

Should female health providers be involved in medical male circumcision? Narratives of newly circumcised men in Malawi

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Abstract

Background

The Malawi government has endorsed voluntary medical male circumcision (VMMC) as a biomedical strategy for HIV prevention after a decade of debating its effectiveness in the local setting. The “policy” recommends that male circumcision (MC) should be clinically based, as opposed to the alternative of traditional male circumcision (TMC). Limited finances, acceptability concerns, and the health system’s limited capacity to meet demand are among the challenges threatening the mass rollout of VMMC. In terms of acceptability, the gender of clinicians conducting the operations may particularly influence health facility-based circumcision. This study explored the acceptability, by male clients, of female clinicians taking part in the circumcision procedure.

Methods

Six focus group discussions (FGDs) were conducted, with a total of 47 newly circumcised men from non-circumcising ethnic groups in Malawi participating in this study. The men had been circumcised at three health facilities in Lilongwe District in 2010. Data were audio recorded and transcribed verbatim. Data were analysed using narrative analysis.

Results

Participants in the FGDs indicated that they were not comfortable with women clinicians being part of the circumcising team. While few mentioned that they were not entirely opposed to female health providers’ participation, arguing that their involvement was similar to male clinicians’ involvement in child delivery, most of them opposed to female involvement, arguing that MC was not an illness that necessitates the involvement of clinicians regardless of their gender. Most of the participants said that it was not negotiable for females to be involved, as they could wait until an all-male clinician team could be available. Thematically, the arguments against female clinicians’ involvement include sexual undertones and the influences of traditional male circumcision practices, among others.

Conclusion

Men preferred that VMMC should be conducted by male health providers only. Traditionally, male circumcision has been a male-only affair shrouded in secrecy and rituals. Although being medical, this study strongly suggested that it may be difficult for VMMC to immediately move to a public space where female health providers can participate, even for men coming from traditionally non-circumcising backgrounds.

Introduction

In 2007, the World Health Organization (WHO) and the Joint United Nations Programme on HIV and AIDS (UNAIDS) recommended Voluntary Medical Male Circumcision (VMMC) to be part of the comprehensive HIV prevention strategy, particularly in high HIV prevalence regions where heterosexual sex is the main mode of transmission and where male circumcision (MC) rates are low.¹ The WHO recommendation was based on evidence from three randomised controlled trials²⁻⁴ and various observational studies that suggest male circumcision provides some degree of protection in female-to-male transmission of HIV.⁵⁻⁷

Malawi is one of the sub-Saharan African countries with a high HIV prevalence (11%) and 81% of its male population is uncircumcised.⁸ For almost a decade, there was a debate in Malawi as to whether male circumcision prevented HIV infection. Those who did not believe it was preventive claimed that there was no difference in HIV prevalence between traditionally circumcising and non-circumcising areas. This argument persisted despite the Malawi Demographic and

Health Survey (MDHS) as well as HIV Surveillance Sentinel Reports depicting circumcising districts as having lower rates of HIV compared to circumcising sites.⁸⁻¹¹

As the Malawi government adopted VMMC as an HIV prevention strategy, the Roman Catholic Church in Malawi advised its adherents to get circumcised and encouraged them to do so in hospitals.¹² The endorsement of a religious institution for VMMC in the Malawian setup was important as it addressed one of the major potential barriers to VMMC uptake, thus the association of medical male circumcision (MMC) with religion. Acceptability studies have pointed out religion as one of the reasons why people would be reluctant to get circumcised.¹³⁻¹⁴ In some places, people associate male circumcision with specific religions and/or tribes, and they would not get circumcised for fear of being branded as embracing that religion or recognising the religion or tribe as better than theirs. In Malawi, male circumcision is mainly practiced by Muslims in terms of religion and by the Yao in terms of tribe. Male circumcision has therefore been viewed largely as Islamic and/or Yao cultural practice.

