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Perceptions of voluntary medical male circumcision among circumcising and non-circumcising communities in Malawi

Stuart Rennie[a,*], **Brian Perry**[b], **Amy Corneli**[b], **Abdullah Chilungo**[c], and **Eric Umar**[d]

[a]Department of Social Medicine, UNC Bioethics Center, University of North Carolina at Chapel Hill, Chapel Hill, NC, USA

[b]FHI 360, Social and Behavioral Social Sciences Department, Durham, NC, USA

[c]Invest in Knowledge, Zomba, Malawi

[d]Department of Community Health, College of Medicine, University of Malawi, Blantyre, Malawi

Abstract

Three randomised controlled trials in Africa indicated that voluntary medical male circumcision (VMMC) is an effective method to reduce a man's risk of becoming infected through sex with an HIV-positive female partner. The success of recent public health initiatives to increase numbers of circumcised men in Malawi has been very limited. We conducted in-depth interviews (IDIs) and focus group discussions (FGDs) with men, women, and male adolescents from non-circumcising and circumcising communities in southern Malawi to better understand their beliefs about male circumcision and the promotion of VMMC for HIV prevention. Results revealed that beliefs about male circumcision, in general, are strongly mediated by Malawian culture and history. Participants have attempted to develop a new meaning for circumcision in light of the threat of HIV infection and the publicised risk reduction benefits of VMMC. Several study participants found it difficult to distinguish VMMC from traditional circumcision practices (*jando* and *lupanda*), despite awareness that the new form of circumcision was an expression of (western) modern medicine performed largely for public health purposes. Greater recognition of background cultural beliefs and practices could inform future efforts to promote medical male circumcision as an HIV prevention strategy in this context.

Keywords

male circumcision; AIDS; HIV prevention; Malawi; religion; cultural practices; sexuality

Introduction

A link between HIV and male circumcision was first hypothesised at the start of the HIV epidemic (Alcena, 1986; Fink, 1986). Early ecological data in Africa indicated a correlation between regions in which male circumcision was traditionally practiced and lower HIV prevalence (Moses et al., 1990). A large number of subsequent cohort and observational

*Corresponding author. stuart_rennie@med.unc.edu.

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studies in Africa also pointed in the direction of a lower HIV prevalence among men who were circumcised (Szabo & Short, 2000). In 2005, the Cochrane Center conducted a systematic review across a range of study designs to evaluate the evidence that male circumcision reduces the risk of men acquiring of HIV-1 and HIV-2 through heterosexual intercourse (Siegfried et al., 2005). The review concluded that although the preponderance of studies showed an association between male circumcision and the prevention of HIV, the studies varied widely in quality, and randomised controlled trials (RCTs) were needed to control for confounding factors.

Between 2005 and 2007, three RCTs in Africa reported results on the association between male circumcision and HIV infection. All three trials – in South Africa, Kenya and Uganda – were stopped early on ethical grounds, because the circumcision arms of the trials had a significantly lower rate of HIV transmission than the non-circumcising arms (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007). These studies showed that within the clinical trial setting, male circumcision lowered the relative risk of female-to-male HIV transmission between 51% and 60%. On the basis of these findings, the World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS) stated that male circumcision is an efficacious HIV prevention intervention that should be implemented in high-HIV prevalence settings, albeit by well-trained health professionals, in safe conditions, and only under condition of informed consent or parental permission (otherwise referred to as voluntary medical male circumcision) (WHO & UNAIDS, 2007). Although circumcision in itself only provides a slight reduction of HIV transmission risk (from infected females to males) for individuals, arguments projected that circumcision of a large number of males could help substantially reduce HIV incidence at a population level. According to estimates based on mathematical modelling, 22% of HIV infections between 2011–2025 could be averted if an 80% male circumcision prevalence rate is attained and maintained among 14 priority countries in east and southern Africa by 2015 (WHO & UNAIDS, 2011).

