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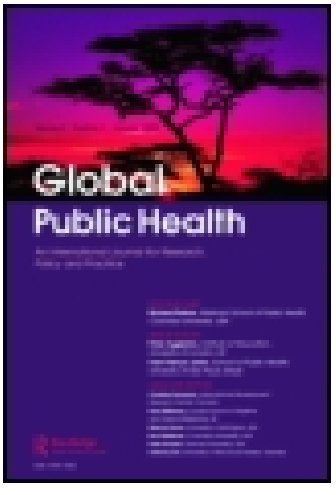

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Sex is never the same: Men's perspectives on refusing circumcision from an in-depth qualitative study in Kwaluseni, Swaziland

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Faced with an HIV prevalence of 31% among 18- to 49-year-olds, Swaziland developed a male circumcision policy in 2009, following compelling scientific evidence from three randomised controlled trials. Utilising United States Agency for International Development funds, the state set out to circumcise 80% of adult men in 2011. Only 8667 of the targeted 150,000 men were circumcised during the campaign. This paper presents findings from a 2012 to 2013 in-depth qualitative study among Swazi men. Methods included 13 focus group discussions, 20 in-depth interviews, 16 informal interviews and participant observation. We argue that the campaign's failure can be partly explained by the fact that circumcision was perceived as a threat to Swazi masculinities, a factor hardly considered in the planning of the intervention. Results show that men believed circumcision resulted in reduced penis sensitivity, reduced sexual pleasure and adverse events such as possible mistakes during surgery and post-operative complications that could have negative effects on their sexual lives. Given the conflicting state of scientific data about the effects of circumcision on sexuality or sexual pleasure, this study addresses important lacunae, while also demonstrating the need for more research into the relationship between sexuality, masculinity and health interventions seeking to involve men.

Keywords: male circumcision; masculinities; sexuality; Swaziland; HIV

Introduction

With an HIV prevalence of 31% among 18- to 49-year-olds, Swaziland has the highest HIV prevalence in the world (Swaziland Ministry of Health, 2012). Faced with this reality, the Government of Swaziland, with financial aid from the United States Agency for International Development (USAID), established a male circumcision (MC) policy with an initial goal of circumcising 80% of Swazi men by the end of 2011. Following three randomised controlled trials (RCTs) in South Africa, Uganda and Kenya, which showed that MC reduces HIV transmission from women to men by 51–60% (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007), the World Health Organization proclaimed there was 'evidence beyond reasonable doubt' of MC's effectiveness. Despite the fact that the surgery is offered for free in Swaziland and often includes free transport and other incentives, as of 2012, only 48,083 men had been circumcised, suggesting that the target of circumcising 180,450 men by 2015 is unlikely to be met (WHO, 2012). With uptake remaining modest and time running out, Voluntary Medical Male Circumcision

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(VMMC) implementers received additional funding worth US$25 million from President's Emergency Plan for AIDS Relief (PEPFAR) in 2014 to reach the 80% coverage of VMMC by 2019.

The MC initiative set up by the Government of Swaziland in 2011 was called the Accelerated Saturation Initiative and also referred to as Soka Uncobe (Circumcise and Conquer). Futures Group was responsible for implementing the programme with key partners: Population Services International (PSI Swaziland), Jhpiego (an non-governmental organization [NGO] affiliated with Johns Hopkins University), Matchboxology, John Snow International and several other local partners. The implementers were all aware that MC had never been tried at the population level as a health intervention aimed at adults. Acknowledging the difficulty of the task and armed with considerable funds, they orchestrated a public health campaign meant to create demand for MC among the population (K4 Health, 2011).

To demonstrate commitment from the Swazi Government, several steps were taken to promote the intervention. For the first time in history, His Majesty, King Mswati III, was invited to participate in the launching of a health intervention, which he did together with the Honourable Minister of Health, Benedict Xaba, and staff from the US Embassy. This coordinated action was meant to demonstrate the political will of Swazi leadership. Communications materials were distributed in most public spaces, and the circumcision campaign was vigorously advertised. Efforts were made to remove structural barriers such as transport by offering fuel vouchers or free transport for MC clients. Advocacy campaigns were put in place with trade unions, local businesses, members of the royal family, traditional leaders and healers, religious groups and the government. Communications programmes were carried out through school visits, community dialogues, road shows and church messages, complemented by a mass media campaign via radio, murals, billboards, taxi advertising and posters.

Justman et al. (2013), reflecting on lessons learned from successful MC campaigns that have led to high uptake of MC, has suggested that mass media campaigns and political leadership have proven key. However, these factors were present in the Swazi setting. So why did uptake remain poor? Adding to this conundrum, the results of quantitative acceptability studies carried out in the country prior to MC scale-up suggested that acceptability was 87% (Tsela & Halperin, 2006) and 72.4% (PSI, 2010) among adult males between the ages of 18 and 49.

MC was not only to be introduced in Swaziland but also in other sub-Saharan countries where HIV prevalence was high and MC prevalence low (World Health Organization and Joined United Nations Programme on HIV/AIDS, 2007). Prior to the scale-up of MC services in these countries, a meta-analysis was carried out to investigate acceptability of MC in eastern and southern Africa; the authors concluded that acceptability ranged between 29% in Uganda and 87% in Swaziland (Westercamp & Bailey, 2007); a second study carried out in neighbouring South Africa reported that MC was perceived positively (Lagarde, Dirk, Puren, Reathe, & Bertran, 2003). Figure 1 shows the areas and countries where the MC acceptability studies were carried out.

