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Towards a context-specific understanding of masculinities in Eswatini within voluntary medical male circumcision programming

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ABSTRACT

Compelling evidence from three randomised controlled trials, which showed that voluntary medical male circumcision (VMMC) reduces HIV acquisition from women to men by up to 60%, led to WHO recommending that VMMC be implemented in 14 priority countries. As one of the priority countries, Eswatini aimed to reach 80% VMMC coverage among boys and men aged 10–49 years since programme inception in 2009. By the end of 2019, however, the country had reached a modest 40%. VMMC is intrinsically tied to perceptions of masculinity and male gender identity. Comprehending the role of context-specific masculinity as it relates to VMMC may contribute to our understanding of community attitudes towards VMMC and men's decision-making. Drawing on focus group discussion data, this study aimed to explore the linkage between sexuality, masculinity and health interventions within Eswatini. Using critical discourse analysis, the study identified two discourses: sexuality, masculinity and circumcision, and income, masculinity, and circumcision. In the first discourse, participants constructed discursive linkages between circumcision as an adult and loss of penile sensitivity, decreased libido and sexual performance, and adverse events. The second discourse, income, masculinity, and circumcision located circumcision within the social and material realities faced by Swazi men, gender norms and provision within family structures.

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Introduction

Three randomised controlled trials in South Africa, Uganda and Kenya demonstrated that voluntary medical male circumcision (VMMC) can reduce HIV transmission from women to men by up to 60% (Auvert et al. 2005; Bailey et al. 2007; Gray et al. 2007). Stating that these three trials and other observational studies provided sufficient evidence for the efficacy of VMMC, the World Health Organisation (WHO) recommended

the rapid scale-up of VMMC as an intervention to curb HIV transmission (WHO 2007). This intervention specifically targeted 14 Eastern and Southern African countries with high HIV prevalence and low male circumcision rates (WHO 2007). One of these countries was Eswatini, which has the highest global HIV prevalence at 27.3% among adults aged 15–49 in 2018 (UNAIDS 2018).

Between 2009 and 2019, the Eswatini National AIDS Program (ENAP), under the Ministry of Health, in collaboration with international and local non-governmental organisations with donor support, implemented a VMMC programme with the goal of achieving 80% coverage (Golomski and Nyawo 2017). Initially, the Eswatini VMMC programme received funding for a 5-year project starting in 2009. However, the programme was cut short in favour of a more aggressive PEPFAR funded campaign called the Accelerated Saturation Initiative in 2011, locally known as *Soka Uncobe*, meaning circumcise and conquer (Golomski and Nyawo 2017). *Soka Uncobe* aimed to circumcise 152,000 Swazi men in one year with funding of around 15.5 million USD. About 11,000 circumcisions were performed in 2011 (Golomski and Nyawo 2017).

Quantitative acceptability studies conducted before *Soka Uncobe* was implemented suggested that demand for VMMC services was high, ranging between 74.2% (PSI Research & Metrics (2010)) and 87% (Tsela and Halperin 2006). Following these studies, a meta-analysis of quantitative acceptability studies, which included Eswatini, suggested that despite fear of pain, cost and safety, VMMC was a generally acceptable intervention and the researchers stated that no additional acceptability studies were necessary (Westercamp and Bailey 2007). Despite huge demand creation efforts and the development of VMMC clinics nationally between 2009 and 2019, VMMC uptake in Eswatini remains nominal (Golomski and Nyawo 2017). Other demand creation strategies included the hiring of clinicians, vigorous demand creation and awareness campaigns, mass media advertisements, and community-based mobilisation (Golomski and Nyawo 2017). In 2017, Eswatini had a VMMC prevalence of 26.7% among men 15 years and older (SHIMS 2017).

The lack of uptake of VMMC demonstrated that HIV prevention work needs to go beyond mathematical modelling to examine the complex and dynamic socio-sexual context imbued with violence, familial structure breakdown, gender norms, poverty and inequality, in which the interventions are being carried out (Vincent 2008). Additionally, the acceptability of VMMC is influenced by culture, religion, and age (Kebaabetswe et al. 2003; Scott, Weiss, and Viljoen 2005; Tsela and Halperin 2006). In their study conducted in traditionally non-circumcising rural communities in sub-Saharan Africa, Khumalo-Sakutukwa et al. (2013) argue that demand creation and programme implementation for VMMC does not adequately include and respond to the context in which it is located.

