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Of dreams and nightmares: implementing medical male circumcision in eSwatini (Swaziland)

Nolwazi Mkhwanazi

Introduction

I arrive at 'the hub', the main offices of the *Soka Uncobe* campaign in Ezulwini, eSwatini.[1] Ned, the American cameraman, Sipho, his Swazi translator, and Johannes, the Swazi driver, are already there. It is around 7.30 in the morning. Ned and Sipho are packing the camera equipment into the minibus painted with a blue and orange logo proudly proclaiming *Soka Uncobe* (Circumcise and Conquer). We planned an early start so that we could check that all the equipment was working before we set off on our trip around the country. Ned is conducting video ethnographies as part of the 'demand creation' strategy for *Soka Uncobe*. Our first stop is bustling Manzini, the economic capital of eSwatini. We find our way to the Catholic church. When we enquire at the convent if there are any priests around, a young man leads us to the building across the road and tells us to wait in the garden. A few minutes later he reappears with an older man dressed in jeans and a black and grey windbreaker. He introduces himself as Father Ndlovu and steps forward to shake our hands as we introduce ourselves to him. Ned explains that we are part of the *Soka* campaign and that we would like to ask him about the church's stance on male circumcision. Father Ndlovu hesitates – he seems to have been caught off guard. After a few moments he agrees. 'Circumcision,' he says, speaking into the microphone, 'is not something that we would encourage to prevent HIV. What we say, as clergymen, is to abstain until you are married.' Sipho asks if abstaining will really help prevent the spread of HIV. 'Yes,' Father Ndlovu responds, slightly more animated. 'Yes, it will help because it is evident that Swazis are very active when it comes to sex.' As a parting statement, Father Ndlovu reminds us that going to heaven or hell is linked to doing good or bad. 'If circumcision is good, or doesn't intend bad, morally speaking, then we [the clergy] can't say it is something evil. We can't say if you are circumcised you can't go to heaven.' This is our first interview of the day. We thank Father Ndlovu for his time. We hop into the minibus and head for the taxi rank, the transport hub of any town, to solicit other views.

In this article, I describe the accelerated saturation initiative (ASI), *Soka Uncobe*, which took place in eSwatini in 2011 and 2012, to comment on HIV humanitarian health interventions in Africa; the dreams that underpin them;

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[1]The research for the article was conducted while the country was still known as Swaziland. In 2018, the name was officially changed to eSwatini.

and the dynamics of their implementation. I argue that the dream(s) and assumptions that underpinned *Soka Uncobe* posed challenges for its implementation, and ultimately contributed to its failure. While *Soka Uncobe* was a very different intervention to those we have seen on the African continent in the past – the vaccination campaigns of the 1970s and 1980s, or even the mass provision of antiretroviral therapy in response to HIV – its implementation, I suggest, is not fundamentally different from other humanitarian interventions.

Humanitarian interventions of which *Soka Uncobe* is an example are planned, driven and implemented by transnational humanitarian organizations that appear when they have identified an emergency, intervening in the lives and bodies of a target population, often altering subjectivities and then disappearing as much of the health infrastructure falls into disrepair. These actions are theorized as displays of 'governmentality' or 'experimentality' (Nguyen 2009), both of which indicate a form of power and surveillance and are techniques of 'government-by-exception' (*ibid.*). In instances of government-by-exception, interventions are funder-driven and directed by organizations based in the global North; they rarely cooperate with local governments, despite the rhetoric (Rottenburg 2009). They seek total control. These interventions often have their own logics, rules and forms of accounting that are standardized, and they are implemented by subcontracted providers familiar with these logics. This form of domination of the South by the North through biomedicine is not new.

Soka Uncobe was an HIV intervention in eSwatini that aimed to circumcise 80 per cent of all HIV-negative men aged fifteen to forty-nine years over a twelve-month period. Its planning began in 2010 and it officially ended in 2012. The idea of the ASI originated from the findings of the randomized controlled trials carried out in South Africa, Uganda and Kenya to see if male circumcision had any effect on men acquiring HIV from women. The results from the trials suggested that male circumcision could reduce female-to-male HIV transmission by up to 60 per cent. Prompted by these findings, the World Health Organization (WHO) and UNAIDS issued a statement recommending medical male circumcision for HIV prevention in countries with high HIV prevalence and low male circumcision rates.

With a prevalence rate of 26 per cent in the adult population and 19 per cent in the general population, eSwatini was, at the time of the intervention, described as the 'epicentre' of the HIV/AIDS epidemic. With a population of 1.2 million, a landmass of approximately 17,200 square kilometres and low rates of circumcision (at 8 per cent), this tiny kingdom was thus the ideal place to produce more knowledge on the efficacy of medical male circumcision through an ASI that aimed to scale up the number of people the intervention would reach (152,000) in a short period of time (12 months).

