Male Circumcision Polemics and Masculinities in southern Malawi

A Master’s Thesis
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Medicalised male circumcision evidence is said to be clearer and compelling...
But the subject is controversial...
For religious, cultural and other reasons...
There are many challenges but an increased number of men...
Will be seeking MC...
  Dr Sibongile Dludhlu (2008)
SUMMARY

Recent studies and literature have revealed that HIV prevalence in sub-Saharan Africa is still at epidemic levels; 11.9% and 18.1% for Malawi and South Africa respectively, as new infections occur among “older heterosexual couples, long-term stable relationships and those involved in multiple concurrent partnerships” (Azevedo et al. 2010; Simpson 2009). Presently, there is little headway in HIV prevention programmes, as many prevention “technologies” are being tried on women. For men medicalised male circumcision (MMC) an “armamentarium” or practice that “remains controversial” for HIV prevention has been proposed (Azevedo 2010; Eaton et al. 2007). Nevertheless, the evidence from randomized trials that MMC can prevent HIV is a “historical landmark” in health and prevention of sexually transmitted diseases (Azevedo et al. 2010; Kalichman 2010; Dinh 2010). Contrary to the reports that men do not seek sexual health care services and utilize intervention programmes, current media reports and acceptability studies have reported men seeking MMC at both public and private hospitals, (Mfutso-Bengo et al. 2010; Ngalande et al. 2007).

Therefore my research objective was: What motivates men to (not) seek MMC, how, where, when and why? This is an anthropological study inspired by social constructionist and critical male study approaches. I inquired how adult men have responded to current MMC spoken, audio, written discourses and polemics to situate and illuminate their social practicalities and complexities in relation to MMC as a strategy for HIV prevention. I received ethical clearance from College of Medicine Malawi to collect data in southern Malawi. A mixed method approach was used: free listing and ranking, participant observations, in-depth interviews, discourse analysis of local audio, print media and focus group discussions. The data was analysed using critical discourse analysis and gender performance (Butler 1990). Despite the enthusiastic reports from international health organizations about the MMC association with HIV prevention, local adult men feel the procedure is too late and unnecessary. Others draw on what I call “vernacular knowledge” (Scott 1998) and “social autopsies”, spousal and community gaze to counter arguments for MMC and the medical benefits. Despite the conflicting roles of spousal and community gaze, a few men are seeking MMC and ironically, they argue it’s not for HIV prevention, but rather for their hygiene and sexual pleasure!
CHAPTER ONE

Introduction

Reflexivity: Doing fieldwork at home, unfamiliar territory?

According to Crick, it is better to understand a text if one knows something about the writer, the experiences upon which the text is based and circumstances of its production (1989:29). This statement pushed me to consider including my fieldwork experiences as part of the discussion, as I had faced taunting and concern from my classmates and some professors as they wondered how I was going to ask men to identify themselves as uncircumcised and summon myself to ask about their genitalia in the presence or absence of the spouse. They always asked if I was going to let the men show me their nakedness to confirm their status, and that statement was followed with much laughter. Initially it used to bother me, as I thought men in my country would be uncomfortable and refuse to talk to me. I presented my research ideas to my husband, who welcomed the idea, and I asked for his opinion, which was positive since he couldn’t wait to see me home after being away for about nine months.

I was inspired to study men for a change, as I felt we had so many epidemiological studies on men and HIV prevention but we were not making headway. There are so many HIV interventions that include women and children in Malawi, however, not much has been said about men. Further, during my medical anthropology classes, I began to learn new concepts and the notion of masculinities—the idea that there are subjective perceptions of men, and I had grown up in Malawi where the idea of deconstructing phenomena is not common. I ended up having an “academic crush” on critical studies on men. I wanted to deconstruct the “myth of male domination” in my society and view men as men, striving to survive in the HIV era.

Hence, I discussed my research idea with my supervisor, who echoed the same sentiments as my classmates that finding married men who were willing to identify themselves as uncircumcised would be difficult; but he was quick to say that it would not be impossible, which further encouraged me to go flat out in preparing my proposal. The

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1 Please not that I differentiate between traditional male circumcision (MC) and medicalised male circumcision (MMC) taking place in the clinic, however to reduce the confusion to the reader I maintain to use traditional male circumcision to emphasise the village type.
bone of contention was that I am a woman, very young woman, married. I have a baby and a very supportive husband, who helped in piloting some of my research guides.

How could I convince men in my society to open up and share their most secretive and private issue- their genitals? Most researchers had argued that “silence and denial” facilitated the spread of HIV (Watkins 2004; Bisika 2008). However, I was encouraged by Guttman (1997) who argues that most men do not associate their body with their private parts; however, they make reference to it. I noted that I was warmly welcomed by men and some invited me to their homes to meet their spouses. I believe it was because of my positionality, performance and “enactment of hybridity”, which means acknowledging the multiple identities of a researcher in a setting. I am a Tonga by birth, a Ngoni woman by marriage and here I was doing research among the Lomwe, Manganja, Yao couples. Hence as a student researcher, married to a son of the soil and a Christian, they believed I was one of them (Narayan 1993).

In addition, having grown up in the north, schooled in the south of Malawi and Zimbabwe, at the back of my mind, I considered myself a “native” in between worlds. As a student researcher, exuberant, down to earth, confident and strongly determined self, I let men become friends, they relaxed in my presence and they opened up to share their lives with or without their spouses present (Nayaran 1993; Tillman-Healy 2003; Rabinow et al. 2007).

Thesis structure
My thesis is structured as follows: the introductory chapter discusses my positionality, snapshot of MMC and HIV reports in Malawi and the research objectives with theory. The second chapter illuminates my work in the context of previous studies and identifies the main concepts and perspectives of the study. Chapter three includes the methods section and presents a description of the fieldwork and my study settings. From the fourth chapter to the sixth chapter, I share my experiences among the men and women in a Malawian village and a city. I begin with the role of the media in (MMC) to situate the media polemics and critically analyse how the information on MMC has been disseminated and received. I dedicate chapter five to learning about adult males’ perception of men as men; I play close attention to their vulnerabilities and practicalities and how these affect their sexual health and uptake of MMC. The role of women as spouses and partners in the context of MMC is made visible, in chapter six, contesting the
decision-making and limited role in HIV/AIDS prevention and husbands seeking sexual health. In the final chapter, seven, the discussion pays close attention to my findings, existing literature, theory, conclusion and recommendations. Each chapter is concluded with a short description of its contents.
This thesis addresses the question of why men seek medicalised male circumcision (MMC) in Malawi, and in it I explore the views of men and women in southern Malawi: Blantyre and Mbulumbuzi, an urban and rural setting respectively.

The procedure has received a great deal of medical, research and health-promotion attention internationally by health organizations and regionally by research experts and medical doctors. However, I explore the views of why MMC is yet to be accepted and implemented by most ordinary adult Malawian men as a strategy for HIV prevention. Since the 2007 WHO/UNAIDS communication to scale up MMC and despite the positive forecast for an increase in the number of adult men seeking MMC from local researchers, the print media, private sexual reproductive health organizations and international AIDS experts, the prevalence of MMC in Malawi has only increased to 26.7% from 20.9% in MDHS 2004 (Ngalande et al. 2006; Rennie et al. 2007; Westercamp et al. 2006; Mfutso-Bengo et al, 2010). The Malawi government has yet to officially roll out the procedure, citing lack of local research evidence to resolve how best to adopt MMC as a strategy for HIV risk reduction.

Despite the lack of official roll out of MMC, adult Malawian men are seen at private hospitals seeking the procedure. This thesis discusses how these adult men from uncircumcised ethnic groups have related to the evidence of MMC as an HIV preventive strategy. The study focuses on how being uncircumcised has affected men’s and women’s ethnic identities, perceptions of manhood, sexuality, risk and whether or not their experiences have influenced their sexual health seeking behaviors and ultimately their uptake of MMC.

**Traditional male circumcision, MMC and its relevance**

Male circumcision is the “removal of prepuce by surgical means in the hospital context or in a ritual context with a religious, social and cultural meaning” (Muula et al. 2007:358). With the advent of the link between MMC and HIV infection, the term “medicalised male circumcision” is defined as “the complete removal of foreskin by skilled health care workers in a health facility (Ministry of Health 2010c).

The MMC procedure is suggested to have medical benefits that include HIV risk reduction, prevention of cervical cancer (in women) and papilloma virus (in men), syphilis, chancroid as well as urinary tract infections (Bowie and Geubbels 2007;
The correlation of MMC and HIV prevention has been demonstrated with compelling evidence from three clinical trials (Auvert et al. 2005; Bailey et al. 2001; Gray et al. 2008) showing a 60% reduction in HIV acquisition, leading various countries in the sub-Saharan Africa to consider adopting the procedure.

**HIV prevention and MMC trials**

The national HIV prevalence in Malawi is currently 12% and the incidence rate on the adult population affected over a period of one-year stands at 1.6% (Ministry of Health 2009a). New HIV infections occur among long-term stable relationship, as 18% of men are having sexual intercourse with more than one sexual partner over a period of one year (Ministry of Health 2009a). The Monitoring and Evaluation HIV Report 2009 mentions both a low prevalence of MMC as well as gender inequalities and imbalances (including masculinity) as facilitating the spread of HIV (Ministry of Health 2009a).

However, there is ambiguity towards the data on MC from the Malawi Demographic Health Survey (MDHS 2004). In Malawi, there is a higher HIV prevalence among circumcising communities as compared to the non-circumcising ones: 13.2% for circumcising men compared to 9.5% for non-circumcised men (MDHS 2004). Hence there is no straightforward relationship between circumcision and HIV prevalence in this country.

On the other hand, an MC situation analysis (Mfutso-Bengo et al. 2010) argues that due to confounding factors, high rates of MC and HIV prevalence are associated with ethnicity. The higher prevalence of HIV among circumcised Yao and Lomwe men can be an indication that MMC does not offer partial protection. Hence ethnicity is a force to reckon with in relation to MMC in Malawi and that further, complicates decision-making at an individual, couple, family and national level. However, equally important is the need for acceptance and contextual validity of research data to inform research translation into practice as shown in this study.

**Research Objectives**

- I propose to explore, why men and women seek MMC in southern Malawi.
• I propose to have a better understanding of men’s motivations towards MMC and to investigate their subjectivities and complexities in relation to HIV prevention in southern Malawi.

Main Research Question
What motivates men to (or not) seek MC, how, where, when and why?

Research sub-questions
• How does the notion of masculinities affect or influence HIV risk perception, MMC and health-seeking behaviour of men in southern Malawi?
• What is the role of the spouse or “sexual partner” in acceptance of MMC when and why?
• How does the current print and audio media and everyday MMC discourse influence men’s masculine and ethnic identity and the uptake (or not) of MMC.

Theoretical Framework
I turn to theoretical notions of gender performance to further shed light on my research questions and give further insight to the responses of the participants in this study.

Gender performance perspective
In preparation for this study, I reflected on the theoretical notion of performance in studying masculinities as inspired by Judith Butler (1990) with a Foucauldian perspective to consider gender identity constructions and underlying power relations. I chose Butler and Foucault’s work to formulate my questions and help with my analysis of gender as a performance for couples and individual men in relation to gendered relations during my observations and interviews in the hospital and village setting.

I follow Butler’s discussions on gender performativity to investigate the underlying complexities that various heterosexual men and their partners find in the construction of their identity and subjectivities in the face of adult MMC for HIV prevention. Butler argues that gender is not a naturally given identity, but rather a cultural one. She argues for “gender acts—whereby bodies performatively enact sexed or
gendered identities according to socially sanctioned codes” (1990:154). Thus, one is not merely a body, but a discursive and enactment of the body—“one does their body differently from one’s contemporaries, and from one’s embodied predecessors and successors as well” (Butler 1988:521). Therefore, the assumption is that men and women continuously act and express themselves differently in discursive statements to demonstrate their masculinities and feminities.

In addition, by drawing on a Foucauldian understanding of power, Butler (1990) distinguishes the personal, political, private and public gender relations as “fiction” intended to maintain the hegemonic social ideologies. Ironically, she also recognizes that some individuals are “socially impossible” and they do not conform to the hegemonic ideologies. Is this a possibility for agency—in the sense of authority to act or lack of power to act? Thus, I reflect on people’s enactment of their identities as multiple, discursive and unstable, as I assessed the possibility of agency and change during my interactions with various couples and men as they moved in and out of situations during my fieldwork.

From a gender performance and Foucaudian perspective, I have come to understand that people may discuss their identities differently depending on a situation. I wondered if some men in Malawi have their own understanding of MMC. They grew up knowing there is traditional male circumcision among the Yao—a practice to certify that their adolescent boys had come of age. They may have heard the stories about MMC from the radio, read a newspaper article or been encouraged by peer or spousal gaze. However, very few men have followed through on MMC. I wondered whether it was just enactment when most men spoke about desiring MMC in public, whilst in private they never implemented their decisions. Most adult men have heard and seen how their male friends who were traditionally circumcised and circumcisers have become infected and died of AIDS. What was their motivation to seek MMC or to reject it? I now turn to the literature review.
CHAPTER TWO
Literature Review

Ethnographic data on adult male MMC as a strategy for HIV prevention in sub-Saharan Africa and in Malawi in particular is scarce (Wawire 2010; Becker 2005). There is a great deal of ethnographic literature on traditional male circumcision for adolescent boys, as the practice is still popular in the region as a “rite of passage” for boys to attain their manhood (Heald 1995; Shefer et al. 2007, Jimmy-Gama 2009). This review considers the significance of studying masculinities and HIV prevention in the context of adult MMC in the face of clinical trials and the universal call to scale up the procedure. The discussion includes an anthropological analysis to situate MMC practice in broader polemics and to show the contingencies of MMC discourses in public spaces. Furthermore, the review will focus on how being uncircumcised has affected men’s manhood and sexuality. On a broader plane, I problematise some notions: “sexuality”, “circumcision” and masculinity” drawing examples from Africa and the West as well as the Malawian context to highlight the gaps in the literature and concepts related to my study.

Male circumcision as a concept

MC as a practice has been discussed since the nineteenth century, with several meanings, including a rite of passage and sparking debates in time and place (Frazer 1904; Kratz 2000; Silverman 2004).

To problematise and reveal the ambiguities of MC further, I discuss traditional male circumcision practices in various countries. In some societies, traditional male circumcision serves as an embodiment of masculine and gender identity whereas, in other communities, it is a symbolically pronounced ritual. In some groups, only a small part of the foreskin is cut to distinguish ethnic groups: for example, the Luo from the Kikuyu in Kenya, Lomwe in Malawi (Heald 1995; Wawire 2010; Munthali et al. 2004). However, some scholars write about their ambivalence towards adult MMC, and highlight the contention that medicalising male circumcision is encouraging men to prove their manhood through unrestrained sexual activities in Malawi and Tanzania (Muula et al. 2007; Brewer 2007). In the face of MMC scale-up messages, it is imperative to elicit how Malawian adult men differentiate between traditional male circumcision and MMC as a strategy for HIV prevention to assess how research is translated into practice.
Traditional male circumcision is culturally determined in Malawi, based on religion, region and ethnicity. It is a custom for some adolescent boys to attain their manhood, in the central and southern region, though the practice seems to be declining among formerly circumcising communities (MDHS 2004; Muula 2002; Munthali 2006). Although in Malawi MMC is not part of a formal policy, coupled with voices of dissent on the practice, (Ministry of Health 2009c) has acknowledged Voluntary Medicalised Male Circumcision (VMMC) as a strategy to be considered under HIV prevention. The media too has noted with interest that currently there are adult men seeking circumcision services at private hospitals and ngalibas [traditional circumcisers] (Ministry of Health 2009b; Mfuuto-Bengo 2010)

Randomized trials, southern Africa and Malawi

There is extensive literature on the three randomized trials that showed that MMC could lead to a 60% reduction in HIV infection among men in sub-Saharan Africa (Auvert et al. 2005; Bailey et al. 2001; Grey et al. 2008). The evidence from the trials above, states that the removal of Langerhans cells, which are highly susceptible to HIV and are found in the foreskin and epithelial cells, will allow the men to develop a protective keratin layer to reduce female-to-male HIV transmission (Azevedo et al. 2010; Higgins et al. 2010)). Thus, MMC representing a “surgical vaccine” (Weiss et al. 2008a; Wawire 2010) and its protective factor has received wide acknowledgement from major journals in reviews and commentaries (Silverman 2004; Cohen 2005; Dinh 2010).

However, other researchers argue that the data on MMC shows conflicting results, especially on how much foreskin should be cut and for a greater surface area to reduce HIV transmission (Dinh et al. 2010; Templeton et al. 2009). Furthermore, in a report from Kenya on a randomized trial of HIV positive men and circumcision, MMC did not reduce HIV transmission to their female partners (Wawer 2009:374). In addition, South African studies with a modelled combination approach for national MMC with antiretrovirals report a reduction in HIV incidence rates (Sawires 2007). However, in particular Malawi, there is no straightforward correlation between circumcision and low HIV prevalence, thus policy makers are hesitant to officially accept MMC as a measure
to prevent HIV transmission, citing the above ambiguous findings (Weiss 2010; MDHS 2004)²

Masculinities vis-à-vis MMC and HIV/AIDS

Masculinities refer to the plurality of ways of being men and use of the term contests the belief that men are a privileged group that cannot change due to their socialization, “traditions” and biological makeup. Most of the initial studies on masculinity and HIV/AIDS tend to study the concept as self-evident—manhood as “natural, healthy and masculinity as ever strong” compared to universal female subordination and powerless (Spronk 2005; Kimmel et al. 2005).

There is evidence that men adhering to particular masculine identities influence their health seeking behaviour. In southern Africa, discussions on “hegemonic masculinity”—the most honored and desired way of being a man—perpetuates AIDS due to the risks and sexual conquest attached to the construction (Peacock et al. 2009; Simpson 2009). In Malawi, most studies on adult men and HIV, center on men who hold “traditional” views about masculinity, “deep seated cultural beliefs”, that tend to “normalize sexual adventures, multiple partnership” fostering a sense of invulnerability (Bowie 2007; Jimmy-Gama 2009; Kaler 2003). However, there is a growing literature that posits that the language of plural “masculinities” provides space for negotiation, contestations and transformation and that has positive consequences for work on AIDS; for it views men as having agency to change their ways in changing social circumstances (Becker 2005; Bujra 2000; Connell 2005; Morrell 2001; Spronk 2005).

Nevertheless, to the best of my knowledge based on literature, in Malawi, there are scant studies on masculinities and adult MMC for HIV prevention. There are a few adult male circumcision studies and they tend to be informed by demographic approaches focusing on surveys and reporting on the prevalence of traditional male circumcision in the country. Further, these studies concentrate on ‘acceptability and feasibility’ of MMC without problematising “masculinity” and view of the notion as contested and fluid to capture the nuances of adult men in relation to MMC (Westercamp and Bailey 2006; Ngalande et al. 2006; Limwame and Kumwenda 2008). In addition, most of the studies on MMC in Malawi do not consider disabusing local male dominant masculine identities

² Malawi Demographic Health Survey 2004
and culture master narratives (Rennie et al 2007; Muula 2007; Mfutso-Bengo et al, 2010) to pave the way for vulnerable men fighting for HIV prevention.

**Role of women and MC**

According to reports from feminist studies, matrilineal societies where women hold an undeniable power, few women seek health care on their own or influence their male partner’s health care, thus there is need to consider how women influence men’s decisions for seeking MMC (Arnfred 2004; Becker 2005; Pereira 2003). In Malawi, Kishindo (1995) argues that the success of family planning (including sexual reproductive health) is dependent on men; since it is the men as husbands or brother who control a woman’s fertility and (sexual health). Some researchers are ambivalent about the role of women and Muula (2007), cautions the interpretation of “acceptability” of MMC among women, as in some societies they do not have the influence to make key decisions in health and sexual matters. On the other hand, acceptability reviews done in Malawi have shown high MMC acceptability among women (Westercamp and Bailey 2006; Ngalande et al. 2006; Siegfried 2003). Further, other studies show how women from circumcising communities have the power to persuade their uncircumcised partners to seek the practice from traditional circumcisers in private (Mfutso-Bengo et al, 2010). This reproach has to be investigated to elicit women’s influence on men seeking health care in contemporary Malawi and in particular their decision for MMC.

**Sexuality and adult male circumcision**

The concept of sexuality is broad and salient in constructions of selfhood, manhood and notions of pleasure, desires, as well as a source of disease in most literature on HIV/AIDS and male circumcision in Africa (Simpson 2009; Kimmel et al. 2005).

