

THE DEMAND FOR MEDICAL MALE CIRCUMCISION

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Abstract

This paper measures the demand for adult medical male circumcision using an experiment that randomly offered varying-priced subsidies and comprehensive information to 1,600 uncircumcised men in urban Malawi. We find low demand for male circumcision: only three percent are circumcised over a three month period. Despite the low overall level of take-up, both price and information are significant determinants of circumcision. Still, the main barriers

likelihood of take-up by almost two percentage points. There was no significant interaction between information and price.

Due to the small sample size of those who were circumcised, our ability to estimate which types of men select into the surgery is limited. However, we do find some suggestive evidence. Not surprisingly, those who reported as willing to be circumcised at baseline were the most likely to get a medical circumcision. Men living closer to the clinic or who had heard that others had been circumcised at the clinic were more likely to get circumcised. Ex-ante risk may also predict selection into male circumcision: men who used a condom that last time they had sex and those who had fewer sex acts in the past month are more likely to get circumcised in our data. Men who are least at risk of HIV are most likely to adopt male circumcision, universal male circumcision roll-out campaigns will be less cost-effective than estimates suggest. However, we caution generalizing these results given the small sample of men who take-up circumcision.

While price and information were important barriers for some men, simply providing free medical circumcisions and comprehensive information was not enough to motivate most to get circumcised. At baseline, the most common reasons men cited were cultural or religious norms or the fear of pain from the surgery. While the information and price of circumcision significantly affected attitudes towards future circumcisions along some dimensions, there were no impacts on views about norms or pain.

There are several important limitations to our findings. First, the study was conducted during the initial phases of male circumcision scale-up in Malawi. It may be that future demand increases with more government support, information campaigns, and with increased male circumcision adoption within the population. Second, our analyses measuring the determinants of take-up are identified off of a small sample and the results should be interpreted with this in mind. Third, our results do not speak to the effect of negative prices on the

demand for male circumcision which may be one way that would stimulate demand especially given the physical and psychological costs of the surgery

Still, our results have significant policy implications and make important new contributions to the literature. First, the demand for medical male circumcision may be much lower than previous acceptability studies or media reports suggest. Second, simply providing free medical male circumcisions and information about male circumcision and HIV transmission was not enough to generate sufficiently high demand that would induce significant population level benefits. Moreover, these interventions had no impact on changing attitudes about cultural and religious norms about male circumcision or the fear of pain from the surgery. The implication of our results is that reaching the goal of circumcising 80 percent of adult men by 2015 may be much more difficult than merely increasing the supply of free circumcisions.

The paper proceeds as follows: Section 1 presents background information on male circumcision and what is known about the determinants and barriers to take up. Section 2 presents the data and experiment. Section 3 presents the results on male circumcision take-up. Section 4 outlines the empirical strategy to identify the effects of price and information on take-up. Results are presented in Section 5. Section 6 discusses other possible barriers to take-up and Section 7 concludes.

I. Background

A. Traditional Male Circumcision in Malawi

It is currently estimated that approximately 11 percent of adults are infected with HIV in Malawi, giving the country the 9th highest infection rate in the world (UNAIDS, 2010). Malawi was named as a high priority country for the scale-up of medical male circumcision not only because of its high HIV prevalence, but also because the majority of men (81 percent) are not circumcised (MDHS, 2010)

As in other African countries, the practice of male circumcision is deeply cultural

percent across countries (Westercamp and Bailey, 2007). Malawi, approximately 37 percent reported that they would be willing to get circumcised in 2010 (Bengo et al., 2010). However, it is difficult to infer true behavior from hypothetical answers about the willingness to get circumcised (Maula, 2007; Westercamp and Bailey, 2007).

Another approach to quantifying the demand for male circumcision is to simply count the number of medical male circumcisions conducted within a country or region. By the end of 2010, just over 555,000 medical circumcisions were performed for HIV prevention in the 14 priority countries, representing approximately only 2.7 percent of the target. In Malawi, one estimate provided by the Ministry of Health reports that 2,119 medical male circumcisions were conducted in facilities across the country between 2008 and 2010 (WHO, 2011). However, many of these circumcisions may be substituting for traditional circumcisions. Records of the circumcisions conducted at health facilities in 2010 found that only 14.8 percent were adults; the remaining constituted infants, children and adolescents (Bengo et al., 2010).

These statistics may suggest fairly low demand for male circumcision alternatively they may reflect limited supply or access. Moreover, facility-based reports of the number of men circumcised do not provide sufficient information to estimate how many men chose to get circumcised. Those statistics are missing the denominator that is needed to estimate demand.

