Communication-related factors influencing the uptake of voluntary medical male circumcision among men in Lilongwe Urban, Malawi

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Abstract: Voluntary Medical Male Circumcision (VMMC) has been promoted as an effective biomedical intervention in the reduction of the risk of new HIV and STI infections. The government of Malawi and its stakeholders including the World Health Organization have committed a lot of resources to VMMC programming. However, research shows that its uptake among men is still low in Malawi. This study, therefore, investigated the communication-related factors that influence decision-making in the uptake of VMMC among men in Lilongwe, Malawi. To achieve this aim, twenty-five men, aged between 18 and 35 years old were interviewed on what influenced them to undergo VMMC. The study found that the respondents were influenced to uptake VMMC mostly by peer pressure and the need for conformity; partner/girlfriend demand and considerations; and advice from health personnel. The paper concludes that although the final decision was theirs to make, the men in the study underwent circumcision under duress and/or coercion. It cannot be said to be voluntary. The medical necessity of VMMC can be said to be voluntary if it is negotiated and consented to without duress. Although the

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PUBLIC INTEREST STATEMENT

Voluntary Male Medical Circumcision (VMMC) is one of the effective strategies for reducing new HIV/AIDS infections. The WHO and UNAIDS recommended the inclusion of male circumcision in HIV-prevention guidelines in countries in Southern Africa, including Malawi, with low circumcision rates and generalized epidemics. VMMC in Malawi was launched in 2012 with the government aiming to achieve 80% coverage among men aged 10–34 by 2020. Considering that there are more barriers than enablers of circumcision, this target of circumcising 80% of the eligible men was quite ambitious. The barriers include social and cultural factors and physical pain, whereas the benefits include improved sex, hygiene, and protection from HIV. However, when the VMMC campaign was scaled up across the country, uptake remained relatively low. It was from this background that the researchers examined the communication-related factors that influence men to uptake VMMC. The findings reported in this paper are part of ongoing studies in Behaviour Change communication being carried out by the department.
respondents mentioned the HIV and STI infection risk reduction properties, hygienic advantages, and cervical cancer reduction properties of VMMC as benefits of VMMC, these had very little influence on their decision. It is recommended that current intervention messages be reviewed and modified to incorporate new ideas that can address the shortcomings that the current crop of messages has with the aim of increasing the uptake of VMMC programmes or other health focused behaviour change programmes.

Subjects: Social Sciences; Behavioral Sciences; Communication Studies

Keywords: circumcision; decision-making; HIV/AIDS; uptake; voluntary medical male circumcision

1. Introduction

Voluntary Medical Male Circumcision (VMMC) refers to “the complete removal of the penile foreskin under aseptic (clinically clean) conditions” (Population Services International (PSI), 2014, p. 8). VMMC has been recognized by the World Health Organization (WHO) and United Nations Program on HIV/AIDS (UNAIDS) (WHO, 2012) as an effective biomedical intervention against Human Immunodeficiency Virus (HIV). Under the recommendation of the WHO and the UNAIDS, programs to scale up the uptake of VMMC in Eastern and Southern Africa are underway (WHO, 2012).

With over 1 million people living with HIV in Malawi and the prevalence estimated at 9.2% in 2016 (Avert, 2018), HIV and AIDS continue to be prominent public health issues in the country. Several programs are being implemented as part of the prevention strategies including the Prevention of Mother to Child Transmission (PMTCT), Voluntary Medical Male Circumcision, and Condom Provision and programming (Avert, 2018). VMMC, a biomedical intervention against HIV and AIDS, became known to many Malawians after the 2007 WHO and UNAIDS recommendations that medical male circumcision be prioritized as an additional HIV prevention strategy based on strong and consistent scientific evidence (WHO, 2012).

Based on scientific modelling, the WHO and UNAIDS have set a target of circumcising 80% of the eligible males by 2015 in priority countries in order for those countries to have a significant reduction of new HIV infection among males and females (Dickson et al., 2011). The priority countries are Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe (PSI, 2014).

In Malawi, VMMC programming began in 2011 and was formally launched in 2012 (Kripke et al., 2016). The government of Malawi committed to achieve VMMC coverage of 80% among men aged 10–34 years by 2020, the equivalent of approximately 2,101,566 circumcisions to be undertaken in the whole country and 1,888,847 in the priority districts by 2020 (National AIDS Commission (NAC), 2014). The coverage was revised down to 60% among 10–35 year old males by 2019 in selected zones and the same percentage across the country by 2015 (NAC, 2015). The government of Malawi together with its stakeholders developed the VMMC communication strategy to provide a direction on demand creation and roll out of VMMC countrywide (US President’s Emergency Plan for AIDS Relief PEPFAR, 2017a). In some East and Southern African countries, strategies to improve VMMC uptake included one or a combination of different interventions, which could emphasise additional, restructured, or intensified information, education or communication services or more structural aspects (Atkins et al., 2020). In Malawi, the communication strategy which was extensively used was branding the VMMC campaign using a brand name “Ndife Otsogola” (we are forward thinkers) (PSI, 2014). “Ndife Otsogola” VMMC branding and its associated communications aimed at portraying an individual who is forward thinking and would choose beneficial interventions being promoted without hesitancy. The VMMC branding was developed with the leadership of the John Hopkins University (JHU) Centre for Communication Programme—Bridge II project with
funding from the United States Agency for International Aid (USAID) (JHU, 2014). The aim of the Bridge II project for demand creation was to increase levels of knowledge on the benefits of VMMC; increase demand for uptake of VMMC services; create an enabling environment for VMMC and foster its widespread acceptance; and, increase consistent safer sexual practices post-VMMC (Johns Hopkins Center for Communication Programs, 2014).

