

To Cut and Run: Donor Approaches to Male Circumcision in Southern Africa

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Abstract: Male circumcision is being heralded in the scientific and policy communities as a highly effective intervention that could significantly reduce the number of people being infected with HIV in a number of high prevalence countries in southern Africa. However, the scale-up of male circumcision in most southern African countries has been slow. This article discusses the rollout of medical male circumcision as an HIV prevention strategy in southern Africa, and it highlights the limitations of Western-inspired approaches to HIV prevention. Through a brief history of male circumcision in southern Africa and an analysis of donor-recipient relations, it looks at the cultural and institutional features that have created resistance to the message and inhibited effective implementation.

Introduction

The last ten years have seen growing interest in and advocacy for male circumcision in Africa as a means of HIV prevention. Recent attention to male circumcision has been spurred initially by public health specialists and picked up by international organizations and Western donors including, and most notably, the World Health Organization (WHO) and UNAIDS.¹ Buttressed by findings from a series of scientific clinical trials that showed circumcision could reduce the risk of HIV transmission from a female to a male by as much as 60 percent, WHO and UNAIDS in 2007 recommended that fourteen priority countries in Africa rapidly implement a scale-up male circumcisions so as to reach a circumcision rate of 80 percent, circumcising 20.3 million African men, by 2015.² Likened to mass vaccination campaigns, the scale of the medical intervention to circumcise African males is unprecedented. Since 2007, donors have poured more than \$130 million into circumcision campaigns in the fourteen African nations. Perceived as a highly cost-effective, “one-time” biomedical intervention with lasting protective benefits, male circumcision has become a priority HIV prevention strategy for donors working in southern Africa.³

The rollout of medical male circumcision programs in most southern African countries had a very slow start, however, and faced many challenges. According to the latest data from WHO and the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), published in July 2014, only about six million medical male circumcisions had been performed in the priority countries, representing less than 30 percent of the targeted goal.⁴ Although the rollout has significantly increased its outputs since 2011, donors and their partners agree that the target of 80 percent coverage by 2015 is out of reach for most countries.⁵ Despite the findings of acceptability

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studies that were conducted in many southern African countries, and African governments' support for including male circumcision as part of their HIV prevention strategy, donors have confronted challenges creating demand for circumcision among African males, and have often been frustrated by the pace of implementation on the part of African governments.

This article discusses the rollout of medical male circumcision as an HIV prevention strategy in southern Africa, and highlights the limitations of Western-inspired approaches to HIV prevention. The article is based on seven months of field work in Botswana and South Africa in 2012 that included interviews with key informants within PEPFAR, the U.S. Centers for Disease Control (CDC), implementing NGOs and local NGOs, the National AIDS Councils and the Ministries of Health, as well as analysis of primary documents and participant observation of health clinics, temporary circumcision sites, health meetings and conferences. The interviews and field observations revealed competing approaches and priorities between donors and recipient governments, and contested cultural frames within southern African communities and between donors and recipient governments that significantly impacted one's receptivity to male circumcision as an HIV prevention strategy. Through a brief history of male circumcision in southern Africa and an analysis of donor-recipient relations, this article looks at the cultural and institutional features that have created resistance to the message and inhibited effective implementation. I argue that the slow take-up of male circumcision cannot be attributed solely to the nature of local populations. Western cultural and normative assumptions about "good practice," "efficacy," and "scientific knowledge" all require critical examination.

As the global community increasingly relies on biomedical interventions to combat infectious diseases, from AIDS to ebola, there is a danger of minimizing the impact of vaccines and therapeutics if we fail to comprehend the social context. Social scientific research can be very relevant and instructive to global and Western medical campaigns by providing insight on the geographic and social pathways of disease transmission, and local attitudes towards clinical trials and biomedical interventions. The recent ebola outbreak in West Africa unequivocally highlighted the need for the global public health response to understand stigma around disease in West Africa, food insecurity, and labor shortages across the region, how cash circulates in local economies, and local drug and medication networks, to name a few issues on which social scientists have already amassed a wealth of knowledge.

Program evaluations of male circumcision campaigns, conducted and funded by donors, tend to focus on resource and capacity constraints, service quality, demand creation, and program efficiencies as factors that need to be addressed in order to accelerate scale-up. While technically accurate in their analysis, what is missing from these evaluations is any introspection on how the normative presumptions underlying medical circumcision roll out, as well as the donor-recipient dynamic are impacting the scale up. Medical male circumcision is perceived by many Africans as a donor-driven agenda and a projection of Western power in southern African countries, in large part because it is being pushed within a cultural frame that privileges Western biomedical knowledge and expertise over indigenous knowledge. To Western donors and observers, it is a humanitarian effort, a component of development assistance aimed at aiding African countries in the fight against HIV. Yet, as scholars such as Paul Farmer and Mahmood Mamdani have warned, humanitarian efforts in Africa have a

checkered past, are easily ensnared in local and global power dynamics, and have a complex and even contentious relationship with citizen rights.⁶ In this article, I draw on historical lessons to explore the limitations of humanitarian, Western models of global health, and the pitfalls of donor-recipient relations.

Global Health and Empire: Full of “Good Intentions”

This section emphasizes the relevance of history for the contemporary practice of global health, and lessons learned for modern humanitarian health. Indeed, while global health is touted as a “hot new field,” many of the problems and debates within global health are not new, nor are efforts to affect the health of populations far from home.⁷ The Spanish Royal Philanthropic Expedition (The Balmis Expedition) to bring smallpox vaccination to the New World and Asia in the first decade of the 1800s offers an early moment in international health in which to examine the intersection of global health and empire. The first large scale mass vaccination of its kind, the historic legacy of the pioneering Balmis expedition in international health will be briefly revisited in order to highlight some important continuities as well as ruptures with contemporary global health. Male circumcision, like vaccinations, is a once off procedure. The mass scale up of male circumcision in southern Africa has largely been viewed as akin to a vaccination campaign—visionary at the time, humanitarian in its origins, and full of good intentions, like the Balmis expedition.

