

Situation analysis of male circumcision in Malawi

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A draft report prepared by the College of Medicine

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ACKNOWLEDGEMENTS	4
ABBREVIATIONS AND ACRONYMS	5
GLOSSARY OF TERMS	6
LIST OF TABLES	7
LIST OF FIGURES.....	9
EXECUTIVE SUMMARY	10
1. INTRODUCTION	13
OBJECTIVES OF THE SITUATION ANALYSIS	15
2.1 MAIN OBJECTIVE	15
2.2 SPECIFIC OBJECTIVES.....	15
3.0 METHODOLOGY.....	15
3.1 STUDY SITES AND SAMPLING CONSIDERATIONS.....	15
3.2 DATA COLLECTION METHODS	17
Objective 1:.....	17
Objective 2:.....	18
Objective 3:.....	18
Objective 4:.....	19
Objective 5.....	20
3.3 DATA HANDLING AND PROCESSING	20
3.4 DATA MANAGEMENT AND ANALYSIS.....	21
3.5 STUDY LIMITATIONS.....	22
4. FINDINGS	23
4.1 CHARACTERISTICS OF PARTICIPANTS	23
4.1.1 Demographic characteristics of KABP respondents.....	23
4.1.2 Socioeconomic status of KABP respondents.....	23
4.2 DETERMINANTS OF MALE CIRCUMCISION IN MALAWI	27
4.2.1 Religion.....	27
4.2.2 Ethnicity	28
4.2.3 Social determinants	31
Social desirability.....	31
Socioeconomic status.....	33
Perceived health and sexual benefits.....	34
4.2.4 Medical indications.....	35
5. DISTRIBUTION OF MALE CIRCUMCISION IN MALAWI	36
5.1 PREVALENCE OF MALE CIRCUMCISION IN MALAWI	36
5.2 AGE AT MALE CIRCUMCISION	41
5.2.1 Age at which male circumcision is conducted	41
5.2.2 Trends in male circumcision	45
5.2.4 Estimated number of and timing male circumcisions in traditional settings.....	46
6 KNOWLEDGE, ATTITUDES AND PRACTICES SURROUNDING MALE CIRCUMCISION.....	48
6.1 KNOWLEDGE OF MALE CIRCUMCISION	48
6.2 ATTITUDES AND PERCEPTIONS ABOUT MALE CIRCUMCISION	50
6.2.1 Attitudes and perceptions of non-circumcised men towards male circumcision	50
6.2.2 Perceptions of women towards male circumcision.....	50
6.2.3 Perceived benefits of circumcision	53
6.2.4 Perceived consequences of circumcision.....	53

6.3	ACCEPTANCE OF MALE CIRCUMCISION	56
6.3.1	Personal acceptance of circumcision among uncircumcised males	56
6.3.2	Acceptance of circumcision for children of circumcised and uncircumcised men.....	59
6.3.3	Willingness to pay for male circumcision	62
6.4	PREFERRED AGE OF CIRCUMCISION AND PROVIDERS.....	64
6.5	DECISION-MAKING ABOUT WHETHER A MALE SHOULD BE CIRCUMCIZED OR NOT	64
7.	SERVICE DESCRIPTION OF MALE CIRCUMCISION IN MALAWI.	65
7.1	LOCATION AND TIMING:.....	65
7.2	TRAINING OF PERSONS PROVIDING MALE CIRCUMCISION:	66
7.3	COSTS ASSOCIATED WITH MALE CIRCUMCISION	67
7.4	PROCEDURE OF MALE CIRCUMCISION:	71
7.5	ADVERSE EVENTS.....	72
7.6	PACKAGE AND SERVICE LINKAGES.....	72
8	FACTORS AFFECTING RATES OF MALE CIRCUMCISION IN MALAWI.....	73
8.1	FACTORS DECREASING RATES OF CIRCUMCISION	73
8.2	FACTORS THAT NEED TO CHANGE IN ORDER TO INCREASE PROVISION OF HEALTH FACILITY-BASED MALE CIRCUMCISION	74
8.3	FACTORS THAT WOULD INCREASE DEMAND	74
9	SERVICE AVAILABILITY ASSESSMENT	76
9.1	HEALTH FACILITY TYPES.....	76
9.2	INFRASTRUCTURE, EQUIPMENT AND SERVICE AVAILABILITY.....	76
9.3	SERVICE OUTPUTS.....	77
9.4	MALE CIRCUMCISION SERVICE BENEFICIARIES.....	77
9.5	HEALTH WORKERS CAPACITIES.....	78
9.6	HEALTH WORKERS TRAINING NEEDS.....	78
9.7	MALE CIRCUMCISION COSTS ESTIMATES.....	79
10	SOCIO-POLITICAL ENVIRONMENT IMPACTING MALE CIRCUMCISION IN MALAWI.	80
10.1	TRANSLATIONAL ISSUES IN MALE CIRCUMCISION	80
10.2	NORMATIVE CULTURAL OR RELIGIOUS ISSUES.....	80
10.3	GROUPS THAT MIGHT OPPOSE MALE CIRCUMCISION	80
10.4	MEDIA COVERAGE ON MALE CIRCUMCISION IN THE LAST 2-3 YEARS.....	82
10.5	POLICY ENVIRONMENT	84
	APPENDICES.....	86
	APPENDIX 1 LIST OF ORGANISATIONS CONSULTED FOR DOCUMENTS ON MALE CIRCUMCISION.....	86
	APPENDIX 2. SUMMARY OF PUBLISHED AND UNPUBLISHED STUDIES ON MALE CIRCUMCISION IN MALAWI.	88
	APPENDIX 3 KABP SURVEY MALE.....	94
	APPENDIX 4 KABP SURVEY FEMALE	105
	APPENDIX 5. KEY INFORMANT INTERVIEW (KII) GUIDE.....	112
	APPENDIX 6: FOCUS GROUP DISCUSSIONS (FGDs)	114
	APPENDIX 7 QUESTIONNAIRE FOR HEALTH FACILITY SURVEY	117
	APPENDIX 8. HEALTH PRACTITIONERS SURVEY	120
	APPENDIX 9. STANDARD MC THEATRE SET INSTRUMENTS AND SUPPLIES USED IN MALAWI.....	124
	APPENDIX 10 STANDARD MALE CIRCUMCISION PROCEDURES REPORTED PRACTICED IN DISTRICT HOSPITALS.....	125
	APPENDIX 11. MEDIA SOURCES CONSULTED	127

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BLM	Banja La Mtsogolo
CHAM	Christian Hospitals Association of Malawi
DHO	District Health Officer
FGD	Focus Group Discussion
FHI	Family Health International
GVH	Group Village Headman
HIV	Human Immune deficiency Virus
HTC	HIV testing and Counseling
IDI	In-depth Interview
IEC	Information, Education and Communication
KABP	Knowledge Attitude Behaviour and Practices Survey
KII	key Informant Interview
MDHS	Malawi demographic and Health Survey
MO	Medical Officer
NHSRC	National Health Sciences Research Committee
PLWHA	People Living With HIV/AIDS
STI	Sexually Transmitted Infection
SRH	Sexual and Reproductive Health
TA	Traditional Authority
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund Agency
USAID	United States Agency for International Development
WHO	World Health Organization

GLOSSARY OF TERMS

Alombwe	Guardians of initiates at the <i>ndagala</i>
Chikunja	Any cultural practice that is considered to be evil by the Christian religion
Chitedze	Buffalo bean - a creeping bean plant. The surface of its fruit is hairy and it itches when in contact with the skin. It also has aphrodisiac, hypnotic and other medicinal properties
Jando:	A male initiation ceremony among the Yao. It is a rite of passage from childhood to manhood. It also involves circumcising the initiates
Kata msumbu	The removal of a foreskin from a man's penis
Kuchotsa fumbi:	A practice among initiates whereby they are encouraged to have sex with a girl soon after the coming out ceremony. In some cases it is said that the female partner has no say and cannot refuse the male.
Liyogo:	A ceremony which takes place after the wounds of the initiates has healed. It is marked by bathing and feasting.
Kuwumbala	Being initiated/circumcised
Msupa	A charm which protects people from witches and wizards
Mwini zoma:	The owner of the initiation camp
Nakanga:	A man who is in charge of the initiation camp
Namkungwi:	Counselor to the initiates. In Lomwe culture, he may also double as a "circumciser"
Ndagala:	A grass hut, usually in the bush or close to a river bank where initiates stay after being circumcised
Ngaliba:	Circumciser – a man who is entrusted with the task of circumcising men.
Thezo/zoma/simba	All these terms mean the place where the initiates stay as they are healing from the wounds inflicted during the circumcision and they get counseled on traditional/social norms

LIST OF TABLES

Table 1	Distribution of respondents for KII and FGDs
Table 2	Characteristics of the men interviewed in the KABP survey
Table 3	Characteristics of the women interviewed in the KABP survey
Table 4	Indications of male circumcision in selected hospitals
Table 5	Prevalence of male circumcision by background characteristics according to the MDHS 2004, PNG 2004 survey, and circumcision situation analysis 2009.
Table 6	Distribution of population circumcised in Malawi by region
Table 7	Age distribution of males circumcised in selected district hospitals
Table 8	Regional distribution of indications for male circumcision (n=1648) in selected district hospitals
Table 9	Distribution of ages at which male circumcision is conducted by socio-demographic characteristics
Table 10	Knowledge of the definition of male circumcision (KABP survey)
Table 11	What women think of circumcised males (KABP survey)
Table 12	Male perceptions of benefits and negative consequences of male circumcision (KABP survey)
Table 13	Female perceptions of benefits and negative consequences of male circumcision (KABP survey)
Table 14	Proportions accepting male circumcision before and after information on benefits of circumcision is provided
Table 15	Male and Female acceptance of circumcision for their children following information on linkage between male circumcision and HIV.
Table 16	Acceptable costs and sources of money for paying for circumcision
Table 17	Preferred ages for circumcision for children (KABP survey)
Table 18	Costs of circumcision (traditional and modern facility circumcisions)
Table 19	Facilities surveyed as part of the male circumcision survey by facility type
Table 20	Infrastructure, equipment and service availability by health facility type

Table 21	Service outputs per health facility type
Table 22	Composition of male circumcision beneficiaries per health facility type.
Table 23	Number of health workers surveyed per health facility type
Table 24	Experience of health workers on male circumcision related tasks
Table 25	Number of health workers needing male circumcision training in the public sector
Table 26	Specific training needs for various cadres of health personnel

LIST OF FIGURES

- Figure 1: Percentage of men aged 15-49 circumcised by wealth quintile in the 2004 Malawi demographic and Health Survey
- Figure 2: Percentage of men aged 15-49 circumcised by education level and marital status in the 2009 situation analysis
- Figure 3: The prevalence of male circumcision by region for the years 2004 and 2009, based on the MDHS (2004) and Situation Analysis KAP survey (2009)
- Figure 4: Map of male circumcision showing prevalence (%) at sampled district level. (Left panel)
- Figure 5: Map of male circumcision showing projected district prevalence (%) based on district ethnic distribution. (Right panel)
- Figure 6: Prevalence of male circumcision in selected districts in 2004 and 2009
- Figure 7: Indications for male circumcision in different age groups in selected district hospitals
- Figure 8: Yearly trends in male circumcision by age group in selected district hospitals
- Figure 9: Distribution of ages at which circumcision is carried out in various regions(KABP survey 2009)
- Figure 10: Proportion of uncircumcised males accepting circumcision before and after male circumcision HIV link is provided.

EXECUTIVE SUMMARY

Male circumcision, the surgical removal of all or part of the foreskin of the penis is one of the oldest and most common surgical procedures worldwide. It is usually practiced for religious, cultural, social and religious reasons. Research evidence has in the past shown that male circumcision has a number of health benefits: including reduced risk in acquisition of urinary tract infections; syphilis; chancroid and the human papilloma virus in circumcised men and cervical cancer in women whose partners are circumcised.

Recently research evidence has unequivocally demonstrated a linkage between male circumcision and HIV infection acquisition with estimates suggesting up to 60% reduction in HIV acquisition among circumcised men. Since the publication of this evidence, there has been a great deal of interest in using male circumcision as part of HIV prevention strategies in high HIV prevalence countries where the virus is mainly transmitted heterosexually and since 2007 the WHO and UNAIDS have recognized male circumcision as an effective intervention for HIV prevention particularly in regions where the incidence of heterosexually acquired HIV infection is high, such as Sub-Saharan Africa.

The present situation analysis sought to document existing status of male circumcision in Malawi. The analysis specifically sought to: review what are the key determinants of male circumcision in Malawi; determine the prevalence and socio-demographic distribution of male circumcision in Malawi; review and document previous studies conducted on male circumcision in Malawi; describe existing service packages, uptake and determinants of uptake of male circumcision in Malawi, explore the knowledge, attitudes and perceptions about male circumcision in Malawi, assess acceptability of introducing male circumcision amongst circumcising and non circumcising communities, document the associated costs of procuring male circumcision and document the socio-political environment that impact on male circumcision in Malawi.

The main findings of the situation analysis are as follows:

Determinants of male circumcision: The analysis has found that male circumcision in Malawi is mainly practiced for religious and cultural reasons especially among the Moslem and Yao populations although other ethnic groups notably the Lomwe and religious groupings also to some extent undertake male circumcision. Additionally circumcision in Malawi is determined by perceived health benefits in terms of reduction in risk of contracting sexually transmitted infections including HIV/AIDS. To a smaller extent circumcision is also practiced for medical indications. However despite the overwhelming evidence elsewhere, the demand for circumcision as a preventive HIV/AIDS strategy is still rudimentary although there is some evidence that the trend may be changing with more people especially among older groups in non traditionally circumcising population groups demanding circumcision. This demand for circumcision can be improved by providing further information on the benefits of male circumcision as has been shown with increased acceptance of male circumcision if linked to potential benefits in terms of HIV prevention as well as other health benefits, knowledge of which is at present quite low.

Prevalence of male circumcision: About one in four (26.7%) of the male population is circumcised with the largest proportion of circumcised men being amongst the Yao and Moslem segments of the population where circumcision is almost universal and typically conducted in early adolescence. Because of the demographic distribution of these population groups, most circumcision occurs in the southern region followed by the central and northern regions. The review has documented that circumcision in Malawi is typically practiced in traditional settings as part of rites of passage or religious practice outside formal health facilities although since the advent of the HIV/AIDS pandemic the trend appears to be changing with increasing circumcisions being conducted in the health sector. Current information indicates that male circumcision is viewed in the wider community as an Islamic and Yao ritual and not readily acceptable by other ethnic and religious groups. In the past few years uptake of male circumcision has gone up but largely in the already circumcising communities with no change in circumcision rates amongst the non circumcising communities which form the majority of the Malawian population. Amongst the non Yao or Muslim communities of the southern region, the situation analysis documents incomplete circumcision according to standard definition as being prevalent especially amongst the Lomwe and Mang'anja ethnic groups where self reported rates of circumcision may in actual fact be inflated and over estimate prevalence of recommended circumcision practice.

Knowledge, Attitudes and behaviours on male circumcision:

Correct knowledge of circumcision and its benefits is reasonably high, around seven tenths of the male population and highest amongst Yao and Moslems and the relatively literate districts of the northern region but correspondingly poor in the southern and central regions of the country mirroring the national education levels. Knowledge of the benefits of circumcision as an HIV prevention strategy or indeed health benefits in general is very low, more so amongst males compared to women and likely to be mentioned by those that already have accessed circumcision than those not circumcised.

The general attitude on male circumcision is to link it with Muslim faith and Yao culture and this directly affects its acceptability in Malawi. To some extent, this perception is compounded by an incomplete understanding of the potential benefits of male circumcision in HIV prevention as well as other health benefits. These perceptions influence how acceptable male circumcision is. Up to seven tenths of uncircumcised males do not find circumcision acceptable for themselves or their children however acceptance improves in information on the health benefits and potential for HIV prevention is provided to them. This change is however not dramatic and would require a strong IEC approach to change attitudes as despite these benefits being made available to them still up to half of the uncircumcised males still find circumcision unacceptable largely for religious and ethnic reasons, emphasizing the importance faith and ethnic leaders may play in improving acceptance of male circumcision. The majority of people in Malawi would prefer early circumcision, conducted before adolescence.

Almost two thirds of the population would be willing to pay for circumcision if made available and they would pay as much as MK1, 000 for it and this is further corroborated by findings from the BLM where uptake of circumcision at a cost has been demonstrated from anecdotal evidence available at present. Evidence from the

situation analysis indicates that people are already spending on average amounts higher than this to access male circumcision in direct as well as indirect costs. However there are sections of the population, almost one fifth who would only access male circumcision if it is provided for free emphasizing the need for a deliberate approach to improve access for all sections of the population. In almost all cases the preferred provider of circumcision is indicated as the formal health sector with only a third and especially those communities that initiate their children preferring traditional circumcisers.

Socio-political environment impacting male circumcision: Male circumcision has not been adequately studied with very few studies conducted and mostly descriptive studies in specific settings and population groups. Because of this paucity of local data, male circumcision as practiced has not been included in national sexual and reproductive health strategies although evidence suggests that this is also changing especially with the inclusion of male circumcision as part of the national HIV prevention strategy. Debate on the merits of male circumcision in the media has been recently stirred by the information linking circumcision with HIV/AIDS although such debate has been muted and not really focused on the potential benefits of male circumcision, nor the importance of considering male circumcision as part of a wider preventive strategy and the tone of the debate reflects the perceptions about male circumcision alluded to earlier. Stigma and lack of acceptance of male circumcision by some ethnic and religious groups remains widespread and strategies to include these social groupings in designing interventions to increase uptake of male circumcision is going to be mandatory.

Health service capacity to provide male circumcision: Most health workers (98%) are willing to take part in the scale up of male circumcision. The ideal personnel proposed for this scale up were doctors and clinical officers. Most health workers know the role of circumcisions in HIV prevention. In terms of training, 22% of all health care workers will need added training before scale up of male circumcision with the greatest need in doctors and clinical officers (73%). Training will need to include theoretical and practical aspects of male circumcision, STI diagnosis and management, infection prevention as well as counseling. Despite this, central and district hospital are able to role out male circumcision on day 0. However 77% of mission hospital and 71% of community hospital would need support on some of the requisite capacities before they can start providing male circumcision.

1. INTRODUCTION

Male circumcision, the surgical removal of all or part of the foreskin of the penis is one of the oldest and most common surgical procedures worldwide. It is usually practiced for religious, cultural, social and religious reasons. Recently, research evidence has shown that male circumcision has a number of health benefits: including reduced risk in acquisition of urinary tract infections; syphilis; chancroid and the human papilloma virus in circumcised men.¹ Furthermore, it has been established that cervical cancer is 2 to 5.8 times more frequent among women partners of uncircumcised males compared to partners of circumcised males.²

The linkage between male circumcision and HIV infection acquisition has also recently been explored. A 25-year longitudinal study of a birth cohort of New Zealand children concluded that male circumcision may reduce the risk of sexually transmitted infection acquisition and transmission by up to one half, suggesting that there are substantial benefits accruing from routine neonatal circumcision³ More recently, a 60% reduction in HIV acquisition among circumcised men aged 18-24 years was demonstrated in a study from South Africa.⁴ Subsequently, two other studies in Kenya and Uganda have demonstrated reduction in risk of HIV acquisition of 53 and 48% respectively among circumcised men.^{5, 6}

Since the publication of these results, there has been a great deal of interest in using male circumcision as part of HIV prevention strategies in high HIV prevalence countries where the virus is mainly transmitted heterosexually. In fact, in March 2007, the WHO and UNAIDS recognized male circumcision as an effective intervention for HIV prevention particularly in regions where the incidence of heterosexually acquired HIV infection is high, such as Sub-Saharan Africa.⁷ Guidelines have been developed on the practice of safe male circumcision and tools been developed for countries to use when considering scaling up of this intervention.⁸

Malawi is one such country in Sub-Saharan Africa with high HIV prevalence and where the majority of males are not circumcised. However, even though male circumcision is now considered a proven public health intervention, its widespread introduction in countries such as Malawi, where communities either circumcise males using traditional methods or do not circumcise at all, is an issue which

¹ Moses S, Bailey RC, Ronald AR. 1998. Male circumcision: assessment of health benefits and risks. *Sexually Transmitted Infections* 74:368–373.

² Castellsague X, Bosch FX, Munoz N, Meijer CJLM, Shah KV, et al. 2002. Male circumcision, penile human papillomavirus infection, and cervical cancer in female partners. *New England Journal of Medicine* 346:1105–1112.

³ Fergusson, D.M., J.M. Boden, and L.J. Horwood, *Circumcision status and risk of sexually transmitted infection in young adult males: an analysis of a longitudinal birth cohort*. *Pediatrics*, 2006. 118(5): p. 1971-7.

⁴ Auvert, B., Taljaard D, Lagarde E, Sobngwi-Tambekou J, Sitta R, et al., *Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial*. *PLoS Medicine*, 2005. 2(11): p. e298.

⁵ Bailey, R.C., et al., *Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial*. *Lancet*, 2007. 369(9562): p. 643-56.

⁶ Gray RH, Li X, Kigozi G, Serwadda D, Nalugoda F et al., *Male circumcision for HIV prevention in men in Rakai, Uganda: A randomised trial*. *Lancet*, 2007. 369: p. 657-666.

⁷ WHO/UNAIDS, *Male Circumcision Situational Analysis Toolkit*, 2009. WHO, Geneva

⁸ WHO/UNAIDS, *Male Circumcision Situational Analysis Toolkit*, 2009. WHO, Geneva.

requires careful consideration. In light of this, several stakeholders' consultations have been held in the country to examine the applicability of these research findings to the Malawian context.

Male circumcision is not just a medical intervention with public health significance; but, also a cultural practice, which has always had wider social, political, religious and ethical dimensions. To adequately address issues of acceptability, accessibility and feasibility of male circumcision, especially among currently non-circumcising populations, among whom the introduction of male circumcision has the greatest potential impact, a situation analysis was proposed. The situation analysis sought to generate relevant data that could be used to inform and guide future initiatives to promote male circumcision as part of a comprehensive HIV prevention strategy in Malawi. The key focus of the situation analysis therefore was to document existing status of male circumcision in Malawi. The analysis specifically sought to:

- Review and document previous studies conducted on male circumcision in Malawi
- Examine what are the key determinants, of male circumcision in Malawi using existing data sources published and unpublished as well as using additional data collected as part of the analysis
- To determine current rates, service providers and behaviours that determine current and future male circumcision practice in Malawi
- To explore knowledge, attitudes and perceptions of people in Malawi about male circumcision in general and as an HIV prevention strategy.
- To assess the acceptability of introducing male circumcision as an HIV prevention strategy in both circumcising and non-circumcising communities in Malawi.
- To investigate the feasibility of implementing a male circumcision strategy for HIV prevention in Malawi.
- To document the unit costs of providing male circumcision at different health facility levels and estimate costs needed for national uptake and scaling up of male circumcision as a public health intervention.
- To provide recommendations on whether male circumcision should be adopted as one of the strategies for HIV prevention in Malawi.

OBJECTIVES OF THE SITUATION ANALYSIS

2.1 MAIN OBJECTIVE

The main objective of the situation analysis was to generate relevant data that could be used to inform and guide initiatives to promote male circumcision as part of a comprehensive HIV prevention strategy in Malawi

2.2 SPECIFIC OBJECTIVES

The specific objectives of the situation analysis were:

1. To determine current rates, service providers and behaviours that determine current and future male circumcision practice in Malawi
2. To explore knowledge, attitudes and perceptions of people in Malawi about male circumcision in general and as an HIV prevention strategy.
3. To assess the acceptability of introducing male circumcision as an HIV prevention strategy in both circumcising and non-circumcising communities in Malawi.
4. To investigate the feasibility of implementing a male circumcision strategy for HIV prevention in Malawi.
5. To provide recommendations on whether male circumcision should be adopted as one of the strategies for HIV prevention in Malawi.

3.0 METHODOLOGY

The situation analysis used the methodology proposed by WHO situation analysis tool kit. The toolkit was adapted to the local context to collect the required information. Main methods included:

- a) Desk review
- b) Key Informant Interviews (KII) and Focus group Discussions (FGDs)
- c) Knowledge, Attitude, Behavioral and Practice (KABP) survey
- d) stakeholder consultation meetings
- e) service availability assessment
- f) supply and demand analysis

3.1 STUDY SITES AND SAMPLING CONSIDERATIONS

The situation analysis was conducted to cover the whole country as much as possible. Specific study sites varied according to the nature of the information to be collected and in some cases a sample of the country was selected.

For qualitative information purposive sampling of circumcising and non circumcising communities was done based on region and district. Data was collected from three districts each in northern and central regions and 4 districts in the southern region. The districts selected were as follows:

North: Chitipa, Mzimba and Nkhatabay
Centre: Lilongwe, Nkhotakota and Ntcheu
Southern region: Nsanje, Blantyre, Mangochi and Mulanje.

These districts were selected because they are specific to some of the 30 distinct tribal groups present in the country thereby ensuring an almost equal representation of major tribal groups in the country. At the same time, their geographical locations allowed for valid assessment of the feasibility of male circumcision. The same districts provided the sampling frame for the KABP survey.

Respondents for the KII were recruited amongst medical personnel, traditional initiators, traditional leaders, religious leaders, political leaders, traditional healers and Ministry of Health officials. A total of 135 KII were conducted as indicated below in Table 1. Respondents for the FGDs included traditional community leaders, religious leaders, circumcised and uncircumcised men for a total of 53 FGDs as indicated in the table below.

Quantitative information on KABP was collected from a household survey of men and women in each of the districts selected. Sample size was determined based on the following assumptions:

- i. The expected prevalence of MC in each of the selected districts, using the results of 2004 Malawi Demographic and Health Survey (MDHS 2004).
- ii. A household non-response error of 10%. This was based on similar studies, again informed by the MDHS 2004.
- iii. A precision or error bound on the estimate of 95%.
- iv. A design effect of 2.
- v. An average household size of 5, and
- vi. The proportional of male adults (those aged 18 years and above) of 1.1.

For the facility male circumcision survey we conducted a census of all rural and district hospitals in Malawi. Following consultation with stakeholders, the decision was made to exclude all other health facilities smaller than those above. For government and CHAM these numbered 71 facilities spread as follows:

- i. Central East zone: 12
- ii. Central West zone: 12
- iii. South East zone: 13
- iv. South west zone: 13
- v. Northern zone: 21

Additionally all private hospitals in these zones were also be included.

In terms of study population, the situation analysis targeted both males and females aged 14 and above (from 18 years of age) from circumcising and non-circumcising groups communities in Malawi. Other persons studied included medical personnel, traditional initiators, traditional leaders, religious leaders, political leaders, zonal

health officers, traditional healers, Ministry of Health Officials and academic professionals in the area of health.

Table 1. Distribution of respondents for KII and FGDs

KII		FGD	
Group	Number	Group	Number
Members of parliament	7	Community Leaders	10
District health Officer / Medical Officer (Govt. Hospitals)	10	Religious leaders	10
Medical Officers (CHAM)	10	Circumcised men (Health facility)	3
Clinical officers responsible for MC	10	Circumcised men (traditional setting)	10
Christian Church leaders	10	Uncircumcised men	10
Traditional authorities	10	Women	10
Nurses	10		
Muslim leaders	10		
Leaders of youth organizations	10		
Traditional circumcisers	10		
People Living with HIV/AIDS	10		
Media correspondents	10		
Leaders of women's organizations	10		

3.2 DATA COLLECTION METHODS

Data collection methods for each objective were as indicated below.

Objective 1:

To determine current rates, service providers and behaviors that determine current and future male circumcision practice in Malawi

To determine current practice in terms of rates, service providers and behaviours that determine male circumcision a guided desk review was conducted. The desk review aimed to review the current situation using existing materials from programmes, projects and any studies that have been conducted in Malawi. The following key questions were addressed:

1. What are the key determinants of circumcision?
2. Whether there has been any discussion of male circumcision in relation to HIV/AIDS, hygiene, religion and culture?
3. Whether there have been any completed or ongoing studies on male circumcision?
4. The estimated number of male circumcisions conducted per annum by various service providers (traditional and clinic based) and any geographical and socio-demographic variations?
5. What are the existing programmes for male circumcision and a description of the nature of the programmes?
6. What is the estimated trends in male circumcision practice

7. What are the government policies relating to male circumcision including any plans in relation to male circumcision practices
8. Mapping of male circumcision prevalence
9. Mapping of sexual and reproductive health services and programmes and any linkages to male circumcision, family planning, and HIV testing and counseling.

Existing published and unpublished documents were identified and reviewed from various sources including academic institutions; institutional review boards (IRBs), government ministries, non-governmental organizations, religious and cultural organizations. To aid identification of potential sources of information, key informants (Appendix 1) such Ministry of Health personnel, the print and broadcast media, Civil Society Organizations and Non Governmental Organizations, UN agencies, etc were interviewed to locate potential sources of data. All collected data was collated and documented (Appendix 2) and a desk review report produced to guide further data collection as proposed in the next step. To facilitate this, the report was shared with and discussed by key stakeholders.

Objective 2:

To explore knowledge, attitudes and perceptions of people in Malawi about male circumcision in general and as an HIV prevention strategy.

To explore the knowledge, attitudes, behaviors and practices about male circumcision in general and as an HIV prevention strategy a KABP survey was conducted in the sampled districts amongst men and women using an interviewer administered questionnaire adapted for the WHO Male Circumcision Tool Kit (Appendix 3 and 4) and this was complemented by information collected through KII and FGDs (appendix 5 and 6).

Objective 3:

To assess the acceptability of introducing male circumcision as an HIV prevention strategy in both circumcising and non-circumcising communities in Malawi

To gather perceptions of opinion leaders in society and the general population, key informant interviews and focus group discussions were conducted. FGD guides and Key informant interview guides are attached in Appendix 3 and 4 respectively. In each selected area the following FGDs were conducted with.

- a) Men who have been circumcised by traditional circumcisers
- b) Men who have not been circumcised
- c) Women in areas where men are normally circumcised
- d) Women where men are not normally circumcised
- e) Community leaders

In total, 5 focus groups discussions were conducted in each district, hence 53 focus group discussions in total.

In-depth interviews were conducted with key informants as follows:

- a) Senior health service personnel from both government, CHAM and private service providers
- b) In each selected area or district an average of 13 Key Informant Interviews (KII) were conducted for a total of 135 interviews.
 - i. 1 Member of Parliament
 - ii. 1 Traditional Authority,
 - iii. 1 traditional healer
 - iv. 1 traditional circumciser
 - v. 1 clinician providing circumcisions.
 - vi. 2 religious leaders, Christian and Muslim
 - vii. 1 person living with HIV/AIDS
 - viii. 1 representative of a women group
 - ix. 1 representative of a Youth Group
 - x. 1 Correspondent of a Media House
 - xi. 1 experienced Nurse
 - xii. 1 experienced Clinical Officer

Additionally, in each of the areas selected for these interviews, a short household survey of men and women was conducted among men who have been circumcised and those not circumcised and women whose partners were circumcised or not. This was done to get additional insight into knowledge, attitudes and preferences of people in these areas (Appendices 3 and 4).

Objective 4:

To investigate the feasibility of implementing a male circumcision strategy for HIV prevention in Malawi

To investigate the feasibility of implementing male circumcision as an HIV prevention strategy we would ideally have done a service availability mapping exercise. However due to the time constraints and urgency of the information required, it was decided to conduct a male circumcision survey. The male circumcision survey included a health facility and health practitioner's survey. Information collected included:

- catchment population served by the facility,
- personnel availability
- resources for surgical services,
- availability of HIV testing and counseling services,
- family planning and sexually transmitted infection services
- current scope of circumcision services.

For the practitioners survey information was collected on :

- whether they were currently offering the service or may be able to offer the services,
- knowledge and experience of providers to provide safe circumcision services
- Their attitude to offering male circumcision services.

Data collection tools are attached in appendices 6 and 7. The information collected was used to determine current capacity of health facilities and practitioners to

provide circumcision services, current trends in demand and supply for circumcision services and how male circumcision services could be safely increased.

Objective 5.

To provide recommendations on whether male circumcision should be adopted as one of the strategies for HIV prevention in Malawi

To meet the above objective several stakeholder workshops were proposed from which a stakeholder analysis will be conducted. The main purpose for the stakeholder workshops will be to appraise stakeholders of the current situation to facilitate their understanding and participation in the situation analysis review. The first of these workshops was conducted soon after the guided desk review at which point they also contributed to the further refinement of the data collection tools and methodologies. The second stakeholder consultation will be conducted when the present report is presented.

3.3 DATA HANDLING AND PROCESSING

KNOWLEDGE ATTITUDES BEHAVIOUR AND PRACTICES (KABP) SURVEY

A two-stage survey methodology was adopted to produce a district representative sample of households. A team of experienced enumerators were recruited to collect data. They were given 3 days intensive training on the questionnaire, and had two days of a pilot study in order to (a) acquaint themselves with the questions, (b) afford them an opportunity to ask questions, seek clarifications, and make general questions where necessary, (c) accustom them with survey, interviewing, and house selection techniques. The exercise also sought to familiarise them with the problems they were going to encounter in the field and at the same time share their previous experiences in such exercises. Since the questionnaire was translated into a local language, the pilot study was also designed to clear any ambiguities and problems in its interpretation and administration.

For the KABP, two teams were formed under a supervisor, and each team would cover a district. Each supervisor was responsible for checking consistency in the filling of questionnaires, and time management. Each enumerator was required to sign their name on the questionnaire, the date of the interview, the time the interviews started and the time when they ended. Each supervisor would then provide a field report for each district.

Once the questionnaires were filled, these were sent to a dedicated computer room for data capture. Data entry proceeded concurrently with data collection, once these are received at the data entry point. A data entry screen, mirror of the questionnaire, was developed in Microsoft Access. The data entry screen allowed for both single response and multiple response type of questions. Data entry delimiters were constructed to minimize errors. Data was entered once in MS Access, and then exported into Statistical Package for Social Sciences (SPSS) for variable coding. We

maintained the same variable coding to that in the questionnaire for easy referencing. The data entry screens and SPSS data have been submitted.

FOCUS GROUP DISCUSSIONS AND KEY INFORMANT INTERVIEWS

Data was obtained from research participants during focus group discussions and in-depth interviews. Fifteen Research Assistants or Data Collectors and the Principal Investigators conducted both the focus groups and in-depth interviews. They used semi-structured interview guides whose copies are appended to this report (Appendix 5 and 6). The interview guides were translated into Chichewa, Chitumbuka and Chiyao and the focus groups and in-depth interviews were administered in Chichewa, Chitumbuka, Chiyao and English. All focus group discussions and in-depth interviews were audio taped.

The recorded data from each focus group and in-depth interview were transcribed verbatim by the Research Assistants whilst in the field. They used hard covers to write the recorded information. The transcripts from the hard covers were then entered into the Computer by Secretaries. The electronic transcripts in Chichewa, Chitumbuka and Chiyao were translated into English by the Research Assistants. All the translations were later checked by the Principal Investigators to see if they made sense. All the electronic transcripts are appended to this report.

