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Doubt, defiance, and identity: Understanding resistance to male circumcision for HIV prevention in Malawi



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ABSTRACT

Global policy recommendations to scale up of male circumcision (MC) for HIV prevention tend to frame the procedure as a simple and efficacious public health intervention. However, there has been variable uptake of MC in countries with significant HIV epidemics. Kenya, for example, has embraced MC and has been dubbed a 'leader' by the global health community, while Malawi has been branded a 'laggard' in its slow adoption of a national programme, with a strong political discourse of resistance forming around MC. Regardless of any epidemiological or technical evidence, the uptake of international recommendations will be shaped by how a policy, and the specific artefacts that constitute that policy, intersect with local concerns. MC holds particular significance within many ethnic and religious groups, serving as an important rite of passage, but also designating otherness or enabling the identification of the social and political self. Understanding how the artefact of MC intersects with local social, economic, and political contexts, is therefore essential to understand the acceptance or resistance of global policy recommendations. In this paper we present an in-depth analysis of Malawi's political resistance to MC, finding that ethnic and religious divisions dominating recent political movements aligned well with differing circumcision practices. Political resistance was further found to manifest through two key narratives: a 'narrative of defiance' around the need to resist donor manipulation, and a 'narrative of doubt' which seized on a piece of epidemiological evidence to refute global claims of efficacy. Further, we found that discussions over MC served as an additional arena through which ethnic identities and claims to power could themselves be negotiated, and therefore used to support claims of political legitimacy.

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1. Introduction

... in Aleppo once, Where a malignant and a turban'd Turk Beat a Venetian and traduc'd the state, I took by the throat the circumcised dog, And smote him thus.

(Shakespeare, *Othello* – scene ii)

These words of Othello, his final speech before committing suicide, illustrate one of the many historical ways that male circumcision (MC) has taken on meaning as an important social signifier designating otherness or enabling the identification of the

social and political self. Yet today MC is being championed by the global health community as an efficacious HIV prevention strategy, particularly in generalised HIV epidemics in sub-Saharan Africa, based around findings from clinical trials that measured reduced HIV incidence in circumcised men compared to control groups (Dickson et al., 2011; Lissouba et al., 2010; World Health Organization and UNAIDS, 2011). Calls for scale-up of MC are often presented within a discourse of 'evidence-based policy', a public health narrative which justifies policy intervention on the grounds of epidemiological (and potentially cost-effectiveness) data, but risks divorcing the components of a health policy from any social and political importance they hold (Barnes and Parkhurst, 2014; Russell et al., 2008).

In Africa, there has been variable acceptance and uptake of MC as a national HIV prevention strategy. On the one extreme is Kenya, a multi-ethnic, multi-religious society which nevertheless has embraced the procedure, and is seen as a leader in achieving goals of very high coverage MC for men of sexually active ages. At the

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other end has been Malawi, in many ways similar in its multi-ethnic and multi-religious nature, and a country with a higher HIV prevalence than Kenya, yet where there was significant initial resistance to a national MC programme (Dickson et al., 2011; World Health Organization, 2012).

The contrasting policy paths taken by Kenya and Malawi point to the fact that it is not just the presence or absence of a cultural practice such as MC within a country that will shape political acceptance of the procedure for health promotion. Rather, this paper argues that there is a critical need to explore how local MC practices intersect with existing patterns of political contestation, which in turn affects the potential for an artefact like MC to be constructed, incorporated into, and thus utilised within existing power struggles.

This paper draws on research conducted in Malawi between 2009 and 2012 consisting of media and document reviews as well as 31 in-depth interviews. Ethical approval was obtained from the London School of Hygiene and Tropical Medicine Ethics Committee and the Malawi Ministry of Health National Health Sciences Research Committee. Interviewees were initially selected purposively from personal knowledge of the HIV response in country as well as informal discussions with local HIV researchers. Efforts were made to sample representatives of government, donor agencies, traditional/religious leaders and academics. From members of each group further respondents were identified through snowball sampling to identify those who could provide information about the MC debates and/or provide insights on differing ethnic and religious perspectives. This process identified three to eight additional individuals in each category. Interviewees were classified as follows: donor representatives: 3; government bureaucrats: 10; politicians: 4; academics: 7; traditional or religious leaders: 7. Media sources consisted of print media (local and international newspapers) as well as online media (e.g. the Nyasa Times), and radio and television sources. These were identified through online searches, contact with media houses and libraries, and through professional colleagues. Data from media sources were included if they specifically addressed issues of HIV prevention and provided insight into contestation or policy response, with the explicit objective to identify public views on MC and HIV policy. These were then compared against interview data. Data coding was done manually by one author using both pre-defined and data generated codes, enabling generation of themes from the literature and from the research. Pre-defined codes derived from the aim of the research to understand opposition to MC, identifying ethnic, religious, or political views of MC. During the data analysis phase, findings were discussed between authors, generating of new codes for exploration and developing the main results themes. One emergent theme on how MC was constructed in political terms led to our revisiting the historical literature; strategically searching for descriptions of Malawi's history of political and ethnic contestation. This was combined with our interview findings to construct a historical context on ethnicity, religion and identity politics to further inform our analysis.