Since 2008, voluntary medical male circumcision (VMMC) initiatives have increasingly taken place in sub-Saharan Africa. In December 2011, the President's Emergency Plan for AIDS Relief (PEPFAR) announced support for >4.7 million VMMCs over the next two years. In November 2013, the CDC reported the results of PEPFAR-funded VMMC sites between 2010 and 2012 in nine sub-Saharan countries: Botswana, Kenya, Malawi, Mozambique, Namibia, South Africa, Tanzania, Uganda and Zambia (Centers for Disease Control and Prevention [CDC], 2013). Between 2010 and the end of the 2013 fiscal year, an estimated 1,020,424 circumcisions were conducted in Africa for the purpose of HIV prevention with PEPFAR funding and CDC support. Kenya performed the most circumcisions (386,752), followed by Uganda (205,812) and Zambia (105,518). However, the total number of circumcisions conducted in Africa under PEPFAR only constitutes a minute fraction of the earlier UNAIDS target of reaching 20 million circumcisions by 2015 (WHO & UNAIDS, 2011).

Malawi is one of the target countries identified for VMMC initiatives by UNAIDS and PEPFAR, due to its high-HIV prevalence (11%) and low rate of male circumcision (21%). However, the country has been one of the slowest to implement male circumcision as part of a comprehensive HIV prevention strategy, despite the findings of an early acceptability

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study that indicated VMMC would be embraced if safe, affordable and confidential (Ngalande, Levy, Kapondo, & Bailey, 2006). The Mortality and Morbidity Weekly Report (MWWR) stated that only 8198 males had received VMMC under PEPFAR during its reporting period, by far the lowest of all PEPFAR target countries; in addition, those circumcised had the lowest uptake of HIV testing and counselling (53%), the lowest post-operative follow-up within 14 days of VMMC (5.4%), and the highest rate of HIV prevalence among those agreeing to be HIV tested (CDC, 2013). In comparison, the general population of Kenya is roughly 2.5 times that of Malawi (45 million vs. 17.3 million), but the 386,752 circumcisions conducted in Kenya is approximately 40 times greater than the number performed in Malawi during the same period.

In terms of government engagement, male circumcision was only officially mentioned as a promising approach for the first time in the Malawi National HIV Prevention Strategy 2009–2013 (Malawi National AIDS Commission, 2009) where the short-term aims are to '… develop male circumcision policy, intervention and communication guidelines based on international and local evidence'. In 2010, top Malawian HIV officials stated in the press that male circumcision would not be implemented due to 'lack of evidence' (Tenthani, 2010). According to WHO/UNAIDS, only 3119 VMMCs had been conducted in Malawi between 2008 and 2010 (WHO & UNAIDS, 2011), though there are recent indications that some scale-up is occurring. The Malawi Ministry of Health, in conjunction with USAID, reportedly piloted VMMC in clinics in Mulanje district, where 4348 men and adolescent boys were circumcised in 4 weeks (Rozario, 2012). On August 13, 2012, the newspaper Malawi Today (2012) reported that since September 2011, 15,000 men and adolescents have been circumcised out of a national target of 250,000 circumcisions to be performed by 2015. A more recent report in the Nyasa Times (2013) stated that 42,000 males had been circumcised, while government officials optimistically claimed that 2 million would be circumcised by 2016.

In Malawi, traditional male circumcision is predominantly practiced by the Yao ethnic group and Muslim communities in the south of the country, although other ethnicities (such as the Lomwe) also practice a rite involving partial circumcision (*lupanda*). The Yao conduct circumcision as part of an elaborate initiation ceremony for young boys (usually between 8 and 13 years old) called the *jando*, which is typically performed between July and late September each year, and lasts one month. The *jando* incorporates moral, cultural and sexual education (*mwambo*) of the initiates by elders as they make their passage into adulthood. The relationship between the Yao ethnic groups and Muslim communities is complex. Approximately 93% of the Yao in Malawi are Muslim (Malawi National Statistical Office [NSO] & ORC Macro, 2005), and circumcision is regarded by Muslim and Yao groups as an integral part of a boy's transition into adulthood and the life of the community. But while many Muslims identify themselves as Yao, conservative Muslims often refrain from participation in some village-based Yao practices, considering them to be in conflict with their religious convictions. For this reason, some mosques in Malawi offer circumcision without traditional Yao ceremonial elements (Dicks, 2012).