³ Households were sampled across selected districts based on expected prevalence of male circumcision using the results of 2004 Malawi Demographic and Health Survey (MDHS 2004). The survey included men older than 18. Initially, 81 percent of men reported being opposed to circumcising their children.

C. Determinants of and Barriers to Takeup

Previous studies have explored possible barriers to takeup of medical male circumcision, the majority however, as discussed above, use hypothetical acceptances as a measure of demand rather than observing actual circumcisions. In addition, most are unable to determine causal relationships due to omitted variables that may be correlated to both demand and other factors.

Perceptions of the cost of a medical male circumcision have been reported as barriers to takeup. These include the perception of a long healing period, perceived pain associated with the surgery, lost wages, or the cost of the circumcision procedure itself (Lukobo and Bailey, 2007; Herman-Roloff et al., 2011; Westercamp et al., 2012).

The belief or knowledge that circumcision is protective against HIV may also be an important determinant of hypothetical demand (Bengo et al., 2010; Albert et al., 2011; Westercamp et al., 2012). In a paper most similar to ours, Godlonton, Munthali, and Thornton

priority compared to other surgical procedures and that readily available.⁸ To conduct our study, we partnered with a private provider that had begun offering circumcisions in 2010, becoming a leader in private provision of medical male circumcision in Malawi.¹⁰ The clinic, which

enumeration areas as defined by the Malawian National Statistics Office. Each enumeration area was subdivided into a total of 114 neighborhood blocks which were demarcated using roads and rivers as natural dividing lines. Blocks were randomly selected into the study, stratified by enumeration area. On average there were 4 blocks per enumeration area.

Within each selected block, a household census was conducted in which men who were eligible for the study were identified. Eligibility was defined as any man – regardless of circumcision status – who was a permanent resident in the household and between the ages of 18 and 35 years. In households with more than one eligible man, one man was randomly selected as the target respondent¹²

After the selection of an eligible respondent and obtaining informed consent, the baseline survey would commence, first with questions to determine the respondent's circumcision status. The full survey was only administered to uncircumcised men. In total, 1,634 uncircumcised men completed baseline surveys. Follow-up surveys were conducted in 2011, approximately one year after the baseline, in which 77 percent of the men who were interviewed at baseline were reinterviewed¹³. We use two samples in our analysis, the full sample of 1,634 men interviewed at the baseline and the follow-up sample of 1,252 men who were interviewed at both the baseline and the follow-up.

C. Randomization

Immediately after the baseline survey, each respondent was given a voucher for a subsidized circumcision at the partner clinic branch valid for approximately three months. Vouchers contained a voucher ID that could be linked to each

¹² Data from the Demographic and Health Survey of Malawi finds that 23 percent of men living in urban areas in the Central Region (where Lilongwe is located) were circumcised. This is higher than the 19 percent male circumcision prevalence rate across the entire country.

¹³ The attrition rate is relatively higher than other panel studies in rural Africa mainly due to the high mobility of men living in an urban area (Anglewicz et al., 2009)

D. Sample

Table 1, Column 1 presents the summary statistics for the full sample of the 1,634 men interviewed at baseline.¹⁸ The sample consists of men who are on average almost 27 years old and relatively well educated, having completed eleven years of school. Individuals spend approximately \$142,325MK per month on various expenses (median of \$99).¹⁹ Just more than 17 percent of the respondents are from a circumcising tribe, defined as a tribe with over 20 percent circumcised men in the Demographic and Health Survey (MDHS, 2010).²⁰ Most men in the sample have ever had sex (87.5 percent; not shown) and have had approximately 4.2 sexual acts in the past month. Just less than half of the men (46.4 percent) report abstaining from sex in the past month, with almost 6 percent reporting having multiple partners. Of those who had sex in the last month 39.5 percent report using a condom the last time they had sex. On average, 21.7 percent of the sample report they have a high likelihood of being currently HIV positive. Just under half (48 percent) have ever had an HIV test.

We asked a number of questions to elicit perceptions about male circumcision. When asked about their beliefs about male circumcision and HIV, 49 percent had the correct prior belief that circumcised men were less likely to contract HIV. Almost half of the men (49 percent) reported that they were willing to be

¹⁸ Our sample is generally similar to other studies conducted in urban Malawi. For example, urban men living in the Central region in the MDHS (2010) had on average 7.7 years of education, 25 percent had used a condom at last sex, and 55.6 percent had ever been tested for HIV. The ethnic composition of respondents is not representative of the study area due to the fact that only uncircumcised men were eligible for the survey; approximately one third of the men are Chewa (34.6 percent), 24.7 percent Ngoni, 13.5 percent Lomwe, 12.8 percent Tumbuka and the remaining 15 percent include Nkhonde, Nyanja, Tonga, Yao and others (not shown).

