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Social complexities of informed consent and assent among young males undergoing voluntary medical male circumcision in Eswatini

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ABSTRACT

Introduction As part of an effort to meet ambitious male circumcision targets in Eswatini, programme implementers have increasingly focused on young males, raising questions about informed consent. Males aged 10–19 years account for more than two-thirds of those circumcised since 2008 when internationally funded circumcision campaigns began in Eswatini. The ethical guidelines of these programmes conform to international standards, requiring that informed consent or assent be obtained prior to surgery. This article examines clients' levels of circumcision-related knowledge following the assent process, as well as how ethical guidelines were enacted in everyday practice in a setting where family dynamics and norms relating to autonomy and consensus make obtaining informed consent complex, especially when clients are incentivised with football kits and other material goods to encourage circumcision.

Methods We conducted qualitative research in a health clinic where circumcision services for HIV prevention were being offered. Methods included focus group discussions, in-depth interviews, participant observation and informal interviews with young men undergoing circumcision in the clinic.

Results Implementers paid little attention to risks, focusing more on benefits of circumcision. Incentives, usually in the form of sporting goods, increased participation, while also limiting autonomy. We also found that parental authority overpowers young males' preferences regarding circumcision. Young males' understanding of the risks associated with circumcision was poor. Most assumed HIV testing was obligatory.

Conclusion The drive to eliminate HIV infections in Eswatini has opened the door for interventions such as targeted circumcision campaigns. In contradiction to international ethical guidelines and the policies of the Ministry of Health and voluntary medical male circumcision (VMMC) implementers, we conclude that, in practice, respect for young males' rights and decision-making in the VMMC consent process is limited by complex social, economic and political realities.

WHAT IS ALREADY KNOWN ON THIS TOPIC

- ⇒ This study examined practices of informed consent and assent, specifically how consent for a voluntary medical male circumcision (VMMC) intervention was carried out among young males in Eswatini.
- ⇒ Most studies examining VMMC interventions focus on how to increase uptake or the relationship between VMMC and HIV incidence.
- ⇒ The few studies that focus on ethics examine the ethics of intervention design or the ethics of promoting VMMC.

WHAT THIS STUDY ADDS

- ⇒ This study critically analysed practices of consent and assent in relation to cultural norms of respect, the use of incentives and the extent to which the pressure to reach targets may have compromised the consent and assent process.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE AND/OR POLICY

- ⇒ This study will assist policy-makers and VMMC intervention implementers to better understand the factors shaping the consent process in contexts such as Eswatini.
- ⇒ This study will also stimulate further research and inquiry into intervention ethics, particularly in the Global South.

INTRODUCTION

The Kingdom of Eswatini has the world's highest HIV prevalence: 27% among 15–49 year olds.¹ In 2009, faced with daunting statistics and with financial and technical support from international donors, Eswatini's Ministry of Health (MOH) set an ambitious goal to circumcise 80% of men aged 10–49 years.² The global shift to include voluntary medical male circumcision (VMMC) as an HIV prevention strategy and the Swazi decision to back a VMMC programme were predicated on what the WHO described as 'evidence beyond reasonable doubt'.³ Three randomised controlled trials (RCTs) in South

Africa, Uganda and Kenya showed that circumcised men had an up to 60% relative risk reduction of acquiring HIV from women.⁴⁻⁶

The number of men participating in VMMC has been far lower than expected by implementers, especially adult men.⁷⁻⁹ In 2018, a survey among 20–34-year-old uncircumcised Swazi men found that 81% were not considering circumcision.¹⁰ Most young men in Eswatini were circumcised during ‘MC Fridays’ and the ‘back to school’ (BTS) biannual campaigns that targeted young males during school holidays using community mobilisers who visited schools around the country to recruit VMMC clients.

During data collection in a larger VMMC study, the respondents, who were older Swazi males, viewed the higher VMMC uptake among 10–14 year olds with a deep concern. They questioned young men’s comprehension of the possible negative effects of getting circumcised, including loss of sexual sensitivity and other potential permanent complications. Allegations of VMMC implementers ‘buying foreskins’ also circulated in popular discourses, which simultaneously questioned the use of incentives to attract young men: Why were donors seemingly willing to pay for young men’s foreskins? The issue of consent and assent within the VMMC programme has also been marred by public controversy related to some adolescent boys apparently being forced to circumcise or to take an HIV test, cases that have been publicised in the media.

