

GETTING RESEARCH INTO HEALTH POLICY AND PRACTICE

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Doubt, Defiance, And Identity: Resistance To Male Circumcision Policy In Africa


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Social Science and Humanities in HIV/AIDS Conference
Paris, July 2013

*Doctoral support provided by UNC Chapel Hill

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

W. Shakespeare *Othello* – scene ii.

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MC as an HIV prevention tool

- South Africa - Orange Farm trial 3,000 men ages 18 to 24. Approximately 60% less likely to acquire HIV if circumcised.
- Uganda - Rakai District trial, 4,996 men ages 15 to 49. Approximately 51% less likely to acquire HIV.
- Kenya – Kisumu trial - 2,784 men ages 18 to 24. Approximately 59 percent less likely to acquire HIV.

Source: WHO/UNAIDS 'clearinghouse on male circumcision'

http://www.malecircumcision.org/research/clinical_research.html

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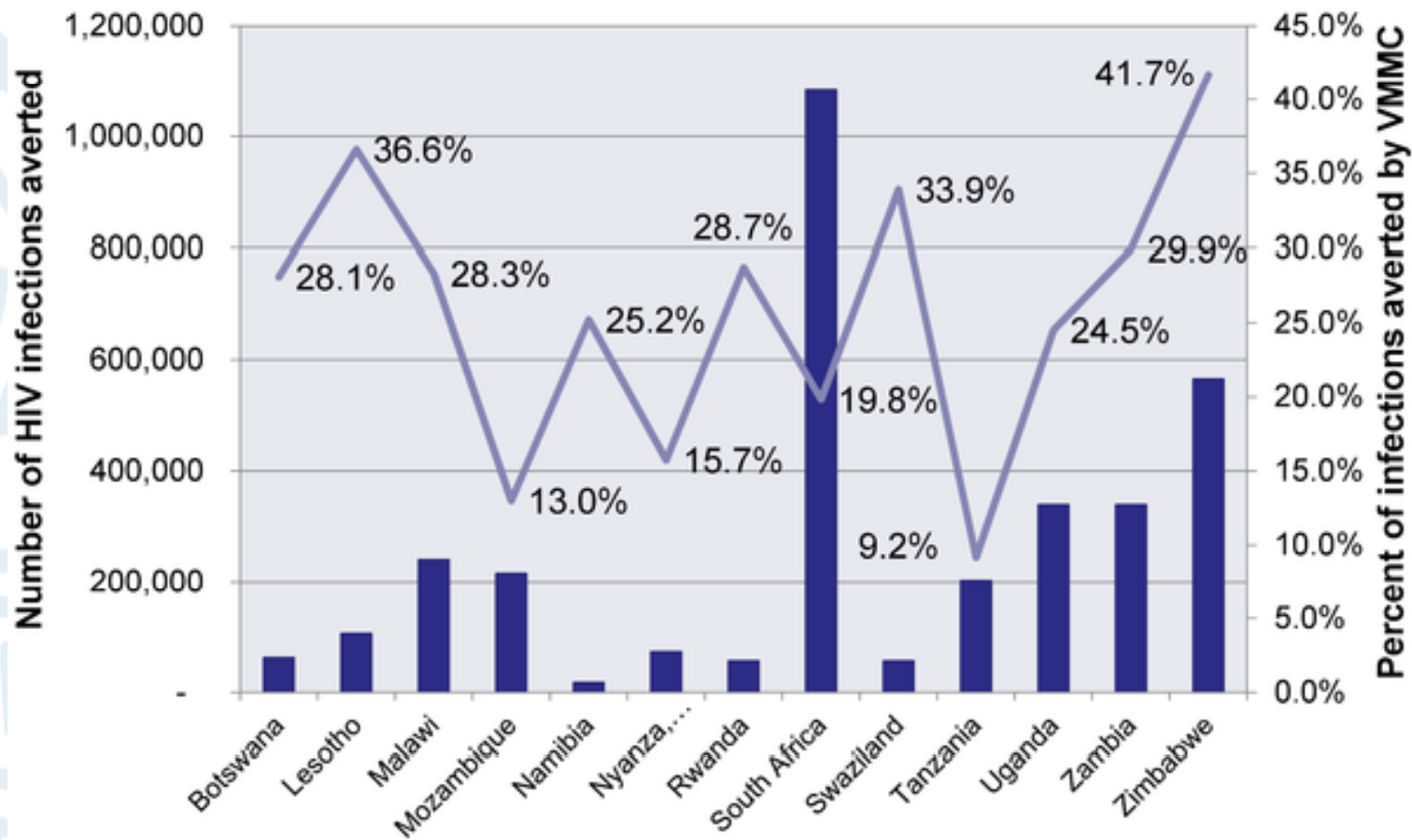
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Source: Perera et al 2010 *Annals of Family Medicine*