¹⁹ Expenditures categories were: Clothes, fabric, or shoes, Medical expenses at a clinic, doctor, pharmacy, or traditional doctor, Food: maize, meat, vegetables, sugar, transportation costs, and cell phone minutes. We report pre-devaluation prices.

²⁰ This includes the Yao, Mang'anja, Nyanja, and Lomwe.

²¹ To elicit these beliefs, respondents were asked: "If a man is circumcised, is he more likely, less likely, or about the same as an uncircumcised man to get HIV?"

circumcised. This is slightly lower than the median acceptability rate of 65 percent from circumcision acceptability studies across-Saharan Africa (Westercamp and Bailey, 2007), but higher than the Malawi Situational Analysis from Lilongwe where 37 percent reported the willingness to get circumcised (Bengo et al., 2010). On average, men lived approximately one kilometer away from the partner clinic and 19 percent had ever heard of someone getting circumcised there.

that 43 vouchers were redeemed, take-up rate of 2.63 percent (Panel A). Restricting the sample to the 1,252 who were also interviewed at the follow up, the take-up rate was 3.3 percent as measured by redeemed

social, and psychological costs associated with the surgery. On the other hand, some men did get circumcised; understanding the determinants of uptake may provide insights that could benefit medical male circumcision scale efforts. Because participants and comprehensive information were randomly allocated at the baseline, we can measure the causal effect of these factors. We also examine how various personal characteristics are correlated with uptake. Importantly, because of the low overall rate of uptake, the results in this section should be interpreted as suggestive, as they may not be generalizable to other settings or in case of a

variables X, include: age, age squared, logged total expenditures, years of schooling, indicators of belonging to a circumcising tribe, believing to be circumcised, believing his risk of having HIV was high, having ever had an HIV

equality of the average values of the baseline characteristics information treatment group. Similarly, Column 3 presents the value of an F-test of joint equality of the mean values of each baseline characteristic in the randomly assigned prices. For almost all of the baseline characteristics we cannot reject equality suggesting that the respondents in the information groups and price group are balanced on key observable characteristics. In total, we tested 50 baseline characteristics and 16 percent were statistically significant at the 10 percent level across the different assigned prices. 12 percent were statistically significant across the information treatment or control groups.

In addition, there are also no significant differences in follow-up survey completion across the information treatment groups assigned prices; the p-value of the joint test of significance for having a complete follow-up survey is 0.705 or 0.964, respectively (not shown). Attrition also does not differentially vary across price or information by baseline characteristics. To test this, we run separate regressions of being surveyed at the follow-up on each baseline characteristic, indicators for each information treatment (price), and interactions between the baseline variable and each information treatment indicator (price indicator).

declines monotonically thereafter with increasing price. No one was circumcised who had to pay the highest amount.

Table 3, Columns 1 through 4 presents regression estimates from equation 1 of the effects of price on actual circumcisions as measured by the clinical records. Those offered a free circumcison were 0. Tw 5.48 0 Td f d

responses to “negative prices” or financial incentives. Future research offering compensation in either cash or kind may be an important next step.

B. Information

One possible reason for low circumcision take-up even when the procedure was free is that men did not know or understand the medical benefits of male circumcision. Recall that at baseline only 49

Baseline beliefs about the relationship between male circumcision and HIV infection may be important to consider when examining the impact of knowledge on takeup. Wilson et al (2013) found that men who had different beliefs about male circumcision and HIV responded differentially after getting a circumcision in terms of their sexual behavior. Similarly, it may be possible that only those receiving new information may respond in this study. If baseline beliefs are correlated with takeup, there is no additional effect of the comprehensive information (not shown.)

C. Other Determinants – Non-Randomized Results

Table 5 presents how baseline characteristics are correlated with takeup of male circumcision and having any interaction with the clinic. It is important to note that these variables were not randomized at baseline and thus do not represent causal estimates. However, they can provide some insights into additional important factors for the demand for male circumcision.

One of the most important predictors of getting circumcised was openness to a circumcision defined as reporting willingness to be circumcised at the baseline. Those who reported being willing to circumcise at the baseline were between 2.6 and 3.1 percentage points more likely to receive a circumcision reported by the clinic, and almost 9 percentage points more likely to have had any interaction with the clinic.