We begin with a background overviewing aspects of HIV and MC. This is followed by our reflection on the historical context and then our results sections which look at the interface of these issues in shaping local political discourse around MC for HIV prevention. Two dominant narratives in the discussions about MC by local policy makers are explored: The first is a *narrative of defiance* that framed MC as an imposition by external donors. It configured resistance to MC as part of a wider project of maintaining Malawi's sovereignty by resisting domination by powerful countries, especially as it related to issues of sexuality. The second is a *narrative of doubt* that revolved around pieces of local evidence that appeared to contradict international arguments on the efficacy of MC. This

discourse of resistance developed as the international policy transfer process interacted with key elements of Malawian political life, including the construction of boundaries around political groups that overlap with religious and ethnic belonging and could be signified by MC status; as well as sensitive concepts of sexuality and national sovereignty. We further discuss how the process of contestation and debate around MC in Malawi ultimately shaped local groups' claims of political legitimacy or exclusion.

2. Background

2.1. Clinical efficacy of male circumcision for HIV prevention

For many years in the global HIV community there was speculation over the potential protective effect of male circumcision. Observational evidence appeared to show lower rates of HIV amongst population groups or countries where circumcision rates were high (Bongaarts et al., 1989; UNAIDS, 1999), but reviews of available studies at the time found mixed results (Siegfried et al., 2005). Observational data are highly subject to confounding effects, such as the correlation of circumcision with particular religions, and hypothesised behavioural differences between circumcising and non-circumcising populations. Between 2005 and 2007, however, results from three separate randomised controlled trials (in South Africa, Uganda, and Kenya) were published (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007), all finding significant protective effects of medical male circumcision. A meta-analysis combining the data from these three studies pooled their result to produce an aggregate estimated protective effect of 56% (less likely to acquire HIV in the circumcised arm versus the non-circumcised controls) (Mills et al., 2008). These three experimental trials were seen by many in the public health community to provide definitive evidence on the protective effect of MC in heterosexual HIV epidemics. They also provided justification to many in this community for policy action.

2.2. MC and HIV in Malawi

Despite the international consensus, national data from Malawi presents seemingly inconsistent results. The 2010 Demographic and Health Survey (DHS) includes statistics of HIV infection from a sample of 6834 men, reporting an HIV prevalence of 10.3% in circumcised men, but only 7.9% in non-circumcised men (National Statistical Office (NSO) [Malawi] and ICF Macro, 2011). Such figures naturally raise questions about the protective effect of MC. However, just as earlier observational studies in Africa were not convincing, these local findings also present observational data, equally susceptible to confounding. Anecdotal statements (presented in results sections below) were that higher HIV prevalence was seen in lakeshore areas where many men are circumcised. However, past studies have often found increased HIV risk in lakeshore populations, hypothesised due to sexual networking of mobile groups (Deane et al., 2010), transactional sex linked to fishing value chains (Béné and Merten, 2008; Gordon, 2005) (specifically identified as occurring in Mangochi district in Malawi (Nagoli et al., 2010)), and prevalence of genital schistosomiasis increasing susceptibility to infection (Mbabazi et al., 2011).

Poulin and Muula (2011) recently attempted to explain the seeming contradiction between MC and HIV in Malawi by analysing data from within one high-circumcising, high-HIV, district (Balaka). Analysing data available for a sample of women, they found that women with circumcised spouses had a lower probability of HIV infection to those with un-circumcised – a finding that would appear to reinforce the hypothesis that MC is protective within a given epidemiological setting.