However, with the rolling out of the VMMC campaign across the country, the Malawi Demographic Health Survey (2015–16) report showed that VMMC uptake was at 28% among men aged 15–49 (National Statistical Office (NSO) [Malawi] and ICF, 2017). According to the Government of Malawi (GoM) and National AIDS Commission NAC (2014), the cumulative number of VMMCs performed through 2014 in Malawi since the introduction of VMMC in the country in 2011 was 150,000 which is considerably less than needed to reach 80% coverage. Furthermore, if we focus only on those men who were circumcised through the VMMC programme, the numbers are even lower as reported by the US President’s Emergency Plan for AIDS Relief (PEPFAR) that only 393,675 men were circumcised through the VMMC programme throughout the country by June 2017 cumulatively since 2012 (PEPFAR, 2017a). This figure is way below the 2020 target of 1,300,568 circumcisions (NAC, 2014), and the chances of reaching the target by 2020 are very slim.

The VMMC uptake has been shown to be affected by several factors and challenges. Studies of the uptake of VMMC in Tanzania and Zimbabwe (Chiringa et al., 2016; Plotkin et al., 2013) respectively, as well as in Malawi (NAC, 2015) established that social and cultural factors, as well as physical pain, were barriers to the uptake of VMMC while the perceived benefits (including improved sex life, hygiene and protection from HIV) were facilitators. A study conducted in Kenya and other countries such as South Africa, Tanzania, and Zimbabwe found that barriers to VMMC uptake included increased burden on clinics, long waits for care, misleading mobilisation, low client follow-up rates, and inconsistent messaging among others (Gilbertson et al., 2019). Most VMMC studies have focused on analysing the barriers and facilitators of VMMC uptake and have contributed towards the knowledge in designing communication strategies, but few have been undertaken to get a deep understanding of communication-related factors that influence the uptake of VMMC from an individual’s perspective. According to Atkins et al. (2020) interventions to improve VMMC uptake have been implemented and adopted as good practices in VMMC, but this notwithstanding their impact has not been well documented. On the demand side, there have been concerns with regard to how VMMC information is packaged to avoid misconceptions, especially among non-circumcising communities and individuals who may view such campaigns as an affront to their culture (Kenya National AIDS Control Programme, 2010). In Malawi, the brand name, “Ndife Otsgolga”, was developed with different groups of people in mind such as traditional leaders, faith-based leaders, women, young men, and older men aged 15 to 49 through the use of Information, Education and Communication (IEC) materials. In a situation such as this, the campaign can be affected by lack of accurate information leading to rumors, fears, misinterpretation of facts, and sometimes political interference (Kenya National AIDS Control Programme, 2010) as shall be illustrated below. Faced with these possible challenges, need arises to investigate communication-related factors that can increase VMMC awareness among communities and individuals and that can influence people to uptake it regardless of one’s age, level of education, religion, ethnic group, or whether one comes from a circumcising or non-circumcising community. Therefore, our study investigated the communication-related factors that influence decision-making in the uptake of VMMC among men in Lilongwe Urban, Malawi. This article specifically answers the question: what are the communication-related factors that influence decision-making in the uptake of VMMC among men in Lilongwe, urban, Malawi?

2. Acceptability of VMMC in Malawi

In Malawi, male circumcision is not completely new. Some ethnic groups (e.g., Yao and Lomwe) perform traditional circumcision when initiating their young men into adulthood.
The Yao conduct circumcision as part of an elaborate initiation ceremony for young boys (usually between 8 and 13 years old) called the jando, which is typically performed between July and late September each year and lasts one month. The jando incorporates moral, cultural and sexual education (mwambo) of the initiates by elders as they make their passage into adulthood. (Rennie et al., 2015, p. 3)

Muslims in Malawi also perform circumcision as part of practicing their faith (NAC, 2015). These types of male circumcisions (traditional and religious) might not offer the same health benefits as conferred by VMMC because traditional circumcision is mostly partial, where not all of the foreskin is removed (NAC, 2015). Elsewhere, male circumcision has mostly been associated with religion, with almost universal circumcision among Jews and Muslim men (99% and 98%, respectively), with other religions being divided on whether to circumcise men or not (World Health Organization and Joint United Nations Programme on HIV/AIDS, 2007). The WHO/UNAIDS (2007) report shows that male circumcision is almost universal in North Africa and most of West Africa, which are primarily Islamic states. In Malawi, the National AIDS Commission (2012) reports that male circumcision is also associated with religion with 72% of circumcision related to religion. Other studies have also established links between the prevalence of circumcision in selected regions and religion (Parkhurst et al., 2015; Rennie et al., 2015). It is, therefore, not surprising that acceptance of VMMC and uptake of VMMC in Malawi is common in areas with mainly Islamic religion practicing populations.

