THE CONTROVERSIAL CUT

Rolling out mass male circumcision in Eswatini

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FOREWORD

For as long as I can remember, I have had the desire to be a writer. I wanted to write something so special and beautiful that it would make readers across the world sit up and take notice. Over the years, the desire to write a book grew within me, but the problem was: I had no idea what to write about. The story just wouldn't come. For years, the frustration mounted. Where is my book? Be careful what you wish for. I had no idea that during those years I would live the story that would become my book: *The Controversial Cut: Rolling Out Mass Male Circumcision in Eswatini* – the book I needed to write.

The issue of medical circumcision (MC) in Eswatini is a deeply emotive and controversial one, and no clear consensus exists in the country. This book documents the mass-implementation of this programme and the circumstances and challenges surrounding its roll-out. I have documented my experiences not only from my perspective as the country's MC Co-ordinator, but also as an outsider to the Kingdom's customs and culture.

But, before we launch into the story, allow me to introduce myself:

I am Ayanda Nqeketo, an umXhosa male from the Eastern Cape in South Africa. I was circumcised in June 1988 as part of amaXhosa tradition – a tradition that would initiate me into manhood. Although

my engagement to lead the scale-up of male circumcision services in Eswatini had nothing to do with my Xhosa upbringing, my experiences as a rural umXhosa man did indeed help pull me through difficult times.

I am Ayanda Nqeketo, a medical anthropologist. I hold a Bachelor of Arts degree, an Honours degree in Sociology, and a Master of Arts in Medical Anthropology from the University of the Western Cape. As such, my particular interests and strengths in training involve understanding human beings and their health.

I am Ayanda Nqeketo, an experienced researcher with the Human Sciences Research Council (HSRC). For five years of my career, I was a researcher on the Social Aspects of HIV/AIDS and Health (SAHA) Programme. This research extends beyond medical interventions and strives to address health problems at their source – at social and population levels. My main areas of interest included the development of strategies for male involvement in reproductive health issues, health policy, and health systems. In addition, I took an active interest in bringing knowledge about HIV/AIDS into communities. I actively engaged in training traditional surgeons and nurses and working with initiation schools to reduce the risk of HIV transmission and injuries during traditional male circumcision and initiation in the Eastern Cape.

Through this programme, I was able to investigate the complexity of public health issues affecting the people of the Eastern Cape and its leadership within the historical context of indigenous knowledge systems. I have written and co-authored numerous articles on traditional male circumcision and the prevention of mother-to-child transmission (PMTCT).

I am Ayanda Nqeketo, a former practitioner of HIV/AIDS management at the Southern African AIDS Trust (SAT) for South Africa. I have worked with many local non-governmental organisations (NGOs) and have been instrumental in assisting and developing HIV/AIDS policies, programmes, and funding proposals in Tanzania, Malawi, Mozambique, Zimbabwe and Zambia.

In my role as the medical male circumcision programme co-ordinator in Eswatini, some people referred to me as a doctor. I'd like to set the record straight: I am not a medical doctor; nor am I a medical specialist. For that reason, I did not initiate the Eswatini programme – my role was simply to offer expertise in its implementation.

I have paid for this book with my blood, sweat, frustration, and even emotional pain. At times, the process has been emotionally devastating. I don't mean to imply that my job was difficult. Not at all! I enjoyed what I did, within the scope of my work. However, as an outsider, what did prove difficult was managing daily professional relationships with some of the stakeholders. Thank you to my family, friends and mentor for their endless support during these difficult times.

Who would have thought that one day I would live in the epicenter of the pandemic and become part of the HIV fight through the subject that I loved? Or that I would write a book about my role as the face of the mass male circumcision scale-up? Or even that a procedure that is part of my culture would happen to be part of a global HIV solution!

The "living" of the events of this book proved to be something of a roller coaster ride, so writing about them drained me at times, too. This long, tiring, and politically sensitive journey wasn't a walk in the park, but there was much to keep me going, which I have enjoyed recording and writing about.

