

## Factors that influence uptake of voluntary medical male circumcision services at Nakivale HC III. A cross-sectional study.

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### Abstract

#### Background

The global male circumcision prevalence is estimated at 37–39 % of men globally are circumcised, of which close to half of the circumcisions are for religious and cultural reasons. The study aims to determine the factors that influence the uptake of voluntary medical male circumcision services at Nakivale HC III.

#### Methodology

A cross-sectional study employing quantitative measures. The study involved adult males who attended healthcare services at Nakivale Health Center III, aged 15 to 50 years. The data was exported to the IBM Statistical Package for Social Sciences (SPSS) version 20 software for analysis. Data were analyzed using percentages and frequencies for univariate analysis and the Chi-square test for bivariate analysis.

#### Results

Most of the participants were students 39(28.3%) and the least was unemployed 16(11.6%). 75(54.3%) were influenced by their spouse to take up safe male circumcision 75(54.3%). 62(44.9%) covered more than 5 km from home to the hospital, while the least covered less than 5 km, 58(42.0%). The majority of the participants indicated that fear of delayed wound healing was the main barrier to safe male circumcision (34.1%). 71(51.4%) of the participants indicated that there is enough privacy at the public health facility. 70(50.7%) indicated that the health facility provided information about Voluntary Medical Male Circumcision. 55(39.9%) indicated that the duration taken to be attended to at the health facility was between 1 and 3 hours.

#### Conclusion

The major influential factors to Voluntary Medical Male Circumcision were the advice of Spouses, fear of delayed wound healing, privacy of clients, and duration taken to be attended to at the health facility.

#### Recommendations

Both Government and private medical facilities should be well-staffed with experienced professionals and equipment to boost the uptake of medical male circumcision.

**Keywords:** Uptake of voluntary medical services, male circumcision, Nakivale Health Centre III

**Submitted:** 2024-11-20 **Accepted:** 2025-03-17 **Published:** 2025-07-11

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#### Background

The global male circumcision prevalence is estimated at 37–39 % of men globally are circumcised, of which close to half of the circumcisions are for religious and cultural reasons. It is also assumed that 99.9 % of Muslims and Jews are circumcised. On the other hand, it is assumed that a minimum prevalence of 0.1 % of Male Circumcision was for medical reasons. More than 14 million adolescent and adult males in East and Southern Africa have undergone male circumcision for HIV prevention in the past decade. The proportion of men circumcised ranges from 14% in the mid-northern region to 69% in the Mid-Eastern region. The prevalence of male circumcision was highest among young people aged 15–29 years at over 45% (Uganda AIDS

Commission, 2017). According to various studies, the uptake of this service has steadily improved over the years, and its effect has been tremendous. (Loevinsohn et al., 2020). Refugee settlements attract individuals from various nations and with different cultural beliefs and meanings of circumcision.

In the Kibera division, Kenya, the factors that were associated with VMMC among men aged 18-50 years were the level of education of the participants, medical and hygiene reasons that motivated them to go for the service while the barriers to uptake included the cost, fear of pain, and the long recovery period. (Gikunju et al., 2014). In a rural district of Matare in Zimbabwe, among 234 males aged 15-29 years. Participants were asked about their views

regarding the type, place, and age of circumcision. Among social and cultural factors, the circumcision decision was made by fathers among 40.5% of respondents, while 36.7% made personal decisions. 37% viewed circumcision as worthless, 30% as shameful, 20% linked it with promiscuity, 10% viewed it as honorable, and 3% felt it was denied by the gods. On psychological factors, 71% of the respondents feared operation, pain, bleeding, and other complications. 74% feared wound complications and delayed healing, 62% felt that circumcision was a dehumanizing act, and only 10% did not feel ashamed. 159 (68%) felt that circumcision would lead to stigma, 26 (11%) had no fear of stigma and discrimination, and 21% reported that it had no impact on them. Among socio-economic factors, 72% reported not having time, 95% reported absenting from work during recovery, 49% were uncertain of the pain leading to loss of the job, while only 4% considered transport as a barrier (Irene et al., 2016)

In Uganda, in Gulu in 2016, factors that enhanced uptake of male circumcision services were: adequate knowledge of VMMC, being young and single, partner involvement, peer influence, perceived increased libido after circumcision, and availability of the services. On the other hand, barriers to uptake were: sexual abstinence during the healing period, penile appearance after circumcision, religion, culture, and misconceptions about circumcision. (B. M. Nanteza et al., 2021). The study aims to determine the factors that influence the uptake of voluntary medical male circumcision services at Nakivale HC III.