We conducted research in Blantyre, Malawi on the broader institutional, religious, and cultural factors that could make the implementation of VMMC in Blantyre challenging from

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a practical, social or ethical viewpoint. Here we focus on describing how men, women, and male adolescents from ethnic or religious groups who traditionally do not circumcise, as well as key informants from circumcising and non-circumcising communities, perceive male circumcision in general and as an HIV prevention strategy.

Methods

We conducted a qualitative, descriptive study in southern Malawi in 2008, after the results of the RCTs of VMMC were released but before official public health efforts were initiated in Malawi to increase the number of circumcised males. In-depth interviews (IDIs) were conducted with adult and adolescent males from non-circumcising groups in Bangwe and Mpemba, two peri-urban districts near Blantyre. Focus group discussions (FGDs) were also conducted with women and men from the same non-circumcising communities. Participants in the IDIs were asked to discuss any possible social consequences of promoting circumcision for HIV prevention; religious and ethnic identities tied to traditional male circumcision and initiation rituals; and their general acceptance of male circumcision. During the FGDs, a vignette approach was used to facilitate discussion (Hughes & Huby, 2002), where participants responded to a story about whether a 30-year-old man from a non-circumcising group would decide to get circumcised to reduce his risk of acquiring HIV. Questions focused on how becoming circumcised might affect the character's religious and ethnic identity and how he may be perceived by his community after he is circumcised. We also conducted IDIs with key informants (KIs) representing various communities on the issue of male circumcision, to broaden the description of communities' perceptions of introducing VMMC. KIs were asked to describe their opinion as well as their perceptions of their community's beliefs on VMMC; on the relationship between male circumcision and religious and ethnic identity; how non-circumcising and circumcising communities view one another; and on changing traditional circumcision and initiation practices for HIV prevention.

We partnered with local Health Surveillance Assistants (HSAs) to purposefully recruit (Patton, 2002) potential participants as the HSAs were known to people within the communities. For the IDIs and FGDs with adult men and women, HSAs directly contacted individuals who they knew belonged to a non-circumcising group. A similar process was followed to recruit adolescents; however, the HSAs first explained the study to a parent or caregiver and only proceeded to speak with the adolescent if the parent/caregiver gave their permission. KIs were identified by their role as a religious leader, traditional healer, or clinic-based medical staff and were approached by the HSAs. For all groups, a recruitment fact sheet was used by the HSAs to describe the study and an appointment time was set for individuals interested in participating in the study.

All IDIs and FGDs were audiotaped, with the participants' permission, and conducted in the local language by trained interviewers/moderators. Interview text was simultaneously transcribed and translated into English following a transcription protocol (McLellan, MacQueen, & Niedig, 2003). Qualitative thematic analysis techniques were used to analyse the data (Guest, MacQueen, & Namey, 2012). Separate codes, identifying major content areas in the interview guides, were developed for each data source (e.g., IDI, FGD) and

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compiled into codebooks, including specific definitions of codes and inclusion and exclusion criteria as a means of improving inter-coder reliability. Two analysts coded the data in NVivo 9.0 (QSR, 2010). While reading through the transcripts data-driven codes were also identified and added to the respective codebooks. To assess inter-coder agreement the analysts independently applied codes to a random sample of three FGD and four IDI transcripts, and subjective assessment methods were used to assess overall agreement (Guest et al., 2012). After coding all of the transcripts in each data source, a detailed memo was constructed for each major theme that emerged within a data source or across data sources. Each thematic memo identified sub-themes. Memos also noted suppositions and cross-referenced other thematic memos when sub-themes cut across major themes. As relationships between different themes became clearer, themes were combined into more general thematic concepts, which cut across all three data sources and summarise participants' views about male circumcision.

