Invisible men

The social complexities of involving males in biomedical HIV prevention in Eswatini

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CHAPTER FOUR

Social complexities of informed consent and assent among young males undergoing voluntary medical male circumcision in Eswatini[13]

Abstract

As part of an effort to meet ambitious male circumcision targets in Eswatini, programme implementers increasingly focused on young males, raising questions about informed consent. Males aged 10-19 account for more than two thirds of those who have been 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 incentivized with football kits and other material goods to encourage circumcision.

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.

Implementers paid little attention to risks, focusing more on benefits of circumcision. Incentives, usually in the form of sporting goods, increased young males' participation, while also threatening their autonomy. Our findings suggest that parental authority overpowers young males' preferences regarding the decision to circumcise. Young males' understanding of the risks associated with circumcision was poor and most assumed HIV testing was obligatory.

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

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Introduction

The Kingdom of Eswatini has the world's highest HIV prevalence, 27% among those aged 15–49 years (SHIMS 2017). Faced with these daunting statistics, in 2009, and with financial and technical support from international donors, the Eswatini's Ministry of Health (MOH) set an ambitious goal to circumcise 80% of men aged 10–49 years (Njeuhmeli et al. 2011,).[14] Both the global shift to include circumcision as an HIV prevention strategy and the Swazi decision to back a VMMC program were predicated on what the World Health Organization (WHO) described as 'evidence beyond reasonable doubt' of its efficacy (WHO, 2007). Three cornerstone randomized controlled trials (RCTs) in South Africa, Uganda, and Kenya together showed that circumcised men were up to 60% less likely to acquire HIV (Auvert et al. 2005; Bailey et al. 2007; Gray et al. 2007).

For a plethora of factors, the number of men participating in VMMC has been far less than expected by the implementers, especially among adult men (Adams and Moyer 2015, Golomski and Nyawo 2015, Mkhwanazi 2020). In 2018, a survey among 20–34-year-old uncircumcised Swazi males found that an astounding 81% were not considering to get circumcised (Reynolds et al. 2018). Between 2009, when the VMMC policy was implemented, and 2019, 70% of all those who were circumcised were adolescents under the age of 20 years (Eswatini VMMC National Operational Plan 2019-2023). Most adolescents in Eswatini were circumcised during 'MC Fridays' and the 'Back to School' (BTS) biannual campaigns that targeted young men during school holidays using community mobilizers, who were sent to schools around the country to recruit potential VMMC clients.

During data collection in a larger VMMC study, the respondents, which were older Swazi males, viewed the higher VMMC uptake among their 10–14-year-old counterparts with deep

[14] This percentage was calculated through mathematical modelling. Njeuhmeli et al. (2011) found that attaining the goal of 80% circumcised would significantly reduce the number of new HIV infections and in the long run save significant funds because of the averted treatment and care costs.

concern. The fact that as adults they were shunning away from the surgery for many reasons and yet younger boys were getting circumcised, made them question the young men's comprehension of the possible negative effects of getting circumcised such as loss of sexual sensitivity and potential complications which may be permanent in some cases. There were also allegations of 'buying foreskins' by VMMC implementers using incentives to lure the young men. This led us into examining the assent and consent process among males below 18 years going for circumcision services.

The process of obtaining consent and assent within the challenging VMMC program has also been marred by public controversy related to some adolescents apparently being forced to circumcise or to take an HIV test, which has been publicized in the media. Quoted by IRIN news (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." It should be noted that in 2004 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 pivotal VMMC RCTs was published and the benefits of circumcision were still questionable. A decade later, The Times of Swaziland published a report (Magagula 2014) of an adolescent who was forcefully tested for HIV before getting circumcised. Magagula states that:

> There was drama at the Family Life Association of Swaziland (FLAS) offices in Manzini, when a young boy refused to be tested for the Human Immuno Virus (HIV). The boy frantically cried, as he fruitlessly resisted the test, telling the counselor that he had only come to get circumcised and not to be tested for HIV. His grandmother, who was his guardian, heard none of it as she insisted that he took the test, lest he suffer

untold consequences when they returned home. The boy, at the insistence of his grandmother, was eventually tested and told of his results.

