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### Invisible men

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

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## CHAPTER SIX

### Discussion and Conclusions

Three years after HIV was identified as the cause of AIDS in 1984, the first of many HIV vaccine clinical trials was launched at the National Institutes of Health Clinical Center in Bethesda, Maryland. Till today, the hunt for a magic bullet in the form of an HIV vaccine or cure has proven elusive. This failure has been masked by the discovery of novel potent biomedical HIV prevention technologies such as voluntary medical male circumcision (VMMC) and using HIV drugs to prevent new HIV infections in the form of Test and Start, Pre-exposure Prophylaxis (PrEP) and Post Exposure Prophylaxis (PEP). The absence of a vaccine or cure has not halted imaginaries of magic bullet solutions from being fostered by many HIV policy makers and implementers, many of whom seem to cling to the idea that medical technologies on their own will end HIV and AIDS. Nguyen and Lock (2010:1) raise caution against such assumptions and argue:

It is commonly assumed that biomedical technologies, if equitably distributed, will dramatically improve the health and wellbeing of people everywhere. In principle we agree that this is indeed the case with respect to the majority of such technologies, but two major provisos need serious consideration. The first is that human bodies are not everywhere the same; they are the products of evolutionary, historical, and contemporary social change resulting from ceaseless interactions among human beings, their environments, and the social and political milieux in which they live. The second is that biomedical technologies are not autonomous entities: their development and implementation are enmeshed with medical, social, and political interests that have practical and moral consequences.

Building on this and similar arguments, this thesis has critically engaged the assumption that the availability of biomedical HIV technologies such as circumcision and HIV treatment would result in the targeted populations utilizing the technologies as envisioned by donors and policy makers. Specifically, this study sought to examine the problem of poor uptake among Swazi men of readily available biomedical HIV services such as circumcision and Test and Start in Kwaluseni and Ludzeludze between 2013 and 2020.

Despite achievements made by the Swazi HIV program, especially towards reaching UNAIDS 95-95-95 targets, recent data indicate the continued problem of poor uptake of HIV services among men in Eswatini. For example, the country aimed to achieve 80% VMMC coverage by the end of 2018 as stipulated in the national circumcision strategic plan but VMMC prevalence was only 26.7% among males aged 15 years and above despite receiving money calculated by donors to be enough to reach the 80% target (SHIMS 2017). Although the country is doing relatively well in its care and treatment program, men are still accessing treatment at lower rates than women and have also had less success in suppressing viral loads (see the annual PEPFAR Country Operational Plan COP 2020:13 for Eswatini).

In-depth findings on men's perspectives on these technologies and the implications of the findings on the uptake of these technologies have been discussed in their respective chapters in this thesis. In this final chapter, I bring together key findings and discuss how participating in HIV interventions like circumcision and Test and Start is a complex social process like any other health seeking behavior (Pool and Geilser 2005, Kippax and Stephenson 2012). This is why focusing on the social, political, and biomedical equally, is of paramount importance in bringing the HIV epidemic under control in a sustainable fashion. Despite being a surgery that involves a man's most symbolically important organ, the penis, circumcision is deemed by its advocates to be just a snip, a quick and easy minor surgery. I have argued how this is a fallacy and below I have summed up some of my findings and arguments. Secondly, I discuss the

shortfalls of glossing efficacy and effectiveness of interventions discovered in randomized controlled trials and how this may lead to fallacious assumptions that the availability of potent technologies is equivalent to finding a solution. Lastly, I reflect on theoretical concepts utilized in this thesis and the importance of ethnography in health programming and (lack of) discipline diversity in global health.

### **Looking back from 2021**

When I started to work in the field of circumcision intervention, it was one of the most exciting HIV programs in the country and one of the best funded areas in HIV prevention. The results from the three seminal circumcision RCTs (Auvert et al. 2005; Bailey et al. 2007; Gray et al. 2007) sparked a lot of hype and hope in the field of HIV, almost like the discovery of the COVID-19 vaccines through very quick RCTs. This exhilaration in Eswatini's HIV Program was compounded by the immediate availability of donor funding to circumcise virtually all HIV negative Swazi men, i.e., 80% of Swazi men.

As a novice in the field back in 2009 when I was hired as a research assistant to kickstart the circumcision program in the country, I was also blinded by the hype, huge funding and global public health experts surrounding me, and therefore had a myopic view of the program. I never thought such an intervention, stuff that dreams are made of, would soon become an incubus for many of these experts, including the Eswatini and US Government. After several months of implementing the program in 2009, what was termed as early adopters started running dry and I could tell there was a problem, a big one. While still a novice, I started to get a better understanding of what was happening; most Swazi men were not deluded by the circumcision hype like I was when I started working in the program. At work we could not find enough circumcision clients to enroll in our research and within my social networks it was clear that circumcision was not a popular intervention. I engaged in heated discussions with family and

friends. Small talk in bars about circumcision quickly turned into fierce debates. The gap between demand and the numbers expected by implementers was growing by the day.

Despite all these glaring signs, particularly the drop in the number of clients seeking circumcision, the program decided to scale up circumcision and circumcise 80% of HIV negative Swazi males. In military fashion, fully equipped state of the art circumcision clinics and circumcision trained medical staff were deployed all over the country in anticipation to cut the foreskins of around 152,000 males in one year. The funding was there, the staff was there, the supplies were enough and the global experts were also closely managing this project, so what could go wrong?