In 2004, Member of Parliament, Marwick Khumalo, reportedly told members of his constituency that ‘all male children should be circumcised. To show my seriousness, I have taken all my sons for circumcision’.¹¹ When the statement was made, there was no conclusive evidence that VMMC was an efficacious HIV prevention technology and the WHO had not approved it as an HIV prevention intervention. None of the three VMMC RCTs had been published and the benefits of circumcision were still questionable. This has led citizens to wonder what motivated Khumalo’s support of circumcision?

Worth noting is that all the cornerstone VMMC RCTs did not include males between 10 years and 14 years, meaning there was no evidence from the clinical trials that VMMC would be efficacious or important in preventing new HIV infections in this age group, an age group that is less sexually active compared with their older counterparts. Also, when the VMMC policy in Eswatini was adopted in 2009, the target was males aged 15 years and above.

A decade later after the MP’s speech, the Times of Swaziland published a report¹² about a young boy who was forcefully tested for HIV before getting circumcised. Magagula stated that:

There was drama at the Family Life Association of Swaziland offices in Manzini, when a young boy refused to be tested for HIV. The boy frantically cried, as he fruitlessly resisted ... telling the counsellor that he had only come to get circumcised and not to be tested for HIV. His

grandmother...insisted that he take the test ...the boy, at the insistence of his grandmother, was eventually tested and told of his results.

With the aim of informing intervention practices in the context of growing public distrust and continued circumcision hesitancy, we set out to examine the assent and consent process for circumcision services among adolescent boys below 18 years using qualitative methods, including clinical observation and interviews with targeted young males. We see ethnography as an important remedy against the dominance of ‘economics, decision analysis and legal procedures’ in policy and bioethics debates.¹³ We examine how obtaining informed consent/assent has been practiced in the face of social realities on the ground.

Drawing on our unique ethnographic data, we argue that the universalistic bioethical concepts and norms guiding global health and governmental approaches ‘clash’ with contextualised understandings, norms and practices on the ground. Our research shows that the challenge of obtaining young males’ assent is made more complex and problematic in cross-cultural contexts where one-size-fits-all global health guidelines are deployed. Adolescent comprehension of circumcision-related risks was a serious concern and there were observable contradictions between the notions of individualised consent embedded in the VMMC programme and Swazi understandings of personhood. Gender and age-related hierarchies have a significant impact on decision making power, making the one-size-fits-all approach of informed consent and assent particularly problematic. One may ask: To what extent can we talk about young males’ assent and consent in contexts where parental authority is rarely questioned and almost never challenged?

METHODS

This study draws on ethnographic fieldwork conducted between May 2013 and August 2014 among Swazi boys and men being targeted by VMMC programmes. Research was conducted in a clinic offering free VMMC services during the 2013 BTS campaign, and a diverse sample of VMMC clients were recruited from rural and urban areas.

Research for this project was carried out under the umbrella of the MaxART project (Maximising ART for Better Health and Zero New HIV Infections). The MaxART consortium is led by Swaziland’s MOH and also includes the University of Amsterdam, the Clinton Health Access Initiative (CHAI), the Southern African HIV and 40 AIDS Dissemination Services (SAfAIDS), the South African Centre for Epidemiological Modelling and Analysis, the National Emergency Response Council on HIV and AIDS, the Swaziland National Network of People Living with HIV (SWANNEPHA) and the Global Network of People Living with HIV (GNP+).

Data collection

Data was collected using focus group discussions (FGDs), in-depth interviews (IDIs), participant observation and informal interviews. Data collection was carried out by the second and third authors. All participants referred to in this article were young males. In total, 6 FGDs, 11 IDIs and 14 informal interviews were held. We also observed six group counselling sessions in the clinic.

In total, 48 young males took part in the study; each FGD had between 3 and 8 participants and lasted for an average of 50 min. IDIs lasted about 30–40 min and were held outdoors in a private place but within the clinic premises. Informal interviews were held wherever the conversation started as long as the participant was comfortable. Some were as short as 10 min while others lasted up to 45 min. Although it was known within the clinic that we were researchers, we opted not to use a questionnaire or recorder when conducting informal interviews with young males to encourage greater rapport. FGDs and one-on-one IDIs were recorded on an audio recorder. Relevant information from informal interviews was written down immediately after the conversation.

