Advances in Sciences and Arts

Journal homepage: https://asa.must.ac.mw/

RESEACH ARTICLE
Vol. 2 Issue 1

Category
Arts

Correspondence to:
kentmphepo95@gmail.com

Citation
Mphepo, K. Y. G., Muula, A. S.,Sadalaki, J., Alfonso, W.T., & Mfutso-Bengo, J. (2025). "The Bible teaches about circumcision of the heart, not the flesh. This [VMMC] is not for us". Factors behind resistance to voluntary medical male circumcision among the Chewas of Dowa in Central Malawi. *ASA*, 2(1). https://doi.org/10.37872/2025.0201.12

Supporting info
Please refer to the journal's official website on https://asa.must.ac.mw/

Received
6th Jun 2024

Accepted
1st Feb, 2025

Published
14th March 2025

DOI
https://doi.org/10.37872/2025.0201.12

Factors behind resistance to voluntary medical male circumcision among the Chewas of Dowa in Central Malawi

Kent Y.G. Mphepo[1], Adamson S. Muula[1], John Sadalaki[1], Witness Tapani Alfonso[2], Joseph Mfutso-Bengo[1]

[1]Department of Public Health, Kamuzu University of Health Sciences, Blantyre, Malawi
[2]Center for Social Research, University of Malawi.

Abstract Globally, the estimated prevalence rate of male circumcision is around 38.7% with half of the circumcisions conducted for religious and cultural reasons. In Malawi, research shows that only 28.0% of the men aged 15–49 are circumcised. This figure includes 18.0% circumcised by traditional practitioners and 9.0% by medical professionals revealing how much resistance this process has met among Malawian males. Comparing the progress of the voluntary male medical circumcision between the Southern and Central region, much resistance and low uptake is recorded and experienced in the Chewa-dominated Central Region. What factors have contributed to this resistance?

Methods: A qualitative research approach that interviewed 118 participants (78 males and 44 females). We conducted 11 Focus Group Discussions (FGDs) (involving 67 males and 36 females); a total of 13 In-Depth Interview (IDIs) (involving 8 males and 5 females) and 6 Key Informant Interviews (involving 3 males and 3 females).

Findings: Study confirmed that VMMC's unpopularity in Dowa was due to: a) deep-rooted thinking that circumcision rituals were for Yaos while Chewas' was "*gulewankulu"*[1], proudly called *"mpingo wa aloni"*[2] b) Religious orientation and beliefs c) Misconceptions about the VMMC procedure (e.g. what was being cut off – the foreskin or head of the penis? d) Poor community sensitization initiatives which overlooked other key benefits of VMMC e) Low involvement of frontline health-workers in primary level facilities f) Accessibility and cost of accessing the service.

Conclusion: Chewas view VMMC services from cultural and religious prisms. Implementing agencies must explore integrating services into cultural and religious forms and institutions such as *mpingo wa Aloni,* due to its cultural, religious and communication value.

Keywords: *Chewa, VMMC services, resistance, circumcision, culture, religion*

1. Background

Malawi is one such country in Sub-Saharan Africa with high HIV prevalence and where the majority of males are not circumcised (Bengo et al., 2010; National AIDS Commission, 2019a). In an effort to control the spread of HIV and based on scientific evidence, in March 2007, the World Health Organization (WHO) and Joint United Nations Programme on HIV/AIDS (UNAIDS) recognized male circumcision as an effective intervention for HIV prevention in regions with high HIV prevalence and low male circumcision rates, such as the Sub-Saharan Africa (Hellandendu, 2008; National AIDS Commission, 2019b). This effectively meant the adoption of VMMC as an HIV preventive strategy in Malawi (Mutombo et al., 2015; UNAIDS & World Health Organisation, 2021; World Health Organization, 2018). Despite taking this step, the progress and up take levels of VMMC among the Malawian men has been extremely low and discouraging (Kripke et al., 2016; National AIDS Commission, 2015). Globally, the estimated prevalence of male circumcision is pegged around 38.7% with half of the circumcision performed for religious and cultural reasons (Chatsika et al., 2020). But current statistics shows that roughly only 3 out of every 10 men aged 15–49 in Malawi are circumcised. This figure includes even those that are traditionally

[1] *Chewa dancing masqueraders considered a link between ancestors and the living*

[2] *'Aaron's Church' based on the golden calf motif in Exodus 32:4-35*

circumcised (Davis et al., 2018; Matoga et al., 2022). It is not a secret that the progress of VMMC in Malawi is not impressive despite all the efforts and resources committed in this service (Matoga et al., 2022; Rennie et al., 2015).