The research was reviewed and approved by the College of Medicine Research Ethics Committee in Malawi, by the Institutional Review Board at the University of North Carolina at Chapel Hill in the US, and by the Protection of Human Subjects Committee at FHI 360 in the US. All individuals aged 18 years or older provided their oral informed consent. Adolescents under the age of 18 provided their oral informed assent and a parent/caregiver provided their oral parental permission for the adolescent to participate in the research.

Results

A total of 73 adult men and women from communities in Blantyre district participated in eight FGDs. Separate FGDs were carried out with adult men (4 total FGDs, *n*=33 participants) and adult women (4 FGDs, *n*=40 participants). In addition, a total of 34 IDIs were conducted with men (*n*=10) and adolescent boys (*n*=17) from the Blantyre townships of Bangwe, Mpemba and Zingwangwa, and seven KIs. KIs were Islamic (*n*=3) and Anglican (*n*=1) religious leaders, traditional healers from communities practicing the *jando* (from Mangochi) and *lupanda* (from Blantyre) circumcising traditions (*n*=2), and a medical practitioner (*n*=1).

Several themes were identified across all data sources. These included: 1) male circumcision is considered a rite of passage for young men in the community; 2) male circumcision is closely associated with one's religious identity; and 3) the acceptability of clinic-based male circumcision is multidimensional.

Male circumcision as a rite of passage

As a rite of passage, traditional male circumcision was discussed by several of the KIs and IDI and FGD participants, particularly by two traditional healers, as a practice that should be done at a certain age in a boy's life, by a specific member of the community, and in a special 'sacred space' where boys are isolated from the rest of their community and gain the knowledge that will prepare them for adulthood.

Both KI and IDI participants discussed how male circumcision is traditionally done as a rite of passage for young men and that there are particular times this should occur in a boy's life.

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Most KIs and just over half of the IDI participants felt that circumcision could be done at an early age (including infancy) to ensure the cutting happens when the pain is minimized and before sexual debut. However, there was some doubt expressed by one Islamic KI as to whether their community, in particular new mothers, would allow their newborns to be circumcised:

> Women would feel too sad to see the child being inflicted with pain especially that the child is very tender and new. (Islamic KI)

A third of the IDI participants felt that boys must be at least in their adolescence in order to ensure they understand the cultural significance of circumcision and are able to provide their assent. Understanding why they are being circumcised was viewed as both an ethical issue (the child should have the right to decide whether he is circumcised or not) and as matter of usefulness (so the knowledge, life-skills and moral lessons gained from the activity can benefit the individual and the community). For these participants, the act of circumcision remained closely linked with a child's transition to adulthood:

> According to our tradition, parents would be concerned as they would say there is nothing their children have gained out of it for they send a child to be circumcised so that he can be taught morals, but in this case [newborn circumcision], he is just too young to be traditionally advised. What they have done is just circumcising him because a child who is 7 days old cannot understand anything. (Adult Male IDI)

> The earliest is 10 and oldest is 13 years. This is because the person is still young at this age compared to one above and for the earliest, the person is not too young not to understand what is happening. (Adolescent Male IDI)

When KIs were asked about whether adult circumcision would be acceptable in their communities, responses were primarily negative, citing that traditional circumcision among adult men would be culturally inappropriate. Participants described that the promotion of circumcision among adult males could have unsettling implications because circumcision is associated with passage from boyhood to manhood. For example, one Islamic KI stated 'an adult cannot go to the village and mix with boys and his sons'. Several FGD participants stated that if an adult were to get circumcised their community would ridicule them, because men are expected to have already taken on the responsibilities that boys are taught during their initiation rites. By getting circumcised later in life they are demonstrating that their 'adulthood' was previously 'lacking':