This study is shaped against this backdrop. We follow Arthur Kleinmann's proposal of utilizing ethnography as an important remedy against the dominance of ''economics, decision analysis, and legal procedures'' in policy and bioethics debates (Kleinmann 1999:89, Molyneux and Geissler 2008: 687). We examine how the process of obtaining informed consent/assent has been practiced in the face of these social realities on the ground. We argue that Western reductionist philosophy and universalistic bioethical concepts and norms guiding the global and governmental approaches 'clash' with contextualized understandings, norms and practices. As far as we know, there is no ethnographic inquiry into VMMC consent and assent in Eswatini.

Firstly, some adolescents' comprehension may be questioned for several reasons as discussed below and secondly, there is a contradiction with Swazi perspectives on personhood, which is relational and hierarchical, and this makes obtaining adolescents' assent complex and problematic. The applicability of implementing VMMC bioethical guidelines which originate from Western reductionist philosophy is also examined. In Swazi culture, your gender and age-related hierarchy may have a significant impact on decision making power therefore making the one-size-fits-all approach of informed consent and assent particularly problematic. One may ask: To what extent can we talk about adolescent assent and consent in contexts where parental authority is rarely questioned and almost never challenged?

Methods

This study draws on ethnographic fieldwork between May 2013 and August 2014 on the response of Swazi boys and men's response to VMMC. 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.

Data collection

The data was collected using focus group discussions (FGDs), in-depth interviews (IDIs), participant observation, and informal interviews. All participants were male adolescents. In total, there were 6 FGDs, 11 in-depth interviews, and 14 informal interviews. We also observed six group counselling sessions in the clinic.

In total, 48 male adolescents took part in the study; each FGD had between three and eight participants, and lasted for an average of 50 minutes. In-depth interviews lasted for about 30–40 minutes and were held outdoors in a private place 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 minutes, while others lasted up to 45 minutes. 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 adolescents to make the interview less formal, and we could sense an open atmosphere as we conversed. FGDs and one-on-one in-depth interviews were recorded on an audio recorder. Relevant information from informal interviews was written down immediately after the conversation in the form of field notes.

Data analysis

All data besides that derived from informal conversations was audio-recorded and transcribed from a combination of siSwati and a bit of siTsotsi (local slang) into English. Transcripts were inductively coded (using QSR International NVIVO version 10) after the recordings were listened to twice. Thematic content was used for data analysis.

Ethical considerations

This research was part of a larger study that broadly looked at male involvement in HIV health service uptake 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 part of the study and this was recorded in the audio recorder before data collection started.

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 10-19 years. Some of the eligible participants had been circumcised in the two days previous 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 (Chava and David 1996; Green and Thorogood 2004).

Findings

This study found that it is a challenge for adolescents to exercise their agency due to several social factors, including cultural notions regarding respect and consensus. These challenges were due to issues such as respect for older people, the use of incentives 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 the country's VMMC ethics, which were developed using the UNAIDS and PEPFAR guidelines, conflicted with contextual realities on the ground. The findings below are grouped according to the thematic areas that emerged from the data analysis.

Respect and autonomy

Respect, especially for one's elders, is a core value celebrated in Eswatini, and this sentiment was often echoed by the young men interviewed whom were also socialized in this fashion. They reported that wanting to adhere to their parents' wishes was a main factor in deciding (not) to be circumcised and, further, that disobeying would be perceived as a sign of disrespect.

The data illustrate the simultaneous reciprocal and hierarchical relationships in this context. In accordance with Swazi norms, parents, and especially fathers, are expected to provide economically for their children. Dependents – not only children, but also wives – are expected not only to consult with parents or husbands regarding important decisions such as taking lifesaving HIV drugs (Dlamini-Simelane and Moyer 2017), but also to respect and follow any advice given.[15] Although Eswatini law defines an adult as anyone aged 18 or older, because of local practices and norms, even those over 18 years often still require parental approval when making medical decisions, including circumcising as discussed below. In the context of vigorous VMMC campaigns and a high prevalence of HIV, some parents have advised their sons, including their adult sons, to get circumcised. In such cases, young men have very little veto power and most submit to the surgery even if they have misgivings. During an FGD with five adolescents, I 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 adolescents, they all said 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 to the surgery 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*."

[15] Dlamini-Simelane and Moyer (2017) make a similar argument in regard to the limited ability of married Swazi women to access antiretroviral treatment without the approval of their husbands.

