Published in final edited form as:
AIDS Behav. 2010 October ; 14(5): 1207–1211. doi:10.1007/s10461-009-9656-5.

Framing Male Circumcision to Promote its Adoption in Different Settings

Franklin D. Gilliam[1], **Ronald A. Brooks**[2,3], **Arleen A. Leibowitz**[2,3], **Lee E. Klosinski**[3], **Sharif Sawires**[3,4], **Greg Szekeres**[4], **Mark Weston**[5], and **Thomas J. Coates**[3,4]

[1] Departments of Public Policy and Political Science, UCLA, Los Angeles, CA, USA

[2] Department of Public Policy, UCLA School of Public Affairs, 3250 Public Affairs Building, Box 951656, Los Angeles, CA 90095, USA

[3] Center for HIV Identification, Prevention, and Treatment Services, Semel Institute, UCLA, Los Angeles, CA, USA

[4] Program in Global Health, UCLA Geffen School of Medicine, Los Angeles, CA USA

[5] Policy Consultant, Dorset, UK

Abstract

The effectiveness of male circumcision in preventing transmission of HIV from females to males has been established. Those who are now advocating its widespread use face many challenges in convincing policy-makers and the public of circumcision's value. We suggest that frames are a useful lens for communicating public health messages that may help promote adoption of circumcision. Frames relate to how individuals and societies perceive and understand the world. Existing frames are often hard to shift, and should be borne in mind by advocates and program implementers as they attempt to promote male circumcision by invoking new frames. Frames differ across and within societies, and advocates must find ways of delivering resonant messages that take into account prior perceptions and use the most appropriate means of communicating the benefits and value of male circumcision to different audiences.

Keywords

Male circumcision; HIV prevention; Implementation; Communication tools; Frames; Africa; Latin America; The Caribbean

Introduction

Clinical trials in Uganda, Kenya and South Africa have shown that male circumcision is an effective biomedical method of reducing female-to-male transmission of HIV. In each of the trials, the procedure reduced HIV acquisition among men during vaginal intercourse by ~60% [1–3].

Male circumcision therefore has the potential to reduce sharply HIV infection rates in countries with high HIV prevalence but low rates of circumcision. Modelling studies have estimated that HIV incidence in such countries could decline by between 25 and 67% in 10 years, depending

on uptake of circumcision [4]. In Sub-Saharan Africa, 5.7 million new infections and 3 million deaths could be averted in the next 20 years [5].

It is not yet clear whether male circumcision will also have a protective effect in settings with low HIV prevalence. While it is unlikely that widespread implementation of the procedure in these settings will be justified in terms of HIV prevention alone, consideration of its broader health benefits may persuade policy-makers to make circumcision more widely available. For men who have sex with men, meanwhile, the protective effect against HIV has not yet been established [6].

Despite the promise of male circumcision as a preventative tool in the battle against HIV and other diseases, many countries have yet to be convinced of its value. In the Caribbean and Latin America, for example, circumcision barely registers on health policy-makers' radar screens. Even in Africa, where HIV prevalence is high, some governments have still not implemented programs to roll out the procedure.

This paper is primarily concerned with communicating to policy makers the positive impact of male circumcision on community health. Improving the public's understanding of the value of male circumcision is also important, but public action to provide facilities and financing for male circumcision is a necessary precondition to enable individuals to receive circumcision in a clinical setting. While individuals are responsible for taking action once the facilities and financing are in place, the perceived public support for male circumcision encourages policy makers to promote its implementation.

One of the central arguments of this think piece is that the manner in which male circumcision is framed will have a direct impact on its future adoption. Framing, a concept derived from the social and cognitive sciences, is a means of shaping perceptions and developing understanding of social issues. How an issue such as male circumcision is framed, we posit, will influence the attitudes of policy makers and the public to the procedure and thereby facilitate or impede policy development and implementation.

This article first discusses the importance of framing in building public and political support for male circumcision. It then reports on perceptions of the procedure in Africa, the Caribbean and Latin America. The piece draws on the deliberations of a conference—*From Scalpel to Scale-up: Shaping Perceptions of Male Circumcision*—hosted in Mexico City in August 2008 by UCLA's Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) and the National Institute of Mental Health (NIMH).

