ORIGINAL RESEARCH

"Our [Yao people's] circumcision is of the 'brain' not of the 'penis'": factors behind the resistance to voluntary medical male circumcision among Yao people of Mangochi in Southern Malawi

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Abstract

Aim

Malawi officially launched Voluntary Male Medical Circumcision (VMMC) in 2012 after the 2007 joint WHO /UNAIDS recommendation that VMMC be a key HIV prevention strategy for Sub-Sahara African region. Malawi data, however, contradicted the findings of three randomized studies conducted in Uganda, Kenya and South Africa between 2005 and 2007. While randomized trials demonstrated that male circumcision could contribute to a 60% relative reduction of HIV acquisition by men through heterosexual intercourse, HIV prevalence in Malawi was highest in the Southern Region where 47% of males were traditionally circumcised yet Central Region had 15.4% and Northern Region, 6.3%. By December 2018, Malawi had only achieved 756, 780 surgeries constituting 31% against the target of 60% of eligible men. The low achievement was due to resistance to services even in traditionally circumcising Yao communities. This study sought views of Yao respondents in Mangochi district, in Southern Malawi, on VMMC.

Methods

156 participants were interviewed (103 males and 53 females): 15 FGDs (involving 86 males and 50 females); 17 IDIs (involving 14 males, 3 females); 3 Key KIIs (involving 3 males, 0 females). For this paper, the authors only analyzed FGDs, IDIs and KIIs. Quotes from FGDs were not significant.

Results

The study identified that VMMC: a) did not contribute to societal moral values; b) involved female circumcisers; c) threatened chiefs' political authority and economic gains; d) threatened continuity of jando; e) was impotent against witchcraft; f) provided by inefficient providers; g) resembled Yao circumcision; h) wrongly translated as 'm'dulidwe wa abambo.'

Conclusions

The key barrier to VMMC services in Yao communities of Mangochi was the mistrust between government and implementers on one hand and Yao communities on the other due to inadequate engagement prior to the rollout of services.

Keywords; VMMC interventions, Traditional Circumcision, HIV prevention, Mangochi, Yao people

Introduction

WHO and UNAIDS recommended voluntary medical male circumcision (VMMC) as a key HIV prevention intervention premised on findings from three randomized trials which occurred in Uganda, Kenya and South Africa[1]. These studies showed that VMMC had a 60% HIV prevention efficacy among heterosexual men[2–6].

Paradoxically, in Malawi, HIV prevalence was highest in the Southern Region where almost 47% of males were traditionally circumcised and lowest in the Central and Northern Regions where only 15.4% and 6.3% males were traditionally circumcised respectively[7–9]. From a sample of 6,834 men, the 2010 Malawi Demographic and Health Survey showed that 10.3% HIV positivity was established in men who were circumcised compared with only 7.9% in non-circumcised men[10]. However, the Balaka study by Poulin and Muula demonstrated that VMMC was, indeed, protective to HIV infection upon reporting lower cases of infection among women whose husbands were circumcised[9]. Higher HIV prevalence in traditionally circumcising areas of Malawi such as Mangochi district than in non-circumcising areas can therefore be attributed to other social factors such as the culture of mobility, transactional sex in the fishing industry and susceptibility to infection due to genital schistosomiasis infections[11].

With national HIV prevalence at 10.6% of men and women aged between 15 and 64 and a population projected at 19.5 million by the end of 2021, Malawi remains a priority country for VMMC interventions[10,12,13]. 67% of new HIV infections in 2015 resulted from unprotected sex. Heterosexual sex accounted for 12% of all new cases in 2015[14,15].

Malawi government sought to eliminate HIV/AIDS as a public health threat by 2030[16]. Thus, VMMC was prioritized as a key intervention to reduce new HIV infections because it provided life-long partial protection unlike similar interventions such as condom use[11,17,18]. Nonetheless,