VMMC is intrinsically tied to perceptions of masculinity and male gender identity which include sexual health, self-identity, risk compensation, and sexual pleasure and performance (Humphries et al. 2015). Masculinity, here, is understood as the socially and culturally endorsed and internalised behaviours and roles that dictate the behaviour of men (Brown, Sorrell, and Raffaelli 2005). Masculinity is intrinsically tied to power relations – that is, not only how masculinities subjugate femininities, but also how masculinities subjugate alternative masculinities (Morrell 1998). That is, how masculinity can be performed is policed by locally specific dominant conceptions of

manhood. Historically, Black men in Southern Africa have been 'othered' in public health interventions (Mfecane 2018) and in the context of HIV were viewed as putting themselves and women at risk (Feirman 2012). This framing of masculinity has been popularised in health discourse and has ascribed to men a set of risky behaviours which increase HIV transmission, such as non-condom use, heavy drinking, violence towards women and other men, and multiple and concurrent partnerships (Morrell, Jewkes, and Lindegger 2012). However, there has been a shift in the research and interventionist gaze in the last decade, moving away from viewing men as the 'problem' (Peacock and Levack 2004) and reframing them as 'partners' in research and interventions (Mfecane 2018).

Studies of masculinity and VMMC within the African context have predominantly focussed on South Africa (Humphries et al. 2015; Mdedetyana 2019; Vincent 2008). This research has found that VMMC is linked to conceptions of masculinity and male gender identity. Humphries et al. (2015), who conducted their research in rural KwaZulu Natal, argues that perceptions of VMMC are closely tied to understandings of sexual health, sexual pleasure and performance, risk compensation behaviours and self-identity. They further state that perceptions of the impact of VMMC on sexual health and performance affect men's decisions whether or not to undergo circumcision. Vincent (2008, 424), who conducted research in the Eastern Cape, stated that male circumcision rites within traditionally circumcising communities in South Africa are symbolically saturated by the enhancement of masculine virility, the performative enactment of the separation between men and women, preparation for marriage and adult sexuality and the hardening of boys for warfare. Mdedetyana's (2019) research demonstrated that traditionally circumcising cultural groups, such as Xhosa communities, may position men who undergo VMMC as not real men because they have not undergone *ulwaluko*, which is a traditional circumcision practice that integrates circumcision with cultural practices and teaching (see also Mfecane 2020). Due to the complex cultural significance of circumcision, Mdedetyana (2019) argues that VMMC programmes need to engage with traditional notions of masculinity.

Limited studies have examined the nexus between masculinity and VMMC in Eswatini. Eswatini is not a traditionally circumcising country (Adams and Moyers 2015), and norms of masculinity within Eswatini impact men's uptake of VMMC (Adams and Moyer 2015). Adams and Moyer (2015) ethnographic study demonstrated that some Swazi men viewed circumcision as a threat to masculinity and VMMC as likely to reduce future sexual performance. Due to the high HIV acquisition and prevalence among Swazi women, gender activism and public health programming continue to view men as a problem within the Eswatini context. Feirman (2012), one of few scholars who have theorised about masculinities in Eswatini, argues that men have been conceptualised as aggressors and women as passive victims in relation to HIV acquisition. Feirman (2012) further argues that this kind of positioning fails to understand the complex structural and social dynamics that underly HIV prevention work. That is, these constructions do not consider factors that may limit men's safer-sex practices and the material circumstantial that bar access to support services (Feirman 2012).

This study follows on from the ethnographic study done by Adams and Moyer (2015) and investigates the linkage between sexuality, masculinity and health

interventions within Eswatini. Understanding the nexus between these concepts allows public health practitioners to develop more nuanced and context specific interventions to address the complex structural and social dynamics that are embedded within HIV prevention programmes such as VMMC. We employed a qualitative approach to examine the role of masculinity and sexuality in VMMC uptake for men aged 18-49 years in the capital city of Eswatini, Mbabane.