From the meta-analysis (Westercamp & Bailey, 2007, p. 34), it was concluded that despite fears about pain, safety and cost, 'Overall it was felt that MC would be accepted in these countries', and that, 'because the level of acceptability across the nine countries was quite consistent, additional acceptability studies that pose hypothetical questions to participants are unnecessary'.

Lagarde et al. (2003, p. 94) conducted a study in an area in South Africa that did not practice MC and made similar predictions based on their findings.

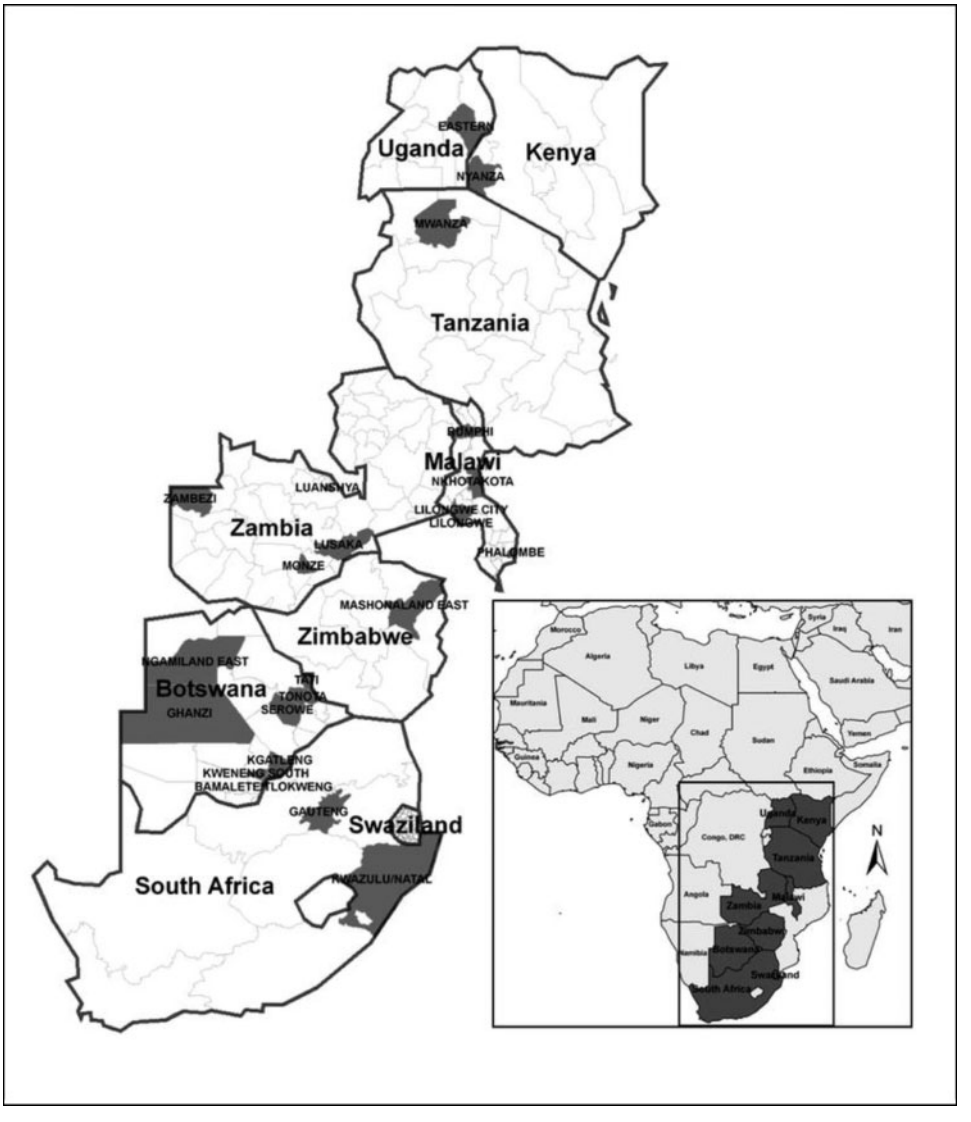

Figure 1. Countries that have implemented MC acceptability studies.
Source: Westercamp and Bailey (2007).

The ambitious goals of the Swaziland MC initiative were established both by mathematical models, which stated that 80% of a country's population needed to be circumcised for MC to have a substantial impact (Njeuhmeli et al., 2011), and by research on the acceptability of the intervention. In the case of Swaziland, we argue that establishing the acceptability of an intervention (PSI, 2010; Tsela & Halperin, 2006) is a lengthy process because respondents may need time to reflect and consult their family, friends and partners, especially when the intervention is directed at the penis, a physically and symbolically sensitive part of a man's body.

This paper explores the inability of the implementers to reach their targets in Swaziland, with a particular focus on men's refusal of services. More specifically, the

findings from this study demonstrate the relationship between masculinities and low uptake of circumcision services, addressing an important lacuna in the literature relating to the use of adult MC in high prevalence settings to reduce HIV acquisition among men.

Methods

The study was conducted in Kwaluseni, a peri-urban community in central Swaziland. The area was chosen because of its proximity to the first and largest clinic to offer stand-alone, free MC services in the country. *Litsemba Letfu* (Our Hope) Men's clinic, a state-of-the-art purpose-built clinic, sponsored by USAID, is located along a busy highway on the upper level of a roadside shopping mall, a few doors down from the Matsapha New Start Voluntary Testing and Counseling Centre. They have been performing MC surgeries since 2009. Kwaluseni is about 20 minutes walking distance from *Litsemba Letfu* Men's Clinic, making it easily accessible to the men living in Kwaluseni.