According to WHO (2006:5)

> Sexuality is a central aspect of being human throughout life and it encompasses, sex, gender identities, roles, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, practices and relations. While sexuality can include these dimensions, not all of them are experienced or expressed. Sexuality is influenced in interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.
However, sexuality as a concept has been approached as self-evident, natural and “fixated as crises” among men in sub-Saharan Africa (Undie and Benaya 2006; Morell 2001). The men are viewed as “hypersexualised”, irresponsible beings capable of continuously transmitting the HIV virus without care (Higgins et al. 2010; Gibson and Hardon 2005). The literature on sexuality and traditional male circumcision in Malawi concentrated on adolescent boys attaining manhood, encouraged to prove their manhood through sexual prowess or by increasing the number of sexual partners in their sexual networks (Munthali et al. 2004; Diallo 2004; Wawire 2010).

I acknowledge sexuality studies that emphasize men defining manhood through sexual prowess and sexual desire to further knowledge about sexualities and HIV prevention (Arnfred 2004; Becker 2005; Maleta et al. 2010). However, there is growing literature that criticizes sexual studies that do not show how subjectivities are influenced by gender, class and context (Caldwell 1989; Morrel 2005; Harrison 2002). In Malawi, there is a lacuna of deconstructed “sexualities” studies that discuss men and sexuality in a gendered way (in particular on adult male and MMC) (Hearn 2005; Ngalande et al. 2006; Limwame and Kumwenda 2008) in order to view men just as vulnerable and active agents in HIV prevention. Ironically it is not only men who bring HIV into homes (Arnfred 2004; Higgins 2010) and women are not the only change agents for sexuality problems.

**Media discourses and adult male circumcision**

Media discourses defined as oral, audio, text are forms of communication, interaction, entertainment, disseminating news that influence societies and are difficult to escape (Kaler 2010; Lwanda 2005; Spronk 2005). Most studies in Malawi about health knowledge and risk perceptions mention the radio as one of the sources where their respondents first heard about HIV/AIDS (Barden-O’Fallon 2004; Meekers et al., 2007). In relation to media presentations, in southern Africa and the debates on MMC are followed both in the public and private arena through the newspapers, radio, television and at initiation ceremony, respectively (Shefer et al. 2007; Gqola 2007; Spronk 2005). In the West, the *New York Times* and *The Wall Street Journal* have released evocative and informative headlines on MMC for men in sub-Saharan Africa (Altman 2008; Schoof 2007).
It is equally important is to consider how oral and written sources on MMC are presented, represented and interpreted in the popular media and among men to counter stereotyping and how that affects masculinities in general (Kaler 2010; Harrison 2002). To the best of my knowledge, based on literature, there are scant studies on MMC as a strategy for HIV prevention and media representation in Malawi. Other report studies presented by CMPD\(^3\) and REACH Trust\(^4\) (Asibu et al, 2009) mention low rates of radio listening on programmes about HIV/AIDS among men in Mangochi. According to a study by Karlyn (2001) and (Meekers et al, 2007) on promoting behavioral change through a radio campaign, it was difficult for most participants to recall and especially among women to remember the specific messages for specific risk groups.

The MC Situation Analysis (Mfutso-Bengo et al. 2010) mentions the role of media as playing a muted role on its presentation of MMC and concentrating on pejorative language about traditional male circumcision between circumcising and non-circumcising communities. Other studies (Karlyn 2001; Meekers et al. 2007) discuss the lack of knowledge about messages conveyed and learnt by respondents, hence the need to assess the reach effect of both print and audio media discourses.

\(^3\) Country Minders of People’s Development an NGO catering to HIV orphans and vulnerable children

\(^4\) REACH Trust-Research for Equity And Community Health NGO.
CHAPTER THREE

Methods

Setting

My fieldwork took place at a time when, the HIV/AIDS and Nutrition Secretariat in Malawi had announced a reduction in HIV prevalence in Malawi from 14% to 12% and the news that Global Fund refusing to fund Malawian HIV/AIDS programmes due to ambiguous information circulating on circumcision in the country. The debates and discussions in the mass media on MC country play an important role in my study. Men in the urban setting followed the press releases and most men in the rural setting followed radio conferences, which was a key motivator for them to seek or not seek MMC. Another key factor, to be considered is the move by the Ministry of Health and their partners to stage a baseline study on MMC in 2008-2009, and a situation analysis on MMC to learn about the public response on the practice. Some private clinics opened their doors to provide MMC at a fee of US$ 7 - $15. The above context is important to remember, as it is significant to understand some of the responses from the participants.

This study took place in two sites: at a private hospital in Blantyre (a commercial city) and a village, Mbulumbuzi, in the Chiladzulu District. Mbulumbuzi is part of Blantyre Agricultural Development Division in the southern region of Malawi. It is a 45 minutes drive from Blantyre. Both districts practice traditional male circumcision. The inclusion of men from an urban setting, Blantyre, was to capture men who had undergone MMC and the inclusion of a rural setting, Mbulumbuzi, was to enrich the findings. I was interested in studying why adult men with neighbors and friends who were circumcised who had heard about MMC had decided not to seek the practice.

![Figure 1. Map of Malawi](image)
Mbumbuzi is a multicultural rural community including Lomwe, Yao, Manganja, Tumbuka, Ngoni and Chewa ethnic groups and with a population of about 13,000: 9500 male- and 4200 female-headed household (Malawi Government 2009). The dominant tribe is matrilineal and matrilocal Lomwe, however due to multiculturalism, married couples can either live in the husband’s or wife’s village. There are various religious practices in the district: Christianity- Presbyterians, moderate Islam, Pentecostals and Catholics.

The inhabitants of Mbumbuzi depend on agriculture for their livelihood. The education enrollment for girls is low and most women depend on their partners for economic wellbeing. Mbumbuzi is one of the busiest and cheapest trading centres, where agriculture produce are sold at cheaper price on Tuesdays and Fridays during the week. Most men are involved in small-scale businesses as fish sellers, agriculture producers, or clothing and grocery wholesalers.

Both Chiladzulu and Blantyre are part of the Southern District with 20.5% HIV prevalence, and 10.2% for men aged 15-49 years (Ministry of Health 2009a). The Chiladzulu district, just like Blantyre, has a high HIV prevalence at 15.1% (MDHS 2004). The district has 23,000 people who are enrolled in the HIV programme and 13,366 are said to be on ante-retroviral treatment (ART) (Malawi Government 2009).

Study Type

This study was exploratory, relying on mixed method research approach in order to integrate and validate various perspectives on data collected over a period of six weeks from May-June 2011. It concentrated on a few case studies with comparative elements from the urban versus rural men and couples to capture the nuances of adult men’s narratives including their subjectivities and complexities when seeking or not seeking MMC as an HIV prevention strategy.

Sampling

The study population was heterogeneous. The study was done in a multi-cultural community, involving Lomwe, Yao, Manganja, Ngoni Tumbuka and Chewa with willing adult male and female ethnic group representatives some of whom were selected with the

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5 Chiladzulu District Socio-economic Profile 2009-2014
help of research assistants. The study sample included seven couples with spouses who were not circumcised at the village level, seven individual men (four who had had MMC and two who were circumcised but HIV positive), 15 urban based men who filled in the free listing forms. Purposive and snowballing sampling was employed to find the above respondents. Five focus group discussions were held with health workers, young adults, women, men only and key informants. The groups had an average of seven people per group. The health workers, young adults and key informant groups were mixed with more than five women each. Snowballing sampling combined with a maximum variation approach (adult men, married or not, with or without willing partners) was employed to provide a wide range of eligible participants, from various ethnic groups to provide room for wide base of participants for the group discussions.

**Data collection techniques**

A mixed method research component was incorporated and acknowledged for triangulation to validate and integrate various perspectives on the data collected (Green and Thorogood 2004; Lwanda 2005). The techniques included: filling in free listing forms, doing a critical discourse on newspaper and radio programmes on MMC, in-depth discussions, which are discussed in detail below.

**Free listing**

Free listing is a semi-structured research method that is used to gain familiarity with user vocabulary, define and learn common understanding of participants (Rapid Assessment Methods) (Chambers 1983). It involves listing items, words with a paper and a pen that respondents believe belong to a particular domain and they are described and ranked according to the investigator’s research needs.

Before the actual fieldwork, I piloted the free listing forms that were used to identify and describe local terminologies, nuances and colloquialisms of masculinity, MMC discourses and sexual health-related terms.

15 urban Men (5 administrators, 4 drivers, 2 doctors, 4 support staff) were recruited from my previous workplace. I asked for verbal consent from all participants and most of them knew me since I had interacted with them on several other projects. These men had helped me with translations using the vernacular in the past, thus they did not find it strange to help me pre-test some of my research questions and forms.
They were asked to fill in the forms at their convenience. The forms had three columns: the first was to identify a local terminology depicting male circumcision, and masculine identities. The second column asked the participant to describe the terminologies, and the last column to rank the terms according to frequency of use in the area. They did the same for sexual transmitted problems that the men faced and they ranked them according to severity. In addition, the listings were ranked from local male emic perspectives, based on frequency and common usage to inform my research questions and analysis.

**Mass media search**

Qualitative content and critical discourse analysis- studies the way social power abuse, dominance and inequalities are enacted, resisted by text, talk in the social arena (Van Dijk 1993b:353) was carried out on both print and audio media. This was done in order to contextualize how current available mass media on MMC were presented and how presentations influence everyday discourses, men’s masculine and ethnic identity and the uptake (or not) for HIV prevention. The search was conducted at two media houses that boast the highest readership in Malawi: The Nation Publications Limited and Blantyre Print. The researched period covered January 2001 to May 2011 to find overlapping fundamentals on MMC debates before and after the trials in sub-Saharan Africa and in particular, Malawi. The search was conducted manually in the media house libraries as most of the newspapers are yet to be digitalized and put online.

In the newspaper library room.

The key word search was “HIV/AIDS” to capture all discussions related to MMC and HIV. A total of 100 articles were found over a period of a week and captured on a digital camera then transferred to my laptop for further critical analysis on the meanings and content presented. The primary search of HIV articles included the words “Adult, masculinity, men” as search words to screen for more specific articles related to my topic; 42 articles were found. The secondary search ended with “MMC and HIV prevention” as search words and a total of 11 articles were identified. For the three stages above, the articles were read through twice, noting the themes in the process. The

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6 Courtesy of Malawi Broadcasting Corporation, Radio 1, Radio Islam and Zodiak Broadcasting Corporation
primary and secondary search involved a thorough content analysis and the criteria included the words “research, Malawi, MMC and HIV prevention” and these were transferred to another folder ready for data coding and further critical discourse analysis.

Radio programmes.

Radio programmes were not part of the data collection techniques in my proposal. However as in-depth and group discussions were staged, I learnt that most of the respondents had learnt about MCC from the radio. I followed up on five radio stations to share some of the programmes on MMC to further contextualize, learn the various perspectives being aired on traditional male circumcision and MMC and to deepen my research study.

I asked radio presenters to compile any radio programmes on traditional male circumcision and MMC for HIV prevention as a dominant theme. However, most radio stations argued that they did not keep excerpts of programmes on traditional male circumcision because of lack of storage material, thus they were forced to recycle some materials and lost traditional male circumcision materials. However, I managed to get two programs that uploaded on my laptop from CD’s for further analysis.

**In-depth Interviews**

This study was about a sensitive topic and in-depth interviews were used as according to Greene and Thorogood (2004:93) to give couples enough time to share issues that were important to them in relation to MMC as well as to follow up and clarify on the sensitive issues.

In-depth interviews were performed with seven couples at the village level close to a health centre and four men seeking MMC through a combination of purposive and convenience sampling methods respectively. The couples were chosen if the male was uncircumcised and for their willingness to: share their motivation to seek or not to seek MMC practice, share their knowledge, perceptions of MMC and, to be interviewed more than twice. It was a rare opportunity for me to find participants willing to spend their time with a researcher, discussing their genitals, MMC and the role of sexual partners in a relationship, when they could have been doing other productive work.

The interviews took place at couple’s homes for about one and half hours. I presented a question to both man and wife and I let them decide who would respond. I
let the couple discuss the question by themselves once in a while, directing the discussion to answer the questions on my research guide. Further, I observed how few women would interrupt their husband to counter argue and how some men were at a loss for words when issues of extra-marital affairs and MMC were discussed. The participants would illustrate the couple’s communication channels, negotiations, complexities in relating to one another, their fears and sexual lives, as well as aspirations or desires for MMC or not.

Of my four male respondents from the private hospital, two were unmarried with steady partners and their age ranged from 26-45 years. The four men were willing to talk to me on their seven-day review after circumcision and again later at a place of their choice to discuss their MMC experiences, motivation for undergoing the procedure, their decision making process and the role of their partners and spouses.

**Focus groups**

Five focus group discussions (FGD) were conducted as part of triangulation and to answer hypothetical questions, as well as to reach information saturation. Studies have shown that data saturation by FGD for small-scale research occurs after the fourth discussion (Denscombe 2003). FGD elicited discourses on dominant social values, thus they raised issues for exploration and participant validation within a community.

Group discussions took approximately one-two hours, with refreshments provided after the first hour. The hypothetical questions about how they would respond if their partner was to suggest MMC was the starting point. These discussions presented diverse voices, opinions, people’s fears and narrations about real life cases on MMC and sexual reproductive problems.

Both my male and female research assistants were available to help with serving refreshments and sometimes helped to take notes and fuelled the group discussions by taking part as key informants.

**Participant Observation**

After becoming accustomed to meeting with my participants, in the third week, I increased my entry points in the village by adding the welding shade and the chip/pork/goat street braai, places where men spend their afternoons rumour mongering
about what is happening in the community, country and giving comments to women passing by.

In the middle of the village there was a grocery that provided the coldest fizzy drinks and this place became my second stop. Initially, I would sit and discuss absolutely nothing with the customers, but as days and weeks went by, I could find a group of men waiting to discuss any topic: use of proverbs, men’s sexuality, MMC, aphrodisiacs or additional comments on some of the topics we had already talked about. Follow-up comments included debating about MMC and “real and ideal” men identities in relation to the HIV era.

The informal chats during my lunch breaks, rotating at the braai, welding shed and the shop were the most interesting moments, as besides learning the latest gossip, friendships were born while the men relaxed and shared their subjectivities and complexities as men struggling to understand traditional male circumcision and MMC in the HIV era.

Data collection guides
All the data collection guides were developed only as guides and much flexibility was given to probing approaches and letting the men tell their own stories in order to get as much information as possible.

In-depth and focus group discussions guides were developed in English and translated into vernacular Chichewa, which is Malawi’s second official language. I included all four research questions and a hypothetical question (how spouses would respond if their partner had suggested MMC) in both guides.

Initially, I had planned to tape-record all individual and group interviews. However as I introduced my tape recorder during the in-depth interviews, I realized participants became so uncomfortable and they would use some English words when I had not ask them to. Most of the individual participants became pretentious and the follow-ups for those particular interviews were done without the recorder. However, for all group interviews, after getting the participants’ consent with the help of research assistants, a tape recording was made in Chichewa and translated into English for further analysis.
Data analysis

I use data analysis as part of methodology for triangulation by inquiring on the (oral/talk/audio discourse), (written texts in the newspapers and existing literature) with participant observation about MMC (Jick 1979, Cohen and Manion 2007). I use triangulation as an attempt to validate and provide richness in my data. Discourse analysis entails looking at how and what people said at a particular moment, what they heard or read about MMC in our interactions (Van Dijk 1993b, Hoslag 2009). The discourses, texts and interviews were transcribed and translated from the vernacular Chichewa into English and coded in Atlas-ti (Atlas ti.v5.0, Scientific Software development, Berlin) for easy access and ongoing analysis. Codes, such as power relations, traditional MC, MMC, sexuality, ethnicity and masculinity, gender performance were used to organise data into themes and summarised in order to find relationships and patterns for writing my thesis (Green and Thorogood 2004). Other codes such as “social autopsies, vernacular knowledge, and new man” tried to give meaning and insights to the data to explain local people’s experiences and perceptions of MC and MMC.

Further, I employed critical discourse analysis (Blommaert 2005, Van Dijk (1993) Foucault 1980) to reflect on the above content, context: talk, audio, text, language used during verbal interactions in order to consider conflicting ideas, power differentials, meanings and nuances of MMC among men in search of their motivation and interpretive meaning (Geertz 1973). The free listing was analyzed by creating a list of all words and phrases presented, sorted on a single sheet and ranked according to frequent usage and commonality to summarise ethno-classifications.

The presentation of data includes: coded narratives, language as rhetoric (by using proverbs and brackets in quotes, newspaper reports and radio summaries) that were compared and validated with the existing literature, observations, concepts and research questions (Green and Thorogood 2004).

Ethical consideration

I received my formal ethical approval from College of Medicine Research and Ethics Committee (COMREC) in Malawi, which facilitated access to the village settings and private hospital. I recognized ethical considerations of both confidentiality and informed consent at all levels, during study design, data collection and analysis (Goodwin et al. 2003).
The discussion on MMC is sensitive as sexual matters are touched upon. I ensured that no one was coerced to take part in this study; people participated on a voluntary basis. Verbal informed consent, was (sometimes recorded) in either English or Chichewa (the vernacular), depending on literacy levels (see appendices 6a and 6b) for people to show their willingness to participate in the study before data was collected. Moreover, participants were informed of guaranteed confidentiality at all times and asked to identify themselves with pseudonyms during all recordings and narrations. Participants were informed about the right to drop out whenever they felt they could not go on as well as their contribution to the knowledge base on men and sexual health.

**Limitations of the study**

It was difficult to confirm if the men I interacted with were indeed uncircumcised. It was against my ethical consideration to ask the men to show their nakedness.

I got access to interview men who had undergone MMC during the last week of the fieldwork due to administrative issues beyond my control; however, I was able to meet the men twice, at the hospital and at a place of their choice on another day.

The use of proverbs, as I realised later, was very important, as most men interviewed alone and in group discussion, tended to use them to depict ironic sentiments or as a form of indirect communication to run away from using uncouth language.

I included data collected from gossip, though the method was not part of my proposal as I learnt that I learnt more of social practice through that method. Most of extra-marital affairs were learnt through that method (Watkins 2004, Anglewicz 2010).

Despite most couples being friendly and open with me, sometimes there was great performance when I discussed their sexual histories without regard to MMC. Sometimes, the men dominated the interviews and I was forced to respectfully ask the woman to give her side of the story. However, despite persuasion, some women (two) said very little in the presence of their spouses, whilst others were not shy at all.

Some men were quite open with their sexual life, maybe because I was a woman and they wanted to show off their sexual prowess. Moreover, most of the confessions about cheating and informing others about their HIV positive status came from the men. The men would disclose this information whenever their spouses were away; for example, at their place of work, when we met in the street and started to have an informal
conversation or when accompanying me to my home. Thus it became difficult to confirm the narrations during the subsequent couple interviews.

Another limitation was that I lost one of my couple participants, and a woman after the first contact had been made. When I went for follow-up, the woman told me I was not welcome at her home and I was not allowed to speak to her. I tried to find out why, but she refused to divulge the main reason.

Despite the few limitations I met with women participants and the delays at the private hospital, I think a combination of mixed methods including: mass media, interviews with men in the absence of their spouses, a woman-only focus group, and a mixed group discussion with young couples, health workers and key informant interviews gave more than enough data for analysis. A “thick description” will follow (Geertz 1973) which is not an only way of presenting data, it entails a detailed investigation of “webs of meaning” and that allows for a detailed study of presentations, subjectivities, and events in various contexts in order to generalize within.
CHAPTER FOUR
The Role of Print and Audio Media and Male Circumcision

Circumcision: Not a Death Catalyst—Senior Chief July 2005
Man gets circumcised forcibly at 39!—Police Reporter 2006
MC lowers HIV Infection—HIV/AIDS Expert 26 December 2006
MC: A Caution!—Policy Maker February 2007
MC Does Not Prevent HIV Infection—Diplomat 16 December 2009
Combating HIV: the Islamic Way—Director NGO19 February 2010

The above newspaper headings are from print media, a source of information for Malawian health issues, from January 2001-May 2011. I undertook content analysis to understand the national/local context in which deliberations about male circumcision (MC) and polemics took place in Malawi to describe public press presentation, biased towards a critical discourse analysis and how that affected public perception of MC.