When the WHO/UNAIDS recommendation of using VMMC as a biomedical intervention against HIV was made, it was not easily accepted within the country from both government officials and religious leaders, with the former indicating that donors were imposing foreign practices on the government and the latter arguing it is against their belief and other learned individuals questioning the scientific evidence itself (Parkhurst et al., 2015). Therefore, beliefs and deep-rooted perceptions about male circumcision have played big roles for and against the acceptance of VMMC as a biomedical intervention in HIV prevention in Malawi (Parkhurst et al., 2015). For example, Christians (a majority in Malawi) perceive circumcision as a practice for Muslims while other ethnic groups apart from the Yao and Lomwe consider circumcision as not cultural and contrary to their traditions (NAC, 2015).

Ethnicity has been shown to be closely correlated with religion and that within certain ethnic groupings with high circumcision prevalence, circumcision is greatly influenced by religion (WHO and Joint United Nations Programme on HIV/AIDS, 2007). The Yao and Lomwe in Malawi are the two ethnic groups that circumcise their males. Circumcision between Yao and Lomwe is an integral part of the rite of passage to manhood. The VMMC communication strategy has also taken advantage of this cultural heritage to introduce medical male circumcision in the initiation ceremonies as a way of scaling up VMMC in Malawi, though it has met some resistance, especially from traditional leaders arguing that it dilutes initiation ceremony values (Parkhurst et al., 2015).

Research has further shown that people with tertiary education have better health behaviours and health outcomes than those with lower levels of education (Smedley & Syme, 2000). Increased education leads to a better understanding of health issues such that individuals are better able to discuss in detail, specific health issues with specialists (Zimmerman & Woolf, 2014). However, the influence of education on circumcision is varied across countries and it has been shown that in some countries (Uganda, Tanzania, Kenya, and Ethiopia) circumcision prevalence is common among individuals with secondary school and tertiary education while in Malawi and Lesotho circumcision prevalence is lower among those with high education attainment (WHO and Joint United Nations Programme on HIV/AIDS, 2007). As such, the level of education seems to be playing double roles as an influencing factor as well as a deterring factor.

The prioritization of VMMC within the HIV and AIDS resource pool and commitment of major stakeholders influenced the Government through the Ministry of Health (MoH) and other donor-
related stakeholders to start scaling up VMMC in Malawi in 2011 (Center for Disease Control (CDC), 2014), which showed promising outcomes in the beginning but later slowed down (NAC, 2015); hence, the need for this study to investigate the communication-related factors that influence uptake of VMMC in Malawi.

3. Theoretical framework
The VMMC communication strategy in Malawi was developed based on theories that reinforce healthy behaviours (NAC, 2012). From behavioural theories people can adopt new ideas or practices from others. The idea of people adopting a new idea from others is best explained by Rogers’s (2003) Diffusion of Innovations (DOI) theory. According to Rogers (2003), an innovation is an idea that is perceived as new by an individual; diffusion is the process of communicating an innovation among members of a social system; and adoption is a decision to fully use an innovation as the best course of action (Rogers, 2003). Having established that circumcision is not popularly practiced in Malawi and that it is more of an “innovation” that has been shown to work in most countries where it is practiced, the DOI is deemed a reasonable theory to explain the VMMC uptake decision-making process.

The DOI theory is characterized by four elements: an innovation, communicated via certain channels, over a period, to members of a social system (Rogers, 2003). The theory stresses that any invention needs to have a relative advantage (be it economic or social) for it to be adopted. The theory points at an innovation’s compatibility with existing values and practices as being essential for it to succeed in being adopted in addition to simplicity and ease of use (Rogers, 2003).

The theory also suggests that diffusion occurs in social systems and not independently. Peer-to-peer conversations are very important. According to this theory, impersonal methods such as media advertisements can spread information about new innovations, but adoption is spread by conversation; that is, those who have successfully adopted the innovation will assure others of less risk or uncertainties, e.g., embarrassment, financial loss, etc. (Rogers, 2003). The exception to social system concepts are the early adopters who usually see the risks as low, either because they are better informed or are financially secure. The rest needs reassurance from trusted peers that the innovation is beneficial. This is the reason many diffusion-style campaigns tend to use peer networks, recruiting well-connected individuals to spread new ideas through their own social networks.

The DOI theory demonstrates how opinion leaders and change agents have a lot of influence on all levels of adoption (the early majority, the late majority, and the laggards), and more often on the persuasion and decision stages (Bertrand, 2004). VMMC is a new idea for most Malawians as it is not religiously or culturally universal. To accept or reject it, the information has to move through the various stages with the help of the different adopter categories. The concept of DOI theory has been used to analyse the adoption of VMMC policies, strategies, and initial VMMC program implementation, as well as assessing progress towards scale-up in the WHO/UNAIDS VMMC priority countries (UNAIDS/WHO, 2009). In this article, the DOI theory has been used to evaluate the communication-related factors that influence decision-making to uptake VMMC.