Smallpox infection entered the New World in the sixteenth century from the Iberian Peninsula and ravaged the indigenous population for several centuries after the Spanish conquest.⁸ Many efforts to halt the impact of the smallpox virus were made throughout the world over several centuries.⁹ But it was not until 1797 that Edward Jenner discovered that material taken from a human pustular lesion caused by cowpox virus and inoculated onto the skin of another person produced a similar infection. He then demonstrated that an inoculated individual was protected from infection with the smallpox virus. Within a decade of his discovery “vaccination,” the word Jenner invented for this procedure, was at the forefront of the medical and political world.¹⁰ The practice of vaccination subsequently spread rapidly around the world.

Responding to a large outbreak of smallpox in the Spanish colonies, King Carlos IV of Spain signed a royal edict in 1802 for a humanitarian expedition, led by physician Francisco Xavier De Balmis and Jose Salvany, to vaccinate all Spanish subjects throughout the world. In addition to providing free vaccinations De Balmis was charged with training local physicians to be able to carry on vaccination campaign, and setting up local boards that would document immunizations and keep registries.¹¹ In order to preserve the vaccine during the journey, twenty-two orphaned children were brought along. Certainly unlikely to meet ethical, hygienic, and professional standards today, the passing of vesicle fluid from the ulcerated skin of one child to another child proved an effective way of carrying the vaccine at a time when refrigeration, sterile containment, and asepsis were non-existent.¹²

While King Carlos IV was known as a humanitarian and compassionate king, economic and political motivation were surely involved in his decision to embark on such an ambitious expedition. Paul Farmer and others have correctly pointed out that historically, and especially during imperial colonial times, international health was most often advanced through, and

because of, commercial and economic interests.¹³ The expedition set off in 1803, and first stopped in the Canary Islands. However, to De Balmis's surprise the vaccine was already being introduced in the Canary Islands by a rival imperial power, the Danes. The expedition then sailed to Puerto Rico where De Balmis suffered another disappointment. Again, to his surprise the smallpox vaccination was already being instituted on the island. But this time, it had been introduced by local physicians with the support of the government. This infuriated De Balmis, who then argued that his was the only "true vaccine," and began to revaccinate the locals. In his "scientific reasoning" De Balmis believed that Dr. Francisco Oller and his local colleagues would have made many errors while disseminating the smallpox vaccination.¹⁴

The territory covered by the expedition in the Americas and Asia was vast, and included the contemporary countries of Mexico, Venezuela, Peru, Ecuador, Columbia, Cuba, the Philippines, and China. Over the course of almost four years, hundreds of thousands of people were vaccinated, local vaccine brigades were established, and local doctors and healers were trained. In some places, members of the expedition were welcomed and warmly received by the local population. In others, they encountered political rivalry, financial interests, cultural beliefs, and outright resistance that thwarted vaccination efforts.¹⁵ Resistance to the introduction of the vaccine remained in some areas, with patients having to be physically restrained in some instances in order for them or their children to receive the vaccine. The accounts of resistance often reflect more than simply a cultural or religious clash, but an acute awareness of power asymmetries, problems of agency and understanding in these loaded relationships. Looking back, however, the expedition is viewed as a relative success, and it contributed to the growth of the population in the Americas by the late 1800s. The practice of smallpox vaccination in most places, however, was intermittently continued, and smallpox continued to ravage the globe for another 150 years.

What is instructive about this early example of a humanitarian undertaking driven by the spirit of enlightenment and a faith in science is that science and good intentions alone do not guarantee a successful campaign. International health, or global health, has always been a politically charged undertaking requiring complex negotiation with potential beneficiaries and competing benefactors. If this was true during imperial colonial times where public health campaigns were imposed on subjects, it is surely even more so the case today where no formal colonial relationship exists and human rights, in principle at least, are universal. Indeed, the Balmis expedition highlights the inherently unequal contractual exchange between benefactor and beneficiaries. Learning from historical experience, contemporary donor programs must work to make them more equal, through training of local doctors and healers, for example, greater consideration of who sits on the national and international AIDS councils, the democratization of the scientific domain through more deliberative and inclusionary processes, and the like. Political negotiation and consultation with local heads of government is important but not necessarily sufficient. More attention must be paid to bring on board communities by wooing church leaders and community elders. Finally, contemporary global health requires a new participatory framework that promotes dialogue and cooperation between donors and recipients, and facilitates self-sufficiency and development for the beneficiaries.

Why Male Circumcision is Not Like a Vaccination Campaign: A Brief Social History

All over the world, male circumcision has rarely been simply a technical, value-neutral act. On the contrary, even when performed in medical settings, male circumcision is a practice that carries a host of social meanings. In a number of African and Oceanic societies, circumcision relates to manhood and what it means to be a man, and is performed as part of a rite of passage into adulthood. In Jewish and Muslim societies, but less so in Christian societies, male circumcision carries religious connotations.¹⁶ More recently, male circumcision has entered the field of public health and has been promoted as an aid for a range of medical and social conditions.¹⁷

Crucially, however, male circumcision is almost always a political act, enacted upon others by those with power.¹⁸ Indeed it is often performed in the broader interests of a public good, but with profound consequences for individuals and society. Thus, while the current discussions of male circumcision as an HIV prevention strategy approach often dismisses the procedure as rather trivial or inconsequential—like a routine vaccination—a brief historical account of male circumcision in southern Africa will show otherwise.¹⁹

The vast majority of circumcised men in Africa have not been medically circumcised.²⁰ In communities and regions where circumcision is prevalent, it is most often done in a traditional context and as part of an initiation process into adulthood. In communities where male circumcision is low, non-circumcision often had historical roots in the rejection of traditional male circumcision practices common elsewhere in the sub-region.²¹

At one time, most of the indigenous groups in southern Africa practiced circumcision, including all Nguni speakers and Sotho speakers. Even a small number of San groups adopted male circumcision as a result of contact with Tswana communities.²² The prevalence of circumcision among these groups varied in time and place, and the practice was started and stopped at various times among the indigenous populations, and as a result of a number of influences, including colonialism and Christianity.