A major assumption in HIV prevention intervention is that if the services are brought closer to the people, Eswatini men, as rational consumers, will utilize these lifesaving services. This was the case in 2009 and it is still the case today. Despite my own enthusiasm for the interventions at hand, within a year of starting to work in the field, I could observe that getting men to access HIV services was about more than guaranteeing access to evidence-based medical services. Swazi men were reluctant to get circumcised for many reasons and the project reached less than 10% of its target goal. Despite potential to ask questions and learn from this failure, implementers doubled down on the push to reach the magical 80% circumcision rate and the country's national circumcision operational plan, which was heavily backed by donor funding, stipulated that 80% of Swazi males should be circumcised within five years. Seemingly having failed to learn any crucial lessons from the previous years, the policy makers were once again unhappy with the slow uptake of circumcision services in the country, despite funds and circumcision staff being available. Their disappointment was exacerbated by the fact that other countries such as Kenya were close to reaching 80% coverage. In fact, the countries with high uptake had revised their targets to 90% circumcision prevalence. Eswatini and a few other southern African countries were portrayed as performing poorly. Often, the quick and easy

solution for the policy makers and financiers was to blame implementers and get a more 'capable' NGO to do a better job. The context and reasons why Eswatini men were not eager to get circumcised were overlooked or considered not to be a real reason for poor uptake. This was likely based on the assumption that a rational person who lives in a country with the highest HIV prevalence in the whole world would just 'get a snip' and be safer from acquiring HIV. Since the program started in 2009, more than 15 NGOs, largely international, have been involved in the circumcision program. Some left the country after 'failing to reach targets' and somehow found their way back in again, and 'failed'. I think we can say that the problem was not with the implementing organizations. The problem was that many Swazi men did not view circumcision as 'just a snip' as was purported by many public health specialists. In 2007 when the idea to circumcise millions of African men was gaining momentum, Peter Aggleton (2007:15) raised caution and argued that circumcision had 'profound individual and social consequences.' He continued to warn that social scientists, historians and psychoanalysts have researched and written about circumcision for a number of years, 'but in its current global incarnation for HIV prevention, male circumcision is being talked of as if it were the most trivial and inconsequential of matters' (Ibid.).

Below I summarize why circumcision, an irreversible surgery, is not just a quick snip that reduces chances of acquiring HIV and should rather be understood as a controversial technology with serious social consequences.

### **Discussion of Main Findings**

Before discussing main findings, discussing the similarities and differences of circumcision and Test and Start is important. As seen in the empirical chapters, this thesis largely focused on circumcision and only one chapter considered men and Test and Start. Starting with similarities, both circumcision and Test and Start arose from RCT findings which proved their efficacy. Both technologies were hailed as game changing and donor support quickly followed

to support rollout in most sub-Saharan countries. Another similarity is the fact that men were a crucial target group for both technologies. Circumcision for HIV prevention targets only males. Males are also a key target group for Test and Start because of their low uptake of HIV services and the fact that if men are not on treatment, they are more likely to infect their partners. Another similarity is that circumcision and Test and Start are both one way or another irreversible. Circumcision is a surgery that removes the foreskin and reversing it or restoring the foreskin is virtually impossible. Stopping the utilization of HIV treatment once started is hazardous and also strongly cautioned against because of potential treatment resistance, which may lead to death in the long run. Lastly, both interventions are offered in formal health care facilities where it is widely noted that men are not fond of those spaces.

However, there are obvious differences between the two technologies. One is a surgery done in a theatre and the other a pill taken anywhere the user is comfortable. Another important difference between these interventions is that Test and Start is for HIV positive people yet circumcision was designed for HIV negative men. This noteworthy difference is important because someone who is already HIV positive is arguably more likely to utilize treatment compared to convincing a healthy HIV negative man to go through a genital surgical procedure that will confer partial HIV protection, which is one of the reasons why uptake of circumcision in Eswatini is low.

### **Why is the circumcision program failing in Eswatini?**

VMMC coverage levels in certain countries, including Malawi, Namibia, and Swaziland, have been and continue to be so low that attaining WHO/UNAIDS target coverage levels is unlikely without significant strategic changes in both demand creation and service delivery (Njeuhmeli et al. 2018).

To a certain extent I agree with the above statement. Before the scale up of circumcision in Eswatini and many other sub-Saharan countries, Hankins, Forythe, and Njeuhmeli (2011:1)

noted the importance of ‘strong political leadership, country ownership, and stakeholder engagement, along with effective demand creation, community mobilisation, and human resource deployment...’. Khumalo-Sakutukwa et al. (2013) argue that demand creation and programme implementation for VMMC does not adequately include and respond to the context in which it is located. The crux of the matter, I have argued, lies with what it means for a Swazi man to be circumcised, and not necessarily demand creation (marketing) and service delivery. What is at stake when a Swazi man is circumcised? How do Swazi men make sense of the risks and promised benefits associated with adult circumcision for HIV prevention? Taking into account the well-touted benefit of circumcision in lowering chances of HIV acquisition and some ulcerative STIs, what are the social consequences of removing one’s foreskin in a society that has not practiced circumcision in recent history?