In the last decade, the rate of male circumcision has remained stable in Malawi. In 2004, the rate of men aged 15-49 who were circumcised was 21% while in 2010, the rate was 22%.⁹⁻¹⁰ However, there has been an increase in the number of traditionally non-circumcising groups that have been circumcising. For this group, the rate was 7% in 2004 while in 2010, the number increased to 37%.⁹⁻¹⁰ The majority of the men from circumcising tribes get circumcised by a traditional practitioner of male circumcision (TPC) as a rite of passage and or on religious grounds.¹⁵

Even before the WHO’s official recognition and recommendation of male circumcision as an HIV prevention strategy in 2007, various studies had been conducted exploring the potential acceptability of MMC by traditionally non-circumcising people as an HIV prevention strategy. In 2007, Westercamp and Bailey reviewed male circumcision acceptability studies that had been conducted in sub-Saharan Africa.¹⁶ Despite being studies that were conducted prior to recognition of MC as efficacious in prevention of female-to-male HIV transmission, all thirteen studies from nine countries showed high acceptance rates. For uncircumcised men, a median proportion of 65% (range 29-87%) were willing to be circumcised. A higher proportion, 69% (47-79%) of women favored circumcision for their partners. Furthermore, 71% (50-90%) of men and 81% (range 70-90%) of women were willing to circumcise their sons. More acceptability studies have been conducted after MMC recognition. While some of the studies targeted all groups, various studies targeted specific groups like women,¹⁷⁻¹⁸ acceptability by adolescents,¹⁹ neonatal circumcisions²⁰ and traditionally circumcising groups.²¹⁻²²

Acceptability studies have reported potential barriers to people’s adoption or acceptance of MMC. Studies have identified barriers related to the operation itself that include pain, bleeding, possible infections and other complications.^{16,20} Barriers related to sexuality include loss of penile sensitivity and sexual desire, reduction in penile size, loss of ability to satisfy a woman and conversely excessive desire and

tendency to have multiple partners.¹⁶ Barriers associated with loss of identity, ethnicity and religious identity have also been identified. Some people have also argued that, with neonatal MMC, the child's autonomy is not respected—that circumcision should be an individual's personal informed choice and not a parental decision.²⁰ Even though some traditionally circumcising groups acknowledge benefits of MMC, some cite failure to experience the actual rite of passage as a barrier.²³ There has been no published documentation, however, of traditionally non-circumcising men's opinions on female health providers taking part in the circumcision process. The most closely related research was carried out in a South African study that reviewed the experiences of nurses who attended to traditionally circumcised initiates who experienced complications and sought medical care as a result. This study depicted a situation in which the initiates and their guardians were not comfortable to be treated by female nurses. Furthermore, female nurses who were from traditionally circumcising groups experienced a dilemma when treating the initiates with circumcision complications since they believe penises are not supposed to be touched or seen by women in a non-sexual, non-marital context.²³

Many acceptability studies were conducted before the mass adoption of medical male circumcision. These studies do not unearth potential health facility-based barriers to male circumcision, either because the participants did not bring them up or because the researchers did not ask questions around such issues. Most of the questions, as noted by Westercamp and Bailey, were based on various hypothetical scenarios such as questions that asked whether people would have preferred to be circumcised if MC were found to reduce the risk of HIV acquisition.¹⁶ Now that mass MMC services have been introduced, it is important to explore the situation, establishing where MMC services are available and assess the numbers seeking the services, the ages and population segments that respond and the factors that inhibit or facilitate uptake of the services.

This study was one of the 'reality-based studies' that explore the experiences of traditionally non-circumcising men who were circumcised at a health facility, with a special interest in finding out factors that could deter some men from seeking or accessing VMMC at health facilities. The main intent was to establish participants' experiences that could make potential clients privy to such information unwilling to get circumcised in health facilities. This paper specifically highlights the views of men who had been circumcised in health facilities regarding the involvement of female health providers in male circumcision and other related concerns.

Methods

This qualitative study used focus group discussions (FGD) to establish experiences of men who had been circumcised in health facilities. A total of six FGDs were conducted, and the men were recruited through the health facilities where they were circumcised. Clinic staff asked the men who presented to be circumcised if they would be willing to participate in a research study. Those clients who indicated that they would be willing to participate were approached through their contact details by the health facility manager. Men who had been circumcised between two and six months prior to the start of the study were eligible to participate. This interval gave the participants adequate time for a full recovery from the circumcision procedure and a reasonable temporal proximity to the procedure for good recall of

the experience. A neutral venue was identified where the discussions took place.