Soka Uncobe was thus unique in being both an experiment and a humanitarian emergency intervention. As both, those who planned the intervention justified it as being 'of importance not only for the survival of eSwatini but also as evidence to the world that HIV can be slowed in the absence of a vaccine'.[2] It was an experiment in the sense that, through its implementation, it was also meant to provide evidence that would legitimate the ASI (Nguyen 2009). As a humanitarian emergency intervention, it was justified through the use of techniques of enumeration

[2]See p. 7 of the 'MC ASI Action Plan 2010–2012'.

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(Benton 2012). Mathematical modelling and costing studies that were conducted prior to presenting the idea to the Swazi cabinet projected that, if 80 per cent of HIV-negative men were circumcised within a year, 88,000 new infections (including 36,000 new infections among women) would be averted by 2025, saving the country US$650 million in HIV care and treatment. Additionally, HIV incidence would be reduced by 75 per cent by 2025. The figures provided evidence of the urgency, which would result in lives and money being saved in the future. The figures also justified the mass resources that were mobilized by PEPFAR (US President's Emergency Plan for AIDS Relief) and foreign donor agencies for the financial and technical support of the ASI.

Ethnography inside an accelerated saturated initiative

In July 2011, Ian, the director of the research centre where I worked, received an email from a colleague for whom he had done some work in the past. The colleague, Jeffrey, was now working in eSwatini and was part of the *Soka* campaign.[3] Jeffrey asked Ian if he, or anyone he knew, would be interested in conducting a process evaluation of the campaign, since the one he and his team had conducted previously had not resulted in any improvements to the campaign. He emphasized that he was now looking for someone who was not familiar with the campaign. Ian immediately thought of me, not only because I am a Swazi national, but because he thought such a project would be fascinating for a medical anthropologist.

In August 2011, I landed at the still functional and central tiny Matsapha airport (which was soon replaced by the bigger, remote King Mswati III International Airport). Once through immigration, I was met by Johannes, who led me to a large white four-by-four that bore a round sticker that depicted the Swazi and US flags encircled by the words 'President's Emergency Plan for AIDS Relief', with 'Swazis and Americans' along the bottom. As soon as Johannes turned the car on, a cold blast of air came through the dashboard. Although it was winter, it was hot enough in eSwatini to require air conditioning.

Johannes drove me to the *Soka Uncobe* head offices in Ezulwini, at what the staff referred to as 'the hub', next to the five-star Royal Villas. It was where the main office of the Futures Group[4] could be found, and where the various heads of the components of the campaign met every week. I was in time for the weekly operations meeting. Johannes introduced me to Jeffrey, who in turn introduced me to various members of the implementing team. He briefly explained to me what each person's role was. As we sat down, a well-dressed woman in her late twenties walked in and sat at the head of the table. With her American accent, but also her manner of speaking and the air of authority she exuded, I realized that she was in charge of operations. She was also by far the youngest person. Jeffrey introduced me officially to those in the meeting and to Jane, sitting at the head of the

[3]In eSwatini, among the implementers, *Soka Uncobe* was referred to simply as the *Soka* campaign rather than the officious-sounding 'accelerated saturation initiative'.

[4]Since this episode, the Futures Group has merged with five other organizations and is now known as Palladium. On their website, they describe themselves as a 'global impact firm' that is in 'the business of making the world a better place'.

table. He explained that as part of the process evaluation, I would be interviewing most of them, going on site visits, and joining the communications team as they went around the country making video ethnographies. He asked everyone present to make themselves available for interviews and to answer any questions I had. After the meeting, I was given a box with all the correspondence, minutes of meetings and statistics that had been gathered, and a CD that contained more documents.

This article is based on these unpublished sources, my participation in and observation of the *Soka Uncobe* campaign in August and September 2011, and the research I conducted for the process evaluation. The process evaluation, a technology of surveillance in itself, was a component of the overall implementation of the initiative. Its purpose was to help the implementers document and address any challenges to the success of the intervention. I was given permission to use the documents for the report and for future publications. I do not think that at the time the ASI was seen as a failure. In line with anthropological ethical practices, I have tried to protect the people and organizations involved beyond what can be found in the public domain. Pseudonyms have been used to protect the identities of individuals.

To collect the data for the evaluation, I used a mixture of methods. First, I reviewed all the documents relating to *Soka Uncobe* and the Back to School subcampaign (BTS) (see below), including emails, minutes of meetings, official documents, memos, IEC (information, education and communication) materials and presentations. Second, I worked closely with four programme associates who had been involved on the previous evaluation and were familiar with different components of the campaign. These programme associates were the least guarded in their responses to my questions and were useful interlocutors: they attended weekly meetings at the hub that were used for planning, to report back on the week's activities and to discuss successes and challenges. Third, I interviewed the leaders of the programme components and the regional coordinators to obtain a better understanding of the dynamics of implementing the campaign. Fourth, I visited three sites: Piggs Peak, Siteki and Matsapha. Finally, I travelled around the country observing the communications team during one of their 'pulse-taking' activities, which involved filming people's (men's, women's and adolescents') responses to the campaign and the idea of male circumcision – what they called 'video ethnographies'.