3.4 DATA MANAGEMENT AND ANALYSIS

QUALITATIVE DATA

All the processed data from the FGDs and KIIs was saved electronically on Compact Disks (CDs) and on computer. Analysis of the focus group and in-depth interview transcripts was carried out manually. It involved the identification of recurrent patterns and themes from both the conceptual framework and thorough reading of the transcripts. The Chichewa, Chitumbuka Chiyao and English transcripts were read in their entirety to identify themes that re-occurred across all the focus groups and in-depth interviews. The themes or categories were coded inspired by the questions in the focus group discussion guide and in-depth interview guide (Appendix 5 and 6).

QUANTITATIVE DATA

After variable coding in SPSS, we ran frequencies for consistency checks, data cleaning and transformation. Consistency checks included, among other things, verification of the total valid cases, missing values and correct categories. Any wrong entries were corrected by refereeing to a corresponding questionnaire. Where necessary, certain variables were categorized or collapsed if the data was sparse in some categories. New variables were also created from existing ones. To answer the objectives of the study, we generated frequency tables and charts for each key variable, mainly for the background characteristics of the respondents, the male circumcision status of the respondent, their knowledge, attitudes and behaviour and practices. We then generated cross tabulations to assess associations between certain attitudes, behaviours and practices and current status of male circumcision.

3.5 STUDY LIMITATIONS

Malfunction of Tape Recorders during Interviews

On few occasions, the tape recorder malfunctioned; and in some venues where the interviews were conducted there was background noise which made the voices of participants difficult to hear on the recordings of some focus group discussions and in-depth interviews.

Failure to conduct some focus groups and in-depth interviews

Some potential participants didn't turn up for scheduled FGDs and In-depth Interviews. Some participants didn't turn up for the FGDs and IDIs because they were so busy doing other activities that they didn't have time to come to the scheduled venues although they had accepted to come for interviews on the scheduled dates – this led to low turn up and the rescheduling of some interviews.

Recruitment of men circumcised at a health facility

Originally, we planned to recruit men circumcised at health facilities in each selected district. However, during recruitment, we failed to find sufficient numbers of men for focus group discussions in some districts because in some Hospitals, people in charge were not willing to give us contact information of men circumcised in their hospitals for confidentiality reasons while in others it was difficult to trace sufficient men to constitute a focus group discussion. To make up for this, we managed to recruit twenty-eight men circumcised at Kawale BLM Clinic in Lilongwe with the kind assistance of Dr. Brendan Hayes. The men formed three focus groups. We also conducted in-depth interviews with men circumcised at health facilities in the districts where we could not find sufficient numbers.

4. FINDINGS

4.1. CHARACTERISTICS OF PARTICIPANTS

4.1.1 Demographic characteristics of KABP respondents

Information was collected on the socio-economic and demographic characteristics of men and women which were sampled for the KABP survey. In total, 3734 men were sampled and interviewed across Malawi. Eighty eight percent of the men were from the rural areas and 34.4%, 25.1% and 40.5% were from the northern, central and southern region of Malawi respectively (Table 2). Distribution across the ten districts was even with Mzimba contributing the highest proportion (12.4%) and Blantyre and Ntcheu district contributing the least proportion (8.2%) each. Most of the men (71.4%) were married. Just over half of the men were Christians belonging to the catholic (18.9%), CCAP (18.9%), Adventist/ Baptist (9.4%) and Anglican (3.4%) churches. About 15.2% of the men were Muslims.

For women, a total of 1211 women were sampled and interviewed across Malawi amongst whom 85% were from the rural areas and 28.2%, 30.9% and 41 % were from the northern, central and southern region of Malawi respectively (Table 3). Distribution across the ten districts was even with Lilongwe contributing the highest proportion (12%) and Chitipa district contributing the least proportion (8.7%) each. Most of the women (82.4%) were married. Just below half of the women were Christians belonging to the catholic (17.4%), CCAP (17.5%), Adventist/ Baptist (5.9%) and Anglican (2.9%) churches. About 14.8% of the women were Muslims.

4.1.2 Socioeconomic status of KABP respondents

More than three quarters (88.6%) of the men had attended school with 65.6%, 32.7% and 1.7% attending primary, secondary and tertiary education. Most (42.9%) of the men were involved in farming. Farming and business were the main sources of income for the majority of men and 65.7% owned some livestock. Ownership of a radio was 73.1%. Only 6.5% and 2.8% of the men had access to electricity and a flush toilet respectively.

Likewise as shown in table 3, the majority of the women had been to school with 86.2%, 13.4% and 0.4% attending primary, secondary and tertiary education in the rural areas. Attendance of school as expected varied across the regions and districts. Farming and business were the main sources of income for the majority of women and access to radio was high with 62% and 81.7% in the rural and urban areas respectively. Only 2.4% and 39% of the women had access to electricity in rural and urban areas respectively.

Table 2: Characteristics of the men interviewed in the KABP survey

	Malawi %	Area		region			District										
		Urban (%)	Rural (%)	North (%)	Centre (%)	South (%)	Blantyre (%)	Chitipa (%)	Lilongwe (%)	Mangochi (%)	Mulanje (%)	Mzimba (%)	Nkhatabay (%)	Nkhotakota (%)	Nsanje (%)	Ntcheu (%)	
All men	3734	11.2	88.8	34.4	25.1	40.5	8.2	10.5	9.6	12.1	11.6	12.4	11.6	7.2	8.6	8.2	
Marital status																	
Married	71.4	59.9	72.8	66.2	74.9	73.6	67.8	78.8	75.6	73.5	74.4	62.7	58.4	73.5	78.2	75.4	
Tribe																	
Chewa	17.8	26.2	16.8	5.2	57.5	4.1	7.2	0.3	80.6	4.4	3.5	8.2	6.3	87.0	1.6	4.9	
Yao	14.0	15.4	13.8	0.7	3.8	31.6	27.5	0.0	5.1	82.3	3.5	1.3	0.7	4.1	1.9	2.0	
Tumbuka	12.5	15.4	12.1	34.7	0.6	1.0	3.6	8.0	1.1	0.4	0.2	74.3	16.1	0.4	0.3	0.3	
Lomwe	12.5	14.4	12.3	1.1	3.2	28.0	24.9	0.5	4.5	7.7	71.1	0.9	1.9	1.9	1.3	2.9	
Sena	7.9	10.6	7.6	0.1	0.6	19.1	4.6	0.0	1.1	0.4	0.5	0.2	0.0	0.0	84.6	0.7	
Ngoni	11.5	7.9	12.0	4.5	30.6	5.7	20.3	0.8	4.5	3.3	0.5	10.2	1.6	1.9	2.2	86.3	
Tonga	8.7	3.1	9.2	23.9	1.3	0.3	0.7	0.0	0.8	0.2	0.0	1.7	69.5	2.2	0.3	1.0	
Amang'anja	4.5	3.8	4.5	0.5	1.4	9.7	11.1	0.0	2.0	0.7	19.7	0.4	0.9	1.1	7.8	1.0	
Nkhonde	0.3	0.5	0.3	1.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.6	1.9	0.0	0.0	0.0	
others	10.2	2.6	11.2	28.4	0.9	0.5	0.0	89.9	0.3	0.4	1.2	2.2	1.2	1.5	0.0	1.0	
Religion																	
catholic	18.9	19.4	18.8	19.0	22.3	16.7	22.7	17.9	22.8	4.9	24.8	27.5	10.7	8.1	17.0	34.2	
CCAP	18.9	22.0	18.5	28.4	14.6	13.5	20.3	30.3	20.3	2.4	26.9	34.3	20.3	7.8	4.4	13.8	
Anglican	3.4	6.5	3.0	1.6	5.0	3.9	5.7	1.0	1.9	6.4	1.4	0.2	3.5	13.7	2.2	1.0	
Adventist/Baptist	9.4	11.9	9.1	8.1	8.6	10.9	14.3	2.3	9.2	3.3	11.1	3.9	17.8	3.0	18.3	12.8	
Moslem	15.2	17.9	14.9	0.8	14.5	28.0	13.3	0.3	4.5	79.0	3.9	0.9	1.2	43.3	1.9	0.7	
others	34.2	22.3	35.8	42.2	35.0	26.9	23.7	48.2	41.2	4.0	31.8	33.2	46.5	24.1	56.2	37.5	
School attendance (Yes)	88.6	92.8	88.1	96.7	83.2	85.2	90.5	96.4	82.5	76.4	88.7	96.3	97.2	82.2	87.9	85.0	
Level of education																	
primary	65.6	45.2	68.4	57.3	70.9	70.4	57.0	59.2	66.7	76.9	74.9	57.8	55.0	69.8	69.5	76.7	
secondary	32.7	48.6	30.6	40.6	27.3	28.4	40.4	39.0	30.6	22.5	24.5	39.2	43.6	28.4	29.1	22.5	
tertiary	1.7	6.2	1.1	2.1	1.8	1.2	2.5	1.9	2.7	0.6	0.5	2.9	1.4	1.8	1.4	0.8	
Occupation																	
farming	42.9	14.7	46.4	46.6	51.7	34.2	27.2	55.8	51.1	31.2	30.2	46.4	38.4	50.4	50.6	53.4	
casual labour	12.8	13.5	12.7	10.7	9.5	16.6	15.9	7.5	8.4	14.8	23.7	11.4	12.8	10.4	10.4	10.1	
employed	10.9	24.4	9.2	11.0	10.0	11.5	16.6	10.5	13.1	11.3	12.6	9.9	12.6	8.2	5.3	7.8	
business	18.2	23.7	17.5	11.1	17.7	24.7	23.5	13.6	18.4	32.7	21.4	6.5	13.7	17.2	18.9	17.3	
student	12.5	20.3	11.5	18.5	7.6	10.4	12.9	11.3	7.3	8.4	9.8	22.7	20.5	9.0	11.6	6.8	
others	2.7	3.4	2.6	2.2	3.5	2.6	4.0	1.3	1.7	1.5	2.3	3.0	2.1	4.9	3.1	4.6	
Asset ownership																	
Radio	73.1	74.0	72.9	75.3	71.5	72.2	71.9	95.0	72.6	79.3	72.7	68.4	68.9	65.2	62.8	75.8	

Bicycle	55.5	43.1	57.1	54.2	52.2	58.6	34.8	91.1	58.3	78.1	60.0	52.9	35.0	51.4	56.8	45.7
House servant	3.2	6.2	2.7	4.5	2.6	2.5	2.4	17.3	5.3	5.1	2.1	4.8	2.6	0.0	1.3	1.8
Oxcart	2.8	0.3	3.2	6.4	2.5	0.4	0.0	16.3	2.1	0.0	0.5	11.2	0.0	0.4	1.0	5.0
Livestock	65.7	37.6	69.3	75.8	60.6	60.1	50.5	95.8	58.5	71.1	52.8	69.6	67.7	59.7	67.3	64.1
Thatched	73.0	38.6	77.3	75.2	73.3	70.9	55.8	94.9	65.6	89.2	58.4	71.2	65.8	82.0	78.6	74.5
Iron sheets	30.8	55.2	27.3	33.7	25.2	32.3	39.5	75.2	33.5	33.1	37.4	25.4	29.2	14.1	17.6	25.5
Electricity	6.5	33.7	2.6	7.2	8.0	5.0	12.3	10.0	15.1	7.4	1.4	10.4	3.3	5.1	1.4	2.2
Lamp	89.9	61.8	93.2	93.7	85.5	89.2	77.0	99.2	78.0	98.4	88.3	88.2	94.7	85.7	88.8	94.2
Pit latrine	92.5	77.8	94.2	96.7	88.0	91.4	88.8	100.0	83.6	97.5	95.5	93.6	97.1	88.1	79.3	93.2
Flash toile	2.8	17.2	0.7	2.9	4.5	1.6	3.3	3.7	9.8	3.3	0.0	5.1	0.5	1.6	1.1	0.7

Table 3: Characteristics of the women interviewed in the KABP survey

	Area		Region			Place of interview										
	Urban	Rural	North	Centre	South	Blantyre	Chitipa	Lilongwe	Mangochi	Mulanje	Mzimba	N/bay	N/kota	Nsanje	Ntcheu	
Mean age	38.1	37.1	35.9	39.1	36.7	36.4	35.9	37.7	33.9	36.5	34.7	37.3	39.6	40.5	40.3	
% married	84.2	82.4	82.4	82.3	82.9	83.5	81.8	90.8	81.7	79.2	89.0	76.1	80.0	87.7	74.1	
Tribe																
Chewa	31.2	20.5	4.1	58.4	6.9	15.6	0.0	77.2	4.1	3.0	5.8	6.0	94.5	5.0	1.7	
Yao	12.9	13.7	0.3	2.4	31.0	32.0	0.0	3.4	88.4	5.3	0.0	0.9	2.7	0.8	0.8	
Tumbuka	12.4	9.6	33.9	1.3	0.2	0.8	9.7	2.8	0.0	0.8	73.3	14.7	0.9	0.0	0.0	
Lomwe	7.6	9.6	0.6	1.6	21.2	15.6	0.0	2.8	0.8	63.6	0.0	1.7	0.9	0.8	0.8	
Sena	10.0	9.1	0.0	0.5	22.0	4.1	0.0	0.0	2.5	0.8	0.0	0.0	0.0	82.6	1.7	
Ngoni	14.7	14.9	5.0	34.6	6.7	22.1	0.0	11.7	1.7	0.8	14.2	0.0	0.0	2.5	94.9	
Tonga	2.9	8.4	26.5	0.0	0.4	1.6	0.0	0.0	0.0	0.0	3.3	74.1	0.0	0.0	0.0	
Amang'anja	3.53	4.44	0.00	0.27	10.28	8.20	0.00	0.69	1.65	22.73	0.00	0.00	0.00	7.44	0.00	
Nkhonde	0.6	0.3	1.2	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.8	1.7	0.0	0.0	0.0	
others	4.1	9.5	28.3	0.8	1.4	0.0	89.3	1.4	0.8	3.8	2.5	0.9	0.9	0.8	0.0	
Children																
% with children	96.4	94.9	94.7	96.2	94.3	95.1	95.2	95.0	92.6	94.7	93.3	95.7	98.2	95.0	95.7	
Religion																
catholic	17.3	17.4	17.4	20.5	15.0	27.0	11.4	22.9	4.1	22.9	29.2	10.4	2.8	5.1	34.9	
CCAP	14.3	17.5	29.4	13.6	11.0	14.8	42.9	17.4	0.8	24.4	30.8	15.7	4.6	2.5	17.4	
Anglican	9.5	2.9	2.6	6.9	2.6	6.6	0.0	0.0	3.3	0.8	0.8	7.0	23.1	0.0	0.0	
Adventist Baptist	6.5	5.9	7.4	5.0	5.7	8.2	2.9	4.2	3.3	9.2	0.8	18.3	2.8	1.7	8.3	
Muslim	17.3	14.8	0.3	14.1	26.2	15.6	0.0	3.5	85.1	4.6	0.0	0.9	40.7	0.8	1.8	
others	35.1	41.5	42.9	39.9	39.4	27.9	42.9	52.1	3.3	38.2	38.3	47.8	25.9	89.8	37.6	
School attendance																
yes	88.7	72.8	89.2	70.8	68.6	83.6	91.3	76.6	58.8	76.5	90.5	85.7	59.1	54.2	74.8	
primary	62.7	86.2	78.9	84.7	83.5	77.5	78.1	78.9	83.3	88.1	80.6	78.0	84.6	85.9	92.0	
secondary	34.7	13.4	20.1	14.5	15.9	21.6	21.9	19.3	16.7	11.9	18.5	20.0	15.4	12.5	8.0	
tertiary	2.7	0.4	1.0	0.8	0.6	1.0	0.0	1.8	0.0	0.0	0.9	2.0	0.0	1.6	0.0	

Occupation															
farming	36.1	71.9	67.7	76.8	58.9	48.4	67.6	71.0	56.2	47.0	66.7	69.0	80.7	85.7	80.3
casual labour	1.2	5.2	1.5	4.3	7.1	6.6	1.0	4.1	2.5	15.9	1.7	1.7	3.7	2.5	5.1
employed	10.7	2.3	5.6	2.7	2.6	2.5	3.8	2.1	4.1	2.3	7.5	5.2	3.7	1.7	2.6
business	39.1	15.9	18.5	13.2	24.1	35.2	22.9	17.9	28.9	24.2	15.8	17.2	10.1	7.6	10.3
student	0.6	0.7	1.8	0.0	0.4	1.6	2.9	0.0	0.0	0.0	0.8	1.7	0.0	0.0	0.0
unemployed	9.5	3.7	5.0	1.6	6.3	4.9	1.9	2.8	8.3	9.8	7.5	5.2	0.0	1.7	1.7
other	3.0	0.3	0.0	1.3	0.6	0.8	0.0	2.1	0.0	0.8	0.0	0.0	1.8	0.8	0.0
Asset ownership															
Radio	81.7	62.0	70.2	58.4	66.7	76.3	98.5	64.1	73.6	66.4	68.3	55.7	54.5	52.5	55.1
Bicycle	42.3	49.0	51.0	40.8	52.1	39.6	98.1	47.6	64.8	53.4	45.8	34.8	44.5	52.5	28.8
House servant	9.7	2.5	3.8	4.3	3.1	2.5	66.7	4.8	3.2	2.5	4.2	1.7	5.5	4.2	2.5
Oxcart	1.8	2.6	6.3	1.9	0.9	0.8	75.0	2.8	3.1	0.8	9.2	0.9	0.9	0.0	1.7
Livestock	44.0	64.2	65.9	56.9	61.7	67.9	98.7	51.8	60.2	54.3	57.1	53.5	52.3	65.5	67.9
Thatched house	35.9	79.1	76.0	74.5	71.1	63.1	100.0	66.0	87.0	50.4	65.5	71.7	80.7	87.7	78.8
Iron sheets	72.4	30.1	39.8	25.9	45.1	63.8	100.0	35.7	40.0	49.6	34.5	28.3	18.2	25.7	21.2
Electricity	39.0	2.4	9.0	7.9	7.8	16.4	100.0	14.8	9.8	2.3	11.8	4.4	6.5	4.2	0.8
Lamp	68.6	92.9	91.0	85.0	92.6	89.5	100.0	81.9	94.9	98.5	81.4	93.7	81.8	86.5	91.5
Pit latrine	86.0	92.0	95.1	89.6	89.7	94.1	100.0	85.1	98.3	96.9	92.4	93.6	89.7	68.4	94.9
Flash toilet	17.9	0.5	3.1	3.7	3.1	5.2	0.0	8.5	6.1	0.8	6.3	0.0	1.9	2.0	0.0

4.2 DETERMINANTS OF MALE CIRCUMCISION IN MALAWI

4.2.1 Religion

Circumcision has historically been associated with religious practice and in Malawi the practice is common among Muslims. Published evidence from surveys conducted in Malawi report that most respondents had been circumcised for religious reasons⁹. This is corroborated by findings from key informant interviews conducted during the desk review which indicate that male circumcision is an Islamic religious ritual predominantly practiced among Moslems throughout the country. Key informants reported that it is a religious requirement for all Moslem men to be circumcised and for this reason, they pointed out that almost 100% of Moslem adolescents and men are circumcised. As a religious ritual, they expressed that Moslem men are circumcised as a precondition for joining Islam or being a Moslem man. Almost all the respondents noted that it is predominantly practiced among Moslems throughout the country. They observed that it is a religious requirement for all Moslem men to be circumcised. Thus one respondent said,

“R: Ok, because this issue is more of an Islamic practice, most of the people that are circumcised are Muslims. But for us Christians this practice is still not known, maybe that’s why we are not circumcised.” (IDI #15).

Another retorted:

“If one is being circumcised, people would think that one is changing religion from Christianity to Islam especially if they are not told why people get circumcised because circumcision is associated with the Islamic faith. There are more Christians than Muslims here so you can easily know that this one is a Muslim and this one is a Christian if they are circumcised or not”. (IDI # 16)

Published literature indicates that Muslims practice circumcision as an affirmation of their relationship with God in a practice also called *tahera* meaning purification¹⁰, a sentiment reported by Moslem informants in the key informant interviews who explain that circumcision is associated with cleanliness among Moslem men and that those that are not circumcised are seen as unclean. In fact, our respondents explained that Prophet Muhammad (Peace be upon him) himself was circumcised as a sign of being clean and he urged all true Moslem men to emulate his example. They also explained that circumcision is recognized in the Bible and that all the Prophets in the Old Testament were circumcised including Jesus Christ. One FGD participant said; *“Yes it was written in the Bible. God told the Israelites not to be with an uncircumcised person”.* (P3, FGD 10).

Another participant said; *“When we closely look at the word circumcision it’s not that it has just started now, it was there during the days of Jesus and generation of Jesus. It was part of their culture during that time. That is why here many who do circumcision are Muslims; because it was a ritual during the time of Muhammad who founded their religion. That is*

⁹ ORC MACRO, (2004) Malawi Demographic and Health Survey 2004. Calverton, Maryland: ORC Macro.

¹⁰ UNAIDS. Male circumcision: global trends and determinants of prevalence, safety and acceptability. UNAIDS and WHO. 2007. Geneva.

why they like doing circumcision, but we cannot say it was their laws, but it was just their culture or cultural norms". (P5, FGD 2).

Apart from Muslim faith, other religions practice circumcision as a religious ritual e.g. among the Jewish religions but the practice does not appear to be mandatory among the other religions who mostly take a neutral stance on circumcision. As explained by one Muslim respondent, circumcision is recognized in the Bible and that all the prophets in the Old Testament were circumcised including Jesus Christ. Despite this, apart from Moslems, there are some Christians who also circumcise their children especially those that belong to the Yao tribe as part of their culture. For example, in Mangochi district it is reported from the KII that 75% of Yao's who Christians are also circumcised regardless of their religious affiliation. Christian men from other tribes also go through the circumcision process if they want to join Islam. This usually happens when a man is marrying a Moslem woman. On average, it is reported by the key informants that about 5 to 10% of all male circumcisions done per year in the areas where the interviews took place happen because of the above reasons.

In the Malawi Demographic and Health Survey (MDHS) of 2004¹¹, circumcision was reported to have been undertaken among 93.3% of the Muslims, 13.9 of Christians, 21.2 % of Seventh day Adventist and Baptist, 19.4 of Anglicans, 6.1% of the CCAP and 8.6% of Catholic men aged between 15 and 49 sampled in the survey. A national survey amongst adolescents conducted in 2004 reports a similar trend with circumcision being commonest amongst Muslim youth (78%) as opposed to only 3% amongst Catholics, 6.3% amongst Protestants, 14.3% amongst Revivalists and 6.1% amongst other religions.¹²

In the KABP survey conducted as part of the male circumcision situation analysis, circumcision was reported to have been undertaken among 96,4% of the Muslims, 13.0 of other Christians, 16.4 % of Seventh day Adventist and Baptist, 38.1 of Anglicans, 16.1% of the CCAP and 8.6% of Catholic men (Table 2). When respondents for the KABP survey were asked why male circumcision is carried, the majority (over 85%) irrespective of education status, ethnicity, religion nor age thought male circumcision is done because of religion.

4.2.2 Ethnicity

Apart from religion, ethnicity appears to be the other major determinant of circumcision in Malawi. Information from KII indicated almost all men of the Yao tribe are circumcised. Respondents indicated that male circumcision has been part of Yao culture for centuries and that it has been passed on from one generation to the other among the Yao. They observed that Arabs who brought Islam to the Yao people found them already practicing Male Circumcision.

Information from key informants and focus group participants from Mangochi, Mulanje and Blantyre indicated that men of the Yao, Lomwe and Mang'anja tribes

¹¹ ORC MACRO, (2004) Malawi Demographic and Health Survey 2004. Calverton, Maryland: ORC Macro.

¹² Munthali AC, Zulu EM. The timing and role of initiation rites in preparing young people for adolescence and responsible sexual and reproductive health behaviour. African Journal of Reproductive Health. 2007; 11[3]:150 – 167.

are circumcised during traditional initiation ceremonies. They indicated that male circumcision has been part of their cultures for centuries and that it has been passed on from one generation to the other. They also observed that circumcision among the Yao involves complete removal of the foreskin while that of the Lomwe, for example, involves partial removal of the foreskin. The two quotations below highlight this;

“As part of promoting our Lomwe culture, a lot of people go there to practice their culture so they go to Tsimba so as to be circumcised and not to be seen as children”. (P4, FGD 10).

“Both Muslims and Lomwes practice circumcision but they are different in the way they use it and their circumcision is different. The Yaos is complete while the Lomwes is partial. The Yao remove the whole foreskin while the Lomwe just cut part of it so as there is bleeding”. (P6, FGD 10)

As a cultural practice, male circumcision is a rite of passage for boys. For a boy to become a man in the three tribes, he has to undergo circumcision. As a rite of passage, circumcision is performed during the traditional initiation ceremonies at the initiation camp commonly known as *Ndagala* among the Yao, *Tsimba* among the Mang'anja and *Thezo/Zoma* among the Lomwe. The participants also noted that traditional male circumcision is not practised among the Chewa, Sena, Tonga, Ngoni, Tumbuka and Lambya. However, they emphasized that men from such tribes undergo circumcision whenever they want to join Islam, marry Muslim women, on medical reasons and upon their personal requests at the hospital.

One of the respondents said, *“traditionally... male circumcision is not a part of the custom here in Nkhatabay unlike may be in the Yao culture..... people who come for circumcision either come on personal requests at the hospital or when a patient has a medical indication that requires them to have circumcision but otherwise generally as a custom here in Nkhatabay-Bay amongst the Tonga people circumcision is not part of their culture.” (IDI # 121).*

Another respondent said; *“We've not talked to a lot of people concerning male circumcision, but what they know in their hearts is that circumcision is for our friends from the southern region, they think those are the ones who get circumcised, but it's because they don't know and understand it. Maybe it's because it has something to do with AIDS that's why it's rarely talked about and they consider it to be more of culture and tradition of our friends rather than ones responsibility to protect themselves from the HIV virus”. (IDI # 16)*

Another participant also said; *“The problem with circumcision is that it is done by Muslims, so, let the Muslims do it. As for us, we are Chewa and we do what is for us as Chewa, which is how it should be”. (P10, FGD 2).*

Here the participants were very quick to point out that nowadays there are stories from the media linking male circumcision to the prevention of HIV transmission. As a result of this, there is an increasing demand for male circumcision services in both government and private hospitals. They also observed that most men who are accessing these services are educated ones who have read the literature about the reduced risk of HIV infection among circumcised men.

Respondents, especially from Mangochi also noted that there are some members of other tribes or ethnic groups that undergo circumcision when they would like to join Islam or marry a Moslem woman/Yao woman. In Islam, to which the majority of Yao people belong, uncircumcised men are considered as unclean and they are sometimes stigmatized.

National survey data also indicates this to be the case. For example, among respondents in the 2004 MDHS who reported to have been circumcised, 82.3% belonged to the Yao tribe, 29.8% to the Lomwe tribe, while amongst other tribes the prevalence of circumcision was generally very low, below 7%. Amongst adolescents in the 2004 national survey as part of the Protecting the Next Generation: Understanding HIV Risk Among the Youth (PNG) Project conducted by the Guttmacher Institute, the majority of circumcised adolescents were from the Yao tribe (63.5%) followed by the Lomwe (15.9%), Mang'anja tribes (9.7%), Chewa (9.0%), Sena (6.3%) and almost none (<1%) amongst the Tumbuka, Tonga, Ngoni and Nkhonde tribes.¹³

This is further corroborated in the 2009 male circumcision situation Analysis which indicates that amongst Yao respondents, 90.3% were circumcised and among the Lomwe, Mang'amja and Chewa respondents the rates were 42.8%, 30.9% and 26.8% respectively whereas in the other tribes the less than 10% of the respondents were circumcised.

In the ethnic groups practicing circumcision, especially amongst the Yao of Mangochi and other parts of Malawi, circumcision is performed as a rite of passage, during the *Jando* initiation ceremony. During this ceremony, male initiates are circumcised as a sign of manhood and faithfulness to their cultures and this typically happens in and around puberty. Male circumcisions are also performed on religious grounds. In Islam, male circumcision is considered as a religious ritual for male Moslems. These circumcisions are either done at *Jando* or in a mosque. The only difference is that initiates who are circumcised at a mosque are taught the Islamic beliefs while those go through the *Jando* ceremony are taught traditional beliefs and social norms. Additionally, male circumcisions are performed on social grounds. Among the Yao, male circumcision is a requirement for marrying a Moslem/Yao woman. Usually, order males (24 years above) who want to marry are the ones who fall under this category. The circumcision is done on demand and it is performed at home.

In these communities, uncircumcised men are considered as unclean among the Yao and they are sometimes stigmatized. However, among the Lomwe and the Amang'anja, such stigmatization is not common. In fact, among the Lomwe and the Amang'anja, uninitiated men are the ones who are stigmatized. They are called all sorts of names such as *wodyera ku nkongo* (one who eats with his back) and *mlukhu osavinidwa* (uninitiated). They are not allowed to visit initiation camps and if they dare to come close, they are caught and initiated against their will. They are also seen as people who are not grown up (they are considered as children by those who are initiated)

¹³ Munthali AC, Zulu E, Madise N, Moore A, Konyani S, Kaphuka J and Maluwa Banda D. Adolescent sexual and reproductive health in Malawi: Results from the 2004 National Survey of adolescents. Occasional report no 24. New York: Guttmacher Institute.

However, there are some Lomwe who have stayed with the Yao for a long time and they also circumcise their boys as a custom. As such, both the Yao and Lomwe practice circumcision as part of their cultures. The Lomwe practice circumcision during the *Chidototo/Simba* traditional initiation ceremony. The initiates who undergo circumcisions at the *Simba* go through some sufferings and tough time during the initiation ceremonies and these hardships make them become enduring and persevering people. In addition, instructions about morality and personal hygiene are given to the initiates during the ceremony.

4.2.3 Social determinants

Social desirability

Male circumcision is also performed because of social or health related reasons. A desire to conform may be a strong determinant for demanding circumcision and this is mentioned as a potential factor especially amongst ethnic groups living amongst the Yao tribe. As indicated earlier especially by respondents in Mangochi, uncircumcised men are stigmatized and thus demand circumcision to conform and respondents indicate that up to about 10% of the circumcisions in places such as Mangochi may be due to this. Additionally apart from religious demands, those marrying into Yao communities typically have to undergo circumcision whether or not they join Islam as a religion. Munthali et al., (2006)¹⁴ in a study amongst adolescents in selected districts of Malawi report youth as indicating that they underwent circumcision because they envied peers who had been circumcised and undergone initiation ceremonies. In the same study, another influence to undergo circumcision was the presents that new initiates are given as part of the initiation ceremony.

Most of the participants in the in-depth interviews and focus group discussions stated that they had heard about the association between male circumcision and a reduced risk of HIV infection before they were asked to participate in this particular study. Most of them said that they got this information in the media, workshops and in some literature that has been published about studies that were conducted in some countries in sub-Saharan Africa. Through these sources of information, they were convinced that circumcised men have a reduced chance of contracting or transmitting HIV to their sex partners. One respondent said,

“R: Yea we....we have read and I have attended ...um... some workshops where results of ... research done in some parts of Africa had revealed that there was a link between males who are circumcised and the reduction in HIV transmission.” (IDI # 21).

Another respondent said

“R: Yeah, I know. In fact I have attended several meetings like I attended one which was hosted by Banja La Mtsogolo and it was discussed that there is an association between the two. The one who was facilitating the workshop said that when a man is circumcised, the

¹⁴ Munthali AC, More AM, Konyani S and Zakeyo B. Qualitative evidence of adolescent's sexual and reproductive health experiences in selected districts of Malawi. 2006. Occasional Report no 24. New York: Guttmacher Institute.

foreskin is removed and it leaves the front of the penis to be hard making it difficult to be easily cracked and even if that man sleeps with an infected woman he doesn't have cuts and because the HIV normally penetrates the blood through an opening on the skin, by a certain percentage, a circumcised man is protected but the protection is I mean not 100%. Yeah." (IDI # 1).

This particular respondent just like the other respondents noted that male circumcision does not offer 100% protection against HIV infection. In fact, almost all respondents stated that the studies that were done reported that male circumcision could reduce HIV infection by 60%.

When they were asked to explain why they thought this was the case, some respondents attributed the reduced risk of HIV infection to the fact that the foreskins of circumcised men do not retain vaginal fluids after intercourse and that they are so hard (strong) that they do not develop cuts during intercourse as a result of friction. *"In some literature they say that uncircumcised people are pre-disposed to get HIV/AIDS because of the foreskin than those who are circumcised since their foreskins have some evidence of putting some mucus or fluids so once you remove it then the foreskin of the penis it is dry so those fluids which are... they prefer to ...their media for HIV/AIDS they cannot survive".* (IDI # 22).

Another respondent said, *"R: Ya currently I could proudly say from my understanding and from the experience that I have had of course we could agree that there is association or relationship between male circumcision and the reduction of risk of HIV/AIDS transmission. Currently I could proudly say there has been ah of course a relationship in the sense that when somebody is circumcised, he has a reduced chance of becoming infected with the virus. The formation of the skin when it has been exposed and one which has not been exposed are different in texture so having that with a different texture you have a harder texture to the skin that has been circumcised because it has been exposed while the one which is not exposed because it hasn't been circumcised is a bit stiffer. So as a result when there is that friction and the cuts have been made it will be difficult for somebody whose skin is hard to have some cuts unlike the one with soft skin the cuts are very easily to be made. So in such a way if you have cuts that is a direct entry point for HIV unlike a place where you don't have any cuts so we are looking at the place where we have soft tissues and hard tissues that's where the demarcation comes in."* (IDI # 10).

The respondents also welcomed the idea of introducing male circumcision as one of the prevention strategies against HIV infection. They stated that it was a positive step towards combating the HIV/AIDS pandemic. One respondent felt that male circumcision is better than condom use in the sense that it is done once and does not need to be repeated every time one is having sexual intercourse like the condom. However, the respondent was skeptical about the 60% reduced risk of HIV infection among circumcised men. She noted that the 60% reduced risk could not be guaranteed for every circumcised man. She observed that condom use offers almost 99% protection from HIV infection if it is used consistently and effectively unlike the 60% reduced risk of HIV infection offered by male circumcision. Thus *"R: Well it's something positive (laughing) (I: can you explain what you mean?). I mean we can have an additional method that can help prevent HIV transmission I know (I: mmh) especially that the intervention is only applied once (I: mmh) as compared to a condom for example that has to be used every time (I: mmh) people have sexual intercourse (I: mmh) so I think it is one of the best ways for circumcised men to prevent themselves from HIV/AIDS. But the problem*

of this method is the issue of probability which you can't guarantee (laughing) I mean the 60% chance can not guarantee every individual that they will not get HIV infection (laughing) (I:mmh) so if you are giving 60% chance what about one who wears a condom? I know its 99% to 1% if it is used effectively." (IDI # 27).