Health facility representatives introduced the participants to the research team. This was primarily done to assure the participants that the interviewers had sought the centres' permission and confirm the participants' previously granted consent. Indirectly, it also served to definitively identify participants as those who had indeed been circumcised at the centres. FGDs were conducted in Chichewa, the main local language of Malawi. Transcription was done in Chichewa and later translated into English.

Data were analysed using narrative analysis. Narratives that described sensory experiences, thoughts, feelings, and the shared symbolic meanings of the experience of being circumcised in the presence of a female health provider were isolated.

A total of 47 men, with a mean age of 23 years participated in the FGDs. The majority (35) were single and 12 men were married. All the men were from traditionally non-circumcising ethnic backgrounds. These interviews were conducted with men who had been circumcised at private health facilities that provide MC alongside other services in Lilongwe district. The men had been circumcised at different health facilities that belong to one private health institution over a period of four months extending from two to six months before the study. The interviews were conducted in the year 2011.

Results

Men were asked to share their experiences during the period they went to the health facility for male circumcision. The unique experience for the majority of the participants was the involvement of female health providers in the operating room. This topic generated a lot of debate among the participants when there were opposing views, or prompted the participants to passionately come up with various reasons for the position they all took if there were no opposing views. The discussions identified a primary narrative based on consistent view around the phallic symbol in the interaction between men and women.

Overall, the majority of the participants in all FGDs objected to the presence of a female health provider in the operation room. The participants' objections were based on two thematic areas: (1) the potential negative outcome of the circumcision process due to the female presence and (2) the risk of clients being exposed as men who had been circumcised and the consequent potential stigma they could suffer in the community. Participants said that these two potential consequences could be avoided by making VMMC to be provided by male health providers only or giving men an option to choose the involvement of female health providers. The main reason given as to why only men could be involved included that VMMC is an elective procedure and therefore can be scheduled so that male health providers only are involved on a particular day.

Objection to Female Health Provider Involvement

The majority of the study participants gave two main reasons explaining their objections to female health provider involvement in male circumcision: (1) potential negative impact on circumcision outcome and (2) clinician or client discomfort or embarrassment.

Negative Impact on circumcision outcome

The majority of the participants objected to female health provider involvement in male circumcision, either as clinician or nurse, and in general being present in the operation room, because the presence of a woman could compromise the outcome of the operation. The compromised outcome could be in form of the operation taking too long, which could lead to local anaesthesia losing its efficacy and the man experiencing pain, or a bad operation that would lead to aesthetically poor results due to suture line disruption for instance. Three main reasons were reported for this potential outcome.

Clinician and clients' discomfort or embarrassment

It was reported that both the man and clinician would experience discomfort and uneasiness. Participants argued that undressing before a woman when in perfect health is associated with sexuality and therefore both the man and the female provider would be uncomfortable. The clinician was considered prone to some mistakes that could end up compromising the outcome. One participant argued:

"Yes, I would undress before a female clinician when I am very sick and I would never feel embarrassed. Even the clinician would be looking at a very serious person and would not find it troubling, after all I would either be in pain or perhaps unconscious. But think of a situation where you are in perfect health and you lie on your back and unzip."

Sexual arousal

Some participants reported that undressing before a woman when in perfect health and then the woman touching their private parts could naturally arouse an erection leading to a scenario that would be embarrassing for both the health provider and the client. One participant argued:

"Honestly, think about it, you are lying down there and the nurse comes, touches you and cleaning your member with spirit so that she can inject you... I mean, unless you are not normal, you are bound to respond to that touch."

A participant commented that it was very natural that one would have an erection especially when the woman was very beautiful to which other participants retorted that it did not matter whether the female clinician was beautiful or not, the mere fact the a woman touches your genitals when you are in perfect health would incite sexual feelings.

The study participants reported that not just the client would be affected by the scenario but the female clinician as well. Men explained that before the operation, health providers had to prepare the penis and this involved massaging it. This is sensitive as it is very likely that the men would have an erection. The erection could be embarrassing to both the clinician and the client or indeed affect the clinician as she operates. A participant reported:

"Female clinicians are human beings as well and if they noticed you had an erection, they would also perhaps be sexually aroused, and it would affect them as they do the operation."