Framing: Implications for Communicating the Benefits of Male Circumcision

Framing male circumcision is a critical endeavor, because how public health officials, advocacy groups and other stakeholders present its benefits and risks is likely to determine the extent to which it has popular and political support.

It is useful if we begin with a working definition of a frame. Frames have been defined as “organizing principles that are socially shared and persistent over time,” which structure how people understand the world [7]. Individuals and societies have pre-set expectations and attitudes that shape how they respond to new information. When news breaks about the effects of a health intervention such as male circumcision, for example, it is likely that different societies will respond in different ways depending on their prior knowledge and beliefs.

Frames exist for all issues and are influenced by the cultural models and beliefs by which individuals come to understand a particular issue. Perhaps the most important function of a frame is to define attribution of responsibility for an issue; this is influenced by whether

"individualizing" or "systemic" frames are more prominent in the public discourse regarding a particular issue [8]. If the issue is "individualized" or seen as a private matter, then the burden of responsibility is with the individual. In contrast, if the issue is seen from a "systemic" frame, then the locus of responsibility is with society or government. How the public and policy makers understand and respond to any social issue is a function of how it is framed.

Previous research indicates that framing is an increasingly important tool in the public health arena [8–10]. Its influence can be seen in an example provided by Gilliam [11], who found in a US campaign to provide fluoridated water that presenting the intervention purely from a children's oral health point of view was ineffective in persuading the public, and hence policy-makers, of its merits. This was in large part due to the fact that the original communication strategy resulted in the public understanding the issue as essentially private; that is, children's oral health would improve if parents monitored their children's tooth brushing and flossing.

Successful frames have the capacity to move an issue up the public agenda and therefore make the issue more salient to policy makers. In the example above, advocates reframed the issue to show that good oral health contributed to better educational outcomes, so children's oral health was successfully moved from the private to the public domain and the perceived accountability for it from parents to the state.

Like oral health, male circumcision may be initially perceived of as an individual issue, steeped in culture and religious overtones. In order to gain the support of policy makers, it will be necessary to communicate that male circumcision can improve the health of a community and therefore is an appropriate place for government initiatives.

Framing: Lessons From the Cognitive and Social Sciences

Gilliam [11] presents five key lessons of framing developed in conjunction with the FrameWorks Institute (a Washington, DC think-tank), to be borne in mind by advocates of male circumcision. The first comes from the cognitive sciences and reminds us that communication is "fast and frugal." That is, due to their limited cognitive capacity, people look for shortcuts—in the form of informational cues—to understand an issue, and once they come to an understanding it is hard to shift perceptions. The initial exposure to communication is therefore crucial. Lesson two is that people reason within the frame; put differently, we understand the issue with the communications elements that are defined by the frame. The upshot is that we assign responsibility for the problem and its resolution dependent upon the nature of the frame. Shanto Iyengar [12] identifies two ways of framing that bear on the attribution of responsibility—episodic and thematic. Episodic presentations focus on individual actors engaged in specific events at particular places and times. Thematic presentations highlight the trends, environments, and contexts of social issues. In his research on exposure to television news reports, Iyengar finds that episodic stories lead to individual levels of attribution, while thematic stories lead to societal levels of attribution. With regards to male circumcision, this comes down to defining whether it is the individual or society that is responsible.

The third lesson for researchers and advocates is that uninterpreted numbers are not the same as frames. Because numbers presented out of context are often meaningless, people default to their preconceived notions about the issue. In many instances this works against the stated goals and preferences of the advocate. When using numbers, therefore, they should be used sparingly, relatively, and in a given context. This approach is called "social math" and relies on using similes and analogies to provide a point of reference (e.g., "the heart is like a pump; the eye is a camera; photosynthesis is like baking bread"). While presenting scientific findings is an important function of social advocacy, it is important to recognize that "expert" understandings are often not shared by the broader public, and are therefore best addressed to

policy makers. Even if a report or paper is intended for a professional audience, the ease of electronic transmissions means that it is likely that the data will seep into the public domain.