There is no statistically significant effect of age on actual takeup, despite the large proportion of men who stated being “too old” was a reason to not get circumcised at baseline.

interacted with having a prior HIV test are significantly associated with getting a circumcision.

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opportunity costs were lower. Additionally, there were some reports that men were unable to schedule a time at the clinic when the clinician was available. This speaks to the importance of the need to promote both demand and ensure supply of male circumcision services. Among those men who made any contact with the clinic, they made an average of 2.25 calls to the clinic, 2.12 visits, and 1.9 attempts for surgery. Even among those who eventually got circumcised it took some effort; these men made 1.75 calls, 1.33 visits, and 2 surgery attempts.

VII. Conclusion

This paper measures the demand for medical male circumcision and the response to price and information using a randomized trial. No prior study, to our knowledge, has measured the demand for male circumcision. Overall, the demand was relatively low ranging from 2.6 to 8.9 percent using clinic and self-reported data respectively. This is particularly low when compared to the target of 80 percent set for male circumcision rollout strategies.

Price was not the only barrier to receiving a male circumcision, but certainly was for some. In addition, information—while a significant factor—is not the main barrier to take-up. Openness to male circumcision, $-v(\)]$ TJ-2(w)]TJ -0.004 Tc 0.218w

effectiveness estimates Njeuhmeli et al(2011) which were calculated using the DecisionMakers' Program Planning Tool (DMPPT) developed by USAID and UNAIDS. This model accounts for many parameters such as demographic, epidemiological, and cost factors but does not take into account possible population-level spillovers from increased take up. If spillovers are important for HIV incidence, costeffectiveness estimates would underestimate the savings lost from low take

Riordan 1991; Riley 2001) or those who pay for a good ~~view~~ the investment as a sunk cost and therefore be more likely to use it (Thaler 1980; Arkes and Blumer 1985). Despite these arguments a number of ot

high priority. However, there must be joint efforts on both increasing demand particularly among high risk groups and ensuring reliable supply quality services during scale up. Reducing price or providing information may be one way to reach targeted levels of male circumcision coverage, but clearly is not the only strategy needed. How to incentivize high risk adult men in endemic areas to get circumcised is an important question for future research.