Distribution and Determinants of Male Circumcision in Malawi

Malawi has a low prevalence of male circumcision (MC) with a national circumcision rate between 21% (in 2004) and 28% (in 2016) of men with an estimated further growth to 38% by 2021(Matoga et al., 2022; National Statistical Office, 2015). The majority of circumcised men reside in the Southern Region, where according to the 2004 DHS 33.1% of men self-report as circumcised with significant pockets of circumcision along the lakeshore (Goodwin, 1864). This compares to 12.2% in Central Region and 5.0% in Northern Region (Mhagama et al., 2021). Like in other countries in the region, the majority of circumcision in Malawi occurs in the context of religious and traditional rites of passage, although increasingly, modern healthcare facilities are offering the service both as part of the traditional process and as uncircumcised men become increasingly aware of the benefits of VMMC (Katisi & Daniel, 2015; Muula, 2007; Parkhurst et al., 2015; Rennie et al., 2015; Shumba & Lubombo, 2017). But while it is known that VMMC uptake is better in the southern region compared to the central and northern regions, little exploration has been done on what could be the real drivers of the low uptake. In order to acquire an in-depth understanding of the socio-political and economic drivers behind the low uptake of VMMC services among the Chewa people of Central Region of Malawi, a qualitative study was carried out in Group Village Headman's Mwancheka area, T/A Dzoole, in Dowa district, Central Region. Results of this study clearly indicate that deep-rooted cultural and religious factors are at the center of the resistance.

2. Methods

Study design and setting

Field work was conducted between November, 2018 and December, 2020. Data analysis was conducted between July 2019 and November, 2020 and report was finalized by December 2021. In Dowa data was collected from Mwancheka Village, TA Dzoole, a predominantly Chipeta-Chewa area known for loyalty to Chewa and Christian ethos.

Study Population

We used the non-probability purposive sampling method and eligible participants were chosen in collaboration with traditional leaders. We interviewed adult men and women, youth (married and unmarried), initiates, health service providers, cultural gate keepers, religious leaders, commercial sex workers and VMMC clients among others. In search for clarity on some issues, researchers consulted other sources of information outside the sample study area.

Data collection tools

A total of 118 respondents were interviewed (78 males and 44 females were interviewed). The data was collected using 11 FGDs, involving 67 males and 36 females, comprising men, women and the youth; 13 IDIs (8 males 5 females) with critical members of the community; and 6 KIIs (3 males and 3 females). Researchers sought voluntary consent from participants. Interviews were audio-recorded in Chichewa, transcribed verbatim and translated into English. The audio, verbatim transcripts and translations were coded and kept in secure places for confidentiality and data security reasons. We used NVIVO 12 software to enhance data management and processing. Thematic Framework data analysis facilitated pinpointing, examination and recording of patterns and themes. The themes have been presented as results of the study.

Ethical considerations

The study was approved by 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. For minors, adults provided consents prior to interviews. Permission was granted from the Dowa District Council, Police and traditional authority (TA) of the study area.

Findings:

Dowa is a district in the central east of Malawi and is populated by the two tribes namely Chipeta Chewas and Ngonis. The study findings confirmed the existing reports that the majority of men in Dowa are not circumcised. Through the interaction with men and women but also key stakeholders in the community and health zones of Traditional Authority Dzoole in the district, the study found that the factors inhibiting uptake of VMMC among

men in the district can be grouped into 7 main categories namely: the thinking that circumcision rituals were for the Yao people – theirs' was *gulewankulu*; religious orientation and beliefs; misconceptions about the VMMC procedure (what was being cut off – the foreskin or head of the penis? poor community sensitization initiatives which overlooked other key benefits of VMMC; low involvement of front line workers at the onset including health workers; and, accessibility and cost of accessing the service. The findings below give a broad-brush and in-depth understanding of the socio-political, social-political and socio-economic drivers behind the low uptake of VMMC services among the Chewa people of Dowa in the Central Region of Malawi.