The most common and technically accurate description of circumcision is the surgical removal of the foreskin. However, as my research has shown, circumcision has deep social meanings and results in a permanent transformation to the physical body. Aggleton (2007:15) argues that:

All over the world male circumcision has its roots deep in the structure of society. Far from being a simple technical act, even when performed in medical settings, it is a practice which carries with it a whole host of social meanings. Some of these meanings link to what it is to be a man, with circumcision taking place as a rite of passage into adulthood.

In traditional settings such as the Xhosa tribe in neighboring South Africa, circumcision is a marker of adulthood and masculinity, of becoming a complete man. It is used to distinguish between men and boys in the context of social, political and economic life. In many cultures, only circumcised men can have sex, be married, inherit land or hold public office. Historically, in many African cultures, traditional circumcision practices were accompanied by ceremonial and educational activities meant to initiate boys into adulthood while solidifying a sense of



belonging to both the ethnic group and to their age mates. Many circumcising societies, like the Xhosa, still continue these practices in the present (see Mfecane 2020 and Mdedetyana 2018). Traditional circumcision is not without its risks. Some die in the process and many are left with penile injuries and permanent deformities. A Dutch doctor, Dingeman Rijken, even set up a graphic website to expose the deaths and penile mutilations resulting from botched traditional circumcisions in South Africa. Despite this, boys continue to undergo circumcision due to its deep social meaning. Similar arguments could be made for those who get circumcised for religious reasons such as Jews and Muslims. The drive to get circumcised is deeply embedded in culture. In a country such as Eswatini where there is no recent traditional or religious circumcision practice, it is important to understand what meanings Swazi men attach to getting circumcised, especially when they are already sexually active.

The nexus between sexual performance and circumcision has ominously been largely a peripheral factor in the eyes of the implementers. I have argued that sexual function is an important marker of being a 'real' Swazi man. Respondents in this study stated that a real Swazi man is a male who has a wife, children and is able to take care of them and support them financially. To gain this status means a man has to be physically, financially, and sexually capable.

Contrary to traditional circumcision, men in this study argued that circumcision may have a negative impact on their lives as men and threaten their masculinity in various ways. Specifically, many respondents, circumcised and uncircumcised, argued that getting circumcised in adulthood may affect their sexual lives by lowering sensitivity of the penis and thereby leading to poor sexual desire and consequently performance. Most respondents argued that the major reason for many people to have sex is not for procreation but rather recreation, and circumcision was seen to be a threat to this by reducing sexual pleasure. Performing sexually is connected to being 'a real man' (Bourdieu et al. 2001; Groes-Green 2009;

Courtenay 2000; Ratele 2011; Igonya and Moyer 2013) and potential threats to this key masculine quality led to many men not to go for circumcision.

The potential loss of penile sensitivity following circumcision in older males remains a contentious one in the scientific community, with conflicting findings from different studies (Morris and Krieger 2013; Royal Dutch Medical Association 2010; Adams and Moyer 2015; Earp 2015, 2016). Exacerbated by ambiguous and sometimes misleading information from service providers about this sensitive issue, men then rely on word-of-mouth from trusted messengers such as friends and relatives or other people they know who have gone through the procedure. This word-of-mouth advice seems to nullify public health information which largely ignores the effects of circumcision on sexual enjoyment post circumcision, with some respondents equating circumcision to castration (see Chapter 5). An analysis of the findings also showed that people seem to trust people they know more than strangers who may be paid by NGOs to market a product such as circumcision. Promoters of a certain technology like circumcision may be viewed as biased because of their agenda to sell the service and get paid in return for their foreskin. Whereas a friend or family member may be a more believable and trusted messenger since they have no benefit from selling the technology.

Also, deciding to get circumcised is not done by the targeted male alone, others, such as the partner, or in case of an adolescent a grandmother or father, also influence the decision. This means that the decision is taken after deep consultation and thought, especially because it involves a man's penis, an organ that is not only a physical object but one that has deep social meanings and is directly linked to masculinity. Another error is the expectation from implementers of the circumcision program that setting up clinics and marketing the intervention is all it takes to convince men to utilize circumcision services. The accelerated saturation initiative (Soka Uncobe) disaster covered in Chapter 2 is a classic example of this misconception.

Further complicating the poor uptake of circumcision is the potential for penis deformation or even amputation. A man has only one penis and so treating the intervention as a simple cut is a fallacy. Many participants argued that the risks or such occurrences, however small, were simply not worth taking. In fact, circumcision carries with it the risk of adverse events during and after surgery. The worst adverse event resulting from a medical circumcision is death. Under medical conditions this is rare and only six deaths were confirmed by WHO in 2018 to have occurred in Sub Saharan Africa since 2009 (see: [https://www.who.int/immunization/programmes\\_systems/interventions/TT\\_and\\_VMMC/en/](https://www.who.int/immunization/programmes_systems/interventions/TT_and_VMMC/en/)). The second worst adverse event resulting from a circumcision is the social death of a man caused by the mutilation or even loss of a penis from a botched circumcision. Although rare, total penile amputations are not unheard-of during circumcision surgeries provided by trained medical personnel guided by rigorous protocols from WHO and PEPFAR. Glans amputations and excessive penile skin removal are also some of the intra-operation adverse events that sometimes occur during circumcision surgeries, especially among males below 15 years. Intra-op penile injuries among 10–14-year-old boys has contributed to the WHO and PEPFAR terminating circumcision funding and support to this age group. Post circumcision, one of the most severe adverse events can result from serious wound infection such as gangrene which can lead to penile amputation. These serious adverse events are not common but they do occur, and circumcision protocols state that there should be a threshold of 2% for adverse event rates in medical circumcision programs (see PEPFAR Best Practices for Voluntary Medical Male Circumcision Site Operations, 2013). However, when it happens to one individual, his normal sexual life and social existence as a man may effectively be over. In short, circumcision has the potential to end a Swazi man's life as a 'real Swazi man' as defined by respondents in this thesis.