Sampling

Participants were purposively sampled at the clinic. Eligible participants were those who had come for the VMMC procedure, had received both group and one-on-one counselling and were between 10 years and 19 years. Some of the eligible participants had been circumcised in 2 days prior to our interaction and had come for wound care at the clinic. The sample size was not predetermined as the main goal was to reach data saturation such that the research questions would be answered.¹⁴

Data analysis

Aside from informal conversations, all data was audio recorded and transcribed from a combination of siSwati and siTsoetsi (local slang) into English. The second and third author are native siSwati speakers and bilingual in English. Transcripts were inductively coded (using QSR International NVIVO V.10) after recordings were listened to twice. Thematic content was used for data analysis. The first and second authors worked in partnership to analyse the material presented in this article.

Ethical considerations

This research was part of a larger study that broadly looked at male involvement in HIV health services in Eswatini and was approved by the Scientific and Ethics Committee of the MOH. Permission to conduct the study in the clinic was granted by the nurse in charge. After explaining the risks of the study, the nurse gave us permission to obtain assent from the clients. All participants verbally assented to be a part of the study and this was audio recorded before data collection.

Since this study is about ethics and consent practices, reflecting on this study's consent/assent process is crucial. We believe one of the reasons why clients

opened up during data collection was because the data collectors clearly stated that they were not working for the VMMC programme. No participant declined to be part of this study and some may argue that this may be because previous research has shown that it is difficult for research participants in a hospital setting to draw a line between the study and service delivery in the hospital. For more on this issue, please see Dixon-Woods *et al* and Molyneux *et al*.^{15,16} Ethnographic research has shown that in biomedical research studies conducted in health facilities, some participants assume that by agreeing to take part in a clinical trial they are at the same time being treated of the disease they are suffering from. This is labelled as therapeutic misconception¹⁷ and has been argued to undermine autonomy and consent. Since these studies often take place in existing health centres that participants use in their daily lives, some participants fear refusing to take part in a research study because they believe it would jeopardise future access to services from the health facility. We were cognizant that this may have also been at play in this study.

Patient and public involvement statement

Our research was conducted within the MaxART consortium, which included MOH and PLHIV advocacy organizations Stop AIDS Now, SWANNEPHA, and GNP+. Patient representatives associated with these PLHIV organizations were consulted in the design of the larger substudy, which sought to understand how men engaged in HIV prevention services, including VMMC. Preliminary findings were shared with these representatives. Participants in the study were young male clients at a VMMC clinic and were not involved in recruitment or study design. Because contact information of participants was not collected to guarantee confidentiality, it is not possible to share results directly. Published findings will be shared with the PLHIV organizations, the participating clinic and the Eswatini MoH.

Limitations

This was a qualitative study and sample size relied on data saturation as described above. This means the findings cannot be generalised to the whole VMMC programme in Eswatini. Another limitation is that data were not collected from the parents/guardians of the adolescent boys.

Findings

This study found that adolescent boys struggled to exercise agency due to social factors, including cultural notions regarding respect and desire for consensus. Complicating factors included culturally engrained respect for older people, the use of incentives by interventions to increase uptake, poor comprehension of scientific terms related to the risks and benefits of the intervention and the option of testing for HIV or not. Applying national VMMC ethical guidelines, which were developed following the Joint United Nations Programme on

HIV/AIDS (UNAIDS) and President's Emergency Plan for AIDS Relief (PEPFAR) advice, proved difficult given contextual realities on the ground. Findings are grouped according to the themes that emerged from data analysis.

Respect and autonomy

Respect, especially for elders, is a core value in Eswatini. This was often echoed by the young men interviewed. Their desire to adhere to their parents' wishes was a main factor in deciding (not) to be circumcised and, further, they described disobedience as a sign of disrespect. Young men's relationships with parents are both reciprocal and hierarchical. Parents, and especially fathers, are expected to provide economically for their children, while dependents, including children and wives, are expected to consult parents or husbands about important (health-related) decisions,¹⁸ and to follow advice given. Dlamini-Simelane and Moyer make a similar argument in regard to the limited ability of married Swazi women to access antiretroviral treatment without the approval of their husbands. Although Eswatini law defines an adult as someone over 18 years, local norms and practices dictate that those over 18 years often require parental approval when making medical decisions. In the context of vigorous VMMC campaigns and a high prevalence of HIV, many parents have advised their sons, including adult sons, to get circumcised. Young men have little veto power and most submit to the surgery, even if they have misgivings.