On the same issue of male circumcision, one of the respondents wondered whether male circumcision indeed reduces the chance of HIV infection. Of course he admitted that he had heard rumors that male circumcision reduces the risk of HIV infection but that he did not have the evidence and was skeptical about the reduced risk. He talked about the high death rates of people in areas that are predominantly circumcising as one of the reasons for his skepticism about this issue. He thus said, *"Yea I have heard it as a rumor. I will put it in that way. My question has always been how true this rumor is because I still believe, unless proven otherwise that at the moment those who are practicing male circumcision are mostly our colleagues the Muslims. My question which I would put forward to you is that have you gone to Muslim areas and have you been told that they are not dying? Because if you go for instance, to a district like Mangochi which is perceived to be a Muslim area and you are told nobody has never died of HIV/AIDS then this research you are trying to pursue will be seen to be effective because now government will implement it by saying from today onwards let all Malawian males go for circumcision. So, I doubt about this reduced risk based on death rates in those areas where there are Muslims who undergo male circumcisions. So I have heard about it but I don't have evidence to that effect. I will just tell you for your information that I had my cousin who actually passed away and yet he was circumcised when he was 38 years old. So, I have problems with it (male circumcision). As such, what I will only suggest is that if it is proved that it is effective then I think it should start from childhood. Adults may be but I still believe that there will be some problems because somebody who is 38 or 30 years old to undergo circumcision I don't know. Yah, so, what I can say at the moment is that I have heard about it but I don't have the evidence." (IDI # 12).*

Socioeconomic status

Elsewhere, especially in western European countries circumcision has been associated with socioeconomic status. There is a paucity of published data on association between male circumcision and socioeconomic status. The only nationally representative study in Malawi that looked at male circumcision and socioeconomic status is the 2004 MDHS¹⁵ which found no major differences in prevalence of male circumcision by wealth quintile, urban/rural or education status as indicated in Figure 1 below.

¹⁵ ORC MACRO, (2004) Malawi Demographic and Health Survey 2004. Calverton, Maryland: ORC Macro.

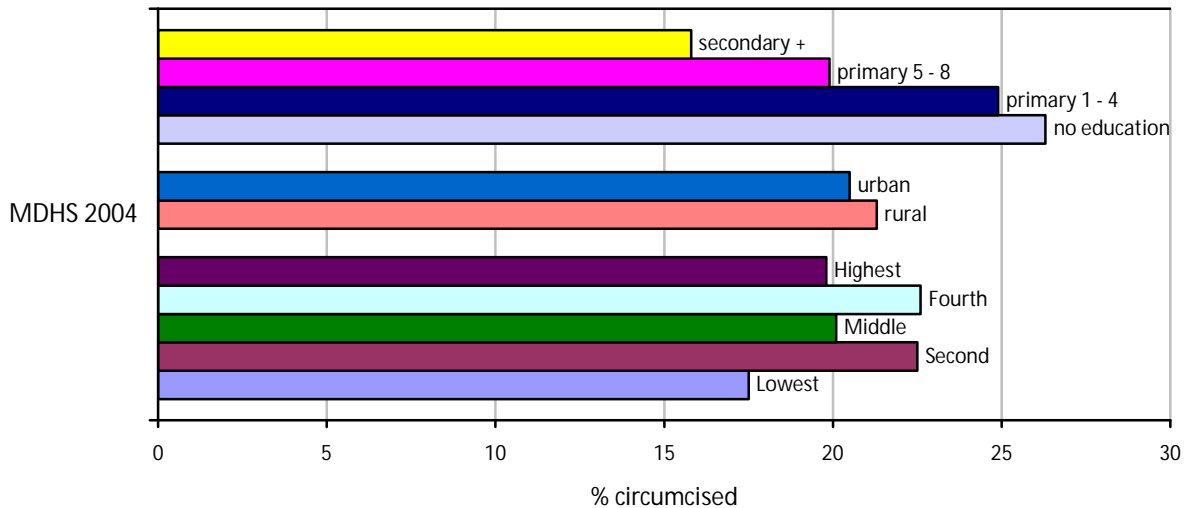


Figure 1: Percentage of men aged 15-49 circumcised by wealth quintile in the 2004 Malawi demographic and Health Survey

In the 2009 SITAN circumcision was more common amongst those that reported to have been married and those who had only a primary education compared to the unmarried and those with secondary or higher education (Figure 2)

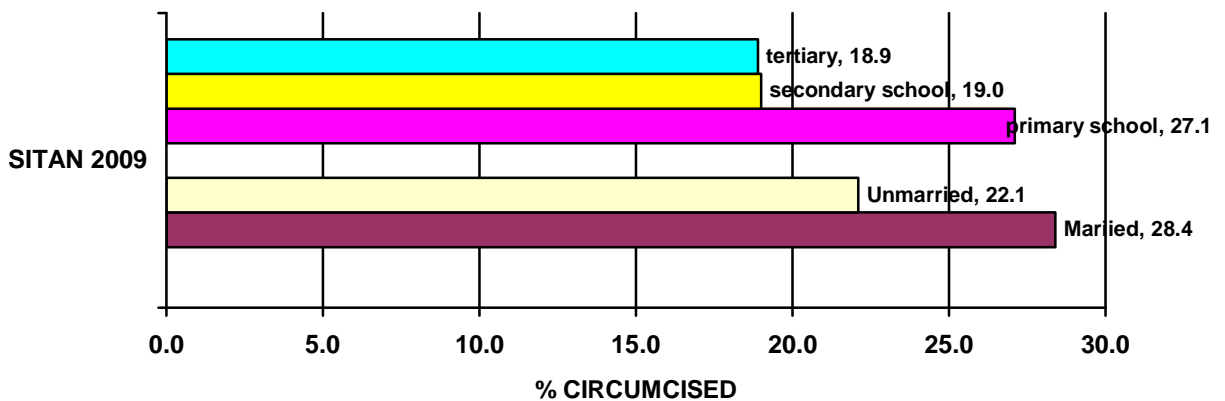


Figure 2: Percentage of men aged 15-49 circumcised by education level and marital status in the 2009 situation analysis.

Perceived health and sexual benefits

Amongst the published and unpublished literature and interviews with key informants there is some indication to suggest that male circumcision in Malawi is driven by perceived health benefits. Amongst Muslim informants it was reported that male circumcision aids cleanliness. Ngalande et al., 2004 report in their study that respondents associated male circumcision with better genital hygiene and less risk of sexually transmitted infections and early diagnosis and treatment of genital conditions. Additionally respondents report perceived enhanced sexual pleasure amongst partners of males who are circumcised¹⁶.

¹⁶ Ngalande R, Levy J, Kaponda C and Bailey R. Acceptability of male circumcision for prevention of HIV infection in Malawi. AIDS Behaviour 2006, 10(4):377 – 385.

In another study by Limwame and Kumwenda (2008) women groups interviewed from the central region were of the view that a circumcised penis is not sexually satisfying because the circumcised men are perceived to be cold and slippery.¹⁷ Another study by the Malawi Human Rights Commission (MHRC), (2005) reports among others that circumcision is carried out to protect young boys from hurting themselves when they have sex with a girl and also that circumcised boys especially those circumcised in traditional settings were better sexual performers as opposed to those who underwent circumcision within a Christian/Islamic setting who eventually suffer from divorce in later life because they are not as good sexual performers.¹⁸

Among the studies cited that looked at knowledge attitudes and practices only the respondents in the study by Limwame and Kumwenda (2008) mentioned any beneficial effect of male circumcision in preventing HIV infection. It is reported that male circumcision prevents HIV infection because the foreskin hides the virus and removing it therefore reduces risk of infection. Additionally, *a circumcised man can wash away the virus after taking a bath as well as because the penis head becomes hardened to survive bruises when having sex which can expose one to infection.* However other respondents from the same survey reported that they had never heard of circumcision as a way of HIV prevention and that circumcision cannot prevent HIV infection but other sexually transmitted infections.

In the 2009 SITAN, male circumcision was associated with perceived health benefits amongst 10.7% of the urban respondents as opposed to 5.1% of the urban respondents. Amongst the regions, circumcision was said to be beneficial for health reasons among 9.7% of respondents in the south, 5.1% in the centre and 3.9% in the north. The majority however thought circumcision was mostly for religious reasons. Respondents from Mangochi, Blantyre, Mulanje and Nsanje were more likely to associate male circumcision with perceived health benefits (about 10%) while very few of the respondents in other districts thought circumcision had any health benefits. In terms of education, those that had attained secondary and tertiary education were more likely to perceive circumcision as having health benefits (8.2% and 6.8% respectively) compared to only 4.8% amongst those with only primary education. Ethnically, male circumcision was more likely to be associated with health benefits in the circumcising ethnic groups of the Yao, Lomwe, and Mang'amja than the other ethnic groups while the Yao (17.6%) were more likely to associate male circumcision with health benefits than the other ethnic groups (< 10%).

4.2.4 Medical indications

There is a lack of published or collated information on circumcisions conducted on demand in Malawi. To get a glimpse of the range of medical indications for circumcision data was abstracted from selected health facilities as explained in section 2.3. A total of 1734 individual level data on male circumcisions were abstracted in 10 government health facilities in period 2006-2008. Common indications for male circumcision identified included religion, cosmetic, on demand,

¹⁷ Limwame K and Kumwenda M. 2008. HIV prevention and Multiple Concurrent Partnerships in Malawi.

¹⁸ Malawi Human Rights Commission. 2005. Cultural Practices and their Impact on the Enjoyment of Human Rights , Particularly the rights of women and Children.

paraphimosis, phimosis, warts, ritual and initiation. These are summarized in the Table 4 below. As shown in the table, medical indications and demand accounted for only 24.1% of all the circumcisions recorded and abstracted from the selected health facilities. This would suggest that overall medical indications may not be the major determinant of circumcisions in Malawi. However when data from Mangochi is removed because only summary data were available and also where the main indication is religious or ritual, medical indications assume a prominent indication for circumcision in the other facilities. This data has to be viewed with caution because of the incompleteness of the hospital records as well as the unrepresentativeness of the facilities sampled. Anecdotal evidence also suggest that uptake of male circumcision on demand has over the past 2 to 3 years increased substantially especially in the private sector.¹⁹

Table 4: Indications of male circumcision in selected hospitals

Indication	Frequency	Percent
Cosmetic	8	0.5
On demand	12	0.7
Paraphimosis	63	3.6
Phimosis	344	19.8
Warts	11	0.6
Religion	1186	68.4
Ritual and initiation	26	1.5
Missing	84	4.8
Total	1734	100

5. DISTRIBUTION OF MALE CIRCUMCSION IN MALAWI

5.1 PREVALENCE OF MALE CIRCUMCISION IN MALAWI

From the desk review only two nationally representative surveys had looked at prevalence of male circumcision in Malawi prior to the present situation analysis, both conducted in 2004. According to the Malawi Demographic and Health Survey of 2004, the estimated prevalence of male circumcision amongst men aged 15 to 49 years was 20.7%. Circumcision amongst males was commonest in the southern region at 33.1% followed by the centre (12.2%) and northern region (5%). From this survey, circumcision was more common in older age groups, 25 years and above where it was about 21% and above compared to the younger age groups, less than 25 years of age where circumcision rates were 18.4% in the 15-19 years age group and 17.1% in the 20-24 years age group. As indicated in the section on determinants circumcision rates also varied by religion and ethnic group (Figure 1) being more common amongst Moslems and amongst the Yao tribe.²⁰ The results from the two surveys are reproduced in Table 5 below.

¹⁹ In the reporting period, while QECH reported having conducted 102 circumcisions in 2008, a private clinic, BLM reports to have conducted 170 circumcisions and the majority were for perceived health benefits or cosmetic considerations.

²⁰ ORC MACRO, (2004) Malawi Demographic and Health Survey 2004. Calverton, Maryland: ORC Macro.

Table 5. Prevalence of male circumcision by background characteristics according to the MDHS 2004, PNG 2004 survey, and circumcision situation analysis 2009.

Background characteristic	Percent circumcised		
	MDHS (n = 3114)	PNG (n = 2052)	SITAN (N = 3734)
Age			
12-14		17.0	
15-19	18.4	24.2	25.5
20-24	17.1		26.9
25-29	20.8		25.7
30-34	21.4		25.5
35-39	25.0		24.5
40-44	26.7		28.9
45-49	22.3		21.4
>50			31.8
Region			
North	5.0	2.0	4.7
Centre	12.2	12.3	20.2
South	33.1	34.5	49.6
Residence			
Rural	21.3	21.9	28.3
Urban	20.5	17.2	26.4
Total	20.7	21.0	26.7

Similar figures are reported in the PNG survey of 2004 where overall circumcision rates amongst adolescents was found to be 17% with similar regional, religious and ethnic variations as in the MDHS survey.²¹

In the SITAN 2009, circumcision is reported amongst 26.7% of all males sampled which may be an indication of an increase over the 2004 reported prevalence of 20.7%. Age, place of residence and regional trends follow the same patterns reported in 2004 (Table 6). However in the SITAN 2009, the prevalence of circumcision has increased in the centre and southern regions by approximately 8 and 16% respectively while it has remained almost the same in the northern region.

If the current rates are applied to the population religious distribution reported in the 2008 Population and Housing Census, the above rates would translate, based on current population, into 636, 347 of the male population aged 18 and above as having been circumcised and just over 5 million not circumcised in Malawi²². The lowest number of circumcised males is in the northern region at 45, 730 while 205, 461 and 370, 948 men aged 15 and above are circumcised in the central and southern regions respectively (Table 4).

²¹ Munthali AC, Zulu E, Madise N, Moore A, Konyani S, Kaphuka J and Maluwa Banda D. Adolescent sexual and reproductive health in Malawi: Results from the 2004 National Survey of adolescents. Occasional report no 24. New York: Guttmacher Institute

²² Applying the prevalence rate of 26.7% circumcision in the population 18 and above based on the SITAN 2009; percentage of Moslems estimated at 13% and Christians at 80% based on the 2009 population census; and population of males aged 18 and above estimated at 6, 365, 771 on results of the 2009 population census.

Table 6. Distribution of population circumcised in Malawi by region

All religions (excluding % religion	% circumcised	population 18+	# religion	# circumcised	
Christians	80	11.6	2,972,335	2,377,868	275,833
Moslems	13	93.3	2,972,335	386,404	360,515
					636,347
Christians					
North	96	11.6	378,905	363,749	42,195
Centre	83	11.6	1,271,497	1,055,343	122,420
South	73	11.6	1,321,933	965,011	111,941
					276,556
Muslims					
North	1	93.3	378,905	3,789	3,535
Centre	7	93.3	1,271,497	89,005	83,041
South	21	93.3	1,321,933	277,606	259,006
					345,583
Totals					
North					45,730
Centre					205,461
South					370,948

1. Religion distribution based on Population and Housing Census 2008
2. % circumcised based on the MDHS 2004
3. Population figures based on 2008 Population and Housing Census results

Overall, the country prevalence as estimated by the present situation analysis is 26.7% compared to 20.9% in DHS2004. The pattern among the regions has remained the same, with more in the southern region (49.6%), followed by the central region with prevalence of 20.2%, and the northern region being the least (4.7%). The Figure below shows an increasing trend in the south and central regions, whereas this has remained constant in the northern region.

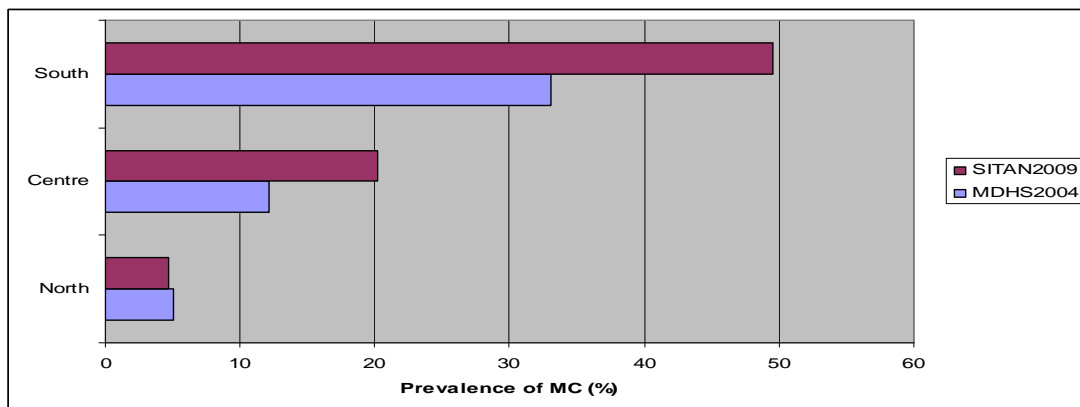


Figure 3: The prevalence of male circumcision by region for the years 2004 and 2009, based on the MDHS (2004) and Situation Analysis KAP survey (2009).

District prevalence of male circumcision is presented in figure 4 and Figure 6 below which shows a high prevalence of circumcision in Mangochi (90.2%), Mulanje (51.4%), Blantyre (32.7%) and Nkhoswe (54.6%) while it is reported at less than 10% in the rest of the sampled districts. When the prevalence by ethnic group is applied nationally based on ethnic distribution of the population in Malawi the

picture appears as in Figure 5. As expected high prevalence of male circumcision is observed in the southern followed by the central and northern regions and is mostly concentrated along the Yao and Lomwe dominated districts of the southern region and along the lakeshore districts with high Muslim populations. As observed above, there has been increase in proportions of males circumcised in the circumcising districts when compared to the levels in 2004 while it has remained largely at the same level in the other districts.

As part of the SITAN 2009 KABP Survey respondents were not only asked about their perceived circumcision status but also given a standard definition of what constitutes male circumcision. Based on the standard definition, the reported circumcision prevalence of 26.6 drops to 23.0 meaning that about 3.6% of the population that considered themselves circumcised were in fact probably not circumcised by standard WHO definition. However no visual inspection was performed as part of the KABP survey. The differences are attenuated mostly amongst the Lomwe tribes of Mulanje where the reported circumcision status of 51.4% drops by almost half to 24.6 when the standard definition was provided to the respondents likely reflecting the practice of circumcision in the district which is not really complete removal of the foreskin but partial circumcision. This is further corroborated in the knowledge section where despite a high circumcision rate reported for the district, correct knowledge of circumcision is low compared to the other high circumcising district of Mangochi.

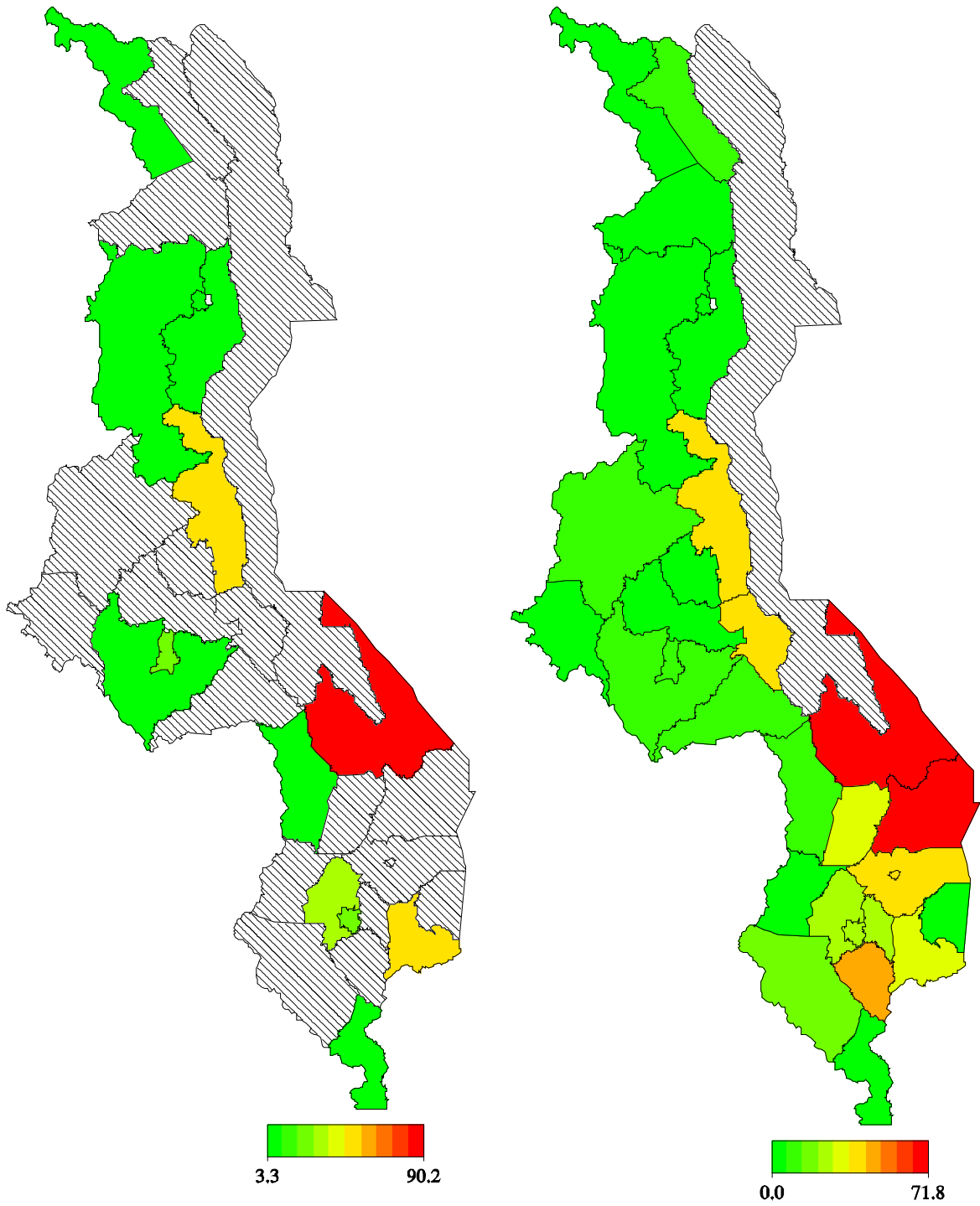


Figure 4: Map of male circumcision showing prevalence (%) at sampled district level. (Left panel)

Figure 5: Map of male circumcision showing projected district prevalence (%) based on district ethnic distribution. (Right panel)

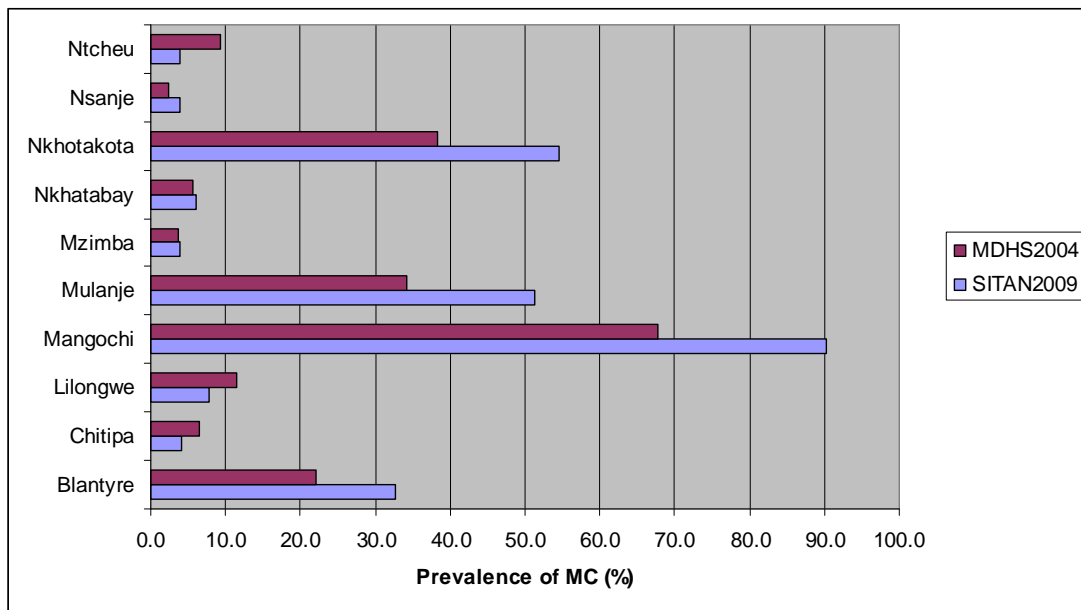


Figure 6: Prevalence of male circumcision in selected districts in 2004 and 2009.

5.2 AGE AT MALE CIRCUMCISION

5.2.1 Age at which male circumcision is conducted

Most focus group participants in all categories noted that ethnic groups that circumcise send their children for Male Circumcision between the ages of 9 and 12 year (below 24 years). They said the adolescents are circumcised at this age range because it is the age of the right of passage from childhood and adulthood in those ethnic groups. During this period, the male children are sent to initiation camps for initiation rites and they are circumcised as part of their rite of passage. They also noted that middle aged (25 -40 yrs) men are circumcised when they would like to marry a Moslem woman or would like to become a Moslem. Thus

"...sometimes we hear that a grown up man who has married a Muslim goes for circumcision and they let it." (P10, FGD 1).

They also observed that middle aged men nowadays are getting circumcised on hygienic grounds after being advised to do so by medical doctors.

From the sample of 1734 abstracted hospital records as part of the desk review process, 88.6% were circumcised before the age of 18 years while the majority of these were between the ages of 5 and 10 years (69.2%) (Table 7).

Table 7: Age distribution of males circumcised in selected district hospitals

Age	Frequency	Percent
<5 years	179	10.3
5-10 years	1200	69.2
11-17 years	100	6.8
>17 years	203	11.4
Missing	52	3.0
Total	1734	100

The age distribution of male circumcisions conducted in the health facilities (Table 7) is likely a reflection of the variation in the indications for conducting the circumcision. Table 8 shows indications of circumcision by region including both individual level data and summary data. There is substantial regional variation in the indications. For example, in the northern region 54.6% of circumcisions were conducted for medical indications, and 18.5% were for religion, followed by rituals and on demand, each contributing 7.6% respectively. In the centre, medical indications accounted for 84.5% of all circumcision recorded, while ritual circumcision was second at 4.7%, followed by religious purposes circumcision. However in the southern region it is observed that even in facilities most circumcision occurs for religious purposes (89.3%).

Qualitative data indicates that with the advent of HIV, there has been an increase in circumcisions conducted for religious reasons within the public health sector especially in circumcising communities of Mangochi²³. Because of the above explanation, facility circumcisions occur at an early age in the southern region where they are conducted as part of religious or cultural rituals (89% of all circumcisions reported) compared to the northern and central regions where they are mainly conducted for medical indications, 54.5 % and 84.5% respectively.

Table 8: regional distribution of indications for male circumcision (n=1648) in selected district hospitals

		INDICATIONS				Total
		On demand	medical	religion	Ritual	
Region	north	7.6	54.6	18.5	7.6	100.0
	centre	1.2	84.5	2.8	4.7	100.0
	south	0.5	6.3	89.3	0.2	100.0
	Total	1.2	25.4	72.0	1.6	100.0

Figure 7 shows the differences in indications for circumcision in different age groups in all other visited hospitals excluding Mangochi district. In general most facility circumcisions are conducted for medical indications, > 75%. In the age group <5 years, the majority of circumcisions were due to medical conditions (89%) followed by religious /ritual reasons (10.3%) and on demand (<1%). In the age group 5 to 17 years, almost one in five circumcisions were conducted for cultural and religious reasons (about 22%) while medical indications accounted for 77% of the

²³ Mwalanda G quoting a clinical officer at Mangochi District Hospital. Safe circumcision 20th January 2005. Nation publications Limited

circumcisions. In the older age groups, over 18 years of age, about one in 10 circumcisions were conducted for religious/cultural reasons while 84% were conducted for medical reasons and 5% conducted on demand (Figure 3). In Mangochi where only summary data was available almost all the circumcisions conducted during this period were for religious and cultural reasons and were highest in the age group 5 to 10 years old with almost no circumcisions conducted in the older age groups.

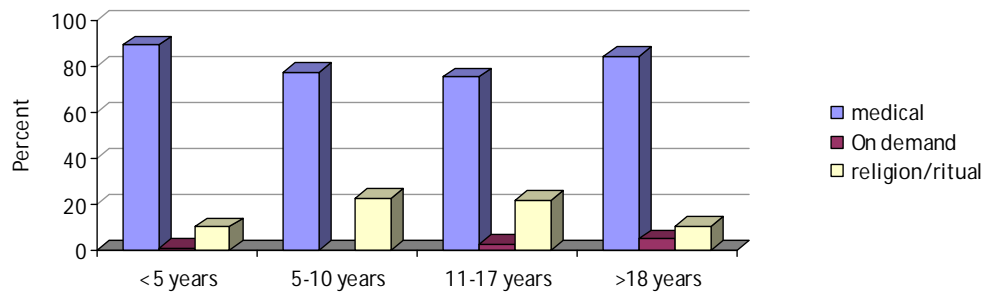


Figure 7. Indications for male circumcision in different age groups in selected district hospitals

Of the circumcisions conducted on demand in the facilities visited excluding Mangochi, the majority occurred in older men aged 18 and above. However over the 3 year period covered during the facility data abstraction there has been a small increase in circumcision on demand in the age group 11-17 years of age and a small decline in the older age group over 18 years of age (Figure 8). This could be attributed to a potential shift in circumcising communities from conducting circumcision in traditional facilities to facility circumcisions in this age group. The anecdotal evidence of a potential increase in circumcision on demand among the older age group is however not evident in the sampled facilities. On the other hand in Mangochi district which has the largest Yao and Muslim community, almost all circumcisions were conducted on demand as part of religious or cultural rituals.

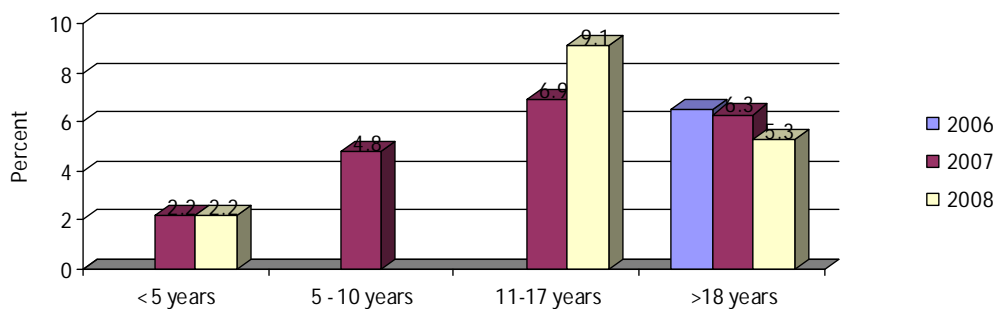


Figure 8. Yearly trends in male circumcision by age group in selected district hospitals

Amongst circumcised males in the KABP survey done as part of the SITAN 2009, the age distribution at which male circumcision is conducted is shown in Figure 9 disaggregated by region and place of residence. In general the majority of male circumcisions are conducted during puberty followed by the period just before

puberty (2-8 years) and this is unsurprising as they are linked to rites of passage as indicated in the preceding sections. Notable here is the fact that up to almost a third (4.3% at birth and 31.9% at adulthood) of circumcised males in the northern region had their circumcision at birth and adulthood respectively as opposed to the main circumcising regions of centre and southern region and this may be a reflection of determinants of circumcision in the region which are not so much linked to rites of passage and initiation ceremonies as opposed to the other regions. Likewise circumcision at the extremes of age i.e. birth and adulthood was reported more commonly amongst urban respondents than rural respondents.

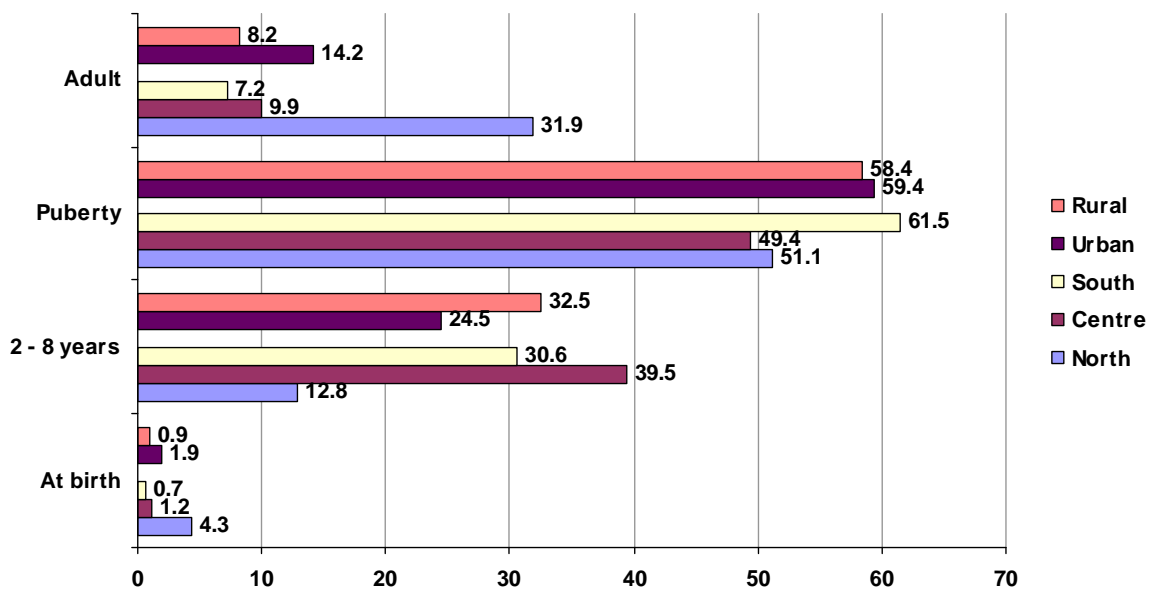


Figure 9: Distribution of ages at which circumcision is carried out in various regions (KABP survey 2009)

There is also an ethnic, district and religious differences in ages at which male circumcision is practiced based on the results from the KABP survey of the SITAN 2009 as indicated in Table 9 below. In general circumcision is clustered around 2 years up until puberty and very little occurs in the extremes of age except amongst the Nkhonde where it was reported exclusively to have been done in adulthood and the Tumbuka where relatively quite a lot of circumcisions (10%) occurred at birth. Additionally those with some school attendance were also likely to have their circumcisions at birth and adulthood compared to the rural dwellers. These variations as indicated above are likely explained by the variation in indication for the circumcision, provider of circumcision and the linkage the practice has to rites of passage and initiation ceremonies and the ages at which these occur.

Table 9. Distribution of ages at which male circumcision is conducted by socio-demographic characteristics.