2.3. 'Scale up' in Sub-Saharan Africa

In 2007 the WHO and UNAIDS officially promoted MC as an HIV prevention intervention. Subsequently, 13 high prevalence countries in East and Southern Africa were identified for 'scaling up' male circumcision - which the WHO has taken to branding 'Voluntary Medical Male Circumcision' (VMMC) ([World Health Organization and UNAIDS, 2011](#)) (here the term will be simply referred to as MC, as this is how it is commonly discussed). The case for scale-up was presented by Njeuhmeli and colleagues as justified based on the health services costs of providing the procedure, and the benefits of HIV infections averted ([Njeuhmeli et al., 2011](#)).

According to a 2012 progress report by the World Health Organization, of the 13 priority countries targeted, Kenya was leading the way, achieving 45.5% of their target circumcisions (Kenya set a target of 94% of men aged 15–49 years, while other countries were judged against a lower target of 80%). Malawi, however, fell at the other end of the list, with less than 1% of their target coverage ([World Health Organization, 2012](#)). In *PLOS Medicine*, [Dickson et al. \(2011\)](#) studied the differential uptake of MC in target countries. The authors (including representatives from several global health bodies, including WHO, UNAIDS, USAID, and the US CDC and PEP-FAR programme) present Kenya as the sole country labelled an 'innovator' for its early and widespread adoption of MC, while Malawi, was labelled one of two 'laggards' (along with Lesotho) for slow progress in following global recommendations. Dickson et al. discuss factors that they felt could help to explain the variability in uptake, yet they limit their explanatory investigation to programmatic elements "for which progress towards scale-up over a 3-y [ear] period could be objectively quantified" (page 3). As a result, their analysis concludes that, "potential predictors of innovation and early adoption ... include having a VMMC focal person, establishing a national policy, and having an operational strategy, as well as having a pilot or demonstration site with government involvement" (page 7).

2.4. Public health's political myopia?

The fact that an article attempting to explain variable uptake of MC, only considers a few quantifiable, decontextualized and apolitical factors is, in many ways, a telling indictment of the mainstream public health community's continued failure to adequately address the political nature of decision making; especially when considering a procedure with such important and diverse cultural, religious, and political meanings. [Dickson et al. \(2011\)](#) state that their conceptual approach "postulate[s] that the socio-political context and cultural relevance of an innovation are also critical factors influencing the widespread adoption of an innovation." (page 7) Yet they rely on quantifiable (and potentially tautological) indicators such as existence of a pilot project, or 'presence of a VMMC champion' as predictors of 'successful' scale up. Socio-cultural factors are described as "barriers that need to be overcome" (page 4) rather than valid considerations that affect local decisions to scale-up in the first place.

In a related example, [Tulloch and colleagues \(2011\)](#) analysed the uptake of an adult male circumcision programme for HIV prevention in Tanzania and South Africa, framed as a process of 'getting research into policy and practice.' While there was some mention of cultural practices, the slow development of a national policy in South Africa is described as resulting from "poor in-country communication of the research, coupled with weak public understanding of, and engagement with, science" (page S5).

While there are many public health authors who do indeed recognise the importance of social and political concerns in decision making (often utilising the terminology of 'evidence informed'

rather than 'evidence based' policy – (c.f. [Bowen and Zwi, 2005](#); [Oxman et al., 2009](#))) critics such as [Russell et al. \(2008\)](#) see these as exceptions in the public health field, stating:

Critiques of the 'naïve rationalist' model of policy-making abound in the sociological and political science literature. Yet academic debate on health care policy-making continues to be couched in the dominant discourse of evidence-based medicine, whose underlying assumptions – that policies are driven by facts rather than values and these can be clearly separated; that 'evidence' is context-free ... and that policy-making is essentially an exercise in decision science – have constrained both thinking and practice (page 40).

2.5. The social meaning of MC

Russell et al. express the frustration of countless social scientists who confront public health discourses that appear to assume that epidemiological evidence is the only thing to consider in political decision making (c.f. [Barnes and Parkhurst, 2014](#); [Berridge and Stanton, 1999](#); [Davis and Howden-Chapman, 1996](#)). Yet regardless of any epidemiological data or biomedical effects, the technical components (or artefacts) embedded in health policies can often have other context-specific social meanings of importance to populations and, therefore, to policy decision makers. It is these social meanings that must be explored to understand the uptake of any body of global health evidence or global policy recommendations.