Eswatini being one of the smallest countries in the world geographically and demographically, when serious adverse events occur the news spread like wildfire and keep many Swazi men

from accepting circumcision as an intervention for HIV partial HIV protection. Recently, PEPFAR and WHO issued guidance to countries to stop offering circumcision to males 10-14 years because of higher rates of serious adverse events such as glans injury (WHO 2020) and poor consenting and assenting processes among this age group. In Chapter 4 this policy shift is critically discussed and raises questions about the millions of 10–14-year-old African boys who were circumcised since the circumcision program started more than a decade ago. Were these boys put at risk of penile injury? Were they circumcised without adequate consent and assent procedure? Probably, and that is why there has been a policy shift recently.

The partial protection effect of circumcision in HIV acquisition leads to arguments about the intervention being futile due to the fact that circumcised men are still required to use condoms every time they have sex. Weighing the partial protection benefits, which are not significant for many, versus the sporadic but significant risks associated with circumcision, leads many men not to go for the surgery which is irreversible.

### **Life Changing Decisions – Irreversibility of Circumcision and Test and Start**

One of the major reasons for the poor utilization of circumcision and Test and Start services among men is the fact that reversing one's decision after utilizing the services is impossible, and if possible, as in the case of starting treatment, stopping and starting can have dire consequences such as resistance to treatment which could at worst ultimately lead to death.

With circumcision, the stakes are too high for most men. Firstly, as discussed above, circumcision is done on a man's most symbolically important organ. Secondly, it is irreversible. Already most respondents complained of poor sexual sensitivity post circumcision in adulthood and also heard of severe adverse events, which may also lead to permanent penile disfigurement. Had circumcision been easily reversible or something one can put on and off like a condom before and after sex, there is a good chance more Swazi men could have tried getting circumcised at least once. The surgical removal of the foreskin results in a permanently

circumcised penis and taking HIV treatment is a lifelong decision because stopping can have adverse effects such as drug resistance. Such major irreversible decisions become a major obstacle for most Swazi men and need wider consultation.

Due to being irreversible and being an unpopular surgery because of its effects on penile sensitivity and possible adverse events, the likelihood for most (80% as targeted) Swazi men to make a decision to get circumcised as desired by implementers is implausible. This is more so because since 2020, PEPFAR, the major circumcision donor, has stopped countries from circumcising 10–14-year-old males. Meaning implementers need to convince men aged 15 years and above to go for a circumcision and Chapter 2, 4, and 5 discussed how convincing older males is more difficult compared to younger males.

For Test and Start, the process starts with knowing your HIV status before you are linked to care and treatment. Chapter 3 showed that HIV diagnosis is still difficult owing to a variety of factors in the local communities, including the fact that HIV testing and treatment are usually offered at health facilities where men are less likely to go. Although most of the participants believe in the efficacy of ART in improving the health of HIV-positive individuals, the uptake of Test and Start among men is facing bottlenecks because of the fear of receiving a positive HIV test result, lack of hospitality in public health facilities, the widespread use of traditional and alternative medicine, concerns regarding early initiation of treatment, stigma, conspiratorial ideas about the origins of HIV and Western HIV interventions, and the lack of confidence and trust in the political stability and financial capacity of the Eswatini government to have the financial capacity to pay for HIV drugs in the long term. Despite having lower HIV prevalence compared to their female counterparts, Eswatini men have a higher mortality rate, illustrating these issues affecting men.

Many respondents who had never received an HIV test argued that fear of knowing their HIV status was holding them back from testing. The country has the highest HIV prevalence in the

world and has a very small population. This has resulted in almost every Swazi to know of someone close to have contracted HIV or even died from AIDS. The fear to go for an HIV test persists even with the acknowledgement from respondents that treatment is effective. This is due to the history of HIV in this context. HIV was and is still called by many as ‘umbulalave’, meaning nation destroyer. Early HIV prevention programs used threats and scare tactics to try and influence people to practice safer sex. Even during this era of widely available care and treatment, HIV/AIDS is still called fearsome or sinister names such as ‘silwane’ (animal). Also, treatment is taken for life yet many respondents doubted the Eswatini government of being capable to procure enough ARVs for at least the next half a century. Drug stock outs, including ARVs is a common occurrence and frequently reported in national media, so some respondents raised concerns about starting treatment that is not guaranteed to be available in the future. From the perspective of a policy maker and implementer, deciding to get tested and start treatment is a no brainer due to the known benefits but from the targeted population there is a lot to consider. As discussed in Chapter 3, stigma still persists despite almost a fifth of the population being on treatment. Patients on treatment after getting their ARV refills from health centers normally throw away the original ARVs containers and use containers for other pills such as supplements or pain killers.