Deep-rooted pride in the Chewa culture

Since the district is a home to the majority Chewa and few Ngoni people, the cultural and historical background of these two tribes revealed that they did not practice male circumcision. As such, the study found that most of the Chewa men found it strange and a betrayal of their culture if they got circumcised. They knew gulewankulu as an initiation ritual for their boys. They, therefore, expressed suspicion that government wanted to impose a foreign culture on them since traditional circumcision was popular among the tribes in the Southern Region, especially the Yao men. Men in Dowa, therefore, posited that getting circumcised was congruent to denouncing their culture and adopting a practice meant for male Yaos.

"*I am a Chewa man, why should I go for circumcision? Do you want me to become a Yao?"* Such expressions were very common in the discussions and it was clear that even within their social circles, a circumcised Chewa man would be regarded as a 'foreigner'. *"In our area, circumcision has come to light when medical circumcision was introduced but in the past we used to hear it from other tribes like the Yao. We just said they circumcise each other but we did not really know what they really cut…Just recently heard they said we should also get circumcised so there are a lot of questions,"* **[FDG, Service Providers – Dowa]**. As a result of the newness of circumcision in Dowa, there had been resistance to access services. The married women were apprehensive too. They opined that letting a man

go for circumcision was akin to giving him a license to become promiscuous since he would begin to feel immune to STIs such as AIDS. *"Not many [men] are going ...for instance in the village telling a married man to go for circumcision with a view to prevent contraction of diseases they will say 'they are already married and getting circumcision will be [like] getting a license [for promiscuity]' The wife [will] say, 'you are married why do you want to get circumcised when we have stayed together all this time without any problem?'* **[IDI, Traditional Leader – Dowa].**

Deep-rooted pride in being a predominantly Christian community

The Chewa people of Dowa also equated going for circumcision with joining Islam, something they did not want to do. *"Firstly, people don't go because it is ingrained [in the Chewa people] that circumcision is for Muslims or the Yao and now it is a strange thing for a Chewa to go for circumcision since if he gets circumcised it will be like he has joined Islam. This is deep-rooted here,"* **[FDG, Service Providers – Dowa]**. Dowa district has a population of about 772,569 and is mostly dominated by Christians with the Catholic Church and the Presbyterians of the conservative Nkhoma Synod of the CCAP Church being the majority (26% and 22%). Muslims, who are mostly associated with male circumcision, only take up less than 1 percent of the entire population[3]. The study findings established that many Chewa men in the district avoided VMMC because their churches were not dogmatic on this doctrine such that members were not 'required' to get circumcised. *"Firstly, people don't go for VMMC here because it is ingrained [in the Chewa people] that circumcision is for Muslims or the Yao."* The study found that, due to the domination of the Christianity in the area, their salvation centered on the circumcision of the heart not of the flesh. This meant that one needed to convert to Christ and live by Christian values such as keeping God's commandments with no need to go for physical circumcision in order to be holy in the eyes of God based on Deuteronomy 30:6[4] and Romans 2:29[5] like one male participant put it: *"…the Apostle says that true circumcision is one of the heart and not of the flesh. This [VMMC] is not for us as*

[3] *According to NSO (2018) Malawi Population and Housing Census report*
[4] *The Lord shall circumcise your hearts and hearts of your descendants…"*
[5] *"… and circumcision is circumcision of the heart, by the spirit."*

Christians," **[FGD, Adult Men – Dowa].** Largely, participants suspected that the coming of VMMC services in the area was widely regarded as an effort to Islamize Christian people. It was also established that churches that were situated in Mwancheka area did not play an active role in supporting and promoting circumcision. "*As Christians, we do not make [put] emphasis on circumcision"* **[IDI, Religious leader - Dowa].**

Misconceptions and fear about the VMMC procedure due to lack of comprehensive knowledge

Some misconceptions, like the one that said that sperms of a circumcised man came out with more strength than those from the uncircumcised man, were a motivator for adoption of services. However, these may also inhibit uptake of services. The lack of clarity and myths around VMMC procedures is one area that needs due attention and response. For example, many respondents were not very sure of what exactly was cut off from the penis during the surgery. People just say the 'foreskin' of the penis others just say the '[head of the] penis' so when you think about it, eeh! It's scaring."(FGD ….. Women are apprehensive; because she doesn't know how long the wound takes to heal" [FDG participant - Khuwi Health Centre - page 34].