		At birth (%)	2 - 8 years (%)	Puberty (%)	Adulthood (%)
Area	Urban	1.9	24.5	59.4	14.2
	Rural	0.9	32.5	58.4	8.2
Region	North	4.3	12.8	51.1	31.9
	Centre	1.2	39.5	49.4	9.9
	South	0.7	30.6	61.5	7.2
District	Blantyre	1.1	11.6	75.8	11.6
	Chitipa	0.0	0.0	22.2	77.8
	Lilongwe	4.0	36.0	48.0	12.0
	Mangochi	0.3	39.4	56.2	4.1
	Mulanje	2.0	15.7	70.6	11.8
	Mzimba	11.1	16.7	66.7	5.6
	Nkhatabay	0.0	15.0	50.0	35.0
	Nkhotakota	0.7	40.4	48.9	9.9
	Nsanje	0.0	23.1	46.2	30.8
	Ntcheu	0.0	33.3	66.7	0.0
Marital status	yes	0.8	31.9	57.7	9.6
	no	1.5	30.5	60.5	7.5
Tribe	Chewa	1.2	34.3	53.6	10.8
	Yao	0.2	37.9	58.8	3.1
	Tumbuka	11.8	0.0	58.8	29.4
	Lomwe	2.1	15.5	69.1	13.4
	Sena	0.0	21.4	42.9	35.7
	Ngoni	4.8	4.8	76.2	14.3
	Tonga	0.0	37.5	37.5	25.0
	Amang'anja	0.0	18.8	59.4	21.9
	Nkhonde	0.0	0.0	0.0	100.0
	others	0.0	18.2	27.3	54.5
Religion	Catholic	2.5	15.0	60.0	22.5
	CCAP	6.3	9.5	61.9	22.2
	Anglican	0.0	25.6	67.4	7.0
	Adventist/Baptist	0.0	17.6	61.8	20.6
	Moslem	0.2	39.6	55.1	5.1
	Others	2.0	17.6	65.7	14.7
school attendance	yes	1.1	29.8	59.9	9.2
	no	0.6	37.6	52.6	9.2

5.2.2 Trends in male circumcision

The trends in MC in the sampled districts and years shows a declining pattern over the period from 2006 to 2008. Despite this, recorded data indicates small increases in the number of circumcisions carried out in Mangochi, Mulanje, Mzimba, Nkhatabay and Nsanje. In the central hospitals of Kamuzu in Lilongwe and Queen Elizabeth in Blantyre, there is a decreasing trend (Figure 10).

Because of the quality of the data and the incompleteness of reporting²⁴ in some cases no substantive hypotheses can be made about current trends. However, combined with information from qualitative reports, it is not surprising to see some increase in number of circumcisions carried out in the district hospitals as there is a potential shift from traditional circumcision to facility based circumcision. For the central hospitals which are based in urban areas, the decline could be attributed to other providers coming on the market especially for circumcisions conducted on demand for example in Blantyre where over the same period private institutions such as BLM, Adventist Hospital have recorded increased number and demand for male circumcision. For example in Blantyre from 2006-2008, QECH conducted 102 circumcisions whereas BAH in the same period performed 222 circumcisions and Banja La Mtsogolo Ginnery Corner clinic has performed 132 circumcisions in the first 7 months of 2009 and mostly for reasons other than medical indications.

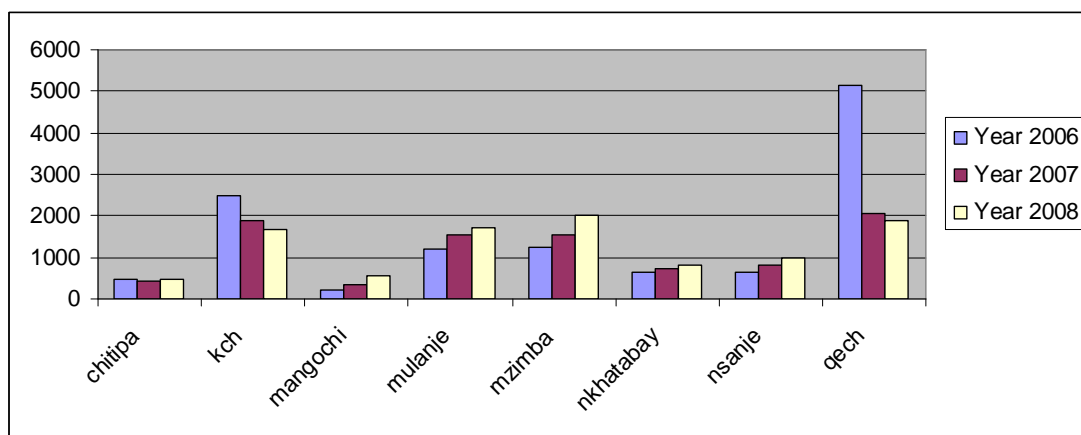


Figure 10: Total number of circumcisions in sampled districts hospitals.

5.2.4 Estimated number of and timing male circumcisions in traditional settings.

Male circumcisions in traditional settings are conducted once per year as part of the rite of passage for boys. Normally, they are carried out during the *Jando* initiation ceremony. They are performed by the *Ngaliba* at the *Jando / Thezo / Simba*. The initiation ceremonies take place at the *Ndagala / Simba / Thezo*, initiation camps. In most cases, the initiation ceremonies are done between June and August every year (this is a cold season and it helps the wounds to heal easily – in addition, this is the period when people have finished harvesting crops for food and for sale and it helps them to prepare well for the Ceremonies). Apart from the Traditional Initiation Ceremonies which happen annually, there are other circumcisions that are done throughout the year. Such circumcisions are performed either at Hospitals or in people’s houses. These other circumcisions are done upon request and in the areas we have been to, they perform between 400 and 500 circumcisions on demand per year– these circumcisions are usually done when an uncircumcised man would like

²⁴ In most government facilities when circumcisions are conducted on demand the data are usually not recorded in theatre books and only summaries exist for such information.

to marry a Moslem/Yao woman or when a man decides to become a Moslem. The *Ngalibas* noted that circumcisions on demand are on the increase nowadays. As a rite of passage, circumcision is performed during the Traditional Initiation Ceremonies at the initiation camp commonly known as *Ndagala*.

6 KNOWLEDGE, ATTITUDES AND PRACTICES SURROUNDING MALE CIRCUMCISION

6.1 KNOWLEDGE OF MALE CIRCUMCISION

The situation analysis KABP survey asked male respondents what they understood by male circumcision. Respondents were asked to choose a definition of circumcision between removal of the entire foreskin, removal of foreskin but not the entire skin, removal of the penis and other definitions. Majority of the men (63.7%) mentioned that the removal of the entire foreskin constituted circumcision whilst 17.5% said removal of the foreskin but not the entire skin was circumcision. About 1.8% said the removal of the penis was circumcision while about 15.1% mentioned other forms of definitions for circumcision.

Knowledge of correct definition of male circumcision was higher amongst urban respondents (71.9%), respondents from the northern region (74.8%) as a whole as well as the sampled districts in the northern region and Mangochi (91.1%) as well as amongst the Yao (87.9%), Tumbuka (76%), Tonga (76.5%) and Nkhonde (84.6%) and Anglican (73.4%) and Muslim (86%) respondents. Knowledge of the definition of male circumcision was however lowest amongst respondents from the central region (53.4%), the districts of Lilongwe (49.4%), Mulanje (37.3%), Nsanje (42.6%) and Ntcheu (46%) and amongst the Lomwe (44.2%), Sena (43.6%) and Amang'anja (48.8%) respondents as indicated in Table 10 below.

The incomplete understanding of the definition of male circumcision likely inflates the circumcision prevalence in places such as Mulanje where almost half of those that initially reported having been circumcised were in actual fact partially circumcised. When the real definition was provided to them circumcision prevalence dropped from 51.4% to 24.6%. There appears to be no major differences by socioeconomic status although those with secondary or higher education and those of higher socioeconomic status (having a house servant, electricity and living in iron sheet roofed houses) tended to have better knowledge.

Table 10. Knowledge of the definition of male circumcision (KABP survey).

	Knowledge of definition circumcision					Total
	removal of entire foreskin	removal of foreskin but not entirely	removal of penis	refused to answer	Others	
Malawi	63.7	17.5	1.8	2.0	15.1	100.0
Area						
Urban	71.9	16.3	2.2	2.5	7.2	100.0
Rural	62.7	17.6	1.7	1.9	16.1	100.0
Region						
North	74.8	7.0	0.8	1.1	16.3	100.0
Centre	53.4	18.9	3.2	3.2	21.3	100.0
South	60.5	25.7	1.7	1.9	10.2	100.0
District						
Blantyre	65.5	20.1	3.4	2.4	8.5	100.0
Chitipa	68.2	7.4	0.5	2.4	21.6	100.0
Lilongwe	49.4	18.2	3.2	4.4	24.7	100.0
Mangochi	91.1	6.3	0.2	1.3	1.1	100.0
Mulanje	37.3	54.5	0.5	0.7	7.0	100.0
Mzimba	77.1	5.0	0.7	0.7	16.6	100.0
Nkhatabay	78.4	8.7	1.2	0.5	11.3	100.0
Nkhotakota	66.9	20.3	2.6	1.9	8.3	100.0
Nsanje	42.6	18.9	4.1	4.1	30.2	100.0
Ntcheu	46.0	18.3	3.7	3.0	29.0	100.0
Age						
<20 years	58.7	17.0	2.7	2.4	19.2	100.0
20-24 years	64.8	16.1	2.6	1.8	14.7	100.0
25-29 years	59.5	20.7	1.5	2.0	16.3	100.0
30-34 years	67.3	17.5	1.9	1.5	11.9	100.0
35-39 years	67.5	16.0	1.5	1.2	13.9	100.0
40-44 years	67.4	19.2	0.4	2.5	10.5	100.0
45-49 years	66.3	14.6	1.5	2.0	15.6	100.0
50 years or more	65.3	17.4	0.9	1.8	14.5	100.0
Marital status						
yes	64.5	18.0	1.4	1.7	14.4	100.0
no	61.3	16.0	2.8	2.5	17.5	100.0
Tribe						
Chewa	58.0	18.4	3.3	3.3	17.0	100.0
Yao	87.9	9.1	0.6	1.6	0.8	100.0
Tumbuka	76.0	4.8	1.1	0.6	17.5	100.0
Lomwe	44.2	46.2	1.1	1.5	7.0	100.0
Sena	43.6	20.3	4.1	4.1	27.8	100.0
Ngoni	55.3	15.4	2.6	1.9	24.8	100.0
Tonga	76.5	9.2	1.0	0.0	13.3	100.0
Amang'anja	48.8	34.4	1.3	1.3	14.4	100.0
Nkhonde	84.6	0.0	0.0	0.0	15.4	100.0
others	68.0	8.2	0.8	3.0	19.9	100.0
Religion						
catholic	57.0	19.4	2.4	1.8	19.5	100.0
CCAP	64.6	18.6	1.6	1.9	13.3	100.0
Anglican	73.4	13.7	2.4	2.4	8.1	100.0
Adventist Baptist	57.3	19.4	3.3	3.6	16.4	100.0
Muslim	86.0	11.3	0.7	1.3	0.7	100.0
others	58.1	18.2	1.5	1.9	20.4	100.0
School attendance						
yes	64.1	17.5	1.8	1.8	14.8	100.0
no	60.7	17.1	1.5	3.4	17.3	100.0
Level of education						
primary	61.3	18.4	1.9	1.9	16.5	100.0
secondary	69.5	15.7	1.7	1.3	11.8	100.0
tertiary	73.6	17.0	0.0	3.8	5.7	100.0
Asset ownership						
Radio	64.9	17.3	1.3	1.8	14.7	100.0
Bicycle	64.7	18.3	1.2	1.7	14.1	100.0
H/Servant	68.1	20.2	1.1	2.1	8.5	100.0
Oxcart	56.6	10.8	2.4	0.0	30.1	100.0
Livestock	65.3	16.2	1.3	1.8	15.4	100.0
Thatched	63.7	16.6	1.5	2.1	16.2	100.0
Iron sheets	67.0	18.7	1.5	1.4	11.4	100.0
Electricity	77.0	14.4	1.6	1.6	5.3	100.0
Lamp	64.4	17.0	1.5	1.8	15.3	100.0
Latrine (pit)	65.1	17.1	1.4	1.8	14.5	100.0

6.2 ATTITUDES AND PERCEPTIONS ABOUT MALE CIRCUMCISION

6.2.1 Attitudes and perceptions of non-circumcised men towards male circumcision

Key informant and focus group discussion respondents were asked to state what they thought about circumcision. In response most of the respondents stated that it would depend on one's religion and culture. They said Christians and non-Yao might oppose male circumcision and would not love to have their children or themselves circumcised. They explained that Christians may oppose male circumcision because they see it as part of the Islamic religion. Thus one of the respondents said,

"R: Well, Muslims are by nature the ones who commonly practice male circumcision. It's their tradition so even Christians are afraid to be circumcised for fear that they will be labeled Muslims." (IDI # 1)

As such, most Christian churches discourage their members from being circumcised and from attending the traditional initiation ceremonies describing the practices as evil (*Achikunja*). This would also apply to non-Yao people who do not practice male circumcision. They see male circumcision as part of the Islamic religion and Yao culture and they would not like to assimilate it. However, they said for Moslems and Yao people, they would feel they were missing something if they were not circumcised. On this, they stated that the government would have to do much sensitization among Christians and non-Yao people about the benefits of male circumcision. They would have to convince people that it was being introduced as a health intervention and that it was de-linked from Islam and Yao culture. They further stated that people should be told the truth about the benefits of circumcision and this should not be exaggerated – people should know that male circumcision only reduces their chances of being infected with HIV.

One respondent said, *"R: I think it depends upon how the messages really gets to them because if they are just told that if you are circumcised you won't have HIV then, probably all of them will rush to get circumcised but if they are told the truth that it only reduces the risk but the risk is still there, some may consider taking up the circumcision but others they may evaluate their own a risk taking behaviors and may decide whether it's worthy taking it or not(I: ok) but there are also cultural factors that may affect its uptake." (IDI # 46).*

6.2.2 Perceptions of women towards male circumcision

Respondents were also asked to say what they thought might be perceptions of women towards male circumcision. Some of the respondents felt that women's perceptions towards male circumcision would depend on location or where they

come from. For instance, they said women in circumcising societies would view circumcision differently from women in non-circumcising societies.

Thus one respondent said, *"R: It depends on where that woman is coming from. For example most women from this area, mainly here in Nkhotakota clearly know what circumcision is all about, regardless of whether that woman comes from a Muslim society or not but here because it is like the tradition that most men get circumcised, women know. For others like from other districts, I would say that may be they don't know what circumcised men do so they cannot say anything or think anything about circumcision unless that woman is provoked like to say this time when people will start talking about it, they may have something to say, but honestly I cannot say what all women think about it."* (IDI # 1).

Respondents also said that generally women enjoy having sex with circumcised men. They were then asked whether this was true in both circumcising and non-circumcising societies and they said it was common among women to like circumcised men.

Female respondents of the KAPB survey were also asked what they thought of circumcised men and the majority, corroborating the findings of the KII indicated that they thought circumcised men were Muslim, of the Yao tribe and sexually initiated. Women from Chitipa and Nkhotakota were more likely to associate circumcision with the Yao compared to other districts while those from Mulanje and Mangochi were more likely to perceive circumcision as being associated with being sexually initiated (Table 11).

Table 11: What women think of circumcised males (KABP survey)

		promiscuous	Muslim	clean	Yao	sexually initiated	others
Area							
	Urban	1.2	43.3	9.1	39.0	2.4	14.0
	Rural	1.6	36.3	3.5	30.6	7.1	25.0
Region							
	North	2.9	37.2	1.8	16.4	0.4	41.2
	Centre	0.3	46.3	4.8	42.9	1.4	10.7
	South	1.9	30.7	5.8	32.6	13.9	22.6
District							
	Blantyre	1.0	44.8	7.6	50.5	6.7	1.9
	Chitipa	10.4	66.7	6.3	12.5	2.1	2.1
	Lilongwe	0.7	43.4	2.8	45.5	0.0	13.1
	Mangochi	0.9	27.8	6.1	45.2	23.5	6.1
	Mulanje	3.8	17.7	8.5	12.3	21.5	40.0
	Mzimba	1.7	24.4	1.7	14.3	0.0	58.0
	Nkhatabay	0.9	38.3	0.0	20.6	0.0	40.2
	Nkhotakota	0.0	64.2	11.0	22.9	3.7	9.2
	Nsanje	1.7	35.3	0.8	26.9	2.5	37.8
	Ntcheu	0.0	31.0	1.0	61.0	1.0	9.0
Marital status							
	yes	1.8	36.4	4.6	31.9	6.2	24.0
	no	1.1	42.5	3.9	31.8	8.9	20.1
Ethnicity							
	Chewa	0.4	49.4	6.5	34.1	3.1	14.9
	Yao	0.6	33.3	6.4	46.8	17.9	6.4
	Tumbuka	2.6	28.1	1.8	17.5	0.0	50.0
	Lomwe	2.8	20.8	5.7	19.8	17.9	34.0
	sená	1.9	34.6	0.9	25.2	4.7	37.4
	Ngoni	1.3	33.1	3.2	53.5	1.3	10.8
	Tonga	0.0	39.3	0.0	19.0	0.0	41.7
	Amang'anja	1.9	34.6	3.8	21.2	9.6	30.8
	Nkhonde	33.3	66.7	0.0	0.0	0.0	0.0
	others	7.1	58.9	8.9	16.1	7.1	12.5
Religion							
	catholic	3.2	32.6	4.2	35.3	4.7	23.2
	CCAP	0.6	38.1	4.8	30.4	4.8	25.0
	Anglican	2.2	43.5	19.6	37.0	8.7	13.0
	Adventist Baptist	0.0	35.0	3.3	26.7	5.0	30.0
	Muslim	0.6	45.3	6.4	34.3	15.7	8.1
	others	2.0	35.8	2.5	29.5	4.5	29.3
School attendance							
	yes	2.0	36.3	4.3	32.5	6.9	22.6
	no	0.7	41.0	5.1	29.7	5.5	25.3
Education level							
	primary	1.3	36.2	3.9	32.0	6.8	24.3
	secondary	5.0	37.4	6.5	34.5	7.2	15.1
	tertiary	0.0	28.6	0.0	57.1	0.0	14.3
Occupation							
	farming	1.4	38.0	4.0	32.9	5.1	24.8
	casual labour	2.0	31.4	0.0	25.5	17.6	23.5
	employed	2.5	37.5	7.5	42.5	5.0	10.0
	business	1.9	37.2	6.3	30.0	9.2	19.3
	student	0.0	42.9	0.0	28.6	0.0	28.6
	unemployed	2.0	33.3	5.9	21.6	7.8	33.3
	other	12.5	37.5	12.5	50.0	0.0	0.0
Asset ownership							
	Radio	1.8	37.7	4.8	33.5	6.6	21.3
	Bicycle	1.9	32.6	4.1	33.8	7.7	24.5
	House servant	2.7	56.8	2.7	35.1	0.0	10.8
	Oxcart	0.0	29.2	4.2	25.0	0.0	41.7
	Grass thatched house	1.1	37.8	3.4	31.8	6.0	24.4
	Iron sheet house	2.8	35.6	6.6	31.9	7.4	21.1
	Electricity	1.3	34.2	10.5	48.7	5.3	11.8
	Paraffin lamp	1.5	37.2	4.2	31.3	6.8	23.6
	Pit latrine	1.7	36.8	4.8	31.4	7.1	22.9
	Flush toilet	3.1	40.6	9.4	53.1	3.1	6.3

6.2.3 Perceived benefits of circumcision

KABP survey male respondents were asked to mention the perceived benefits of male circumcision. In rural areas, men mentioned reduced transmission of sexually transmitted diseases (27.9%), reduced transmission of HIV (23.7%), cleanliness (19.3%) and increased sexual pleasure (10.6). However, over half of the men (53.4% in rural men and 45.1% amongst urban males) could not mention any benefits of male circumcision signifying the importance of community mobilization if male circumcision is to be scaled up as an HIV intervention. See Tables 12 below.

Female respondents were also asked to mention the benefits of male circumcision. In urban areas, 53.3% and 44.8% thought that male circumcision reduced the transmission of sexually transmitted infections (STIs) and HIV respectively. However, for rural women only 29.9% and 23.5% of the women mentioned STIs and HIV respectively. Mentioning of these benefits did not vary across the religion and school attendance. More importantly these perceived benefits were mentioned more frequently by women as opposed to men (Table 13).

Both men and women also mentioned cleanliness and increased pleasure as some of the benefits of male circumcision. Mention of these benefits was more common amongst socio-demographic groups with a higher prevalence of male circumcision than those with lower prevalence of male circumcision.

6.2.4 Perceived consequences of circumcision

About one third of the urban male respondents perceive bleeding and infection to be the commonest consequence of male circumcision (28.1% and 27.8% respectively) compared to about one fifth amongst rural men (19.0% and 22% respectively). Almost half of the men could not mention any complications of male circumcision (38.5% and 49.2% among urban and rural men respectively). Respondents from the northern region (19.8% and 20.1%), southern region (27.0% and 29.7%) were more likely to mention bleeding and infections respectively as complications of circumcision compared to central region respondents (17% and 20.2% respectively). Mention of these complications was also more common amongst those from the circumcising districts of Blantyre, Mangochi and Mulanje, amongst the Yao and Lomwe and amongst Moslems following the reported distribution of prevalence of male circumcision (Table 12).

Most women, 42.5% and 33.6% in urban and rural areas respectively, mentioned infections as the main negative consequence of having male circumcision. This varied across the regions with 40.6% in the southern region mentioning this reason against 26.3% in the northern region. Bleeding was the other complication associated with male circumcision by women. About 15.8% and 13% in urban and rural areas mentioned bleeding as a complication of circumcision. Again, most women citing this as complication came from the southern region (17.7%) against only 7.0% from the northern region. Citing of complications was associated with education levels with 60% of women with tertiary education citing bleeding as a complication compared to only 14.4% of those that attended only secondary school education (Table 13).

Table 12. Male perceptions of benefits and negative consequences of male circumcision (KABP survey)

Area	Perceived benefits of circumcision among males (%)						Perceived side effects of circumcision amongst males				
	Reduced STI	Reduced HIV	Cleanliness	Pleasure	Other	Unknown	Infections	Impotence	Bleeding	Other	No knowledge
Urban	36.7	30.2	20.4	10.5	3.3	45.1	28.1	1.7	27.8	14.7	38.5
Rural	27.9	23.7	19.3	10.6	3.4	53.4	19.0	3.0	22.0	13.7	49.2
Region											
North	33.2	28.4	19.0	7.1	2.3	51.2	19.8	2.4	20.1	11.7	53.0
Centre	22.6	20.7	15.5	11.7	2.4	59.5	13.9	2.3	20.2	14.0	53.4
South	28.8	22.6	23.4	14.2	5.8	48.0	27.0	4.1	29.7	17.2	33.6
District											
Blantyre	29.9	23.2	19.2	11.9	5.6	52.0	37.0	4.0	31.0	12.5	34.5
Chitipa	33.4	25.5	19.1	5.4	1.9	51.9	17.5	3.6	20.5	7.8	56.8
Lilongwe	22.6	20.0	15.8	11.3	0.6	62.6	12.8	0.9	19.8	11.6	57.8
Mangochi	29.0	24.6	36.2	10.1	1.4	44.9	34.0	4.0	42.0	16.0	20.0
Mulanje	36.3	26.2	30.0	17.2	10.5	33.0	39.7	4.1	28.1	26.7	13.7
Mzimba	28.9	28.1	19.9	8.4	3.1	52.0	20.7	2.0	21.1	10.7	52.3
Nkhatabay	37.2	31.1	17.9	7.2	1.9	49.9	20.9	1.7	18.7	16.2	50.4
Nkhotakota	24.8	17.4	18.3	11.0	4.6	54.1	15.7	3.3	20.7	18.2	47.9
Nsanje	20.8	18.4	16.6	13.8	2.5	60.4	12.6	4.1	27.6	16.0	45.2
Ntcheu	21.7	22.9	14.0	12.4	3.5	58.1	14.4	3.6	20.5	15.1	50.7
Marital status											
yes	28.6	23.7	19.6	10.8	3.5	51.8	19.8	2.6	22.2	14.4	47.8
no	29.7	26.4	19.0	10.1	3.1	54.1	20.7	3.2	23.9	11.9	49.0
Tribe											
Chewa	23.7	21.6	14.8	10.2	3.3	58.8	14.6	1.2	18.9	14.1	55.1
Yao	21.7	18.3	25.0	11.7	5.0	56.7	41.7	0.0	31.3	12.5	22.9
Tumbuka	30.3	26.8	21.6	7.7	2.5	50.5	23.4	2.7	20.4	10.9	49.7
Lomwe	37.2	30.1	31.1	16.5	7.4	33.7	37.3	3.8	30.1	19.5	22.9
Sena	19.8	16.3	16.7	14.0	2.3	60.1	12.7	4.1	30.2	15.7	44.4
Ngoni	26.4	24.3	16.4	11.1	2.6	57.2	16.5	4.4	20.9	16.0	50.3
Tonga	37.3	32.6	17.0	8.0	2.2	50.7	19.5	1.9	21.1	16.6	49.8
Amang'anja	27.3	20.0	23.6	16.4	6.4	48.2	30.0	3.8	22.5	15.0	38.8
Nkhonde	27.3	18.2	27.3	0.0	9.1	45.5	16.7	0.0	25.0	0.0	58.3
others	32.7	23.8	17.8	5.6	2.3	53.5	16.6	2.9	21.9	7.0	57.1
Religion											
Catholic	30.1	25.6	19.1	13.9	4.9	47.4	22.6	3.5	19.9	14.2	48.1
CCAP	37.3	29.5	21.4	9.6	3.8	45.7	22.9	2.4	26.0	13.5	42.8
Anglican	20.0	14.7	14.7	13.3	4.0	60.0	20.5	1.3	29.5	10.3	46.2
Adventist/Baptist	29.3	27.6	22.3	12.4	3.2	49.5	22.3	5.1	26.4	12.8	43.6
Moslem	31.0	27.6	24.1	10.3	0.0	65.5	41.7	0.0	33.3	33.3	0.0
Others	24.2	20.6	18.0	8.5	2.6	59.1	16.3	2.0	20.6	13.8	53.0
School attendance											
yes	30.2	25.6	20.1	10.6	3.5	51.0	21.2	3.0	22.8	13.8	46.8
no	15.0	12.1	12.1	9.8	2.3	68.2	7.3	0.9	21.0	13.2	61.2

Table 13. Female perceptions of benefits and negative consequences of male circumcision

Area	Benefits of male circumcision					Negative consequences of MC				
	Reduces	STI	HIV	Cleanliness	Increases	Pleasure	Others	Infections	Impotence	Bleeding	Others
Area	Urban	53.3	44.8	16.2	12.4	27.6	42.5	4.1	15.8	55.5
	Rural	29.9	23.5	18.5	18.7	42.2	33.6	6.6	13.0	57.6
	North	30.5	21.2	15.3	12.7	46.6	26.3	12.3	7.0	60.9
	Centre	37.2	28.3	15.7	7.9	45.5	34.6	4.4	13.1	61.4
	South	32.7	27.9	20.4	24.6	34.6	40.6	4.2	17.7	51.9
Marital status	Married	33.5	25.9	18.1	17.3	40.0				
Tribe	Chewa	38.7	28.0	16.1	8.3	47.6	35.6	2.8	7.6	64.4
	Yao	37.8	29.9	26.0	32.3	21.3	44.7	0.9	20.2	50.0
	Tumbuka	23.5	11.8	11.8	5.9	60.8	29.4	9.2	9.2	57.8
	Lomwe	19.4	14.3	19.4	20.4	49.0	34.0	1.0	17.5	57.7
	Sena	36.7	38.8	20.4	12.2	36.7	22.8	8.9	9.9	67.3
	Ngoni	45.6	35.3	8.8	14.7	32.4	46.1	8.6	22.7	42.2
	Tonga	20.0	28.0	28.0	24.0	32.0	23.8	3.8	8.8	73.8
	Amang'anja	20.5	20.5	20.5	29.5	43.2	36.7	6.1	20.4	53.1
	Nkhonde	0.0	0.0	0.0	0.0	0.0	0.0	50.0	0.0	50.0
	others	44.4	41.7	11.1	11.1	36.1	41.2	41.2	14.7	23.5
Religion	catholic	35.0	26.2	11.7	23.3	38.8	39.9	7.4	17.2	47.2
	CCAP	34.0	31.0	16.0	10.0	44.0	41.5	9.2	14.8	49.3
	Anglican	32.4	29.7	27.0	21.6	43.2	51.2	2.3	11.6	58.1
	Adventist Baptist	41.5	26.8	19.5	19.5	36.6	35.0	1.7	5.0	66.7
	Muslim	42.7	29.3	26.0	28.0	20.7	39.1	1.4	16.7	56.5
	others	26.1	23.9	15.2	11.3	50.4	28.1	7.9	12.3	62.1
School attendance	yes	36.3	29.1	16.5	16.9	39.1	38.1	6.9	14.7	52.8
	primary	33.1	26.3	16.8	17.5	40.6	35.8	6.8	14.4	55.1
	secondary	50.5	38.5	15.4	15.4	33.0	48.8	7.2	14.4	42.4
	tertiary	60.0	80.0	0.0	0.0	0.0	40.0	0.0	60.0	60.0

6.3 ACCEPTANCE OF MALE CIRCUMCISION

6.3.1 Personal acceptance of circumcision among uncircumcised males.

Non circumcised respondents were given information linking male circumcision to the prevention of HIV transmission. Following this they were asked whether the provided information had changed their opinion about accepting being circumcised. The majority (80.8%) indicated opposition to circumcision before any benefits of circumcision in HIV prevention were presented to them. After getting some information on the role of circumcision on HIV prevention, a majority (63.2%) still remained skeptical of the benefits of circumcision while 36.8% changed their opinion about being circumcised up from 19.2% a change of almost 100% indicating that providing the right information on circumcision could increase acceptability of male circumcision (Figure 10).

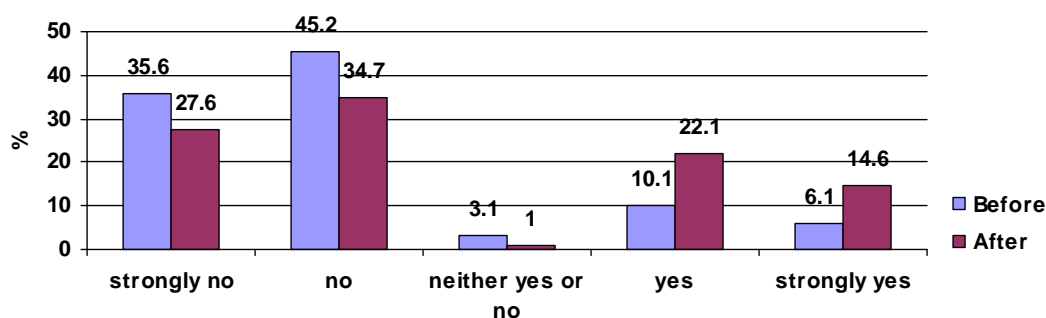


Figure 10, Proportion of uncircumcised males accepting circumcision before and after male circumcision HIV link is provided

When asked why they would change their opinion on acceptance of male circumcision, almost a quarter (25%) of both urban and rural respondents indicated medical reasons as the reason for their opinion while almost half indicated ethnicity as the main reason for their opinion. Social desirability and hygiene considerations were indicated by 11.1% and 9.1% of the urban respondents as opposed to 10.8% and 5.5% of the rural respondents. Amongst those indicating social desirability of circumcision, the majority indicated perceived health benefits followed by cosmetics as the reasons for the social desirability of circumcision. Over half of the respondents from the central region, the Chewa, Sena, Ngoni and Amang'anja respondents indicated ethnicity as the main reason for their opinion on acceptance of male circumcision and a quarter of Nkhonde respondents indicated social desirability as the main determined on whether or not circumcision would be acceptable to them (Table 14). In general the reasons governing acceptance remain largely the same before or after information is provided but the percentage of people indicating medical or hygiene reasons for their opinions improves after proving the information.

