FGD who was in the group narrated his experience as follows:-

"We were picked up in a vehicle to be taken to the MC site and be told about the procedure with the promise of being brought back after the sensitization. After the talk, we were told that we should undergo the operation. However, when we refused, we were chased away from there and even the transport that we had been promised back to the polytechnic was not given. We walked all the way back."

The personal experience of a discussant that had undergone MC was that the waiting was too long and those unwilling to undergo MC were not offered the promised tests. There was also the concern that the needles used for anesthetic injection was too big making the whole process too scaring.

4.5.2 Service Provision Models and Staff Training For VMMC Clinics

Majority of the respondents preferred having the procedure carried out in health facilities as these had more hygienic environment and the staff was well trained. According to the secretary of NRHS, the VMMC services are offered in various models to cater for the different clientele, there are the mobile clinics where the providers pitch tent, offer the services and then leave. The second model is the outreach where the VMMC team takes trained staff to offer services within a health facility and at the end of the day they leave. The third model is the static one where the team has identified health facilities and they have permanent VMMC service providers stationed there full time to offer VMMC services. The last model is moonlight which is the offering of the service during the evening and night. This is meant for those who are shy to be seen entering the VMMC sites as they go for MC fearing that they would be stigmatized.
From the assessments of the service providers, the mobile model is the most preferred. The health centers are least preferred since the clients find them inconveniencing because of the long queues that are usually associated with such facilities, the mixed clientele, the fear of being seen as they go for MC and possibility of acquiring of other diseases.

As a way of encouraging the uptake of the services, the service providers have endeavored to separate the VMMC services from the other medical services that are offered by the health care providers. Where VMMC takes place, there is the separation of the services for the children, the youth and the adults. The VMMC hours of services are also extended unlike in the normal medical ones that run between 8 am and 5 pm. Those seeking circumcision can visit the centers at hours that are suitable to them. The queues are very limited and the staff is adequate to handle those who come seeking the services to avoid the long waits.

The staff that perform MC have been specifically trained for that purpose. According to the secretary of the NRHS, there is special package that is used for the training of providers of male circumcision. This package is based on a detailed curriculum that includes counseling, HIV testing, and infection control. The professionalism of the service providers was corroborated by the respondents in the focus group discussion who said that the counselors were fine and very receptive of the clients and their attitude was an encouragement to those who went to seek the services at the sites. However, there was concern about the surgery itself. The respondents who had undergone MC had an issue with the surgery procedure.

A 19 year old participant who had undergone the operation had this to say about the surgery:—

"The needles that the surgeons used were so big and the process of administering anesthesia so scaring. The person preparing you plays with your penis until it is upright and then they put "a
ring "around it. After that they inject right on to the penis. That thing can make someone impotent. In fact, we have heard that the medicine that they use for anesthesia is on trial from China and is meant to make men impotent”

The respondents were of the opinion that there should be a more friendly form of anesthesia because the local one which is applied means that the client observes the whole procedure where as they would prefer to just wake up to the fact that the cut has taken place. As one discussant said:

“Watching the surgeon cut off part of you is very scaring. It would have been better if I was fully asleep and then woke up after it had been cut”.

Majority of the respondents preferred sites that are purposely set up for MC and these include the mobile, outreach and moonlight sites. The reasons for this is because in purposely set up clinics, there is not much queuing, the clientele is not mixed as they have all purely come for MC, and those who are scared of being seen going for the cut can avoid the stares and the name calling that may follow later. Above all, there is very little chance of acquiring infections like would occur in a hospital set up.

The service providers have clinics within very close proximity to the clients and there are various types of models that are operated. Those who seek MC can choose those that are suitable for them. Distance of clinic from home or institution therefore, does not become an issue as the clinics are set up within easy reach of the clients and they can select the preferred location of the VMMC sites.
4.5.3 Effect of the Gender of the Service Providers on Uptake of VMMC Services

According to the key informant, the gender of the service providers has not been a big issue because the service provider has trained a large number of male service providers. However, there are instances when the clients do not wish to be handled by the female service providers and this wish of the clients is normally respected. This is mostly where the clients are adults and feel that it would be inappropriate for the young female service providers to prepare them for the procedure. This is especially so in cases where the clients are older. As for the trainees that were the respondents in this study, the majority were alright with the female surgeons performing MC on them. It was also their belief that the female surgeons will be gentle. A small percentage was of the opinion that being fondled by the female service providers during the procedure may result in an erection therefore interfering with the surgery process.