Parental advice seemed to be particularly important among younger adolescents, but in some cases older adolescents, including those above the age of consent, also felt constrained. 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*." Unlike most of those interviewed, he managed to exercise his agency and navigate the obstacles posed by his father, however, he was forced to do this secretly.

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 they were motivated by the promise of football jerseys and soccer balls. Some clearly stated that they would not have come to the clinic had they not been offered incentives. This finding means many adolescents 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 soccer goods.

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

Participant 1: They told us that we would be given soccer balls if we got circumcised.

Participant 2: Also, they said they would give us a soccer kit if more than 20 of us got circumcised.

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

In an in-depth interview, 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, the promises of material goods and food appear to have been important motivators.

Informed?

Although it was called group counselling, the counsellor would basically 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 and pain during and after the procedure among many other facts. These facts were often classed together with common misconceptions such as using foreskins remaining after circumcision procedures for making

soups. As this was the first ‘counselling’ provided to clients, few were actively engaged and some did not ask any questions or raise any concerns. Possibly due to age difference with the counsellor and group dynamics influence on people being afraid to expose their ignorance or ask questions that may be regarded as a taboo especially when talking to an older person, questions were often asked when we spoke to people individually during interviews. Perhaps due to the fact that the adolescents had already signed the consent forms, the counsellor used this as an opportunity to provide information about the imminent surgery.

We also found that many adolescents 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 using 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 (Faden, Beauchamp, and King 1986; Silverman 1989; PEPFAR Best Practices for VMMC Site Operations, 2017). All of the interviewees had already had a one-on-one counselling session as well as group counselling before the interview, but few were well versed on the risks associated with the surgery they were about to undergo. When one 15-year-old was asked during an interview 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 about circumcision.*” A 16-year-old adolescent characterized 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 to be 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*.”

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 the group counselling sessions, the counsellor stuck closely to an official script. He would stand and address the group of seated adolescents. 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*?"

Dismissing legitimate pain concerns as 'rumours' did not seem to encourage the adolescents to voice their 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 anesthetic before they are circumcised and painkillers after the surgery, yet the counsellor labelled this as a rumour. It is common knowledge that wounds are associated with pain, despite the size of the wound. Not only were common effects dismissed, HIV prevention and methods to avoid HIV, such as condoms or abstinence, were not addressed. The group session, focused primarily on wound care and risks associated with wound healing and the benefits of getting circumcised. Intra operation risks were not discussed despite being the most serious complications of getting circumcised. Amputations, excessive skin removal, and negative reactions to anesthetic drugs are some of the risks of getting circumcised, but participants were not informed about these serious complications. Arguably, appropriate and comprehensive counselling should be one of the most important aspects of the VMMC procedure at the clinic.

When talking with participants, during data collection, we could sense their anxiety in the tone of 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

HIV testing

Findings indicate that adolescents had poor knowledge about their HIV testing options prior to being circumcised. Some of the adolescents were not even aware that they were going to receive an HIV test and some stated afterwards that they were not told that they had an option. When a 14-year-old was asked during an in-depth interview if he had been given the option to test for HIV, he replied: "*No, they did not. It's obvious because they won't circumcise you without testing you*[16]*. They do not ask whether you want to test or not. They just put you into a room and then test you. Once you register for MC it's obvious they will test you first. If they find that you have a certain illness they will send you back*." According to the adolescent, he was not asked if he wanted to be tested for HIV or not and, like most of the participants, he thought HIV testing was obligatory. Another 15-year-old confirmed this: "*No, I was not told that. They did many things to me that I was not told about. A woman even put something around our arms that compressed it [BP Machine]. What was that thing for*?"

The above excerpts show that in many, if not most cases, adolescents are not given enough information about HIV testing and other medical procedures prior to being circumcised and that HIV testing is seen as a sine qua non for VMMC. The Eswatini circumcision consent form actually has two main sections to be filled in by the parents of adolescents. The first one is on allowing the health care provider to screen the adolescent client for HIV and the other is for agreeing to circumcision. Perhaps the counsellors relied on the signed informed consent

[16] It was a common misconception among many Swazis that an HIV test is obligatory before getting circumcised. See Adams and Moyer 2015. Also see Skolnik et al 2014.

document and if both sections were marked ‘yes’ by the client’s parent the assumption was that the client had discussed this with the parent and was therefore aware that they have actually assented to being tested for HIV. Or maybe the counsellors do not always follow consent and assent protocols in practice.