In view of this, elderly people in Dowa found no reason why they should get circumcised. They left it [circumcision] to children. "Sometimes it is fear when you think of how you feel with a small wound so you fear to be cut as an elder…," [FGD, Community Leaders - Dowa].

Poor community sensitization which overlooked other key benefits of VMMC such as prevention of cervical cancer

The study found that besides preventing HIV, VMMC contributed to the prevention of cervical cancer, an area that had not been given enough attention as aptly stated by one participant. *"The protection [prevention] from cervical cancer [is another benefit of circumcision]. This point isn't well known but it is important that it should be heard because in this area we don't value... Cervical cancer isn't choosing sides whether you are a Yao or a Chewa so maybe during mobilization meeting it should be the agenda then we will understand the benefit of circumcision in this area,"* **[FGD, Community Leaders - Dowa].** This view was corroborated by other participants

who emphasized the need to consider including messages on cervical cancer because of the risk it was posing to people in the area. *"Let us put HIV aside, currently the lives of people are at risk because you can protect yourself from HIV but there is no cure for cancer,"* **[FGD, Community Leaders - Dowa].** One striking finding regarding circumcision and cervical cancer was that some men in Mwancheka area who had resisted VMMC for long decided to get circumcised after noticing that circumcision protected women from cervical cancer. *"... I went to the hospital and I saw a poster saying circumcision protects men and also women from cervical cancer so an uncircumcised man causes the woman to suffer from cervical cancer. This message was the one that made me become afraid... I was encouraged and I made the decision ...my two sons were old enough so I went with my sons,"* **[FGD, VMMC Clients - Dowa].**

Low involvement of front-line workers including health workers at the onset

While there had been awareness about circumcision at village level as indicated by one chief, front line health workers were not actively involved in campaigns to create awareness about male medical circumcision which had created a gap with regard to Information, Education and Communication [IEC] resulting in very low uptake of VMMC services. Health workers only took advantage of people who visited the health facility for HIV testing and other services. *"We rarely go into the villages on male circumcision awareness campaigns but when they come to the hospital for HIV testing we discuss the topic of circumcision so they hear it here first"* **[FDG, Service Providers - Dowa].** In addition, sensitization on VMMC was very poor, as compared to safe motherhood which included clear benefits of delivering at the health facility. VMMC did not mention its benefits. *"Just to add, these days, sensitization on VMMC is very poor, it cannot be compared to safe motherhood saying the benefits of delivering at the hospital is such and such. VMMC doesn't have this,"* **[FDG, Service Provider - Dowa].**

Accessibility and cost of accessing the service

Distances of the VMMC supply centers also seriously affected the uptake of the intervention. The study established that along the Khuwi Health center, for example, supply of VMMC services was not continuous as they only offered services on

specific days. It was discovered that the only place where VMMC services were offered whole week was at Mponela Hospital and this was costly for potential clients since the distance to Mponela was long and the transport costs were too high for prospective clients to bear. This was one factor that demotivated potential clients from accessing services. "*I think transport is another challenge. Here we do not provide the service frequently and when someone is looking for this VMMC service, we link with the VMMC district coordinator at the district hospital and in most cases, they just tell us to refer the clients to Dowa district hospital and at the clients' cost and most people here do not have money for transport like boys so they just go back home and give up,"* **[FGD, Service Providers – Dowa].**