Participants considered interactions with female providers in non-professional terms, usually with sexual overtones. They believed that clients might have an erection when a female provider touches or inspects his penis, thereby creating an awkward situation for both the provider and the client. However, most participants concluded that as long as the provider was a trained professional, and the client did not know her, MC services being provided by females would not be a problem. A few participants believed that a female provider might perform services better than a male provider because women are more “understanding” and “gentle” when providing services compared to men.
5.1. Introduction

This section of the project provides the summary, discussions, conclusion from the research and recommendation on the best way forward. It is noted that the uptake of VMMC services would require proper channels of providing information, which would then influence the attitude towards MC and the general choice of the same as an HIV prevention method.

5.2. Summary

From this study, it came out that a large number of the youth in this area have the proper information on what MC entails. This clearly came out during the Focus Group Discussions where the participants were able to graphically explain the process that they were taken through during their visits to the VMMC sites. Overall, the respondents had a very high level of awareness of the protective effects of male circumcision such as reduction in the rates of HIV and STI infections and occurrence of penile cancer. Non-circumcision was mentioned by most participants as a significant cultural characteristic that distinguished the Luo from other communities, and some expressed fear that introducing circumcision could cause loss of this cultural identity. In as far as service providers attitude and service provision are concerned, the barrier to MC uptake was the long distance to the health facilities. Distance as a barrier to uptake was discussed in terms of reaching the facility, getting home from the facility (especially if the MC client is believed to be weak and in pain), and seeking follow-up care.
5.3 Discussions

The respondents were aware of the procedures of MC and discussants were able to describe the process that one went through from the time they checked into a VMMC site up to the time they left to go back home. From the description it was quite clear that they understood the procedures and it is this understanding that acts as a deterrent to the uptake of the service by some youth. This is because they know what to expect and this makes them apprehensive. Eighty five percent of the respondents had heard about MC and so they had the information which would enable them to decide on whether or not to undergo the operation.

However, fifteen percent had not heard about MC. A big number of respondents were also aware of the medical benefits of MC and the complications that may arise if one underwent the operation. The possible incidence of adverse effects was a common barrier to uptake. The most common effects discussed included pain and bleeding during- and post-MC, and delayed healing. Others mentioned included negative effects on male reproduction resulting from the anesthetic injection, problems with appearance, torsion, infection, reduction in penile size, and surgical “accidents” that would mar appearance or impair function. Some participants noted that clients who have a bad experience will share their experience in the community.

From this awareness therefore, participants in this study identified perceived fear of pain and other healing complications. The results therefore support Westercamp and Bailey’s (2007) argument that more men would be willing to get circumcised if MC services were provided safely, inexpensively, with minimal pain and adverse complications. The findings further support Bailey and associates’ (2002) earlier call for education and counseling programs about the health benefits and risks of MC, in order to allow individuals to make informed decisions and
personal choice on MC. This could have a positive influence on the adoption of the practice as those who are already circumcised become role models for others, and as perceived fears and apprehensions are removed through sharing of experiences between circumcised and uncircumcised men.