## Methodology

### Study design

This was a cross-sectional study employing quantitative measures. This design is appropriate because it helps the researcher to study phenomena at a particular point in time (Polit & Beck, 2010). Quantitative methods of data collection were employed. Quantitative methods help to study the numbers of a problem and to determine percentages.

### Study setting

The study was conducted at Nakivale Health Centre III. This is a health facility in the Isingiro district that serves several native Ugandans and thousands of refugees from neighboring countries. Isingiro District is located in southwestern Uganda, 37 Kilometers southeast of Mbarara city, the second-largest city in Uganda. Nakivale Health Center is 50 kilometers from Mbarara city, which is almost an hour's drive. Isingiro borders Tanzania in the south, Rakai, and Mbarara.

### Study population

The study involved adult males who attended healthcare services at Nakivale Health Center III, aged 15 to 50 years.

## Eligibility

### Inclusion criteria

All adult males between the ages of 15 to 50 years willing to participate in the study were recruited.

### Exclusion criteria

The study excluded adult males between the ages of 15 to 50 years who were very ill, those who declined to consent were absent during data collection, and those who were already circumcised.

## Sample Size Determination

The sample size was estimated by Kish and Leslie's standard formula (1965),  $N = Z^2PQ/E^2$ . Where N is the sample size, Z is the score corresponding to 95% of the confidence interval, which is 1.96, and P is the percentage of participants who have ever done VMMC in a study that was done by Nanteza et al. (2018) was estimated to be 0.694.  $Q = 1 - P = 1 - 0.694 = 0.306$

$E =$  Level of error expected which is 0.05  $N = (1.96)^2 \times 0.05 \times (0.5) / 0.05^2$ ,  $N = 326$

The study was adjusted for the finite population as follows: Fisher et al. (1998)

$nf = n / (1 + (n/N))$  Where;  $nf$  = desired sample for population  $< 10\,000$   $n$  = desired sample size for population  $> 10\,000$ .  $N$  = number of adult males who attended Nakivale HCII in the last two months (200)

$nf = 326 / (1 + (326/200))$  and  $nf = 15124.4$ ; thus, 124 adult males aged 15-50 years shall be considered.

## Sampling technique

Consecutive sampling was used to get the study participants. The researcher included all the adult males aged 15-50 years who met the inclusion criteria and were conveniently available as part of the sample.

## Data collection tools

Data were collected from participants using a researcher-administered questionnaire, which was developed from the literature review. The questionnaire comprised a section for demographic characteristics, knowledge about VMMC, and socio-cultural factors associated with its uptake. The questionnaire was translated into Runyankole local language, for a better understanding of the participants.

## Data collection procedure

After obtaining ethical approval and all permission protocols, the researcher explained the purpose of the study to individual male participants in a conducive and private environment and asked them to consent to the study. Those who consented were subjected to a researcher-administered questionnaire that took about 15 to 20 minutes per participant. The researcher cross-checked for completeness of the questionnaire before releasing the participant.

Afterward, the filled questionnaires were kept well in the researcher's bag, only accessible to him.

### Data management and quality control

The questionnaires were translated into Runyankole, the local language commonly used in the area. The questionnaires were pretested on 20 participants at Rwekubo Health Center IV, also in Isingiro district. Questions that were found to be abstract were restructured or deleted from the questionnaire. The questionnaires were administered by the researcher to minimize errors. Questionnaires were cross-checked at the end of every interview and were kept safely to protect them from loss or destruction.

### Ethical considerations

The proposal was approved by the university's Research and Ethics Committee for Bishop Stuart University. An

introduction letter was sought from the Nursing head of the department to seek permission from the relevant offices, including the District Health Officer, Isingiro district, and the Nakivale Health Center in charge. Consent was sought from each participant in data collection who was above 18 years, and assent was sought from participants below 18 years of age.

### Data analysis

The questionnaires were coded, entered into Microsoft Excel, checked, and cleaned. The data was then exported to the IBM Statistical Package for Social Sciences (SPSS) version 20 software for analysis. Data were analyzed using percentages and frequencies for univariate analysis and the Chi-square test for bivariate analysis.