Source: Hankins et al. 2011 *PLOS-Medicine*

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Radically different responses

- Kenya as an ‘innovator’, Malawi as a ‘laggard’ (Dickson et al. 2011, *PLOS-Medicine*)
 - Kenya conducted over 200,000 MC procedures within a national programme to scale up
 - Has achieved over 45% of its target of 94% coverage for men aged 15-49
 - Malawi has resisted developing a national programme.
 - Has achieved less than 1% of its target of 80% coverage



Country	Key Elements of VMMC Program Scale-Up						Total Scale-Up Score)
	Situational Analysis Completed* (Full or Selective)	Leadership: Prominent National Champion Engaged	Leadership: National Dedicated Focal Point in Place	VMMC Policy or Similar Guidance Approved*	National Strategy and Operational/ Implementation Plan Approved*	Pilot/ Demonstration Sites: Government Involvement	
Botswana	3	3	3	3	2	2	16
Kenya	3	3	3	3	2	3	17
Lesotho	3	0	1	1	1	1	7
Malawi	1	0	1	1	1	1	5
Mozambique	3	0	0	0	0	1	4
Namibia	3	0	2	1	1	2	9
Rwanda	1	1	1	1	1	2	7
South Africa	2	0	1	1	1	2	7
Swaziland	3	1	2	2	2	3	13
Tanzania	2	0	1	1	2	2	8
Uganda	2	0	1	1	0	1	5
Zambia	2	0	2	2	2	2	10
Zimbabwe	3	0	1	2	1	1	8

Score range is 0 (lowest) to 3 (highest).

*The grading is based on the date of publication or official launch of these documents.

doi:10.1371/journal.pmed.1001133.t004

“potential predictors of innovation and early adoption ... include having a VMMC focal person, establishing a national policy, and having an operational strategy, as well as having a pilot or demonstration site with government involvement” (page 7)

Source: Dickson et al (2011) *PLOS-Medicine*

Questions

- Why?
- What explains Malawi's resistance to adopting MC as a national HIV prevention policy?
- What might help understand differing rates of adoption and scale up of MC as an HIV prevention activity in high prevalence countries?

Public Health – political myopia?

- Standard recognition in social and policy studies literature around international policy transfer requires
 - Consideration of local political realities
 - Policy adoption and implementation as political processes
 - Consideration of how artefacts of the policy fit within local socio-cultural context
- Public (and global) health discussions of MC fails to address the political nature of MC.
 - Framed as a technical issue
 - Emphasis squarely on health implications particularly HIV transmission
 - Shows confusion or ignorance when MC is not taken up as recommended
 - E.g. branding countries ‘leaders’ and ‘laggards’ without every considering what other reasons a country might have to adopt (or not) a technical recommendation.
 - Tries to find quantitative variables (assumed generalisable?) to explain uptake rapidity. (c.f. Dickson 2011)