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progress towards VMMC targets in Malawi was slow[12,13,19]. By December 2018, a total of 756,780 surgeries had been conducted, representing 31% against the target of 60% of all eligible men in Malawi[11]. Ironically, VMMC uptake was low even among the traditionally circumcising Yao people of Southern Malawi where traditional male circumcision rate was highest[13,16]. Just like in other African ethnic groups, male circumcision among the Yao was mainly used as religious ritual and defines ethnic identity boundaries[17,18]. According to a study conducted by Bernadette Chipuwa, men in Mangochi preferred traditional circumcision to facility circumcision because of the pride that they underwent pain without anesthesia; the use of a traditional knife that was perceived to improve one's sexual performance when he gets married in future; and to ensure that circumcision was not performed by people who were themselves not circumcised[18]. These findings were in consonance with other studies that showed that cultural perceptions are key determinants of negative perceptions to VMMC services among males[14,17,18]. However, key among the factors pushing African ethnic group away from VMMC was the fear that VMMC may overshadow traditional male circumcision which is an important forum for passing down values and traditions to future generations[19,20]. This was possibly the reason why as late as 2019, 85.4% of all circumcisions among Yao people of Mangochi and neighboring Machinga district, continued to happen in unsafe and high-HIV-risk environments particularly during bush initiation rituals[13]. This Yao mindset was in keeping with the works of the prominent African scholar, John Mbiti, who posits about the Ubuntu ethics of the African people: "… [*The] individual becomes conscious of his own existence, rights, duties and obligations through other individuals, society and the environment. There is no real personal existence independent of the society and environment.*"[19]. In contrast, VMMC interventions were perceived to put emphasis only on biomedical outcomes. The question these researchers sought to answer was: why did Yao adult males resist VMMC? This study sought to explore barriers to the uptake of voluntary medical male circumcision services among adult Yao men of Mangochi district of Southern Malawi.

Methods

Research Design

This was an exploratory qualitative study to gain a deeper and broad-brush understanding of the cultural context of male circumcision and perceptions towards voluntary medical male circumcision (VMMC) services in a traditionally circumcising community.

Study Period and Place

Desk review was conducted from November, 2015 to December 2017. Field work was conducted from October 2018 to December 2020, data analysis began in July 2019 and ended in November 2020 and report writing from November 2020 and ended by December 2021. In Mangochi, the study was conducted in Group Village Headwoman Chowe in T/A Chowe, a predominantly Yao area that was known for strict loyalty to Yao and Islamic traditions, beliefs and practices.

Study Population and Selection

Study participants' sampling followed non-probability purposive method. Eligible study participants were identified in consultation with local leaders. Respondents therefore, included: adult men, adult women, married youth, unmarried youth, health service providers, traditional leaders, gate keepers, religious leaders, sex workers and VMMC clients. Pursuant to clarity and verification on certain claims by respondents, researchers consulted other groups within and outside the sample study area.

Inclusion and Exclusion Criteria

The study targeted all males and females aged 18 to 24; 25 to 34; and 35 to 49 (since these are considered to be the most productive and sexually active members of society); those living within the data site unless special expertise was sought. Those who did not fit into this category were left out.

Data Management and Analysis

All interviews were audio recorded and transcribed verbatim into Chichewa/Yao and later translated into English. Completeness and integrity were measures of data quality. The audio, verbatim transcripts and translations were coded and kept in secure places for confidentiality and data security reasons. The researchers used NVIVO software to enhance data management and processing. Thematic Framework data analysis facilitated pinpointing, examination and recording of patterns and themes as they emerged from data sets.

Ethical Considerations

The study got approval from the National Committee on Research Ethics in the Social Science and Humanities (NCRSH). Written or thumb printed consents were collected from all participants prior to interviews. In case of minors, an adult was required to provide such consent on their behalf. Permission was also obtained from Mangochi District Council and the traditional authority (TA) of the area.

Findings

Presentation of findings follows the eight reasons why Yao communities resisted VMMC services namely: it did not contribute to societal moral values; it involved female circumcisers; its promotion lacked secrecy; it threatened chivies' political authority and economic gains; fear that it sought to replace jando; it was considered impotent against witchcraft attacks; it was provided by inefficient providers; it was not different from the full circumcision that Yaos practiced; its roll-out lacked consultations with Yao gatekeepers, which; and its messages were wrongly targeted.

a) VMMC did not contribute to societal moral values

Respondents reported that traditional male circumcision in Yao communities was administered during boys' rites of passage ritual called jando. In this context, it was accompanied by the impartation of cultural education which shaped boys into responsible members of their communities. VMMC on the other hand, was shunned because it was perceived to lack this vital communal function. This is also despite the fact that most respondents were aware of VMMC's potential to reduce the risk of HIV by as high as 60-70%. It was, nonetheless, not seen as a priority because Yao people attributed good health in the individual to good moral character, a function they felt traditional circumcisers played well at societal level: *"Ours (Yao people's circumcision) was the circumcision of the brain not of the penis as they are portraying it now … As Yaos we were circumcised for cleanliness, moral discipline and transition to manhood,"* **[KII, Yao Culture Expert[1]].**

He went on to say:

"The circumcision we are talking about by the educated/elites (VMMC), they are circumcising to enable people to keep on practicing love making [without morality]. This is very wrong and it is the reason why there are high cases of HIV because people believe that …they will not contract the disease.

b) VMMC involved female circumcisers

In Yao culture, 'jando' was a ritual practiced in secrecy by Yao males only and it happened in the bush camps purportedly away from the knowledge of women and children. They were not happy, therefore, that VMMC implementers are using radio to promote services. They were also not happy with the involvement of female service providers in VMMC interventions because it contradicted their worldview on male circumcision. This contributed to low VMMC uptake of services in Yao-dominated areas:

"…people are not happy when they go to the hospital and a female nurse will be operating them, they tend to wonder that as old as I am, why a lady should conduct the circumcision …" **[KII, Yao Culture Expert & Sheikh - Mangochi]**.