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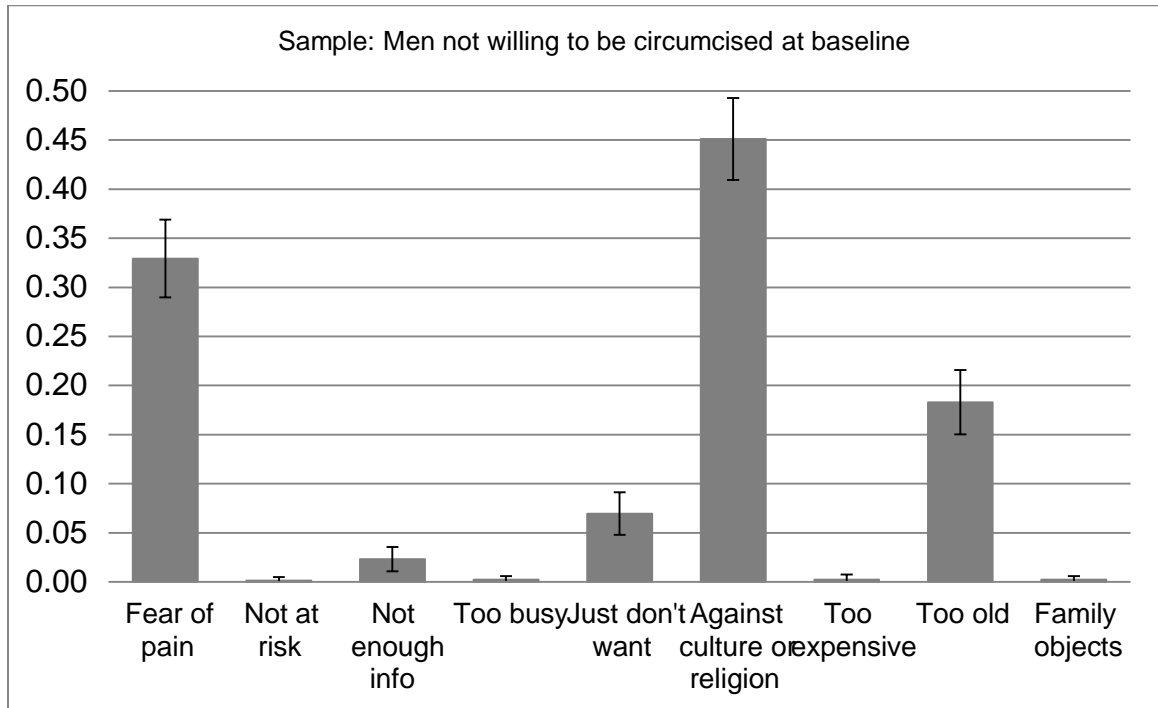
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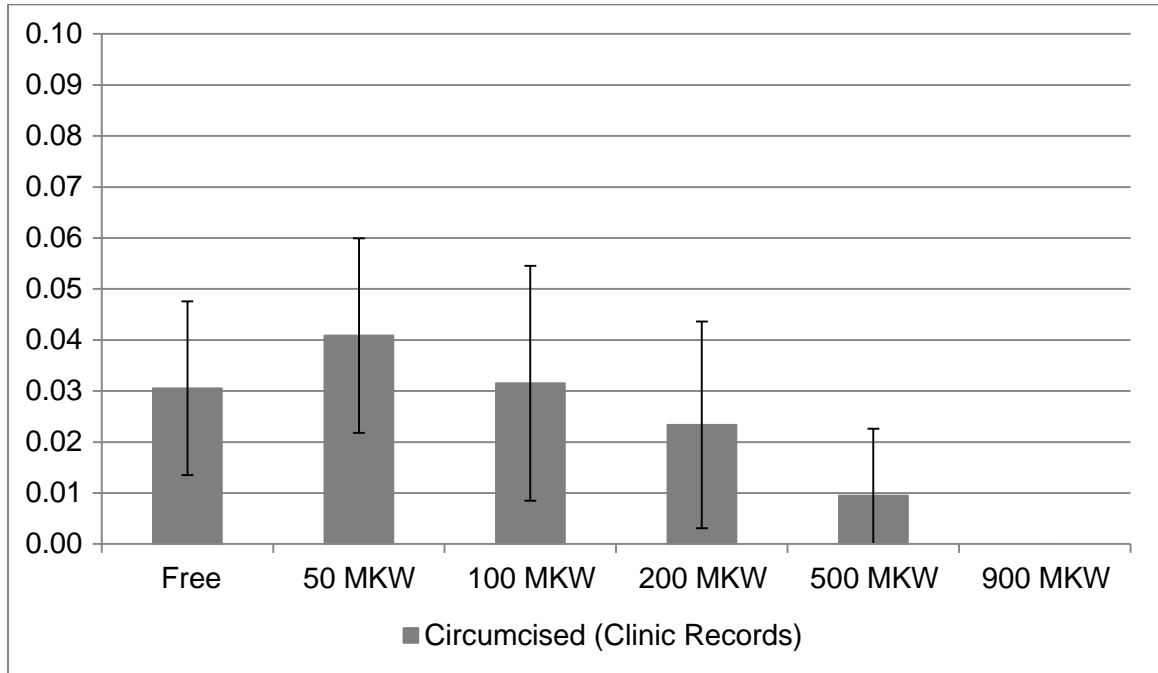
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Figure 1: Reasons against circumcision



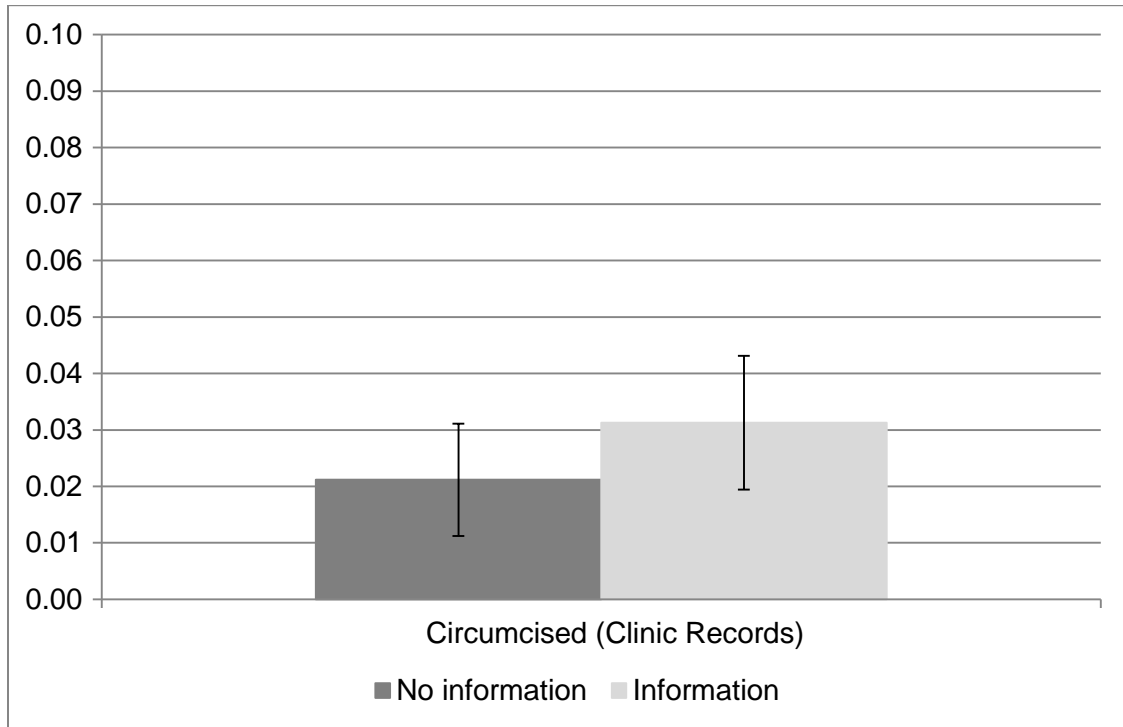
Notes: Sample includes 634 men interviewed at baseline. Circumcision is measured by clinical records. Average rate was 2.6 percent.