Table 14, Proportions accepting male circumcision before and after information on benefits of circumcision is provided

Area		Before information provided								After information provided							
		Why not accepting circumcision								Why accepting circumcision							
		Medical	Ethnicity	Hygiene	Social desirability	Health	sexual	Cosmetic	SES	Medical	Ethnicity	Hygiene	Social	Health	sexual	Cosmetic	SES
Urban	Urban	13.2	65.8	7.1	12.8	8.9	3.6	0.4	0.4	25.8	45.6	9.1	11.1	20.6	3.5	0.3	0.0
	Rural	12.4	69.4	5.2	13.3	5.4	2.6	0.3	0.2	25.3	50.2	5.5	10.8	16.0	3.3	0.1	0.2
Region	North	13.6	66.2	3.2	17.8	4.4	1.6	0.1	0.1	27.0	47.1	4.2	14.5	15.7	3.0	0.1	0.1
	Centre	3.3	80.2	6.5	8.0	5.2	1.3	0.3	0.3	15.3	60.7	6.1	7.0	15.1	1.7	0.3	0.3
	South	20.5	61.6	8.3	11.2	9.1	6.0	0.8	0.5	33.5	42.4	8.7	8.4	19.4	5.7	0.2	0.2
District	Blantyre	14.8	63.7	7.1	13.7	10.4	3.3	0.5	1.1	25.6	44.4	10.0	11.1	21.7	2.8	0.0	0.0
	Chitipa	12.1	69.5	5.5	16.4	2.9	1.7	0.0	0.3	23.6	52.2	5.2	18.1	12.5	3.2	0.3	0.3
	Lilongwe	3.5	80.4	6.3	7.9	4.4	0.3	0.0	0.0	17.6	64.7	5.9	4.6	13.1	1.6	0.3	0.0
	Mangochi	16.3	53.1	8.2	22.4	4.1	2.0	0.0	0.0	34.0	42.6	6.4	12.8	17.0	2.1	0.0	0.0
	Mulanje	33.6	45.5	7.0	14.7	9.1	4.9	0.7	0.7	49.0	29.9	4.8	15.0	12.9	5.4	0.0	0.7
	Mzimba	12.4	67.8	2.7	19.3	3.5	1.0	0.2	0.0	25.7	47.7	4.4	15.0	15.0	3.5	0.0	0.0
	Nkhatabay	16.4	61.4	1.6	17.4	6.7	2.1	0.0	0.0	31.2	42.1	3.0	10.9	19.3	2.3	0.0	0.0
	Nkhotakota	4.4	71.1	11.4	10.5	6.1	1.8	0.0	0.9	10.9	51.3	10.9	10.9	21.0	1.7	0.0	1.7
	Nsanje	18.2	70.2	9.8	5.8	9.1	9.1	1.1	0.0	30.5	47.7	10.4	2.5	21.9	8.2	0.4	0.0
	Ntcheu	2.6	83.9	4.5	7.1	5.6	2.2	0.7	0.4	14.5	60.3	4.2	8.0	14.9	1.9	0.4	0.0
Marital status	yes	12.3	70.0	5.1	12.5	5.7	2.9	0.3	0.3	23.8	51.8	5.7	11.4	15.9	3.6	0.2	0.1
	no	13.3	66.2	6.2	15.4	5.7	2.0	0.4	0.1	29.5	44.5	6.2	9.9	17.7	2.5	0.1	0.3
Tribe	Chewa	7.0	75.6	5.7	9.6	4.4	1.5	0.0	0.0	17.9	59.1	6.0	6.9	15.7	1.8	0.2	0.2
	Yao	9.1	56.8	11.4	22.7	4.5	2.3	2.3	2.3	28.9	40.0	8.9	15.6	11.1	4.4	2.2	0.0
	Tumbuka	11.9	69.3	3.2	17.8	3.7	0.5	0.2	0.0	27.9	47.4	4.2	13.5	15.8	2.3	0.0	0.0
	Lomwe	27.4	43.5	8.7	18.7	12.2	4.8	0.9	0.9	45.5	28.6	7.1	17.0	17.4	4.5	0.4	0.4
	Sena	17.6	72.8	9.6	4.0	9.2	8.4	0.8	0.0	26.7	52.6	8.8	2.8	21.5	6.8	0.0	0.0
	Ngoni	5.8	77.8	6.1	10.3	6.7	1.9	0.6	0.3	19.1	53.3	7.2	8.8	16.6	2.8	0.0	0.0
	Tonga	14.7	63.3	1.7	17.5	5.2	2.4	0.0	0.0	28.4	41.9	4.0	10.9	20.5	2.3	0.0	0.0

	Amang'anja	16.7	65.4	5.1	11.5	7.7	6.4	0.0	1.3	26.8	51.2	8.5	6.1	17.1	9.8	0.0	1.2
	Nkhonde	8.3	75.0	0.0	8.3	8.3	0.0	0.0	8.3	41.7	41.7	0.0	25.0	0.0	0.0	0.0	0.0
	others	12.0	71.0	4.8	15.6	3.0	1.5	0.0	0.0	21.6	55.0	4.9	16.7	11.9	3.6	0.3	0.3
Religion																	
	catholic	11.9	67.7	5.9	15.1	5.5	2.8	0.4	0.0	25.7	48.9	5.1	11.6	15.3	2.3	0.2	0.4
	CCAP	15.1	64.8	5.3	15.3	6.2	1.5	0.0	0.6	27.6	45.8	5.9	13.2	17.3	3.0	0.2	0.2
	Anglican	11.1	72.2	4.2	4.2	11.1	2.8	1.4	0.0	15.1	49.3	8.2	5.5	31.5	4.1	0.0	0.0
	Adventist Baptist	17.4	67.1	8.5	9.7	5.4	5.4	0.0	0.0	25.6	43.5	9.2	9.9	24.4	5.3	0.0	0.0
	Muslim	25.0	25.0	16.7	25.0	8.3	0.0	0.0	0.0	46.2	46.2	23.1	15.4	30.8	7.7	0.0	0.0
	others	10.1	72.7	4.4	12.9	5.5	2.5	0.5	0.3	24.7	53.7	5.1	10.0	13.5	3.5	0.2	0.1
School attendance																	
	yes	12.9	67.8	5.5	13.7	5.9	2.7	0.4	0.2	26.1	47.9	6.1	11.1	17.0	3.4	0.2	0.2
	no	8.1	81.8	4.8	9.1	5.3	2.4	0.0	0.5	18.8	68.5	4.2	8.5	11.3	3.3	0.0	0.0
Occupation																	
	farming	12.4	68.6	5.8	14.3	5.4	2.3	0.4	0.2	24.1	52.8	4.6	10.7	15.0	3.0	0.0	0.2
	casual labour	13.2	69.2	6.3	13.0	5.3	3.1	0.3	0.3	26.4	50.3	7.3	9.4	18.8	4.5	0.3	0.0
	employed	17.8	57.5	11.0	17.8	5.5	4.1	0.0	0.0	32.0	41.8	9.8	12.1	17.6	4.7	0.0	0.0
	business	14.1	74.4	1.3	11.5	5.1	2.6	0.0	0.0	23.5	48.3	6.4	12.3	17.1	3.5	0.5	0.3
	student	13.7	68.3	5.8	13.7	5.0	2.8	0.3	0.2	29.4	44.4	6.1	10.4	17.6	2.0	0.0	0.3
	others	11.5	70.4	5.2	13.2	5.2	2.3	0.3	0.2	14.5	56.5	2.9	10.1	18.8	4.3	1.4	0.0
Asset ownership																	
	bicycle	12.4	57.9	9.7	15.2	9.7	2.8	0.7	0.7	25.4	50.7	6.9	11.0	16.0	3.8	0.2	0.3
	house servant	12.8	69.5	5.2	13.3	5.5	2.8	0.2	0.2	24.3	45.9	8.1	14.9	14.9	5.4	1.4	1.4
	oxcart	12.7	68.8	5.4	13.6	5.5	2.8	0.3	0.3	20.7	56.1	1.2	8.5	15.9	3.7	0.0	0.0
	grass_thatched_house	7.8	62.5	9.4	18.8	9.4	0.0	0.0	0.0	24.5	51.1	5.5	10.6	16.4	3.3	0.2	0.2
	iron_sheetroofed_house	12.4	68.6	5.8	14.3	5.4	2.3	0.4	0.2	27.9	46.4	7.0	12.3	15.3	3.2	0.0	0.2
	use electricity	13.2	69.2	6.3	13.0	5.3	3.1	0.3	0.3	25.2	41.5	11.6	13.6	19.0	3.4	0.7	0.0
	parafin_lamp	17.8	57.5	11.0	17.8	5.5	4.1	0.0	0.0	25.9	49.9	5.8	11.0	15.9	3.5	0.1	0.2
	pit latrine	14.1	74.4	1.3	11.5	5.1	2.6	0.0	0.0	25.7	50.0	5.8	11.2	15.9	3.4	0.1	0.1
	flash toilet	13.7	68.3	5.8	13.7	5.0	2.8	0.3	0.2	23.1	41.5	12.3	16.9	21.5	3.1	1.5	0.0

6.3.2 Acceptance of circumcision for children of circumcised and uncircumcised men.

When asked whether they would consider circumcision for their sons, the majority (71.9%) of uncircumcised males indicated opposition to circumcision compared to circumcised men (5.5%) and women (55.8%) (Figure 11). The levels of opposition amongst uncircumcised males and women to circumcision however decline following provision of information linking male circumcision to HIV prevention and declines even further when other health benefits are included. Amongst circumcised males there is not much change in opposition but then the levels are extremely low at baseline. In all instances acceptance increases as more information is provided on the beneficial effects of male circumcision amongst all the groups studied. Acceptance of circumcision amongst circumcised adult males is 3 to 4 times higher than uncircumcised males and twice as much compared to women at baseline but these differences narrow down to almost equal levels of acceptance when further information is provided on benefits of male circumcision.

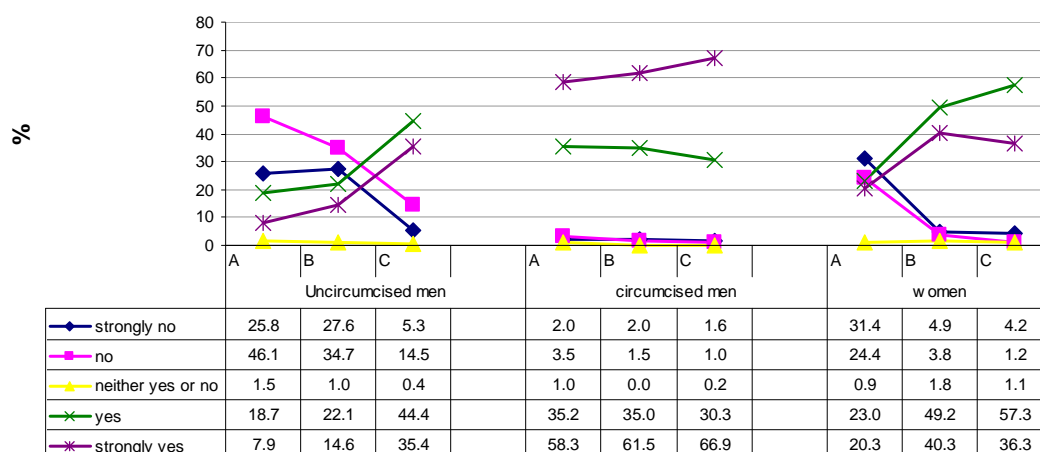


Figure 11. Acceptance of circumcision before and after information on benefits of circumcision is provided.

Almost half of the male respondent changed their view on circumcision on their children following being given information about the benefits of circumcision and there was not much variation between urban and rural males, 50.2% and 46.6% respectively. When considered according to region, district and age groups there was not much variation in acceptance of their children's circumcision despite new information on the link between male circumcision and HIV. Except amongst the Nkhonde (75%) and Muslims (72.7%) there were no major differences in changes in acceptance according to the other socio-demographic variables (Table 15). Amongst women the pattern was largely similar although with slightly higher levels of acceptance but generally following the pattern of the prevalence of male circumcision in the sample with above average opposition to circumcision amongst those with a higher socioeconomic status as identified by having flush toilets (16.7%), the Tumbuka (13.8%) and those from Mzimba (12.5%) while the opposition in the other socio-demographic groupings was mostly below 10%.

Table 15: Male and Female acceptance of circumcision for their children following information on linkage between male circumcision and HIV.

	yes	no	strongly no	no	yes or no	yes	strongly yes		yes	no	strongly no	no	yes or no	yes	strongly yes
Area															
Urban	50.2	49.4	2.9	4.4	0.0	43.4	49.3	50.2	65.3	34.7	5.9	2.0	0.0	58.4	33.7
Rural	46.6	53.1	1.9	7.1	0.2	43.1	47.8	46.6	66.0	34.0	3.9	1.1	1.2	57.1	36.7
Region															
North	46.8	52.9	0.9	0.7	0.0	43.0	55.3	46.8	51.4	48.6	5.7	2.3	2.9	52.0	37.1
Centre	42.4	57.3	1.0	12.5	0.6	41.3	44.6	42.4	59.6	40.4	1.7	0.6	0.0	78.5	19.2
South	51.1	48.4	4.0	10.3	0.0	44.3	41.4	51.1	80.4	19.6	4.6	1.0	0.8	50.0	43.6
District															
Blantyre	50.6	48.8	2.1	13.8	0.0	44.7	39.4	50.6	83.2	16.8	0.0	0.0	0.0	67.7	32.3
Chitipa	38.4	61.3	2.2	1.5	0.0	48.2	48.2	38.4	49.5	50.5	0.0	2.0	5.9	76.5	15.7
Lilongwe	35.3	64.1	1.7	10.9	0.0	37.0	50.4	35.3	55.3	44.7	1.6	1.6	0.0	87.5	9.4
Mangochi	59.2	40.8	0.0	6.5	0.0	54.8	38.7	59.2	96.3	3.7	7.8	0.9	0.9	28.7	61.7
Mulanje	53.9	46.1	1.2	4.1	0.0	44.4	50.3	53.9	76.7	23.3	7.8	1.9	1.9	37.9	50.5
Mzimba	49.7	50.1	0.5	0.5	0.0	47.5	51.5	49.7	44.2	55.8	10.7	1.8	3.6	46.4	37.5
Nkhatabay	51.6	48.2	0.5	0.5	0.0	35.1	63.9	51.6	60.4	39.6	5.9	2.9	0.0	38.2	52.9
Nkhatakota	52.2	47.8	0.0	3.4	0.0	53.4	43.1	52.2	72.7	27.3	3.5	0.0	0.0	56.1	40.4
Nsanje	46.5	52.3	9.3	15.9	0.0	41.7	33.1	46.5	67.0	33.0	1.3	1.3	0.0	75.6	21.8
Ntcheu	46.7	53.3	0.7	17.8	1.5	40.0	40.0	46.7	55.1	44.9	0.0	0.0	0.0	91.1	8.9
Age															
<20 years	43.7	56.3	0.0	9.9	0.0	48.1	42.0	43.7	70.0	30.0	4.9	0.0	0.0	46.3	48.8
20-24 years	52.9	47.1	1.2	4.5	0.0	41.1	53.3	52.9	71.1	28.9	1.7	0.0	1.7	51.3	45.3
25-29 years	49.7	49.5	2.5	6.4	0.0	46.8	44.3	49.7	71.9	28.1	6.9	0.8	0.0	51.9	40.5
30-34 years	52.7	46.5	2.6	6.2	0.0	46.1	45.1	52.7	62.9	37.1	3.5	1.8	0.9	54.9	38.9
35-39 years	50.6	49.4	3.0	4.5	0.8	36.1	55.6	50.6	69.2	30.8	5.1	1.3	2.6	60.3	30.8
40-44 years	52.2	47.8	1.0	7.1	0.0	47.5	44.4	52.2	68.7	31.3	5.1	1.7	1.7	57.6	33.9
45-49 years	39.7	60.3	3.0	9.0	1.5	26.9	59.7	39.7	62.2	37.8	5.7	1.9	0.0	73.6	18.9
50 years or more	36.4	63.2	2.9	9.1	0.0	41.1	46.9	36.4	57.2	42.8	2.8	2.1	1.4	62.7	31.0
Tribe															
Chewa	42.9	56.6	1.0	7.0	0.0	45.8	46.3	42.9	64.2	35.8	2.2	0.7	0.0	66.9	30.1
Yao	51.2	46.3	9.1	9.1	0.0	31.8	50.0	51.2	93.9	6.1	5.2	0.7	0.7	38.6	54.9
Tumbuka	46.8	53.2	0.0	0.5	0.0	43.8	55.7	46.8	45.9	54.1	13.8	0.0	3.4	48.3	34.5
Lomwe	56.2	43.8	1.5	6.1	0.0	42.3	50.0	56.2	75.2	24.8	3.6	1.2	1.2	50.0	44.0

	Sena	45.3	54.3	8.3	16.7	0.0	43.9	31.1	45.3	68.6	31.4	1.4	1.4	0.0	75.3	21.9
	Ngoni	48.9	50.8	0.5	14.8	1.0	41.8	41.8	48.9	56.3	43.8	1.2	0.0	0.0	74.4	24.4
	Tonga	52.7	47.0	0.6	0.0	0.0	35.0	64.3	52.7	61.4	38.6	3.6	5.5	0.0	41.8	49.1
	Amang'anja	47.6	51.6	1.5	7.5	0.0	50.7	40.3	47.6	73.9	26.1	12.5	2.5	2.5	57.5	25.0
	Nkhonde	75.0	25.0	0.0	0.0	0.0	0.0	100.0	75.0	75.0	25.0	0.0	0.0	0.0	33.3	66.7
	others	37.3	62.1	3.1	1.6	0.0	51.9	43.4	37.3	53.4	46.6	0.0	1.8	5.5	70.9	21.8
Religion																
	catholic	43.7	55.8	3.2	8.1	0.4	42.8	45.6	43.7	61.6	38.4	4.9	0.8	1.6	59.0	33.6
	CCAP	50.0	50.0	0.7	5.9	0.0	40.7	52.8	50.0	58.8	41.2	5.2	1.7	2.6	56.9	33.6
	Anglican	51.4	48.6	0.0	7.7	0.0	35.9	56.4	51.4	72.5	27.5	3.3	0.0	0.0	70.0	26.7
	Adventist Baptist	51.0	49.0	0.0	7.8	0.0	39.9	52.3	51.0	69.7	30.3	4.3	2.1	2.1	55.3	36.2
	Muslim	72.7	27.3	0.0	0.0	0.0	37.5	62.5	72.7	94.5	5.5	6.0	0.0	0.7	34.7	58.7
	others	45.4	54.2	2.4	6.3	0.2	46.0	45.0	45.4	60.3	39.7	2.6	1.9	0.4	68.0	27.1
School attendance																
	yes	48.0	51.6	1.8	6.6	0.2	42.5	48.9	48.0	65.4	34.6	5.1	0.7	1.1	57.6	35.6
	no	35.3	64.7	4.7	9.4	0.0	51.8	34.1	35.3	66.5	33.5	1.7	2.2	1.1	56.7	38.3
Education level																
	primary	46.4	53.0	2.4	8.4	0.1	41.8	47.3	46.4	64.1	35.9	4.9	0.9	1.3	58.2	34.7
	secondary	51.2	48.8	0.9	3.9	0.2	43.1	51.9	51.2	72.7	27.3	5.7	0.9	0.0	55.7	37.7
	tertiary	46.5	53.5	0.0	0.0	0.0	52.6	47.4	46.5	66.7	33.3	0.0	0.0	0.0	50.0	50.0
Occupation																
	farming	77.7	21.1	1.5	0.5		22.7	75.3	1.5	63.2	36.8	3.4	1.1	1.5	61.1	33.0
	casual labor	78.8	20.2	1.2	1.2	1.2	33.7	62.8	1.2	70.4	29.6	0.0	0.0	0.0	45.7	54.3
	employed	76.9	22.0				30.0	70.0		57.9	42.1	8.7	0.0	0.0	65.2	26.1
	business	80.1	17.2	3.3	1.1		33.7	62.0	3.3	72.0	28.0	4.5	2.5	0.6	47.1	45.2
	student	75.0	25.0				38.9	61.1		75.0	25.0	0.0	0.0	0.0	60.0	40.0
	unemployed	83.3	16.7		11.1		33.3	55.6		80.9	19.1	9.8	0.0	0.0	53.7	36.6
	other	78.3	20.2	1.5	0.5		22.7	75.3	1.5	60.0	40.0	40.0	0.0	0.0	60.0	0.0

6.3.3 Willingness to pay for male circumcision

For those that were not circumcised they were asked how much they would be willing to pay for circumcision and how they would find the money to pay for this. Table 16 presents amounts the survey respondents would be willing to pay for circumcision. About two thirds in both urban and rural areas indicated willingness to pay up to MK1, 000 for a circumcision with a quarter preferring not to pay anything for it and just over 5% were willing to pay more than MK1, 000 for a circumcision (Table 16). In general more respondents from the centre followed by the southern and northern regions preferred not to pay anything. Likewise over a third of the respondents from Blantyre, Lilongwe, Nkhotakota, Nsanje and Ntcheu indicated preference of not having to pay for circumcision. In the extremes of age i.e. <20 and >50 years there was preference for free services while more of those with tertiary education indicated a willingness to pay more than MK1,000 for circumcision. The majority of respondents were willing to either use their savings or sell some commodities to access male circumcision while only the literate were more likely to invest by borrowing to cover the circumcision costs compared to other groups.

Table 16. Acceptable costs and sources of money for paying for circumcision

Area	Acceptable cost			Money source				
	up to K1000	> K1000	none	savings	borrowed	commodities	Available now	
Area	Urban	66.4	6.7	26.8	76.6	7.5	9.3	6.5
	Rural	67.5	7.1	25.5	61.3	5.6	27.5	5.5
Region	North	70.8	12.3	17.0	55.3	6.9	32.2	5.6
	Centre	60.9	2.3	36.8	76.6	2.7	17.9	2.7
	South	67.5	4.1	28.4	65.4	6.4	20.3	7.8
District	Blantyre	67.0	1.0	32.0	76.9	4.6	13.8	4.6
	Chitipa	70.9	9.9	19.1	50.0	5.3	39.5	5.3
	Lilongwe	66.7	1.6	31.7	73.5	4.8	20.5	1.2
	Mangochi	81.8	4.5	13.6	78.9	5.3	15.8	0.0
	Mulanje	77.7	4.5	17.8	63.8	7.1	20.5	8.7
	Mzimba	71.4	12.5	16.1	53.0	7.2	35.5	4.2
	Nkhatabay	70.1	13.7	16.2	61.2	7.6	24.1	7.1
	Nkhotakota	55.0	6.7	38.3	72.2	2.8	22.2	2.8
	Nsanje	54.0	5.8	40.1	56.0	7.1	26.2	10.7
	Ntcheu	57.8	0.9	41.4	83.1	0.0	12.3	4.6
	Age	<20 years	69.6	5.0	25.4	54.9	13.5	18.0	13.5
20-24 years		74.6	7.5	17.9	64.0	4.6	25.9	5.6
25-29 years		66.2	9.0	24.9	64.3	5.2	26.0	4.5
30-34 years		70.7	5.1	24.2	66.7	2.0	28.0	3.3
35-39 years		64.9	12.2	22.9	61.0	10.0	24.0	5.0
40-44 years		68.5	4.5	27.0	64.5	1.6	30.6	3.2
45-49 years		69.1	7.3	23.6	58.1	7.0	32.6	2.3
50 years or more		51.7	6.2	42.1	65.9	3.4	26.1	4.5
marital status	yes	65.7	7.5	26.7	63.1	4.7	28.8	3.4
	no	72.2	6.6	21.2	61.2	8.4	20.1	10.4
Ethnicity	Chewa	63.9	3.9	32.2	65.4	6.6	25.7	2.2
	Yao	78.3	0.0	21.7	70.0	10.0	10.0	10.0
	Tumbuka	71.5	10.8	17.7	51.3	7.1	37.2	4.5
	Lomwe	73.3	4.2	22.5	69.4	4.9	19.4	6.3
	sená	55.4	5.8	38.8	55.4	8.1	25.7	10.8
	Ngoni	63.0	4.6	32.4	77.2	0.0	18.4	4.4
	Tonga	68.6	14.1	17.3	64.2	8.2	20.1	7.5
	Amang'anja	67.3	3.6	29.1	63.2	7.9	18.4	10.5
	Nkhonde	83.3	16.7	0.0	50.0	0.0	50.0	0.0
	others	70.4	10.4	19.2	52.9	5.8	36.5	4.8
Children	yes	65.4	7.5	27.0	63.4	4.7	27.8	4.1
	no	71.4	6.1	22.4	62.0	8.7	20.3	9.0

Religion								
	catholic	67.0	6.4	26.6	63.9	5.4	27.2	3.5
	CCAP	72.4	8.5	19.1	63.7	6.3	25.3	4.6
	Anglican	67.5	5.0	27.5	56.0	8.0	20.0	16.0
	Adventist Baptist	73.6	6.4	20.0	64.5	5.5	20.9	9.1
	Muslim	62.5	12.5	25.0	85.7	14.3	0.0	0.0
	others	62.6	7.0	30.4	60.8	5.9	27.4	5.9
School attendance								
	yes	68.4	7.2	24.4	63.0	5.9	25.5	5.7
	no	51.9	6.2	42.0	57.8	6.7	28.9	6.7
Education level								
	primary	67.4	5.8	26.8	62.7	6.7	27.2	3.4
	secondary	70.6	9.2	20.2	62.3	4.9	24.1	8.7
	tertiary	59.1	13.6	27.3	88.2	0.0	0.0	11.8
Literacy								
	yes	80.0	20.0	0.0	20.0	40.0	20.0	20.0
	no	53.2	6.5	40.3	63.2	2.6	28.9	5.3
Asset ownership								
	radio	67.8	7.5	24.7	64.8	5.3	26.1	3.8
	bicycle	68.4	6.9	24.6	62.8	5.7	27.2	4.2
	house servant	72.4	20.7	6.9	76.7	3.3	16.7	3.3
	oxcart	71.0	0.0	29.0	40.9	0.0	50.0	9.1
	livestock	66.7	7.2	26.1	57.2	5.7	31.8	5.4
	grass_thatched_house	66.4	6.7	26.9	61.6	4.7	30.5	3.2
	iron_sheetroofed_house	67.9	8.9	23.3	67.6	6.9	16.7	8.7
	use electricity	64.6	15.2	20.3	73.4	7.8	9.4	9.4
	parafin_lamp	67.1	7.1	25.8	62.2	5.6	27.8	4.4
	pit latrine	66.7	7.5	25.8	63.5	5.3	26.3	4.9
	flash toilet	68.0	12.0	20.0	73.9	8.7	8.7	8.7

6.4 PREFERRED AGE OF CIRCUMCISION AND PROVIDERS

Both uncircumcised and circumcised males would prefer to have their son's circumcised as early as possible before 8 years of age, 74.2% and 70.9% respectively. However circumcision during puberty is also acceptable for both circumcised and uncircumcised males. The majority of uncircumcised males (92.5%) would prefer to have the circumcision provided by a medical practitioner while among circumcised males the preferred provider is medical practitioners (65.1%) but almost a third of them would still prefer a traditional circumciser (Table 17).

Table 17: Preferred ages and providers for circumcision for children

Age	Uncircumcised		Circumcised	
	Preferred %	Acceptable %	Preferred %	Acceptable %
At birth	11.3	10.2	6.8	9.6
2-8 years olds	62.9	28.9	64.1	29.8
At puberty	16.7	30.5	26.8	34.5
Marriage	0.4	1.5		0.9
Initiation	4.7	9.8	1.3	5.7
At any time	1.5	7.5	0.2	8.1
At some other time	2.5	11.7	0.8	11.5
Total	100.0	100.0	100.0	100.0
Provider				
medical personnel	92.5		65.1	
traditional circumciser	7.5		33.8	

6.5 DECISION-MAKING ABOUT WHETHER A MALE SHOULD BE CIRCUMCIZED OR NOT

Respondents in the in-depth interviews and focus group discussions were asked to state the person who makes decisions about whether a male should be circumcised or not. Most of the participants said that such decisions are made by the head of the family who in most cases is the husband. Thus

" Well I....I might not be able to speak for their culture but I think for the Yao tradition....I think the....the male or the head of the family is the one who makes such decisions. However the women are the ones who take the male children for circumcision because I think it is their tradition." (IDI 21)

Some respondents also reported that in some cases parents (both the mother and father) make such decisions. *"Mostly it is the parents. The village headman is just informed of what the parents have decided so it's the parents who decide"* (IDI 1).

Some participants said that such a decision is made by the entire family. They said parents of the child, both the father and mother, are involved in the decision-making process. It is up to them to decide to send their child for circumcision or not. Thus, some participants in focus groups said;

"The main rule is that these days a person fears his parent. So, if the parent is much concerned, we can listen to the parent not another person from somewhere. Because if the parent can refuse, or if a chief can command, for people to say ah is the child yours? What if he can die their? But if a parent is been taught very well as the same with what my friends have already said, that it is easy to send there child to the hospital" . (P5, FGD 2)

7. SERVICE DESCRIPTION OF MALE CIRCUMCISION IN MALAWI.

There are two main types of service packages for male circumcision in Malawi: Traditional circumcision conducted in traditional settings in the village, home or mosque and circumcisions conducted at modern health facilities. Below the service package for both traditional circumcision and modern facility circumcision is described in terms of location of service delivery, training of providers, cost, adverse events, procedure, and package.

7.1 LOCATION AND TIMING:

A majority of interviewed respondents stated that most circumcisions occur in rural areas where there are traditional facilities for conducting Male Circumcision as part of their traditional cultures. Under *Jando*, a male initiation ceremony which also involves circumcision of the initiates, the principle facility is called *ndagala*. *Ndagala* is a grass thatched hut constructed outside a village, normally along a river bank where initiates stay during the whole period of the rite of passage process and where circumcision also takes place.

Respondents in circumcising communities noted that both urban and rural Moslems and Yao people circumcise their youth in this set up. Yaos residing in town normally send their children to their villages to be circumcised during school holidays. They do so because there are no traditional structures for conducting male circumcision in urban areas. Apart from the *Ndagala*, circumcisions are also performed at home in some cases. Usually this is done to adults. In some cases male circumcision is also done in a Mosque. Here, apart from the surgical removal of the fore skin, focus also is on inculcating the initiates in the teachings of the Quran. Moslem men are normally circumcised at the Mosque in order to separate Yao culture from religion, i.e. Islam. In addition, circumcision at the Mosque is either performed by a Health Worker or *Ngaliba* and there are no *supas* or traditional medicine used during the circumcision. After circumcision, counselling is done by the Sheikh and revolves around the Islamic faith and the circumcised dance *sikili (dhikir)*.

In most cases, the initiation ceremonies are done between June and August every year (this is a cold season and it helps the wounds to heal easily. In addition, this is the period when people have finished harvesting crops for food and for sale and it helps them to prepare well for the Ceremonies. Apart from the Traditional Initiation Ceremonies which happen annually, there are other circumcisions that are done throughout the year. Such circumcisions are performed either at Hospitals or in people's houses. These other circumcisions are done upon request and in the areas we have been to, they perform between 400 and 500 circumcisions on demand per year. These circumcisions are usually done when an uncircumcised man would like to marry a Moslem/Yao woman or when a man decides to become a Moslem. The *Ngalibas* noted that circumcisions on demand are on the increase nowadays.

Amongst the Lomwe, circumcision is also performed at the *Chidototo* Traditional Initiation Camps for Lomwe boys. Nowadays, circumcisions are also performed at the Health Centre. People are being told that if they circumcise, there are chances that they might not contract HIV/AIDS. So, some men are going for circumcision at the Clinic. People hear it from members of support groups (of people living with HIV/AIDS) who attend workshops at the Clinic and Mulanje District Hospital. They say that they are told that male circumcision can help men to avoid catching the HIV/AIDS virus.

For modern facility circumcision, the procedure is usually carried out under sterile conditions in theatre or treatment rooms. The set up of the treatment rooms vary by type of facility. In the public health system most circumcisions are conducted in tertiary and secondary facilities of the health system which usually are central and district hospitals. Additionally other mission, rural and larger health centres also conduct circumcision. Within the private sector larger private practices e.g. BLM which presently has 18 facilities conducting male circumcision and others are also able to conduct male circumcision and available and used facilities vary by facility type.

7.2 TRAINING OF PERSONS PROVIDING MALE CIRCUMCISION:

Ngalibas are trained by fellow *Ngalibas* to become circumcisers. The art of circumcision is handed down from one generation to another (inherited). Most *Ngalibas* in Mangochi have also been trained by Save the Children (*Mchanda ni mchanda Project*) to do circumcisions safely. The Save the Children project discouraged them from using one razor blade when circumcising the initiates or any man. It encouraged them to use one razor blade per circumcised man and provided them with instruments and materials for performing circumcisions safely. Sheikh Ponyani explained that he underwent a two-week HIV/AIDS orientation in which he was trained in how to do circumcisions safely by Save the Children.

The *Namkungwi / Mwini zoma* acquires circumcision techniques and skills from a former *Namkungwi*. Usually elderly men are the ones who are entrusted with this task and it is handed down from one person to another – however, it is not inherited. This is different in the Yao culture where apart from *Ngalibas* being trained by fellow *Ngalibas*, the skill is handed down from one generation to another.

For modern facility settings the procedure requires a surgeon and an assistant, a nurse and a runner and one more person to help with cleaning the theatre after use and also transporting patients. On average, our observation is that, there usually are three people working in a theatre/room conducting circumcisions. From the health facilities data, we found out that MC was provided by surgeons, medical officers and clinical officers. About 79.3% of circumcisions were provided by clinical officers, whereas surgeons provide 15.5% of circumcisions, and medical officers gave 4.2% of the reported circumcisions. All circumcisions were carried out at district hospital facility were for free.

7.3 COSTS ASSOCIATED WITH MALE CIRCUMCISION

The normal charge for Male Circumcision is between K200 and K300 per child and is given to the *Ngaliba* and anybody performing the circumcision. However, orphans and the poor are exempted from paying. Apart from monetary payments, parents of circumcised children give a chicken to the chief and the *Nakanga* (2 chickens in total). They also give flour to the *Nakanga* which he puts in a winnowing basket (*lichelo*) and gives it to the *Nakanga* during the coming out ceremony of the *Jando* to signify that all the boys have come out safely from the *Jando*. There are also other costs associated with the *Jando* ceremony in which the boys are circumcised. For example, parents have to prepare gifts such as *thobwa*, tea and bread, soap, body lotions when the wounds heal and the initiates can now start bathing. This ceremony is called *Liyogo*, where the initiates take a bath in a river. In some cases, parents donate goats to the chief at their own will.

There are also some costs associated with the coming out ceremony of the initiates from *ndagala*. For example, there is the *Mchopi* (*kuchezera komaliza*) ceremony which is done about three days before the initiates come home. They sing all night long, both at the *Jando* and parents/relatives at home. They celebrate that the initiates have healed properly and soon they will be coming home. In the morning, each circumcised child stands on one leg on a line and his parents pay K50 to the *Nakanga* to redeem the child. They also go out to cut some trees and destroy the entrance to the *Jando* in preparation for the coming out ceremony. On the day the initiates come home from *ndagala*, parents buy suits for their children and pay *Alombwe* (guardians for the children at the *Jando*). Parents also redeem their children from the chief by putting money on each of the child. Finally, there is *kusupa* the children. The money which is put in the plate goes to the senior guardian. The senior guardian is the one who chooses *alombwe*, the guardian who spends nights at the *Jando* with the initiate. The money which is put in the pocket of the child is taken by the child.

Another associated cost is food. Daily, parents/relatives of the initiates take food to the *ndagala*. On special occasions like *Liyogo*, the coming out ceremony, special foods are also prepared for the celebrations.

For circumcisions performed during the *Zoma* traditional initiation ceremony amongst the Lomwe, the initiates pay between K200 and K250 to the *Mwini zoma*. Out of this amount, K100.00 is sent to the TA. If one's parents cannot afford the fee, they are asked to bring a chicken to the *Mwini zoma*.

In modern facility settings, as with all health care, circumcisions are provided free of charge in the government facilities while clients have to pay in those facilities where health service provision is provided at user fees. The review could not establish the real cost from a provider perspective not a user perspective and such information will be collected during the planned substantive data collection. However, data from BLM²⁵ indicates that the average price per client in BLM clinics is MK950 while it costs the organization MK680.

²⁵ Chipeta-Khonje A, Hayes B, Khonde D and Mahuka H. Operations research on male circumcision services (MC): Informing MC policy in family planning clinics. NAC Research Dissemination Conference, 2009.

The general associated costs are indicated in Table 18 (not disaggregated by providers) below.