Method

Study setting and context

Eswatini has a population of just under 1.1 million. It is a predominantly youthful population with median age of 20.5 years (Central Statistical Office (Swaziland) et al.) 2017). Eswatini is classed as a lower middle-income earning country, ranked 112 in the world in terms of gross domestic product per capita. Despite this classification, 39.7% of Swazis were living under the international poverty line (1.90 USD) between 2016 and 2017 (World Bank, 2021). Unemployment is also high at 28% (CIA 2021).

According to UNAIDS, in 2018 Eswatini had 210,000 people living with HIV. HIV incidence was 8.62 per 1000 across all age groups, with 78,00 new infections and 2,800 people dying from HIV-related illnesses in 2018. Eswatini has made significant progress since 2010 in reducing the number of HIV-related deaths by 35% from 3800 to 2400 deaths a year (UNAIDS 2018). The Global Fund (2020) states that '... Eswatini, together with Switzerland, are the first countries to achieve the '95-95-95' global HIV target... meaning Eswatini reached the target an entire decade in advance.' Despite this success, women are disproportionately affected by HIV in Eswatini, with 63.16% of adults living with HIV being women. New infections among women aged 15-24 years old are more than four times those of young men (2,400 new infections as compared with 500 new infections in 2018). However, women are more likely to seek treatment for HIV than men.

Data for this study were collected in Mbabane East Inkhundla, a constituency with the largest male circumcision clinic in Eswatini and the highest number of medical male circumcisions between 2015 and 2019. Due to its relatively small geographic size, Mbabane East has one of the highest population densities of all Inkhundla¹ in Eswatini. People migrating from rural areas look for accommodation in places such as Mbabane East, resulting in informal settlements and urban poverty.

Participants

To be eligible for the study, men had to be residents of Mbabane East and between 18-49 years of age. The reason for targeting this age group was twofold. First, the VMMC program targets men between 15 and 49 years. Secondly, including 15 to 17-year-olds would require parental consent, and this would have been a potential bottleneck in the data collection phase. Circumcision status was not used as an eligibility criterion. Men were purposively sampled throughout the constituency. The lead author (AKA) targeted spaces where men are usually found in groups. These spaces included shops, a park next to a *Shisa Nyama*², and other areas where men usually

congregate. All participants in this study were found during working hours during the week. About half were unemployed and those who were employed were working in construction and transport and were paid based on how on hours worked or trips made. In total, 6 focus group discussions (FGDs) took place involving 36 participants. The age range of the recruited participants was between 19- and 46-years-old. At the time of data collection, of the 36 participants, 14 participants were circumcised, and 22 participants were uncircumcised. 15 participants were married, and 21 were single. In terms of education level, 2 participants had completed primary education, 22 had completed secondary education, 4 were attending tertiary education, 2 had completed vocational training, 7 had completed a diploma, and 6 had completed a degree

This study received ethical clearance from the Eswatini Science and Ethics Committee as part of a larger ethnographic study focussing on Eswatini men's uptake of HIV services conducted by the lead author. The information sheet and informed consent form were read to the participants, explaining the objectives of the study participant eligibility, participant involvement, the risks and benefits, confidentiality and anonymity, and the dissemination of the study results. The participants were given time to ask the researcher questions. The participants in this study consented verbally and the consent process was audio recorded. No compensation was given for participating in this study.

Data collection

This study utilised FGDs to collect data. FGDs offer an opportunity to glean information from several participants in a single setting, as well as being social events that tap into everyday interactional interchange (Wilkinson 1998; Kitinger 1995). On average, each FGD lasted about 45 minutes. FGDs were conducted by the lead author largely in siSwati. As a Swazi man, the lead author notes that age difference between participants in the FGD may have influenced what was spoken about. However, where possible participants were selected from naturally occurring groups and involved groups of men who already knew one another.