Traditionally, the Luo removed the lower six teeth as a rite of passage into adulthood (while the neighboring Bantu groups practiced MC as a rite of passage). Recently, the practice of removing teeth has nearly ceased, and no practice has taken its place. From the study, majority of the respondents (66%) were not aware that MC is an old cultural practice among the Luos that took various forms and was performed on young boys either by themselves or by those who were older than them and had undergone the ritual. The practice of Luo ritual circumcision is still rampant in some parts of Luo land such as parts of South Nyanza, Siaya and the vicinities of Lake Victoria regions but not in urban areas. Therefore, a large number of the young generation, especially the urbanized have not heard of this ritual (K’Aoko, 1986). Despite this fact, some discussants still hold beliefs that circumcision was culturally alien practice with socio-political implications and that promoting it could dispose the Luo men who choose not to circumcise to stigmatization and labeling. If there are relevant socio-cultural issues that are not adequately being attended to, then people may mistrust the public health intentions of MC. Engaging non-circumcising and circumcising communities in broad-based dialogue on the socio-cultural and public health implications of MC could help diffuse the current perceptions and motivate circumcision-seeking behaviour.

In as far as service providers attitude and service provision are concerned, the barrier to MC uptake was the long distance to the health facilities. Distance as a barrier to uptake was discussed
in terms of reaching the facility, getting home from the facility (especially if the MC client is believed to be weak and in pain), and seeking follow-up care. However, according to the Secretary of NRHS the VMMC services are offered in various models to cater for the different clientele. Most participants talked about interactions with female providers in non-professional terms, usually with sexual overtones. Participants believed that clients might have an erection when a female provider touches or inspects his penis, thereby creating an awkward situation for both the provider and the client. However, by the end of the discussion, most participants concluded that as long as the provider was a trained professional, and the client did not know her, MC services being provided by females would not be a problem. A few participants believed that a female provider might perform services better than a male provider because women are more “understanding” and “gentle” when providing services compared to men.

5.4 Conclusion

Although the Luo of Kenya are traditionally non-circumcising and consider circumcision as culturally alien, many youth in this study would welcome MC if the procedure was less painful and brought with it few complications; if broad-based community dialogue, counseling, and education on the social and health benefits and risks of MC were encouraged; and if it was promoted on the strength of its public health good rather than for HIV prevention only. From the study it came out that the primary barriers to MC uptake included too much time away from work, cultural values, the possibility of adverse effects and a desire to maintain the status quo. Participants also reported that too much time away from work, especially if the man is the sole provider for the family could also be a barrier to seeking the service. However participants viewed MC as a medical intervention that exists outside of culture.
5.5: Recommendations

The study has applied its key findings to develop recommendations which may be used to inform policy formulation on VMMC and also form the basis for further research.

- The government should carry out door to door campaigns to popularize circumcision as a tool for lowering the rate of HIV transmission.

- The government should have mass counseling for both men and women on the advantages of MC.

- The health care providers should demystify the belief that circumcision results in loss of virility or otherwise and properly educate the people on the link between MC and HIV transmission.

- There is need for showing educative documentaries on MC and how it has helped in the reduction of HIV transmission in other countries.

- There is need to have positive role models in the community. This could involve those who have undergone MC and can share with others the advantages of the undertaking.

- The service providers should carry out MC seasonally and in designated areas to reduce the stigma attached to the practice.

Finally, there is need for a change of attitude among the Luos that MC is an alien culture and practicing it will make them slaves of other people’s culture. They should be made to understand that VMMC brings with it a lot of health benefits that make their sex and reproductive lives more enjoyable and satisfying. Further research should be undertaken for a complete understanding of how to overcome cultural barriers and biases that people have.
REFERENCES


APPENDIX A: PARTICIPANT’S QUESTIONNAIRE AND ANSWER SHEET -
ENGLISH STUDY TITLE: FACTORS AFFECTING THE UPTAKE OF VOLUNTARY
MEDICAL MALE CIRCUMCISION SERVICES AMONG THE TRAINEES IN YOUTH
POLYTECHNICS IN KISUMU COUNTY

A. CHARACTERISTICS OF STUDY AND GENERAL POPULATION: DEMOGRAPHIC
INFORMATION

1. What is your age group?
   A. 18-25 B. 26-30 C. over 30

2. What is your married status?
   A. Single, never married  B. Married  C. Living together, not married  D. Divorced or
   Separated  E. Widowed