For instance, the history of male circumcision in Botswana is documented as far back as 1874, and was practiced on young, primarily Bakgatla, boys as part of an initiation school, or *bogwera*, that prepared the initiates for manhood.²³ By the early 1900s, the practice was largely abandoned by Tswana groups in part as a result of the influence of Western missionaries, in particular the Dutch Reformed Church, who discouraged the practice.²⁴ The government of Botswana's first independent president, Seretse Khama, which sought to coopt as well as curtail the power of the chiefs, further weakened the practice. In large part as a direct "tribal" challenge to his political rival Seretse Khama and the sovereign identity of the new Botswana state, Kgosi Lincwe II reintroduced circumcision among the Bakgatla around Mochudi in 1975.²⁵ Ironically, the circumcisions were done at the Deborah Retief Hospital run by the very same Dutch Reformed Church that had pushed to abolish the practice.²⁶

Male circumcision is a practice steeped in social meaning. Societal socio-economic changes and specific impacts of Christianity and western education have brought about changes in the logistics of male circumcision and initiation as well as the education it confers on boys. However, the fundamental idea of marking the transition to manhood, and the link to one's ancestors, has remained stable.

There is a substantial body of social science literature on male circumcision, particularly in the context of initiation practices, dating back to before the colonial era and peaking in the 1930s with the birth of African Studies and the evolution of the nascent discipline of anthropology.²⁷ The early nineteenth century accounts by visitors and travelers were often sympathetic, but with the introduction of Christianity and colonialism, missionary and colonial writing on male circumcision and initiation tended to be more critical. Later work by anthropologists tended to view male circumcision and initiation as markers of primitive societies, and were concerned with documenting their transformation in the face of Western and capitalist influences.²⁸ Deacon and Thomson recently compiled a comprehensive literature review of male circumcision and initiation covering broad topics including the duration, timing and age of boys during circumcision practices; the educational role of initiation practices; the historical relationship of circumcision to biomedicine; the importance of the instrument used for circumcision, complications and post-operative care, and the ethics of documenting such a private and often secretive practice as well as the politics of who gets to tell the story and who's story is actually being told.²⁹

Historically, chiefs controlled initiation ceremonies and circumcision, although this varied by group and was increasingly less the case with the introduction of colonization. For example, in Botswana and parts of the Limpopo region of South Africa, centralized control of male circumcision and initiation remained important, whereas in the Eastern Cape region of South Africa, the practice was decentralized. Among the Zulu and the Swazi, it has been widely reported that circumcision was abolished by Shaka and Mswazi because it interfered with military training and rendered the boys vulnerable for an extended period of time.³⁰ With the introduction of colonialism and capitalism, control over circumcision and initiations tended to shift away from chiefs to familial patriarchs and village elders.³¹ Formerly a means of mobilizing labor for chiefs, circumcision and initiation practices evolved to serve the labor needs of the family before young males would establish their own family.

A mechanism of social authority for the maintenance of social order, hierarchy and control, indigenous circumcision goes beyond the physical act, and is expected to prompt proper and responsible behavior in adult males who have now shed their childish ways.³² Recent scholarship, however, highlights shifts in the cultural and social meaning of circumcision among the Xhosa group in South Africa in particular, arguing there has been an erosion of the role of circumcision schools in the sexual socialization of young men, where circumcision is now associated with a right to access unlimited sex.³³ Thus, in the contemporary context, and in southern African societies so deeply penetrated by colonialism, apartheid, and industrialization, the role of circumcision rites is clearly shifting.

In the context of the modern nation-state, indigenous circumcision practices can conflict with a liberal democratic constitutional order. As Louise Vincent demonstrates with the case of South Africa, state's efforts to regulate such circumcision traditions are highly intertwined with broader projects to institutionalize a culture of rights, elevate the state as the sole actor tasked with ensuring social order and control, and disseminate norms of appropriateness and acceptability consistent with accepted liberal democratic values.³⁴ Such regulation has not gone unchallenged, and is often viewed as being the result of foreign influences and Western values. Indeed, although ironic, it may not be surprising that southern African governments have

generally shown a willingness to buy into Western donor mass medical circumcision campaigns. Medicalization of circumcision would lead to greater state regulation and control, and it has the potential to undermine other forms of social authority, including that of traditional leaders.³⁵

Recently a prominent group of South African scientists wrote an op-ed in the *South African Medical Journal* calling for the abolition of unsterile male circumcision in light of a number of initiate deaths, pitting rights against culture and tradition against modernity.³⁶ Interestingly, however, a recent study has also shown that among South African communities that practice indigenous circumcision, there is low acceptability of medical circumcision, with participants stating it is against their religion or culture.³⁷ Cultural complexities around circumcision abound. In 2009, King Goodwill Zwelithini kaBhekuzulu revived the practice of male circumcision among Zulu males as a cultural practice and to help stem the tide of HIV in KwaZulu-Natal Province.³⁸ While the decision has surely contributed to greater success of the medical male circumcision campaign in KwaZulu-Natal, it has also raised a number of thorny issues over the role of the state versus communities or families in regulating the rights of children and the role of tradition in sexual education and behavior change.³⁹