I presented the preliminary findings of my evaluation on 20 September 2011 during 'a critical reflection event'[5] involving some partners and stakeholders. This was followed up with a written report. In the report, which was necessarily short and fairly general, I gave four standard recommendations: regular and consistent communication; effective planning; accountability; and regular monitoring and evaluation. The interpretation that I present in this article is an extension of this evaluation, building on reflections that date from this time in the field. What writing an article allows me to do is to provide an argument for and an interpretation of what I observed and experienced at the time. It allows for a more detailed and critical commentary, one that can include the individual voices of those to whom I spoke. There was no space for the latter in the process evaluation report.

[5]These events were held after each evaluation and were intended for the various heads of units and implementing partners to hear the findings of the evaluation and discuss a way forward.

The opportunity to have conducted research on this ASI provides a unique perspective on the dynamics of HIV humanitarian emergency interventions in Africa. *Soka Uncobe* was the first ASI on voluntary medical male circumcision globally, and it did not deliver on what it set out to do: at the end of the campaign, only 11,000 of the target of 152,000 men had been circumcised. By and large, little has been said or written about this failure, certainly not by any of the implementing partners. Thus, pivotal to my question about the dreams that underpinned the ASI is how we explain the failure of the first ever ASI related to medical male circumcision.

While the question regarding the dreams that underpinned the ASI has never been asked, Smith (2012), Maibuse and Mavundla (2014), Adams and Moyer (2015) and Golomski and Nyawo (2017) have attempted to provide explanations of why men did not volunteer to be circumcised for free at one of the many sites dotted around the country. These authors focus on the beliefs and practices of Swazi men and the meanings that the men attached to circumcision. While many Swazi men may simply not have wanted to be circumcised, the explanations given by these authors subtly blame Swazi men for the failure of the campaign by depicting them as being 'knowledge deficient', superstitious and holding misconceptions (Maibuse and Mavundla 2014).

By focusing on dreams and positing a relationship between the dreams that underpinned the ASI and its ultimate failure, this article offers a different understanding and representation of the ASI. The perspective I provide is from inside the campaign; I examine the experiences and attitudes of the planners and the implementers rather than the intended beneficiaries, and how the conception (the dreams) and implementation of the ASI contributed to its failure. While much of the evidence that I discuss relates to and speaks to the entanglement of science and politics, and the pervasiveness of 'therapeutic domination' in Africa (Rottenburg 2009), my intention is to present the empirical evidence, through unpublished documents, words and experiences of people within the ASI, to explain how the ASI was intended to work and how it unfolded in eSwatini. To make my argument, I focus on three key features of the campaign that contrast the dreams and the actuality. These are the campaign's obsession with targets, the extent of the involvement of local structures, and the participation of local staff in making decisions about improving uptake. On the first point, I rely quite heavily on the actual wording within the documents, and so the quotes in the following section are lengthy.

'Forty, that is not a good number for us': targets and time frame

I begin with excerpts from three different points in the unfolding of the campaign that capture the mood of the US planners and implementers during the different phases of the ASI.

Excerpt 1 from the 'MC ASI Action Plan 2010–2012'

> It is possible to reach the target in a shorter period of time, especially given that the level of demand is unknown. It is also possible to manipulate other variables (e.g. the number of days a week, more MCs [male circumcisions]/day). For example, if we were to

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> incorporate 1 MC Saturday/Month at all sites an additional 480 MCs would be done each month. This would add an additional 5760 MCs and could reduce the time line by nearly three weeks. (p. 26)

The above excerpt is drawn from the initial project plan presented to the Swazi cabinet. Optimistic and enthusiastic in tone, the authors of the document are overly confident that the target can be reached even sooner than the stipulated time frame. The language is one of an experiment – variables can be manipulated. A suggestion is even made about how to speed up the process, rather than propose a contingency plan in case the targets are not reached within the time frame. When I asked the Ministry of Health representative about who decided on the time frames and how the decision was made, he told me that it was the planners. 'When people started talking about the target of 152,000, they were talking about six months,' he said. 'And I was seated there in the meeting depressed. Then they said OK. They actually could see that six months is not going to work. So they started talking about a year and I said a year and 152,000 [is not possible]. I was like depressed. Simply because … I am not a clinician and as such my thinking is a bit different from the rest. For me, when you are talking about changing social norms, eSwatini being a non-circumcising nation, you must be serious in terms of the targets that you set yourself.' He paused, carefully choosing his next words. 'There is no way that you can circumcise 152,000 people in a non-circumcising country within a period of six months. I don't care if it is a period of twelve months. That is not going to happen. We are dealing with human beings and changing social norms is a process.' He added, 'It is easy for someone with a laptop to press buttons and say, "Yes, with a population of 1 million if we divide this in months it can be done in six months, easy!"'