The case of MC merely provides a particularly poignant example. For thousands of years (evidenced in ancient Egyptian, Greek, Roman, and biblical texts), MC has captured concepts of purity, masculinity, maturity, or divine selection ([Gollaher, 2000](#); [Silverman, 2004](#)). Throughout history, MC has also served as a signifier of identity and of otherness between groups ([Aggleton, 2007](#); [Mitchell, 1970](#)). In the quote leading this paper, Othello identifies the 'malignant Turk' by both his turban and his circumcision status, dehumanising him to the status of a dog, deserving of death for his attack on a Venetian. While this is a literary example, history has shown numerous cases where the group identification provided by MC can be a trigger for violence. [Aggleton \(2007\)](#) for example, states, "during the Ottoman and Moorish Empires, in Nazi Germany, in India at partition and in the recent genocides of Bosnia and East Timor, a man's circumcision status had serious consequences for how he was treated: with violence, torture and death being the consequence for those who fell short of the mark" (page 15).

Aggleton also notes the plastic nature of the concept, illustrating how in the confines of global public health agencies, MC is presented as 'just a snip' (quoting a representative at a WHO/UNAIDS meeting), yet he goes on to argue that MC "is nearly always a strongly political act, enacted upon others by those with power, in the broader interests of a public good but with profound individual and social consequences" (page 15). As such, it is critical to understand the political contexts in which MC is used, and ethnic and religious aspects of identity politics in which MC is understood. The political context in which MC is understood, however, will be a product of the history through which it evolved – in particular the importance of ethnic identity and the role of ethnic identification in political contests.

2.6. Historical context - MC alignment with political divisions

[Lieberman \(2009\)](#) has argued that the more ethnically stratified a population, the harder it is for the government to achieve collective action on HIV. Such stratification exists in both Kenya and

Malawi, yet the two countries appear to have radically different responses to MC as an HIV policy. Lieberman (2009), however, particularly focuses on the role of ethnic 'boundaries' in shaping political responses, explaining that these boundaries "may cause members of social groups to focus on the status implications of being associated with the problem targeted by the policy ..." Continuing to explain: "... not all problems map onto ethnic boundaries, but when boundaries are strong, there is good chance that problems and solutions will be considered in ethnic terms" (page 36).

As in many other parts of the world, MC in Malawi has served as an artefact of cultural signification. That is to say, the physical presence or absence of the procedure (the artefact) can be used to signify group membership. As one traditional leader interviewed explained:

MC is for Yao visibility, for Yao respect and it belongs to us. It is important for the rite of passage for boys to adulthood. [...] it is everything! (#24, 23/04/2010)

[Note – Interview references are given by anonymous interview number and date]

Malawi is of course not alone to see MC used as an artefact of cultural signification, yet what appears to be particularly relevant is how divisions over the practice of MC map onto the ethnic and religious identities that have played important roles in political division and contestation for power.

2.7. Ethnicity, religion and identity politics

Ethnicity has a social and political role in the public lives of many African societies, although how it impacts on political life is the subject of considerable intellectual debate (Berman, 1998; Mbiti, 1975). In Malawi, Vail and White (1989) attribute the beginning of the process of ethnic identification to the colonial administration which found 'tribes' to be a useful taxonomy to construct local administrative hierarchies. Religious missionaries work further entrenchment of ethno-regional identification: as while the north accepted Scottish missionaries in 1878, according to Vail and White they were rejected for fear of dominance of external ideas and culture in the Yao-speaking Muslim south and Chewa-influenced central region (see also Page (1980)).

Post independence (1964), anti-colonialist and nationalist sentiments were widespread (Kaspin, 1995), but Malawian political life would be dominated for thirty years by the highly autocratic President, Hastings Banda (Forster, 1994; Posner, 1995). Publicly denouncing tribalism, in practice Banda promoted regional and ethnic division, forming an alliance with the predominantly Chewa central region that enabled the region to dominate the country's political and economic development agenda (Englund, 1996; Osei-Hwedie, 1998; Vail and White, 1989).