*Figure 1. Photo by author. Boxes of ART littered on a path from the Mbabane Government Hospital, the biggest referral hospital in the country, to the nearest bus stop from the hospital.*



*Figure 2. Photo by author. ART boxes piled together with rubbish after the path was swept in the morning. Worth noting is that the containers are only for HIV pills and no medication containers for other illnesses. When the lead author asked the man who was tasked with keeping the place clean, he stated that this is a daily occurrence.*

Despite the above challenges, unlike circumcision which targets healthy men, when men fall sick, they are likely to end up at a health facility and will access care and treatment services. The major problem is testing them while they are still healthy and linking them to treatment early before they can infect others and keeping them on treatment.

One of the barriers in men accessing testing and treatment services in the health centers is also argued to be due to the lack of patient confidentiality. Where patients get their ARV refills is clearly demarcated and this has led many people fearing to access ART because they might be seen by other people who may know them queuing for ARVs, thereby exposing their HIV status. This has led some government facilities to set up men's corners within health facilities to help address this problem. Below is a picture from Pigg's Peak Government Hospital, the first government facility to have a men's corner which was set up by the organization I worked for in July 2019.



*Figure 3: Photo by author showing the male outpatient department at Pigg's Peak Government hospital.*



The organization I worked for, CHAPS, was responsible for bringing the clinic in a box to Pigg's Peak Government Hospital. This was after the hospital management had frequently requested from us to support them with a clinic in a box so that more men could come to the facility. They were complaining that they were failing on a continuous basis to reach their targets of men accessing services at the health facility. Despite setting up men's corners in health facilities, whether men will come to health facilities in the desired numbers remains unknown. Results from this thesis point out that health services should be brought to the targeted groups in a package acceptable to them and not attempt to drag targeted individuals to health facilities, where issues such as poor hospitality from hospital staff, lack of confidentiality and inconvenient operational hours were raised. Due to long queues in public hospitals and clinics, staff, which is usually in short supply, aim to process as many clients as soon as possible so that they can assist everyone. As a result, quality suffers. It is not uncommon for a patient to spend eight hours at Mbabane Government hospital's outpatient department for an illness such the common cold.

### **Resisting Technologies: Why epidemiological evidence is not enough to influence uptake**

Despite the Eswatini government implementing circumcision for HIV prevention since 2009, there is still a narrative of doubt and defiance among the target population and many other people, including crucial stakeholders such as members of parliament who keep questioning the origins, agenda and efficacy of circumcision in preventing new HIV infections. During the national HIV-AIDS conference of Eswatini in 2016 which I attended; a member of parliament questioned why NGOs were busy promoting circumcision because there is no evidence that it reduces new HIV infections. He went on to state that NGOs are driving circumcision programs for the money they were receiving from donors. In August 2019, another member of parliament during a parliament submission, questioned if circumcision works and why the country was

implementing a program that is not supported by evidence. During an inter-ministerial meeting in July 2019 which I was a part of together with senior government officials from different government ministries, many were questioning the effects of circumcision on the penis and sexual function. Between 2015-2019 during several community meetings organized to promote circumcision, there were a lot of questions asked by Chiefs and other important community stakeholders about why we (me and the circumcision program) are implementing the circumcision ‘agenda’ or propaganda and if circumcision will benefit Eswatini or if it was a trick to reduce African countries’ populations.

The perpetual narrative of defiance towards donor hegemony was framed by arguments that the circumcision program was being imposed and clearly untrusted. It was clear that there was resistance on the circumcision program. Chiefs are usually very vocal about issues affecting their communities, but they hardly promoted circumcision and only a few chose to be vocal proponents of the program. This narrative of doubt about the efficacy and agenda of the circumcision program views were prevalent during field work as shown in Chapter 2 and also during my time working as an implementer of the circumcision program between 2015-2021. Swazi men and politicians underscored the fact that circumcision is not just a ‘snip’, as I have stated above. Clearly, circumcision is not just a minor surgical procedure, it has deep social meanings, is permanent and is interpreted and perceived differently in different contexts.

### **Do Swazi males decide on their own to circumcise?**

In siSwati language, a young boy’s penis is called ‘*ligwayi lagogo*’, literally meaning grandmother’s cigarette. Despite being a patriarchal society, grandmother represents the main household in the family and is arguably one of the most important figures in a household. If a boy wants to get circumcised, the consent process is not only the responsibility of the parents, but the grandparents may also be involved. Even when someone like an 18-year-old is legally allowed to consent for himself to get circumcised, socially he does not have the authority to

make that decision on his own: the parents and sometimes grandparents need to make that decision. In Chapter 4, the social complexities of obtaining consent were clearly outlined and shows that seeking circumcision services is a very social and complex process and not just about legal or bioethical definitions of consent and assent. To signify this complexity, WHO, more than 10 years after recommending that males 10 years and above should be circumcised, rescinded its policy on circumcising males 10-14 years old because of inadequate consent/assent capability among young males.