To minimize its impact on the campaign, service NGO implementing agency representative testified: *"What we do when we book them for the service, we inform the clinic that there is this [prospective] client who is not comfortable with assistance from female providers. In that case, they are deliberately assisted by men throughout the entire process*," **[KII, NGO Implementing Agency Officer – Mangochi].**

c) VMMC threatened chiefs' political authority and economic gains

The study established that initiation ceremonies benefited local Yao leaders not only in maintaining a political and religious grip on community members but also rewarded them both pecuniary and in kind for every child undergoing Jando rites. Hence embracing VMMC meant gatekeepers giving away political authority and economic gains. A key informant explains:

"…This time around you are telling the chiefs that circumcision should be done at the hospital. The chief cannot promote this because he is benefiting nothing …." **[KII, Yao Cultural Expert & Sheikh]**

Nevertheless, study communities suggested that integrating VMMC into traditional initiation rituals would maintain their authority and economic gains while at the same time VMMC would be promoted without resistance. A culture expert said this on the matter:

"…*The only way this (VMMC) would be done was through the chinamwali set up, which is acting as Malawi Revenue Authority (MRA) [for chiefs] in the village and collecting the tax when children are going to simba .*" [**KII, Yao Culture Expert and Sheikh – Mangochi]**

d) Fear that VMMC had come to replace jando

Some Yao traditional leaders were particularly suspicious of government's intentions for introducing VMMC services in a traditionally circumcising community. They also questioned the rationale behind the tendency of closing down initiation camps that had overlapped with the school calendar sometimes using violent approaches without considering the state of the wounds that initiates had. They found this contradictory particularly because health facilities usually provided VMMC services while schools were in session. Agreeing with chiefs, a culture expert said:

"They cannot just go there and violently take all the children out of the camp like they have done. What happens to the unhealed wounds that those kids may still have?" **[KII, Yao Culture Expert & Sheikh]**.

e) VMMC was considered impotent against witchcraft attacks

Traditional male circumcision was shrouded in beliefs of magic and fear of attack from witches. Angaliba were perceived to have special powers passed down on them by Yao ancestors to provide magical protection to initiates and their wounds while they were out in the bush. The VMMC services providers were hence considered risky to send kids to because lacked such powers and skills. One Ngaliba said:

"*For example, at the [village] nursery school, health service providers… conducted their circumcision…and they left. It happened that… I administered circumcision to at the same place and they got healed fast, whilst those who underwent hospital circumcision did not get healed. The chief called me [about it] and I told him … They were supposed to protect the place by administering the rituals,"* **[IDI, Ngaliba, Chowe - Mangochi].**

f) VMMC services were provided by inefficient providers

A perception that trained medical circumcisers were inefficient also discouraged Yao communities from accessing VMMC services. According to some respondents, communities felt that traditional circumcisers were much quicker, proficient and thorough than trained health personnel. Instances were reported of some minors being referred to the angaliba for corrective circumcision after they had been poorly operated on at the facility:

"… surprisingly, you find that those that have undergone the hospital circumcision are not well circumcised.' As a result…these people still come back to me for circumcision," [Ngaliba, Chowe - Mangochi].

g) Complacency that jando was similar to VMMC in HIV prevention

As a circumcising ethnic group, Yao males felt that the efficacy in HIV prevention of their traditional circumcision was just as effective as and even better than VMMC. They boasted that their boys got circumcised before or during adolescents and by the time they become sexually active their penis skin had hardened. They attributed high HIV prevalence in Mangochi to the presence of non-Yao populations. A key informant reported:

"I remember I was circumcised when I was 8 years old … [for many years] my private part was in direct contact with the trouser [such that] it (the wound) became a scar that had the potential to reduce the acquisition of HIV. But, [adult] people that go and get circumcised now…, since the penis is tender, the moment he will have sex, he will have a cut in wound… since it has not fully recovered," [**KII, Yao Culture Expert & Sheikh]**.

h) VMMC promotion lacked secrecy and wrongly translated circumcision as 'm'dulidwe wa a bambo'

There was a general acceptance that the media was an effective method in ensuring that communities had adequate knowledge about VMMC through such open communication tools as radio, television and newspapers. Generally, respondents, particularly gatekeepers and adult

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men, were against disseminating male circumcision messages using mobile vans and other open media since it was a big embarrassment to their culture.