Excerpt 2 from the 'Targets updated' document, 17 September 2010

> [The] Futures Group is confident that, although this is the first global attempt to successfully complete an ASI, it is fully feasible to perform the Futures Group Team's role in achieving the ASI objective to circumcize 80% of the at-risk population within the timeframe and budget of this project. We currently project (*based on updated targets, described in detail below*) that 113,400 MCs on HIV-negative men ages 15–49 will be performed under the ASI initiative, with additional MCs provided to the not-at-risk population who opt-in to the service after receiving initial screening services through the initiative. Overall, 141,800 men will receive services through the initiative (*this updated target reflects MCs achieved between the original proposal submission and ASI implementation dates*). The absolute number of circumcisions performed may be adjusted as more is learned through monitoring and evaluation during the ASI itself. However, the overall ASI objective, to circumcize 80% of the at-risk men, will remain constant for the project. (italics in original)

The above excerpt is taken from a document produced three months after the first excerpt. The Futures Group, which was awarded the contract by PEPFAR to lead the ASI, wrote this document. Again, the tone is confident but also reassuring. There is a sense of conviction in the projection regarding how many men will be reached solely based on calculations that are constantly updated. The reader is assured that the objective of the ASI will not change.

Excerpt 3 from an interview with the Head of Human Resources, August 2011

> The MOVE [Models of Optimizing Volume and Efficiency] teams were adapted according to the original plans of the ASI with what we thought would work here to ensure the highest quality of care while getting the highest number of clients through the system every day … Everything is sort of couched around the idea of forty circumcisions per day so that the four beds are to accommodate forty circumcisions per day because that was the assumption of the original doable target here but that has changed a lot based on experience with implementation … [forty] that … that is not a good number for us.

The last excerpt is from an interview I conducted six months into the campaign. The tone has changed to one of fatigue and defeat. In stressing the difference between the initial plan and the experience of implementing it, the speaker suggests that the initial targets were unrealistic. For the ASI to reach the objective of circumcising 80 per cent of HIV-negative males between the ages of fifteen and forty-nine years, approximately 152,000 men had to be convinced to undergo medical male circumcision in one year. In a country where men do not recall their fathers or forefathers before them being circumcised, this was no ordinary feat, a sentiment shared by the representative of the Ministry of Health earlier.

Rolling out the campaign

In the plans, thirty-five sites would operate, each reaching forty clients daily. Every site was to be staffed by a team that complied with the Models of Optimizing Volume and Efficiency (MOVE), a blueprint developed from male circumcision trials in Orange Farm, South Africa. The MOVE team initially comprised one doctor (since only doctors could perform circumcisions), seven nurses, one theatre runner, two counsellors, one hygienist/cleaner, one receptionist, one booking agent and one data capturer.[6]

Knowing that eSwatini was 'not a circumcising nation' before the ASI began, an ambitious advertising campaign was initiated to educate people about the health benefits of medical male circumcision and to 'create demand'. A South African-based communications consultancy led the campaign. It used national radio, television and local print media to disseminate information about the campaign and about the health benefits of medical male circumcision in English and Siswati. They branded a fleet of minibuses, a popular form of transport in eSwatini, with the campaign's orange and blue colours. Murals of young men advocating for circumcision were painted on local shop walls and on the walls of *spazas* (convenience stores). Billboards were erected in key sites imploring men to get circumcised, stating that it was 'safer than STIs'. A team of young people was hired to spread the word in communities.

The project timelines for *Soka Uncobe*, stipulated in the 'MC ASI Action Plan 2010–2012', were that six months would be spent on preparation, from June to December 2010. This would be followed by twelve months of implementation (January to December 2011) and three months of wrapping up (January to March 2012). Even before the anticipated start in January 2011, the date was

[6]At a later stage, an expert client was added as an essential component of the team.

moved to the first week of April because PEPFAR/USAID was unable to give a date when sufficient supplies and equipment would be available. *Soka Uncobe* was officially launched in April 2011 with only ten of the anticipated thirty-five MOVE teams in place. In the first week, seventeen people used the service. As the weeks went by, a trickle of clients attended, and by the middle of June, only 1,526 circumcisions had been performed. When I started the evaluation in August, only 3,500 of the 152,000 male circumcisions had taken place. During the BTS sub-campaign, a further 3,769 circumcisions were performed, a figure below the anticipated 7,000 for the sub-campaign.

The obsession with numbers underscores the over-reliance of 'foreign donors' on 'enumerative and probabilistic practices to quantify problems and their trajectories' (Benton 2012). It is also an obsession with legitimacy and accountability. For *Soka* to be accountable to the foreign funders, it needed to prove its success through the number of circumcisions provided and the number of staff recruited. As an HIV humanitarian intervention, HIV was framed as an emergency and the emergency needed to be averted. Indicators and numbers thus became crucial technologies in accounting for the progress of the intervention (Park 2015). Creating the numbers to show progress was not easy. The system used to collect data and to create unique identification numbers for clients required internet connectivity. In some sites there was no internet connectivity and information had to be manually captured and uploaded onto the system later. This led to a series of backlogs and was a major logistical nightmare, as various components of the campaign depended on the client identification numbers.