When the Banda regime collapsed, the first democratic election in 1994 saw the ascent of President Bakili Muluzi, a Muslim from the minority Yao ethnic group. Commentators argue that the politicisation of religious identity became increasingly pronounced during this time. Osei-Hwedie (1998) for instance argues that the multi-party elections carved deep divides along ethnic and regional lines, and Englund (1996, 2011) notes that in readiness for the general elections, religious groups appeared to attempt to consolidate a political base. He comments that Muslim visibility was demonstrable through a strong influence in national development agenda, international relations with Islamic states, and with an increase in the number of mosques built (Englund, 2011), presenting the following particularly vivid example:

When it was announced in 1999 that Muluzi had won a second term in office, the chairman of a township mosque climbed to the roof of his house and shouted that the Yao had won and Islam will rule Malawi. A successful landlord, he went on to declare that if any of his tenants had voted for some other party than UDF, they should leave his houses immediately (page 171).

Muluzi handpicked a political outsider, Bingu Wa Mutharika, a Christian Lomwe from the South, as his successor, who won the following election with a strong vote from the southern region. Despite a switch from a Muslim president to a Christian, ethnic and religious tensions heightened, with some raising concerns that the country would be 'Islamised' (Dicks, 2012; Englund, 2011) and speculation that Mutharika would advance Yao/Muslim visibility in recognition of their election support. Publication of global evidence on the efficacy of MC for HIV prevention coincided with this period.

Malawi's electoral history illustrates how the relationships between ethnic, religious, and regional identification and politics is not fixed, but rather can be continually revised and reconstructed to serve political ends. Recent analysis suggests that for the first three Malawi elections (1994, 1999, and 2004), regional belonging and patronage dominated voting in the northern and southern regions of Malawi, while it was only in the central region that ethnic identity shaped party support (Ferree and Horowitz, 2010). In the 2009 election, regionalism was apparently overcome when Mutharika won his second term in office with support in all three regions. Following the elections of 2009, however, Mutharika was seen to provide patronage and administrative appointments disproportionately to Southern Lomwes (Von Doepp, 2012).

Kaspin (1995) warns against oversimplification of ethnicity in Malawi, yet the identity politics imbued in current constructions of ethnic or religious groupings has at times had profound implications for elections and power politics. Of relevance here, then, is not to identify any true or natural ethnic divisions, but rather to note that politically relevant identities are dynamic and (re)constructed over time, producing boundaries of division between groups. Particular artefacts of signification, such as circumcision status, can then become relevant within political debates when differences in practices between groups align with these boundaries. In particular, traditional practices of MC are widely seen to align with contemporary established ideas of Malawi's history of ethnic and religious competition (e.g. Christian vs Muslim, or Chewa vs Yao).

2.8. Results 1 – discourse of resistance to MC

As noted, for several years Malawi presented a strong discourse of resistance to the idea of MC for HIV prevention. Yet this resistance must be understood as embedded within the historically rooted socio-political context in which MC debates played out. An analysis of interview and documentary data illustrate two particular narratives used to frame the resistance to MC policy Malawi: a *narrative of defiance*, and a *narrative of doubt*, both of which challenged MC with reference to historical political concepts.

2.8.1. Narrative of defiance

The first identified theme in the resistance discourse was a *narrative of defiance*. Within this narrative, Malawi's resistance to MC was portrayed as resistance to the imposition of ideas from outside groups and international donors. This narrative was evidenced in interviews with local officials, for example, with one Ministry of Health official stating:

Donors must not force male circumcision onto the Ministry [...], say do it! No, that is irresponsible science (#5, 02/05/2010)

The construction of MC as being 'forced' from outside equally appeared in the media, with a front page headline from *The Daily Times* newspaper reading: "donors demand circumcision" (19/02/2010).

Within interviews, further claims were made linking MC with donor agendas. Concurrent international debates about Malawi's laws around homosexuality also appeared to feed into the debate. One interviewee for example drew a link between the introduction of MC with the threatened pull out of many international NGOs and some donors over Malawi's criminalisation of homosexuality in 2010 (#29, 26/05/2010). Similarly, quoted in *The Nation*, a Government official said:

Let me tell you Malawians here that the issue is about gay rights. The donors have told us on several occasions that they will not give us money until we start recognising same-sex marriage (15 December 2011: page 2).