4. Methods
The study design was qualitative in nature. Data were collected from men aged between 18 and 35 years who were either circumcised or uncircumcised on the day of the interview. The study aimed to capture data from several VMMC sites such as Likuni, Area 18, Kawale, Area 25, and Lumbadzi Health Centres within Lilongwe urban, but by the time of data collection only Bwaila VMMC site was operational. Other sites had been closed due to a lack of funding from USAID.

4.1. Sampling of study participants
This study employs the homogenous sampling technique. Homogenous sampling is a method of purposive sampling that aims to achieve a homogeneous sample, that is, a sample whose units
share the same traits or characteristics (Etikan, 2016). The choice of this technique is in recognition that the research questions only apply to a specific group of individuals sharing a specific characteristic. The characteristics of interest were that of men who had undergone VMMC or had decided to undergo VMMC, being aged between 18 and 35 years old and being present at Bwaila VMMC site in Lilongwe (the study site), the capital city of Malawi either to get circumcised or for a VMMC review (for those that had gotten circumcised prior). Etikan (2016) further argues that with homogenous sampling, “the researcher decides what needs to be known and sets out to find people who can and are willing to provide the information by virtue of knowledge or experience” (p. 2). The age range of 18–35 was of interest because the UNAIDS/WHO (2009) mathematical modelling on the effectiveness of VMMC projected that if men aged 15–35 are targeted and the 80% target is achieved, then there would be substantial decrease in new HIV infection, which would, in the case of Malawi, also change the HIV prevalence trend. It was, therefore, generally expected that clients to the VMMC site would fall within the age range of interest.

4.2. Data collection
Data were collected from 25 men aged between 18 and 35 who were present at Bwaila VMMC site for uptake of VMMC or for a review after undergoing VMMC prior to the days of data collection. Consent was sought from Bwaila VMMC site manager who in turn alerted staff working on the site about the study and sought their support in providing a conducive environment for the researcher to undertake the study. The data collection process at the Bwaila VMMC site was started by the researcher reporting at the reception area where clients were registering for different services. With the help of the receptionist, all clients of eligible age were introduced to the study and were asked if they were willing to participate. Willing clients (all the eligible individuals) were directed by the receptionist to the interviewer who was in a private room provided by the site personnel. The interviewer started by explaining the aim of the study and how the findings would be utilized. He also clarified any other concerns that the prospective interviewee had. Upon the participant giving verbal consent, the interviewer then conducted face-to-face interviews that were guided by a semi-structured questionnaire. All the interviews were recorded using voice recorders and later transcribed. Of the 25 respondents who participated in this study, 10 were already circumcised and were at the site for a VMMC medical review while 15 were uncircumcised at the time of the interview but were waiting to be circumcised the very same day. Most of the respondents were aged between 18 and 24 years (17 of the 25) with less in the higher age group, 25–35 (eight out of 25). Out of these, six were married and 19 were single. Each interview lasted about 45 minutes and the data collection process took a total of 10 working days to complete in a period that spanned 1 and half months (October to December, 2018) for individual interviews with participants.

5. Data analysis
The data collected were qualitative. The data obtained from the 25 participants were subjected to thematic analysis. Recorded interview data from the 25 semi-structured interviews were imported into an ATLAS.ti Version 7 primary document as *.mp3 (a coding format for digital audio). As more data were being added, main themes related to the research question started emerging and provided direction as to how the data could be interpreted. From the transcribed data (respondents’ narratives), the following themes emerged: respondents’ awareness of VMMC; respondents’ knowledge about VMMC and associated concepts; and respondents’ VMMC uptake decision-making influencing factors. Codes were assigned to specific responses or themes and phrases that linked the responses to a specific theme or subthemes were then analysed further to describe the ideas that were coming out of the data. The data were examined, categorized, synthesised, and recombined to produce descriptive statements and interpretations.

5.1. Ethical considerations
The National Committee on Research and Social Sciences initially granted permission to conduct the study. In addition, the researchers obtained informed consent from all the participants in the study. Some participants could neither read nor write, so verbal consent was sought from each of the participants. The purpose of the study was explained to each one of them, and they were further assured of anonymity in the sense that all the collected data were going to be treated with
utmost confidentiality. To ensure the participants’ anonymity, the data collection tool did not collect any information that could reveal the identity (specifically, names or photos of respondents). Furthermore, all collected data were treated as confidential and were not used beyond the scope of the study. After transcription, the recorded data were deleted. For purposes of confidentiality, only the researchers had access to the raw data.

6. Study limitation
The major limitation with this study was the collection of data from only one VMMC site because the other sites had been closed. This poses challenges in generalizing the results and/or to replicate the study.