In sum, male circumcision in southern Africa is fraught with a great deal of cultural and historical baggage, and it engenders a host of cultural complexities that both support and discourage its acceptance. Clearly, as a number of social scientists have argued, more research is needed on the role that gender, power, male sexual behaviors and practices, and the construction of masculinity and sexuality in African contexts will play in the outcomes of such a large scale strategy.⁴⁰

Clinical Trials

Clinical trials conducted in South Africa, Kenya, and Uganda have shown that medical male circumcision reduces the risk of HIV infection for males from a female partner by as much as 60 percent.⁴¹ These findings prompted WHO and UNAIDS to issue a global recommendation for male circumcision to be added as an HIV prevention strategy, especially in high prevalence countries. The trials were preceded and prompted by several observational studies suggesting a correlation between male circumcision (most often performed in a non-medical setting) and the risk of contracting HIV in several parts of Africa.⁴² Yet, the process of knowledge making around the correlation between male circumcision and HIV prevention has proceeded along typical Western scientific lines, with the randomized, controlled clinical trial as the hallmark of biomedical research, with generalizable and replicable findings, and a process that clearly distinguishes the “experts” (knowledge producers) from lay people/research subjects (knowledge consumers). Limited research on non-medical male circumcision as an HIV prevention strategy has been conducted.⁴³ Furthermore, while WHO, UNAIDS, and major donors acknowledge the need to “educate” and include traditional leaders and circumcisers, the focus has tended to be on transferring knowledge on basic biomedical procedures to the community leadership, a unidirectional flow of knowledge.

AIDS clinical trials in the United States in the late 1980s and 1990s were distinctive because of the militancy of many of the patients and their ability to forge a social movement whose members demanded to evaluate knowledge claims, disseminate information, and insert lay

people into the process of knowledge construction, thereby leveling the conventional hierarchy of power and knowledge in science and medicine.⁴⁴ Yet, as AIDS trials flourished in developing countries, have we seen a similar leveling of the hierarchy between research experts and lay subjects? Of the just over 600,000 subjects in HIV prevention trials, over 500,000 are in Africa.⁴⁵ What role do these subjects have in informing the construction of new scientific knowledge? Does knowledge about HIV ever flow bi-directionally or from the zones of neglect in the so-called Third World back to the citadels of science in rich Western countries?⁴⁶

Bastos's study of global responses to AIDS reveals no "global unleashing" of the knowledge-making process. In fact, she concludes, "knowledge flowed throughout the world, but through limited channels and rarely in a multidirectional manner. Persuasion and hegemony, rather than a truly interactive dialogue, characterize the development and transmission of knowledge."⁴⁷ South Africa may appear as an exception given its large numbers of prominent medical scientists with strong connections to Western medical and academic institutions, and its capacity to conduct cutting edge research in a number of its own institutions. There may also be a greater degree of local accountability in some countries than Bastos suggests, particularly in countries where the government has insisted on playing a regulatory role. But the dichotomy between knowledge producers (medical experts, often Western trained) and knowledge consumers (the majority of southern African citizens) remains. As a result, often critical local information and context can get overlooked, precluding local buy-in and inhibiting policy and program implementation.

The scientific community's willingness to take up male circumcision as an HIV prevention strategy was slow in coming. Halperin and Bailey attribute this early cautious skepticism in part to the international public-health community's reluctance to tackle a social practice and behavior so deeply embedded in complex webs of cultural values and religious beliefs.⁴⁸ However, by the early 2000s the climate had changed. The donor community was becoming weary with behavior change strategies towards AIDS prevention, unsure if their interventions were actually having an impact on HIV prevalence. At the same time, evidence-based, biomedical interventions were increasingly being pushed within the international public-health community. The clinical findings that short, targeted treatments of anti-retroviral medicines dramatically reduces the transmission of HIV from mother to child during labor, as well as the more recent findings that antiretroviral drugs can also prevent HIV infection in HIV negative persons have emboldened the scientific community to believe that with the global scale-up of such biomedical interventions the goal of an AIDS-free generation is within our reach.⁴⁹

Similarly, the scientific community pushed for rigorous evidence, through randomized, controlled clinical trials, to demonstrate the efficacy of male circumcision as an HIV prevention strategy. The Southern Africa Orange Farm trial, which enrolled 3,274 uncircumcised men, aged eighteen to twenty-four years showed a 61 percent protection against HIV acquisition.⁵⁰ The trial in Kisumu, Kenya, of 2,784 HIV-negative men aged eighteen to twenty-four years showed a 53 percent reduction of HIV acquisition in circumcised men relative to uncircumcised men.⁵¹ The trial of 4,996 HIV-negative men aged fifteen to forty-nine years in Rakai, Uganda showed that HIV acquisition was reduced by 51 percent in circumcised men.⁵² The trials provided conclusive proof that male circumcision offers a partial protective effect for HIV prevention. They also proved instrumental in reframing male circumcision as a

biomedical/public health intervention, positioning it as a modern health discovery rather than a social and cultural practice steeped in historical meaning.

The reality is that male circumcision is both a biomedical intervention and a cultural practice. Yet, the debate and discourse surrounding male circumcision quickly became polarized (public health vs. social and contextual perspectives). Medical male circumcision has been pitted against indigenous male circumcision, seen to have a more limited effect on HIV prevention because it often takes place after sexual debut and generally less foreskin is removed than with medical male circumcision.⁵³ Randomized, clinical trials have provided conclusive evidence that medical male circumcision can reduce men's risk of contracting HIV. However, in areas where high numbers of males have been non-medically circumcised, the correlation between male circumcision and HIV status is not always demonstrable in survey data.⁵⁴ Rather than seek to understand some of the underlying causes of this, or consider some of the ways social science research can be made integral to clinical trials, international organizations such as the WHO and UNAIDS along with donors pushed a process of limited engagement with indigenous male circumcision practitioners focused on providing them with basic biomedical education.⁵⁵ This paternalistic, one-way information transfer approach has not been productive in creating common ground, collaboration, or trust between scientists and non-medical practitioners and indigenous populations.⁵⁶ Instead, the dichotomies in how we think and talk about male circumcision are reinforced by the narrow focus of randomized, clinical trials that claim objectivity and value neutrality. The end results are global health programs that are Western designed and perceived to be Western imposed.