Table 18. Costs of circumcision (traditional and modern facility circumcisions)

		Transport cost	Food cost	Medical bill	Phone bill	Other expenses	Money source				
		Mean	Mean	Mean	Mean	Mean	saved up for	borrowed	sell of commodities	family has money now	others
Area	Urban	139.37	1432.67	288.59	4.35	1112.70	42.6	0.0	14.9	28.7	13.9
	Rural	87.91	1906.07	277.85	13.15	867.53	39.4	1.6	22.6	30.3	6.2
Region	North	176.88	855.57	206.93	8.11	464.88	47.4	0.0	18.4	23.7	10.5
	Centre	80.36	1625.01	244.35	2.23	531.63	60.2	3.1	14.3	10.6	11.8
	South	96.78	1987.93	305.03	19.08	1074.14	33.9	1.2	23.5	35.8	5.6
District	Blantyre	53.84	1529.40	498.31	1.20	528.02	56.6	2.0	8.1	13.1	20.2
	Chitipa	406.82	227.27	201.82	27.27	318.18	50.0	0.0	25.0	12.5	12.5
	Lilongwe	196.30	1421.11	579.74	0.00	275.94	54.5	4.5	9.1	13.6	18.2
	Mangochi	414.56	2442.20	272.70	323.75	1480.31	27.4	1.0	28.1	41.4	2.0
	Mulanje	29.86	1275.25	188.07	15.62	555.58	32.4	1.0	23.5	37.3	5.9
	Mzimba	127.27	1166.67	363.64	0.00	762.50	25.0	0.0	16.7	41.7	16.7
	Nkhatabay	66.67	1112.53	108.84	0.00	356.12	61.1	0.0	16.7	16.7	5.6
	Nkhotakota	62.04	1697.53	182.20	2.78	575.38	62.1	3.0	15.2	9.8	9.8
	Nsanje	240.00	1960.20	241.33	0.00	742.86	75.0	0.0	0.0	25.0	0.0
	Ntcheu	18.75	1035.00	231.25	0.00	612.50	42.9	0.0	14.3	14.3	28.6
	Age	<20 years	116.28	2137.61	357.98	18.70	1376.34	40.7	1.7	20.3	28.8	8.5
20-24 years		139.23	2188.79	439.28	17.57	1389.76	42.0	1.5	22.1	26.7	7.6
25-29 years		155.57	2579.95	366.35	6.53	1167.00	40.9	0.9	13.9	37.4	7.0
30-34 years		101.81	1950.24	258.04	45.92	853.99	32.4	2.0	21.6	38.2	5.9
35-39 years		144.03	1318.17	255.87	0.57	624.57	42.6	5.9	17.6	27.9	5.9
40-44 years		29.23	1587.50	127.23	0.00	480.47	40.7	0.0	23.7	25.4	10.2
45-49 years		58.82	798.33	160.14	0.00	266.01	23.5	0.0	29.4	32.4	14.7
50 years or more		26.06	1187.69	141.21	0.00	403.41	43.4	0.6	26.0	25.4	4.6
Marriage	yes	86.59	1804.35	268.97	8.83	815.26	40.5	1.7	21.7	29.8	6.3
	no	136.54	1985.41	311.65	16.10	1160.71	38.2	1.0	20.4	31.4	8.9
Ethnicity	Chewa	67.39	1686.44	194.04	2.35	652.03	58.7	2.6	13.5	14.8	10.3
	Yao	115.45	2219.40	291.52	24.02	1262.73	31.1	1.3	25.9	37.1	4.6
	Tumbuka	440.00	710.00	850.00	33.33	145.45	30.8	0.0	15.4	38.5	15.4
	Lomwe	58.72	1116.17	352.12	2.33	523.71	41.2	1.0	16.5	29.9	11.3
	Sena	229.41	1850.19	210.00	0.00	626.67	78.6	0.0	0.0	14.3	7.1
	Ngoni	5.76	1348.75	306.67	0.00	418.24	64.7	0.0	5.9	11.8	17.6
	Tonga	87.50	0.06	0.05	0.00	100.00	80.0	0.0	0.0	20.0	0.0
	Amang'anja	126.56	2068.24	387.57	46.88	428.32	41.2	2.9	26.5	23.5	5.9
	Nkhonde	0.00	7000.00	0.00	0.00	0.00	0.0	0.0	100.0	0.0	0.0
	others	122.92	166.68	47.51	0.00	315.01	30.0	0.0	30.0	30.0	10.0
Children	yes	87.10	1824.11	265.42	8.80	803.69	40.2	1.7	22.1	29.6	6.4
	no	128.44	1919.47	326.99	19.25	1199.25	38.9	1.0	19.2	32.3	8.6

Religion		155.18	1838.50	456.08	3.89	464.43	46.2	2.6	15.4	20.5	15.4
	CCAP	84.34	1314.11	331.67	24.59	506.22	44.3	1.6	13.1	31.1	9.8
	Anglican	20.50	1734.29	199.03	0.00	1192.72	38.5	2.6	35.9	23.1	0.0
	Adventist Baptist	156.67	965.79	276.52	12.33	498.85	36.4	0.0	6.1	39.4	18.2
	Muslim	121.50	2096.32	216.91	14.45	1110.98	37.2	1.1	23.3	32.3	6.0
	others	29.49	1410.89	443.91	1.58	468.54	50.5	3.1	18.6	21.6	6.2
School attendance											
	yes	110.42	1893.86	294.02	13.54	980.47	41.9	1.9	18.8	29.6	7.8
	no	32.80	1586.42	228.83	1.50	595.42	32.6	0.0	30.9	32.0	4.6
Education level											
	primary	83.86	2019.24	288.19	10.24	960.11	40.3	2.2	20.0	30.4	7.1
	secondary	147.54	1541.57	301.14	19.17	1062.18	44.6	1.3	15.9	28.7	9.6
	tertiary	460.63	1788.57	386.67	42.86	400.00	75.0	0.0	0.0	12.5	12.5
literacy											
	yes	60.00	594.29	75.18	0.00	210.90	24.0	0.0	28.0	48.0	0.0
	no	35.55	1831.76	280.49	2.11	668.22	29.9	0.0	33.1	30.7	6.3
Asset ownership											
	radio	103.54	1780.54	307.35	12.21	772.13	40.2	1.5	22.1	28.9	7.4
	bicycle	112.23	1930.47	262.71	14.72	920.68	35.6	1.8	26.1	29.4	7.1
	house servant	24.00	1991.67	451.54	45.83	590.67	28.6	0.0	28.6	28.6	14.3
	oxcart	.	.	.	.	.	0.0	0.0	0.0	0.0	0.0
	livestock	114.26	1730.72	253.73	6.89	831.41	38.0	1.9	25.7	28.1	6.3
	grass_thatched_house	93.04	1970.30	288.33	6.20	947.12	38.8	1.5	22.6	31.3	5.8
	iron_sheetroofed_house	120.34	1601.91	295.33	22.98	659.17	42.6	1.7	20.5	27.8	7.4
	use electricity	31.54	1778.33	512.90	19.23	652.58	57.1	0.0	21.4	14.3	7.1
	parafin_lamp	109.24	1855.28	275.44	7.40	895.26	38.7	1.7	21.9	31.6	6.1
	pit latrine	106.28	1909.41	278.86	12.01	912.77	37.9	1.6	22.6	31.9	5.9
	flash toilet	61.23	1625.00	546.43	42.31	88.46	62.5	0.0	12.5	25.0	0.0

7.4 PROCEDURE OF MALE CIRCUMCISION:

In traditional settings, *Ngaliba* is the one who performs the circumcision. They keep finger nails of the index finger of their left hand long. They use it to hold together the foreskin and cut it to prevent cutting the head of the penis. At *ndagala*, the initiates are advised and supervised by their guardians to keep their legs wide open (especially when sleeping at night). This prevents the wound from friction with the thighs. If the initiate is an older person, he is advised not to sleep closer with his wife, to prevent the penis from erecting. This prolongs the healing process.

After circumcision, they apply iodine or spirit to the wounds. They tie the wound with a white clean cloth. They also prescribe apply powdered *kaliwuti*, *papaya* or *Chitedze* leaves to the wound. The herbs/medicines speed up the healing process of the wounds. After the circumcision ceremony, the circumcised are encouraged to "*kujasa mauta*". This is a practice where initiates are encouraged to have sexual intercourse with their female counterparts. However, this practice as observed by the respondents is being discouraged nowadays due to the HIV/AIDS pandemic.

In addition, respondents noted that circumcisions performed in village camps are often not safe because they are sometimes wrongly done and may lead to the initiates bleeding heavily to death. They also bemoaned the practice of some *Ngalibas* who use the same equipment repeatedly exposing the initiates to HIV/AIDS. Because of this parents are encouraged to take their children to hospital for circumcision in order to protect them from HIV/AIDS. Other respondents also observed that organisations like World Vision and Save the Children have trained *Ngalibas* on how to conduct safe circumcisions. They have been taught to use one blade per initiate.

In modern facilities ideally a purpose built operating theatre or minor procedures room is required although in most district hospitals visited the operation is done in various places including theatres, treatment rooms and dressing rooms using a fixed height table. There is usually an instrument trolley or table on which the sterile instruments are unpacked. The procedure room floor is made of material that can easily be cleaned or disinfected. The Lighting is arranged so that the penis is well lit and the surgeon can see what they are doing. Emergency medications and equipment for managing anaphylactic reactions should be available. The materials and equipment used comprise a circumcision set (see appendix 7) and anaesthesia.

In adults preferably local anaesthesia is used as it is less risky and less expensive. The main technique used is the ring block technique. The nerve supply to the penis is the twin dorsal penile nerves. These are located at the 11 o'clock and 1 o'clock positions near the base of the penis. They fan out towards the glans penis. The standard procedure is the dorsal slit method. Preparation starts with scrubbing and gowning. A full description of the process is appended in appendix 6. From the visited facilities, circumcisions were mostly provided through local anaesthesia (n=1379, 71.5%), whereas general anaesthesia was second most used (n=454, 26.2%)

7.5 ADVERSE EVENTS

The respondents noted that sometimes there are adverse events after performing the circumcision. However, they associated the adverse events to traditional beliefs among the people – for instance, when there are differences between parents, they believe that the child's wound may produce blood continuously. However, the respondents did not quantify the number of adverse events encountered per year.

In modern facility settings in Malawi most clinicians do the above dorsal slit technique with some few variations e.g. most clinicians do not mark the line of incision ending up with either removing too much skin or too little skin and consequently this does not look good. Others suture continuously leading to lots of complications, the commonest being hematomas and bleeding. Additionally others use big sutures which give a very bad outcome, bad scars, and pain. There was no data available from the visited facilities to examine the extent of these theoretical adverse events as the process does not capture such information and where adverse events occur, the patients would typically report to another unit than the one where they underwent the procedure.

7.6 PACKAGE AND SERVICE LINKAGES

The materials that are used to perform male circumcisions include scalpels, mostly donated by Save the Children in the case of Mangochi district or razor blades. They also use *Nsupa* that protects the *ndagala* and the children from witches/wizards during the initiation ceremony. Powdered traditional medicine for example *chipisyawago*, *kaliwuti*, *chitedze* and *papaya* leaves are used to aid in the healing process. The following western medicines and materials: iodine, chloromphenicol, panadol, penicillin, gloves and cotton are obtained from hospitals or non-governmental organisations, like Save the Children. The package does not include any formal linkage with the health service in terms of HIV Testing and Counselling (HTC), Sexually Transmitted infections (STIs) or other Reproductive Health (RH) services although such is done in some cases on ad hoc basis.

For the modern facility setup there is no defined standard male circumcision package within the government facilities and there is no linkage of male circumcision services to STI, HTC and other RH services in most hospitals. In most institutions visited clients are not even offered free condoms and are not offered HTC as part of the service delivery.

8 FACTORS AFFECTING RATES OF MALE CIRCUMCISION IN MALAWI

81 FACTORS DECREASING RATES OF CIRCUMCISION

We asked respondents in the KII and FGDs to mention factors which determine rates of male circumcision in Malawi. The respondents outlined the following as the main factors determining Male Circumcision in the Malawian context: Religion, Ethnicity and Age.

They said religion was the chief factor determining rates of male circumcision in Malawi. Almost all the respondents noted that Male Circumcision is an Islamic religious ritual and is predominantly practiced among Moslems throughout the country. They observed that it is a religious requirement for all Moslem men to be circumcised – for this reason, they pointed out that almost 100% of Moslem men are circumcised. They also noted that Male Circumcision is associated with cleanliness among Moslem men and that those that are not circumcised are seen as unclean. Here they observed that Christians and other non-Moslems might not welcome circumcision because of its association with the Islamic religion unless they are well informed about the implications of going for male circumcision.

Ethnicity was mentioned as the second major factor determining rates of circumcision in Malawi. They said that 100% of circumcised men are Yao. They noted that Male Circumcision has been part of Yao Culture for centuries and that it has been passed on from one generation to the other among the Yao. They observed that Arabs who brought Islam to the Yao people found them already practicing Male Circumcision.

In addition, respondents noted that there are some members of other tribes or ethnic groups that undergo circumcision when they would like to join Islam or when they would like to marry a Moslem woman/Yao woman. The third factor which determines the rates of male circumcision is age. Respondents noted that Yao people send their children for Male Circumcision at the ages of 9 – 12 years (below 24 years). They are circumcised at this age range because it is the age of the rite of passage from childhood and adulthood. During this period, the male children are sent to initiation camps for initiation rites and they are circumcised as part of their rite of passage. However, middle aged (25 -40 yrs) men are circumcised when they would like to marry a Moslem woman or would like to become a Moslem. The respondents also noted that middle aged men are also getting circumcised on hygienic grounds after being advised to do so by their doctors or after getting information that circumcision reduces the chances of HIV transmission. On this they observed that adult circumcision is not safe because it can lead to complications. So, they felt people's age could dispel some men from accessing male circumcision services.

Thus “R: I think the factors that can affect the male circumcision now. We are talking of HIV/AIDS and people have realized that circumcision is good for prevention of HIV transmission. Now the issue is about age. Age limit could be one of the factors (I: mmh) because people can say ooh this is a good way let me be circumcised at the age of 40 or 50 (I: mmh) Yah... so there will be those factors. Circumcision at such an age could lead to more complications. I have more stories from newspapers that one or two people were forced to be circumcised at the age of 40 or 50 and had devastating consequences. So age is one of the factors which could hinder this. Aah secondly because of the association of male circumcision with the religious belief of Muslims, some people won't accept it. They may think they will be converted to Islam if they go for circumcision. So some people or their religions can say no we don't believe in this. (IDI # 39).

8.2 FACTORS THAT NEED TO CHANGE IN ORDER TO INCREASE PROVISION OF HEALTH FACILITY-BASED MALE CIRCUMCISION

Respondents were asked to state factors that need to change in order to increase the provision of male circumcision services in health facilities. In response, respondents mentioned the following as the most important factors that need attention; Training of health personnel to perform male circumcision operations, equipment for male circumcision operations and other resources such as space/room for such operations.

On the training of health personnel, they noted most health workers who perform circumcision operations in health facilities have not undergone training in performing male circumcisions.

“R: It is supposed to train more health pro... health workers so that there is no any ... the problem is...some of the health workers they don't know how to perform the procedure...so it...it can be ... it could be easier if many health workers they can know that procedure....how it is done safely....then we can find other instruments which they are easier for circumcision....then sensitization to the communities and it must be clear....because for cosmetic circumcision previously ..formally...it was done as a private thing so you...you were not allowed to do circumcision on normal working hours because it is cosmetic it s not a disease but you are allowed to do circumcision for those with...with indication like parathimosis or anything...that is you can put on the list....priority but for cosmetic you can postpone it means you will miss paternity...so if we...we are many who ...there are many health workers who can provide this services then it must be also be free and some of the instruments – forceps.... For doing it fast.” (IDI # 47)

8.3 FACTORS THAT WOULD INCREASE DEMAND

Most respondents stated that massive public sensitization could increase demand for male circumcision. They noted that most Malawians are not aware that male circumcision could reduce the chance of HIV transmission from a woman to a man and that people need to be educated about this. They stated that people need to

understand why male circumcisions should be performed. They felt that such information could be conveyed to the public through the media and more specifically through radio announcements and public meetings. People could also be counseled about male circumcisions when they come to the hospital. In such counseling, people should be well informed about the benefits and risks of undergoing male circumcision and that it should be left to them to decide to go for circumcision or not. The respondents felt that circumcision services should be offered to people just like any other health service available at a health facility and that people should be at liberty to access such services. Some respondents suggested that community leaders such as Traditional Leaders and Religious Leaders who opinion leaders in the communities should also be engaged in sensitizing the public about circumcision. They said that when the community leaders speak, people listen to them and it would be easy to convince people to go for circumcision if these leaders are involved in the sensitization activities.

"R: *I think basically for a man to have an idea to say I would want to be circumcised one has to ... have the information as to why he should opt for that intervention,....what are the benefits of one being circumcised? Is it for general cleanliness or the view of that one will be protected from the risk of being HIV infected or the risk of infecting the wife with HIV? Generally those are some of the aspects that we should intervene ...so I think the strongest aspect would be IEC which is Information Education and Communication. Secondly for us to be able to provide the service because one can make the decision and if he comes to the hospital and finds that the hospital is not providing then one can be discouraged. So, the hospitals should have the necessary resources to offer male circumcision." (IDI #21)*

"Through the same, there could be other influential ...leaders who may encourage people to get this service. So we also need to engage people who influence the parents for example church leaders to understand what this intervention is all about and just as we speak to the community the church leaders should be in the forefront in encouraging parents to have their children circumcised. " (IDI #27).

9 SERVICE AVAILABILITY ASSESSMENT

Understanding of context in which MC services are being offered is essential as it can inform both short term and long term decisions regarding prioritization of areas for investment to scale up MC. For instance, such information can be used to define infrastructure and equipment needs, types and level of training for health workers. It can also be the basis for design of supervision and quality improvements systems and monitoring and evaluation efforts.

In order to provide this important information health facility and practitioner's surveys were carried out.

9.1 HEALTH FACILITY TYPES.

56/ N (x%) of health facility in the country were involved in the health facility survey. 21% were from the northern region, 38% from the centre and 41% from the southern region. The composition of the health facilities per type is shown in Table 1. The mean size of catchment area population per health facility type were 250,000, 205, 086, 95,380 and 51,200 for central, district, mission and community hospitals respectively.

Table 19: Facilities surveyed as part of the male circumcision survey by facility type.

Facility type	Number	%
Central Hospital	3	5.36
District Hospital	22	39.29
Mission Hospital	24	42.86
Community Hospital	7	12.50
<i>Total</i>	<i>56</i>	<i>100.0</i>

9.2 INFRASTRUCTURE, EQUIPMENT AND SERVICE AVAILABILITY.

A structured questionnaire was used to assess capacity of health facilities to provide male circumcision under standard condition. Capacity of health facilities were assessed by noting whether or not the health facility has minimal infrastructural and equipment needs and also by noting if services that would support provision of MC were available. In general central and district hospitals seem to have the all the prerequisite elements essential to provide a quality package of MC in a safe manner. However, depending on element being assessed, variable gaps were identified in capacities of community and mission hospital with latter tending to fare badly between the

two as only 23%(5/22) of mission hospitals has all the 10 capacities compared to 29% (2/7) of community hospitals (Table 20).

Table 20: Infrastructure, equipment and service availability by health facility type

Facility type/ availability (%)	Central	District	Mission	Community	Total
Basic facilities	100 %	100 %	91 %	43 %	88%
Electricity supply	100%	100%	95%	83%	96%
Water supply	100%	100%	95%	86%	95%
Outpatient rooms	100 %	100 %	91 %	86 %	94 %
Surgical equipment	100 %	100 %	92 %	67 %	92 %
Autoclaving equipment	100%	100%	100%	86%	98%
STI services	100%	100%	96%	100%	98%
VCT services	100%	100%	100%	100%	100%
Minor surgeries	100%	100%	90%	71%	92%
MC procedures	100%	100%	91%	57%	91%

9.3 SERVICE OUTPUTS

Out of 48, 193 minor surgeries done in the surveyed health facility, only 3,548(7.3%) were circumcisions. Male circumcision therefore constitutes a small percentage minor surgery burden. On average most of the circumcisions are done at central hospital than any other type of health facility. The least mean number of circumcisions per facility per year are done at community hospital level. Number of HIV tests provided by health facility mirrors this picture. This variation in service level reflects fundamental issues of access availability and accessibility.

Table 21: Service outputs per health facility type

Facility type/ Service delivered	Central	District	Mission	Community	Total
Circumcision (mean/ year)	115.3	103	96	4	93
Minor surgeries(mean/year)	1,250	3,406	478	108	1,721
HIV testing (mean/year)	129,420	28,531	2,886	3,365	19,193

9.4 MALE CIRCUMCISION SERVICE BENEFICIARIES

Among male circumcision beneficiaries for whom records were complete (n=3,296), 17.6% were infants, 23.3% were children, 40.1% were adolescents while 14.8% were adults. Composition of beneficiaries per health facility type was variable; proportionately more infants and children were circumcised at central and district hospitals compared to mission and community hospitals. The latter tended to provide mc services to adolescents and adults as detailed in Table 22.

Table 22: Composition of male circumcision beneficiaries per health facility type.

Facility type/ beneficiary	Central N(%)	District N(%)	Mission N(%)	Community N(%)	Total N(%)
Infant	60(29.1)	219(13.4)	302(22.0)	0(0)	581(17.6)
Child	76 (36.9)	363(22.2)	459(33.5)	5(5.6)	903(23.3)
Adolescent	57(27.7)	825(50.6)	388(28.3)	51(57.9)	1321(40.1)
Adult	13(6.3)	225(13.7)	221(16.1)	32(36.3)	491(14.8)
Total	206	1,632	1,370	88	3,296

9.5 HEALTH WORKERS CAPACITIES

347 health workers were interviewed in the 36 public health facilities. Complete information was available for 326 of them. Of these, nearly a half 47.2% were nurses, 36.8% clinical officers and 9.8% were doctors. The distribution of health workers cadre by health facility type is shown in Table 23 and 24.

Table 23: Number of health workers surveyed per health facility type

Cadre/ facility type	Doctors	Clinicians	Nurses	Counselors	Others	Total
Central	2 (6.2)	7(5.83)	8(5.1)	0(0)	0(0)	17(5.2)
District	21(65.6)	71(59.1)	70(45.5)	2(100)	6(33.3)	170(52.1)
Mission	7(21.8)	30(25)	54(35.0)	(0)	11(61.1)	102(31.2)
Community	2(6.2)	12(10)	22(14.2)	(0)	1(5.6)	37(11.3)
Total	32	120	154	2	18	326

Table 24: Experience of health workers on male circumcision related tasks

Cadre/ facility type	Doctors	Clinicians	Nurses	Others	Total
Performed MC	61.2%	87.1%	0%	37.5%	42.20%
Assisted MC	100%	96.6%	100%	100%	98.68%
Patient screening	91.6%	98.2%	92.3%	100%	96.63%
Operative care	100%	100%	100%	100%	100%
MC counseling	100%	100%	100%	100%	100%

9.6 HEALTH WORKERS TRAINING NEEDS

Overall, 21.8% (63/289) of the health workers expressed the need for more training in male circumcision. Among the different cadres, the expressed training need was 46.1% for doctors, 27.3% for clinical officers and 13.1% for nurses. Using number of government only employed health workers as of July 2009, the estimated number of health workers needing MC training is as shown in Table 25.

Table 25: Number of health workers needing male circumcision training in the public sector

Health worker	Number of HW	% training needed	Number of needing training
Doctors	139	46.1%	64
Clinicians	680	27.3%	186
Nurses	2924	13.1%	383
Total	3743	21.8%	633

The specific training needs required by the health workers according cadre are as shown in table 26.

Table 26. Specific training needs for various cadres of health personnel

Cadre/ facility type	Doctors	Clinicians	Nurses	Others	Total
Theoretical	100	93.8	91.6	100	93.8
Practical	100	98.4	94.3	100	96.8
STI diagnosis and treatment	80	97.3	95.1	100	95.7
Infection prevention	100	100	93.9	100	97.2
Counseling	100	95.83	96.6	-	97.01
Comprehensive	85.71	96.30	97.92	100	96.91

9.7 MALE CIRCUMCISION COSTS ESTIMATES

In the private sector²⁶, an ingredients based methodology to estimate the cost of providing a male circumcision procedure taking into account health workers time (a clinician, assistant nurse and HCT counselor), surgical materials, drugs and equipment shows the estimated cost of MC to be around MK 1,163.09. Surgical materials and health workers time are the major cost drivers accounting for 58.5% and 39.7% respectively. A standard 7-10 day training of a health worker to perform MC (including 2 days of counseling) would cost on average MK 105,750 but this varied from MK66,227.00 to MK234,822.00 with accommodation costs explaining most of the disparity. Each session of training on average takes 6 participants. This number might be increased to 15 participants at an average cost per trainee of MK95, 175.00.

²⁶ Brendan Hayes, BLM Personal communication

10 SOCIO-POLITICAL ENVIRONMENT IMPACTING MALE CIRCUMCISION IN MALAWI.

10.1 TRANSLATIONAL ISSUES IN MALE CIRCUMCISION

The term "Male Circumcision" is translated as *kuwumbala* in Yao language. *Kuwumbala* literally means removal or cutting of the foreskin (*kata msumbu*). Although it is a neutral word, it can sometimes be used negatively by non-circumcised men in order to insult a person because it associates the person with the cutting of his foreskin. However, when it is used among circumcised men, it is used to respect a person who is circumcised. Among the Lomwe and Mang'anja, they use the term "*mdulidwe*" which also connotes "cutting" (of the foreskin). Normally, the term *mdulidwe* is not commonly used among circumcised men. Instead it is used by uncircumcised men to insult those that are circumcised. A man who is not circumcised is called "*wosadulidwa*" or "*wodyera ku nkhongo*". The term "*wosadulidwa*" means uncircumcised while "*wodyera ku nkhongo*" means "one who eats through the back of his head" and it is an insult to an uncircumcised person.

10.2 NORMATIVE CULTURAL OR RELIGIOUS ISSUES

Our respondents stated that Male Circumcision is both a cultural practice and a religious ritual. As a religious ritual, they expressed that 100% of Moslem men are circumcised as a precondition for joining Islam or being a Moslem man. As a cultural practice, male circumcision is a rite of passage for boys. For a boy to become a man, he has to be circumcised. It is also a requirement for men who would like to marry Yao women to be circumcised. In fact Yao women are discouraged to marry uncircumcised men. As a rite of passage, circumcision is performed during the Traditional Initiation Ceremonies at the *Ndagala / Thezo / Simba / Zoma*. The respondents also noted that there are few non-Yao people who get circumcised. For example, they stated that the *Lomwe* circumcise because they lived and interacted with the Yao in Mozambique where they came from and still live together today. They also noted that some men from other tribes get circumcised whenever they would like to marry Yao women or become Moslems. It is common knowledge that typically people from the same tribe tend to marry those from a similar tribe as such tribes that have not intermarried as much and who do not practice male circumcision may not participate in male circumcision.

10.3 GROUPS THAT MIGHT OPPOSE MALE CIRCUMCISION

Moslem and Yao respondents indicated that some Christian faiths and *anthu a mtundu* are likely going to oppose MC because they see it as part of the Islamic religion and as an uncivilized ceremony. Although Yao men and some Lomwe men in TA Chikumbu circumcise during the *Jando* and *Simba* ceremonies, some Christians don't allow their followers to go for the ceremonies. For example, there were some Christian boys who joined the *Jando* Ceremony in 2008 in Mulanje and when the church leaders heard about it, they sent someone to remove the Christian boys from the *Jando* Ceremony. After meeting the *Ngaliba* and *Nakanga*, they refused to release the boys. Eventually the church leader himself went to Chief Kachingwe, who acts on behalf of TA Chikumbu, and demanded the release of the boys. Unfortunately, it is not allowed in their culture and the Chief refused to release the boys from the *Jando*. There are also some Yao and Lomwe people who don't circumcise because they are Christians in general.

Some key informants reported that most Christian churches discourage their members from being circumcised and from attending the traditional initiation ceremonies describing the practices as evil (*Achikunja*). Those who attend the ceremonies are sometimes excommunicated from the church. They also explained that non-Yao's especially the Ngoni and Chewa think male circumcision is a painful process/procedure and so they would not want to get circumcised. For example, they noted that Ngoni men who live among the Yao always refuse to get circumcised.

The observations above were confirmed by our focus group and in-depth interview respondents. Most of the respondents stated that it would depend on one's religion and culture. They said Christians and non-Yao might oppose Male Circumcision and would not love to have their children or themselves circumcised. They explained that Christians may oppose Male Circumcision because they see it as part of the Islamic religion. Thus one of the respondents said, "*R: Well, Muslims are by nature the ones who commonly practice male circumcision. It's their tradition so even Christians are afraid to be circumcised for fear that they will be labeled Muslims.*" (IDI # 1)

As such, most Christian churches discourage their members from being circumcised and from attending the traditional initiation ceremonies describing the practices as evil (*Achikunja*). This would also apply to non-Yao people who do not practice male circumcision. They see male circumcision as part of the Islamic religion and Yao culture and they would not like to assimilate it. However, they said for Moslems and Yao people, they would feel they were missing something if they were not circumcised. On this, they stated that the government would have to do much sensitization among Christians and non-Yao people about the benefits of male circumcision. They would have to convince people that it was being introduced as a health intervention and that it was de-linked from Islam and Yao culture. They further stated that people should be told the truth about the benefits of circumcision and this should not be exaggerated – people should know that male circumcision only reduces their chances of being infected with HIV.

One respondent said, "*R: I think it depends upon how the messages really gets to them because if they are just told that if you are circumcised you won't have HIV then, probably all of them will rush to get circumcised but if they are told the truth that it only reduces the risk but the risk is still there, some may consider aa taking up the circumcision but others they*

may evaluate their own risk taking behaviors and may decide whether it's worthy taking it or not (I: ok) but there are also cultural factors that may affect its uptake." (ID1 # 46).

10.4 MEDIA COVERAGE ON MALE CIRCUMCISION IN THE LAST 2-3 YEARS.

Information was collected from radio stations, television station and print houses located in Blantyre. Appendix 7 lists the sources of our information, contact persons, types of stories on MC which have been covered in the past three years and the frequency at which they were reported. Most articles about Male Circumcision started appearing in both the print and electronic media in 2006. In this year there was an article in the Nation Newspaper entitled "Circumcision Boom." (Masingati I., Circumcision boom, National Newspaper of 22nd October, 2006). In the article, Isaac Masingati reported that the demand for circumcision in private clinics was rising following media reports that male circumcision could reduce the chances of HIV transmission from a woman to a man. He echoed the words of a private clinical officer at Mwachira in Lunzu and a BLM Advocacy and Corporate Relations Officer who stated that their clinics experienced heavy traffic of men demanding circumcision on hygienic grounds after being advised by doctors, on reports that circumcised men have lesser risks of contracting HIV and on cultural grounds as part of their initiation ceremony.

In the electronic media, there was a discussion on Male circumcision which was featured on FM 101 during a programme entitled "Health Feature" presented by Simeon Shumba. In the programme, Simeon Shumba reported about a Stakeholders' meeting on male circumcision which was held at Mount Soche Hotel in Blantyre. During the program, he interviewed Dr. Mary Shawa, the Principal Secretary in the Office of President and Cabinet responsible for HIV/AIDS and Nutrition. Dr. Shawa expressed skepticism on the success of male circumcision as a prevention strategy against HIV acquisition among men in Malawi. She explained that currently, the highest rates of HIV transmission are in districts or areas where male circumcision is being practiced. She therefore wondered whether such a program would succeed in reducing the number of HIV infections among men. She also stated that 58% of HIV infected people are women and wondered why only men are being targeted in HIV prevention and whether adult men would be targeted and yet they may have already been infected.

In general, stories about male circumcision started being reported in the media after NAC and other stakeholders organized a Stakeholders Meeting on Male Circumcision at Mount Soche Hotel in 2006 following results of successful male circumcision studies in South Africa, Kenya and Uganda.

Some themes on male circumcision coverage in the media

Forced circumcision

Out of all the news items retrieved from Nation Publications archives, forced circumcision was a dominant theme, reported thrice at different periods and locations. This was reported in Mchinji district on 10th October 2006. The story was titled *Circumcision by default* and was reported by Edwin Nyirongo. A similar story was reported in Bvumbwe in Thyolo district on 10th August 2006. The title was *Man gets forcibly circumcised* and was reported by Olivia Kumwenda. Another story was reported in Chikwawa district on 3rd January, 2008. It was titled *Man in forced circumcision* and was reported by Emmanuel Mwamba. A common thread in all these stories is that the men were forcibly circumcised after allegedly trespassing or peeping in an initiation camp. In the Chikwawa incident, a man who was also an initiation counselor was:

..in deep pain after sustaining deep cuts in his genitals when villagers forcibly circumcised him on December 9 using Panga knives as punishment for peeping in other peoples initiation camp [2]The Nation, Man in forced circumcision, reported by Emmanuel Mwamba, 2008.

Similarly in Bvumbwe, Thyolo district, a man was forcibly circumcised when he went to rescue his son who had been detained by a circumcision group.

The son was grabbed as he was walking near the simba and when the father heard about the incident he went to the place to get his son but upon arrival, he was welcomed by a group of simba people who forcibly circumcised him [3]The Nation, Man gets forcibly circumcised, reported by Olivia Kumwenda, 2006.

The reasons for the forced circumcision go beyond trespassing and peeping to encompass tribal conflicts arising from differing tribal perception of MC as reported in the Chikwawa case. Here, the complainant is Lomwe and the perpetrators were Yao.

[The complainant]...claimed the difference arose because of misunderstandings between the two initiation camps [Yao and Lomwe] over circumcision. The Yao circumcise their initiates while the Lomwe do not....i am just a victim of circumstances. I was told that I was not the target but because they had caught me I had to pay the price on behalf of other people who mocked them (for circumcision). They said they did this as punishment to my tribe [3] The Nation, Man in forced circumcision, reported by Emmanuel Mwamba, 2008.

As reported in all cases, those circumcised forcibly suffered injuries and had to be referred to a hospital. The man in the Bvumbwe case sustained soft tissue injuries. The man in the Mchinji case was detained at the initiation camp for three weeks (*two weeks at an initiation camp and one week at the house of the initiation leader*) because his wound was not healing fast. In the Chikwawa case, he was referred to hospital after his wound was not treated for thirteen days. All the above cases were reported to police and offenders were charged.

Conflict between school and initiation calendar

Conflict between school and initiation calendar was another dominant theme, as reported in two articles. In some areas, some chiefs had not released children from initiation camps though schools had opened [4] (Nation Publications, Chiefs defy

ministry on initiation ceremonies, 4th September 2008). According to the Ministry of Education, Initiation ceremonies are supposed to be done during long school holidays. However, as observed by chiefs, the ideal period to carry out MC initiation ceremony is soon after harvest:

We appreciate the importance of education but we cannot bow down, our tradition dictates that we hold the ceremonies soon after harvesting and that is between July and September. The initiates live in grass huts in bushes and the ceremony needs plenty of food [5]. (The nation, school, initiation clash, by news reporter, 20 Oct 99)

When this article was written school, children were going on long holidays in November.

10.5 POLICY ENVIRONMENT

The main policy under which male circumcision could fall is the Reproductive Health Policy. The policy states that the purpose of the national RH programme, as per the national RH policy, is: *To promote through informed choice, safer reproductive health by men, women and young people, including increased use of high quality, accessible reproductive health services* and the goal is stated as *Improved sexual and reproductive health for all men, women and young people in Malawi, especially the vulnerable and underserved*. Amongst its components, the RH programme has: Family planning; Maternal and Neonatal Health (including management of unsafe abortion); Prevention and management of STI/HIV/AIDS; Prevention, early detection & management of cervical, breast and prostate cancer; Infertility; Syphilis screening in all pregnant mothers; Mitigation of harmful practices; Obstetric fistula; Prevention of Mother to Child Transmission of HIV. Guidelines for each of these have been developed but in all there is hardly any mention of any potential benefit of male circumcision to further the goals of the RH programme.