In this ethnographic study, data were collected in two phases. The first phase of data collection was done in a seven-week period, from May to June 2012, and the second phase was from May to June 2013. A range of qualitative methods, including focus group discussions (FGDs), in-depth interviews, participant observation (PO) and informal conversations were employed. In total, the authors conducted 20 in-depth interviews and 13 FGDs. PO and informal conversations (16) ran concurrently with these techniques for the whole data collection period. Field notes were used to record all POs and informal interviews. Through POs, we participated in participants' daily lives, and this took place in various places including football fields during football tournaments, outside shopping complexes and in *sheebens*. By observing participants, we mean that we spent time with them, took part in naturally occurring collective discussions, listened to what they said, how they said it, where they said it and asked questions to clarify interesting or relevant information. Some POs included respondents who had been included in FGDs, in-depth interviews and other respondents.

As a demonstration of our appreciation, we organised a small *braai* (barbeque) for FGD participants. During the *braai* we informally discussed issues related to MC and HIV. This means some respondents were interviewed more than once but in different settings. Although the lead researcher did not reside in the study area, he stayed about 35 kilometres away and would leave late in the evening on Fridays and some Saturdays, when men would spend more time out with their friends. Some of those interviewed also introduced the lead researcher to other people in the community, including their friends and family members. One 26-year-old man who lived in the community served as a gatekeeper to the lead researcher, keeping him abreast of issues relevant to the research and inviting him to participate in the everyday lives of him and his friends. This greatly improved rapport and security, as the area is known for high crime rates. With his help, we identified sites where men were likely to be found when not working, and he accompanied the lead researcher to those sites and introduced him. Research sites included a football field, a car wash and *sheebens* (pubs and bars in the community). The lead researcher was intentionally introduced as a student researcher working on MC rather than as a researcher working with NGOs. NGOs are known for promoting HIV prevention programmes and being associated with them might have led to social desirability bias. Following introductions and initial small talk, the topic of circumcision and other health issues would be discussed. Occasionally the conversations turned to heated debates between the men and sometimes women. *Sheebens* and other places where men gathered proved to be good places to observe such debates.

Sensitive issues such as sexual feeling and function were discussed freely in these settings. Most would agree that circumcision is a highly sensitive topic, shaped by religious, ethnic, gender and other cultural norms. According to Teunis (2001), ethnographic research is the most appropriate method to explore such sensitive topics. Although the lead researcher had openly declared himself as a researcher, in some cases, especially when he hung out in the field, some participants were not aware of his role as a researcher. This was also helped by the fact that he would not carry a questionnaire or a recorder in such situations, unlike in organised interviews like FGDs and in-depth interviews. We believe such unguided and 'seemingly unobserved or unrecorded' conversations added to the depth and richness of the data. Much of our insight emerged from conversations, jokes and arguments in naturally occurring groups. It was not uncommon for the lead researcher to observe small groups of men discussing MC, normally with one man present who was circumcised and other men curious about the procedure and its effects. These discussions provided insight into how some uncircumcised men came to 'know' certain things about circumcision. The lead researcher would also minimally participate in such debates, mainly probing and asking questions for clarification.

For in-depth interviews, male participants included a mixture of 14 uncircumcised and 6 circumcised males ages 15–42, with each interview lasting an hour on average. The 13 FGDs were comprised of mixed circumcised and uncircumcised males ages 19–47. A total of 81 men took part in the FGDs. Each FGD had between 4 and 12 men and lasted between 1 and 2 hours. More than half of the participants had completed high school with only six who had tertiary education. A majority of the men were unemployed and spent a lot of time in the community. Informal interviews were not timed; some were as short as 15 minutes, whereas others lasted an entire afternoon. In all FGDs, circumcised men were fewer than uncircumcised men. The ratio of circumcised to uncircumcised participants was approximately 1:4, similar to the national circumcision prevalence of 26% (WHO, 2012). The FGDs provided a platform for recruiting additional participants. This was mostly the case when recruiting circumcised men, which was not easy, especially given that 75% of circumcised men are under the age of 20 (WHO, 2012). Because circumcised men generally were outnumbered, we tried to compensate by giving them extra time and attention. The methodological strength of well-orchestrated FGDs is that they can approximate more 'natural' interaction than do individual structured interviews, providing insights into social norms of communication and the way people talk to each other about particular topics (Green & Thorogood, 2004).

Due to the fact that our approach was ethnographic, and based on a relatively small sample, we did not aim to generalise our findings. We sought to understand men's emic perceptions on MC and the meanings surrounding the intervention in a naturally occurring setting. All respondents were conveniently sampled although a few (circumcised) were purposively sampled, especially for FGDs, because of the scarcity of circumcised males in the community. No participants refused to take part in this study. Most men we approached indicated that they thought MC was an interesting topic worthy of further discussion and agreed to be interviewed on the spot. Some claimed to be busy and asked to be interviewed at a later time, possibly as a means to meet alone with the lead researcher, who was often accompanied by his de facto assistant. The use of ethnographic techniques to promote rapport (meeting potential research subjects in informal community settings, approaching them in the context of their everyday lives, using their language, sharing meals and drinks) likely attributed to the high acceptance

rate. This was also enhanced by the fact that the lead researcher was a young Swazi man who shared the same language, gender and age of the participants.