The focus group questions included demographic questions such as marital status, employment, education. Each FGD started with an icebreaker. Following this, broad questions were posed to the FGD participants, which included: what do you know about circumcision; what are your views about circumcision; are you circumcised (probe why yes or no); when were you circumcised; why do men decide to get circumcised or not; do you know where circumcision services are offered? The question about participants' own circumcision status was asked after eliciting more their general opinions on circumcision.

All FGDs were audio-recorded and translated into English by the lead author with assistance from the co-authors.

Data analysis

Initially, a thematic analysis was conducted on the dataset which was developed as part of a larger project examining VMMC uptake, masculinities, and collective decision

making in accessing health services. Drawing on Braun and Clarke (2012), we used an inductive approach to familiarise ourselves with the data and identify themes in the data. In our analysis of the larger study dataset, masculinity and sexuality emerged as predominant themes. Subsequently, data on masculinity and sexuality were also focussed on. The focus on masculinity required an analysis that focuses on enactments of social power and dominance as constructed in talk (Van Dijk 1993).

Using critical discourse analysis (CDA) and drawing on the work of Chong and Lynette (2007), we acknowledge that discourses of HIV cannot be separated from social ideology around gender, and broader global and local arrangements of power. Other research in on gender and HIV (e.g. Rudrum, Oliffe, and Benoit 2017; Rudrum, Oliffe, and Brown 2017) has deployed CDA as a means to examine the nexus between gender and public health. Chong and Lynette (2007) argue HIV or AIDS discourse acts to transmit norms, values and beliefs regarding gender, sexuality, ethnicity, geography and race, which are ungirded by power relations and social inequality (see also Ojikutu and Stone 2005; Rudrum, Oliffe, and Benoit 2017; Rudrum, Oliffe, and Brown 2017). Our analysis drew on Fairclough's three-dimensional framework for the analysis of discourse through a focus on text, discursive practice and social practice. The authors first performed a textual analysis on data from FGDs, paying special attention to syntactic devices such as metaphor and rhetoric (Fairclough 2006). Subsequently, the text was read in relation to broader social, political and economic factors specific to Eswatini (Fairclough 2006).

Findings

Two main discourses were identified through the analysis: sexuality, masculinity and male circumcision; and income, masculinity and male circumcision. The first of these discourses discursively links sexuality, masculinity and male circumcision. The second locates male circumcision within the social and material realities confronting Swazi men, especially in relation to gender norms and family structure.

Sexuality, masculinity and male circumcision

Many uncircumcised participants positioned VMMC as a threat to sexuality and masculinity. The discourse featured throughout the data corpus. Uncircumcised participants established discursive linkages between circumcision as an adult and loss of penile sensitivity, decreased libido and sexual performance, and adverse events. As Mandla uncircumcised 42-year-old participant explained:

When you are circumcised, they say sex ceases to be nice. Some say it is the foreskin that makes sex nice or the moist glans. One day we had a meeting in [*Inkhanlida*], the women were saying the uncircumcised penis is nicer because the foreskin tickles them. When you are circumcised it becomes like a rubber. When you are old like me, then you get circumcised, you will become like a castrated bull. You see, a castrated bull becomes sombre and loses body strength. So that is what happens when you get circumcised when you are an older male. We do not know what they use in the theatre. We do not know the side effects of the injections they use. Maybe the injections lower your libido. So, this thing is better when you are young. So, for us [older men] it is better to remain as we are. People say different things, so it is better to remain as we are.

At the beginning of the extract, the participant positions circumcision as a process that takes away sexual pleasure and discursively links circumcision with age. While he constructs women as preferring men who have been circumcised, he situates this as a less favourable condition for men too by describing the circumcised penis as becoming dry and hard like 'rubber'. Sexual desirability by women here is situated as not outweighing the perceived loss of masculinity. The participant positions himself as 'older male' and circumcision as a procedure that takes away masculinity, through comparing it to the castration of a bull. The bull is discursively symbolic in Eswatini of virility, strength, leadership and status. The linguistic symbolism of the castration of the bull is also discursively tied to a loss of cultural and social standing within the community as the bull is also symbolic of leadership and high social standing. A castrated bull has little symbolic value within a herd of cattle. The participant constructs three effects of VMMC, which are loss of sexual pleasure, losing strength and becoming sombre. In doing this, the participant locates sexuality, strength and virility as key features of masculinity. While describing the glans as being rubber like, Mabuza in the FGD corroborated his comments by saying: 'The glans then becomes dry and hard like a heel'.