Sample selection of press coverage of MC was done manually through desk research at two main media houses in Blantyre, which boast the highest readership in the country. The search words were directed by the reporter’s presentations of the main headlines and the relevance structure in the newspaper articles. I experienced some difficulty in opening stacks of newspapers, manually searching from front page, editorial, daily-features, short stories and entertainment pages. I left out all the spor- t pages, as I believed that MC stories would not be featured in those sections. In one media house, the newspapers were indexed; however the search was quite exhaustive and time-consuming, as some articles were not on the library shelves. The search words included the words “male circumcision” (in English). I did not get the chance to search for articles in the vernacular Chichewa, due to time constraints and vernacular version of the news is printed once in the weekend paper; thus it is a repeat of stories presented in English version throughout the week.

In the course of conducting my in-depth, informal and focus group discussions, I learnt that most participants in the villages had heard about MC on the radio. In Malawi, the newspaper is not an effective media for transmitting information to the masses because most of the ordinary people cannot afford to spend US $1.10 per day buying

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7 Most urban based men (the ones that underwent MMC) had read something on MC in the newspaper. No man interviewed at the village level mentioned the newspaper as a source of information for MC.
dailies. Furthermore, some people are uncomfortable reading English, so the dailies are not where they receive their news. Three of the men who underwent the MMC are office based workers who receive the local dailies on a daily basis except weekends. Thus, they argued that the newspapers are part of their daily lives as such they followed the latest local, business and foreign news. These urban based men also followed the presentations on MMC to the extent that one of the respondents kept some articles in his drawer for reference and this will be discussed further below.

Most men told me that a radio is their companion. They listen to it before they start their day to know the time and to listen to the news before they go to work and their children to school. When men in the village go to their farms or any place of work they usually carry their portable battery radio like a bag on their shoulders or neck. In the night, in candle-lit homes, most families listen to the latest radio drama, news in vernacular and a popular program zamumaboma [what has happened in the various districts] on a particular day for entertainment. During my rides into the village, my escort, who was a Catholic, would switch on Radio Maria, a Christian radio station, to entertain his customers. That too reminded me of the importance of the radio as a source of information. Studies done on the extent of the reach and effect of radio communication in Malawi reveal that more men are highly exposed to the radio programmes and their recall is better than women (Meekers et al., 2007; Watkins, 2004).

I went to five radio stations to learn about their programs on MC to further contextualise and deepen my research study. Unfortunately, the low budgets of some radio stations meant that they are forced to recycle their CDs and tapes, thus material on MC was not available. Some reporters wanted to be paid before releasing information and as a student researcher I could not afford to do this. In the end, three out of five radio stations shared their programs.

Newspaper Articles Results

The newspaper search yielded 11 articles, two of which discussed MC without reference to the MMC trials in Kenya, Uganda or South Africa (Muula 2007). The themes in these two articles were biased towards adolescent initiation ceremonies as safer and not influencing new HIV infections, as well as an adult man being forced to be circumcised for challenging the circumcising community. These articles appeared from 2005-2006. Generally the articles before the MMC trials discuss traditional MC among
circumcising societies and their challenges due to sharing circumcising knives/cutters that was fuelling the HIV epidemic. Further, the article discuss how post-ceremonial activities among adolescent boys who were involved in sexual acts to prove their manhood exacerbated the virus.

If people are dying of HIV/AIDS and related illnesses, blame it on promiscuity but not on initiation ceremonies, we stopped using one object (cutter) for circumcision, so circumcision is no longer an agent of death [Senior Chief, Zomba 2005]

The adult man who was forcibly circumcised at 39 due to trespassing on the initiation grounds reveal the social conflicts that are present between the (non)circumcising communities. However the hand of the law enforcers catered for the case and punished the traditional circumciser for unlawful wounding (Kumwenda 2006)\textsuperscript{8}.

The son was grabbed as he was walking near the simba (initiation grounds)[...] and when the father heard about the incident he went to fetch his son [...] but was grabbed forcefully and circumcised [Police officer 2006]\textsuperscript{9}

Both stories call upon the local chiefs, as mediators, to support adolescents not to become infected and for non-circumcised men to be spared the shame and agony of forced MC.

\textsuperscript{8} The Nation 16 August 2006
\textsuperscript{9} The Nation 10 August 2006
MMC and foreign experts

The main themes for the remaining nine articles included: MC as strategy for HIV infection, discussions on various research done regionally and internationally, caution on interpreting the results, as well as the pros and cons of the medicalised procedure. These articles started appearing in late 2006 and most seem to be influenced by several research conferences on MMC taking place in the regional or global arena.

The deliberations to consider MMC as a strategy for HIV prevention were first presented in 2006 at consultative meetings attended by research experts and local doctors. The presentations were performed by foreign doctors (not from Malawi) and local policy makers from the national AIDS Council were called upon to comment on the scientific results from the MMC trials. The foreign doctors advocated for MMC among 15-18 year olds as their first target group and this was to be followed by neonatal circumcision. Most of the articles on consultative meetings brought together various voices; the experts, critics, donor and policy makers, but not people at grassroot levels. A research expert from Zambia presenting the arguments on MMC during a news conference in Lilongwe quoted researchers who suggested that foreskins harbour the virus and when they are cut,
there is 40 to 50% reduction in the chance that one can get infected with HIV. The researcher also made reference to traditional MC and problematised the procedure by quoting the complication rates and comparing it with the results from the clinical trials to substantiate his presentation. Six of the 11 articles presented by the research experts from Britain, America, regional and international organisations took the same line of argument by presenting the drawbacks of traditional MC and building upon MMC with its partial protection\textsuperscript{10}.

Generally the, local newspapers reported on foreign research experts who were enthusiastic about medical benefits of MMC, especially on the results of MMC for HIV prevention, sexual function and satisfaction (Kumwenda, 2008, Mmana 2007, Nyirongo 2010, Somanje 2006). Other presentations centred on showing how MMC improved a man’s body image, prevented cancer of the penis, the cervix in women and thrush infections (Mmana 2007, Kumwenda 2008). However, most of the experts presentations above were quick to emphasise the partiality of MMC as a preventive method and called upon men to use condoms at all times.

However, there were diplomats from Europe and America who have refuted the idea that MMC reduces HIV infection, which causes further confusion among readers. They argued, “More circumcised men have AIDS than uncircumcised men” (US AIDS Diplomat 2010\textsuperscript{11}). A researcher from the Caribbean questioned the effectiveness of becoming circumcised and being forced to wear condoms, as some men were reluctant to use them (Mmana 2007). An article: “Bisankoni and HIV/AIDS Confusion”, further illustrates the confusing information about MC as the author argues that Yoweri Museveni, the Uganda President, refuted the idea that MC reduced HIV infection among Ugandans, but emphasized abstinence among the youth as the main preventive strategy (Bisankoni 2006)\textsuperscript{12}. Hence, it is not only leaders in Malawi who are presented as sceptical about the results on MMC.

\textsuperscript{10} Please refer to picture (1) on page 34 and Annex 6 for evidence of newspaper presentation on MMC in Malawi

\textsuperscript{11} The Nation 16 December 2009

\textsuperscript{12} Uganda Snubs NAC on Male Circumcision, Daily Times 28 December 2006
The local response from the articles presented in newspapers was varied, however, they carried a common tone: Caution! Malawi representatives, as health ministers, directors of national AIDS bodies, and HIV Units have been sceptical about results on MMC and they argued that the results were “exaggerated and misleading” for the Malawi nationals. There were headlines such as: Malawi to consider MC to tame HIV (18 December 2006) and Report MC with Caution! National Aids Commission (6 May Daily Times 2007) where Malawian policy makers called for local research studies to confirm the results and refused to accept the data presented in the region and internationally.

*We have traditional MC in the country, but we never thought it would play a vital role in fight against any diseases* [National AIDS Commission Director 2006]

*The MC trials have provided compelling evidence; however there is need for individual countries to analyse objectively their country situation and resolve in the process of adopting MMC as a strategy for HIV prevention* [Health Minister 2007]

*There is danger that people who have been circumcised will feel that there are fully protected from HIV ...we need more research and clear guidance for MMC can be substituted for a condom* [Chief Executive AIDS Trust 2007]

However, it is imperative to note that the above articles do not compare or critically discuss the regionally based data on MMC with local statistics on MC in Malawi. The local policy makers interviewed, continuously note the 60% protection rate from the clinical trials however, they refer to the need for more local research revealing their ambivalence in accepting the regional MC results.

There were very few articles that unravelled the religious discussions in relation to MMC. The reporters presented MC as a Jewish custom, following God’s declaration and others mentioned MC as a rite for purification among Muslims, as demanded by the Quran (Mmana 2007). Some articles gave more space and voices to Muslim leaders, as they argued that they had adopted safer practices during their traditional MC ceremonies since local chiefs and a medical doctor were made overseers of the ceremonies (Mmana 2005; Nyirongo 2010). However, Muslim leaders in the newspaper articles also echoed

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13 Minister of Health in 2007, Marjory Ngaunje, April 2007, Malawi News.
14 Malawi News, 17-23 Mach 2007
the scepticism about MMC need for further research nationally to validate MC data being presented regionally and internationally.

*It is wrong to be circumcised (MMC) for HIV prevention because it was meant for purification* [Chairperson Muslim Association 2008]^{15}

*In fact we recommend that when jando (male initiation ceremony) is being carried out, It should be done by a doctor or that he should be around to supervise the process. We should not let jando spread HIV/AIDS* [MAM Executive Director 2010]^{16}

*The benefits of MC are exaggerated and misleading most people* [Acting Director HIV AIDS Unit 2008]^{17}

*There is need to be focused as a country because any information over MMC might erode the gains made in the fight against HIV/AIDS* [Policy Maker Lilongwe 2007]^{18}

Further, candid arguments are presented during consultative meetings and roundtable discussions during conferences as policy makers argued that the procedure was ineffective since men who were circumcised during the clinical trials also became infected (Kumwenda 2008). A newspaper article presented on “Gaps in HIV/AIDS Research” in Malawi mentions how a policymaker^{19} refutes the idea that the youths hold the view that MMC provides total immunity against HIV, because she had not seen the report(Editorial Analysis 2011). Despite seeing the reports of 60% HIV reduction from the MMC clinical trials, Malawian policy makers are still sceptical and call for local researched data to confirm the findings and that tends to exude controversial and confusing tones for lay people, evidenced by the young adults group discussions below.

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^{15} The Malawi News 17-23 March 2007
^{16} The Nation 19 February 2010
^{17} The Nation 26 August 2008
^{18} The Minister of Health Nation 22 October 2007
^{19} Mary Shawa- Principal Secretary of HIV/AIDS
Dan

I present Dan as a man who followed the debate about MC in the local dailies up to the extent of keeping them in his office desk. He confesses that he does not understand the research arguments for HIV prevention but he was interested in the aspect of MMC for pleasure.

Dan is a thirty-three old man who has been married for the past four years with a child. He is a banker and is on a two week leave from work. Initially, we met at the hospital where he had gone to have his seven-day follow-up visit. I had asked him for a second interview at a place of his choice, and that is why we met in his office at his place of work.

I was ushered into his office by a secretary. I had not expected to find him in a track suit and a cap on his head. He saw my surprised look and reminded me that, he was still on holiday and had just come to the office to meet me. He confessed that he could not be seen around town with a young beautiful woman and his wife not hear about it. I reminded him that I was a student researcher, married and I would not mind visiting them at their home and having the interview in the presence of his wife to curb any suspicions, he flatly refused and prompted me to start interviewing.

I asked Dan to narrate his feelings after having been circumcised at thirty-three. He informed me that he did not invite me to his home because he did not want his brothers or uncle to know that he is circumcised. It was only his wife, the doctor, two of his closest friends, and I who knew that he was circumcised. He mentioned that he had read about MC for the first time in 2007. From then on, he would keep the newspaper cuttings that had stories about MC. I did not believe him and I told him so. He took a small key from one of his drawers on the right and opened a metal money box that was on the left corner of his desk. He told me to look away because they were other things that were not meant for my eyes. He brought out a couple of papers, newspaper cuttings; some were printed from the internet with information about MC. Most of the information was on the sexual benefits of the practise. “I only liked to read about the sexual pleasure parts and I did not understand the research parts”, he said to me.

I asked him to share his opinion about what he had read about MC on some of the newspaper articles. He tried to recollect, what he had read, however he picked up the articles from his table and began reading them out loud and making comments. He began with an article that showed men on a roundtable and discussing the benefits of MC.
He confessed that he was not comfortable in discussing research issues. It took Dan almost five years to make the final decision to take a leave from work and get circumcised. He had made up his mind a long time ago that he wanted to get circumcised, but as a Ngoni man, he could not tell his people? He vowed to keep it a secret and argued, “It’s not part of me...as a Ngoni man, I have betrayed my people; but I am also a happy man” he retorted and smiled at me.

*I will tell you, I have read all those newspaper cuttings and news on the internet over and over again and have spoken to my wife over and over again about MC. The truth is I have...aaagh, noo, my wife has never complained. She is too good to me. I used to have an awfully long foreskin and each time I would make love to my wife I used to feel uncomfortable. Sometimes I had to stop and draw the foreskin back during sex and it used to make the process too busy for me. Whenever, I went for beer drinking and my friends would start talking about how much better their sex life is...I would come back to my office on Monday and re-read the newspaper cuttings to make myself not lose heart. I know and have read that MC is not a “magic bullet” but for the sake of my sex life and my peace of mind that my babe (wife) will enjoy great sex, that is why I got cut!*

Dan confessed to me that he was in pain as being close to his wife had caused his wound not to heal as he expected; any slight erection had caused much pain. His leave days had ended the previous day and had come to the office, not only to meet me but to extend them. He said he was not ready to put on suits everyday as that would require wearing mini-briefs that would make him squirm with pain. He laughed, but it was a forced laughter, and he winked at me and said, it’s for his babe (wife)!

Below is one of the copies of a newspaper articles20, I saw in Dan’s office, where research experts respond to questions presented by policy makers from various countries during the XVII International AIDS Conference in Mexico about MMC leading to sexual dysfunction. The reporter presented the article in a form of a technical report, full of technical jargons. The experts drew upon technically loaded studies that were done in USA as well as in Kenya to substantiate that MMC improves the man’s sexuality; as their penis became “harder and bigger”. There are two female voices, as a foreign researcher and a Malawian policy maker who raise contentious issues about MMC and men in

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20 Article written by Bright Kumwenda 26 August 2008
context. The Malawi representative to the conference was heard saying Malawi is yet to conduct local research on MMC and confirm the claimed findings.
Circumcision enhances sexual pleasure – research

A participant asking a question during one of the circumcision sessions. – Pic: Bright Kamwende

Sexual Function and Satisfaction in Kisumu, Kenya, between 2002 and 2005, said there are no differences in sexual functions between the uncircumcised and circumcised men. Krieger, a statistician at the University of Washington in the US, evaluated sexual function and pleasure among men aged 18-24 in a randomised, controlled trial on prevention of HIV infection in Kenya. Participants were randomised 1:1 to circumcision or delayed circumcision (the control group). At one, three, six, 12, 18 and 24 months, 7,984 participants underwent detailed evaluation.

"One hundred were excluded from the analysis as they crossed-over, some were not circumcised within 30 days of randomisation, others did not complete the baseline interviews, or were outside the age range. "For the circumcision and control groups, respectively, report of any sexual dysfunction decreased from 23.6 percent to 23.9 percent at baseline to 6.2 percent and 5.8 percent at 24 months," said Krieger.

He said this means circumcision is not associated with any sexual dysfunction. "In fact, 64 percent of circumcised men reported that their penis was "much more sensitive" and 34 percent rated their ease of reaching orgasm as "much more," he said.

Krieger’s survey corroborates two other surveys—one by the Population Services International (PSI) in Zambia and another one by Robert Bailey who co-authored a book The Post-circumcision Studies of Sexual Function and Risky Behaviour in Kenya. The aim of PSI’s quantitative and qualitative research was to better understand key motivators and barriers to accessing circumcision services.

The survey reveals that penis hygiene appears to be an important motivator for men seeking male circumcision, with both circumcised and uncircumcised men agreeing that male circumcision leads to better genital hygiene.

Picture 1: Circumcision enhances sexual pleasure. The Nation 26 August 2008
MMC another dead end or loose end:
Discussion of newspaper articles among young adults.
I present the following group discussion to further contextualise how the ordinary young adult couples: six women and seven men, three of them Moslems and the rest were Christians; in a village setting, understood the presentation of MMC in newspapers. Although the youngest woman and man were aged 22 and 24 respectively, these young adults were able to voice their confusion, fears, and subjectivities in the face of MMC presentations in the media and in the HIV era.

These young adults invited me to come and talk to them as they had heard I was talking to couples in the village. They assured me that they would organise themselves and when I arrived early on a Wednesday morning for the group discussion; I found them doing daily devotions and I attended their closing ceremony.

I explained my research objectives and asked for the participants’ consent to be part of the study. They all laughed as they remarked they had invited themselves to be part of my study.

There is a programme on the radio in Malawi known as What the newspapers have written today and it was from this programme that four of the participants had heard the protective nature of MMC and mixed confusing messages on the same. I learnt that on almost all radio stations, time is given either in the morning or late in the afternoon to share with their listeners what the dailies had written about on a daily basis. “I like listening to the Zodiak newspaper reports because they are more thorough and give a bit of information about a story and it feels as if I bought the newspaper”, said Amos. Other two responses came from Peter and John about the same station, Botomani, said he once heard that MMC prevents HIV on Capital FM, another radio station; which I noted down and reminded myself in my diary to follow up. The group resolved to call me aunt, each time they responded to my questions.

Aunt, circumcision stories are very hard to follow, today they tell you it reduces HIV infection”, tomorrow they tell you, they are yet to see the results...and another day, they tell you, Malawians have not accepted the results, aunt, to what and to whom are we going to listen to? [Sarah, young adult FGD]

They all lie, they just want us to die, what is new with MMC? [Peter, young Adult FGD]
The stories for MCC are from the outside world, they are here to inform us, of how they are researching, here in Malawi, we need to know [Brazi young adults FGD]

You are just lying, MCC is there in all public clinics, even Health centres, here in Chiladzulu, Chitera...hesitant...I think so, I heard that at Thyolo district hospital they had a week long MCC programme, so you see [Amboba young Adults FGD]

Below is one of the newspaper articles that capture the confusing messages about MMC.

Picture 3: MMC does not prevent infection. The Nation 16 December 2009

Christian men also reported confused sentiments about the way the government of Malawi had handled MMC in the newspapers. The men in the group interview queried how they were supposed to understand and accept MMC, when there was so much confusion among dialogues of experts, representatives from the pool of donors-WHO, UNFPA, SADC, USAID and presentations full of technical jargons. A case example is the article above, where a USA AIDS diplomat declared that MMC does not prevent HIV and there was need to consider the procedure with other preventive strategies such as condom use. However, the Minister of Health did not respond to the MMC claims, he just thanked the diplomat for the donated office space; hence maintaining the muted response that other authors on MMC refer to (Mfutso-Bengo 2010) by some local policy makers.

Sometimes, reporters generally draw information from randomized trials in Kenya, South Africa and Uganda as presented in technical reports without editing to
make them comprehensible for the masses and that further confuses the readers as evidenced by the group discussion.

*Inner part of the foreskin harbours cells, which act like a receptors for HIV*
[Researcher expert August 2006]²¹

*More circumcised men have AIDS than uncircumcised men [US Diplomat 2009]*

*They are control groups that are part of 30 days randomisation and others never completed baseline interviews [US Research expert March 2008]*²²

The men in the young adults group interview declared their hesitancy to seek MMC because, of the above media presentations and coupled with that a week before a traditional circumciser had died and the all the participants in the group discussion provided a quick “social autopsy”-(entails other villagers providing narratives of a person’s social, sexual, medical histories coupled with generalisations on the cause of their death) (Watkins 2004:677). By discussing the deceased man’s sexual history of having two wives, and other casual partners in Blantyre city as he was fond of visiting and sleeping over at intervals. Brazi stated maybe he travelled to the city to get ARV in order to keep his HIV status a secret- a remark which brought laughter and further evaluations on the deceased circumciser. However the discussion ended with participants agreeing that it was rumoured that the circumciser was on ARV’s and had died of AIDS. Anne came in and said out loud, “the government is blind, they do not know what they are saying and they want our men to follow the dead end and die”. Most men and women in the group discussion echoed the same idea and asked, *Can the government not see that even their circumcised neighbours are also dying in large numbers? MCC or NO MCC…There is no difference!* [Young adults FGD, sentiments]

Overall portrayal

Newspaper reporting in Malawi for MMC tries to balance its presentations, as reporters control the relevance structures of the newspaper articles. However, reporters concentrate on the dominant voices of foreign research experts, policy makers and a few female reporters. These foreign research experts draw on studies done elsewhere, for example in the USA and regionally to support their thesis on medicalised circumcision.