> People will say 'oh [he] is already an adult and he went to get circumcised. He should not get worried about such issues because he is himself a master of his life'. […]Some would make fun of him. He has become cheap, he is stupid. (Female FGD)

Four of the KIs and several of the IDI participants mentioned that circumcisers must have specific qualities, knowledge, and characteristics. Specific characteristics included that circumcisers should be male; from the same tribe as the initiate; familiar with the moral teachings essential to adulthood (more importantly 'manhood'); experienced and considered knowledgeable concerning the techniques of circumcision; and patient (i.e., willing to spend time with the person being circumcised and explain the significance of the event). Two of

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the KIs described how in *jando*, circumcision is conducted by an *Ngaliba* who not only maintains all of the necessary qualities of a circumciser but also serves as a mystic and entertainer:

> The Ngaliba has special training to circumcise; they also have special skills to protect the camp from witches […] The circumciser entertains people at the village ground with dancing and whatever he may plan. (Traditional healer from Mangochi)

Participants described that the circumciser must be able to provide boys with the appropriate education that would 'transform' them into knowledgeable and responsible men in the community. Ngalibas provide traditional *mwambo* education. Similarly, Islamic institutions educate boys prior to circumcision about the religious significance of the practice. Upon returning from these sites, circumcised 'men' are believed to possess greater knowledge and ability to contribute to the betterment of their families and community:

> The people from this community look upon people who have not been circumcised as ignorant people, not knowing what they are doing. […] I mean they cannot be taken as real men. They cannot be trusted to offer anyone advice. Even if they can say something practical they are rebuked and ridiculed, 'you didn't go there and there is nothing sensible you can tell us'. (Male FGD)

A few IDI participants described that while clinics and hospitals (where VMMC would be performed) can provide information about the health benefits of circumcision and other HIV risk reduction strategies, staff are unable to provide the other important traditions associated with circumcision:

> For it to be done at the hospital they would be thinking that 'our rituals will not be performed' because these are done in secluded places, at the hospital the rituals cannot happen. (Adolescent Male IDI)

One of the KIs thought that people in his community would have difficulty transitioning from traditional camp-based to clinic-based male circumcision, because the change in venue may impact the symbolic and celebratory nature of the initiation rite:

> Circumcision is nice because of the fun that people derive from it … People want the stupid part of dancing. It's what makes them enjoy. So if it is at the clinic, then it won't have that fun. While some people are already sending their children to the clinic, majorities are not and many people would not send their children there. (Traditional healer from Mangochi)

Male circumcision and religious identity

All three of the Islamic KIs stated that among Muslims circumcision is considered an essential act of devotion and should be observed by all of God's followers:

> Circumcision is God's decree. Every person who believes in God and his commandments is supposed to be circumcised. (Islamic KI)

Other Islamic leaders added that since the practice is ordained by God, it is therefore beneficial to all mankind. One KI cited the story of Abraham who, after circumcising

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himself, proceeded to circumcise each male in his family, including his slaves. KIs described that circumcision was included as one of several practices that are 'natural' and appropriate practices to be done by people of faith:

> The prophet said that if you remove these things [hair from upper lip, armpit and pubic area, finger nails, and foreskin] then you are a well human being. […] the way the prophet explained, you will see that he did not just say that men should be circumcised, but he said naturally this thing must be removed, that is showing that, practically these five things must be removed and anyone would feel the same way. (Islamic KI)

As a result, the Islamic KIs stated that Muslim communities in Malawi tend to be at the forefront of circumcision promotion.