During an FGD with five adolescent boys, we asked how they decided to get circumcised; one 12-year-old boy said, 'my mother said I must circumcise, and there was nothing I could do about it. I had to agree because it's my mother. Because I respect her, what else was I going to do?'. An 11-year-old boy said, 'My cousins and I did not want to get circumcised, but she [mother] did not give us a chance to refuse'. In another FGD with three adolescent boys, they all said that they most likely would not have been circumcised if their parents had not insisted. Although some indicated they might have gotten circumcised eventually, others were opposed entirely. One 13-year-old said, 'My mom made me come and get circumcised; I would have been against it because I once saw some boy who had gone to get circumcised, and he had the stitches bursting and rotting, which means his penis will never grow any bigger now and he may never have children'.

Parental wishes seemed particularly important among adolescent boys, but in some cases older males, including those above the age of consent, also felt pressured to obey. For example, one 19-year old who decided to get circumcised against his father's wishes reported, 'My father hates these MC [male circumcision] things. ... He gives many reasons and says they are doing it to us because we are black'. When asked if it was normal for his father to make decisions for him given his age, he responded: 'Of course, like most parents do. You cannot just pierce your ears if you feel like it's a cool thing because your parents might punish you for that. ... The same has happened to

me with circumcision. I will have to find a way of hiding from my father that I have been circumcised'. A Kenyan study argued that adolescent boys 'may neglect to obtain parent/guardian consent for VMMC in their bid to avoid negative social experiences among peers associated with being uncircumcised'.¹⁹

Use of incentives to increase uptake

Although we did not ask participants questions about their family's economic situation, our findings suggest that for some at least, poverty and hunger may have influenced their decision to assent. Some stated that they had come to the clinic because of the bread and juice they had been promised. Others said that they were motivated by the promise of football jerseys and footballs. Some clearly stated that they would not have come to the clinic had they not been offered incentives. This finding means many adolescent boys were not getting circumcised for better health outcomes such as reduced chances of acquiring HIV but rather for short-term personal material gains such as the sporting goods.

When asked what community mobilisers had promised them, participants from one FGD offered the following responses:

Participant 1: they told us that we would be given footballs if we got circumcised.

Participant 2: also, they said that they would give us a football kit if more than 20 of us got circumcised.

Participant 1: someone told us that we will get free bread here to eat, but we have not seen that yet.

In an IDI, a 15-year old reported similarly, 'Well, like I said, we came here as a group and we hope to get what we were promised [football kit]. If they do not give us what they promised us, I will tell the others not to come'. When asked if he did not also come for the benefits of circumcision, he responded:

Well, also that, but the most important thing is what we were promised. Have you seen the football boots that they will give us or the colour of the jersey? ... If they don't give us them, then I will tell the others that these people are liars and that they are not serious. I will also complain to them and my coach. ... He is the one who said we must listen to the guys from the NGO. He also told us they will give us a football kit that we can play with when we challenge other teams, especially around Christmas holidays because there are many football tournaments in the area.

Such exchanges make clear that in addition to parents, other adults, including football coaches, helped to influence young men's decision to circumcise. Additionally, promises of material goods and food appear to have been important motivators.

Informed?

Although it was called group counselling, the counsellor would generally lecture attendees about the advantages of getting circumcised, how to care for the circumcision wound, downplay risks and dismiss prevalent myths. Misconceptions were conflated with real complications

of circumcision such as possible serious adverse events (AEs) and pain during and after the procedure among many other facts. These facts were often grouped together with common misconceptions such as using foreskins remaining after circumcision procedures for making soup. The effect was to make young men feel silly or ignorant if they had any objection to circumcision. As this was the first ‘counselling’ most had ever experienced, few actively engaged and some did not ask questions or raise concerns. Age difference with the counsellor and group dynamics likely discouraged young people from asking questions. They seemed to not want to expose their ignorance or ask questions that might be regarded as a taboo when talking to older persons. Yet, they did feel comfortable asking such questions to us during one-on-one interviews. Counselling was also offered after the adolescent boys’ parents had already signed the consent forms, which suggests that counsellors were more focused on advising on the VMMC procedure and aftercare than encouraging informed assent.