The revised STI guidelines of 2008 ²⁷ only obliquely mentions male circumcision in light of its potential as a harmful practice if conducted in traditional settings under unsterile conditions and the attendant practices such as *kutchotsa fumbi* which increase the risk of sexually transmitted infections including HIV/AIDS. The tone of existing policies and guidelines is also echoed in the life skills curriculum for primary and secondary schools ²⁸ , ²⁹ where the issue of male circumcision is only addressed in light of its potential as a risk factor for STI and HIV/AIDS but no direct reference is made for its potential for hygiene improvement.

It is possible that these policies and guidelines were developed at a time when the evidence base for male circumcision's linkage with HIV/AIDS was not strong enough and may in future be revised. However the general protective effects of male circumcision which have been well known for some time ought to have been

²⁷ Ministry of Health. 2008. Management of sexually transmitted infections using the syndromic approach; A trainers Handbook.

²⁸ Malawi Institute of Education. 2004. Life skills and sexual reproductive health education training manual for secondary schools. Malawi Institute of Education.

²⁹ Malawi Institute of Education. 2004. Life skills and sexual reproductive health education training manual for primary schools. Malawi Institute of Education

addressed earlier and the fact that they were not addressed may point to a potential obstacle to be overcome in any male circumcision programming strategy.

The newly developed HIV prevention strategy for Malawi³⁰ however acknowledges the potential role of male circumcision in strategic objective 1 of reducing sexual transmission of HIV where it specifically calls for the development of a male circumcision policy, interventions and communication guidelines based on international and local evidence which the present desk review is part of.

³⁰ National AIDS Commission. National HIV Prevention Strategy 2009 -2013. National AIDS Commission.

APPENDICES

APPENDIX 1 LIST OF ORGANISATIONS CONSULTED FOR DOCUMENTS ON MALE CIRCUMCISION.

FEEDBACK OF MALE CIRCUMCISION STUDIES, REPORTS AND DOCUMENTS CONDUCTED IN MALAWI IN DIFFERENT ORGANISATIONS.

#	ORGANISATION	REPORT	COMMENT	CONTACT PERSON	NUMBER
1	PSI	HIV Prevention and Multiple and Concurrent Partnership in Malawi	Successful	Simon Sikwese	
	CSR	1. Qualitative Evidence of Adolescents Sexual and Reproductive Health Experiences in Selected Districts of Malawi. 2. Adolescent sexual and reproductive Health in Malawi. Results from 2004 National Survey of Adolescents. 3. The timing and role of initiation rite in Preparing young people for adolescence and responsible sexual and reproductive behaviour in Malawi	Successful	Alister Munthali	
	NAC	Report of the National Stakeholder Consultation on Male Circumcision and HIV Prevention	Successful	Blackson Matatiyo	
	Malawi Network for Aids Service	No Reports	Successful	Akuzike Tasowana	
	Ministry of Health		Need clearance from Ministry	Mr Nkhata	
	Malawi network for people living with HIV	No Reports	They only attend meetings	Mr Kamanga	
	BLM	WHO MC Manual	Successful	Timothy Bonyongo	
	Concern Universal		Their server is not working cant retrieve data	Mr Msiska	
	Baylor Children Foundation	No Reports	Successful	Richard Mwewe	
	Save the Children	No Reports	Successful	Receptionist	
	Malawi Bridge Project	No Reports	Successful	Receptionist	
	NSO	Malawi Demographic Health Survey 2004	Successful	Internet/Librarian	
	Wadonda Consult	No Reports	Successful	Dr Mvula	
	KCN	Acceptability of Male Circumcision for	Will bring the report	Dr R.C Ngalande	

		Prevention of HIV Infection in Malawi			
	John Hopkins	No Reports	Successful	Fatima Zulu	
	Red Cross Malawi	No Reports	Successful	Leonard Maganga	
	UNC	No Reports	Successful	Chifundo Zimba	
	Muslim Association of Malawi	No Reports	Successful	Muhamad Kongwe	
	Malawi Human Rights Commission	Cultural Practices and their Impact on the Enjoyment of Human Rights, Particularly the Rights of Women and Children.	Successful/internet	George Makhaira	
	Internet	Acceptability of Male Circumcision for Prevention of HIV Infection in Malawi			
		Male Circumcision and HIV Infection; The case in Malawi			
		Knowledge, Beliefs and Attitudes about Male Circumcision in Four Districts of Malawi.			

APPENDIX 2. SUMMARY OF PUBLISHED AND UNPUBLISHED STUDIES ON MALE CIRCUMCISION IN MALAWI.

NO	STUDY	DESCRIPTION	CONCLUSION
1	<p>Title: Qualitative evidence of adolescents’ sexual and reproductive health experiences in selected districts of Malawi.</p> <p>Author: Alister C Munthali, Ann M Moore, Sidon Konyani, Bernie Zakeyo</p> <p>Date of publication: 2006</p>	<p>Method: Data were collected using semi structured in-depth interviews (IDIs) conducted in 2003 with adolescents aged 12–19 years.</p> <p>Study site: This study was conducted in Blantyre (urban) and in four rural districts: Rumphi in the Northern Region, Ntchisi and Mchinji in the Central Region and Mangochi in the Southern Region.</p>	<p>This study was not entirely about circumcision but it explored factors that affect adolescents’ hopes of achieving their aspirations and hopes. These factors included circumcision. The study documents reasons why adolescents go for circumcision and some of the issues about circumcision that could increase the adolescent risk of HIV/AIDS.</p> <p>Reasons for circumcision:</p> <ul style="list-style-type: none"> • Was associated with being clean since Jesus himself underwent circumcision. • Envyng people who had undergone initiation ceremonies and circumcision. • Those who did not circumcise did so because of religious reasons and because in some instances they were required to pay. <p>Increasing risk of HIV/AIDS</p> <ul style="list-style-type: none"> • Majority was initiated and circumcised aged 12 or younger. • Circumcised boys were advised to have sex with girls in a ceremony known as kuchotsa fumbi without which they were told that they would die or feel pain in the penis. • Circumcised boys were told not to use condoms so that the circumcised penis gets healed to the fullest. • Very few respondents reported that they were told to use condoms or to abstain from sex or about the dangers of HIV.
2	<p>Title: Adolescent Sexual and</p>	<p>Method: Data was collected from a nationally</p>	<p>This study collected information about adolescents’ experience</p>

	<p>Reproductive Health in Malawi. Results from the 2004. National Survey of Adolescents. Occasional Report No.24</p> <p>Author: Alister Munthali, Eliya M Zulu, Nyovani Madise, AnnM Moore, Sidon Konyani, James Kaphuka and Dixie Maluwa Banda</p> <p>Date of publication: 2006</p>	<p>representative household survey on adolescent (12–19-year-old females and males) between March and August 2004.</p>	<p>with circumcision.</p> <ul style="list-style-type: none"> • Circumcision was performed on close to 20% of males. Twenty one percent of the adolescents aged 15 – 19 years were circumcised whilst 14.8% of those 12 – 14 years of age were. • Most were circumcised between the ages of six and 11. • 32.2% of adolescents had gone through initiation ceremonies where circumcision took place.
<p>3</p>	<p>Title: The Timing and Role of Initiation Rites in Preparing Young People For Adolescence and Responsible Sexual and Reproductive Behavior in Malawi</p> <p>Author: Alister C. Munthali, Eliya.M Zulu</p> <p>Date of publication: 2007. <i>Afr J Reprod Health</i> 2007; 11[3]:150-167)</p>	<p>Method: This data was collected through 102 in-depth interviews (IDIs) conducted in Malawi with male and female in-school and out-of-school adolescents and married and unmarried adolescents aged 12-19 in 2003.</p>	<p>Results described in this paper are as follows:</p> <ul style="list-style-type: none"> • male circumcision is mostly practiced in the Southern region of Malawi among Yaos and Muslims. • While only 21% of boys had been circumcised nationally, 35%, 12% and 2% of boys in the southern, centre and North were circumcised respectively. • male respondents from the southern districts of Blantyre and Mangochi were more likely to report circumcision than those from other districts. • Circumcision was often done between ages 10 and 15. Out of those who were circumcised, 26% were circumcised before age 10 and about 8% above 14. • The regional, ethnic and religious differences for circumcision for boys are very much similar to the ones observed for participation in initiation rites suggesting that initiation rites for boys are strongly linked to circumcision. <p>Reasons for circumcision</p> <ul style="list-style-type: none"> • Boys in Mangochi noted that is it their cultural obligation to circumcise. • Sign of maturity. • Presents are given after the ceremony, especially new clothes are bought.

4	<p>Title: Male Circumcision and HIV Infection; The Case of Malawi.</p> <p>Authors: Michelle Poulin, Adamson S Muula</p> <p>Date of Publication:</p>	<p>Methods: The study involved 1239 married women and their spouses in Rumphu, Balaka and Mchinji rural areas who also had an HIV test.</p>	<ul style="list-style-type: none"> • In the study, only 6% of women in Mchinji and 2% of women in Rumphu reported their husbands to be circumcised. • Compared with Balaka, a predominantly Yao district, 69% underwent initiation ceremonies and 79% of all women in Balaka reported having circumcised spouses. • Women with circumcised husbands were significantly less likely to be HIV+. • A Malawian woman, who resides in Balaka, having circumcised husband decreases her propensity to be HIV infected substantially by 8 percentage points, which is consistent with the randomized studies. • In a district like Balaka where other ethnic groups are present, being Yao was not associated with having an HIV positive woman.
5	<p>Title: Acceptability of Male Circumcision for Prevention of HIV Infection in Malawi.</p> <p>Authors: Ngalande RC, Bailey R, Levy JA, Kaponda CN, Kawala L, Mhango L, Chitsulo C</p> <p>Date of publication: 2006</p>	<p>Methods: Focus group discussions with men and women aged 16-80yrs were conducted in four communities across Malawi.</p>	<ul style="list-style-type: none"> • Acceptability was lower in the northern region where the practice is little known. • Younger people were more likely to accept the intervention than older groups. • If service was introduced, acceptance is likely to vary by region , but many parents and younger people would use the service if they were safe, affordable and confidential.
6	<p>Title: Knowledge, Beliefs And Attitudes About Male Circumcision in Four Districts of Malawi</p> <p>Authors: Rebecca C. Ngalande, Judith Levy, Chrissie P.N Kaponda, Robert C. Bailey</p>	<p>Methods: Focus group discussions with men and women aged 16-80yrs were conducted in four communities across Malawi.</p>	<ul style="list-style-type: none"> • Commercial sex workers had more knowledge of association between HIV and male circumcision. • Adults from the northern and central region had least knowledge about circumcision and HIV/ STI. • Respondents associated circumcision with Islam, medical problems and genital hygiene. • Except in the north, all women preferred circumcised men for sexual partners.

	Date of Publication: 2004 (International conference on AIDS)		Barriers to circumcision included: <ul style="list-style-type: none"> • Fear of infection with HIV during the procedure. • Lack confidentiality amongst the providers. • Fear of expulsion from church.
7	Title: Malawi Demographic and Health Survey- Chapter 11, HIV/AIDS and Other Sexually Transmitted Infections (Chapter 11). Authors: D. Zanera and I. Miteka Date of publication: 2004	Methods: A national representative sample of men aged 15-54 years old.	<ul style="list-style-type: none"> • Based on this sample, 21% of Malawian men are circumcised. • Younger men in age groups 15-19 and 20-24 are less likely to have been circumcised with about 18% than those at older ages. • There are no differences between urban and rural areas in terms of proportion of men circumcised. • Men living in the southern region are much more likely to be circumcised than men in other regions (33% compared with 5% in the north and 12% in the central). • Circumcision was more common amongst men with just primary or no education than those with secondary education. 26% had never attended education, 24% primary (1-4), 19.9% primary (5-8) and 15.8% secondary and tertiary education. • The practice of male circumcision varies widely across ethnic groups and religion. 82% of Yao men and 30% of Lomwe men are circumcised and the rate for other ethnic groups is only 7% or lower. • Muslims (93%) are much more likely to be circumcised than those who belong to other religious groups. • However, Christians also practiced circumcision with 21% SDA or Baptist, 20% Anglican men and 14% men of other Christian denominations circumcised.
8	Title: HIV Prevention and Multiple Concurrent Partnerships in Malawi- Qualitative Research Study Report	Methods: Focus group discussions were held with married (15 – 49 years old) and sexually active unmarried youth (aged 15-24) and truck drivers in Blantyre, Lilongwe, Mzuzu, Rumphi, Karonga, Nsanje, Nkhatabay, Machinga,	FGDs revealed the following: <ul style="list-style-type: none"> • Respondents were of the view that the foreskin hides or keeps the virus after intercourse hence increasing the likelihood HIV transmission.

	<p>Authors: Ken Limwame and Monica Kumwenda</p> <p>Date of publication: 2008</p>	<p>Dowa, Mangochi, Phalombe, Chikwawa, Mulanje and Kasungu districts.</p>	<ul style="list-style-type: none"> • It was believed that circumcised men could wash away the virus after a bath and because their forehead is hardened, it could survive bruises when having sex which can expose one to infection. • However, the respondents did not believe HIV transmission since transmission is through “blood”. However, other sexually transmitted infections could be prevented by male circumcision. • Many had never heard of circumcision as a means of HIV prevention and doubted its effectiveness since many Muslims, who are circumcised, have died from the disease. • Circumcision, as practiced among the Yao, was believed to be unsafe because they use the same razor however others said nowadays the common practice is that each initiate has a razor. • FGDs with women in the central region mentioned that a circumcised penis is not sexually satisfying as an uncircumcised one because they are cold and slippery.
<p>9</p>	<p>Title: Cultural Practices and their Impact on the Enjoyment of Human Rights, Particularly the Rights of Women and Children.</p> <p>Author: Malawi Human Rights Commission</p> <p>Date of Publication:</p>	<p>Methods: This study utilized a three-pronged approach in its data collection exercise. Literature review, focus group discussions, and face-to-face interviews in order to capture data. Nine districts across the country were sampled purposively to cover practices of all the major ethnic groups in the country.</p>	<ul style="list-style-type: none"> • About 17% of the respondents said that Jando (circumcision for boys.) was a practice that was prevalent in their areas. • Boys as young as 6yrs of age underwent this initiation rite and the period for initiation differed from place to place but ranged from 2wks to 2months. • Circumcision differs from one locality to another. In some places the circumcision involves cutting the membrane that connects the foreskin and the inner part of a penis. In other places this involves cutting off the entire foreskin with a knife and yet in other places the circumcision involves cutting off the foreskin using fingernails of circumcision administrators. • In some areas, the counselors used the foreskin from

			<p>the first and last initiate to make medicine that the initiates drink to overcome homesickness.</p> <ul style="list-style-type: none">• The purpose of carrying out circumcision for boys is to protect them from hurting themselves when they have sex with a girl.• After circumcision, boys were advised to have sexual intercourse with any girl as soon as they go back home. And the belief is that if the boys do not have sex their penises would shrink and become too small for sex.
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APPENDIX 3 KABP SURVEY MALE

MALE CIRCUMCISION SITUATION ANALYSIS SURVEY

INTRODUCTION AND CONSENT

Hello. My name is I work for We are conducting a survey across the country and we are talking to men and women in an effort to find out more about male circumcision. Your contribution will be of great importance to us. We would very much appreciate your participation in survey.

The interview will last about.....

There is no right or wrong answers to the questions; we would like to learn about your personal thoughts and attitudes. If you don't understand a question, please tell me and you can add further information at any stage.

Your answers will be kept strictly confidential. Your personal responses will be seen by only a very few of my colleagues and your name will not be used in relation to the answers you give.

May I begin the interview now?

YES

NO

DISTRICT:		T/A:	
Enumeration Area:			
Interviewer ID: |_|_|	Date of interview: |_|_|/|_|_|/|_|_|	Supervisor's signature:	
			Date received in office: |_|_|/|_|_|/|_|_|

RECORD TIME STARTED INTERVIEW: ___ : ___

1. DEMOGRAPHICS

1.1	How old are you?	|_|_| Years Day/Month/Year |_|_|/|_|_|/|_|_|	
1.2	Are you married	1= yes 2= No	
1.3	Which tribe do you belong to?	1 = Chewa 2 = Yawo 3 = Tumbuka 4 = Lomwe 5= Sena 6= Ngoni 7= Tonga 8= Amang'anja 9= Nkhonde 10= Other (specify.....)	
1.4	Which language do you principally speak?	1 = Chichewa 2 = Chiyao 3 = Chitumbuka 4 = Chilomwe 5= Chisena 6= Chingoni 7= Chitonga 8= Chimang'anja 9= chinkhonde 10= Other (specify.....)	
1.5	Do you have any children?	1 = Yes 2 = No →	Q1.7
1.6	How many children do you have?	Boys |_|_| Girls |_|_|	
1.7	Where were you born?	1= District..... 2= Traditional Authority..... 3= Other.....	
1.8	What is your religion?	1= Catholic 2= CCAP 3= Anglican 4= Adventist/Baptist 5= Moslem 6= Other (specify.....)	
1.9	Have you ever attended school	1= Yes 2= No →	Q1.11
1.10	What is the highest level of school you attended? <i>If Primary or secondary indicate the highest class</i>	1 = Primary |_| → 3 = Secondary |_| → 4 = Tertiary	Q1.12 Q1.12

	<i>completed</i>		
1.11	Have you ever participated in a literacy program or any other program that involves learning to read or write (not primary school)	1= Yes 2= No	
1.12	What is your occupation, that is, what kind of work do you mainly do?	1 = Farming 2 = Casual labour 3 = Employed 4 = Business 5 = Student 6 = Other (specify.....	
1.13	Do you usually work throughout the year, seasonally or once in a while?	1= Throughout the year 2= Seasonally/Part of the year 3= Once in a while	
1.14	Are you paid in cash or kind for this work or are you not paid at all?	1= Cash only 2= Cash and Kind 3= In kind only 4= Not paid	
1.15	Do you own the following	Radio | _1_ | | _2_ | Bicycle | _1_ | | _2_ | House Servant | _1_ | | _2_ | Oxcart | | _1_ | | _2_ | Livestock | _1_ | | _2_ | House Grass thatched | _1_ | | _2_ | Corrugated iron sheets | _1_ | | _2_ | Use Electricity | _1_ | | _2_ | Paraffin lamp | _1_ | | _2_ | Toilet Pit latrine | _1_ | | _2_ | Flash Toilet | _1_ | | _2_ |	
2.	Are you circumcised?	1 = Yes 2 = No 3 = Don't know	
3	Please describe what you think male circumcision is <i>Listen to what the respondent says and tick and / or fill in the options below. Do not show or describe the options to the respondent.</i>	1= Removal of the entire foreskin (the skin that can be rolled forward or back over the head of the penis 2= Removal of the foreskin but not necessarily the entire foreskin 3= Removal of the penis 4= Refused to answer 5= Other (specify.....	
<i>Once the question has been answered, please explain that:</i> MALE CIRCUMCISION IS THE SURGICAL REMOVAL OF THE ENTIRE FORESKIN, WHICH IS THE SKIN THAT CAN BE ROLLED FORWARD OR BACK OVER THE HEAD OF THE PENIS. IF LESS THAN THE ENTIRE FORESKIN HAS BEEN REMOVED, THIS IS NOT "FULL" CIRCUMCISION. (PICTURES OF AN UNCIRCUMCISED, NOT "FULLY" CIRCUMCISED, AND CIRCUMCISED PENIS MIGHT BE HELPFUL, AND WILL BE PROVIDED WITH THIS TOOL KIT!)			
4.0	<i>Now that I have told you what circumcision is, let me ask</i>	1 = Yes →	Q17

	<i>you again.....Are you circumcised?</i>	2 = No 3 = Don't know	
4.1	If 'No' Why aren't you circumcised?	1 = Religion 2 = Culture 3 = Personal Choice 4 = Complications Such as a. Infections b. Impotence c. Bleeding 5= Other (specify.....)	
5	Why do you think male circumcision is carried out? <i>Listen to what the respondent says and tick and fill in the options below. Do not show or describe the options to the respondent.</i>	1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status	
6.0	Would you consider being circumcised? <i>Give the interviewee the choice of the following options</i>	1 = Strongly 'no' 2 = No 3 = Neither 'Yes' or 'No' 4 = Yes 5 = Strongly Yes	
6.1	What are your reasons for this answer?	1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status	
7.0	<i>Please refer to Demographics information if he has male children and ask.. Is any of your sons circumcised?</i>	1= Yes 2= No 3= Don't know →	Q9
7.1	Why?	1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status	
	<i>If the response is 'Yes' or 'No' to Qn 7.0 -----→ → → →</i>		Q9
8.0	<i>If they don't have a male child or the male child is very young to be circumcised ask...</i>	1 = Strongly 'no' 2 = No 3 = Neither 'Yes' or 'No'	

	If you had a son, would you want him to be circumcised?	4 = Yes 5 = Strongly Yes	
8.1	What are your reasons for this answer?	1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status	
	If the response is 'Strongly No' or 'No' to Qn 8 -----> → → →		Q9
8.2	If 'yes' When would be the best time for him to be circumcised? <i>Give the interviewee the choice of the following options</i>	1 = At Birth 2 = When he is a child, perhaps 2-8 years old 3= At Puberty 4= Marriage 5= Initiation 6= At any time 7= At some other time (specify.....)	
8.3	Why would he be circumcised at this time?	1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status	
8.4	What other times would you prefer for him to be circumcised that would be okay? <i>Give the interviewee the choice of the following options</i>	1 = At Birth 2 = When he is a child, perhaps 2-8 years old 3= At Puberty 4= Marriage 5= Initiation 6= At any time 7= At some other time (specify.....)	
8.5	Who would you like to circumcise your son?	1= Medical Personnel 2= Traditional Circumciser 3= Other	
9	What do you think the benefits of male circumcision would be?	Reduces risk of STI transmission |_1_| |_2_| Reduces risk of HIV transmission |_1_| |_2_| Cleanliness |_1_| |_2_| Increases sexual pleasure |_1_| |_2_| Other.....	

		Don't know.....	
10	What do you think the problems or negative consequences of male circumcision might be?	1= Infections 2= Impotence 3= Bleeding 4= Other..... 5= Don't know	
<p><i>Tell the respondent that:</i> RECENT STUDIES SHOW THAT MALE CIRCUMCISION REDUCES THE RISK OF BEING INFECTED WITH HIV. BEING CIRCUMCISED IS NOT ENOUGH ON ITS OWN TO PROTECT FROM HIV AND CIRCUMCISED MEN MUST CONTINUE USING OTHER FORMS OF PROTECTION!!</p>			
11.0	Based on this information, would you consider being circumcised?	1= Strongly 'No' 2= No 3=Neither 'No' or 'Yes' 4= Yes 5= Strongly 'Yes'	
11.1	What are your reasons for this answer? <i>If your response to the above question is 'strongly No' or 'No', ask questions 12 and 13 only and end the interview</i>	1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status	
12.0	Has this information changed your opinion about supporting your son's circumcision?	1= Yes 2= No	→ Read instruction after Q12.1 below
12.1	If 'yes' Would you accept the idea that he be circumcised? <i>Give the interviewee the choice of the following options</i>	1= Strongly 'No' 2= No 3=Neither 'No' or 'Yes' 4= Yes 5= Strongly 'Yes'	
<p><i>If the answer is "Strongly no," "No" or "Neither yes or no" to tell the interviewee the following:</i></p> <p>CIRCUMCISION ALSO HAS OTHER HEALTH BENEFITS. INFANTS HAVE A LESSENERD CHANCE OF DEVELOPING INFECTIONS OF THE URINE, CHILDREN AND ADULTS DO NOT HAVE PROBLEMS WITH THE FORESKIN BECOMING TOO TIGHT AROUND THE PENIS, THERE IS A LESSENERD CHANCE OF GETTING INFECTIONS UNDER THE FORESKIN, AND ADULTS HAVE A LESSENERD CHANCE OF GETTING SOME SEXUALLY TRANSMITTED DISEASES.</p>			
13.0	Has this information changed your opinion about supporting your son's circumcision?	1= Yes 2= No	→ End of interview
13.1	If 'yes' Would you accept the idea that he be circumcised? <i>Give the interviewee the choice of the following options</i>	1= Strongly 'No' 2= No 3=Neither 'No' or 'Yes' 4= Yes 5= Strongly 'Yes'	
<p>—If the respondent answered "No" or Strongly No" to Question 01.0, this is the end of the survey— Express thanks to the respondent for their time and information. Remember to ask them if they have any questions for you. You may need to refer to the briefing you have been given, however, if you don't know the answer to a question, do not be afraid to say so.</p>			
14.0	Would you still be worried about anything to do	1= Yes	

	with male circumcision?	2= No →	Q15
14.1	If 'yes' What would you be worried about?	1= Infections 2= Impotence 3= Bleeding 4= Other (specify.....)	
15	If you had to pay for the operation, what is the most you would be prepared to pay?	1= Up to K1000 2= More than K1000 3= None	
16	What would be the source of this money?	1= Saved up for 2= Borrowed 3= Sell of commodities 4= Neither, because my family has this money now	
<p>—End of survey for uncircumcised male respondents—</p> <p>Express thanks to the respondent for their time and information. Remember to ask them if they have any questions for you. You may need to refer to the briefing you have been given, however, if you don't know the answer to a question, do not be afraid to say so.</p>			
17	Why are you circumcised?	1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status	
18	How old were you when you were circumcised?	|__|__| Years	
19	Who performed the circumcision?	1= Medical Personnel 2= Traditional Circumciser 3= Other	
20	Where was the circumcision done?	1= Health Facility a.Central Hospital b.District Hospital c.Rural Hospital d.Health Centre e.Private clinic 2= Mosque 3= Church 4= Initiation Camp	
21.1	Can you estimate how much you spent on transport?	Mk	
21.2	Can you estimate how much you spent on Food?	Mk	
21.3	Can you estimate how much you spent on medical bills (consultation, drugs, surgery etc)?	Mk	
21.4	Can you estimate how much you spent on Phone bills?	Mk	
21.5	Can you estimate other expenses?	Mk	
22	What was the source of this money? <i>Give the interviewee the choice of the following options</i>	1= Saved up for 2= Borrowed	

		3= Sell of commodities 4= Neither, because my family has this money now 5= Other (specify.....)	
23	What do you think the benefits of male circumcision might be?	1= Reduces risk of STI transmission 2= Reduces risk of HIV transmission 2= Cleanliness 3= Increases sexual pleasure 4= Other..... 5= Don't know 6= None	
24	What do you think the problems or negative consequences of male circumcision might be?	1= None 2= Infections 3= Impotence 4= Bleeding 5= Other	
25	Are you pleased that you are circumcised? <i>Give the interviewee the choice of the following options</i>	1= Strongly 'No' 2= No 3=Neither 'No' or 'Yes' 4= Yes 5= Strongly 'Yes'	
26.0	Would you recommend male circumcision to others? <i>Give the interviewee the choice of the following options</i>	1= Strongly 'No' 2= No 3=Neither 'No' or 'Yes' 4= Yes 5= Strongly 'Yes'	
26.1	What reasons would you give in your recommendation?	1= Reduces risk of STI transmission including HIV 2= Cleanliness 3= Increases sexual pleasure 4= Other..... 5= Don't know 6= None	
27.0	<i>Please refer to Demographics information if he has male children and ask..... Is any of your sons circumcised?</i>	1= Yes 2= No 3= Don't know → <i>Read Instruction after Q28.5 below</i>	
27.1	Why?	1 = Medical 2 = Religion/Ethnicity 3 = Hygiene 4= Social determinants a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status 6= Other (Specify).....	
27.2	How old was he when he was circumcised?	|__|__| Years	
27.3	Who performed the circumcision?	1= Medical Personnel 2= Traditional Circumciser 3= Other	

27.4	Where was the circumcision done?	1= Health Facility a. Central Hospital b. District Hospital c. Rural Hospital d. Health Centre e. Private clinic 2= Mosque 3= Church 4= Initiation Camp	
27.5	Can you estimate how much you spent on transport?	Mk	
27.6	Can you estimate how much you spent on Food?	Mk	
27.7	Can you estimate how much you spent on medical bills (consultation, drugs, surgery etc)?	Mk	
27.8	Can you estimate how much you spent on Phone bills?	Mk	
27.9	Can you estimate other expenses?	Mk	
27.10	What was the source of this money? <i>Give the interviewee the choice of the following options Read Instruction after Q28.5 below</i>	1= Saved up for 2= Borrowed 3= Sell of commodities 4= Neither, because my family has this money now 5= Other (specify.....)	
28.0	<i>If they don't have a male child or the male child is very young to be circumcised ask...</i> If you had a son, would you want him to be circumcised?	1 = Strongly 'no' 2 = No 3 = Neither 'Yes' or 'No' 4 = Yes 5 = Strongly Yes	
28.1	What are your reasons for this answer? <i>If the response is 'Strongly No' or 'No' to Qn 28.0 go to Q29.0</i>	1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants a. Social desirability b. Perceived health benefits c. Perceived sexual benefits d. Cosmetics 5= Socio-economic status	
28.2	If 'yes' When would be the best time for him to be circumcised? <i>Give the interviewee the choice of the following options</i>	1= At Birth 2= When he is a child, perhaps 2-8 years old 3= At puberty (10-16 years) 4= Marriage 5= Initiation 6= At any time 7= At some other time(specify.....)	
28.3	Why would he be circumcised at this time?	1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants	

		a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status	
28.4	What other times would you prefer for him to be circumcised that would be okay? <i>Give the interviewee the choice of the following options</i>	1 = At Birth 2 = When he is a child, perhaps 2-8 years old 3= At Puberty 4= Marriage 5= Initiation 6= At any time 7= At some other time(specify.....)	
28.5	Who would you like to circumcise your son?	1= Medical Personnel 2= Traditional Circumciser 3= Other (specify.....)	
<i>Tell the respondent that:</i> RECENT STUDIES SHOW THAT MALE CIRCUMCISION REDUCES THE RISK OF BEING INFECTED WITH HIV. BEING CIRCUMCISED IS NOT ENOUGH ON ITS OWN TO PROTECT FROM HIV AND CIRCUMCISED MEN MUST CONTINUE USING OTHER FORMS OF PROTECTION			
29.0	Has this information changed your opinion about supporting your son's circumcision?	1= Yes 2= No → → Read Instruction after Q29.1 below	
29.1	If 'yes' Would you now support your son's circumcision? <i>Give the interviewee the choice of the following options</i>	1 = Strongly 'no' 2 = No 3 = Neither 'Yes' or 'No' 4 = Yes 5 = Strongly Yes	
<i>If the answer is "Strongly no," or "No" or "Neither yes or no"] tell the interviewee the following</i> CIRCUMCISION ALSO HAS OTHER HEALTH BENEFITS. INFANTS HAVE A LESSENER CHANCE OF DEVELOPING INFECTIONS OF THE URINE, CHILDREN AND ADULTS DO NOT HAVE PROBLEMS WITH THE FORESKIN BECOMING TOO TIGHT AROUND THE PENIS, THERE IS A LESSENER CHANCE OF GETTING INFECTIONS UNDER THE FORESKIN, AND ADULTS HAVE A LESSENER CHANCE OF GETTING SOME SEXUALLY TRANSMITTED DISEASES			
30.0	Has this information changed your opinion about supporting your son's circumcision?	1= Yes 2= No → → END OF INTERVIEW	
30.1	If 'yes' Would you now support your son's circumcision? <i>Give the interviewee the choice of the following options</i>	1 = Strongly 'no' 2 = No 3 = Neither 'Yes' or 'No' 4 = Yes 5 = Strongly Yes	

RECORD TIME FINISHED INTERVIEW: ___ : ___

This is the end of your interview. Thank him for his time, participation and information. Remember to ask them if they have any questions for you. You may need to refer to the briefing you have given, however, if you don't know the answer to a question, please do not be afraid to say so

Feedback from the interviewer...	
Was there any disturbance in one way or another during the interview? (Explain what happened)	
Was there anyone within the vicinity where the	

interview took place? (Mention the relationship with the interviewee)	
Were there any questions that seemed difficult or confusing to the interviewee? (Explain)	
Were there any questions that the respondent was not comfortable with and couldn't express himself fully? (Explain why in your own opinion)	
Any other issues?	

APPENDIX 4 KABP SURVEY FEMALE

INTRODUCTION AND CONSENT

Hello. My name is I work for We are conducting a survey across the country and we are talking to men and women in an effort to find out more about male circumcision. Your contribution will be of great importance to us. We would very much appreciate your participation in survey.

The interview will last about.....

There is no right or wrong answers to the questions; we would like to learn about your personal thoughts and attitudes. If you don't understand a question, please tell me and you can add further information at any stage.

Your answers will be kept strictly confidential. Your personal responses will be seen by only a very few of my colleagues and your name will not be used in relation to the answers you give.

May I begin the interview now?

YES |__|

NO |__|

DISTRICT:		T/A:	
Enumeration Area:			
Interviewer ID: |_|_|	Date of interview: |_|_|/|_|_|/|_|_|	Supervisor's signature:	
			Date received in office: |_|_|/|_|_|/|_|_|

RECORD TIME STARTED INTERVIEW: ___ : ___

1. DEMOGRAPHICS

1.1	How old are you?	|__|__| Years Day/Month/Year |__|__|/|__|__|/|__|__|	
1.2	Are you married	1= yes 2= No	
1.3	Which tribe do you belong to?	1 = Chewa 2 = Yawo 3 = Tumbuka 4 = Lomwe 5= Sena 6= Ngoni 7= Tonga 8= Amang'anja 9= Nkhonde 10= Other	
1.4	Which language do you principally speak?	1 = Chichewa 2 = Chiyao 3 = Chitumbuka 4 = Chilomwe 5= Chisena 6= Chingoni 7= Chitonga 8= Chimang'anja 9= chinkhonde 10= Other	
1.5	Do you have any children?	1 = Yes 2 = No →	Q1.7
1.6	How many children do you have?	Boys |__|__| Girls |__|__|	
1.7	Where were you born?	1= District..... 2= Traditional Authority..... 3= Other.....	
1.8	What is your religion?	1= Catholic 2= CCAP 3= Anglican 4= Adventist/Baptist 5= Moslem 6= Other	
1.9	Have you ever attended school	1= Yes 2= No →	Q1.11
1.10	What is the highest level of school you attended? If Primary or secondary indicate the highest class completed	1 = Primary |__| → 3 = Secondary |__| → 4 = Tertiary	Q1.12 Q1.12
1.11	Have you ever participated in a literacy program or any other program that involves learning to read or write (	1= Yes 2= No	

	not primary school)		
1.12	What is your occupation, that is, what kind of work do you mainly do?	1 = Farming 2 = Casual labour 3 = Employed 4 = Business 5 = Student 6 = Unemployed 7 = Other (specify.....)	
1.13	Do you usually work throughout the year, seasonally or once in a while?	1= Throughout the year 2= Seasonally/Part of the year 3= Once in a while	
1.14	Are you paid in cash or kind for this work or are you not paid at all?	1= Cash only 2= Cash and Kind 3= In kind only 4= Not paid	
1.15	Do you own the following	Radio | _1_ | | _2_ | Bicycle | _1_ | | _2_ | House Servant | _1_ | | _2_ | Oxcart | _1_ | | _2_ | Livestock | _1_ | | _2_ | House Grass thatched | _1_ | | _2_ | Corrugated iron sheets | _1_ | | _2_ | Use Electricity | _1_ | | _2_ | Paraffin lamp | _1_ | | _2_ | Toilet Pit latrine | _1_ | | _2_ | Flash Toilet | _1_ | | _2_ |	
2.	If a man were circumcised, what would you think of him?	1= Promiscuous 2= Moslem 3= Clean 4= Yao 5= Sexually initiated 6= Other (specify).....	
3	What do you think the benefits of a man being circumcised might be?	Reduces risk of STI transmission | _1_ | | _2_ | Reduces risk of HIV transmission | _1_ | | _2_ | Reduces risk of HIV transmission | _1_ | | _2_ | Cleanliness | _1_ | | _2_ | Increases sexual pleasure | _1_ | | _2_ | Other.....	
4	What do you think the problems or negative consequences of male circumcision might be?	1= Infections 2= Impotence 3= Bleeding 4= Other (specify).....	