Cutting to the Chase: Scaling-up Male Circumcision in Southern Africa

But the promise of hard evidence, value for money, and tangible results is understandably very appealing to the international development sector.⁵⁷ Evidence-based interventions and policymaking have been embraced as a means to improve clarity and outcomes in development.⁵⁸ Backed by scientific evidence, and a renewed sense of urgency to identify novel and efficacious methods to reduce HIV transmission, the WHO/UNAIDS 2007 recommendation for scale-up of male circumcision in countries with high HIV prevalence and low prevalence of male circumcision, including all of the countries in southern Africa, set a target of circumcising 80 percent of all uncircumcised adult men by 2015. It was projected that achieving this goal would avert one in five new HIV infections by 2025.⁵⁹

The process of planning and implementing such a massive scale-up of male circumcision in southern Africa followed a rather familiar course. Once a scientific and public health consensus was forged around the benefits of circumcision, African country policy programs and initiatives were expected to come in line with the accepted international formulations. African governments took their lead from international donors and "expert advice" and incorporated male circumcision into their National Strategic Frameworks for HIV and AIDS. With the reauthorization of PEPFAR in 2008, the United States began to develop five-year Partnership Frameworks with African governments that included male circumcision as part of HIV prevention. The strategic plans and partnership frameworks are impressive, with the requisite emphasis on multi-sectoral, integrated, and the standardization of internationally endorsed principles and practices. Indeed, the overarching structure of the programs established were in

line with directives from WHO, UNAIDS, and major international donors. From the donors' perspective, this was the outcome of lengthy consultative processes. We should not underestimate the power imbalance between donors and recipient countries, however, and the agenda-setting power of donor governments such as the United States. In all southern African countries, donors sit on the internationally mandated National AIDS Councils, the bodies responsible for providing strategic direction, establishing guidelines and policy, and funding proposals for the AIDS response. Donor and international "experts" also have been substantially involved in consultations and planning to develop countries' national strategic frameworks.⁶⁰

Initially, donors were receptive to the idea of integrating male circumcision into existing health services and infrastructure. However, it quickly became apparent that adult male circumcision could not be prioritized in that way, and that countries would not be able to meet their targets. Overworked doctors and under-staffed clinics resisted prioritizing what, in effect, is a voluntary, non-emergency procedure. According to the mathematical modeling, the benefits of an adult male circumcision program would only be realized if the vast majority of males could be circumcised in a short period of time. Expediency was critical. As a result, donors began to design a model for male circumcision that would be implemented similar to a vaccination campaign. Driven largely by public health CDC experts, the argument was made that the campaign did not require a long-term investment in health infrastructure but rather could be run as a once-off investment in temporary health services. This greatly appealed to U.S. lawmakers who liked the idea of a short-term investment with dramatic, long-term results.

Thus, in 2010, the WHO released "Considerations for Implementing Models for Optimizing the Volume and Efficiency for Male Circumcision Services" (MOVE) that laid out a framework to standardize a temporary, mobile surgical model that could be applied to male circumcision services.⁶¹ Today, the vast majority of circumcisions continue to be performed using donor funding, and at donor operated MOVE sites. For example, during October 2009–September 2012, a total of 1,924,792 male circumcisions were performed in fourteen countries using PEPFAR funding provided through U.S. government agencies; of this total, 1,020,424 were conducted at approximately 1,600 U.S. government-supported sites.⁶² These are temporary tent structures that can easily be assembled and disassembled and moved to different locations. The MOVE model typically uses one doctor or surgical staff along with four supporting staff. It is estimated that eighty male circumcisions can be performed per team per day using the MOVE model.⁶³

In addition, the donor model of male circumcision uses well-established nongovernmental or development partners such as Population Services International (PSI), Jhpiego (an affiliate of Johns Hopkins University), I-TECH (affiliated with the University of Washington), and the Futures Group who have been awarded contracts to implement various aspects of the male circumcision campaigns, including marketing, training, and implementation. Since the intent is not health systems strengthening, interviews conducted with PEPFAR and ACHAP staff confirmed that the bulk of these contracts are spent on highly paid consultants and temporary international staff, many of whom are seconded to the Ministries of Health. In Botswana, for example, PEPFAR supports over 150 personnel based within the Ministry of Health, and the Gates Foundation funded ACHAP supports an additional one hundred personnel.⁶⁴ They are

often highly skilled and highly paid personnel—over \$100,000/per year. In Swaziland, over half of the PEPFAR contract to Futures Group was spent on hiring expatriate surgeons to train clinicians.⁶⁵

Overall, international donors have invested well over \$130 million in male circumcision, with the largest annual expenditure of \$42 million coming in 2012.⁶⁶ Despite the significant investment in resources, progress in implementing the scale-up of male circumcision has been slow until very recently. As of December 2013, 5.82 million African men in the designated priority countries had been circumcised. This figure constitutes around 27 percent of the goal to circumcise 20.3 million African men by 2015.⁶⁷ Furthermore, progress in scaling up circumcision has varied from country to country, with Kenya and Ethiopia achieving 85.3 percent and 98.4 percent respectively of their national goal. South Africa has circumcised the most number of adult males, 1.4 million. Yet, this constitutes only 32 percent of their national goal. Others like Malawi and Namibia have yet to achieve 5 percent of their national goals.⁶⁸