Importantly, the participant in the first extract positions VMMC programmes and the medical model as the agents of his emasculation by saying it is not clear what medications are used in the procedure nor what the side effects will be. Within this construction, the VMMC programme is constructed as the agent of the castration. It is not then just the circumcision itself that emasculates the participant, but something that is done within the procedure. This is apparent when the participant states that 'we do not know what they use in [the operating] theatre' and 'maybe the injections lower your libido'. The participant finishes by stating that there are many contradictory opinions surrounding VMMC, and because of this, it is better or safer not to undergo the procedure and 'remain as we are'. The VMMC campaign in Eswatini is funded through global funders. Although local efforts have made various attempts to localise the initiative, these campaigns remain guided by international guidelines and goals that are not necessarily aligned with local specificities.

Participants make a discursive linkage between VMMC and the amputation of the phallus (and by extension masculinity). Healing is also positioned as related to youthfulness. Senzo, a 38-year-old uncircumcised man stated:

As we grow up, we find ourselves contracting several illnesses along the way. But when you are young, you are still fresh and don't have these diseases. So, these illnesses that I have caught along the way as I grow up may result in poor healing of the wound. I have heard many people who had rotten penises because maybe they had *mzimbomubi*³ and their body was not strong enough to heal. Maybe they had other underlying conditions which caused the complications.

Similar to the first extract, age is positioned as an important factor to consider when undergoing male circumcision. Youthfulness is constructed as a necessary for recovery. The participant in the first extract stated, 'So, this thing is better when you are young. So, for us [older men] it is better to remain as we are.' The participant above states, 'when you are young, you are still fresh and don't have these diseases'. The consequence according the first extract is that older men 'becomes sombre and

[lose] body strength' and in the extract above, older men get 'rotten penises' because of *mzimbomubi*. Age, masculinity and health are all discursively linked. Older men are positioned by participants as unsuited to circumcision because they will experience ill health and lose aspects of the masculinity, symbolised through the imagery of the castrated bull and rotten penis.

Mcebo, a 29-year-old uncircumcised participant drew on anecdotal evidence to position circumcision as a threat to masculinity through the risk of amputation of the penis:

My fear is that what if the wound doesn't heal properly and gets disrupted. That is what caused me not to circumcise. A friend of mine didn't heal properly and he kept going back to hospital many times and the penis was almost cut [off] due to this.

VMMC guidelines state that circumcision programmes must have an acceptable adverse event rate lower than 2% for moderate and severe adverse events combined (PEPFAR, 2013). From a biomedical vantage point, such a rate may be considered low and acceptable. In contrast, several uncircumcised participants in the study position adverse events as a serious threat to masculinity. Anecdotal evidence by the above participant is used to legitimise his claim. However, the participant uses discursive softening through the use of word 'almost' when describing the adverse event to make his argument more robust. Across the data corpus, adverse events were anecdotally referred to, with many participants stating that they had personally seen or heard of someone with a serious complication following circumcision. Perceived potential loss of, or damage to, the penis is thereby constructed as a threat to masculinity through the negative affect adverse events can have on future sexual performance.

Some participants offered an alternative construction of the link between male circumcision and masculinity. Traditional conceptions of masculinity situate men as the protectors of their families. VMMC demand creation campaigns have leveraged these gender norms and have positioned circumcision both as prevention for HIV, and from penile and cervical cancer caused by HPV (Rudrum 2020). Many circumcised men in this study linked circumcision with the protection for family members. Sdumo, a 28-year-old circumcised man said:

After I impregnated my [then] girlfriend [now wife], I decided to be a responsible lover and father. I heard about the benefits of circumcision from a friend who used to work for one of your NGOs. The issue of preventing cervical cancer for my wife was very motivating for me. The fact that my chances of getting STIs including HIV were now low, meant I was also going to protect her. I did it for her [laughing]. I also did it for my son. I do not want to die from things such as HIV and be unable to provide for my family yet there are ways to prevent HIV such as getting circumcised. Being a father also motivated me to be a hard worker and work for my wife and baby. I also now drink moderately. I can no longer disappear on a Friday and comeback Sunday evening. I am now a better man.