5.0	<p>Please refer to Demographics information if he has male children and ask..... Is any of your sons circumcised?</p>	<p>1= Yes 2= No 3= Don't know → Read instruction after Q7.3</p>	
5.1	<p>Why? If the response is 'No' to Q5.0 read instruction after Q7.3</p>	<p>1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status</p>	
5.2	<p>When was he circumcised? Give the interviewee the choice of the following options</p>	<p>1 = At Birth 2 = When he is a child, perhaps 2-8 years old 3= At Puberty 4= Marriage 5= Initiation 6= At any time 7= At some other time (specify)</p>	
5.3	<p>Why was he circumcised at this time?</p>	<p>1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status</p>	
5.4	<p>What other times would you prefer for him to be circumcised that would be okay? Give the interviewee the choice of the following options</p>	<p>1 = At Birth 2 = When he is a child, perhaps 2-8 years old 3= At Puberty 4= Marriage 5= Initiation 6= At any time 7= At some other time (specify)</p>	
5.5	<p>Why would he be circumcised at this time? Please read instruction after Q7.3 after this Question!!!</p>	<p>1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status</p>	
6.0	<p>If they don't have a male child ask...</p>	<p>1 = Strongly 'no' 2 = No</p>	

	If you had a son, would you want him to be circumcised?	3 = Neither 'Yes' or 'No' 4 = Yes 5 = Strongly Yes	
6.1	What are your reasons for this answer? <i>If the response is 'Strongly No' or 'No' or 'Neither' to Qn 6.0 go to Q8.0</i>	1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status	
7.0	If 'yes' When would be the best time for him to be circumcised? <i>Give the interviewee the choice of the following options</i>	1 = At Birth 2 = When he is a child, perhaps 2-8 years old 3= At Puberty 4= Marriage 5= Initiation 6= At any time 7= At some other time (specify)	
7.1	Why would he be circumcised at this time?	1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status	
7.2	What other times would you prefer for him to be circumcised that would be okay? <i>Give the interviewee the choice of the following options</i>	1 = At Birth 2 = When he is a child, perhaps 2-8 years old 3= At Puberty 4= Marriage 5= Initiation 6= At any time 7= At some other time (specify)	
7.3	Why would he be circumcised at this time?	1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status	
<p><i>Tell the respondent that:</i> RECENT STUDIES SHOW THAT MALE CIRCUMCISION REDUCES THE RISK OF A MAN BEING INFECTED WITH HIV. BEING CIRCUMCISED IS NOT ENOUGH ON ITS OWN TO PROTECT FROM HIV AND CIRCUMCISED MEN MUST CONTINUE USING OTHER FORMS OF PROTECTION.</p>			

8.0	Based on this information, would you change the way you think of uncircumcised men?	1= Yes 2= No → →	Q9.0
8.1	If 'yes', How?	..... ..... ..... ..... .....
9.0	Has this information changed your opinion about supporting your son's circumcision?	1= Yes 2= No → → Read instruction after Q9.2	
9.1	If 'yes' Would you now support the idea of your son being circumcised? Give the interviewee the choice of the following options	1 = Strongly 'no' → Read instruction after Q9.2 2 = No → Read instruction after Q9.2 3 = Neither 'Yes' or 'No' → Read instruction after Q9.2 4 = Yes 5 = Strongly Yes	
9.2	What are your reasons for this answer?	1 = Medical 2 = Religion/Ethnicity 3= Hygiene 4= Social determinants a.Social desirability b.Perceived health benefits c.Perceived sexual benefits d.Cosmetics 5= Socio-economic status	
<p><i>If the answer is "Strongly no," or "No" or "Neither yes or no"] tell the interviewee the following:</i> CIRCUMCISION ALSO HAS OTHER HEALTH BENEFITS. INFANTS HAVE A LESSENERED CHANCE OF DEVELOPING INFECTIONS OF THE URINE, CHILDREN AND ADULTS DO NOT HAVE PROBLEMS WITH THE FORESKIN BECOMING TOO TIGHT AROUND THE PENIS, THERE IS A LESSENERED CHANCE OF GETTING INFECTIONS UNDER THE FORESKIN, AND ADULTS HAVE A LESSENERED CHANCE OF GETTING SOME SEXUALLY TRANSMITTED DISEASES.</p>			
10.0	Has this information changed your opinion about supporting your son's circumcision?	1= Yes 2= No → →	Q13
10.1	If 'yes' Would you now support the idea that your son be circumcised? <i>Give the interviewee the choice of the following options</i>	1 = Strongly 'no' 2 = No 3 = Neither 'Yes' or 'No' 4 = Yes 5 = Strongly Yes	
11.1	Can you estimate how much you spent on transport?	Mk	
11.2	Can you estimate how much you spent on Food?	Mk	
11.3	Can you estimate how much you spent on medical bills (consultation, drugs, surgery etc)?	Mk	
11.4	Can you estimate how much you spent on Phone bills?	Mk	
11.5	Can you estimate other expenses?	Mk	
12	What would be the source of this money?	1= Saved up for 2= Borrowed	

		3= Sell of commodities 4= Neither, because my family has this money now	
13	If you wanted to encourage an adolescent or adult man to be circumcised, what would you say to him?	..... .. ..... ... ..... ... ..... ... ..... ... ..... ... ..... ... ..... ... ..... ... ..... ... .....

RECORD TIME FINISHED INTERVIEW: ___ : ___

This is the end of your interview!!!!!!! Thank him for his time, participation and information. Remember to ask them if they have any questions for you. You may need to refer to the briefing you have given, however, if you don't know the answer to a question, please do not be afraid to say so!!!

Feedback from the interviewer...	
Was there any disturbance in one way or another during the interview? (Explain what happened)	
Was there anyone within the vicinity where the interview took place? (Mention the relationship with the interviewee)	
Were there any questions that seemed difficult or confusing to the interviewee? (Explain)	
Were there any questions that the respondent was not comfortable with and couldn't express himself fully? (Explain why in your own opinion)	
Any other issues?	

APPENDIX 5. KEY INFORMANT INTERVIEW (KII) GUIDE

NAME OF INTERVIEWEE: _____

ORGANIZATION/DISTRICT: _____

POSITION HELD: _____

NAME OF INTERVIEWER: _____

DATE OF INTERVIEW: _____

1. Did you know of the association between male circumcision and a reduced risk of HIV infection, before we contacted you? Yes/No

If the answer is no, give a brief overview of the issue.

Follow-up: What do you think about it now that you have heard about it?

2. What do you think non-circumcised men might think about male circumcision?
3. What do you think women think about male circumcision?
4. What do you believe are the main factors affecting rates of male circumcision in Malawi?

Follow-up: Can you say which factor you think is the most important and which is least important?

Follow-up: Is there any stigma attached to a man being circumcised or uncircumcised?

5. If we wanted to increase the provision of health facility-based male circumcision, what do you think are the most important factors we would need to change?

Prompt: Funds/resources could be one, but how would they need to be spent?

Prompt: Do you think staff in health posts, clinics, and hospitals know how to do the operation?

Prompt: What role would your organization be able to play in increasing services?

6. If we wanted to increase demand for male circumcision (the number of People wanting it), what sort of things should we do?

Prompt: How could we encourage men to be circumcised? How could we get parents to get their children to be circumcised?

Prompt: Who do you think would have the most influence on people, if we were to ask someone to publicly support a programme?

Prompt: What messages do you think would have the most influence on people, to encourage male circumcision in adolescents or adults? What about for the parents of newborns or children?

Prompt: At what age do you think parents would like to have their male children circumcised: at birth; as children?

Prompt: Circumcising male newborns and babies is technically easier than circumcising older boys or men and there are fewer complications. Would this influence the decision of parents to have their male infants circumcised?

7. What ideas do think people have about male circumcision?

Follow-up: From what you have said what do you think the main defining factor would be for how someone saw the results of male circumcision?

Follow-up: Do you think men would have riskier sex after circumcision, such as taking more partners or not using a condom, thinking that they are now protected from acquiring HIV and STIs (because they are circumcised)?

8. Who else do you think we should interview? *Follow-up: How do I contact them?*
9. Programmes for any male circumcision will include the offer for VCT test, with referral counseling and medical services if the person is HIV positive. Do you think this policy of offering HIV testing will affect a programme to have to increase male circumcision?

Follow-up: If a country wanted to prioritize male circumcision services to men who are HIV negative (since these men will benefit from HIV prevention), how

Follow-up: How might men seeking circumcision react to such a policy?

10. What do you think of the idea of adding counseling on sexual and reproductive Health services to for men who are being circumcised? By this, I mean things such as counseling about means of contraception, or counseling about how to improve sexual or domestic relationships between couples.
11. What is the tradition in this area about male circumcision? (The term 'male Circumcision may need to be explained)
Ask for the reasons behind any traditions-why it is done or not done?
12. Who takes the decision about whether a male is to be circumcised?
13. Has that changed in recent times?
14. Do you know if male circumcision is available at the nearest health facility (government or faith-based)?

APPENDIX 6: FOCUS GROUP DISCUSSIONS (FGDs)

FGD GUIDE

LOCATION (DISTRICT): _____

NUMBER OF PARTICIPANTS: _____

FGD ID #: _____

DATE OF INTERVIEW: _____

Facilitator _____

Recorder _____

Transcriber _____

Date _____

1. FGD with circumcised men

1. Am I right in thinking that most men in this area are circumcised?
2. What ages is it done at? (*Prompt: where it is done*)
3. Who does it?
4. How much do people generally pay for male circumcision? (*Remember traditional male circumcision providers might require some payment or offering other than money*)
5. What memories do people have of being circumcised?
6. Would people have their sons circumcised soon after birth? If not, at what age would people prefer them to be circumcised? (*It may be necessary to prompt about it being done at birth or as child, and the pros and cons of it*)
7. Who would people trust most to carry out this operation?
8. What happens during and after male circumcision in a health facility?
9. What happens during and after male circumcision when it takes place in a traditional way?
10. What are the benefits of male circumcision?
11. Have people heard that male circumcision can reduce the chance of catching HIV?
12. As male circumcision only reduces the chance of infection, what other ways of avoiding HIV should people use?
13. Programmes for male circumcision will likely include the offer VCT with referral to counseling and medical services if the person is HIV-positive. What do you think people may think about this policy of offering VCT?
14. Some programmes for male circumcision for young men are considering enhancing the male circumcision service by adding sexual and reproductive health services such as discussions or counseling around sexual relations, staying healthy, and means of contraception or even substance abuse (alcohol, drugs). Currently, men seldom have a place to receive these services. What do you think people might think about this idea?

2. Questions to men in the group who were circumcised using traditional methods

1. What was it like having the male circumcision itself done?
2. Do people have memories of it?
3. Are there any risks related to the traditional male circumcision process?
4. What suggestions might people have for improving the way male circumcision is done in the traditional setting?
5. What are the costs of traditional male circumcision? (*In money or other items*).
6. In some places, males are circumcised at a health facility and taken to initiation camps for the traditional rites. What do you think people think about this?
7. Which do people think is safer: the traditional method of male circumcision; or male circumcision at a health facility?
8. At what age would people prefer their sons to be circumcised? (*Prompt: about it being done at birth or as a child - why*)
9. What might stop parents from using a health facility for the circumcision of their sons?
10. How much would people in this community be able to pay for a male circumcision operation if it were done at a health facility?

3. Questions to men who are not circumcised (uncircumcised men)

1. What is the first thing that comes into people's minds when they hear the term "Male circumcision"?
2. Why might some men not be circumcised?
3. Who are the people who are circumcised?
4. What are the benefits of male circumcision?
5. What are the disadvantages of male circumcision?
6. What would encourage men to be circumcised?
7. What would encourage parents to get their sons circumcised?
8. At what age would parents prefer their sons to be circumcised?
Prompt: about it being done at birth or as a child - why
9. How would people react when told that circumcised men have reduced risk of being infected with HIV? (*Probe: uncircumcised men, circumcised men, women*)
10. Do men who are not circumcised ever consider getting circumcised?
Probe: do they actually get circumcised?
11. Who makes decisions about male circumcision in this community?
12. How much would people be willing to pay for male circumcision in a health facility?
13. How much is normally charged for male circumcision in health facility in this area?

4. Questions to women in communities where men are normally circumcised

1. How men are normally circumcised in this area?
Probe: why that place
2. Have there been any changes to this pattern in recent years?
Probe: Why
3. How do women look at circumcised men?
4. What does a man being circumcised mean to a woman? (if a man who was uncircumcised decided to get circumcised, what would that mean to a woman)
5. What does a son's circumcision mean to a mother?
6. (In this community) Would a woman consider marrying a non-circumcised man?
Probe: How is the woman married to a non circumcised man viewed in the community?
7. Would a mother consider not having their son circumcised? If yes, why? If no, why not?

8. What do women think are the benefits of circumcision?
9. What do women think are the negative, or bad, things of a male child or man being circumcised?
10. Do you pay for male circumcision in this area?
Prompt: How much - at health facility, at initiation camp (Ngaliba)
11. How much would be a fair price for male circumcision operation?
12. Is there any difference between sex with a circumcised man and sex with uncircumcised man?
13. Programmes for male circumcision will likely include the offer VCT with referral to counseling and medical services if the person is HIV-positive. What do you think people may think about this policy of offering VCT?

APPENDIX 7 QUESTIONNAIRE FOR HEALTH FACILITY SURVEY

Questionnaire for Health facility survey

District:_____ Name of facility:_____ Date:_____

Type (Hospital, Health Centre, Private Clinic, etc)_____

Informant:_____ (name, position)

Interviewer:_____

1. What is the approximate catchment population served by this facility?_____

2. What is the average total client load per day?

a. Inpatient_____

b. Outpatient_____

3. What proportion of the clients served by this facility are of the following ethnic or religious background?

Religion	Ethnicity
a. _____ %	a. _____ %
b. _____ %	b. _____ %
c. _____ %	c. _____ %
d. _____ %	d. _____ %
e. _____ %	e. _____ %
f. _____ %	f. _____ %
Total _____ 100%	Total _____ 100%

4. How many of the following medical personnel work at this facility?

a. Doctors: Male___ Female___

b. Clinical officers: Male___ Female___

c. Nurses: Male___ Female___

d. Counsellors: Male___ Female___

e. Other clinical staff (specify)_____ : Male___ Female___

5. Does this facility have basic surgical facilities?

a. Surgical theatre(s) Yes___ No___

b. Outpatient minor surgical / procedure room(s) Yes___ No___

c. Functioning surgical and emergency equipment (clock, lamps, oxygen, etc.) Yes___ No___

2. Does this facility have reliable electrical power? Yes___ No___

What is the source(s)?

a. Connected to grid___

b. Generator___

c. Other (specify)_____

3. Does this facility have adequate water supply? Yes___ No___

What is the source(s)?

a. Running water from city supply___

b. Running water from a captive source (e.g, a well)___

c. Other (specify)_____

4. Does this facility offer services for individuals with sexually transmitted infections? Yes___ No___

a. Are STI services dedicated (i.e., STI clinic)___

b. or integrated (e.g., in general outpatient services)___

5. Does this facility offer counselling and testing for HIV? Yes_____ No_____
 - a. Are services dedicated (i.e., VCT clinic)_____
6. Does this facility offer family planning counselling and services? Yes_____ No_____
7. Does this facility have sterilizing equipment (must be in working order)?
 - a. Autoclave: Yes_____ No_____ Number_____
 - b. Pressure cooker: Yes_____ No_____ Number_____
 - c. Other means: Yes_____ No_____
8. Does this facility have adequate supplies for basic infection prevention?
 - a. Chlorine or other appropriate decontaminant: Yes_____ No_____ Number_____
 - b. Gloves (surgical, examination, for cleaning staff): Yes_____ No_____ Number_____
 - c. Waste disposal (sharps boxes, contaminated waste containers, etc.): Yes_____ No_____
9. In the past 12 months, were the following routinely carried out at this facility? If yes how many
 - a. Caesarean section: Yes_____ No_____
 - b. Minor surgeries, e.g., surgical wound repair: Yes_____ No_____
 - c. Vasectomy or tubal ligation: Yes_____ No_____
10. Does this facility carry out HIV testing? Yes_____ No_____
 - a. How many tests per 12 months?_____
11. Please describe that type of HIV counselling that this facility provides?_____
12. Does this facility provide condoms to the public? Yes_____ No_____
 - a. How many in the last 12 months?_____
13. Does this health facility perform male circumcision? Yes_____ No_____

If 'no' to Question 13, please move to Question 25.
14. How many male circumcisions were performed in the last 12 months?_____
15. How many male circumcisions were performed on each of the following groups over the same 12-month period?
 - a. Infant (0–2 years)_____
 - b. Child (3–9 years)_____
 - c. Adolescent (10–16 years)_____
 - d. Adult (17 and over)_____
16. Please indicate the approximate proportion of male circumcisions done for what reason or indication?
 - a. Medical indications_____%
 - b. Religious practice_____%
 - c. Cultural practice_____%
 - d. Personal preference_____%
 - e. Other reasons (specify) _____: _____%
 - f. Unknown_____%
17. What type of counselling do male circumcision patients routinely receive as part of the procedure?
 - a. Pre-procedure counselling about the male circumcision procedure: Yes_____ No_____
 - b. Pre-procedure counselling about risks and benefits of male circumcision: Yes_____ No_____
 - c. Counselling about HIV and STI prevention: Yes_____ No_____
 - d. Post-procedure counselling about postoperative care: Yes_____ No_____
 - e. Post-procedure counselling about risk reduction: Yes_____ No_____
 - f. Post-procedure counselling about resumption of sexual activity: Yes_____ No_____
 - g. Counselling about other male reproductive health topics: Yes_____ No_____

(specify) _____
18. Who provides this counselling?

- a. The clinician performing the male circumcision: _____
 - b. A nurse or other assistant assisting on the procedure: _____
 - c. A counsellor: _____
 - d. Other: _____(specify) _____
19. What is the normal charge for male circumcision paid by the patient (specify the currency):
- a. Infant male circumcision: _____ Currency: _____
 - b. Child male circumcision: _____
 - c. Adolescent male circumcision: _____
 - d. Adult male circumcision: _____
20. What additional charges or costs might apply (e.g., antibiotics, return visits, extra bandaging, etc):
- None _____ Some _____ (specify)
- _____
21. If male circumcision were to be promoted in this area, in your opinion, could this facility provide male circumcision services? Yes _____ No _____ Uncertain _____
- a. Please explain why you gave this answer: _____
22. What might the facility need to be able to introduce (or, if the facility does them, increase the number of) male circumcisions?
- a. Would equipment and instruments, such as surgical tables or operating instruments, be needed: Yes _____ No _____ (specify): _____
 - b. Would medications be needed: Yes _____ No _____ (specify): _____
 - c. Would disposable equipment, medicines and supplies be needed, (e.g., anaesthetics, sutures, gloves, syringes/needles, sharps boxes, etc.): Yes _____ No _____ (specify): _____
 - d. Would training of staff be needed: Yes _____ No _____ (specify what type of staff and what type of training): _____
 - e. Which type of staff is authorized to perform male circumcision?
 - f. Would a surgical / procedure room to perform the surgery be needed: Yes _____ No _____
 - g. If yes, do you have a room that could be used if equipment was supplied: Yes _____ No _____
- What else would be needed? _____

APPENDIX 8. HEALTH PRACTITIONERS SURVEY

Please read out loud:

We are carrying out an assessment in this district of the experience and knowledge that health professionals have of male circumcision. We would like to learn of your experiences with male circumcision (if any) and your opinions about providing male circumcision at health facilities in this district. Please answer the questions as truthfully as possible. We will not use your name or refer to you personally when reporting the results of this assessment. You are free to refuse to answer any questions, but we would appreciate your giving us truthful answers to the questions you do answer.

District: _____ Name of facility: _____ Date: _____

Type (Hospital, Health Centre, Private Clinic, etc) _____

Gender of informant: Male _____ Female _____

Interviewer: _____

6. What is your designation?
 - a. Medical Officer _____
 - b. Clinical Officer _____
 - c. Nurse _____
 - d. Counsellor _____
 - e. Other (specify) _____
7. What is your specialty, if any? _____
8. How long have you been practicing (medicine / nursing)? _____
9. How long have you been working at this facility? _____
10. What type of organization do you work for?
 - a. Government _____
 - b. Church-based _____
 - c. Private _____
 - d. Other _____
11. Have you ever performed a male circumcision? Yes _____ No _____
12. Have you ever assisted in a male circumcision? Yes _____ No _____

If yes, what was your role(s)?

 - a. Assist the clinician during the procedure: _____
 - b. Patient screening: _____
 - c. Pre- or Post-operative preparation and care: _____
 - d. Counselling: _____
 - e. Other: _____ (specify): _____
13. If yes, approximately how many male circumcisions have you performed/assisted (total)? _____
14. In the last 12 months, have you performed/assisted any male circumcisions? Yes _____ No _____
 - a. If yes, how many male circumcisions have you performed/assisted in? _____
 - b. How many of these were performed at this health facility? _____
15. In the last 12 months, did you perform/assist in male circumcisions outside this health facility? Yes _____ No _____

If yes, where did you perform/assist in the male circumcisions?

 - a. In another health facility _____
 - b. In a private clinic _____
 - c. In the village _____

- d. Other _____ (specify): _____
16. What were some of the reasons the male circumcisions were performed (you can check more than one answer?)
- Medical indications _____%
 - Religious practice _____%
 - Cultural practice _____%
 - Personal preference _____%
 - Other reasons (specify) _____%
 - Unknown _____%
17. What were the ages of the males you circumcised?
- Infant (0–2 years) _____
 - Child (3–9 years) _____
 - Adolescent (10–16 years) _____
 - Adult (17 and over) _____
18. How much is charged for a male circumcision? _____ (local currency)
19. What additional charges or costs might apply (e.g., antibiotics, return visits, extra bandaging, etc)?
- | | | | |
|------|---|------|-----------|
| None | / | Some | (specify) |
|------|---|------|-----------|
-
20. What training have you received to perform male circumcisions?
-
21. If you were to be asked to perform/assist in male circumcisions, would you need additional training? Yes _____ No _____
22. If yes, what training do you think you should receive?
- Theoretical (for example, lectures or reading): _____
 - Practical clinical training (i.e., performing male circumcision): _____
 - STI diagnosis and treatment: _____
 - Infection prevention: _____
 - Counselling: _____
 - Comprehensive (all of the above): _____
 - Comments: _____
23. In your opinion, are there advantages to a man being circumcised?
Yes _____ No _____ Makes no difference _____
24. Please state whether you agree or disagree with the following statements:
- | | |
|--|------------------------|
| a. Male circumcision helps to improve hygiene | Yes / No / Do not know |
| b. Male circumcision reduces risk of STI | Yes / No / Do not know |
| c. Male circumcision reduces risk of HIV infection | Yes / No / Do not know |
| d. Male circumcision prevents HIV infection entirely | Yes / No / Do not know |
| e. Male circumcision increases risk of HIV | Yes / No / Do not know |
| f. Male circumcision reduces risk of penile cancer | Yes / No / Do not know |
| g. Male circumcision increases sexual pleasure | Yes / No / Do not know |
| h. Male circumcision reduces sexual pleasure | Yes / No / Do not know |
| i. Men who are circumcised are more promiscuous | Yes / No / Do not know |
| j. Women prefer men who are circumcised | Yes / No / Do not know |
25. Have you seen male circumcisions (carried out by someone else) that resulted in complications or adverse events? Yes _____ No _____
- How many: _____
 - Over how many years: _____
 - Please estimate what were the main types of complication or adverse event (you may mark more than one option):
 - Excessive bleeding _____
 - Infection _____

- c. Disfigurement_____
- d. Impotence_____
- e. Other_____

26. Has any male circumcision that you have performed resulted in a complication or adverse event? Yes _____ No _____
- a. How many: _____
 - b. Over how many years: _____
 - c. Please estimate what were the main types of complication or adverse event.
 - a. Excessive bleeding_____
 - b. Infection_____
 - c. Disfigurement_____
 - d. Impotence_____
 - e. Other_____

Please read out loud:

International health organizations have concluded that male circumcision is an important and effective means of reducing the risk of HIV infection. The national government is considering recommending that males be offered circumcision to reduce the chances of the men becoming infected with HIV and other STIs. We would like to get your opinions of the challenges that would have to be addressed to promote male circumcision and make it available to a large number of males in this district. I am now going to ask you some questions about how male circumcision might be made available to many people.

27. In your opinion, who should be permitted to perform male circumcisions? (Please mark one of the options listed)
- a. Medical Officers: Strongly agree / agree / neither agree not disagree / disagree / strongly disagree
 - b. Clinical Officers: Strongly agree / agree / neither agree not disagree / disagree / strongly disagree
 - c. Male nurses: Strongly agree / agree / neither agree not disagree / disagree / strongly disagree
 - d. Female nurses: Strongly agree / agree / neither agree not disagree / disagree / strongly disagree
 - e. Traditional and religious male circumcision providers: Strongly agree / agree / neither agree not disagree / disagree / strongly disagree
 - f. Other (specify): _____ Strongly agree / agree / neither agree not disagree / disagree / strongly disagree
28. In your opinion, what would be the best age for male circumcision?
- a. Infants (0–2 years) _____
 - b. Children (3–9 yrs) _____
 - c. Adolescents (10–16 yrs) _____
 - d. Young men (17–24 yrs) _____
 - e. All ages _____
 - f. What are your reasons for choosing the age group above?

29. In your opinion, what will be the major difficulties or challenges in providing male circumcision to a large number of males in this district?

- a. _____
 - b. _____
 - c. _____
30. In your opinion, what things could be done to increase the number of males who become circumcised in this district?
- a. _____
 - b. _____
 - c. _____
31. If male circumcision were provided to many people in this district, what do you think the charge should be for the procedure? _____
32. If male circumcision were promoted in this district, would you be willing to offer male circumcision services? Yes _____ No _____

APPENDIX 9. STANDARD MC THEATRE SET INSTRUMENTS AND SUPPLIES USED IN MALAWI

MATERIALS/REQUIREMENTS

1. Ideally a purpose built operating or minor procedures table although most districts operation is done using a fixed height table.
2. An instrument trolley or table on which the sterile instruments are unpacked.
3. Procedure room floor made of material that can easily be cleaned or disinfected.
4. Lighting arranged so that the penis is well lit and the surgeon can see what they are doing.
5. Emergency medications and equipment for managing anaphylactic reactions should be available.
6. EQUIPMENT

<ol style="list-style-type: none"> a) Instrument tray wrapped with sterile drape b) Fine toothed dissecting forceps c) 4 artery forceps: 2 curved and 2 straight d) Curved scissors e) Stitch scissors f) Needle holder g) Sponge holding forceps h) Scalpel knife handle/blades i) "O" drape(80cm x 80cm with a 5cm diameter hole for the penis) j) Galipot for antiseptic solution k)Antiseptic solution (povidine iodine or cetrimide) l) Plain gauze swabs (10cm x 10cm; 10 for the procedure; 5 for dressing) m) Petroleum jelly impregnated gauze n) Sticking plaster 	<ol style="list-style-type: none"> o) 15 mls of 1%lignocaine (without adrenaline) p) 10 ml syringe q) Injection needle 18 or 21 gauge r) Suture material (at least 2 sutures per procedure: vicryl or chromic 3'0 or 4'0 on a needle 3/8 circle reverse cutting or cutting) s) Sterile marker pen (optional) t) Gloves, masks, caps, aprons, eye wear, clean theatre uniform, theatre shoes. u) Condoms and information material for the client v) Medicated soap or alcohol based preparation for scrubbing w) Sterile towels for drying hands
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ANAESTHESIA

In adults preferably local anesthesia which is less risky, less expensive. The main technique used is the ring block technique. The nerve supply to the penis is the twin dorsal penile nerves. These are located at the 11 o'clock and 1 o'clock positions near the base of the penis. They fan out towards the glans penis. The maximum safe dose that can be given is 3mg/kg body weight. The responsibility is with the surgeon to check the vial, correct agent, correct concentration and expiry date. To avoid injecting into the blood stream, once the needle is in place, aspirate to make sure no blood enters the syringe and this should be repeated each time the needle is moved before any additional lignocaine is given. The technique involves using a 23 gauge needle, injecting approximately 1ml subcutaneously at 11 o'clock position the without withdrawing the needle advancing into the subdermal space making sure the needle is freely mobile. Then inject 2-3mls to block the dorsal penile nerves then advance the needle subcutaneously and inject 1-2mls around the same side of the penis to the 6 o'clock position. Withdraw the needle and repeat the procedure starting in the 1 o'clock position to complete a ring of anesthetic. After injection massage the base of the penis for 10-20 seconds to increase the diffusion of the lignocaine. Once anesthetic is administered surgeon should wait 3-5min(timed by the clock). Sensation should be tested by pinching the foreskin with a forceps.

APPENDIX 10 STANDARD MALE CIRCUMCISION PROCEDURES REPORTED PRACTICED IN DISTRICT HOSPITALS

STANDARD PROCEDURE

The standard procedure is the dorsal slit method. Preparation starts with scrubbing and gowning though optional the next steps should be followed

STEP 1

SKIN PREPARATION

Prepare skin with an antiseptic solution starting with the glans and shaft of the penis, and moving out into the periphery. Holding the penis with a dry swab, retract the foreskin in order to clean the glans. Prepared area should include the penis, scrotum, the adjacent areas of the thighs, suprapubic area so that there is no risk of the surgeon touching unprepared skin.

DRAPING

This provides a sterile operative field and helps prevent wound contamination. The edges hanging below the table should be considered non sterile. If need be additional local anaesthesia to the frenulum should be given after draping.

STEP 2

Retract the foreskin and remove any adhesions.

STEP 3

Mark the intended line of incision. With the foreskin in the natural resting position, indicate the intended line of incision with the marker pen. The line should respond with the corona, just under the head of the penis. One can also use dabs of gentian violet or even the tip of a sterile artery forceps.

STEP 4

Grasp the foreskin with artery forceps at the 3 o'clock and 9 o'clock positions. Apply the forceps so that there is equal tension on the inner and outer aspects of the foreskin.

STEP 5

Place 2 artery forceps on the foreskin in the 11 o'clock and 1 o'clock positions. Check that the inside blades are lying between the glans and the foreskin and haven't passed through the urethral meatus.

STEP 6

Between the 2 forceps, make a dorsal slit in the 12 o'clock position. Use a dissecting scissors up to the previously marked incision. Any skin tags on the foreskin can be trimmed to leave approximately 5mm of skin proximal to the corona.

STEP 7

Stop any bleeding by picking all bleeders with a fine forcep and tying or under running the bleeder with the absorbable suture being used for the procedure. Take care not to place stitches too deeply especially in the frenular area where the urethra may be injured.

STEP 8

Place a horizontal mattress suture at the frenulum taking care to align the midline skin raphe with the line of the frenulum.

STEP 9

Place a vertical mattress suture opposite the frenulum i.e. 12 o'clock position. This suture should be placed so that there is equal amount of skin on each side between 12 o'clock and 6 o'clock positions. Place 2 further vertical mattress sutures in the 9 o'clock and 3 o'clock positions.

STEP 10

Place 2 or more simple interrupted sutures in the gaps between these 4.

STEP 11

Check for bleeding, if none then apply dressings. Place a piece of Vaseline gauze around the wound then place sterile dry gauze over this and secure in position with adhesive tape. Take care not to do this too tightly and compromise blood supply to the glans. The dressing should be left on for 48 hours

VARIATIONS TO THE TECHNIQUE

Foreskin abnormalities like phimosis and paraphimosis require the procedure done differently but generally following similar principles.

In Malawi most clinicians do the above dorsal slit technique with some few variations like

- Lots of people do not mark the line of incision ending up with either removing too much skin or too little skin. Cosmetically this does not look good
- Others suture continuously leading to lots of complications. The commonest being haematomas and bleeding
- Others use big sutures which give a very bad outcome, bad scars, pain

APPENDIX 11. MEDIA SOURCES CONSULTED

Coverage of MC stories by electronic and print media houses in the past three years.

Media Source	Contact	Story Type	When reported	Number of times reported
Nation Publications	Mr Chipala <i>Librarian</i>	1. Safe circumcision	20.01.2005	Once
		2. Circumcision by default/force in Mchinji	10. 10.2008	Once
		3. Circumcision enhances pleasure	26 th august, 2008	Once
		4. Chiefs defy ministry of education on calendar of initiation ceremonies	4 th SEPT. 2006	Once
		5. Man circumcised by force in Chikwawa	3 rd Jan, 2008	Once
		6. Circumcision boom	22 nd Oct. 2008	Once
		7. Man gets circumcised forcibly	10 th August 2006	Once
		8. Woman assaulted at initiation site	16 th August 2006	Once
		9. Initiation grounds breed violent men?	7 th march 2002	Once
		10. Schools, initiation clash	20 th Oct. 1999	Once
		11. Initiators initiated	26 th NOV 2003	Once

Blantyre Limited	News	Mr Sam Banda-0999341448. <i>Librarian</i>	During the period of data collection they were moving their archived material to another building.	-	-
MBC		Mr Milton Thole- 0999322349 Mr Felix Pashane-0888596674	Some programmes on MC have been done. But due to busy nature of contacts, we did not get the material	-	-
Radio Islam		Mr Adam Phiri-0999394525 Producer/announcer	Some programmes on MC and HIV done after NAC conference on the same. But we did not manage to get actual recordings	-	-
Radio Maria		Raphael Mulozowa 0999349019 Mr Blazio Machedemba 0999559593	Programmes on and HIV/AIDS were done. We did not manage to get hold of the recordings	-	-
Calvary Radio		Shepherd Naphulu	Some programmes on MC and HIV and AIDS were done. The recordings were lost when their computer crashed	-	-
Power 101		Simeon Shumba 0999421784	Some programmes were done after NAC conference. We managed to get two recordings. It was difficult to retrieve all recorded programmes from their archives.	-	-
TVM		Gladys Gandali 0888356428 Molton Kalepsya 0888861615	Some programmes on MC and HIV and AIDS were done. But we were not able to get hold of the recordings because of busy nature of our contacts	-	-