The obsession with numbers underpins a dream of control and order. In this dream, enough marketing emphasizing future benefits for the individual (including a reduced risk of acquiring prostate cancer), for the country (lower HIV prevalence rates) and for the world (an AIDS-free world) was expected to convince Swazi men of the rationality of science so that they would line up to be circumcised. This dream left no room for a situation in which Swazi men, like many others before them, would doubt the usefulness of undergoing a procedure that was not 100 per cent effective, and were simply not convinced by the numbers.

Involving local structures?

It is noon on the first day of the video ethnographies. Ned, Sipho and I find ourselves in a seminary outside the town of Siteki where priests in training are sitting down to have lunch. We approach a table of three men. Peter, one of the men, fields all the questions. He talks about the *Soka* campaign as being worthwhile, even though he hasn't yet undergone circumcision. When Ned asks him why, he says that he has heard about all the advantages of circumcision but not the disadvantages. He explains that he can only make a decision once he has all the facts and can weigh them up himself. As a provocation, Ned asks him if God supports circumcision. Peter provides a lengthy answer about how God hasn't spoken on this issue yet. 'The true definition of circumcision is to accept Jesus,' says Themba, who has been quiet all along. 'If you circumcise and accept Jesus then you have truly circumcised but if you just remove the foreskin then you have only gone halfway because you will get HIV. But if you have Christ in your life then you

won't get HIV. If you have Christ in your life and you get circumcised, then I can say you are almost 90 per cent safe.' Ned asks him if he is circumcised, Themba responds that he is not. He explains that while he understands and sees the benefit of circumcision, he has decided to circumcise by accepting God.

The second feature of the campaign was an unwillingness to involve local structures, including churches, despite the official rhetoric. In the interviews, the various implementers of *Soka* acknowledged that the design of the ASI originated in the United States; however, official documents credit the government of the kingdom of Swaziland (often abbreviated to GKOS) with the idea and the design of the work and action plan. For example, the USAID quarterly progress report commenting on the period from 1 April to 30 June 2011 stated that 'the Government of the kingdom of Swaziland launched the *Soka Uncobe* brand in March 2011'. In an interview, Meredith Mazzotta, one of the PEPFAR team in eSwatini, said that the Ministry of Health had 'the policy lead' on the campaign and was 'driving the implementation' (Mazzotta 2011). The team also stated that the campaign had strong support from the Swazi government. Furthermore, they stressed the importance of engaging traditional and community leaders. In an interview, the representative of the Ministry of Health explained to me that the ASI was '100 per cent funded by USAID/PEPFAR. They [USAID/PEPFAR] have got the means. But the Ministry of Health, the only things they have done is actually approve at policy level to say this is the way to go … Government is not contributing a cent.'

Despite what was laid out in the action plan of July 2010, in the build-up to implementation there was little or no involvement of government or of traditional or community leaders. During the early stages of implementation, local employees of the campaign constantly raised the issue of the importance of having the approval of King Mswati III. This was initially ignored. Only in June 2011 were meetings with the king requested. His support for the campaign was granted in July but this was already too late, since, in the eyes of many, the campaign was already discredited. Since the start of the campaign, staff from government ministries had repeatedly complained that they were not being drawn into the initiative. They said that, despite the rhetoric, *Soka Uncobe* was a US government initiative. In the debriefing to the US ambassador, Earl Irving, on 9 May 2011, the team contracted to review the social and behaviour change communications strategy had commented on the fragmented approach and the breakdown of coordination between the Swazi government and US government *Soka* teams. They reported that Swazi government officials perceived *Soka* as being led by the US government. The review emphasized the need for – and desire of – Swazi government officials to be fully involved in the planning and execution of the campaign. However, as late as August 2011, in a process evaluation undertaken by Jeffrey's team, the lack of involvement of Swazi government officials was acknowledged again as having an adverse effect on the campaign. At this late stage, the recommendation was once again for 'bringing in government leaders … to advocate for MC'.[7]

The planning of how the implementation of the ASI would unfold took place outside eSwatini. By the time it was presented to the cabinet and the Ministry

[7]See p. 15 of the 'Process evaluation report' for 2011.

of Health, every move was already carefully plotted. Since the addition of sub-campaigns[8] had not been part of the initial plan, the planning and implementation of the sub-campaigns, such as BTS, became the critical place where the extent of the involvement of local structures could be ascertained. The idea behind the BTS sub-campaign was to target school-going youth so that they would enrol for circumcision to be carried out during the school holidays, thus giving them enough time to heal. To 'create demand', the plan was for the implementing partners and the Ministry of Health to work with the Ministry of Education. The latter would identify schools to be targeted. In practice, the implementers did not adhere to the list of schools initially identified by the Ministry of Education.