I survived not only the frustration of difficult moments, but the limited support from some of the stakeholders who were supposed to be sharing the burden with me. In the midst of these challenges, I fell in love with a beautiful Swazi woman, who ended up being my life partner. If it were not for her and her love, I have no doubt that I would have left my job earlier than anticipated. But I persevered for her – and for my love of the Swazi people. Continuing with my work there made me not only stronger and wiser, but it essentially became the subject matter of this book. In the chapters that follow, you will find a

recollection of memories. I have recalled conversations and situations as I've remembered them – they are not reproduced verbatim.

I have decided to protect the identities of some of the people who made my work more challenging, as well as those who gave me tremendous support. However, I have not interfered with the facts surrounding my role in HIV prevention efforts and strategies in Eswatini, or the rapport I had with the general population; newspaper editors; journalists; different sectors of society; government officials; members of parliament; and cabinet ministers. Among these individuals are those who responded to the national call to action.

It is important to clarify from the outset that my story is only one man's perspective, and my opinions are based on subjective experience. Therefore, I am only the conduit for this version of the truth as it unfolds over the coming chapters.

A note about the name change from Swaziland to Eswatini

In 2018, Swaziland changed its name to Eswatini (eSwatini in *siSwati*), meaning "land of the Swazis". Although the events in this book took place while the country was still called Swaziland, I have used the new name, Eswatini, throughout. However, correspondence and newspaper articles featured in these pages have been faithfully reproduced as they appeared at the time, and, as such, will refer to the old name Swaziland. I have also used the name Swaziland where it forms part of a registered company or organisation's name.

CONTENTS

1

THE BEGINNING

This is the story of the mass implementation of medical male circumcision in Eswatini, and all of my experiences associated with the implementation of this programme. Based on my own involvement and observations as the co-ordinator of medical male circumcision in the country, what follows is both a biography and an ethnography of that process. I have also focused on the controversies that emerged; how they were handled; and how they affected the roll-out of male circumcision services in the country.

As a South African umXhosa male, I was employed as an outsider to Eswatini, so observing the roll-out within a somewhat foreign culture was interesting, to say the least. But, before we go any further, let me provide you with some background. The entire need for the programme started from an analysis of the HIV situation in Eswatini. This was followed by a global medical debate about the need to scale up male circumcision in the context of HIV prevention.

I was very privileged to spend four years working in Eswatini. This beautiful corner of the world is full of wonderful surprises that most foreigners will never get to see. But, like every African country, it faces big challenges. Currently, none of these are bigger than the HIV pandemic.

The HIV/AIDS pandemic in Eswatini

Since its emergence more than three decades ago, HIV has spread rapidly, reaching epidemic proportions within a short space of time. Countries in the sub-Saharan region have borne the brunt of its devastation. Eswatini's first case of HIV was diagnosed in 1986. Since then, the rate within the sexually active population (15–49 years) has escalated to 26%.[1]

In this small, landlocked southern African country, one in four adults is estimated to be living with HIV. For this reason, the Kingdom of Eswatini is classified as the epicenter of the global HIV pandemic. His Majesty King Mswati III was quoted as saying: "HIV/AIDS has been a national disaster since its first arrival in the Kingdom around 20 years ago. We refused to acknowledge its awful potential."

In 1999, the disease reached crisis levels and was officially declared a national disaster by His Majesty King Mswati III. He said:

> *"I expect all Swazis to take a blood test, to know our own HIV status, so that we can take necessary steps to protect ourselves and to live in a responsible and healthy manner. As parents, we need to protect and educate our children. And, as a nation, we must practise the tradition of family and community support for those in need. The enemy has entered the gates of the Kingdom. It will take all our resolve, and the full commitment of each of us, to win this war. With the blessings and guidance of Almighty God we shall succeed and ensure a safe and secure future for all our people." (James Hall, 2002).*

1 Central Statistical Office, Macro International (2008). Swaziland Demographic and Health Survey 2006–2007, Mbabane.

When speaking specifically about young adults aged 25–29, the number is much higher: 49%. Eswatini is clearly a nation "at war" – the common enemy is HIV. The HIV/AIDS situation is a dire one:

- HIV and AIDS now represents the biggest threat to the economic and social development of the Kingdom of Eswatini. Its effects are forcing the government to divert funds from other development priorities, in an attempt to limit its spread.
- HIV and AIDS affects not only the individual, but their family, community, and ultimately their country. According to the latest figures, life expectancy in the Kingdom is just 48 years – one of the lowest in the world. This has resulted in a large number of orphaned or vulnerable children (OVC). In 2010, an estimated 78 000 children were classified as OVC (Dlamini and Chiao, 2015).
- With such a high prevalence among the most productive working age range, responsibility for the care of orphaned and vulnerable children often falls upon older generations, such as grandparents.
- Eswatini is currently one of only five sub-Saharan African countries to achieve the target of getting more than 80% of eligible people on antiretroviral treatment (ARTs). Among pregnant women, treatment access is also high, at 83%. As a result, the number of AIDS-related deaths in Eswatini is declining (Central Statistical Office, Macro International, 2008).
- Vulnerable groups at risk of HIV infection include: Sex workers; migrant populations; prisoners; men who have sex with men (MSM); and injecting drug users (IDUs). Latest estimates suggest two in three female sex workers in the country live with HIV. This highlights the lack of access to HIV services experienced by such groups. Fortunately, Eswatini's Ministry of Health developed a framework in 2011 to place a special focus on ensuring access to prevention and treatment among most-at-risk groups (MARPs).[2]

2 http://www.avert.org/hiv-aids-swaziland.htm#sthash.kABK2hHc.dpuf

- In recent years, the number of people in Eswatini aged 15–49 years testing for HIV and receiving their results has rapidly increased: From 16% in 2009 to an estimated 40% in 2011. Although this indicates a considerable improvement in the accessibility and acceptability of HIV testing, efforts must continue to encourage testing uptake.

The global medical debate[3]

Evidence from Kenya, South Africa and Uganda has shown that male circumcision reduces the risk of heterosexually-acquired HIV infection in men by approximately 60%. When performed by well-trained health professionals in properly equipped settings, it is safe. In countries and regions with heterosexual epidemics, high HIV and low male circumcision prevalence, male circumcision is being included in comprehensive HIV prevention packages.

Alone, male circumcision is only partially protective, but when combined with HIV testing and counselling services, condoms, safer sexual practices, and the treatment of sexually transmitted infections, it is highly effective. Male circumcision and the prevention of the transmission of the virus that causes AIDS are at the core of this global medical debate.

Some people argue that it is a quick and effective way to reduce HIV infection, while others say that, like female circumcision, it should be considered a form of genital mutilation. Those in the first camp argue that circumcision helps protect against HIV, because cells under the foreskin are vulnerable to the virus. When the foreskin is removed, the skin on the head of the penis becomes less sensitive, so is less likely to suffer micro-cuts, thereby reducing the risk of infection.

3 This section draws from the following: Larke, (2010); Gray (2007); Bailey (2007); Parkhurst (2015).

Those in the second camp point out that research on whether circumcision reduces the likelihood of men contracting infections is inconclusive. The British Medical Association's line is: "The medical harms or benefits have not been unequivocally proven, but there are clear risks of harm if the procedure is done inexpertly."[4]

Activists who are anti-circumcision want doctors to stop viewing the procedure as a minor and inconsequential operation – in adults as well as in children. Its members argue that circumcision reduces penile sensation; might harm the immune system; reduces pheromone production; and disrupts the body's natural function. The Royal Dutch Medical Association has adopted as official policy the line that the circumcision of boys is medically unnecessary[5]. It has advocated a strong policy of deterrence, arguing that condoms are the most effective way to prevent HIV infection.

Rennie et al, 2007, argued that, given the results of the recent clinical trial and the steady rise in new HIV infections in resource-poor countries, it would be unethical to not seriously consider one of the most promising – although also one of the most controversial – new approaches to HIV prevention in the 25-year history of the pandemic. This trial caught the attention of some major players. The World Health Organisation and UNAIDS now all support circumcision as a preventative measure against HIV.