On the other hand, the few participants who were not opposed female health provider involvement said that these providers could not distract the process; in essence, they said they would be more empathic and could be better than male providers. One participant suggested:

"Women could be better than men, they would be very gentle and just like male providers are known to be better midwives, and the female providers could be better circumcisers, maybe because they can only imagine how painful it might be."

Risk of community disclosure and consequent stigma

Another reason for excluding women from MC was that female providers would tell other women or people in general that they have seen or circumcised a certain man, and they would believe that the man did it for purposes of making themselves less vulnerable to HIV infection so that they could indulge in promiscuity. One participant commented:

"Women are talkative and even if they are doctors, you know this is different from attending to a sick person. They would go about telling people that Mr... came for circumcision."

This was repeated by the majority of the participants including the few that indicated that they were not opposed to females being involved in the clinic.

VMMC in a male-only setting

Male circumcision is an elective procedure not a disease

The majority of the men suggested that female health providers should not be involved in male circumcision since circumcision is not a disease or an illness. They argued that the client is not in a state that is urgent and that if they were not treated they would not risk worsening the condition. It was further argued that exposure of male private parts to a female health provider can only be justifiable in the context of serious illness or injury. In the case of VMMC, although it is done at the hospital, it should not be seen in the same way as an illness or disease. One participant commented that when seeking VMMC, the person is not necessarily in danger and it is something that they could live without. A client could comfortably choose to be treated by a specific clinician since they can wait for another day or go to a different health facility. He argued:

"You are not sick, you are intact and you could always reschedule an appointment if no male clinician was available."

Although the majority of the men objected to female health providers' involvement, some men especially who were circumcised without female provider involvement, likened MC to child delivery and therefore argued that they were comfortable to be "treated" by a woman. However, the majority of participants suggested that child delivery and male circumcision cannot be compared. One participant said:

"In MC, the man is in good health therefore needs privacy. It is not like the person cannot live for another day with the skin while in child delivery, there is no way you can delay delivery. This is an emergency. When a woman goes to deliver, she would not mind who is helping her because all she wants is to be helped. This is different from circumcision, as you are perfectly well."

Exposure of private parts to women for the purpose of VMMC is unjustifiable

Men said, given that they are very healthy and functioning normally, it would be easier for them to expose their genitals to a fellow man than a female, even if she was a health provider. Many participants explained that when one is seriously ill, it does not matter what kind of health provider attends to them. In contrast, with MC, they are fully aware and awake, so that it is very embarrassing when they have to expose their manhood to a woman. One participant commented:

"Being circumcised by a woman or having one in the room is similar to wearing a torn short that shows your manhood and you are aware that a woman is looking at you but you can't hide it."

It was said that one could be very unfortunate and meet a female provider who happens to be acquainted to the client. Apart from being embarrassed and uncomfortable during the process, the man is would be uneasy to meet the provider outside the health facility. Other participants said even if the two did not know each other, that encounter would acquaint them to the provider. One participant argued:

“Even if you were meeting her for the first time, chances are that after this encounter, you would meet her elsewhere, it only requires first meeting, after that you see them so often.”

In all FGDs, participants mentioned how embarrassing it would be if the female provider were to disclose this to other people. When told that health providers are bound by ethical principles that would prevent them from disclosing, in the two FGDs in which this was brought up, participants said much as they believed that providers would keep secrets, circumcision is not like the other conditions where an individual is sick. This is a normal person and the clinicians, especially being women, were considered likely to tell their friends.

No effort was made during the interviews to establish how many men were circumcised where a female provider was present. However, it was clear in the discussion that those men, who indicated in their contribution that a female provider was present, were the ones who vehemently objected their presence while men who indicated that there was no female provider were more in general not too opposed. One man who was circumcised in the presence of a woman explained:

“I was not sure whether the nurse would be there or not, but the thought of her being there was interesting at first. Then it turned out that she would be involved and I really didn't know what to do. The most sensitive moment was when she finally walked towards me to start the procedure and I didn't know how to react.”

Pain management

Several men described their experiences of pain during the operation. All participants who mentioned pain as a problem during the operation said that it was towards the end of the procedure, that the anaesthesia had stopped working and they could feel pain as the clinicians were suturing. One participant explained:

“For me, it was all fine at the beginning and I felt no pain but, towards the end, I started feeling different because I could feel as the doctor was piercing the skin; it was painful and felt very uncomfortable.”