It is difficult to assess how much pressure was being placed on government officials to take up MC or other issues. The Global Fund claimed that the reason for not approving its 2010 Round of funding was due to technical weaknesses in the application. Furthermore the WHO does not have binding authority to force member states to take up policies. Yet the obvious preference to scale up MC by the global public health community (e.g. defining countries who do not as 'laggards') would be interpreted within Malawi's long history of clashes with, and resistance to, influence from outside actors.

Indeed, tensions over the historical imposition of foreign policies, influence, and values on the African continent has been long recognised (c.f. Chazan et al., 1999), and has been used to explain resistance to other politically sensitive global health policies (Okunzi and Macrae, 1995; Schneider, 2002). In Malawi, resistance to outside influence has been a recurrent historical theme. It was noted above how acceptance or resistance to missionaries helped to construct early ethno-regional identities. Page (1980) further describes the Chewa's struggle against colonising influences, including 19th century challenges to their political and economic power by Ngoni and Yao settlers and Swahili traders, and late 19th and 20th century European missionaries and colonial government. He further explores how historical resistance could be embedded into local cultural practices, describing how European demands for labourers during the First World War were resisted through Nyau cultural practices and rituals. More recently, the Mutharika administration is recognised to have adopted anti-western rhetoric and positions (for instance, resisting calls liberalise exchange rates, or chastising donor support of NGOs) in response to civil society opposition (c.f. Cammack, 2012; Wroe, 2012).

Malawi's cultural and policy history, therefore, provides not only a context in which the idea that MC was being 'demanded' was easily understood, but also one whereby a narrative of defiance to global cultural neo-imperialism could serve as a mechanism of political legitimisation, reinforcing ideas that certain ethnic or religious traditions could defend Malawi from outside influence.

2.8.2. Narrative of doubt

A second narrative identified in the discursive analysis of text and interview data was a *narrative of doubt*, in which the scientific credibility or applicability of the epidemiological claims of efficacy of MC was challenged. This political narrative may have been particularly suited to the Malawian context, as Dionne and Poulin have identified a range of anecdotal evidence of scepticism of the links between MC and HIV within the general population as early as 2001 (Dionne and Poulin, 2013). In a survey they found that a higher proportion of respondents felt MC increased HIV risk than

decreased it (35% compared to 14%). In our study, the resistance amongst policy makers to the international epidemiological data was found to particularly centre on two arguments. One was to seize on local epidemiological evidence – particularly a finding showing that HIV prevalence was higher in areas where there were higher levels of MC. The second was to challenge the whole of the randomised trial evidence, sowing doubt about their local applicability.

Regarding the first of these, as noted above, observational data in Malawi has indeed shown that HIV prevalence is highest in some areas which have high levels of circumcision. As one politician interviewed argued:

Why is it that in Mangochi those people [...] Muslims and Yao have the more HIV/AIDS but almost everybody circumcising in the lakeshore districts? (#26, 18/05/2010)

The local *Nyasa Times* newspaper also reported Dr. Mary Shawa, the Principal Secretary in the Office of the President Cabinet (and the government spokesperson on AIDS at the time) as saying:

HIV prevalence is high even in parts of the country where the practice [MC] is common [further arguing that] ... MC results from other countries do not apply to Malawi ... MC is ineffective because places where traditional circumcision is practiced in Malawi have high HIV prevalence ... (14/04/2010)¹

Confusing statements over epidemiological data were also manifest in other quotes that cast doubt on the MC randomised trials themselves. For example, one government official was quoted in the *Daily Nation* newspaper as saying:

I do not accept that male circumcision only offers 60% protection, meaning there is still a risk of contracting HIV of 40% or more (11 August 2008: page 21).

This appears to illustrate confusion over the concept of risk reduction, whereby a 60% lower risk ratio for infection is incorrectly presented to mean that there is a 40% chance of infection for circumcised men (rather than being 60% less likely to acquire HIV in any given year). Yet doubt over the international evidence was also expressed by government officials with media quotes such as:

[...] with due respect to learned researchers, I find their findings on MC questionable. (*Daily Nation* 26 August 2008: page 19)

And Dr. Shawa quoted as saying:

We [...] have no scientific evidence that circumcision is a sure way of slowing down the spread of AIDS (*Nyasa Times*, 16th September, 2010: page 1)

While the nuances of the epidemiological details may be difficult for some non-epidemiologists to grasp, for national HIV policy makers (many of whom are clinicians) this narrative of doubt appears to serve as a useful rhetorical device to resist a national MC policy by identifying Malawian (local) data in opposition to foreign research findings. It also can serve to marginalise particular groups

¹ This quote raises the important difference between traditional circumcision practices which may not match the procedures undertaken in WHO-promoted medical circumcision. That said, the possibility that traditional circumcisions are not equivalent to medical male circumcision would reduce the weight of these local data in contradicting global claims of MC efficacy.