3. Discussion

The study findings show that despite many benefits told, circumcision is seen as cultural identity for Yaos not Chewas and taken as more of a mandatory practice for Muslims than Christians. The desire to associate with Chewa culture was a stumbling block to the uptake of VMMC services in Dowa district. Masego Katisi & Marguerite Daniel noted the same for another non circumcising tribe in Botswana, "We wondered when this SMC came. We do not want other cultures transferred to our culture. Bakgatla and Balete are people who do circumcision culturally (Katisi & Daniel, 2015). Why couldn't they go to them? Our men here never did that. How could I speak to the tribe about this?" Despite the resistance the study has found that with flexibility and honest engagement it is possible to strike a compromise between the gate keepers of culture and VMMC providers such that circumcision may be carried out in a clinical setting, with initiation rituals being performed traditionally, either before or after circumcision. Anecdotal reports of this pattern are available for a group in Botswana, who go through the initiation ceremony at a traditional initiation school and are then brought to hospital in town for circumcision to be performed. Further notes that Ngalande refers to pockets of Yaos in Malawi who circumcise their sons at the facility and send them to participate in traditional ceremonies WHO, (2009). Due to deep rooted religious beliefs church representatives reported that they were not interested in mobilizing their members to get circumcised since Christian theology did not make circumcision mandatory:

"The Apostle Paul in the Bible teaches about circumcision of the heart, not the flesh. This [VMMC] is not for us Christians," **[FGD, Adult Man – Dowa].** The community linked getting circumcised to becoming a Muslim as this is not a Christian practice, Parkhurst noted the same, Christians think that they will look stupid or inferior if they agree with the tenet of Islam (Parkhurst et al., 2015). Archbishop Bernard Malango, Chair of the National AIDS Commission also associated MC with Islam (Parkhurst et al., 2015). Hence need for sustained engagement with religious beliefs gatekeepers and the community on the benefits of VMMC.

A quantitative study by Masese *et al* (2021) in Machinga one of the traditionally circumcising districts lists fear of pain during the procedure (63%, n = 165) and bleeding (31%, n = 82), age, marital status with p-value threshold of 0.25 as frequently cited barriers (Masese et al., 2021). Despite this, the study found that there is some positive trend in the acceptability of male circumcision at a VMMC facility as opposed to traditional setting in the region and across the continent. In a Nigerian study, 92% of the 280 adults interviewed were circumcised by a traditional circumciser, but they reported that only 62% of their 1417 children had undergone the procedure in a traditional way. These could be used as ambassadors of VMMC in the communities they come from.

The study has also noted the loss of opportunity to market other benefits of VMMC like reduction of cervical cancer cases during community sensitization initiatives. In Dowa district several participants emphasized the need to consider cervical cancer because it is on the rise. This finding is compatible with a study by Wirth *et al* (2016) which found that several participants expressed willingness to get circumcised in order to protect their spouses from cancer. The overlooking left the perception that VMMC package is for males only hence need to have cervical cancer equally sensitised as a benefit package for women from VMMC (Wirth et al., 2016).

As has been noted, the lack of involvement of front-line health-workers in primary level facilities has had negative impact on the follow up support to VMMC clients at the community and household

level. “The job is done by the top dogs so we don’t know what is next so we can’t follow-up because it is too confidential,” [FDG, Health Worker - Dowa]. These are key workers as not all clients heal as predetermined, hence portray negative side of VMMC when this could be mitigated through follow up support visits by front-line health-workers. Furthermore, it is time that the VMMC approach be extended beyond the thinking that it is the domain of front-line health workers only. The teachers once trained/oriented are key to dissemination of the benefits of VMMC “At school, we have HIV/AIDS youth clubs but because they were not taught [VMMC] …it is hard [for a teacher] to explain in clear detail the benefits,” [FDG, School Teacher- Dowa]. Hence need to widen involvement of frontline staff.

The study further confirmed that distance to VMMC contributes to the low uptake of VMMC in the area as it showed that out of the four facilities within the study area only one facility, Mponela hospital, offered services continuously. Prospective clients who come on a wrong day left without getting circumcised yet they had spent their own money for them to come World Health Organization (2009.) also notes the same for Sudan and Nigeria where high cost was an important facilitator for using traditional circumcisers (World Health Organization, 2018). However, in South Africa, Kenya, Zambia and Malawi there was evidence that prospective clients opted for medical circumcision to avoid the costs associated with traditional circumcision (communal festivities that follow the boy’s finishing initiation rites). Further notes that paying for male circumcision services at health facilities was not a barrier by the traditionally circumcising Lunda and Luvale since they had always paid traditional circumcisers. This is a window that can further be explored as VMMC eventually is a cost that must be borne by individuals.