On the other hand, nearly half of the IDI participants (the majority of whom were adolescents) either personally rejected the idea of being circumcised or at least had difficulty deciding whether it was appropriate given their non-Muslim background. Several men and adolescents during the IDIs viewed male circumcision as non-Christian, and those who profess to be Christian should avoid engaging in such activities. The Anglican leader also mentioned how male circumcision is not endorsed by Christian doctrine:

> When we talk about circumcision in our religion, it just acknowledges that in the past circumcision was practiced, but in terms of telling people that they should observe circumcision, no that we don't do. (Anglican KI)

However, when conversation focused on the acceptability of VMMC for the purpose of HIV prevention, perspectives were often split. Several IDI participants agreed that as a risk reduction strategy men would be willing to have the operation, particularly if it's done discreetly. By the same token, some FGD participants mentioned that men should not be discouraged from getting circumcised due to ethnicity and religious beliefs because circumcision status is private and has no impact on one's faith:

> They would not perceive him differently because no one would know and no one would undress him to check if he circumcised. (Female FGD)

> The people may not [consider] him to have changed his faith because he will continue to pray according to his faith. (Male FGD)

However, other FGD participants thought that if a man considers himself Christian he should not engage in activities which are considered 'Muslim', regardless of the impact circumcision might have on HIV transmission:

> He is a Christian and he would not want to do what Muslims do. Therefore, he would not go and get circumcised. (Male FGD)

Acceptability of VMMC

The use of safe medical practices to perform male circumcisions in a clinic setting was viewed positively by all study participants. Several KIs, including the clinical officer and all Islamic and Anglican leaders, claimed that clinicians were better qualified to conduct the procedure because they are medically trained, have access to sterile cutting tools, have safer

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facilities, have effective anaesthetics, and are better able to provide medicines that dull the pain and allow the boy/man to heal faster than traditional circumcision practices that often occur in the 'bush'. Clinics were also viewed as culturally neutral, in that they did not promote the traditions and beliefs of a particular ethnic or religious group:

> I think hospitals would be the appropriate places [for circumcisions to occur] […] because we people have different traditions and if a Lomwe like me would be traditionally circumcised it would be like I am abandoning my culture where circumcision is not practiced and I have adopted a new culture which is not good. If it would be the modern one [i.e., clinic-based] then many people would want to be circumcised regardless of their tribe, for example the Tumbuka, Sena or Lomwe would all want to be circumcised. (Adolescent IDI)

In addition, some IDI participants thought that less time and expense would be involved in clinic-based circumcisions as compared to those done traditionally in the village, which often involve elaborate, expensive ceremonies and community celebrations upon the return of the initiated youth:

> I for one I would go for the one done at the hospital, where there would be no expenses for the celebrations that are done after because when the person is coming from the camp, you find that they spend money on clothes, food, even a goat and for one who is just doing this for the first time they would not afford, but at the hospital it does not require this. Because when it is done at the hospital, it is like a personal thing, you go there, it is done and you go back home. (Adult Male IDI)

Nearly all of the IDI participants stated that they believed that adult male circumcision would be more painful than circumcision done during infancy or early adolescence. In part, this was due to the fact that men would understand more about what was involved in the procedure and would therefore fear/expect that the procedure will involve a great deal of pain and the wound will be a hindrance. Some participants also felt that because the organ was more mature cutting the foreskin would be more painful. Yet, similar to KIs, these males thought that clinic-based circumcision had better access to proper anaesthetics and procedures which allowed the wound to heal faster.