Following WHO and UNAIDS policy guidelines, African countries have embarked on vast circumcision drives aimed at adults and parents of newborn boys. This prompted UNAIDS to issue a position statement and to develop a UN Work Plan on MC and HIV. In line with this plan,

4 http://lincolnshirescb.proceduresonline.com/chapters/p_male_circumcision.html#therapeutic.

5 https://www.knmg.nl/circumcision. KNMG-viewpoint-Non-therapeutic-circumcision-of-male-minors-27-05-2010-v2 (2).

UNAIDS is working with countries to determine the potential role of MC within their comprehensive HIV prevention programmes.

Male circumcision: Consultation and adoption

Eswatini is one of those countries receiving support through the United Nations Work Plan. Despite increased investment in HIV and AIDS interventions, Eswatini has been losing the war against the pandemic, and HIV prevalence is escalating. The Maputo Declaration by African health ministers, which pronounced 2006 as the year for accelerating HIV prevention in Africa, positioned male circumcision among the key priority interventions. Through support from the UN Work Plan on Male Circumcision and HIV, and as part of the broader strategy for accelerated HIV prevention in Africa, a male circumcision country stakeholder consultation meeting for Eswatini was held at Esibayeni Lodge, Matsapha, on 26–27 September 2006.

The meeting drew representation from most of the key stakeholders in the country, including high-profile people in the health sector, such as the Ministry of Health (MOH). It also included a panel of experts linked to the UN Working Group on MC at a global and regional level. Relevant traditional and cultural authorities were represented by the Chiefs and the Traditional Healers Association (THA).

Participation by stakeholders across the spectrum helped to broaden the discussions to cover the whole range of clinical, economic and socio-cultural issues relating to MC in Eswatini. With international support, the MOH embraced male circumcision in its comprehensive HIV package.

The government of the Kingdom of Eswatini undertook education, awareness, and promotion campaigns to raise knowledge among the population on the benefits of male circumcision, as well as the demand for it as an elective surgery. The government also set a goal to reduce HIV transmission by circumcising 80% of 15- to 24-year-old males within

five years, and adopting the introduction of neonatal male circumcision, for long-term sustainability.

Enter the MC Co-ordinator

In the midst of Eswatini's pandemic and the Ministry of Health's desire to deal with it through a multi-pronged approach that included MC, I found myself at the centre of the country's HIV/AIDS challenge as the MC Co-ordinator.

Before I go into the details of my four-year tenure, let me start by telling you something about myself and my upbringing. I was born on 10 October 1973 in Mqwangqweni village, near the small town of Ngqeleni, just outside uMthatha. My village is in western Pondoland, Eastern Cape, South Africa, which was officially known as the Transkei at the time. I lived in that village until I was 17 years old.

In those days, our village lagged far behind the developments in bigger cities, like uMthatha. There was no running water, ablution facilities or electricity. Yet, even as a small child, my spirit was happier in the village than in town. There was a strong sense of community and neighbourliness. I enjoyed all of the responsibilities and chores that were expected of my siblings, cousins and me.

By herding livestock (*ukolusa*), cultivating/working the land and harvesting the fields (*ukulima*) and horse riding, we were offered a perfect rural experience of rolling hills, deep gorges and cliff tops.

My grandfather owned several horses. As a family, we felt privileged. It was the quickest mode of transport from one village to the next. I am an expert horse rider. In the unfortunate event of a death in the family, we would be sent to far-off villages to give close family and relatives death notification (*ukubika umphanga*). Not a single family member owned a car. In fact, if my memory serves me correctly, there were only two homesteads in the entire community that owned cars: The school

principal, who was not originally from our area, and a shop owner, who was also not from our community.

As boys in the village, we used to swim (*ukuqubha*) in the river. I was never good at that. I only joined in because of peer pressure. We would also do bird trapping (*ukuthiya*), which would be roasted in the evening. Meat was scarce in rural areas, so the birds offered a source of protein to balance our families' diets. Our parents did not just slaughter a sheep or goat on a whim. They were precious commodities.