The *Soka* implementers had set a target of reaching 215 schools in order to recruit clients. Only 126 schools were visited and only 426 students were registered from those schools. Using teachers and guidance counsellors to recruit male students for circumcision was a particular challenge. Some teachers felt that registering students for male circumcision services was not their job; others felt uncomfortable talking about male circumcision. Gender, age sensitivity and privacy were issues for both boys and teachers. Some boys did not want their teachers to know that they were going for circumcision; others were uncomfortable discussing circumcision with female teachers or even with older male teachers.

A large percentage of the boys who came for male circumcision services during the school holidays were recruited in other ways. The implementing partners blamed the low numbers on the inadequacy of the Ministry of Education. I was told that the Ministry of Education had requested to 'give the directive' on the BTS sub-campaign, and while at first they had worked well with the implementing partners in its planning, they reneged on their duties at the time of implementation. I was also told that the Ministry of Education 'did not give the necessary ministerial directive' to the schools administration, thereby creating problems for the sub-campaign. The responses of site managers and regional coordinators were different. They told me that they had tried to explain how to go about things in eSwatini, but their suggestions had fallen on deaf ears and so they had given up. Gcina described the relationship between *Soka* and the Ministry of Health as being characterized by 'friction'.

This friction is the result of a dream of total control. Once again, the planners (and the US implementers) aspired to control every aspect of *Soka.* The flipside of the dream of total control is the nightmare of things falling apart. By their unwillingness to involve local structures, the planners and implementers of *Soka Uncobe* were agents in turning the dream into a nightmare.

Disregard of local knowledge

It is Friday and I am on my final site visit. The site is in Siteki at the top of the Lubombo mountain range. Circumcision is being conducted in a large tent erected on the grounds of the local park, opposite a dilapidated cemetery where white settlers from the late 1800s are buried. The town is known for not having

[8]These were small campaigns targeted at particular groups of people, i.e. schoolchildren or cane cutters.

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water. Bheki takes me on a tour of the site. As I enter the tent, I meet the data capturers, who are the first port of call for men coming for circumcision. Next, Bheki leads me to the place where HIV testing and counselling occur, then to where the circumcision takes place, and finally to where those who have undergone circumcision recover and are given something to eat and drink. On this particular day, there are more staff than clients on the site. I am drawn to Thandeka,[9] who is sitting outside. I ask if I can join her. She agrees. I ask if I can talk to her about her experience of *Soka Uncobe*. In the animated conversation that ensues, she tells me about her frustrations with her job, the implementation of *Soka* and the campaign in general. I ask if I can record the conversation for my use in understanding the campaign. She agrees. I press record. 'So you were saying …' I begin to prompt her to continue with what she was telling me earlier. 'I have just joined this organization – circumcision. It is a month now. But I have seen many things on the ground. It is not what is expected of us to do or what we are supposed to be doing, like what is on paper. It is very different when you are implementing.'

Thandeka proceeds to tell me that they regularly run out of painkillers, and that often they end up using ones that are not the correct strength. I ask her about other challenges that they have faced and she tells me about the particular problem affecting the sugar-belt region – Mhlume and Simunye – during the implementation of the sub-campaign aimed at men working in the cane fields.

'We have a problem [in the sugar belt],' she begins. 'There are many sugar cane workers, what you call the cane cutters, growers and whatever. They [the implementers] approached the sugar mills and told them that they want to provide circumcision in that area and they said "Yes", we should come. But the sugar mills are private organizations which have their own policies. So you need to write a small letter, a page like this, as to how you are going to work with them, an MOU [memorandum of understanding].' Her voice rises passionately. 'But when I told them [the implementing partners] I was told that *Soka* already has an MOU with the Ministry of Health. The MOU with the Ministry of Health is for the services, it is not for the company. I mentioned this to the head of HR. I said, "Please look into this." In the sugar belt, they have all their services. They don't need anything. All they need is for us to show them how things are done. They want this service to remain for sustainability and for continuity. That's all.'

'So are you saying that all they need is the training on how to conduct circumcisions?' I ask her.

'They need … they just need training,' she explains in an exasperated tone. 'They need to see what instruments we use, how it is done and they'll do it on their own. Right now they've given us a room and we have taken our equipment there. But when we leave we will take everything with us. It's not nice. They don't know when we are going to leave or what is going to be left with them, if anything at all will be left with them. It is not right.' Thandeka pauses for a while and then turns to me and says, 'So, what I really don't understand is why is it a hassle to just write a small MOU. It's not tying anybody down.'

As indicated by the title of this section, the third feature of *Soka Uncobe* was the disregard for local knowledge. One of the WHO/UNAIDS key recommendations

[9]I have chosen not to disclose what Thandeka's job was in order to protect her anonymity.

is that 'MC should be provided with full adherence to medical ethics and human rights principles, including informed consent, confidentiality, and absence of coercion'. During *Soka Uncobe*, certain incentives were introduced to encourage people to visit the sites. Transport was introduced to take clients to the sites, even though the sites were initially chosen because of their accessibility. Food was also used as an incentive. As Phindile, one of the regional managers, explained, 'That's the only incentive you can give and it's something which can be hidden as an incentive.' Indeed, it was couched in terms of helping the men to recover from the procedure. In a country where more than two-thirds of the population lives on less than a dollar a day, food clouded the fine line between informed consent and coercion.