Participants in three male FGDs and in all four female FGDs described how local interpretations varied on how circumcision reduces risk of HIV infection and on the perceived effectiveness of male circumcision for HIV prevention. Several women from two Bangwe discussion groups mentioned that people in the community are saying that male circumcision can reduce one's risk by removing the foreskin; thereby 'infections' are less likely to be harboured under the foreskin and absorbed by the penis after intercourse. Others stated that circumcised men are at lower risk for infection because the penis stays dry, rather than remaining damp, and is less likely to be injured during sex. On the other hand, several participants in both male and female FGDs mentioned that most people in their community do not believe that male circumcision can reduce a man's risk of contracting HIV. Participants explained that earlier public health messages stated that traditional male circumcision can increase a man's risk of HIV infection. Given this, messages promoting VMMC as an HIV prevention strategy cause confusion as to the true efficacy of the intervention and many people consider the current public health messages to be unfounded:

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> To add, it may not be true that circumcision may help reduce the spread of HIV because through workshops, statistics have also shown that places like Mangochi where the practice of circumcision is mostly done are perhaps in the highest brackets in terms of spread of HIV. (Male FGD)

While the majority of IDI participants liked the idea of a new HIV prevention option for men, they expressed concern with VMMC being that option. Since adults are likely to have already engaged in sex (typically viewed as 'adult' behaviour), they may already be infected with HIV and therefore VMMC is pointless, at least as far as HIV prevention is concerned. Likewise, male and female FGD participants thought that offering VMMC to adults would also be inappropriate because adult circumcision would promote promiscuity, and men choosing to be circumcised would be stigmatised as immoral:

> If one is of my age and has already contracted HIV, I think it would be of no use for this person has already been infected, maybe if done at a younger age it would be better. (Adult Male IDI)

> They would say 'look [name of man] has gotten himself circumcised while he is already an adult. He just wants to prove that he wants to continue womanizing'. (Female FGD)

As a result, some IDI participants felt that VMMC may result in greater infection because it would encourage reduced condom use and increased sexual risk-taking. Several female focus group participants also said they feared that promotion of VMMC would inadvertently promote premarital sex and sexual immorality. They stated that the same thing happened when condoms were first promoted in their community.

> Some will not be using condoms. […] This is because some people might understand it wrongly that after they are circumcised chances they will get HIV are eliminated. (Adult Male IDI)

> I think this would increase the spread of HIV in the country […] some adolescents would become promiscuous because they are told that they cannot contract HIV after being circumcision. For example they would increase the number of their sexual partners. (Adolescent Male IDI)

For many IDI participants, VMMC was described to be too invasive and the health benefits too insufficient to warrant adoption, particularly given that condoms are still to be used after circumcision. Rather, abstinence and self-control were better ways to prevent infection.

Discussion

The relatively new intervention of VMMC appears to be viewed from a number of 'prisms'. Respondents are not coming to the issue of VMMC 'cold' or neutrally, but instead laden with certain perspectives grounded in Malawian culture and history. VMMC, a medicalised form of circumcision, seems to be viewed in a different way than circumcision as traditionally understood (albeit with certain similarities) and these differences are viewed by respondents in a positive, negative, and sometimes ambiguous light. In general, it seems that respondents are trying to negotiate a new meaning for circumcision in the light of VMMC

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for HIV prevention. Male circumcision was not considered a normal course of action for the majority of Malawians in the past, and now communities have to come to grips with the idea of undergoing a procedure with deep ethnic and religious resonance, albeit in clinical contexts for largely public health reasons.

From the perspective of male circumcision as a rite of passage, the understanding of VMMC is incongruent with traditional rites of passage associated with circumcision, particularly in regard to older males. Traditional Yao and Islamic circumcision is performed during early adolescence, between the ages of 10 and 12 whereas VMMC is usually targeted for men from 13 to 49 years of age. Circumcision in VMMC is not performed by someone who is a link to local cultural heritage (as is a traditional Ngaliba). Rather, doctors are 'special' in the sense of having an unusual competence and social status, but this expertise and standing does not have the same cultural resonance. Traditional circumcision and VMMC both involve some sort of knowledge transfer, but the knowledge is significantly different. The traditional knowledge associated with male circumcision is moral, sexual, cultural, educational and to some extent secret and mysterious. The modern knowledge in VMMC is medical, i.e., about HIV and how to protect oneself and others from an infectious disease. Circumcision as an act of cutting is traditionally embedded in a larger celebratory occasion (involving food, dance, song, seclusion, etc.). VMMC removes the act of cutting from traditional circumcision and medicalises it. Instead of an Ngaliba enacting part of a ritual of social transformation, a surgeon provides a medical service by safely removing the foreskin; instead of being initiates entering into 'sacred space', those receiving VMMC are patients being served in a clinical environment.