²¹ The Nation 18 December 2006
²² The Nation 26 August 2008
The voices of local policymakers and religious leaders are sceptical about MMC’s protective nature, however, they do not discuss national statistics to contextualize their ambiguity. The ordinary people, men and woman in the street and their perceptions are silent and absent. It is generally women reporters (one woman reporter); female policymakers (as the sitting Minister of Health and Principal Secretaries and Directors) who are given the chance to comment on how research on MC has been a contentious issue since 2006.

The Radio Programmes

My radio, My companion, My informer!

Most women in the village reported that they cannot read newspapers or listen to the radio, due to problems of inaccessibility and cannot afford to buy batteries to listen on their own. They wait for their husband to come back from work, to be entertained and if their husband has not made enough money to buy batteries, they go to bed without listening to the radio. However, in relation to MMC, most women and men were unable to recall from which radio station they had heard about MMC. Some responses on the topic of radio programmes included;

I heard on the radio about MMC they were saying...they are saying... listen, they said, they are saying they have found out that MMC can prevent HIV...[he laughs]...these people do not have a place to throw their money...I mean how does this MMC being practised by my friends, the Moslem, turn around and help fight HIV? [aPhiri, IDI]

I heard on radio was it Zodiak? MIJ? Radio 1 MBC...I do not remember which one in particular, but one of them... [FGD, IDI both women and men]

If you switch to radio Islam, they always have those discussions, but I do not remember...let me think, when I remember, I will get back to you...[Nachisale, [Informal discussion]

Some of the programmes that most people were able to recall without difficulty included, Tikuferanji [Why are we dying] an HIV/AIDS radio drama and Radio Doctor, a program that replies to people’s health needs through letters. However, it was difficult for both the village and urban men and women to recall the actual program and what they learnt. Some respondents said that they only walked in on programmes relaying health messages.
but not the actual name of the programme when it was ending. Despite most respondents not recalling the specificities, others were able to recount the radio presentations;

*They are saying, Listen, they are saying in the radio that they have found that research is saying MMC reduces HIV (laughs), these research people are lying to us, that is what they are saying and I think they have too much money to waste...I cannot go about seeking MMC...what for* [Daud, IDI village]

*We have stayed all this while and we have seen with our own eyes how our friends, the ones who have been circumcised whilst young, they are just dying and today research says MMC prevents HIV...is it madness?* [Ngoni man IDI, village]

*What they say is just madness, pure madness, they are coming from nowhere and these radio people they just say, they say MMC can help reduce HIV, but I will tell you that is not true, go to the clinic and see all kinds of men, the circumcised are there too and receiving ARVs* [mother to Emily IDI village]

Moreover, in regard to listening and recalling MMC programmes, few male and female respondents have time to follow the discussions. Less than half of the respondents had followed an entire program on MMC and this was because they had walked in on the programme. A few individuals, mostly men, recalled the presenters of MMC information on the radio, without the specifics. Most women and men remembered Mary Shawa, the Principal Secretary for Office of the President on Nutrition and HIV/AIDS, as well as Thecra Ngwira and Mr Imran Kazembe, presenters from Radio 1 and Radio Islam, respectively as having said something about MC and most of them argued it was a long time ago, they could not recall.

**Behind the Microphone and Voices of the Unheard!**

Generally among the couple respondents, most women questioned the accessibility of the radio, as it is viewed as a marker of wealth and might not be found in most households, or among women in the villages. I captured parts of the programmes from *Titani and Kwunika Mdulidwe* and *What is on Air*, programs from Radio 1, Radio Islam and Zodiak Broadcasting Station, respectively, to give a context to my study, triangulate with oral discourse findings and to show that the culture of silence on sexual matters in Malawi as it is slowly being unveiled. I also critically analyse the content to further assess the knowledge and gender power relationships (Ahlberg 2010).
“Ready!...are you ready....ready...ohh mama....ready...are you ready or mama
are you ready...” is a jingle that introduces a programme by Thecra Ngwira called
Titani23 [What shall we do], a programme that specialises in discussions, sharing
knowledge and finding an answer to social issues. This is a 25-minute programme with a
woman speaking in a soft, clear, soothing and powerful voice that attracts listeners to sit
down and take some time off to learn. She begins by throwing questions to her listeners,
“Can a circumcised men get infected with HIV?” and moves on to introduce her
panellists who are from all over the country and who show she is gender sensitive. She
has gone out of her way to give a balanced voice to issues and has visited her panellists in
their homes and place of work, a haematologist from the northern region based at a
College of Medicine, a Moslem chief from the southern region, a female researcher from
a health science college in the central region, two ordinary men and women, one man
who is HIV positive and one circumciser.

I also listened to a programme presented by Radio Islam: Kuvunika za
Mdalidwe24 [To look at circumcision]. The programme began with a jingle calling upon
all Malawians to help with AIDS health problems presented by Yusuf Chinyada, who is a
fast speaker, and Abdullah Zizionere, a hush and slow speaker. The panellists for the
programme included two government officials (women and men), five NGO male
officials and a woman from the district.

Both programs were candid in their presentation of issues of MMC and HIV
prevention among Malawians. They gave a brief background of MC from the Bible and
Quran perspectives, concluding that it is part of the law for all men to be circumcised.
They continue with the well-known example of the trials in Kenya, Uganda and South
Africa, with variations on the HIV prevalence in various districts in Malawi. The radio 1
presenter spoke in March (2007) about HIV information as presented by the national HIV
Unit: about 930,000 people in Malawi who have HIV and the 99,000 who were put on
ARVs. Chinyada presented the data on the five district namely Salaam, Nkhotakhota,
Machinga, Mangochi and Zomba, as areas that are predominantly Yao, Islamic and have
the highest HIV prevalence. Both presenters spoke about the technical question of a
rumour: the causal link between MC and HIV /AIDS! They also questioned the

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23 Consent from Thecra Ngwira Radio 1 Malawi Broadcasting Corporation.
24 Consent to quote the programme granted by Mr. Imran Kazembe Radio Islam
unavailability of MMC results on Malawi\textsuperscript{25} and the need to explain the controversial statement that Malawians do not practice MC, when the Yao and some Lomwe groups do, leading to concerns about the social meanings of circumcision in a country that upholds collectivism; thus emphasising strong national ties as compared to individual ethnic differences.

Following the rumour about MMC, both programmes recognised problematic areas in the fight against HIV infection. Kuwunika za Mdulidwe adopted a heavy technical tone, contrasting discourses to inform their listeners how the government had refused to accept MMC because it does not reduce HIV infection. However, the specific government official did not speak and remains another ‘negatively muted’ voice recognised as raising contentious arguments about MC in the country. The government official is said to have argued that MC is higher among Moslems and they are the ones dying, proving that MC does not work. The Moslems responded by accepting that they were dying; however, they were not the causative agent.

\textit{Look, look at Islamic countries, Nigeria, Egypt and Libya as having smaller HIV prevalence like 1\%, 3 \%, all because they circumcise...it is those from the outside that bring HIV infections to our people...}[representative Malawi, Moslem Association-MAM]

\textit{It is the big bosses from the government and their workers and all these business people, the ones that buy fish...they come and sleep with our women...that is how diseases is spread} [Muslim woman, radio interview]

Further, the reporters presented the technical/expert voices and the raised issues included: condom use, polygamy and having multiple sexual partners. The national researcher from \textit{Titan}i programme drew his message from the prescribed Abstinence, Be Faithful and Condomise prevention strategies rather than completely depending on MMC for HIV prevention. Religious leaders and non-governmental officials centred on the moralistic discourse of fidelity, abstinence, however they were quick to add that even with circumcision, if men could not be faithful and they needed to use condoms always. It is of great consequence to realise how the various voices of the religious organisations

\textsuperscript{25} The results from the Situation Analysis 2010, are not encouraging, due to donor pressure the government has been forced to lay the ground for VMMC as an HIV prevention strategy.
that were once mute on HIV prevention are able to inform their followers to use condoms and give women a chance to speak their mind and share their ideas nationwide.

**Behind the microphone: Voices of dissent.**

*Why now?* is the question the majority of respondents presented after asking them about their opinion on medicalised MC. Religious leaders, policy makers, researchers and women are playing a blame game on the subject of MMC. The conversations are full of paradoxes and ambiguity as you listen to their responses. Some presenters and respondents spoke of Moslems exacerbating the HIV infections, whilst others spoke of the hate speeches against Muslims and Yao initiation ceremonies. Unlike the newspapers, the radio programmes question the issue of ethnic and religious identity: which is also a bone of contention for most men interviewed during the radio programme and specifically the ones from Mbulumbuzi village.

Some radio presentations are candid about the marks of ethnic and religious differences and they discuss them by drawing various voices from several regions in the country. The messages that are clear on radio; include the notion of “othering”—the ‘in groups’ those who circumcise—and the ‘other’ Malawians who do not practice MC. The government negative and “muted” stand on MMC has been viewed from other social circles, especially the circumcising community, as discriminatory and confrontational resulting in a blame game causing Moslems to feel that they are hated because they are circumcised during initiation ceremonies. Moslem leaders and the only woman in the program Kwunika Mdulidwe argue,

*AIDS is not among the Moslems, and it is not coming from the five districts that have been identified above, rather AIDS is brought by outsiders, those people that come for business* [radio Islam]

The Moslems’ argument is that the above five districts are tourist-based destination and they are also near the lake, thus most fish business people and government officials visit the lake for their meetings and it is those people that have brought HIV among the Yao people. The same argument was also shared by a researcher at John Hopkins-Malawi, who states that is difficult to rule out MMC as not being effective because they are many social factors that are beyond the government’s control in the above-mentioned tourist

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26 Part of my personal notes
areas. She argues that most of these men, from Mangochi, Machinga also travel to South Africa and they are absent from home for many months. Some of the men are involved in anal sex with tourists and, their women also go for the tourists to get money for their upkeep. Thus it is difficult to compare the MC and HIV prevalence from these areas.

In addition, it is not Moslem men who feel ‘othered’ (distinguished as an outer group that does not belong), uncircumcised men also feel threatened. The question from most of the men during interviews (in-depth and group discussion) was if we wanted to “Islamise” them in their old age. Most adult men could not differentiate between traditional MC by the Yao and MMC and that MC has been presented to Jews and gentiles in the Christian bible.

R1: Really, for an adult man to go all the way to the district hospital and get MC it’s a joke!
R2: Maybe for their own son, but for the old man... What for?
R3: Maybe it’s for your own good but alas, it’s a waste of time...I have already fathered children, have had sex with my wife, why now... [He begins to laugh]
R1: Why now? MC has been there since time immemorial; we are all going to die why now, what is different now? [FGD at the welding shade]

The voices of women from the same village echo the sentiment of the men mentioned above. Most married women have accepted their husbands as they are and are not prepared to encourage their spouses to ongola mtengo utakula kale (to strengthen a tree when it is already old). They argue that MC for an adult man is not advisable as some women feared he might die during the process.

Chapter Conclusion

It is a combination of the tension, between the government officials, conflicting discourses from policy makers, moralistic discourses and ethnic identities that have made the MMC discourses incomprehensible in Malawi. Acceptance of MMC is proving hard to sell to non-circumcising communities. Men are accepting MMC for sexual pleasure than for HIV prevention.

Radio stations have tried to present balanced programmes on MC and HIV prevention, however, due to unwarranted “othering”, there are still people for whom MC is socially impossible and they cannot consider it as a prevention strategy.
Others have recognised that as Muslim or Christian men, whether circumcised or not, HIV prevention needs to be taken more seriously as an ethnic or religious issue. Uncircumcised men have to consider the moral, technical and conflicting discourses presented by both the print and audio media, their families and spouses depending on accessibility and availability. Whether a man does (not) go to be circumcised is of great importance; however of greater significance is the notion that he has the knowledge for decision-making, rather than just arguing based on lack of information.
CHAPTER FIVE
Masculinities and the Malawian Male

Perceptions of masculinity among adult men in society

Inspired by critical studies on men (Connell 2005; Morrell 2002; Simpson 2007, 2009), as they focus on studying actual behaviour, life and practices, I tried to pay a close attention to Malawian men by sharing time with them at various workplaces, homes, streets and leisure centres. What makes an adult man in the Malawian society? That question was usually thrown back at me and most men argued, because I am a woman, a married woman, I knew what made a man. I would slowly explain that I was in their society to learn about them as men, living either in the village or in the city. Most men responded with the notion of “tradition” or “culture” to legitimise their identity.

R1: in my culture, to be a real man, means to be principled, tough in decision-making and to always protect your family, that is very important... [Timothy, free listing Blantyre]

R2: a real man, real men... in my tradition, have children, if you are able to sire...to have your own that call you...wawa (term used among the Ngoni to show respect to adult males) then you are a real man... [John, informal conversation]

The main requirement among men in Malawi is being able to have a wife, children and money to take care of their family. Most men mentioned that they felt more respected when they provided financial support for their families and were not lacking. Other men felt elated, when they were referred to as mphongo (strong, respected men, with children) tonde wa tonde (man likened to a goat, who is able to have children) Thus, men in both the village and the city could only be found at home during the lunch and after hours since they work hard, in menial labour jobs, subsistence farming, vending or office work to bring a little something for their wife and children at the end of the working day or the month.

R2: to be a man is to love your woman and to remember to tell her that you love her and if you are not married, you need to cement the relationship with marriage [Fred, free listing Blantyre]

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27 Term used to refer to a man who has done great things or with a bit of wealth among chewa and ngoni
28 Tonde watalisana, playerful term to exhilarate a man’s ego, after showing off their sexuality, children
R4: to be a man, is having the ability, the ability to have children from your own loins, that is very important, than having all the monies, driving cars and having many women, when all is done...have something to show off your life...children...[Chisale, FGD key informant]

R7: a real man is tonde wa tonde (best, he-goat) the best man among men, the one who is able ejaculate. [Omwale, IDI village]

Not having children is a matter of serious concern among men in most African society. Men argued that it mattered less to be poor and to have people laughing at your house full of children than have people calling you names like chumba, chumbayira, gojo, anagwa mpapaya²⁹ (a man who is unable to have children). Most studies in southern Africa on the notion of adult males confirm the importance of having children and being married as defining what it means to be a man.

I have my four children...he laughs...I cannot even afford a holiday for my wife, I work Monday to Sunday and I see cars passing by, men with their spouses going to the lake, I am thirty-one years old and I have not gone to Mangochi (tourist resort area) or taken my four children to see the lake...I have failed, my duty as a man as a provider...I have failed... [Jona, IDI village]

However, I noticed some differentials among masculine identities. Some respondents argued that things have changed. Some men argued that, before you take someone else’s child to be your wife, “a man needs to be a real man by themselves” (Sam, IDI Blantyre). As men go about working and overworking themselves, it is because they feel they have not reached the expectation of being a “real” man. Other argued that they would never reach this expectation as they are poor, fallible; they cannot afford to go on a holiday or share their money with their wife; for her shopping as life is hard.

Male sexual drive discourse

To some men, biology is important and plays a crucial role in expressing their feelings and that is significant not only for their sexuality, but also for a masculine identity. In some circles, some men believe there are various hypotheses to understand men’s uncontrollable sexual behaviour. Some men believe they do not have a choice or

²⁹ Terms used among Chewa, Lomwe to indirectly refer to someone who cannot have children
control over their sexuality, making it impossible for them to have just one woman to satisfy their needs. They say, they have one big vein that connects their penis to the brain and it is the vein that makes a man’s life sexually uncomfortable.

A real man is the one who... when they sit closer to a woman, all his being, his thoughts think of sleeping with that woman...that is a real man [Adamson Machine, free listing Blantyre]

A real man, is one who has children from his loins and they are others who say amuna mbale or amuna akadya (man’s identity equalled to his eating habits) and those men are respected because of such, however for me, a real man is the one who can get aroused by looking at a woman’s body. [Driver, informal conversation, Blantyre]

The difference between a woman and a man is that a man has a penis and when he is aroused you can tell, and there are the ones who initiate sexual intercourse but with a woman you can’t tell, they are on the receiving end... [John, informal discussion, village]

Most men argued that, they see beautiful women and appreciate their body or thighs and at that opportune moment they feel strong under their waistbands; most men accept this as part of their identity as men. They mention, they need to feel the “electricity” under their waistbands once in a while to confirm their masculinity; however most of them say that, they do not act upon it.

Other men, do not only want to feel and appreciate with their eyes; they would rather go all the way and have penetrative sex to affirm their masculinity. Most respondents, agreed that a man should ejaculate to confirm what most women look for in a man... “A real man, amakodza, azikhodza” (A man, a “real” man should ejaculate) (aunt Mercy, IDI village). Thus, some men wait to get home to their partners, while others look for casual partners to satisfy the feeling and the moment they are done, life goes on. I found out that adult men believe in taking a bath right after sex with an unusual partner. Jacob, one of the key informants during an informal discussion informed me that during his “crazy days with women”, he would go for a bath immediately after ejaculating whenever he suspected that the woman might not have been clean. I asked him if he had ever been afraid of getting a disease. He confessed that he never realised he was going to get any disease until after the sex act was done.
To be a man: circumcision or no circumcision

One of my assumptions before fieldwork was that I was going to find queues of men seeking MC at hospitals or in the ngalibas (traditional circumciser) homes, because these were adult men and not young boys seeking to confirm something lacking in their manhood. When I asked some men in the village about MMC, they did not understand and told me they had not heard about it. That is why these men responded that there were too old to go to simba (traditional ceremony to get initiated) and get circumcised. I also noted the same negativity for seeking the practice at the hospital as most adult men felt it was too far to travel and miss time off work, and again the timing was bad. Men from 28-42 years old asked me... “why now?, are you not too late?

I could not respond, as I waited to get a response from them. I presented another controversial question, asking if they felt less than a man for not being circumcised. At first, most men did not answer but retorted that they had fathered children and that was enough for them to be identified as any adult man and to be given due respect. However, they were a few men who felt, the pressure to be circumcised and to please their women; however most of them argued that they sought MC for the sake of hygiene and sexual pleasure.

I also noted how men referred to themselves as the osavinidwa (term for the uninitiated, it is derogatory) and they said it without much care or emphasis. I thought maybe it was an issue of performance, something I had asked in male group discussions. However, in the individual male discussions, gossiping moments, the men accepted their identity as uninitiated and I realised that, these men were responding calmly because of my gender. Men made use of referential strategies; I do not circumcise because I am neither Chawa, Yao, nor a Muslim discourses. I realised their response would be biased as they would not want me to know that, their manhood had been challenged by their uncircumcised status.

Aunt, I can be surrounded by circumcised men and they can call me names, wosavinidwa-the uninitiated...mmm, I don’t mind, don’t I have my children?

[Phiri, IDI village]

There are differences in the types of men...my sister... some of us are not Lomwe Chawa and Yao, we do not do what they do, it’s not part of my culture [Ophiri IDI village]
To circumcise is part of being...them... the Yao and Lomwe and our friends from the Muslim faith, they do that, not me [Chisale, FGD, Key informants]

I hear they call be-little us by calling us unclean men, how come we do not stink, we are able to wash our genitals the same way every man does...he laughs...

[Max, Informal chat, village]

In addition, I found that some men noted terms such as “wajando, wovinidwa, kuwumbala” referring to the circumcised. For the uncircumcised, there were terms, such as osavinidwa, wodyera kunkongo, however most men interviewed did do not identify with the second group of terms that degrade them for being uncircumcised. I also learnt that the terms were used mostly by circumcising communities as a referential strategy. The idea of being considered uninitiated, unclean and wodyera kunkongo (the one who eats with his back a demeaning term for uncircumcised) could be used playfully and sometimes for cursing among male friends, beyond this it becomes unpalatable and offensive.

The relationship between MMC and masculinity

I also noted, based on the respondent responses, that that there is no link between MMC and masculinity. Most adult men were not bothered by the lack of MC status because they argued that the procedure never interfered with their fertility and sexual pleasure. Most couples had an average of two children and the women echoed the same unconcerned tone over MMC. The men who spoke of seeking MMC for sexual pleasure mentioned that they could not tell anyone about their decision; they did it for their women rather than social desirability.

In an all male group discussion, respondents stated that it was difficult to seek MMC because it would not enhance any part of their body as they were too old to and some feared pain to go through the procedure. The average age among the men in this group discussion was 34.