Not surprisingly, we found that many adolescent boys did not fully understand the risks and benefits of the surgery, even after they had been counselled. To determine the participants’ level of knowledge, the authors asked the participants basic facts about circumcision such as the partial protectiveness of the surgery and the need to use condoms after getting circumcised. Ethical norms dictate that the participants should have been informed about all benefits and risks in a language proper to their age-related level of understanding the intervention.^{20–22} Although all interviewees had a one-on-one counselling session as well as group counselling before the interview, few were well versed on the risks associated with the surgery. When one 15-year old was asked if he had been informed about risks during counselling, he replied, ‘No, they did not say. They just asked if a parent agreed to get me circumcised. They never mentioned any negative things’. A 16-year-old with an astute understanding of the relationship between global health interventions, social marketing and capitalism characterised the VMMC campaign as ‘advertising’: ‘They were just advertising it when they came to my school, and all the negative things I have heard from people were not from those promoting VMMC. I have heard it could make you unable to have children ... Why would they say negative things when they are promoting something? That would be a bad thing to do for their job’. In a quantitative survey conducted in South Africa, Tanzania and Zimbabwe,²³ it was found that VMMC counselling in the three countries included VMMC benefits but paid little attention to risks associated with the surgery.

The group counselling sessions were conducted by one male counsellor each morning after all the VMMC clients scheduled for the day had assembled in the waiting room. Judging from the repetitiveness of these group sessions, the counsellor clearly stuck to an official script. He would stand and address the group of seated adolescent boys. As if in a classroom, the counsellor would pose a question

and solicit specific answers; the counsellor behaved like a teacher and the clients like obedient students. In one of the group sessions, after the participants had told the counsellor what they thought were the advantages of circumcising, he responded: ‘Yes, that is one of the reasons for circumcising. ... Another thing that causes panic when we talk about circumcision is the issue of pain after circumcision. Many of you will agree with me that they have been hearing rumours about this. Now, will you mention some of these rumours being spread around?’.

Describing pain after circumcision as a ‘rumour’ did not encourage adolescent boys to voice pain-related concerns. Pain before (from the sting of an aesthetic injection penetrating through the base of the penis) and after circumcision is a given, which is why circumcision clients are given a shot of anaesthetic before they are circumcised and painkillers after the surgery. Yet, the counsellor routinely labelled pain as a rumour. Not only were common side effects dismissed, neither were HIV prevention methods such as condoms or abstinence addressed during the sessions. The group sessions focused primarily on the benefits of getting circumcised, wound care and risks associated with wound healing. Intraoperation risks were not discussed despite being the most serious of possible complications. These include amputation, excessive skin removal and negative reactions to anaesthetic drugs.

Appropriate and comprehensive counselling should be one of the most important aspects of the VMMC procedure at the clinic. All clients should be encouraged to ask questions and raise concerns. When talking with participants, we observed anxiety in their voices when they asked questions. They were deeply concerned about feeling pain while being cut, mistakes during surgery and infections after the surgery, which they often referred to as the ‘rotting’ of the penis. We did our best to answer their questions and address their concerns, but as anthropologists our reassurances likely did not have the same impact as answers from a medical professional would have had. At the same time, we think it is important to stress that we did not take any extraordinary measures to build trust with research participants, having met all of them on the day of our interactions with them. Group counselling practices are increasingly normalised as a reasonable response in overburdened medical contexts, but the clinic where we conducted our research was well funded and the group setting did not seem conducive to achieving its stated goal of improving clients’ understanding of the procedure they were about to undergo.

HIV testing

Lack of knowledge among adolescent boys following counselling extended to HIV testing. Some were not aware that they were going to receive an HIV test and some stated that they had not been informed they could refuse. When a 14-year old was asked if he had been given the option to refuse a test, he replied: ‘No, they did not. It’s obvious because they won’t circumcise you without

testing you (It was a common misconception among many Swazis that an HIV test is a *sine qua non* before getting circumcised. See Adams and Moyer¹⁵). They do not ask whether you want to test or not. They just put you into a room and then test you' Like most participants, he thought HIV testing was obligatory.