### **Minding the gap: remedicalization of HIV and the difference between efficacy and effectiveness of interventions**

In the introduction I discussed the rapid advancement of potent biomedical HIV interventions over the last 15 years and a shift in effort from behavior-focused programs to clinical service delivery of these interventions. I also illustrated how targets have been set based on mathematical modeling showing the impact of these technologies at population level. Budgets followed suit and also aimed to reach targets deduced from the models. The community side or rather supply side has been largely a peripheral factor. At the 2<sup>nd</sup> International Conference for the Social Sciences and Humanities in HIV which I attended in Paris in 2013, Richard Parker, a medical anthropologist argued that ‘current combination approaches fail to pay attention to the community-based approaches of the earliest years of the epidemic... he illustrated that complex political and social issues have been poorly attended to and require the ongoing attention of social scientists’ (see Hyde and Lees 2013, <http://strive.lshtm.ac.uk/news/strive-2nd-international-conference-social-sciences-and-humanities-hiv>). Although there are efforts such as human centered design to ‘generate demand’ for the new biomedical technologies such as circumcision, a substantial amount of focus and funding is on the supply side. This bias towards the supply side has led to the continued disappointment of circumcision and PrEP programs in Eswatini.

Unfortunately, lessons from the difficulty of implementing these interventions largely caused by low demand have seemingly not been learnt. For example, despite facing an extremely limited supply of COVID-19 vaccines like most African countries when these vaccines were made available to the global north, Eswatini discarded more than 10,000 COVID-19 vaccines because they had expired in November 2021. It was further reported by the Swazi Observer (2021) that ‘what is more challenging for [Eswatini] government is that another 87,750 doses at the [central medical stores] CMS will reach their expiry date on January 31, 2022. By the end of January next year, if the uptake of the vaccine does not pick up approximately 98,232 doses of Pfizer vaccine will expire... By the end of March next year [2022] if the uptake of the vaccine still continues at a snail pace the county might be forced to throw away 102,120 doses of the vaccine. This means out of the 461,240 doses of the vaccine that were received by the country 206,480 doses might go to waste.’ Close to 207,000 (45%) vaccines expiring in a country with a population under 1.2 million people is significant especially when you consider how difficult it was to source these lifesaving vaccines. Clearly, there is poor demand for the vaccines which was probably overlooked and this has greatly affected the effectiveness of COVID-19 vaccines at population level. The effectiveness of the COVID-19 vaccines, just like circumcision and Test and Start, relies on very high uptake rates of the technology.

In Chapter 1, I described the difference between efficacy and effectiveness of an intervention and why glossing the two is problematic (Kippax and Stephenson 2012). For an efficacious intervention to be effective, it has to be correctly used by the targeted population and I have described the challenges of convincing Swazi men to utilize these efficacious technologies. The availability of these technologies is not the end of new HIV infections but rather the beginning of a complex socio-political process to engage target populations in utilizing the technologies in the way they were designed to be used. This process involves understanding the context’s political landscape, history, gender norms such as masculinities, supply side

(health facilities) inefficiencies, and the recognition that human beings are social agents that live within communities and not necessarily detached rational individuals.

The findings in this study show that there is a disconnect between HIV-AIDS implementers' goals and realities on the ground. I have also shown that the existence of new efficacious HIV prevention technologies and the substantial funding that often comes with the technologies does not mean that the technologies will be utilized by the targeted populations. Effective HIV prevention requires sustained social practices that reduce the likelihood of HIV transmission (Kippax and Stephenson 2012). Social meanings and practices such as seeking circumcision, Testing and Starting treatment among men are crucial. To understand the social meanings and behavior of target populations and to facilitate uptake of these interventions, ethnography, behavioral science, and many other specialists such as marketing specialists need to work together to come up with solutions. Medical professionals and public health specialists on their own cannot solve such complex issues, which are more social than medical, meaning medical officers may not be the only tool required for the job but are part of a set of tools required to execute the job. Currently, medical professionals occupy key positions and social scientists are somehow playing peripheral roles and at this stage of the epidemic where new technologies need to be deployed and utilized by populations, a multi-disciplinary team is needed more than ever to increase uptake and consequently the effectiveness of these technologies.

### **Masculinities and health**

Spronk and Hendriks (2020:1) caution that there is a persistent misguided view that African sexuality is different from Western or Eurasian sexuality. As an opening paragraph in their book, they state the following:

Images and stories about “African sexuality” abound in today’s globalized mediascape. From the current wave of homophobia to female genital mutilation, from promiscuity, transactional sex and HIV to sexual violence and corrective rape, these images and

stories often produce a dark picture of the African continent. This darkness is nothing new: it goes back to old stereotypes about African savagery and sexual permissiveness. In one form or another, sticky stereotypes continue to inform media coverage and popular opinions but also, to a certain extent, academic research on sexuality in Africa. Sex is thereby predominantly approached as a problem, urgently in need of solutions and interventions (usually from global health initiatives or sexual rights activists).

Others have also argued that the aim to circumcise millions of African men and boys is deeply embedded in racist colonial views of African sexualities. According to Fitzgerald (2020:250), Swazi men also viewed the circumcision program as racist and she reported that a police officer who was conversing with her future husband stated the following:

... Americans and Europeans are always testing their drugs in Africa. Haven't you heard? AIDS came from a vaccine that went wrong! Then, when they realized what they had done, they created an industry to treat it. And this circumcision project? It is the same thing! All the money they are pouring into HIV in this country should be spent dealing with poverty and unemployment issues, our real problems.