## Results

### Socio-demographic characteristics

**Table 1: Socio-demographic characteristics**

Variable	Category	N(%)
Age	18-29 years.	62(44.9)
	30-39 years	44(31.9)
	40-49 years	14(10.1)
Marital status	Single	68(49.3)
	Married	49(35.5)
	Divorced/ separated	3(2.2)
Level of education	No formal education	15(10.9)
	Primary	61(44.2)
	Secondary	31(22.5)
Occupation	Tertiary education	13(9.4)
	Civil servant	28(20.3)
	Self-employed/Businessman	37(26.8)
	Student	39(28.3)
Religion	Unemployed	16(11.6)
	Catholic	23(16.7)
	Protestant	50(36.2)
	Seventh-day Adventist	25(18.1)
Nationality	Moslem	10(7.2)
	Born Again Christians.	12(8.7)
	Ugandan	61(44.2)
	Tanzanian	13(9.4)
	Rwandese	34(24.6)
	Congolese	6(4.3)
	Sudanese	6(4.3)

(Table1) One hundred twenty-four (124) adult males were selected to participate in the study, and only one hundred twenty (120) adult males fully completed the study, yielding a response rate of 98.8%. On age the majority of subjects were aged between 18 to 39 years, 106(76.8%), and the least were aged 40-49 years 14(10.1%), on marital status, most of the participants were single, 68(49.3%) and the least were

divorced 3(2.2%). The majority of the participants had attained a primary level of education (42.2%), and the least had tertiary education 13, 9.4%). On occupation, most of the participants were students, 39(28.3%), and the least were unemployed, 16(11.6%). On religious affiliation, most of the participants were protestant, 50(36.2%), and the least were Muslims, 10(7.2%). On the nationality, most of the

participants were Ugandans, 61(44.2%), and the least were Sudanese, 6(4.3%), and Congolese, 6(4.3%).

## Health-care-related factors influencing the uptake of Voluntary Medical Male Circumcision services

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**Table 2: Health-care-related factors influencing uptake of Voluntary Medical Male Circumcision services**

Variable	Category	N(%)
Voluntary Medical Male Circumcision services at the health facility in your sub-county	Yes	53(38.4)
	No	67(48.6)
Health education about Voluntary Medical Male Circumcision services at the health facility.	Yes	68(49.3)
	No	52(37.7)
The health facility near your home provides information about Voluntary Medical Male Circumcision.	Yes	70(50.7)
	No	50(36.2)
Enough privacy at the public health facility	Yes	71(51.4)
	No	49(35.5)
Duration taken to be attended to at the health facility	Less than an hour	38(27.5)
	Between 1 and 3 hours	55(39.9)
	More than 3 hours	27(19.6)

Table 2, most of the participants indicated that there is enough privacy at the public health facility, 71(51.4%), and the least agreed with the statement, 49(35.5%). Most of the participants indicated that the health facility provided information about Voluntary Medical Male Circumcision 70(50.7%), and the least declined 50(36.2%). Most of the participants received health education about Voluntary Medical Male Circumcision services at the health facility

68(49.3%), and the least did not 52(37.7%). The majority of the participants did not know that Voluntary Medical Male Circumcision services are at the health facility in their sub-county, 67(48.6%), and the least were aware, 53(38.4%). Most of the participants indicated that the duration taken to be attended to at the health facility was between 1 and 3 hours, 55(39.9%), and the least mentioned was more than 3 hours, 27(19.6%), as shown in Table 4.

## Personal factors influencing the uptake of Voluntary Medical Male Circumcision

**Table 3: Personal factors influencing uptake of Voluntary Medical Male Circumcision**

Variable	Category	N(%)
The main reason for circumcision	Health/ hygiene	44(31.9)
	Sexual satisfaction	44(31.9)
	Protection from STIs/ HIV	25(18.1)
	Traditional/ cultural values	7(5.1)
Influenced to take up safe male circumcision	Yes	75(54.3)
	No	45(32.6)
Influencer of safe male circumcision	Parental influence	24 (17.4)
	Spouse influence	68(49.3)
	Peer influence	28(20.3)
Distance from your home to the health center	Less than 5km	58(42.0)
	More than 5km	62(44.9)
Barriers to safe male circumcision	Fear of pain	29(21.0)
	Fear of delayed wound healing	47(34.1)
	Fear to hurt my wife's/girlfriend's preference to an uncircumcised penis	38(27.5)
	Fear of going against my traditional beliefs	6(4.3)
Opinion about safe male circumcision	Very good	57(41.3)
	Good	41(29.7)
	Poor	22(15.9)