WHO, UNAIDS, and international donors all expressed a degree of surprise and frustration at the slow progress. Not only does the science demonstrate the efficacy of circumcision as an HIV prevention strategy, but subsequent surveys conducted in several countries suggested broad acceptability of adopting circumcision as a prevention strategy among the population.⁶⁹ Explanations for the slow uptake in circumcisions are multiple and complex. In their program evaluations and reviews, donors have tended to focus on improving programmatic efficiencies through task shifting and task sharing, the introduction of new technologies such as non-surgical methods of circumcision, and improving management capacity of governments.⁷⁰ Program reviews also emphasize the importance of tailoring demand-creation interventions and service delivery models to specific age group of clients.⁷¹

Yet program evaluations offer little introspection on how the donors' approach to male circumcision and the assumptions implicit in that approach may have thrown up barriers to its implementation. The push for expediency and the framing of male circumcision as a once-off medical procedure contributed to poor marketing, messaging, and buy-in among the recipient populations. In the smaller, more homogenous societies where HIV prevalence is the highest and expectations for the male circumcision campaign were most ambitious, the programs proved most disappointing. In Swaziland, PEPFAR's goal was to circumcise 80 percent of all men fifteen to forty-nine in one year. But mixed messaging, entrenched local customs, false rumors, and gender imbalances all contributed to the program falling far short of its goal.⁷² Marketing for the national campaign "*Soka Uncobe*" (Circumcise and Conquer), handled by the Futures Group, linked circumcision with masculinity. Was the message intended to be circumcise and conquer HIV? Or circumcise and conquer women? Other messaging such as "*lisoka lisoka ngekusoka*" (literally, "the lover boy is a lover boy thanks to circumcision") appeals to the young playboy but is off-putting to married men.⁷³ Similar campaigns were observed during the seven-month research trip in Botswana, where billboards read "*Banna tota*" (real men) circumcise.

The macho, male-centered messaging also explicitly excluded women from the conversation around circumcision. This was odd, given women's influence as mothers and as partners. In fact, in Kenya, one of the few countries that has almost hit its target to circumcise over 80 percent of the male population, studies suggest women's support of male circumcision

was instrumental in the program's success. In many southern African countries, women were targeted for infant circumcision but largely left out of the messaging for adult male circumcision. Also, given that the majority of those contracting HIV in southern Africa are women, a prevention program that excluded women and appeared to appeal to men's macho desires had the effect of alienating many AIDS activist organizations and groups that could have been natural supporters of the circumcision campaign.

Mixed messaging has also been impacted the acceptability of male circumcision. Scientists and public health experts from the outset stated that as circumcision does not offer full protection against HIV, the message to African males must be "circumcise but still use a condom." However, many males reported not seeing the value of medical male circumcision when continued condom use was still recommended after the procedure.⁷⁴ Furthermore, information about the benefits of male circumcision was not disseminated in a clear and understandable way. A law student from Swaziland complained, "First they told me that circumcision will not really protect me against HIV. Then they tell me that I cannot have sex for some weeks or months after circumcision."⁷⁵ In the end, he declined the procedure.

Mixed messaging and hurried information opened the door to numerous false rumors and speculations in a number of countries. Many men were turned off from medical circumcision because of the supposed pain of the process, and the perception the circumcision would decrease their sexual pleasure and may even make them sterile. At focus group discussions in Swaziland men were reported saying: "A real Swazi man is defined as someone who has a wife and children, and is able to take care of family. In order to have a wife and children, a man has to be sexually functional—the issue of circumcision introduced a threat to this."⁷⁶ Rumors in several countries also began to abound about what happens with the foreskin after the procedure. Some men feared it would be sold to traditional healers who could use it to bring back luck to them.⁷⁷ In sum, the circumcision campaigns were ill-prepared to deal with the dilemma of getting Western, scientific circumcision messages across in communities with different health care systems that rest on different truth claims.

Donors' push for expediency also created friction between themselves and recipient governments. In Swaziland, where PEPFAR insists the program was initiated and driven by the Swazi government, some Swazi AIDS professionals described the campaign as "an exercise in bullying." While PEPFAR points to extensive consultation in the form of weekly and monthly meetings, prominent AIDS activists said the regular meetings were used by Futures Group to rubber stamp decisions, rather than consult. Even within Swaziland's National Emergency Response Council on HIV/AIDS, the perception was the PEPFAR and its partners had their own agenda, and would not listen to the input of others.⁷⁸

In Botswana, the push to quickly rollout male circumcision clashed with the more deliberative decision-making process of the Botswana government.⁷⁹ An elite-driven, stable democracy, Botswana has been highly successful politically and economically, in part because of a culture of consultation, enshrined through the Kgotla system dating back many generations, which allowed the Botswana state to coopt key societal constituencies to support its agenda. In addition, the importance of equity and uniform coverage in the provision of social services has been key to successful, long-term development planning. Thus the Botswana government was initially reluctant to quickly establish stand-alone clinics in select

communities. It instead sought a holistic, consultative process that would offer equitable access to male circumcision services through integrated health clinics. Responding to donor demands for expediency, one senior health official remarked: “Scientists can get ahead of themselves by not fully appreciating the policy process. Within government there are a lot of things that need to click right. We have our own pace of doing things. Safe male circumcision requires a logistical change in the way the healthcare system is oriented.”⁸⁰

The Botswana government did eventually agree to adopt the MOVE model of stand-alone clinics, but only after considerable political pressure was brought to bear on it. Ambassador Eric Goosby, former head of the U.S. Office of the Global AIDS Coordinator, paid a visit to Botswana’s President Ian Khama during his March 2011 visit and specifically appealed to President Khama to ensure a quick uptake of male circumcision.⁸¹ Others suggested it took a follow-up letter from the U.S. Ambassador to the Minister of Health later that year to really get the government moving on male circumcision.⁸² In the end, donor prioritization of expediency and efficiency led to the bulk of resources being spent on skilled experts and technical assistance without the requisite investment in community advocacy and mobilization, and a rocky implementation in the crucial early years.