Data collection began with FGDs. Themes that emerged from the FGDs were explored further using in-depth interviews and informal interviews. Interviews were conducted in siSwati and *siTsotsi* (local slang) with a combination of English when considered convenient to the participants. In-depth interviews and FGDs were conducted in secluded places for privacy and better audio quality. These interviews were audio recorded and then transcribed in English by the lead researcher who is bilingual.

Data were analysed manually from the first interview until saturation was reached. This means that the sample size was not predetermined. Data analysis was an ongoing process and was done by both authors. Thematic content analysis was used for data analysis and themes were coded inductively. This means that data were organised into recurrent themes and we sought to present the key elements of the participants' accounts. Themes were developed as data were being collected and codes were also defined in the very early stages of data collection.

Ethical considerations

This study received ethical clearance from the Swaziland Scientific and Ethics Committee and the University of Amsterdam. The first author had been trained in human subjects' protection previously when working for International Center for AIDS Care and Treatment Programs Columbia University Mailman School of Public Health. Informed consent procedures were observed throughout the study. All participants signed an informed consent immediately before taking part in the study. Because adolescents aged 15–17 years were also part of this study, parental/guardian consent was first obtained before young men were asked to assent on their own in private.

Findings

The findings presented reflect the key themes that emerged from data analysis. Overall, MC was perceived negatively, contradicting the findings of the MC acceptability studies carried out prior to the MC intervention (Lagarde et al., 2003; PSI, 2010; Tsela & Halperin, 2006; Westercamp & Bailey, 2007). This finding seems accurate, especially given the low numbers of men who accessed services during the campaign (WHO, 2012).

Our ethnographic approach allowed for a free exchange between researcher and interview subjects, giving respondents time to ask questions related to, for example, the likelihood of individual health benefit, likely short-term side effects of circumcision surgeries and requirements for using condoms following successful circumcision. Both the tone and content of these discussions made it apparent that many men viewed circumcision with deep ambivalence, expressing concerns about the fear of loss of sexual pleasure and unwillingness to undergo a surgery that would only result in partial protection, issues which, notably, were not addressed in the public health circumcision campaign.

Fear of pain a major barrier?

Our research shows that, contrary to what was reported in previous acceptability studies, fear of pain was not a significant barrier to uptake. A common response from men regarding this issue was that all surgeries have an element of pain but people still

underwent surgery if they believed it would benefit them. In two weeks of informal conversations with men about circumcision, the issue of pain hardly emerged as a barrier. As fear of pain had been widely reported as a possible barrier to MC (Westercamp & Bailey, 2007), one of the questions posed in our subsequent interviews was, 'is pain one of the reasons for you not to circumcise'? The men in the FGD did not take this question lightly. One 37-year-old uncircumcised man said during an FGD:

> What are you trying to say about us? You know the Xhosas (a tribe in South Africa that customarily circumcises boys as a rite of passage into manhood) circumcise and they do not even use an anesthetic. Yet they go up to the mountains to undergo the surgery and some even die, yet they still continue to do it. Also, these boys [pointing at a younger man in the FGD] circumcise more than we (older men) do; so are you trying to say we are cowards? No. We are not. They do it because they are convinced and feel it is necessary. We just have our problems with it.

Because enduring pain is perceived as a demonstration of manhood, men insisted they would be willing to undergo a painful surgery if convinced it would benefit them personally. Further interviews highlighted distinctions between generations regarding the issue of pain. Interestingly, younger men and adolescents expressed greater worries about pain, but they were also more likely to undergo circumcision surgery than were the older men, who did not seem too concerned about pain. Whereas such a division might be expected in an FGD setting where there is always an increased risk of desirability bias and reproduction of social norms, similar conclusions can also be drawn from our individual interviews with men. As will be discussed further below, issues of masculinity were clearly entwined with the issue of circumcision. However, our research suggests that because many men seem to welcome the opportunity to prove their manhood by enduring pain, this particular factor is unlikely to be a main driver of men's decisions to refuse circumcision.

MC as a threat to masculinity

Male participants consistently defined a 'real Swazi man' as someone who has a wife, children and who is able to take care of them. Further, a man must be sexually functional in order to have a wife and children. Circumcision was perceived as a threat to men's ability to function sexually, thereby indirectly threatening his ability to maintain his family and, consequently, his manhood. Uncircumcised men of all ages expressed concerns that they would lose sexual sensitivity following circumcision, which might then reduce their ability to enjoy sex and satisfy their sexual partners. Many were also concerned that the surgery could be botched, leading to what the medical literature blandly refers to as an adverse event (AE).

Concerns of loss of sexual pleasure

Our data make clear that concerns about loss of sexual pleasure were one of the most salient barriers to MC uptake. This finding came up in the first FGD and was a consistent topic of discussion throughout the entire fieldwork period, especially during PO and informal interviews. With the exception of three adolescents who reported that they believed girls liked a circumcised penis better, more than half of the male participants reiterated the potential loss of sexual sensitivity in FGDs, in-depth interviews and during informal conversations.

The following excerpts exemplify the extent to which the fear of loss of sexual pleasure affects MC uptake.

A 25-year-old uncircumcised man said in one informal interview:

> I hear them say that it reduces the chances of getting HIV and other diseases but I do not think the penis head remains as sensitive as it was before, because it gets dry.

A 31-year-old circumcised man said in an FGD:

> A friend of mine lied to me and he said after getting circumcised I would enjoy sex better. Also, the MC Ambassador was telling us that you would enjoy sex better after circumcision. But now it (penis head) is almost like rubber and there is no longer that feeling when entering the female.