7. Results and discussion

7.1. Communication-related factors which influence the uptake of VMMC among men
There are several factors which influenced respondents to go for or undergo VMMC. The main goal of VMMC recommendation by UNAIDS is to reduce the prevalence of HIV in the countries of interest (Kripke et al., 2016; WHO, 2012) and most of VMMC communication and demand creation tools are focused on the message of reducing one’s risk of contracting HIV (NAC, 2012; PSI, 2014). However, apart from this perceived benefit, the respondents in this study mentioned peer pressure, girlfriend/partner influence, and advice of a medical personnel as the communication factors that influenced them to undergo VMMC. This does not mean that the participants were not aware of the benefits of VMMC but that their decision was based on their interpersonal relationship with others. The communication factors are discussed in detail below.

8. Peer communication
Some respondents mentioned friends or peers as a factor that helped them to make a decision to go for VMMC. In other words, peer pressure was a factor that influenced their decision to go for VMMC. The need to conform to a group and encouragement from friends was highlighted in the respondents’ responses that showed that peer influence was at work. One respondent said:

   Like I said, my brother was circumcised around 2015-16, and I was asking him whether circumcision is good or bad and he told me to come and see for myself. When I said “No”, he said we would discuss this only when I am circumcised (interview with a 30 year old uncircumcised and unmarried man with secondary school education).

In trying to mobilise others to uptake VMMC, some mobilisers make use of peer pressure including use of abusive and/or stigmatizing language (Gilbertson et al., 2019) which is the case in the example given above. An uncircumcised man is considered not man enough to discuss the advantages and disadvantages of circumcision as that topic is preserved of circumcised men only.

   According to the Kenya National AIDS Control Programme (2010) “male peers especially those who have undergone MC can be important ambassadors in the MC campaign” (p. 16). For example, one respondent said “A good number of my friends were circumcised and they could tell the benefits and I thought I should come to get circumcised myself” (interview with a married uncircumcised man with secondary school education aged 26) and another respondent said that, “Seeing that all my friends were circumcised, and they could tell me the counselling provided by the medical officers as well as that the wound heals quickly, I was convinced that what I was thinking was not as difficult as I thought and I decided to come” (interview with an unmarried uncircumcised man aged 19). This response resonates with the idea that male peers can play a critical role in quelling the myths about pain, excessive bleeding, and mutilation (Kenya National AIDS Control Programme, 2010) associated with VMMC.

   Respondents who reported having been influenced by peers to undergo VMMC also highlighted that their peers had a positive attitude towards VMMC. These respondents had a feeling that their
peers would be happy to know that they too had undergone circumcision. For example, when asked what he thought his peers’ reaction would be to the news of him being circumcised, one respondent said, “I believe they will be happy, some of them wanted to escort me but I decided to come with my wife in case something happens” (interview with an unmarried circumcised man with secondary school education aged 30). Some respondents felt that group cohesion would be enhanced if they were all circumcised, as evidenced by the following response: “I am thinking that they will be happy, because in the past in our group there were only two guys who were not circumcised, so they will be happy to know that all of us are circumcised” (interview with a circumcised unmarried man with tertiary education aged 25).

It should also be pointed out that peers tend to see the benefits of VMMC on a personal level, something they use to encourage others to also go for circumcision. The sentiments of the respondents are evidence of this. One respondent said that, “If you find that something is good, it is good to tell your friends so that they might also get the same benefit. If I don’t tell them they won’t know there is VMMC nor will they know about the benefits” (interview with a married circumcised man with secondary school education aged 35). Another respondent did not want to be the only uncircumcised person in a group, and he said that “Most of my peers feel it’s important because most of them are circumcised, it was just me who wasn’t, they also encouraged me to come here” (interview with an unmarried and uncircumcised man with secondary school education aged 32). Finally, another respondent felt that “Most people come for VMMC after they see their friends, because men usually share things and admire each other” (interview with an uncircumcised and unmarried man with tertiary education aged 24).

Of interest in these findings is the extent to which peer communication influenced the decision of uptake of VMMC among men in Lilongwe Urban. This is in line with Rogers (2003) Diffusion of Innovation (DoI) theory, which discusses the role peers play in helping individuals adopt a new innovation. Peers form a large swathe of early adopters that convert to the early majority (Kenya National AIDS Control Programme, 2010, p. 14). The advantages and sometimes disadvantages of using the peer approach have been seen in some health interventions (Bertrand, 2004; MacVaux & Schiavone, 2010). This study shows that a good number of respondents apart from knowing the HIV infection risk reduction properties of VMMC seem to have been influenced by uptake of VMMC by peers. Some respondents decided to do it because most of their peers were circumcised and did not want to feel like outsiders within their groups. Others were told to either go for VMMC or stop talking to their peers.

The findings reveal that peer communication can have some effect on the VMMC uptake decision-making of the respondents. The communication was through verbal encouragement, subtle coercion, and pieces of advice. Some peers are considered to have encouraged their peers to go for VMMC by sharing with them the benefits of VMMC and how that would positively affect their friends. Others were not interested in discussing the issue with their peers but subtly coerced them to go to VMMC for them to understand the benefits better. Further still, others advised their peers to go for VMMC out of care and goodwill. The findings further show that the technicalities of peer communication are complex and this could be a study on its own, but one thing that is clear is that no matter how the peers communicated, the messages were effective which led to some respondents making a decision to uptake VMMC based on peer communication.