Discussion

Most scholars studying ethics related to circumcision in Sub Sharan Africa often focus on issues related to evidence from the cornerstone VMMC trials (Bell 2015, Camargo 2013, Ncayiyana 2011, Van Howe, Svoboda and Hodges 2005) and the effects and ethics of early infant and adult circumcision on sexuality (Earp, 2015, Hammond and Carmack 2017, Adams and Moyer, 2015, Earp 2014, Khumalo 2014). We have taken a step further in these debates and critically analyzed the concept of consent and assent in this context, examined the use of incentives, and the overall effects of pressure exerted to implementers of the VMMC program and how this pressure is filtered down to the targeted population and how it eventually erodes the principles of informed consent and assent. This pressure may lead to health care workers downplaying the real risks and over emphasizing the benefits during the consent process in order to reach donor high targets.

Reaching VMMC targets set by policy makers is proving to be elusive in Eswatini, especially among males outside of the adolescent cohort (Adams and Moyer 2015, Golomski and Nyawo 2016, Reynolds et al. 2018). Not reaching targets has serious consequences for implementers such as loss of funds and job losses. This pressure is trickled down to community and health care workers to do everything possible to reach targets to avoid loss of jobs. This sometimes leads to the health care workers and mobilizers to overlook critical aspects of patient rights such as assent.

As (Feierman et al. 2010:123) argue, anthropologists ‘are able to elucidate how medical interventions are experienced by those with little power. Intensive ongoing research at the local

level often leads to conclusions and forms of understanding that diverge strikingly from what would be expected by global planners'. In this case, contrary to VMMC ethics and best practices guidelines, the patient decision making process to circumcise or not does not necessarily lie within the adolescents' control. One can even question if assent exists in this context. These decisions are significantly affected by those surrounding the adolescent, and especially by more powerful family members. The findings indicate that the ethical guidelines promoted by the Government of Eswatini, together with Donors, policy makers and the implementing partners, VMMC campaigns are not in harmony with the realities of the Swazi context.

This research confirms the findings of Feierman et al. (2010, 125) who state that 'ethnographies across eastern and central Africa (and other places) demonstrate that 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'. (Geissler et al. 2008, 696-707) also 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.

Some adolescents who wanted to be circumcised for reasons such as better hygiene after getting circumcised and peer pressure from friends who were already circumcised, were able to resist their parents' power when they refused to sign for them to get circumcised. They exercised their agency, stating that their parents or guardians did not sign for them and that they found

other people to do it for them. This was also reported in a study by (Schenk et al. 2014, 170-184), which looked at VMMC in Zambia and Eswatini where adolescents were suspected of forging their parents' signatures on the parental consent form. In this study, a 19-year-old participant reported wanting to get circumcised despite his father's disapproval, and ended up getting circumcised without his father's approval and knowledge, but the study by Schenk et al. (2014) suggests that there may be other younger males who would choose to circumcise and are prevented from doing so by their parents/guardians.

Recruitment is arguably the most significant task of the VMMC project and certain strategies are used to increase uptake, including offering incentives. The use of incentives has been proven to increase participation in research (Bentley and Thacker), despite the level of risk posed by the research or intervention (Leung et al. 2002). A systematic review of circumcision demand creation interventions concluded that the most acceptable and effective interventions are financial incentives (Ensor et al. 2019). Institutional review boards, which review ethical issues related to human subjects research, are increasingly questioning the use of incentives on their effects in coercing potential participants to increase participation in interventions and research (Singer and Bossarte 2006). Incentives were a key aspect of the VMMC project, even though the country's guidelines prohibit the use of incentives, following UNAIDS (2008, 15), which advises, 'incentives to men and incentives to providers for reaching targets should be avoided'.

Free transport and packages for wound care were provided freely, but these may be considered necessary extensions of the service to ensure uptake and quality of wound care post circumcision. Other incentives though, such as football kits, bags, t-shirts, and soccer balls, may have influenced some adolescents to get circumcised. Some adolescents stated that they might not have decided to get circumcised had there been no gifts offered to them. Some argue that such gifts are not coercive in any way, but rather a form of manipulation, persuasion or a

nudge (Faden, Beauchamp, and King 1986; Grant and Sugarman 2004, Evens 2016). Others argue that giving poor people compelling incentives is not overt coercion but rather a covert formula of manipulating their vulnerability and therefore potentially limiting their decision-making ability (Steinbock 1995; McNeill 1997; Lemmens and Elliott 1999; Geissler et al. 2008).