A 26-year-old uncircumcised man said during an in-depth interview:

> It's one hell of a thing. I would never do it because ever since it (MC) has been here you hear about the good side of it and not the disadvantages … my two friends who got circumcised complain about it, they say it (sex) is never like before; it has never been the same. They (public health campaign) never report the end result; they just talk about reduced chances of getting HIV and other STIs.

A 22-year-old circumcised man who was fixing a minibus with his assistant said the following during PO:

> You see, ever since I got circumcised I've been hearing negative things about this thing (circumcision). At first I thought it was a good thing but my friends tell me that I will have erection problems when I get older.

Such statements were common and representative of the men we interviewed. It appears that individual men who have undergone circumcision in Swaziland routinely complain to their peers about loss of sexual pleasure following the surgery and, further, that such conversations are more likely to influence men's expectations of sexual pleasure and performance following circumcision than are the public health campaigns, which went so far as to promote circumcision as a sexual enhancer in Swaziland, without being explicit about what such enhancement might entail.

For example, the Senior Programme Officer responsible for MC from the Swaziland National AIDS Programme said, 'circumcised men naturally perform better sexually' in an interview with the Times of Swaziland (Ndlela, 2012). Men argued that losing sexual sensitivity would mean that they would not be as sexually potent as they used to be. Failure to perform sexually is seen as emasculating because it is associated with the inability to maintain healthy relationships and father children, both of which are a basis for claims to Swazi adult masculinity and wholeness (Bourdieu, Poupeau, & Discepolo, 2001; Groes-Green, 2009).

Fear of botched surgeries

Men's worries about damage to their penises and their sexual functioning should not be construed as irrational, especially given that most adult MC studies report that complications do occur. Complications in surgery even occur under the most rigorous

protocols, including the three RCTs where 1.5–3.8% of all surgeries resulted in AEs (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007). From a biomedical perspective, the risk of AEs might be considered acceptable when weighed against population benefit. However, it seems any risk, even a mild AE such as swelling of the penis, is considered too high for most individual men in this study to consider, as illustrated in the following excerpts.

A 31-year-old uncircumcised man said during an in-depth interview:

> Does it not happen that they make a mistake? A neighbor of mine got circumcised and he took a very long time to heal. As people we heal differently and some take too long and you find that you have a swollen penis for weeks and the penis does not get back to its original state.

Another 23-year-old uncircumcised male said the following during an FGD:

> It happens that when they circumcise you a mistake happens and they told us when they came to school to teach us about MC that there is a possibility of such things happening. They said sometimes you get an infection and the penis might even rot. This means your whole life has been damaged, you cannot do anything about it and that means you will not be able to have a wife and kids … my friend got circumcised and his penis was so swollen it took a very long time for it to heal … We all learnt from him. Yes it happens that they cut you in a bad way and they also stated this themselves and this would affect your whole life. You cannot tell me that you do not have a penis and expect to have a wife and a home. You will not be able to have a child for your whole life.

From a biomedical and public health perspective the complications described in the above quotes would be defined as 'a mild adverse event', but as we can see from the quotes, men take any complication very seriously when it concerns the penis. Participants considered things such as botched surgeries and lengthy time in healing as AEs. No information was given to the participants about AEs in the study as we only wanted to investigate what meanings they attached to MC.

The futility of MC

Poor uptake of MC was exacerbated by the fact that it is only partially protective against HIV acquisition. Abstinence, being faithful and using condoms (ABCs) messaging has been the mainstay of prevention activities over the last decade in Swaziland. It is against this backdrop that MC has been introduced. After the first RCT on MC was published, the principal investigator in the South African trial, Bertran Auvert, praised MC as 'equivalent to what a vaccine of high efficacy would have achieved' (Auvert et al., 2005, p. 1120). Contrary to Auvert's bold claim, the men interviewed in our study argued that because MC is only partially protective, it is useless to them as a means of individual protection. Their major concern was that circumcised men are still required to use condoms and therefore individual men could not see the value of circumcision, especially given that male condoms are more efficacious in the prevention of HIV and other sexually transmitted diseases (Pinkerton & Abramson, 1997). The logic of a public health benefit was not considered convincing from an individual perspective, but men also questioned the extent to which health information could be trusted when it seemed to counter what they had been told in previous campaigns. An uncircumcised 33-year-old man said in an FGD:

> we were told about ABC, which is being faithful, condomising … hmm and abstaining. So I think circumcising makes no sense with these things. Why circumcise if you abstain? Why circumcise if you condomise? Why circumcise if you are faithful? They tell you to circumcise and also use condoms, why? This thing is not 100% effective so why don't you just leave the circumcision thing and condomise?

The following extract, published in *The Times* of Swaziland on 20 May 2012 (Mathunjwa, 2012) during the data collection period, quotes a 44-year-old man who was 'mysteriously' circumcised without his consent after he was involved in a car accident:

> I never wanted to be circumcised as I did not believe in it. A number of people including doctors I worked with at the Nhlangano Health Centre tried to convince me to be circumcised but I told them that I was not going to do it. The reason was that I had been told that once a person is circumcised, he no longer enjoyed sex. I then decided that I would not do it especially because I was faithful to my wife.

The above excerpt reiterates the belief that MC reduces sexual pleasure, but goes further to claim that circumcising is useless if you are practicing other preventative measures. The man stated that he was faithful to his wife so he did not see why he should circumcise.