Conclusion

“Basic and clinical science have provided us with highly effective interventions to treat and prevent HIV infection. If we markedly scale-up globally the implementation of these interventions, we can dramatically alter the trajectory of the pandemic towards the ultimate goal of an AIDS-free generation.” – Dr. Anthony Fauci, Director, NIAID, July 23, 2012 (AIDS2012 Conference)

Medical male circumcision is one of the biomedical interventions the scientific community is counting on to help curb new HIV infections and significantly reduce its impact on communities. Such scientific interventions are appealing in that they offer a one-off intervention that theoretically can be replicated in multiple settings. They supposedly produce a beneficial effect without requiring a change in behavior on the part of the recipients. Thus donors have been pumping increasing amounts of funding into global health research in the past decade, with the assumptions that scientific advances can dramatically alter disease trajectories and the scale of epidemics.

But as this article has argued regarding the case of male circumcision campaigns as an HIV prevention strategy in southern Africa, the translation of scientific advances into public health policies and their implementation is not linear, and can be a rocky and contentious process. There is a role for social scientific research to lend insight and context, leading to improved outcomes. The assumption that scientific knowledge will be embraced as ‘the truth’ in all communities, and will trump other ways of knowing ignores the fact that knowledge exists at many different levels, and is contextualized differently. The scientific and public health communities have framed medical male circumcision as a technical issue. But it can also be deeply political and cultural, and in these contexts other “knowledges” and incentives can be more compelling. Thus, while male circumcision has demonstrated efficacy under ideal conditions, it will only be effective in real-world settings and in certain circumstances when contextual factors including social networks, political debates, and cultural values are favorable.

From the outset, not enough attention was paid on the part of biomedical researchers and public health experts to how male circumcision will operate in real people's lives. The assumptions that evidence pertains only to verifiable and measurable facts, and that scientific knowledge is generalizable, does not take into account the fact that context-specific factors contribute to ensuring validity and applicability of evidence in real world settings. At the level of communities, even in societies with little recent history of circumcision, male circumcision was being introduced and overlaid onto existing cultural and societal hierarchies, social norms about gender relations and generational relations, and political dynamics and contestations. There was an expectation on the part of donors that male circumcision could be expeditiously introduced without sufficiently educating local communities on the merits of scientific evidence and interventions, or fully considering the social and cultural context in which male circumcision would be conducted. This contributed to a climate of misinformation at times, and the misuse of alternative understandings of male circumcision to promote particular political agendas in certain local contexts.

At the level of government, global health experts and donors underestimated the extent to which translating the scientific evidence on male circumcision into policy and implementation is not just a technical problem of knowledge exchange or translation, but is also a political challenge. Policymaking is a complex and essentially political process that is influenced by several factors and involves trade-offs between competing interests and values. Donors paid little attention to the ways in which male circumcision would be politicized, and the extent to which such policies would involve budget and priority considerations as well as social considerations beyond clinical outcomes—such as questions of equity, justice or morality—all of which can influence decision-making.

The failure of donors to consider the social, political, and cultural context led to male circumcision being perceived in many southern African countries as part of a donor driven agenda. Resistance to male circumcision became part of a broader challenge to donor dependence and influence in many societies. Moving forward, if scientific and biomedical health interventions are going to play the transformative role they are capable of, greater attention must be paid early on to ensure culturally sensitive and relevant implementation.

Notes

- 1 See <http://www.who.int/mediacentre/news/releases/2007/pr10/en/> (accessed June 28, 2013).
- 2 Auvert et al. 2005; Gray et al. 2007. WHO and UNAIDS identified thirteen priority countries for scale-up of VMMC: Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Uganda, Tanzania, Zambia, and Zimbabwe. PEPFAR is supporting activities to implement VMMC in these thirteen countries and also in Ethiopia, making a total of fourteen priority countries. See WHO/UNAIDS 2011a.
- 3 Sgaier, Reed, Thomas, and Njeuhmeli 2014.
- 4 "Scale-up of Voluntary Medical Male Circumcision for HIV Prevention in Africa: Update on Priority Countries – July 2014" (www.malecircumcision.org; accessed December 8, 2014).

- 5 Sgaier, Reed, Thomas, and Njeuhmeli 2014.
- 6 Farmer, Drobac, and Agoos 2009; Mamdani 2008.
- 7 Brown 2008; Farmer, Drobac, and Agoos 2009; Mamdani 2008.
- 8 Franco-Paredes, Lammoglia, and Santos-Preciado 2005.
- 9 Fenner et al. 1988.
- 10 Franco-Paredes, Lammoglia, and Santos-Preciado 2005.
- 11 Tarrago 2001.
- 12 Ibid.
- 13 Farmer, Drobac, and Agoos 2009.
- 14 Christenson 2006.
- 15 See Franco-Paredes, Lammoglia, Santos-Preciado 2005; and Tarrago 2001.
- 16 Aggleton 2007.
- 17 Ibid.
- 18 Male circumcision has been a defining marker of hierarchy and social difference. "During the Ottoman and Moorish Empires, in Nazi Germany, in India at partition and in the recent genocides of Bosnia and East Timor, a man's circumcision status had serious consequences for how he was treated: with violence, torture and death being the consequence for those who fell short of the mark." Ibid. p. 15
- 19 At a WHO/UNAIDS consultative meeting, male circumcision was described as "just a little snip." Ibid.
- 20 Deacon and Thomson 2012.
- 21 Ibid.
- 22 Krige 1956; Hammond-Tooke 1993; Schapera 1960 and 1978; Van der Vliet.
- 23 Willoughby 1909; Brown 1921.
- 24 Schapera 1936.
- 25 See Gulbrandsen 2012.
- 26 Mosothwane 2001.
- 27 Deacon and Thomson 2012.
- 28 Ngxamngxa 1971.
- 29 Deacon and Thomson 2012.
- 30 Ibid., Fuze 1979; Wheelwright 1905.
- 31 Deacon and Thomson 2012.
- 32 Vincent 2008a.
- 33 Vincent 2008b.
- 34 Ibid.
- 35 A Botswana study also highlighted tension between medical science and Setswana tradition in the practice of circumcision. See Sabone et al. 2013.
- 36 See Ncayiyana and Rehle 2014.
- 37 Mark 2012.
- 38 "SOUTH AFRICA: Zulu King revives male circumcision." December 15, 2009.
(<http://www.irinnews.org/report/87441/south-africa-zulu-king-revives-male-circumcision>;