"In the past, circumcision was a total secret such that even the boy's mother did not know why her child was going to ndagala (or initiation camp)…And when we were there they strictly told us not to tell anybody what had exactly happened to us…[During ndagala] drums were bit loudly to drawn out the crying that happened in the camp as boys were being circumcised. No woman would dare come close to where circumcision was taking place," **[KII, Sheikh & Al-Haji - Mangochi].**

They also indicated that they did not like the use of the words "mdulidwe " or "kudulidwa " like the media puts it because amongst the Yaos it is kuvinidwa not kudulidwa. One Sheikh said: *"Mind you, in our communities we don't call circumcision "kudulidwa" or "mdulidwe". We call it "kubvinidwa." Here, we don't like the expression 'm'dulidwe wa abambo.' Do women get circumcised? Why call it 'mdulidwe wa abambo' as if there is another circumcision for women,"* **[IDI, Sheikh - Mangochi].**

Discussion

This study established and confirmed that Yao communities in Mangochi were generally antagonistic towards VMMC despite a few advantages that they admitted it had among them less pain, cheaper to implement, earlier healing, a hygienic environment and an assurance of prevention of HIV infection[21]. It demonstrated that much of the resistance stemmed from practices, within the delivery of VMMC services, which were perceived to infringe upon the practice of traditional male circumcision[6,13,22,23]. The key cultural prism was that traditional male circumcision served the interests of the wider community while VMMC only served the wellbeing of the individual client. For example, it showed that Yaos practiced male circumcision as a ritual through which males transitioned from childhood to adulthood i.e. through *jando* communal duties and responsibilities were instilled in initiates as one key informant argued: *"…our circumcision was the circumcision of the brain not the penis…*" By this he meant during their stay in the initiation camps, boys spent time gaining life skills that would help them become useful citizens of their communities. John Mbiti, posits that in the African context, the rights, duties and obligations of the individuals are only exercised with full conscience of the implications they will have on the entire community such that there is nothing like 'I am free to do whatever I like'[24]. VMMC interventions were perceived to contravene this worldview since they seemed to focus on disease prevention for one male. Besides, they were appalled that VMMC campaign used messages that promised men sexual prowess in bed. They also promised that women and girls would consider clients "cool" upon getting circumcised. This was insensitive to the cultural and religious context of male circumcision and contrary to the findings of the Malawi Male Circumcision Situational Report of 2010 which demonstrated that communities viewed VMMC from a cultural and religious context[25]. Again, being a predominantly Islamic community, targeting of adult men with male circumcision was perceived to be misplaced because every Muslim Yao man had already undergone circumcision during adolesence[24]. Community leaders, who already had vested and political interests in traditional circumcision deliberately framed the VMMC campaign as an attempt by government to replace local circumcision practices that were rooted in Islamic dogma. Chiefs could, therefore, not promote VMMC because it had economic benefits. Implementers further offended Yao gatekeepers by not limiting their messaging to health outcomes such as HIV and cervical cancer prevention. These messages were generally considered obscene and meant to dilute Yao culture. The Daily Times of 19th June, 2017 observed: *"The chiefs are concerned that the medical circumcision is diluting their initiation culture..."* Resistance was further exacerbated by the violent manner in which government and other agencies, particularly NGOs, disrupted traditional initiation camps where their lifespan had overlapped with the school calendar. Yao respondents found such incidents not only patronizing but also demeaning, sacrilegious and an aggression against their culture and the Islamic faith. On this premise, communities felt justified to claim that VMMC was a ploy by government and stakeholders to suppress or eliminate the Yao culture and the Islamic faith that they represented. Involvement of female VMMC service providers was also considered sacrilegious to their tradition and religion since in both cultures women had no place in initiation rituals[15,26,27]. Similarly, there was a perception that VMMC sites were not fortified against spells from ill-intentioned people hence not safe from spells. Based on this philosophy, these researchers posit that the Yao people opposed VMMC primary because they found it contradictory to the main function of male circumcision rituals and ceremonies in their culture and religion although they also acknowledged its role in preventing HIV infection and cervical cancer.

Study Limitations

Being a purely qualitative study, this report lacks statistical basis upon which conclusions can effectively be grounded.

Conclusion

In conclusion, we find three key undercurrents to the eightfold Yao resistance to VMMC services. First, service providers did not effectively engage Yao communities before rolling out services consequently they did not customize services and messages to the Yao culture and taste. Secondly, the Yaos valued traditional male circumcision rituals and ceremonies since they were instrumental in preserving their culture for posterity. Thirdly, Yaos felt that government was simply insensitive to their cultural and religious needs in four ways: it used female circumcisers; resorted to violence when shutting down jando camps; and, finally, permitted sexually explicit messages and offensive terminologies such as m'dulidwe in their territory where culture and religion did not allow it.

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Conflict of interest

The authors declare that they have no conflict of interest.

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