4. Conclusion

The study has revealed underlying factors behind low uptake of VMMC among men in nontraditional circumcising communities like TA DZoole in Dowa. The study has found that there is need for the community entry and implementation strategies that target the elimination of stigma, religious and cultural identity that associate circumcision with Islam or that is a practice set aside for the reserve of the traditionally circumcising ethinic groups such as the Yaos predominatly found in southern Malawi. There is also need to close the chasm of

knowledge around VMMC procedures, associated pain including wound healing interval to wade off the negative myths that rule in the absence of adequate knowledge. The study has also found that the opportunity was missed at the onset to effectively engage the communities especially female and married men on the other benefits of circumcision like prevention of cervical cancer. There is need for innovative ways and special emphasis on the youth since these will be the drivers to patronage of VMMC in the next decade. The study has also found that there is need to learn (through learning tour visits with key gate keepers) from local and global traditional non-circumcising societies who scaled up adoption of VMMC. There is need for intensified use of interpersonal communications approaches which allow communities to ask questions and clarify issues.

5. Acknowledgements

The author shall always remain indebted to the following people who contributed either directly or Advances in Sciences and Arts indirectly in various capacities in the development of the manuscript of this paper:

Protocol development and Principal Researcher – Kent Y.G. Mphepo. Overall study supervision – Professor Mfutso Bengo (Primary) and Professor Adamson Muula (Secondary). Community mobilization: Mangochi – GVH Chowe and Dowa – GVH Mwancheka. Data collection – Kent Mphepo with support from: Facilitation – Shaibu Msusa. Note taker – Mercy Makumba with support from Iquiba Onani and Soflet Blackson. Data transcription – Shaibu Msusa, Martha Simchimba, Only'm Mphepo and Hope Kalua. Data analysis – Richard Thindwa, Martha Simchimba & MacWellings Phiri. Data editing and organization – Felix Phuka, Ms. Annie Banda. Drafting – Witness Tapani Alfonso & John Raymond Sadalaki. Library and ICT support – Dr. Diston Chiweza, Apatsa Selemani and Lyson Ndaona. All respondents in Dowa and Mangochi. Initial insights on the Chewa people – Prof. Kanyama Phiri, Lester Chikoya, Rev. Dr. Winston Kawale, Joel Suzi, Blackson Matatiyo, Prof. Yusuf Juwayeyi, USA.

6. Funding

Financial sponsorship – ACEPHEM

7. Conflict of interest

The authors declare that they have no conflict of interest.

8. References

Bengo, J. M., Chalulu, K., Chinkhumba, J., Kazembe, L., Maleta, K. M., Masiye, F., & Mathanga, D. (2010). *Situation analysis of*

male circumcision in Malawi. College of Medicine.

Chatsika, Z. J., Kumitawa, A., Samuel, V., Azizi, S. C., & Jumbe, V. C. (2020). Voluntary medical male circumcision and sexual practices among sexually active circumcised men in Mzuzu, Malawi: a cross-sectional study. *BMC Public Health*, *20*(1). https://doi.org/10.1186/s12889-020-8309-5

Davis, S. M., Hines, J. Z., Habel, M., Grund, J. M., Ridzon, R., Baack, B., Davitte, J., Thomas, A., Kiggundu, V., Bock, N., Pordell, P., Cooney, C., Zaidi, I., & Toledo, C. (2018). Progress in voluntary medical male circumcision for HIV prevention supported by the US President's emergency plan for AIDS relief through 2017: longitudinal and recent cross-sectional programme data. *BMJ Open*, *8*(8), e021835. https://doi.org/10.1136/bmjopen-2018-021835

Goodwin, H. (1864). *Memoir of Bishop Mackenzie*. https://ixtheo.de/Record/1484648994

Hellandendu, J. M. (2008). Contributory factors to the spread of HIV/AIDS and it impacts in sub-Saharan African countries. *European Scientific Journal*, *8*(14), 144–156.