Table 3, most of the participants were influenced by their spouse to take up safe male circumcision, 75(54.3%), and the least was due to peer influence, 28(20.3%). The majority of the participants covered more than 5 km, 62(44.9%), from home to the hospital, while the least covered less than 5 km, 58(42.0%). Most of the participants had a very good opinion about safe male circumcision (41.3%), and the least. The

majority of the participants indicated that fear of delayed wound healing was the main barrier to safe male circumcision (34.1%), while the least indicated fear was of going against traditional beliefs 6(4.3%). Most of the participants were circumcised for health/hygiene and sexual satisfaction, 88(73.8%), and the least for traditional/cultural values, 7(5.1%), as shown in Table 5.

independent and dependent variables. This marks the foundation of the implementation of services that are directed to improve the uptake of VMMC.

### Association between socio-demographic characteristics and uptake of VMMC

This relationship was investigated in this study, which helped to understand the causal effect among the

**Table 4: Association between sociodemographic characteristics and uptake of VMMC**

Variable	Category	Uptake of Voluntary Medical Male Circumcision		X <sup>2</sup>	df	P value
		Yes N(%)	No N(%)			
Age	18-29 years.	44(48.9)	18(60.0)	5.326 <sup>a</sup>	2	0.070
	30-39 years	32(35.6)	12(40.0)			
	40-49 years	14(15.6)	0(0.0)			
Marital status	Single	50(55.6)	18(60.0)	1.085 <sup>a</sup>	2	0.581
	Married	37(41.1)	12(40.0)			
	Divorced	3(3.3)	0(0.0)			
Education level	No formal education	7(7.8)	8(26.7)	18.913 <sup>a</sup>	3	0.000*
	Primary	52(57.8)	9(30.0)			
	Secondary	18(20.0)	13(43.3)			
	Tertiary	13(14.4)	0(0.0)			
Occupation	Civil servant	16(17.8)	12(40.0)	13.170 <sup>a</sup>	3	0.004*
	Self-employed/businessman	34(37.8)	3(10.0)			
	Student	26(28.9)	13(43.3)			
	Unemployed	14(15.6)	2(6.7)			
Religion	Catholic	12(13.3)	11(36.7)	18.031 <sup>a</sup>	4	0.001*
	Protestant	41(45.6)	9(30.0)			
	SDA	15(16.7)	10(33.3)			
	Moslem	10(11.1)	0(0.0)			
Nationality	Born Again	12(13.3)	0(0.0)	5.953 <sup>a</sup>	4	0.203
	Ugandan	46(51.1)	15(50.0)			
	Tanzanian	10(11.1)	3(10.0)			
	Rwandese	22(24.4)	12(40.0)			
	Congolese	6(6.7)	0(0.0)			
	Sudanese	6(6.7)	0(0.0)			

*\*significant p value ( $\leq 0.05$ ) acceptable level*

Table 4, a significant relationship between socio-demographic characteristics of education level  $X^2(df=3)=18.913$ , p value=0.000, education level  $X^2(df=3)=13.170$ , p value=0.004, and religion  $X^2(df=4)=18.031$ , p value=0.001 with uptake of VMMC.

### Association between health-related factors and uptake of VMMC

**Table 5: Association between health-related factors and uptake of VMMC**

Variable	Category	Uptake of Medical Male Circumcision	Voluntary Male	X2	df	Pvalue
		YES N(%)	NO N(%)			
Voluntary Medical Male Circumcision services at the health facility in your sub-county	YES	42(46.7)	11(36.7)	0.912 <sup>a</sup>	1	0.339
	NO	48(53.3)	19(63.3)			
Health education about Voluntary Medical Male Circumcision services at the health facility	Yes	52(57.8)	16(53.3)	0.181 <sup>a</sup>	1	0.671
	No	38(42.2)	14(46.7)			
The health facility near your home provides information about Voluntary Medical Male Circumcision	Yes	50(55.6)	20(66.7)	1.143 <sup>a</sup>	1	0.285
	No	40(44.4)	10(33.3)			
Enough privacy at the public health facility near your home	Yes	52(57.8)	19(63.3)	0.287 <sup>a</sup>	1	0.592
	No	38(42.2)	11(36.7)			
Duration taken to be attended to at the health facility	Less than an hour	20(22.2)	18(60.0)	22.346 <sup>a</sup>	2	0.000*
	Between 1 and 3 hours	52(57.8)	3(10.0)			
	More than 3 hours	18(20.0)	9(30.0)			