The findings in this paper corroborate with those of Friedland et al. (2013), which showed that adolescents have relatively poor knowledge about the risks associated with VMMC. Some of the participants stated that they were not told about any risks. This was also evident in the group counselling sessions that we attended, which focused on benefits and wound-caring techniques rather than risks. Schenk et al. (2014) have also noted that risks and certain procedures were not well discussed before VMMC clients were circumcised in Eswatini.

Despite clients not stating clearly the risks related to circumcision, during one-on-one interview sessions they raised concerns related to potential risks of circumcising. 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 adverse events (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. In the trailblazing VMMC RCTs, AEs occurred despite strict protocols, happening in 1.5 to 3.8% of all the surgeries (Auvert et al. 2005; Bailey et al. 2007; Gray et al. 2007). A study in Lesotho also found that circumcision clients assumed that HIV testing before getting circumcised is obligatory (Skolnik et al 2014).

In 2020, more than ten years after the VMMC program was introduced in Eswatini, donors issued guidance that circumcisions among 10–14-year-old males should be stopped immediately. One of the reasons for this guidance is the higher risk of serious adverse events

among 10–14-year-old males. PEPFAR's COP 20 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 two adverse events occur almost exclusively in boys under age 15, especially in those age 10 and 11. All glans injuries and 90% of fistulas occur in those under age 15". One may ask why it has taken over a decade for such guidance to be implemented, especially when serious adverse events are reported almost immediately? If circumcising 10–14-year-old males is not safe today, it was not safe in the last decade when millions of 10–14-year-old males were circumcised in many African countries including Eswatini. Of those millions, it would not be surprising to discover that hundreds, if not thousands of African boys, have deformed penises resulting from glans injuries and fistulas. Besides the risk of penile mutilation, another reason found in WHO (2020:6) VMMC guidelines is that:

> Adolescents' capacity to give informed consent varies. Like physical, emotional and intellectual capacity, children's capacity to make independent decisions that affect their own health evolves at varying rates. Some boys 10–14 years may have the capacity to give consent for VMMC, while others may not. Usually, adolescents ages 15 years and older are able to give informed consent. For younger adolescents, assessments as to whether a boy can give informed consent should be made on a case-by-case basis. As a general principle, health care providers should seek to postpone non-emergency invasive and irreversible interventions until the child is sufficiently mature to provide informed consent.

Many may ask why such important guidelines about the risk to penile injury to younger boys and their difficulty in assenting is only being raised now?

With the penis's centrality in a Swazi man's masculinity (Adams and Moyer 2015), adolescents who are in the process of achieving the much-anticipated status of being a 'real man' should

be made aware of these possible serious AEs, as they might undermine their desired sexual prowess and functionality (Kageha Igonya and Moyer 2013; Bourdieu 2001; Ratele and Tamale 2011; Wentzell 2013). The lack of information provided about risks associated with VMMC may backfire on the programme if community members spread information they get from sources such as the Internet, newspapers and importantly word of mouth from friends and relatives, especially if these risks are dismissed as myths or 'rumours' (Geissler 2005; Geissler and Pool 2006; Kaler 2009). Labelling pain after VMMC surgery a 'myth' is likely to cause distrust in the VMMC program and negatively affect uptake.

Conclusion

As recommended by international ethical guidelines, policies adopted by the MOH and VMMC implementers rightfully claim to encourage respect for adolescents' rights and respect for their decisions in the consent process. In this paper, we have argued that during dire times such as the current HIV predicament faced by Eswatini, the most severe in the world, public health initiatives like circumcision campaigns aim to mitigate the spread of the epidemic and consequently assent becomes a far-fetched reality. Realities on the ground such as power differentials, cultural norms around authority and respect, the provision of incentives, lack of VMMC information such as risks and HIV testing, and the pressure by clinic workers to achieve donor targets all contribute to the complexity of the assent process. The notion that marginalized populations, such as Swazi adolescents, may be able to give full assent in a context like this is a fantasy.