R2: yes, it’s true, how do you differentiate when you have had three children with the same woman, MMC for what, it cannot help me? [Aphiri, FGD on the welding shade]
R3: the idea of MMC for adult man like me...NO! I am respected men and that procedure will just cause me pain for no apparent reason, I can’t discuss that, I am a grown up man...(laughs) [Omoyo, FGD on the welding shade]

my sister, the sex is done at the same place, with the same genitals, by the same people, it’s a lie when they say, MMC enhances sex, it’s the same man doing it, and sex is in the head, not in the genitals. [Bemba, IDI village]

R8: are we going to die when we have reached adulthood? it is the uptake of such new procedure when a man is already grown that leads them to their death [Jona, informal conversation, Blantyre]

Most of the adult men at both the urban and village level were asked if they felt less of a man without circumcision, and most of them retorted a strong no. However, they argued that the practice was not part of them, drawing on the imaginary boundaries that are becoming more exposed in the social and political arena. They mentioned that they felt at peace, as MC was not part of their culture and they were not married to Yao women; who never let go of their husbands, women who were able to coax and insisted their husband get circumcised. Non-Yao women also agree that it is easier for their Yao sisters to encourage a man to seek MC. Most men declare that the Yao women are indeed gifted with the power of persuasion.

The Malawian male and notions of STIs and HIV/AIDS

I asked men through free listing to name some sexual and reproductive health problems, in vernacular or English, and to rank them according to their severity. The rankings were also discussed during the young adult and women only FGDs. I noted that out of the 15 sheets of paper given out, only 13 were returned and only two people identified HIV as a severe health problem for men. At the village level, I did not give out the papers as I was informed by my male research assistant that most men in the village would not feel comfortable writing down their ideas. I tried three times to give out the free listing sheets, however, each time the men would say that their eyes do not see well; hence I discussed the terms in group or individual discussions at village level for validation.
The men argued that HIV was not listed on the free listing sheets as one of the severest sexual health problems because of it’s symptomless and it takes a longer time to show any signs. In Malawi, the virus is said to have an 8-10 years incubation period (Ministry of Health 2009a). I noted, as I listened to the HIV discourse, and validated some of the MMC and sexual health terms during group discussions, I found that most people did not view HIV as a risk and deadly anymore. Most respondents have come to accept that the virus has stayed and it can be treated with life-prolonging drugs, the ARV’s. Most people view the drugs as treatment that they are cured and they are thanking the government, as not as many people are dying in the village.

There is HIV out there, ...but now it is being reduced as more people are taking ARV, people are now going for testing and (coughs) when they have been told they are positive, ...they are easily accepting and disclosing to their families because they know they are getting ARV... [Nambewe, FGD key informant]

...nowadays there is nothing to be afraid of, HIV has become like malaria, when you get it, you get medication, and days have gone when your hair will look permed like ...or have spots and dry skin, those days are gone, (laughs) we all look the same, what is the point we are going to get infected... [Omwale, IDI village]

MSF\textsuperscript{30} has come to our rescue, whether you have the virus or you do not have the virus, there is no difference aunt...everything is coming from China\textsuperscript{31} [Ophiri, IDI, Health worker]

Contrary to the findings about strong stigma and depressing numbers of deaths due to HIV/AIDS by Gounder (2006) during my study more people are going for testing and accepting their status and seeking for ARV’s in this era. However, what is worrisome is the notion that adult Malawians who are sero-positive are the ones driving the epidemic, however in a study done by Morah (2007) the researcher found this perception to be invalid.

\textsuperscript{30} Medecins Sans Frontieres NGO providing various HIV/AIDS programmes in the country
\textsuperscript{31} Local saying, to emphasise neither differences, nor variations
However, in private discussions, in their homes with their spouses and alone in my presence during informal chats, most men were ambiguous about the procedure for HIV reduction because of the evidence from the “social autopsies” (Watkins 2004) and what Scott calls “vernacular knowledge” (a way of knowing which is built upon local experiences and perspectives derived from a lived point of view (1998:1). The social autopsies and vernacular knowledge showed a village evaluation of MC in the absence of MMC, hence both female and male respondents argued that circumcised men were getting infected with HIV and dying, just as the uncircumcised men.

*What is the difference, are we all not dying, what is the difference...the circumcised or not, we are getting ARVs* [Bemba, Informal chat]

*Aunt, there is difference between wajando (initiated), all these men are getting infected, what is that going to help us* [Make mwana IDI]

*...worse off, the ones that do the cutting also die, this man who passed away last week, he was one of them...a ngaliba- traditional circumciser...* [Banda, IDI]

In the free listing exercise, in the urban setting, the main listed STI problems included, *chindoko* (syphilis), *mabomu* and *chizonono* (gonorrhoea), *mauka* (vaginal discharge, chancroid with inguinal) in any order and it is imperative that most men are able to name the problem, however men cannot give proper descriptions as they argue that they have never suffered from them. Further, I noted how men discussed how they delay going to the clinic because they do not accept they have an STI. Some argued, they waited to get traditional help and the problem would just dry up. However, a few men cautioned their friends on using traditional medicine as they were bound to suffer from infertility problems.

Despite STI’s accounting for a significant burden on the Malawian male, I was surprised to hear problems associated with impotency as causing severe strain among men. This was not the first time that issues of impotence had come up. Men had laughed at me, during our gossip moments at the welding shade when a Peter –(passer-by) had delivered a message to say the *gondolosi* (*Mondia whitei*- an aphrodisiac that increases libido, erection) could not be found and when I inquired what it was, most men hushed the issue and we all continued sipping our drinks on a Wednesday afternoon. Further,
during an in-depth discussion and informal discussions, some men to the idea that all men are seeking gondolosi to please their women. I found out that most working class men are seeking the aphrodisiac for their libido and sexual pleasure. In my study, I noted problems of impotency on the free listings; being raised such as kugwa mupapaya (Chewa/Lomwe for impotency), kudutsidwa ndikalulu mphechepeche (Chewa/Lomwe for impotency), or kutondeka kuwuka, Kuguzguka (Tumbuka for being impotent, failing to get erection). However, I did not go in-depth with the above problems, as they were not part of my study objectives.

**MC for HIV risk reduction: desire does not translate into action!**

The medical discourse about MMC is being sold by medical experts, donors and at the national level, governments are involved in debates to inform their nationals about the benefits of a practice that has existed since time immemorial. Generally, men at the grassroots level had heard very little about MMC and they drew their logical arguments from their social practicalities, autopsies and local knowledge in relation to traditional MC practices predominant among the Yao.

Despite drawing on the barrier of their age, most men drew upon the social autopsies as evidence for neighbours or adversaries who had died of AIDS and had been circumcised. Some of the respondents continuously advised me to visit the clinic on Tuesday and Thursday and see the numbers of people that were on ARV’s, from both circumcising and non-circumcising communities. Thus most people drew on the vernacular knowledge about traditional MC to show their lived experiences and they logically argued that in their community there were no differences as the initiated were dying just like the uninitiated. Most of the men interviewed, remarked that the government and health officials were lying to them and the above evidence was used to substantiate 90% of the couple’s or men’s negative responses to accepting MMC for HIV reduction.

*What can you tell us, just yesterday, yesterday we buried one of the circumcisers, and everyone around here, knows he died of AIDS, what can you tell us that is new. [IDI, health worker]*

*We are all dying, there is no difference, the circumcisers are dying, wajando, wosavinidwa,(the initiated/uninitiated) there is no difference, pukhusi lamoyo*
"uzisungira wekha" [a (non) circumcised men, we are all dying, one needs to guard their own life] [IDI, Sena, village]

However, there is a group of men that is enthusiastic to seek MMC and this is because they have nursed the idea of getting circumcised for a long time and they feel now is the right time to have the operation. I noted how peer pressure or peer gaze played an important role among these men since they were able to refer to the many discussions that they had with their male friends and they would confess that sometimes they were so envious and really wanted to go for MC, however they never get the time or the opportune chance to do it.

...as for me, I thought about it for a long time, since I was at a boys boarding school, I really want to have it done... but, I will do it...he laugh" [Informal interview, banker]

I just heard that this MMC, can be difficult for men who help themselves (keeps quiet)... you know when you don’t have your woman by your side...it helps to masturbate...but, I don’t know they say it’s not as good as with the skin(laughs) [Informal chat, business man]

I think about it all the time, and I discussed it with my spouse, and she supported me, I really envy my friend, but I do not know when is the right time” [informal chat, Ngoni man]

They were very few men and couples at the village level who agreed to consider the idea of seeking MC. The female spouses at village level would confess, in the absence of their husband, that most of the adult talk on MC was "was just talk, talk, talk, without action, as months had passed since they presented the case to them". However, men in the urban centres, due to their exposure to media debates and workshops showed their eagerness to become circumcised. However, they were not forthcoming in implementing their decisions. The urban-based men also reported having spoken with their spouse (some men talked of harbouring the idea of circumcising since 2003, others between 2005-2007 and most responses in the 2009-2011 period) and had received a positive response to seek the service at their convenient time and were promised total support.
The notion of a “new man” and the Malawian male

I reflect on the notion of the “new man” to capture the idea that some men do not just discuss about seeking MMC; rather they have implemented their decision to undergo the procedure for various reasons as presented below.

Under masculinities, the notion of the “new man” is a relatively recent phenomenon that posits for a novel generation of men who are more responsible, progressive and in favour of gender equality as juxtaposed with men holding hegemonic identities (Morrell 2002; Becker 2005; Spronk 2005). The dominant AIDS discourses in most studies focus on the negative image of the “African man” as domineering, with multiple sexual partners; however the notion of the “new man” provides room for negotiations or individual differences (Spronk 2005; Backer et al. 2005).

The equation put forward is “the more new age guys, equals the less HIV/AIDS” (Lindegger and Maxwell 2005; Kimmel et al. 2005; Ouzgane and Morrell 2005). I reflect on the notion of the “new man” in order to offer an alternative reading of masculinities, their experiences, agency, and subjectivities in relation to MMC.

Chiye

I presented Chiye to capture the notion of the “new man” among Malawian males as being vulnerable and seeking health care services. Chiye tries to offer an alternative reading of the man he is; as well as the putting to the fore challenges men face with such constructions in the HIV era.

At the hospital

The reception area was full of people, men and women with babies on their back, some on their laps. Everyone was seated and I took the vacant space on the bench to wait for my turn to see the doctor. I was not sick, but I had come to meet participants for my study. I was not so sure how to wait for them. If I went into the nurse’s offices, I was afraid they would view me as part of the staff, but again, as a researcher I wanted to observe men’s behaviour at a hospital.

I looked around the room with greater interest, taking in as much as I could. To my right, there was a calendar and another framed piece that stated the core values of the hospital. I kept on moving with the queue and the observations continued. On the wall right in front of me there were price posters for condoms, pills and a message that stated
that you needed to have a receipt after every transaction. There were various rooms and offices: the nurse manager’s room, a kitchen where somebody was preparing eggs, a consultancy, procedure room close to the doctor’s office, which was also labelled the same, and resting rooms which were furthest from the reception. When I looked behind me, I saw a list of family planning methods neatly displayed with descriptions. I did not take more time looking as I was jostled to fill the vacant chair and when I looked at my watch, an hour and fifteen minutes had passed.

I began to think that maybe the men would not turn-up. Some men would enter the hospital and leave after seeing the long queue and, in my mind, I felt I had lost my participants because of the long queues. I counted the men who were waiting for their turn to see the doctor—seven. On the previous day, I had seen queues of men sitting at the clinic and hospitals for ARV’s. Many men were taking their wives and babies for ante-natal visits and I learnt such couples are served first to encourage the man to be interested in their baby’s health. Men at church were taking turns to take their baby outside for recess during church services. I tried to understand, to make sense of these changes in the Malawian male.

I had not met the doctor since I walked in at the hospital. I did not want to disturb him, but again I was not sure the men would turn up for their seven-day review. The doctor had explained that some men healed faster after the MMC procedure, thus, they would not turn up for their reviews. In the middle of my thoughts, I heard my name being called and I was told to step into the corridor. I was taken to one of the resting rooms, where the doctor informed me that I was allowed to work for the day and that one of my research participants had arrived. I was asked to seek consent from the potential participant myself. The doctor spoke to a man who had been following us to take a seat on one of those big consultation chairs and to recline and left us to our discussion.

I presented myself as a Malawian research student who was interested in finding men’s motivation for being found in that hospital that day and what were some of the problems they faced being man in their society. Chiye did not hesitate to tell me that he did not have the time, however, I asked for the possibility of speaking for a few minutes and then meeting later at a place of his choice to follow up on our discussion. He agreed to give me thirty minutes that turned to fifty as we were so caught up in our discussion and had not followed the time. We met again the following day during lunch hour to discuss part of his life.
At the restaurant

The following day we met at the restaurant, I arrived early to find or to choose the best place to sit in case the restaurant got busy so I could still have time to talk with minimal noise and activities. I bought myself a coke and let my thoughts wonder. I realised, I had been everywhere where most men are likely to be found, in their homes, at their places of work, at the beer houses, braai shades and today at a restaurant. The restaurant was a drive-in with a huge fenced yard covered with straw mats, African style. The tables were simple, made of pine and covered with clean plastic table cloths. A menu card, with a candle cup, I was told were to keep away the flies and for decoration. There was a wooden holder with salt and pepper, vinegar and sauce.

At exactly 1230, I heard a "hie" and a man in a dazzling suit sat opposite me. He thought I would never come as it was rare for people in Malawi to do research over lunch. I reminded him of business meetings and he declared that those were paid for by the company. I declined his offer to buy me a meal, then I accepted another drink and I gave him a chance to share his story.

He began with a local proverb, *okaona Nyanja anakaona ndi mvuu yomwe* (explicating complementary benefits). He mentioned that he went for MMC, not because of the many theories that he heard during the counselling sessions about the cancers. He confessed that the clinicians were very thorough in their MMC counselling and if a man refused to listen, they were going to get infected. Chiye refused to acknowledge that the recent polemics on MMC encouraged him to go for the procedure, rather he argued that it was his peers who should be honoured for playing the role of talking about the practice during their drinking sprees.

Chiye stated that MMC is not a woman’s “thing”, a woman does not matter at all. He argued that men go on their own to get cut and they ask their friends to pick them up and leave them at their home. The woman is only informed of the decision that was made in her absence later when it is time to sleep. He argued it was peer pressure, when he heard his friends saying they are taking time to ejaculate and that their women are being more appreciative and thanking them a thousand times. Such confessions make a man go crazy, when he is alone he feels less of a man if his wife is not being expressive after sleeping together.
Chiye learnt about the MMC benefits of better sex in 2003. He declared that he did not want to lie to me, but that a man has many a woman before they settle down and he was one of those men. He had been enjoying his senior bachelorhood and enjoying some of the beautiful ladies in the city. However, Chiye became a bit serious and informed me the main reason it took him so long to make a decision to seek MC after knowing of its benefits was his fear of dying. His father had died of diabetes and he felt he had the disease too. He mentioned that when one has sugar problems it is hard for wounds to heal and for the blood to clot and he feared he would put his life in danger.

However, after going for counselling and having his blood sugar levels checked, he weighed the benefits of being circumcised and that is how I found him at the clinic on the Monday morning. Moreover, I noted how Chiye seemed not to have respect for his wife and I asked him to talk about it. I was just curious as I felt that he would have told me about diabetes the day we met at the hospital. I thought there was more that he was not saying and I just became curious and I probed more. He looked me in the eye and informed me, a woman should be loved but should not be trusted with one’s life. I asked him to elaborate.

He cleared his throat, and said women are no different, whether fat or thin, the English type or the African, all of them were the same and they could kill too. It had taken him a long time to trust his wife, because some of the ladies he had dated had cheated on him and he felt luck was on his side because he was HIV negative as he does not remember using protection more than half of the time. He had lived a crazy life, mixing beer, women and a bit of chamba-marijuana. He mentioned that maybe what saved him was keeping away from hard-core prostitutes and going after college girls. However, he argued that he is a changed man, because after seeing how wasted one of their friends became after being diagnosed with HIV, it became a big lesson to him. Before I bid him farewell we had discussed issues to do with homosexuality and how he cheated on his wife. However he refused to allow me include the discussions about those parts, as he argued they made him feel ashamed and less of a “real’ man!

Chapter Conclusion

I have worked to present an understanding of masculinities in Malawi to give a solid background to my discussion of men as men. I have shown their vulnerabilities and complexities as men, breadwinners, initiators of sex, fathers, seeking MMC or not.
Informed by social autopsy, vernacular/local knowledge and medical discourses on MMC, there are divided aspirations among men. There is no strong correlation between male circumcision and masculinity and many uncircumcised men are not pressured to seek MMC neither for HIV prevention nor for social desirability.

However, the peer and spousal gaze causes some men to be envious of their peer’s penis, and the desire to please their women is forcing some men to consider seeking MMC, hence, those married to spouses from circumcising societies undergo the procedure at traditional circumcisers, in order to please their woman.

What is of great concern is what accounts for the desire or acceptance by most men to be circumcised, coupled with the unspecified time for implementation. If and when MMC will be applied is as imperative as providing sexual pleasure or preventing new HIV infections among couples.
CHAPTER SIX
The role of the Spouse/Partner in Seeking MMC OR NOT

Malawian couple in their home

My interactions with men at their work-places brought smiles on people’s faces as I bought vegetables and relish for my home, tried to buy a carrier bag from one stall, onions, cabbages from another, stopped by to greet someone, or sometimes just walking by and raised my hand to wave. Men would invite me to their homes to meet their spouse and eat the afternoon meal. I declined out of politeness and I knew I was not prepared to eat at each of the homes of the seven couples I had chosen to work with. It would have been viewed as showing ingratitude if I’d eaten at one house but refused to do so at another. However, I could not run away from the Malawian hospitality of offering field produce during harvest time as families have plenty and guests feel honoured to accept. I could not carry bulky carrier bags with pigeon peas, peas, green mealies, or groundnuts in the end I accepted and shared with my research assistants.

I was inspired to talk to couples\textsuperscript{32} in relation to MC because, the marriage social institution has been mentioned as influential in most family planning (Chimbiri 2007, Pouline 2006) intervention programmes. My other assumption was that couples who are married or just living together need their spouses to negotiate their sexual health complexities and make health decisions. I wanted to learn and describe a man’s sexual partner’s perspective in their search for MC from a predominantly matrilineal society where power symbolically lies with women. Some studies in Malawi describing couples’ sexual, reproductive health preferences and behaviours are biased towards women’s weak and passive roles and their low status (Clark et al. 2009; Kaler 2004; Kishindo 1995).

During our interactions in their homes, most men referred to their wife as “mother”, “Nangozo” (principal surname for females among chewa), make \textit{mwana}\textsuperscript{33} (mother of a baby) as a sign of respect, love and appreciation for being there for him. On the other hand, women viewed their husband as their parent or guardian and would refer to them as “father, father of the baby” as some of them had come from poor, orphaned homes and they felt their husband was at first their provider, the parent that

\textsuperscript{32} Include cohabitation, marriage, casual partners, married in the church, traditional, Muslim as long as there were not circumcised

\textsuperscript{33} Mother of so and so...insert child’s name
they never had and then a spouse. I found out that the several ways that couples relate to one another is important and it might indirectly inform their openness with each other as well as during the interviews. In my presence in their homes, I never witnessed spouses referring to each other on a first name basis. However, during recreational drinking times, married men, bar waitresses and senior bachelors referred to each other by their first names. I soon realised that the informal interviews during my pop-ins at couples’ homes, provided richer information than the scheduled, serious sit downs with a recorder at hand interviews.

I found out that there is lack of communication between couples and men were not happy with the way their spouses related to them. Three of the seven couples confessed to each other in my presence that they no longer had enough time to spare to have quality time as their husbands were travelling for fish business at the lake. Men at the grocery shop and street braai as well group discussions echoed the same. They felt their women stopped being free and open with them, the moment they got married. Men sought the courtship days when they could cuddle and play with their girlfriends. The men felt their spouses were not expressive or flexible enough to let them enjoy the fruits of their marriage such as bathing, or being naked together. On the other hand, the women complained (individual interviews and group discussions) that their spouses were secretive, since they have learnt that men watch blue movies and preferred seeking prostitutes to express their sexual needs. Married women expressed being at a loss because when they try to please their men, by wearing beads or trying out new styles in bed, it led to accusations that they had become prostitutes.