Food was a point of contention throughout the campaign. Ironically, the disagreement was not about its use but about the amount and type of food provided. The contention highlighted the divisions between those who sat behind the desks at the hub and those who were on the front lines, making sure that circumcision services were delivered to men in a culturally sensitive way. This issue of food further highlighted the divisions among the implementers – between those who were concerned with Western ideas about science, evidence and ethics and those who were concerned about treating people with dignity. The regional managers and site managers, who were all Swazi, repeatedly told me about how their attempts to advise on how to proceed were dismissed. Phindile labelled not being consulted as 'abuse of the highest'. Gcina expressed her frustration about the disorganization and insensitivity of the campaign. Using the example of clients being given a glass of juice after the procedure, she explained that the kind of juice they were given was appropriate for young children but not for adults. She explained, too, that muffins were a strange choice for a snack because many rural adults did not know what a muffin was and would have preferred plain bread or even just water. 'One time I even wrote an email,' she exclaimed. '[I wrote] give them four slices [of bread], not many. Four slices, whether they are dry or with just ordinary juice which has been diluted. I wish we could have a chance to re-plan, if ever we will continue, because vouchers would work much better.'

Gcina also hinted at sites where the protocol was no longer followed because of similar issues. At many of the sites, staff on the ground had begun making decisions about how best to implement *Soka Uncobe*. At one site, the nurses had begun using their own money to buy food to ensure that people were fed and that the food was appropriate. Phindile explained that this was a big problem because there was no way to reimburse the nurses who were already paid a pittance for their work. At another site, a doctor was performing circumcisions on boys as young as eight years old. When I asked about boys who were underage, some of the site staff said that they could not turn them away.

In one of the weekly meetings, Zodwa, a site manager, raised the issue of the rumours that were circulating about what was being done with the foreskins. There were variations to the rumours but a popular one at the time was that the foreskins were being turned into a spice called 'Benny spice' (cf. Adams and Moyer 2015). The site manager tried to explain to the people at the hub that men needed to see their foreskins and give verbal consent for the skin to be incinerated, rather than just assuming that it would be. Before she could explain the importance of people feeling in control of making decisions about their body

parts, she was told that the rumour was absurd and that more would be done to educate men about the procedure. Later, she explained to me:

> I'm sorry, when you talk with these people they just cut you – no, no … We are talking to foreigners who don't understand us. You see, we are not given the liberty to deliberate it properly, to tell them that this is the case. No, we are not given that chance. … [So, for example,] if I cut my hand here by accident and then they chop it, there's a way of disposing of that part. Any part of the body, if you cut it, you talk to the person. There is a concern. The concern is for the surgery, but the concern is also for the disposal. This is another issue in Swaziland [eSwatini].

Zodwa went on to describe an incident that occurred while she was working as a nurse at the Raleigh Fitkin Memorial Hospital. 'A woman came [to the hospital] who turned out to be fourteen months pregnant. [The woman thought she had been pregnant for this length of time.] She was married but had been unable to conceive,' she began. 'As a woman, somehow you can tell yourself I'm pregnant and the stomach will grow.' During the woman's false labour, since she had a phantom pregnancy, Zodwa removed some clots from her uterus that the woman mistook for her infant. Zodwa wanted to examine the clots before she disposed of them, so she put them in the sluice room. When the woman's husband came to check on her, she told him that Zodwa had taken her baby away. When Zodwa attempted to explain what had happened, the woman dismissed her, saying, 'You don't know what you're talking about, young nurse.' Zodwa understood that the woman just needed evidence that she had given birth. 'So I went to the sluice room and picked up another clot and took it to the woman. I said, "This is yours." She was amazed, even happy. Now the husband will appreciate her. He has seen how she has tried but that it wasn't successful,' Zodwa continued. After the couple had seen the clot, they gave Zodwa permission to dispose of it. 'So it's the same. It's the same even if you cut the skin – you keep it until your relatives come. We get permission [from the relatives]. We can incinerate it or whatever we do but first we get permission. It seems small but it's big, it's big in their minds,' Zodwa stated resolutely. The dream of total control, in this instance, resulted in ignoring local knowledge.

Concluding notes

As we drive back to the hotel at the end of the day, Ned spots a group of young men sitting outside a tavern drinking beer. He asks Johannes to stop so that he can talk to them. We get out of the minibus and approach the tavern. As soon as the young men see the camera, their postures stiffen. Sipho asks the men if we can talk to them about what they know of the *Soka Uncobe* campaign. No one answers. Their eyes are fixed on Ned, who is carrying the camera. A young man stumbles out of the tavern holding a quart of Black Label beer and asks us what we want. Sipho explains that we are here to find out what they know about the campaign. He agrees to be interviewed. We move away from the group so they are not captured in the shot. Ned begins filming. The young man tells us that he has heard of the campaign but he doesn't know much about it. Sipho asks if he is circumcised. He laughs and tells us that he is not. Sipho asks him why not. By now a small group of his friends are standing around us. One

of them tells us he is afraid; he explains that if something goes wrong, he will never get an erection again. The other men laugh. Someone else says that he needs to see the evidence that circumcision really works, and a third person says that he will wait to see if it really works for his friends who have been circumcised.