9. Spousal communication (girlfriend/partner influence)

The study also found that girlfriends and sexual partners also played a part in some of the respondents’ decision to get circumcised. Some respondents indicated that they decided to go for VMMC as part of caring for their girlfriends or sexual partners. Issues of trying to prevent their girlfriends from contracting cervical cancer or STI, cultural assimilation, as well as mere insistence from the partner/girlfriend were brought up as some of the reasons why the respondents decided to go for VMMC. The respondents were either afraid of losing their partners or feared something bad would happen to their partner if they did not get circumcised, and they decided to get circumcised as a sign that they care. One respondent said, “The main influence for me to get
circumcised was my girlfriend. She literally told me to go and get circumcised, and the fear of losing her made me come here” (interview with an unmarried circumcised man with secondary school education aged 18). This is an example of going for circumcision for the fear of losing a girlfriend/partner. A question may arise whether this form of decision-making was voluntary or coercion since the respondent was actually forced to undergo VMMC failing which he could have lost his loved one. Another respondent had this to say,

I was concerned when my partner was suffering, because I was wondering why she could be in such pain, but I thought the pain always come with sexual intercourse and I decided that if circumcision would help her, then I needed to do it (circumcision) (interview with a married uncircumcised man aged 29 years).

It is this suffering of the partner that influenced the respondent’s decision to go for circumcision. Finally, one respondent said that “My wife went to attend the traditional girls’ initiation ceremony and when she came back, she encouraged me to come for circumcision” (interview with a married uncircumcised man aged 26). No reason was given why the woman insisted that her husband should go for VMMC. The reasons that the girlfriend or partners had for encouraging their men to go for circumcision were not part of the scope of this study and as such were not discussed in this paper.

It can be argued that the respondents’ VMMC uptake decision was based on their partners'/girlfriends' requests or insistence. Here we note that spousal communication played a big role in influencing a partner to undergo VMMC. While it was beyond the scope of this study to establish why the partners/girlfriends requested or insisted that their partners get VMMC, some studies have established some perception of increased sexual pleasure after VMMC procedure among couples (Brito et al., 2017), which may be speculated as a reason why the women would request their spouses to get VMMC in addition to the reduction of the risk of contracting HIV and cervical cancer. These findings correspond to what has already been established in other studies (see Plotkin et al., 2013). The finding that partners influence VMMC uptake decision-making is in line with other studies highlighting influencing factors for VMMC uptake (Brito et al., 2017) and provides an opportunity for VMMC programmers to develop other initiatives to encourage uptake of VMMC among men.

10. Advice from medical personnel
Advice from medical personnel was also mentioned by some respondents as having played a part in their decision to uptake VMMC. Most of the respondents who highlighted this in their responses mentioned that they had gone to a clinic to seek medical help on STI-related issues. It was through the STI counselling session with the medical personnel that VMMC was mentioned as an option for preventing future infections, and this is what influenced the respondents to make their decision to get circumcised. One respondent said, “If I had not accepted what the medical people advised me, I believe I would have had problems with my sexual organs” (interview with a married circumcised man aged 35 years).

A study in South Africa found that when partners are counselled together with VMMC clients in educational sessions, there is an opportunity to discuss other issues, such as sexual and reproductive health (Atkins et al., 2020; Marshall et al., 2017). This finding corresponds to what one respondent in this study said, “My partner came to the clinic for testing, and the medical personnel said I needed to get circumcised to avoid contracting the disease she had” (interview with a married uncircumcised man aged 32 years). In another instance, one respondent said, “I was encouraged by medical personnel who told me that it would be better if I was circumcised” (interview with a married uncircumcised man aged 30 years). Finally, another respondent said that “I met a doctor at my workplace who advised me to come for medical circumcision” (interview with a married circumcised man aged 31 years).

The circumstances that led the medical personnel advising clients to undergo VMMC are varied and can only be inferred from and are beyond the scope of this study. However, the advice of medical personnel influenced the decision-making of some respondents. Medical personnel are in the forefront promoting health behaviours and, for most patients, what a medical personnel says is always true and likely to be
followed (While, 2015). For example, a study which surveyed South African men who were up taking VMMC services found that 83% of them reported that if it was not for the advice of the VMMC advisers, they would not have been circumcised (Atkins et al., 2020; Marshall et al., 2017). These are typical examples of an opinion leader or influential person influencing the decision of an individual on a health-related matter. However, in this particular case, this raises a question as to whether this kind of decision-making could be regarded or interpreted as totally voluntary (as the “V” in VMMC stands for “Voluntary”) or under duress. This may require further study to be able to correlate the two well as some of the responses from some of the respondents show that some of their VMMC uptake decisions were made based on the advice of a medical personnel only.