*\*significant p value ( $\leq 0.05$ ) acceptable level*

In Table 5, there was a significant association between the hospital-related factor of duration taken to be attended to at the health facility,  $X^2(df=2)=22.346$ , p value 0.000, with uptake of VMMC.

### Association between personal factors and uptake of VMMC

**Table 6: Association between personal factors and uptake of VMMC**

Variable	Category	Uptake of Medical Circumcision	Voluntary Male	X2	df	P value
		YES N(%)	NO N(%)			
The main reason for circumcision	Health/ hygiene	35(38.9)	9(30.0)	31.774 <sup>a</sup>	3	0.000*
	Sexual satisfaction	42(46.7)	2(6.7)			
	Protection from STIs/ HIV	9(10.0)	16(53.3)			
	Traditional/ cultural values	4(4.4)	3(10.0)			
Influenced to take up safe male circumcision	Yes	54(60.0)	21(70.0)	0.960 <sup>a</sup>	1	0.327
	no	36(40.0)	9(30.0)			
Influencer of safe male circumcision	Parental influence	15(16.7)	9(30.0)	11.782 <sup>a</sup>	2	0.003*
	Spouse influence	59(65.6)	9(30.0)			
	Peer influence	16(17.8)	12(40.0)			
Distance from your home to the health center	Less than 5km	44(48.9)	14(46.7)	0.044 <sup>a</sup>	1	0.833
	More than 5km	46(51.1)	16(53.3)			
	Fear of pain	18(20.0)	11(36.7)	25.215 <sup>a</sup>	3	0.000*



Barriers to safe male circumcision	Fear of delayed wound healing	41(45.6)	6(20.0)			
	Fear to hurt my wife's/girlfriend's preference to an uncircumcised penis	31(34.4)	7(23.3)			
	Fear of going against my traditional beliefs	0(0.0)	6(20.0)			
Opinion about safe male circumcision	Very good	49(54.4)	8(26.7)	32.732 <sup>a</sup>	2	0.000*
	Good	35(38.9)	6(20.0)			
	Poor	6(6.7)	16(53.3)			

*\*significant p value ( $\leq 0.05$ ) acceptable level*

Table 6 indicates that there was a significant association between personal factors of main reason for circumcision  $X^2(df=3)=31.774$ , p-value 0.000, Influencer for safe male circumcision  $X^2(df=2)=11.782$ , p-value 0.003, barrier to safe male circumcision  $X^2(df=3)=25.215$ , p-value 0.000

and opinion about safe male circumcision  $X^2(df=2)=32.732$ , p-value 0.000.

## Discussion

### Personal factors associated with the uptake of VMMC

Study findings indicate that there was a significant association between personal factors of the main reason for circumcision (p-value 0.000), influencer for safe male circumcision (p-value 0.003), the barrier to safe male circumcision (p-value 0.000), and opinion about safe male circumcision (p-value 0.000). These study findings are similar to the study findings of (Rupfuts et al., 2014). This revealed that those with a circumcised friend were more likely to be circumcised compared to those without a circumcised friend. Other significant factors associated with VMMC uptake were fear of poor wound healing, having a circumcised relative, encouragement by a friend or relative, and discussing circumcision with a female partner. This is because third-party referrals are important in marketing, encouraging someone to get circumcised. The use of circumcised friends and/or relatives in marketing the program can assist in improving VMMC uptake.

In this study, having negative opinions, like a fear of pain, was one of the reasons for circumcision unwillingness. The association between fear of poor wound healing and VMMC was linked to the long abstinence period and fear of potential partner infidelity, which were given as reasons for not being circumcised in this study. This is further supported by the finding that more than a third of the circumcised individuals had abstinence periods of less than six weeks. (Plotkin et al., 2013) There were similar findings in Tanzania, where it was noted that the long wound healing period, resulting in abstinence for a prolonged period, was a barrier to VMMC uptake. Thus development and use of surgical devices that shorten the healing period may increase VMMC uptake.