Lesson four relates to the order of communications. Because people are cognitive misers (i.e., they do not want to spend a lot of time figuring out what a communication is about), they stop cognating when they believe they have landed on the appropriate understanding. This means that using “bait and switch” strategies is unlikely to work. For example, if a communication begins by saying, “you might think male circumcision is about the loss of virility, the diminution of culture, or the over reach of government, let me tell you something different,” there is a risk that, because this description of circumcision aligns with the most readily available frames, audiences will stop processing the information and move onto the next task. They may never hear the second part of the communication explaining why the first is inaccurate.

Finally, lesson five reminds us that people will be more likely to take action if they can see a role for themselves. From this perspective, failure to act is seen as a cognitive problem, not moral failing; in order to place themselves in an action scenario people must be able to clearly see what steps they should take. One way to accomplish this is to provide a simple, concrete presentation of the problem, thus making it clear as to the appropriate action.

Taken together, these five lessons provide a primer on the importance of framing for social change. Moreover, they raise the point that framing is more than simply dissemination; rather it is a strategic and analytic process that, when properly employed, can move public acceptance and political support in the desired direction. It is important to understand how frames function in order to have an impact at the policy or program level. Having a societal or policy goal differentiates framing from social marketing, which seeks to affect actions by individuals, drawing on models of persuasion and behavioral theory.

Perceptions of Male Circumcision in Africa, the Caribbean and Latin America

This section provides examples of how male circumcision is currently viewed in three different settings: Africa, the Caribbean and Latin America. Africa is the setting of the three clinical trials, where heterosexual sex is the primary mode of HIV transmission and there are moderate to high rates of male circumcision reported among its diverse populations. In contrast, the Caribbean is a setting where heterosexual sex is the primary mode of HIV transmission but with low rates of male circumcision. In contrast to settings with high rates of heterosexual HIV transmission, in Latin America HIV infection rates are high among men who have sex with men and male circumcision rates are low. Understanding the frames through which policy-makers and the public at large view male circumcision will be crucial if advocates are to tailor campaigns to their environments.

In Kenya, where one of the male circumcision trials was conducted, 83 percent of men are already circumcised [13]. Only three of the country's 42 ethnic groups do not traditionally practice circumcision. The most common circumcision scenario is for traditional circumcisers to perform the surgery on young teenage boys as part of a rite of passage to manhood. The procedure is carried out without anesthetic, as it is supposed to be painful in order for the boy to become a man, and in 35 percent of cases there are adverse reactions to the surgery. In recent years, many families have begun to choose clinical circumcision, in order to avoid the large costs of traditional surgery and the ensuing celebration. Safety does not play a large role in the decision to use clinical practitioners, so this may not be a compelling frame for those attempting to persuade families to switch from traditional methods.

The largest non-circumcising group is the Luo, who constitute 12% of Kenya's population. HIV infection rates are highest among this group [13]. In focus groups and key informant

interviews among the Luo, Bailey and colleagues [13] found that although there were concerns about cost, safety and pain, 60% of the men interviewed said they would prefer to be circumcised, and 62% of women said they would prefer their male partners to be circumcised. The belief that maintaining cleanliness is easier for circumcised men is the main factor behind this preference, suggesting that hygiene and overall health may be persuasive frames for advocates.

In Uganda, where another of the trials was conducted, the positive results of the study, known widely for the reduction in HIV incidence, had a large impact on public willingness to present for circumcision [14]. Surveys conducted before and after the trial recorded a great increase in the numbers of men who wanted to be circumcised.

Shifting cultural beliefs around circumcision is a major challenge in Uganda. Focus groups prior to the Rakai trial found that men believed that they should have excessive and vigorous sex before circumcision surgery, to compensate for the weeks of abstinence they have to endure afterwards. There is also a belief that healing can be assisted by urine and vaginal fluids, and a cultural tradition that the first sexual episode after surgery should not be with a man's regular partner.

All these traditions, of course, heighten the risk of HIV infection. It is important, therefore, for advocates of circumcision to be clear about the extent of the protective effect of circumcision, and that there is a continued risk of infection after surgery. Kiwanuka [14] argues that the procedure should be presented as part of a broader HIV prevention package, including messages about sexual abstinence, condom use and fidelity to one partner.