Figure 2: Medical Male Circumcision and Price of Circumcision



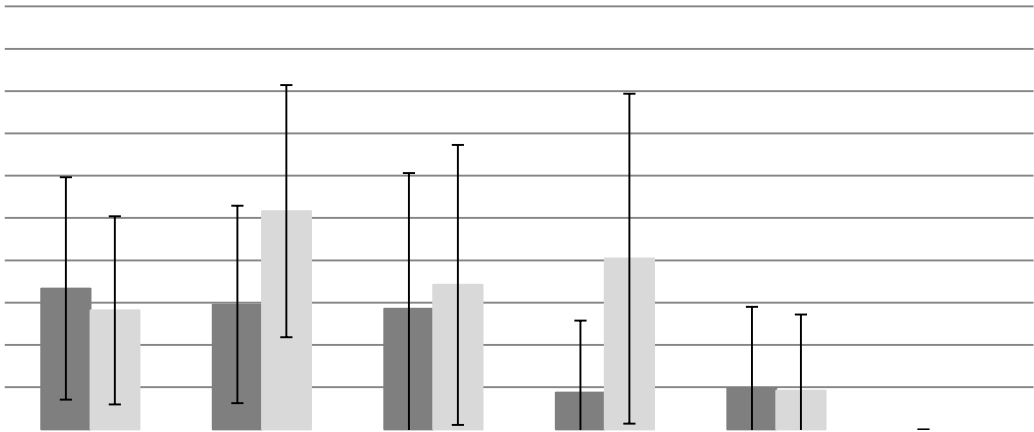
Notes: Sample includes 634 men interviewed at baseline. Circumcision is measured by clinical records. Average rate was 2.6 percent.

Figure 3: Medical Male Circumcision and Information



Notes: Sample includes 634 men interviewed at baseline. Circumcision is measured by clinical records.

Figure 4: Medical Male Circumcision, Price and Information



Notes: Sample includes 634 men interviewed at baseline. Circumcision is measured by clinical records.

Table 1: Sample Statistics - Full Sample

	Mean, SD		Balance		Attrition	
			Information	Prices	Information	Prices
	(1)	(1)	(2)	(3)	(4)	(5)
Age	26.686	[5.783]	0.739	0.777	0.198	0.250
Years of schooling	11.055	[2.466]	0.320	0.164	0.073	0.848
Expenditures	21,325.05	[27,371.47]	0.718	0.534	0.727	0.177
Circumcising tribe	0.171	[0.376]	0.717	0.784	0.199	0.465
Num sex acts last month	4.205	[7.251]	0.884	0.902	0.949	0.843
Multiple partners in past month	0.058	[0.234]	0.003	0.037	0.147	0.931
Abstinence last month	0.461	[0.499]	0.656	0.169	0.614	0.971
Condom use at last sex	0.395	[0.489]	0.040	0.304	0.418	0.393
Belief of high likelihood HIV	0.217	[0.413]	0.959	0.699	0.598	0.256
Ever had an HIV test	0.482	[0.500]	0.873	0.771	0.798	0.044
Willingness to circumcise	0.493	[0.500]	0.058	0.884	0.150	0.098
Circumcision is protective	0.488	[0.500]	0.207	0.978	0.338	0.587
Heard of anyone circumcised at clinic	0.196	[0.397]	0.046	0.491	0.218	0.113
Distance to the clinic (in km)	0.969	[0.442]	0.044	0.316	0.922	0.169