The above excerpts show that in many, if not most, cases, adolescent boys were not given enough information about HIV testing or other medical procedures prior to being circumcised. The Eswatini circumcision consent form has two main sections to be filled in by parents. The first gives permission to test the adolescent boys for HIV and the second gives permission for the circumcision. Counsellors relied on the signed informed consent document and seemed to presume that parents had already discussed both circumcision and HIV testing with the adolescent boys, but this clearly was not the case. Folded into their presumption was the belief that young male clients had already assented to be tested for HIV and to be circumcised, so little effort was made to ensure this was the case. In practice, adolescent boys seemed to be assenting to the procedures because they believed that they had little choice and they often did so despite having many questions and concerns. It seemed then that counselling sessions were a missed opportunity on all fronts. For many of the youngsters, their visit to the clinic marked their first semi-independent engagement with the healthcare system. It could have served as an excellent opportunity to build trust between young men and the biomedical system in Eswatini; instead, the emphasis seemed to be on circumcising as many young men as possible in as short time as possible.

DISCUSSION

Most scholars studying circumcision-related ethics in sub-Saharan Africa have focused on the cornerstone VMMC trials,²⁴⁻²⁷ the ethics of early infant circumcision and the effects of adult circumcision on sexuality.^{7 28-30} The reason why little attention has been given to consent practices among adolescent boys is likely because African VMMC programmes initially focused on males aged 15 years and above. One study¹⁹ examined gaps in the consent process among VMMC clients in Kenya and its effects on the psychosocial outcomes among adolescent boys. Here, we have attempted to go a step further, critically analysing practices of consent and assent in relation to cultural norms of respect, the use of incentives and the extent to which pressures on VMMC implementers to meet donor-defined targets may lead healthcare workers to downplay the risks and overemphasise the benefits of circumcision.

Reaching VMMC targets set by donors and policy-makers in Eswatini is proving to be elusive.^{7 8 10} Not reaching targets has serious consequences for implementers such as loss of funds and job loss. This pressure is passed to community and healthcare workers who know that failure to reach targets is likely to lead to job loss. The rise in performance-based financing for global health interventions is contributing

to this pressure on implementers. Focus is on reaching targets within a specified budget and period. For example, PEPFAR has a cost per circumcision attached to funding for VMMC such that when a country is given VMMC funding, those funds are expected to return a proportional number of circumcisions. This 'tyranny of numbers'³¹ boils people down to mere numbers, decontextualises them and effaces the reality of everyday life and experience. We have observed that this can lead some health workers and community mobilisers to overlook critical aspects of patient rights, including those related to adolescent boys' assent.

Ethnographic methods that seek to establish trust with research participants are often able to provide critical insight into the ways that medical interventions are experienced by those with little power in everyday situations.³² Intensive ongoing research at the local level can lead to forms of understanding that diverge from what might have been anticipated by those who plan and implement global health interventions. Our research has shown that, contrary to the presumptions of client agency embedded in Swazi VMMC best practices and ethical guidelines, the patient's decision-making process to circumcise or not does not lie within the control of most young males. Our findings indicate that the ethical guidelines promoted by the VMMC programme of Eswatini are not in harmony with the realities of the Swazi context, where cultural norms and practices related to consent and age-related respect are at odds with presumptions of agency and rational choice enfolded into target-oriented policies and donor-reliant VMMC campaigns. This research echoes findings that 'across eastern and central Africa (and other places) ... many important health decisions are made by groups, based most often on extended family, but also on other bases such as neighbourhood or religious congregation'.³² Offering a more critical perspective,³³ some argue that:

Formal ethics share characteristics with the scientific gaze that they govern: they view social fields, such as a trial community, 'from above', detached from its members' social practices, and set out principles and rules a priori; they regard separate entities (persons, groups), rather than relations and processes, as elementary particles of moral reasoning, which they frame as individual rights and decisions ... they regard with suspicion the mundane material needs of members of a trial community, focusing instead on abstractions such as rational choice and autonomy.

Recruitment is arguably the most significant task of VMMC campaigns and certain strategies are used to increase uptake, including offering incentives. The use of incentives has been proven to increase participation in intervention research, despite the level of risk posed by the research or intervention.³⁴ A systematic review of circumcision demand creation interventions concluded that the most accepted and effective interventions are financial incentives.³⁵ Institutional review boards which review ethical issues related to human subjects' research are increasingly questioning the use of incentives in interventions and research and their coercive effect on potential participants.³⁶ Incentives were a key aspect of VMMC

campaigns in Eswatini even though national guidelines prohibited their use and UNAIDS guidelines³⁷ advise that ‘Mandatory or coerced male circumcision is a violation of a range of human rights, including rights to dignity, bodily integrity and personal autonomy. Target numbers of procedures, incentives to men and incentives to providers for reaching targets should be avoided’.