Here Mcebo positions getting circumcised as protective of both his wife and child. Despite numerous effective treatment options for HIV, the above participant constructs an HIV diagnosis as something he can die from. This is supported by other participants who stated that being a man is synonymous with being fit and healthy. Contracting a disease means that men can no longer provide for their families. Some circumcised participants stated that since they sometimes cheated on their partners, circumcision reduced the likelihood of transmitting HIV and HPV to their partners.

These findings are supported by other scholars (Humphries et al. 2015; Mdedetyana 2019; Mfecane 2020; Vincent 2008) who state that male circumcision is intrinsically linked to traditional conceptions of masculinity and sexuality. Understanding the discursive link between circumcision and masculinity needs to consider the local context. However, there is a dearth of research on Eswatini masculinities, especially beyond the lens of HIV and alcohol consumption. The above discursive linkages, although diverse, are rooted in traditional notions of masculinity. Centred in the participants' accounts are constructions of sexual prowess and men as protectors of the family.

Income, masculinities and male circumcision

Throughout the data, participants cited loss of income during the recovery period as a reason for not undergoing circumcision. Loss of income was also discursively linked to gender roles and provision for family.

What makes it difficult for men like us, those who work like us. One day in our job when your car is broken, you are stressed. So, if the days are three, then you are dead. You are in serious trouble. Sometimes this thing [circumcision] takes too long to heal say when you have side effects [complications] and that would lengthen your time off work, yet you are supposed to provide for your family. Some people have *mzimbomubi* so such people will never heal within the expected time like a week or so, they will likely have wound disruption and take much longer [to heal]. So, what will happen to their income? How will they feed their children? (Mabuza, 33 year old taxi driver)

The quotation above locates the ability to undergo circumcision in the social and material realities faced by men in precarious employment. According to the World Bank (2021), despite being classified as a lower middle-income country, a concerning 58.9% of Emaswati live below the national poverty line in 2017 with high unemployment. This means any time away from finding income may have serious consequences. This economic precarity is clear through Mabuza saying that if he is out of work for one day, he is 'stressed'. However, should he be out of work for three days, he is 'dead'. Recovery time and possible adverse events would threaten the participant and his family's day-to-day survival, especially since men are often the breadwinners within the household and there is no one else who can provide. Mabuza constructs his immediate survival as dependent on being able to work every day. HIV prevention is not of an immediate concern when lack of income implies immediate death.

Participants also positioned having time off work to undergo circumcision as a privilege reserved for those with permanent employment and benefits that allow for paid leave. Stephen, a 36-year-old man said:

For us time is money. For people like us, who get piece jobs, we are always looking out for opportunities to get work. What I see, for me, men who are self-employed will find it difficult to get circumcised because time is money. Also, people in construction, for example, they may want to get circumcised but because they are paid for every hour worked, they may opt not to get circumcised because they will lose money.

Likewise, 28-year-old plumber Skhulu said:

You see, for me I have to wait for piece jobs. Whenever I see a new building coming up, I approach them to ask if I can do plumbing for them. Also, I have a list of customers who call anytime when there is a tap or geyser leaking. If I miss out on those opportunities, I

am gone. If they were saying when you are unable to work because of circumcision, we are given a grant like the disabled or the elderly. My brother, many of us would be already circumcised.

Despite VMMC being a free of charge service, men are not compensated for the time needed away work. Skhulu emphasised how his business is built on relationships with existing clients, and should he be unable to attend to their calls, he would lose income in the longer term through the loss of those clients. He does however position the provision of compensation of lost income as a potential solution to accessing VMMC services. Nhlanhla, a 29-year-old brick layer stated shared a similar perspective.