(e.g. the Muslims and Yaos of Mangochi) who had higher HIV prevalence despite their circumcision status.

2.9. Results 2 – MC and the politics of identity

This final section of the results turns to explore how the debates over MC fed back into identity politics, exploring how discussions about national MC policy became a means to construct claims about who had the authority to speak on behalf of the Malawian people, with MC seen as a definitive symbol of group signification. One Yao Muslim scholar, for example, stated that circumcision is a 'controversial issue' in Malawi because (he felt) the Government believes that the country is for Christians. This respondent claimed:

Those that believe in Christianity do not see the importance of male circumcision as a tradition and think that agreeing to it means that they have agreed to follow Islam. Because of the difference in beliefs, Christians think that they will look like they are stupid or inferior if they agree with a tenet of Islam. (#11, 12/03/2010)

This argument was echoed by a Government official who referred to Malawi as 'a non-circumcising society', (#29 21/05/2010) arguing MC is a tradition confined to certain minority ethnic groups only.

Further interviews conducted with members of the Tumbuka ethnic group, who are primarily Christian and do not traditionally practice circumcision, typically referred to MC as a Muslim and Yao tradition and were reluctant to discuss it; instead MC was presented in denigrating language by referring to it as a 'bad cultural practice'. Similarly, interviews conducted with many Chewa respondents resulted in MC being dismissed as a Yao or Muslim tradition that did not concern them. Indeed, not only was there reluctance to discuss MC in the interviews, but one respondent even argued that discussing MC was 'tantamount to encouraging it' (#14/30/03/2010).

Some religious and ethnic leaders interviewed also presented views that the procedure was so significant that discussing MC for health reasons could confuse congregations, as the practice could imply that the individual belonged to another religion or ethnicity. One religious leader (a church elder) stated:

[p]eople would start saying the church elders were 'selling them' to those ethnic groups that circumcise because circumcision is perceived identity for that Yao ethnic group and need not be exported. (#03, 19/02/2010)

While the religious leader above expressed a view that MC had implications for *ethnicity*, an ethnic Chewa traditional leader alternatively framed MC as *religiously* relevant, stating:

[t]he big fear about circumcision is that if a person has been circumcised the truth of it is that that person will be regarded as a Muslim because the people who practise circumcision are Muslims. (#14, 30/03/2010)

The interconnectedness between MC and political authority was further illustrated by a Yao Muslim traditional leader, who believed that Government officials were considering making MC a legal offence, stating:

What I have heard recently from the Chief Advisor on AIDS in the Presidential Cabinet Office, Dr. Mary Shawa, is not recommending male circumcision. She says that those people who are

circumcised should be arrested. She says this on the radio at meetings and we have heard about this! (#21, 21/04/2010)

While we did not find collaborative evidence of calls for circumcised individuals to be *arrested*, such views reflect how national policies on MC are nevertheless constructed into claims of cultural identity, political legitimacy, or fears of exclusion. Dr Shawa's statements explored in the previous section helped to construct a narrative of doubt, yet she was also interviewed as part of this study (permission to quote granted), and a main worry she presented was that Malawi is not a 'circumcising society'. She claimed,

when the MC issue was put to the traditional chiefs from the northern and central [non-circumcising] regions, they asked, 'Do you want us to be Muslims?' She further noted that in Malawi 78–80% of people are non-circumcising Christians (#29, 26/05/2010).

This association of male circumcision with Islam was also at the heart of a statement made by the Archbishop Bernard Malango, Chair of the National AIDS Commission, that MC was associated with Muslim rather than Christian areas which saw no differences in HIV rates despite the practice ([Church of England Newspaper \(2010\)](#)) – utilising the signification of MC for a particular group while also reproducing on the narrative of doubt explored above.