Circumcision is not widely practiced in Latin America—in Brazil, for example, rates are below 5%. Focus groups in Brazil, Ecuador and Peru, where overall HIV prevalence is low but where higher rates have been recorded among men who have sex with men (MSM), found that many MSM would consider circumcision if it was proven to be a safe and effective HIV prevention method [15]. Circumcision is seen as an effective way of promoting hygiene, and some believe it will make sex less painful for insertive partners. On the other hand, men reported concerns over a potential loss of sensitivity in the penis after circumcision; increased exposure to infections since the glans is uncovered; scarring of the penis; and a lack of lubrication. Some men were worried that their partners might be unfaithful in the period following surgery when they must abstain from sex. As in Africa, moreover, many were fearful of the surgery itself [16].

Even after the success of the African trials, there has been little discussion about male circumcision in Latin American policy, media and even scientific circles. Many feel that the procedure is more useful in Africa, where HIV infection rates are much higher. Those attempting to roll out the procedure in this region may therefore find that framing it as part of a holistic men's health package that helps improve hygiene and prevent sexually transmitted infections, urinary tract infections, penile cancer and cervical cancer, is a more fruitful strategy than solely emphasizing its benefits for HIV prevention.

In the Caribbean as in Latin America, few men are circumcised and there has been little discussion of the procedure. In the wake of the African trials, Figueroa [17] conducted a survey of 143 men and women who attended sexually transmitted disease clinics in Kingston, Jamaica. Two-thirds had heard of circumcision, while only nine percent of the men reported being circumcised. Perceived benefits of the procedure included hygiene, increased sexual satisfaction and protection against STIs and HIV/AIDS. However, 27% of men did not know of any benefit. Among women, hygiene was the seen as the biggest benefit, suggesting that framing the procedure in terms of cleanliness might be an effective way of tailoring messages to women.

When told about the African trials, 66% of women said they would encourage their partners to be circumcised, whereas only 34% of men would consider it. Seventy-one percent of women and 57% of men would recommend their infant sons to be circumcised. Receptivity to circumcision among this sample of respondents is mixed, therefore, with significant differences between men's and women's attitudes towards the procedure.

A further survey in the Caribbean, of eighteen National AIDS Program Coordinators, found that there was little discussion of the procedure in the region [18]. Only four of the coordinators reported that there had been debate among policy makers in the wake of the African trials. The public health community also has paid little attention to male circumcision. Clinicians believe there are more urgent health problems in the region than HIV/AIDS, and that waiting lists for other surgical procedures are already too long.

Conclusion

Despite the obvious promise of male circumcision as an HIV prevention tool, advocates of the procedure face a wide range of challenges in different parts of the world. In Africa, where the public is generally very receptive to male circumcision once they become aware of the benefits, the main challenges lie in persuading policy-makers to implement programs, educating people about the limits of its protective effect, and redirecting male circumcision from traditional providers to hygienic clinics. In Latin America and the Caribbean, on the other hand, the public, health professionals and policy-makers lack information on the benefits of male circumcision for HIV prevention and protection against other health threats.

Choosing the appropriate frames is vital for overcoming these challenges. The same frame can be used with both policy makers and the public. In this case, the frame might be enhancing the health and well being of the community. Although the frame doesn't change, one may begin the conversation with policy makers by citing statistics and results from the randomized trials, while the message to the public may need to be more tailored to cultural norms and understandings. In societies where male circumcision is seen as a rite of passage that is deeply rooted in culture and performed by traditional circumcisers, debates around circumcision policies will be different than in settings where the procedure is seen as a method to prevent HIV transmission. Advocating a societal frame of protecting the community's health may encourage men who would have been circumcised in a traditional rite of passage ceremony to seek circumcision in a hygienic clinic, where safer sex education can also be provided.

Where HIV is still a highly stigmatized disease, it may be less successful to promote circumcision as a means of preventing HIV and more fruitful to present circumcision as a means of maintaining good hygiene and providing protection against sexually transmitted infections (STI), including syphilis, HIV, and chancroid. This strategy may also prove useful in settings where HIV is not prevalent, or where the main mode of HIV transmission is intravenous drug use. Changing the opinions of the public and policy makers requires shifting the frame that is dominant in people's minds to one that is more amenable to the preferred course of action.