Furthermore, in this study, it was noted that participants who had good intentions, like knowing their HIV status and sexual satisfaction, had higher odds of uptake of voluntary male medical circumcision. This study result is contrary to earlier results of (Rupfuts et al., 2014) This indicated that Fear of knowing HIV status, coupled with the prerequisite that only HIV-negative men are circumcised, is a bottleneck to the success of the program. These men would most likely have been tested for HIV outside the VMMC program, making the success of the program dependent on the performance of other HIV testing programs. (PEPFAR, 2012). However, in this study, due to mass sensitization about VMMC reducing the risk for HIV by 60% could be the reason why men want to get to know their HIV status alongside VMMC.

### Association between socio-demographic characteristics and uptake of VMMC

This study's findings indicate a significant relationship between socio-demographic characteristics of education level, occupation, and religion with the uptake of VMMC. This is because factors that help in decision-making that affect the uptake of VMMC, participants with higher education levels, employed, and without religious barriers, were able to uptake VMMC. Similarly, a study by (Nanteza et al., 2018) Indicated that Location (rural or urban), tribe, education level, and occupation were associated with the circumcision status of male respondents and had a significant relationship with VMMC.

### Education level

In this study, there was a significant relationship between education and voluntary male medical circumcision. Being in higher education had higher odds of male medical circumcision. These study results are similar to the study findings of (Tusabe et al., 2022) This revealed a relationship between higher education and voluntary male medical circumcision. This can be explained by higher education being linked with awareness creation about VMMC, reduced risk of infection, improved penile hygiene, and perceived improvement in sexual performance. As education increases, young men are more likely to perceive themselves to be at high risk of HIV infection, most likely because they understand the dynamics of HIV

infection. Therefore, it is imperative to implement VMMC interventions targeting out-of-school youths with higher levels of school dropouts. (Mangombe & Kalule-Sabiti, 2019)

## Religion

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This study's findings show a significant relationship between religion compared to other religious affiliations. Being a Muslim had higher odds of taking up voluntary male medical circumcision. This is because the Muslim community supports circumcision. This study is contrary to key findings of (Mangombe & Kalule-Sabiti, 2019), which indicated that Youth who belonged to Pentecostal churches and apostolic sects were less likely to perceive themselves to be at a higher risk of HIV infection compared to respondents with no religion. However, the findings of the current study do not support previous research, which found that these men perceived themselves to be at no risk for HIV infection. Apostolic sect members usually put stringent restrictions on sexual behavior, which makes them believe that they are not at risk of HIV infection. For instance, they encourage intermarriage within the church, virginity tests for young girls, polygamy practices, and the use of the Holy Spirit to detect adultery (Mangombe & Kalule-Sabiti, 2019). This has implications for young men affiliated with the apostolic sect's perception of HIV infection. Studies have shown that religion impacts human behavior and health outcomes. However, religious and cultural beliefs make VMMC difficult among non-circumcising communities. This makes sensitization and mobilization of community leaders crucial for the success of the VMMC program (Rupfute et al., 2014)

## Occupation

In this study, there was a significant relationship between occupation and voluntary male medical circumcision. Being unemployed had higher odds of undertaking voluntary male medical circumcision. These study results are similar to what was highlighted in a study by (Chatsika et al., 2020) Which noted that students and those who were unemployed were significantly associated with being involved in transaction sex. The odds of being involved in transaction sex were four times higher among the students compared to those with formal employment, and the odds of being involved in transaction sex among those unemployed were six times higher compared to those with formal employment. In this study, the variation in the results can be explained by the fact that to undertake voluntary male medical circumcision needs you need to ask for leave days, which may not be awarded automatically; thus, participants who are not employed find it easier to undertake voluntary male medical circumcision. (PEPFAR, 2012).

## Conclusion

The major influential factors to Voluntary Medical Male Circumcision were the advice of Spouses, fear of delayed

wound healing, privacy of clients, and duration taken to be attended to at the health facility.

## Recommendations

Both Government and private medical facilities should be well-staffed with experienced professionals and equipment to boost the uptake of medical male circumcision.

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