Among Yao Muslims, being circumcised is a religious obligation, something that male adherents to Islam are strongly expected to do. From this point of departure, circumcision is familiar and acceptable, but how and why VMMC is conducted may be foreign and can still be a source of misgivings and concern. VMMC is touted as an individual's voluntary choice (that is the 'V' in VMMC), not a customary obligation. The motive for VMMC is disease prevention, rather than obedience or devotion to God's law. Those who see circumcision as a religious obligation and want VMMC may need to devise some sort of new tradition or ritual around circumcision. Furthermore, male circumcision in a religious context is generally regarded as non-sexual or at least the sexual connection is not made explicit; in VMMC, there is a more explicit link between the procedure and sex as circumcision is conducted to reduce risk of sexually transmitted disease. In the Malawian context, VMMC may threaten to draw religious obligation and concerns about sexuality (particularly promiscuity and extramarital sex) closely together – making very strange bedfellows. Studies conducted elsewhere in Malawi have revealed similar, unintended cultural impacts of promoting VMMC, such as an increasing 'pathologizing' perception of the foreskin as a dangerous bodily feature, associated by itself (independent of behaviour) as a source of risk (Mkandawire, Dixon, Luginaah, Armah, & Arku, 2014).

VMMC is a modern, biomedical intervention done for individual health and public health reasons. In the Malawian context, it is also a social intervention with multiple, sometimes conflicting meanings. Some embrace this form of circumcision and the secularity/modernity it embodies; others may be suspicious or recoil from VMMC. VMMC is seen by some as

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something beneficial, analogous to other medical advances; perhaps coupled with the idea of the 'old' circumcision as regressive and backward. Others view VMMC as something suspicious or harmful, including doubts about beneficial effects of circumcision, worries about pain, concern about increased risk of HIV infection despite circumcision, including rumours about VMMC and sterilisation of Africans. These results are compatible with a recent study in Malawi that revealed that even the cultural elite in Malawi (secondary and tertiary graduates) tend not to distinguish medical circumcision from traditional circumcision, and associate circumcision in general with higher HIV prevalence, the latter due to initiates being instructed by mentors to engage in unprotected sex soon after the circumcision takes place (Myroniuk, 2011). Similarly, a more recent qualitative study among Malawian health policy makers and traditional leaders indicated that decisions around VMMC are strongly mediated and shaped by religious, cultural and political considerations, in contrast to decisions (for example) about which drugs to use for management of sexually transmitted infections or to prevent maternal transmission of HIV (David, 2013).

The tensions and concerns marking the relationship between traditional circumcision and VMMC may partly explain the relatively slow uptake of VMMC in Malawi, despite the results of early acceptability studies. The more VMMC becomes part of the fabric of Malawian life, actively promoted by public health authorities, the more the above-described concerns may arise and potentially dissuade men and boys from circumcision. This point is echoed in a recently published survey, conducted in rural Malawi, that concluded that acceptance of VMMC is likely to be low in communities divided by ethno-regional identities that also shape the practice of circumcision (Dionne & Poulin, 2013). Efforts to increase uptake of VMMC in Malawi will have to take meanings associated with the 'new circumcision' into account when developing strategies to help men and boys decide whether they want to be circumcised. Similar qualitative research should be done in other countries promoting VMMC as part of an HIV prevention initiative, to assess the cultural determinants impacting on intervention and promotion efforts within often multi-culture environments. This information may provide insight into the attainability of the UNAIDS' VMMC targets in these countries.

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