Free transport and packages for wound care were provided, but these may be considered necessary extensions of the service to ensure uptake and quality of wound care post circumcision. However, other incentives such as football kits, bags, t-shirts and footballs influenced some young males to get circumcised. Some stated that they might not have decided to get circumcised had no gifts been offered. Some researchers have argued that gifts such as those offered to adolescent boys in Eswatini should not be seen as coercive, but rather as a form of manipulation, persuasion or a nudge.^{20 38} Others have argued that giving poor people compelling incentives may not be seen as overt coercion but rather as a covert way of manipulating vulnerability and potentially limiting decision-making ability.^{33 39–41} We align ourselves with the latter camp.

Our findings also corroborate with a study conducted in Eswatini, which showed that adolescent boys have relatively poor knowledge about the risks associated with VMMC.⁴² Some participants stated that they were not informed about any risks. This was also evident in the group counselling sessions that we observed, which focused on benefits and wound-caring techniques rather than risks. Other studies^{23 43} similarly noted that risks and certain procedures were not well discussed before VMMC clients were circumcised in Eswatini.

Despite clients not being able to clearly state risks related to circumcision during one-on-one interviews, they routinely raised concerns and asked question about potential circumcision risks. Their fears were not unfounded because all surgeries hold some level of risk. In the case of VMMC, these may range from swelling and bleeding to more serious AEs such as penile skin loss, severe infection, torsion of the penis and injury to the penis’s glans and shaft. Although serious AEs are a rarity when VMMC is performed by a trained doctor in a fully provisioned clinic as it is the case in Eswatini, complications may still occur and those undergoing such surgeries should be adequately informed.

In 2020, more than 10 years after the VMMC programme was introduced in Eswatini, donors issued guidance that circumcision among 10–14-year-old males should be stopped immediately. One of the reasons for this guidance was recognition of the higher risk of serious AEs among this age group. For example, PEPFAR’s Country Operational Plan 20 (COP20) guidance⁴⁴ states that ‘Despite great progress in some countries the progress is coming from the under 15 age band and this will not be funded in COP20 due to SAEs [serious adverse events]’. Recent analyses have demonstrated that all glans injuries and 90% of urethral fistulas occur almost exclusively in boys under the age of 15 years.⁴⁵ Like PEPFAR, the WHO also updated

its VMMC guidelines to advise against targeting adolescent boys between the ages of 10 years and 14 years, who are now characterised as lacking the ‘capacity to make independent decisions that affect their own health’.⁴⁶ Some may ask why such important questions about the risk to penile injury to younger boys and their difficulty in assenting are only being raised now by the bodies tasked with establishing global health guidelines, especially given that serious AEs had been reported almost immediately? We might also ask what the long-term effects of such neglect may be in a context where the motives of biomedical research and interventions are already routinely questioned, especially by older men?

CONCLUSION

As recommended by international ethical guidelines, policies adopted by the MOH and VMMC implementers claim to encourage respect for adolescent boys’ rights and respect for their decisions in the consent process. The ongoing HIV crisis in Eswatini has prompted an exceptional public health response. The drive to eliminate HIV infections opened the door for interventions such as adolescent boys-targeted circumcision campaigns that would be considered untenable in most countries. Although the desire to defeat HIV is admirable, surely it should not come at the expense of young men’s right to have a say on whether they should be circumcised, or their future trust in biomedicine.

Contributors RB and EM were responsible for the study design, which they developed with input from the larger MaxART consortium. Data collection was completed by Swazi citizens, RB and FS, as part of their fully funded PhD trajectories at the University of Amsterdam under a supervisory team that included Moyer. Although Moyer and other Amsterdam-based co-supervisors visited Eswatini and participated in national and international workshops during which primary results were shared, the research process was intentionally designed to produce collaborative processes and recognise the vital importance of RB and FS as researchers in the MaxART consortium. RB and EM analysed and drafted the article. The article was finalised by EM with input by RB and FS. As the guarantor, RB is responsible for the overall content of this article. He accepts full responsibility for the work and/or the conduct of the study, had access to the data, and controlled the decision to publish.

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Competing interests None declared.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Consent obtained directly from patient(s).