Another participant with similar experience explains why he experienced the pain towards the end of the procedure as well:

“I think the doctors were not ready to start the procedure and so they injected me first, and then they started pacing around putting together the things they needed for the operation. When they started to operate, the power of the injection had started to go down. I don't think I would have felt the pain if they were ready with everything before they injected me.”

Privacy

Men also raised their concerns with privacy at the clinics. Participants mentioned that they expected the clinics to uphold privacy given that they believed that circumcision was a sensitive issue. Privacy was breached or not ensured in several ways that included the operating room and the reception area.

Operation room unsecured

Participants mentioned that many people could go in and out of the operation room, and this did not ensure privacy. One participant commented:

“Although they explained and it was agreed that we were going to have privacy, later on it was like an office... anyone could come in—even women.”

Furthermore, the client was visible to anyone who walked into the room since the theatre table was not secured. Participants reasoned that either the bed should have been secure so that only the provider(s) attending to them could see them.

“When you go there for circumcision they expose you on an open ground and everyone who came into the room or close to the room could see you.”

Some participants said that privacy was compromised by how the theatre rooms were located. They said that the theater was located in a place where people passing outside could see the client inside who were not shielded by anything any person inside the room and those walking outside.

“For me, I felt that any person passing by could see you on the theatre table because they left the window on one side open and then they did not use the screen to prevent anyone who looked through the window from seeing you, and you know these clinics that are in our townships—not secure from trespassers.”

Reception conversation

Men also reported uneasiness when they spoke to the receptionist. The men stated the setup of the reception did not ensure privacy. In particular, they found it embarrassing when they came to ask for the service. They also complained that the receptionists would raise their voices when explaining the service. This was echoed by many respondents as making them uncomfortable. One participant commented:

“I went for a follow-up... at the reception the way they ask you about what you have come to do, it is on top of their voices and they expect that you should explain all that in front of people who are also waiting to be helped... regardless of the gender of people present. The circumcision topic is sensitive in our culture and needs to be respected.”

Another participant shared his experience with the receptionist whom he reported as raising her voice more than he wanted or was necessary:

“I walked to the reception, and I tried to be very close to the receptionist so that no one else could hear us. I was surprised when she raised her voice and I turned around just to see if the people could hear her. I tried to look at her and leaned forward so she could tell that I wanted her to lower her voice or that she could tell that she could speak with a lower voice and I could hear her.”

Discussion

The early adopters of VMMC can shed some light on potential barriers to MMC based on their experiences. This knowledge is crucial, as it can inform how the massive rollout of MMC could be designed or adjusted to become more effective and client-friendly. This pioneering study suggested that the presence of female health clinicians in health facilities providing VMMC could be an impediment to men who want to access the services. Men who have been circumcised in health facilities in the presence or absence of a female health worker largely objected to the attendance of women in the operation room specifically. Despite being from traditionally non-circumcising groups and valuing the importance of medical circumcision, the men did not

embrace female health providers as part of the health system that should be involved in the circumcision process. While many studies have assessed the acceptability of VMMC, the issue of female involvement has never surfaced as a potential deterrent for men to seek or access MC services at health facilities. This finding is important at a point when Malawi is rolling out its VMMC program.

The Malawi health system has been providing circumcision to male adults for various medical reasons. However, MMC has never been provided in clinics at a level that could have incited debates around the appropriate gender of health providers. The question of whether or not female health providers should be involved in MMC represents an important issue that will arise as VMMC scales up in Malawi and in many other countries or places that are traditionally non-circumcising. With the upsurge in interest in MC among traditionally non-circumcising men in Malawi, the health system is bound to experience increased demand and a resulting strain on its human resource capacity. The participants of this study recognised MMC as preferable to traditional circumcision, but while health facilities were the place of choice, the participants generally felt uneasy being circumcised in a setting where female health providers are involved. The unease stemmed from the need to undress and be touched by female providers in a situation regarded as unwarranted. It was argued that the procedure is elective and could wait if male health providers were not available to perform it. Logically, it could be imagined that men from traditionally non-circumcising groups would not object to female involvement given that they don't come from circumcising groups where the procedure is secretly done by men only. However, this study revealed that the need to keep male circumcision a secret or out of females' purview is beyond the traditionalist need of secrecy as a rite of passage.