I don’t know how to explain, but when John’s father comes home, it’s hard to be free with him. Sometimes I am so tired and I just want to sleep, but he always want us to sleep together everyday...aaagh, these men they always want to have everyday and everyday [John’s mother IDI alone]

Aunt where else can we go, whether it’s today or tomorrow, my husband does not say what he wants in bed and when you ask them, he says nothing, he just mumbles and when he is done, he sleeps, what else can I do? [Aunt Jane IDI alone]
R3: there is a lot of pretence, how can a man watch a Nigerian or ...whatever blue movie you call it (laughter) and come and lie to me that they watched a blue movie, how do I know, maybe he passed by the resthouse and had those prostitute help him....yees, its hard to take...I don’t know about ...you, I cannot take it...[FGD, women only]

Aunt, technology has helped us, there are blue-movies, you know...there is kissing, different positions, I want to try with my wife, but if I try she will say where did I learn it from...so I try with the new woman or the prostitute...I don’t fear my wife, but it’s difficult to convince her on some of these new things ...[Mada IDI village]

Further, I noted how men have relaxed their grip on their women as they let their wives visit the health facility by themselves and allowed them to relay health messages. Most men were repulsed by the long queues at the health facility and that is why they do not attend; however what is most important to note, is that they allow their spouses to attend. A man discussing MC said,

It’s good news to hear my wife talking about it and it is good she has learnt it from those many health talks that take place at the facility, but where has she tasted the one that is cut...me...as a ngoni man...have slept around in my teenage hood, but for my wife to bring such news...where has she tasted it...my wife has no say on that matter, such matters should come from me as the leader of the house [Ombewe, IDI village]

Differentials and contradictions among couples

The wabesa [the idea of having one’s man snatched away] phenomenon

There is a famous bar in the village for my fieldwork, where five married men visited after work for recreational purposes. Most women in the village perceived this bar as a threat, since they feared that the beautiful prostitutes would overpower their men. The seven married women constantly reminded me, that they spend their days at home taking care of their children, while their spouses were working hard to bring money home. These women knew that the moment their husband left their home they were at the mercy of many women whom they met. However, five married women believed, their husband would not go for other women as he would remember the love and the
attention he received at home. I noted how women complained of frequent accusations from their husband. Despite the accusations, six married women believed that men became angrier if you responded to their accusation as “culturally” they say *mamuna ndi mwana* (a man is like a child) thus has to be treated like one. Women believed that ill-treating their spouses provoked them to leave, thus they blamed themselves if their husband left. “When a man leaves you for other women...*wabesa*... it’s your own fault...*wabesa*!” Thus all the married women informed me that they tried to dress well, be flexible in the bedroom and be presentable at all times.

Four of the married men drew on the religious discourses to explain their sexual weaknesses. They believed it was the devil that caused them to cheat on their wife; however, as grown men they have tried to stop and wait for their spouses to take care of them. The men argued that they have directed most of their energy to finding money and taking care of their families, rather than spend it on prostitutes and getting diseases because the world is no longer the same. On the other hand, some women have realised the dangers of STI’s. They confessed that when they sense foul play from their husband, they resorted to showing a united front as a couple in the daylight but in the evening they would sleep in different bedroom and argued that they did not want to die early and leave their children without a mother. Others mentioned that, when they saw or felt any changes in their man’s private parts, they moved out of their bedrooms and slept in the living room (feigning illness if they were staying with their in-laws) until their man got better. However, the couple’s sex life is never the same.

*How can you feel that you are living with a man and they live a lie,... aunt, listen... you sleep with your husband only and have never cheated on him, then you see strange things on him, I go crazy, I do not know about you, but sex has to stop, I will die and what of my children...* [Nyakumwenda, IDI village]

*I stopped sharing the bed with my wife, she sleeps in her own room, not because I want her to, but what can I do, she has caught me twice with an STI, I am sorry, but I do not know what happens, I always bring it upon myself...the devil, my sister sometimes the devil takes over my life, but I am sorry for my wife...* [Temwa, IDI, village]
There was a heated debate among couples during group discussions with key informants from various churches: Pentecostal, Seventh Day, Presbyterians, leaders of Muslim community, village headmen and senior health workers. The participants discussed the possibility of differences between women and men because many spouses who had been caught in extra marital affairs argued that it was difficult to leave their extra-marital-affair partner because they proved to be sexier and more pleasurable than their wives. Many men confessed to having slept with various women before their marriage and they were able to differentiate the pleasures of each woman. Hence, when their marital wives failed to sexually satisfy them, they were forced to seek other women or prostitutes.

I noted that women retorted that there were no differences in women’s genitals, but it was the techniques that their spouses used that would make sex pleasurable or not. Women mentioned that the reason why some prostitutes were sexually insatiable is because they used traditional medicine. The women said that in most cases married women do not partake in traditional medicine since they are married and do not need to attract a variety of men for money. However the men maintained the idea of differences among women, stating that when women go on contraception, they become very wet in their private parts and sex was no longer pleasurable.

**R1:** there are great differences between women, for some women you can go on the whole night and keep on repeating, you feel too much sexual pleasure and you want to go on...there is a difference...

**R2:** yes, there is a difference, with some you just do it once and you are tired and you sleep...laughter...

**R6:** let me give you an example of a teacher who visited my home and complained how his wife’s private parts were never dry and how it was putting him off sex, and how he was pondering to go for prostitutes but because of HIV, he was scared...you see that is why some men cheat on their wives. [FGD, Key informants]

The discussion on the differences among sexes and sexual pleasure could not be contained as both sexes felt that was the main reason for the sexual and reproductive health problems in Malawi. Men felt their women needed to learn techniques from others and improve their sexual techniques and women retorted that men had to accept that
women’s bodies are the same, but the men too, had to improve their sexual technique. In addition, the discussion on sexual pleasure became more heated when I linked sexuality to circumcision, as I will narrate below.

**The Malawian woman and male circumcision**

Most studies on MC in Malawi (Mfutso-Bengo et al, 2010) have concentrated on adolescents and less than five have focused on women (Ngalande et al, 2004; 2006; Pouline et al. 2006; Zanera and Mitheka 2004; Limwame and Kumwenda 2008), however they are biased towards surveys and focus groups. The studies are upfront in revealing the perceptions, benefits and demerits of MC, however not much ground is given to show the nuances and complexities that women go through for MC decision making. In this study, I give women a chance to share their ideas, fears and experiences with MC in the comfort of their homes and in the presence of their husbands.

I noted how women let down their guard and opened up to voice one of their main concerns, whilst looking into their husband’s face. I saw how men looked away or down and thought about the right response. Instead of responding to me, the couple would start their own conversation about MC, referring mostly to examples of traditional MC. Further, most women who had not heard about MC for HIV prevention, asked their husband about the necessity of the practice for an older man. I realised how carefully most men choose the right words to respond to the need for MC. Most of them responded, curtly, the time was not right. They argued that it was too late for advocating for them to have MC now.

*You health people, you are late, how can an old man like me be seen with a cut penis, for what...I have travelled from Zimbabwe, South-Africa and Botswana with my foreskin, and I never got sick, being faithful is very important...[42 year old man, village]*

*Now, now, how can an adult men like me be seen with wrapper around my waist and miss going to the market for six weeks...what for, my wife...laughs, I cannot do that...[Chisoni, IDI, village]*

I found out other men never asked for their wife’s opinion on MMC. They argued that the operation was going to take place on their body, thus it was not a woman’s issue. I tried to bring out the idea that since they were married, they were now one body;
however, most men downplayed the idea arguing that the MMC pain was theirs alone and on their own body and no one else was allowed to command or negotiate with the body of the head of the family.

*R: the percentage is very low, mmm it cannot happen, a woman cannot contribute to any development in the home, the man is the president of a home; he can dictate, rule over anything in the home, to do this or that, but a woman to make a decision... (hesitant) ...I am not sure, woman cannot tell a husband what to do... (IDI health worker)*

Some men argued that women had their own pain during labour and no one negotiated with that pain. Hence, most women gave up the discussions by acquiescence; a few were able to decline the practice of MC as they felt they had advanced in age and only two women accepted the idea of MC for HIV prevention, but asked their husbands to discuss the issue further in private.

There were great debates in groups of women alone and men alone as well as among key informant group discussions as they considered the question of whether or not a circumcised penis performs better sex or not. Most men were unable to answer the question and argued that they were not in a position to respond to such a question. They stated the best person to answer were the women because they are the ones that can tell the difference. Other men argued that, one if the main reasons adult men silently seek MC was because they heard it enhances a man’s sexual performance. However, a few uncircumcised men were reluctant to accept the idea of better sex after circumcision and argued that they had never had sex problems in their families, thus they could not tell.

On the other hand, I spent some time with ngalibas (traditional circumcisers), who argued that most uncircumcised adult men came to them in the night to discuss circumcision privately. Unfortunately, because of rules, the circumcisers refused to circumcise at night but they would agreed with the men to do it away from their home.

There were two main camps, among women; one that debated there was no difference between a man who is circumcised or not, because they had married one with a foreskin and had no sexual problems. They said that they could not differentiate between the two circumstances as they had only slept with one man and they were satisfied. I noted how these women maintained that to differentiate if sex improved with a circumcised man, it was because a woman was promiscuous and that was why she was able to tell the difference.
R1: how can you tell that a man is better, when you sleep with the same man over and over again...since you got married, you found your man uncircumcised and now you say, the one who is better is the one circumcised...how?

R2: there is no difference, but I think that a woman can differentiate, a circumcised one is more sweeter...laughter from women

R3: (laughter) walawa...walawa...walawa... (She has tasted it...she has tasted it, she has tasted it), what better explanation can we give, she has tasted yosenda (a circumcised penis) that is why she can differentiate...so much laughter...

R2: look here, women, let us not lie to each other, there is no difference, we accept what we have, let those with... whether they say, siyosenda, yosadulidwa, siwajando (terms used to demean the uncircumcised) it belongs to my man and my man is able to satisfy me...retorts angrily...more laughter...[FGD women only]

Most women wajando amakanda pantima (touches the heart)...most women amatisilira (they envy) circumcised men (Chisale, man, key informant)

However, other women, refused to accept the idea of saying sex is the same everywhere. They argued, sex is not the same, as men have different styles that they use to please their woman. Genitalia were just a tool; it was a man’s ideas that made sex enjoyable. At the same time, other women felt uncomfortable expressing their opinions as they thought we were using uncouth language- mwalaula. Other women felt we had to discuss such issues to learn from them because they were few forums where women met to discuss sexual problems. Further, women mentioned that the days had gone when sexual pleasure was only for the man, as it is supposed to be both ways. Women too should reach orgasm, whether with a circumcised penis or not.

Other women mentioned that MC enhances the beauty of a man’s genitalia and it also helped in reducing the incidences when a woman’s hair could cut him causing his genitalia to bleed. However their worst fear was the idea that MMC would give leeway to extra marital affairs, as some men would believe that they had a “natural condom”. The women discussed their logic as follows,
When you say the penis head becomes harder and can be protective, then that is a “passport” for our men to sleep with any woman...[nyamanda, IDI village].

nooooooo, we are all going to die of AIDS, when you say MC will reduce HIV, you will open all the doors for men to go and get circumcised and they will be going around with their penis in their hands...noooo, that means they can place it anywhere [Naphiri, IDI village].

I also noted that it was not only women who feared that MC would encourage sexual licence. Married men expressed their doubts that MC would reduce the risk of HIV, as they believed that some men might understand MC as the new chishango-type of a condom (the national brand of condoms in Malawi) and that might confuse the protection that the real condom provides. Most men agreed that males had problems in accepting health messages and issues with their genitalia proved to be conscientious. The message of MMC could be discussed amongst men, at leisure times and at drinking joints, with much interest; however, they never took it home to discuss with their partners. Generally, married men mentioned that they feared the wrath of their women on MMC; as their wife might link it to their husband becoming promiscuous. For the few men that had presented the idea of MMC to their wife, they were met without much discussion and a positive nod; however, others were met with acquiescence. The majority of those who got approval to seek male circumcision were those with partners who were Yao.

Medical discourse
I refer to the medical discourse to contextualise MMC daily interactions and to further echo the women’s sentiments on the practice. The medical reports presented on the benefits of MMC mention its protection against cancer in both men and women. Most of the village women were not conversant about the link between MMC and cervical cancer in women, as well as papilloma virus in both women and men was absent. However, the women knew that MC is for hygiene and can help reduce the problem of mauka (vaginal discharge and discomfort).

34 Predominantly circumcision ethnic group
Circumcision is for hygiene and when a person’s foreskin is removed, it helps. For example, when a man has not bathed for a long time and they sleep with a woman, when you pull back the foreskin...sungu (rash), and madeya (dirt) are there...but for a man who is cut... they do not have them. [FGD women only]

What I do not understand is, how you can say MC helps to prevent HIV when it does not prevent mauka and gonorrhoea, it does not make sense, I thought HIV is more deadly, maybe am illiterate, but it does not make sense [Peter’s mother IDI]

Things are not well in Malawi, I do not know, but mauka, gonorrhoea, syphilis, all that, whether it is a circumcised one or not, HIV kills them both [aunt Jane, informal chat]

Look here, women, when these men do not bath, sometimes men do not take time to pull back the foreskin, they just splash water on their bodies and they are done...the stench, the stench when you are close to them does not bless me. [FGD women]

However, other women argued that it was the role of women to wash their husband’s private parts. I noticed how the oldest women in the group took it upon themselves during group discussions to give sexual tips on how to please a spouse. In relation to the stench and madeya (dirt), the older women, mentioned how women are supposed to keep earthen wear pots or basins under their bed and a clean special towel under the bed to use after sex. The women believed that is why their husbands did not have hygienic and sexual health problems because they could clean them up after each session as a sign of respect and gratitude to their husbands. However, the older women blamed the younger women for forgetting their “culture” of not taking greater care of their husband after sex, arguing that it’s a practice belonging in the past and that was the reason why men were having extra marital affairs.

**Spousal communication and negotiation for MMC**

During group discussions and informal chats, more women mentioned that it was easier for them to broach the subject of MC to a man during courtship rather than in marriage.
Women argued that it was easier to encourage a boyfriend, when you agreed to start sleeping together, and when you notice that he is not circumcised, to advise him to become circumcised. Married women argued that it was easier to negotiate with their then boyfriends *cum* husbands on sexual matters. However in the marriage bed it becomes very difficult to negotiate as most men control the marriage bed without any assistance.

Further, women complained that to broach the subject of MMC, could destabilise their marriages, as their man would start accusing them of being promiscuous and having had intercourse with circumcised men. Most women feared to lose their marriages and confessed that bringing up sexual matters in their households was a taboo.

_Noo, that cannot happen, he will ask you, we have three children with an uncircumcised penis, who has told you its better with a circumcised one...this marriage is over...what will a woman do...some of these health interventions will just pass us by._ [Nurse aid, key informant]

_Marriage is hard to come by, why should I waste my time on small issues like MC, when I know it’s not part of his ethnicity, women why should we give away our men for free, I refuse because I want to keep my man._ [Naphiri, IDI]

In relation to MC, women drew upon ethnic and religious explanations for their fears. Some argued that MC was not part of their husband’s identity and it would be against their principles to encourage their spouses to go against their family’s ideals and “tradition”. Others feared that, when their man went for the operation they might not come back [die], and the woman would not forgive themselves for the rest of their lives.

However, there was a group of women who argued that married men are easy to relate to and the most opportune manner to encourage one’s spouse is in a loving tone and with a meek voice. Some women argued that men do need not to be pursued or encouraged by words. They argued that it is best, that one uses not only a meek voice, but rather “actions can be louder than words” and women were advised to use their bodies more when negotiating with their spouses. The older women argued that they never demanded much, but they continued to appeal to their spouses because they spoke more with bodily actions.
The younger generation of women, believed life has changed and in the HIV era spouses need to speak to each other and let each other know of the dangers of HIV infections. These women agreed that if MC results showed that MC could prevent HIV, they could encourage their husband to go for MC. However, they had seen with their own eyes that there is no difference—wojandulidwa, wosajandulidwa (terms used to poke fun on those who are not circumcised). Circumcised or not, all men get infected with mauka, gonorrhoea, syphilis and HIV, as they meet these men queuing at the hospital to get their ante-retrovirals- ARV’s.

**The role of the wife/partner and MC**

I never got a chance to meet with the spouses of some of the participants that had MMC. Due to time constraints and late access to these men, I was able to meet them only twice before during the last week of my field study.

However, through inference, from my discussions with men who had attended their seven-day review at a private hospital in Blantyre, I noted that most women played a supportive role, a confidante or an alibi for the men who sought MMC. Men confessed that it was difficult to stay at home after undergoing the procedure and to keep it a secret from your family, especially when staying with extended family. The first few days right after the operation, most men depended on their wife to keep their children and in-laws away by feigning illness on the part of the head of the family. However, as the days passed and the pain and bleeding did not recede it became more difficult as most people wanted to know the seriousness of the illness.

In addition, I noted how before the end of the week after circumcision, most of the men would ask their wife or partner not to come in their presence as they got aroused, leading to excessive pain and a tear; thus some men complained of excessive pain and a bit of swelling. A 26-year-old man asked his girlfriend to stop visiting him and taking care of his pain because she was helping to fuel the pain.

*Aunt, when my babe, comes home, I try to be at my best behaviour, but alas these things to do with nature, I always find myself in trouble, I want her, but it hurts.*

[John, circumcised man]
Look here, it’s hard to sleep in the same bed with your wife and pretend you are not a man, are you crazy, it is difficult to do these things as an adult, dame the pain. [Thom, circumcised man]

I learnt through their husband that most of these women made themselves scarce during their husband’s recuperation period. However, they were able to keep their husband’s “MMC secret”, especially from the immediate family for their privacy and peace of mind, as the men usually demanded and were happy that their demands were met.

**Aunt Mercy: a married woman voice can be heard**

I share this piece to further contextualise and show that the veil of silence over sexual health complexities for women is slowly lifting and that there is hope for more voices to be heard, when we give them a chance. I found her under a mango tree on a straw mat talking to a group of boys who were helping her to eat sugar-cane. I was used to seeing her with her husband, taking a stroll or accompanying each other to the market to buy groceries. During one of their strolling days, I met Aunt Mercy in the market, as she was buying onions, and spoke about my research study. She was interested and asked me to visit her. I took up the invitation and informed her that I would visit on Wednesday afternoon and that is how I found myself at her home. Sitting close to her, that day, I realised, she is a beautiful woman, light complexion, 28 years old, quiet and a bit shy.

I greeted her and at the same time she told the group of boys to go away. I asked after her husband health and she smiled and told me he was well and sleeping in the house. I asked her to narrate what marriage is all about in a Malawian society and she smiled and called to her children to go and play at the neighbours as they were too near; they might eavesdrop on adult women stories and she laughed.

*Marriage is what life is all about, and it is between a woman and a man who have really come to an understanding that they cannot live apart and they need to live together and share their dreams. However, they are times when a man is very poor and cannot afford to cater to the needs of the woman, like providing basic necessities, that is when most marriages break, because as a woman, we enter into marriage expecting to get our basic needs met. Sometimes the man tries to get a little something, that is fair and fine, but it hurts to find out that there are*
some men out there who cannot afford to take care of their wife. However, times have changed and a woman can work to provide for their family, thus both men and women are able to bring something home for the good of their family.

Married life is more respected when the gifts of children are seen running around the house as you see my three boys...it brings much joy to have them, as they are in a way a seal of our love with my husband. We cherish them a lot, but I do not want to paint a picture as though all is rosy in marriages. A good marriage is difficult to have because one has to work for it. Some couples cannot have children when they plan to and the blame is usually on the wife. However, when you look around it is the men who have problems as some of them cannot ejaculate and some I hear have problems with their testicles, that one is smaller than the other, thus they are not able to manufacture enough sperm, a challenge that most men face. Sometimes you hear of women seeking the traditional healer to receive medication to prepare their wombs and for the other medicine to be hard with their man to increase his potency and chances of fertility, however it is not the same. Couples do it out there, for the sake of their family.

However, there are other times, when our spouses are involved in extra marital affairs, I am not saying my husband, but I am speaking of men out there who are insatiable, men who do not want to miss a beautiful woman. It is well when these men marry for their religion, two or three wives, but others continue to sleep with casual partners outside their marriages, which makes it very difficult for women to enjoy their marriage as there are more fights and mistrusts in such unions.

On the other hand, women, too are forcing their men go out to other women. Sometimes, we do not bath frequently, some women have elongated labia’s and wear beads and they perform better in bed, hence our man leave us for those women. On the other hand, men too, have their own weaknesses, the more money they have, the more problems they give to their spouses. Most men with money in their pockets believe they can get any woman they want, thus amanyenga moonjeza (they become promiscuous). However, there are other men,

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35 Custom of elongating labia, predominant in the north, beads for decoration and sexual appeal on a woman’s body
despite having a lot of money, they still love their wife and do not go for casual sex.