I grew up stick fighting (*ukubetha intonga*). That was a way of defining a social hierarchy and establishing the first line of defence in the event of conflict with other boys from neighbouring communities. In this activity, my skills proved only average. However, I was always protected by my uncles and my brother. Other boys my age knew that I was untouchable. I had grown up playing with older boys (*amakhwenkwe amadala*) who were three to four years my senior. As a result, I was always the youngest on the team. By the time my uncles and elder brother, Zuko, were ready for initiation, they could not leave me behind. So, I was the only boy in the village who was initiated at the age of 16.

When my uncles were ready to go for initiation into manhood, they were between 19 and 22 years of age. They told the youngest uncle (*utatomncinci*) that they wanted to go for initiation. He then called a meeting, at which the date for the ceremony was decided and preparations begun.

The rest of the secret and sacred ritual followed. As a graduate of initiation school, I am not supposed to dwell on those details, because there is a long-standing belief that non-graduates must not know about the details of the ritual. A sacrifice believed to convey blessings was performed. This process of initiation was characterised by three stages: Preparation for the seclusion; the seclusion; and the coming-out ceremony as a man. Initiation is an African way of marking the transition of a child to an adult.

I certainly do believe that my way of life enriched me. The opportunity provided to me to live in both urban and rural worlds was very empowering. I only visited urban areas during school tours because none of my relatives lived or stayed in townships. My first encounter with shoes – besides the gumboots we boys wore to take the cattle to the dipping tanks – was when I was in Standard 3 (Grade 5) and went on tour to the town of Butterworth. Although not my size, my mother had borrowed shoes for me from a neighbour. I never got to enjoy that trip because my feet were so blistered.

Growing up in rural Transkei, I never for a moment thought that I would get the opportunity to pursue a higher education. I was born to parents who did not complete matric. My father Mayoyo Nqeketo could not write his name; and my mother Nophumzile Nqeketo, while she could read and write, had to drop out of school when she was still in Standard 6 (Grade 8) when she married my father through an arranged marriage (*ukuthwala*).

Ukuthwala begins with a young woman being forced, or pressured, by a man and his friends or peers to move to his home, with the intention of compelling her or her family to endorse marriage negotiations. In South Africa, the custom originated from the Xhosa-speaking clans – particularly in my home, Pondoland. This type of arrangement becomes traditionally acceptable, as long as cultural rules are followed. More often than not, though, a man forced a young woman he selected and then sent word to her family that he would be paying bride wealth (*lobola*), usually in the form of cattle. While highly unusual, in some instances, either the girl or her family would not approve of the suitor.

In that environment, one cannot help but look for an escape: My father chose to go to Johannesburg to work as a miner on a contract. I don't know his history as a miner, but I know that at a later stage, he worked for Iron and Steel Corporation (ISCO) as a labourer in Vanderbijlpark. My mother was a housewife and raised the five of us

with the help of my grandmother Violet (*Masiwela*) Nqeketo, and grandfather Elliot (*Gobucingo*) Nqeketo. I was yet another victim of the migrant-labour system. I was not with my father for most of my childhood. My grandfather raised me, and I referred to him as my father. I salute him for his guidance and love! May your soul rest in peace, Nyawuza (our clan name).

Soon after my grandfather passed away, Zuko, my elder brother, took over the role of the father figure and, on behalf of my mother and the rest of my siblings, regularly collected money from my father to pay school fees and living expenses. My mother stayed in the Transkei to raise us kids, and my father remained in Vanderbijlpark. He saw us only once a year for a month. I am grateful to my late father for his support. He really tried. May his soul rest in peace. I am grateful to him because today all five of his children – three brothers and two sisters – had an opportunity to get a tertiary education at university. We are all graduates with good jobs. What more could we ask for?

Village schooling

There was no preschool education in my village. There was only a primary school named after our family: Nqeketo Primary, Junior and Secondary School, which was a stone's throw from our home. Most youth in my village quit school early and looked for short-term jobs. If they couldn't find jobs, many would opt to drink alcohol and smoke marijuana (*intsangu*), or to get married and start a family. All of these were acts of self-proclaimed adulthood.