11. Conclusion
The findings of the study show that peer communication and the need for conformity, spousal communication (partner/girlfriend’s influence), and medical personnel’s advice were the communication-related factors that led the participants to go for VMMC. The findings showed that peer-to-peer communication had some influence on VMMC uptake decision-making among some men in the study area; and that apart from HIV infection risk reduction, prevention of cervical cancer, and personal hygiene, men were also influenced by partners/girlfriends, and advice from medical personnel as factors when deciding to uptake VMMC.

The findings of this study have some important implications with respect to VMMC in the sense that the men in the study underwent circumcision under duress and/or coercion. Although the final decision was theirs to make, it cannot be said to be voluntary. Regardless of the aim of undertaking circumcision, i.e. increased sexual pleasure or HIV/AIDS prevention or hygiene reasons, it is apparent that the men in the study experienced some form of reproductive coercion. The medical necessity of VMMC can be said to be voluntary if it is negotiated and consented to without duress. Therefore, among several others, the communication-related factors discussed in this paper need to be considered for their own merit when designing communication strategies for similar campaigns or for other related campaigns in the future. They can present an important aspect for explaining why some programmes are successful and why others fail. The low uptake of VMMC in Malawi cannot be fully explained if these factors have not been examined and analysed in detail. It is not enough to label a health intervention as a failure or a success when all factors have not been fully considered and explained. Programmes such as VMMC require careful and thorough research before being implemented. Therefore, it is a recommendation from this study that current intervention messages and their target audiences be reviewed and modified to incorporate new ideas that can address the shortcomings that the current crop of messages have. It is also important that programmes such as VMMC should employ a combination of strategies to ensure their success. It is further recommended that VMMC policymakers should review the communication strategies which were developed, such as the “Ndife Otsoyola” to incorporate the communication-related factors discussed in this paper.

Acknowledgements
We would like to thank the following institutions: Center for Disease Control in Malawi, Jhpiego, and Lilongwe District Health Office for allowing us to conduct the study within their jurisdiction and providing the necessary approvals that allowed us to do the study freely.

Funding
The authors received no direct funding for this research.

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Competing interests
There are no competing interests to report on.

Informed consent
Informed consent was obtained from all study participants. Ethical approval to conduct the study was also sought from Malawi’s National Commission for Science and Technology (NCST).

Citation information
Cite this article as: Communication-related factors influencing the uptake of voluntary medical male circumcision among men in Lilongwe Urban, Malawi. Peter Mhagama, Patrick Makano & Chimwemwe Tsitsi, Cogent Medicine (2021), 8: 1892289.