Notes:

Notes: Sample consists of 1634 men who were interviewed at baseline. Expenditures categories were: Clothes, fabric, or shoes, Medical expense doctor, pharmacy, or traditional doctor, Food: maizes, meat, vegetables, eating out, transportation costs, and cell phone minutes. Median expenditures were 12,000 Kwacha. Believing circumcision is protective is generated from two questions that asked: i) "If 100 circumcised men each slept with a woman who is HIV positive last night, how many of them do you think would get HIV?"; and ii) "If 100 uncircumcised men each slept with a woman who is HIV positive last night, how many of them do you think would get HIV?"

Columns 2 and 3 present the p-values from separate regressions testing the difference in each baseline variable across the information treatment (Column 2), or circumcision price (Column 3). Columns 4 and 5 present the p-values from separate regressions of being in the follow-up sample on each baseline variable interacted with information treatment indicator (Column 4) or an indicator of each price (Column 5). The p-values are either on the interaction of information and baseline variable, or the joint test of the interactions of each price and the baseline variable.

		Number of Men	% of Full Sample	
<u>Panel A: Full Sample (N=1634)</u>				
Clinic Data	Circumcised	(1) 43	(2) 0.0263	
		Number of Men	0.739	0.7772
<u>Panel B: Follow-up Sample (N=1252)</u>				
Clinic Data	Circumcised	(1) 41	(2) 0.033	(3) 0.369
Clinic Data	Circumcised at non-partner clinic	25	0.020	0.225
	Circumcised at partner clinic after validity period	9	0.007	0.081
	Circumcised at partner clinic during validity period	36	0.029	0.324
Total (clinic or survey)	Circumcised			

CIDSV.44 rcumc68An Jm 0.37 k 7.38 C1(BDC68 - BDC 17.07 a5 1.668 3(r)1(a)3(c)26)5(n)5(w)26(th)5(7.38C N/A04(0.=CID4)5(1)5(8 T

Table 3: Voluntary Medical Male Circumcision Take-Up and Price

Dependent Variable:	Circumcised (Clinic)		Circumcised (Clinic)		Circumcised (Self-Report: Valid Clinic + Non-expired Clinic)		Any clinic interaction (Self-Report)	
	Full Sample				Follow-up Sample			
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Free	0.031*** [0.012]	0.026** [0.011]	0.036*** [0.013]	0.030** [0.013]	0.065*** [0.018]	0.054*** [0.019]	0.108** [0.050]	0.107** [0.052]
50 MKW	0.041*** [0.010]	0.038*** [0.010]	0.053*** [0.013]	0.051*** [0.014]	0.080*** [0.019]	0.066*** [0.016]	0.132** [0.055]	0.140** [0.055]
100 MKW	0.032** [0.014]	0.026* [0.013]	0.035** [0.017]	0.027 [0.017]	0.063*** [0.023]	0.050** [0.022]	0.142** [0.057]	0.142** [0.058]
200 MKW	0.023** [0.010]	0.023** [0.010]	0.031** [0.013]	0.029** [0.013]	0.042** [0.018]	0.042** [0.018]	0.104** [0.050]	0.102** [0.051]
500 MKW	0.009 [0.007]	0.006 [0.008]	0.012 [0.009]	0.010 [0.011]	0.029 [0.018]	0.025 [0.017]	0.086 [0.063]	0.077 [0.063]
Observations	1,634	1,634	1,252	1,252	1,252	1,252	1,252	1,252
R-squared	0.007	0.034	0.009	0.040	0.011	0.049	0.008	0.067
Incl. controls?	N	Y	N	Y	N	Y	N	Y
Ave of dep variable (900 MKW)	0.000		0.000		0.008		0.157	

Notes:

Robust standard errors clustered by block and interview date. Control variables include: age, age squared, logged total expenditures, years of school respondent is of a circumcising tribe, whether the respondent reported he was willing to be circumcised, if the respondent thought his risk of having HIV was high, if the respondent ever had an HIV test, the interaction of belief of high risk and having an HIV test, if the respondent had heard of anyone who circumcised at the partner clinic, if the respondent correctly believed that circumcision was associated with lower risk of HIV, distance to the clinic, number of sex acts in the last month, and indicators for whether the respondent used a condom at last sex, abstinence in the last month, and multiple concurrent partnerships. We also include an indicator of whether the respondent was allocated to the information treatment. For covariates with missing values, the median has been imputed, and a dummy included for whether or not the covariate is missing included. * significant at 10%; ** significant at 5%; *** significant at 1%. Interaction with the partner clinic includes male circumcision, counseling, visits, or phone calls.