Both men and women need each other to enhance their manhood and womanhood in the presence of their children. A man may go out and spend some of his leisure time with friends at a drinking joint but he remembers that his woman is his greatest friend whom he shares his secrets and weaknesses with. When a man has an STI, a woman is there to remind him to go to the clinic and get his twelve injections and not to stand on top of the roof and let the whole world about your husband’s mischief that will not get you anywhere. However when he brings the STI, the second time and the third, just know that he will not keep you alive, that is why this is my second marriage...Life is precious, a man should not steal the life away because of other women...With HIV it is better to be safe than sorry.

During her narration, the woman’s husband woke up and came to look for her. She introduced me as a researcher friend of hers and the husband nodded but informed her that he wanted his tea, as it was getting late. He went back into the house. Aunt Mercy asked if I had any burning issue that I needed her to talk about as she needed to attend to her husband. I asked her to talk about MMC and HIV prevention. She responded that she did not know what that was. I explained to her that they were studies about MMC that suggested it could reduce the risk of HIV; she just laughed and continued to say,

Some of the men hear about MC when they re-settle in areas where they practice MC. That is the place they start to learn of some of these strange practices. If God created a man with foreskin why should it be cut... however, the problem is here, where most people circumcise, it is difficult to present that idea...I have known two circumcisers who have died in this area and they died of AIDS. A man is a man, you cannot force him to circumcise if he does not want; he has his rights and ethnicity. However, if condoms failed and we are seeing it with our own eyes in this village that MC has failed; my evidence is; go to the ARV clinic and see for yourself who queues to get medication.

I am a free woman; I do not envy men who are circumcised. I do not feel the pressure to have my man circumcised to prevent HIV. I am afraid for other
women, whose circumcised men continue to sleep around, I am afraid, that one too shall become a statistic...with those words...

I then heard from the house “Naphiri, can you get into the house please”? We smiled at each other and waved me goodbye. I was left alone, I packed my recorder, notebook and left the house with no escort.

Chapter Conclusion

In this chapter, I have discussed how women play an important role in a marriage or sexual relationship and especially on issues to do with MMC as an alibi. Despite most women being less conversant on medical issues concerning MMC, their knowledge of traditional discourses seems to be adequate for them to make logical arguments. On the other hand, contrary to the messages that most women are passive about STI and HIV prevention, they are able negotiate their way to prevent re-infections by sleeping in separate rooms and seeking health care.

However, of great concern is that the marital bed is not a levelled field in terms of sexual expression as both men and women counterattack each other on issues of sexual performance. To some MMC is not an issue, but sexual tactics are. The impact of blue movies is yet to be discussed in couple’s homes. Men too, are still secretive about their exposure to STI’s at a time and that will lead to an increase in infections. Spousal refusal to grant the decision for MMC may arise due to issues of sexual licence.

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Respectful way of addressing one’s wife in the presence of visitors, also a principal surname for females among chewa
CHAPTER SEVEN
Discussion

The objective of this study was to explore why men seek MMC in Malawi. It was my intention to inquire and determine if men were actually seeking MMC and if so, were they motivated by reports in the media that MMC would reduce their risk for HIV. I wanted to understand if their spouses had a role in their decision to seek MMC and if they did, how that was expressed. The notion of ethnicity and sexuality was also considered because they force people to think, rethink, interrogate and determine the idea of “who is man” and the notions of masculinity in African societies in the HIV era. It is beyond the scope of this thesis to exhaustively discuss the determinants of MMC including religion, hygiene, tradition, pain, and cost (Mfutso-Bengo et al. 2010; MDHS 2004; Ngalande et al. 2006; Rennie et al. 2007).

I reflected on the theoretical notion of performance in studying masculinities as inspired by Judith Butler (1990) with a Foucauldian perspective to consider gender identity constructions and underlying power relations. Butler maintains that gender is not naturally given, but a performance that have a social and symbolic meaning, people continuously act different depending on the situation they are in. On the other hand, Foucault argues that there are manifold relations of power which permeate and characterize—characterize and constitute the social body—and these relations cannot be established, consolidated nor implemented without the production, accumulation, circulation and functioning of a discourse (1980a:93). Hence, as Butler argues for women and men enacting differently in various situations and Foucault presents multiple forms of power that make up the social body through discourse; these approaches help to explain the variations in people’s enactment of identities, experiences, decision-making for men and their partners in the face of adult MMC for HIV prevention.

In this study, participants showed little enthusiasm for seeking MMC from either public or private hospitals in both urban or village settings. Nearly all respondents at the village level made constant reference to the symbolic traditional MC to legitimatize their disassociation with MMC. Male circumcision as an initiation ceremony exudes meanings beyond the individual. A previous study acknowledges the current low prevalence of
MMC in Malawi (Mfutso-Bengo et al. 2010). Contrary to my findings, some authors have demonstrated a high MC acceptability rate among women and men in sub-Saharan Africa (Bailey 2006; Ngalande et al. 2006; Siegfried 2008, 2009). These researchers argued that there was no need for further acceptability and feasibility studies because of the consistency of the ‘high acceptability’ data. However, I argue that people may discuss their identities and desires differently depending on a situation. Hence high acceptability does not mean action and that is what my analysis clarifies—by considering gender performance I argue that most men show a strong desire for MMC in public spaces; however, in their private homes and in the presence of their spouse, implementation takes a longer time or does not occur at all.

To my knowledge, there are no previous studies in Malawi that looked at the reach effect of the print or audio media on MMC, although, there is much work on family planning (MDHS 2004; Meekers et al. 2007; Bisika 2008). I draw on critical discourse analysis (Van Dijk 1993; Foucault 1980a) which argues that the power of discourse depends on its continuous reproduction among the elite and those who hold positions. I show various official and expert voices explicating MMC and dominating the local dailies since 2006, which is contrary to findings of Mfutso-Bengo (2010) that the media is mute on MMC discussions. Hence the production of newspaper articles dominated by journalist and expert voices continue to disseminate news and the “truth” for the few. MMC presentations to the masses are dominated by expert knowledge, full of technical jargon so that the voices of the lay people and women at grassroots levels are quoted less and their interpretation is usually absent. Furthermore, various experts both international and regional send mixed messages about MMC and tend to confuse and inhibit successful MMC dissemination. In a country where education levels are low among men and even lower among women, only a few people have access to the dailies it is difficult to assess the impact of print media on MC presentations (Meekers et al. 2007; MDHS 2004). I argue that newspaper reporters tried to balance MMC polemics in the print media; however the lack of access to the dailies and the dominancy of expert knowledge inhibits the dissemination of MMC through newspaper to people at a grassroots level.

The radio is another medium of communication that disseminates information on MMC. By applying a critical discourse approach, I note that radio announcers use the
radio programmes to bring to the fore controversial, confrontational and informative tone and content on MMC presentations. The radio presentations are produced by the power of knowledge and the knowledge is dominated by the programme presentations and the interviewed. Despite debates that local languages do not accommodate research jargon, radio presentations and discussions in the current study, the radio programmes I investigated had no problems in articulating in the vernacular (Moto 2004; Lwanda 2005). Both presentations tackled the issue of MMC as a technical question presented as a rumour; to discuss the causal link between MMC and HIV risk reduction. The current study brings to the fore, the use of negation, denials, blame and hatred speeches by leaders in authority and people at grassroots levels. Previous studies on the reach effect of the radio stations are based on surveys and do not provide the specifics that people learn, talk about and relay from individual radio programmes (Kishindo 1995; MDHS 2004; Mfutso-Bengo et al, 2010; Meekers et al, 2007). I argue that the current study provides a contextualized presentation of MMC as voices from women and men from the grassroots levels are considered and give an interpretation of MMC informed by vernacular knowledge (Scott 1998). However, it is the lack of response from local policy makers, misinformation and denials about MMC that lead to negative remarks being aired to the masses.

Previous studies (Munthali et al. 2006, Zanera and Mitheka 2004, Wawire 2010) the uptake of MMC defined and enhanced men’s manhood. In the current study, there was no association between “masculinities” and MMC. Using the gender performance and critical discourse analysis, most of the respondents interviewed employed referential strategies to counter their arguments for social desirability. Men adopted various forms of language to maintain their manly performances. In the current study, most men in public spaces felt pressured in the public spaces and envied their peer’s penis for sexual pleasure. However speaking to the same man in the private or in the presence of their spouse they acted differently.

In a study explicating heterosexual identities, Simpson (2007) examined the concept of masculinity as a performance among Zambian men and the anxieties that surround their masculine identities in relation to HIV/AIDS. According to Simpson, men feel pressured under the gaze of peers as they try to live up to dominant “manly performance” in public (Simpson 2007) and in private they act on the same dominant
identities by continuing to conquer multiple sexual partners. Locally, a study by Mfutso-Bengo (2010) suggests that local men do not seek MMC for social desirability. I argue that peer and spousal gaze forced men to consider MMC, ironically not for HIV prevention but for sexual pleasure.

The current study found that ethnicity was a force to be reckoned with in influencing men to seek MMC. By drawing on gender performance approach, the discursive element of my informants’ discussions of their bodies reveal how men with a strong kinship and ethnic system identified themselves differently in their aspirations to seek MMC. Previous studies (Muula 2007; Zanera and Mitheka 2004; MDHS 2004) refer to the marks of ethnic identity as a challenge in their recommendations and further reflection, however a rich “social commentary” about a “problematised ethnicity” is yet to be discussed. Most of the respondents in the current study, made use of referential strategies to disassociate themselves from showing their vulnerabilities and contesting the imaginary boundary markers presented by ethnicity. However, because men express themselves distinctively, they sought MMC despite not being part of their symbolic identity.

The role of women in MMC decision making is a debatable as most studies attest to the limited role that women play in sexual health decision making (Muula 2007; Kishindo 1995). To the contrary, studies done by Ngalande (2006) and Limambe and Kumwenda (2008) revealed that women had a high MMC acceptability and had knowledge about the correlation between MMC and HIV prevention. Most women in the latter study argued that a “circumcised penis was not sexually satisfying because it was cold and slippery” (Mfutso-Bengo 2010:100). By using gender performance with a Foucauldian perspective, this study reveals that women demonstrated their womanhood distinctively, in the private arena. Despite, arguments that women do not have power or influence on sexual health matters, in their bedrooms during intimate moments, women use their powers of persuasion to encourage their uncircumcised partners to seek male circumcision for their (the women’s) sexual pleasure.

The gender performance perspective argues that gender relations are “fiction” meant to maintain social inequalities. However, by drawing critically on gender
Men may become empowered by being informed by expert knowledge and increase HIV infection. Moreover, because MMC is done on a man’s body and since they have the power to enact their bodies in various ways, women feared that MMC would encourage sexual license or “sexual disinhibition”; whereby their husbands would become indifferent as they argue that it was their body and hence they sleep with any woman, feigning natural protection from MMC and perpetrating the acquisition of HIV (Azevedo et al. 2010; Kaler 2005). Hence gender relations in the face of MMC and HIV prevention are not fictitious at all.

Power is manifested in various ways, in the sense of authority to act or lack of power to act depending on a situation and discourses presented. By drawing on gender performance with a Foucauldian perspective, men showed they can “socially impossible” by acting parallel to their “ethnic” identities. For the sake of “positive self-preservation” by avoiding the community gaze, the few men sought MMC away from their residential towns. Hence community identities go beyond the individual. Men use specific languages, their bodies and referential strategies to move from one situation to another to maintain their manly performance. Nevertheless, implementing MMC showed an opportunity to negotiate and revise “traditional” and “cultural” narratives that view men as intolerable at seek sexual health care.

Hence, by drawing gender performance with a Foucauldian perspective during various fieldwork interaction, with men in their homes, alone, with their spouses provided the space to reflect on people’s enactment of their identities and presentations of power relation as multiple, discursive and unstable. I assessed the possibility of agency, the power to act or not as we established friendships, health-colleague, researcher-participant relationships with respondents as they moved in and out of situations during my fieldwork. From a gender performance and Foucauldian perspective, I have come to understand that people may discuss their identities and power relations differently depending on a situation living an opportunity for change despite various structural forces.
The limitations of the study

The main limitation of the study is that it was conducted for six weeks in two districts. Although a few men were included from urban Blantyre and few couples from Mbulumbuzi to enrich the findings of this study, it was difficult to confirm if indeed the men we were talking to were not circumcised.

I have tried to be reflexive in my study; however as a woman, some men were unable to express themselves fully as they were afraid to use crude language in my face. I paid particular attention to language and use of proverbs, euphemisms, and figurative speech as a communicative tool “for indirection, to avoid embarrassment, to reinforce daily discourses” because when words failed them, proverbs tended to “vitalise the narrations” (Moto 2004; Lwanda, 2005; Yankah 1989). Despite my inadequacies in grasping local proverbs, I was able to discuss some of these in follow-up and group discussions. However, it is imperative to note proverbs and that sometimes straight-talk among adult Malawians is difficult; for example, *Tonde azinunkha* (a male goat should prove itself, which speaks about a man bragging about his infidelity) (Lwanda 2005:233).

The use of the performance and Foucauldian perspective to explain men motivation to (not) seek MMC may be biased because a discussion on identities as discursive tends to overlook individual “histories, cultures, tradition” and in practice such a scenario is phenomenal. Despite the notion of gender performance providing variations between men and women identities and experiences, there is a tendency to forget the structural influences.

However, by adopting gender performance with a Foucauldian perspective, the structural forces and influence on people is incorporated. However it becomes difficult to measure the outcomes of power relations. The assumption that a positive outcome was due to a possibility of changes in power relations is difficult to measure in reality. Further I learnt that, measurement of power from a male point of view is rare and inadequate because they are developed for women and out of context (Blanc 2001). In relation to the a man’s power to act or not regarding seeking MC, many uncircumcised men in Malawi are sceptical about the reduction in HIV risk, however they believe in *okaona Nyanja anakaona ndimvuu yomwe* (those who went to see the lake, they saw hippos) thus a man receives complementary services: he goes seeking MMC for hygiene sake and they get counselling for sexual and health information as well the medical proved fact that MMC reduces the risk of HIV infection.
Conclusion

On the whole, the aim of this study was to explore adult men’s motivation in seeking MMC in the HIV era among uncircumcised men in southern region in Malawi. By exploring men’s motives for MMC, their social practicalities and the complexities they face, and the role of their partners/spouses and mass media in influencing their decision to go through the procedure, I wanted to bring to the fore various constructions, enactments and discourses of men as men in southern Malawi.

The main objective was to explore Malawian adult men’s experiences as they differentiated between “traditional” MC and MMC as a strategy for HIV prevention to assess how research is translated into practice and on a broader plane, whether or not their experiences have influenced their sexual health seeking behaviours and ultimately their uptake of MMC.

Some of the uncircumcised men grew up witnessing circumcision ceremonies and they have also seen their circumcised friends dying of AIDS. Others have read or heard about MMC for prevention of cancer or other STIs, as well as HIV prevention from the newspapers or radio, however, only a handful of men have shown the desire to take up MMC. Hence my interest was to study what motivated these men to have MCC as an adult.

Most men argued that they sought MMC as adults by citing the cultural master narratives, which disassociated them from the circumcising ethnic groups and that their “culture” barred them from circumcising whilst young. In relation to men’s identity, ethnicity plays an important role in the construction of masculine identities, which leads to further complications when MMC is introduced as a potential strategy for HIV prevention. MMC in the face of a shared “culture” and “tradition” seemed to be incompatible, as there was limited understanding and differentiation between MMC and traditional male circumcision. However, a few men began to visit traditional circumcisers and private hospital for the procedure. Ironically, the reported motivating factors were the need for hygiene and sexual pleasure, and not HIV prevention.

The need to assess the role of women, especially the spouse/partner in MMC, revealed the limited role that women play as confidantes on sexuality issues and how
very few women understood MMC. However through group discussions and in-depth interviews, many women revealed their worst fear of unlimited sexual license after the procedure. It interesting to note that for most women, a lack of MMC was not an issue in their homes, rather it was the loss of intimacy and foreplay discussions that were full of polemics that were never resolved.

The newspapers and audio media opened the masses to international communications and polemics about the effectiveness of MMC. However, in practice, men and women discussed and created their own interpretation of MMC by drawing on the “social autopsies” or “vernacular knowledge” (Scott 1998) to logically understand the medical and traditional male circumcision discourses. An understanding from below or rather “vernacular knowledge” (Scott 1998) was shared during all interviews, informal chats and discussions to counter the argument for MMC.

In conclusion, despite my small sample size, this study has illuminated the complexities that men and women face in their sexual health and specifically in seeking or not seeking MMC. Uncircumcised adult men and their spouses are vulnerable to HIV, however, seeking MMC is one of the many strategies still being deliberated in Malawi. It is a combination of misinformation, the availability of “vernacular knowledge”, “social autopsies” and medical discourses, as well as peer, spousal and community gazes on MMC that have informed men and women in Mbulumbuzi, Blantyre and Malawi as a whole to take cautionary steps over implementing MMC. The view from the international organizations has yet to convince the people at the grassroots level. However, as they say in Chichewa, *phukusi lamoyo sasungilana* (everyone is a custodian of their life) and men are slowly realizing their vulnerabilities and taking out their time from busy schedules to treat their bodies differently from their forefathers, fathers and brothers.

**Recommendations**

There is need to consider men as men, without the “dominant hegemonic” identities, as many Malawian men are susceptible not only to HIV, MCC but to the dominant male constructions. MCC can be made to be readily available to infants at health facility level to support scaling up efforts.
**Abbreviations**

AIDS - Acquire Immuno Deficiency Syndrome
ART - Ante-ritroviral Treatment
ARV’s – Ante-retrovirals
BLM – Banja La Mtsogolo
COMREC – College of Medicine Research and Ethics Committee
FGD – Focus Group Discussions
HIV – Human Immuno Virus
HRCSI – Health Research Capacity Strengthening Initiative
IDI – in-depth interviews
MAM – Moslem Association of Malawi
MBC – Malawi Broadcasting Corporation
MC – Male Circumcision
MDHS – Malawi Demographic Health Survey
MIJ – Malawi Institute of Journalism
MMC – Medicalised Male circumcision
MDHS – Malawi Demographic Health Survey
SITAN – Male Circumcision Situation Analysis
VMMC – Voluntary Medicalised Male Circumcision
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UNAIDS

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Van Dijk, T. A.
van Klinken, A. S.  

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Wawire, S. N.  

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Westercamp, N., and RC Bailey  

World Health Organisation and the Department of Reproductive Health and Research  

Yankah, K.  

Zanera, D. And I. Miteka  
Annexes

Research Guides

Respondents’ background Information
The name is for the purpose of identification and pseudonym will be used in the final report.

Pseudonym/Reference number/Names: Age ranges: 
Religious affiliations: Location: 
Level of Education Marital Status
Data collection tool

1. Free listing sheets

The free listing and ranking sheet served to elicit and learn about various local constructs of manhood and MC discourses and related terms to guide the research questions. The listings were used to identify and describe local colloquialism and nuances (Chambers 1983, Price 2002) in order to understand the sexual and reproductive health problems faced by men’s.

- The list of terms for manhood and MC should were listed and ranked according to the most used in the society.
- The list with sexual health problem was ranked in their hierarchy, starting with the least severe.

<table>
<thead>
<tr>
<th>Name/List words used to describe manhood in vernacular/English</th>
<th>Give a description of the listed word</th>
<th>Rank the list according to commonality and most used in the community</th>
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<tr>
<th>Name/list words that depict MC in your society</th>
<th>Give a description of the listed words</th>
<th>Rank according to commonality and most used in your society</th>
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<tr>
<th>List health sexual and reproductive problems faced by men in vernacular/English</th>
<th>Give description of the problems</th>
<th>Rank the problems according to severity</th>
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Free listing and Ranking Sheet: Chichewa

**Zidziwitso za gulu loyankha**
Dzina ndi lozindikira gulu ndipo dzina lamadulira lidzagwiritsidwa mu malemba otsiriza.

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<thead>
<tr>
<th>Dzina lamadulira:</th>
<th>Nambala yachindikiro:</th>
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<tbody>
<tr>
<td>Mayina akubadwa:</td>
<td>Zaka zakubadwa:</td>
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<tr>
<td>Mpingo:</td>
<td>Mało:</td>
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<td>Sukulu yomaliza:</td>
<td>Njira zopangira kafukufuku</td>
</tr>
</tbody>
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**Cholinga chakafukufuku**

1. Kufufuza zamzibambo weni weni, zizindikiro, zisonyezo muchikhalidwe chathu.
2. Kufufuza zamau osonyeza zamdulidwe kudela.