Katisi, M., & Daniel, M. (2015). Safe male circumcision in Botswana: tension between traditional practices and biomedical marketing. *Global Public Health*, *10*(5–6), 739–756. https://doi.org/10.1080/17441692.2015.1028424

Kripke, K., Chimbwandira, F., Mwandi, Z., Matchere, F., Schnure, M., Reed, J., Castor, D., Sgaier, S., & Njeuhmeli, E. (2016). Voluntary medical male circumcision for HIV prevention in Malawi: modeling the impact and cost of focusing the program by client age and geography. *PLoS ONE*, *11*(7), e0156521. https://doi.org/10.1371/JOURNAL.PONE.0156521

Masese, R., Mwalabu, G., Petrucka, P., & Mapulanga, P. (2021). Key challenges to voluntary medical male circumcision uptake in traditionally circumcising settings of Machinga district in Malawi. *BMC Public Health*, *21*(1), 1–11. https://doi.org/10.1186/S12889-021-11979-Z

Matoga, M. M., Hosseinipour, M. C., Jewett, S., & Chasela, C. (2022). Uptake of voluntary medical male circumcision among men with sexually transmitted infections in Lilongwe, Malawi: a protocol for a pre-interventional and post-interventional study. *BMJ Open*, *12*(1), 1–10. https://doi.org/10.1136/bmjopen-2021-057507

Mhagama, P., Makono, P., & Tsitsi, C. (2021). Communication-related factors influencing the uptake of voluntary medical male circumcision among men in Lilongwe Urban, Malawi. *Cogent Medicine*, *8*(1), 1892289. https://doi.org/10.1080/2331205X.2021.1892289

Mutombo, N., Maina, B., & Jamali, M. (2015). Male circumcision and HIV infection among sexually active men in Malawi. *BMC Public Health*, *15*(1), 1–9. https://doi.org/10.1186/s12889-015-2384-z

Muula, A. S. (2007). Circumcision as HIV prevention. *Focus (San Francisco, Calif.)*, *22*(6), 1–4.

National AIDS Commission. (2015). *National HIV prevention strategy*. National AIDS Commission.

National AIDS Commission. (2019). *National policy on voluntary medical male circumcision*.

National AIDS Commission. (2019). *VMMC national communication strategy 2020-2025*. https://www.malecircumcision.org/sites/default/files/document_library/2nd National VMMC Strategy-Kenya (2014-2019).pdf

National Statistical Office. (2015). *Malawi Demographic Health Survey*. National Statistical Office.

Parkhurst, J. O., Chilongozi, D., & Hutchinson, E. (2015). Doubt, defiance, and identity: understanding resistance to male circumcision for HIV prevention in Malawi. *Social Science and Medicine*, *135*, 15–22. https://doi.org/10.1016/j.socscimed.2015.04.020

Rennie, S., Perry, B., Corneli, A., Chilungo, A., & Umar, E. (2015). Perceptions of voluntary medical male circumcision among circumcising and non-circumcising communities in Malawi. *Global Public Health*, *10*(5–6), 679–691. https://doi.org/10.1080/17441692.2015.1004

737

Shumba, K., & Lubombo, M. (2017). Cultural competence: a framework for promoting voluntary medical male circumcision among VaRemba communities in Zimbabwe. In *African Journal of AIDS Research* (Vol. 16, Issue 2, pp. 165–173). https://doi.org/10.2989/16085906.2017.1337040

UNAIDS & World Health Organisation. (2021). *Voluntary medical male circumcision: steady progress in the scale up of VMMC as an HIV prevention intervention in 15 Eastern and Southern African countries before the SARsCoV2 pandemic*. *March*, 1–2. https://www.unaids.org/sites/default/files/media_asset/JC3022_VMMC_en.pdf

Wirth, K. E., Semo, B. W., Ntsuape, C., Ramabu, N. M., Otlhomile, B., Plank, R. M., Barnhart, S., & Ledikwe, J. H. (2016). Triggering the decision to undergo medical male circumcision: a qualitative study of adult men in Botswana. *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV*, *28*(8), 1007–1012. https://doi.org/10.1080/09540121.2015.1133

797

World Health Organization. (2018). WHO progress brief: voluntary medical male circumcision for HIV prevention in priority countries of East and Southern Africa, July 2017. In *Progess Brief*. World Health Organization.