There was not a single person in our village who had a university degree. The majority had passed Grades 7, 8 or 9 at most. And those who were employed worked mostly within different sectors of the Transkei government. But, most of the people in our village were uneducated and unemployed, so looking after our fathers' livestock was the general past-time. We were a poor village surrounded by other poor villages.

Growing up, I developed a rebellious attitude towards school. In fact, I hated it. It took a village for me to acquire an education. My mother and our neighbours – including my friends – used to gang up against me and force me to go to school. Once there, I would not participate in class, which used to get me into trouble. I would then receive double punishment for not participating and not raising my hand when I knew the answer.

I continued my painful schooling until I passed Standard 7 (Grade 9) in 1989. I then proceeded to Jongilizwe College in Tsolo to complete my high school education. The boarding school was perceived to be for the privileged and wealthy. That was my first exposure to a daily shower or bath and a three-meal-a-day diet. At boarding school, I was taught English by Indians and foreigners, mostly from Ghana.

I passed matric in 1994 with an exemption, which meant I qualified to register at any university in South Africa. I went to Cape Town in 1995, sincerely wanting to study further. I started sending applications to institutions of higher learning and to potential sponsors. I secured admission at the University of the Western Cape for a Bachelor of Arts degree in 1996. That taught me the importance of determination. In the interim, I stayed with my uncle Mongezi Nqeketo, who was by then living in the city. I was determined to change my life and not become another unemployment statistic.

In 2000, watched by my mother and uncle, I walked out of the university's Great Hall a graduate.

I registered for an Honours degree in 2001, but I did not have enough money to pay the registration fees. So my father decided to sell one of his pregnant cows – just to enrol me for the second time. Unfortunately, he died of throat cancer that year. My greatest regret is that I never had the opportunity to compensate him for investing one of his precious assets in my education.

2

JUMPING INTO THE FIRE

Apart from the medical debate referred to in Chapter One, the story of the MC scale-up in Eswatini could not be considered separately from the Eswatini's historical context. Given the steady rise in new HIV infections in Eswatini, it would be unethical to not seriously consider one of the most promising, yet controversial approaches to HIV prevention in the 25-year history of the epidemic (Rennie et al, 2007).

Policy conversations and regulatory framework related to an MC scale-up in Eswatini were a continuation of an initial costing study conducted in 2007, which assessed demand for male circumcision services; the cost-effectiveness of the intervention; and the impact of a scale-up of male circumcision on the HIV/AIDS pandemic (Martin et al, 2007).

That particular study acknowledged that the cultural, professional/medical, and financial implications of MC would be significant. Based on those findings, the Ministry of Health asked the United States government to assist the MC Task Force with male circumcision, and its public and private sector partners with implementing the main conclusions of the study.

In 2007 and 2008, the government of Eswatini received additional funding from the President's Emergency Plan for AIDS Relief (PEPFAR)

through a United States Agency for International Development (USAID) funding mechanism called the Health Policy Initiative Task Order 1 (HPI TO1) to recruit a programme co-ordinator.

The MC programme co-ordinator was to be seconded into the Ministry of Health (MOH) to work under the direction of the MOH Deputy Director for Clinical Services as Chair of the Male Circumcision Task Force. This position was initially set to be a two-year contract based in Mbabane, with an option for extension, depending on the availability of funding.

The MC programme co-ordinator was tasked with the following responsibilities:

- Providing technical assistance to the MOH and other stakeholders in policy development and strategic planning.
- Additional responsibilities included:
  - Co-ordinating and managing programme activities.
  - Providing targeted assessments of operational barriers.
  - Facilitating a dialogue between the public and private sectors, faith- and community-based organisations, and donors.
  - Engaging the private sector in programme scale-up.
  - Strengthening managerial and technical capacity within the MC Task Force.
  - Developing policies and guidelines in areas such as medical practice; procurement; communication; licensing and accreditation; task shifting; quality assurance and monitoring.

The hunt for the male circumcision programme co-ordinator

I heard about the MC Co-ordinator position by word of mouth; through a former colleague who told me about the opportunity for a short-term consultancy on male circumcision in Eswatini. I had been involved in related local activities and had actively participated in dialogue