At work we are paid for every hour worked. Imagine if I could be away for 5 days? What would I bring home month end? If I had the money to cover the days off, I would be circumcised by now and my wife would be happy too but for now she understands because I am the bread winner.

Here, Nhlanhla emphasises how every 'hour' away from work impacts on his ability to make money. Once more, the participant links material survival with gender norms within the family. He occupies the 'bread winner' role within the family. While he states that both he and his wife would favour medical male circumcision, their current material realities do not allow for this.

Eswatini's high levels of unemployment, poverty and inequality continue to impact and shape communities and individuals (Mattes 2020). From 2015 onwards, an Afrobarometer survey noted increased poverty in the country (Mattes 2020). The triple burden of inequality, poverty and unemployment is intricately interwoven with HIV and gender norms. This means HIV and other non-urgent health matters may be relegated to lower priority as a result of socioeconomic challenges.

Discussion

The links between masculinity, sexuality and health are complex and may prevent access to and use of HIV prevention services such as VMMC. Mathematical modelling and quantitative acceptability studies too often fail to engage with the complex psycho-social processes affecting the uptake of HIV prevention services such as VMMC (Box 1976).

The interface between masculinity, sexuality and gender norms comprises one set of factors influencing the acceptability of VMMC. This was explored in this study via the discourse - sexuality, masculinity, and circumcision - whereby VMMC is discursively linked to masculinity, sexuality, age and social standing. Similar to those in Adams and Moyer (2015) study, participants in this study were suspicious of the imposition of 'outside' Western-centric biomedical interventions. In future programmes, men and communities need to be involved early as partners in the development, implementation and roll-out of HIV prevention activities so as to ensure their align with local circumstances.

A second discourse identified in this study – income, masculinities and circumcision – stresses the importance of locating access to services such as VMMC within the context of poverty and precarious employment that local men experience. Doing so is essential if future HIV programmes to engage with the material context in which intervention

takes place. As signalled in this study, it is not enough for VMMC programmes to be provided free of charge; instead, participants should receive compensation for incidental expenses and time off work.

Conclusion

In moving forwards, a shift towards *communitas*⁴ in HIV prevention could offer an effective, community owned, comprehensive, and sustainable solution. Kippax et al. (2013, 1372) maintain that ‘effective public health policies and HIV prevention programmes should build on a sense of solidarity, common purpose, and collective responsibility to fight HIV and AIDS.’ Leclerc-Madlala (2014, 1203) has signalled how ‘the long-term solution to HIV control in sub-Saharan Africa is likely to largely pivot on the strength of people’s sense of collective agency’.

In order to do this, health practitioners need to engage with understandings of men and masculinity within their social and material contexts. This will allow for a more nuanced understanding of some of the challenges VMMC programmes face. Importantly in the context of this study, there is a need to engage with Eswatini masculinities in ways that financially compensate men in accordance with the socio-economic context and which gain community buy-in in for all aspects of programmes activities. This means working towards a collaborative approach to HIV prevention that recognises the plurality and fluidity of masculinities in contexts such as Eswatini (Feirman 2012). Tailoring interventions in a culture-positive way may also increase ownership and sustainability.

Notes

1. *Tinkhundla* is a local term for constituencies. *Inkhundla* is an administrative subdivision below the four regions and the country has 59 *tinkhundla*.
2. *Shisa nyama* is a place where barbequed meat is sold, and people usually congregate for food and beverages. Locally this is also known as a *braai* area.
3. *Mzimbomubi* has no Western medical or English language equivalent. Instead, *mzinbomuni* is a traditional Swazi understanding of a condition from which an individual heals slowly, is prone to infection and has other poor healing outcomes for both minor and severe injuries. The condition is related to age. The literal translation is “bad body” or “ugly body”.
4. Within this context, *communitas* may be defined as the collective agency or oneness experienced when a group, such as men in a specific context, works towards a shared goal (See Turner, 2012).

Disclosure statement

No potential conflict of interest was reported by the authors.

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