3. What is your ethnic group?

4. What is the highest level of education you have completed?
   A. Primary(up to Std8) B. Secondary(up to form 4) C. Tertiary level and above

5. What is your religion?
   A. Roman Catholic  B. Anglican  C. Lutheran  D. No religion  E. Other  F. Don’t
   know

B. KNOWLEDGE, ATTITUDES AND PRACTICES OF MC AND HIV

6. Have you ever heard of MC?
   A. Yes.  B. No

7. Have you ever heard that MC reduces the risk of HIV infection?
A Yes  B No

8. Have you ever heard that MC reduces the risk of other STIs?
A Yes  B No

9. Have you ever heard that MC helps improve penile hygiene?
A Yes  B No

10. Have you ever heard that MC reduces risk of penile cancer?
A Yes  B No

11. Have you ever heard of any complications arises from MC?
A Yes  B No

12. Can you mention any complications of MC procedures

C. WHAT DO YOU THINK ABOUT CIRCUMCISED AND UNCIRCUMCISED MEN BASED ON THE FOLLOWING STATEMENTS?

13. It is easier to get HIV when a male is
A Circumcised  B Uncircumcised  C No difference  D Don’t know

14. It is easier to STD if a male is
A Circumcised  B Uncircumcised  C No difference  D Don’t know

15. It is easier to maintain penile hygiene when a male is
A Circumcised  B Uncircumcised  C No difference  D Don’t know

16. It is easier to get penile cancer if a male is
A Circumcised  B Uncircumcised  C No difference  D Don’t know
D. FOR EACH, INDICATE WHETHER YOU AGREE OR DISAGREE WITH THE STATEMENT. IF YOU DO NOT KNOW WHAT TO SAY, JUST TICK DO NOT KNOW

17. Circumcised men have more sexual feelings then uncircumcised men
A Agree B Disagree C Don’t know

18. Circumcised men enjoy sex more than uncircumcised men
A Agree B Disagree C Don’t know

19. Women prefer men who are circumcised
A Agree B Disagree C Don’t know

20. Circumcised men can safely have sex without using a condom and don’t get infected with HIV.
A Agree B Disagree C Don’t know...

21. The MC procedure pain is unbearable
A Agree B Disagree C Don’t know...

22. The tip of the penis needs to be covered with a foreskin
A Agree B Disagree C Don’t know

23. It is very important for all males irrespective of their age to be circumcised
A Agree B Disagree C Don’t know...

24. MC proves manhood
A Agree B Disagree C Don’t know

25. MC is an old practice in our community and does not need to be reintroduced
A Agree B Disagree C Don’t know
26. What if it is offered free of charge, will you choose to be circumcised?
A Yes, I will definitely do  B No I will remain uncircumcised
C Already circumcised  D Don’t know

27. Would you choose to be circumcised if it is said to be reducing the risk of HIV infection?
A Yes, I will definitely do  B No I will remain uncircumcised
C Already circumcised  D Don’t know

28. Given that, there is no or minimal complications, will you choose to be circumcised?
A Yes, I will definitely do  B No I will remain uncircumcised
C Already circumcised  D Don’t know

29. Would you recommend circumcision for your son or any young male you know?
A Yes, I will definitely do  B No I will remain not.
C Already circumcised  D Don’t know

30. In your opinion what is the ideal age of performing MC?
A Infant <1 year  B Child (1–13 years)  C Adolescent(14-19 years)  D Adult >20 years
E No preferences  F Don’t know

31. In your opinion at who is the ideal person to perform MC
A Medical doctors  B Nurses  C Traditional circumcisers  D No preferences
E Other(Specify)  F Don’t know

32. In your opinion at what is the ideal place of performing MC?
A Health facilities(state/Private)  B At home  C No preferences
D Other(Specify)  F Don’t know
33. How much do you think is the cost of MC procedure?
A Free  B Less than Kshs 500  C Between Kshs 500-1000
D Between Kshs 1500-2000  E More than Kshs 2000  F Don’t know