Building on the same arguments as above, a manuscript titled 'A new Tuskegee? Unethical human experimentation and Western neocolonialism in the mass circumcision of African men' by Fish et al. (2021) provides an in-depth analysis of race and colonialism in the research and implementation of the circumcision program in Africa. The arguments made in this manuscript reflect similar racial concerns that were also highlighted by many respondents in this thesis. Fish et al. (2021:2025) argue that:

As with all forms of cultural imperialism, subjects' perspectives have been marginalized in VMMC policy making; but without extensive input from African communities on their own terms, Western health policy is merely repeating the errors and harms of its colonial past.

The framework of hegemonic masculinities in African settings is virtually synonymous with 'bad men', leading to negative racist stereotypes such as 'African masculinities' which are often viewed to be problematic to society (Spronk and Hendriks 2020).

Since in this thesis I have employed the concept of hegemonic masculinities in an African setting, what I would like to note in this concluding chapter regarding hegemonic masculinities is that this type of masculinity is relational and legitimizes unequal gender relations (Messerschmidt 2019) and not necessarily bad, fixed, or the most dominant form of masculinities. This legitimization of unequal gender relations is not only disadvantaging to women but harms men as well. I have shown in this study that both men and women find it normal for men not to seek medical attention and be seen in health facilities frequently. In this context, women and men frown upon a man who shows these 'effeminate' qualities. For example, a man who may have a low libido due to the reported decreased penile sensitivity following a circumcision may actually be emasculated by their female partner for failing to carry out a core duty of being a man. In some cases, circumcised men are reported to find it difficult to buy sex from sex workers. Nkhambule (2016), a journalist of the biggest Newspaper in Eswatini, the Times, found that 'Sex workers in Manzini and Matsapha have banned circumcised men from seeking their services because they take rather too long to reach orgasm'. This public rejection of circumcised men may lead other males to refuse getting circumcised because getting access to sex and being sexually capable is an important marker of masculinities in this context. What I found in this study is that men feared losing sensitivity of the penis following circumcision and therefore rejected the technology. The major problem was not just men's fear of losing their own pleasure during sex, but the real fear was the failure to achieve the ultimate goal of pleasing and satisfying their partners to sustain their relationships. In Chapter 2 and Chapter 5, I illustrated how males' well-intention of satisfying their partners sexually and to feed them, can also restrict the males from lifesaving HIV interventions such as circumcision. After getting circumcised, men are required to take a few

days off from work and in some cases, it can be several days if the man works manual labor. Men who are paid based on time at work viewed this as a problem because time lost at work would mean they did not have a pay check for the days away from work and consequently fail to feed their wives and children, who expect to be fed by their husband/father. The men would then refuse to get circumcised for that reason. This is an example of positive hegemonic masculinities where men sacrifice their health for the benefit of their families to get food. Messerschmidt (2019:40) argues that hegemonic masculinity also includes:

“Positive” actions as bringing home a wage, sustaining a sexual relationship, and being a father. This means men often behave in ways that does not benefit them but benefits women and children. The concept of hegemony would be irrelevant then if it only referred to, for example, violence, aggression, and self-centeredness; hegemony is constituted through consent and active participation in a wide range of ways.

One can argue then that if these men in the above circumcision example lived in egalitarian societies where men are not viewed as the sole breadwinners, perhaps this barrier of time lost at work would not stop them from getting circumcised.

As Messerschmidt (2019:89) emphasizes the relational nature of hegemonic masculinities, he suggests that future research on hegemonic masculinities should also include local constructions of femininities. To take the concept of hegemonic masculinities forward, he (Ibid.) says ‘given the fact that hegemonic masculinities necessarily constitute a relationship, femininities are essential to the amplification of the reformulated model of hegemonic masculinities and thus must be a principal part of future research’. When it comes to men’s health, societies such as the context where this study was conducted have legitimized men’s poor access to health services and men’s poor health in general. More research and interventions which also includes femininities is needed to address this harmful culturally acceptable gendered behavior.



## **Perspective blindness – A lack of a multidisciplinary team of policy makers and implementers**

In this section, I borrow heavily from Matthew Sayed's book titled 'Rebel ideas: The Power of Diverse Thinking (2019)'. According to Sayed (2019), perspective blindness refers to the fact that people are usually blind to their own blind spots. This is similar to the Invisible Gorilla Test (see Chabris & Simons 2010) where research participants failed to see a gorilla passing through a stage because their attention and focus was on counting the number of passes between basketball players. The total focus on the number of passes caused them to overlook what was happening in the background.

Conducting an inquest following the September 11 attacks, Sayed (2019) argued that our thinking is so habitual such that we sometimes fail to realize how these modes of thought filter our perception of reality. He used the concept of perspective blindness to analyze how the Central Intelligence Agency (CIA) failed to spot the terror attacks clues from Bin Laden's videos recorded in caves. His main argument is that the agency could not spot some signs before the attack because of lack of cultural diversity. The major problem argued by Sayed is that 'most of the hired candidates look too similar - white, male, Anglo-Saxon, Protestant Americans.' This means the agency did not have people in their team who were familiar with the Muslim religion who could fully appreciate Bin Laden's threat.