3. Conclusions

Readers of this journal will be well aware that the global transfer of policy will be shaped by how the policy, and the specific artefacts that constitute the policy, intersect with local cultural, political and economic contexts (c.f.: [Parkhurst and Lush, 2004](#); [Schneider and Stein, 2001](#); [Shiffman, 2003](#)). Readers will similarly recognise that the depoliticisation of global health recommendations is common, often couched in a language of 'evidence-based policy' which fails to acknowledge that policy decisions will include many other social concerns and values outside disease prevalence or intervention cost-effectiveness (c.f.: [Lin, 2003](#)). The quote from [Russell and colleagues \(2008\)](#) presented earlier particularly critiques the 'naïve rationalism' of those health policy discussions which assume politics and evidence can be simply separated and evidence is context-free – as this fails to capture the reality of political decision making.

The global calls for MC as a policy response to HIV appear to have followed this trend towards (naïve) rationalisation. Resistance to scale up is defined as 'lagging' behind in an implicitly obvious or correct policy direction. Supporting data to justify MC scale up almost universally look at epidemiological and medical cost data (c.f. [Njeuhmeli et al., 2011](#)), without consideration of the other concerns a government may have with regards to adopting international policy recommendations. Nor is there typically any deep engagement with the local contextual meanings and importance of the artefacts contained within global health policy dictates. However, for such a deeply and historically entrenched cultural practice as MC, these issues become particularly relevant. From an epidemiological perspective, there is strong consensus of potential health benefits that can be realised by making MC widely available in heterosexual HIV epidemics, and we are not arguing against making such important interventions available where they can be beneficial. But for the public health community to understand why or how their recommendations will be accepted or resisted there remains an important need to engage with politics, identity, and the roles that artefacts such as MC play in national contexts.

Kenya is often held up at the opposite end of the MC spectrum from Malawi in its rapid scale up of a national MC programme. Of course, ethnicity is an equally important political variable in Kenya, with Lynch (2006) explaining that the “processes of ethnic negotiation and renegotiation are ultimately fuelled by the desire to stake claims to, and access resources controlled by the Kenyan state and external agents” (page 49). Yet, ethnic competition in Kenya, as it has been historically constructed at least, does not easily map onto divisions in MC practices. Kenya’s political parties and coalitions have often been delineated in ways which bisect MC divisions. The Kenya African National Union (KANU), which was in power for over 40 years after independence, was originally a coalition consisting of primarily Luo (traditionally non-circumcising) and Kikuyu (traditionally circumcising) members (Oyugi et al., 2003). Indeed, perhaps the most entrenched competition for political power in Kenya has occurred between the Kalenjin and the Kikuyu (Lynch, 2011) – yet both of these groups traditionally circumcise. In all these ways, while MC might indeed signify otherness in Kenya, the political importance and implications of a government programme promoting MC would be much less salient than in Malawi where the ethnic and religious divisions dominating recent political movements align well with differences in circumcision practices. As such, this alignment of MC divisions with boundaries of historical political competition may be one of the most significant factors explaining the different policy responses to MC.

Resistance to donor hegemony provides a historically established and popular means of building political support in Malawi, a country with a long history of resistance to external influence. Linking to the specific artefact of MC further enabled individuals to render visible their allegiance to Christian and also Chewa populations to entrench their position as the legitimate decision makers in the country, while excluding circumcising groups such as the Yao and Muslims, both of which could be associated with MC. Defining Malawi as a ‘non-circumcising society’ equally serves to delineate the boundaries of local authority for political influences.

Local actors interviewed commonly used the phrase that MC was being ‘pushed’ or ‘demanded’ – either by the government, or by donors. It may therefore be unsurprising that the World Health Organization has explicitly defined its promoted strategy as ‘voluntary medical male circumcision’, which is likely a response to resistance narratives framed around imposition of ideas (hence *voluntary*), as well as the important cultural associations of MC (hence *medical*). Reframing MC in this way may be an attempt to avoid political resistance, yet risks continuing a trend to depoliticise the procedure (c.f. Aggleton, 2007).

This research on MC in Malawi illustrated that lines of division on MC align particularly well with ethnic and religious identities that have served as boundaries of historical political contestation. Yet the policy did more than simply reflect strained ethnic and religious relationships. The nature of the policy: based on epidemiological data from Kenya, South Africa and Uganda; formulated in Geneva; advocated by dominant global health actors; and falling along the fault-lines of Malawian identity politics; brought together a mix of powerful debates that allowed for a protracted discussion about identity, national sovereignty, and the right to rule.

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