<table>
<thead>
<tr>
<th>Mau amene timagwiritsa nchito posonyeza mzibambo</th>
<th>Longosolani mauwo</th>
<th>Lembani mau amene amgwiritsidwa nchito kwambiri mdela</th>
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<th>Mau amene timagwiritsa nchito posonyeza zamdulidwe</th>
<th>Longosolani mauwo</th>
<th>Lembani mau amene amgwiritsidwa nchito kwambiri mdela</th>
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<th>Matenda opatsirana pogonana amene amavutisa azibambo</th>
<th>Longosolani matendawo</th>
<th>Lembani matenda amene amavutisa kwambiri</th>
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2. In-depth Interviews

They were used to inquire adult men subjectivities, motivations and how that affects various masculine constructions in relation to MMC for HIV prevention on a deeper level.

Preliminary topic list:
- Various constructs and notions of manhood, ‘master culture narratives’ and health seeking behaviors of men
- Influence of MC discourses, everyday and media discourses
- Motivation for male circumcision, MMC and its implication on manhood, HIV prevention
- Focus on adult males and partners and their sexual and reproductive health problems
- Socio-cultural factors that facilitate or impede MMC receptivity
- Power relations in relation to decision making for MMC and HIV prevention

In-depth Interview Guide
Respondents’ background Information

<table>
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<tr>
<th>Pseudonym/Reference number/Names:</th>
<th>Age ranges:</th>
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<tr>
<td>Religious affiliations:</td>
<td>Location:</td>
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<td>Level of Education</td>
<td>Marital Status</td>
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Masculinities and Health
How would you describe an adult man in your society?
What are the characteristics of an adult man?
What is an “ideal” or a “real”, “inadequate” man in your society? Contrast and Probe
Any other words that you use to describe the various types of men in your village/town?
Who or what can influence your manhood? (Men, peers, women, “others”)
How do men express pain, discomfort, ill health?
How does your society perceive a man with a frail body, ill health, STI?

Seeking MMC
Why did you visit the clinic?
How did you know about MMC services at the clinic?
What influences your health seeking, sexual health decision-making? Who and why?
What responsibility do you think men (as a man) have for reducing HIV transmission? (How, why?)
How would you describe the efforts of “real” men to reduce HIV? (how, why?)
What is your opinion on MMC and HIV prevention?

For men in the village/Hypothetical question?
If your partner would propose MC, how would you respond? Why?

Male Circumcision Questions
Can you describe what you consider to be MC/MMC?
How do men in your society seek MC and why?
What are the benefits and demerits of being circumcised (sexuality, risk, and stigma).
What considerations do you have about (not) being circumcised? Why not? Probe.
How have everyday and media discourses influenced your ideas about MMC? Probe.
Is there anyone who has influenced your decision making to have MMC? how, when, why?
How do women in your household influence decisions on MMC?
In-depth Guide: Chichewa

Zidziwitso zamunthu woyankha
Dzina ndi lozindikira gulu ndipo dzina lamadulira lidzagrirtsidwa mu malemba otsiriza.

Dzina lamadulira: Nambala yachindikiro:  
Mayina akubadwa: Zaka zakubadwa:  
Mpingo: Malo:  
Sukulu yomaliza: Njira zopangira kafukufuku

Zifukwa za kafukufukuyu:
- Kufufuza za ziwonetsero kapena zizindikiro za mzipambo.
- Kufufuza cholinga chaazibambo posakasaka kudulidwa.
- Kufufuza kudulidwa malinga mwa moyo watunthu, maganizo azibambo, zokambidwa; chiopezo chakudulidwa; kudulidwa ngati kuli njira yina yotetezera kutenga kwa chilombo cha HIV
- Kufufuza zimzibambo weniweni, khalidwe lake, maganizo a pamudzi ndi otani malinga zizindikiro zaabambo kusata apo njira zofufuza chithandizo chaku chipatala.
- Kufufuza maganizo azibambo pa okha pankhani yakudulidwa

Zizindikiro za mwamuna ndi za umoyo
- Ziwonetsero kapena zizindikiro za mzipambo ndi chani?
- Inu mukati uyu nde mzipambo weniweni muma tanthauza chani kapena mutha kuti sonyezera kapena kuti fotokozeza mzipambo weniweni.
- Kodi chikhaliidwe chathu chimatanthauza bwanji zaumuna?
- Ndi thawi, umuna umasintha njira zotani?
- Chikhaliidwe chathu, kuumva kwa umuna/mwamuna mu mzipambo kumasintha bwanji? Ndiponso zifukwa zake zo sintha ndi chani ndi zimasintha nthawi yanji?

Kupanga Chisanko
- Munadwalapo? Chitandizo munachipeza bwanji?
- Amai kunyumba anadwalapo? Chitandizo anachipeza bwanji?
- Azibambo amtenga gawo lanji pankhani yazaumoza?
- Azimai amatenga mbali yanji posonyezera kapena pofotokozeza zamzibambo weniweni.
- M’mudzi unowu pakati paazibambo ndiaziimai, amene amayang’ana chithandizo chazaumoza kapena chamatenda opatsirana poganana ndindani

Kudulidwa ndi kupewa kwa chilombo cha HIV
- Maganizo anu pankhani yakulididwa ndiwozotani?
- Mdela lino azibambo omwe ama dulidwa ndi ati? Ndipo zaka zakubadwa zawo ndi zingati
- Chisankho chodulidwa chasintha munjira zotani masiku ano? Malinga ndi malo odulidwa, mtengo odulidwa kapena anthu omwe ama tsogolera kudulidwa?
- Ubwino wa kudulidwa ndiwozotani?
- Mwamva zotani pankhani yakulididwa ndi kutetedzedwa kwa kotenga chilombo cha HIV?
- Kodi azimai amatenga mbali potandizira azibambo pakhani yakulididwa?
Mdelu lanu, azimai kapena azibambo osadulidwa amawonetsera mnjira zotani chilakolako chodulidwa? Ndiponso ngati samawonetsera chilakolako chimenechi chifukwa chake chiyani?

Ubale kapena mgwirizano pa azibambo ndi azimayi pa nkhani izi

- Njira zotani mmene mumawona kuti azibambo ali ndi udindo kapena mbali wochepetsa kafalitsidwe ka chilombo ka HIV? Ndiponso chifukwa chanji mukuwonera choncho?
- Azibambo enieni ama panga bwanji kuti asake kapena afufuze njira zochepetsa kafalitsidwe ka chilombo ka HIV?
- Maganizo anu pankhani yochepetsa kafalitsidwa kwa chilombo cha HIV, ndi otani?
- Ndi njira zotani mmene azimayi kapena azibambo amapanga chisanko kapena kotenga gawo pankhani ya kulera ndi yogonana?
- Ndi njira zotani mmene azimayi kapena azibambo anga thandizire chisankho kapena gawo loti mzibambo afufuze chithandizo cha kudulidwa ngati njira yoziteteza kwa chilombo cha HIV?
3 Participation Observation Guide

<table>
<thead>
<tr>
<th>Place</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>The observations will be used to establish rapport, with hospital staff and for sampling purposes to negotiate times for interviews with men and partners seeking MC from the clinic. An intensive observation will be done on a few couples to identify the gender power relations in sexual and reproductive and health seeking.</td>
<td></td>
</tr>
</tbody>
</table>

**Topic lists**

**At home**
- Description of the household, atmosphere and environment interaction with their ‘significant other’
- Participant’s interaction, attitudes with other men, family and others any other activities

**At the hospital**
- Attending clinic personnel’s
- Observing men’s interactions
- Interactions with hospital staff
- The description of the environment, space and hospital atmosphere
- As a recruitment place
- any other activities

3. Participation Observation: Chichewa.

**Dzina lamalo:**

**Nambala yachizindikiro:**

**Cholinga chakafufukuyi**
- Kufufuza ndikucheza ndiazibambo pankani yakudulidwa.
- Kufufuza zambali ndimphamvu imene azibambo ndiazimai alinayo posakasaka chitandizo chamavuto amatenda opatsirana pogonana
- Kusakasaka wotenga nawo nbali mukafukufukuyi

**Chipatala**
- Kuyangana mene azimai ndiazibambo amakahaira akafrica pachipatala
- Kufotokoza kachezedwe kazibambo ndiazimai akakhala pachiptala ndiwogwira nchito malowo
- Kufotokoza mene malo achipatala amakahaira
- Zochitika zina ndi zina

**Pakhomo**
- Kufotokoza zochitika zapakhomo
- Kufotokoza makhaliidwe abambo ndi amai, m’banja mwawo
- Kachezedwe kamzibambo, ndianzake, ndianthu ena
- Zochitika zina ndizina
4. Focus group discussion Guide

Respondents’ background Information

<table>
<thead>
<tr>
<th>Pseudonym/Reference number/Names:</th>
<th>Age ranges:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious affiliations:</td>
<td>Location:</td>
</tr>
<tr>
<td>Level of Education</td>
<td>Marital Status</td>
</tr>
</tbody>
</table>

The name is for the purpose of identification and pseudonym will be used in the final report.

Data collection tool

The focus group discussions were employed for triangulation, with key informants, health workers, separate groups of men, women and a mixed young adult group.

FGD’s, preliminary topic list for the above groups

- Masculinities, fluid, shifting constructions, identities and contestations
- MMC and male circumcision for HIV prevention
- MMC and sexual relationship and ‘master culture narratives’
- MMC, male circumcision discourses and implications on men, couples, community
- Health seeking behavior and sexual reproductive health problems
- Gender power relations and decision making for sexually transmitted diseases and MMC in particular
- Hypothetical question: If your partner would propose MC, how would you respond? Why?

Focus Group: Chichewa

Kafukufuku wa gulu la azibambo kapena azimai.
( gulu laazimayi/Azibambo, wokwatiwa)

Zidziwitso zamunthu woyankha

Dzina ndi lozindikira gulu ndipo dzina lamadulira lidzagwiritsidwa mu malemba otsiriza.

Dzina lamadulira: Nambala yachindikiro:

Mayina akubadwa: Zaka zakubadwa:

Mpingo: Malo:

Sukulu yomaliza: Njira zopangira kafukufuku

Zifukwa za kafukufukuyu:

- Kufufuza za kudulidwa malinga mwa moyo watunthu , maganizo azimai,azibambo zokambidwa; chiopsezo chakudulidwa; kudulidwa ngati kuli njira yina yotetezera kutenga kwa chilombo cha HIV
- Kufufuza mbali yaazimai/azibambo posonyeza kapena kufotokoza zamzibambo weniweni, khalidwe lake, maganizo a pamudzi ndi otani malinga zizindikiro zaabambo kusata apo njira zofufuza chithandizo chaku chipatala, chithandizo cha kudulidwa ndiponso chithandizo cha kupewa ka chilombo ka HIV.
- Kufufuza maganizo azimai/azibambo pa okha pankhani yakudulidwa
- Kufufuza maganizo azimai ndiaazibambo pakhani yakulera ndikupewa matenda opatsirana pogonana

Hypothetical question: Maganizo azibambo/amaim ndiwotani wachikondi wawo akabweletsa nkhani yamulidwe pakhomo?

Zizindikiro za mwamuna ndi za umoyo

- Ziwonetsero kapena zizindikiro za mzibambo ndi chani?
• Inu mukati uyu nde mzibambo weniweni muma tanthauza chani kapena mutha kuti sonyezera kapena kuti fotokozerana mzibambo weniweni.

Kodi chikhalidwe chathu chimathanthauza bwanji zaumuna?
• Ndi thawi, umuna umasintho njira zotani?
• Chikhalidwe chathu, kuumva kwa umuna/mwamuna mu mzibambo kumasintho bwanji? Ndipono zifukwa zake zo sintha ndi chani ndi zimasintho nthawi yanji?
• M‘mudzi unowu pakati paazibambo ndiazimai, amene amayang‘ana chithandizino chazaumoyo kapena chamatenda opatsirana pogonana ndindani


Kudulidwa ndi kupewa kwa chilombo cha HIV
• Maganizo azimai/azibambo mdela lino pankhani yakudulidwa ndiwotani?
• Mdela lino azibambo omwe ama dulidwa ndi ati? Ndipo zaka zakubadwa zawo ndi zingati
• Chisankho chodulidwa chasintho munjira zotani masiku ano? Malinga ndi malo odulidwa, mtengo odulidwa kapena anhu omwe ama tsogolera kudulidwa?
• Ubwino wa kudulidwa ndi chani?
• Mwamva zotani pankhani yakudulidwa ndi kuteledzedwa kwa kotenga chilombo cha HIV?
• Kodi azimai amatenga mbali potandizira azibambo pakhani yokadulidwa?
• Mdela lanu, azimai kapena azibambo osadulidwa amawonetsera mnjira zotani chilakolako chodulidwa? Ndipono ngati samawonetsera chilakolako chimenechi chifukwa chake chiyani?

Ubale kapena mgwririzano pa azibambo ndi azimayi pa nkhani izi
• Njira zotani mmene mumawona kuti azibambo ali ndi udindo kapena mbali wochepetsa kafalitsidwe ka chilombo ka HIV? Ndiponso chifukwa chanji mukuwonera choncho?
• Azibambo enieni ama panga bwanji kuti asake kapena afufuze njira zochepeetsa kafalitsidwe ka chilombo ka HIV?
• Maganizo azimai pankhani yochepetsa kafalitsidwe ka chilombo cha HIV, ndi otani?
• Ndipo njira zotani mmene azimayi kapena azibambo amapanga chisankho kapena kotenga gawo pankhani ya kulera ndi yoqonana?
• Ndipo njira zotani mmene azimayi kapena azibambo anga thandizire chisankho kapena gawo loti mizibambo afufuze chithandizino cha kudulidwa ngati njira yoziteteza kwa chilombo cha HIV?
5. Problem Analysis Diagram

Figure 3. Problem analysis diagram

Showing potential barriers for adult Malawian males to seek male circumcision for HIV prevention.
Annex 6: Newspaper articles

Annex 7a and b: Consent Forms
INFORMED RECORD/VERBAL CONSENT FORM

HIV Prevention? Male Circumcision Polemics and Masculinities in Southern Malawi.

You are asked to participate in a research study conducted by Blessings N. Kaunda, a graduate student in the Amsterdam Masters in Medical Anthropology at University of Amsterdam. The study is being conducted as part of the student thesis and is sponsored by Health Research Capacity Strengthening Initiative (HRCSI)-Malawi. Your participation in this study is entirely voluntary. Please read the information below and ask questions about anything you do not understand, before deciding whether or not to participate.

IDENTIFIER___________________  Pseudonym________________________

Purpose of Study
I am conducting a research on men and the health seeking behaviour patterns and in particular investigating male circumcision in Malawi. I would like to learn how men and their partners (women) define and identify an adult male in the home and society and how men seek health care. I would also like to know how and why men and their partners decide to go for male circumcision. My research will take place in the Blantyre. If you agree to participate, I will be conducting interview discussions.

Procedures
Participation in this study is voluntary. The discussions will take approximately an hour or less. If at any time, you want to stop, I will do so without any penalty. You are free to refuse to answer any question I pose to you at any time.

I have questions that I prepared for our discussions. However as we continue in our discussion more questions will arise. I will encourage you to share your thoughts, discuss issues openly and where I do not understand I will ask you to elaborate. All the information from you will be kept confidential.

Further, I am not providing any compensation for any participants in this research study. However the information I collect from you and your community will help address the issues, values and struggles men face as adults seeking health care and male circumcision in their homes and local community.

I would like to record our discussion to help me remember what you tell me, and so that the information can be analysed later for writing my thesis. I assure you that all the recordings will be kept confidential and no one in the community or any authority will have access to the recordings. I will only share the recordings with my supervisors in local supervisor at College of Medicine and at school in Amsterdam. If you decide during the discussion that you do not want the recorder on, it can be turned off.
If you do not want to use the recorder, I would take written notes. This information will also remain confidential and only be shared with my local supervisors at College of Medicine and in my school in Amsterdam, the Netherlands.

If you have any questions about this study, your rights or any complaint, please contact Prof J. Mfunso-Bengo at the College of Medicine Research Ethics Committee (COMREC), Private Bag 360, Blantyre 3. Malawi, phone number: 01874740 or alternately Dr Mathanga at Malaria Alert Center on 01870145.

Contact details to prepare for the discussions…………………………………………………………………………………………
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__________________________________________________________________________
Name of Participant and Signature ________________________ Date

__________________________________________________________________________
Name of Investigator and Signature ________________________ Date

Thank you for agreeing to participate in this study.
Chichewa version

Chilolezo chovomera ndipakamwa kuti tikufunsemi mafunso


Dzina la madulira____________________  Nambala yachizindikiro__________

Cholomba Chakafukufu
Ndikupanga kafukufuku wamatenda osiyana isiyana, komanso mavuto okhuza abambo punkhani yosakasaka chitandizo akadwala, kapena kufunafuna njira yoti adulidwe kuno kuBlantyre. Ndikufuna titadziwa makhalidwe a zibambo mudzi muno, pokhudza nhanyi. Kafukufuku yitidziwa kudziwa kuti m’zibambo ndimu nthani, khalidwe lake, mavuto amene amakumana nawo, ngati m’zibambo pakhomo, pofuna kusakasaka chitandizo akadwala, kapena pofuna kudulidwa.

Ndondomeko yakafukufuku
Ngati inu mulo la kutenga nawo mbali mka fukufuku yiyi, mudzafunsi dwa mafunso amene alipo kale, mafunso ena azibwela pomwe tikukambirana. Ndikupepheni kuti mumasuka, mulongosole mwatsatane-tsatanu maganizo anu. Ndikapanda kumvetsetsa, ndikufusanino kuti mULONGOSOLENSO. Maganizo onse mufutokoze tikamacheza ndi achinsinsi, pakati painu ndi ine, koma zotsatira zake zikalembedwa mumabuku kusukulu yau kachenjede.

Kafukufuyi ndi wosakakamiza, ndipo ngati simukufuna kulowa nawo, palibe chovuta. Mulu ndiufulu kusiyi kutenga nawo mbali nthawi ina ili yonse, kapena kakhana kuyankha funso; palibe chovuta.

Zokambiranazi, zitenga mphindi zo thepo. Sindikupereka cholowa m’anja kwawina ali yense amene akutenga nawo mbali mka fukufukuyi. Koma zokambirana zathu zithandiza mugwiridwe kanchito ndiazizambamo mapologalamu azaumoyo.

Kuti ndikathe kulemba zolongosoka, ndikupemphani kugwiritsa nchito chitenga mau. Mukafuna kuzimitsa chitenga mau panthawi ina ili yonse, palibe vuto. Ndikutsimikiza kuti palibenzo wina akathe kumvera zokambirana zathu mudzi muno, kupatulako azipuzitsi anga kusukulu. Ngati simukufuna kujambulidwa, kodi mungalore kuti ndizilemba fundo zanu pakuchesa kwathu?

Ngati muli ndi mafunso, chidandaulo pokhudza kafukufuku ameneyu, chonde pezanani ndi Prof J. Mfunso-Bengo ku College of Medicine Research Ethics Committee (COMREC), Private Bag 360, Blantyre 3. Malawi, kuimba foni pa 01874740 kapena Dr. Mathanga kuMalaria Alert Centre, kapena kuimba foni pa01870145.
Malo amene mumapezeka kapena telefoni nambala kuti ticheze.............................................................................................................
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Dzina laothenga mbali ndi Saini ________________________ Date

Dzina la ofufuza ndi Saini ________________________ Date

Zikomo potenga mbali mukafukufuku
Annex 8: Letter of approval from the Ethics Committee

17th May 2011

Ms. Blessings Kaunda
Malawi Alert Centre
Blantyre 3

Dear Ms Kaunda,


I write to inform you that COMREC reviewed the above mentioned proposal which you resubmitted for expedited review and I am pleased to inform you that COMREC approved your proposal but you need to take into consideration the following factor:

- On point number 12 on the consent form, you were asked to add space for the investigator to provide their name, signature and date as well but you have omitted space for signature. Would you therefore, correct this and submit an amended protocol for our file?

As you proceed with the implementation of your study I would like you to take note that all requirements by the college are followed as indicated on the attached page.

Yours Sincerely,

[Signature]

Prof. J.M. Wambura
CHAIRMAN - COMREC

[Signature]

Approved by
College of Medicine
17 MAY 2011
(COMREC)
Research and Ethics Committee