Clearly, men question the efficacy of the intervention, arguing that ABC are more efficacious at an individual level than MC in lowering HIV acquisition, preventing pregnancy and other STIs, and that, contrary to MC, condoms protect both partners. Because there are other more effective ways of preventing HIV acquisition, some men could neither accept nor justify circumcision.

Fear of the unknown and irreversibility of circumcision

Another factor that men give for refusing circumcision is that it is an irreversible procedure. The HIV epidemic has seen many interventions being implemented and the field of HIV prevention is very dynamic when considered in historical perspective. As discussed above, ABC were promoted as the main preventative measures for more than a decade prior to the introduction of MC as a prevention technique. In 2014, with support from the Dutch NGO, Stop AIDS Now! the Swazi Government piloted a treatment as prevention intervention called MaxART. From the perspective of those targeted by public health campaigns, one must be cautious following the advice of experts who shift their recommendations citing science, especially when scientific claims are entwined with multi-million dollar donor initiatives and political partnerships. Men stated that because the field of HIV is dynamic, new and better interventions (including a possible cure) may be introduced in the future. The dynamic nature of public health knowledge also led them to question what could happen in the future if a new disease would emerge that may be easily acquired by those without a foreskin.

A 34-year-old uncircumcised man said in an FGD:

> You see now what you will hear is that there will be a new disease that affects those without a foreskin. Those that are circumcised may have problems. You will hear that the foreskin was there for a reason. So then there will be problems because the foreskin is already dead and cannot be replaced. They will tell you that if you have a foreskin you are safe, so what will happen to those that have circumcised?

Another uncircumcised man, age 42, said during an informal interview:

> We were told that if you are HIV positive you should not breastfeed your baby. Now we are told that you should breastfeed your baby even if the mother is HIV positive. So you can see for yourself that these people are just not sure themselves so how can you trust what they are saying today?

Frequent changes in HIV prevention programming seem to introduce a lack of trust towards public health claims. Underlying this distrust in science were concerns about mankind's tampering with nature and God's will. Some men argued that God had created them with a foreskin for a reason, and that all body parts served a function. Removing something with which one was born was seen as a big mistake by some of the men. Others reached beyond biomedical and public health examples to make their argument, pointing out that the world is now facing problems such as global warming because humans have damaged the ozone layer.

An uncircumcised bartender, age 37, said during an informal interview:

> You see Michael Jackson had all the money in the world but doctors messed him up and he ended up looking like a doll. He tried to change how God had created him and at the end he died and left all his money behind just because doctors could not fix him. Doctors know a bit and God knows all so who are they to temper with what He has created?

Men easily blamed problems associated with modernity on human interventions and mankind's tampering with nature, demonstrating a distrust caused by the seeming mutability of scientific claims.

Suspicion towards the origins of HIV and western health interventions

Beyond their broad-based distrust of biomedical and public health claims, participants were specifically suspicious about anything related to HIV and HIV interventions. Most of these participants' HIV knowledge was limited, hence the many conspiracy theories surrounding the origins of the disease. Older participants, in particular, stated that HIV and other 'modern' diseases such as tuberculosis originated in the West and were intentionally introduced to Africa. They argued that the intentional spread of diseases from the West to Africa was a form of neocolonialism and expressed strong beliefs that white people wanted to decrease the number of blacks because their fertility was too high. This reasoning helped participants make sense of the presence of high HIV prevalence in Southern Africa, which for them was difficult to understand given that the virus did not originate there. The following is an excerpt from an in-depth interview with a 41-year-old uncircumcised man:

> Participant: Have you ever seen an HIV positive white person where you come from (The Netherlands)?
>
> Researcher: Well it is hard to see someone who is HIV positive but overall the HIV prevalence there is less than 1%.
>
> Participant: Have you ever seen an HIV positive white person in this country?
>
> Researcher: Hmm actually I do not know.

> Participant: That's why these things make me angry. It is only us (black people) that die from it (HIV). I wish to see just one HIV positive white man and find him lying in bed with AIDS and then I will be fine. Even if you can go to Mbabane Clinic or any other good hospital, you will not find them HIV positive. You find that they have disease like high blood pressure, leukemia and none of them have HIV and then you find that there are twenty of us who are HIV positive.

One uncircumcised 30-year-old man said during an in-depth interview:

> You see this (MC) might be a way of increasing HIV prevalence. These people (foreign-led implementation teams) know about MC and they have done a lot of research within it. They know that if you are circumcised there will be reduced sensitivity and then you will be forced not to use a condom and then after that you get AIDS. They know exactly about the effects of MC. So when the sensitivity is lowered, they will not wear condoms that will further reduce sensitivity and then not use it. So it is a way of increasing HIV or some form of business. But also I think it is a way of decreasing the population.

A 36-year-old uncircumcised man said during an in-depth interview:

> One thing that amazes me is that now we are living in economic crisis. They are busy saying it is for free, who is funding this whole thing? What are their motives? They are trying to decrease our numbers. You see if I were to get circumcised at this age I would not be able to get an erection as hard as I used to by the age of 40 years. I know of someone who is complaining about it today. He says ever since he got circumcised he cannot have three rounds of sex … they are killing us, they are trying that … you see the way we Africans are multiplying is too high. So when they look at our life expectancy they know that by the time you are at 40 years you are about to die and so they want us not to be able to get an erection and consequently be unable to have more children. They calculated that if you give birth after the age of 40 you would be causing more orphans in the country so this thing was planned against us Africans.