The reasons for men's reluctance for female clinicians to be involved in medical male circumcision drew from three main thematic areas. Undressing before or in the presence of a woman for a healthy man only happens in a context of sexuality. Removing clothes and exposing themselves to a woman in a non-sexual space and being touched (scrubbing) took on the sexual symbol of foreplay. Men described the process of preparing the penis, swabbing and injecting as the most embarrassing moments, especially when done by a woman. They would avoid eye contact with the provider and in almost all cases, they would have an erection. They also drew parallels from TMC, where the ceremony is secretive and does not involve women in any way. It was apparent in this study that elements of TMC influenced the participants' views. The participants' reluctance to compare MMC with child delivery, where male health providers are involved and women's bodies are exposed, depicted how VMMC can be thought of as a procedure that should not be looked at using a medical practice prism.

It was evident that the men in this study were concerned about privacy. Men would have liked to be circumcised in a space where there was limited exposure in terms of people who could see and touch them. Mangena et al. (2011), reports of boys who were brought to the hospital after experiencing complications at a traditional initiation camp subsequently experiencing shame when they were taken care of by female nurses. The study also highlights the need for secrecy when the initiates were brought in at night and the escorts demanded to be attended by a male health provider

in isolation rooms. While this scenario is associated with tradition, it depicts men's need for privacy. Their preference for male health providers suggests that there are some underlying similarities between TMC and MMC regarding privacy.

Another important question that this study raised was the current level of experience and training of the health providers. The preference of MMC over TMC lies in the fact that MMC is considered to be safer. It is therefore important that MMC should continue to be seen as safer. The failure of health providers to exhibit professionalism by preparing and completing the procedure before anaesthesia wears off could be detrimental to the perception of MMC safety. The health providers should be well trained to be able to provide optimum service. It is likely that the health system in Malawi will be overwhelmed once more men start to seek VMMC services. With a limited number of experienced practitioners, the health system runs the risk of adverse outcomes that could deter people from seeking circumcision services.

MMC is "just" another medical procedure that any competent clinician, male or female, can perform. However, contextual realities or preferences should be taken into consideration if men are to be encouraged and free to be circumcised in the clinics. With the shortage of health providers in Malawi, female health provider aversion by potential VMMC clients might contribute to slow uptake of VMMC. There is need to explore ways that the health system could manage to cope with the demand for VMMC.

Limitations of the study

Although eligible men indicated that they would come for interviews on the day they were circumcised as well as when they were called for the interviews, many did not turn up. Most of the FGDs ended up having the minimum of six participants, and on several occasions they did not take place because we had less than six people. This could lead to a differential bias if the people who did not come were of a particular view.

Conclusion

Our study found that some Malawian men prefer that VMMC should be conducted by male health providers only. This was because traditionally male circumcision has been a male-only affair shrouded in secrecy. This study strongly suggests that, despite its medical basis, it may be difficult for VMMC to immediately move to a public space in which female health providers can participate.

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	<h2 style="margin: 0;">CALL FOR APPLICATIONS FOR AN MCDC MSc SCHOLARSHIP</h2>	
<p>The Malaria Capacity Development Consortium (MCDC), funded by the Wellcome Trust, supports postgraduate training of African candidates interested to develop a science career within the field of malaria research. Funds are available to sponsor one (1) Malawian candidate to undertake a Master Degree course in an African institution in a health science discipline, such as immunology, epidemiology or statistics, in preparation for the second phase of the MCDC programme. Eligible MSc degree programmes would be 1-year, full time programmes, that can be completed by March 2015</p>		
<p>The award will be for a sum of up to \$20,000. This may be used to –</p> <ol style="list-style-type: none"> a. Cover course fees. b. Pay research expenses related to the conduct of the degree. c. Pay an upkeep stipend and relevant travel. 	<p>Application procedure: Candidates wishing to be considered for this scholarship should –</p> <ol style="list-style-type: none"> a. Submit an application to the MCDC CoM Director either by post (College of Medicine, Private Bag 360, Blantyre: Attention: Dr. WL Mandala) or by email (wmandala@medcol.mw) b. Include a copy of your transcript and a recent CV with the application c. Include one reference letter 	
<p>All applications must be submitted by Friday, August the 23rd 2013.</p>		