- accessed January 5, 2015); McQuoid-Mason 2013.
- 39 Duval Smith 2010.
- 40 See Upton 2010; Heald 1999.
- 41 Auvert et al. 2005; Bailey et al. 2007; Gray et al. 2007; Siegfried et al. 2009; Wamai et al. 2011.
- 42 Kapiga et al. 1998; Hunter et al. 1994.
- 43 Deacon and Thomson 2012.
- 44 Epstein 1996.
- 45 HIV Vaccines and Microbicides Resource Tracking Group 2014.
- 46 Epstein 2002.
- 47 Bastos 1999, p. 151.
- 48 Halperin and Bailey 1999.
- 49 At the 2012 International AIDS Conference in Washington, DC, Dr. Anthony Fauci proclaimed, "Basic and clinical science have provided us with highly effective interventions to treat and prevent HIV infection. If we markedly scale-up globally the implementation of these interventions, we can dramatically alter the trajectory of the pandemic towards the ultimate goal of an AIDS-free generation." (July 23, 2012) (Conference attended by the author). Fauci is the head of the US National Institute of Allergy and Infectious Diseases
- 50 Auvert et al. 2005.
- 51 Bailey et al. 2007
- 52 Gray et al. 2007.
- 53 Deacon and Thomson 2012.; Peltzer et al. 2008.
- 54 Connelly et al. 2008.
- 55 WHO/UNAIDS 2010a.
- 56 Wreford 2005, 2006, and 2007.
- 57 Eyben 2013.
- 58 Elsewhere, I demonstrate that while this approach can be very useful, it can also be misused and have perverse consequences when used in an organizational environment in which hidden and invisible power determine what knowledge counts and hierarchical ways of working block communications and dialogue. See Johnson forthcoming 2016.
- 59 UNAIDS 2013.
- 60 PEPFAR 2010.
- 61 WHO 2010.
- 62 U.S. Centers for Disease Control 2012. The Bill and Melinda Gates Foundation is the second largest donor of male circumcision.
- 63 Edgil 2011.
- 64 Mtg with ITech official in Gaborone, Botswana, June 21, 2012.
- 65 Smith and GlobalPost 2012.
- 66 As a result of budgetary cuts across the board, \$32 million was spent on male circumcision in 2013. HIV Vaccines and Microbicides Resource Tracking Working Group 2014.
- 67 "Scale-up of Voluntary Medical Male Circumcision for HIV Prevention in Africa: Update

- on Priority Countries – July 2014.” (www.malecircumcision.org; accessed December 8, 2014).
- 68 WHO 2014.
- 69 Westercamp and Bailey (2007) compiled MC acceptability studies conducted in East and Southern Africa from 1998 to 2006. They comprehensively reviewed thirteen acceptability studies among traditionally uncircumcised society and concluded that MC is very well accepted. The data revealed that; uncircumcised men willing to be circumcised were 65 percent, women favoring circumcision for their partners were 69 percent, men willing to circumcise their sons were 71 percent and women willing to circumcise their son were 81 percent.
- 70 Sgaier et al. 2014. In many settings, lack of skilled healthcare workers has been a challenge, as have interrupted supplies of necessary medical supplies and equipment. Historically male circumcision has been a surgical procedure performed by doctors. However, in many African countries, doctors are in short demand, and governments and doctors have been reluctant to divert their time away from caring for critically ill patients to perform what in essence is a voluntary procedure on well patients. To address this challenge, several companies have devised a non-surgical method of performing circumcisions. Prepex, one such non-surgical medical device, has just recently been approved by the FDA, and pre qualified by the WHO for use in low-resource settings. (See WHO 2013). In addition, donors are increasing funding in several countries to train thousands of nurses to perform circumcisions, and African governments are putting in place task shifting policies. (See 2014. “Zimbabwe Nurses to Undergo HIV Mentorship Programme.” *The Herald*. February 10, 2014. <http://allafrica.com/stories/201402100483.html>; accessed December 5, 2014).
- 71 Macintyre 2014; Hatzold et al. 2014.
- 72 Smith and GlobalPost. 2012.
- 73 Ibid.
- 74 IRIN NEWS 2013; Gonzalez 2013. Similar campaigns were run in Botswana, where billboards read “*Banna tota*” (real men) circumcise.
- 75 IRIN NEWS 2013.
- 76 Gonzalez 2013.
- 77 Smith and GlobalPost. 2012; Kedikilwe 2012.
- 78 Ibid.
- 79 See Johnson forthcoming 2016.
- 80 Mtg with Botswana Ministry of Health Official, January 31, 2012.
- 81 *Botswana Gazette*, March 7, 2011. (www.gazettebw.com)
- 82 Mtg. with ITech staff, June 21, 2012.

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