Ironically, it seemed the aggressive nature of the circumcision campaign exacerbated peoples' suspicions. The vigorous advertisements and incentives to circumcise people helped to create what might be considered a 'counter epistemic convergence' (Kaler, 2009). Put simply, this concept refers to a situation whereby there is scepticism among the general population about the motives of a health intervention such as MC. This is often propelled by rumours and can be a major obstacle in a public health campaign. The participants in this study questioned why such a surgery should be free, pointing out the strangeness of an intervention that went so far as to collect people where they resided and gave out incentives to those who agreed to be circumcised. Similarly, the use of a toll-free number seemed to be an extraordinary measure difficult to justify. Neither were they convinced by the demonstration of national political will. A few participants questioned why it was that national ambulance service sometimes failed to reach dying people in some parts of the country, when the Soka Uncobe campaign seemed to have no trouble reaching everyone no matter the remoteness of their village. The extraordinariness and clear expense of the campaign fuelled beliefs that those promoting circumcision must be profiting is some way that was not apparent. A few went so far as to suggest that the foreskins might be being used for witchcraft purposes given the fact that powerful 'magic potions' are made from body parts, especially parts cut from people who are still alive (Fellows, 2008). A less sinister, but more humorous explanation was that foreskins were being shipped to South Africa where they were being used as a substitute for calamari or for making the instant soup known as Benny (Burtscher, 2012).

Adolescents' perceptions of MC

When compared to older men, younger men interviewed in this study seemed to favour circumcision. Their perceptions about the procedure were mostly positive and they were usually informed about MC at school during campaigns such as 'MC Saturdays' and the Back-to-School Campaign. These campaigns specifically targeted pupils during school holidays or on Saturdays. Education and peer pressure seem to have played a big role in increasing uptake among school going males. More than 75% of those who have been recently circumcised in Swaziland are adolescents below the age of 20 (WHO, 2012).

Another factor contributing to adolescents' positive perceptions about MC is that they believed that girls preferred circumcised men. A 16-year-old uncircumcised adolescent said the following during an informal interview:

> Girls say it is nice and the guys say it is nice when you have sex after you have been circumcised. The girls say a circumcised penis is nicer so we also want to get circumcised. So we also get tempted to circumcise so that we could make them enjoy. Some girls actually say they do not want an uncircumcised penis.

For the young men, one of the reasons to get circumcised was to increase their chances of being liked by women. This was based on the assumption that sex is better with a circumcised man. They argued that compared to an uncircumcised man, a circumcised man can last longer before ejaculating, therefore satisfying the woman. They also stated that once you are circumcised it becomes difficult to get HIV and STIs.

It should be noted that some of the circumcised participants said they would recommend circumcision to their friends and colleagues because it is a good thing to do. They said that a circumcised man is safer from STI's, including HIV, and was cleaner. Some went as far as stating that sex was better and that they would not ejaculate prematurely, thereby helping their partners to climax. Some also said wearing condoms was much easier after the foreskin was removed. This finding is similar to what Riess et al. (2010) found in Kisumu, Kenya among circumcised men.

Discussion

With HIV incidence at 2.38% (Swaziland Ministry of Health, 2012), MC remains as one of the most important HIV interventions in Swaziland. With more funding coming from PEPFAR, the country needs innovative ways to improve uptake in order to reduce the number of new infections and reach the 80% coverage target.

As far as we know, this was the first ethnographic study looking at poor uptake of MC in Swaziland and this has resulted in new findings. Differences between the findings of the quantitative acceptability studies (PSI, 2010; Tsela & Halperin, 2006) carried out in Swaziland and our findings may be attributed to the fact that ours was a qualitative in-depth study, a research approach that may increase internal validity when research topics are socially embedded and culturally sensitive. It is also important to note the limited value of quantitative studies in predicting future behaviour, especially when questions are simplified and ask people to anticipate behaviour based on hypothetical situations that exclude cultural contexts (Green & Britten, 1998). For example, Tsela and Halperin (2006, p. 6) concluded that, 'When asked if they would like to get circumcised if circumcision was found to reduce the spread of HIV, 87% said they would'. A question like this may be overly simplistic and leading, leaving out many of the physical and social realities that men may face during and after MC. They do not state the possible

negative effects of MC, nor are respondents usually given time to reflect on the question. Such questions make no distinction between individual and population health benefits and do not mention the fact that MC only provides partial protection to the individual and has, although unlikely, possible complications. Our findings, as shown above, indicate that participants viewed complications as any negative outcome that could be caused by circumcising, including the potential loss of sexual sensitivity. The World Health Organization and Joined United Nations Programme on HIV/AIDS (2007, p. 16) clearly states that 'studies are inconsistent (in their findings)' in determining whether MC has an effect on sexual function.

Despite the inconsistent studies about the effects of adult MC on sexual function (Morris & Krieger, 2013; Royal Dutch Medical Association, 2010), our research suggests that with these conflicting reports and inadequate explanation from MC providers, men rely on (often sensational) stories about links between circumcision and sexual function that are reported in the press, Internet and from friends. There is a clear need for more research on this subject if public health campaigns expect to answer the concerns of men refusing circumcision.

Ratele (2011) has argued that the significance of the penis in any man's life extends well beyond the organ as a physical object, extending to include powerful meanings. For many men (and their female partners), masculinity is closely tied to sexual performance. The penis is not only a source of pride, pleasure and procreation, but it is also a symbol of identity, most specifically manhood (Igonya & Moyer, 2013). A non-functioning penis challenges one's status as a man, hence the uncircumcised participants in this study are most likely to view with suspicion and fear any attempt to alter their penises. We argue that this factor, which was a key finding, was not given sufficient weight by the planners of medical MC campaigns targeting adult men living in non-circumcising societies.