Driving back to the hotel, I am struck by the rational and reasonable responses of the young men. The key assumption underpinning the *Soka Uncobe* campaign is that Swazi men would unquestioningly and unequivocally accept the notion that they should be circumcised as this *may* prevent them from acquiring HIV, even though this was not certain. The absurdity of this proposition was picked up by members of the communications team who began the report on a workshop they had held on how to create demand by noting that 'logic, medical research and statistics do not suffice as persuasive tools' when asking men to undergo a painful procedure that only 'lowers the risk'. They added that what the men were being asked to do – have their foreskins removed – was 'illogical and counter-intuitive', especially if the message to use a condom during sexual intercourse was emphasized. What the team, rightly, picked up on was the disjuncture between what was dreamed up in the boardroom through techniques of enumeration and the 'grounded' reasoning of the intended beneficiaries of the intervention.

Soka Uncobe, the medical male circumcision ASI that took place in eSwatini, started off as a dream and then, for many of those involved, turned into a nightmare when the intended beneficiaries did not flock to the circumcision sites in droves as was expected. The framing of the epidemic in Swaziland as the epicentre of a global health challenge made the country a perfect site for an HIV intervention requiring action on as many people as possible in a short period of time – an accelerated saturation initiative. The ways in which the urgency of the intervention was framed constrained the possibilities of how to intervene. Guided by the dream of improving global health and underpinned by the logic of HIV exceptionalism (Benton 2012), an ASI designed, implemented and funded by US-based organizations became the only way in which the tiny, resource-poor kingdom of eSwatini could be saved. In many countries in Africa where humanitarian interventions occur, the state or government, if it exists, is unable to provide much-needed life-saving biomedical technologies – antiretrovirals, vaccines, other pharmaceuticals, and so on. Thus, when the humanitarian health organizations intervene in 'exceptional' circumstances, they are often given total control. They become the 'government-by-exception'. Using techniques of enumeration, they decide how populations should be acted upon without taking into account people's needs, physically or psychologically. What happened in eSwatini serves as a reminder that science and numbers are not enough to drive the success of an intervention.

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Abstract

This article uses the accelerated saturation initiative (ASI) *Soka Uncobe*, which took place in the kingdom of eSwatini in 2011 and 2012, to comment on HIV humanitarian health interventions in Africa. *Soka Uncobe*, the first ASI on voluntary medical male circumcision, aimed to circumcise 80 per cent of all HIV-negative men aged fifteen to forty-nine years over a twelve-month period. Using written and verbal accounts, I draw attention to the dreams and hopes behind the design of the initiative. I also highlight the dynamics of the implementation of *Soka Uncobe*, and, in doing so, I chart the path to its ultimate failure by

showing the reluctance of the implementation partners (based mainly in the global North) to take seriously what have now become well-known critiques of why humanitarian interventions fail. Ultimately, I suggest that, despite having the potential to produce some critical results, *Soka Uncobe* was no different from previous transnational humanitarian health interventions. Thus, an exposé of why it failed is pivotal to this article about the dreams that underpinned the first ever ASI related to medical male circumcision.

Résumé

Cet article utilise l'initiative de saturation accélérée (ASI, de l'anglais Accelerated Saturation Initiative) intitulée *Soka Uncobe*, mise en œuvre dans le royaume d'eSwatini en 2011 et 2012, pour commenter les interventions humanitaires de santé relatives au VIH en Afrique. *Soka Uncobe*, la première ASI de circoncision masculine médicale volontaire, visait à circoncire 80 pour cent de la population masculine séronégative âgée de quinze à quarante-neuf ans sur une période de douze mois. S'appuyant sur des récits écrits et oraux, l'auteur attire l'attention sur les rêves et les espoirs derrière la conception de l'initiative. Il souligne également Ies dynamiques de la mise en œuvre de *Soka Uncobe* et, ce faisant, suit l'itinéraire de son échec en montrant la réticence des partenaires de mise en œuvre (essentiellement basés dans les pays du Nord) à prendre au sérieux ce que sont désormais devenues des critiques bien connues des raisons de l'échec des interventions humanitaires. Enfin, l'auteur suggère que *Soka Uncobe*, bien qu'ayant le potentiel de produire des résultats critiques, n'avait rien de différent des interventions humanitaires transnationales de santé précédentes. Ainsi, un exposé des raisons de son échec est un élément central de cet article concernant les rêves qui sous-tendaient la toute première ASI relative à la circoncision masculine médicale.

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