E. BARRIERS TO MC

34. Are you circumcised
A Yes  B No

35. If you are, what was the reason for circumcision?
A Traditional  B Religious  C Medical  D Other  E Don’t know

36. Who performed the circumcision procedure?
A Medical staff (Nurse/Doctor/other)  B Traditional circumciser  C Other(Specify
D Don’t know

37. At what age were you circumcised?
A Infant <1 year  B Child (1–13 years)  C Adolescent(14-19 years)
D Adult >20 years  E Don’t know

38. Where did the circumcision take place?
A Health facility(state/Private)  B At home  C Other (Specify)  D Don’t know

39. If you are not circumcised, what is your primary reason?
A It is costly       B It is against my religion       C It is against my tradition
D Fear of complications.       E It is painful       F No reason
APENDIX B: QUESTIONNAIRE GUIDE FOR FOCUS GROUP DISCUSSIONS

1. What is your feeling about the idea that the Luo should not embrace Male Circumcision?

2. Do you think that it is a practice that should be embraced by all men?

3. What is your feeling about the Government’s approach in the introduction of Male Circumcision among the Luo?

4. If Male Circumcision is considered a rite of passage, should it still be done among the Luo?

5. Are you aware of any form of Male circumcision that took place among the Luos in the old days?

6. What does the society think of men who have been circumcised?

7. What are the factors that would discourage or encourage you from going for MC?

8. What is your feeling towards the abstinence period which men are meant to observe as they heal from the MC?

9. Which would be the ideal places for the performance of MC?

10. Do you think that the men who have undergone MC should be isolated as they heal?

11. If the set up and the procedure for MC were different would you go for it?

12. Do you consider MC costly? Why?

13. In some health facilities, female health workers perform MC, what is your feeling about this?

14. Do you know of a VMMC site?

15. How close are you to a VMMC site?

16. If the site was close enough for you to walk there, would you go for the services?

17. When you went for VMMC, what was your experience from the start until you underwent the surgery?
18. When you visit the health facilities that you want MC what is usually the reaction of the health workers?

19. Is there a special room within the health facilities where those seeking VMMC services go to?

20. Are there particular health care providers who attend to those who go to seek VMMC services?

21. Apart from being told that MC reduces the rate of transmission of HIV what else are the benefits?

22. How in your opinion do you think MC can be made more acceptable to the non-circumcising communities?

23. What do you think about the theory that MC leads to loss of penile sensitivity?

24. As MC is not a cultural practice of the Luo, why do you think it would be good for the Luo to embrace it?
FACTORS AFFECTING THE UPTAKE OF VOLUNTARY MEDICAL MALE CIRCUMCISION SERVICES AMONG THE YOUTH IN KISUMU

You are asked to participate in a research study conducted by Margaret Akinyi Egessa from the Institute of Gender and African Studies at the University of Nairobi.

If you have any questions or concerns about the research, please feel free to contact: Margaret Akinyi Egessa: Telephone Number 0725 255 223

PURPOSE OF THE STUDY

To examine the factors affecting the uptake of vmmc services among the youth in Kisumu County.

PROCEDURES

If you volunteer to participate in this study, you to fill a questionnaire and participate in a group discussion.

POTENTIAL RISKS AND DISCOMFORTS

The study carries with it no potential risks or discomforts to the participants.

POTENTIAL BENEFITS TO SOCIETY

This study will play a pivotal role in assisting policy makers put in place measures to increase the number of youth who are going to uptake VMMC services.

PAYMENT FOR PARTICIPATION

There will be no monetary benefits attached to your participation in this study.

CONFIDENTIALITY

Every effort will be made to ensure confidentiality of any identifying information that is obtained in connection with this study.
PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don’t want to answer and still remain in the study.

RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty.

SIGNATURE OF RESEARCH PARTICIPANT/LEGAL REPRESENTATIVE

I have read the information provided for the study “FACTORS AFFECTING THE UPTAKE OF VOLUNTARY MEDICAL MALE CIRCUMCISION SERVICES AMONG THE YOUTH IN KISUMU COUNTY” as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

Name of Participant: ________________________________