Despite the negative attitude towards MC from older men, adolescents seem to be more willing to utilise the intervention. This finding is also backed by the MC prevalence figures. As we have stated above, more than 75% of all those who were circumcised since the MC programme's inception are males below the age of 20 (WHO, 2012). As more than half of Swaziland's population is below 18, this could mean that the country's goals of zero new HIV infections may be heavily influenced by adolescents' positive involvement in HIV mitigation programmes.

It is also important to note that older men's poor uptake of MC services is not particular to Swaziland but to most of the countries targeted by WHO to increase uptake where circumcision is not a traditional custom. Our findings address a gap in the literature, as well as the particular MC programme in the Kingdom of Swaziland.

Limitations

This study was purely qualitative and the sample size was based on data saturation. Generalisations from such as small scale study are virtually impossible and therefore findings are only context specific. However, regarding the importance of the topic, more intensive and rigorous research needs to be done to supplement the limitations of such small studies.

Conclusion and recommendations

Seeking MC is a social and complex process just like any health-seeking behaviour (Kleinman, 1980; Pool & Geissler, 2005). The concept of masculinities has long been

argued as one of the major reasons why men barely use health services in general (Clatterbaugh, 1997; Courtenay, 2000; Leichliter et al., 2011; Mor, Masterson-Allen, Goldberg, Guadagnoli, & Wool, 1990; Skovdal et al., 2011; Verbrugge, 1985; Waldron, 1988), but was not taken into full consideration when implementing the MC intervention. In spite of the fact that MC promoters often stated that MC is only partially protective and that circumcised men should use condoms, it was argued by many Swazis that the frequently used siSwati slogan, Circumcise and Conquer, simplified and reinforced the concept of masculinity, indirectly suggesting that being circumcised would enhance an individual man's ability to conquer HIV, thereby indirectly encouraging reckless behaviour among both circumcised men and their sexual partners.

This paper has illustrated a range of social factors that help to explain men's refusal to partake in circumcision services offered in Kwaluseni. Despite the small scale of our study, we have high confidence in the internal validity of our findings. However, as stated above, our findings are contextual and cannot be generalised to the wider population of Swaziland. Based on our findings, we make the following recommendations.

More research on the effects of MC on sexual pleasure

One of the biggest barriers to MC uptake in this study was the fear of loss of sexual pleasure after getting circumcised. Circumcised and uncircumcised men stated this and while there is a dearth of conclusive scientific evidence on this critical issue, it would be problematic to reject such reports. It is therefore recommended that more in-depth research be carried out on this. Sexually active adult men should be asked about their sexual experiences before and after getting circumcised. We recommend this should be done using an appropriate research technique such as ethnography, given that this is a sensitive issue. For uncircumcised men, simple questions such as 'do you think circumcising has any effect on sexual sensitivity or pleasure?' would probably suffice.

The MC campaign should address men's concerns

Due to the fact that MC is linked to men's sexuality, more information and attention should be provided regarding the advantages and disadvantages of circumcising. For example, the rate and type of AEs (which are relatively minor and quite low) must be made known to the public. Concerns about sexual pleasure must be discussed and scientific findings on the topic must be made available. Other advantages of MC besides reduced HIV risk, such as reduced risk for several STIs and cervical cancer, should be made clear.

Integrate MC into existing HIV prevention strategies and create a comprehensive health package for men

In Swaziland, the MC programme should be integrated with other HIV prevention interventions, rather than promoted as a stand-alone intervention. Also, MC services should be provided with other interventions targeting men's sexual and reproductive health because it appears that men are concerned about maintaining their masculine dominance, which is heavily linked with their sexuality. Services such as prostate cancer screening, STIs and diabetes (known to negatively affect erections) should be made available together with MC services to improve men's health in the country.

Clear messaging for everyone

Promoting circumcision as a sexual enhancer and slogans such as *Soka Uncobe* (Circumcise and Conquer) might have negative consequences, as young men seem to think getting circumcised will increase their chances of having sex. The word '*Uncobe*', meaning conquer, might instil a false sense of security among circumcised men. Due to the fact that women do not get counselling about MC, they may not know the facts about the intervention but may rely on information they come across from everyday discourse, including media reports.

Empower men through HIV education

More education is needed about HIV in general. The origin of HIV should be explained in order to debunk common myths and suspicions about the origins of HIV and Western interventions. The Swazi nation should also be continuously educated about the latest science and technology in HIV treatment and prevention. The dynamic science in HIV prevention should be made available to the Swazi populace. Swazis should be informed about the funding and why it is so important to promote the MC intervention.

Rigorous acceptability studies in the future

For future health interventions in the country, rigorous, contextual and in-depth acceptability studies should be carried out before mass interventions can be implemented to avoid wasting donor funds that are already in short supply. The poor utilisation of MC services can be seen as a lesson for future population-size interventions. Interventions targeting men should account for the role of masculinities and other social factors. Such acceptability studies should strive to allow for open-ended questioning and rapport-building between researchers and representative populations to increase the reliability and validity of findings. Closed survey instruments are rarely sensitive enough to predict future individual behaviours, particularly when those behaviours are shaped by social and cultural factors. Although MC is a biomedical intervention, seeking it is a social process, and a complex one. Such studies should not be carried out by NGOs known for promoting HIV interventions to minimise the possibility of social desirability bias.

Disclosure statement

No potential conflict of interest was reported by the authors.

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