In concluding, Sayed (2019) asks the following questions: 'Why did this homogeneity among CIA agents matter? If you are hiring a relay team, don't you just want the fastest runners? Why would it matter if they are the same color, gender, social class, etc.? Yet this logic, while sound for simple tasks like running, flips for complex tasks like intelligence. Why? Because when a problem is complex, no one person or 'type' of person has all the answers. We all have blind spots, gaps in our understanding', if homogenous people are in the same group, they become

collectively blind (Sayed 2019). Read more on this at <https://www.bbc.com/news/world-us-canada-49582852> or in Rebel Ideas: The Power of Diverse Thinking (2019).

Most of the major NGOs implementing HIV interventions in Eswatini are dominated by foreign workers trained in medicine or public health, especially in senior management where work-plans, budgets and most program decisions are made. This is also true for the donor employees supporting HIV-AIDS programs in Eswatini. My analysis of the poor uptake of HIV interventions among men in Eswatini points to the fact that engaging men to utilize HIV prevention technologies is a complex social issue and requires a diverse team to understand and appreciate. This is because complex issues normally cannot be solved by one person, profession, or idea, but requires a diverse set of skills and experiences to overcome each other's blind spots.

I have argued in this thesis that the major problem with the current HIV program in Eswatini is the way it has framed poor uptake of readily available HIV services among men. The problem is not only the supply side but mainly poor demand for services. Deciding to (not) utilize a service – health seeking behavior – is a social process and not a medical one and ethnography becomes an invaluable tool to address this issue. To better understand and overcome such problems, social scientists and to a certain extent, marketers, are imperative since they are trained to understand societies and consumption of goods and services. Unfortunately, many HIV programs in Eswatini are implemented by organizations with a heavy bias towards clinical staff from managers to staff on the ground. It is important to have medical people to deal with the medical side of the HIV program, such as administering treatment and monitoring viral load, removing the foreskin and other biological issues related to the job. A multidisciplinary team will address perspective blindness and ensure all crucial aspects of the HIV program are well understood and positions are occupied by a comprehensive team of professionals, including locals that will better understand their communities than foreign armchair

professionals that spend most of their time in offices and meetings. The lived experiences and perspectives taking place at grassroots (communities) should be well known, understood, and appreciated in big boardroom meetings where decisions are made for the people. In fact, planning and implementing the services should be made together with targeted populations.

With the increasing availability of biomedical HIV technologies such as circumcision, early access to ART, PrEP, PEP, and potential injectable long-acting ART, and now COVID-19 vaccines, problems of uptake, as studied in this thesis, are becoming increasingly important especially with pressure from policy makers, donors and governments to reach HIV epidemic control and the holy grail herd immunity for COVID-19. Large amounts of funding are being poured into biomedical technologies, yet achieving overall targets from some programs is still a challenge. The challenge is largely due to poor uptake of these widely available and free technologies. Getting an emic perspective regarding these interventions from the targeted populations requires an ethnographic approach that will bring a thick description and understanding of problems and provide in-depth knowledge about barriers affecting uptake.

I do not believe any other research methodology besides ethnography could have unearthed the findings presented in this thesis. This was the first ethnographic study in Eswatini studying men's perceptions on circumcision and Test and Start. The issues discussed can be considered as sensitive and hard to dig out using questionnaires, whether quantitative or qualitative questionnaires. Being like a fly on the wall, spending several months with the same participants and gaining deep rapport, greatly assisted in learning more about the emic perspectives of the problems being studied.

I have shown throughout the thesis how the targeted populations exhibited concerning levels of distrust towards 'western' public health interventions. The men studied in this thesis did not want to contract HIV or die from HIV-AIDS, but the suspicion of international NGOs roaming around their communities in big SUVs hunting down their foreskins and publicly declaring that

the aim is to reach a target of 80% circumcision coverage did not help in building trust between the communities and implementers. Groups such as African men have been marginalized by health programs in the past and they also experienced colonization and racism. There is a need to find ways to build trust based on mutual respect between implementers and the targeted populations. The question is how could this trust be forged and how long would it take?

Just like it happened after the three circumcision RCTs, the development, manufacturing, and making available of efficacious COVID-19 vaccines to the people, is the first step in a long arduous journey as there is still more challenging work of convincing the targeted population to utilize the vaccine within a limited timeline. I conclude by borrowing once again from Vinh Kim Nguyen's (2019:1299) experience working in Ebola in West Africa. He argued that:

The mistrust of authority in the DRC [Democratic Republic of Congo] also reflects a growing global mistrust of experts and science. Vaccine refusals are a growing problem worldwide, and they have already resulted in measles epidemics in the United States and France and in outbreaks elsewhere. Mistrust of public health authorities may thus be the new norm, and smoldering epidemics merely a symptom. State-of-the-art medical interventions won't be enough without serious efforts to rebuild trust, informed by social science rather than pious liturgies. Displays of armed force feed a vicious cycle of mistrust, infection, and violence. If we continue down that path, those seemingly fantastical dystopian outbreak movies, with their heavily armed global health forces and rebelling populations, may not be so far from reality in the near future.

Indeed, Nguyen's 2019 premonition became reality in 2020. In Eswatini and neighboring South Africa, the military, clad in full combat gear carrying rifles, was deployed by the respective commanders in chief to ensure that no civilian broke COVID-19 lockdown rules. With the worrying trend of vaccine hesitancy in many countries including Eswatini, it may not be

surprising then when security forces are deployed to monitor if every civilian is vaccinated before accessing public spaces.