In presenting male circumcision to both policy makers and the public, it will be important to stress the benefit to the health of the community, shifting the public perception of male circumcision as solely a personal choice, influenced by religion, tradition and culture. Advocates and program implementers must use narratives that take into account pre-existing perceptions, concerns and values; they must tailor the content and tone of messages to their audiences; and they must establish the most suitable medium for delivering messages and programs. Frames are a communication tool, and the role of the advocate is to reframe an issue in a way that aligns the proposed solution with the existing cultural values. If advocates allow

an issue to go unframed, they can only hope that the dominant or default frame aligns positively with their desired outcome. The use of one frame over another will determine to a large extent the nature of the public discourse on male circumcision. Only by focusing on frames as a means of getting their message across will they be able to increase political support and uptake of male circumcision and trigger the large health benefits that it offers.

Acknowledgments

Funding for the development of this manuscript was provided by grants #MH081636 and #P30MH58107 from the National Institute of Mental Health. We also wish to thank Susan Nall Bales, President of the FrameWorks Institute, for allowing us to borrow some of their language and approach.

References

1. Avert B, Halyard D, Laggard E, Sobngwi-Tambekou J, Sitta R, Puren A. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. PLoS Med 2005;2(11):1112–22.
2. Bailey RC, Moses S, Parker CB, et al. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. Lancet 2007;369(9562):643–56. [PubMed: 17321310]
3. Gray RH, Kigozi G, Serwadda D, et al. Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. Lancet 2007;369(9562):657–66. [PubMed: 17321311]
4. Nagelkerke NJ, Moses S, de Vlas SJ, Bailey RC. Modelling the public health impact of male circumcision for HIV prevention in high prevalence areas in Africa. BMC Infect Dis 2007;7(16):16–31. [PubMed: 17355625]
5. Science Daily. WHO and UNAIDS recommend male circumcision as a step towards HIV prevention. Science Daily. Mar 29. 2007 document on internetAvailable from: http://www.sciencedaily.com/releases/2007/03/070328110815.htm
6. Millett GA, Flores SA, Marks G, et al. Circumcision status and risk of HIV and sexually transmitted infections among men who have sex with men. JAMA 2008;300(14):1674–84. [PubMed: 18840841]
7. Reese, SD.; Gandy, OH.; Grant, AE. Framing public life. New Jersey: Lawrence Erlbaum; 2001.
8. Lawrence RG. Framing obesity: the evolution of news discourse on a public health issue. Press/Politics 2004;9(3):56–75.
9. Dorfman L, Wallack L, Woodruff K. More than a message: framing public health a advocacy to change corporate practices. Health Edu Behav 2005;32(3):320–36.
10. Korn D, Gibbins R, Azmier J. Framing public policy towards a public health paradigm for gambling. J Gambl Stud 2003;19(2):235–56. [PubMed: 12766471]
11. Gilliam, F. Framing lessons from the cognitive and social sciences: implications for communicating male circumcision. Paper presented at from scalpel to scale-up: shaping perceptions of male circumcision; Mexico City, Mexico. August 2008;
12. Iyengar, S. Is anyone responsible? How television frames political issues. Chicagom, IL: University of Chicago Press; 1991.
13. Bailey, RC. Perceptions of male circumcision in Kenya. Framing lessons from the cognitive and social sciences: implications for communicating male circumcision; Mexico City, Mexico. August 2008;
14. Kiwanuka, N. Perceptions of male circumcision in Uganda. Paper presented at from scalpel to scale-up: shaping perceptions of male circumcision; Mexico City, Mexico. August 2008;
15. Pilotto, J. Perceptions of male circumcision in Brazil. Paper presented at from scalpel to scale-up: shaping perceptions of male circumcision; Mexico City, Mexico. August 2008;
16. Sanchez, J. Perceptions of male circumcision in Latin America. Paper presented at from scalpel to scale-up: shaping perceptions of male circumcision; Mexico City, Mexico. August 2008;
17. Figueroa, P. Perceptions of male circumcision in Jamaica. Paper presented at from scalpel to scale-up: shaping perceptions of male circumcision; Mexico City, Mexico. August 2008;
18. Bain, B. Perceptions of male circumcision in the Caribbean. Paper presented at from scalpel to scale-up: shaping perceptions of male circumcision; Mexico City, Mexico. August 2008;