References
Atkins, K., Yeh, P. T., Kennedy, C. E., Fonner, V. A., Sweat, M. D., O’Reilly, K. R., Baggaley, R., Rutherford, G. W., & Samuelson, J. (2020). Service delivery interventions to increase uptake of voluntary medical male circumcision for HIV prevention: A systematic review. PLoS ONE, 15(1), e0227755. https://doi.org/10.1371/journal.pone.0227755
Avert. (2018). HIV and AIDS in Malawi. https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/malawi
Bertrand, J. T. (2004). Diffusion of innovations and HIV/AIDS. Journal of Health Communication, 9(sup1), 113–121. https://doi.org/10.1080/10810730400271575
Brito, M. D., Khosa, S., Pananokoa, S., Fleming, P. J., Lerebours, L., Donatost, Y., & Bailey, R. C. (2011). Sexual pleasure and function, coital trauma, and sex behaviors after voluntary medical male circumcision among men in the Dominican Republic. The Journal of Sexual Medicine, 14(6), 526–534. https://doi.org/10.1016/j.jsemm.2017.01.020
Center for Disease Control. (2014). Launch of VMMC activities in Malawi brings new tool for HIV prevention. http://www.cdc.gov/globalaids/success-stories/vmmc_malawi.html
Chirungu, I. D., Ramathuba, D. U., & Mashau, N. S. (2019). Factors contributing to the low uptake of medical male circumcision in Mutare Rural District, Zimbabwe. African Journal of Primary Health Care & Family Medicine, 8(2), 966. https://doi.org/10.4102/ajphfm.v8i2.966
Dickson, K. E., Tran, N. T., Samuelson, J. L., Njeuhmeli, E., Cherutich, P., Dick, B., Hankins, C. A., Hankins, C. A., & Farley, T. (2013). Voluntary medical male circumcision: A framework analysis of policy and program implementation in Eastern and Southern Africa. PLoS Medicine, 8(11), e1001133. https://doi.org/10.1371/journal.pmed.1001133
Etikan, I. (2016). Comparison of convenience sampling and purposive sampling as the method of sampling American Journal of Theoretical and Applied Statistics, 9(1), 1–4. https://doi.org/10.11648/j.ajtas.20160501.11
Gilbertson, A., Onigbi, B., Odongo, F. S., Halfors, D. D., Rennie, S., Kvaro, D., & Luseno, W. K. (2019). Voluntary male circumcision for HIV prevention among adolescents in Kenya: Unintended consequences of pursuing service-delivery targets. PLoS ONE, 14(11), e0224548. https://doi.org/10.1371/journal.pone.0224548
Johns Hopkins Center for Communication Programs. (2014, July 1). BRIDGE II Project facilitates workshop for Journalists on VMMC in Malawi. https://ccp.jhu.edu/2014/07/01/bridge-ii-project-facilitates-workshop-journalists-vmmc-malawi/
Kenya National AIDS Control Programme. (2010). Communication strategy for voluntary medical male circumcision in Kenya. https://www.malecircumcision.org/sites/default/files/document_library/T11_Communication_Strategy_for_VMMC_in_Kenya
Krippa, A., Chen, P.-A., Vazzeno, A., Thanhanghayagam, A., Pilloy, Y., Loykisooniol, D., Njeuhmeli, E., Kiwango, E., Castor, D., Njeuhmeli, E., & Bonnece, C. (2016). Cost and impact of Voluntary Medical Male Circumcision in South Africa: Focusing the program on specific age groups and provinces. PLoS One, 11(7), e0157071. https://doi.org/10.1371/journal.pone.0157071
MacIntosh, J., & Schiavone, F. (2014). Limits to the diffusion of innovation: A literature review and integrative model. European Journal of Innovation Management, 17(2), 197–221. https://doi.org/10.1108/14601061410460258
Marshall, E., Rain-Taljaard, R., Tsepe, M., Morikwe, C., Taljaard, D., Hatungimana, F., Xaba, D., Malana, T., Lissouba, P., Puren, A., & Avert, B. (2017). Obtaining a male circumcision prevalence rate of 80% among adults in a short time: An observational prospective intervention study in the Orange Farm township of South Africa. Med. J. S. Afr., 96(4), e5328. https://doi.org/10.1097/MOD.00000000000005528
National AIDS Commission. (2012). VMMC communication strategy for Malawi. 2012-2016. https://www.malecircumcision.org/sites/default/files/document_library/VMMC_Communication_Strategy_for_Malawi_December_2012_FINAL.pdf
National AIDS Commission. (2014). National strategic plan (NSP) for HIV and AIDS 2015–2020. National AIDS Commission (NAC).
National Statistical Office (NSO) [Malawi] and ICF. (2017). Malawi demographic and health survey 2015-16. NSO and ICF.
Parkhurst, J. O., Chilongozi, D., & Hutchinson, E. (2015). Doubt, defiance, and identity: Understanding resistance to male circumcision for HIV prevention in Malawi. Social Science & Medicine, 135(Suppl.C), 15–22. https://doi.org/10.1016/j.socscimed.2015.04.020
PEPFAR. (2017a). PEPFAR country fact sheet: Malawi. https://www.pepfar.gov/documents/organization/199568.pdf
Plotkin, M., Castor, D., Mziray, H., Küver, J., Mpuya, E., James Luvanda, P., Hellor, A., Curran, K., Lukoboduurel, M., Ashengo, T. A., & Mahler, H. (2013). “Man, what took you so long?” Social and individual factors affecting adult attendance at voluntary medical male circumcision services in Tanzania. Global Health, Science and Practice, 1(1), 108–116. https://doi.org/10.9745/GHSP-D-12-00037
Population Services International. (2014). VMMC demand creation toolkit. http://www.psi.org/wp-content/uploads/2014/09/VMMC_Demand_Creation_Toolkit.pdf
Rennie, S., Perry, B., Corneli, A., Chilungu, A., & Umor, E. (2013). 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/10.1080/17441692.2015.1004737
Rogers, E. M. (2003). Diffusion of innovations. Free Press. http://books.google.com/books?id=Smedley, B. D., & Syne, S. L. (Eds.). (2000). Promoting health: Intervention strategies from social and behavioral research. National Academy Pr.
UNAIDS/WHO/SACEMA Expert Group on Modelling the Impact and Cost of Male Circumcision for HIV Prevention, (2009). Male Circumcision for HIV Prevention in High HIV Prevalence Settings: What can Mathematical Modelling Contribute to Informed Decision Making? PLoS Medicine, 6(9), e1000109. https://doi.org/10.1371/journal.pmed.1000109
While, A. E. (2015). Promoting healthy behaviours – Do we need to practice what we preach? London Journal of Primary Care, 7(6), 112–114. https://doi.org/10.1080/17571472.2015.1113716
WHO. (2012, July). WHO | Voluntary medical male circumcision for HIV prevention. http://www.who.int/hiv/topics/malecircumcision/fact_sheet/en/
WHO/UNAIDS. (2007). Technical consultation on male circumcision and HIV prevention: Research implications for policy and programming. WHO/UNAIDS technical consultation 6–8 March 2007 conclusions and recommendations (Excerpts). Reproductive Health Matters, 15(29), 11–14. https://doi.org/10.1016/S0968-8080(07)29307-3
World Health Organization and Joint United Nations Programme on HIV/AIDS. (2007). Male circumcision: Global trends and determinants of prevalence, safety, and acceptability. World Health Organization & UNAIDS.
Zimmerman, E., & Woolf, S. H. (2014). Understanding the relationship between education and health [Discussion Paper]. Institute of Medicine. http://namedrupleshooting.org/uploads/2015/06/understandingtherelationship.pdf