Dependent Variable:

Circumcised
(Clinic)

Circumcised
(Clinic)

Circumcised

Dependent Variable: Barrier to circumcision due to -	Culture or Religion	Fear of pain	Too expensive	Too busy	Not at risk	Not enough info	Family objects	Number of reasons
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Information	0.035 [0.031]	0.009 [0.025]	0.018* [0.010]	-0.043* [0.023]	0.023*** [0.008]	-0.044* [0.026]	0.042*** [0.015]	0.057* [0.034]
Free	-0.052 [0.053]	-0.035 [0.039]	-0.066** [0.032]	0.092** [0.039]	-0.004 [0.020]	-0.024 [0.042]	-0.020 [0.031]	-0.099*** [0.036]
50 MKW	0.004 [0.055]	-0.031 [0.034]	-0.051 [0.040]	0.068 [0.050]	-0.009 [0.020]	-0.005 [0.048]	-0.003 [0.028]	-0.022 [0.048]
100 MKW	-0.027 [0.068]	-0.013 [0.045]	-0.051 [0.037]	0.072 [0.045]	-0.009 [0.019]	0.003 [0.048]	-0.027 [0.035]	-0.060 [0.050]
200 MKW	-0.047 [0.055]	-0.034 [0.047]	-0.039 [0.043]	0.095*** [0.035]	-0.024 [0.018]	-0.014 [0.055]	0.001 [0.036]	-0.089* [0.054]
500 MKW	-0.009 [0.057]	-0.060 [0.047]	-0.049 [0.040]	0.051 [0.045]	0.026 [0.030]	-0.015 [0.048]	0.038 [0.039]	-0.027 [0.045]
Observations	1,072	1,072	1,072	1,072	1,072	1,072	1,072	1,072
R-squared	0.054	0.023	0.055	0.038	0.051	0.032	0.039	0.046
Incl. controls?	Y	Y	Y	Y	Y	Y	Y	Y
Ave of dep variable	0.271	0.146	0.046	0.170	0.019	0.230	0.088	1.130

Notes:

	Increased HIV risk (1)	Decreased HIV risk (2)	No impact on HIV risk (3)	Don't know (4)	Uncircumcised men (5)	Circumcised men (6)	Difference (Circumcised - Uncircumcised) (7)	Ratio (Circumcised Uncircumcised) (8)
Information	-0.007 [0.005]	0.038* [0.023]	-0.030 [0.021]	-0.002 [0.001]	-1.879* [1.105]	-8.751*** [2.224]	-6.801*** [1.787]	-0.094*** [0.025]
Constant	0.010** [0.004]	0.830*** [0.012]	0.158*** [0.012]	0.002 [0.001]	89.505*** [0.745]	51.312*** [1.731]	-38.193*** [1.365]	0.579*** [0.018]
Observations	1,248	1,248	1,248	1,248	1,246	1,246		

Appendix Table B: Attitudes towards Circumcision

Dependent Variable:

	Too old (1)	Just don't want (2)	(3)	(4)
Information	0.005 [0.015]	0.015 [0.015]	0.018 [0.015]	-0.011 [0.022]
Free	-0.018 [0.022]	-0.023 [0.032]	0.013 [0.025]	0.012 [0.046]
50 MKW	-0.007 [0.027]	-0.021 [0.029]	0.034 [0.025]	0.007 [0.043]
100 MKW	-0.031* [0.018]	-0.020 [0.035]	0.029 [0.030]	0.038 [0.051]
200 MKW	-0.018 [0.027]	-0.012 [0.033]	-0.006 [0.025]	0.055 [0.050]
500 MKW	0.006 [0.021]	-0.038 [0.034]	-0.002 [0.023]	-0.002 [0.054]
Observations	1,072	1,072	1,072	1,252
R-squared	0.032	0.047	0.032	0.135
Incl. controls?	Y	Y	Y	Y
Ave of dep variable	0.049	0.062	0.083	0.745

Notes:

Robust standard errors clustered by block. Control variables include: age, age squared, logged total exper years of schooling, whether the respondent is of a circumcising tribe, whether the respondent reported he was willing to be circumcised, if the respondent thought his risk of having HIV was high, if the respondent ever had an HIV test, the interaction of belief of high risk and having an HIV test, if the respondent had heard of anyone who