MC as an artefact of cultural significance

- Deeply entrenched cultural practice
 - For millennia MC has been an indication of purity, masculinity, maturity, or divine selection (c.f. Greek, Roman, biblical texts)
- Signifier of identity and of otherness
 - Use in conflicts to identify or intimidate others
 - “during the Ottoman and Moorish Empires, in Nazi Germany, in India at partition and in the recent genocides of Bosnia and East Timor, a man’s circumcision status had serious consequences for how he was treated: with violence, torture and death being the consequence for those who fell short of the mark” (Aggleton, 2007 *Reproductive Health Matters* - page 15)

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Mapping MC divisions onto 'ethnic boundaries'

- History of ethnic competition and conflict in different countries
 - Kenya - Kikuyu, Kalenjin, Massai circumcise, Luo do not
 - Malawi - Yao circumcise, Chewa do not
- Religious divisions as well in both countries.
 - Muslim's traditionally circumcise, Christians do not
- MC divisions align well in Malawi with historical political competition, patronage and contestation for power. Some alignment in Kenya, but equally strong competition between groups with shared MC practices (e.g. Kikuyu and Kalenjin)
 - Malawi recent Muslim president, saw discourse of 'fear of Islamification'

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Local data vs global consensus

- While the RCTs are taken in the Public Health community to ‘prove’ efficacy of MC for HIV prevention, differences in local observational data.
 - Kenya, higher HIV prevalence in regions with low circumcision rates
 - Malawi, higher HIV prevalence in regions with high circumcision rates
- Such local data are less powerful in epidemiological terms to prove effect (due to potential of confounding and ecological fallacy)
- Yet as pieces of technical ‘evidence’ they can easily serve as legitimization points within political arguments defiant of global recommendations.

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Discourse of Resistance to MC in Malawi

- **Narrative of defiance**

- Resisting donor imposition, aligning with other powerful anti-dependency discourses.

“Donors must not force male circumcision onto the Ministry [...], say do it! No, that is irresponsible science”



- Rejection of round of funding from the Global Fund constructed as neocolonialism
 - Opposition to Malawi criminalisation of homosexuality and imposition of MC

Discourse of resistance cont.

- **Narrative of doubt**

- Questioning epidemiological findings, focus on piece of local information

“I do not accept that male circumcision only offers 60% protection, meaning there is still a risk of contracting HIV of 40% or more” (Government Official quoted in *Daily Nation* 11 August 2008:21)

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

Senior government official:

“So when you are looking at those people, they are saying, hang on a minute. I am not going to be a Muslim, because circumcision in Malawi is associated with the Muslim religion. The majority are not circumcised and in some districts where they don't even know about circumcision the HIV prevalence rate is very low.”

- Citing evidence that HIV prevalence is higher in areas that circumcise more:

“Why is it that in Mangochi those people [...] Muslims and Yao have the more HIV/AIDS but almost everybody circumcising in the lakeshore districts?”

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(Re)Construction of identity and legitimacy

- MC has become a political tool to reify positions of power and claim political legitimacy
 - MC integrated into broader political struggles – e.g. independence from donors
 - Entrenching position of Chewa or Christian groups as the legitimate decision makers in Malawi,
 - Aligning ethnic/religious identity with a range of other established discourses
 - Solidifying political divisions on ethnic lines (or the use of ethnicity as a political lever)

“...not all problems map onto ethnic boundaries, but when boundaries are strong, there is good chance that problems and solutions will be considered in ethnic terms.” (Lieberman 2009 – Boundaries of Contagion)(page 36)



Conclusions

- MC constructed by public health community in depoliticised way;
- Explaining differential uptake requires political lens;
- MC highly contested, historically and in present day;
- Politics shapes interpretation and use of MC evidence;
- MC debates can become a part of identity politics.



When do global technical recommendations (e.g. MC) become politically contested?

- Do divisions in MC practice map onto existing or historic lines of political contestation?
- Does MC fit into, or support, an existing political power struggle?
- How easily can MC be constructed into (or integrated within) existing political discourse(s)? (can it be used to leverage power or entrench legitimacy)?
- Can the 'evidence base' be contested differently in different localities, undermining the legitimacy or authority of global recommendations?

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