Ethics approval This study involves human participants. The research was approved by the Swaziland National Health Research Review Board in July 2014 (reference number: MH/599C/FWA 000 15267). Permission to conduct the study in the clinic was granted by the nurse in charge. After explaining the risks of the study, the nurse gave us permission to obtain assent from the clients. All participants verbally assented to be a part of the study and this was audio recorded before data collection. Participants gave informed consent to participate in the study before taking part.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request. The anonymised interview transcripts on which arguments made in this article are based can be accessed by contacting the corresponding author.

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Reflexivity Statement

Study Conceptualisation

How does this study address local research and policy priorities?

Both HIV and update of voluntary male medical circumcision were key research and policy concerns in Eswatini at the time research was carried out and, indeed, continue to be so.

How were local researchers involved in study design?

Eswatini researchers, including Baas, who is co-author of this paper, took the lead to develop the study design in consultation with key public health practitioners in the Eswatini ministry of health.

Research Management

How has funding been used to support the local research team(s)?

Research funds were used to pay PhD salaries to the two co-authors from Eswatini while they completed their dissertations at the University of Amsterdam. Additionally, all expenses incurred while conducting research were reimbursed. They both received four year contracts. Additional funds were used to compensate Swazi research assistants who helped recruit research subjects and transcribe recorded interview material when required.

Data acquisition and analysis

How are research staff who conducted data collection acknowledged?

Both researchers involved in data collection are co-authors of the submitted paper.

How have members of the research partnership been provided with access to study data?

All transcribed interview materials have been shared with all co-authors and members of the social science team based in The Netherlands and in Eswatini. Those who collected the data have approval rights on all manuscripts written based on their collected data.

How were data used to develop analytical skills within the partnership?

The corresponding author was one of the PhD supervisors for Baas and on the examination committee for Zwayne's PhD. Extensive discussions were held between the three authors following preliminary analysis of the data with the aim of mentoring Baas and Zwayne to improve their analytical skills as part of their PhD training.

Data interpretation

How have research partners collaborated in interpreting study data?

Please see above. As ethnographic data analysis is primarily an interpretive exercise, PhD mentoring entails a close reading of junior researchers' preliminary analysis, coding terms and interpretations. However, because both Swazi authors had greater knowledge of the history, culture, and health policies of Eswatini, they were also able to guide the third author in more nuanced interpretations of the data.

Drafting and revising for intellectual content

How were research partners supported to develop writing skills?

As PhD researchers enrolled in the University of Amsterdam's anthropology department, both PhD co-authors participated in academic writing coursework. Additionally, they participated in writing seminars organized by the corresponding author and received feedback on manuscripts from a professional editor.

How will research products be shared to address local needs?

Preliminary findings of our research were regularly shared during closed-door Ministry of Health HIV policy meetings in Eswatini. Similarly, all published papers are sent to those responsible for HIV policy making in Eswatini.

Authorship

How is the leadership, contribution and ownership of this work by LMIC researchers recognised within the authorship?

We provide an authorship statement which recognizes the work of the two LMIC researchers who collected data and contributed to the writing of the article (both are co-authors).

How have early career researchers across the partnership been included within the authorship team?

Two of the three authors are early career researchers.

How has gender balance been addressed within the authorship?

Two of the three authors identify as female and the third author identifies as male. The corresponding author is considered an expert in the field of masculinity studies, especially where it intersects with the field of gender and development. This meant that extensive discussions were also held between the authors regarding the gendered aspects of the research process and the interpretation of the data.

Training

How has the project contributed to training of LMIC researchers?

The main contribution consisted of PhD training for the LMIC researchers involved in the project. Zwayne has already successfully defended her PhD and Baas has completed his dissertation manuscript and is awaiting the formal defense.

Infrastructure

How has the project contributed to improvements in local infrastructure?

The project has contributed to the development of new health infrastructures intended to make men feel more welcome in public HIV testing and treatment facilities.

Governance

What safeguarding procedures were used to protect local study participants and researchers?

Safeguarding procedures included regular debriefing with researchers and other project team members to discuss past and potential future concerns, as well as the design of research and community engagement practices to minimise harm or violence. This included pre-study discussions with local community leaders, including people living with HIV, and clinical staff. Local researchers were also asked to always advise someone of their plans, location, and movement via a team WhatsApp group.